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Papulonecrotic Tuberculid as the Initial Manifestation of Lymph Node Tuberculosis

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Introduction & Objectives:

Tuberculids are rare cutaneous hypersensitivity reactions ("id" reactions) to mycobacterial antigens, typically associated with an underlying active tuberculosis focus elsewhere in the body. These lesions usually do not yield positive cultures for *Mycobacterium tuberculosis*, making diagnosis challenging. However, modern molecular techniques such as Polymerase Chain Reaction (PCR) can detect mycobacterial DNA in cutaneous tissue, providing a critical diagnostic clue. We present a rare case of papulonecrotic tuberculid, serving as the initial presentation of ganglionar tuberculosis, aiming to emphasize the dermatologist's role in recognizing cutaneous manifestations of systemic diseases.

Clinical case:

A 37-year-old woman from Guinea-Bissau was referred to our Dermatology department with a one-year history of papules and pustules on her limbs. She denied systemic symptoms. On physical examination, multiple papules, pustules, and hyperpigmented scars were observed on the upper limbs, buttocks, thighs, and lower legs. An initial diagnosis of infectious folliculitis was considered, and treatment with oral doxycycline and topical clindamycin and benzoyl peroxide was initiated, resulting in only transient improvement. Due to recurrence, blood tests and skin biopsies for histopathological and microbiological evaluation were performed. Notable findings included an erythrocyte sedimentation rate >100 mm/h. Histopathology revealed ulceration with a non-necrotizing granulomatous infiltrate. Microbiological cultures were negative. However, PCR analysis of the skin biopsy identified *Mycobacterium tuberculosis*, and the Interferon-Gamma Release Assay (IGRA) was positive.

Based on clinical, histological, and molecular findings, the diagnosis of papulonecrotic tuberculid was established. The patient was referred to Infectious Diseases, where further workup, including imaging and lymph node aspiration, confirmed the presence of ganglionar tuberculosis. Standard antituberculous therapy was initiated: rifampicin, isoniazid, pyrazinamide, and ethambutol for two months, followed by four additional months of isoniazid and rifampicin. Four weeks after starting treatment, complete resolution of the cutaneous lesions was observed, with no emergence of new lesions.

Conclusion:

This case highlights a rare presentation of papulonecrotic tuberculid as the cutaneous manifestation of ganglionar tuberculosis. Diagnosis was made possible by combining clinical suspicion with histopathology and molecular techniques, particularly the identification of *Mycobacterium tuberculosis* DNA by PCR, despite negative cultures. Dermatologists play a crucial role in identifying systemic diseases based on cutaneous findings.

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