28. A CASE OF INTERSTITIAL GRANULOMATOUS DERMATITIS WITH ARTHRITIS

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Background: We describe a patient presenting with skin lesions, iritis and synovitis. Histology was characteristic of interstitial granulomatous dermatitis with arthritis (IGDA).

Methods: Our case highlights the clinical features of this rare entity, and we recap its diagnosis and management. We also report the occurrence of iritis with IGDA, a previously unreported phenomenon.

Results: Our patient, a previously well 56 year old Caucasian postman, presented with a 3 month history of illness, starting with red, painful eyes and photophobia. 4 weeks later, a painful rash developed, starting on the forehead, spreading to the rest of face and limbs. This was accompanied by painful, swollen ankles and knees. On examination, he was afebrile. There was an erythematous nodulo-papular rash over the cheeks, hands, feet, and patellae, with overlying vesicles on the forehead, and inside the nose. Examination of the eyes revealed grossly injected conjunctivae bilaterally with normal pupillary responses. There was synovitis of both ankles and knees.

Investigations revealed normocytic anaemia, normal white cell count. CRP was 330, with plasma viscosity of 2.47 mPa.s (ref range 1.50–1.72 mPa.s). The patient was commenced on i.v. aciclovir. Chest X ray was clear, and 3 sets of bloods were unremarkable. ANCA, ANA, RF, HIV and hepatitis serology were all negative. Serum ACE was normal. Ophthalmology review confirmed iritis. A diagnosis of granulomatous inflammatory disease, with superimposed viral infection of skin lesions, was made, although subsequent viral swabs were clear. Skin biopsy demonstrated interstitial granulomatous dermatitis with prominent neutrophils and palisading histiocytes, pathognomonic for interstitial granulomatous dermatitis with arthritis (IGDA).

The patient received 3 i.v. infusions of 500 mg methylprednisolone, with dramatic improvement in eye, skin and joint symptoms. CRP declined to 100, and he was discharged on 30 mg prednisolone daily. 4 weeks post-discharge, the patient’s symptoms had improved, with no new skin lesions but some residual synovitis of both ankles and minimal redness of both eyes. He was commenced on oral MTX, and 6 weeks later was completely asymptomatic. CRP fell to 8.

Conclusion: IGDA was first described in 1993. Histology is defined by an interstitial and palisading granulomatous dermatitis. It has many cutaneous manifestations, including linear or archiform dermal bands on the trunk, erythematous indurated plaques on the lower limbs, or erythematous papular eruptions on the hands. Arthritis in IGDA tends to follow a chronic relapsing and remitting course, is non-erosive and non-deforming. Interstitial granulomatous dermatitis has been recognized in those with seropositive RA (although is rarely associated with nodular disease). To date, there are no reports of iritis in those with IGDA, as opposed to our case, where it was the first feature of systemic inflammation. Reported successful therapies in IGDA include low doses of corticosteroids, ciclosporin and MTX.

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