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DERMATOLOGY IMAGES

Idiopathic facial aseptic granuloma: A diagnosis to keep in mind

Granuloma asséptico facial idiopático: Um diagnóstico a ter em mente

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Idiopathic facial aseptic granuloma (IFAG) is a benign pediatric condition characterized by painless red nodules, usually single and often located on the cheeks, with a tendency for spontaneous regression within a mean of 11 months, usually without scarring[1]. Although its pathogenesis is unclear, several hypotheses have been proposed: a foreign-body reaction against a persistent embryologic cyst, part of the spectrum of granulomatous childhood rosacea[2], or a persistent reaction to an insect bite or trauma[3]. The hypothesis of an infectious etiology seems unlikely due to consistent negative cultures[1].

A 2-year-old girl was referred to our clinic for an asymptomatic erythematous nodular lesion on the left cheek present for 2 months (Figs. 1A and B), where the infant's mother recalled an insect bite. She had previously received oral amoxicillin-clavulanic acid for 10 days without benefit, and surgical drainage was then performed with discharge of a cloudy hematic content. Cultures for bacteria and fungi were negative, as well as blood tests including *Bartonella* serologies. Immunophenotyping of the lesion content did not show atypical cells. Cell block cytology showed predominantly inflammatory cells with lymphocytes, abundant histiocytes and multinucleated giant cells, compatible with a granulomatous process. Skin ultrasound (US) showed a well-defined subcutaneous nodular formation, with lobulated contours and posterior acoustic reinforcement, outlining a hypoechogenic content inside, without calcium deposits. Based on the medical history, physical examination, and US findings, a diagnosis of IFAG was made. The lesion presented mild improvement after 2 months of oral clarithromycin (15 mg/kg/day). Oral erythromycin (40 mg/kg/day) combined with topical ivermectin (10 mg/g cream) were then started, with progressive improvement in 4 months (Fig. 1C).

Discussion

We present this case to emphasize the importance of considering IFAG in the differential diagnosis of acquired facial nodules in children, to avoiding unnecessary investigations and/or invasive therapeutic procedures, as occurred in this case. Despite its prolonged course, it is important to reiterate its benignity and its tendency for spontaneous resolution. Diagnosis is clinical, but cutaneous US, a non-invasive modality, can help to improve the diagnostic accuracy. US findings may vary with the disease phase but commonly show a well-defined oval-shaped, hypoechoic solid lesion without calcium deposits, which can narrow the differential diagnosis,

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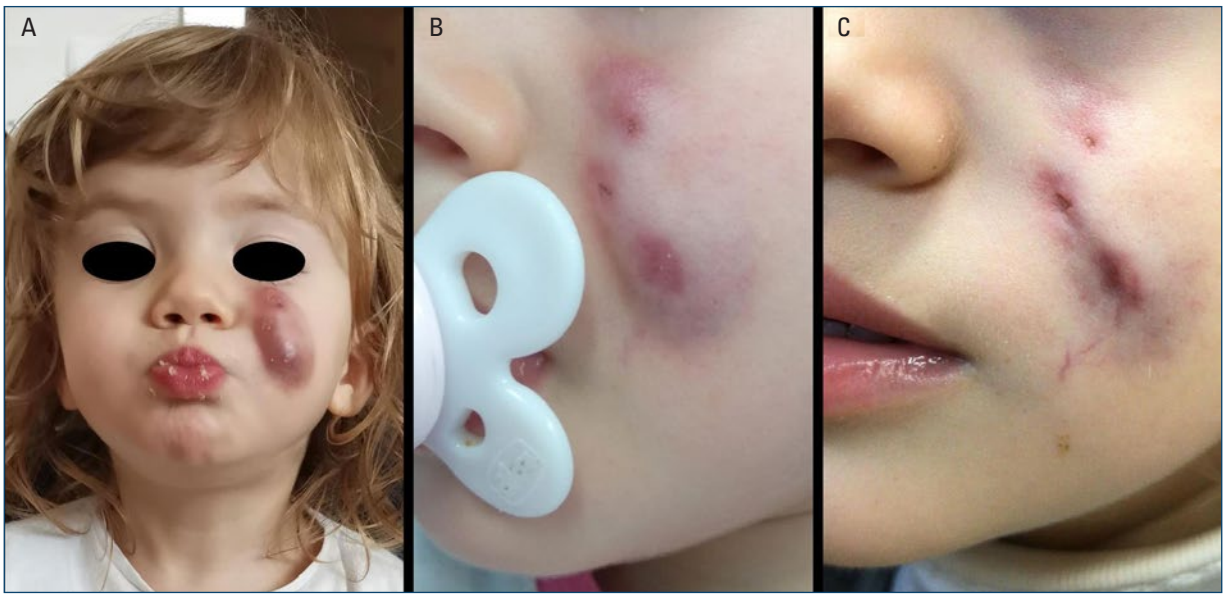

Figure 1. A single painless erythematous nodule on the cheek with several months of evolution in a 2-year-old girl. **A:** before. **B:** after. **C:** surgical drainage and after 2 months of oral clarithromycin 15 mg/kg/day.

namely exclud e pilomatrixoma[4]. Although no well-defined treatment has emerged, a conservative approach is preferred due to the natural history of IFAG. Antibiotics such as oral clarithromycin (15 mg/kg/day) or metronidazole (20 mg/kg/day) used for several months (mean of 2-3) have been associated with good results[4]. As our case was quite refractory to clarithromycin, after 2 months we changed to erythromycin, with total resolution of the lesion.

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Ethical disclosures

The authors declare that they have followed the protocols of their work center on the publication of data from patients. Consent for publication was obtained.

Conflicts of interest

The authors have no conflicts of interest to declare.

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