

Conflicts of interest. None declared

REFERENCES

- 1 Wisely CE, Liu KC, Gupta D, Carlson AN, Asrani SG, Kim T. Reticular bullous epithelial edema in corneas treated with netarsudil: A case series. *Am J Ophthalmol* 2020;**217**:20–6.
- 2 Bhargava M, Sen S, Bhambhani V, Paul RS, Dutta C. Reticular epithelial corneal edema as a novel side-effect of Rho kinase inhibitors: An Indian scenario. *Indian J Ophthalmol* 2022;**70**:1163–70.
- 3 Fernandez MM. Reticular epithelial edema in edematous corneas treated with netarsudil. *Ophthalmology* 2018;**125**:1709.
- 4 LoBue SA, Moustafa GA, Vu A, Amin M, Nguyen T, Goyal H. Transient reticular cystic corneal epithelial edema with topical netarsudil: A case series and review. *Cornea* 2021;**40**:1048–54.
- 5 Chen H, McMillin JC, Frankfort BJ, Al-Mohtaseb Z. Reticular epithelial edema: An uncommon side effect of ROCK/NET inhibitor netarsudil. *J Glaucoma* 2020;**29**:e124–6.

VIJAYALAKSHMI SENTHIL KUMAR, GEORGE V. PUTHURAN
Department of Glaucoma

NAVEEN RADHAKRISHNAN
Department of Cornea

Aravind Eye Hospital, Madurai, Tamil Nadu, India

PIYUSH KOHLI
Department of Vitreoretinal Services, CL Gupta Eye Institute, Moradabad, Uttar Pradesh, India
kohli119@gmail.com

[To cite: Senthilkumar V, Puthuran G, Radhakrishnan N, Kohli P. Reticular epithelial corneal oedema secondary to topical netarsudil drops. *Natl Med J India* 2023;**36**:274–5. DOI: 10.25259/NMJI_675_22]

Puzzling papular eruptions on an old scar

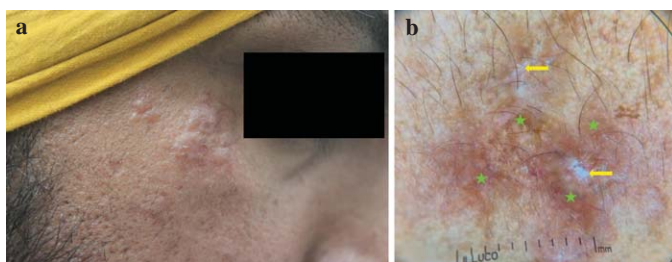


FIG 1. (a) Unilateral involvement of the right upper malar area in the form of skin-coloured grouped papules; (b) dermoscopy shows white areas of stellate and linear scarring (yellow arrows) on the background of brown to erythematous homogeneous areas (green stars) (IDS-1100, $\times 10$)

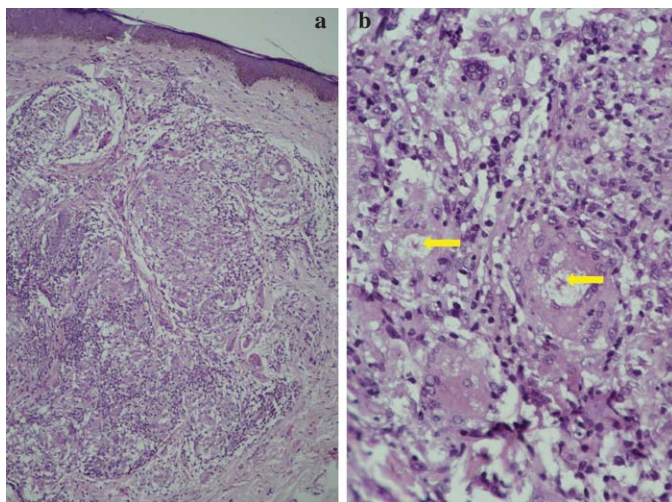


FIG 2. (a) Biopsy shows thin epidermis with flattening of rete-ridges. The underlying dermis is packed with many non-necrotizing granulomas (H&E, $20\times$); (b) these granulomas are composed of epithelioid histiocytes with minimal lymphocytic cuffing. Some of the granulomas also show asteroid bodies (yellow arrows; H&E, $40\times$)

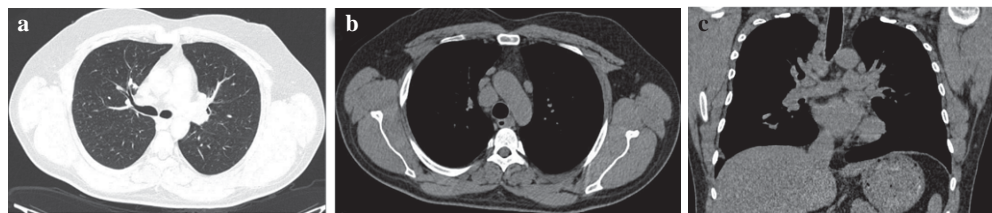


FIG 3. (a) NCCT chest shows multiple well-defined discrete sub-centimetre peri-lymphatic nodules with upper lobar predominance; (b) axial NCCT image shows multiple discrete, enlarged right paratracheal lymph node; (c) coronal NCCT image shows multiple discrete, enlarged right paratracheal and hilar lymph nodes

A 32-year-old man, who sustained an abrasion on his right cheek 7 years ago, presented with skin-coloured asymptomatic papules over the scar for 3 months. Dermatological examination revealed non-tender, grouped skin-coloured papules over erstwhile abrasion on the right malar prominence (Fig. 1a). Dermoscopy of the lesions showed linear to stellate scarred areas on translucent erythematous to brown homogeneous background (Fig. 1b). Skin biopsy revealed non-necrotizing epitheloid granulomas with Langhans giant cells with minimal lymphocytic cuffing and asteroid bodies suggestive of sarcoidosis (Figs 2a, 2b). The patient did not have any symptoms of pulmonary sarcoidosis such as breathlessness, cough, haemoptysis and weight loss. CT chest revealed multiple discrete to confluent pleural, peri-lymphatic and fissural nodules in bilateral lung fields (Fig. 3a); with multiple enlarged discrete lymph nodes in pre/para-tracheal, pre-vascular, pre/sub-carinal and bilateral hila; the largest measured 23 mm in the right para-tracheal region (Figs 3b, 3c). Trans-bronchial biopsy showed non-caseating granuloma suggestive of sarcoidosis and was negative for *Mycobacterium tuberculosis*. The patient was diagnosed as a case of cutaneous as well as pulmonary sarcoidosis and was started on systemic steroids and is on follow-up.

Around 10%–38% of patients with systemic disease present with cutaneous sarcoidosis.¹ The reported latency period of scar sarcoidosis before its reactivation in old cutaneous scars is between 6 months and 59 years.² Scar sarcoidosis may precede or coincide with systemic sarcoidosis or may be a sign of relapse of systemic disease activity.³ Reactivation of old scars is believed to be highly specific for sarcoidosis and an approachable site of biopsy from skin obviates the need for more invasive procedures in the form of trans-bronchial biopsies.⁴

Conflicts of interest. None declared

REFERENCES

- 1 Fernandez-Faith E, McDonnell J. Cutaneous sarcoidosis: differential diagnosis. *Clin Dermatol* 2007;**25**:276–87.
- 2 Suh SY, Ahn JH. Scar sarcoidosis with systemic involvement after blepharoplasty. *Int J Ophthalmol* 2021;**14**:1288–90.
- 3 Su O, Onsun N, Topukçu B, Özçelik HK, Cakýter AU, Büyükpınarbaşıly N. Disseminated scar sarcoidosis may predict pulmonary involvement in sarcoidosis. *Acta Dermatovenerol Alp Pannonica Adriat* 2013;**22**:71–4.
- 4 Atci T, Baykal C, Kaya Bingöl Z, Polat Ekinci A, Kiliçaslan Z. Scar sarcoidosis: 11 patients with variable clinical features and invariable pulmonary involvement. *Clin Exp Dermatol*. 2019;**44**:826–8.

PANKAJ DAS
pankaj3609@gmail.com

AMUL GUPTA
Department of Radiodiagnosis and Imaging

SANGHITA BARUI
Department of Pathology

GAUTAM KUMAR SINGH, AMIT BAHUGUNA, DEVYANI SAPRA, AKANKSHA GUPTA, PRASHANT BELLAD
Department of Dermatology
Base Hospital Delhi Cantt, Delhi 110010, India

[To cite: Das P, Gupta A, Barui S, Singh GK, Bahuguna A, Sapra D, et al. Puzzling papular eruptions on an old scar. *Natl Med J India* 2023;**36**:275–6. DOI: 10.25259/NMJI_652_22]