Lipoatrophic Panniculitis

Case Report and Review of the Literature

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Background: Lipoatrophic panniculitis (LP) is a rare disease of childhood characterized by eruption of tender erythematous nodules and plaques followed by circumferential bands of lipoatrophy often seen on the arms and legs. This condition has also been known as lipophagic panniculitis of childhood, annular atrophy of the ankles, and partial lipodystrophy.

Observations: A previously healthy 8-year-old boy was evaluated for tender, raised plaques on the ankles, which progressed to circumferential atrophy of the distal lower extremities. Biopsy specimen analysis revealed a dense mixed infiltrate extending into the subcutaneous tissue as well as lipophages within the fatty lobules. A diagnosis of LP was made, and the patient began treatment with prednisone and hydroxychloroquine. Methotrexate was added later to the regimen as a steroid-sparing agent, and the dose was increased over the course of 3 months, by which time the cutaneous disease progression was nearly halted. However, the patient continued to have lower leg pain with bone changes demonstrated on magnetic resonance imaging.

Conclusions: We report this case and review of the literature to call attention to the clinical features of LP and its association with skeletal changes. Our patient’s response to combination therapy is of interest and contributes to the limited literature about management of this disease.

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ing into the subcutaneous fat (Figure 2). No vasculitis or polarizable foreign body was identified. Numerous lipophages were evident in the fatty lobules. Periodic acid–Schiff, Gomori methenamine silver, acid-fast bacilli, and Warthin-Starry stainings revealed no microorganisms.

Given the patient’s family history of Crohn disease, a workup consisting of abdominal and pelvic computed tomography, upper and lower endoscopy, and biopsies were performed, and all findings were within normal limits. Laboratory results were also within normal limits, with the exceptions of a repeatedly elevated erythrocyte sedimentation rate (ESR) (up to 51 mm/h), mild normocytic anemia, and an elevated platelet count (592 × 10^9/L). (To convert platelets to number/L, multiply by 1.0.) Assay results were also normal for quantitative immunoglobulins (IgA, IgG, and IgM), circulating anti-neutrophil cytoplasmic antibody, peripheral antineutrophil cytoplasmic antibody, anti–Saccharomyces cerevisiae antibody, antinuclear antibody, alpha 1-antitrypsin phenotype, primary immunodeficiency, Lyme disease, and human immunodeficiency virus (HIV) antibody.

Nine months into the course of his symptoms, the patient was referred to our institution, where it was noted that the disease process had skipped to other areas of his body, including new involvement of both wrists and the left buttck and left posterior thigh. These new lesions were accompanied by pain, tenderness, and redness. The patient had a weight of 25.4 kg, height of 128.3 cm, and body mass index of 15.4 (calculated as weight in kilograms divided by height in meters squared), which represents approximately the 50th percentile for each characteristic. Findings from the rest of his skin examination were within nor-
mal limits. There were no clinical signs of insulin resistance, such as acanthosis nigricans. He underwent further laboratory evaluations, including complete blood cell counts, a complete metabolic panel, and assays of pancreatic enzymes, thyroid function, tissue transglutaminase antibody, anti-microsomal antibody, C-reactive protein, and ESR. All laboratory test results were within normal limits except the ESR, which was elevated to 30 mm/h.

Based on the clinical features and classic histologic finding of lipophages within the fatty lobules, the diagnosis of LP was made. The patient began treatment with prednisone (20 mg/d, approximately 1 mg/kg) and hydroxychloroquine (100 mg/d) and showed a rapid initial response of decreased edema and erythema. However, his disease relapsed when the prednisone dose was tapered to 10 mg/d, resulting in increased tenderness and erythema. Ten months into the illness, methotrexate was added to the treatment regimen as a steroid-sparing agent, given as 15-mg intramuscular weekly injections, then gradually increased to 25 mg weekly over the course of

Figure 3. Clinical arrest of panniculitis after 3 months of therapy. A-D, There remains circumferential lipoatrophy of ankles and lower calves as well as isolated areas of lipoatrophy on the posterior left thigh and left buttock.
3 months. The prednisone dose was gradually tapered over the course of the next 6 months. His ESR decreased to 2 mm/h, with clinical cessation of the progression of his panniculitis but with focal areas of atrophy remaining (Figure 3).

Despite the improvement of his skin lesions, the patient continued to have pain localized to his lower legs. Magnetic resonance imaging of the calves revealed increased T2-weighted signal from the subcortical and cortical bone within the mid shaft of both tibiae, most consistent with a stress reaction. However, no definite fracture was identified. A bone mineral density measurement showed normal status for chronologic age. At last follow-up, the patient had cessation of lipoatrophy maintained for 12 months and continued to respond well to methotrexate therapy.

### COMMENT

Progressive LP is also known as lipophagic panniculitis of childhood, annular atrophy of the ankles, and partial lipodystrophy. It has a distinctive clinical presentation and histologic findings but usually lacks systemic findings. Clinically, there are eruptions of erythematous nodules and plaques followed by a striking circumferential band of lipoatrophy, principally of the arms and legs. Associated laboratory findings include elevated ESR, thrombocytosis, and microcytic anemia. The end-stage atrophic phase of disease is chronic, but this condition is otherwise self-limited and not fatal. Differential diagnoses include “noninflammatory” lipoatrophy and inflammatory lipoatrophy or lipodystrophy. Dunnigan-

### Table. Summary of Reported Cases of Lipoatrophic Panniculitis

<table>
<thead>
<tr>
<th>Source</th>
<th>Cases, No./Sex/Age, y</th>
<th>Affected Areas</th>
<th>Associated Diagnoses</th>
<th>Treatment; Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Winkelmann et al² (n = 17)</td>
<td>12/F and 5/M Age range, 1 to 11</td>
<td>Legs (n = 14), feet (n = 2), thighs (n = 10), arms (n = 9), trunk (n = 5), face (n = 4)</td>
<td>NR</td>
<td>Observation (n = 6); remission in 1 of 6 Prednisone (n = 8); remission in 8 of 8 Chloroquine (n = 1); remission in 1 of 1 Prednisone and chloroquine (n = 2); remission in 0 of 2</td>
</tr>
<tr>
<td>Martinez et al⁷ (n = 1)</td>
<td>1/F/3</td>
<td>Arms, legs, buttocks</td>
<td>Chromosome 10q26 abnormality</td>
<td>Prednisolone and azathioprine; good response (complication, avascular necrosis of bilateral femoral heads)</td>
</tr>
<tr>
<td>Billings et al⁵ (n = 3)</td>
<td>1/M/3, 1/F/6</td>
<td>Arms, legs, arms, legs</td>
<td>Rheumatoid arthritis Type 1 DM, Hashimoto thyroiditis</td>
<td>Prednisone; complete response Potassium iodide solution; no response</td>
</tr>
<tr>
<td>Roth et al² (n = 1)</td>
<td>1/F/4</td>
<td>Ankles, thighs, knees</td>
<td>NR</td>
<td>Combined prednisone and dapsone; halted disease progression</td>
</tr>
<tr>
<td>Madasseri et al⁴ (n = 1)</td>
<td>1/F/4½</td>
<td>Ankles, calves</td>
<td>NR</td>
<td>Combined prednisone and dapsone; halted disease progression</td>
</tr>
<tr>
<td>Dimson and Esterly⁶ (n = 1)</td>
<td>1/F/6</td>
<td>Ankles, calves</td>
<td>Graves disease, alopecia areata</td>
<td>Observation; atrophy remained localized and stable Corticosteroid cream under occlusion and cold quartz light; skin appeared normal, and atrophic bands remained unchanged</td>
</tr>
<tr>
<td>Shelley and Izumi⁸ (n = 1)</td>
<td>1/F/6</td>
<td>Ankles</td>
<td>NR</td>
<td>Prednisone; complete response</td>
</tr>
<tr>
<td>Falcini et al¹⁰ (n = 1)</td>
<td>1/F/8</td>
<td>Legs</td>
<td>NR</td>
<td>Prednisone and pentoxifylline for 3 mo; good response</td>
</tr>
<tr>
<td>Melchiorre et al⁶ (n = 1)</td>
<td>1/F/12</td>
<td>Calves</td>
<td>NR</td>
<td>Hydroxychloroquine (400 mg/d) and prednisolone (30 mg/d); suppressed active lesions, but lesions reappeared on tapering of prednisolone dose to &lt;20 mg/d Dapsone, azathioprine, and antimalarial agents; unsuccessful Corticosteroids; effective (complication, avascular necrosis of femoral head) Hydroxychloroquine; remission</td>
</tr>
<tr>
<td>Handfield-Jones et al¹³ (n = 2)</td>
<td>1/F/24</td>
<td>Cheeks, upper outer arms, buttocks, thighs</td>
<td>Raynaud phenomenon</td>
<td>Observation; no new lesions after 2 y</td>
</tr>
<tr>
<td>Nelson¹² (n = 1)</td>
<td>1/F/36</td>
<td>Ankles, calves</td>
<td>NR</td>
<td>First episode, dapsone; complete resolution Second episode, sulphapyridine added to dapsone regimen; not tolerated</td>
</tr>
<tr>
<td>Umbert and Winkelmann¹¹ (n = 2)</td>
<td>1/F/47</td>
<td>Buttocks, thigh, arm</td>
<td>NR</td>
<td>Prednisone (up to 200 mg/d) combined with antimalarial drug; no response</td>
</tr>
<tr>
<td>Nelson¹² (n = 1)</td>
<td>1/F/57</td>
<td>Trunk, legs, arms, breasts</td>
<td>NR</td>
<td>Prednisone, azathioprine, and antimalarial agents; unsuccessful Corticosteroids; effective (complication, avascular necrosis of femoral head) Hydroxychloroquine; remission</td>
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</table>

Abbreviations: DM, diabetes mellitus; NR, not reported.

²Age reported as range only for entire study population; youngest patient was aged 0.67 years.
Lipoatrophic panniculitis is a diagnosis of exclusion that requires evaluating the patient for infection (with, eg, fungus, acid-fast bacilli, spirochetes), autoimmune conditions, other causes of panniculitis (eg, pancreatic disease, alpha-1-antitrypsin deficiency), hepatitis or liver failure, vasculitis, immunodeficiency, local trauma or foreign body, and HIV. Treatment options include prednisone, antimalarial agents, saturated solution of potassium iodide, and dapsone, all of which have varying degrees of efficacy. Our patient responded well to a combination of prednisone, hydroxychloroquine, and methotrexate. We present our case to contribute to the growing body of literature on this relatively uncommon entity and to call attention to potential associated skeletal problems. Further studies are needed to determine the efficacy of various treatment options for this progressive disease.

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REFERENCES