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Case Report

# Facticial Panniculitis and Löfgren's Syndrome: A Case☆

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ABSTRACT

We herein report a patient who came to the hospital because of a polyarticular joint pain, fever and cutaneous lesions. She had silicone implants in her buttocks, a surgery performed 3 years before. We made a biopsy of the skin of the buttocks (facticial panniculitis due to silicone) and of the pretibial surface of the inferior extremities (erythema nodosum). A chest X-ray and a CT scan revealed bilateral hilar lymphadenopathy, and a transbronquial biopsy showed granulomatous inflammation. She had a good response to rest and anti-inflammatory drugs, so the removal of the silicone implants has not been necessary yet.



## Paniculitis facticia y síndrome de Löfgren inducidos por silicona: a propósito de un caso clínico

*Palabras clave:*
Silicona
Paniculitis facticia
Síndrome de Löfgren
Antiinflamatorios no esteroideos

RESUMEN

Se presenta el caso clínico de una paciente que ingresó en nuestro servicio por clínica de poliartralgias, fiebre y lesiones cutáneas que afectaban a la región glútea y pretibial. Refería como antecedente la aplicación de inyecciones de silicona líquida en los glúteos con fines estéticos 3 años antes. Se realizó biopsia cutánea de las lesiones en la región glútea cuyo estudio anatomo-patológico fue compatible con paniculitis facticia por silicona así como de la región pretibial que fueron compatibles con eritema nodoso. La radiografía de tórax y el TAC torácico mostraron adenopatías hiliares bilaterales, y en la biopsia transbronquial se evidenció componente inflamatorio granulomatoso. La evolución fue satisfactoria con reposo y antiinflamatorios no esteroideos, por lo que no fue necesaria la extracción de la silicona.



## Introduction

Prostheses or silicone injections for cosmetic use to enhance or correct volume lead to tissue scarring. Although silicone has been considered an inert material, it is now known to produce local or systemic adverse reactions, with a latent period even lasting decades. Between local reactions it induces factitual panniculitis[1] due to foreign body or systemic reactions and some cases of connective tissue disease have been described.[2] In recent years several cases of sarcoidosis that occurred after injection of silicone for esthetic purposes in distant localizations[3–8] have been described in the literature. Most of these cases required the use of corticosteroids for symptom control, together with the removal of the silicone.

We describe a patient who, after the injection of liquid silicone, presented a local complication (factitious panniculitis) along with systemic complications (Löfgren syndrome).

## Case Report

The patient is a 44-year-old woman without medical or surgical history of interest, a native of Colombia, a resident in Spain for

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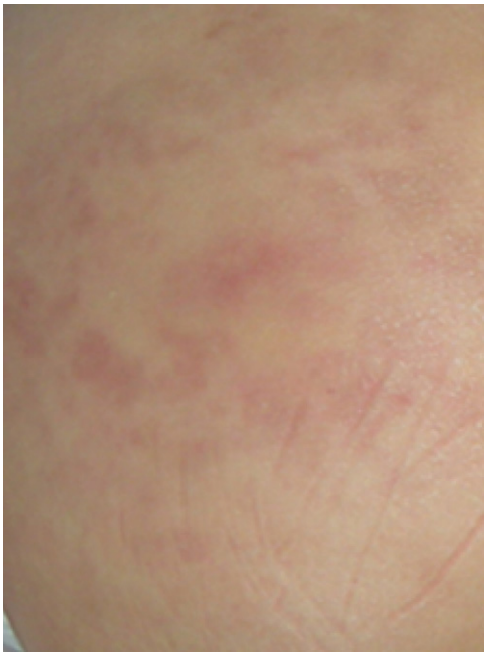

**Fig. 1.** Erythematous, raised lesions on the buttocks (factitious panniculitis).

10 years. She had a history of liquid silicone injections in the buttocks 3 years earlier while in Colombia.

She was by rheumatology due to joint pain in knees with posterior involvement of the ankles, elbows and wrists of one week of progression, along with a raised, erythematous, nonpruritic, painful skin lesions on both buttocks (Fig. 1) and fever (37.6 °C). The patient did not present general manifestations or morning stiffness, no manifestations suggestive of infection and denied foreign travel in recent months, as well as drug and alcohol consumption.

Physical examination found her hemodynamically stable, afebrile and in good overall condition. Musculoskeletal examination found a local temperature increase on both knees, with pain on flexion and extension, without erythema or effusion, along with swelling and increased local temperature in both ankles. The dermatological examination found erythematous papules, painful on palpation, indurated to the touch, on both buttocks.

As additional evidence, a blood test showed normocytic and normochromic anemia with a hematocrit of 27.7% (nv 36–45) and hemoglobin of 9.4 g/dl (nv 12–16), together with a platelet count of 540,000 (nv 130–450). A search for iron deficiency showed (Fe: 18; vn 37–145) with normal ferritin, vitamin B12, folic acid and serum protein, and a peripheral blood smear which only highlighted a slight basophilia. The rest of the analytical studies only revealed subclinical hypothyroidism, with a slightly elevated TSH and normal thyroid hormones, for which we consulted the endocrinology department, which stated that the patient did not require replacement therapy. There was no leukocytosis or left shift, and renal and hepatic functions, ions and coagulation were normal. Acute phase reactants showed a sedimentation rate of 110 mmHg and C-reactive protein 28.8 mg/dl. Autoimmunity testing revealed rheumatoid factor of 24 U/l, antinuclear antibodies 1/80, with negative anti neutrophil cytoplasmic antibodies. The angiotensin converting enzyme (ACE) was within normal values (ECA: 38; vn 18–58). Requested blood cultures were negative, and urine sediment was normal. Requested serology for hepatitis, human immunodeficiency virus, rubella, cytomegalovirus, Epstein–Barr virus, Toxoplasma, Treponema pallidum, Borrelia, Mycoplasma and Chlamydia were negative.

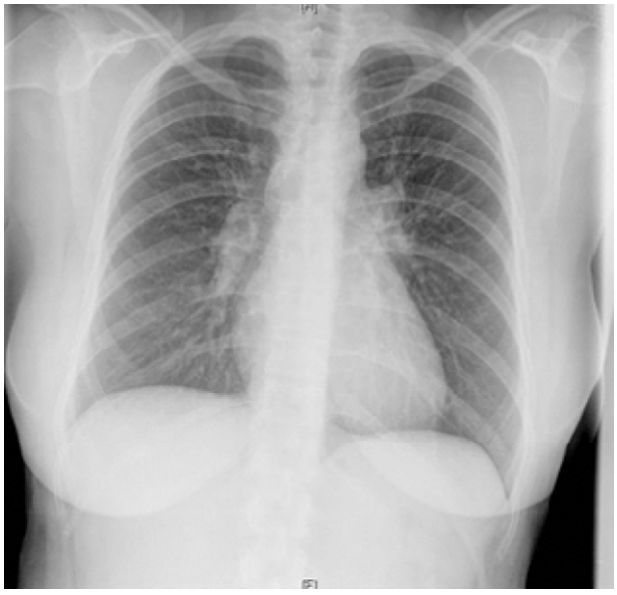

**Fig. 2.** X-ray: bilateral hilar lymphadenopathy.

We performed a chest X-ray which displayed bilateral hilar lymphadenopathy (Fig. 2). To rule out a possible TB we performed a Mantoux test that was negative and serial urine auramines, which were also negative. We performed a high-resolution CT of the chest, which was compatible with grade I sarcoidosis (bilateral hilar and mediastinal lymphadenopathy) (Fig. 3). The transbronchial biopsy showed an inflammatory component in the bronchoalveolar lavage fluid and with a CD4/CD8 ratio of 5.26, with 80% of histiocytes, 15% lymphocytes and 5% neutrophils.

During admission we also found palpable and painful erythematous nodular lesions on the tibial region of both lower limbs (Fig. 4). After consulting with the dermatologist we performed a biopsy of the skin lesions of the buttocks and lower limbs. Pathology reported many histiocytes laden with lipid-containing cytoplasmic vacuoles affecting the septa and adipose tissue, which supported, given the clinical context, a diagnosis of factitious panniculitis due to silicone (Fig. 5). In contrast, biopsy of the skin over the pretibial showed

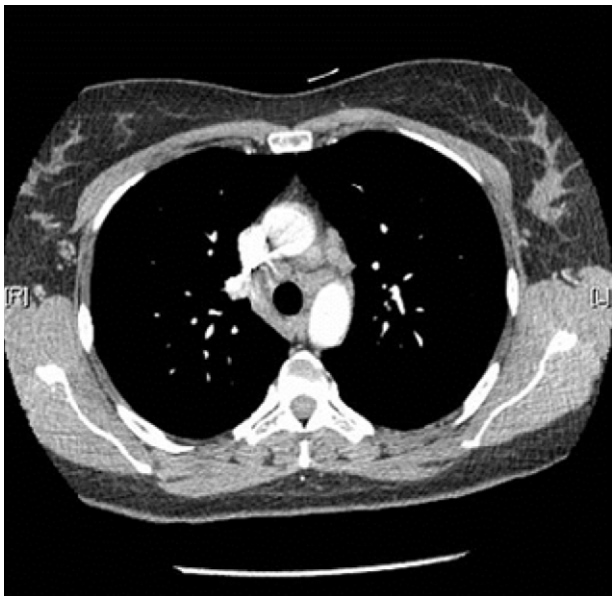

**Fig. 3.** Chest CT: hilar and mediastinal lymphadenopathy (grade 1 sarcoidosis).