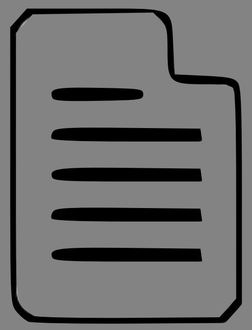
LESÃO EM PÁLPEBRA:

APRESENTAÇÃO RARA E DE DIFÍCIL DIAGNÓSTICO

THAÍS VENANCIO
FERNANDO DALMINA
LARISSA RODRIGUES
JOANA PINHEIRO
LUCIANA TORRICO
NATÁLIA CHEVRAND

HOSPITAL NAVAL MARCÍLIO DIAS
2024

RELATO DE CASO



PACIENTE DO SEXO MASCULINO, 1 ANO E 4 MESES, NATURAL DO RIO DE JANEIRO

QUEIXA PRINCIPAL: “FERIDA NO OLHO”

RELATO DE CASO

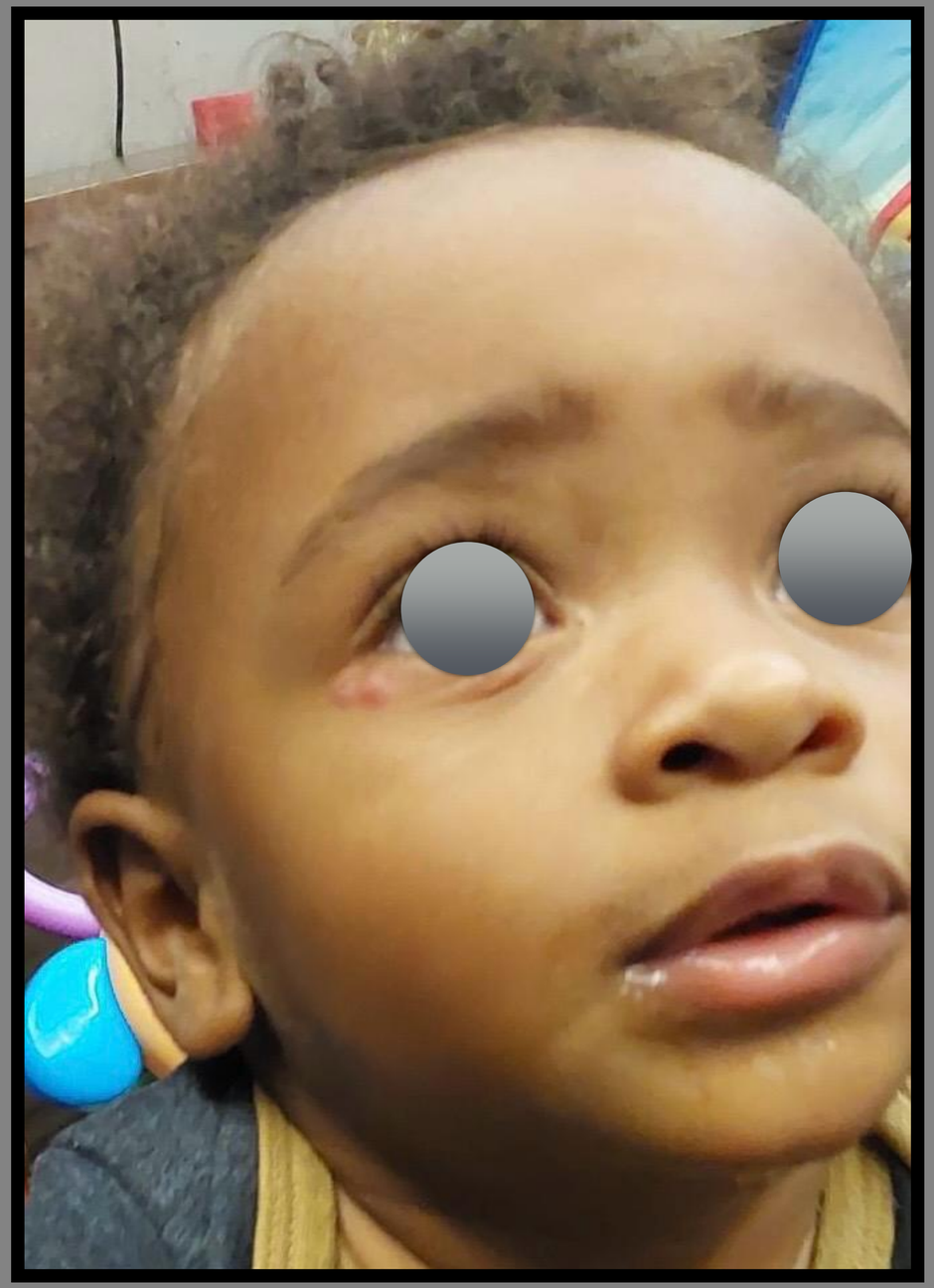
HDA:

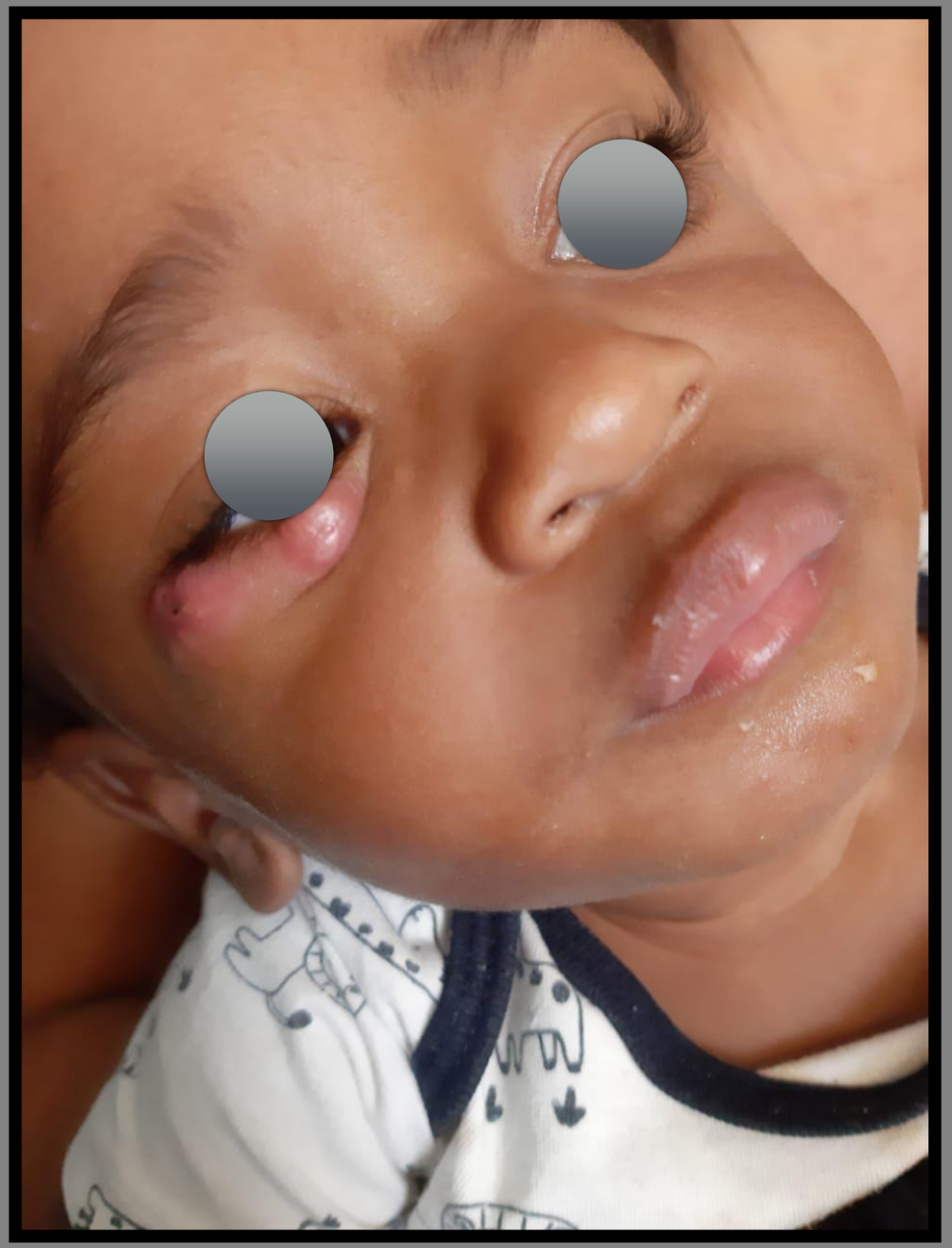
PACIENTE INTERNADO EM ENFERMARIA DE PEDIATRIA COM HIPÓTESE DE CELULITE ORBITÁRIA PARA TRATAMENTO COM ANTIBIOTICOTERAPIA ENDOVENOSA E ACOMPANHAMENTO CLÍNICO.

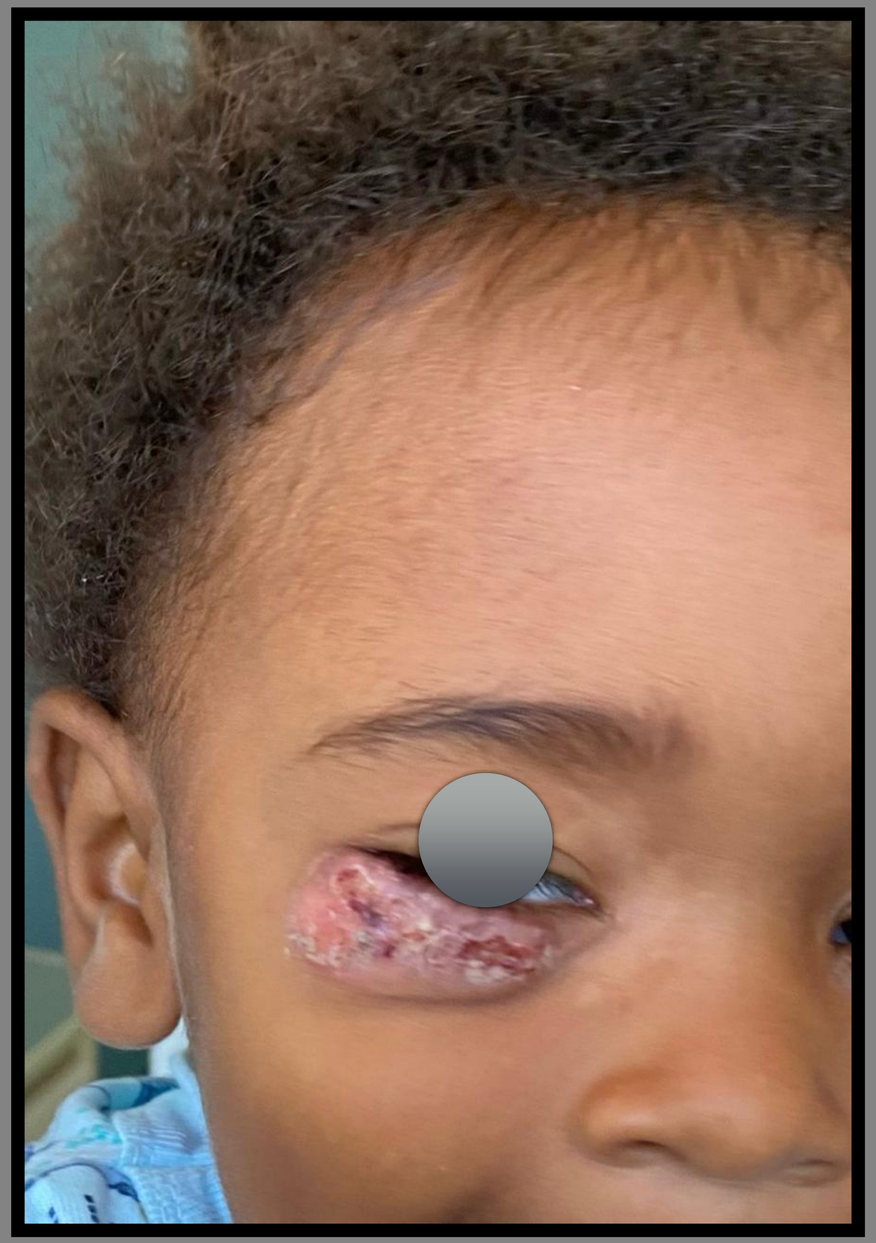
SOLICITADO PARECER DA EQUIPE DE DERMATOLOGIA DEVIDO À PÁPULA NORMOCRÔMICA PRURIGINOSA EM PÁLPEBRA INFERIOR DIREITA, QUE EVOLUIU PARA NÓDULO E EM SEGUIDA PARA TUMORAÇÃO, ALÉM DE NOVAS LESÕES PAPULARES EM OMBRO E FLANCO.

JÁ HAVIA FEITO USO DE CEFALEXINA ORAL POR 7 DIAS, TOBRAMICINA POMADA POR 7 DIAS E AMOXICILINA COM CLAVULANATO ORAL POR 2 DIAS, SEM MELHORA.

NEGAVA SINTOMAS SISTÊMICOS E NEGAVA CONTATO DIRETO COM ANIMAIS, PORÉM BRINCAVA TODOS OS DIAS EM PARQUINHO DE AREIA.

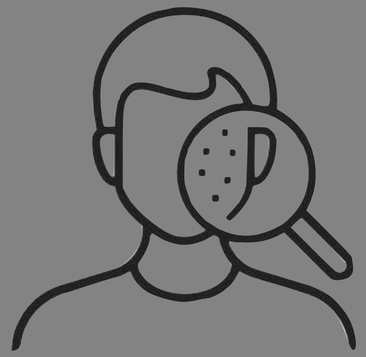






RELATO DE CASO

HPP:
GESTAÇÃO A TERMO, COM ALTA 2 DIAS APÓS O NASCIMENTO; ICTERÍCIA SEM NECESSIDADE DE FOTOTERAPIA
NEGA INTERNAÇÕES PRÉVIAS, INFECÇÕES E ALERGIAS.



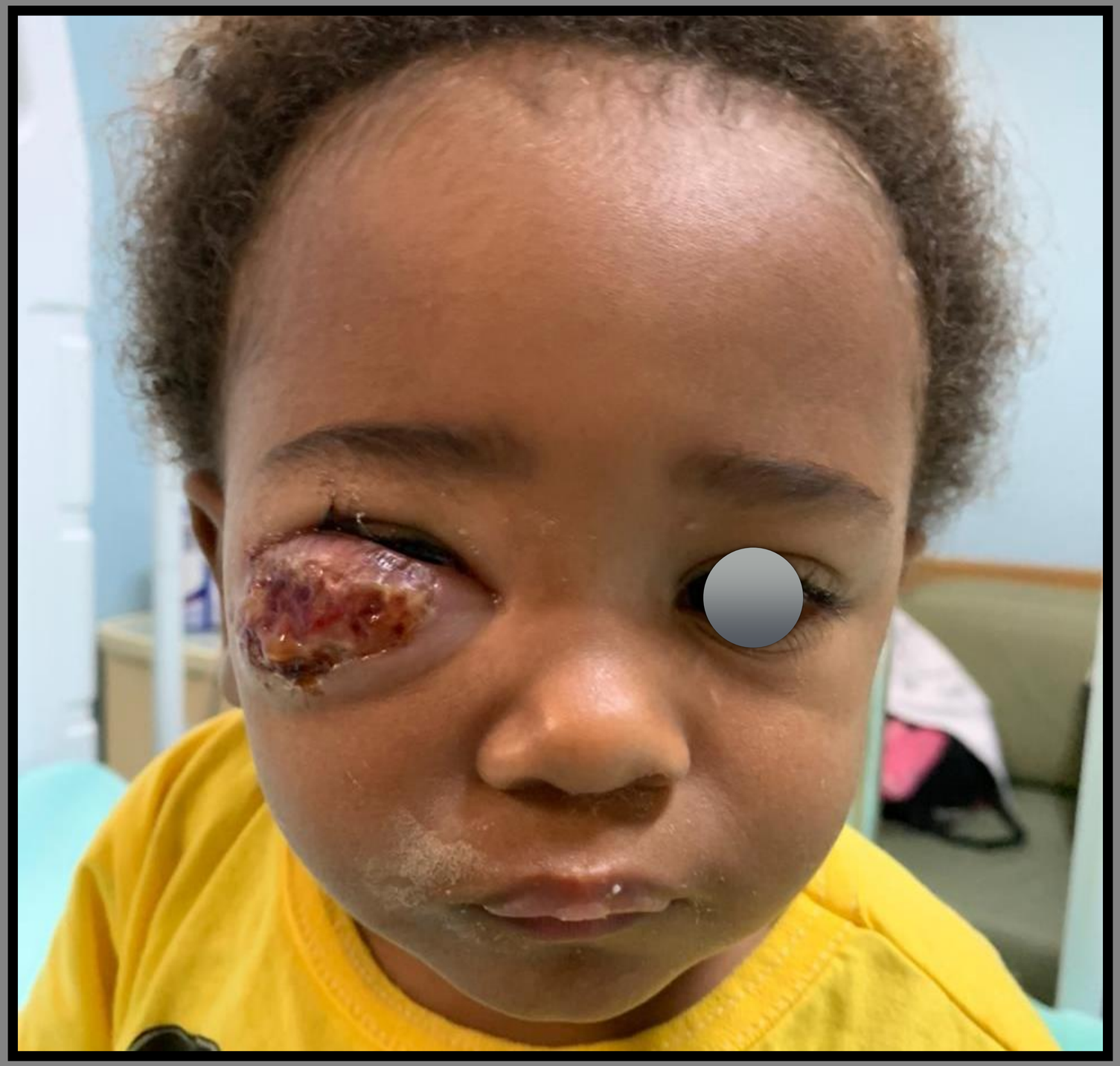
EXAME FÍSICO:
PACIENTE ACOMPANHADO DA MÃE, EM BOM ESTADO GERAL, AFEBRIL, NORMOCORADO, HIDRATADO, ACIANÓTICO, ANICTÉRICO E CHOROSO.

PÁLPEBRA INFERIOR DIREITA: TUMORAÇÃO FRIÁVEL EXULCERADA RECOBERTA POR CROSTA HEMÁTICA COM SAÍDA DE SECREÇÃO SEROHEMÁTICA; ABERTURA OCULAR PREJUDICADA.

FLANCO DIREITO E OMBRO ESQUERDO: PÁPULA NORMOCRÔMICA.

ABDOME: FLÁCIDO, INDOLOR, NÃO APRESENTANDO VISCEROMEGALIAS OU MASSAS PALPÁVEIS.

NÃO APRESENTAVA LINFONODOS PALPÁVEIS E EXAME OFTALMOLÓGICO SEM ALTERAÇÕES.



HIPÓTESES DIAGNÓSTICAS

ESPOROTRICOSE

SARCOMA

TB CUTÂNEA

CONDUTA

SOLICITADOS EXAMES LABORATORIAIS COM SOROLOGIAS;

SOLICITADA TOMOGRAFIA COMPUTADORIZADA DE CRÂNIO E ÓRBITAS;

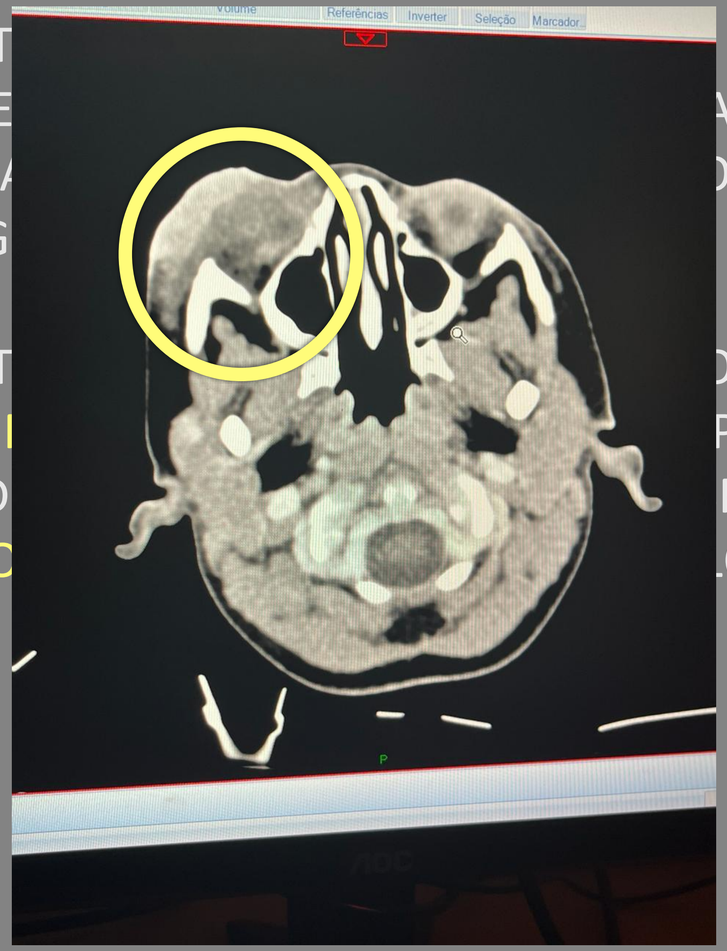
REALIZADA BIÓPSIA INCISIONAL DAS LESÕES.

- ANATOMOPATOLÓGICO
- CULTURA PARA FUNGOS, BACTÉRIAS E MICOBACTÉRIAS

EXAMES COMPLEMENTARES

- TOMOGRAFIA COMPUT
  AUSÊNCIA DE LESÕES E ATOSAS. AUSÊNCIA DE COLEÇÕES EXTRA-AXIAIS A O, SEM EVIDÊNCIAS DE CALCIFICAÇÕES PATOLÓG

- TOMOGRAFIA COMPUT ONTRASTE:
  AUMENTO DE PARTES I PLANO SUBCUTÂNEO EM REGIÃO PERIORBITÁRIA D PONTANEAMENTE HIPERDENSO DE PERMEIC LOCAL.



EXAMES COMPLEMENTARES

- LABORATÓRIO:

  HEMOGLOBINA 12,5 | HEMATÓCRITO 36,5% | LEUCÓCITOS 7.500 | PLAQUETAS 357.000 | PCR< 0,8

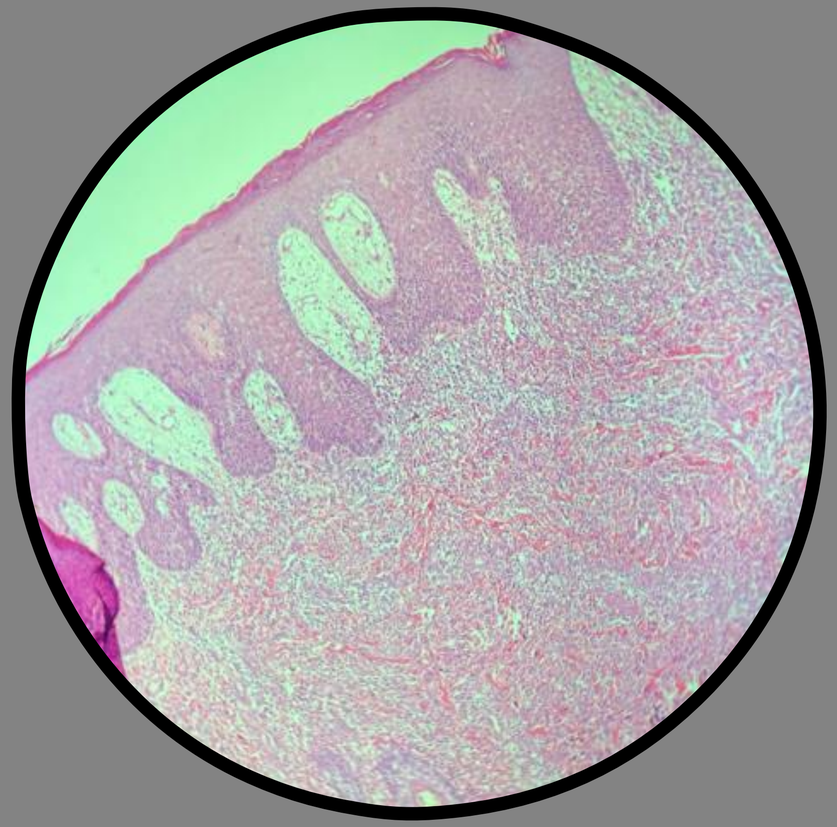
  ANTI-HIV NÃO REAGENTE | PPD NEGATIVO | IGG BARTONELLA HENSELAE REAGENTE 1:640 (TÍTULOS > 1:320 SUGESTIVO DE INFECÇÃO RECENTE) E IGM NÃO REAGENTE

- CULTURA PARA FUNGOS, BACTÉRIAS E MICOBACTÉRIAS DO FRAGMENTO: NEGATIVA

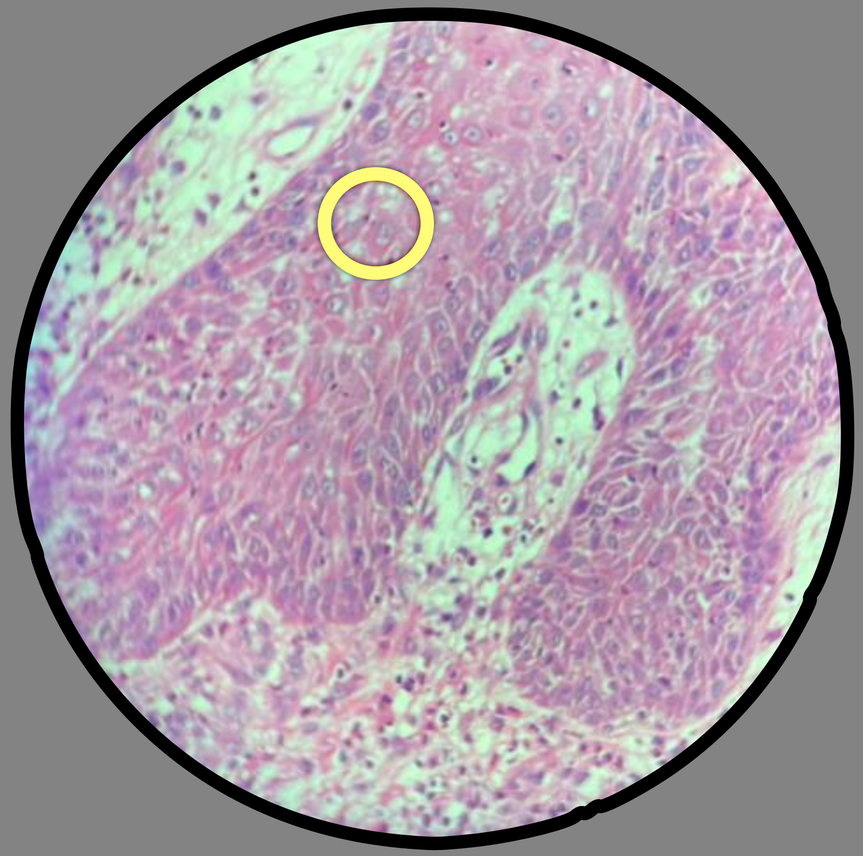
ANATOMOPATOLÓGICO

- PUNCH DE PÁLPEBRA INFERIOR DIREITA, OMBRO ESQUERDO E FLANCO DIREITO: EPIDERME ULCERADA SOBRE PROLIFERAÇÃO VASCULAR E INFILTRADO INFLAMATÓRIO NEUTROFÍLICO, POEIRA NUCLEAR, HISTIÓCITOS, LINFÓCITOS E EOSINÓFILOS ENTREMEADOS POR TRAVES DE COLÁGENO HIALINIZADO. AUSÊNCIA DE MALIGNIDADE NAS AMOSTRAS.

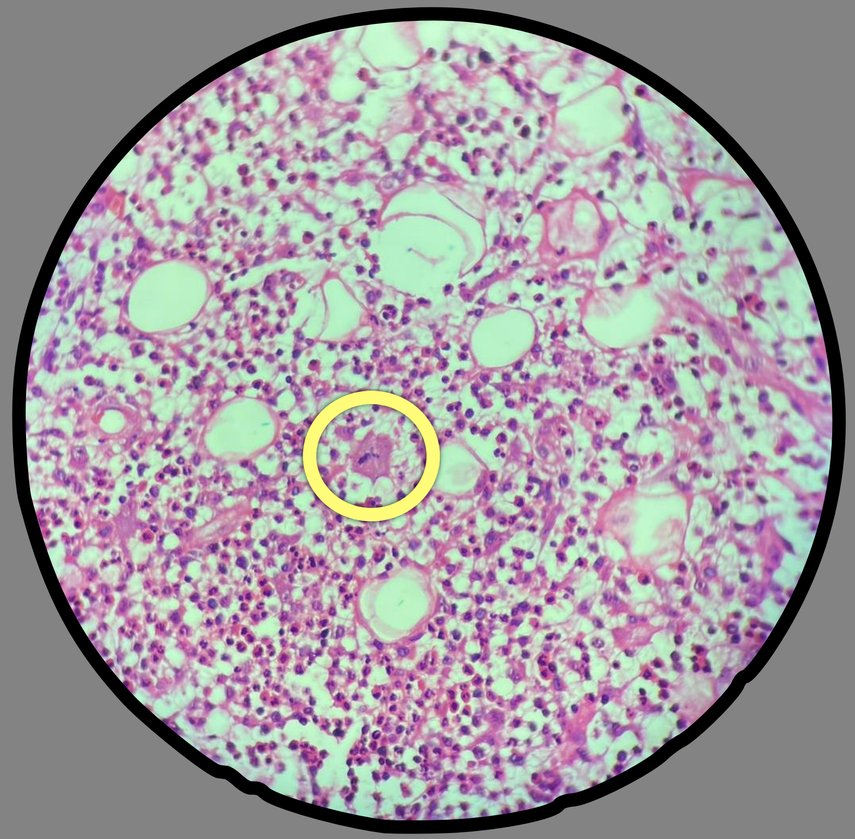
- COLORAÇÃO PAS E GROCOTT: NEGATIVA PARA FUNGOS.



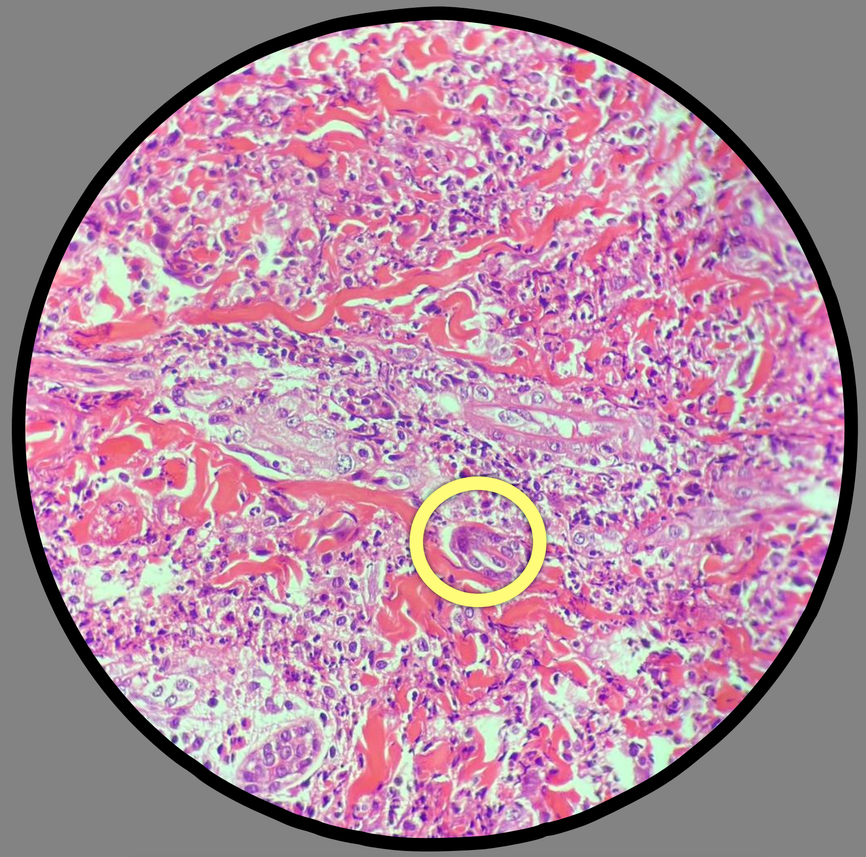
Epiderme espessada e edema nas papilas dérmicas



Exocitose de células inflamatórias (neutrófilos e linfócitos)

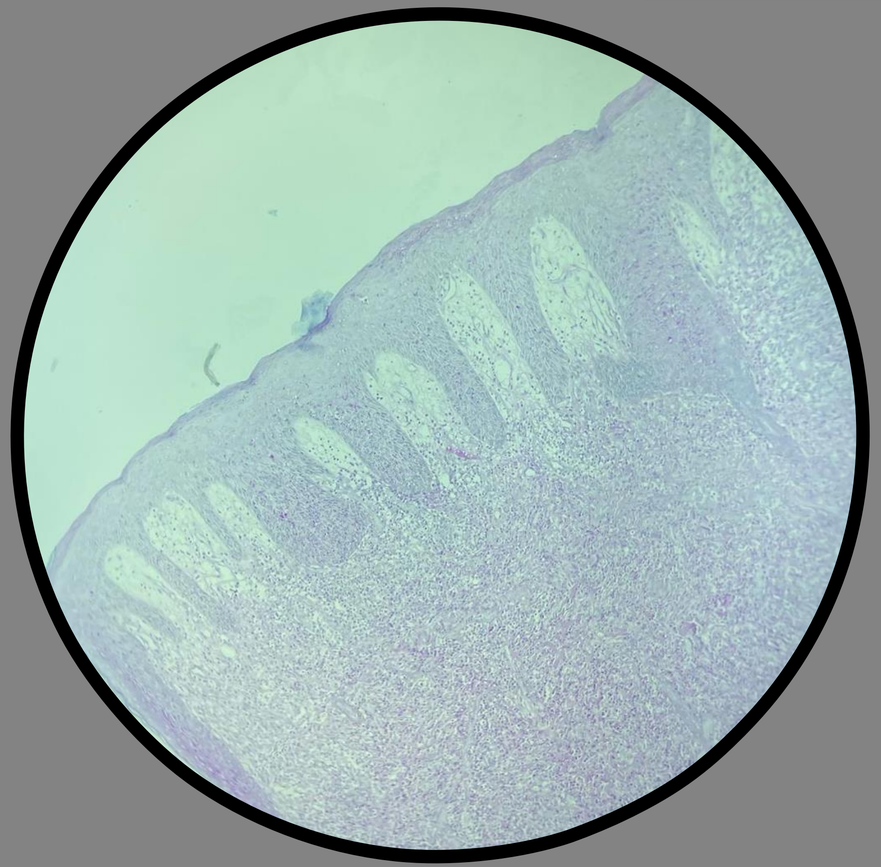


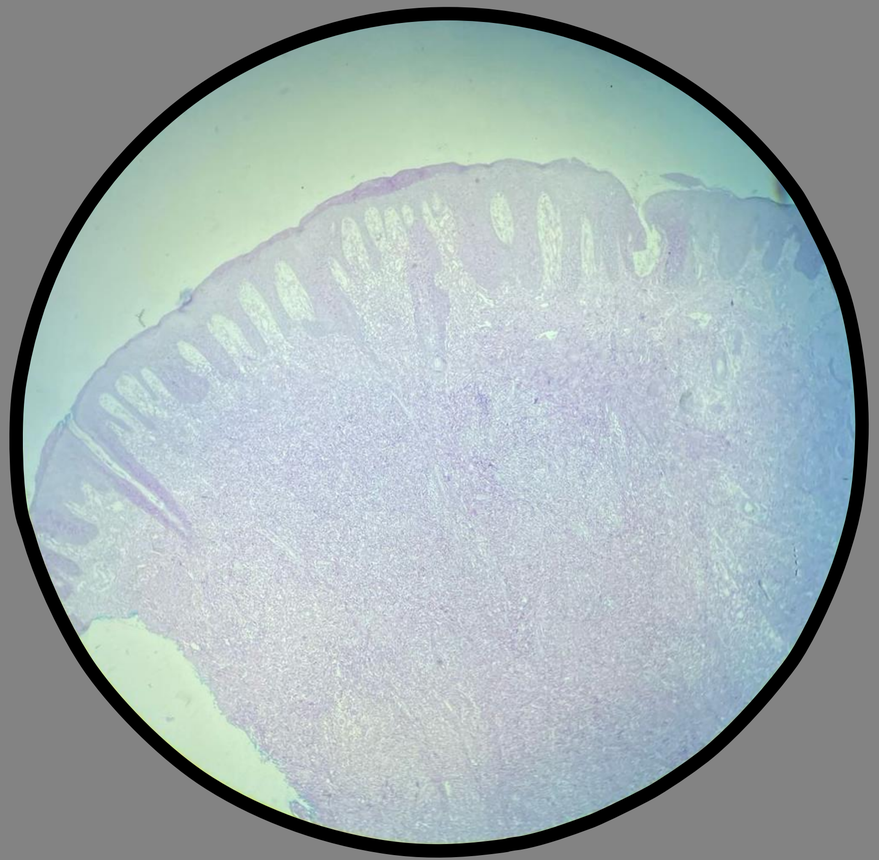
Mitoses



Proliferação endotelial permeado por neutrófilos

Coloração PAS com ausência de células fúngicas na amostra





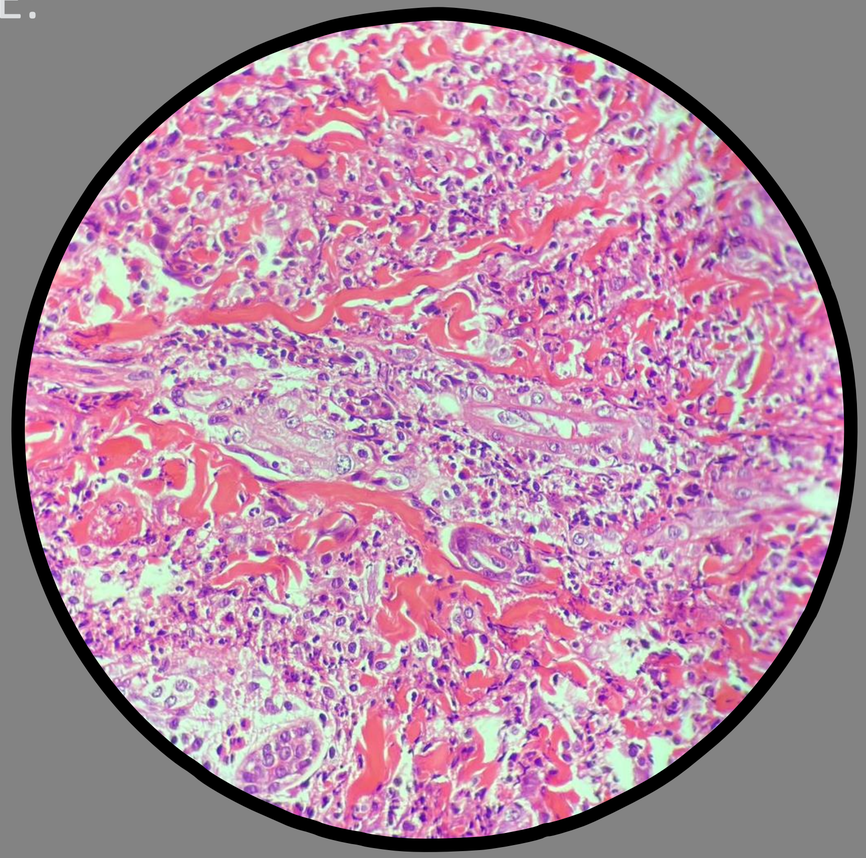
APÓS RESULTADO DOS EXAMES

INICIADO TRATAMENTO COM AZITROMICINA VO 2,5ML/DIA

RESPOSTA CLÍNICA RÁPIDA E SIGNIFICATIVA

DIAGNÓSTICO

DIANTE DO QUADRO CLÍNICO-EPIDEMIOLÓGICO, EXAME HISTOPATOLÓGICO, SOROLOGIA REAGENTE E RÁPIDA RESPOSTA AO TRATAMENTO, CHEGAMOS AO DIAGNÓSTICO DE:



ANGIOMATOSE BACILAR

CONCEITO

DOENÇA SISTÊMICA RARA, ASSOCIADA A INFECÇÃO PELA BACTÉRIA GRAM-NEGATIVA DO GÊNERO BARTONELLA SPP., EM DESTAQUE AS ESPÉCIES B. HENSELAE E B. QUINTANA;

INICIALMENTE ASSOCIADA À INFECÇÃO PELO HIV, TEM SIDO DESCRITA EM DOENTES IMUNODEFICIENTES NÃO INFECTADOS PELO HIV, COMO PACIENTES COM LINFOMA/LEUCEMIA, E MAIS RECENTE EM DOENTES IMUNOCOMPETENTES.

TRANSMISSÃO PODE SE DAR ATRAVÉS DA ARRANHADURA DO GATO, PULGAS DE GATOS, CARRAPATOS (B. HENSELAE) E INFESTAÇÃO POR PEDICULUS HUMANUS CORPORIS (B. QUINTANA)

CLÍNICA

- LESÕES CUTÂNEAS: PRINCIPAL MANIFESTAÇÃO; AUSENTES EM ATÉ 45% DOS CASOS.
- PODEM SER LESÕES SOLITÁRIAS, MAS MAIS FREQUENTEMENTE, MÚLTIPLAS E DISPERSAS.
- PÁPULAS, PLACAS, TUMORES ANGIOMATOSOS, RARAMENTE HIPERQUERATÓSICOS OU NÓDULOS NORMOCRÔMICOS, COM COLARETE DESCAMATIVO EM BASE DA LESÃO CARACTERÍSTICO.
- HÁ DESCRIÇÕES DE ACOMETIMENTO DE MUCOSA ORAL, CONJUNTIVAL, GASTROINTESTINAL, GENITAL FEMININA E VIAS AÉREAS.
- PODE ACOMPANHAR SINTOMAS SISTÊMICOS: FEBRE, ANOREXIA, PERDA DE PESO, NÁUSEAS, VÔMITOS, DIARRÉIA E DOR ABDOMINAL SE HOUVER ACOMETIMENTO VISCERAL.

DIAGNÓSTICO

BIÓPSIA CUTÂNEA

Angioproliferação disposta em lóbulos, com vasos formados por células endoteliais proeminentes; em áreas de celularidade mais densa, podem ser observadas atipias e mitoses. Predomínio de neutrófilos no infiltrado celular e ocasional leucocitoclasia.

Presença de bacilos no interstício ou intracelular encontrados à coloração de prata como Warthin-Starry; À microscopia óptica observa-se proliferação capilar disposta em lóbulos e resposta inflamatória com neutrófilos;
Pela imunocitoquímica diferencia-se a espécie.

DIAGNÓSTICO

OUTROS MÉTODOS AUXILIARES:

- PCR;
- CULTURA DE SANGUE E TECIDOS;
- SOROLOGIA PARA BARTONELLA SPP.

DIAGNÓSTICOS DIFERENCIAIS: GRANULOMA PIOGÊNICO, SARCOMA DE KAPOSI, LINFOMA CUTÂNEO, LINFOMA DE HODGKIN, LINFOMA NÃO-HODGKIN E MICOBACTERIOSES ATÍPICAS.

TRATAMENTO

ERITROMICINA

DOXICICLINA

OUTRAS OPÇÕES: RIFAMPICINA E OUTROS MACROLÍDEOS

DURAÇÃO DO TRATAMENTO AINDA NÃO BEM ESTABELECIDA, SENDO GERALMENTE MANTIDA POR CURSOS MAIS LONGOS DE 2 A 4 MESES.

DOENÇA DE BOM PROGNÓSTICO E RARAMENTE APRESENTA RECIDIVAS APÓS TRATAMENTO COMPLETO.

PODE SER FATAL QUANDO NÃO ADEQUADAMENTE TRATADA, PRINCIPALMENTE EM PACIENTES COM ACOMETIMENTO VISCERAL OU EM PACIENTES COM IMUNODEFICIÊNCIA.

Pediatric Dermatology Vol. 11 No. 4 338–341

Bacillary Angiomatosi Immunocompetent Child: Reported Case

Maria A. Paul, M.D., M.Sc.Hyg.,* Alan B. Fle
Janet S. Wieselthier, M.D.,*† and Wain L.

*Departments of *Dermatology and †Pathology, Bowman Gray Sc University, Winston-Salem, North Car*

Abstract: Bacillary angiomatosis, an infectious p with *Rochalima* spp., was thought until recently to be infected or otherwise immunosuppressed patients. In giomatosis was reported in several immunocompeten sive literature review failed to find references to bacilla immunocompetent children. We describe a 6-year-ol sented with a single, rapidly growing, friable, erythema neck. Histologic examination of a biopsy specimen cor sis of bacillary angiomatosis. The patient was otherwi physical examination was normal. Laboratory studies rology, were normal. The patient was treated with six w romycin without evidence of recurrence. We presen implications of the first case of bacillary angiomatosis petent child.

Bacillary angiomatosis (BA) was first reported in 1983 (1). This vascular proliferation has been closely linked to infection with *Rochalimae henselae* and most commonly affects immunocompromised patients, especially those harboring the human immunodeficiency virus (HIV). Recently, BA was described in five immunocompetent adult patients (2). In this report, we describe the first immunocompetent child with BA.

CASE REPORT

A 6-year-old caucasian girl presented for evaluation of an asymptomatic, enlarging lesion on her anterior neck. She was all developme of a normal ful cently acquire scratch was el

Physical e thematous-to- larette of scale was no hepat The lesion wa granuloma and excision.

Histologic e

Address correspondence to Maria A. Paul, M.D., M.Sc., Hyg., Department of Dermatology, Bowman Gray School of Medicine of Wake Forest University, Medical Center Boulevard, Winston-Salem, NC 27157-1071.

Case Report

Bacillary angiomatosi presentation in an im

J. Bernabeu-Wittel, R. Luque[1], A. Vallejo[3], M. Bernabeu-Wittel[*]

Departments of Dermatology, [1]Infectious Diseases, [2]Pathology, and [3]AIDS and Viral Hepatitis Study Group. Hospitales Universitarios Virgen del Rocío, Sevilla, Spain

Address for correspondence: Dr. José Bernabeu-Wittel, Dermatology Department, Hospitales Universitarios Virgen del Rocío, Avenida Manuel Siurot s/n., 41013 Sevilla, Spain. E-mail: jbernabeuw@gmail.com

DOI: 10.4103/0378-6323.72469

ABSTRACT

Bacillary angiomatosis is a recent immunosupressed hosts with a previ of bacillary angiomatosis in an imm previous exposure to cats, and atypi with ulceration on the left ankle). His and reactive tumor-like vascular prol cells and an inflammatory infiltrate in subcutis. Staining with the Warthin-S bacilli located in the extracellular m Diagnosis was confirmed with the de in bone marrow using polymerase ch

Key words: Bacillary angiomat immunocompetent

INTRODUCTION

The spectrum of Bartonella infections has expanded rapidly since the first HIV-infected patient with bacillary angiomatosis (BA) was described in 1983. Of the 19 species of Bartonella described until now, only 10 were acknowledged as human pathogens; *B. bacilliformis*, *B. quintana*, and *B. henselae* are the most frequently described.[1,2] BA usually affects immunosuppressed hosts, especially HIV-infected patients with a decrease in the CD4 lymphocyte count.[1-6] Hepatic peliosis is exclusively associated with *B. henselae* infection. BA caused by *B. quintana* can develop lytic bone lesions and subcutaneous masses.[2]

There are very few reported cases of BA in immunocompetent patients.[3-11] The skin is the most frequently affected site, presenting as papules, warts, pedunculated and subcutaneous nodules (rarely ulcerated or bleeding), or hyperkeratotic plaques.[1,2] Most patients with BA have been exposed to cats.[1-5,12,13] We describe an atypical case of BA in an imm to c

CAS

A 5 with loca two rem prog plus dire prev exa with left was

Bloo ana abd

How to cite this article: Bernabeu-Wittel J, Luque R, Corbí R, Mantrana-Ber with atypical clinical presentation in an immunocompetent patient. Indian J De
Received: November, 2009. **Accepted:** July, 2010. **Source of Support:** Nil.

Bacillary Angiomatosis in an Immunocompetent Child: A Case Report and Review of the Literature

Matthew Zarraga, DO, Les Rosen, MD,† and David Herschthal, MD‡*

Abstract: Bacillary angiomatosis is an infectious disease caused by 2 gram-negative bacilli, *Bartonella henselae* and *Bartonella quintana*. This disease is characterized by vascular proliferations in the skin and/or visceral organs, and typically manifests in immunocompromised patients. However, we report a case of a 10-year-old immunocompetent female child with a questionable history of being scratched by a cat. Although initially diagnosed as a pyogenic granuloma, a diagnosis of bacillary angiomatosis was made based on histologic examination of the excised lesion demonstrating interstitial bacillary deposition on Warthin–Starry silver stain. The patient was successfully treated with 2 weeks of azithromycin after which all symptoms resolved.

Key Words: bacillary angiomatosis, *Bartonella henselae*, *Bartonella quintana*, immunocompetent child, pyogenic granuloma

(*Am J Dermatopathol* 2011;33:513–515)

CASE REPORT

A 10-year-old African American girl with no significant medical history presented to her dermatologist with a tender chest nodule. The nodule had gradually enlarged over the course of a few weeks. The patient denied fever, night sweats, chills, malaise, anorexia, abdominal pain, diarrhea, or weight loss. When questioned about cat exposure, the patient stated that she recalls playing with a cat that may have scratched her at the site of the lesion. On physical examination, she had a smooth firm nodule, without crust, which was bright red in color. It was solitary, well-circumscribed, dome-shaped, 5 mm in diameter, and sessile. The lesion was clinically diagnosed as a pyogenic granuloma (PG), and an excisional biopsy was done and sent for histopathology.

One week after the biopsy, the patient presented to her pediatrician with fever and enlarged cervical lymph nodes, bilaterally. The patient was tested for human immunodeficiency virus (HIV), which was found to be negative. On hematoxylin and eosin stain, the biopsy revealed lobular proliferations of blood vessels, neutrophilic infiltration, and an interstitial amorphous granular-like material resembling fibrin (Figs. 1, 2).

When stained with Warthin–Starry silver, these granular-like deposits revealed small, rod-like, interstitial bacillary deposition (Fig. 3).

From the *Chief Intern, Palmetto General Hospital, Hialeah, FL; †Dermpath Diagnostics, Pompano Beach, FL; ‡David Herschthal MD Cosmetic Dermatology, Boca Raton, FL.
Reprints: Matthew Zarraga, DO, Palmetto General Hospitals, Department of Medical Education, 2001 W 68th St, Hialeah, FL 33016 (e-mail: drmbzarraga@gmail.com).

A diagnosis of bacillary angiomatosis (BA) was made. The patient was treated on an outpatient basis with azithromycin 250 mg every day for 14 days. Four weeks after the start of treatment, all symptoms had resolved.

DISCUSSION

BA is a systemic disease that was first described in 1983 by Stoler et al[1] in a patient infected with HIV. Most commonly, the disease is seen in immunocompromised patients, in particular, in those with HIV with CD4 T-cell counts below 200 per microliter.[2] However, very rarely will BA manifest in an immunocompetent patient as it did in the above-mentioned child. Only 4 other cases have been reported of BA occurring in an immunocompetent child, one who developed BA lesions near an infected facial wound.[3–6]

The causative agents in BA are *Bartonella henselae* and *Bartonella quintana*, small gram-negative rods in the family Bartonellaceae.[7] The reservoir for *B. henselae* is domestic cats; therefore, transmission can result from cat bites or scratches that are subsequently contaminated with infested cat flea (*Ctenocephalides felis*) feces.[8,9] On the contrary, humans are the only reservoir for infection with *B. quintana*, and the vector for transmission is the human body louse (*Pediculus humanus corporis*).[10]

BA most commonly affects the skin and subcutaneous tissue; nevertheless, it can affect almost any organ system. Skin involvement is caused with equal frequency by *B. henselae* and *B. quintana*; however, subcutaneous and osseous lesions are usually the result of *B. quintana* infection, whereas visceral involvement is almost solely caused by *B. henselae*. Disseminated visceral involvement is termed peliosis with the liver, spleen, and lymph nodes being the most common sites.[11]

B. henselae and *B. quintana* infections stimulate the proliferation and migration of endothelial cells, resulting in cutaneous BA.[12] Clinically, BA has 4 cutaneous patterns: (1) globular angiomatous papules or nodules resembling PG; (2) violaceous nodules, often covered with a fine adherent scale resembling Kaposi sarcoma (KS); (3) lichenoid violaceous plaques typically on extremities, often overlying osseous defects; (4) large, friable, pedunculated, or polypoid exophytic masses. The most common presentation of BA is a reddish purple papule about 1 cm in diameter that bleeds easily when traumatized. Cutaneous lesions are often tender and may develop ulceration, discharge, and crusting. Palpation usually reveals a rubbery, firm, and freely mobile lesion. A subcutaneous lesion presents as a nodule with or without ulceration. The nodules can be as large as 10 cm in diameter and vary in number from one to hundreds. The overlying skin

DE VOLTA AO CASO...

EVOLUÇÃO COM O TRATAMENTO PROPOSTO

APÓS 1 SEMANA

APÓS 20 DIAS

APÓS 45 DIAS

MOTIVOS DA APRESENTAÇÃO

DOENÇA RARA, COM APRESENTAÇÃO ATÍPICA EM PACIENTE IMUNOCOMPETENTE;

DIFICULDADE EM CULTIVAR A BARTONELLA SPP. E PCR POUCO DISPONÍVEL TORNAM O DIAGNÓSTICO DESAFIADOR, NEGLIGENCIANDO A INCIDÊNCIA DE PACIENTES COM ANGIOMATOSE BACILAR CUTÂNEA;

CONSIDERAR O DIAGNÓSTICO DE ANGIOMATOSE BACILAR CUTÂNEA MESMO EM PACIENTES QUE NÃO POSSUAM IMUNOCOMPROMETIMENTO.

REFERÊNCIAS

ZARRAGA M, ROSEN L, HERSCHTHAL D. BACILLARY ANGIOMATOSIS IN AN IMMUNOCOMPETENT CHILD: A CASE REPORT AND REVIEW OF THE LITERATURE. AM J DERMATOPATHOL. 2011 JUL;33(5):513-5. DOI: 10.1097/DAD.0B013E3181EC846A. PMID: 21285862.
https://pubmed.ncbi.nlm.nih.gov/21285862/

Paul, M. A., Fleischer, A. B., Wieselthier, J. S., & White, W. L. (1994). Bacillary Angiomatosis in an Immunocompetent Child: The First Reported Case. Pediatric Dermatology, 11(4), 338–341. doi:10.1111/j.1525-1470.1994.tb00101.x

Anais Brasileiros de Dermatologia - Angiomatose bacilar: revisão da literatura e documentação iconográfica [Internet]. www.anaisdedermatologia.com.br. [cited 2024 Apr 16]. Available from: http://www.anaisdedermatologia.com.br/detalhe-artigo/10074/Angiomatose-bacilar--revisao-da-literatura-e-documentacao-iconografica
http://www.anaisdedermatologia.com.br/detalhe-artigo/10074/Angiomatose-bacilar--revisao-da-literatura-e-documentacao-iconografica

Diniz LM, Medeiros KB, Landeiro LG, Lucas EA. Bacillary angiomatosis with bone invasion. An Bras Dermatol. 2016 Nov-Dec;91(6):811-814. doi: 10.1590/abd1806-4841.20165436. PMID: 28099606; PMCID: PMC5193195.
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5193195/

Velho PENF, Souza EM de, Cintra ML, Moraes AM de, Uthida-Tanaka AM. Diagnóstico da infecção por Bartonella spp.: a propósito de um caso de angiomatose bacilar. Anais Brasileiros de Dermatologia. 2006 Aug;81(4):349–53.
https://www.scielo.br/j/abd/a/6hZmFbpctYqGvwRy7rGWvBw/

Markowicz M, Käser S, Müller A, Lang G, Lang S, Mayerhöfer M, Stanek G, Rieger A. Bacillary angiomatosis presenting with facial tumor and multiple abscesses: A case report. Medicine (Baltimore). 2016 Jul;95(28):e4155. doi: 10.1097/MD.0000000000004155. PMID: 27428207; PMCID: PMC4956801.
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4956801/

https://www.researchgate.net/publication/262631809_Angiomatose_Bacilar_em_Doente_Imunocompetente_A_Proposito_de_um_Caso_Clinico

Rubem David Azulay, David Rubem Azulay, Azulay-Abulafia L. Dermatologia. Rio De Janeiro (Rj): Guanabara Koogan; 2021.Cap 66, pag 911. 8ª ed

Karina, Marina Rovani Drummond, Neves E. Manifestações cutâneas das bartoneloses. Anais Brasileiros de Dermatologia [Internet]. 2019 Sep 1 [cited 2023 Dec 1];94(5):594–602. Available from: https://www.anaisdedermatologia.org.br/en-manifestacoes-cutaneas-das-bartoneloses-articulo-S2666275219300207

Webster GF, Cockerell CJ, Friedman-Kien AE. The clinical spectrum of bacillary angiomatosis. Br J Dermatol. 1992 Jun;126(6):535-41. doi: 10.1111/j.1365-2133.1992.tb00096.x. PMID: 1610703. https://pubmed.ncbi.nlm.nih.gov/1610703/

OBRIGADA