



Case Report

Chronic psoriasiform sarcoidosis in an elderly woman: An uncommon cutaneous clue to systemic disease

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ABSTRACT

Sarcoidosis is a multisystem granulomatous disorder characterized by non-caseating epithelioid granulomas, with pulmonary involvement being the most common manifestation. Cutaneous sarcoidosis occurs in approximately 20–35% of patients and exhibits a wide spectrum of morphologies, often mimicking other dermatoses. Psoriasiform sarcoidosis is an exceptionally rare variant and poses a significant diagnostic challenge. We report a 78-year-old female who presented with painful, pruritic erythematous scaly plaques involving the face, upper limbs, lower limbs, and upper back for 4 years, with recent worsening. Laboratory evaluation revealed elevated serum angiotensin-converting enzyme levels. Contrast-enhanced computed tomography demonstrated pulmonary nodules with interstitial changes and nodules in the liver and spleen. Histopathology of a skin biopsy showed well-formed non-caseating epithelioid granulomas with Langhans giant cells, confirming the diagnosis of cutaneous sarcoidosis. The patient was treated with hydroxychloroquine and mycophenolate mofetil, resulting in significant clinical improvement. Psoriasiform sarcoidosis is a rare clinical mimic of chronic plaque psoriasis. Persistent psoriasiform lesions, particularly in elderly patients and those unresponsive to conventional therapy, should prompt histopathological evaluation and systemic workup for early diagnosis and appropriate management.

Keywords: Cutaneous sarcoidosis, Granulomatous dermatoses, Hydroxychloroquine, Psoriasiform sarcoidosis, Sarcoidosis

INTRODUCTION

Sarcoidosis is a multisystem granulomatous disease of unknown etiology characterized by non-caseating epithelioid granulomas in affected organs. Pulmonary involvement occurs in more than 90% of patients, while cutaneous manifestations are seen in approximately 20–35% and may serve as the first clinical clue to diagnosis.^[1,2] The wide spectrum of cutaneous morphologies has earned sarcoidosis the reputation of being a “great imitator.”^[1]

Psoriasiform sarcoidosis is an exceptionally rare morphological variant, with only isolated case reports described in the literature.^[3] The striking resemblance to chronic plaque psoriasis often leads to misdiagnosis and delayed systemic evaluation. Distinguishing between these entities is clinically important, as therapeutic approaches and prognostic implications differ. We report a rare case of psoriasiform sarcoidosis in an elderly woman with systemic involvement, highlighting its diagnostic challenges.

CASE REPORT

A 78-year-old female with diabetes and glaucoma presented with severely painful and pruritic erythematous scaly plaques involving the face, upper limbs, lower limbs, and upper back for 4 years, with worsening over the preceding month. She also reported chronic fatigue and unintentional weight loss. There was no history of fever, joint pain, photosensitivity, or drug intake; there was no history of any fluid-filled lesion.

General examination revealed stable vital signs and no lymphadenopathy. Systemic examination was unremarkable. Dermatological examination showed erythematous plaques in the periorbital region associated with ectropion [Figure 1], scaly atrophic plaques over both cheeks [Figure 2], and an infiltrated erythematous plaque involving the philtrum and nasal tip [Figure 3]. Multiple thick scaly plaques with crusting were present over the forearms, lower limbs [Figure 4], and upper back, and there were no bleeding points on removal of the scales. Mucosal examination was unremarkable.

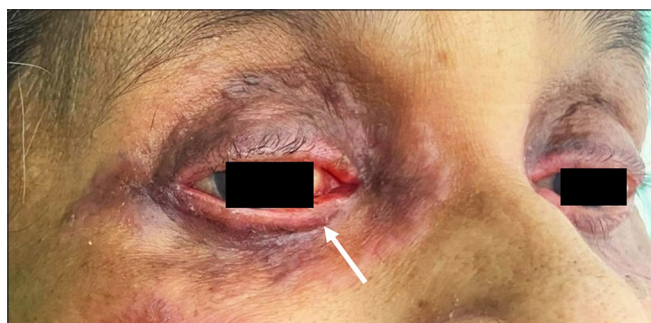


Figure 1: Erythematous plaque in the periorbital area with ectropion (arrow).



Figure 2: Well-defined erythematous scaly atrophic plaques on the cheek (arrow).

Hematological examination showed anemia (hemoglobin: -10.4), and other biochemical investigations were within normal limits. Antinuclear antibody testing was negative. Serum angiotensin-converting enzyme (ACE) level was elevated at 84 U/L. Serum calcium was estimated and found to be within normal limits (9.2 mg/dL). Contrast-enhanced computed tomography of the chest and abdomen revealed multiple pulmonary nodules with interstitial changes and peribronchovascular ground-glass opacities, along with nodules in the liver and spleen, suggestive of systemic granulomatous disease.

Histopathology of the skin showed epidermis with parakeratosis. Dermis showed a granuloma composed of a collection of epithelioid histiocytes and few lymphocytes, and many Langhans giant cells. Reticulin stain showed preserved reticulin framework consistent with cutaneous sarcoidosis [Figure 5].

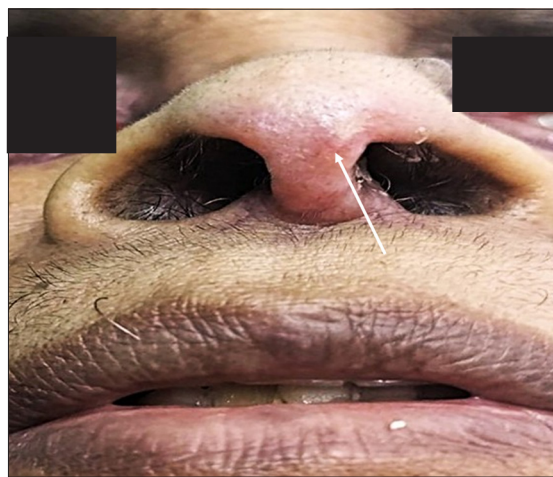


Figure 3: Erythematous plaque seen on philtrum and tip of nose (arrow).



Figure 4: Scaly erythematous plaque with thick scales over the upper limb (arrow).

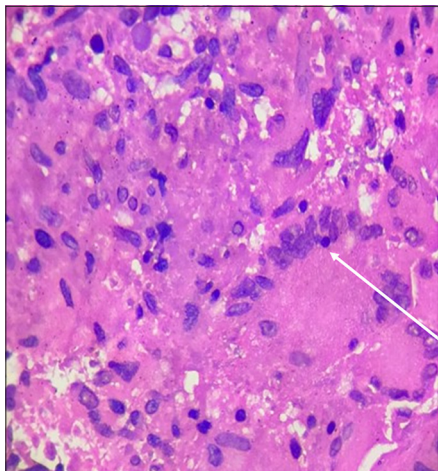


Figure 5: Histopathology of skin showing non caseating naked granuloma (arrow). (Hematoxylin and eosin stain, 40x).

A diagnosis of psoriasiform sarcoidosis with systemic involvement was made. The patient was initiated on hydroxychloroquine 200 mg twice daily and mycophenolate mofetil 500 mg once daily. At 1-month follow-up, there was marked improvement in pain, erythema, scaling, and pruritus, with significant softening of plaques [Figure 6].

DISCUSSION

Psoriasiform sarcoidosis represents one of the rarest morphological variants of cutaneous sarcoidosis, often creating substantial diagnostic difficulty because of its striking similarity to chronic plaque psoriasis. The condition has been documented as an uncommon but important clinical mimic, with fewer than a few dozen cases reported globally. Vega *et al.* described one of the clearest examples of this presentation, highlighting that psoriasiform sarcoidosis may either represent an overlap of two distinct diseases or a shared immunopathogenic pathway involving Th1/Th17 signaling.^[3] Cutaneous sarcoidosis itself is known as a “great imitator” due to its wide morphological spectrum, ranging from papules and plaques to scar infiltration, lupus pernio-like lesions, and erythroderma. In a large clinicohistopathological study from India, Mahabal *et al.* demonstrated that plaque-type lesions were among the most common manifestations, though psoriasiform variants remained exceptionally rare.^[2] Histopathologically, the presence of well-formed non-caseating granulomas with epithelioid histiocytes and Langhans giant cells – findings also seen in our patient – is considered classic for sarcoidosis and forms the basis for diagnosis.^[2]

Sarcoidosis is a systemic granulomatous disease with a predominance of Th1-mediated immunity, while psoriasis is primarily Th17 driven; however, emerging evidence suggests immunologic overlap. Wanat *et al.* discussed how



Figure 6: Post-treatment image showing resolved plaques in the upperlimb.

granulomatous inflammation in sarcoidosis and keratinocyte hyperproliferation in psoriasis may share intersecting immunologic pathways, including interleukin (IL)-12, IL-23, and interferon gamma.^[4] This overlap may explain why sarcoidosis sometimes clinically mimics psoriasis and why psoriasiform lesions may represent a unique inflammatory phenotype rather than coincidental co-occurrence.

The systemic nature of sarcoidosis mandates careful evaluation for extracutaneous disease. Baughman *et al.*, in a landmark review, emphasized that pulmonary involvement remains the most common systemic manifestation, often presenting with nodules, interstitial infiltrates, and ground-glass opacities – radiologic features that paralleled the findings in our patient.^[5] Additional evidence from Baughman *et al.* further supports the utility of imaging and serum biomarkers such as ACE, although these lack complete specificity.^[5]

Dermatologic manifestations carry significant clinical importance, as highlighted by Koneti *et al.* in a narrative review of sarcoidosis.^[1] They underscore that cutaneous disease may be the earliest or only sign of multisystem involvement. Therapeutic decisions in sarcoidosis must be individualized, especially when systemic involvement is present. Hydroxychloroquine is a well-established option for cutaneous sarcoidosis, particularly useful in cases with disfiguring skin disease, photosensitivity, or contraindication to systemic corticosteroids. Vermeer *et al.* demonstrated that hydroxychloroquine monotherapy can be both efficacious and well tolerated, with improvement in cutaneous lesions and systemic symptoms.^[6] Mycophenolate mofetil has also emerged as a promising steroid-sparing agent in sarcoidosis, with Papiris *et al.* reporting its utility in refractory pulmonary and cutaneous disease.^[7] Both agents were used successfully in our patient, leading to marked clinical improvement within 1 month.

Pre-existing glaucoma affected our patient's therapeutic choices since systemic corticosteroids, the first-line treatment for sarcoidosis, can exacerbate glaucomatous visual neuropathy and raise intraocular pressure. To effectively treat the condition and reduce the risk of glaucoma progression, a steroid-sparing regimen containing hydroxychloroquine and mycophenolate mofetil was started.

Collectively, this case reinforces several important clinical insights. First, psoriasiform sarcoidosis, while rare, should be strongly considered in patients with chronic erythematous scaly plaques unresponsive to conventional therapy. Second, cutaneous lesions offer a valuable window into systemic disease, and biopsy remains indispensable in distinguishing sarcoidosis from psoriasis or chronic dermatitis. Third, the therapeutic success of hydroxychloroquine and mycophenolate aligns well with current evidence supporting their roles as steroid-sparing treatments. Finally, understanding the potential immunologic overlap between psoriasis and sarcoidosis may help explain the psoriasiform morphology and suggest avenues for future research into targeted therapies.

CONCLUSION

Psoriasiform sarcoidosis, though rare, should be considered in elderly patients presenting with chronic scaly plaques unresponsive to conventional therapy. Early skin biopsy and comprehensive systemic evaluation are essential for timely diagnosis and appropriate management.

Ethical approval: The Institutional Review Board approval is not required.

Declaration of patient consent: The authors certify that they have obtained all appropriate patient consent forms. In the form, the patient has given consent for their images and other clinical information to be reported in the journal. The patient understands that the patient's names and initials will not be published and due efforts will be made to conceal their identity, but anonymity cannot be guaranteed.

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