Acroangiodermatitis of Mali: A Case Report and Review

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INTRODUCTION

• Acroangiodermatitis of Mali is an uncommon vascular disease of the lower extremity
• It clinically presents as well-circumscribed, slowly-evolving, red to violaceous or dusky macules, papules, or plaques on the lower extremities that mimics Kaposi sarcoma (KS), hence the moniker pseudo-KS.
• Herein, we report a case of a 71-year-old Vietnamese male who presented with violaceous papules and nodules on his lower extremity for which he had never been treated by a dermatologist.

CASE REPORT

A 71-year-old Vietnamese male presented for evaluation of multiple erythematous papules and nodules located on his bilateral lower extremity that had initially appeared 10 years prior.
• Initial treatment regimen included 3 weeks of SMZ/TMP by a prior practitioner
• After initial treatment, he returned with rapid progression of his lesions with increasing number and thickness and purulent discharge
• Physical exam: multiple erythematous and crusted violaceous nodules and plaques located bilaterally on the anterior lower extremity (Figure A)
  • Pertinent labs: CBC and CMP within normal limits.
  • Patient refused HIV testing
• He underwent two 4-mm punch biopsies on the lower legs
  • Pathology: epidermal hyperplasia and hyperkeratosis with dermal fibrosis, a perivascular lymphocytic infiltrate, and small vessels with thickened vessel walls (Figure C)
  • Vascular slits and CD34 expression were notably absent (Figure D)
• Bilateral Venous Doppler studies showed no evidence of DVT or underlying vascular malformations
• Subsequent treatment
  • Topical Clobetasol applied twice a day
  • Within two months of therapy, the patient had alleviation of symptoms and reduction in epidermal changes (Figure B).

DISCUSSION and CONCLUSION

• AAD is an uncommon condition with less than 100 cases reported that usually occurs in males with a history of venous stasis, hemodialysis shunts, AV malformations, or prosthesis.1
• It is also referred to as pseudo-Kaposi Sarcoma due to the clinical and histological resemblance to Kaposi Sarcoma.
• It is hypothesized that AAD is due to alteration of local circulation leading to markedly increased capillary pressure with resultant edema, hypoxia, and neovascularization. 2
• There is no definitive treatment for AAD. Treatment involves correction of the underlying vascular pathology with the goal of reducing inflammation as well as reducing capillary pressure.1
• The reduction in inflammation from the topical steroids likely led to improvement of the lesions.

REFERENCES