Miliarial gout: A rare clinical presentation

To the Editor: Chronic cutaneous tophaceous gout is a manifestation of untreated gouty arthritis that manifests as monosodium urate crystal deposition intradermally or within the subcutaneous tissues of the skin usually over joints or on the ears. Multiple clinical variants of tophaceous gout have been described.1 Milialar gout is an extremely rare manifestation of tophaceous gout and refers to “milia-like” widely distributed papules containing white to cream colored material on an erythematous base.1,2 Here we describe a case of miliarial gout in a patient with a normal serum uric acid level and no previous medical history of gouty arthritis.

A 43-year-old Caucasian man presented with grouped, tender, yellowish-red papules that occurred in crops over the metacarpophalangeal joints of his hands, knees, abdomen, extensor

![Fig 1. Miliarial gout. Erythematous pink to yellow papules over the extensor forearms with a firm 2-cm nodule on the right elbow.](image-url)
forearms, and thighs over the previous year (Fig 1). He reported that these lesions worsened with warm weather and then gradually dissipated. A flesh-colored nodule was present on the right elbow. He denied having pruritus or joint pain. Medical history was significant for diabetes treated with metformin. Family history was negative for cutaneous disease.

Punch biopsy of a typical papule was performed and the specimen placed in formalin. Histologic examination revealed granulomatous dermatitis with amorphous crystalline material consistent with gout (Fig 2). Serum uric acid level was within normal limits at 4.9 mg/dL (normal reference range, 3.5 to 7.2 mg/dL).

Only a few cases of miliarial gout have been previously reported. As with gouty arthritis, a normal serum uric acid level does not exclude the diagnosis. Similar to typical tophaceous gout, miliarial gout can be the initial manifestation of gout. In fact, both of the referenced cases of miliarial gout occurred in the absence of a known history of gouty arthritis. It is unclear whether these patients are predisposed to the development of gouty arthritis in the future. Because there are so many clinical variants of tophaceous gout, patients may present with more than 1 variant. It is likely that our patient’s longstanding nodule on the elbow represents a more typical manifestation of tophaceous gout. Although our patient’s histopathology was typical of tophaceous gout, to actually fulfill clinical diagnostic criteria, as established by the American College of Rheumatology, the biopsy specimen should have been submitted in absolute alcohol to demonstrate monosodium urate crystals by polarized light microscopy.

Allopurinol alone or in combination with colchicine have been reported to improve miliarial gout, and our patient was referred to a rheumatologist for management but was lost to follow-up. The prevalence of gout is reported to be between 0.5% and 1%, and the incidence of gout is increasing, possibly due to an aging population. This case illustrates the importance of considering atypical manifestations of common rheumatologic diseases.

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A case of dermatitis herpetiformis after a mini-gastric bypass surgery

To the Editor: Celiac disease and dermatitis herpetiformis share the same strong HLA association, the presence of circulating IgA antitissue and antiepidermal transglutaminase antibodies, and the same typical histologic features of villous atrophy of the small intestine. Both diseases can be triggered by gluten overload and gastric surgery.

We report a case of dermatitis herpetiformis after mini-gastric bypass surgery with no clinical sign or symptom of celiac disease. Mini-gastric bypass is a modification of the standard Roux-en-Y procedure using a long gastric tube with an antecolic loop gastrojejunostomy. It has become a widely