A 64-year-old lady, known to have hypertension and urolithiasis, presented with a 4-month history of a slowly growing, erythematous-edematous and infiltrative plaque with superficial desquamation, involving all the nose skin surface – except for the root – and both zigomatic areas up to the naso-labial folds (Fig. 1).

The patient came from a remote rural area of the southeastern Sicily, and was a farmer. Personal and familiar anamnesis was negative for autoimmune diseases or skin disorders.

Routine blood exams were within normal limits; serum autoantibodies (antineutrophil cytoplasmic antibodies, anti-ENA, anti-JO1 and anti-ScI70) were negative. Nailfold capillaroscopy and chest X-ray examination were normal.

Histopathological examination of a cutaneous biopsy revealed a granulomatous infiltrate in the dermis, consisting of lymphocytes, histiocytes, and multinuclear giant cells with hyperkeratotic overlying epidermis. A touch-imprint preparation of a skin specimen, showed Leishmania amastigotes, within the histiocytes as well as extracellularly.

Lupoid leishmaniasis (LL) is a rare form of cutaneous leishmaniasis (CL) showing a striking resemblance with some other granulomatous skin diseases of inflammatory or infectious origin.\textsuperscript{1}

In fact, LL is characterized by a typical spreading of the initial lesion leading to an infiltrated plaque with undefined borders, whereas some papules and nodules, often with scaling, may become apparent, presenting a lupoid aspect. The involvement of suggestive areas, as in our case, may further complicate the differential diagnosis.\textsuperscript{2}

Histopathological features are that of epithelioid granulomas, and the detection of amastigotes is often hollow, both in microscopy and cultures.\textsuperscript{3}
It seems that in LL certain strains replicate inside the macrophage, so assuming their ability to evade intracellular destruction or a concomitant defect in the T-cell activation process.\textsuperscript{2,3} Leishmania infantum, the most frequent causative agent of CL in our geographic area, have been rarely linked with LL.\textsuperscript{1,4}

The patient received N-methylglucamine-antimoniate, 1 mL twice-a-week intralesionally (total of 7 doses), with progressive improvement.

**Conflicts of interest**

The authors declare no conflicts of interest.

**REFERENCES**