Calcinosis Cutis

An 18 year old girl with systemic lupus erythematosus and dermatomyositis overlap presented with multiple, non tender subcutaneous swellings over the back, buttocks, thighs, axillae and elbows. Misinterpreted as multiple subcutaneous abscesses, she had undergone multiple incision and drainage procedures elsewhere. On palpation, the nodules were non tender and firm with chalky, white material oozing from incision sites. The radiographs of pelvis and chest revealed extensive non homogenous subcutaneous calcific densities suggestive of calcinosis cutis.

Virchow described calcinosis cutis in 1855. It has been classified into four types: metastatic, dystrophic, iatrogenic and idiopathic types. Dermatomyositis, systemic lupus erythematosus and systemic sclerosis (CREST) classically manifest with the dystrophic calcification. It is characterized by deposition of hydroxyapatite crystals and amorphous calcium phosphates deposited in soft tissues namely intracutaneous, subcutaneous, fascial, or intramuscular planes. Calcinosis cutis in this setting is not due to an imbalance in calcium homeostasis. The exact nature of its origin is still unclear. It is hypothesized that local inflammation may have a role in its pathogenesis. Calcinosis cutis is usually seen in juvenile dermatomyositis. Presentation of calcinosis cutis varies from asymptomatic nodules to severe, painful, disfiguring disease with ulcerative, infective, and mechanical complications. Established cases of calcinosis cutis in this setting have few treatment options with marginal benefit. Diltiazem and aluminum hydroxide antacids have been used. Surgery may be deleterious as it may stimulate further calcium deposition. Early, effective treatment reduces occurrence of this complication.

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