Lipodermatosclerosis

A 49-year-old woman with a past medical history of diabetes mellitus presented with several months’ history of worsening redness and tightening of her lower legs toward her ankles, slightly tender to the touch.

**Key point:** The patient presents with erythema, induration, and tapering of the bilateral lower legs. Of note, she has a background of tortuous veins consistent with venous insufficiency. However, she complains of tenderness rather than pruritus and there is no evidence of weeping or scale, which argues against venous stasis dermatitis. The cutaneous findings were distributed bilaterally, the areas were not warm to the touch, and the patient did not have a fever, which made a diagnosis of cellulitis unlikely. Importantly, she also exhibits the specific finding of distal leg tapering, also
referred to as an “inverted champagne bottle” appearance. Taken together, these findings are consistent with lipodermatosclerosis, a relatively common finding in middle-aged obese patients with venous insufficiency as well as other comorbidities, such as diabetes. Although a clinical differential diagnosis of venous stasis dermatitis, cellulitis, morphea, or other panniculitides may be entertained, a biopsy in this case was consistent with lipodermatosclerosis, showing a mixed lobular and septal inflammatory infiltrate and fibrosis within the subdermal fat. This condition usually occurs in the setting of long-standing venous insufficiency and can lead to painful, progressive induration of the lower legs and can also be associated with ulceration in the affected areas due to compromise of the vascular supply to the skin. Older nodules and plaques may exhibit hyperpigmentation suggestive of prior inflammation.

**Treatment:** In this case, treatment was initiated with a topical corticosteroid and leg compression as well as elevation. The patient had mild improvement with this regimen and was scheduled for a consultation with vascular surgery.

**Note:** Therapy is generally directed at treating the underlying venous insufficiency with interventions such as leg compression and elevation. Often, topical or intralesional corticosteroids are used during the active inflammatory phase, but with only moderate effectiveness. Anabolic steroids, such as stanozolol, danozolol, and oxandrolone, have been used with some success because they enhance fibrinolysis, addressing both the cutaneous manifestations and painful nature of the lesions, but with concordant adverse effects. Other interventions include pentoxyfylline, hydroxychloroquine (recently reported to confer increased efficacy in conjunction with pentoxyfylline), ultrasound therapy, and surgical intervention (phlebectomy, fasciotomy).

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