**Methods**

A literature search on PubMed was conducted using the terms “micropapular sarcoidosis” and “micropapular sarcoid” with no set date range, resulting in 11 articles. Publications were excluded if they involved nonhuman models or if the skin lesions were due to infection or other known etiologies. The initial 11 articles were reviewed by the first author (J.G.L.), and if the article was deemed relevant after title and abstract review, the entire article was further examined to ensure eligibility. Ultimately, 1 article was eliminated using this filtering method. The reference sections of the included articles were also reviewed for relevant studies. One additional article that did not appear in the PubMed search was added from this method.

In addition to the aforementioned reports, a recent case of biopsy-diagnosed MPCS was also included in the present review. A 50-year old Caucasian male presented with a several-month history of progressively spreading shiny papular, nonpruritic skin lesions, which started on his trunk. His medical history was noncontributory, and no systemic symptoms were detected. Skin examination revealed numerous 1- to 2-mm white, shiny nonfollicular papules located on the trunk, back, and shoulders (Fig. 1a–c). Two biopsy specimens from papules on the back were taken and demonstrated interstitial and nodular collections of histiocytes and multinucleated giant cells forming naked granulomas in the upper dermis (Fig. 2a, b). Periodic acid-Schiff-diastase and acid-fast stains were negative for microorganisms. Laboratory and imaging studies including complete blood count, complete metabolic panel, computed tomography scan and upper gastrointestinal endoscopy were all within normal limits, and specifically hilar lymphadenopathy was not identified.

Based on the clinical presentation, lack of systemic symptoms, and biopsy results, a diagnosis of micropapular sarcoidosis was made. The patient was treated with hydroxychloroquine 200 mg p.o. b.i.d. and topical betamethasone. At his 2-month follow-up appointment, the skin lesions had regressed completely. Topical steroids were discontinued, and the dose of hydroxychloroquine was tapered down to 100 mg b.i.d. over the next 2 months. The skin eruption completely resolved, and he remained disease free by the 12-month follow-up.

Including the present study, there are a total of 12 reports on MPCS with an aggregate of 18 patients that were included in the review.