ejpmr, 2023,10(2), 274-276

SJIF Impact Factor 6.222

EUROPEAN JOURNAL OF PHARMACEUTICAL AND MEDICAL RESEARCH

www.ejpmr.com

Case Study

ISSN 2394-3211

EJPMR

DISCOID LUPUS ERYTHEMATOSUS WITH PSORIASIFORM LESIONS

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Article Received on 04/01/2022 **Article Revised on 25/12/2022** **Article Accepted on 15/01/2023**

ABSTRACT

DLE is a sub-type of chronic cutaneous lupus erythematosus, characterized by scaly plaques on the scalp, face and ears which can progress to scarring, atrophy, dyspigmentation. It can affect males and females of any age but occurs more frequently in women. It can be localized or generalized and some may subsequently develop signs of SLE. DLE is typically located on the nose, cheeks, ear lobes, lips. The case discussed presented with scaly erythematous plaques over dorsum of hands and feet with psoriasiform morphology.

KEYWORDS: Lupus erythematosus, photo-distributed, SLE.

INTRODUCTION

Lupus erythematosus is a multisystem disease that mainly affects the skin. The most common types are acute cutaneous lupus (ACLE), subacute cutaneous lupus (SCLE), and discoid lupus (DLE).[1] The most common subtype of chronic cutaneous lupus erythematosus is DLE. The lesions are usually photo distributed and may develop secondary atrophy or scarring.[2] Lupus can occur in all age groups, but DLE occurs more frequently in women in their fourth and fifth decades of life. The pathogenesis of cutaneous lupus erythematosus is multifactorial. Some contributing factors include ultraviolet radiation (UVR), medications, cigarette smoking, and possibly, viruses. The interaction between these factors triggers an inflammatory cascade of cytokine, chemokine, and inflammatory cell responses. Keratinocytes may also participate in lupus skin damage by increasing the apoptotic rate and the production of proinflammatory cytokines, for DLE.[3] On histopathology, in discoid lupus lesions, thickened basement membrane, interface dermatitis, periadnexal inflammation, follicular plugging, and hyperkeratosis are primarily seen.[4]

CASE

The patient was a 63 years old male presented to OPD with complain of erythematous lesions over hands and feet, associated with itching for the past 5 years. Lesions used to heal with depigmentation. Photosensitivity was present. No episodes of fever, joint pains, oliguria. Examination revealed multiple erythematous papules coalescing to form plaques, with peripheral hyperpigmentation and scaling, over dorsum of hands, forearms, lower legs and feet [Figure 1-3]. On histopathological examination, there was thickening of basement membrane, perivascular and periadnexal lymphohistiocytic infiltrate [Figure 4]. ANA was positive and other routine hematological investigations were within normal limits. The patient was started on topical corticosteroids, broad spectrum sunscreen and hydroxychloroquine.

Fig.1

Fig.2

Fig.3

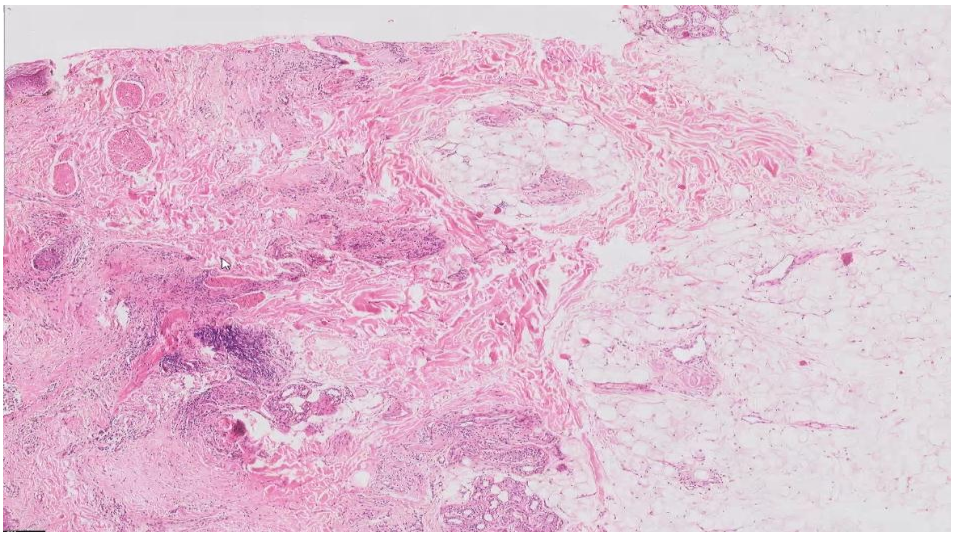

Figure 4: Photomicrograph shows scant inflammatory infiltrate of lymphocytes scattered in the dermis (H & E, x 40).

DISCUSSION

DLE is the most common form of chronic cutaneous erythematosus and can occur as localized form (80%) with lesions on the face, ears, and scalp or as disseminated DLE (20%) with lesions above and below the neck. Disseminated DLE has 28% increased risk of progression to SLE.[5] It is unusual for discoid lesions to present below the neck without the involvement of above the neck area. Some patients with discoid lesions exhibit a photo distribution. However, patients can have discoid lesions on the sun-protected skin, and there is no clear association between sun exposure and their development. Lesions are well-defined, annular erythematous patch or plaque of varying size and may slowly expand with active inflammation and hyperpigmentation at the periphery, leaving depressed central atrophy, scarring, telangiectasia, and hypopigmentation.[6] This explains the morphology and the distribution of rash in our case. Treatment for DLE consists of photoprotection with topical corticosteroids and topical calcineurin inhibitors. Antimalarials are immunotherapeutic and are considered as first-line systemic therapy for CLE.

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