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BULLOUS SUBACUTE CUTANEOUS LUPUS ERYTHEMATOSUS. A CASE REPORT

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Abstract: *Lupus erythematosus is an autoimmune collagen disorder with multiple organs involvement. Subacute cutaneous lupus erythematosus represents about 10% of Lupus erythematosus cases and is frequently drug induced. A 83-year-old female patient, otherwise healthy, presented for disseminated annular lesions with mild pruritus lasting for 5 days. The patient denied any new drug usage in the last two months. Laboratory findings showed raised Anti-Ro antibodies and Anti-La (SS-B). The patient received systemic corticotherapy with the remission of the lesions in one month. Subacute cutaneous lupus erythematosus can present with bullous skin lesions and can arise in elderly people without drug usage.*

Key words: *subacute cutaneous lupus erythematosus, bullous skin lesions*

1. Introduction

Lupus erythematosus (LE) is an autoimmune collagen disorder with multiple organs involvement. Subacute cutaneous lupus erythematosus (SCLE) represents about 10% of LE cases, usually presents with annular or psoriasiform skin lesions located on the non-sun exposed areas and is frequently drug induced [1]. Bullous lesions are very rare in SCLE, based on literature search only 6 cases were reported [1-3].

2. Case presentation

A 83-year-old female patient presented for disseminated annular lesions with mild pruritus lasting for 5 days (Figures 1-3). The patient denies any new drug usage in the last two months. On dermatological examination we found well defined erythematous annular lesions with peripheral erosions on trunk and forearms. We noted also purpuric plaques with central crusts on the legs. Mucosa, hair and nails were not affected. Based on clinical presentation our diagnosis included SCLE, bullous systemic lupus

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erythematosus, bullous pemphigoid, major polymorphous erythema and Rowell syndrome. General examination was normal. Laboratory findings showed raised LDH (277 U/L) and ESR (36 mm/h). Antinuclear antibody (AAN) and anti ADNdc antibodies were negative, Anti-Ro antibodies (SS-A) were highly raised (< 200 U/ml, n.v. <15 U/mL) and Anti-La (SS-B) antibody were slightly raised (27.8 U/mL, n.v. <15 U/mL). Reumatoid factor (FR) and antihistone antibody were negative. Histopathological examination showed thickening of basement membrane, vacuolization and necrosis of basal keratinocytes, lymphocyte infiltrate in dermis with perivascular and periadnexal distribution, suprabasal and subepidermal clefts (Fig. 4-5). We treated the patient with topical steroids (methylprednisolone 17-aceponate bid) and systemic corticotherapy (prednisone 30 mg/day) with the remission of the lesions in one month. The patient also was advice to use photoprotection methods. We noted poikilodermic residual lesions at the first follow-up. After 60 days (second follow-up) we observed only residual hyperpigmentation, especially on the posterior thorax. The patient is periodically evaluated in our department based of the increased age and the possibility of subacute cutaneous lupus erythematosus to act as a paraneoplastic dermatosis preceding a malignant tumor.

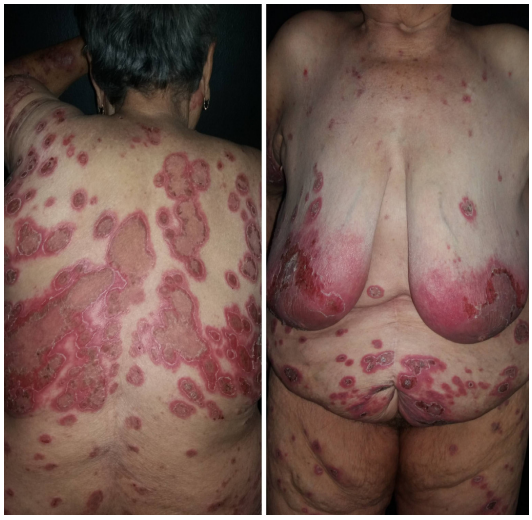

Fig. 1. *Clinical aspect- disseminated annular bullous lesions with central clearing*

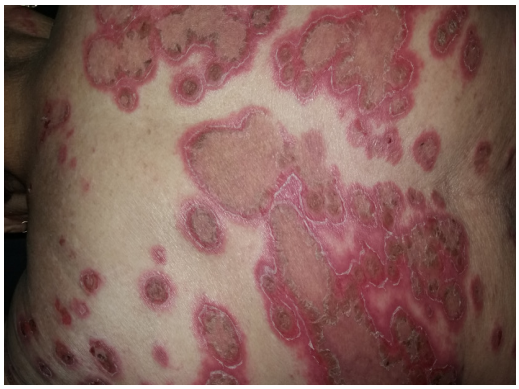

Fig. 2. *Annular lesions on the posterior trunck (detail)*

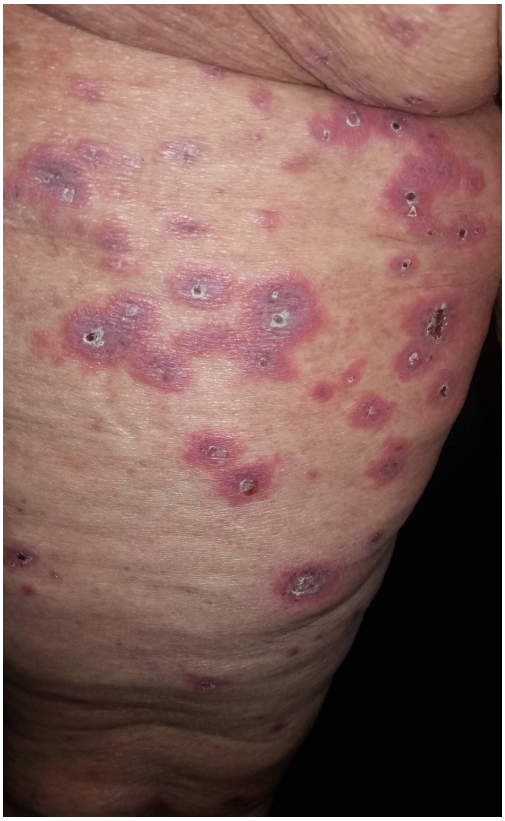

Fig. 3. *Annular, purpuric plagues with central crusts on the lower limbs*

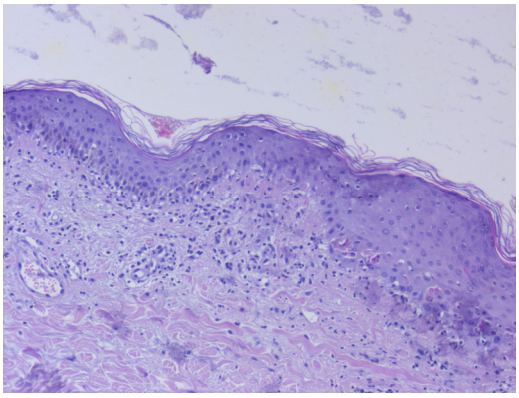

Fig. 4. *Histopathological aspect. Thickening of basement membrane, vacuolization and necrosis of basal keratinocytes, lymphocyte infiltrate in dermis with perivascular and periadnexial distribution, suprabasal and subepidermal clefts*

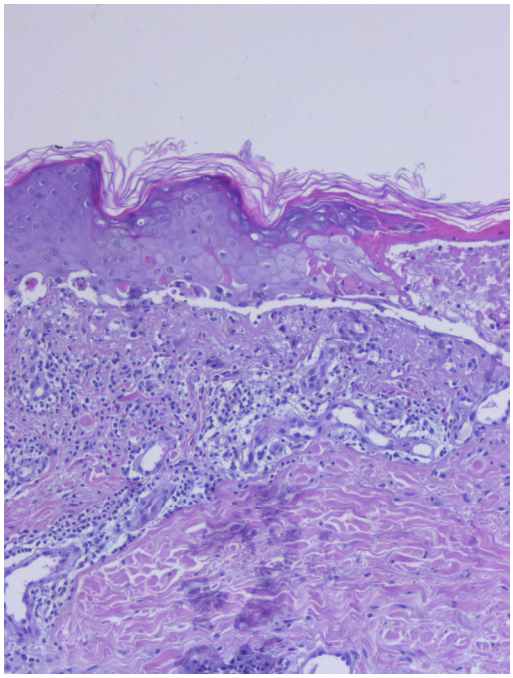

Fig. 5. *Histopathological aspect - lymphocyte infiltrate in dermis with perivascular and periadnexial distribution, suprabasal and subepidermal clefts*

3. Discussion

SCLE is frequently drug induced. The most cited medications are proton pump inhibitors, antitumor necrosis factor (anti-TNF) [4], [5]. In females, chemotherapeutic drugs are the most common drug class involved (54.5%) [6].

Bullous lesions are rarely reported in SCLE. There are uncommon and usually are associated with severe evolution of the patients [7-9]. Interesting association of SCLE with other skin diseases are cited, Peitsch et al. reported a case of SCLE in association with porphyria cutanea tarda [10]. In our case, the lesions were not located on the photoexposed areas and the patient did not present any risk factors for the disease.

After an iatrogenic trigger (drug induced subacute cutaneous lupus erythematosus) is excluded, the main treatment is systemic corticotherapy. Aromatic retinoids, methotrexate, dapsone and hydroxychloroquine were also cited to be efficient for SCLE with bullous lesions [11-12]. However, a combination of dapsone and hydroxychloroquine was efficient in one case [12].

4. Conclusions

Subacute cutaneous lupus erythematosus can present with bullous skin lesions and can arise in elderly people without drug usage.

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