DERM DX

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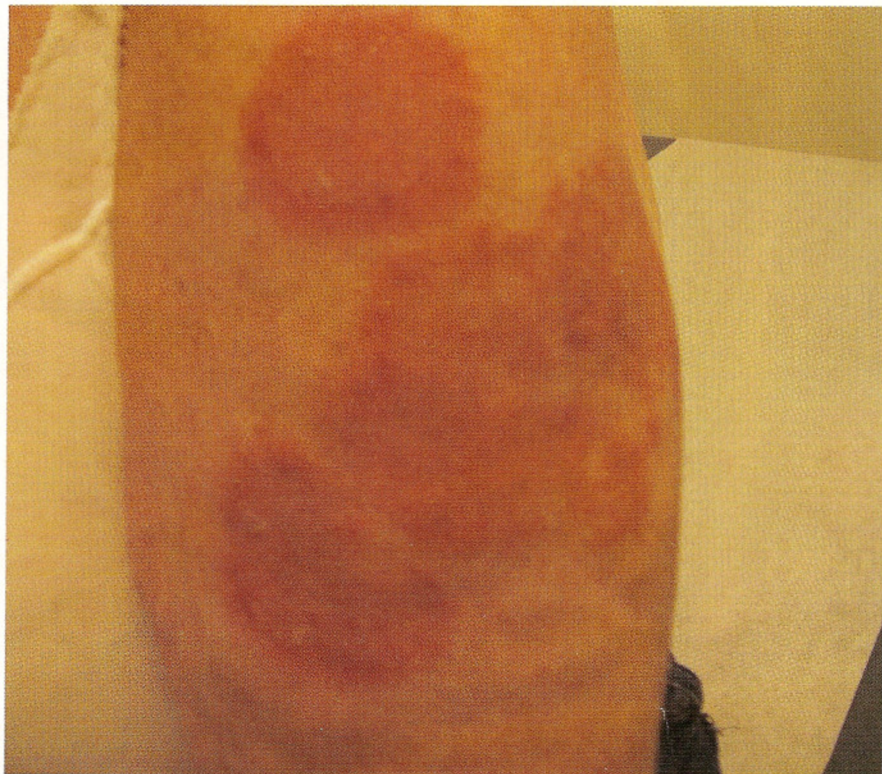
AMOR KHACHEMOUNE, M.D., C.W.S.



Diagnosis:

Subacute Cutaneous Lupus Erythematosus

BY YOON SOO BAE, B.S., MARIANNA L. BLYUMIN, M.D., AND ALEXANDRA B. KIMBALL, M.D., M.P.H.

The term *subacute cutaneous lupus erythematosus* (SCLE) was coined by Gilliam and Sontheimer,[1,2] who developed the classification system for cutaneous lupus erythematosus (LE), which includes acute cutaneous LE (ACLE), subacute cutaneous LE, and chronic discoid LE (CDLE) (**see Table next page**).[1,3] Even though these are considered distinct subcategories of LE, patients with systemic lupus erythematosus (SLE) may present with any subtype of LE individually or concurrently.[4] Although SLE and cutaneous LE share the same basic underlying disease process, patients with SLE show widespread internal as well as mucocutaneous involvement, whereas patients with cutaneous LE have the disease confined to the skin.

Children, adults, and the elderly may be affected by SCLE; however, it is mostly seen among Caucasian women with the mean age of onset in the fifth decade.[3] Overall, there is a three to four times higher incidence of SCLE among women than in men.[5]

CLINICAL FEATURES

SCLE initially presents as photodistributed, non-pruritic papulosquamous or annular polycyclic eruptions that can coalesce into large patches and plaques.[6] The SCLE lesions are easily photoprovoked and can develop into thick hyperkeratotic plaques.[5] Photosensitivity (52% to 85%), periungual telangiectasia (22% to 51%), discoid LE (19% to 35%), and vasculitis (12%) are some dermatological manifestations linked to SCLE.[7] Associated systemic symptoms are mild and include arthritis/arthralgia (43% to 94%), renal disease (11% to 19%), serositis (12%), and central nervous system (CNS) symptoms (6% to 19%).[7,8,9]

Typically, SCLE eruptions are found on sun-exposed areas such as the face, neck, extensor arms, dorsal hands, and the lower limbs, but can also be seen on the abdominal trunk and scalp.[5] The individual lesions may last for months and recur with intermittent periods of remission, making its course chronic and recurrent.[7,10] A subtle gray hypopigmentation and telangiectasia are seen in the center of annular lesions, becoming more obvious as they resolve without scarring. The telangiectasia fades, but the hypopigmentation remains for years, generating unappealing leukoderma.[7] Another possible complication, which was observed in our patient, includes temporary post-inflammatory hyperpigmentation.

The findings that can be attributed to SCLE include the following: elevated Ro(SS-A) and/or La(SS-B) antibodies; positive LE immunofluorescence band test in both uninvolved and lesional skin; low level of complement; an increase in IgG antibodies and erythrocyte sedimentation rate; symptomatic myalgia and phototesting that demonstrates persistence of erythema.[11] In effect, SCLE is diagnosed using a combination of clinical, serologic and histological criteria.