CASE REPORT

A rare case of unilateral discoid lupus erythematosus mimicking lupus vulgaris

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SUMMARY

Discoid lupus erythematosus (DLE) is a chronic type of cutaneous lupus erythematosus which can present in various morphologies, and the diagnosis can be rather confounding. Prompt evaluation and treatment is necessary to prevent disfigurement and systemic involvement associated with DLE. The following case presented a diagnostic dilemma as the lesion mimicked lupus vulgaris.

BACKGROUND

Discoid lupus erythematosus (DLE) is a type of chronic cutaneous lupus erythematosus (LE) which has many morphological variants including peri-orbital DLE, comedonic DLE and hypertrophic DLE.¹ One needs to be aware of the atypical DLE presentations for early diagnosis and treatment. In this case, the lesions presented as unilateral, erythematous, infiltrated plaque and satellite lesions mimicking lupus vulgaris. The diagnosis was delayed by the unspecific presentation and eventually led to cosmetic disfigurement of face for the patient.

CASE PRESENTATION

A 23-year-old woman presented with an erythematous, infiltrated, waxy, ill-defined plaque on the left nasolabial fold extending onto the cheek since 4 months. The plaque measured 10 cm × 6 cm approximately and had been increasing in size gradually. It was covered with scale-crust at places, central atrophy and a few satellite lesions (figure 1). There was no sensory loss over the plaque and no associated pruritus, exacerbating or diminishing factors. Rest of the cutaneous examination, including hair and nail examination, were unremarkable. She did not have any systemic complaints.

Figure 1 Erythematous, ill-defined plaque with scale-crust, scarring and satellite lesions.

Figure 2 (A) Dense nodular lymphohistiocytic infiltrate present in upper, mid and lower dermis. (B) Periodic acid Schiff stain showing thickened basement membrane along with lichenoid interface pathology

INVESTIGATIONS

A punch biopsy from the lesional skin showed interface pathology in the form of lichenoid lymphocytic infiltrate obscuring the dermoepidermal junction and a disrupted basal layer showing vacuolisation and few apoptotic keratinocytes. Follicular epithelium also displayed lichenoid interface pathology (figure 2A). Periodic acid Schiff stain demonstrated thickened basement membrane (figure 2B). Complete blood count was normal, and antinuclear antibody was negative.

DIFFERENTIAL DIAGNOSIS

Lupus vulgaris, cutaneous leishmaniasis and DLE.

TREATMENT

With histopathological findings being corroborative of DLE, patient was started on hydroxychloroquine and a short course of oral steroids along with photoprotection.

OUTCOME AND FOLLOW-UP

Above-mentioned treatment led to gradual resolution of the lesions leaving behind hyperpigmentation and some atrophy (figure 3) over 4.5 months of therapy.

DISCUSSION

DLE is a chronic variant of LE and can lead to scarring, hair loss and hyperpigmentation if it is not treated early and promptly. It has a prolonged course and can have a considerable effect on quality of life. The diagnosis is usually suspected clinically, and histopathology may be required to confirm the diagnosis. Although at the benign end of the spectrum of LE, 1%–5% of patients with DLE may develop systemic lupus erythematosus.² There have been reports of DLE mimicking tinea faciei,³ hypertrophic lichen planus,⁴

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Figure 3 Post-treatment of hyperpigmentation and atrophy.

pseudoxanthoma elasticum,⁵ polymorphic light eruption⁶ and even vitiligo.⁷ Early identification and treatment of such lesions are important to improve prognosis and possibly prevent sequelae. Our patient presented with unilateral involvement of face in the form of ill-defined infiltrated plaque with satellite lesions and central scarring on the left cheek, mimicking lupus vulgaris. Histopathology from the lesion showed classical features of DLE in the form of lichenoid interface pathology and thickened basement membrane.⁸ Patient's systemic evaluation was normal which is expected in patients with limited disease. She was started on potent topical corticosteroids along with hydroxychloroquine 200 mg, given two times per day. A short course of oral steroids was helpful in halting the progression of lesions. There was gradual resolution of lesions over the next 4.5 months, which left behind hyperpigmentation and some atrophy. Patient suffered some cosmetic disfigurement of face as sequelae of DLE, because of the delay in diagnosis which was due to the rare and unspecific presentation. A high suspicion and early diagnostic evaluation with histopathological examination is the key to better management of such cases.

Learning points

- ▶ Discoid lupus erythematosus (DLE) can have varied presentation including like lupus vulgaris.
- ▶ Histopathological examination helps in early diagnosis.
- ▶ Early diagnosis and treatment can prevent atrophy/scarring and deformity.
- ▶ Hydroxychloroquine is one of the first lines of management.
- ▶ 5% of localised DLE and 21% of generalised DLE can progress to systemic lupus erythematosus.

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