

DISCOID LUPUS ERYTHEMATOSUS WITH PROMINANT OPEN COMEDO FORMATION: an unusual clinical presentation

Sema Aytekin*, Rana Anadolu*

*Dicle University, Faculty of Medicine, Department of Dermatology

Corresponding author:
Sema Aytekin

Dicle University Dept. of Dermatology

Diyarbakır/TURKEY

Tel: Work: +90 412 248 8001/4234

Mobile: +90 533 2134959

E-Mail: semaaytekin@yahoo.com

Abstract

A 44-year-old male presented with inflammatory lesions, acneiform pitting scars with comedones on the right aspect of the nose for 5 years. Physical examination also revealed comedones on a mild erythematous base, atrophic scars and telangiectasia. Tracing back the history, there was no malar erythema, oral ulcer, or arthralgia. A skin biopsy showed large follicular plugging, perifollicular dense lymphocyte infiltration and marked melanin incontinence. He was successfully treated with 250mg/day chloroquine for 6 month. Two years later the patient were presented typical lesions for chronic cutaneous lupus lesions with comedo like lesions on the face and upper back. The laboratory tests were all normal. Cutaneous biopsy was characteristic of chronic lupus erythemathosus.

Key words: Erythematous, Cutaneous biopsy, Inflammatory lesions

Introduction

Cutaneous manifestation of lupus erythematosus (LE) are numerous and varied throughout the course of disease within an individual, as well as varying between patients, but usually permit easy diagnosis (1). However, there are atypical lesions that can mimic benign dermatologic disorders. Acneiform lesions are extremely rare reported in lupus erythematosus (2-5). We report on a patient with lesions of giant open comedo formations and who developed typically chronic cutaneous lupus erythematosus 2 years later.

Case:

A 44-year-old male presented with inflammatory lesions, acneiform pitting scars with comedones over the right aspect of nose. The open comedones on the lateral surface of the nose started 5 years ago. The eruption started after trauma from eyeglasses and then gradually extended. Physical examination also revealed comedones with a mild erythematous base, atrophic scars and telangiectasia. (Fig. 1) He had seborrheic skin texture. He had no history of application of topically steroid ointment to the area and exposure to chlorine, industrial oils, and tar. There was history of occupational excessive sun exposure. There was no malar erythema, oral ulcer, or arthralgia. The hemogram, antinuclear antibody test, complement, and urinalysis were within normal limits. Because of the photoaggravation and the absence of pustules and nodulocystic lesions, presence of erythema, diagnostic biopsy was obtained. Histopathological examination showed large follicular plugging and perifollicular dense lymphocyte infiltration and marked melanin incontinence (Fig. 2). He was successfully treated with 250mg/day chloroquine for 6 month. The lesions were improved. Two years later the patient were presented typical lesions for chronic cutaneous lupus lesions with comedo like lesions on the face and upper back. The laboratory tests related with systemic lupus were all normal range. He treated with 250mg/day chloroquine, again.

Discussion:

Cutaneous manifestations of LE may usually mimic a variety of dermatological disorders such as acne rosacea, seborrhoeic dermatitis, photoallergic contact dermatitis,

dermatophytosis, polymorphic light eruption, actinic keratosis or pemphigus erythematosus (1, 5). There are a number of clinical variants of cutaneous LE. More than 20 various unusual clinical subtypes of CCLE that sometimes differ profoundly from the typical clinical form were reported (K). There are very few reports of follicular lesions in LE. These include follicular erythema, petechiae and treatment-resistant acne (2-7). Six cases with acneiform lesions have been reported previously in the literature (1-6). Their ages ranged from 25 to 38 years and 4 out of 6 were females. Three SLE patients with treatment-resistant acne and one discoid lupus erythematosus (DLE) with acneiform pitting scars were reported (2-4).

Deruelle-Khazaal et al. reported a 30-year-old woman with inflammatory lesions and comedones on the face (2). The eruption started after her last pregnancy and was refractory to local and general treatment. She also complained of arthralgia, Reynaud's phenomenon and diffuse alopecia. Cutaneous biopsy was characteristic of chronic lupus erythematosus. Immunofluorescence microscopy of lesional skin showed a lupus band deposit. Antinuclear antibodies were highly positive. The patient was successfully treated with chloroquine (2). Two cases of systemic lupus erythematosus presenting as treatment-resistant acne were also reported by Motel et al (3). These patients were found to have a facial eruption associated with SLE as confirmed by skin biopsy. These investigators postulated that the patients with persistent acne developed lesions of cutaneous LE at the site of acne inflammation as a Koebner response. A male patient with multiple brown-red follicular papules and open comedones, hypopigmented atrophic scars without pustules or nodulocystic lesions over face, chest area and back was reported in 2008. He has a 7-year history of a pruritic and photo-aggravated lesions.

In another report, DLE lesions as acneiform pitting scars on the right nasolabial fold as reported (4). This patient has very similar lesions with pitting scars and comedones to ours. The acneiform pitting scars with LE may be related to the destructive process of pilosebaceous units by periadnexal mononuclear cell infiltration. This reaction may be more marked in the sebaceous gland-abundant area, especially the nose. Akagi et al. reported two cases of DLE with the periocular region and nostril rim (8). In their cases, central atrophic erythematous plaques were noted in the periocular region and nostril rim; however, neither comedones nor acneiform pitting scars were noted. Acneiform pitting scars on the face can also be observed in acne vulgaris, nevus comedonicus, Favre-Racouchot disease, aggregated

dilated pores, radiation-induced acne, drug induced acne, acne of exogenous origin (chlorine, industrial oils, tar) (9-11)). In our case, there was only history of occupational excessive sun exposure, no topically steroid ointment usage, and exposure to chlorine, industrial oils, and tar. The diagnosis was made by the typical histopathology findings of cutaneous lupus erythematosus.

Several hypotheses can be discussed: comedones appear as a result of a prolonged sun exposition as they appear in the disease of Favre-Racouchot, they appear in individuals with pronounced seborrhea and, most likely, the comedones are a peculiar expression of the follicular plugging.

In conclusion, acneiform lesions are rarely reported in lupus erythematosus, however atypical, treatment-resistant acneiform eruptions especially grouped comedones on an erythematous base over the face should attract attention for lupus erythematosus. A skin biopsy is required for accurate differential diagnosis.





Figure 1. Open comedones with a mild erythematous base, atrophic scars and telangiectasia on the right aspect of the nose.

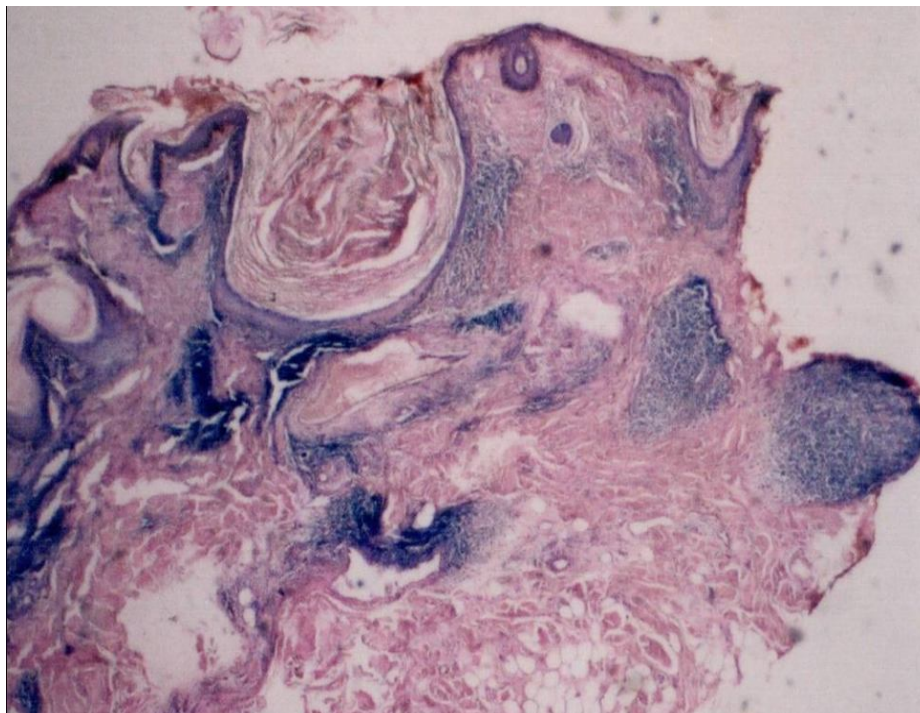


Figure 2. Large follicular plugging and perifollicular dense lymphocyte infiltration and marked

melanin incontinence (HEX 40)

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