

SUBACUTE CUTANEOUS LUPUS ERYTHEMATOSUS WITH PSEUDO-PORPHYRIA AND VITILIGO

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ABSTRACT

Sub acute Cutaneous Lupus Erythematosus (SCLE) is a distinct subset of Lupus Erythematosus. It can present as non scarring psoriasiform or annular polycyclic lesions. About half the patients fulfil the criteria of the American Rheumatism Association for systemic lupus erythematosus. In this report, we present the case of a 45 years old male who came with psoriasiform depigmented plaques and papulovesicular lesions developed after taking some medication. Clinically diagnosed as sub acute cutaneous lupus erythematosus with acral vitiligo. A histopathological study and urine analysis however revealed presence of pseudo porphyria along with the SCLE. Although SCLE is not a rare disease, the association of it with pseudo porphyria and vitiligo is of significance as the treatment for SCLE and pseudo porphyria is photo protection and for the vitiligo it is photo chemotherapy.

Key Words: Sub acute cutaneous lupus erythematosus, pseudo porphyria, vitiligo, psoriasiform eruptions.

INTRODUCTION

Sub acute Cutaneous Lupus Erythematosus (SCLE) is a distinct subset of Lupus Erythematosus characterized by erythematous non-scarring papulosquamous or annular polycyclic lesions on a sunexposed parts with pigmentary changes and telangiectasia associated with mild systemic symptoms and the presence of Autoantibodies.^{1,2}

CASE REPORT

A 45-year-old man Mr. R.K. an agriculturist by occupation presented with generalized erythematous scaly plaques and papulovesicles with areas of depigmentation and hyper pigmentation mainly over the forehead, malar area, nose, scalp, 'V' area of neck and extremities. The skin lesions started 3 years back after taking some medicines

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Fig. 1

Fig. 1. Psoriasiform Lesions on the Sun-exposed parts of the body.

(nature not known) for a small cut wound on right index finger as papulovesicular lesions mainly on sun exposed areas with few isolated lesions on the trunk which had healed with hyper pigmentation. Some papules on the sun-exposed areas progressed to psoriasiform plaques. Lesions were aggravated by sun exposure but there were no systemic disturbances. He was a chronic smoker and known alcoholic but on medical advice is abstaining from it for the last 3 years. Patient was treated with Astemizole and Prednisolone, all the lesions healed with slate gray pigmentation but for the lesions on the face and extensor aspect of forearms. Lesions reappeared 3 months back after the patient stopped taking medications.

Incidental findings of vitiligo lesions were present on the glans, prepuce, both the palms and soles.

Routine hematological examination revealed no

abnormalities but for the ESR, which was 45mm in I hour and 2 months after treatment it was 14mm in I hour. Blood was positive for ANA and urinary porphyrin was present (on quantitative estimation).

Biopsy was taken on admission and showed features of sub epidermal vesicular dermatitis with scant inflammation suggestive of Porphyria Cutanea Tarda or Pseudo porphyria. Repeat biopsy at a later date from different area showed hyperkeratosis, parakeratosis and elongated and pointed rete ridges. Some vacuolated cells are seen in the basal layer. Papillary dermis showed diffuse infiltration by mononuclear cells with many congested blood vessels and perivascular lymphocytic infiltration. The features were suggestive of sub acute cutaneous lupus erythematosus.

Patient was put on oral chloroquine and topical sunscreens. The skin lesions have improved markedly with complete repigmentation of the face and forearm without any scarring. No new lesions have appeared. The patient is on regular follow up since last one and half years.

DISCUSSION

Subacute cutaneous lupus erythematosus is a distinct subset of SLE, which is an autoimmune collagen vascular disease.^{1,2} SCLE lesions are non scarring, less follicular plugging, less persistent and more wide spread than DLE. Pigmentary changes in SCLE is prominent and unlike DLE not associated with dermal atrophy. It can be precipitated by sun exposure, drugs like Griseofulvin,³ Hydralazine,⁴ etc., stress or intercurrent infections. About half the patients fulfil the criteria of the American Rheumatism Association for SLE.⁵ In the present case only 3 of the 11 criteria of ARA is present i.e., Photosensitivity, Discoid rash and Antinuclear antibodies.

Fig. 2

Fig. 2. Psoriasiform Lesions on butterfly area of face, forehead and earlobes and vitiligo on lips.

Drugs like Naproxen, Furesemide, Tetracycline, Dapsone etc. can precipitate Pseudo porphyria and can be an association of Lupus Erythematosus.⁶

Vitiligo as an autoimmune disease is known to be associated with diabetes mellitus, alopecia areata, pernicious anemia. Grave's disease etc.² However, the association of pseudo porphyria vitiligo with SCLE has not been reported as such. In this case report we have tried to highlight the rare association of pseudo porphyria and vitiligo with SCLE.

In the present case drug taken for trauma to the index finger in a chronic alcoholic person might have precipitated the Pseudo Porphyria and SCLE, where Vitiligo lesions are present on the palms, soles and genitalia.

The patient has to be observed for development of overt sign of SLE.

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