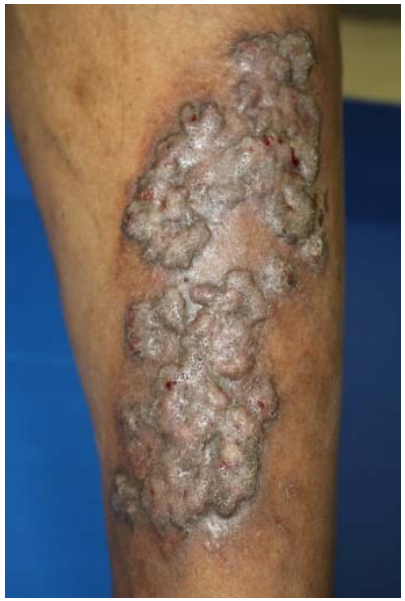
Case 12
A 59 years old Thai man from Prachin Buri province

Chief complaint: Pruritic brownish plaques for a year


(Fig. 12.1)

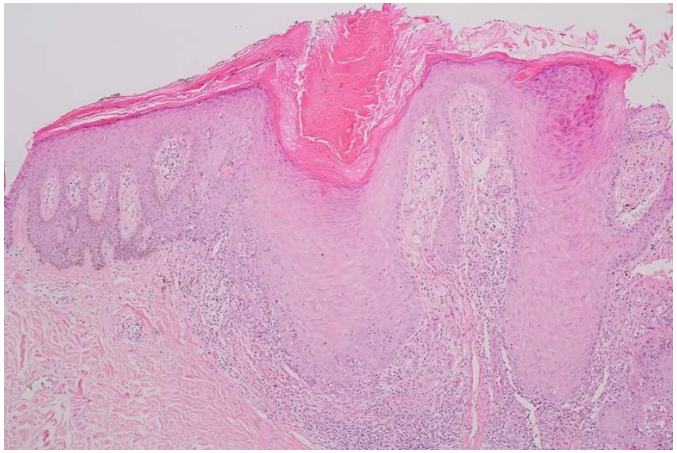
Present illness: The patient presented with progressive itchy, pigmented and verrucous lesions on left lower extremity for a year. He denies other constitutional symptoms. He was diagnosed verruca vulgaris and had previously been treated by unknown topical medications without improvement.

Past history: History of deep vein thrombosis which completely resolved after treatment

Physical examination:
Vital signs: T37.0 PR 70 bpm RR 22 /min BP159/90 mmHg
A Thai male, alert
HEENT: no oral ulcer
Lymph node: no palpable lymph nodes
Cardiovascular and respiratory systems: normal
Abdomen: soft, not tender
Extremities: no pitting edema

Dermatological examination: (Fig. 12.1)
Multiple well-defined erythematous to brownish verrucous hyperkeratotic plaque with surrounding hyperpigmentation on left shin

Histopathology: (S17-11310, Left shin) (Fig. 12.2)


(Fig. 12.2)

- Pseudocarcinomatous epidermal hyperplasia with focal hyper

granulosis and parakeratosis
- Focal licheoid infiltrate of lymphocytes, in associated with scattered necrotic keratinocyte and follicular plugging

Diagnosis: Hypertrophic discoid lupus erythematosus

Treatment:
- Triamcinolone acetonide 10 mg/ml intralesional injection
- 0.05% clobetasol propionate cream apply twice daily

Presenter: Woranit Onprasert, MD

Consultant: Salinee Rojhirunsakool, MD

Discussion:

Hypertrophic discoid lupus erythematosus (DLE) or verrucous lupus erythematosus is a rare subtype of chronic cutaneous lupus erythematosus and represents approximately 2% of total chronic cutaneous lupus erythematosus.[1,2]

A clinical course marked by chronicity and progression of the lesions characterized by thick scaling overlying the discoid lesion or occurring at the periphery of the discoid lesion. The intensely hyperkeratotic lesions are often prominent on the extensor arms, but the face and upper trunk may also be involved.[3]

Clinical differential diagnosis of hypertrophic DLE includes hypertrophic lichen planus which is seen primarily on the shin but often accompanied by intensive pruritus and presence of classic lichen planus lesions. Lichen simplex chronicus (LSC) may look similar to hypertrophic DLE but it is usually characterized by chronic pruritic plaque with prominent lichenification. Other entities that should be considered especially in elderly patients include squamous cell carcinoma, verrucous carcinoma and keratoacanthoma.

Histologically, the epidermis is papillomatous, hyperplastic, and surmounted by hyperkeratotic scales. Large numbers of dyskeratotic keratinocytes are usually noted in the lower portion of the epithelium, associated with a band-like mononuclear infiltrate along the dermal-epidermal junction which seemed to play a key role in the development of the hypertrophic lesions. Older lesions display a thickened basement membrane zone. A second pattern consists of a cup-shaped keratin-filled crater surrounded by an acanthotic epidermis with elongated rete ridge and a sparse mononuclear infiltrate. These changes, in the presence of a deep dermal perivascular, periappendageal, and interstitial infiltrate and mucin deposition, suggest a diagnosis of hypertrophic or verrucous lupus erythematosus.[4-6]

Approximately 5-10% of patients with isolated localized DLE subsequently develop systemic lupus erythematosus.[3] Likewise, patients with hypertrophic DLE probably do not have a greater risk for developing SLE than do patients with classic DLE lesions.[7]

Hypertrophic DLE is treatment resistant. The management of hypertrophic DLE includes general measures like avoidance of sun exposure and specific measures. High-potency topical corticosteroids and intralesional corticosteroids are usually effective.[4] Successful treatment of hypertrophic LE has been demonstrated with acitretin,[8] isotretinoin,[9] and thalidomide[10] in some reports. Our patient showed a very good therapeutic result after treatment with intralesional and topical corticosteroids.

References:

1. Mascaro JM, Herrero C, Hausmann G. Uncommon cutaneous manifestations of lupus erythematosus. Lupus 1997;6:122-131.
2. Sontheimer RD. The lexicon of cutaneous lupus erythematosus - a review and personal perspective on the nomenclature and classification of the cutaneous manifestations of lupus erythematosus. Lupus 1997;6:84-95.
3. Lee LA. Lupus erythematosus. Bolognai J, et al Dermatology 3rd edition Philadelphia:Elsevier;2012:620.
4. Uitto J, Santa-Cruz DJ, Eisen AZ, Leone P. Verrucous lesion in patients with discoid lupus erythematosus. Clinical, histopathological and immunofluorescence studies. Br J Dermatol 1978;98:507-20.
5. Daldon PE, Macedo de Souza E, Cintra ML. Hypertrophic lupus erythematosus: a clinicopathological study of 14 cases. J Cutan Pathol 2003;30:443-8.
6. De Berker D, Dissaneyeka M, Burge S: The sequelae of chronic cutaneous lupus erythematosus, Lupus 1992;1:181.
7. Melissa I. Costner, Richard D. Sontheimer. Lupus erythematosus. Fitzpatrick's Dermatology in General Medicine 8th Edition New York:McGraw-Hill;2012:1917.
8. Al-Mutairi N, Rijhwani M, Nour-Eldin O. Hypertrophic lupus erythematosus treated successfully with acitretin as monotherapy. J Dermatol 2005;32:482-6.
9. Green SG, Piette WW. Successful treatment of hypertrophic lupus erythematosus with isotretinoin. J Am Acad Dermatol 1987;17:364-8.
10. Georgala S, Katoulis AC, Hasapi V, Koumantaki-Mathioudaki E. Thalidomide treatment for hypertrophic lupus erythematosus. Clin Exp Dermatol 1998;23:141.