



# SUBACUTE CUTANEOUS LUPUS ERYTHEMATOSUS

<http://www.aocd.org>

Subacute cutaneous lupus erythematosus (SCLE) is a clinically distinct disease that is associated with **systemic lupus erythematosus** in 50% of patients, and can be associated with Sjögren's syndrome and patients with a deficiency in the second and fourth components of complement. SCLE presents as a small, erythematous, scaly papular eruption in a photosensitive distribution that subsequently leads to a psoriasiform or annular lesion. It is a non-scarring and non-atrophic photosensitive dermatosis. The lesions heal without scarring however, they may leave some dyspigmentation. The most frequently affected areas include the shoulders, forearms, neck, and upper torso. Approximately 50% of patients with SCLE have accompanying joint involvement. Arthralgias are often symmetrical, and usually affect the small joints such as the wrists or those of the hands.

Subacute cutaneous lupus erythematosus occurs in genetically predisposed individuals, most often in patients with the anti-Ro (SS-A) autoantibody, a positive antinuclear antibody (ANA) reaction and human leukocyte antigens B8, DR3, DRw52 and DQ1. The reaction is strongly associated with ultraviolet light and has been shown to be drug induced in certain patients. Drugs such as hydrochlorothiazide, calcium channel blockers, angiotensin-converting enzyme (ACE) inhibitors, **terbinafine**, procainamide, **antihistamines** and tumor necrosis factor antagonists precipitate this disease. Therefore, a drug history is pertinent in the initial evaluation of patients with SCLE and drug withdrawal is necessary.

In certain patients an elevated ESR and a positive rheumatoid factor with decreased complement levels can be seen. In addition, anemia, leukopenia, or thrombocytopenia may be present. A urinalysis should be done and must be performed periodically throughout the patient's clinical course. A **biopsy** on unaffected skin can be performed on sun-exposed or non-exposed locations. Testing of this normal area of skin is called the lupus band test (LBT). A biopsy of affected skin shows the distinctive histopathology of vacuolar alteration of the basal cell layer and an inflammatory lymphocytic cell infiltrate around vessels and appendiceal structures, as well as in the sub-epidermis.

The most effective treatment for SCLE is sun protection in the form of a broad spectrum **sunscreen** and protective clothing. **Corticosteroids topically or intralesionally** can be used, as well as antimalarials such as **hydroxychloroquine** which has decreased efficacy in patients who smoke. Patients should however, avoid the use of **systemic corticosteroids** unless the patient experiences systemic disease or requires short term use. In addition, certain patients can benefit from the use of **dapsone**, thalidomide, interferon, systemic retinoids and immunosuppressive agents.

Lastly, select patients with SCLE have been found to have low levels of vitamin D and should be advised to begin taking vitamin D and calcium supplementation.

**This information has been provided to you compliments of the American Osteopathic College of Dermatology and your physician.**

*The medical information provided in this article is for educational purposes only and is the property of the American Osteopathic College of Dermatology. It is not intended nor implied to be a substitute for professional medical advice and shall not create a physician - patient relationship. If you have a specific question or concern about a skin lesion or disease, please consult a dermatologist. Any use, re-creation, dissemination, forwarding or copying of this information is strictly prohibited unless expressed written permission is given by the American Osteopathic College of Dermatology. For detailed information including links to related topics on this and many other skin conditions with photos, visit: <https://www.aocd.org/page/DiseaseDatabaseHome>*