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Acute onset of a severe rash on the face and dorsal hands

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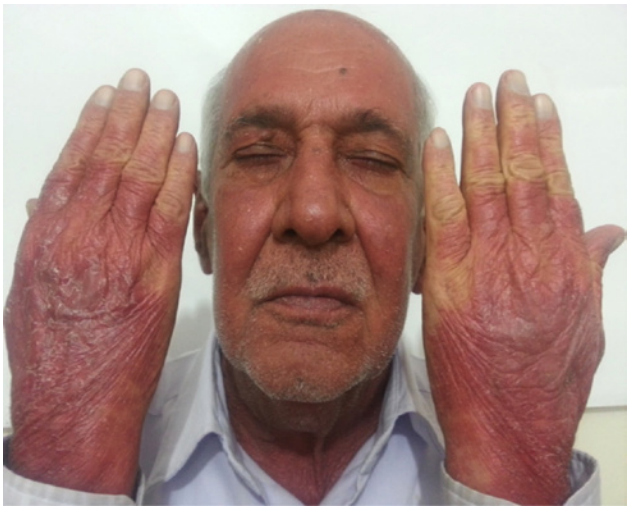

Figure 1. A 57-year-old man presented with a one-month history of photosensitivity. [Copyright: ©2017 Feily.]

The Patient

A 57-year-old man presented with a one-month history of photosensitivity (Figures 1, 2). On physical examination erythematous patches affected all parts of his face and dorsum of both hands. Interestingly the erythematous rash affected the dorsum of hands between the joints but the joints were spared. All laboratory tests were within normal range. A skin biopsy was performed, and histopathologic examination illustrated cutaneous lupus erythematosus.

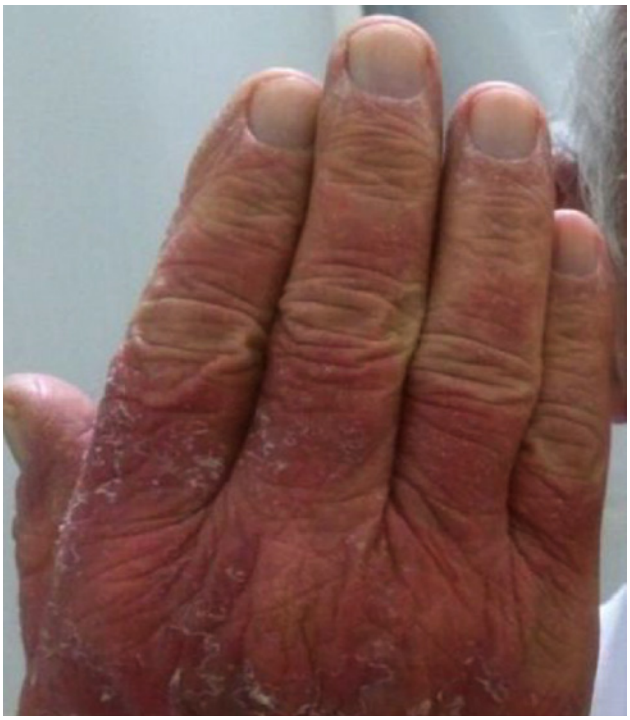

Figure 2. Photosensitive rash affected the interphalangeal spaces; the joints were spared. [Copyright: ©2017 Feily.]

Discussion

Systemic lupus erythematosus (SLE) is a chronic disease that can affect any organ system. Its clinical manifestations are highly variable, ranging from chronic to fulminant. Cutane-

ous lupus erythematosus (CLE) is the second most common finding of SLE. In a majority of cases, CLE is the main and sometimes the only feature of the disease independent of systemic involvement.

Dermatologic manifestations of lupus include malar rash, a fixed erythema that typically spares the nasolabial folds; photosensitive rash, which is often macular or diffusely erythematous on sun-exposed regions of the face and upper extremities and generally persists for more than one day; and a discoid rash which occurs in 20% of patients with SLE and can result in persistent scars. Other less specific cutaneous findings include alopecia, vascular lesions such as livedo reticularis, periungual erythema, telangiectasias, and Raynaud phenomenon.

Photosensitive SLE rashes basically occur on the face or upper extremities. It is necessary to differentiate photosensitive lupus rash from a dermatomyositis rash. In lupus erythematosus the interphalangeal spaces are affected, but in dermatomyositis the erythematous rashes named Gottron's papules are found over the joints and the interphalangeal areas are spared. Our patient was treated successfully with prednisolone and hydroxychloroquine without recurrence after 6-month follow-up.