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A RARE PRESENTATION OF DLE MASQUERADING AS BOWEN'S DISEASE: A CASE REPORT

Dermatology

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ABSTRACT

Discoid Lupus Erythematosus (DLE) is a benign inflammatory disorder of the skin that most frequently involves the face and scalp. It is characterized by asymptomatic, well defined, red, scaly patches of variable size, which heal with atrophy, scarring and pigmentary changes. Bowen's disease is a squamous cell carcinoma in situ of unknown etiology that occurs in both sun exposed and covered areas. It presents as well circumscribed, round to oval, pink or dark red scaly patches which may become hyperkeratotic, crusted or ulcerated.

KEYWORDS

Discoid Lupus Erythematosus (DLE), Bowen's disease

INTRODUCTION:

Discoid lupus erythematosus is a type of chronic cutaneous lupus (CCLE), an autoimmune skin condition that presents as red, inflamed, coin-shaped (discoid) patches and plaques most often on the scalp, cheeks, and ears. It is an asymptomatic condition and scaling and crusting are common features. Bowen's disease is a rare skin disorder. Affected individuals develop a slow-growing, reddish scaly patch or plaque, more commonly on the sun exposed areas of the skin. Bowen's disease only affects the epidermis and the lesions are usually not painful. It is a precancerous condition that commonly affects older individuals and its reddish-brown plaque can sometimes resemble DLE.

CASE REPORT:

A 65-year-old male presented with chief complaints of multiple, asymptomatic, raised pigmented lesions over the lateral aspect of the left thigh for the past 1 year and a similar lesion over the gluteal region for the past 8 months. The lesions were slow and progressive in onset. Itching, pain and burning sensation were found to be absent. There was no history of photosensitivity, atopy, trauma, Tuberculosis or contact with carcinogens. He was a known case of Diabetes Mellitus and Hypertension for the past 20 years and was on regular treatment for the same.

On local examination: A well circumscribed, hyperpigmented, scaly plaque of size 3 x 4 cm was present on the lateral aspect of the left thigh and a similar plaque measuring 2 x 2 cm was seen in the intergluteal cleft. There was no tenderness over the lesions. Xerosis was observed all over the body. The scalp, nails and genitals were normal and the lymph nodes were not palpable.

Clinically, these findings were synchronous with the those of Bowen's disease, thus we further evaluated the patient by performing Dermoscopy and a skin biopsy and examining the histopathological findings.

On Dermoscopy, prominent follicular plugging with perifollicular erythema was seen. There was a pinkish background of erythema with diffuse superficial white scaling. Accentuation of peripheral pigmentation was prominent.

A 1.5mm punch biopsy was drawn from both the plaques.

On Histopathological examination, the epidermis showed the presence of hyperkeratosis, parakeratosis, follicular plugging and mild spongiosis. In the dermo-epidermal junction, loose collections of lymphocytes and histiocytes were present along with hydropic degeneration of basal cells. Pigment incontinence was noticed along the upper dermis.

These findings were suggestive of Discoid Lupus Erythematosus.

The patient was prescribed a broad-spectrum sunscreen, a topical mid potent corticosteroid and tablet Hydroxychloroquine 200mg once a day.

DISCUSSION:

Discoid lupus erythematosus presents with erythematous, well defined discoid patches and plaques of skin with adherent scales giving a crusty appearance, commonly over the scalp, cheeks, and ears. It is associated with photosensitivity and is commonly found on sun-exposed areas. It is a benign disorder of the skin, which heals with atrophy, scarring and pigmentary changes. Carpet tac sign – the presence of keratotic spikes on the undersurface of the scale upon its removal, is usually demonstrable in Classic DLE lesions. Histopathologically, it is characterized by epidermal atrophy, vacuolar degeneration of basal cell layer of epidermis and patchy dermal lymphocytic infiltrate and mucin deposition in the dermis. Malignant transformation can rarely occur in this condition. Biopsies are often required in order to establish a definitive diagnosis and to differentiate DLE from inflammatory, infectious and neoplastic skin diseases [2] DLE is divided into two types: localized and disseminated[1] Localized DLE affects only the face and neck, while disseminated DLE affects the entire body. [3] Patients with discoid lupus erythematosus (DLE) have been found to have elevated interferon levels.[4] DLE is generally not associated with positive ANA titres and patients showing signs of nephropathy, presence of arthralgias and elevated ANA titres (> or=1:320) should be carefully monitored, because they may be at risk of developing systemic Lupus Erythematosus. [5] As permanent scarring may result from treatment failure, early treatment of discoid lupus lesions is essential for the total clearing of skin lesions. Treatment protocol includes strict adherence to sun protection in conjunction with topical or oral corticosteroids, topical calcineurin inhibitors, and systemic antimalarial therapy. Intralesional corticosteroid injections may be used in chronic DLE lesions that are not responsive to topical corticosteroids or topical calcineurin inhibitors.

Bowen's disease is an intra-epidermal squamous cell carcinoma that generally affects fair skinned individuals with a peak incidence in sixth to eighth decade of life. Most common sites are the head and neck followed by the extremities. It can occur in both sun-exposed and unexposed areas. Its etiological causes include chronic ultraviolet radiation exposure, previous radiation, human papillomavirus infection, immunosuppression, arsenic exposure, trauma and genetic factors. It usually presents as a single, erythematous, infiltrated, crusted plaque that may rarely mimic DLE. Various treatment modalities are available for treating Bowen's disease, these include– cryotherapy, curettage, excision and topical 5-FU cream.

CONCLUSION:

A rare presentation of DLE along the unusual sites that are usually protected from the sun's radiation prompted us to report this case. Our report highlights the noteworthiness of taking into consideration the diagnostic dilemma of DLE masquerading as Bowen's disease.

ACKNOWLEDGMENT: None

Conflict Of Interest: The authors declare that there is no conflict of interest.

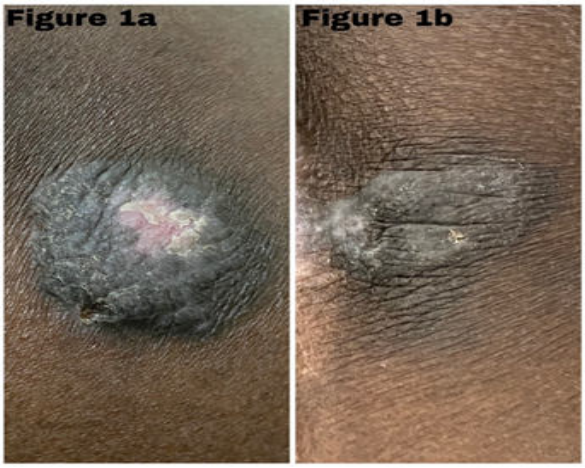

Figure 1a – Hyperpigmented scaly plaque on the lateral aspect of left thigh

Figure 1b – Hyperpigmented plaque in the intergluteal space

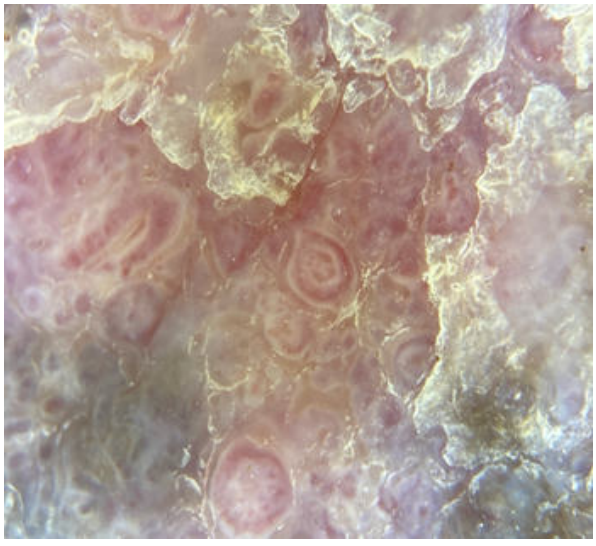

Figure2(Dermoscopy): Prominent Follicular Plugging With Perifollicular Erythema Was Seen. There Was A Pinkish Background Of Erythema With Diffuse Superficial White Scaling. Accentuation Of Peripheral Pigmentation Was Prominent.

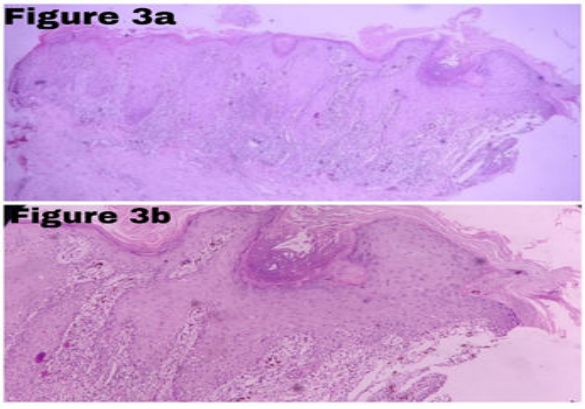

Figure 3a (H&E; 10x): Hyper keratosis and follicular plugging.

Figure 3b (H&E; 40x): DEJ: loose collections of lymphocytes and histiocytes, hydropic degeneration of basal cells with pigmentary incontinence along upper dermis.

REFERENCES:

1. Goodfield MJ, Jones SK, Veale DJ. The connective tissue diseases (Discoid Lupus Erythematosus) In: Burns T, Breathnach S, Cox N, Griffiths C, editors. Rook's Textbook of Dermatology. 7th ed. Oxford: Blackwell Science Ltd; 2004. pp. 5–24. [Google Scholar]
2. 1 James WD, Berger T, Elston D. Psoriasis. In: Andrews' Diseases of the Skin. Clinical Dermatology (Odom RB, James WD, Berger T, eds), 10th edn. Amsterdam: Elsevier, WB Saunders Co., 2006; 157–60.
3. Goodfield MJ, Jones SK, Veale DJ. The connective tissue diseases (Discoid Lupus Erythematosus). In: Burns T, Breathnach S, Cox N, Griffiths C, editors. Rook's Textbook of Dermatology. 7 th ed. Oxford: Blackwell Science Ltd; 2004. p. 5-24.
4. Braunstein I, Klein R, Okawa J, Werth VP. The IFN-regulated gene signature is elevated in SCLE and DLE and correlates with CLASI score. Br J Dermatol 2012.
5. Tebbe B, Mansmann U, Wollina U, Auer-Grumbach P, Licht-Mbalyohere A, Arensmeier M, et al. Markers in cutaneous lupus erythematosus indicating systemic involvement.A multicenter study on 296 patients. Acta Derm Venereol. 1997;77:305–8