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SQUAMOUS CELL CARCINOMA OVER DISSEMINATED DISCOID LUPUS ERYTHEMATOSUS ON NON-PHOTOEXPOSED SKIN

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A patient with disseminated discoid lupus erythematosus who developed squamous cell carcinoma in a lesion of discoid lupus erythematosus situated over a relatively photocovered area is described. Histopathology and direct immunofluroscence confirmed the diagnosis.

Key Words : Disseminated DLE, Non-photoexposed area, SCC

Introduction

The development of squamous cell carcinoma (SCC) over discoid lupus erythematosus (DLE) lesions is rare in Asians. Its occurrence over DLE lesions in non-photoexposed skin is still rarer. A case recently seen by us is being reported.

Case Report

A 66-year-old male presented with multiple erythematous, slightly scaly and atrophic plaques over face, scalp, ear, neck, trunk and limbs of 4 years duration. Few lesions showed follicular plugging and telangiectasia. Initially the lesions were limited to face for 2 years; subsequently they spread to other parts of the body. A diagnosis of DLE was made by a local practitioner and the patient was prescribed topical corticosteroids with temporary benefit. The patient noticed a small growth on a existing DLE plaque over medial aspect of left arm which rapidly increased to a cauliflower like mass over a duration of 4 months. However, there was no significant enlargment of local lymph nodes. There was no history of fever, joint pain, weight loss or any constitutional symptoms. General and systemic examinations were essentially normal.

Routine investigations were within normal limits. Rheumatoid factor, antinuclear factors (ANF), LE cells were also negative and serum complement levels were within normal range. A diagnosis of disseminated DLE with SCC was made. Histopathology from the DLE

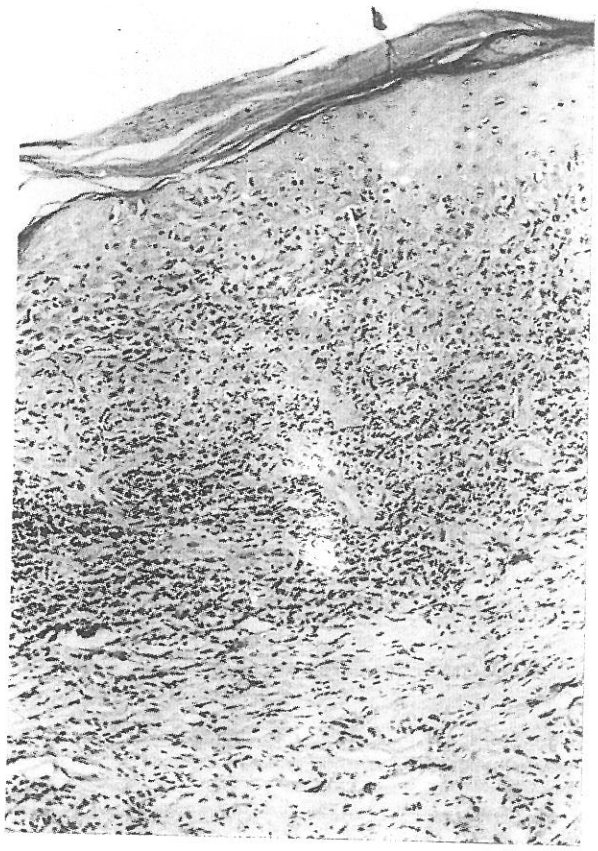

Fig. 1. Showing hyperkeratosis, focal parakeratosis, acanthosis with focal thinning of epidermis and basal cell degeneration (H&E, X 140)

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plaque showed focal epidermal atrophy with basal cell degeneration and lymphomononuclear infiltrate in the dermis (Fig 1) while that from growth revealed features of well differentiated SCC (Fig 2). Direct immunofluorescence from DLE lesion showed degeneration of cell layer with large amount of IgG, IgM in the dermo-epidermal junction. There was deposition of IgA in the upper dermis but complement was absent. The patient was advised surgical excision of

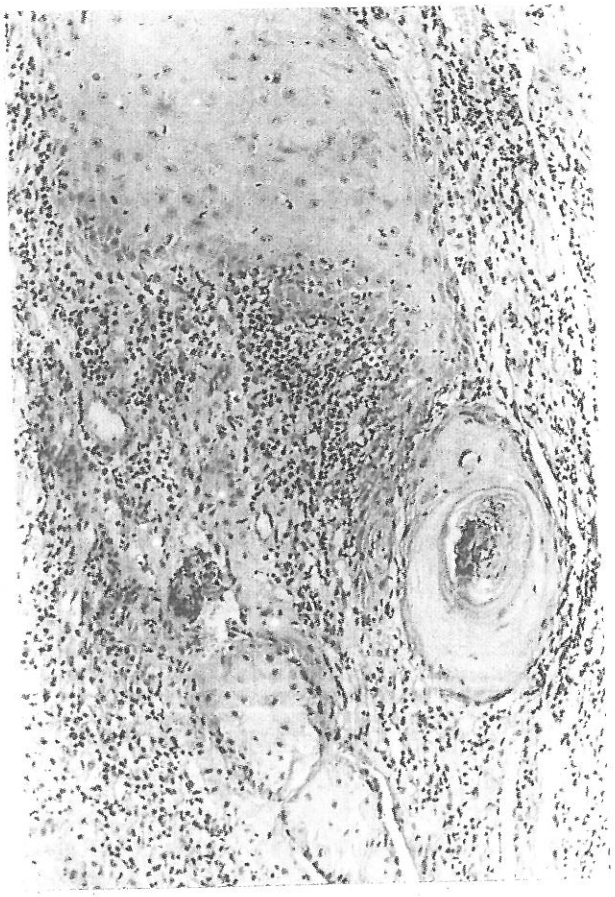

Fig. 2. Showing features of keratinizing squamous cell carcinoma (H&E, X 140).

the tumour and was started on chloroquine and sunscreens for DLE lesions. However, the patient was lost for further follow-up.

Comments

Although the incidence of SCC on DLE is well reported in whites,[1] only few cases are mentioned in coloured population.[2-6] Skin cancers are however, relatively uncommon in black races probably due to inherent pigment protection from carcinogenic effect of solar radiation.[2] SCC can otherwise develop on DLE lesion as such and on scars following DLE. Malignant transformations does not occur in cutaneous lesions of acute or subacute lupus erythematosus. Malignant changes are usually found on plaques of DLE of prolonged duration and these usually develop 2 decades or more after the onset of the disease.[3] In our patient however, SCC occurred over a DLE plaque, which was present since 2 years only. Most of the reported cases of SCC over DLE have been solitary lesion as in our case.[3] Medial aspect of arm near elbow is a relatively photocovered site. Occurrence of SCC over existing DLE lesion on such photocovered area is perhaps almost unknown.

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