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CHILBLAIN LUPUS ERYTHEMATOSUS

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Two cases of chilblain lupus erythematosus (CLE) were seen in females aged 33 years and 18 years. Photosensitivity, chronicity and aggravation in winters were present in both cases. Histopathology revealed follicular keratosis, atrophy and extensive liquefaction of basal cells. Oral pradnisolone with chloroquine resulted in marked improvement in the skin lesions.

Key Words : Discoid lupus erythematosus, Chilblains, Liquefaction degeneration

Introduction

About 6% cases of discoid lupus erythematosus (DLE), predominantly females, develop chilblain like lesions mainly on toes, fingers but also on heels, calves, knees, knuckles, elbows, nose and ears.[1] Chilblain LE lesions persist even when DLE lesions remit with treatment.[1] Occasionally, one or more fingers may also show a curious atrophic spindling, sometimes with hyperextension of terminal phalanges and dystrophy of nails.[2] Chilblain lupus can be treated with chemical sympathectomy.[3] Bullous lesions in DLE were reported.[4] DLE can rarely present as reddish nodular lesions of nose, cheeks, forehead and chin with diffuse erythema of face and easy flushing.[2] Histopathology of CLE is similar to DLE with more of atrophy of epidermis, follicular keratosis, extensive liquefaction degeneration of basal cells and perivascular mononuclear infiltrate in dermis.[5]

Case I. A 33-years-old female developed mild pruritis, burning, Raynaud's phenomenon and chilblains of feet and hands 4 years back. Partial improvement occured in summer. Bilateral symmetrical lesions on the fingers, mid palms, distal half of feet were seen as mottled depigmentation, oedema, erythema, cold blue, stiff fingers. Flexion at proximal and extension at distal interphalangeal joints of some fingers was present. Tapering of some fingers and nail dystrophy of right little finger and toe nails were seen. She developed photosensitivity and erythema of face with periorbital heliotrope, discrete, erythematous, flat smooth surfaced papules on face and extensors of forearms since 15 days. Facial and forearm lesions disappeared with systemic chloroquine (8.4 gms) and topical steroids in 6 weeks. In 7th week, ESR was raised to 22mm and she developed vesiculo-bullous lesions on hands and feet which were treated with 10 mg prednisolone daily for 2 weeks. General physical and systemic examinations were normal. Hb was 11 gm%, TLC was 7500/ DLC was P_{68}, L_{30}, M_0, E_2. ESR was 6mm initially and 22mm with appearance of vesiculo bullous lesions. FBS, blood urea, LE cell phenomenon, BT, CT, Platelet count, Rh factor, urine and stool examinations were normal. Total serum proteins were 5.5 gm%. Histopathologically forearm lesion revealed mild hyperkeratosis, mild atrophy, irregular acanthosis, follicular plugging, extensive vacuolar degeneration and patchy perivascular mononuclear infiltrate in dermis. Histopathology from foot was similar except for massive hyperkeratosis and more of acanthosis.

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Case II. An 18-year-old female suffered from chilblains every winter since 4 years. She developed photosensitivity, arthritis and typical target shaped erythematous maculopapular lesions on dorsum of hands and feet since 1 month. General physical and systemic examination were normal. Routine investigations were normal. ESR was 28 mm. Clinical diagnosis of CLE could not be confirmed as she refused biopsy. She was treated with 10mg prednisolone, tab chloroquine twice daily and topical steroids.

Comments

Case I was diagnosed as a case of CLE as she had Raynaud's phenomenon, chilblains, progressive disease with only partial improvement in summer, tapering of fingers, arthritis, nail dystrophy, periorbital heliotrope resembling dermatomyositis and facial erythema with erythematous papules of face and extensors of forearms. Clinical diagnosis was confirmed histopathologically. Papules and facial erythema disappeared, vesiculobullous lesions healed but chilblains, Raynaud's phenomenon and other chang persisted even in summer. Clinical diagnosis case II could not be confirmed as patie refused biopsy. Erythema-multiforme li lesions disappeared after 3 weeks thou chilblains persisted.

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