DISCOID LUPUS ERYTHEMATOSUS AND ADENOCARCINOMA PALATE
Case report

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Summary

An unusual association of discoid lupus erythematosis and adenocarcinoma of palate is being described. A relationship between the two, however, could not be established.

An interesting association of discoid lupus erythematosis (DLE) occurring in a patient with adenocarcinoma of the hard palate is reported.

Case report

A 60 year old male, with established adenocarcinoma of the hard palate reported to the out-patients department with several dirty red eruptions on the face, the scalp and the ears of seven years' duration. Initially, these had appeared over the bridge of the nose and ultimately extended to other areas of the face and the scalp. The eruptions had remained asymptomatic throughout the course of the disease. On detailed questioning it was revealed that the eruptions showed exacerbation on sun exposure. The adenocarcinoma had appeared 13 years prior to the onset of these eruptions. Patient was operated for the cancer but a perforated palate had remained as a residual defect, and six months before admission the carcinoma had recurred.

Examination of the skin revealed multiple, well-defined, erythematous scaly plaques of varying sizes on face, scalp and ears (Fig. 1). These plaques

Fig. 1 Erythematous scaly plaques with atrophy hyperpigmentation & Keratotic plugs

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Received for publication on 15—7—1980

showed both atrophy and hyperpigmentation. Pigmentation was more at the periphery. Scales were dry and adherent, and several of these were seen as keratotic plugs over pilosebaceous orifices. The plaques were asymmetrically bilateral in distribution. Cicatricial alopecia was seen over the scalp. There was a perforation in the palate with an ulcerated and indurated nodule at the edge, which showed a tendency to bleed on touch (Fig. 2).

Fig. 2 Perforated palate with an ulcer and indurated nodule

There was no lymphadenopathy and systemic examination revealed no abnormality.

All routine investigations such as, hemoglobin, blood counts, ESR, urine analysis, liver function tests and x-ray chest were within normal limits. Blood was negative for LE cell phenomenon and antinuclear antibodies.

Haematoxylin and eosin stained sections from the plaque revealed hyperkeratosis, keratotic plugging and degeneration of the basal cell layer. The corium showed a patchy, periappendageal infiltrate consisting predominantly of lymphocytes, consistent with the diagnosis of DLE.

Histopathological findings from the hard palate were suggestive of adenocarcinoma.

Comments

The association of adenocarcinoma of palate with DLE seem to be a hitherto unreported one. The occurrence of carcinoma on healed lesions of DLE is, however, well-known[1,2,3,4]. An association of carcinoma and systemic Lupus erythematosus too has been reported by several clinicians[2]. They were unable to establish an etiologic association.

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