Recurrence of palmar hypertrophic chronic cutaneous LE after surgical excision

Sir,

Chronic cutaneous lupus erythematosus (CCLE) is the most common form of lupus erythematosus. It is a

chronic persistent disease that is usually confined to the skin. The lesions are most commonly located on the face, scalp and ears.[1] We report CCLE on the thenar eminence of the left hand alone in a young female. The lesion recurred after excision and grafting.

A 26-year-old female had a single reddish, well defined, thick and scaly plaque involving the thenar eminence of the left hand. The face, scalp and other sites were normal. She had never had Raynaud's phenomenon or joint pains. The hemoglobin, leukocyte count, ESR and urine were normal. A provisional clinical diagnosis of CCLE was confirmed by histopathological examination of the involved skin.

She was prescribed chloroquine phosphate 250 mg PO twice a day and topical application of 0.05% clobetasol propionate twice daily for three months, but she did not have a satisfactory response. In view of the limited involvement, a plastic surgeon excised and grafted the lesion. But, unfortunately, one and half year later, it recurred adjoining the excision graft [Figure 1]. This time the response to the treatment was much better elaborate.

Chronic cutareous lupus erythematosus mainly involves the face, scalp and ears.[1] While lesions can occur at any site, isolated discoid lesions below the neck without head and neck involvement are distinctly uncommon (less than 2% of patients).[2] In a review of hospital records of 769 patients with systemic lupus erythematosus, Paris et al found only two patients with palmar involvement.[3] One case had CCLE lesions for twenty years, while in the other patient, the disease began on the palms and soles and gradually involved the arms and face. Warty type of lesions may occur on the palms and soles, causing difficulty in walking. Excision of the lesions and grafting may be successful, and is not always followed by recurrence.[4]

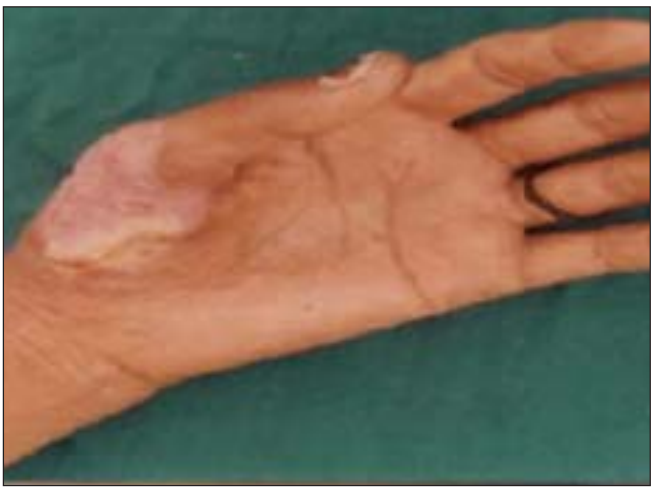

Figure 1: CCLE on left thenar eminence

Palmar involvement in DLE appears to be rare. The palmar skin is much thicker than skin elsewhere. The absence of hair follicles on volar skin does not exclude the development of otherwise classical features of CCLE. The palms are infrequently exposed to natural sunlight. In our patient, involvement was limited to the thenar eminence, which has not been reported earlier. Further, recurrence noticed after excision was similar to an earlier observation noted on the face.[5]

Ramesh Bansal, Rajeev Sen*

Skin, VD and Allergy Clinic, Jhajjar Road, Rohtak, *Department of Pathology, P. G. I. M. S. Rohtak-124001, Haryana, India

Address for Correspondence: Dr. Ramesh Bansal, Skin, VD and Allergy Clinic, Jhajjar Road, Rohtak.
E-mail: drbansalramesh@yahoo.com

REFERENCES

1. Sontheimer RD. Lupus erythematosus. In: Freedberg IM, Eisen AZ, Wolff K, editors. Dermatology in general medicine. 5th edn. New York: McGraw-Hill; 1999. p.
2. Sontheimer RD, Euwer RL, Geppert TD, Cohen SB. Connective tissue diseases. In: Moschella SL, Hurley HJ, editors. Dermatology. 3rd edn. Philadelphia: WB Saunders; 1992. p. 1217-55.
3. Paris LC, Kennedy RJ, Hurley HJ. Palmar lesions in lupus erythematosus. Arch Dermatol 1967;96:273-6.
4. Rowell NR, Goodfield MJ. Connective tissue diseases. In: Champion RH, Burton JL, Burns DA, editors. Textbook of dermatology. 6th edn. Oxford: Blackwell Scientific; 1998. p. 2437.
5. Bansal R. Discoid lupus erythematosus recurs after plastic surgery. Int J Dermatol 2004;43:859-60.