ISSN: 2754-494X

Journal of Dermatology Research Reviews & Reports

SCIENTIFIC Research and Community

Case Report

Open Access

Reporte De Caso Lupus Cutaneo Discoide Generalizado

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ABSTRACT

Jiménez B, Marte I, Hernández D, Rosales L, Vivas S. Lupus erythematosus (LE) is an autoimmune inflammatory disease that includes a wide spectrum of manifestations, from the systemic type to the skin-limited variant, such as cutaneous lupus erythematosus (CLE). We present the case of a 38-year-old female informal retailer who complained of scaling and pruritus on the scalp, with the spread of erythematous lesions to the face, neck, and arms, pruritic for one year. She presented to the dermatology department of the Dr. Enrique Tejera Hospital City. Her evaluation revealed atrophy, corneal plugs, telangiectasias, and white scales. Clinical findings were unremarkable. First-line treatment was initiated with a combination of clobetasol and topical tacrolimus and azathioprine, with little response. Conclusion: LDL is a disease with a heterogeneous clinical spectrum, both in symptomatology and prognosis. The scarring it causes affects patients' self-esteem and quality of life.

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Received: October 13, 2025; **Accepted:** October 22, 2025; **Published:** October 30, 2025

Keywords: Cutaneous Lupus Erythematosus, Sun-Exposed Areas, Atrophy

Clinical Case

A 38-year-old female patient, informal retailer, with an unreported personal history, reported onset of the current disease in May 2023, presenting with scaling of the scalp and pruritus. She used topical steroids with partial improvement. In November, she presented with erythematous lesions on the forehead. She attended a dermatological consultation and a biopsy was indicated due to persistent lesions and their spread to the neck and arms. She returned for consultation in June 2024. She denied any symptoms of myalgia or arthralgia.

Physical Examination

Skin phototype IV/VI according to Fitzpatrick with generalized, bilateral and symmetrical dermatosis predominantly in sun-exposed areas of the scalp, face, arms and anterior chest, characterized by erythematous plaques with regular, well-defined edges, an atrophic center, pruritic, of 1 year's evolution. Figure (1). Dermoscopy: atrophy, horny plugs, telangiectasias and white scales are evident. Figure (2) Paraclinical: blood chemistry and immunological without alterations. Table 1, 2,3. Histopathology: histopathological slide stained with hematoxylin-eosin at 10x, showing thinned epidermis, lamellar orthokeratosis, follicular plugging, dense lymphocytic inflammatory infiltrate in the papillary dermis. Figure (3)

Hemoglobina	12,9 gr/dl
Hematocrito	40%
Leucocitos	6.400
Neutrófilos	60%
Linfocitos	40%
Eosinófilos	0%
Plaquetas	241.000

Glicemia	78mg/dl
Urea	24 mg/dl
Creatinina	0,84 mg/dl
TGO **TGP**	23,4 U/L 18,9 U/L

ANA	0,20 UI/ml
Anti SM	0,29 UI/ml
Anti RO	0,38 UI/ml
Anti DNA	0,31 UI/ ml
Anti LA	0,40 UI/ ml
C3	96,40 mg/dl
C4	21,90 mg/dl
CH50	247,7 UI/ ml

Treatment

Sun protection every 2 hours, high-potency topical steroids (clobetazol 0.05%) for 1 month, oral steroids (prednisone 60 mg daily), and hydroxychloroquine 400 mg for 2 months. No response to treatment was given; therapy was combined with high-potency steroids plus tacrolimus and azathioprine 50 mg, with a satisfactory response after 20 days. Fig (4) (5).

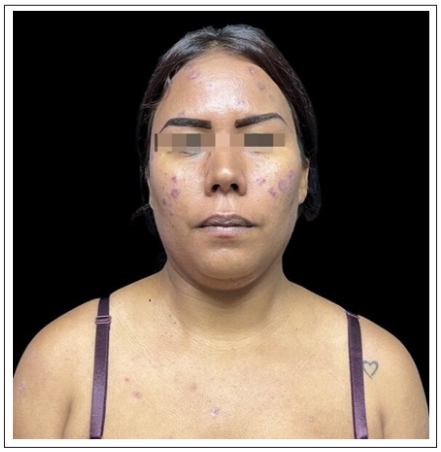

Figure 1

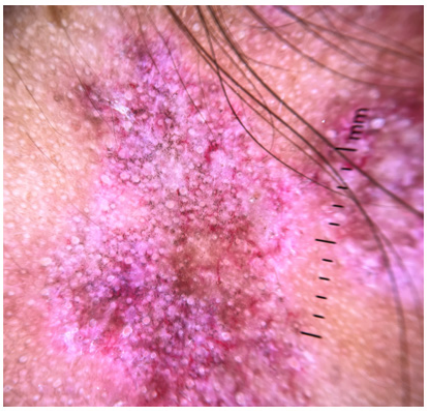

Figure 2

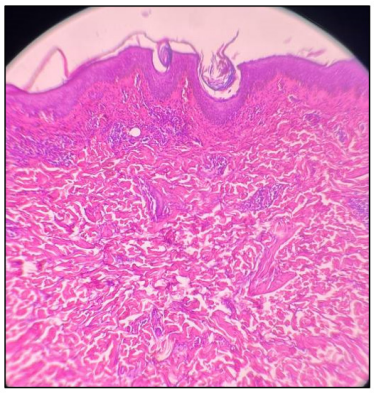

Figure 3

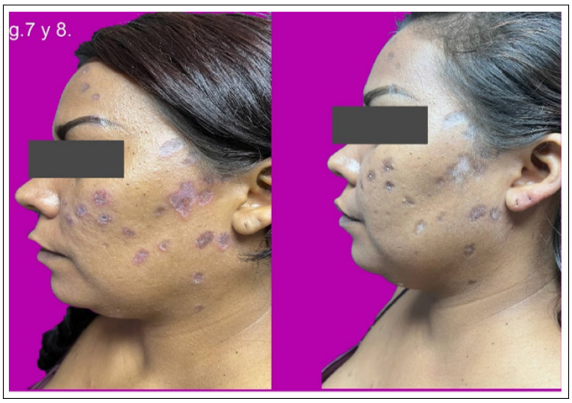

Figure 4

Discussion

Lupus erythematosus (LE) is an autoimmune inflammatory disease that includes a broad spectrum of manifestations, from the systemic type to the skin-limited variant, cutaneous lupus erythematosus (CLE) [1,2].

CLE has a peak onset between the ages of 20 and 40, affects women more frequently (3:1), and Black people more frequently than other races. Discoid cutaneous lupus (DCL) is the most common form of chronic cutaneous lupus erythematosus (CCCLE) and can occur as a localized form (80%) with lesions on the face, ears, and scalp, or as disseminated DCLE (20%) with lesions above and below the neck. The disseminated form, especially when it affects the trunk, is associated with a 28% increased risk of progression to SLE [3,4].

Current first-line treatments for discoid cutaneous lupus (DCL) include photoprotection, topical corticosteroids, and topical calcineurin inhibitors. Candidates for systemic therapy are patients with chronic DCL lesions that do not respond to local therapy or with extensive disease involvement. If treatment is not effective against these measures, other medications can be used that have been shown to have varying degrees of effectiveness.

Studies have shown that in the treatment of DCL, the combination of tacrolimus with clobetasol ointment was more effective than tacrolimus or clobetasol alone, in addition to systemic therapy [3,5-7].

Conclusion

LCD is a disease with a heterogeneous clinical spectrum, both in terms of symptomatology and prognosis. The risk to the patient's life is minimal. However, generalized LCD is associated with a 28% risk of progression to systemic lupus erythematosus. It is important to mention that skin lesions such as scars and deformities caused by the spread and chronicity of LCD, due to the poor response to first-line treatment, affect the patient's self-esteem and quality of life.

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