Blistering eruptions in a Nigerian patient with SLE.

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INTRODUCTION

Systemic lupus erythematosus (SLE) is a multisystemic disorder with variable presentation. Diagnosis is delayed as it usually presents as a chronic febrile illness mimicking more common febrile illnesses in the environment and is suggested when cutaneous features develop. Erythema of the malar area is an early manifestation of SLE but is obscured by the heavy pigmentation in blacks. Cutaneous manifestations of SLE are varied and develop at different stages of the illness. They include photosensitivity, urticaria, butterfly rash, facial oedema, vaculits, alopecia and chelitis. Blistering eruptions are uncommon in patients with SLE.

We present a 27 year old female with SLE and blistering eruptions on the photosensitive region of the face, we also review differential diagnosis of blistering eruptions in patients with SLE...

CASE REPORT

A 27 year old teacher was admitted into the hospital with complains of a facial rash of 3 days duration. The rash started with a burning sensation on the face and was followed by the appearance of blisters within 24 hours. There was also associated swelling of the face and lips (Figure 1). There was no previous history of a similar rash or a history suggestive of photosensitivity. She had been diagnosed with SLE two months earlier (ANAtitre 1:640 ELISA–speckled pattern antibodies to double stranded DNA was also positive). She was treated with pulsed doses of cyclophosphamide and prednisolone. She was discharged home after remarkable improvement.

Examination revealed an acutely ill looking young lady with facial puffiness, bilateral eyelid and lip edema, crusted lesions on the malar, nasal bridge and forehead admixed with purulent exudates suggestive of secondary bacterial infection (Fig 1). There was no intact blister when she was seen. These features on the skin were slightly masked by the application of gentian violet paint (GV). Other significant findings were some petechiae and ecchymotic patches on the upper limb. Her pulse rate was 96 beats per minutes,

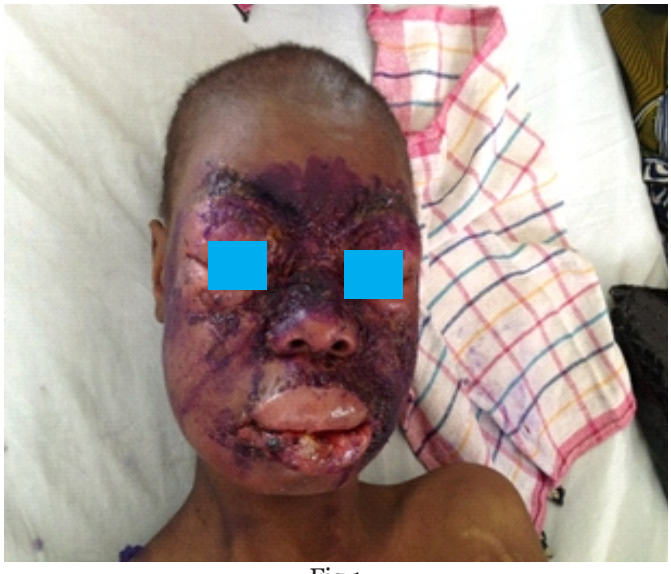

Fig 1

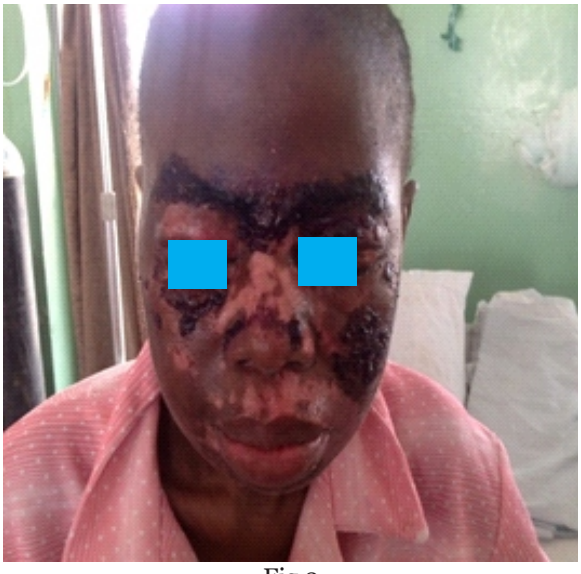

Fig 2

small volume. She was tachypneic with respiratory rate of 24 cycles per minutes and had a mild hepatomegaly. Other systemic examination was unremarkable. A full blood count analysis showed moderate anaemia and mild thrombocytopenia. She had proteinuria, microscopic haematuria, normal electrolytes, urea and creatininine. She also had hypoalbuminemia.

Patient declined to have a skin biopsy. A diagnosis of acute blistering eruption in a patient with SLE to rule out bullous SLE was made.

She was placed on intravenous methyl prednisolone 400mg dly for three days and was continued on prednisolone tablets 20mg daily. Topical repatamulin cream was applied twice daily on the face after cleaning with normal saline. She improved remarkably while on admission and was discharged home 8 days later on prednisolone, hydroxychloroquine and sunscreens (Fig 2).

DISCUSSION

Blistering eruptions in patients with SLE presents a diagnostic challenge especially in the absence of a biopsy. Some have suggested that all bullous lesions in patients with SLE be referred to as bullous SLE. Others have suggested that bullous SLE is a distinct entity with clinical and histologic features.[1-2] In Bullous SLE the blisters are sub-epidermal and presents as acute tense sub- imunoepidermal blisters with neutrophils and nuclear dust at the tips of the dermal papillae. IgA, IgG and IgM are deposited in the basal membrane. The lesions are found predominantly on the face, neck and upper trunk and patient may have oral lesions.[1-2] Photo sensitivity may also occur and glomerulonephritis occurs in these patients. Our patient had blisters in a photosensitive distribution with haematuria suggesting kidney involvement, however there were no intact blisters when the patient was seen three days after the onset suggesting that they were not sub epidermal blisters. Acute lupus flare presents as acute onset flaccid blisters arising mostly in sun exposed areas accompanied by worsening systemic features similar to what was seen in our patient. This diagnosis was also considered on our patient. The acute flare and photosensitivity could have led to the marked facial oedema seen in our patient.

Other differential diagnosis of blisters in a patient with SLE in Table 1 include drug related toxic epidermal necrolysis (TENS) which was unlikely in our patient. She had denied taking any drugs prior to the eruption and she did not have wide spread necrosis of the skin. Other differentials of blistering eruptions in SLE patients include dermatitis hepertiformis, bullous pemphigoid, epidermolysis

	Clinical features	**Histopathology**
Acute lupus flare	Acute onset flaccid blisters favouring sun exposed areas.	severe liquefactive degeneration of the basal layer causing separation of the epidermis and dermis associated dermal oedema.
Bullous SLE	Acute onset tense bullae favouring sun exposed areas	Subepidermal blister with superficial neutrophilic infiltrate
Drug related Toxic epidermal Necrolysis (TENS)	Acute onset, widespread macules,vesicles rapidly progressing coalescing to sheet like erosions with mucous membrane involvement.	Full thickness epidermal necrosis with sparse lymphocytic infiltrate
TEN- like SLE	Subacute onset,rapidly progressing widespread macules,vesicles often with mucous membrane involvement	Full thickness epidermal necrosis with sparse lymphocytic infiltrate

Table 1: Differential diagnosis of blisters in a patient with SLE.[3]

bullosa acquisita. However, the clinical presentation makes all this unlikely even in the absence of immunoflourescent study.

In our environment, photosensitivity, one of the presenting symptoms in lupus erythematosus (LE), is still vaguely defined. Although sensitivity to light in forms of prolonged or delayed erythema is believed to be a common feature in all patients with cutaneous and systemic lupus,[4] the dark skin prevents early feature of photosensitivity such as erythema. Photosensitivity in dark skin becomes obvious when there are textural changes with papules or vesicles.

Factors which may predispose to photosensitivity in a include, drugs, topical agents and cosmetics containing photosensitizers. The patient denied the use of cosmetics as well. The above presentation emphasises the need for sunscreen in the dark skinned with SLE and other photosensitising disorders.

In conclusion blisters occurring in patients with SLE is uncommon, in the absence of a biopsy an acute flare or bullous SLE should be considered. Patients with SLE should be advised to avoid unnecessary sun exposure and also use sun screens.

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