of herpes simplex and varicella-zoster infection from cutaneous
lesions in different clinical stages with the polymerase chain reac-

Accepted June 2, 1997.

Lupus Erythematosus as an Occupational Disease

Sir,
The isomorphic or Koebner’s phenomenon is unusual in
discoid lupus erythematosus (DLE). We describe a patient
with minor DLE in the face, who developed severe DLE
lesions on the hands. These were induced and aggravated by
manual work and caused considerable disability. Even minor
tasks at home became impossible.

CASE REPORT
A 57-year-old male presented with progressive complaints of pain and
a burning sensation in his hands since several months. Erythematous
bluish indurated areas, sometimes slightly scaling, were present on the
palms and volar aspects of the fingers and on the knuckles of the
metacarpophalangeal joints and proximal interphalangeal joints. His
left cheek, forehead and eyebrows showed lenticular pink red plaques.

Immunofluorescence examination of a skin biopsy of the hand
showed granular deposits of IgM and C3c and to less extent of
C1q along the basement membrane of the vessels. A skin biopsy of
the forehead showed an atrophic epidermis with focal degeneration of
the basal keratinocytes. In the dermis an inflammatory infiltrate
was present, which was perivascular and perifollicular. Both immuno-
fluorescence and histopathology were consistent with the diagnosis of
lupus erythematosus (LE). Antinuclear factors and ScI 70 were
negative. Patch tests with the European standard series and an
additional series were positive (+ +) for nickel sulfate after 72 h.

Our patient worked with an aircraft company in the maintenance
of airplane seats. His task was to tear off old seat-coverings, which
requires moderate force.

After a 2-month period of sick leave his complaints gradually
subsided and only a violaceous hue on the hands remained visible.
The lesions in the face but not the hands showed a good response to
clobetasol cream. At home he did not perform any tasks requiring the
use of his hands. Even changing lightbulbs induced aggravation of his
complaint. On the tips of his thumb and second finger of the right
hand some pain remained, which he attributed to the daily winding
of his watch. Some months later he performed some minor reperations
in his home, and promptly extensive plaques developed on his palms
and fingers. This necessitated therapy with hydroxychloroquine, to
which he responded well. However, mechanical pressure invariably
induced the recurrence of the lesions.

DISCUSSION
Irritants, burnings, herpes zoster, mechanical trauma, vaccina-
tion and allergic contact dermatitis can induce DLE (1–4).

The interval between the incident and the onset of DLE varied
from immediately to several years. A causal relationship
between trauma and DLE development was assumed but not
formally proven in these cases.

In our patient, with previous cutaneous LE in the face,
repetitive mechanical exposure most probably induced the LE
lesions of the hands. During a period of sick leave of 2 months
an almost complete cure was achieved, except for the fingers
he used to wind his watch. He reported prompt pain and itch
following minimal use of his hands. After resuming his work
the DLE plaques in the palms gradually appeared again,
preventing him from continuing his job. DLE is normally not
considered to be an occupational disease, but in this case work
conditions elicited or at least aggravated LE.

To some extent our case resembles a recently described
patient with lichen planus/LE overlap syndrome, who
developed lichen planus on the palms possibly because of a
Koebner phenomenon (5). Lesions on the palms and soles
occur in 6% of patients with DLE (6). It remains unclear why
the Koebner phenomenon develops only in a small proportion
of patients.

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Accepted May 16, 1997.

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