

Lupus Erythematosus Hypertrophicus: A Case Report

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Abstract. A 49-year-old woman with longstanding, disfiguring annular hypertrophic lupus erythematosus discoides in the face is reported. The differentiation between the hypertrophic and the profundus types of lupus erythematosus is discussed.

Key words: Lupus erythematosus discoides; Lupus erythematosus hypertrophicus

Lupus erythematosus hypertrophicus (LEH) is a rare variant of cutaneous lupus erythematosus (LE). The hypertrophic form is most often described as combined with the profundus type, although the forms differ clinically as well as histologically. LEH is characterized by chronic discoid lesions with excessive brownish-yellow warty hyperkeratosis. The microscopic changes are seen mainly in the epidermis. In LE profundus, subcutaneous nodules are located beneath normal or mildly erythematous skin. The histopathological findings involve the deeper part of the dermis.

CASE REPORT

A 49-year-old woman, previous healthy, presented almost symmetrical annular, hyperkeratotic lesions with elevated erythematous borders and central atrophy. The size of the lesions was about 5×5 cm (Fig. 1). Besides, she had a 3×3 cm atrophic alopecia located to the vertex and an oval depigmented scar in the front of the right ear. Two small red papules were seen on the nose. The lesions on the front had progressed slowly centrifugally during 15 years. She did not receive any drugs and denied photosensitivity. Treatment with topical steroid had failed probably because the patient was mentally retarded. General physical examination and laboratory investigations including antinuclear antibodies, rheumatoid factors, and STS revealed no abnormal findings.

Histopathological examination showed hyperkeratosis, follicular plugging of the epidermis and hydropic degeneration of the basal layer. In the upper part of the dermis there was oedema and perivascular infiltration of mononuclear cells. Direct immunofluorescence showed

granular deposits of IgM, complement C3 and fibrinogen at the dermo-epidermal junction. No deposits were seen in uninvolved skin from the buttock.

The skin lesions were treated with vaseline with 20% salicylic acid and 1% betamethasone valerate cream and healed satisfactorily.

DISCUSSION

The patient demonstrated a typical clinical picture of LEH. The diagnosis was confirmed by histopathology and immunofluorescence microscopy (8). Moreover, the negative serological findings indicated the chronic discoid nature of the disease.

This rare variant of cutaneous LE was first described by Bechet (2, 3). He reported on two cases with oval lesions of the face near the mouth. Like in our patient, the plaques were symmetrically arranged with an annular configuration, indurated red borders and central atrophy. Bechet, however, used the term LE hypertrophicus et profundus (3, 4). The correct adjective for Bechet's lesion should not be profundus, though the involvement does extend deeply, but hypertrophicus, as pointed out by Arnold (1). In LE profundus, as it is understood in the later literature, the cutaneous infiltrate occurs primarily in the deeper corium with only small epidermal changes. The clinical picture is characterized by firm, sharply defined nodules located beneath normal or almost normal skin (1, 6, 7). Evidence of systemic involvement is often seen in patients with LE profundus (7, 9). One patient with a sudden onset of severe LEH and systemic involvement has been described by Otani (5). Systemic involvement with positive serological findings



Fig. 1. Lupus erythematosus hypertrophicus in a 49-year-old woman. The lesions of the front progressed slowly during 15 years.

cannot be used to differentiate between the hypertrophic and profundus types of LE. Differentiation between the two forms should be based on histopathological criteria.

REFERENCES

1. Arnold, H. L.: Lupus erythematosus profundus. Commentary and report of four more cases. *Arch Dermatol* 73: 15, 1956.
2. Bechet, P. E.: Hypertrophic lupus erythematosus. Society Transactions. *Arch Dermatol Syph* 42: 211, 1940.
3. — Lupus erythematosus hypertrophicus et profundus. *Arch Dermatol Syph* 45: 33, 1942.
4. — Lupus erythematosus hypertrophicus et profundus. A further attempt to elucidate its status. *Arch Dermatol Syph* 61: 495, 1950.
5. Otani, A.: Lupus erythematosus hypertrophicus et profundus. *Br J Dermatol* 96: 75, 1977.
6. Pasher, F., Sims, C. F. & Pensky, N.: Lupus erythematosus profundus (Kaposi-Irgang). Report of a case including a comparative study of the histopathology with that of chronic discoid lupus erythematosus. *J Invest Dermatol* 25: 347, 1955.
7. Tuffanelli, D. L.: Lupus erythematosus panniculitis (profundus). Clinical and immunologic studies. *Arch Dermatol* 103: 231, 1971.
8. Ullman, S., Halberg, P. & Wolf-Jurgensen, P.: Deposits of immunoglobulins and complement C3 in clinically normal skin of patients with lupus erythematosus. *Acta Dermatovener (Stockholm)* 55: 109, 1975.
9. Winkelmann, R. K.: Panniculitis and systemic lupus erythematosus. *JAMA* 211: 472, 1970.

Plantar Lesions of Lichen sclerosus et atrophicus Accompanied by Erythralgia

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This 52-year-old man had several duodenal ulcers between 1950 and 1954 and deep venous thrombosis in the right leg in 1968. Hyperlipemia was found in 1972 and he had been treated with clofibrate and niceritrol which normalized the serum lipid levels.

In February 1976 intensely tender lesions appeared in the arches of both feet. These spread slowly during the following 6 months to reach their

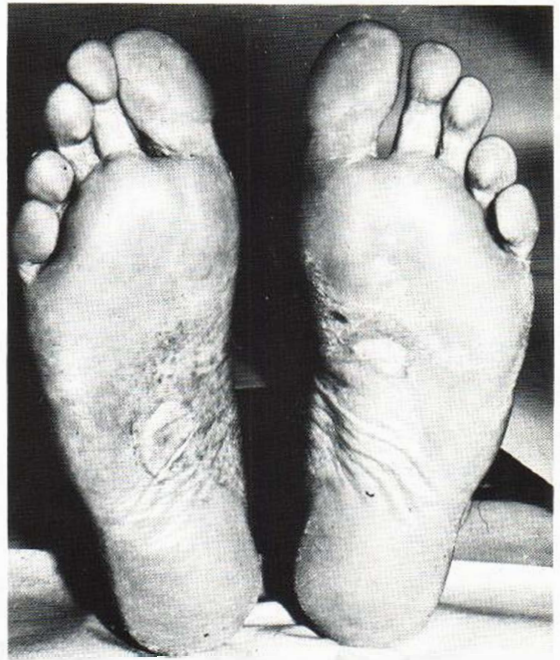


Fig. 1. Lichen sclerosus et atrophicus. Papules vesicles and purpuric scaling lesion surround the lesion on the right foot. Sequelae of a post-thrombotic syndrome.

present size (Fig. 1). During the same period the patient experienced cyclically a painful erythematous swelling of the soles of the feet. This was precipitated by long walks or by hot baths. The pain interrupted his sleep and he could not stand for 2–3 days after the onset of these symptoms. The swelling and erythema subsided within a week but returned after about 2 weeks (Fig. 2) and continued in this fashion for almost a year.

On admission in September 1976 the lesions on the soles of the feet corresponded to those of lichen sclerosus et atrophicus, with hyperkeratotic scales surrounded by erythema. There were no other such skin lesions on his body. Mainly on the right sole and on the tibial aspect of the foot, eczematous lesions with vesicles and purpuric papules and scaling could be seen. There was tenderness to palpation at the site of perforators on the right leg. At one visit the patient showed his right foot during a period of pain. The sole of the foot was swollen by a protruding edema and the plantar skin was red and cyanotic. Severe pain was elicited even by a light touch. The scaling lesion was in the centre of the edema.