

Local Excision in the Treatment of Oral Discoid Lupus Erythematosus

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Abstract. Oral lesions in eight patients with discoid lupus erythematosus (DLE) were treated with local excision. Ten well-demarcated oral lesions were excised and a primary closure was obtained following the excision. Six patients out of seven became symptom-free following the treatment. The median observation time was 1.0 year. The follow-up examination showed erythema in one case and recurrence in one case at the operation site. In the remaining eight operation sites, a soft scar with no sign of recurrence was seen. These results indicate that the method should be investigated further in order to obtain long-term results. Local excision of oral discoid lesions may be a valuable therapeutic supplement in some cases of DLE.

Key words: Lupus erythematosus; Discoid; Mouth mucosa; Oral manifestation; Therapy

The treatment of oral manifestations of discoid lupus erythematosus (DLE), in the following referred to as "oral discoid lesions", has, like the treatment of the skin lesions, undergone a number of changes during recent years. In the 'thirties, injection with heavy metal salts such as gold was advocated (7), while more recent papers mostly recommend treatment with topical steroids (4). Antimalarial treatment may be another alternative (2). In highly resistant cases, and in patients suffering from systemic lupus erythematosus (SLE) as well, systemic steroid treatment may be necessary (3). In spite of the therapeutic progress achieved following the discovery of antimalarials and steroids, oral discoid lesions still represent a therapeutic difficulty. Furthermore the side effects of the above-mentioned drugs necessitate the development of other and more innocuous methods of treatment of the oral lesions. Local excision of oral discoid lesions is one possibility, which has not previously been investigated.

The purpose of the present study has therefore been to evaluate the usefulness of local excision in the treatment of oral discoid lesions.

MATERIAL AND METHODS

The material consisted of 8 patients (7 females, one male), all showing lesions of the oral mucosa clinically and histologically consistent with DLE as described earlier (9). Six patients had discoid skin lesions as well, while 2 patients had only oral lesions. One patient had SLE in addition to the oral discoid lesions. The ages of the patients at the time of treatment ranged between 32 and 70 years, with a mean of 47 years. Two patients had been treated with 0.1% triamcinolone acetonide (Kenalog®) topically without effect during the last 6 months prior to the excision. One patient had been treated with antimalarials (Triquin®) 13 years earlier, with effect on the skin lesions, but without effect on the oral lesions. The patient with SLE had been undergoing treatment with 10 mg prednisone (Prednison®) and 400 mg oxyclozoline sulphate (Plaquenil®) for several years without effect on the oral lesions. The remainder of the patients had not been treated topically or systemically during the last 6 months prior to the treatment.

The duration of the oral lesions at time of treatment ranged between 0.1 and 20 years (mean, 3.8 years).

Criteria for selection of lesions to be excised were that the lesions should be well demarcated, be of limited size and should be in such a topographic position, that primary closure was possible.

Ten lesions were excised from the 8 patients. Nine of the lesions gave symptoms before the treatment was performed. The dominant symptom was a burning sensation, especially from hot or spicy food. Seven lesions were located on the buccal mucosa, one on the vermillion border, one on the labial mucosa and one on the alveolar process. In all patients more than one oral lesion was present and those lesions which were not excised served as control lesions.

Technical procedure

All excisions were done under local anesthesia. In each case an incision was made around the lesion including



Fig. 1. Oral discoid lesion of right buccal mucosa before treatment.

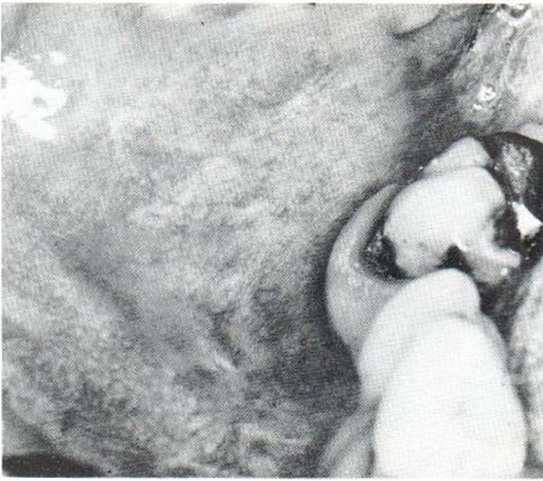


Fig. 2. The same patient as in Fig. 1, 26 months following treatment.

approximately 2 mm of clinically normal oral mucosa, and the lesion was dissected free from underlying muscle or bone. A primary closure was obtained. The observation time following the excision varied between 0.5 year and 3.1 years (median observation time, 1.0 year).

RESULTS

At the time of follow-up examination all operation sites except one had become symptom-free, and at the operation site a minimal, soft scar tissue was seen in 8 cases (Figs. 1, 2). Erythema was found within the scar tissues in one patient, and in one patient recurrence was seen following 12 months and 8 months observation time, respectively. At the follow-up examination all the control lesions were present, indicating that a spontaneous regression of the oral lesions had not taken place during the observation time. Similarly, the present skin lesions had not disappeared during the observation period.

DISCUSSION

Surgical excision of skin lesions in DLE with or without transplantation of normal skin has been reported (5, 6, 8). The indications for such treatment were reviewed by Friederich in 1970 (6). However, Dubois stated (2) that the data were too fragmentary to draw any conclusions about the long-term results, recurrence rates, etc.

The results from surgical treatment of oral discoid lesions cannot be compared directly with re-

sults from similar treatment of the skin lesions. The oral mucosa differ from the skin with regard to structure and function and the therapeutic response of the oral mucosa may differ from that of the skin. This is known from other methods of treatment. Andreassen (1) thus reported three patients treated with antimalarials without effect on the oral lesions in spite of good effect on the skin lesions.

The erythema seen at one operation site is believed to be the first sign of recurrence. Consequently, the recurrence rate in the present study may well be two out of ten excisions with the median observation time of 1.0 year. The long-term recurrence rate may be higher. Several factors may influence the long-term results: method of operation, site, extension and activity of the oral lesions, etc. However, in the present study it has not been possible to draw any conclusions concerning these problems.

Regarding chronic DLE lesions as a symptom of SLE, it is interesting to note that the SLE patient in this study who had two oral discoid lesions excised, did not show any recurrence within the observation time of 37 and 15 months, respectively.

Surgical excision of oral discoid lesions has certain advantages compared with other methods of treatment. It is easy to perform, it does not give rise to side effects and the lesion is removed at one fell swoop. On the other hand the method has its limitations: it cannot be used on extensive and/or poorly demarcated lesions, and only with difficulty on lesions located on the attached oral mucosa. It must be emphasized that this treatment, like other known methods, is only applicable to symptoms, but as long as no treatment for the cause exists, these types of treatment method should be developed.

It can be concluded that the surgical treatment of oral discoid lesions cannot be advocated generally, but the preliminary results indicate that this method should be investigated further in order to obtain long-term results. Local excision might be a valuable therapeutic complement for oral discoid lesions according to the outlined criteria.

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Atypical Necrobiosis Lipoidica of the Face

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Abstract. A 36-year-old healthy man with atypical necrobiosis lipoidica of the face is described. The lesions were annular with a raised erythematous palpable border. The centres were slightly depigmented and atrophic, without telangiectasia or hair loss. Histopathological changes revealed prominent giant cells in small groups without clear granuloma formation. They were located at all levels of the dermis between the collagen bundles.

Key words: Necrobiosis lipoidica

In 1967 Dowling and Wilson Jones (1) reported an unusual variant of necrobiosis lipoidica appearing on the face and scalp. Later, Wilson Jones (5) enlarged upon this previous report and summarized



Fig. 1. Annular areas with a raised erythematous border and slightly depigmented, atrophic centres.

the clinical and histological findings in a group of 29 patients with this condition. The lesions usually affecting the upper face of women in early middle age showed a striking clinical resemblance to annular sarcoid. The histopathology, however, was distinctive. Although it showed some resemblance to ordinary necrobiosis of the legs in non-diabetics, the facial lesions did not tend to form necrobiotic areas to the same extent but had a greater tendency towards multinucleated giant cell reaction. We recently had the opportunity to observe a male patient who had atypical necrobiosis of the face.

CASE REPORT

A 36-year-old man was referred for investigation in 1973. He had developed six circinate lesions over the forehead

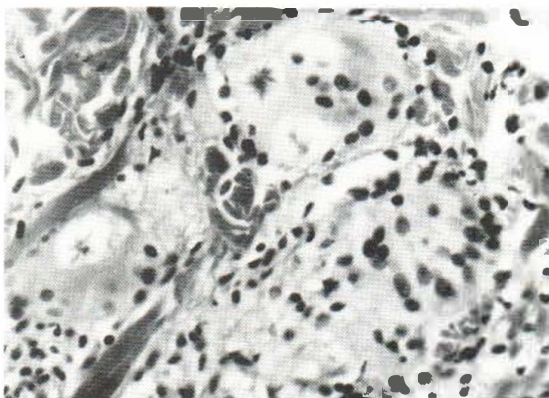


Fig. 2. Large giant cells with asteroid bodies, scattered between the collagen bundles.