Local Excision in the Treatment of Oral Discoid Lupus Erythematosus

Morten Schiödt

Department of Oral Medicine and Oral Surgery, University of Copenhagen, Rigshospital, Copenhagen, Denmark

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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.

Fig. 1. Oral discoid lesion of right buccal mucosa before 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 results 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. Andreasen (1) thus reported three patients treated with antimalarial 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.

REFERENCES

Atypical Necrobiosis Lipoidica of the Face
Inkeri Helander, Kirsti-Maria Niemi and Juhani Tyrkko
Departments of Dermatology, University of Turku and University of Helsinki and Department of Pathology, University of Turku
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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 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. 1. Annular areas with a raised erythematous border and slightly depigmented, atrophic centres.

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