1-800-Zap-My-Zits

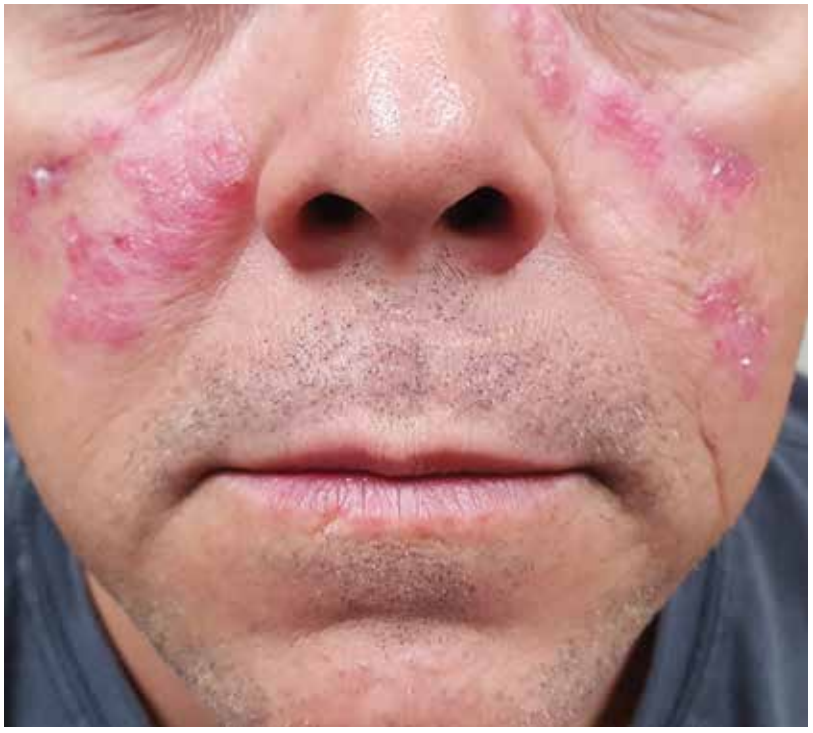
A 52-year-old man is referred to dermatology by his primary care provider for evaluation of facial lesions that first appeared almost a year ago. The patient, who works as a welder, has noticed that sun exposure tends to exacerbate the problem. He denies joint pain, fever, and malaise.

He self-diagnosed the condition as acne and ordered a product from a TV ad, but this cream only made things worse. The asymptomatic lesions persist, despite application of a number of prescription products (2.5% hydrocortisone cream, adapalene gel, and antifungal creams, including tolnaftate and clotrimazole).

The eruption—comprised of discrete, round, scaly lesions—covers a good portion of the bimalar areas of his face. The lesions are purplish red, and on closer inspection, you observe patulous follicular orifices. Some of the older lesions have focal atrophy. The rest of the examination is unremarkable.

What is the correct diagnosis?

a) Dermatophytosis
b) Psoriasis
c) Discoid lupus erythematosus
d) Dermatomyositis



ANSWER

The correct diagnosis is discoid lupus erythematosus (DLE; choice "c"). For those unfamiliar with DLE, it is often mistaken for the other items listed. Biopsy can distinguish among them.

Fungal infection (dermatophytosis; choice "a") of the face is unusual and would have responded in some way to the antifungal cream. Likewise, the use of steroid creams would have markedly worsened a fungal infection.

Although this could have been psoriasis (choice "b"), it's rare for that condition to be confined to the face. It almost always appears elsewhere—the scalp, elbows, knees, and/or nails.

Dermatomyositis (choice "d"), an autoimmune condition, can certainly present with a bimalar rash. However, it is usually accompanied by additional symptoms, such as progressive weakness and muscle pain.

DISCUSSION

DLE can represent a stand-alone diagnosis, or it can be a manifestation of systemic lupus erythematosus (SLE). When present in this bimalar form, the lesions are often mistaken for the "butterfly rash" commonly seen in SLE.

This patient was thoroughly tested for SLE, and no evidence of it was found. Biopsy did, however, show changes consistent with DLE (interface dermatitis with increased mucin formation, among others).

The treatment for DLE is rather simple: It consists of sun protection and oral hydroxychloroquine. This helps reduce inflammation, although the patient will still have residual scarring. **CR**

For more on this topic, see page 38.

Joe R. Monroe, MPAS, PA, practices at Dawkins Dermatology Clinic in Oklahoma City. He is also the founder of the Society of Dermatology Physician Assistants.