ISSN 2349-7203
IJPPR
INTERNATIONAL JOURNAL OF PHARMACY & PHARMACEUTICAL RESEARCH
An official Publication of Human Journals
HUMAN

Human Journals
Case Report
November 2020 Vol.:19, Issue:4
© All rights are reserved by Bharath. A et al.

A Case Report on Discoid Lupus Erythematosus with Positive RA Factor

Bharath. A*, Madhuri. G, Ugandhar.R.E

Department of pharmacy practice, Santhiram College of pharmacy, Nandyal, Andhara Pradesh, India.

Submission: 23 October 2020
Accepted: 29 October 2020
Published: 30 November 2020

www.ijppr.humanjournals.com

Keywords: Discoid lupus erythematous, RA factor, Photosensitivity, multiple joint pains, non-healing oral ulcers

ABSTRACT

Discoid lupus erythematosus is the most common form of chronic cutaneous lupus erythematosus. Classic DLE lesions begin as red-purple macules, papules or plaques and rapidly develop a hyperkeratotic surface. Many patients with untreated classic DLE lesions suffer with progression to large areas of cutaneous dystrophy and scarring alopecia that can be psychologically devastating. A female patient of age 25 years old was admitted in hospital with chief complaints of non-healing oral ulcerations and gum bleeding (gingivitis) since 1 year, alopecia, scarring of the skin tissue all over the body, soft swelling of the joints, dizziness. She was diagnosed as discoid lupus erythematosus with positive RA factor. She has history of parotitis, external otitis 1 year back and treated with tab. Cefixime and vitamin supplements. Oral corticosteroid therapy (prednisolone), immunosuppressants like methotrexate for Rheumatoid arthritis are the treatment options for this condition. Antimalarials (HCQ) are immunotherapeutic and are considered as first line therapy in DLE. After 1 month of topical application, all lesions regressed significantly. Follow-up is very important and necessary for every 3 months because DLE is considered as pre-cancerous condition and for the early detection of systemic lupus erythematosus and to reduce scarring.

INTRODUCTION

Discoid lupus erythematosus is a chronic dermatological disease with clinical manifestations of scarring, alopecia and hyperpigmentation changes in the skin. Early recognition and treatment improves prognosis. The exact cause of Discoid lupus is unknown, it appears to be an autoimmune disease, involving combination of both genetic and environmental triggers. Lupus erythematous affects only skin until it progress to SLE. Other organs can be affected like kidneys, liver, bones etc., Topical steroid for lesions, Oral steroids, antimalarial drugs and immunosuppressants are the mainstay of treatment because lesions are induced (or) exacerbated by ultraviolet exposure (sunlight), photoprotective measures are important.

Discoid lupus erythematous is an autoimmune disease confines mainly to the skin and at other end it is a florid disease with systemic involvement of heart, lungs, bones, kidneys and other organs called systemic lupus erythematosus.

Epidemiology:

Discoid lupus erythematous is a chronic cutaneous lupus erythematous worldwide, the prevalence of DLE is 4.2 cases per 1, 00,000 population. It most often develops in persons aged 20-40 years and is approximately 10 times higher in women than in men.

HUMAN

Etiology:

The exact cause of DLE is unknown. It may be due to harmones or genetic factors or environmental triggers like exposure to UV light and stress.

Pathophysiology:

The pathophysiology of DLE is not well understood. It has been suggested that a heat shock protein is induced in the keratinocyte following UV light exposure or stress, and this protein acts as a target for gamma T-cell mediated epidermal cell cytotoxicity. In some DLE patients, sunlight and cigarette smoking may make the lesions appear. In some patients who are genetically pre-disposed, antibodies are released against their own tissues, which targets proteins like fibrin and fillagrin and degenerates and damages the bone cartilage in joints, leads to inflammation and causes systemic manifestations.

Investigations:

- Hb:11.8g/dl

- ESR: 40mm/hr
- RA factor: ++
- ANA results: 2+ intensity

  Titre: 1:100

  Pattern: Hep 20-10 cells

  Nucleoplasm: positive

  Fine granules
- ANA profile: nRNP/Sm: Borderline(+)

  SS-A: Borderline(+)

  Jo1: Borderline(+).

Treatment:

The patient was treated with Tab. prednisolone 5mg TID, Tab. HCQ 200mg BD, Tab. Methotrexate 10mg OD 2 doses/week, Tab. Folic acid 5mg OD, Tab. Limcee OD, Diprobate topical cream 3 months back.

Dermatologist regimen	Rheumatologist Regimen	First follow up	Second follow up
HCQ(Hydroxychloroquine) 200mg BD Prednisolone 5mg TID	HCQ- 300mg OD Prednisolone-5mg BD Folic acid- 5mg OD Methotrexate-7.5mg twice/week Calciumcarbonate OD	HCQ- 300mg OD Prednisolone 7.5mg OD Folic acid 5mg OD Methotrexate 7.5mg twice/week Calcium carbonate OD	HCQ- 300mg OD Prednisolone 5mg OD Folic acid 5mg OD Methotrexate 7.5mg twice/week Calcium carbonate OD

RESULTS AND DISCUSSION:

She was symptomatically improved in one month and the condition is stable. Her investigations like LFT (SGOT, SGPT, ALT), RFT, ocular tests are found to be normal, so the condition got stabilised. She was counselled to avoid exposure to sunlight, apply sunscreen lotion 30 mins before going out, avoid spicy foods as they worsen the mouth ulcerations and follow regular physical exercises, proper adherence to medications.

CONCLUSION:

Discoid lupus erythematosus is a chronic condition most commonly seen in females than to males. She was suffering with non-healing ulcers, scarring lesions, multiple joint pains, so she was treated with oral and topical steroids to reduce inflammation and lesions, HCQs, disease modifying anti-rheumatic drug(DMARD), folic acid as methotrexate inhibit folic acid synthesis, calcium supplements for bone strengthening. Follow-up is necessary and important as DLE is considered as a pre-cancerous condition and for early detection of prognosis of the condition.

REFERENCES:

1) Suresh Panjwaniz, MD, M.Sc. Early diagnosis and treatment of Discoid lupus erythematosus. JABFM 2009; Volume 22, Page number:206-213

2) Elizabeth, Tkachenko, Discoid lupus erythematosus, Medscape.com/article/1065529.1-19.

3) Brianna Mc Daniel Discoid lupus erythematosus. ncbi.nlm.nih.gov/books/n/shatpearls/article- 24528.

4) Jessica S. Haber, Joseph F. Merola, Victoria P. Werth. Classifying Discoid lupus erythematosus: background, gaps, and difficulties. International Journal of Women's Dermatology 3(2017)562-566.

5) Geetharani Gopalan, Sudha R. Gopinath, Kothandaramaswamy R. Sathesh Pandian. A clinical and epidemiological study on Discoid lupus erythematosus. International Journal of Research in Dermatology. 2019 August:4(3):396-402.

6) K. Kranti, Hemaseshan, J.Juliet. Discoid lupus erythematosus involving gingiva. Journal of Indian society of periodontology volume-16, Issue 1, January-march 2012;126-128.

7) C.K Sreejan, R. Gopakumar, Subhas Babu, R.K Roopashri. Discoid lupus erythematosus. A case report with review of the literature. Journal of Indian academy of oral medicine and radiology; 2009; Volume 21:Issue 1.Page number.37-41

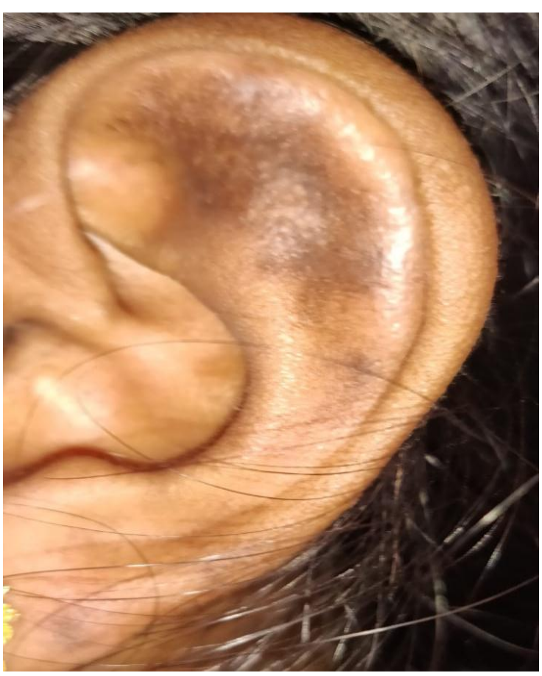

Figure No. 1: Scarring lesions on ear pinna

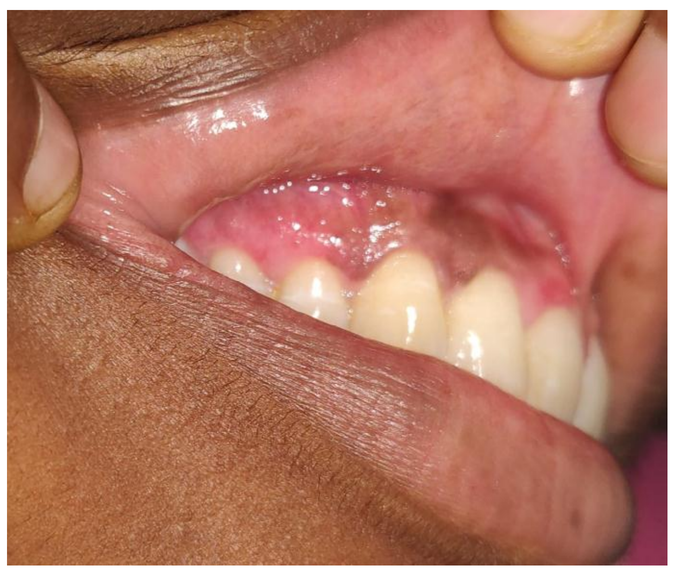

Figure No. 2: Nonhealing ulceration

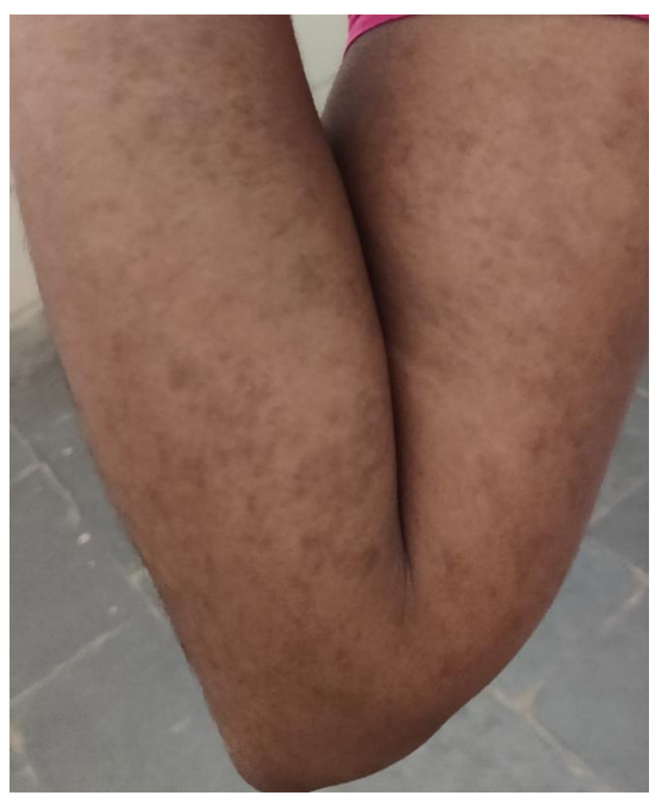

Figure No. 3: Hyperpigmented scars on hand