To the Editor:

Subacute cutaneous lupus erythematosus is a specific form of lupus that occurs with annular or polycyclic erythematous plaques in areas exposed to sunlight. Conventional treatments include the use of sunscreens, topical and oral corticosteroids, sulfones, antimalarial drugs, and immunosuppressive agents including cyclosporine, azathioprine, or methotrexate.

We present the case of a 54-year-old woman—allergic to heparin, with a history of arterial hypertension, deep vein thrombosis in the lower right leg, and bilateral pulmonary thromboembolism resulting from an ankle fracture—who had been monitored for subacute cutaneous lupus erythematosus for 25 years. Since the initial diagnosis, the patient has presented continual outbreaks of cutaneous lesions consisting of annular erythematous plaques with a shiny surface and clear margin around the eyebrows, and on the cheeks and upper back (Figure 1). There were no associated systemic symptoms and tests for antinuclear antibodies (ANA) and anti-Ro antibodies were positive. The condition progressed with successive poorly controlled cutaneous outbreaks that were treated with medium to high potency topical corticosteroids, topical calcineurin inhibitors, oral prednisone (minimum of 15 mg on alternate days up to 60 mg daily), and systemic agents (hydroxychloroquine, azathioprine, methotrexate, and cyclosporine). All forms of treatment had been suspended due to ineffectiveness, poor tolerance, or adverse effects. As the daily dosage of 30 mg of prednisone could not be reduced, subcutaneous efalizumab 1 mg/kg/week was administered and the skin lesions resolved after 2 months (Figure 2). The patient was symptom free at the end of 4 months.

Refractory Subacute Cutaneous Lupus Erythematosus With a Response to Efalizumab

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Figure 1. Clearly defined infiltrated erythematous plaques on the eyebrows, cheeks, and upper lip.

Figure 2. Resolution of the lesions after 2 months treatment with efalizumab.
months of follow-up during which the efalizumab dose was maintained while tapering the prednisone dose. She showed good tolerance to the treatment with no adverse effects, no changes in test outcomes, and a negative ANA titer. Efalizumab is a humanized monoclonal antibody that has proved effective in the treatment of inflammatory illnesses such as psoriasis and lichen planus. Its use has recently been proposed in the treatment of cutaneous lupus, on the assumption that the pathogenesis of this illness is mediated by T cells. Clayton et al described the case of a patient with refractory subacute cutaneous lupus who was treated with systemic efalizumab and who presented improvement of the lesions in 6 weeks with no adverse effects. Some 3 months later the patient presented an outbreak of lesions that was controlled by increasing the dose of efalizumab. Usmai and Goodfield described the case of a woman with erosive oral lichen planus who was being treated with efalizumab. She developed a lupus-like syndrome with discoid lesions in areas exposed to sunlight, positive antibodies, and histology compatible with lupus. The lesions healed in 8 weeks when treated with hydroxychloroquine. Durox et al presented the case of a woman with psoriasis being treated with efalizumab. In view of the risk-benefit relationship, some patients may benefit from future drugs with a similar action mechanism and reduced side effects.

References