OPEN ACCESS Freely available online

Lupus: Open Access

Opinion Article

An Overview of Subacute Cutaneous Lupus Erythematosus

Mac Meroon*

Department of Rheumatology, Federal University of Parana, Curitiba, Brazil

DESCRIPTION

Subacute Cutaneous Lupus Erythematosus (SCLE) belongs to subgroup of cutaneous lupus erythematous. It appears as a widespread photosensitive rash. SCLE affects around 10% of all lupus patients. Patients of any age, gender are affected. SCLE, on the other hand, is more commonly detected in middle-aged women. SCLE is more frequent among Caucasians than other ethnic groups in North America. It is related to various conditions such as sjogren syndrome, rheumatoid arthritis, and crohn's disease. Subacute Cutaneous Lupus Erythematosus (SCLE) is a clinically different condition that is related to systemic lupus erythematosus in 50% of cases and can be connected with sjogren's syndrome and individuals with complement deficiencies in the second and fourth components.

It is a non-scarring, non-atrophic photosensitive dermatosis. The lesions heal without leaving scars. However, they may cause some dyspigmentation. The shoulders, forearms, neck, and upper chest are the most commonly affected regions. Approximately half of all SCLE patients have severe joint problems. Arthralgias are often symmetrical and affect small joints such as the wrists or hands. Subacute cutaneous lupus erythematosus occurs most commonly in patients with an Anti-Ro (SS-A) autoantibody, a positive Antinuclear Antibody (ANA), and human leukocyte antigens B8, DR3, DRw52, and DQ1. Drugs such as hydrochlorothiazide, calcium channel blockers, Angiotensin-Converting Enzyme (ACE) inhibitors, terbinafine, procainamide, antihistamines, and tumor necrosis factor antagonists increase this disease. As a result, a drug history is crucial in the first examination of individuals with SCLE, and drug withdrawal is required.

CLINICAL FEATURES OF SUBACUTE CUTANEOUS LUPUS ERYTHEMATOSUS

SCLE frequently manifests as a non-scarring papulosquamous eruption. An annular plaque with elevated erythematous edges and central clearing is common. Plaques join together to produce polycyclic patterns. They might have an overlying scale. Peripheral vesicles, crusting, and bullae are occasionally seen. The rash is usually symmetrically distributed across sun-exposed areas such as the neck, upper body, and outside arms. Usually, the face is not affected. Post-inflammatory hypopigmentation resolves lesions, normal pigmentation returns with time.

Other symptoms related to lupus in SCLE patients include: Mouth ulcers, diffuse non-scarring alopecia livedo reticularis, periungual telangiectasia. Drug-induced lupus can be difficult to identify from non-drug-induced SCLE. The following are some of the characteristics of drug-induced SCLE: Typically seen in elderly individuals who include malar rash, bullous, targetoid, or vasculitic variants on the legs.

DIAGNOSIS OF SUBACUTE CUTANEOUS LUPUS ERYTHEMATOSUS

Clinically SCLE can be diagnosed with blood testing and a skin biopsy. Antinuclear Antibody (ANA) positivity is seen in around 60% of SCLE patients. More than 80% had Ro/SSA antibody positivity. Less common antibodies include La/SSB, dsDNA, anti-histone, and Sm. The Histology on biopsy can resemble other types of cutaneous lupus. Lymphocytic interface dermatitis with basal layer degeneration is seen. There is less follicular plugging, perivascular and periadnexal lymphocytic infiltration, basement membrane thickening, and dermal mucin than in DLE. In two-thirds of SCLE patients, direct immunofluorescence identifies C3 deposition, granular immunoglobulin IgG, IgM along with the dermal-epidermal interface. An increased ESR and a positive rheumatoid factor with reduced complement levels can be detected in certain individuals. Anemia, leukopenia, or thrombocytopenia may also be present. A urine analysis should be conducted repeatedly during the patient's clinical treatment. A biopsy on undamaged skin can be done in either sun-exposed or non-exposed areas. The lupus band test is used to examine this normal patch of skin. A biopsy of damaged skin reveals the characteristic histology of vacuolar changes in the basal cell layer. Sun protection is important, using broad-spectrum sunscreen and

Correspondence to: Mac Meroon, Department of Rheumatology, Federal University of Parana, Curitiba, Brazil, E-mail: macmerooni@gmail.com

Received: 21-Mar-2022, Manuscript No. LOA-22-16108;**Editor assigned:** 23-Mar-2022, PreQC No. LOA-22-16108 (PQ);**Reviewed:** 07-Apr-2022 QC No. LOA-22-16108; **Revised:** 14-Apr-2022, Manuscript No. LOA-22-16108(R); **Published:** 22-Apr-2022; DOI: 10.35248/2684-1630.22.7.198.

Citation: Meroon M (2022) An Overview of Subacute Cutaneous Lupus Erythematosus. Lupus: Open Access. 7:198.

protective clothing is the most effective therapy for SCLE. Corticosteroids can be applied topically or intravenously.

CONCLUSION

The antimalarials like hydroxychloroquine, have lower efficacy in smokers. Patients should avoid using systemic corticosteroids unless they have a systemic disease or need them for a limited period. Furthermore, dapsone, thalidomide, interferon, systemic retinoids, and immunosuppressive medications may be beneficial in certain people. Generally, SCLE patient's responds well to therapy, but it may flare up again each summer. Around 10%-15% of SCLE patients develop SLE, including neurological dysfunction and renal failure. Substance-induced SCLE might take a long time to resolve when the causative drug is stopped. Finally, some SCLE patients have been discovered to have low vitamin D levels and should begin taking vitamin D and calcium supplements.