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Facial Eruption Mimicking Subacute Cutaneous Lupus Erythematosus: A Diagnostic Challenge

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ABSTRACT

Facial erythematous and scaly dermatoses may represent a diagnostic challenge because of their varied clinical presentations and overlapping features. We report the case of a 39-year-old woman presenting with a chronic relapsing facial eruption clinically and dermoscopically suggestive of subacute cutaneous lupus erythematosus (SCLE). However, immunological investigations were negative and histopathological examination revealed impetiginized eczema. Significant clinical improvement was achieved following antibacterial treatment and supportive skin care. This observation highlights the importance of histopathological confirmation in atypical facial eruptions mimicking lupus erythematosus.

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KEYWORDS:
Subacute cutaneous lupus erythematosus, Facial eruption, Dermoscopy, Impetiginized eczema, Differential diagnosis, Histopathology.

INTRODUCTION

Subacute cutaneous lupus erythematosus (SCLE) is an autoimmune dermatosis characterized by annular or papulosquamous lesions predominantly affecting photo-exposed areas. Several inflammatory and infectious dermatoses may mimic SCLE both clinically and dermoscopically, making diagnosis challenging. Histopathological examination remains the gold standard in doubtful cases. We report an unusual case of chronic facial eczema impetiginized clinically resembling SCLE.

CASE PRESENTATION

A 39-year-old woman with a history of alopecia areata, not previously documented, presented with an erythematous-squamous facial eruption evolving intermittently over eight years.

The lesions were localized on the forehead, nose, malar regions, and perioral area. They appeared as poorly demarcated infiltrated erythematous plaques covered with fine scales. The eruption evolved through recurrent flares characterized by progressive enlargement and multiplication of lesions.

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The patient reported worsening of lesions following the application of topical corticosteroids. More recently, a marked exacerbation occurred after the use of a cosmetic depigmenting product containing thiamidol.

Physical examination revealed multiple infiltrated erythematous-squamous plaques affecting the centrofacial region. No systemic manifestations were noted.

Several differential diagnoses were considered:
- Subacute cutaneous lupus erythematosus.
- Dermatophytosis.
- Seborrheic dermatitis.
- Impetiginized eczema.
- Rosacea.
- Photosensitivity dermatosis.

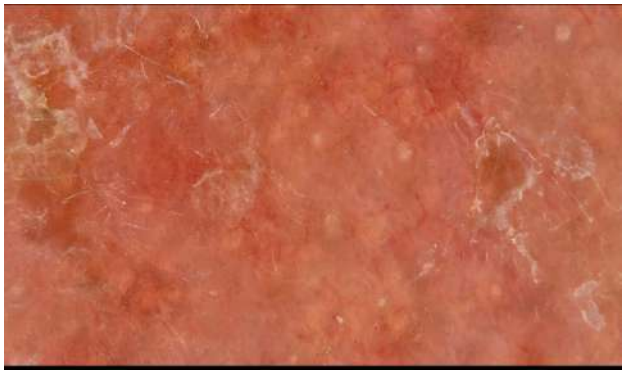
Dermoscopic examination showed features initially suggestive of subacute cutaneous lupus erythematosus, leading to further investigations.

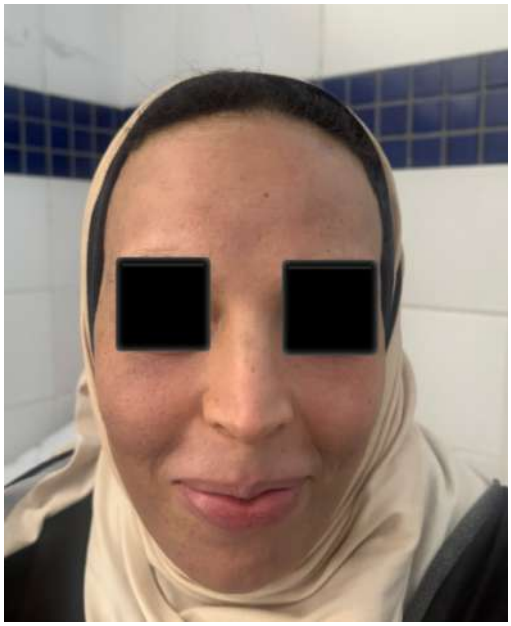
An immunological workup including antinuclear antibodies and lupus-related serologies was negative.

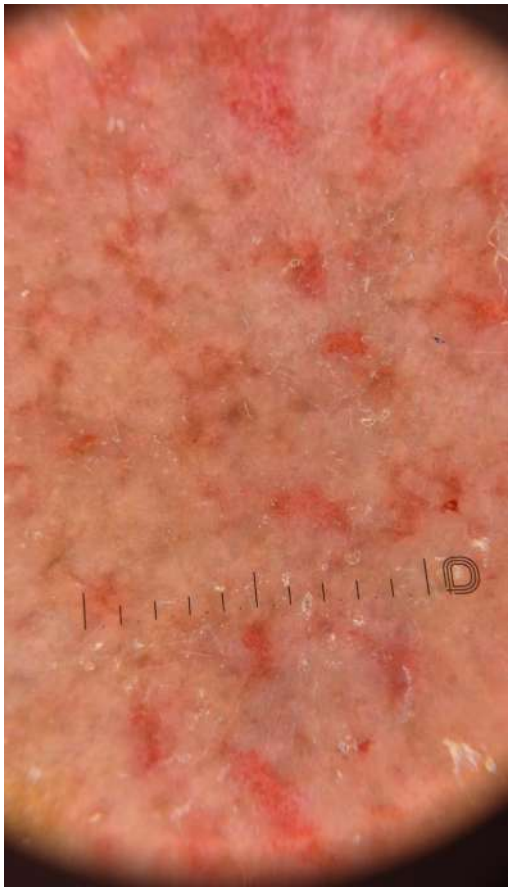
A skin biopsy was subsequently performed. Histopathological examination demonstrated epidermal spongiosis associated with inflammatory infiltrate and secondary bacterial colonization, findings consistent with impetiginized eczema.

Based on these results, the patient received topical fusidic acid twice daily, oral ciprofloxacin 500 mg three times daily, a short course of oral prednisone 5 mg daily for seven days, and a repairing emollient (Cicaplast Baume B5).

The clinical outcome was favorable, with marked regression of erythema, scaling, and infiltration within a few weeks.







DISCUSSION

Facial eruptions mimicking SCLE remain a frequent diagnostic challenge in dermatology. Clinical presentation alone may be insufficient to establish the diagnosis because inflammatory, infectious, and autoimmune dermatoses may share similar characteristics.

Dermoscopy has emerged as a valuable non-invasive diagnostic tool in inflammatory skin diseases. However, its findings should always be interpreted in conjunction with clinical, laboratory, and histopathological data. In our patient, dermoscopy suggested SCLE, but immunological investigations were negative and histopathology ultimately established the diagnosis of impetiginized eczema. The aggravation observed after prolonged topical corticosteroid use may have altered the clinical presentation and contributed to diagnostic confusion. Similarly, the recent use of a thiamidol-containing depigmenting agent may have induced local irritation and exacerbated the inflammatory process.

This case underscores the indispensable role of skin biopsy in chronic facial eruptions with atypical features and emphasizes the limitations of dermoscopy when used as a standalone diagnostic tool.

CONCLUSION

Chronic facial eczema may closely mimic subacute cutaneous lupus erythematosus both clinically and dermoscopically. Histopathological examination remains essential in cases with diagnostic uncertainty. Prompt recognition and appropriate antibacterial and anti-inflammatory treatment can lead to rapid clinical improvement and avoid unnecessary investigations or immunosuppressive therapies.

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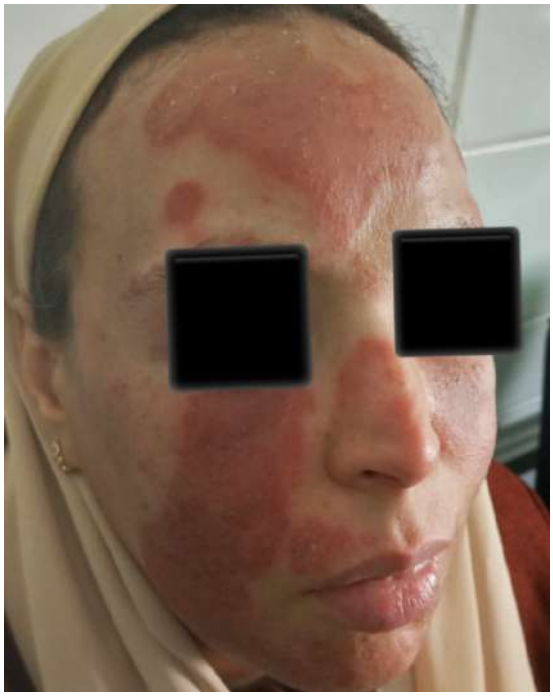

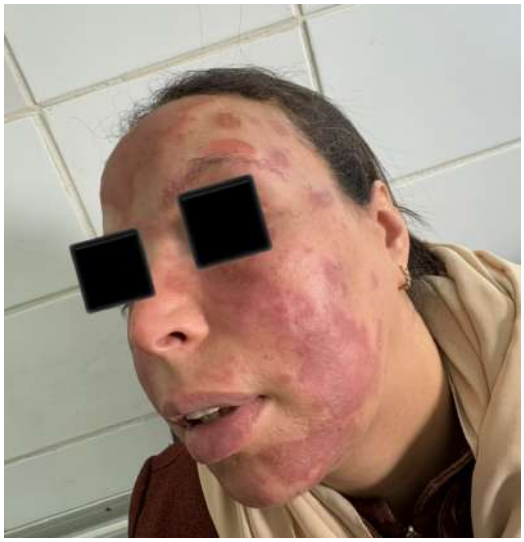

Dermoscopy showed a diffuse erythematous background with regularly distributed dotted vessels and overlying white-yellow lamellar scales. Focal perifollicular hyperkeratosis and scattered milia-like cysts were noted. No melanocytic criteria or other features suggestive of malignancy were observed.