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Eyelid Discoid Lupus Erythematosus Misdiagnosed as Leishmaniasis

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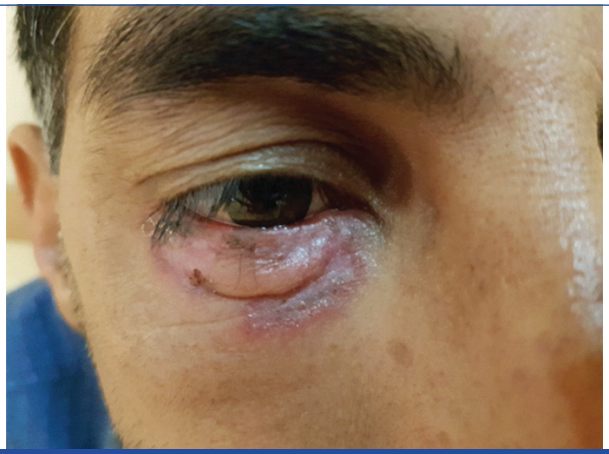
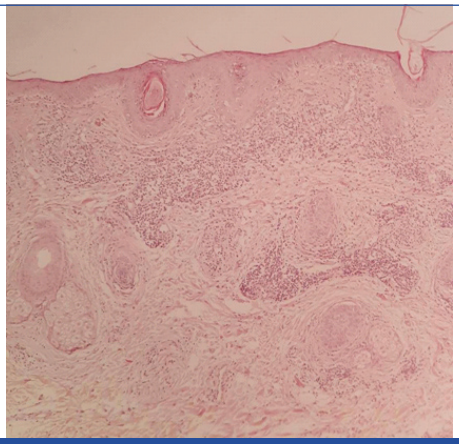
A 42-year-old man presented to the clinic of Dermatology and Hair Transplantation, with a two-year history of right eyelid scarring and associated eyelash alopecia. Upon initial presentation of the patient's symptomatology, he had a positive smear test for leishmania. Therefore, he was diagnosed and treated for eyelid leishmaniasis with several rounds of cryotherapy and glucantim for two years; his lesions were refractory to this initial therapy.

General physical examination was unremarkable. Right eye examination revealed, periocular erythematous, oedematous plaques with active borders, central scarring and lower lid madarosis [Table/Fig-1]. There was no other skin lesion on the body. The lesion was clinically suspicious for cutaneous lupus and a biopsy was performed. Histopathological analysis confirmed Discoid Lupus Erythematosus (DLE) [Table/Fig-2]. Specifically, the sections showed hyperkeratosis with follicular plugging. Thinning and flattening of the stratum Malpighi with focal hydropic degeneration of the basal layer was identified. A brisk perivascular and periadnexal mononuclear lymphocytic infiltrate with some admixed melanophages, around hair follicles was seen. Vasodilation of upper dermal vessels was also present.

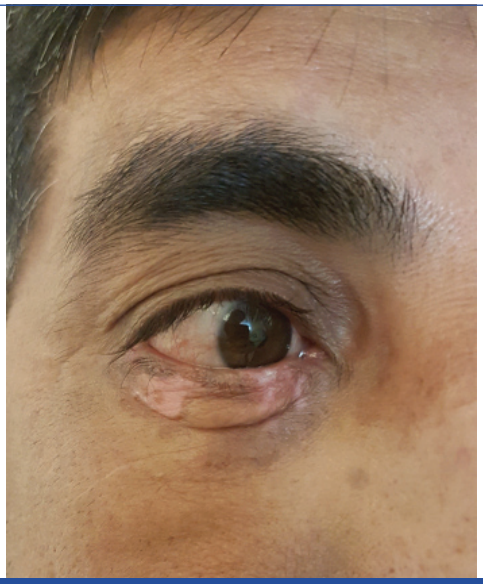


[Table/Fig-1]: Right eyelid examination; periocular erythematous, oedematous plaques with active borders, central scarring and lower lid madarosis.



[Table/Fig-2]: The skin lesion biopsy (H&E staining; Low power).

The patient was successfully treated with hydroxychloroquine 200 mg BID and prednisolone 15 mg daily, resulting in lesional resolution in six months [Table/Fig-3].



[Table/Fig-3]: Successful treatment of the patient with hydroxychloroquine and prednisolone and lesional resolution in six months.

DLE is a chronic, autoimmune disorder that is limited to the skin; morphologically, DLE presents with characteristic acute erythema and discoid lesions [1]. Rarely does DLE involve the eyelid and periocular region [2]. Early diagnosis of DLE is important towards initiating the correct treatment and prevention of permanent scarring and discolouration [1,2]. The differential diagnosis of periocular DLE includes: psoriasis, rosacea, lupus vulgaris, sarcoidosis, Bowen's disease, polymorphous light eruptions, lichen planopilaris, dermatomyositis, granuloma annulare, granuloma faciale and leishmaniasis [2]. There are many misdiagnosed cases in the literature based on the clinical similarities of the aforementioned conditions [3-6]. Similarly, the present patient's treatment was delayed due to an incorrect laboratory-based diagnosis, without noticing the clinical signs. A higher index of suspicion for DLE could have accelerated the biopsy and correct management; the presented clinical scenario, emphasises the importance of physical examination and histopathological examination in dermatological diagnoses.

Patient's consent was obtained before publishing the clinical images.

REFERENCES

[1] Uva L, Miguel D, Pinheiro C, Freitas JP, Gomes MM, Filipe P. Cutaneous manifestations of systemic lupus erythematosus. Autoimmune Dis. 2012;2012:834291.

[2] Yaghoobi R, Feily A, Behrooz B, Yaghoobi E, Mokhtarzadeh S. Palpebral involvement as a presenting and sole manifestation of discoid lupus erythematosus. Scientific World Journal. 2010;10:2130-31.

[3] Sisti A, Fallaha A, Tassinari J, Nisi G, Grimaldi L, Eisendle K. Melanoma in situ mimicking a Lichen planus-like keratosis. Acta Biomed. 2018;88:496-98.

[4] Yaghoobi R, Feily A, Ranjbari N, Lotfi J, Yaghoobi E. Lepromatous leprosy: a commonly misdiagnosed disease. Scientific World Journal. 2010;10:2348-49.
[5] Maor D, Ondhia C, Yu LL, Chan JJ. Lichenoid keratosis is frequently misdiagnosed as basal cell carcinoma. Clin Exp Dermatol. 2017;42:663-66.
[6] Feily A, Namazi MR, Seifmanesh H. Generalized pustular psoriasis-like dermatophytosis due to Trichophyton rubrum. Acta Dermatovenerol Croat. 2011;19:209-11.

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