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Clinical Image

A Patient of Facial Lipoatrophy

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A 40-year-old female presented with gradually reducing muscle bulk over cheeks on both sides of the face for the last 4 years (Figure 1). Initially the affected area became red and itchy and it would exacerbate whenever the area was exposed to sunlight. Gradually she noticed a change of color over the affected area of the face which became brown and eventually started losing muscle bulk.

She also noticed wasting on her scalp which started 6 months back and are slowly growing in size. There was no other depression of the skin anywhere in the body. The patient didn't complain of any oral ulcer, pain in the joints, no difficulty in swallowing, no stiffness or restriction of movement of joints of the hands, no bluish discoloration of finger tips on exposure to cold.

On examination the area over the buccal and massetar area were depressed bilaterally with prominent zygomatic bones, the skin over the affected sites were atrophic and there were numerous dark patches present over the affected sites. There was no fasciculation present. Examination of the facial nerve revealed no abnormalities. Examination of the trigeminal nerve revealed slightly diminished power of muscles of mastication, no other abnormality was found. Two depressed areas were present on the scalp, there was no color change over those lesions, the skin was shinny and atrophic (Figure 2).

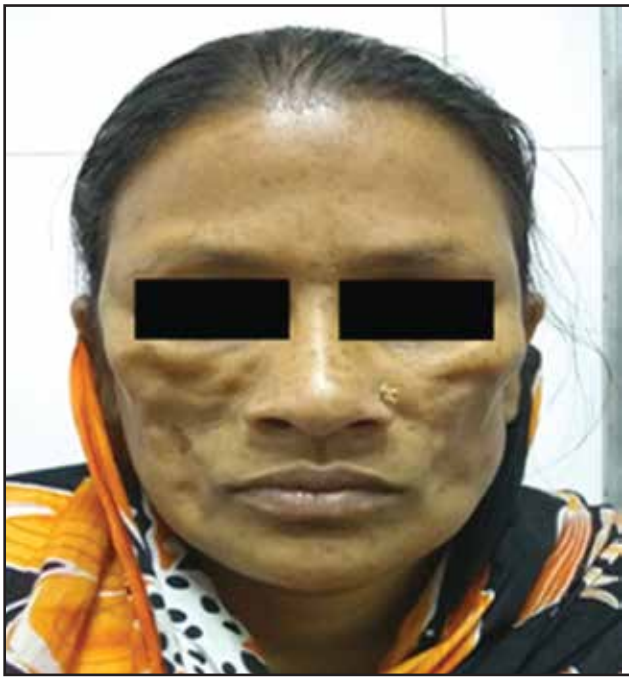

Figure 1: Atrophy of buccal muscles

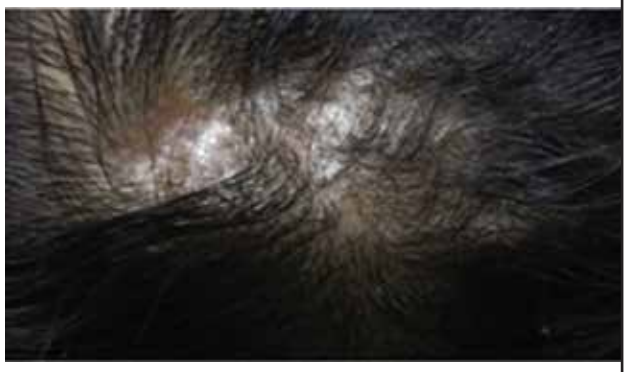

Figure 2: Shiny & atrophic scalp

A complete blood count with differential analysis, electrolytes, creatinine, liver function tests, urinalysis, and a chest radiograph were normal. ESR being 44 mm, CPK 99 U/L, ANA was negative, Anti dsDNA and Ro60 KD were positive. Skin biopsy showed lobular panniculitis with infiltrate of lymphocytes, plasma cells and

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macrophages. Few area of hyalinization of the adipocytes is present. So a diagnosis of Lupus Erythometosus Profundus (LEP) was made.

The anti-nuclear antibody (ANA) test is usually positive, but not required to establish the diagnosis of LEP. Lupus panniculitis occurs in 2–3% of patients with SLE. Due to the fact that the diagnosis of LEP may precede the presentation of SLE, patients suffering from LEP should be monitored for symptoms of SLE.[1] Patients with active SLE almost always test positive for ANA, but ANA negative SLE can very rarely occur in the presence of antibodies to the Ro antigen.[2]

The standard first-line therapy of lupus erythematosus profundus consists of antimalarial agents, such as chloroquine, hydroxychloroquine and quinacrine.[3] The patient was put on hydroxychloroquine and was advised to follow up in 3 months.

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