Autoimmune Resource and Research Centre

Information Sheet

Management of Cutaneous Lupus

Taken from Transcript of a talk by Dr. Christina Saywell (Skin & Cancer Foundation) and Dr. Laura Saywell (Sydney) as printed in the Lupus Association of NSW Newsletter August 1995.

Avoidance of Exacerbating Factors:
The importance of photosensitivity in all forms of lupus cannot be over emphasised. Sunlight is the major preventable cause of precipitating or worsening cutaneous lupus. In our climate the sun's rays are potentially damaging all year round and so it is best to make sun protection part of your daily routine indefinitely. As well as helping your lupus you may reduce the signs of aging and the number of skin cancers compared to those the Dermatologists see on the average Australian skin.

The sun protective value of clothing has recently been emphasised. Close knit weaves, long sleeves, gloves for driving all help. It may not be long before we see many more SPF value labels attached to garments.

Lupus patients are typically sensitive to a wide range of ultraviolet radiation. Other people tend to burn in response to UVB radiation where LE patients react to UVA and UVB. UVA radiation penetrates window glass and can be emitted from fluorescent lights. It is important to remember that sunlight reflects strongly off concrete, water and snow and that it easily penetrates clouds.

Sunscreens are either:

1. Physical Screens – They protect against UVA and UVB and are therefore suitable for LE patients. They work by depositing a layer of particles on the skin's surface which reflects the UV light away from the skin. Zinc and Titanium Dioxide are the most commonly used. The drawback is that they can leave a thick obvious film on the skin. In recent years a new form of Titanium Dioxide (microfine) has been refined which is a lot less opaque and more cosmetically acceptable. **Sunsense** and **Quad bloc** are good brands.

2. Chemical Screens – These only protect against UVB and are not there as appropriate. Re-application of sunscreens throughout the day is mandatory if you are outdoors.

Other factors which may exacerbate LE in certain individuals include wind, the cold and stress. For many there is no obvious factor which can be blamed for a flare.

Topical Steroids:
These are first line treatment for cutaneous lupus. The weaker compounds eg. Hydrocortisone are ineffective. Diprosone and the newer and probably safer elocon (mometasone) are required. They may need to be used under occlusion eg. Under glad wrap to increase penetration into the skin. Ointments, although greasier than creams are probably more effective.

Intralesional Steroids:
Very thick discoid plaques may require steroid injections every few weeks. Creams just cannot penetrate really thick lesions.

Anti-Malarials:
Plaquenil (Hydroxychloroquine) can be prescribed for skin lesions that don't respond to topical treatment as well as for systemic complications of LE, eg. Joint pains, pleurisy and fatigue.

Like the vast majority of drugs, anti-malarials such as Plaquenil do have side effects although these are rare. Effects on the retina of the eye is a rare possibility, but doctors err on the side of caution and recommend regular eye checks during treatment. Other uncommon side effects include nausea, gastric upset, rashes, bleaching of hair and altered skin pigmentation, insomnia and muscle weakness. These effects seem daunting but a very significant number of people do very well on Plaquenil. 75% of rashes respond and there are multiple other advantages such as reducing the rate of progress of LE, improving fatigue, joint pain and sicca symptoms, lowering blood fats and decreasing the risk of blood clots.

Oral Steroids (Prednisolone):
These are rarely indicated for skin lesions alone and their use is dictated by the involvement of the internal organs.

Alternative Treatments for DLE:
Occasionally physical methods of treatment such as liquid nitrogen spray are used for discoid lesions. Tigason, a drug usually used for psoriasis and hereditary conditions with thickened skin may be tried for very thick DLE lesions. Gold injections are a very useful alternative in chronic DLE. 50% of patients will respond, even those in whom nothing else may have worked. However, some patients do have to stop treatment because of side effects, eg. rashes, blood test changes. Thalidomide is also extremely effective. It is however, a major teratogen (causes birth defects). An "epidemic" of malformed babies occurred in the 60's when it was given to pregnant women for morning sickness. Despite these cautions it may be still of great benefit to selected LE patients.

A recent study showed significant improvement of cutaneous LE when exposed to a special narrow band of UV light (UVA 1). This may seem paradoxical considering UV radiation worsens lupus but selected wave bands of light have been used with excellent results in many skin disorders eg. psoriasis, eczema. It is still too early to determine if the widespread use of UVA 1 will eventuate but this is an exciting prospect for the future.

Alternative Treatments for Subacute LE:
Tigason and its related compound, Roaccutane as well as Dapsone may be specifically advantageous for this form of the disease.