A man in his 80s presented with a 2-year history of a pruritic rash on the trunk and arms. It was composed of annular, erythematous polycyclic plaques with peripheral scale and central areas of hyperpigmentation and clearing (Figure). A punch biopsy specimen revealed interface dermatitis with increased interstitial mucin compatible with lupus erythematosus. Serologic test results were positive for antinuclear antibody (titer, 1:640), anti-Ro/SSA, and anti-La/SSB while negative for antihistone, anti-Smith, and anti-double-stranded DNA antibodies. The patient had no coexisting joint, lung, kidney, or mucosal symptoms suggestive of systemic lupus erythematosus. A medication review found a history of omeprazole use beginning 1 month before the eruption’s onset. Drug-induced subacute cutaneous lupus erythematosus (SCLE) was suspected, and the cessation of omeprazole led to marked improvement in the rash after 1 month.

A subset of cutaneous lupus erythematosus, SCLE is characterized by the presence of photodistributed annular or papulosquamous plaques and is strongly associated with anti-Ro/SSA and anti-La/SSB antibodies. As many as 30% of SCLE cases are thought to be induced or exacerbated by drugs. Drug-induced pathogenesis should be considered, especially in elderly patients and those taking multiple medications. Antihypertensives, antiepileptics, antifungals, and proton pump inhibitors are among the most common causative agents. The precise pathogenesis of drug-induced SCLE is unknown; certain drugs may induce a photosensitivity reaction that facilitates the development of SCLE in susceptible individuals.

Drug-induced and idiopathic SCLE are challenging to differentiate, but investigators have found characteristics that might distinguish them. Patients with drug-induced SCLE are typically older at age of onset and more likely to experience systemic symptoms. Also, the drug-induced eruption may be more widespread and can exhibit additional cutaneous morphologic features such as palpable purpura, bullae, and lesions that resemble erythema multiforme. A detailed medication and clinical history, coupled with a meticulous skin examination and histopathologic and/or serologic correlation, is imperative in reaching an early and correct diagnosis.

Management differs between the 2 entities. Immediate cessation of the associated agent is the cornerstone of drug-induced SCLE treatment. Topical corticosteroids and systemic antimalarials, medications used as first-line treatments in idiopathic SCLE, may also be used in drug-induced SCLE to expedite clinical improvement. Physicians must recognize drug-induced SCLE and appropriately diagnose patients of all skin types. Discontinuation of the causative agent will reduce patient morbidity and prevent unnecessary treatment.

ARTICLE INFORMATION

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REFERENCES


Clinical image of omeprazole-induced subacute cutaneous lupus erythematosus in a patient with Fitzpatrick type V skin.