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Low-Dose Isotretinoin For Treatment of Chronic Discoid Lupus in Women of Childbearing Age

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To the Editor:

We present the case of a 29-year-old woman diagnosed with systemic lupus erythematosus in 1988 on the basis of malar erythema, photosensitivity, arthralgia, thrombocytopenia, lymphopenia, and positive results for antinuclear and anti-DNA antibodies. She consulted in August 2004 with multiple erythematous plaques with atrophic centers on the upper region of the trunk and face, along with erythematous lesions with a hyperkeratotic appearance on both palms (Figure 1), with onset several months previously. Both types of lesion were compatible with lupus. At the time of consultation the patient was being treated with prednisone, mycophenolate, and chloroquine, without improvement in the cutaneous lesions. Treatment was prescribed with isotretinoin 40 mg/d, with agreement from the patient to use effective means of contraception. A rapid response was observed and the drug was well tolerated, so treatment was maintained for 6 months. The palmar lesions reappeared from 1 month after the drug was withdrawn. Topical treatment was administered for approximately a year to no effect, leading to initiation of treatment with isotretinoin at a dose of 20 mg/d in order to reduce the toxicity of the treatment. A slower improvement was seen with the new dosage, although from the fifth month of treatment the results were similar to those seen at the

end of the 40 mg/d cycle (Figure 2). The lesions remained stable for 12 months, with no significant changes in triglycerides or hepatic enzymes. The patient used safe methods of contraception during the treatment period. There were no side effects apart from cheilitis and slight xerosis on the face.

Chronic discoid lesions are one of the most common forms of cutaneous lupus erythematosus.¹ These are most commonly found on the face, scalp, and the ears, although palmar lesions are also possible.

Chronic discoid lupus erythematosus can be treated with various topical drugs, like potent corticosteroids,² or imiquimod 5%,³ as well as systemic treatments like thalidomide, hydroxychloroquine, or acitretin. The last 2 are first-line drugs with similar levels of effectiveness,² although acitretin has more associated side

effects. Side effects include cutaneous xerosis, cheilitis, gastrointestinal disorders, increased serum levels of triglycerides, and high risk of teratogenic effects, which oblige patients to use contraceptive measures during treatment and for 2 years after the drug is discontinued.

Meanwhile, isotretinoin has been shown to be effective in the treatment of chronic discoid lupus erythematosus, and it can also be employed as a maintenance treatment at doses of 40 mg on alternate days.⁴ This treatment has similar side effects to acitretin but a lower risk of teratogenesis, which means that female patients prescribed the drug need only take contraceptive measures during treatment and for a month after this is suspended. In the case described here, the patient was planning a pregnancy in the medium term, whereby acitretin was rejected in favor of isotretinoin.



Figure 1. Hyperkeratotic erythematous lesions on both palms.



Figure 2. Improvement of lesions following 5 months of treatment with isotretinoin (20 mg/d).

Given that most women with chronic discoid lupus are of childbearing age, it is encouraging to encounter a treatment that allows for patients to plan pregnancies more easily.

Similarly, we stress that maintenance treatment with lower doses of isotretinoin (20 mg/d) can be useful, allowing lesions to be controlled with reduced systemic side effects.

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Purpura After Application of a Eutectic Mixture of Local Anesthetic

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To the Editor:

Eutectic mixture of local anesthetic (EMLA) is a topical cream containing lidocaine (25 mg/mL) and prilocaine (25 mg/mL) as active ingredients in an excipient of polyoxyethylene and carboxypolymethylene, which produces a pH of 9.4. EMLA is approved by the US Food and Drug Administration for patients aged from 3 years, to be applied on unbroken skin. This product is marketed in Spain as a cream (in 5 g

and 30 g tubes) and as 4-cm self-adhesive patches, and it is frequently used as a topical anesthetic by dermatologists and pediatricians.

The most important side effects in terms of frequency include local blanching and erythema in the area of application, while less-common effects include contact urticaria, irritant dermatitis, allergic contact eczema, and purpura. Systemic complications are exceptionally rare, although the presence of methemoglobinemia—attributed to the metabolite of prilocaine—has been described in children, leading to headaches, blurred vision, unstable walking, cyanosis, and methemoglobin in the blood.

We report episodes of purpura as a result of EMLA use in 2 pediatric patients and review the literature, in which only a few cases of this effect have been described. The 2 patients, aged 9 years and 18 months, were both girls with a history of atopic dermatitis. They were prescribed EMLA with an occlusive dressing for 90 minutes prior to curettage of multiple molluscum contagiosum lesions. When the plastic film was lifted an asymptomatic petechial eruption was seen in the occluded zone (Figure) that resolved

without treatment or sequelae within 2 weeks. Biopsy was not considered necessary given the characteristic clinical appearance of the lesion.

Purpura as a reaction to EMLA is a rare complication which we have found in only 25 published cases.¹⁻⁴ The exact pathogenic mechanism is not known, but it appears to have a toxic rather than allergic basis.³ Although no patch tests were carried out on our patients, other authors report negative results from such tests both in immediate readings (30 minutes) and those taken at 48 and 72 hours.³

It is well known that EMLA cream can have a direct effect on blood vessels, causing blanching and erythema, and that it can even produce structural changes in the vessel walls that lead to extravasation of red blood cells and, consequently, purpura. Atopic dermatitis probably acts as a risk factor, given that abnormalities in the barrier function of the skin favor greater absorption of the drug.¹ The fragility of the skin and blood vessels in children—as shown by purpuric eruptions resulting from efforts like vomiting, coughing, and crying—and the potential trauma from the plastic in the occlusive dressing can also influence the appearance of this uncommon side effect.¹



Figure. Purpura in the area treated with eutectic mixture of local anesthetic.