



IMAGE IN DERMATOLOGY

[Translated article] “Butterfly” or Malar Rash: Not Everything Is Lupus

Rash malar en ala de mariposa: no todo es lupus

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A 73-year-old woman with a past medical history of hypertension, dyslipidemia, and Meniere’s syndrome, and currently on enalapril, zolpidem, betahistine, and simvastatin, presented with a 5-year history of erythematous pruritic plaques in the malar region, formed by the confluence of papules and a few random pustules (Fig. 1A, B).

With a clinical diagnosis of rosacea, she had undergone multiple treatments, both topical (corticosteroids, metronidazole 1%, pimecrolimus) and systemic (isotretinoin 10mg/day, azithromycin 250mg/3 times a week, doxycycline 100mg/day, prednisone 20mg), yet her condition progressively worsened. Among the differential diagnoses suggested, allergic contact dermatitis, chilblain lupus, and acute cutaneous lupus were considered. Blood tests, including a complete blood count, general biochemistry, and autoimmune tests, showed no relevant findings. The histological analysis revealed an acanthotic epidermis with spongiosis, with aggregates of intracorneal neutrophils, hyphae, and fungal spores in the stratum corneum that tested positive to PAS staining, as well as a dense band-like

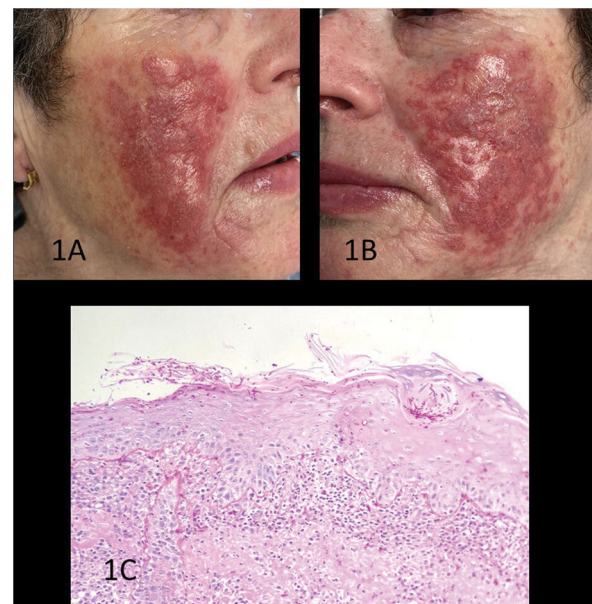


Figure 1

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lymphoplasmacytic infiltrate in the underlying dermis (Fig. 1C), findings consistent with the diagnosis of a facial tinea. Oral terbinafine was administered at 250 mg/day, a

33 topical solution was applied once daily, and a fungal culture
34 was performed, which, after 1 month, tested positive for
35 *Trichophyton tonsurans*. After 4 weeks into treatment,
36 lesions improved significantly, leaving only slight residual
37 hyperpigmentation.

38 Ethical considerations

39 The patient has given explicit consent for the publication
40 of the images and their use for scientific, educational, and
scientific dissemination purposes.

Conflicts of interest

None declared.

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