Images in Dermatology

Omeprazole-Induced Subacute Cutaneous Lupus Erythematosus

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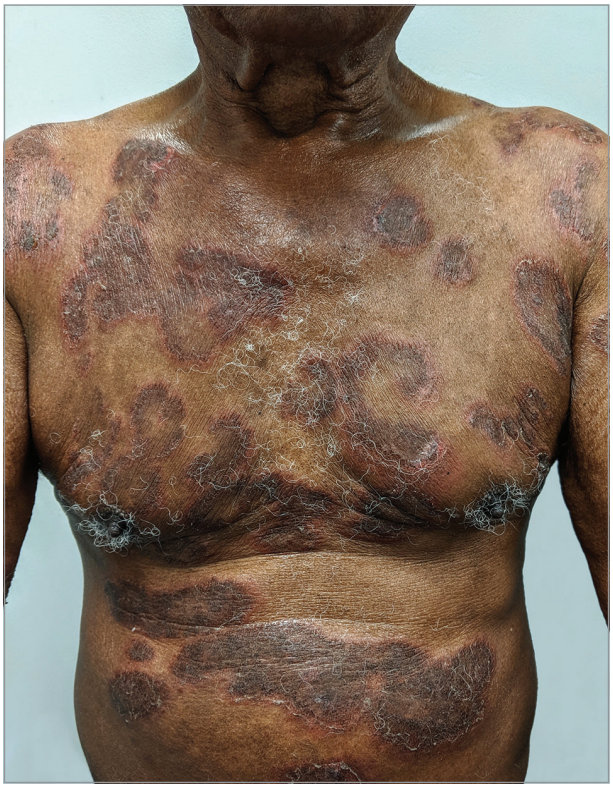
A man in his 80s presented with a 2-year history of a pruritic rash on the trunk and arms. It was composed of annular, erythematous polycyclic plaques with peripheral scale and central areas of hyperpigmentation and clearing (**Figure**). A punch biopsy specimen revealed interface dermatitis with increased 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.



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

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.[1] As many as 30% of SCLE cases are thought to be induced or exacerbated by drugs.[2] Drug-induced pathogenesis should be considered, especially in elderly patients and those taking multiple medications.[3] 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.[3]

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.[4] 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.[5] 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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Published Online: July 8, 2020. doi:10.1001/jamadermatol.2020.2415

Conflict of Interest Disclosures: None reported.

Additional Contributions: We thank the patient for granting permission to publish this information.

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