Mucoscopy of Discoid Lupus Erythematosus on Lower Lip

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A 40-year-male presented with a single red raised lesion associated with burning sensation over the lower lip for the past 5 years. There was no history of bleeding/oozing from the lesion. The patient was non-smoker and non-alcoholic. On examination, a single erythematous to hypo pigmented, well to ill-defined plaque (1 × 1.5 cm) was present over the lower lip [Figure 1a]. The surface of the plaque showed scaling and dark brown to red dots. Rest of the mucocutaneous examination was non-contributory. Histology from the lesion showed hyperparakeratosis with irregular hyperplasia, atrophy of stratified squamous epithelium, and marked mononuclear cell infiltrate including plasma cells with exocytosis of lymphocytes [Figure 1b]. There was no atypia noticed. Mucoscopy was done using a universal serial bus dermatoscope [Dino-Lite AM413ZT; Digital dermatoscope; New Taipei; Taiwan].[1] Mucoscopy showed pink background with presence of whitish to yellowish scales, white structureless areas, blood spots, telangiectasia, irregular vessels, and grayish-black dots at the periphery [Figure 2a and b]. Based on clinical, dermoscopic, and histological features, a diagnosis of labial discoid lupus erythematosus (DLE) was made.

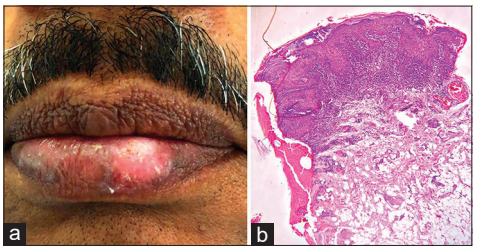

Figure 1: (a) A hypopigmented to erythematous plaque over the lower lip with surface showing scaling and red to brown dots. (b) Histology showing hyperkeratosis, irregular hyperplasia and atrophy, and marked mononuclear infiltrate with plasma cells. [H and E; 100×]

Dermoscopy of the mucosa and its pathologies is termed as mucoscopy.[1] Dermoscopy of DLE involving the lips has been reported to show brown pigment spots, telangiectasia, storiform/hairpin vessels, white structureless areas, ulceration, erosion, bleeding spots, and scales.[2] On dermoscopic-histopathological correlation, grayish-black to brown pigment dots represent pigment incontinence, whitish-yellowish scales represent hyperparakeratosis, white structureless areas represent irregular hyperplasia, and pink background and dilated vessels represent the prominent inflammatory infiltrate. The dermoscopy of mucosal DLE differs from cutaneous DLE in lacking follicular plugs, perifollicular halo, and reduced number of follicular ostia.[3] The most important differential remains squamous cell carcinoma (SCC) of the lip and needs to be ruled out. The dermoscopy of SCC shows central mass of keratin, peripherally distributed polymorphous vessels, ulceration, blood spots, white structureless areas, and perivascular white halo.[4] Actinic lichen planus is another close differential. The presence of wickham striae and violaceous background on dermoscopy can be suggestive of actinic lichen planus. Although histology remains gold standard for differentiating DLE from SCC and actinic lichen planus, a preliminary

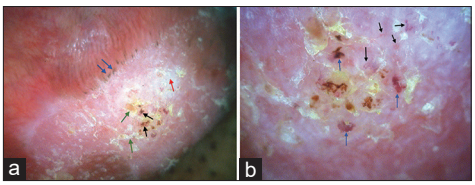

Figure 2: (a) Polarized dermoscopy showing scaling (green arrow), white structureless areas (red arrow), blood spots (black arrows), and grayish-black dots (blue arrow). [Dino-Lite AM413ZT; 200×;Polarizing]. (b) Higher magnification showing telangiectasia, irregular vessels (black arrow), and blood spots (blue arrow). [Dino-Lite AM413ZT; 200×;Polarizing]

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dermoscopic evaluation can give useful clues regarding the diagnosis, which further can help to prognosticate the patient.

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Conflicts of interest

There are no conflicts of interest.

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