

Scalp Discoid Lupus Treated with Intralesional Corticosteroids: Prompt Efficacy and Full Hair Regrowth

H. Hassan^{1*}, A. Moussa¹, M. El Amraoui¹, R. Frikh¹, N. Hjira¹¹Department of Dermatology, Mohammed V Military Instruction Hospital, RabatDOI: <https://doi.org/10.36347/sjmcr.2025.v13i10.106>

| Received: 18.06.2025 | Accepted: 11.08.2025 | Published: 31.10.2025

*Corresponding author: H. Hassan

Department of Dermatology, Mohammed V Military Instruction Hospital, Rabat

Abstract

Case Report

Lupus erythematosus is a common disease that includes a continuous spectrum of conditions, varying from isolated skin lesions to severe multivisceral disease, as seen in Systemic Lupus Erythematosus (SLE). Cutaneous Lupus Erythematosus (CLE) can manifest in various clinical forms: acute CLE, subacute CLE, and chronic CLE, also known as Discoid Lupus Erythematosus (DLE). DLE is the most frequent subtype, accounting for 80% of cases.

Keywords: Lupus erythematosus, Cutaneous Lupus Erythematosus (CLE), Discoid Lupus Erythematosus (DLE), Autoimmune disease, Alopecia.

Copyright © 2025 The Author(s): This is an open-access article distributed under the terms of the Creative Commons Attribution 4.0 International License (CC BY-NC 4.0) which permits unrestricted use, distribution, and reproduction in any medium for non-commercial use provided the original author and source are credited.

INTRODUCTION

Lupus erythematosus is a chronic autoimmune disease. The diagnosis of SLE and CLE relies on a combination of clinical, biological, immunological, and histological findings. Discoid Cutaneous Lupus Erythematosus (DCLE) is a chronic variant of cutaneous lupus erythematosus, typically presenting as erythematous plaques. Exclusive scalp involvement occurs in only about 10% of cases [1], with inflammatory scarring alopecia being the initial manifestation in more than half of patients. We report the case of a patient with

exclusive scalp DCLE treated with intralesional corticosteroids in addition to oral synthetic antimalarials.

CASE REPORT

We present the case of a 65-year-old female patient with a history of treated hypertension, who presented with alopecic plaques on her scalp that had been evolving for one year. Clinical examination revealed five well-demarcated, variable-sized, erythematous, squamous alopecic plaques with telangiectasias (Figure 1).

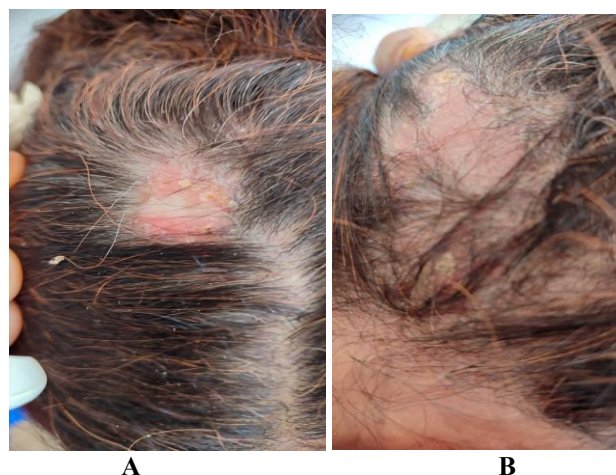


Figure 1: Images of discoid lupus erythematosus of the scalp: A: Well-demarcated, erythematous, scaly plaque on the parietal region. B: Large erythematous, scaly plaque on the temporal region

She did not present with any other cutaneous lupus lesions. Dermoscopy showed an erythematous background at the periphery of the plaque, polymorphic

vessels, perifollicular scales, and central scar-like structureless areas (Figure 2a, b).

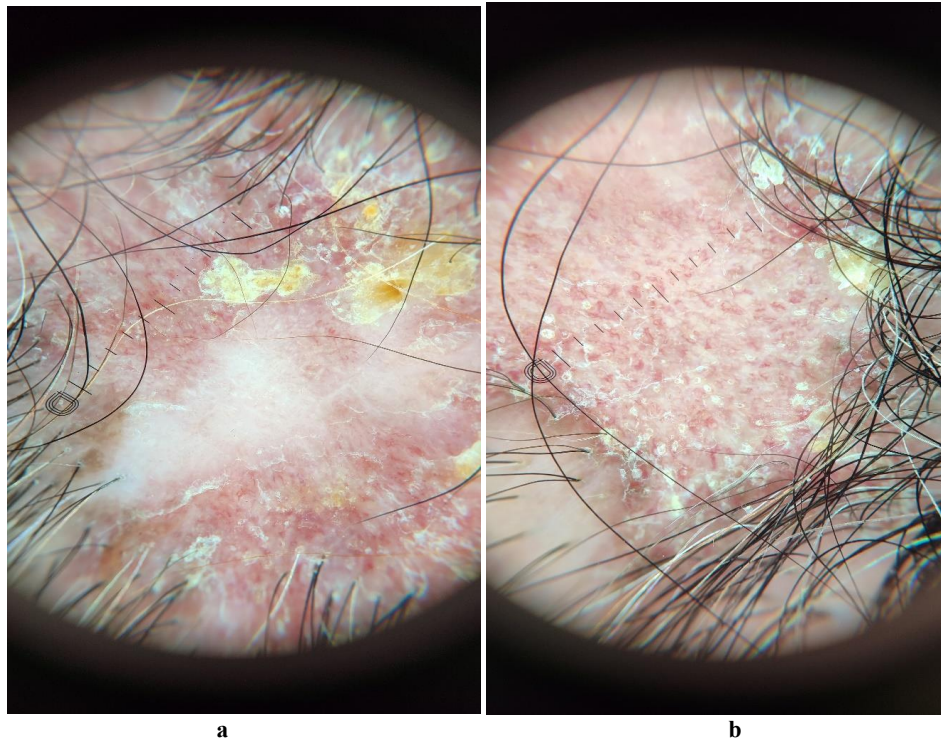


Figure 2: a: Dermoscopy reveals an erythematous background, whitish scales, perifollicular scales, and a central whitish area devoid of structures. b: Polymorphous vascularization, with the presence of linear vessels and telangiectasias

Histology confirmed the diagnosis of discoid lupus erythematosus. The patient was started on oral synthetic antimalarials and received intralesional

corticosteroid injections. The patient showed marked improvement of the lesions and hair regrowth after 3 months of treatment (Figure 3).



Figure 3: Clinical Evolution: Disappearance of alopecic plaques and complete hair regrowth.

DISCUSSION

Chronic Cutaneous Lupus Erythematosus (CCLE) includes discoid lupus erythematosus (DLE), lupus tumidus, chilblain lupus, and panniculitis or lupus

profundus. Theoretically, lupus lesions are characterized by involvement of the dermo-epidermal junction interface. The diagnosis of lupus lesions is based on a combination of clinical, biological, and histological arguments, taking into account the clinical appearance of

the dermatological lesions, their topography, their evolution, compatible histology, and the clinical and immunological context. CCLE often begins between 20 and 40 years of age, but can also affect individuals at the extremes of life. The female predominance is less pronounced than in other forms, with a female-to-male sex ratio ranging from 3:2 to 3:1. All ethnicities are affected. The association with SLE is lower than with acute and subacute CLE, estimated between 10% and 42%. DLE classically consists of erythematous plaques, often with a telangiectatic border, associated with more or less thick scales, and scarring, atrophic, often depigmented, poikilodermic lesions [2]. Scalp involvement is observed in 34% to 56% of chronic lupus erythematosus cases, depending on the series, and scarring alopecia constitutes the initial manifestation in more than half of patients. When associated skin lesions are present, the diagnosis of lupus is straightforward. Chronic cutaneous lupus erythematosus is a common cause of scarring alopecia, significantly impacting patients' quality of life [3]. In the initial stage, alopecic plaques may resemble psoriasis, tinea, or lichen planopilaris. Dermoscopy is an important tool for diagnosing DLE, especially in fair-skinned individuals with predominant scarring alopecia, such as lichen planopilaris. DLE typically presents with larger yellow dots, keratotic follicular plugs, and thick arborizing vessels in active lesions [4]. Histology confirms the diagnosis, revealing orthokeratotic hyperkeratosis, atrophic epidermis, thickening of the basement membrane, significant vacuolar degeneration of the dermo-epidermal junction, lymphocytic infiltrate around the hair follicle and in the superficial and deep dermis, and mucin deposition. Treatment relies on hydroxychloroquine 200mg twice daily, potent topical corticosteroids, and photoprotection.

For our patient, the diagnosis of DCLE was histologically confirmed, and she was started on hydroxychloroquine 400mg/day, combined with intralesional corticosteroid infiltrations every 4 weeks. The evolution was marked by rapid improvement of the lesions and hair regrowth after 3 months of treatment.

CONCLUSION

DCLE lesions localized to the scalp can lead to permanent scarring, disfigurement, and irreversible alopecia. Our case highlights the rapid efficacy of intralesional corticosteroids for alopecic plaques on the scalp, complementing synthetic antimalarials.

REFERENCES

1. P. Huet, G. Barnéon, B. Cribier. Scalp discoid lupus erythematosus: Dermatopathologic—dermatoscopic correlation. *Annales de Dermatologie et de Vénéréologie*. Volume 143, Issue 10, October 2016, Pages 657-660
2. F. Chasset et C. Francès. Manifestations cutanées des lupus érythémateux. *Dermatologie*, 2019-07-01, Volume 21, Numéro 3, Pages 1-16, Copyright © 2019 Elsevier Masson SAS
3. Wilson C.L., Burge S.M., Dean D., Dawber R.P.: Scarring alopecia in discoid lupus erythematosus. *Br. J. Dermatol.* 1992; 126: pp. 307-314.
4. Ilaria Scandagli MD, Elia Rosi MD, Antonella Di Cesare MD. Discoid lupus erythematosus affecting the scalp. *JAAD Case Reports*, 2024-06-01, Volume 48, Pages 72-73, Copyright © 2024 American Academy of Dermatology, Inc.