

Transcript Details

This is a transcript of an educational program. Details about the program and additional media formats for the program are accessible by visiting: <https://reachmd.com/programs/living-rheum/acute-vs-subacute-cutaneous-lupus/54372/>

ReachMD

www.reachmd.com
info@reachmd.com
(866) 423-7849

Spot the Difference: Acute vs. Subacute Cutaneous Lupus

Announcer:

Welcome to *Living Rheum* on ReachMD. On this episode, we'll hear from Dr. Avery H. LaChance, who will be walking through the manifestations of acute and subacute cutaneous lupus.

Dr. LaChance is Director of the Connective Tissue Disease Clinic, Director of the Advanced Psoriasis Therapeutics Clinic, Director of Health Policy and Advocacy, and Program Director of the Dermatology-Rheumatology Fellowship at Brigham and Women's Hospital. She's also an Associate Professor of Dermatology at Harvard Medical School, and she spoke on today's topic at the 2026 Congress of Clinical Rheumatology East. Here's Dr. LaChance now.

Dr. LaChance:

Acute cutaneous lupus has a hundred percent association with SLE, and so frequently, you should absolutely see a positive ANA, and frequently, we see double stranded DNA.

And it really presents with that pathognomonic butterfly rash, and that's the most common thing that we're thinking about. And this rash shows up with these violaceous to erythematous patches and plaques over the malar cheeks, nose, and other areas of the face as well.

But importantly, there should be this striking sparing of the nasolabial fold. So that really helps separate acute cutaneous lupus from some of its mimics, like dermatomyositis, in which that erythema or violaceous hue should cross right over that nasolabial fold. Also, you can have acute cutaneous lupus that doesn't frequently just involve the face. You can have it involving the trunk and extremities, but we see it more predominantly in some of our photo-exposed distributions. And importantly, the pathology for acute cutaneous lupus is really in the epidermis and upper dermis, and so after you treat it, you really shouldn't have a scar left over. But sometimes, you do see some dyspigmentation.

The most important thing in the rheumatologist's mind, I think, is sometimes differentiating between dermatomyositis and lupus. And again, looking for that striking sparing of the nasolabial fold can tell you the difference between acute cutaneous lupus versus dermatomyositis.

But there are a number of other malar rash mimics that can show up, such as rosacea, where a lot of times you'll see papules, pustules, and acne-like lesions. You really shouldn't see those in acute cutaneous lupus. Other mimics can be seborrheic dermatitis, which really actually loves to hug in the nasolabial fold and usually has a little bit more of a greasy scale associated with it.

And then also on the rheumatology side, sarcoidosis, a lot of times, can show up on the nose and cheeks as well. And there, you are looking for a bigger, more granulomatous look. And for those patients, you get these plaques that often can hug down onto the nasal ala and the alar rim. And when you see that for patients with sarcoidosis, if you press on a sarcoidosis lesion, you should get this apple jelly appearance, and that can help you understand that there's more of a granulomatous factor than that pink, erythematous, violaceous look of acute cutaneous lupus.

We then dive into subacute cutaneous lupus, and this has about a 50 percent association with systemic lupus. And the antibodies we frequently see positive in subacute cutaneous lupus are anti-Ro over La. We often see an ANA as well, and like acute cutaneous lupus, the pathology's in the epidermis and upper dermis.

And that gives you the look of what you get for subacute cutaneous lupus, which is where we see these erythematous to violaceous, often annular, polycyclic plaques that frequently have this trailing scale behind it. You're going to think about an Olympic sign with these interpolating rings that cross over amongst one another and are polycyclic and annular. So they're clear in the center with this trailing

scale. Subacute cutaneous lupus can also present with a more psoriasiform look. And so if you have something that looks a little bit like psoriasis, but it's in these photo-exposed sites—predominantly because a subacute cutaneous lupus, akin to acute cutaneous lupus, loves photo-exposed areas—you're going to think about subacute cutaneous lupus on your differential as well.

Now, it's important to note that for subacute cutaneous lupus, especially in your older patients, there can be this medication trigger. So common culprits are hydrochlorothiazide, terbinafine, anti-TNFs, and PPIs. So if you have an older patient who's coming in with what looks like subacute cutaneous lupus, and you confirm that either clinically or on biopsy as well, it's really important to take a look at their med list and say, is there anything that could be driving this from a medication point of view?

Announcer:

That was Dr. Avery H. LaChance discussing acute versus subacute cutaneous lupus, which she spoke about at the 2026 Congress of Clinical Rheumatology East. To access this and other episodes in our series, visit *Living Rheum* on ReachMD.com, where you can Be Part of the Knowledge. Thanks for listening!