Letter to Dermatology

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**Chloroquine-Quinacrine Association in Resistant Cutaneous Lupus**

D. Lipsker  
J.-C. Piette  
P. Cacoub  
P. Godeau  
C. Frances

Service de médecine interne, Centre hospitalier et universitaire, Groupe hospitalier Pitié-Salpêtrière, Paris, France

C. Frances, Service de médecine interne, Centre hospitalier et universitaire, Groupe hospitalier Pitié-Salpêtrière, 47–83, boulevard de l’Hôpital F-75651 Paris Cedex 13 (France)

Feldmann et al. [1] have recently suggested that a chloroquinβquinacrine combination may be efficient for chloroquine or hydroxychloroquineresistant discoid lupus (DL) or subacute cutaneous lupus (SCL), erythematous. In our experience, this combination was useful not only in these conditions but also in patients with refractory cutaneous lesions of quiescent systemic lupus erythematous (SLE).

From March 1993 to June 1994, 15 patients with histologically confirmed refractory cutaneous lupus lesions were included in this study (table 1). There were 14 women and 1 man. The mean age was 39.5 years (range 25-58). Eight patients did not fulfill ARA criteria for SLE: 6 patients with chronic DL, 1 patient with SCL and 1 patient with DL and SCL. Seven patients had SLE according to ARA criteria. Extradermatological manifestations had been quiescent for more than 6 months with low-dose corticosteroids which were maintained unchanged during the trial. Cutaneous lesions were however active: 6 patients had DL and 1 patient had SCL and DL. Previously, patients had been unsuccessfully treated with hydroxychloroquine (15 patients), chloroquine (5), thalidomide (8), reti-noids (7) or dapsone (5).

The initial dose was chloroquine $3 \times 100$ mg/day and quinacrine $2 \times 100$ mg/day. The mean duration of treatment was 6.3 months. The evaluation was based on clinical criteria. Results were considered as excellent when all lesions disappeared (8 patients), good when they improved significantly ($\geq 50\%$; 4) and poor in the other cases (3). The distribution of patients according to lupus subsets is shown in table 1. Improvement occurred within the first month of treatment in 8

Table 1. Patient characteristics and treatment results

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<th>Subset</th>
<th>Sex Age Duration of cutaneous SLE ($\geq 4$ ARA Previous treatments of lupus years lesions, years criteria)</th>
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| DL         | 6 patients with chronic DL, 1 patient with SCL and 1 patient with DL and SCL. Seven patients had SLE according to ARA criteria. Extradermatological manifestations had been quiescent for more than 6 months with low-dose corticosteroids which were maintained unchanged during the trial. Cutaneous lesions were however active: 6 patients had DL and 1 patient had SCL and DL. Previously, patients had been unsuccessfully treated with hydroxychloroquine (15 patients), chloroquine (5), thalidomide (8), reti-noids (7) or dapsone (5). The initial dose was chloroquine $3 \times 100$ mg/day and quinacrine $2 \times 100$ mg/day. The mean duration of treatment was 6.3 months. The evaluation was based on clinical criteria. Results were considered as excellent when all lesions disappeared (8 patients), good when they improved significantly ($\geq 50\%$; 4) and poor in the other cases (3). The distribution of patients according to lupus subsets is shown in table 1. Improvement occurred within the first month of treatment in
patients and within 3 months in 4 patients. Electoretino-graphic abnormalities appeared in 3 of the 15 patients, respectively, after 1, 5 and 15 months, with a blurred vision in 1 case. In these 3 cases (excellent response), withdrawal of the chloroquinequinacrine combination was followed by relapse of skin lesions within 1 month and disappearance of visual abnormalities. These results confirm the efficiency of the chloroquinequinacrine association in the treatment of refractory cutaneous lupus, which has been first established in 1959 by Tye et al. [2]. Although chloroquine may present a greater risk of antimalarial retinopathy compared to hydroxychloroquine [3], the apparently high prevalence of retinal abnormalities observed with the chloroquin©quinacrine combination is not yet understood [4]. Thus, it seems very important that the daily dose of chloroquine and quinacrine should be as low as possible. This treatment implies ophthal-mologic examinations including visual acuity, funduscopic, visual field testing and electro-retinographic examination prior to the start of therapy and at least every 6 months.

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