Danazol and Discoid Lupus Erythematosus

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A 20-year-old woman presented erythematous hyperkeratotic, slightly atrophic plaques in both malar areas. She had no history of fever, malaise, oral ulcers, photosensitivity, arthralgia, chest pain or Raynaud's phenomenon. Physical examination was otherwise unremarkable. Erythrocyte sedimentation rate, complete blood cell count, urinalysis, hepatic enzymes, serum creatinine, immunoglobulins, anti-nuclear antibody, anti-DNA and antiextractable nuclear antigen were normal or negative. A skin biopsy specimen showed features consistent with discoid lupus. Direct immunofluorescence revealed a deposition of immunoglobulins in the dermal-epidermal zone, but these deposits were not present in nonlesional, nonexposed skin. The patient was initially treated with topical corticosteroids, but due to the persistence and apparition of new lesions, a course of hydroxychloroquine was begun. Despite this treatment, she referred premenstrual exacerbation of lesions. Danazol was then instituted (100 mg twice a day orally), and topical corticosteroids and hydroxychloroquine were interrupted. The

Discussion

A hormonal influence is strongly suggested on the clinical expression of lupus erythematosus. Moreover, some female patients may present premenstrual exacerbations of the disease [1]. Danazol, a hete-rocyelic steroid related chemically to 17 α -ethinyltestosterone, has been effective in the treatment of systemic lupus erythematosus with premenstrual exacerbations [2]. Good results have been obtained with 19-nortestosterone in 5 of 10 patients with systemic lupus erythematosus [3]. To our knowledge, premenstrual exacerbations of discoid lupus have been successfully treated with danazol only in 1 patient [4]. Clearly, double-blind studies are needed to clarify the therapeutic potential of danazol in discoid lupus.

References

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