Systemic lupus erythematosus: not just a rash

A previously healthy 11-year-old Chinese girl presented to the accident and emergency department with a 4-month history of persistent rashes over her palms and soles, and a 1-week history of malaise and low-grade fever. Her general practitioner had suggested that the rash could have been caused by hand, foot and mouth disease. On examination, she had non-blanching erythematous macular lesions with few palpable crusted purpura over her palms (figure 1) and soles. Considering her demographic status and unexplained symptoms, a connective tissue disease workup was done. Her serum complement levels were low. Antinuclear antibody was speckled and homogenous with a titre of 640. DsDNA antibodies were quantified >1000 IU/mL. She was treated with oral glucocorticoids. Seven days later, the rash healed with postinflammatory hyperpigmentation. She remains in remission on low-dose glucocorticoids.

This case highlights the diverse presentations of systemic lupus erythematosus (SLE). The prevalence of SLE has been increasing in the UK in recent years with a median age of onset of juvenile SLE at 12 years. The diagnosis is generally guided by the Systemic Lupus International Collaborating Clinics group classification criteria to identify salient features. One-fifth of SLE cases will not manifest the minimum criteria when a child is first seen. These children should remain under surveillance for additional findings of SLE. Cutaneous vasculitis lesions are usually found on the face, palms and soles that are characterised as petechiae or palpable purpura that may blister. They are induced by the formation of immune complexes and neutrophilic infiltration, which is related to disease activity.

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Correction notice This paper has been amended since it was published Online First. We published the author’s name incorrectly, this has now been corrected.

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Contributors The author collated the clinical information and images for the patient, and compiled the manuscript.

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