Answers to Dermato-venereological Quiz on page 176

1. Multiple erythematous annular and discoid plaques in torso and head. The differential diagnoses are: neonatal lupus erythematosus, tinea, eczema, psoriasis, congenital syphilis, erythema multiforme, annular erythema of infancy, erythema annulare centrifugum, granuloma annulare. The most likely diagnosis is neonatal lupus erythematosus (NLE).

2. Other cutaneous features: periorbital and malar rash, papulosquamous lesions. Important extra-cutaneous features: congenital heart block especially complete heart block, hepatomegaly, thrombocytopenia causing petechiae and purpura.

3. Complete physical examination to detect for other cutaneous lesions, hepatomegaly, central nervous system involvement. Electrocardiogram and if necessary echocardiogram, complete blood count, liver and renal profile, anti-nuclear antibody, anti-Ro/SS-A, anti-La/SS-B, anti-U1RNP, coagulation screen such as anti-phospholipid antibodies and lupus anticoagulant. Skin biopsy is only necessary if clinical diagnosis cannot be established. Screening mother for auto antibodies is necessary. Ultraviolet protection is recommended and topical steroid can be used for skin lesions. Complete heart block requires pacemaker implantation.

4. Excellent prognosis is expected with only skin manifestation. Cutaneous lesions are transient and usually resolve by age six to nine months, which correlate with maternal antibody clearance from infant's circulation. Skin lesions rarely cause scarring and other sequelae. Mild topical steroid could be used for skin lesions; systemic agents such as hydroxychloroquine, systemic steroid and immunosuppressants are generally not indicated. Broad-spectrum photoprotection is recommended in infancy. The average mortality from complete congenital heart block in the neonatal period is 15%. Mothers with anti-Ro or anti-La antibodies have a variable risk of delivering a baby with NLE ranging 1-20%. The risk of recurrence of congenital heart block in subsequent pregnancies can be up to 25%. Most infants do not appear to have increased risk of autoimmune diseases, but familial predisposition warrant further follow-up throughout childhood and adolescent period. Asymptomatic mothers of infants with NLE are at risk of developing autoimmune diseases and should be followed subsequently.

Figure 3. Showing lesions resolving at 3 months of age.

Further Reference

1. Hon KL, Leung AKC. Neonatal lupus erythematousus. Autoimmune Diseases 2012, article ID 301274. https://doi.org/10.1155/2012/301274.