An 18-year-old Korean man presented with 2 asymptomatic, annular hair-loss patches on the scalp for 1 year. Physical examination revealed 2 long, arc-shaped, non-scarring, alopecic patches on the right fronto-parietal (Fig. 1a) and left temporo-parietal scalp (Fig. 1b) without overlying skin changes such as erythema or scales. Dermoscopy revealed empty follicles, yellow dots, and many short vellus hairs, but broken hairs were not found (Fig. 1c). The patient was generally healthy and there was no relevant family history or past history of systemic disease or medication. Laboratory findings were non-contributory other than a positive antinuclear antibody test (titre 1:20, speckled pattern). A skin biopsy from the scalp lesion was performed (Fig. 2; full details in Fig. S1).

What is your diagnosis? See next page for answer.
When compared with typical LEP, LALPS is characterized by deposition, and predominant lymphocytic infiltrates in fat findings of LEP demonstrate hyaline fat necrosis, mucin as positive antinuclear antibody results. Histopathological left upper arm in similar geometric configurations, as well other body sites is not common (9). Interestingly, our involvement of SLE in LALPS patient (7). Simultaneous involvement and the development of systemic lupus erythematosus (SLE) LALPS has a reversible clinical course without scarring, show erythematous changes or signs of discoid lupus (1). Although Caucasian, Turkish, Italian and Spanish patients have been rarely reported, the majority of cases occurred in either Korean or Japanese patients (4, 7, 8). The overlying skin in LALPS is usually normal, but may show erythematous changes or signs of discoid lupus (1). LALPS has a reversible clinical course without scarring, and the development of systemic lupus erythematosus (SLE) is a rare phenomenon; so far, there has been only 1 case of SLE in LALPS patient (7). Simultaneous involvement of other body sites is not common (9). Interestingly, our patient had multiple annular-shaped alopecic patches and 2 simultaneous annular cutaneous nodules on the distant left upper arm in similar geometric configurations, as well as positive antinuclear antibody results. Histopathological findings of LEP demonstrate hyaline fat necrosis, mucin deposition, and predominant lymphocytic infiltrates in fat lobules and perivascular and perifollicular regions (10, 11). When compared with typical LEP, LALPS is characterized by a relatively sparse inflammatory infiltrate, more abundant mucin in fat lobules, and higher degree of hyaline fat degeneration. Liquefaction degeneration at the basement membrane zone is also less frequent in LALPS than typical LEP. On immunofluorescent study, LALPS usually have negative findings, while typical LP have shown IgG and C3 deposition at the basement membrane zone or around blood vessels. Only one case of LALPS showed granular IgA, IgM, and C3 deposition in the peribulbar area (12). Major differential diagnoses for LALPS include alopecia areata, trichotillomania, traumatic alopecia, as well as early stages of primary cicatrical alopecia, such as lichen planopilaris and linear morphea. Other conditions, such as alopecia mucinosa and subcutaneous panniculitis-like T-cell lymphoma should be considered in the differential diagnosis (4). Non-invasive dermoscopy can facilitate the clinical diagnosis of LALPS and differentiate it from other types of alopecia. Dermoscopic examination of LALPS shows numerous vellus hairs with or without diffuse telangiectasia and follicular plugging representing epidermal changes; however, broken hairs typically seen in alopecia areata or trichotillomania, and loss of follicular opening (fibrotic white dots) observed in primary cicatrical alopecia are not found (11). Since LALPS has a low rate of progression to systemic disease and spares the upper segment of hair follicles, the prognosis of LALPS is promising using anti-malarial, dapsone, or topical/interlesional/oral corticosteroid treatments (2, 5, 9). However, recurrent cases were noted in 33% of LALPS patients after discontinuing therapy (2). In the present case, the patient was treated with oral hydroxychloroquine and topical corticosteroid, and regrowth of the terminal hairs was observed after a 12-week follow-up period.

REFERENCES