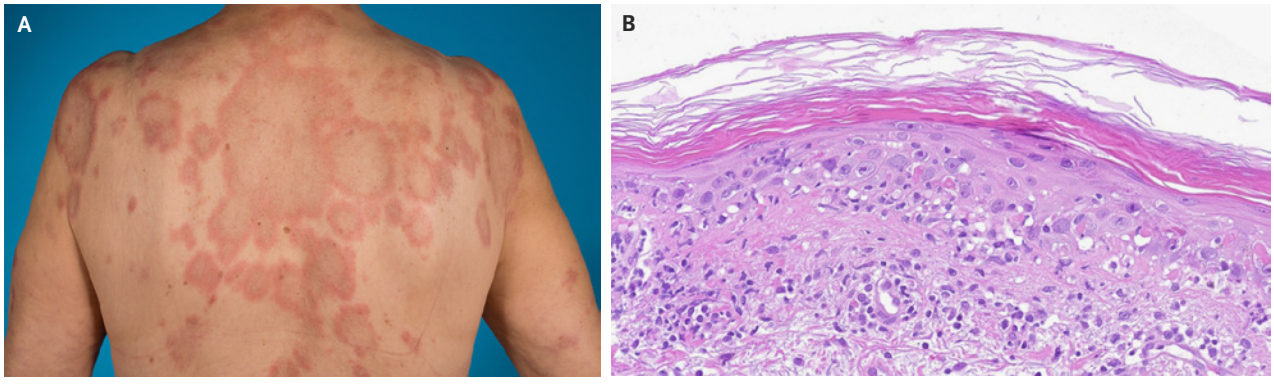
IMAGES IN CLINICAL MEDICINE

Drug-Induced Subacute Cutaneous Lupus Erythematosus



A 73-year-old woman with rheumatoid arthritis presented to the dermatology clinic with burning skin lesions that had emerged on her torso several months earlier. She had taken etanercept for 15 years before the rash started and had been taking pantoprazole for 10 months before the current presentation. Physical examination showed annular polycyclic lesions with indurated, erythematous borders and central clearing on the upper back and arms (Panel A). A quantitative antinuclear antibody test performed with indirect immunofluorescence was positive, and the anti-Ro antibody level was greater than 240 U per milliliter (reference value, <7). Histopathological analysis of a skin-biopsy sample from the patient's back showed vacuolar interface dermatitis with apoptotic keratinocytes (Panel B, hematoxylin and eosin staining), and Alcian blue staining showed dermal mucin. A diagnosis of drug-induced subacute cutaneous lupus erythematosus was made. Lesions in subacute cutaneous lupus erythematosus have annular and papulosquamous morphologic features and anti-Ro positivity in most cases. A thorough medication history is necessary to differentiate drug-induced from idiopathic subacute cutaneous lupus erythematosus. Culprit medications include thiazides, anti–tumor necrosis factor agents, and proton-pump inhibitors — the last of which was considered to be the trigger in this case. Cessation of the offending drug typically leads to resolution of the rash. Pantoprazole was discontinued, and treatment with hydroxychloroquine and topical clobetasol was started. The rash abated after 4 months and had not recurred 1 year after discontinuation of hydroxychloroquine and topical clobetasol.

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This article was published on August 15, 2026, at NEJM.org.

DOI: 10.1056/NEJMicm2605381
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