A 60-year-old male of skin phototype V presented with a one-month history of multiple scaly skin lesions on the anterior chest, back, and face. It was associated with a history of photosensitivity and on-and-off joint pain. He denied any systemic complaints. Cutaneous examination showed multiple well-defined erythematous to hypopigmented scaly papules and plaques [Figure 1a] on the sites, as mentioned earlier. Other mucocutaneous, general, and systemic examinations were within normal limits. Differential diagnosis of subacute cutaneous lupus erythematosus (SCLE) and psoriasis was considered. Dermoscopy (DermLite, DL4, 10x magnification) under polarized mode showed patchy to diffuse white scales, white structureless area, white shiny structures (white shiny structureless area, clods, and lines), focal multicolored (not rainbow) pattern, brown to blue-gray peppering, follicular plugging, and linear, linear curved (comma), and focal dotted vessels [Figure 1b-g]. Laboratory examination showed a positive antinuclear (3+), anti-Ro antibodies, and deranged renal parameters (urea-48 mg/dl, creatinine-3.1 mg/dl). Other investigations were within normal limits. Histology showed hyperkeratotic atrophic epidermis, basal vacuolar degeneration, cytid bodies, dermal melanophages, melanin incontinence, and upper dermal dilated blood vessels [Figure 2a, b]. Direct immunofluorescence showed linear deposition of IgG, IgA, IgM, and C3 along the basement membrane zone. The diagnosis of SCLE was made. The patient was started on oral prednisolone 1 mg/kg/day, hydroxychloroquine 300 mg once daily, along with photoprotective measures. After 2 months of treatment, a significant reduction in scaling and thickness of the plaques along with post-inflammatory hypopigmentation was noticed without any evidence of scarring [Figure 3a]. Repeat dermoscopic examination showed the disappearance of white shiny structures.
scaling, and follicular plugging along with the reduction of vascular structures [Figure 3b-d].

The SCLE is characterized by the presence of cutaneous lesions of papulosquamous or annular polycyclic morphology. It usually has a good prognosis with rare systemic involvement. The lesions typically heal without scarring and with vitiligo-like hypo-depigmentation. Except for the apparent disappearance of scaling, there is no objective way to assess cutaneous lesions’ improvement. The associated hypo to depigmentation even makes the task challenging to appreciate the clinical improvement. Besides, in the absence of systemic features, at times, it can be challenging to differentiate SCLE from clinical mimics like psoriasis, pityriasis rosea, nummular eczema, erythema annulare centrifugum, dermatomyositis, and, most importantly, from disseminated discoid lupus erythematosus, especially in the early stage when the scarring is absent or minimal.

Dermoscopy is increasingly used for the diagnosis of various inflammatory dermatoses. The dermoscopic data of SCLE is limited. Dermoscopic features described for SCLE are diffuse or peripherally arranged whitish scales and a mixed vascular pattern comprising linear, linear irregular, branching, and sparsely distributed dotted vessels over a pinkish–reddish background.[1] In the index case, in addition to the white scales and mixed vascular pattern, we observed new dermoscopic features such as white shiny structures, follicular plugging, and focal multicolored pattern. The multicolored pattern included white, pink, purple, and reddish-orange color. The shiny white structures possibly correlate with the compact hyperkeratosis, and the multicolored pattern to the increased vascularity.[2]

The common mimicker of SCLE, psoriasis, is characterized by the presence of regularly distributed dotted vessels over a pinkish-white background.[3]

The presence of linear, linear branching, and linear irregular vessels is due to the horizontally placed dilated blood vessels below the atrophic epidermis. In contrast, the dotted vessels observed in psoriasis are due to the dilated and tortuous vessels placed perpendicular to the epidermis in the papillary dermis between the elongated rete ridges. Pityriasis rosea typically shows a collarette of scales, central yellow, peripheral or diffuse reddish background, and patchy peripheral or scattered dotted vessels.[4,5] The eczematous conditions commonly have patchy dotted vessels and yellow crust.[6] In addition, white shiny areas, and follicular plugging have not been described in the above conditions. In the index case, the disappearance of the white shiny areas were associated with the lesions’ clinical improvement, a feature that can be used for therapeutic response assessment. In addition, there was a disappearance of scaling, follicular plugging, and blood vessels.

In conclusion, we report new dermoscopic features in a case of SCLE, namely, white shiny structures, focal multicolored pattern, and follicular dilatation and plugging. The disappearance of the above structure correlated with clinical improvement, which may indicate the therapeutic response. Larger studies are needed to verify our findings.

**Declaration of patient consent**

The authors certify that they have obtained all appropriate patient consent forms. In the form the patient(s) has/have given his/her/their consent for his/her/their images and other clinical information to be reported in the journal. The patients understand that their names and initials will not be published and due efforts will be made to conceal their identity, but anonymity cannot be guaranteed.
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Conflicts of interest

There are no conflicts of interest.

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