

Hyperpigmentation Induced by Hydroxychloroquine

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Case Presentation

A 52-year-old Moroccan woman, with a previous diagnosis of Sjogren syndrome (SS), presented to our internal medicine consultation with the appearance of hyperpigmented lesions on lower lip and back of hands (Figure 1). She was medicated with hydroxychloroquine for 4 years at a dose of 400 mg/day. Clinical examination did not show any other localizations. She did not present any other clinical systemic sign suggesting diagnosis of systemic lupus erythematosus. Considering her age, clinical context and current medications, the main diagnoses that were evoked were drug-induced hyperpigmentation, metabolic disorders, endocrinopathies, other auto-immunities, and a paraneoplastic syndrome. We performed biological tests: blood cell count, 8-hour cortisol

level, TSH, red blood cell sedimentation, C-reactive-protein, serum iron, ferritin, AST, ALT, bilirubin, gGT, PAL, urea, creatinine, anti-phospholipid antibodies, 24-hour proteinuria, blood and urine ionograms, virus serologies (HCV, HIV, HBV), ceruleoplasmin, and vitamin B12 levels. A thoracic-abdominal-pelvic CT scan was also requested to rule out a neoplastic origin. As for the immunological workup, anti-SSA and anti-SSB were initially positive, but these same antibodies were found when the immunological tests were redone. Furthermore, biological and radiological investigations came back normal, and the diagnosis of hyperpigmentation induced by hydroxychloroquine was retained. An ophthalmological examination with a visual field was carried out, objective an enlargement of the blind spot, without other abnormality. Hydroxychloroquine was definitively



Figure 1. (A,B) Hyperpigmentation of lower lip (A) and back of hands (B) induced by hydroxychloroquine.

discontinued. Two months later, we noted a stability of the lesions, without appearance of other locations.

Teaching Point

Antimalarials are responsible for hyperpigmentation in 25% to 33% of cases [1]. This side effect is much more common with chloroquine and quinacrine than with hydroxychloroquine [1]. The most characterized locations are the oral cavity, the neck and the front of the legs [1,2]. It appears after months or years of use of the molecule, and it is dose-dependent [1]. Hydroxychloroquine-induced retinopathy is commonly associated. Discontinuation of the drug generally allows clearing of the lesions after a few months. It is important to rule out differential diagnoses, including

other iatrogenic causes, endocrinopathies (Addison disease, Cushing syndrome, hyperthyroidism), metabolic disorders (hemochromatosis, Wilson disease), infections (HIV, Dermatophytes), nutritional disorders [1].

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