Unmasking a malar rash during the COVID-19 pandemic

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DESCRIPTION

A 70-year-old woman presenting with loin pain was found to have an acute kidney injury with a creatinine of 176 µmol/L (78 µmol/L 6 months previously). Urine dipstick was positive for blood and protein with a protein:creatinine ratio of 71 mg/mmol. Her medical history was significant for a recent episode of anterior uveitis for which she had received topical steroid treatment with ongoing ophthalmology follow-up. Other medical history included fibromyalgia, Raynaud's phenomenon and intermittent right leg weakness with no cause identified on an MRI spine. There was no significant family history.

Physical examination was documented as unremarkable. An abdominal CT scan did not show a cause for her pain. She had a strongly positive antinuclear antibody with dense fine speckle pattern, but normal complement levels and anti-dsDNA with a negative panel of extractable nuclear antigens. C-reactive protein was mildly elevated at 12 mg/L. Urine microscopy showed a small number of white blood cells (22/mm^3) and red blood cells (5/mm^3). Transfer to the renal unit was organised.

On transfer, the patient mentioned a tendency to a photosensitive facial eruption of longstanding duration. A malar rash was evident, previously unrecognised due to the wearing of a facemask (figure 1). The main differential diagnosis was tubulointerstitial nephritis with uveitis (TINU). A malar rash is not a recognised feature of this syndrome, and therefore systemic lupus erythematosus was also considered. A kidney biopsy showed a lymphocytic tubulointerstitial nephritis with negative immunohistochemistry, not supportive of lupus nephritis. The patient started treatment with 60 mg oral prednisolone for a diagnosis of TINU. Within 2 weeks, her creatinine had fallen to 88 µmol/L, though the facial rash persisted.

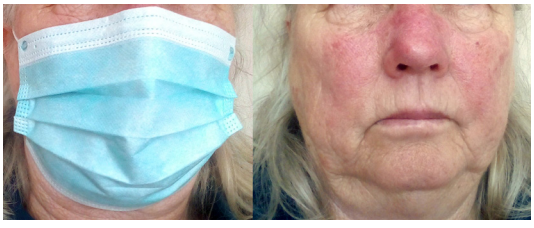

Figure 1 Malar rash with and without a facemask.

As of 15 June 2020, wearing a facemask has been mandatory for staff, outpatients and visitors to hospitals in England, but they may conceal valuable clinical signs. While the 'butterfly' rash seen in this case did not secure a diagnosis of systemic lupus, missing it in other cases could lead to diagnostic delay or misdiagnosis. Removing masks with the clinician at a safe distance may form part of a systematic clinical examination. A detailed history remains of paramount importance. The importance of video consultations have risen during the COVID-19 pandemic. [1] Counterintuitively, these may be superior to face-to-face consultations with a mask because physical signs can be fully assessed.

Learning points

- Clinical examination has become more challenging during the COVID-19 pandemic with social distancing, use of face masks and an increase in telephone consultations.
- A detailed history is vital with consideration of questions on key clinical signs.
- A sensible and sensitive approach is required if examination requires facemask removal.

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