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BULLOUS LICHEN PLANUS – A CASE REPORT

Dermatology

Vignesh NR — Senior Resident, Department of Dermatology, Venereology & Leprosy, Sree Balaji Medical College & Hospital, Bharath University, Chennai 600044, Tamil Nadu, India

Divya. G — Junior Resident, Department of Dermatology, Venereology & Leprosy, Sree Balaji Medical College & Hospital, Bharath University, Chennai 600044, Tamil Nadu, India

Jayakar Thomas* — HOD & Professor, Department of Dermatology, Venereology & Leprosy, Sree Balaji Medical College & Hospital, Bharath University, Chennai 600044, Tamil Nadu, India. *Corresponding Author

ABSTRACT

Bullous lichen planus is a rare variant of lichen planus which has a bimodal onset. It can present either as familial or non-familial types. Here we present a case of 39-year-old male patient with bullous lesions over erythematous to violaceous base with oral involvement.

KEYWORDS

bullous lichen planus, lichen planus pemphigoides

INTRODUCTION:

Bullous lichen planus, an uncommon variant of the classical lichen planus, is one of the subepidermal blistering disorders which has to be differentiated from bullous pemphigoid and lichen planus pemphigoides.

Case report:

A 39-year-old male patient came to the OPD with chief complaints of fluid filled lesions over both the legs for the past 2 days. Patient had similar lesions over the hands which started 20 days before and got resolved with medications, the records of the same was not available. The lesions were associated with itching. No other symptoms like photosensitivity and fever were present.

On examination, multiple flaccid bullae seen over erythematous to violaceous base and not on normal skin. Scaling with pigmentation present over the bilateral flexures of upper limb. Oral examination showed lacy streaks over the buccal mucosa. The general examination was normal. Histopathology showed mild hyperkeratosis, basal cell degeneration with cytoid bodies seen. Lymphocytic infiltrate present in the upper dermis. We started the patient on oral steroids, antihistamines and antibiotic and good response was seen.

DISCUSSION:

Bullous lichen planus is a rare variant of lichen planus which has a bimodal onset. It can present either as familial or non-familial types. Familial form is inherited as autosomal dominant type and has wide spread lesions (1). Bullous lichen planus can be seen during the acute flares of lichen planus. The distribution is predominantly on the extremities commonly over the shins. Dissemination can occur in few cases. Tense multi-locular bullae can be seen. Oral lesions are rarely seen in this type. A close differential diagnosis to be considered is lichen planus pemphigoides. Histopathology of lichen planus pemphigoides will show subepidermal blister with no other features of lichen planus (2) whereas, histopathology of bullous lichen planus will show subepidermal bullae with classical changes of lichen planus (3). In LP pemphigoides, bullae are seen in the lesional as well as in the non-lesional skin whereas in bullous lichen planus only the lesional skin will show bullae. LP pemphigoides will show deposits of C3 and IgG in direct immunofluorescence, whereas immunofluorescence will be negative in bullous lichen planus. Exacerbation of LP pemphigoides can occur with PUVA therapy and drugs like ACE inhibitors. Other differential diagnosis includes bullous pemphigoid which usually develops in elderly population. In our case the bullae was present only over the lesional skin and biopsy was suggestive of bullous lichen planus hence it is published because of its rarity. A combination of corticosteroid and acitretin has given good results. Even monotherapy with acitretin has shown good response.

CONCLUSION:

In our case the bullae was present only over the lesional skin and biopsy was suggestive of bullous lichen planus hence it is published because of its rarity.

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CONFLICT OF INTEREST: The authors declare that they have no conflict of interest.

Figure 1: clinical picture showing bullae over erythematous to violaceous base over both lower limbs

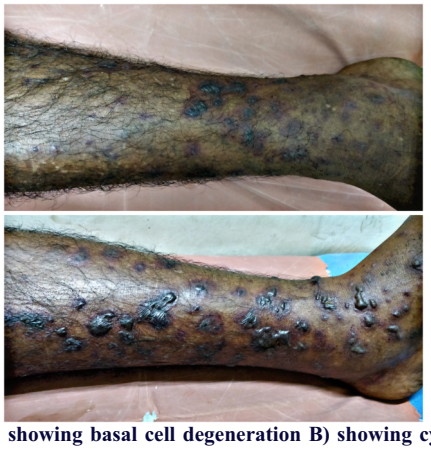
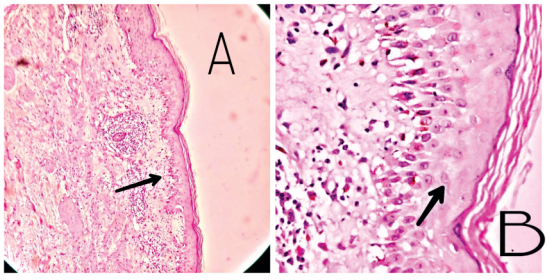


Figure 2: A) showing basal cell degeneration B) showing cytoid bodies



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