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SEGMENTAL LICHEN PLANUS-A RARE CASE REPORT.

Dermatology

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ABSTRACT

Ever since Devergie in 1854 first described linear lichen planus, numerous cases have been reported in the literature, but there have been notably few of the more rare zosteriform or segmental lichen planus1. Lichen planus is characterised by violaceous polygonal papules with fine white lines called wickham's striae. There are a number of variants of lichen planus which can be distinguished from the classical form based on the morphology and distribution of the lesions. Here we report a rare variant of lichen planus, the segmental or zosteriform type of lichen planus on the right infraorbital region in a female patient.

KEYWORDS

Lichen planus, segmental, zosteriform variant, rare.

INTRODUCTION:

Von Hebra originally described LP which he names leichen ruber. The term lichen planus was coined by Erasmus Wilson in 1869[2]. The diagnosis of LP in its classical form is usually not very difficult. The appearance of polygonal papules at sites of predilection frequently in association with characteristic mucous membrane lesions allows for a secure clinical diagnosis. A particularly high prevelance rate has been seen in the Indian subcontinent[3]. LP is characterized by intense and agonising pruritis. After the remission of the papules and plaques of LP, postinflammatory hyperpigmentation, leuko-or pseudoleukoderma as well as atrophy may remain.

CASE REPORT:

45 year old female patient came to the dermatology OPD with complaints of multiple papules and plaques on the right infra-orbital region for the past 6 months. It initially started as one small papule which gradually increased in size and number. The lesions started to appear on her right dorsal aspect of hand. Itching+. No h/o photosensitivity seen. No h/o atopy. No h/o pain. No h/o discharge from the lesion. She is not a k/c/o diabetes mellitus, hypertension, Tuberculosis, hyperlipidemia and thyroid disorder.

On examination multiple hyperpigmented or violaceous papules and plaques seen on the right infra-orbital region, the largest being 2x2 cm in diameter. No tenderness on palpation.

Biopsy was done which showed orthokeratosis, basal cell degeneration with follicular plugging. Granular layer was beaded. Lymphohistiocytic infiltrate was seen in the upper dermis and also surrounding the adnexal structures.

DISCUSSION:

Lichen planus is an idiopathic, chronic, inflammatory disease that affects skin, nail, mucous membranes and appendages. The lesions of lichen planus show Wickham's striae and koebnerisation. LP usually appears as a clinically and histopathologically well recognized entity. Cases of true zosteriform LP-like eruptions are extremely rare.

Tcells play an important role in the development of lichen planus. The frequently involved sites are flexor surfaces of wrist and forearms, dorsal surface of hands, anterior aspect of lower legs, neck and back. Classic LP is seen in the above sites but clinical variants like zosteriform or segmental LP in our case is also possible. Patient complains of severe itching except in actinic LP.

On histopathology, there maybe ortho or hyperkeratosis, beaded granular cell layer, saw toothing of rete ridges, basal cell degeneration, civette bodies or colloid bodies are seen in the epidermis and upper dermis along with band like lymphocytic infiltrate, near the epidermis, almost hugging it.

The differential diagnosis in this case included LP, lichen striatus, inflammatory linear verrucous epidermal nevus and nevus unius lateris. Various infections, drug eruptions, dermatitis herpetiformis, segmental neurofibromatosis, or scleroderma may also display a zosteriform or segmental pattern[4].

With few exceptions, all forms of LP are treated the same way. Depending on the severity, topical and systemic treatment options are available. Topical therapy includes corticosteroids and success has been reported with calcineurin inhibitors also[5]. Systemic therapy options include corticosteroids, dapsone, azathioprine, PUVA. Also successful use of thalidomide and biologics also exist.

CONCLUSION:

Segmental or zosteriform lichen planus is not something we see often even though the treatment options do not change. We hereby report this case for its rarity in occurrence.

Acknowlegment: None

Conflict Of Interest: The authors declare that they have no conflict of interest.

Legends To Figures:

Figure1: Clinical Photographs Showing Violaceous Or Hyperpigmented Flat Topped Papules And Plaques.

Histopathology:

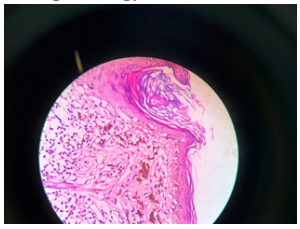

Figure 1: 10 x magnification stained with haematoxylin and eosin stain showing basal cell degeneration and melanophages in the dermis.

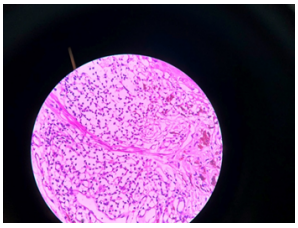

Figure 2 : 40 x magnification stained with haematoxylin and eosin stain showing Band like lymphocytic infiltrate in the upper dermis.

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