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LICHEN SCLEROSUS BEYOND THE GENITALS

Dermatology

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ABSTRACT

Lichen sclerosus is a chronic, inflammatory dermatosis that predominantly affects the anogenital region but can also present in extragenital areas. It is most commonly seen in post-menopausal women and may be associated with autoimmune, hormonal and genetic factors. This case report describes a 60-year old female with extragenital lichen sclerosus involving the bilateral forearms and arms, presenting as asymptomatic hypopigmented atrophic plaques. Histopathological examination confirmed the diagnosis. The patient was managed with high-potency topical corticosteroids and advised regular follow-up. Early recognition and appropriate treatment are crucial in preventing disease progression, scarring and potential malignant transformation, even in extragenital presentations.

KEYWORDS

Genital, Extragenital, Histopathology, Follow-up.

INTRODUCTION:

Lichen sclerosus is a chronic, inflammatory skin disorder primarily affecting the anogenital region, though it can occur elsewhere in the body. The condition predominantly affects post-menopausal women but can also affect men and children. The exact cause is unknown, though autoimmune, hormonal and genetic factors may play a role.[1] Lichen sclerosus can lead to scarring and in some cases an increased risk of squamous cell carcinoma.[2] Early diagnosis and treatment are essential to manage symptoms and prevent complications.[3]

Case Report:

A 60-year old female presented to DVL OPD with complaints of light coloured lesions of varying sizes over bilateral forearms and arms. Lesions initially started over left forearm and then progressed to involve bilateral forearms and arms. She gave no history of associated pain or itching. No history of atopy and photosensitivity. On examination multiple hypopigmented atrophic plaques of varying sizes are present over bilateral arms and forearms. (figure 1) Patient was advised to do skin biopsy and thinning of epidermis with flattening of rete ridges, basal-cell degeneration and homogenized band of dense fibrosis at the papillary dermis was noted, consistent with histopathological findings of lichen sclerosus. (figure 2) Patient was started on potent topical corticosteroids and advised regular follow-up.

DISCUSSION:

Lichen sclerosus is a chronic, progressive inflammatory dermatosis with a predilection for the anogenital region, often resulting in significant morbidity due to both physical discomfort and psychological stress.[1] Although its exact etiology remains unclear, autoimmune mechanisms are strongly suspected, with studies showing an association with other autoimmune disorders such as thyroiditis, vitiligo and type 1 diabetes.[4] Genetic predisposition and hormonal factors, particularly estrogen deficiency, may also play contributory roles, especially in postmenopausal women.[1]

Clinically, LS presents as porcelain-white, atrophic plaques that may coalesce, leading to thinning of the skin, fissuring, and architectural distortion, particularly in the vulvar and perianal areas.[3] Ivory white atrophic or hypertrophic plaques, ecchymosis and crinkled texture are the characteristic features of lichen sclerosus. Symptoms include pruritic, burning, dyspareunia, and sometimes urinary or defecatory discomfort. As the disease progresses scarring with labial resorption, intra-oital narrowing and burying of the clitoris are features seen in genital area. In men, LS often affects the foreskin and glans, potentially resulting in phimosis and urethral stricture. Extragenital lesions, though less common, can occur on the trunk, upper arms and breast.[5]

Treatment primarily involves high-potency topical corticosteroids, which are effective in controlling symptoms and preventing progression.[3] In refractory cases, topical calcineurin inhibitors, phototherapy or surgical intervention may be considered. long-term follow-up is recommended due to the risk of scarring and potential malignant transformation. Patient education, long term monitoring and psychological support are essential components of comprehensive care to improve quality of life and outcomes in the affected individuals.

CONCLUSION:

Lichen sclerosus, though typically affecting the anogenital region, can present with extragenital lesions as seen in this case. Early diagnosis and appropriate treatment with topical corticosteroids are essential to prevent complications such as scarring and malignant transformation. Regular follow-up ensures effective management and improves long-term outcome for affected patients.

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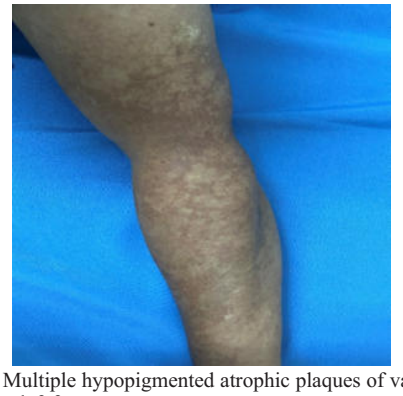

Figure 1: Multiple hypopigmented atrophic plaques of varying sizes present over left forearm.

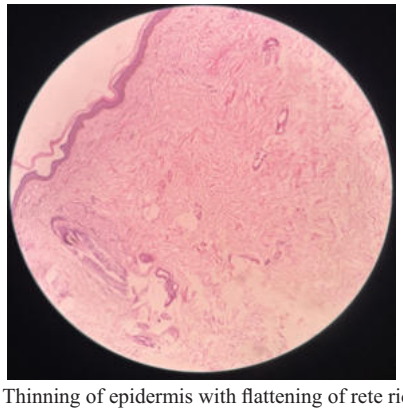

Figure 2: Thinning of epidermis with flattening of rete ridges, basal-cell degeneration and homogenized band of dense fibrosis at the papillary dermis.

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