A Follicular Lichenoid Eruption as Manifestation of Chronic Graft-vs-Host Disease

Sir,

A follicular variant has been described as a rare manifestation of both acute and chronic graft-vs-host disease (GVHD) (1 – 5). We report a patient with a peculiar, follicular, lichenoid eruption as major manifestation of chronic GVHD, and review the literature of follicular GVHD.

CASE REPORT

A 33-year-old woman with refractory anaemia with excess of blasts underwent an HLA-matched allogeneic bone marrow transplantation following preparation with busulfan and cyclophosphamide. She also received methotrexate, on days +1, 3, 6 and 11 and cyclosporin A. Marrow engraftment was achieved successfully on day +27. On day 87 after the bone marrow transplantation, an erythematous-to-violaceous, predominantly follicular, lichenoid papular eruption developed on the anterior thorax, back, arms and thighs (Fig. 1). In addition, numerous erythematous papules were present on the palmar surfaces of the hands, and reticulate white, occasionally erosive lesions were observed on the surface of the buccal mucosae. The patient had diarrhoea with 4 to 5 loose watery stools a day. Histological examination of a follicular papule on the thigh revealed basal-cell vacuolization with dyskeratosis in the basal layer of the follicular epithelium as well as the interfollicular epidermis. A sparse perivascular and perifollicular lymphocytic infiltrate was observed in the upper dermis, with occasional exocytosis into the follicular epithelium. A biopsy specimen of a papular lesion on the palm showed similar findings except for the follicular involvement. No alterations were found in the laboratory studies. The findings were interpreted as grade 2 chronic GVHD, and therapy was started with systemic corticosteroids. The diarrhoea ceased promptly and the cutaneous lesions resolved in the following weeks, but the erosive lesions of lichenoid GVHD in the buccal mucosae were more recalcitrant and resolved more slowly in several months. After 5 years of follow-up, the patient is doing well.

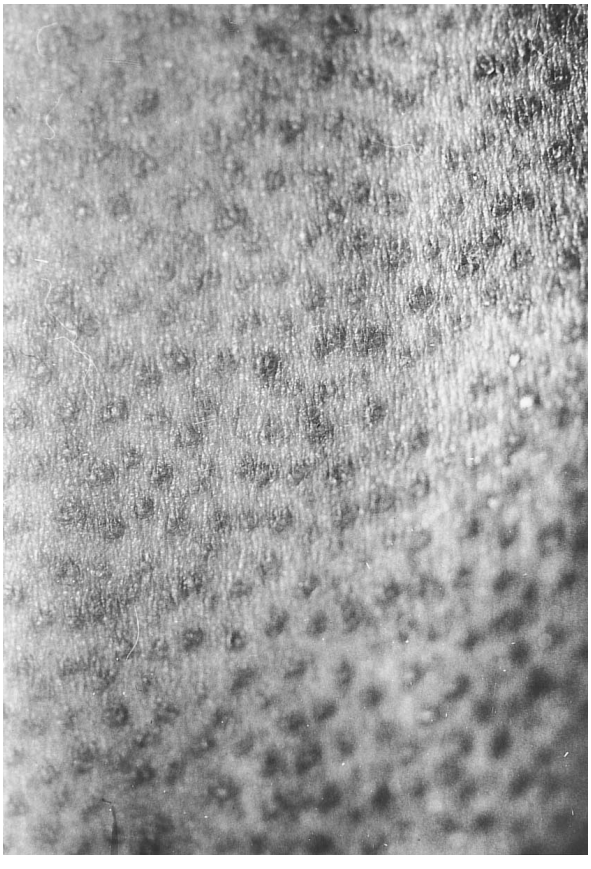

Fig. 1. Close-up of the follicular, lichenoid papules.

DISCUSSION

In the 6 reported cases of acute follicular GVHD, the follicular eruption developed early in the course, and preceded or was simultaneous with the classic maculopapular or scarlatiniform rash. In all these patients the eruption was progressive and persistent, and the patients died shortly after the diagnosis was made (1 – 3). In contrast, in the 3 reported cases of chronic follicular GVHD, the follicular eruption developed late in the clinical course and was associated with an excellent clinical outcome (4, 5).

Although the histologic involvement of the follicular epithelium is considered ubiquitous in GVHD (6), a follicular eruption as major clinical manifestation of GVHD is rare. We evaluated the 143 cases of GVHD seen in our department between 1980 and 1997, and found only 1 of them (present case) with a follicular eruption as major manifestation of GVHD. We were unable to find any other data in the literature about the incidence of follicular GVHD. The preferential involvement of the parafollicular bulge was related to the presence of stem cell populations in this area, and it has been suggested that this region is an early target in GVHD (6). Histologic examination of the reported cases with clinically follicular GVHD showed similar findings in the hair-follicle epithelium and in the epidermis (1 – 5). Why the follicular involvement is clinically expressed only rarely is not understood.

In our opinion, chronic follicular GVHD, as seen in our patient, is a rare clinical variant of the lichenoid form of chronic GVHD, and the diagnosis is made clinically. We would like to emphasize the more favourable prognosis of this variant, which may be related to the delayed time of onset. We also highlight the discrepancy in histologic involvement and clinical expression of GVHD, which will probably become clear with a better understanding of the pathogenesis of GVHD

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