

Erosive Lichen Planus: Two Uncommon Cases

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Sir,

The term “erosive lichen” commonly refers to a clinical-pathological variant of lichen planus (LP), a condition usually reported to involve the oral mucosa and genital semi-mucosa, especially in women.

There are a range of forms of LP involving the oral mucosa: reticular LP (RLP), the most common; erosive LP (ELP), which is less common but not rare; and atrophic LP (ALP), which is rare (1). Other authors prefer to distinguish 6 various clinical forms of LP and, beside those listed above, they also consider a form in plaques, a papular form and, finally, a rare bullous variant (2).

ELP has only exceptionally been described outside of the body regions mentioned above.

We report here 2 patients with severe ELP involving different regions and with parcelled and reticular involvement of the oral mucosa, and sparing of the genitalia.

CASE REPORTS

Case 1

A 58-year-old male farmer was referred to us because of the onset and progressive worsening, over a period of a few months, of a very itchy papulous dermatitis over the left pretibial and inguinal regions. The pretibial plaque was red-brownish in colour, the size of the palm of the hand, and had excoriations. In the inguinal region, the tissue was hypertrophic, lanceolate, lilac with whitish areas over its borders, evidently eroded around its centre, corresponding with the inguinal fold (Fig. 1a). The patient described a burning sensation and showed traces of RLP of the buccal mucosa. Biopsy of the eroded area showed, at low magnification, a band-like chronic inflammatory infiltrate in the upper dermis. The epidermis appeared centrally ulcerated and invaginated; vacuolar degeneration of the basal layer and very rare Civatte bodies were evident over the ulcer edges. The dermis presented an accentuated fibrosis, obscured in the upper part by the inflammatory infiltrate. This was composed predominantly of lymphocytes with some macrophages. Focally, few lymphocytes penetrated the overlying epidermis (Fig. 1b). This allowed us to make a diagnosis of ELP. All routine blood tests were within the normal limits, including the markers for hepatitis B and C. Cyclosporin A (CyA) treatment was started at a dose of 3 mg/kg/day, followed by a rapid improvement and complete remission of symptoms within 2 months. After discontinuation of this drug therapy, less severe ELP recurred; for this reason, this patient is currently treated with CyA (2.5 mg/kg/day) and oral steroids, in rotation.

Case 2

A 68-year-old retired woman, affected by dementia, was referred to us because of chronic (more than 10 years) derma-

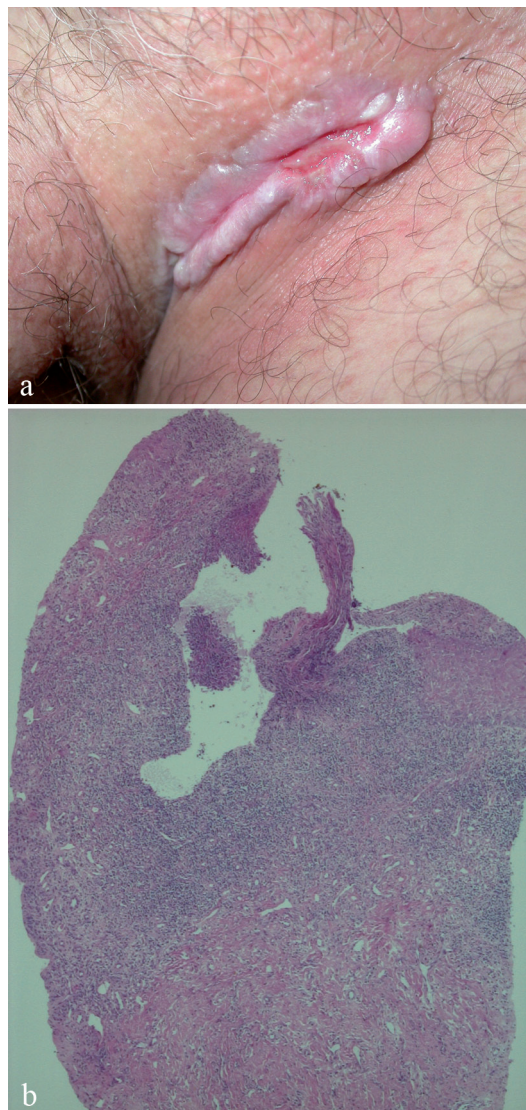


Fig. 1. (a) Erosion of the centre of the lichen plaque over the inguinal regions. (b) Histological aspect. Low magnification outlines the dermal band-like inflammatory infiltration underlying an extensive ulceration of the epidermis.

titis in the plantar regions for which she had been admitted to hospital previously, with a final diagnosis of plantar psoriasis. Therapy with steroid ointments had been proposed, but was ineffective. This patient had mildly infiltrated areas over the plantar regions (Fig. 2a), which were burning and eroded in the centre and affected her walking. Moreover, the patient reported a progressive atrophy of the first 3 ungual laminae of both feet, which, at the time of our observation, had completely disappeared (Fig. 2b). The patient had a very mild RLP of the buccal mucosa, with no signs of phlogosis or alopecia

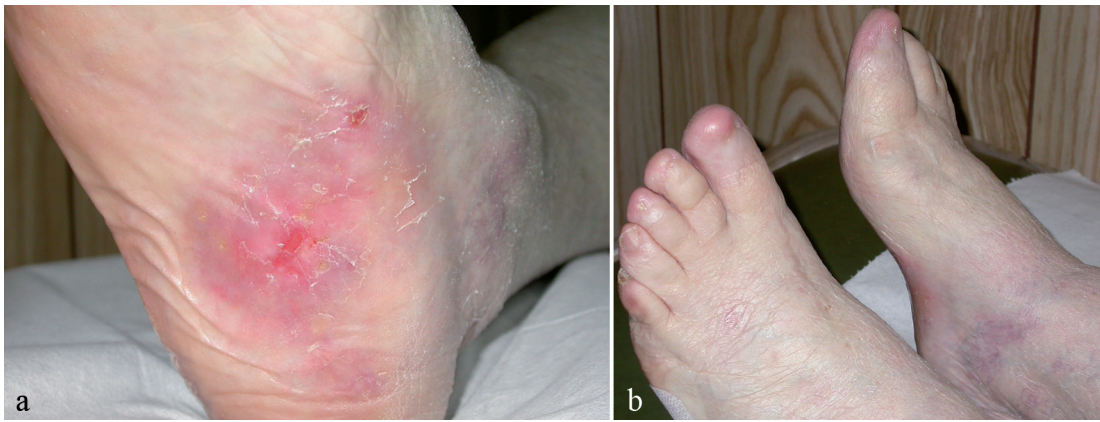


Fig. 2. (a) Plantar erosion on a lilac plaque. (b) Secondary onychotrophy.

of the scalp, had mild (treated) blood hypertension, and was not diabetic. She did not consent to skin biopsy. On the basis of the clinical features and of the complete onychotrophy of some nails, a diagnosis of ELP was proposed. Low doses of CyA 2.5 mg/kg/day, in association with steroid cream twice daily, were followed by an excellent beneficial effect and, in approximately 2 months, normal walking was attained. At present, this patient has been followed-up for approximately 4 months and takes CyA 2 mg/kg/day. No evident effect has been observed on the ungueal laminae.

DISCUSSION

LP is a papulous dermatitis presenting several clinical variants (3). The ELP form involves the oral cavity and genitalia (2, 4). Rare cases of ELP have been reported involving the plantar areas of the skin (5–8). Onychotrophy is considered to be a part of plantar ELP (5) and, in our opinion, is a specific diagnosis allowing this form to be distinguished from psoriasis. ELP of the feet is usually described in subjects who have lesions of the buccal mucosa, genitalia or body (5–6, 8); however, it is possible that the plantar lesions are isolated and not associated to other lesions (7). Alopecia is sometimes present in this clinical condition (5), mostly in the variant leading to atrophic alopecia of the scalp (8). The rare cases described with lesions outside the buccal mucosa involve genital areas that seem to be involved more frequently in women (4) than in men (9). Only 2 cases have earlier been reported in the literature with involvement of the intertriginous areas, similar to our first case (10–11).

Our first patient presented LP of the buccal mucosa, bilateral inguinal areas and of only one limb. The lesions were confirmed by histopathology, and low doses of CyA allowed us successfully to manage the symptoms of this patient, as previously reported by other authors (12, 13).

Our small series of cases allows us to consider drug therapy with CyA, with doses to be adapted from patient to patient, as an excellent tool for the management of inflammation followed by a return to a normal quality of life. The use of topical tacrolimus, which has been

proposed recently (11), appears interesting, largely as an alternative to oral CyA, after a first approach with cyclosporine; however, this needs to be confirmed outside of the genital or mucosal areas where percutaneous penetration is certainly high (12, 14). Also, in a single reported case, topical cyclosporine was applied daily to the plantar ELP with considerable improvement (7).

Finally, the reasons why some atypical locations, such as the inguinal areas or the plantar region, have been involved in such a severe way in our patients remain unclear; one can hypothesize that the plantar surface, and perhaps the groin, are at risk for LP because of the weight load, circulation factors and rubbing (Koebner phenomenon).

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