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CASE REPORT

Eruptive actinic lichen planus - A Case Report

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Abstract

Lichen planus is an idiopathic, inflammatory, papulosquamous disease of the skin and mucous membrane with characteristic morphological and histopathological features. Actinic lichen planus (actinic lp) is a rare variant of lichen planus seen mainly during spring and summer, and lesions primarily involve sun exposed parts of the body. We report a 23 years old married female who presented with actinic lp with associated pain and mucosal involvement which is a rare finding.

INTRODUCTION

Actinic Lichen Planus (ALP) is a rare variant of lichen planus (LP) which affects young adults with dark complexion who live in tropical or subtropical regions. It usually affects sun-exposed areas such as the forehead, dorsum of the hands and the extensor surface of the upper extremities. The high incidence of the disease develop during spring and summer [1,2]. Unlike classic lichen planus, features like pruritus, koebner phenomenon and mucous-membrane involvement are not commonly seen and nails are always spared [3,4]. We present a case of actinic lichen planus with associated pain and mucosal involvement which is a rare finding.

Case Report

A 23 -year- old married female, manual labourer presented with painful skin lesions over face, forearms and hands since 5 months. Lesions started over the forehead and gradually spread to involve other areas; it was associated with itching on exposure to sunlight and on sweating. There was history of similar complaint in the past summer which subsided without treatment over a period of 2 months but no family history of similar skin eruptions. There was no significant drug history before the development of the lesions. Examination revealed violaceous papules, hyperpigmented patches and hyperkeratotic scaly plaques over the scalp, forehead, near medial canthi of

the eyes, nose, cheek , chin, concha of the ears, extensor of hands and forearms, palms, upper back, posterolateral part of the neck and upper chest [Figure 1&2].

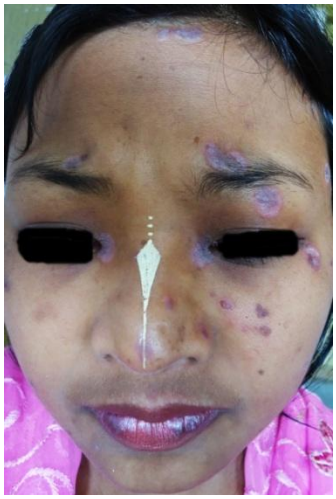

Fig. 1 showing violaceous hyperkeratotic plaques over the face.

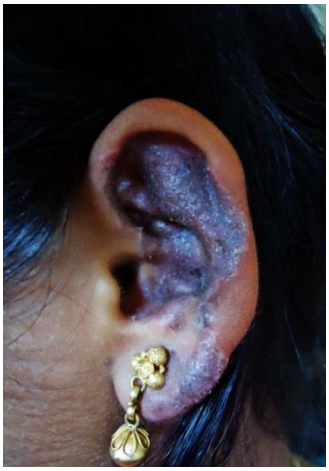

Fig. 2 showing violaceous scaly plaque over the ears.

Lower lip and hard palate were involved with lacy reticulated whitish and violaceous plaques respectively. There was no nail involvement. General physical and systemic examinations were normal. Routine investigations were within normal limit other than raised ESR. ANA, Anti ds DNA were negative. Skin biopsy taken from dorsum of hand showed orthokeratosis, focal hypergranulosis, basal cell degeneration and band like infiltration in the upper dermis [Figure 3].

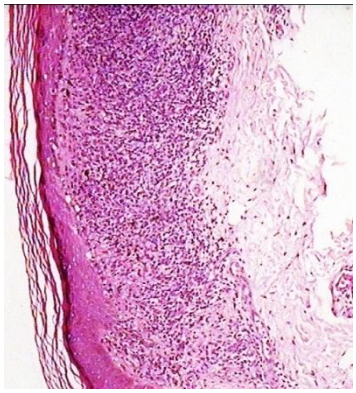

Fig. 3 (H&E X 100) showing basal cell vacuolar degeneration and band like lymphocytic infiltration.

Patient was treated with short course of oral methlyprednisolone 32mg/day, colchicin 1mg/day and topical steroid and sunscreen with considerable improvement on the 10^{th} day [Figure 4&5], after which she was lost to follow up.

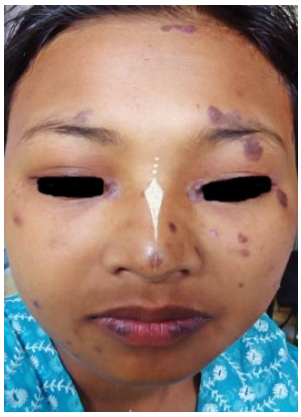

Fig. 4 showing flattening of lesions over the face.

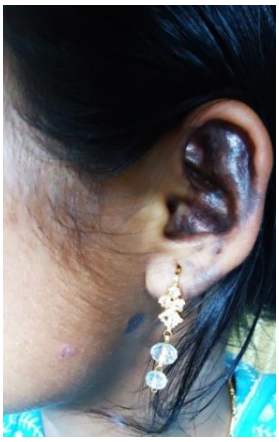

Fig. 5 showing flattening of lesions over the ears.

Discussion

ALP is also known as, LP subtropicus, LP tropicus, LP atrophicus annularis, lichenoid melanodermatitis, LP in subtropical countries and summertime actinic lichenoid eruption [1,4]. Four types of actinic lichen planus have been reported to date: annular, pigmented, classic plaque-like and dyschromic [1,3,5]. Our case is more likely to be of classic plaque-like variant. The non-exposed skin of the legs, trunk, genitalia and oral mucosa is rarely affected [3]. Nails are always spared [3,4]. Our case had an unusual presentation with mild tenderness of the lesions, mucous membrane involvement and peculiar violaceous plaques encroaching the medial canthi of the eyes and large parts of the external ear respectively. The pathogenesis of ALP is not understood; however, ultraviolet radiation appears to be an important inciting factor [2,4]. As ALP has a racial predilection affecting predominantly individuals of oriental origin, and familial cases have been reported [6], it is likely that a combination of environmental factors and genetic predisposition may be important in the pathogenesis of the disease [3]. Histopathological features are similar to classic lichen planus showing hyperkeratosis, wedge-shaped hypergranulosis, necrotic keratinocytes, band-like lymphocytic infiltrate and pigment incontinence [5]. The differential diagnosis of lichen planus actinicus includes discoid lupus erythematosus, polymorphous light eruption, granuloma annulare, sarcoidosis, melasma, morphea, LP pigmentosus and erythema dyschromicum perstans [4,5]. All these can be differentiated by history, histopathologic and immunofluorescence (IF) findings. Treatment strategies should include the use of sunscreen and sun avoidance [5]. Hydroxychloroquine, intralesional glucocorticoids, and acitretin, and topical glucocorticoids with or without occlusion have been used successfully [3,5].

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