

quired extra effort to obtain sufficient sebum for the study. This could explain the small number of *Demodex* found in this region.

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## Lichen aureus: A Case Report

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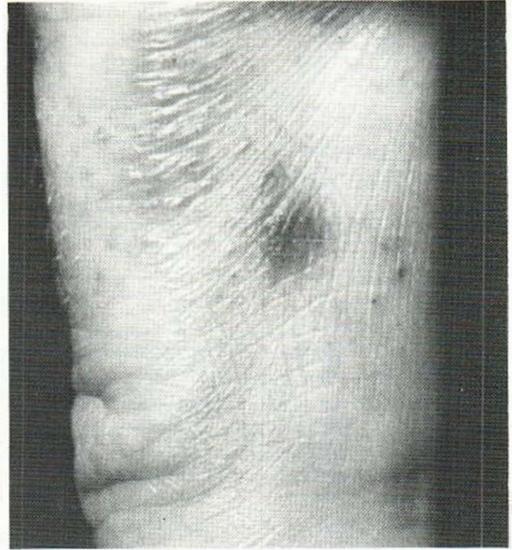
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**Abstract.** Lichen aureus (LA) is a distinctive, rare disease occurring predominantly in males, characterized by solitary rust- or copper-coloured patches of lichenoid micropapules, often present on fingers and calves. A case of LA in a 41-year-old male is presented. Biopsy revealed the characteristic pattern of LA, including a dense dermal infiltrate of lymphocytes and histiocytes containing haemosiderin. No epidermal changes were present.

**Key words:** Haemosiderin; Lichen aureus; Pigmented purpuric eruption

Lichen aureus (LA), also designated lichen purpuricus, was first mentioned as an entity in 1958 (4). Since then only a few sporadic cases have been reported in the dermatological literature (1–3, 6–9). LA may easily be overlooked unless the clinician bears its characteristic clinical and histopathological features in mind.



*Fig. 1.* Lichenoid rusty coloured micropapules on left third finger.

#### CASE REPORT

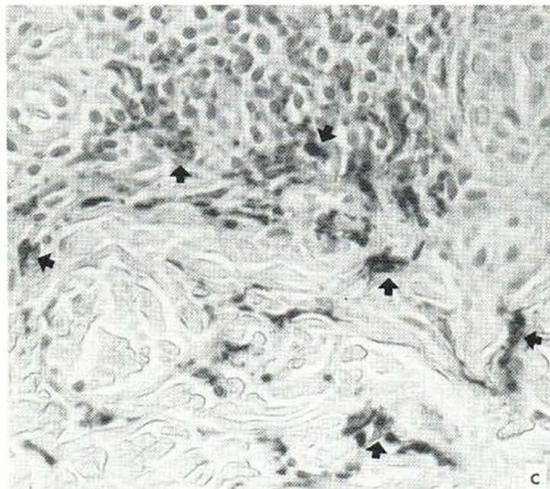
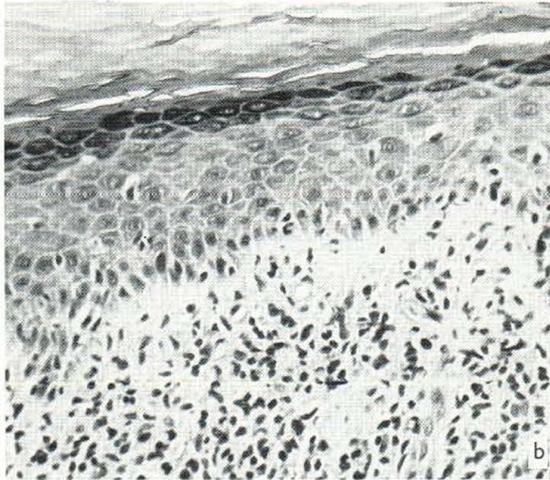
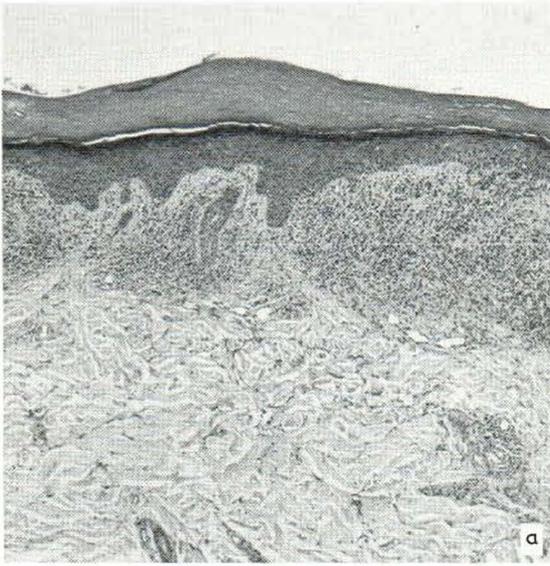
A 41-year-old healthy male was referred because of pigmented patches on the left third finger and left calf, which had been present for about 6 months. Apart from a slight itch, the patient had experienced no subjective symptoms. The referring doctor had considered a bruise, a malignant melanoma, or haemangioma as differential diagnoses. The lesions had remained static apart from an insidious change from reddish brown to rusty or copper colour.

On clinical examination a patch of closely aggregated lichenoid micropapules having a rusty or orange colour was present on his left third finger (Fig. 1) and left calf. The colour remained unchanged by diascopy. Apart from the patches, the patient had widespread, small subcutaneous indolent lipomas on dorsal and lateral aspects of the trunk.

Histopathological examination of a punch biopsy obtained from the central part of the patch on the finger showed partial flattening of the rete ridges over a dense infiltrate of lymphocytes and histiocytes (Fig. 2*a*). The infiltrate was separated from the epidermis by a zone almost free of inflammatory cells (Fig. 2*b*). A few erythrocytes were mingled in the dermal infiltrate. No spongiosis or invasion of cells was seen in the epidermis. Iron-staining with potassium ferrocyanide (Prussian blue) revealed deposits of haemosiderin in the histiocytes located in the deep part of the dermal infiltrate (Fig. 2*c*).

#### DISCUSSION

LA belongs to the group of pigmented purpuric eruptions which includes purpura annularis telean-



giectoides of Majocchi, itching purpura, Schamberg's disease and Gougerot-Blum's dermatitis (5). Like the last two disorders mentioned, LA is apparently more common in males than females, a fact which remains unexplained (1-4, 6-9). Clinically, LA differs from other diseases of the group by virtue of its isolated plaques, often present on fingers and calves. The lesion consists of orange, rust-, or copper-coloured lichenoid micropapules.

Histopathologically, LA is recognized by a dense dermal infiltrate of lymphocytes and histiocytes containing an abundance of haemosiderin, and a subepidermal free zone. Unlike other chronic capillaritides of unknown etiology, LA shows no epidermal basal cell degeneration, exocytosis, or occasional parakeratosis associated with the presence of the erythrocytes in the tissue (5). LA is a benign disorder and is of little inconvenience to the patient. No therapy is warranted.

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*Fig. 2.* (a) Section from central part of lesion shown in Fig. 1. Dense infiltrates of lymphocytes and histiocytes in papillary dermis. There is a narrow, cell-free subepidermal zone (H.E.  $\times 50$ ). (b) No liquefaction is seen in the basal cell layer (H.E.  $\times 125$ ). (c) Numerous haemosiderin-containing histiocytes (arrows) are present in the lower part of the cell infiltrate (Prussian blue,  $\times 220$ ).