Malar Lichen Planus: A New Variant

Nawaf Al-Mutairi and Arun Joshi
Department of Dermatology, Farwaniya Hospital, PO Box 280, Farwaniya, State of Kuwait. E-mail: nalmut@usa.net
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Sir,

Lichen planus (LP) is a common skin disease characterized by itchy, flat, purple papules with white streaks (Wickham's striae) on the surface, affecting the skin over flexural aspects of the upper limbs, such as wrists and forearms, and the shins over the lower limbs. Oral mucosa and genital mucosa, nails, palms, soles and scalp may be involved, either alone or in various combinations (1, 2). Several morphological variants and typical sites of predilection have been described for LP. We report here 2 cases of papular LP, strictly confined to the malar area; a distribution that has not yet been reported for LP.

CASE REPORTS

Two male patients, aged 22 years (Fig. 1) and 29 years had multiple, purple, flat, 2–5 mm, papules on their cheeks, nose, and nasolabial folds for 6–8 weeks' duration. There was no history of similar lesions on the rest of the skin. Their nails, scalps, palms, soles, and oral and genital mucosae were normal. There was no history of intake or topical application of any drugs prior to appearance of the eruption. Clinical differential diagnoses of plane warts and LP were considered. Laboratory investigations, such as complete blood count, clinical chemistry, urinalysis, serology for hepatitis B and C virus screening, antinuclear antibodies and anti-dsDNA antibodies, were normal. Punch biopsies from both the patients showed mild hyperkeratosis, acanthosis, and hypergranulosis in the epidermis. A band-like infiltrate of lymphocytes hugging the basal layer cells, and causing vacuolar degeneration was seen in the upper dermis. Marked pigment incontinence and melanophages were present in the dermis. The findings were consistent with the diagnosis of LP.

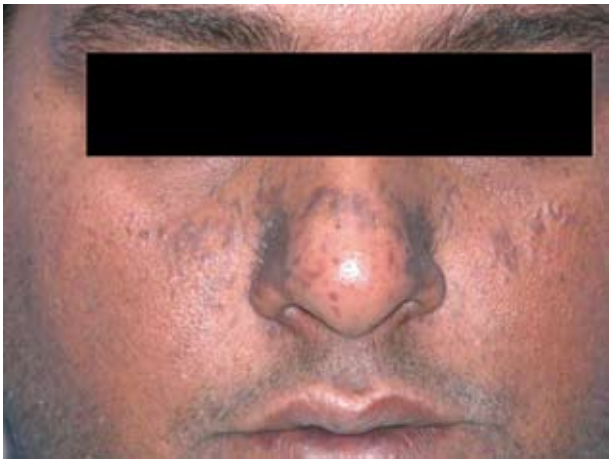

Fig. 1. Violaceous, flat, 2–5 mm, papules of lichen planus on cheeks, nose and nasolabial folds of first patient.

The lesions subsided with mild post-inflammatory hyperpigmentation after twice daily application of mometasone furoate cream for 4 weeks.

DISCUSSION

The common morphological variants of LP are LP ruber, annular, hypertrophic, follicular (lichen planopilaris), atrophic, and actinic LP. Uncommon forms include vesiculobullous, erosive and linear LP (1, 2). A rare flexural variant of LP has been described (3). Hypertrophic LP typically affects the ankles and shins, whereas erosive LP of the skin involves the soles (1, 2). Erosions also occur in LP affecting the oral mucosa (1, 2). Actinic/subtropical LP typically affects the skin of the face. It is reported mainly among children or young adults. Most of these cases are from the Middle East, East Africa or India (4). The lesions in this type of LP occur on sun-exposed skin (usually the face). They are well-defined, discoid or nummular patches, with a hyperpigmented centre surrounded by a striking zone of hypopigmentation. LP pigmentosus (LPP) also shows facial affection (5, 6). This condition is commonly seen in India or the Middle East. In LPP, slate grey to brownish black, diffuse or reticular, blotchy or perifollicular pigmentation is seen mainly on the face and upper limbs. Widespread involvement can occur, but mucous membranes, palms, soles, and nails are not usually involved. Isolated lesions of LP affecting the eyelids (7) and the lips alone have been reported (8).

No discoid or nummular lesion, or peripheral hypopigmentation was noted in these 2 patients. A review of the 2 major standard textbooks of dermatology (1, 2) and Medline search did not reveal any report or description of common papular type of LP strictly affecting the malar area of the face. These 2 patients did not have involvement of any other sites typically affected by LP. They were not taking any medications that could have caused a photodistributed lichenoid eruption. There was no history of them having being employed in any profession involving handling of chemicals causing lichenoid eruptions. LP-like eruption due to contact with colour developers is the most common cause of contact lichenoid eruptions (9). The lesions are itchy

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dusky or violaceous papules on areas of skin exposed to the allergen, such as the dorsum of the hands; however, lesions may also appear at distant sites. Pigmented cosmetic dermatitis is a condition characterized by diffuse or reticular, black or dark brown, hyperpigmentation of the face associated with, or preceded by slight dermatitis, seen in patients applying certain products especially fragrances or pigments, such as perfumes, scented soaps, aftershave lotions, etc (10). The lesions are not papular or sharply demarcated as they were in these 2 patients. The histology of lesions in this condition shows a lichenoid tissue reaction consisting of basal cell liquefactive degeneration and pigment incontinence, and perivascular cellular infiltrate of lymphocytes and histiocytes as seen in allergic contact dermatitis. However, saw-toothing of the epidermis and band-like infiltrate of lymphocytes are not seen, as were noted in the biopsies from these 2 patients. Repeated direct questioning of these patients did not reveal any use of perfumes or aftershave lotions, eau de cologne, etc.; however, the possibility of the use of scented soaps could not be excluded. Since the clinical picture and negative history of cosmetic use did not suggest any contact dermatitis, patch or photo-patch tests were not performed. The eruption has not recurred in the patients although they have continued to use the same soaps as they were using prior to the appearance of the lesions. Hence, we believe that these 2 patients had a distinctive new variant of LP and propose the term "malar LP" for this type of presentation.

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