COEXISTENCE OF LICHEN SCLEROSUS ET ATROPHICUS AND MORPHOEA
(Report of 3 cases)

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Three cases had coexisting lichen sclerosus et atrophicus and morphoea. In two cases, both the types of lesions were simultaneously present from the very beginning, while in the third case, lichen sclerosus et atrophicus developed later in association with an already present and partly treated morphoea.

Key words : Lichen sclerosus et atrophicus, Morphoea, Coexistence.

The occasional coexistence of lichen sclerosus et atrophicus (LSA) and morphoea is interesting.[1] LSA may prove to be closely related to scleroderma (morphoea) as the two conditions can occur together and rarely, scleroderma can produce similar genital lesions like LSA.[2] There is a statistically significant association between LSA and morphoea.[3]

LSA may superimpose on some of the lesions in extensive cases of morphoea. The clinical sign of presence of LSA in these cases is follicular plugging.[4] Even in localised lesions, the two dermatoses may coexist from the very beginning.[5] We are reporting 3 such cases.

Case Reports

Case 1

A 39-year-old male developed a large, oval plaque measuring 8 cm × 5 cm on his abdominal skin at the right side of the umbilicus (Fig. 1) for last 5 months. The hyperpigmented lesion was indurated and smooth. Simultaneously the patient developed a few flat-topped white papules and a large plaque measuring 5 cm × 4 cm near his umbilicus. A few papules were also seen encroaching upon the previous indurated plaque. Follicular plugs were visible on their surface. Associated symptom was nil. The genital region, oral mucosa and other parts of the body were free.

Fig. 1. A large hyperpigmented indurated plaque with smooth surface on right side of the umbilicus. White flat-topped few papules and a large plaque with comedo-like follicular plugs near umbilicus (Case 1).

Histopathology from the indurated plaque showed thickened, closely packed and deeply eosinophilic collagen bundles in reticular dermis. The collagen of the papillary dermis was homogeneous. The eccrine glands were atrophic and lied well inside the dermis. Epidermis was normal. The white papules with follicular plugs histopathologically showed hyperkeratosis with follicular plugging, atrophy of stratum malpighii

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with hydropic degeneration of basal cells, marked oedema and homogenization of the collagen in the upper dermis along with an inflammatory infiltrate in the mid-dermis.

The lesion responded well to topical fluorinated corticosteroid.

Case 2

An 18-year-old male developed a band-like indurated plaque (15 cm×2 cm) on his left forearm for last one year. Surrounding this indurated area and to some extent encroached upon it there were numerous white macules, flat-topped papules and plaques with follicular plugs on the surface. The lesions were symptom-free. Genitalia and other parts were not involved.

The indurated plaque histologically revealed features of morphoea whereas the white papules with follicular plugs showed features of LSA.

Case 3

A 26-year-old lady developed an oval indurated plaque with a smooth surface measuring 8 cm×5 cm on her lower back for the last 8 months. The lesion had violaceous border at the onset. To start with, there was no other associated dermatological problem. Histopathology showed thickened collagen bundles and a moderately severe inflammatory infiltrate in the reticular dermis.

With intralesional hydrocortisone injection, the induration became much less within three months, when suddenly there appeared a few white macules and papules with follicular plugs on the skin surrounding the partially healed original lesion. Genitalia were not involved. These new lesions showed histopathological features of LSA. They responded, later on, to topical fluorinated corticosteroid.

Comments

In the first two cases, morphoea and LSA were associated from the very onset. In the third case, however, treated and partly controlled morphoea secondarily got associated with LSA-type of lesion on the surrounding normal skin.

The mere presence of induration in a lesion of LSA does not necessarily indicate that morphoea is coexistent.[6] The three cases, reported here, had definite clinical and histopathological presence of both LSA and morphoea simultaneously.

References

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