HYPERTROPHIC LICHEN PLANUS SIMULATING SEBORRHOEIC KERATOSIS

To the Editor,

There are many clinical variants of lichen planus one of which is the hypertrophic variety.[1] In this case report, the hypertrophic type mimicked the clinical appearance of a seborrhoeic keratosis.

A 40-year-old man presented with skin lesions of 2 months duration. He also had severe oral lesions which caused burning sensation and painful swallowing. On examination, typical violceous, polygonal papular lesions were seen in the flexor aspects of the wrists and also in the forearms and upper trunk. Annular violaceous lesions were observed in the penis. In the medial aspect of the upper arm, near the shoulder, a large verrucous plaque, about 4x3 cm with a stuck on appearnce was seen. Surrounding this plaque were similar lesions but of a smaller size. A clinical diagnosis of lichen planus was made.

Biopsy of both the classical lesion in the forearm and one of the hyperkeratotic lesions in the upper arm showed the classical features of lichen planus. The patient was treated with prednisolone and dapsone with very good result.

Clinically, hypertrophic lichen planus consists of verrucous plaques covered with fine adherent scales. At the edges of the plaques small flat-topped polygonal papules may be discovered upon careful search, but superficial inspection of the lesion often suggests psoriasis rather than lichen planus.[2] In our case the lesions were different from those described above. Our patient has sharply circumscribed plaques which resembled seborrhoeic keratosis by its stuck-on appearance.

After classical lichen planus, hypertrophic lichen planus is the most common clinical variant.[3] The lesions are chronic and may persists for many years. On histopathology our case showed all features of lichen planus hypertrophicus.[4]

Therapy resulted in quick resolation of these lesions in our case. This is in variance with hypertrophic lichen planus which is usually a chronic process. We report this case mainly to bring to light the unusual clinical presentation of hypertrophic lichen planus simulating seborrhoeic keratosis and also its quick and complete response to treatment. Whether it is a variant of hypertrophic lichen planus or a new morphological variant of lichen planus is debatable.

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TERFENADINE PRECIPITATING ERYTHRODERMA IN PSORIASIS

To the Editor,

Psoriatic erythroderma may show different degrees of disease activity presenting suddenly as erythroderma or gradually evolving

from chronic plaque type psoriasis. In the latter there are usually some areas of uninvoloved skin. Psoriatic erythroderma may be the response to treatments like anthralin and UVB.[1] Itching is not an uncommon symptom among psoriatics. A 70-year-old man having psoriasis for past 36 years came for the treatment to relieve itching. He had chronic plaque type of lesions and suffered from many attacks of erythroderma in the past. He was prescribed terfenadine 60 mg bid. Within 6 hours of taking the first dose he experienced severe burning sensation all over the body and scales over the large plaques began peeling off. The exfoliation was complete within 24 hours of taking the first dose. The patient came the next day with generalised erythroderma without any univolved skin. He improved within 10 days of stopping the drug. A sudden onset of exfoliation of this kind was never seen there in him previously. Eight months later a rechallenge was done by an accidental consumption of terfenadine. This also resulted in total erythroderma by 24 hours in the same manner as on first occasion. Complete evaluation of the patient on both occasions ruled out other precipitating causes of erythroderma in psoriasis.

There is one report of terfenadine precipitating erythroderma in psoriasis.[2] Sudden in onset, almost instant precipitation of erythroderma in this patient indicated terfenadine as the precipitating cause. This has been proved by an accidental rechallenge of the durg.

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PKDL MIMICKING POST-INFLAMMATORY CHANGES OF PITYRIASIS ROSEA

To the Editor,

A 12-year-old boy presented to us with numerous well-defined hypopigmented macules over the lower part of the face, neck, trunk and proximal parts of limbs (Fig. 1)

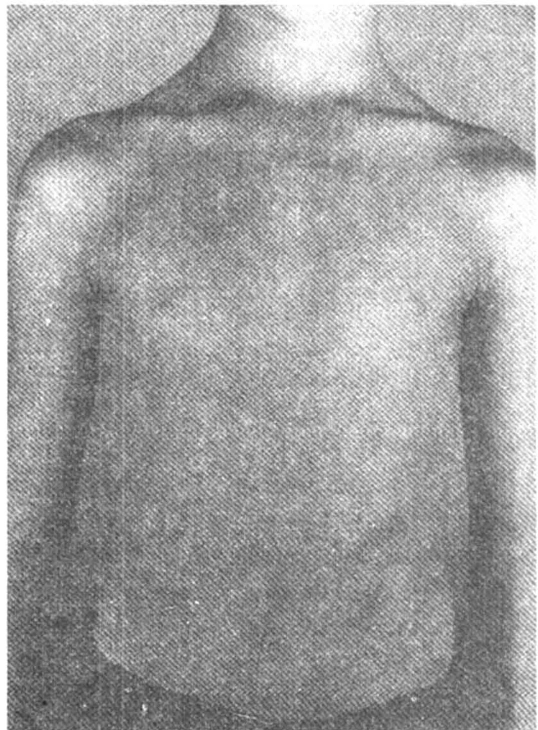

Fig. 1. Hypopigmented macules on the trunk and proximal parts of upper limb.

present for the last 6 months. Some had coalesced to form large patches but most of the lesions on the back were aligned along the long axes of ribs in a stricking "christmas tree" pattern (Fig. 2). The lesions were asymptomatic and slowly progressive while the sensations were intact. There were no features