Concurrent oral and genital involvement in lichen planus

Sir,

The true incidence of lichen planus (LP) is unknown as it can affect one or several regions, can have various clinical appearances, and the diagnosis has to confirmed histopathologically.[1] Therefore, the true LP prevalence can be known only with the joint contributions of gynecologists, dentists, and dermatologists.[2] We selected patients with oral LP (OLP) and genital LP (GLP) lesions and tried to determine concurrent oral, genital, and skin involvements by engaging the cooperation of dermatologists, dentists, and pathologists.

Our study was performed on 38 LP patients who presented to the dermatology outpatient department with oral and/or genital mucosal involvements. All skin, oral, and genital region lesions were histopathologically evaluated and the LP diagnosis confirmed. The age range of these patients was 17–75 years with a mean age of 41.8 years. The disease duration varied between one month and 10 years with a mean value of 5.8 months. Of the 38 LP patients, there were skin lesions in 30 (78.9%), oral lesions in 29 (76.3%), and genital mucosal lesions in 27 (71.0%) [Figures 1-3]. Five (13.1%) patients had exclusive oral mucosal involvement. The oral lesions were accompanied by skin lesions in 23 (60.5%) patients. There were both oral and genital involvements in 18 (47.4%) cases. Seventeen patients had concurrent oral, genital, and skin involvements.

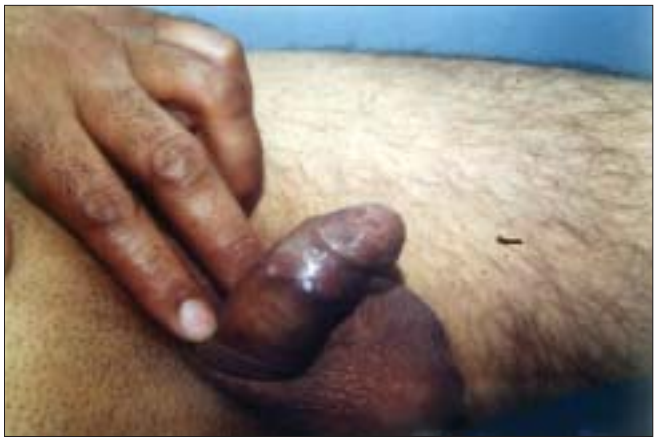

Figure 1: Genital lichen planus in a male patient

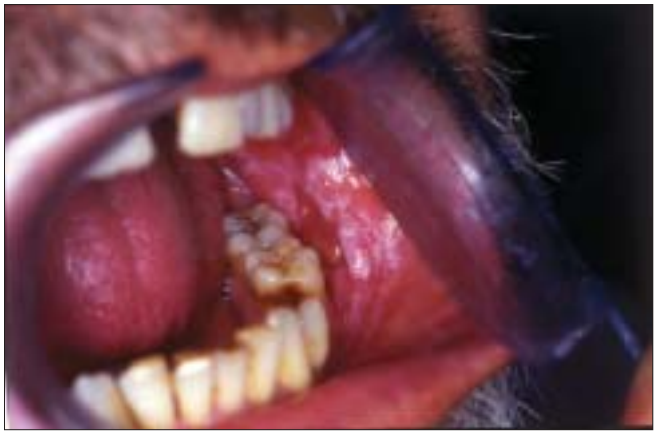

Figure 2: Oral lichen planus in same male patient

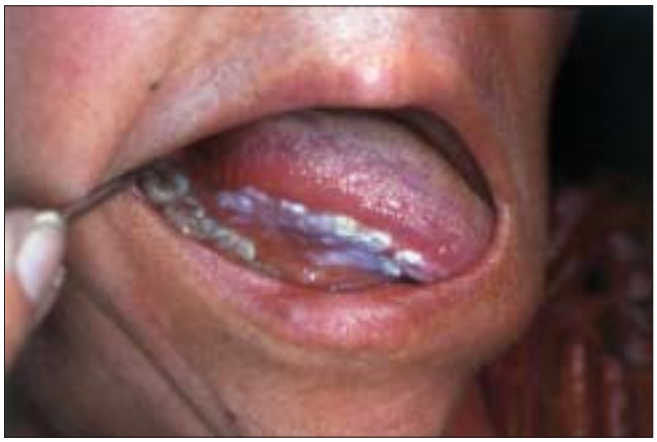

Figure 3: Oral lichen planus in female patient

There was buccal involvement in 26 of the 29 (89.7%) patients with oral mucosal involvement, gingival involvement in eight (27.6%), and glossal involvement in two (6.9%). The lesion was papuloreticular in 22 (84.6%) of the patients with buccal involvement. There was bilateral involvement in 20 patients (76.9%). Erosive type OLP was present in two patients. Genital involvement was present in 22 of 26 (85%) male patients and five of 12 (42%) female patients. The male patients included 15 (68.2%) with glans lesions, 19 (86.4%) with shaft lesions, and five (22.7%) with scrotal lesions. These lesions were papular in 19 (86%) patients, annular in five (22.7%) patients, and erosive in three (13.6%) patients. All annular lesions were located on the glans. The LP lesions were located in the vulva in four of the five (80%) female patients with genital involvement and in the vagina in one.

GLP was found histopathologically in 3.7% of 3350 patients with vulvar biopsies.[3] This rate was reported as 25% in another study on 723 OLP patients.[4] Lewis, *et al*. have found vulvar lesions in 19 (51%) of 37 LP patients.[5] Belfiore *et al*. found vulvar LP (VLP) in 57% of 42 patients, and the higher rate compared to previous studies was thought to be due to the low number in other studies.[3] Genital lesions are usually discovered after oral lesions as they can also be present in completely asymptomatic patients. They have confirmed clinical VLP histopathologically in 11 of 12 asymptomatic patients.[3]

There was a high percentage (47.4%) of concurrent oral and genital involvement in our study. In contrast to previous studies, we found skin involvement in most (79.3%) of the OLP patients. The genital region involvement in male OLP patients was higher than for females, but there was no statistically significant difference. We found no relation between OLP lesion localization and genital mucosal involvement. The rate of genital involvement was not different between OLP patients with skin involvement and those without, with no difference for gender either.

The high rate of skin involvement in our OLP cases in contrast to previous studies may be due to the fact that OLP patients frequently present at ear–nose–throat or dentistry outpatient departments for their first examination and skin lesions may be overlooked. The presence of concurrent oral/genital lesions at a high rate in our study has indicated the need for evaluating all mucosae even if there are no related symptoms or skin involvement. Therefore, we want to emphasize the importance of dermatologists contacting other specialties and ensuring regular follow-up of LP cases.

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REFERENCES

1. Boyd AS, Neldner K. Lichen planus. J Am Acad Dermatol 1991;25:593-619.
2. Eisen D. The evaluation of cutaneous, genital, scalp, nail, esophageal, and ocular involvement in patients with oral lichen planus. Oral Surg Oral Med Oral Pathol Oral Radiol Endod 1999;88:431-6.
3. Belfiore P, Di Fede O, Cabibi D, Campisi G, Amarù GS, De Cantis S, *et al*. Prevelance of vulval lichen planus in a cohort of women with oral lichen planus: An interdisciplinary study. Br J Dermatol 2006;155:994-8.
4. Lewis FM, Shah M, Harrington CI. Vulval involvement in lichen planus: A study of 37 women. Br J Dermatol 1996;135:89-91.
5. Eisen D. The clinical features, malignant potential and systemic associations of oral lichen planus: A study of 723 patients. J Am Acad Dermatol 2002;46:207-14.