LICHEN PLANUS ACTINICUS
(A case report)

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Summary

A case of lichen planus actinicus in a soldier is reported. The case is presented with all the accepted features of this entity. Histopathology confirmed the diagnosis of lichen planus. Role of sunlight as inducing agent is stressed.

Lichen planus was first described by Erasmus Wilson in 1869 (Quoted by Ormsby and Montgomery 1945[1]). Subsequently as varying morphological patterns were noted, different forms of lichen planus were described by many dermatologists, the basic histopathological pattern remaining similar in all of them. In tropical and subtropical regions, a distinct variant has been described known as lichen planus actinicus[2,3,4]. The lesions of lichen planus actinicus develop on exposed areas of skin and are presumed to be light induced. Itching may be the subjective symptom and varies in intensity. A combination of different morphological patterns may be found[5].

Case Report

A 30 years old soldier first noticed a few mildly itchy, erythematous papular eruptions on face, sides of neck, extensor aspects of forearms and dorsa of hands, in December '75. Gradually the eruptions became violaceous and more lesions appeared. On interrogation, he gave history of having been exposed to the sun, 4-6 hours daily for two months before appearance of the eruptions while doing an outdoor course. No history of drug intake, fever, trauma, etc., was present. On examination multiple, violaceous, flat topped, both discrete and confluent, glistening lesions were detected on forehead, nose, malar area of face, sides of neck, extensor aspects of both forearms and dorsa of hands. Lesions on forehead showed depressed hyperpigmented atrophic centre with lichenoid papules on periphery, while a few larger annular lesions were also seen on face. Mucous membranes and covered areas of the body were free (Fig. 1, 2, 3 and 4 Page No. 35,36). General and systemic examination did not reveal any abnormality.

Routine investigations revealed no abnormality. STS were non-reactive. Histopathological findings in a section of the skin were consistent with the clinical diagnosis of lichen planus.

Comments

In a study of 131 cases of lichen planus in Jerusalem, Dostrovsky and

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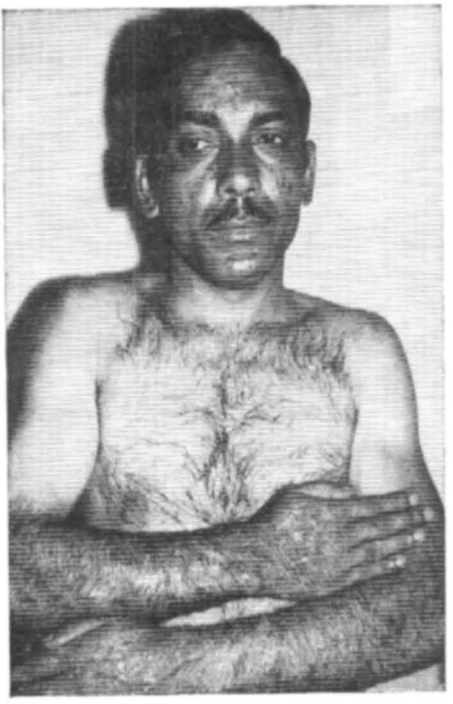


Fig. 1 Lichen planus actinicus showing sparing of covered areas of the body.

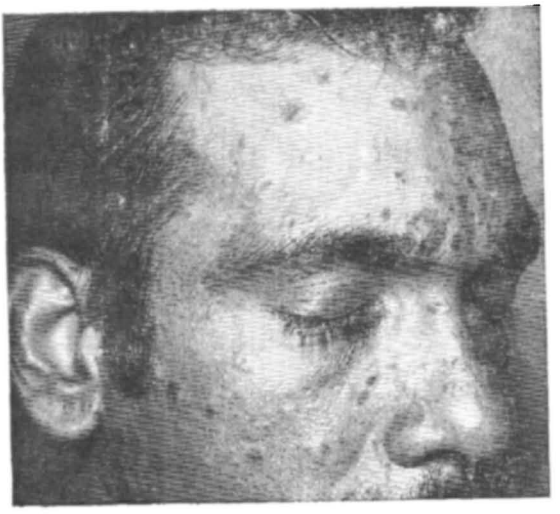
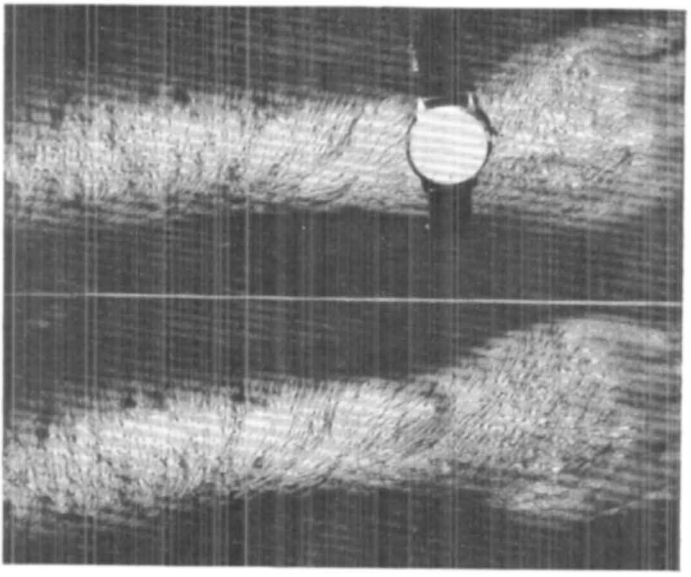


Fig. 2 Annular lesions on forehead and cheeks (Sun-tanned areas)



Figs. 3 & 4 Lichen planus actinicus Shiny violaceous papules on the dorsa of hands. Note sparing of area covered from light by the watch.

Sagher[2] detected 51 cases (38.9%) of lichen planus actinicus in whom slightly itchy annular lesions were found to be confined to forehead and dorsa of hands. EL Zawahry[3] described similar cases under the title of lichen planus tropicus. 40% of the total cases of lichen planus observed by EL Zawahry were of this variety. Mounta Dilaimy[6] has recently reported 20 cases of lichen planus with similar morphology and has suggested the title 'lichen planus subtropicus' to this entity. Annular configuration with threapy rolled border and dark bluish brown centre is taken to be characteristic of these lesions. Almeyda[4] recorded a case of lichen planus actinicus in England following a holiday in Greece, who also presented with all the accepted features of this entity except involvement of forehead. The lesions may be pigmented, dyschromic or like granuloma annulare. In the case reported, dyschromic lesions were not seen. Some cases may show evidence of irradiation injury and resemble discoid lupus erythematoses or actinic dermatitis[7]. Although the lesions develop on exposed areas of the skin and are presumably light induced, no specific wave lengths responsible for this have been delineated so far[8].

In India cases of lichen planus falling under 'actinicus' variety are also seen by dermatologists. However, there is paucity of such recorded cases from this land. It is felt that unless this possibility is kept in mind, cases may pass off as simple lichen planus and a word of caution to prevent the deleterious effects of light on exposed parts may not be conveyed to the patients.

Treatment shortens the course of this condition to about 4-6 months[6]. Use of grenz rays, X-rays and bismuth has been reported to be of some use[9]. Diliamy did not observe any benefit from antimalarials[6]. Griseofulvin has

been shown to be beneficial in lichen planus[10] but it is also a known photosensitizer. In view of the light-induced nature of lichen planus actinicus and potential photosensitivity of Griseofulvin, this drug was not used in our case. Lesions exhibited improvement by using sunscreening agents only. Intralesional administration of steroids accompanied by sunscreen agents is reported to be the best treatment[6]. We have observed this patient for the last one year and have not detected further activity or relapse of skin lesions, with the observance of routine precautions against sunlight.

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