LETTERS TO THE EDITOR

Pulse steroid therapy in generalized *lichen planus*

To the Editor:

Intermittent corticosteroid megadose therapy (pulse steroid therapy) is now being used with increasing frequency in a number of dermatological disorders of immune origin.[1-3] Although etiology of lichen planus remains elusive, several observations suggest that altered immune function is involved in development of clinical lesions.[4] There are only sporadic reports of use of megadose steroid in this condition.[5] We would like to share our experience of successful use of pulse steroid therapy in an elderly female of recalcitrant generalized lichen planus. This 50 -year-old female first developed lichen planus lesions 7 years back. Since then she had suffered periodic exacerbation and remissions. In preceding one year, there was an increase in extent and severity of the eruption. Past therapies included topical steroids, oral antihistaminics and intermediate to high dose of oral and intramuscular steroids for reasonably prolonged period but none was found to have any lasting effect on her lesions. It was then decided to give her steroids in pulse form (Inj. dexmethasone 50 mg dissolved in 5 per cent dextrose solution and given I.V. slowly for 3 consecutive days). All precautions were taken prior to institution of such high dose steroid (serum electrolytes, ECG, X-ray). No other concomitant medicine was allowed, except use of emollients. Within one week of institution of pulse steroid, her lesions started regressing. Itching was reduced by about 90 per cent and she had comfortable night sleep. In her words, she never had it so good. Remission was maintained till about 3 weeks, when a few new active lichen planus lesions reappeared. At that point of time another round of dexamethasone pulse (3 injections of dexamethasone 50 mg i.v. on consecutive days) was repeated. This effectively controlled minor exacerbations. To our surprise, for another 4 months patient was in complete remission, free of any medications, except using moderately potent topical steroids. She continues to be in remission only with hydroxyzine (25 mg three times daily) and topical steroid. Our case illustrates the point that in many cases of generalized lichen planus where oral steroids prove to be ineffective, attempt to induce remission with pulse steroid is worth a trial. It could just be that it breaks the "therapeutic dead lock".

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References

1. Johnson RB, Lazarus GS. Pulse therapy: Therapeutic efficacy in treatment of pyoderma gangrenosum. Arch Dermatol 1982; 118: 76- 84.

2. Hess EV, Harmmen PL. Pulse therapy in rheumatoid arthritis. Ann Intern Med 1981; 94: 128-129.

3. Pasricha JS, Thanzama J, Khan UK. Intermittent high dose dexamethasone cyclophosphamide therapy for pemphigus. Br J Dermatol 1988; 119: 73-77.

4. Taaffe A. Current concepts in lichen planus. Int J Dermatol 1975; 18: 533-538.

5. Snyderj R A, Schwartz R A. Intermittent megadose corticosteroid therapy for generalized lichen planus. J Am Acad Dermatol 1982; 6: 1089-1090.