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Clinical and Dermoscopic Features of a Rare Variant : Actinic Lichen Planus

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Dear Editor,

Actinic lichen planus is considered as an uncommon photosensitive variant of lichen planus affecting primarily on sun-exposed areas [1]. It typically presents in the summer time in patients of Middle Eastern descent [2]. Herein we aim to present the clinical and dermoscopic features of a case of this rare disorder in a young man with dark skin.

A 25-year-old Fitzpatrick type V Ghanaian immigrant presented with 4 years' history of asymptomatic pigmented lesions of forehead. The patient reported onset of lesions in the summer and complete regression in the winter. He had no significant medical history and was not taking any medications. The clinical examination revealed several confluent pigmented papules, forming large pigmented verrucous plaques of the forehead [Figure 1,2]. The dermoscopy had objectified hyperpigmented follicular opening with multiples rosettes. Wickham striae pattern and vascular patterns were not observed [Figure 3]. There were no oral, nails or others skin lesions. Metabolic panel, lipid panel, hepatitis serology and antinuclear antibody were normal. A skin biopsy was performed. The histological examination confirmed the diagnosis of actinic lichen planus [Figure 4]. The patient was treated with tacrolimus 0.1% ointment twice daily. The outcome was favorable.

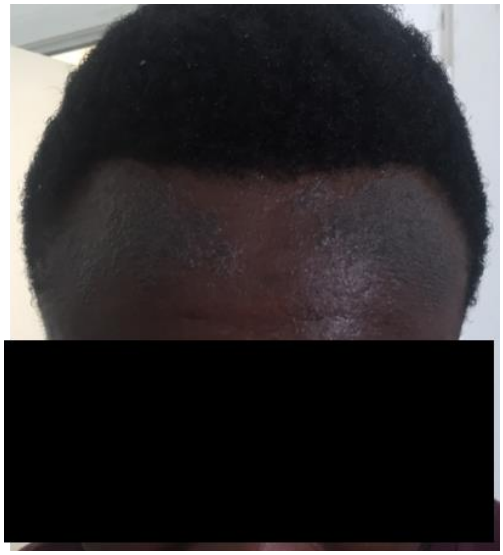

Figure 1: Several confluent pigmented papules of the forehead.

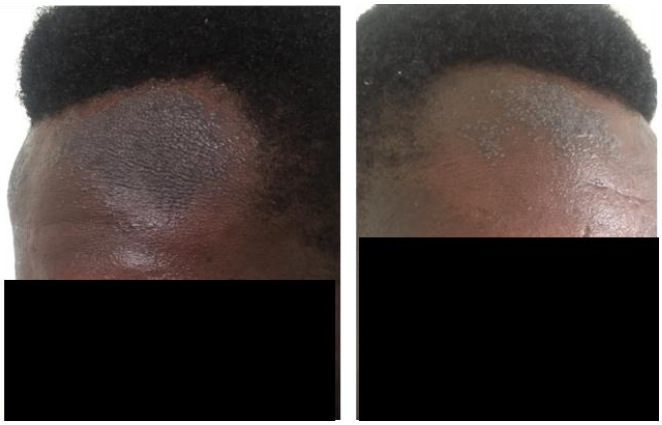

Figure 2: Large pigmented verrucous plaques.

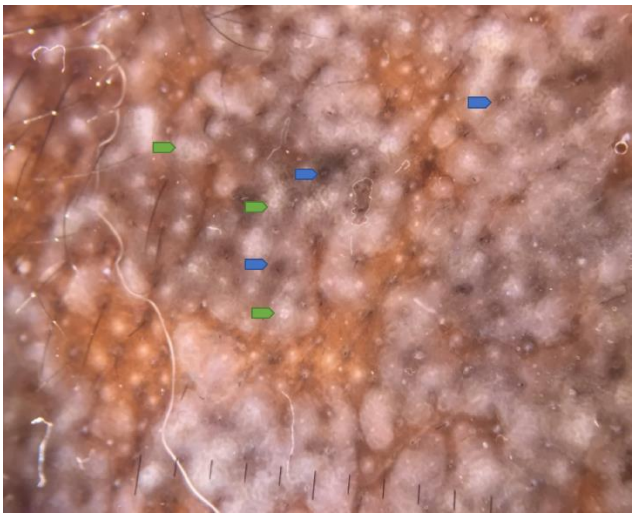

Figure 3: Dermoscopy showing hyperpigmented follicular opening (blue arrows) with multiples rosettes (green arrows).

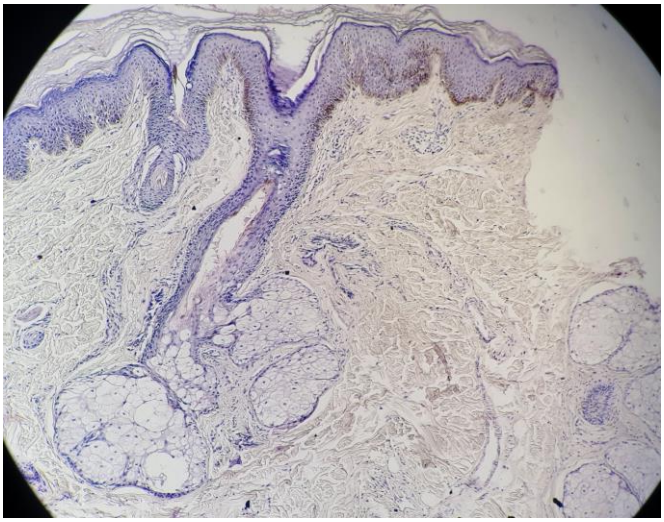

Figure 4: Histological findings showing hyperkeratosis with focal parakeratosis, hyper granulosis, a marked lymphocytic band infiltrate, Civatte bodies and pigmentary incontinence.

Actinic lichen planus is a rare clinical variant of lichen planus that has been reported with a variety of different names: lichen planus subtropicus, lichen planus tropicus, summertime actinic lichenoid eruption, lichenoid melanodermatitis, and lichen planus actinicus [2]. It most commonly occurs in dark complexioned individuals (mainly phototype IV), and in most reported cases the patients are from the Middle East, India and Tunisia, with only a few cases reported in Caucasian patients [3]. The pathogenesis has not been well established, but sunlight appear to be the major triggering factor. The geographical predilection of the condition would suggest that genetic factors and subtropical climates may be involved [2,3]. The eruptions often occur in the spring or summer and involve sun- exposed areas, most commonly the face [2]. Four morphologic patterns have been described. In order of frequency, these are annular hyperpigmented plaques, classic lichenoid papules, a hyperpigmented pattern, and dyschromic papules [2,3]. The classical presentation is gradual development of annular hyperpigmented atrophic plaques mostly over face, surrounded by a hypopigmented halo. Of note, mucosal involvement, pruritus and koebnerization are usually absent in this variant, unlike in classical form [1]. In our case, the patient presented pigmented lesions resembling to the classic lichenoid papules. The dermoscopic feature of ALP is a diffuse peppering pigment pattern arising on a brown background that is seen in the early phase of ALP, fading in color without other identifiable features (absence of Wickham striae pattern and vascular patterns); hyperpigmented follicular openings and isobar sign may be present [4]. The dermoscopic examination of the lesions in our patient revealed an unusual finding that is rosettes. These rosettes correspond histologically to hyperkeratosis. The histopathological findings are like that of the classic lichen planus: Hyperkeratosis with focal parakeratosis, hyper granulosis, a marked lymphocytic band infiltrate, Civatte bodies and pigmentary incontinence are commonly observed [3,4]. Pigmented ALP presents a variable degree of solar elastosis and tends to thinning of the epidermis at the center of the lesion with striking pigment incontinence in the upper dermis and melanophages. Epidermal atrophy may be prominent [4].

Treatment strategies first call for photoprotection with broad spectrum sunscreens [1]. Topical or intralesional glucocorticoids, hydroxychloroquine and dapsone have been used. Treatment with the use of Grenz rays, x-rays, and bismuth have been reported as somewhat effective. Some cases improved with acitretin in combination with topical steroids or cyclosporine for the refractory cases [1,2,4].

The diagnosis of ALP may be difficult to make in the absence of oral, hair, nails and other skin lesions, such as our patient. To our knowledge, this is the second report in literature of a Pigmented ALP described with dermoscopy.

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