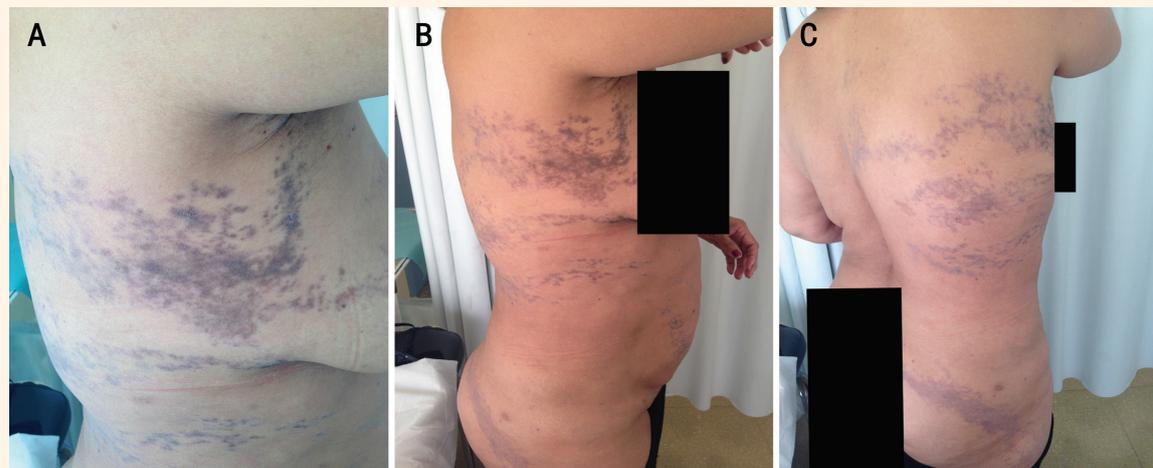


## Lichen *Planus Pigmentosus* with Blaschkoid Distribution

María J. Alonso-Corral,<sup>1</sup>\*Cristina Garrido-Colmenero,<sup>2</sup> Ana Almodovar-Real,<sup>3</sup> Ricardo Ruiz-Villaverde<sup>2</sup>

### الحزاز المسطح المصطبغ مع البلاشكويد

ماريا خوسيه ألونسو-كورال، كريستينا غاريدو-كولمنيرو، آنا المودوفار-ريال، ريكاردو رويز-فيلافيردي



**Figure 1A–C:** Hyperpigmented brown macules on the (A) right submammary region, (B) right hemithorax, right abdomen and (C) right buttock of a 57-year-old woman.

**A** 57-YEAR-OLD WOMAN PRESENTED AT A dermatology unit in Granada, Spain, in 2015 with a two-month history of slightly pruritic brown-coloured macular lesions on the trunk and right arm. She was not taking any medications or using cosmetics and had not been exposed to the sun before the onset of the rash. On examination, clearly defined hyperpigmented brown macules were seen on the right submammary region, right hemithorax, right abdomen and right buttock [Figure 1] with an S-shaped appearance, compatible with the pattern of Blaschko lines. Tests for hepatitis B and hepatitis C were negative. A histological examination showed rich lymphocytic infiltrate and melanin incontinence with slight epidermal atrophy and lichenoid reaction with hypergranulosis [Figure 2]. Considering these features, a diagnosis of lichen *planus pigmentosus* (LPP) with Blaschkoid distribution was proposed. The patient was prescribed topical clobetasol propionate for four weeks. The lesions responded well to the treatment,

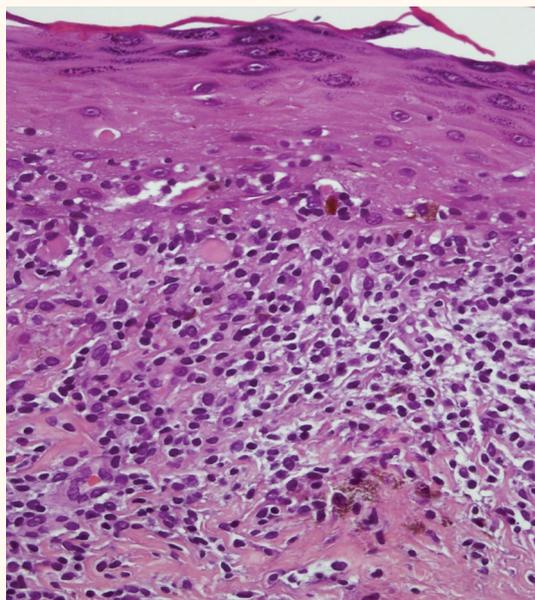
with significant pigment reduction and improvement of the associated pruritus.

### Comment

Various triggering factors, ranging from viral infections and vaccinations to trauma, have been implicated in the aetiology of lichen *planus*.<sup>1</sup> A rare variant of lichen *planus*, LPP is distinguished by hyperpigmented macules or papules. The histological characteristics of LPP include epidermal atrophy, vacuolar degeneration of the basal cell layer and rich dermal lichenoid infiltrate.<sup>2</sup> Kanwar *et al.* suggested that LPP may represent a lichenoid reaction to an unknown agent or stimuli, with regards to the histological concordance between LPP and lichen *planus*.<sup>3</sup> The differential diagnosis of LPP includes conditions such as lichen *striatus*, erythema dyschromicum *perstans*, *incontinentia pigmenti*, linear and whorled nevoid hypermelanosis, occupational

<sup>1</sup>Dermatology Unit, Complejo Hospitalario Torrecárdenas, Almería, Spain; <sup>2</sup>Department of Dermatology, Virgen de las Nieves University Hospital, Granada, Spain; <sup>3</sup>Dermatology Unit, Hospital Universitario San Cecilio, Granada, Spain

\*Corresponding Author e-mail: cristinagarrido86@gmail.com



**Figure 2:** Haematoxylin and eosin stain at x10 magnification showing rich lymphocytic infiltrate and melanin incontinence with light epidermal atrophy and lichenoid reaction with hypergranulosis.

dermatosis with hyperpigmentation and drug-related melanoses.<sup>4</sup> In the current case, these differential diagnoses were not considered as there was no history of inflammatory processes before the beginning of the hyperpigmentation.

The most frequent variant of LPP is linear, as was observed in the current case, with zosteriform or Blaschkoid LPP being much less common.<sup>5</sup> The distribution of LPP along the Blaschko lines was first described by Taniguchi *et al.* in 1993.<sup>6</sup> Dispersed

lesions of classical lichen *planus* can also occur over the Blaschko lines.<sup>7</sup> The majority of LPP lesions are usually distributed in areas exposed to the sun; trunk lesions, such as those observed in the present case, are rarely observed.<sup>8</sup> Both topical and oral treatments for LPP have been used with varying results, including topical steroids, keratolytics, tacrolimus, griseofulvin, prednisone, etretinate and chloroquine.<sup>3,4</sup>

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