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LICHEN SCEROSUS ET ATROPHICUS IN A FEMALE- A CASE REPORT

Dermatology

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ABSTRACT

Lichen sclerosus is known to be an inflammatory disorder of unknown etiology affecting people from 6 months of age to late adulthood. It includes disorders known as lichen sclerosus et atrophicus, balanitis xerotica obliterans (LS of male glans and prepuce and Kraurosis vulvae (LS of female labia majora, labia minora, perineum and perianal region) [1]. By menarche many cases of childhood LS in girls resolve. If lesions persist then atrophy of labia and narrowing of vaginal orifice may follow[2]. Severe scarring may follow and vulval cancer is a rare complication. It usually affects the anogenital area with extragenital lesions occurring in 15-20% of patients[3].

KEYWORDS

Lichen sclerosus, Lichen sclerosus et atrophicus, Kraurosis vulvae

INTRODUCTION:

Lichen sclerosus is a dermatoses which may affect any part of the body, most commonly the genital and anogenital area. Its aetiology is unknown but various factors are thought to be involved[4]. Autoimmunity plays a very important role. There are clinical and histopathological associations between lichen sclerosus and morphea[5]. Edema like feature is seen in the upper dermis but is commonly described as homogenised collagen. Typically LSEA affects the vulval region and extends down to the anal region giving it the figure of eight or keyhole or hourglass appearance. Lichen sclerosus et atrophicus of the vulval region should be considered as a precancerous condition as this may sometimes go in for malignancy.

CASE REPORT:

36 year old female patient came to the dermatology opd with complaints of depigmented lesion over the genitalia since one year. It started as a small papule and progressed to the present size and shape. Intense pruritis was present. H/o small depigmented lesions were just starting to occur over the trunk and shoulder since 3 months. No significant family history. No h/o atopy. No h/o similar complaints in the past. No h/o dyspareunia, dysuria. No h/o urinary or fecal incontinence. No h/o weight loss or loss of appetite.

On examination: A depigmented atrophic plaque is present over the left side of the labia minora. The plaque was found to be extending down to the perianal area. The surface of the skin was wrinkled and it was found to be indurated in a few places. No erosions, fissuring or ulceration seen.

Biopsy was done which revealed hyperkeratosis, parakeratosis and basal cell degeneration. Dermal edema was seen in the upper dermis along with inflammatory infiltrate in the mid-dermis.

DISCUSSION:

Clasically the eruption of LSEA consists of porcelain white coloured papules which gradually coalesce to form plaques which then become atrophic[6]. Follicular hyperkeratosis is an important feature as it helps to distinguish it from morphea. Lichen sclerosus et atrophicus has predilection for the anogenital area and causes atrophic lesion of the vulva. Koebner's phenomenon is said to be well established in LSA[7]. Adults with vulvar LSA are predisposed to squamous cell carcinoma.

In pre-pubertal girls this condition can be confused with sexual abuse. On the other hand sexual abuse and trauma may trigger the onset of LS. Genital LSEA is associated with anal lesions in 30% of cases. Extra genital lesions affected by LSEA are arms, trunk, neck and face. They can occur on pre-existing scars and damaged areas. Lesions can follow blaschko's lines or can occur in a zosteriform distribution.

Histopathological findings include hyperkeratosis with follicular plugging, basal cell degeneration, flattening of rete ridges, pronounced edema and homogenisation of collagen in upper dermis and inflammatory infiltrate is found in the mid dermis. This is differentiated from morphea based on the absence of elastic fibres, basal cell degeneration and presence of follicular plugging

The most common differential diagnoses are guttate morphea and atrophic lichen planus. Ano genial LSA is usually confused with vitiligo, lichen simplex chronicus, vulval intra-epithelial neoplasia and genital lichen planus.

Treatment includes mainly to treat the symptoms, heal the cutaneous symptoms, reduce scarring and to prevent or detect malignant change. Few of the treatment options include topical corticosteroids, emollients, topical calcineurin inhibitors, topical tretinoin, intralesional triamcinolone, topical calcipotriol, cryosurgery, oral stanazolol, PUVA and UVA1 phototherapy.

CONCLUSION:

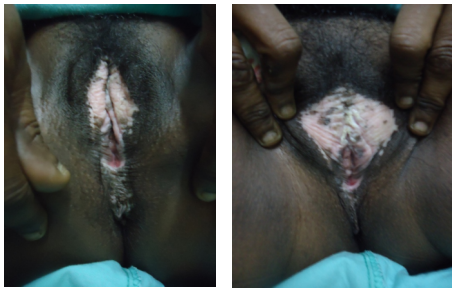
Lichen sclerosus et atrophicus is a chronic condition and occasionally spontaneous resolution can occur especially in girls around menarche and extragenital LS lesions occuring before 30 years of age. We hereby report this case for its rarity in occurence.

ACKNOWLEDGEMENT: None

CONFLICT OF INTEREST: The authors declare that they have no conflict of interest.

LEGENDS TO FIGURES:

Figures: Clinical photographs showing depigmented atrophic plaque.



HISTOPATHOLOGY:

Figure 1: Histopathology showing hyperkeratosis, parakeratosis and basal cell degeneration

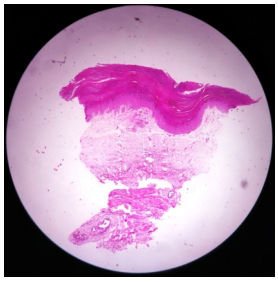
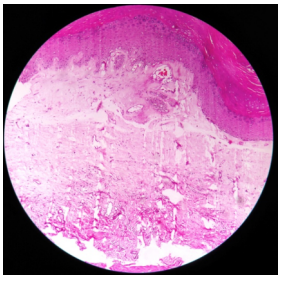


Figure 2: Basal cell degeneration, dermal edema and inflamm atory infiltrate (mid dermis)



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