To the Editor:

Atrophic lichen planus with verrucous epidermal naevus

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Introduction

Verrucous epidermal naevi consist of hyperplasia of the surfaced epidermis and typically appear as verrucous papules that coalesce to form well demarcated, skin coloured to brown, papillomatous plaques. Most lesions present at birth but some develop during childhood and generally reach a stable size at adolescence. A region of skin with a mosaic change would predispose to the development of lichen planus, psoriasis, or other disorders. Few reports describe lichen planus over the epidermal naevus including lichen planopilaris[1,2,3]. We report a patient with verrucous epidermal naevus associated with atrophic lichen planus which responded to oral retinoid treatment.

Case

A 37-yr old female complained of pigmented hyperkeratotic plaques on the body since childhood; which has started from the left leg and spread all over the body in a linear manner including face, scalp and genitalia with recent involvement of palms and soles. She gets new lesions at sites of trauma. She has itching with erythema on sun exposure and no family history of similar illness.

She had linear and scattered hyperkeratotic pigmented plaques with thread like edges with scattered atrophic centres following ulceration, and pigmented verrucous plaques on the legs extending on to the soles associated with nail changes of pterygium, and nail dystrophy. There were no oral lesions.

Skin biopsy revealed parakeratosis, basal cell damage, and pigment incontinence with evenly distributed upper dermal chronic inflammatory cells suggestive of atrophic lichen planus. The histology of verrucous lesions over the leg showed hyperkeratosis, bands of parakeratosis alternating with orthokeratosis, hypergranulosis in the epidermis with mild perivascular infiltrate in the upper dermis suggesting an epidermal naevus.

The diagnosis of atrophic lichen planus associated verrucous epidermal naevus was made.

Treatment of widespread epidermal naevus and atrophic lichen planus is difficult. Topical applications are rarely curative and she had been using local therapy with very poor response. Cosmetically significant, extensive, newly appearing lesions may justify systemic retinoid therapy. Etretinate and acitretin can produce worthwhile reduction of hyperkeratosis in epidermolytic lesions. She was started on oral acetrecin monthly pulse therapy (0.5 mg per kg body weight daily for seven days once a month) with a marked improvement. Usually treatment could clear the overlying skin condition, even though the underlying mutation remains.

Figure 1. *Hyperkeratotic linear plaques.*

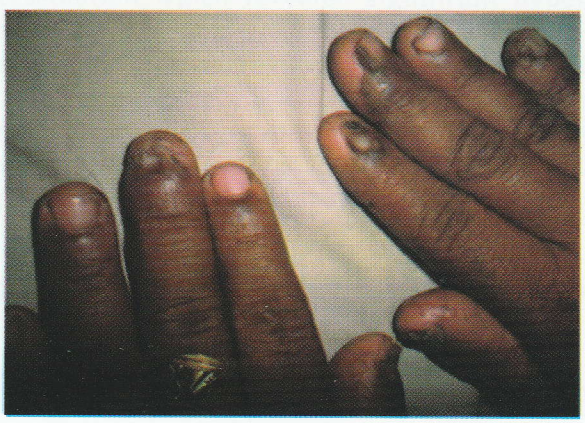

Figure 2. *Nail dystrophy and pterygium.*

References

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