

Lichen striatus on adult

Líquen estriado no adulto

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Abstract: Lichen Striatus is an uncommon inflammatory skin eruption of unknown etiology. It rarely affects adults, and it is characterized by abrupt onset of coalescent papules, in a linear disposition, usually on the extremities. Histopathology shows lichenoid reaction involving follicles and glands. Occasionally, there is overlap with linear lichen planus and "blaschkitis", the main differential diagnoses. It is reported here the case of an adult woman with erythematous violaceous papules on the right side of the neck and face, diagnosed with lichen striatus by clinical and histopathological correlation. The atypical findings and the diagnostic difficulty are discussed.

Keywords: Lichenoid eruptions; Pathology; Skin diseases, papulosquamous

Resumo: Líquen estriado é uma erupção inflamatória incomum, de etiologia desconhecida. Raramente acomete adultos, e é caracterizada pelo surgimento abrupto de pápulas coalescentes, em arranjo linear, usualmente em extremidades. A histopatologia mostra reação liquenóide envolvendo folículos e glândulas. Ocasionalmente há sobreposição com líquen plano linear e "blaschkitis", seus principais diagnósticos diferenciais. Relata-se um caso de mulher adulta com pápulas eritematovioláceas em região cervical e hemiface direitas, cuja correlação clínico-histopatológica permitiu o diagnóstico de líquen estriado. Os achados atípicos e a dificuldade diagnóstica são discutidos.

Palavras-chave: Dermatopatias papuloescamosas; Erupções liquenóides; Patologia

INTRODUCTION

Lichen striatus (LS) is an uncommon dermatosis, generally self-limited, that affects mainly children, being rare reports in adults. Its incidence is slightly higher in women.^{1,2} Its etiology is unknown but it is considered, by many authors, as a manifestation of mosaicism, characterized by the presence of clones of epithelial cells genetically abnormal that through a precipitating event can be recognized by the immune system and induce the affected skin to generate an inflammatory response T-cells mediated, apparent in Blaschko lines.^{3,4} So, it is believed that infections and environmental factors are involved with the majority of cases occurring during Spring and Summer.^{1,2,5} Trauma, pregnancy and drugs are also reported as precipitating factors.^{2,6,7} The diagnosis is essentially clinical, however, in adults, it can be difficult to differ

from other linear dermatoses, specially Linear lichen planus with which overlaps can occur.²

We report here an atypical case of a woman, aged 21, with abrupt onset of violaceous erythematous papules linearly disposed on the neck and right hemifaces, which also suggested the suspicion of linear lichen planus. However, histopathology confirmed the diagnosis of (LS).

CASE REPORT

Female patient, aged 21, presented 5 months before abrupt onset of asymptomatic redish papules on the hemiface, right ear and cervical area that over weeks acquired a purple color. The patient had been taking oral contraceptives for two months but denied use of any other medication prior to the condition.

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She presented serology for hepatitis B and C, HIV and laboratory exams normal. It was observed, when the patient was clinically examined, the presence of violaceous erythematous papules slightly high and rough, coalescent, in linear disposition, located on the right of the cervical and frontal regions, on the right cheek and also on the right ear lobe. (Figures 1 and 2). There was no ungual or mucous involvement.

Histopathology from two sites showed chronic lichenoid dermatitis, with outbreaks of dermal aggression, vacuolar degeneration of the basal layer, multiple necrosis of keratinocytes and decrease of melanin pigment, the lymphocytic infiltrate also affected the deep dermis in an adnexial disposition (Figures 3 and 4). Three months after the first medical appointment it was observed spontaneous regression of the lesions, without changes in pigmentation.

DISCUSSION

Lichen striatus, also called linear lichenoid dermatosis is the appearance of violaceous erythematous papules or hypopigmented papules, with smooth surface or mild peeling, that vary from 2 to 4 mm, that coalesce in linear disposition, forming a band that can be discontinuous, following Blaschko lines and that usually are not pruritic.^{1,3,5} It is typically unilateral, generally affecting one extremity, being unusual the occurrence on the chest or face, as in the case reported here.¹ It has an abrupt onset but its duration is self-limited, with spontaneous resolution of the condition within 12 months, most of the times.^{1,3} Occasionally, there are ungual changes like longitudinal striations, thinning of the ungual plate and onychoschizia.⁸ The most common treatment is topical corticosteroids and



FIGURE 1: Violaceous papules in linear disposition on the anterior cervical region and right frontal



FIGURE 2: Linear erythematous-violaceous lesions on the cervical region, cheeks and in the right ear lobe

there are reports on the satisfactory use of tacrolimus and pimecrolimus for persistent cases.⁹ The regression of lesions may result in residual hypopigmentation, especially in individuals with a high phototype.^{1,3}

Very controversial in the medical literature is the adult “blaschkitis”, proposed by Grosshans and Marot in 1990¹⁰ as a rare and distinct entity from LS. It is an acquired inflammatory linear eruption generally described in adults, consisting of pruritic papules and vesicular eruptions along the ipsilateral lines of Blaschko, generally on the chest. It differs from classically described LS for its quick resolution and frequent recurrence.^{2,3} Besides that, the histopathology corresponds more to a dermatitis spongiotic than to lichenoid, different from LS, in which the lichenoid alterations predominate.^{3,11} However, “blaschkitis” as a

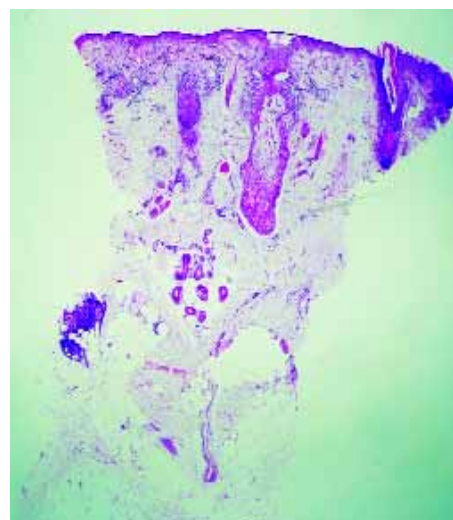


FIGURE 3: Superficial and deep chronic dermatitis, with outbreaks of adnexial, follicular, epidermal lichenoid. HE 100X

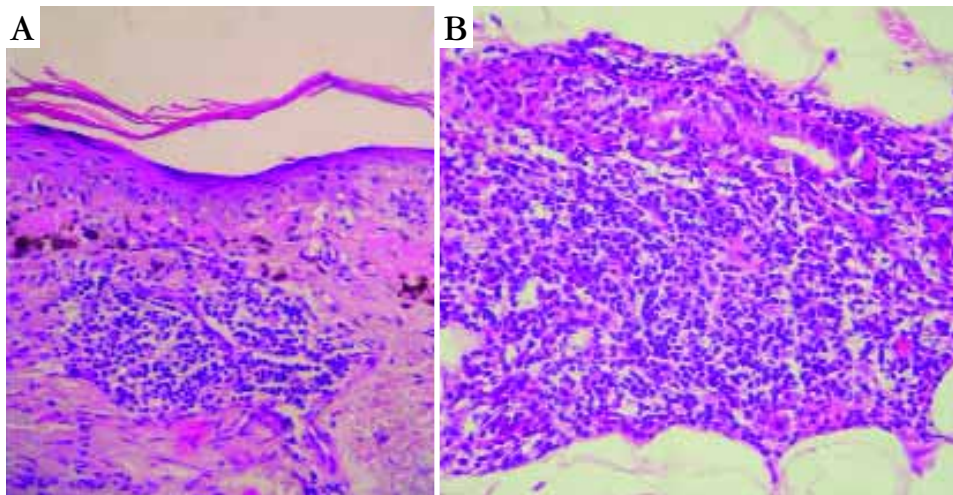


FIGURE 3: A: Skin with epidermal atrophy, hyperparakeratosis, vacuolar degeneration of the basal layer, necrosis of keratinocytes, decrease of melanin pigment and focal lichenoid lymphocytic infiltrate. HE 200X. **B:** In the deep dermis, intense aggression of sweat duct by focal lymphohistiocytic infiltrate. HE 400X

new nosologic entity is not accepted by all scholars. Hofer suggests its non-classification as a new disease or entity, due to the subtle criteria that distinguish it from LS.¹¹ Reiter et al consider it as only a variation.¹² Some authors propose that “blaschkitis” and LS exist in a proposed spectrum named “Blaschko-linear acquired inflammatory skin eruptions” (BLAISE), once its findings are, many times, similar and difficult to differentiate mainly when the vesicular and spongiotic components are less significant.²⁻⁴ Anyway, it is believed that the case reported here corresponds to LS of difficult diagnosis but without the characteristics of “blaschkitis”.

It is important to differentiate LS from other acquired inflammatory dermatosis that may follow the lines of Blaschko, like the lichenoid eruption the drug, disease graft-versus-chronic host lichenoid, lupus erythematosus, psoriasis and atopic dermatitis. However, we emphasize linear lichen planus as its main differential diagnosis.^{1,3}

Different from lichen planus that presents lichenoid infiltrate in stripe in the papillary dermis, the histopathology of lichen striatus shows focal lymphohistiocytic infiltrate and lichenoid, with deep and superficial adnexal involvement.^{1,13} Besides that, there

are other differential histopathological changes like intercellular edema, exocytosis and parakeratosis in general absent in lichen planus and present in the case described here.^{1,4,13} Additionally, linear lichen planus differentiates itself from the striatus for being pruritic, with lesions that also follow the lines of Blaschko, but that are violaceous and polygonal and present Wickham’s striae.^{1,14} In the case reported here although the lesions were violaceous and linear, these findings were absent. Although the histological findings of lichen striatus are variable and their differentiation from lichen planus may be difficult in cases that are in regression, the focal changes and the extension of the infiltrate to the deep dermis, involving vessels, hair follicles and sweat glands are typical of lichen striatus and are present in this case.^{14,15}

In short, it refers to an atypical case of lichen striatus, with morphological characteristics suggesting the disease but with diagnostic difficulties due to the location of the lesions and the age of the patient. It is emphasized the importance of the clinical and histopathological correlation for the correct classification of the acquired dermatosis that follow the lines of Blaschko. □

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