Our Dermatology Online

Case Letter

Lichen planus, about an atypical location

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Sir,

Lichen planus is an inflammatory skin disease of unknown etiology that affects between 0.5 and 1% of the population [1]. Several clinical forms have been described, which may occur at the same time in the same patient [2]. Although the diagnosis of LP can be made clinically, it can sometimes be difficult and histopathological examination is necessary [3]. Lichen planus is characterized by mucocutaneous lesions, classically associated with severely pruritic, polygonal, violaceous, flat-topped papules and plaques that most commonly affects middle-aged individuals [4]. Several subtypes such as hypertrophic, bullous, atrophic, pigmentosus lichen planus have been described [5]. The diagnosis is generally easy but sometimes a histological examination is essential, which shows in the epidermis an orthokeratosis hyperkeratosis without parakeratosis on the dermal-epidermal junction and the superficial dermis. There is a lympho-histiocytic infiltrate in bands with apoptotic keratinocytes (Civatte bodies) in the form of eosinophilic colloidal bodies. Pigmentary incontinence is also observed [1]. The mammary localization is very rare, a case was reported of atrophic lichen planus annular at the mammary level [6]. Dermoscopy is a valuable tool in the diagnosis of lichen planus, it shows the presence of Whikham striae corresponding to hypergranulosis in histology, several morphological subgroups of WS have been described as reticular, circular, linear, globular, Leaf venation, Starry sky/white dots [7]. We can also find a vascular pattern made of dot and linear vessel, pigment patterns were also observed as peripheral dots/globules, peripheral homogeneous pigmentation or a pigment network. In active lichen planus, SW and vascular patterns are predominant, whereas regressive lichen or lichen under treatment is characterized by pigmentary patterns [3]. The management of classic cutaneous LP is essentially based on Class I or II topical corticosteroids, other treatments may be proposed depending on the location and severity of the lesions, including phototherapy (narrow-band UVB), topical and systemic retinoids, systemic steroids, topical tacrolimus, and cyclosporine [1]. We report the case of a young woman with an atypical localization of lichen planus in the breast mimicking a Paget's disease, the diagnosis was rectified after a complete general examination showing mucosal involvement and the typical dermoscopy of lichen

A 30-year-old female patient, with no previous pathological history, who consulted for a breast lesion that had been evolving for 6 months. The clinical examination revealed a patient of phototype III, who presented a well-limited squamous erythematous plaque measuring 7cm, atrophic in places, located on the right breast (Fig. 1a), we also noted the presence of a subcutaneous nodule of firm consistency on the same breast. we suspected initially a tumoral origin. Dermoscopic examination showed a reticular Wickham striae, erythematous background, and dotted vessels (Fig. 1b). The rest of the examination showed a whitish lichenin network in the oral and genital mucosa (Figs. 1c and 1d), which led us to think about the diagnosis of lichen. Histological examination showed hyperkeratosis, orthokeratosis with epidermal atrophy in places at the level of the dermal-hypodermal junction, a banded infiltrate made essentially of lymphocytes and histocytes, with pigmentary incontinence and vacuolization of the basal layer, in favor of a focal atrophic lichen planus (Fig. 1e). A breast ultrasound showed two reactionary breast cysts requiring a posterior ultrasound control.

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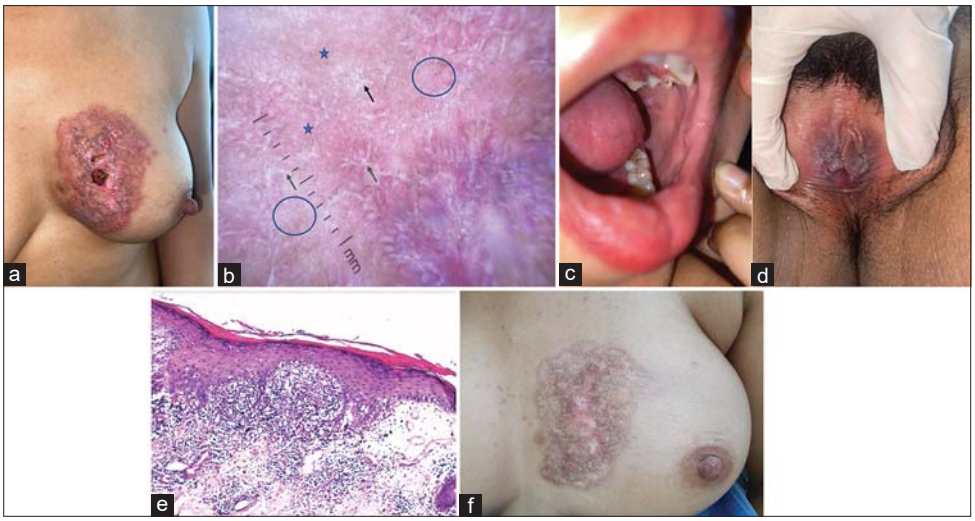

Figure 1:(a) Clinical image showing a well-limited squamous erythematous plaque measuring 7cm in long axis, atrophic in places, located on the right breast. (b) Dermoscopic image showing, a reticular Wickham striae (black arrows) erythematous background (blue asterisks), and dotted vessels (blue circles). (c-d) Clinicals images showing, a whitish lichenin network in the oral and genital mucosa. (e) Histological picture showing Interface lichenoid infiltrate with basal apoptotic keratinocytes. (f) Clinical image after treatment.

Laboratory investigations, including full blood count and liver and kidney enzymes were normal. hepatitis serology was negative. The patient was treated with topical corticosteroid creams for 2 months, with good evolution (Fig. 1f).

Consent

The examination of the patient was conducted according to the principles of the Declaration of Helsinki.

The authors certify that they have obtained all appropriate patient consent forms, in which the patients gave their consent for images and other clinical information to be included in the journal. The patients understand that their names and initials will not be published and due effort will be made to conceal their identity, but that anonymity cannot be guaranteed.

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