Case 23

A 27–years–old thai female from Bangkok

Chief complaint : White papules on left side of neck

Present illness : 6 months ago she developed white tiny papules with minimal pruritus on the left side of neck.With time the lesions progressed and coalesced into plaque.2 months ago she went to a clinic and was treated with topical antifungal twice a day.But the lesion was not improved.

Past history : Healthy,no personal history of any disease

Family history: No one in her family has the same lesion.

Physical exam : A young adult Thai women,not pale,no jaundice ,vital signs :stable

Skin exam:white ,indurated ,well-defined confluent of multiple papules , plaque 3 cm. in size and follicular keratotic plugs at left side of neck.

The other systems : unremarkable

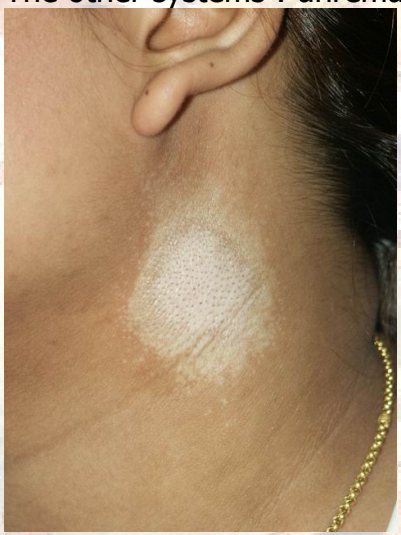

Fig 23.1

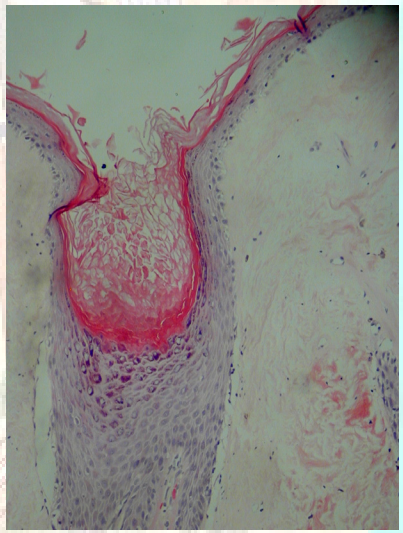

Fig 23.2

Investigation : Anti ANA –negative

Histopathology finding:(s03-13300)

Dense superficial and deep infiltration of lymphocytes, plasma cells in associated with homogenized collagen. Epidermal atrophy,hyperkeratosis

Diagnosis: Lichen sclerosus et atrophicus

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Discussion:

(synonyms: lichen sclerosus,kraurosis vulvae,balanitis xerotica obliterans)

Lichen sclerosus (LS) is a unknown chronic atrophic inflammatory disorder of the females& males anogenital and general skin (upper back, periumbilical, neck, axillae, flexor surface of wrists).It can occur in all age groups of both sexes and mostly often occur the adult females.It also increased risk to squamous cell carcinoma in genital lesion.

Lichen sclerosus is characterized by white , angular , well-defined , indurated papules , plaques and follicular keratotic plugs (known as dells). The patients usually are asymptomatic or in rarely itch in extragenital lesion. While vulvar lesion usually presents with progressive pruritus ,painful ,dysuria,dyspareuria, atrophy of labia minora,clitoral hood,stenosis of the introitus or genital bleeding. The penile LS. usually is preceded by pruritus but may become suddenly phimosis and urinary obstruction.

The primary investigation to perform is skin biopsy. Autoimmune work up is not recommended because association with LS is still questionable.

Histological finding showed a lichenoid infiltrate in the dermo-epidermal junction, compact hyperkeratosis with , dense homogenous fibrosis and edematous in the upper papillary(upper) dermis.

The treatment depends on individual cases. Asymptomatic extragenital LS usually requires no treatment except controlling of pruritus. Genital LS has various treatment. Topical potent glucocorticoids have been found to be useful in both sexes and in all age groups and should be used for 6 to 8 weeks only. Topical tacrolimus and pimecrolimus were tried with successful result in several cases. Topical androgens is not recommended now because the recent studies suggest that it may not be any more efficacious than placebo and can sometimes cause a clitoral hypertrophy. Systemic treatment , including anti-Borrellia antibiotic, potassium benzoate, penicillamine, and, systemic steroid, have not proven effective. Circumcision should be done, which can relieve symptoms of phimosis and result in remission in male.

Prognosis of this condition is good for more acute genital case,especially in pediatrics age groups that may resolve spontaneously. Improvement of extragenital cases and chronic atrophic genital disease is poor. Patients should be followed every 12 months to check for occurrence of squamous cell carcinoma of genitalia.

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