CASE 7

A 51-year-old Thai woman,from Samut-prakarn

Chief complaint:

Asymptomatic linear skin lesion on left side of the nose and nasolabial fold for 6 months.

Present illness:

She has 5 years history of recurrent oral ulcers on both upper and lower lips and buccal mucosa. The lesion at lower lip was biopsied and treated with topical tacrolimus then she lost to follow up.

Six months PTA she had asymptomatic linear hyperpigmented skin lesions on left side of the nose and nasolabial fold.

Past history:

She has got hypertension and hyperlipidemia and takes enalapril(20 mg) ,amlodipine(10 mg)and fenofibrate(160 mg) once a day.

She neither has history of trauma nor excessive exposure to sunlight, alopecia, arthralgia or fever.

Family history:

She has no family history of connective tissue disease.

Physical examination:

A healthy woman.

Skin: linear hyperpigmented and atrophic plaques at left side of the nose and nasolabial fold

purplish patch at lower lip

lacelike whitish patches at both side of buccal mucosa

Otherwise is unremarkable.

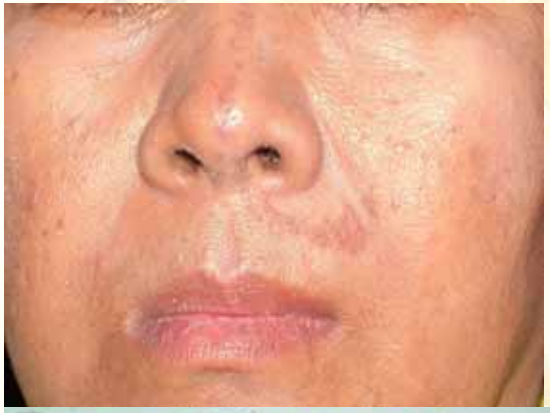

Fig. 7.1

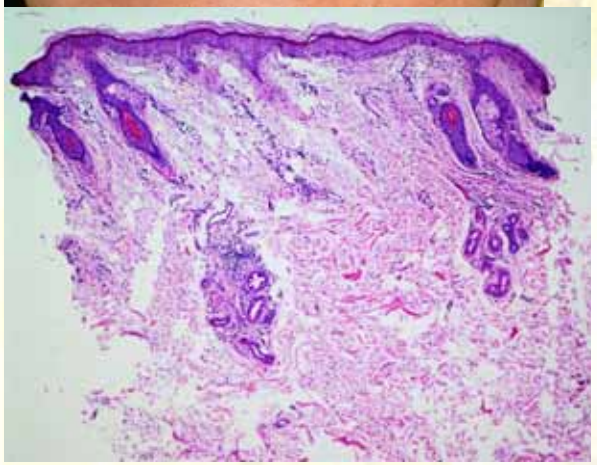

Fig. 7.2

Investigation:

CBC: Hct 8%, WBC 5,640 cells/ml (N 47%, L 43%, Mo 5%, Eo 4%, B 1%), Plt adequate

ESR 21mm/hr, BUN 6 mg/dl, Cr 0.6 mg/dl

U/A: Pro neg, Glu neg, WBC 2-3 cells/hpf, RBC neg

ANA:positive nucleolar titer=1:1280, Anti DNA neg IU/ml

Histopathology

(Slide No S04-12003) from lip

Trere is compact hyperkeratosis, focal epidermal hyperplasia and dense superficial band-like infiltrate of lymphocytes admixed with melanophage obscuring dermo-epidermal junction.

(slides06-07687) from left nasolabial lesion

Superficial and deep perivascular, periadnexal, inflammatory cell infiltrate. Edema, telangiectasia in upper dermis smudged the dermo-epidermal junction. The inflammatort cell composed of mostly lymphocyte.

Diagnosis: Lichen planus and linear cutaneous lupus erythematosus
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Discussion:

Cutaneous lupus erythematosus was devided into 3 groups, ie acute, subacute and chronic. Linear cutaneous lupus erythematosus(LCLE) is a variant of discoid lupus erythematosus. The term LCLE instead of discoid lupus erythematosus with a linear configuration was described by Abe et al.

There are several reports about chronic cutaneous lupus erythematosus (CCLE) and Lichen planus(LP) coexistence or overlap syndrome but no report about the coexistence between linear cutaneous lupus erythematosus (LCLE) and lichen planus . Most cases of LCLE usually follow the line of Blaschko and present in childhood.To our knowledge, this is the first case of LCLE coexistence with LP.

Treatment strategies for CCLE-LP range from topical steroid, antimalarial drug (chroloquin,hydroxychroloquin), topical tacrolimus, cyclosporin,retinoid (acitretrin) and dapsone.

In rare case, LCLE progresses to systemic lupus erythematosus.

In this case, we treat with topical steroid (mometasone). The lesions are improved.

References:

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2. Lee MW, Choi JH. Linear cutaneous lupus erythematosus in the line of Blaschko.Pediatr Dermatol 2001;18(5):396-99.
3. Green JJ,Baker DJ. Linear childhood discoid lupus erythematosus following the line of Blaschko.Pediatr Dermatol 1999;16(2):128-33.
4. Plotnick H,Burnham TK. Lichen planus and coexisting lupus erythematosus versus lichen planus-like lupus erythematosus. Clinical, histologic, and immunopatho-logic consideration. J Am Acad Dermatol 1986;14(5):931-8.
5. Nagao K, Chen KR. A case of lupus erythematosus/lichen planus overlap syndrome. J Dermatol 2006;3:187-90.