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Generalized Lichen Nitidus with Oral Involvement

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Abstract

Observations: Lichen nitidus is a rare dermatosis of unknown origin, characterized by the presence of shiny, pinpoint, skin-colored papules that may be asymptomatic or slightly pruriginous. Generalized form of lichen nitidus, especially, associated with oral involvement is even rare. We report a 37 year-old woman who had generalized lichen nitidus with oral involvement.

Introduction

Lichen nitidus (LN) is an uncommon, chronic, papulosquamous, inflammatory disorder [**1, 2, 3**]. It is usually asymptomatic and characteristically presented with 2-5 mm sized, flesh-colored papules with a flat, shiny surface [**4, 5**]. Lesions are predominantly observed on the chest, abdomen, glans penis and flexor surface of the extremities [**3, 6**].

Lichen nitidus almost always has a localized distribution but it can be rarely generalized. Also, oral involvement of LN is very rare [**7, 8**].

Case Report

A 37 year-old applied with a pruritic papular eruption unresponsive to topical corticosteroid for 2 months. The dermatological examination revealed multiple, shiny, 1-2 mm sized flesh-colored papules on her lumbosacral area, gluteal and abdominal regions and upper extremities. Also, multiple, grouped, 1-2 mm sized grayish-white papules were seen on her hard palate in oral mucosal examination (**Figure 1**). She had subungual hyperkeratosis on her foot nails. The native preparation with KOH was positive. She did not have history of any medication and any manifestations of other systemic disease. The routine laboratory tests were normal.

The histopathological examination of biopsy specimen showed parakeratosis, relatively thinned epidermis over the band like lymphocytic infiltrate (**Figure 2**). Rete ridges were elongated and there was typical small, circumscribed lesion occupying only a couple of dermal papilla. The diagnosis of LN was made clinically and histopathologically.

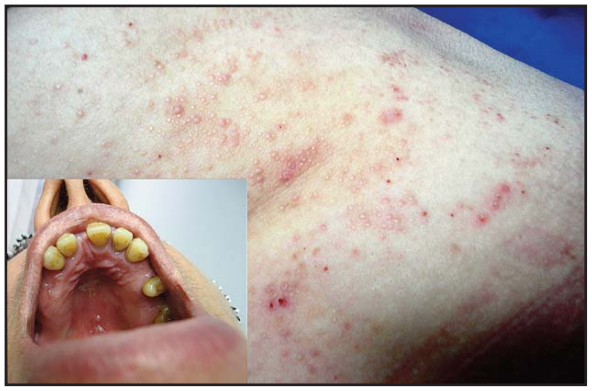

Figure 1. Multiple, shiny, 1-2 mm in diameter, flesh-colored papules. **Small figure:** Multiple, grouped, 1-2 mm in diameter, grayish-white papules are seen on the hard palate

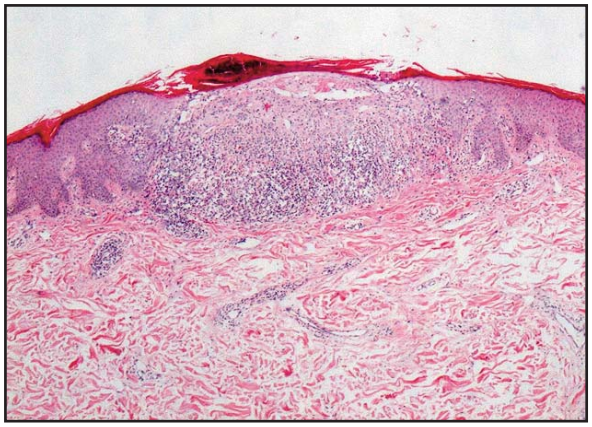

Figure 2. Band like lymphocytic infiltrate under the relatively thinned epidermis and elongated rete ridges and typical small, circumscribed lesion occupying only a couple of dermal papilla (H&E x50)

Itraconazole therapy was suggested to the patient because she had also tinea unguium. Subsequently she was lost to follow up.

Discussion

Lichen nitidus was first described by *Pinkus* in 1901. Some authors suggest that lichen nitidus represents a variant of lichen planus and some of them suspect it to be a type of tuberculid [**3, 9, 10**]. There is no obvious racial or sex predominance but most cases are children and young adults [**1, 3**]. The disease is usually localized and generalized presentation is very rare. The other variants of LN are confluent, vesicular, hemorrhagic, familial, palmar and plantar, spinosus follicular, perforating, linear and keratodermic LN [**2, 3, 8, 11, 12**]. Histopathological findings in all of these forms are similar; atypical acanthosis and parakeratosis in the epidermis, the well-circumscribed, granulomatous, lymphohistiocytic infiltrates, which are composed of epithelioid histiocytes surround by a rim of small lymphocytes and appear to be clutched by elongated rete ridges in a 'ball-and-claw' manner [**1, 2**].

Generalized LN, a rare form of the disease is characterized by multiple, shiny, dome-shaped papules occurring over the entire body [**11**]. In contrast with other forms of LN, generalized subtype is often associated with varying degrees of pruritus [**1**]. Our patient had severe pruritus.

Generalized LN has been rarely reported in association with trisomia 21 (*Down* syndrome), Crohn disease, postpartum thyroiditis and amenorrhea [**12, 13, 14**]. In our patient no associated disease was determined.

The differential diagnosis of LN are keratosis pilaris, lichen planus, follicular eczema, verru plana, pityriasis rubra pilaris, phrynoderma (vitamin A deficiency), lichen simplex chronicus, prurigo nodularis, psoriasis and papular mucinosis. Histopathological examination of the lesion confirms the diagnosis [**11**]. Nails and mucous membrane involvement can be seen rarely in LN. Oral LN lesions have been reported in only several case reports [**15, 16**]. They appear as minute, flat, gray–white papules on the soft palate or white plaques on the tongue and hard palate [**15, 16**].

Spontaneous resolution of LN can be seen, so treatment may not be required in most cases [**3, 10**]. However the clinical course of generalized LN is unpredictable, with most patients experiencing spontaneous resolution several years after the onset of disease [**17**]. The choices of treatment includes systemic and topical corticosteroids, topical pimecrolimus, dinitrochlorobenzene, diphenylcyclopropenone immunotherapy, astemizole, itraconazole, antituberculous agents (isoniazide), low-dose cyclosporine, enoxaparine, retinoic acids (acitretine and etretinat), psoralen and ultraviolet A, narrow band ultraviolet B phototherapy and exposure to intense sunlight [**4, 6, 7, 10, 11, 17**]. We suggested itraconazole to our patient who had also tinea unguium because it is included in the choices of therapy in LN and her lesions were unresponsive to topical steroid. We do not have any idea of the treatment efficacy because the patient was lost to follow up.

We present this case because generalized lichen nitidus is a rare variant of the disease and also oral involvement is seen very rarely. We suggest that the patients with generalized LN should be examined for oral involvement.

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