

Five variants of lichen planus in a middle aged HCV positive female

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Abstract Lichen planus is an inflammatory autoimmune skin disease with characteristic features. Classic LP usually presents as polygonal, pruritic, violaceous flat-topped papules and plaques. Many variants in morphology and location also exist, including nail, linear, oral, atrophic, hypertrophic, annular, eruptive, bullous, inverse, ulcerative, lichen planopilaris, lichen planus pigmentosus. In this case we try to highlight the unusual presentation of five variants of LP in a female patient with chronic HCV.

Key words

Lichen planus; Lichen planopilaris; Lichen planus pigmentosus; Variants; Oral LP.

Introduction

Lichen planus (LP) is an autoimmune inflammatory disease which affects the skin, nail, mucosa and even hair follicle. It is a pruritic skin condition with various variants and clinical manifestations. It is associated with other autoimmune and low immunity conditions notably vitiligo, alopecia areata, dermatomyositis, HCV, diabetes, myasthenia gravis and ulcerative colitis.¹ We are reporting a case of a middle aged female (HCV positive) who displayed 5 variants of LP.

Case report

A 55 year old lady who is a known case of HCV. for which she took antiviral therapy (injectable interferon and oral ribavirin) for 12 months and was currently off medication for last 6 months, presented with multiple violaceous to hyperpigmented itchy macules and papules on abdomen, upper limb, lower limb, palms and soles. There were white Wickham's striae on

bilateral buccal mucosa and examination of forehead and ears revealed hyperpigmented to violaceous macular discoloration. There was atrophic alopecia on scalp with follicular prominences. Examination of nails reveal small, ragged nails and pterygium formation with partial to complete onychia of hand and toe nails (**Figures 1-5**).

On further inquiry she reported that these lesions had been present on and off for the last 2 years. They started from both upper arms and then gradually involved the whole body with partial to complete resolution after some time, leaving behind hyperpigmentation. She had taken Rx for HCV twice (total 12 months) and stopped after her PCR became negative.

Investigations revealed negative HIV serology and VDRL. Anti HCV was positive but PCR (viral load) was less. Her liver function tests were within normal limits.

Discussion

Different diseases coexist with lichen planus. The most frequently associated disorders are diabetes mellitus, HCV and alopecia areata.² A high prevalence of HCV infection was found in

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Figure 1 Hyperpigmented, violaceous macules on body.



Figure 2 Atrophic alopecia areata with follicular prominences.



Figure 3 Hyperpigmentation on forehead, temples and ears; LP pigmentosus.

patients of lichen planus. It is recommended that patients of lichen planus are screened for HCV carrier state.³ There are multiple variants of LP including nail, linear, oral, atrophic, hypertrophic, annular, eruptive, bullous, inverse, ulcerative, lichen planopilaris, vulvovaginal, actinic, lichen planus pigmentosus, lichen planus-lupus erythematosus overlap syndrome, and lichen planus pemphigoides.⁴

In our case report, patients was a chronic HCV patient with oral lichen planus,⁵ and lichen

planus involving nails (pterygium and onychia) of both hands and toes.⁶ Patient had lichen planopilaris with alopecia areata of scalp⁷ and there were multiple hyperpigmented macules on abdomen, back, thighs, palms and soles. There was lichen planus pigmentosus involving her forehead, temples and ears.⁸ Due to presence of sole and palm hyperpigmentation her VDRL and HIV serology was also done which came out negative. This unusual presentation highlighted the need for careful and prompt screening of active as well as carrier Hepatitis C in patients of lichen planus.



Figure 4 Wickham's striae on buccal mucosa.



Figure 5 Pterygium formation, onychia.

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