LICHEN PLANUS MIMICKING SYPHILIS II PAPULES – A CASE STUDY

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DOI: 10.5455/ijmsph.2014.170920143 Received Date: 30.07.2014 Accepted Date: 17.09.2014

ABSTRACT

Lichen planus is a chronic mucocutaneous disease of immunological basis, and of unknown etiology. Women with oral lichen planus may have concomitant manifestations in vulvovaginal areas. A case of vaginal lichen planus is presented with special emphasis on its clinical and microscopic characteristics. Multiple violaceous flat papules over vagina and oral single violaceous plaque associated with mild discomfort was treated with methyl prednisolone and topical steroid. Nail lesions were treated with clonestasol propionate with salicylic acid, which resulted in a favourable outcome.

Key Words: Lichen Planus; Vulvovaginitis; Topical Corticosteroids; Syphilis II

Introduction

Lichen planus (LP) is an inflammatory mucocutaneous condition with characteristic violaceous polygonal flat topped papules and plaques. Pruritus is often severe. Skin lesions may be disfiguring and involvement of the oral mucosa or genital mucosa in severe cases may be debilitating. Oral LP may predispose to the development of squamous cell carcinoma within lesions. Involvement of the scalp and the nails may also occur.[1]

The etiology of LP is unknown, although many studies have investigated and support an immunologic pathogenesis. Lymphocytes, particularly T cells play a major role. Other factors include antigen presenting cells, adhesion molecules and inflammatory cytokines. While most cases of LP are idiopathic, some are linked to medication use or hepatitis C virus (HCV) infection.[2,3]

The clinical entity of vulvovaginal LP has been recognized only in the last 30 years. Management is difficult, owing to the variability and inconsistency of symptoms and signs, the relatively poor histologic correlation, the often fluctuating clinical course and treatment resistance.[4] Patients with LP affecting these sites are often seen by oral medicine specialists or gynecologists, who work in isolation and depend heavily on histopathologists to help them in confirming the diagnosis.[5]

The true incidence of LP is unknown, as it can affect one or several regions, can have various clinical appearances, and the diagnosis has to be confirmed histopathologically. Therefore, the true LP prevalence can be known only with the joint contribution of gynaecologists, dentists and dermatologists.[6,7] Here we report a case of vulvitis due to rare etiology of LP.

Case Report

A 35 year old female patient was transferred from Obstetrics and Gynecology department for evaluation of white discharge per vagina where genital itching was observed since last 1 month. On examination, the discharge was watery and not foul smelling. Further, there were multiple violaceous flat papules present over both labia majora - mimicking hypertrophic lesions of papules syphilide. There were no ulcers or scars. There was no significant lymphadenopathy, and per vaginum and per rectum examinations were normal. A complete microscopic evaluation of white discharge was done for screening the sexually transmitted diseases.

The wet mount, KOH mount and Gram staining were negative except few secondary organisms. Serology of Syphilis was non-reactive. The husband was also screened and no lesions were found. Since the investigations and examinations turned negative, we suspected non-venereal dermatoses as etiology. Among the various cases, the clinical morphology made us to think about lichen planus. On further examinations, flat polygonal hyperpigmented papules of <0.5 cm size were found over both upper and lower extremities. Examination of oral cavity revealed single violaceous plaque with lacy pattern of size 1.5 X 2 cm over left buccal mucosa. The patient was treated with
anti-histamines, analgesics, emollients and topical steroids for 10 days.

On follow up of the patient, the lesions were resolving, but she developed itchy violaceous lesions of size 1 cm each over the scalp, 4 in number over parietal and occipital region. This further helped us to confirm the clinical manifestations of LP. The participant was prescribed with 4 mg methyl prednisolone along with the topical highly potent steroid and salicylic acid for scalp. The lesion resolved completely in 3 months and steroid was tapered off over a period of 2 months. At that time, hand nail changes were present, which were treated with clobetasol propionate + salicylic acid. The patient was reviewed for 6 months – by that time, the nail lesions were also healed.

Discussion

Lichen planus (LP) is a chronic autoimmune disease with an unknown etiology that is marked by the invasion of lymphocytic infiltrate within the epithelial tissue inducing epithelial cell apoptosis and chronic inflammation.[8,9] The main areas involved are the skin and oral cavity, but it can also occur in the vaginal mucosa, scalp and nails.[10]

Any lesions over genitalia makes an individual to think of STD. In this presented case, it was not so. The patient had dermatological disease which was the cause of genital itching and vulvitis. The greater imitator of many dermatological diseases, syphilis may be considered because lichenoid syphilide imitates the LP almost in perfection. By the non-reactive VDRL test the possibility of popular eruption of secondary syphilis was ruled out. The different etiological factors considered for LP are genetic background, dental materials, drugs, infectious agent, autoimmunity, immunodeficiency, food allergy, stress, habits, trauma, diabetes, hypertension, malignant neoplasm and bowel diseases.[11] The pathogenesis of LP is thought to involve four mechanism including antigen specific cell mediated immune response (heat shock proteins, CD4+ T helper cells, CD8+ cytotoxic T cells), non specific mechanism (epithelial basement membrane, mast cells, chemokines, matrix metalproteinases), autoimmune response and humoral immunity (circulating autoantibodies to desmoglin 1 and 3).[12]

Stress was identified as one of the most frequent causes of acute exacerbation of the disease. A recent study suggests that patients with LP exhibit higher levels of anxiety and depression compared with control groups. In addition to the discomfort that is caused by the lesion, many patients are concerned about a possible malignancy, and the contagious nature of the lesion, which is favored by the lack of educational materials available to individuals with the disease. Therefore, the education of patient with LP can minimize their anxiety.[10,13]

No known cure exists for lichen planus. The treatment modalities in LP are still empirical. The rationale for treatment is to provide relief for the patient, if the lesions are symptomatic, to improve function as well as to prevent or prolong the frequency and severity of exacerbations. Systemic and local relief with anti-inflammatory and immunosuppressant agents is often indicated. In some cases, concomitant topical anaesthetics, analgesics and antifungal agents are also indicated. Identification of precipitating factors including diet, dental materials, hygiene products or medication (lichenoid drug reaction) should be undertaken to ensure against hypersensitivity reaction or exacerbation. Treatment or prevention of a secondary fungal infection with a systemic antifungal agent also should be considered in most cases.[14,15]

The fact, that LP patients frequently present at ear, nose, throat (ENT) or dentistry outpatient departments for their first examination and skin lesions, is often overlooked.[7]

Conclusion

The presence of concurrent oral/ genital lesions at a high rate, has indicated the need for evaluating all mucosae, even if there are no related symptoms or skin involvements. Therefore, we want to emphasize the importance of dermatologists contacting other specialities and ensuring regular follow up of LP cases.

References


Source of Support: Nil

Conflict of interest: None declared