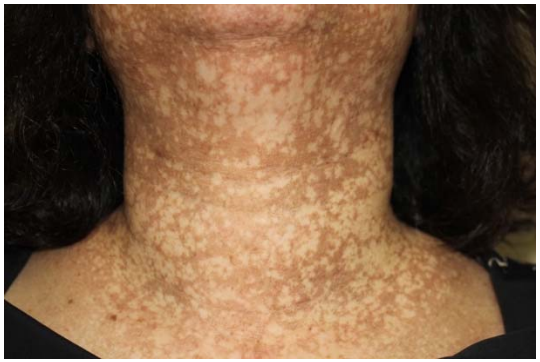
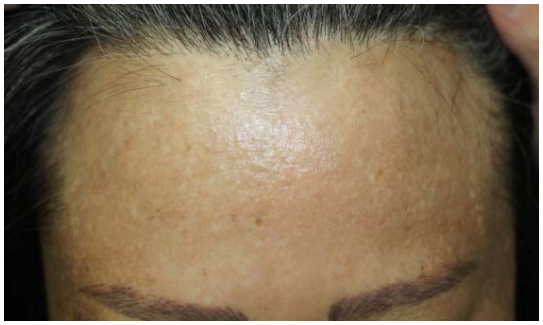
Case 18
A 45-year-old Thai woman from Bangkok

Chief complaint: Multiple reticulate mixed hyper- and hypopigmented patches on face and neck for 30 years


(Fig. 18.1)


(Fig. 18.2)

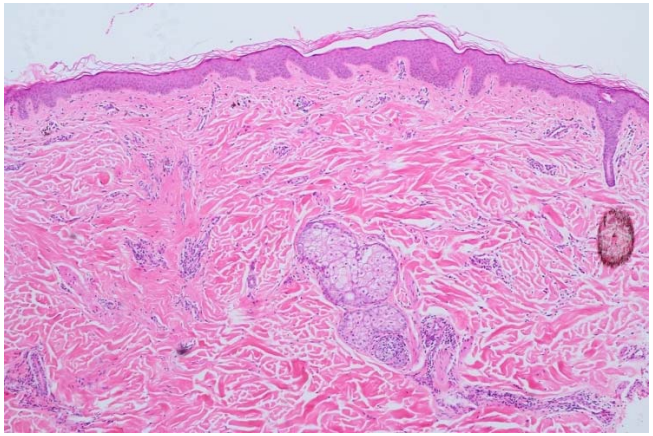
Present illness: 30 years ago, she gradually developed multiple reticulate mixed hyper- and hypopigmented patches on face and neck. Later, she had noticed asymptomatic progressive brownish patches on both cubital fossae, thighs and popliteal fossae. She had no systemic symptoms. She denied a history of photosensitivity and exposure to pesticides, contrast dye, or ionizing radiation. She denied taking any medication or applying any product on affected areas before the rash appeared. She didn't observe recession of frontal hairline or papules on face.

Past history: None

Physical examination: Unremarkable

Dermatological examination: (Fig. 18.1, 18.2)
- Multiple reticulate mixed hyper-and hypopigmented patches on face and neck
- Multiple brownish patches on both thighs, cubital fossae and popliteal fossae
- Mild anterior hairline recession with lonely hairs
- Multiple small skin-colored to brownish papules on forehead

Histopathology: (S16-038697, left ear) (Fig.18.3)


(Fig. 18.3)

- Mild superficial perivascular cell infiltrates of lymphocytes with numerous melanophages
- A column of fibrosis replaces the hair follicle is noted

Diagnosis: Lichen planus pigmentosus coexisting with frontal fibrosing alopecia

Treatment:
- Oral acitretin 10 mg/day
- Topical desoximetasone apply scalp twice a day

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Discussion:

Lichen planus pigmentosus (LPP) is a macular variant of lichen planus with an unknown etiology. The condition was firstly described by Bhutani and Bedi in Indians and subsequently reported in other ethnic groups such as Latin Americans, Middle eastern population, Japaneses and Koreans.[1,2,3] LPP generally occurs in middle-aged individuals with darker pigmented skin.[1,2] It usually manifests as slate grey to brownish-black macules that appear in sun-exposed areas, especially head and neck.[1,4] Flexural involvement, although less, is seen over the axillae, inframammary folds and groin.[1,5] Palms, soles and nails are spared. Mucosal lesion is rarely seen. The pattern of pigmentation is generally diffuse. In addition, reticular, blotchy, follicular and linear variants have been reported.[1,6] Although lesions are generally asymptomatic, mild pruritus and burning sensations are presented in about 30% of patients.[1] Histopathological features include hyperkeratosis, epidermal atrophy, vacuolar degeneration of the basal layer of the epidermis, lymphohistiocytic band-like or perivascular lymphocytic infiltrate, variable Civatte or colloid bodies and dermal melanophages.[1,4] Coincidental cutaneous lichen planus was reported approximately 15% of LPP patients.[1]

Frontal fibrosing alopecia (FFA) is a primary lymphocytic scarring alopecia. It is classified as a variant of lichen planopilaris according to sharing the histopathological features.[7,8] FFA mainly affects postmenopausal women and is predominantly reported in Caucasian.[7] It is characterized by a slowly progressive recession of the frontotemporal hairline and, less often, loss of the eyebrows, eyelashes and alopecia of the axillae, the pubic area and the body area.[7] Perifollicular erythema on the receding hairline, pruritus and pain may be signs of active disease.[8] Lonely hair, perifollicular scaling and hyperkeratosis may be seen in some patients.[7,8] Facial papules, observed in 14-20% of FFA patients, show histological features of lichen planopilaris involving vellus hair follicles.[7,9,10] The clinical course is unpredictable.[7,8]

The coexistence of FFA and LPP was first reported by Dlova in 2013 in South Africa.[3] LPP preceded hair loss and was considered as a herald sign of FFA, however LPP appearing after the onset of FFA has been described.[3,11] It is noteworthy that antimalarials, a treatment option of FFA, may worsen LPP lesions which should be considered in this patient.[11]

There are several treatments for LPP and FFA that have been reported with variable efficacy. For LPP, various therapeutic modalities include topical tacrolimus, topical and systemic corticosteroids, topical and systemic retinoids (isotretinoin, acitretin), low-fluence Q-switch Nd-YAG (1064nm).[12,13,14] Photoprotection is also important in LPP treatment.[13,14] In case of FFA, 5-□ reductase inhibitors (finasteride, dutasteride) have been shown to be the effective drugs, particularly when androgenetic alopecia is

presented.[15,16] Intralesional corticosteroids would be indicated in conditions such as pruritus, erythema, and perifollicular hyperkeratosis.[15] Oral antimalarial agents have demonstrated lower efficacy.[15,16] Topical calcineurin inhibitors are considered as an adjuvant therapy.[15,16] The patient has received acitretin 10 mg/day and topical desoximetasone for 6 months with mild improvement.

References:

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