CASE REPORT

Erosive Lichen Planus: A Case Report.

Balaji N, Sumathi MK, Shanthi V, Sathish Kumar, Vezhavendhan N.

ABSTRACT: Lichen planus is a relatively common, chronic dermatologic disease that often affects the oral mucosa, The strange name of the condition was provided by the British physician Erasmus Wilson, who first described it in 1869. We report a case oferosive lichen planus in a 30 year old female pa tient.

Key words: Lichen planus, chronic dermatologic disease

Oral lichen planus is a common immune mediated mucocutaneous disorder that typically affects the oral mucosa and skin.[1 Lichen planus can also affect other mucosal surfaces such as genitals, anus, and pharynx. Oral lichen planus can present as an erythmatous, atrophic, white linear papules, atrophic ulcers and rarely blisters.

Erosive lichen planus is a chronic painful condition affecting mucosal surfaces of oral cavity and the genitals. Females are most commo nly affected. It usually occurs in buccal mucosa, lateral border of tongue, gingiv a and lips.[3] This heals usu ally with pigmentation. The etiology for erosive lichen planus is unknown. It is considered as an autoimmune disease where the T lymphocytes are triggered by antigen presenting langerhans cells followed by sub epithelial accumulation ofbands ofT lymphocytes. The triggered T lymphocytes ind uce apoptosis ofbasal keratinocytes.

When compared with other types of Lichen planus, erosive and atrophic lichen planus have more chance for malignant transformation. Prognosis of erosive lichen planus dep ends on early diagnosis and periodic review.

CASE REPORT

A 30 year Old female patient reported to the Department of Oral Pathology with the chief complaint of burning sensation ofmouth present

al examination revealed no abnormal deformity.

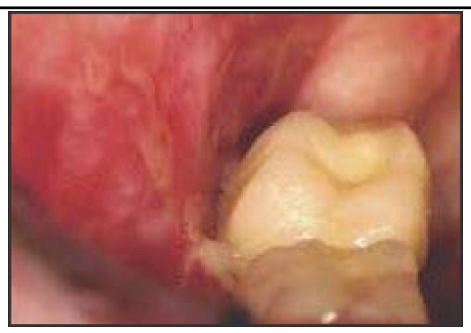

Fig 1: Erosive lichen planus in buccal mucosa

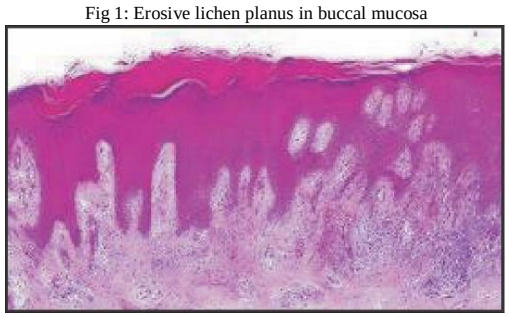

Fig 2: Low power view showing hyperkeratosis and sub-epithelial inflammation

Intra oral examination revealed raw, eroded ulcer on the right buccal mucosa extending up to the retro molar area (Fig-I). There is characteristic white radiating striae on the periphery of the lesion. Incisional biop SY Of the lesion were carried under local anaesthesia and the specimen was fixed and prepared for histopathologic evaluation.

The section showed hyperorthokeratotic stratified squamous epithelium with classical saw tooth rete ridges. Destruction of basal cell layer of the epithelium (hydropic degeneration) was also evident (Fig-2). There was intense band like chronic inflammatory infiltrate subjacent to the epithelium. Clinico-pathologic correlation was suggestive ofErosive Lichen planus.

Erosive lichen planus

DISCUSSION

Oral lichen planus is a common immune mediated mucocutaneous disorder that typically affects the oral mucosa and skin. Oral lichen planus can present as an erythmatous, atrophic, white linear papules, ulcer and rarely blisters.

The reticular form is most common, however, the erosive form is debilitating and difficult to treat.

Most common clinical presentation of the lesion are found on the posterior part of buccal mucosa and in the order of decreasing frequency in the gingiva, tongue, palate, lip and floor of the mouth. They usually heal with scaning.

Treatment options for oral erosive lichen planus are numerous, including both topical and systemic agents. However, therapeutic results are often disappointing. In a recent evidence based review, topical corticosteroids were found to be the most helpful treatment for oral lichen planus. Although topical cyclosporine has been evaluated for treatment of erosive lichen planus, topical corticosteroids when used alone have proved to be more beneficial. Periodic reviews for the malignant transformation have to be done.

CONCLUSION

Oral lichen planus is a common immune mediated mucocutaneous disorder. Reticular pattern is the most common clinical pattern. Erosive Oral lichen planus is considered as premalignant condition with high chance of malignant transformation. Histopathological examination of suspicious area for periodic review is mandatory for better prognosis.

REFERENCES

1. Magalhaes-Junior EB, Aciole GT, Santos NR, Santos JN, Pinheiro AL. Removal of oral lichen planus by C02 laser. Braz Dent J2011;22(6):522-6.

. Artico G, Bruno IS, Seo J, Hirota SK, Acay R, Migliari DA. Lichenoid reaction to carbamazepine in the oral mucosa: case report. An Bras Dermatol 2011; 86 (4 Suppl l): 152 5.

3. Kaplan I, Ventura-Sharabi Y, Gal G, Calderon S, Anavi Y. The Dynamics of Oral Lichen Planus: A Retrospective Clinicopathological Study. Head Neck Pathol- 2011; 13. [Epub ahead of print]

4. Carvalho CH, Santos BR, Vieira CD, Lima ED, Santos PP, Freitas RD. An epidemiological study of immune mediated skin diseases affecting the oral cavity. An Bras Dermatol2011;86(5):905-9.

5. Sharma R, Sircar K, Singh S, Rastogi V. Role of mast cells in pathogenesis of oral lichen planus. J Oral Maxillofac Pathol2011;15(3):267-71.

Address for correspondence:
Dr. Balaji N.
Professor
Department of oral and maxillofacial pathology
Indira Gandhi Institute of Dental Sciences,
Sri Balaji Vidhyapeeth
Pondy - Cuddalore Main Road,
Pillayarkuppam, Puducherry - 607 402.
Email: drsumathibalaji@gmail.com

How to cite this article:

Balaji et al

BalajiN, Sumathi MK, ShanthiV, Sathish Kumar, Vezhavendhan N. Erosive liche
29-30.

Source of Support: Nil, Conflict ofInterest: None declared