Hong Kong J. Dermatol. Venereol. (2006) **14**, 98-99

Dermato-venereological Quiz

YH Chan 陳耀海 and KC Yau 游高照

A 45-year-old gentleman presented with asymptomatic hypopigmented lesions over both of his forearms for 4 years. The lesions started as a small white macules and increased in size gradually. Physical examination showed symmetrical hypopigmented patches over both of his forearms. These patches are made up of serpiginous streaks of hypopigmented macules with atrophic surface and there are intralesional violaceous discoloration and postinflammatory hyperpigmentation (Figures 1 & 2). Incisional skin biopsy was performed over the left forearm lesion and histopathological examination showed compact orthokeratosis, flattening of rete ridges and focal vacuolar alteration of the basal layer. There was mild homogenization of collagen bundles in the upper dermis and patchy perivascular lymphohistiocytic infiltration with scattered melanophages. No epidermal dysplasia is evident (Figures 3 & 4).

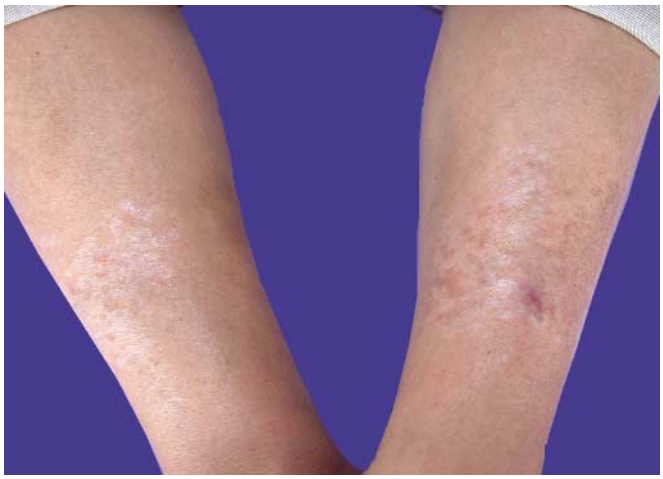

Figure 1.

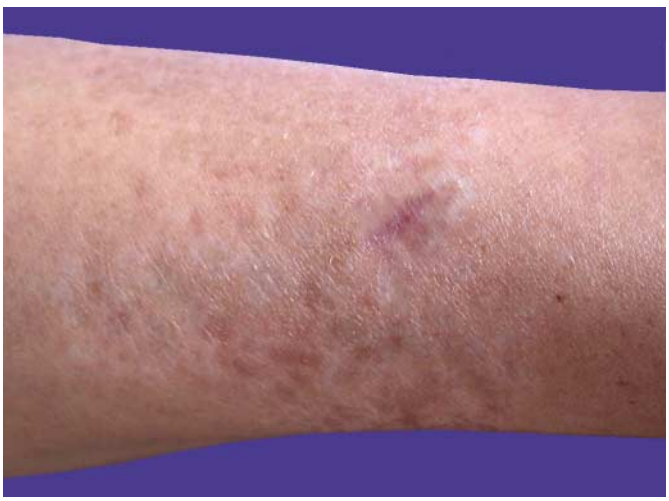

Figure 2.

Private Practice, Hong Kong

YH Chan, MRCP(UK), FHKAM

Public Health Laboratory Centre, Department of Health, Hong Kong

KC Yau, FRCPA

Correspondence to: Dr. YH Chan

Room 1015, 10/F, One Grand Tower, 639 Nathan Road, Mongkok, Kowloon, Hong Kong

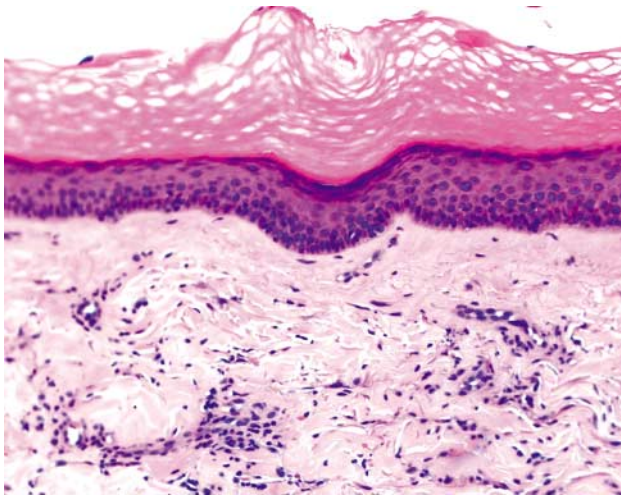

Figure 3.

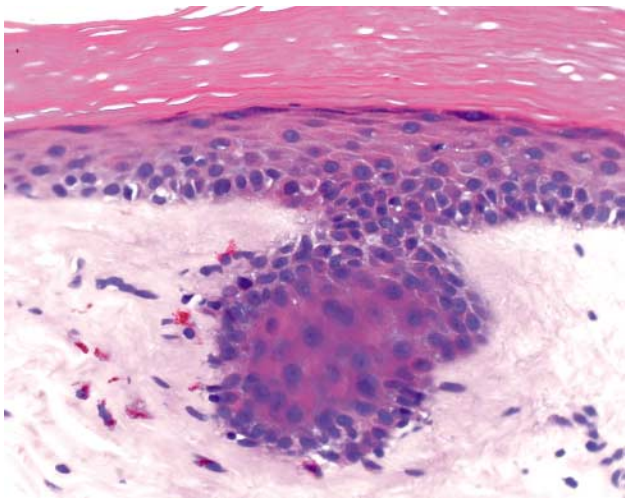

Figure 4.

Questions

1. What is the diagnosis and common differential diagnoses for this patient?
2. What is the commonest site of involvement and presentation of this disease?
3. What complications can occur?
4. What is your treatment for this patient?
5. What is the prognosis for this patient?

(Answers on page 100)

Answers to Dermato-venereological Quiz on pages 98-99

1. The diagnosis for this patient is lichen sclerosus et atrophicus (LSA). Differential diagnoses that should be considered depend on the stage of the disease and include lichen planus, morphea, vitiligo, idiopathic guttate hypomelanosis and child sexual abuse if it occur on genitalia of children.

2. LSA is a rare dermatosis with unknown causes. Male to female ratio is around 1:6. Most of the cases occur at the vulva of young female patients. Male genital cases are seen almost exclusively in uncircumcised men and boys.

3. In male genital LSA cases, complications such as inability to retract foreskin (balanitis obliterans xerotica), urinary obstruction, painful erections. Female LSA cases may develop dyspareunia, urinary obstruction, secondary infection. Squamous cell carcinoma has been reported to occur in few long standing lesions. Extragenital LSA are generally considered to carry no risk of malignant change and the only complication is cosmetic impairment.

4. Extragenital LSA may not require treatment and camouflage may be the only option needed. Superpotent topical steroid is the mainstay for genital LSA. Other modalities such as topical testosterone and tacrolimus, systemic therapy with steroid, penicillamine and retinoid, UVA1 therapy have been reported with variable success. Surgery may be required for phimosis, urinary obstruction and malignancy.

5. Extragenital LSA tends to persist despite superpotent topical steroid therapy. Genital LSA in paediatric patients carries the best prognosis and may resolve spontaneously.