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Case Report

Actinic lichen planus mimicking lentigines in an elderly Korean woman

對於韓國的高齡婦女的黑斑及日光性扁平苔癬問題

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A 68-year-old Korean woman presented with a recurrent eruption on her temple. The clinical findings were compatible with a diagnosis of actinic lentigines. However, the biopsy from the lesion revealed histological findings of typical lichen planus. We concluded that the patient had an atypical form of actinic lichen planus that mimicked actinic lentigines. This case is of interest because the condition that is described is rare in elderly and East Asian patients. This is also an atypical form of actinic lichen planus mimicking actinic lentigines.

一位六十八歲高齡婦女在左邊頭側起了復發性斑疹，臨床意見指出，這種情況屬於光線照射下造成的黑斑。可是，對病變問題作出驗查後，認爲那是典型扁平苔蘚的組織物。我們把這患者病變造成的日光性黑斑和扁平苔蘚的相似度定論爲非典型病例。本病例屬於亞洲高齡婦女當中相當稀有的例子，而且在臨床角度或是病變研究上，相似度高的黑斑和日光性扁平苔癬，這種不尋常的情況也讓我們覺得很有研究價值。

Keywords: Actinic lichen planus, elderly patients, Korean woman, lentigines

關鍵詞：日光性扁平苔癬、高齡、韓國婦女、黑斑

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Introduction

Actinic lichen planus (ALP) is a rare photosensitive variant of lichen planus that is characterised by well-defined annular or discoid patches with deeply hyperpigmented centres that are surrounded by a striking hypopigmented zone. This condition can occur on exposed skin, and is commonly observed on the face.[1] ALP primarily affects Middle Eastern children and young adults in the spring and summer, and it has never been reported in elderly patients. This condition is also rare in the East Asian population, and only one case has been reported.[2,3] This case report describes an elderly East Asian woman that was diagnosed with ALP that presented as an actinic lentigo.

Case report

A 68-year-old Korean woman was referred to our dermatology clinic in September 2011 because of a recurrent eruption on her temple. The eruption first appeared in the spring of 2010 after mountain climbing and resolved spontaneously within a couple of months. The eruption reappeared in March 2011, and gradually worsened. The patient had no history of any contact with or intake of any drugs and denied use of any perfume.

The eruption was distributed only on the left temple, with pigmented irregular macular lesions arranged in a confluent pattern, and there was no indication of a halo of hypopigmentation. Based on these characteristics, the lesions were clinically diagnosed as actinic lentigines (Figure 1). There were no nail changes or mucosal involvement. Laboratory tests were within normal limits. Hepatitis B and C serology was negative. Skin biopsy showed focal basal liquefaction, a distinct presence of lichenoid-type infiltrates of lymphocytes and histiocytes, and pigmentary incontinence in the upper dermis. In addition, Civatte bodies, spongiosis, and prominent clefting at the dermo-epidermal junction were noted (Figure 2). Direct immunofluorescence of the skin lesions was negative. The patient refused to allow a minimal erythema dose to be determined. Therefore, we concluded that the patient had an atypical form of ALP that mimicked actinic lentigines based on the distribution of the eruptions, which were only observed on areas that were exposed to sunlight, and histological findings of typical lichen planus.

Discussion

Virtually all cases of ALP occur in young individuals of Middle Eastern, East African, or Indian descent, with very few cases reported in southern European Caucasians or East Asians.[3,4] Although our case demonstrated the characteristic histopathological findings of ALP, its development in an elderly East

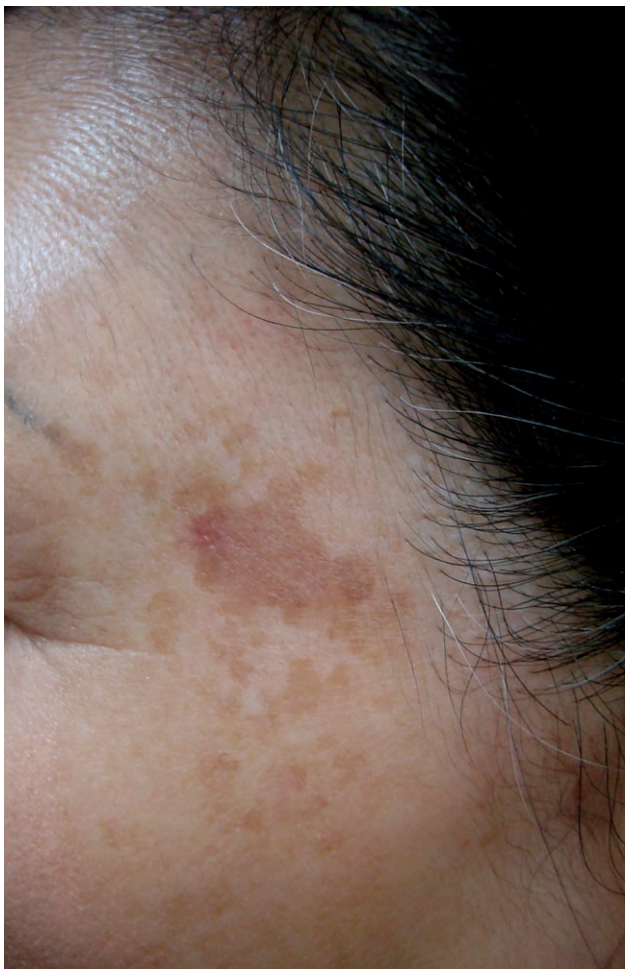

Figure 1. Well-defined brown macular lesions on the left temple.

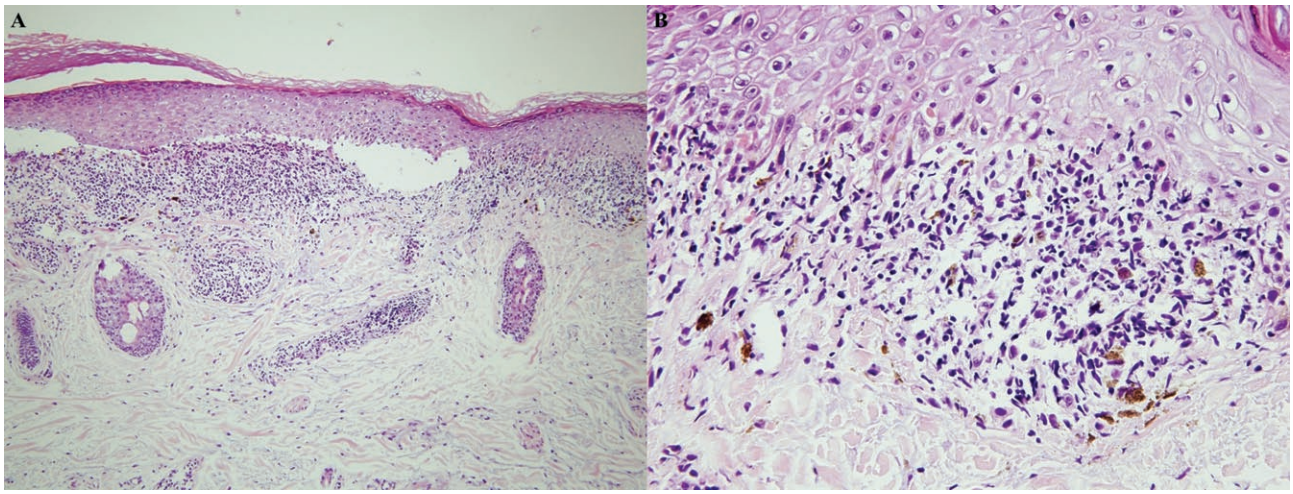

Figure 2. (A) Basal liquefaction, lichenoid-type infiltrates of lymphocytes and histiocytes, pigmentary incontinence in the upper dermis, and prominent clefting at the dermo-epidermal junction (haematoxylin and eosin ×100). (B) Civatte body, spongiosis, and marked pigmentary incontinence were found (haematoxylin and eosin ×400).

Asian woman and its unusual presentation were particularly interesting. Our case represents the oldest patient with ALP that has been reported in the literature.[5,6] Four clinical patterns of ALP have been described: annular, dyschromic, classic plaque-like, and pigmented. The pigmented form is characterised by hypermelanotic patches, with a melasma-like appearance. In contrast to typical pigmented ALP, the lesion in this case was clinically suggestive of actinic lentigines.

The cause of ALP is still unknown; however, ultraviolet radiation appears to be the major precipitating factor. Differential diagnoses of ALP include discoid lupus erythematosus, fixed drug eruption, granuloma annulare, sarcoidosis, melasma, and erythema dyschromicum perstans. A lichenoid drug eruption should be excluded based on the patient's history. ALP treatment strategies should include topical use of sunscreen and sun avoidance. Hydroxychloroquine, ciclosporin, intralesional glucocorticoids, acitretin with topical glucocorticoids, topical pimecrolimus, and intense pulsed light have been used successfully in patients with ALP.[2,4,7] We recommended sunscreen use and sun avoidance as treatment options because our patient had steroid phobia and declined medical treatment. Her lesions did partially improve with sun protection over the following months.

In summary, ALP that affects elderly patients is extremely rare. This report is of interest because the condition that is described is rare in elderly and East Asian patients. This is also the first published example of ALP mimicking actinic lentigines. Therefore, we suggest that ALP should be included in the differential diagnosis of lentigines-like lesions that occur on exposed areas, even in elderly patients.

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