

DERMATOPATHOLOGY UNIT

UPP | Department of Dermatology

UPMC Dermatopathology "Case of the Month" Presentations

UPP - Department of Dermatology, Dermatopathology Unit

5230 Centre Avenue (412) 623-2614

Pittsburgh, PA 15232 (412) 682-6450 FAX

Case Authors: Timothy Patton, DO; Grace Lee, MD, Drazen Jukic, MD

FEBRUARY 2004 CASE OF THE MONTH

CLINICAL FINDINGS

CLINICAL HISTORY:

A 79 year old male was sent to our dermatology clinic for a lesion that was found on a routine physical exam. The lesion was located on the upper abdomen, had been present for approximately one or two years, and was completely asymptomatic. He denied any significant changes in size or appearance in the lesion since it was first noted. The patient was otherwise healthy, on no systemic medications, and without any other skin rashes or lesions.

Physical exam revealed a healthy white male. On his left upper abdomen was a slightly elevated, non-indurated 7cm white plaque with a wrinkled surface and mild follicular accentuation (Figure 1).

A punch biopsy was performed . Pathology revealed an atrophic epidermis with significant papillary dermal edema and homogenization of dermal collagen. A patchy lichenoid infiltrate was present below the edematous dermis. (Figures 2 and 3)

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Figures & Images

1. *Click on the Figure number you wish to review.*
2. *Click on the image to enlarge*



Figure 1

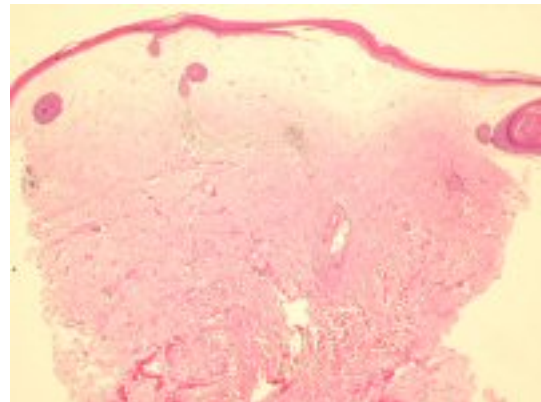


Figure 2

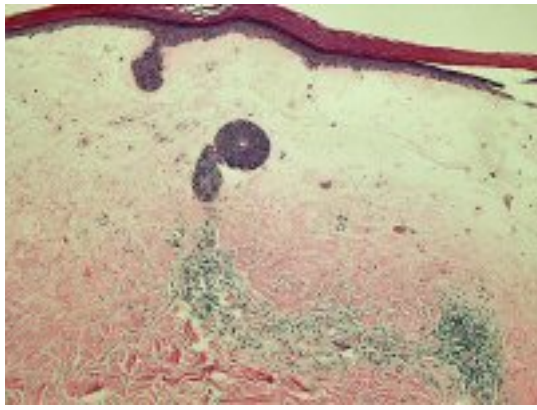


Figure 3

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DISCUSSION & DIAGNOSIS

Diagnosis: Extragenital lichen sclerosus (LS)

DISCUSSION

Lichen sclerosus (also known as lichen sclerosus et atrophicus) is an inflammatory disorder of unknown etiology. It is more commonly described as occurring in the genital region, although extragenital cases also exist. While LS occurring in the genital skin is associated with pruritis, pain, dystrophy, and a progression to squamous cell carcinoma in some cases, extragenital LS is more commonly described as asymptomatic without a higher risk of SCC(1). No universally agreed upon pathogenesis exists; however, infectious (specifically *Borrelia* infection)(2), autoimmune(3), environmental(4,5), and hormonal(6) etiologies have all been proposed. In one series, histologic differences were reported between extragenital and genital LS, suggesting different etiologies for the two diseases(7).

The histologic findings in LS include epidermal atrophy with basal layer vacuolization, edema and homogenous sclerosis of the papillary dermis, and a lichenoid infiltrate below the edema and sclerosis. Histologic differentials include morphea and chronic radiodermatitis. Indeed, some consider LS and morphea to be similar diseases along the same continuum, while other

consider them distinct entities.

First line treatment involves the use of ultra-potent or potent topical glucocorticoids. In men, circumcision can be curative. Other symptomatic therapies including avoidance of irritation and systemic antihistamines can be helpful. Topical hormone therapy (testosterone, progesterone, and estrogen), topical retinoids, topical cyclosporine have all been reported as effective. Destructive modalities including surgical excision photodynamic therapy, and CO2 laser ablation can also be considered in recalcitrant or severe cases. The patient denied the existence of any genital lesions, and was treated with clobetasol proprionate ointment twice daily.

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