Graham–Little–Piccardi–Lasseur Syndrome

Sir,

A 22-year-old male presented to us with the chief complaint of multiple pruritic follicular keratotic and spinous papules initially over wrists and forearms and neck, gradually involving the whole body, sparing face, palms, and soles since past 1 year. Over the past 3 years, the patient had noted patchy hair loss that developed and progressed slowly. On examination, sparse hair were present in axillary and pubic area and patches of scarring alopecia with shiny skin on scalp without erythema were apparent on the scalp [Figure 1]. Multiple violaceous follicular keratotic papules were present on the neck, lower back, and arms [Figure 2]. Axillary and pubic hair were sparse with a history of recurrent episodic shedding since the last 3 years [Figure 3]. The patient denied any constitutional symptom. A general physical examination and systemic examination found nothing relevant. No specific laboratory data were found. On histopathological examination (HPE) of the scalp, there was hyperkeratosis, mild acanthosis, and follicular plugging with dense perifollicular lichenoid inflammation, with vacuolar change of outer root sheath and occasional necrotic keratinocytes. Deep dermis showed perifollicular lamellar fibroplasia, collapsed fibrous sheaths, and reduction in hair follicular number [Figure 4].

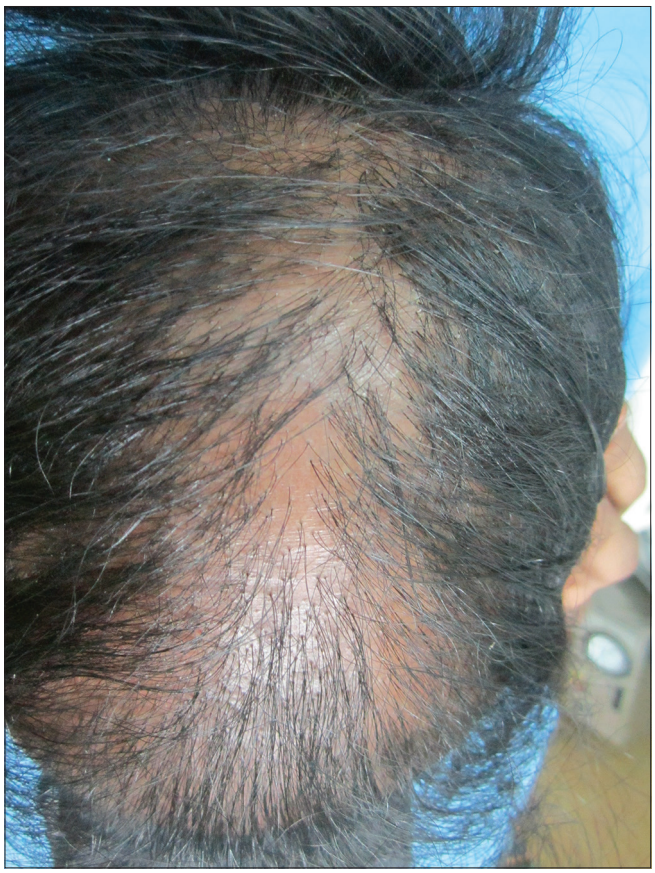

Figure 1: Cicatricial (scarring) alopecia present on the scalp

Based on the above characteristics, clinical and HPE features, a diagnosis of Graham–Little–Piccardi–Lasseur (GLPLS) syndrome was made. GLPLS is considered as a variant of lichen planopilaris. Its exact etiology is not known, but primarily involves an immune-mediated inflammatory reaction against the bulge region of hair follicles resulting in cicatricial alopecia.[1,2]

The disease is chronic and slowly progressive and relatively rare, most reported patients with the syndrome are middle aged postmenopausal women.[3] Only a few case reports shows male patients, which may be because of less male patient reporting to hospital. The onset of the disease occurred most commonly in postmenopausal woman and an average of 26–52 year of age in all cases were seen. In two previous case reports, GLPLS was associated with other diseases such as androngen insensitivity syndrome and atopic dermatitis.[4]

Histopathology reveals a dense perifollicular lymphocytic infiltrate thus, explaining scarring alopecia [Figure 4]. Lymphocytes extend into the basal layer and there is focal vacuolar alteration of the follicular basement membrane.[5] HPE close differentials are causes of scarring alopecia, viz. folliculitis spinulosa decalvans, discoid lupus erythematosus, and pseudopelade of brocq.

Declaration of patient consent

The authors certify that they have obtained all appropriate patient consent forms. In the form the patient(s) has/have given his/her/their consent for his/her/their images and other clinical information to be reported in the journal. The

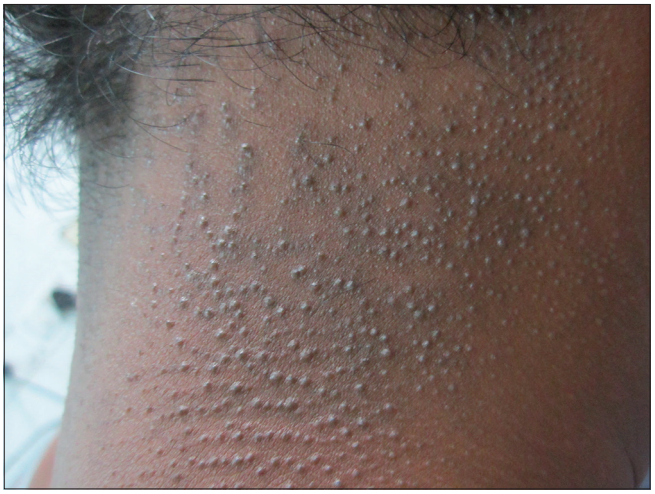

Figure 2: Follicular prominences were present on the neck

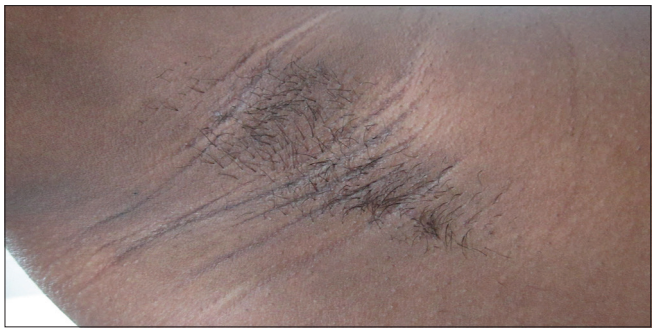

Figure 3: Noncicatricial alopecia of the axilla

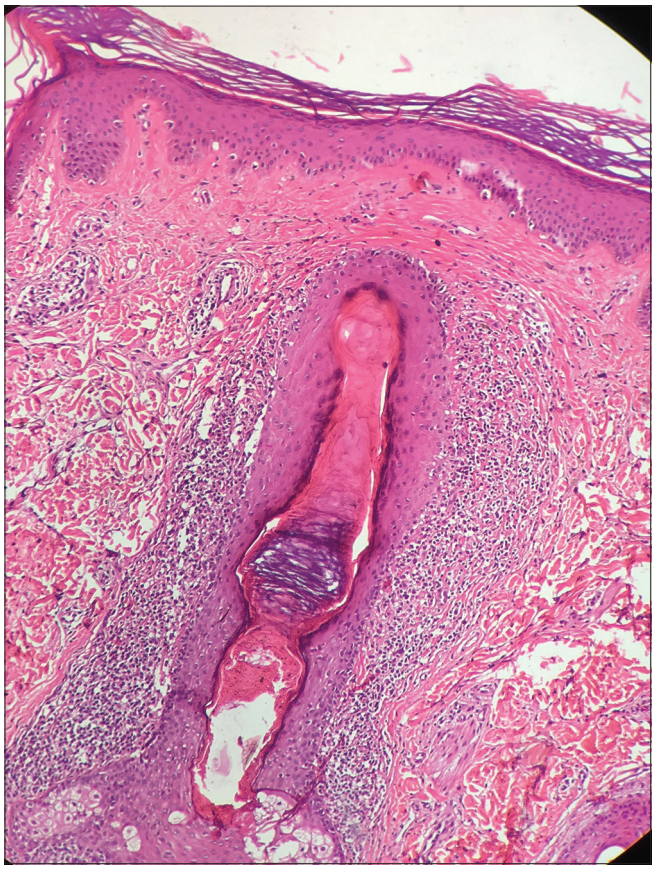

Figure 4: Hematoxylin and eosin stain (×40) showed hyperkeratosis, mild acanthosis, and follicular plugging. Dense perifollicular lichenoid inflammation is present, with vacuolar change of outer root sheath and occasional necrotic keratinocytes. Interfollicular epidermis is spared. Deep dermis shows perifollicular lamellar fibroplasia, collapsed fibrous sheaths, and reduction in hair follicular number

patients understand that their names and initials will not be published and due efforts will be made to conceal their identity, but anonymity cannot be guaranteed.

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Nil.

Conflicts of interest

There are no conflicts of interest.

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References

1. Srivastava M, Mikkilineni R, Konstadt J. Lassueur–Graham-Little–Piccardi syndrome. Dermatol Online J 2010;13:12.
2. Yorulmaz A, Artuz F, Er O, Guresci S. A case of Graham-Little-Piccardi-Lasseur syndrome. Dermatol Online J 2015;21.
3. Vega Gutierrez J, Miranda-Romero A, Perez Milan F, Martinez Garcia G. Graham-Little–Piccardi–Lassueur syndrome associated with androgen insensitivity syndrome (testicular feminization). J Eur Acad Dermatol Venereol 2004;18:463-6.
4. Owczarek W, Ziajka E, Paluchowska E. Lassueur–Graham-Little–Piccardi syndrome in a patient with atopic dermatitis and allergic rhinitis – Case report. Postepy Dermatol Alergol 2010;27:65-8.
5. Pai VV, Kikkeri NN, Sori T, Dinesh U. Graham-Little– Piccardi–Lassueur syndrome: An unusual variant of follicular lichen planus. Int J Trichol 2011;3:28-30.

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