Hyperpigmented papules over labium majus: A venereal cause or something else

Sir,

Lichen planus (LP) is an idiopathic inflammatory skin disease affecting the skin and mucosal membranes.[1] LP over genital area can mimic other venereal diseases.

A 42-year-old female presented with a history of skin lesions over the right side labium majus for 3 months. She noticed the lesions over the right side labium majus 3 months back which gradually increased in size and number. Mild itching was present. History of any genital lesion was not present in husband. On examination, hyperpigmented, soft papules over the right side labium majus were seen and few lesions were showing umbilication and white scale [Figure 1]. Mucosal examination was normal. Serological test results for human immunodeficiency virus and VDRL were negative. Examination of the husband revealed no genital lesions. Based on clinical features, differential diagnosis of molluscum contagiosum and bowenoid papulosis was made. Dermoscopy of the lesions showed Wickham striae in globular and reticular pattern in the center, with areas of bluish-gray dots and globules, few out-of-focus vessels, and purple-gray background suggestive of LP [Figure 2]. Histopathology of the lesion showed acanthosis, hyperkeratosis, and prominent granular layer. The dermoepidermal junction showed dense lichenoid lymphocytic infiltrate along with melanophages in the superficial dermis with artifactual cleft formation between epidermis and papillary dermis [Figure 3]. Based on dermoscopy and histopathological findings, final diagnosis of LP was made. The patient was started on topical clobetasol propionate 0.05% gel twice daily, and after 3 weeks of treatment, significant improvement was seen [Figure 4].

In the present case, morphology of lesions and the presence over genitalia in a sexually active female was suggestive of some sexually acquired infection. We kept the differential diagnosis of molluscum contagiosum and bowenoid papulosis. Three clinical forms of vulval LP are described. These are classic/papular, hypertrophic, and erosive LP. In classic type, typical violaceous papules, small plaques, or annular lesions are seen on the outer labia majora, inter labial sulci, and clitoral hood.[2] However, sometimes, as in the present case, atypical morphology favors other diagnosis. Typical cutaneous lesions of LP on vulvar skin may be modified probably due to humidity, high temperature, PH, and bacterial flora.[3] Recently, Mahajan *et al.* described a biopsy-proven case of hypertrophic LP over labia majora mimicking lichen simplex chronicus.[3] Itching is usually a predominant symptom in the classic and hypertrophic variants, whereas soreness, pain, and dyspareunia are common in erosive LP.[2] In our patient, mild itching was present.

Superpotent topical steroids are the first-line treatment for vulval LP. Other treatment options are calcineurin inhibitors, oral retinoids, dapsone, cyclosporine, methotrexate, and hydroxychloroquine.[2] Classic LP often

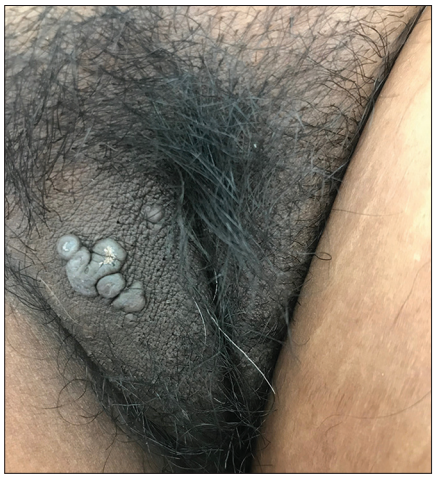

Figure 1: Hyperpigmented, soft papules over the right side labium majus

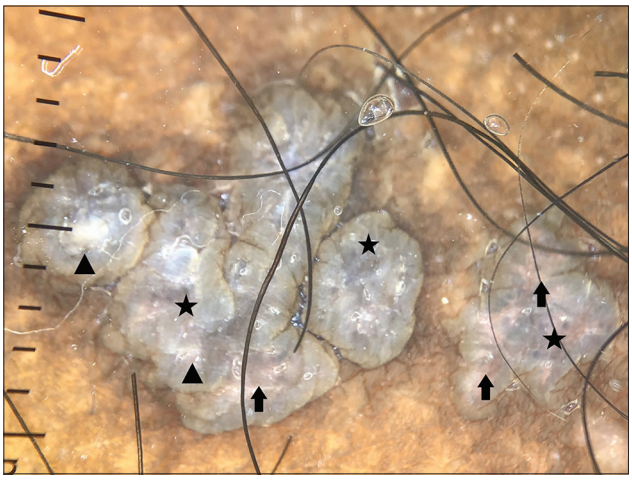

Figure 2: Dermoscopy (Dermlite DL4n, polarized) showed Wickham striae (triangle) in globular and reticular pattern in the center, with areas of bluish-gray dots and globules (star), few out-of-focus vessels (arrow) and purple-gray background suggestive of lichen planus

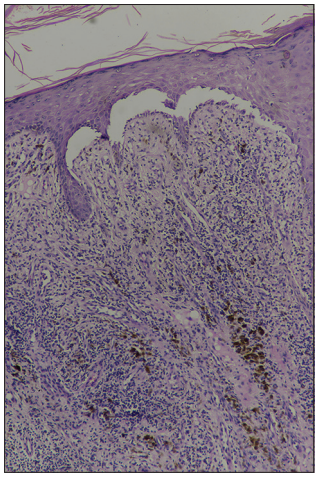

Figure 3: Histopathology showed acanthosis, hyperkeratosis, and prominent granular layer. The dermoepidermal junction showed dense lichenoid lymphocytic infiltrate along with melanophages in the superficial dermis with artifactual cleft formation between epidermis and papillary dermis (H and E, ×100)

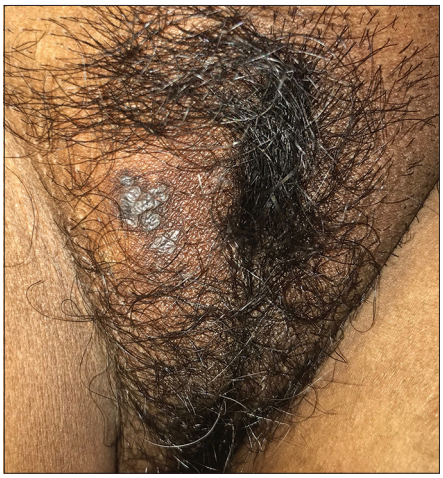

Figure 4: Improvement with 3 weeks of topical steroid treatment

clears completely, hyperpigmentation may take months to resolve.[2] Our patient's lesions also responded well to superpotent topical steroids, however, hyperpigmentation persisted.

Our case highlights that LP over genital area can mimic molluscum contagiosum or bowenoid papulosis. Treatment of molluscum contagiosum, bowenoid papulosis, and LP is totally different. Whenever there is doubt in diagnosis, dermoscopy followed by biopsy is required to confirm the diagnosis.

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 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.

Financial support and sponsorship

Nil.

Conflicts of interest

There are no conflicts of interest.

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Quick Response Code:

Website: www.ijstd.org

DOI: 10.4103/ijstd.ijstd_16_21

How to cite this article: Prabha N, Khare S, Yadav H, Hussain N. Hyperpigmented papules over labium majus: A venereal cause or something else. Indian J Sex Transm Dis 2022;43:232-3.

Submitted: 23-Feb-2021 **Revised:** 06-Mar-2021
Accepted: 20-Sep-2021 **Published:** 17-Nov-2022