

Unilateral acrosyringeal lichen planus of palm

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ABSTRACT

Lichen planus (LP) is a pruritic, benign, papulosquamous, inflammatory dermatosis of unknown etiology that affects either or all of the skin, mucus membrane, hair and nail. It presents with varied morphology on the palms and soles. Here we present a case of unusual acrosyringeal variant of LP on palm. The diagnosis was confirmed histologically.

Key words: Acrosyringeal, lichen planus, palm

INTRODUCTION

Lichen planus (LP) is a common chronic eruption of an unknown cause, and it is characterized by pruritic, plain topped and purple colored papules. The sites of predilection are the extremities, trunk and mucosa. Palmoplantar involvement in LP has been uncommonly described and the palmoplantar lesions differ from classical lesions occurring at other body sites.^[1,2] Here we report a case of a 30-year-old male who presented with multiple, discrete asymptomatic punctate keratoses and pits over left palm since one month. A diagnosis of acrosyringeal lichen planus was made on clinicopathological correlation. We report this case for unusual clinical and histological features.

CASE REPORT

A 30-year-old male presented with multiple, discrete asymptomatic punctate keratoses and pits over left palm since one month. These lesions were gradual in onset and progressive in nature. There was no history of vesiculation or oozing or of similar lesions elsewhere on the body. Examination revealed multiple tiny pits some containing keratotic plugs [Figure 1]. Mild scaling was seen at the edges and some of the plugs also showed collarette scaling. No other skin lesions were seen on the body. Nails and oral mucosa were normal. There was no history of any other systemic or skin disease. There was no history of any drug intake prior to lesions.

A diagnosis of palmar lichen nitidus, LP and pompholyx was thought and a skin biopsy was obtained from a representative lesion.

Histopathological examination revealed compact orthokeratosis, focal parakeratosis, hypergranulosis, irregular slightly saw-tooth acanthosis with focal vacuolar alteration of basal layer with degeneration of basement membrane and few necrotic keratinocytes. In papillary dermis, band-like dense lymphocytic infiltrate mainly in juxtaposition to the acrosyringium with sparing of surrounding epidermis was seen. Liquefaction degeneration of the acrosyringeal basal cell layer with a dilated acrosyringium having a parakeratotic plugs were seen as prominent finding [Figures 2 and 3]. A dilated acrosyringium with parakeratotic plug on histology, explained punctate keratoses seen clinically. However, even on multiple step sections, epidermal perforation could not be found. Thus probably spontaneous shedding of parakeratotic plugs was speculated as a cause of pits seen clinically. On clinicopathological correlation, a diagnosis of acrosyringeal LP of palm was made. Patient is advised to apply topical clobetasol and 3% salicylic acid cream twice daily along with moisturizers and is under follow-up.

DISCUSSION

Lichen planus of the palms and soles causes diagnostic confusion because of the rarity with which it occurs and the atypical morphology of lesions at these sites.^[2,3] Various morphologies

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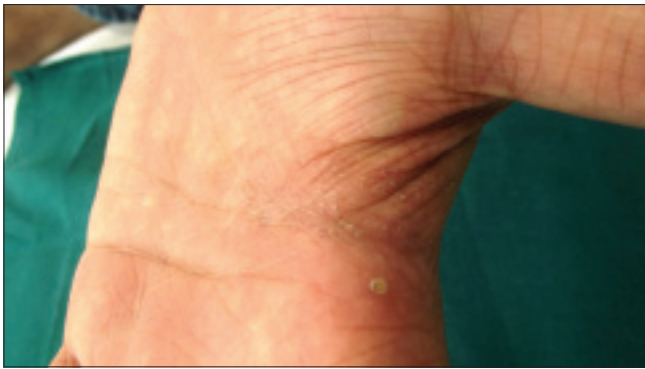


Figure 1: Slightly scaly patch with pits and punctate keratoses on left palm

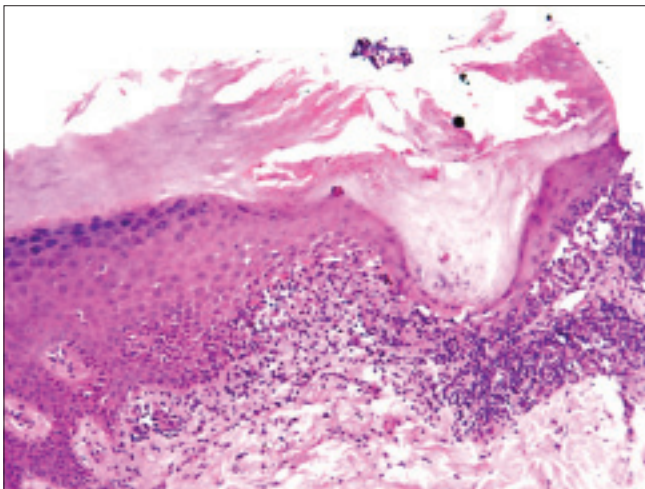


Figure 3: Dilated acrosyringium with parakeratotic plug with liquefactive degeneration of the acrosyringeal basal cell layer and sparing of surrounding epidermis (H and E, ×100)

described, include yellowish hyperkeratotic papules, erythematous scaly plaques, diffuse keratoderma, ulcerated lesions, vesicle-like papules, diffuse palmar hyperpigmentation, umbilicated papules,^[3-5] hyperkeratotic pitted plaques with perforation of epidermis (perforating LP)^[6] and keratotic plaque with pits containing plugs (acrosyringeal LP).^[7] In patients with exclusive palmoplantar involvement, diagnosis is usually missed clinically and histopathology is important in such cases.

Keratotic plaques with punctate keratoses or pitting over palms are always a diagnostic dilemma. The conditions to be considered for such presentation as in our case are punctate porokeratosis, lichen nitidus, punctate palmoplantar keratoderma, arsenical keratoses, porokeratotic eccrine ostial and dermal duct nevus and lichen planus.^[2,3,6,7]

Khandpur *et al.* reported four cases of hyperkeratotic pitted plaques on palms and soles and suggested that presence of plugs within the pits is suggestive of lichen nitidus, and violaceous rim indicates LP.^[2] However in our case, though presence of plugs within pits was seen clinically, histopathology

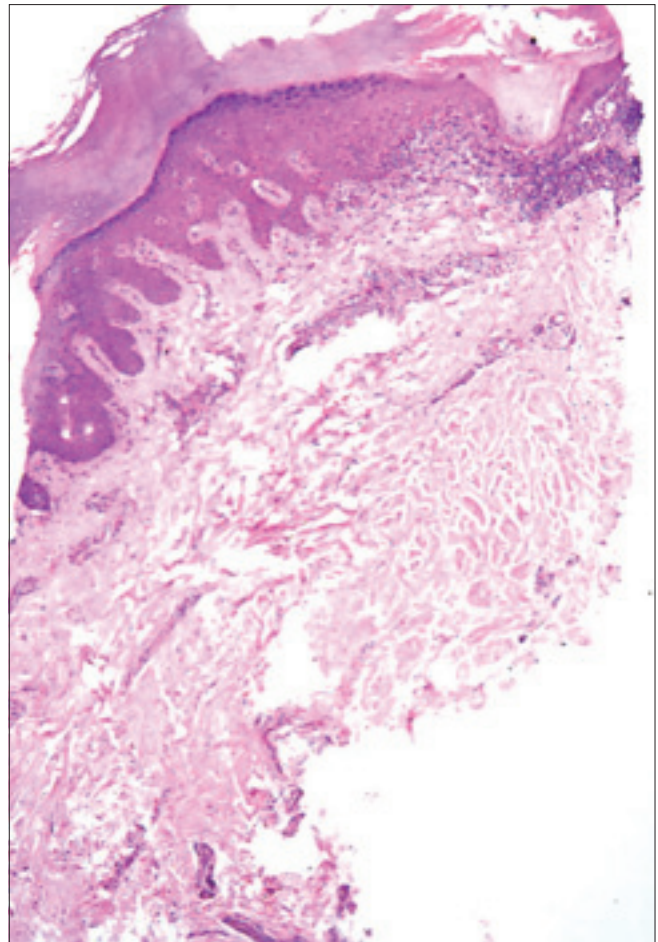


Figure 2: Compact hyperkeratosis, hypergranulosis, irregular acanthosis and lymphocytic infiltrate in dermis with interface change involving only acrosyringium at extreme right of figure (H and E, ×40)

was suggestive of acrosyringeal LP. Further, no violaceous border was seen clinically in present and also in previous case reported by us.^[7]

Enhamre *et al.* coined the term acrosyringeal LP in 1987.^[8] After that, Mugoni *et al.* described five cases of LP on palms with acrosyringeal LP in one of them.^[5] One of the characteristic finding seen in our case was acrosyringeal accentuation of dermal infiltrate with vacuolar interface affecting only acrosyringeal basal layer and acrosyringeal parakeratotic plug. We found similar findings in our previous case also.^[7]

We suggest that acrosyringeal LP is a unique clinicopathological variant. In such cases presenting with pits and plugs on palm, it should be included in differential diagnosis of lichen nitidus.

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