NOTES & COMMENTS

A case of acral lichen sclerosus et atrophicus

To the Editor: We read with great interest the case report of palmar lichen sclerosus et atrophicus by Seyffert and colleagues.[1] We recently managed a 67-year-old woman with acral lichen sclerosus, which clinically presented as multiple, white, hyperkeratotic papules, involving the bilateral palms, flexural wrists, toe webs, and the sides of the feet and toes (Figs 1 and 2). Similar to the case reported by Seyffert et al,[1] she did not have any anogenital involvement, and her lesions were limited to the acral regions throughout her disease course. At the time of presentation, the patient reported soreness and pain when walking and during palpation, but denied pruritus. Despite the distribution of the lesions on her palms and soles, these lesions did not affect her daily functioning.

Histopathologic examination demonstrated edema and homogenization of the connective tissue in the papillary dermis with scattered lymphocytes and a compact stratum corneum consistent with lichen sclerosus et atrophicus (Fig 3). She was managed with halobetasol propionate 0.05% cream twice daily, and, with treatment, the patient noted the lesions on the feet became soft, purpuric, and sore, resulting in her discontinuing topical corticosteroid therapy.

Extragenital lichen sclerosus may occur in approximately 6%-20% of the patients and often involves the trunk and proximal extremities.[2,3] Involvement of the palms and soles is rare and may be limited to these locations or occur in more widespread disease.[2,4-6]

Diagnosis of lichen sclerosus presenting on the acral regions should prompt the clinician to perform a thorough physical examination to assess for genital lichen sclerosus and consider long-term follow-up to assess for development of genital lichen sclerosus.[7] One case report described a patient who presented with lichen sclerosus initially of the extremities that subsequently involved the perigenital region.[8] Therefore, lichen sclerosus should be considered in the differential diagnosis in the setting of ivory atrophic or bullous palmar-plantar lesions, even when lesions are isolated to acral regions.[1]

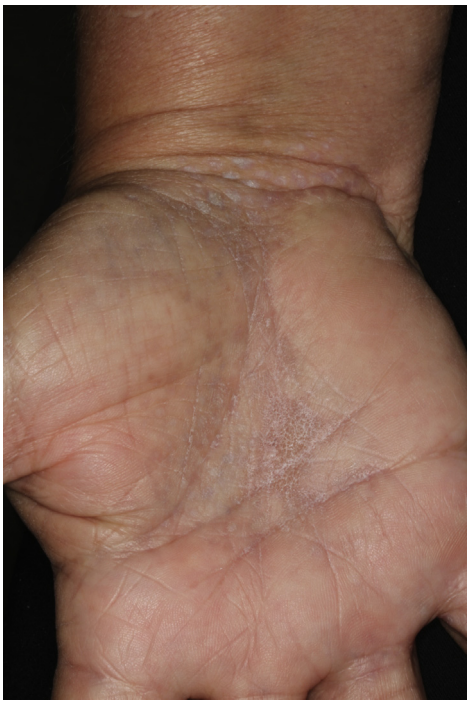

Fig 1. Lichen sclerosus. Multiple, white, hyperkeratotic papules of the palm and wrist and scaling on the palm.

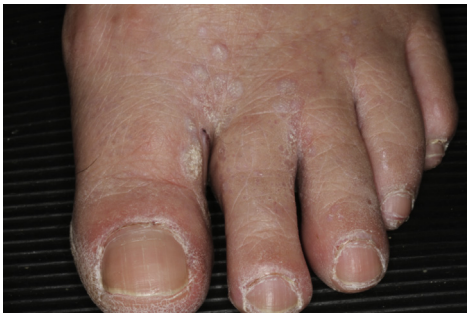

Fig 2. Lichen sclerosus of the foot. Multiple, well-circumscribed, white papules with overlying scale with scale and erythema also involving the toe webs.

This may lead to earlier diagnosis of genital disease, initiation of proper treatment, and reduction of the patient's risk of developing scarring and squamous cell carcinoma of the genitalia.[3,4,7] Although squamous cell carcinoma arising in extragenital lichen sclerosus has been reported, this is rare and has not involved lesions of lichen sclerosus in acral sites.[4,9]

Acral lichen sclerosus represents a diagnostic and treatment challenge. Although this patient had an

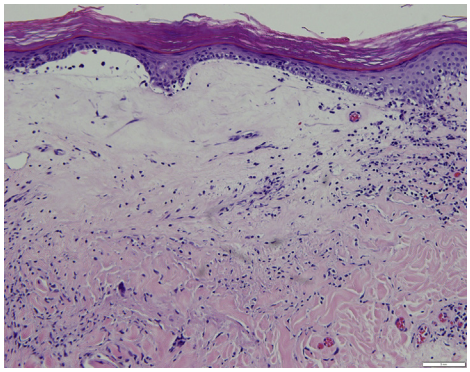

Fig 3. Histology of lichen sclerosus demonstrating edema and homogenization of the connective tissue in the papillary dermis with scattered lymphocytes and a compact stratum corneum.

unusual clinical presentation, classical features of lichen sclerosus demonstrated by histopathological examination facilitated in establishing the accurate diagnosis. It is possible that these lesions of the hands and feet, located at sites that may be susceptible to recurrent friction and trauma, developed due to the Koebner phenomenon, which has been described in extragenital lichen sclerosus.[3] However, it would be interesting to evaluate if patients with isolated acral lichen sclerosus also have an autoimmune phenotype with increased level of T-helper cell type 1 cytokines, reported in vulvar lichen sclerosus, or if lesions develop in response to a different pathophysiologic process.[3]

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Conflicts of interest

None disclosed.

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