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Bullous lichen planus : Case report

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Abstract
Lichen planus is a chronic inflammatory autoimmune disease in which autoantibodies are generated against the basal keratinocytes, leading to its degeneration. The prevalence of oral lichen planus (OLP) ranges from 0.5% to 2.2% of the population. We report a case of A 45-year-old female with reddish white patches on her left inner cheek region and tongue. The histology confirm the diagnosis of bullous lichen.

Keywords: Lichen, bullous, autoimmune, autoantibodies

Introduction
Lichen planus is a mucocutaneous disease characterized by nonspecific inflammation. It leads to the severe destruction of the epithelial basal layer. OLP usually presents bilaterally on the oral mucosa and has various patterns, with reticular, erythematous (erosive), plaque and ulcerative being the most common. These patterns may coexist in the same region or may alternate in time [1]. Bullous lichen planus (BLP) is relatively a rare variant of lichen planus. Most patients with BLP are associated with multifocal involvement and skin lesions [2]. We report a case of a female adult with an oral bullous lichen.

Case Report
A 45-year-old female patient reported to our department with a chief complaint of reddish white patches on her left inner cheek region and tongue for past 2 years with associated burning sensation. She felt fluid-filled swelling that ruptured subsequently. The patient was previously under topical antifungal therapy that temporarily reduced the burning sensation. Patient had no relevant medical, dental, or familial history and maintained good oral hygiene. She had no chewing or smoking habit and consumes spicy foods. On inspection of left buccal mucosa [Figure 1], a single erythematous lesion with was seen the inner side of the left cheek with another well-limited erosion on the right side of the tongue. It was soft in consistency with elevated white irregular margins. The surface was rough and non-tender on palpation. The patient presented with no other skin abnormalities. A skin biopsy was performed, and showed regular, hyperkeratotic and acanthotic squamous epithelium. At the level of the superficial chorion, presence of multiples cells , especially plasmocytes and lymphocytes with epithelial cleavage and so the diagnosis of bullous lichen was made. Patient was advised for medical and stress management. She was advised to take topical application of corticosteroids. Regression of lesion was seen completely over the end of 6 weeks.

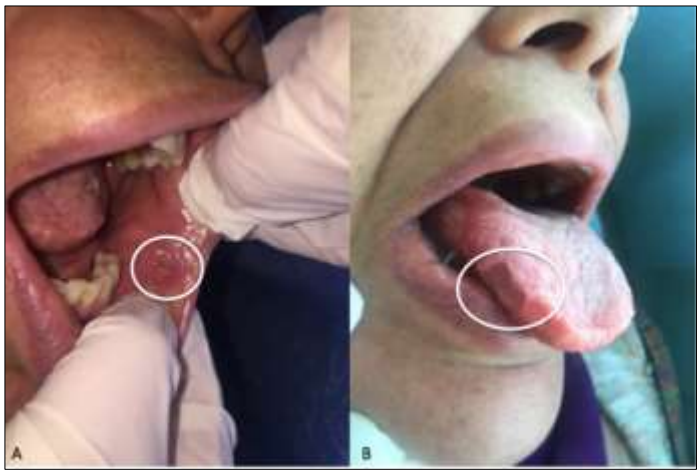

Fig 1 : A single erythematous lesion with was seen the inner side of the left cheek with another well-limited erosion on the right side of the tongue

Discussion
Lichen planus is a chronic inflammatory autoimmune disease in which autoantibodies are generated against the basal keratinocytes, leading to its degeneration. The etiology of the lesion is not well defined although stress is a commonly associated factor in these patients [3]. The prevalence of oral lichen planus (OLP) ranges from 0.5% to 2.2% of the population and it is considered the most common skin disease involving the oral mucosa. The typical age of onset ranges from 30-60 years, and it is more common in women [4, 5]. The most commonly affected sites are the buccal mucosa, the tongue and the gingiva. Involvement of the palate and lips is rare, and even rarer is the involvement of the oral floor. Burning symptoms, itching and pain are particularly seen in the ulcerative and erythematous

variants [6]. The characteristics of lichen planus are flattened, polygonal, pruritic, and violaceous papules with grayish-white scaly surfaces [7]. According to the literature, the reticular pattern is the most frequent pattern, followed by the erosive pattern, but bullous lichen remain rare [8, 9]. There are two variants of BLP: familial and nonfamilial. The familial variant is more common than the nonfamilial variant. Familial BLP occurs at an earlier age with longer duration of disease and more extensive eruptions, and increased tendency to involve nails is seen in familial BLP when compared to nonfamilial variants [10]. BLP commonly appears on the oral mucosa and the legs with blisters developing near or on pre-existing LP lesions. BLP of the nails has also been described in literature [11]. Athough, there is a report of BLP developing in the skin graft donor site of a psoriatic patient [12].

In most cases, the lesions depict hyperkeratosis with hypergranulosis or acanthosis or both. Moderate-to-dense lymphocytic band is seen mostly in papillary dermis. Basal cell degeneration is seen in most of the cases reported. Presence of saw-tooth rete ridges is seen rarely. Clear epithelial or subepithelial clefts are present in most of the cases with the presence of civatte or colloid bodies [13].

Systemic drugs such as prednisolone or topical application such as triamcinolone when used separately or together give good prognosis . Phototherapy such as broadband ultraviolet-B therapy has proven to help in the eradication of BLP. Usage of retinoids such as tretinoin can also help in controlling the lesions [13].

Conclusion

Lichen planus is a mucocutaneous disease. Oral examination at least once/twice a year still remain the most effective preventive measure in order to early detect the neoplastic derailment of OLP, and fot the lesions that are clinically compatible with lichen, they should undergo biopsy for definitive diagnosis and should be followed up for life. In case changes in the appearance of these lesions are found during follow-up, further biopsies should be carried out, because their malignant potential is not yet clear.

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