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PHOTOLETTER TO THE EDITOR

Dermoscopy of atypical lichen sclerosus involving the tongue

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Abstract

Involvement of tongue during the course of lichen sclerosus is extremely rare, with only five — to our knowledge — described cases in the English literature. We present clinical and dermoscopic findings of a female patient who concomitantly developed genital, skin and oral lesions of lichen sclerosus. Tongue involvement consisted of a linear atrophic whitish plaque, strikingly mimicking "en coupe de sabre" scleroderma. Dermoscopic examination revealed a well demarcated, linear, dense, white, homogenous area, with papillae projections hardly seen in the affected area. Dermoscopy of lesions located on the trunk revealed whitish plaques with comedo-like openings in the center and an erythematous halo at the periphery. Since clinical differentiation of oral LS and other oral diseases appearing as white atrophic plaques is almost impossible without using histology, we believe that dermoscopy might represent an additional tool, contributing to the final diagnosis, and thus avoiding an ablative procedure at this site-sensitive localization. (*J Dermatol Case Rep*. 2012; 6(2): 57-58)

Key words:

dermoscopy, lichen sclerosus, oral mucous membranes, oral mucosa

A 42-year-old woman visited our outpatient clinic with 1-year history of an asymptomatic gradually expanding sclerotic lesion of the tongue. Physical examination revealed a firm, linear, slightly depressed, glazy, white plaque, located at the dorsum of the tongue, measuring 3.5x0.8 cm (Fig. 1A). Papillae of the tongue in the affected area were almost absent, as a result of the extreme atrophy. Rest of the oral mucosa was normal. Furthermore, four — 0.5-2 cm in diameter — white, hyperkeratotic, atrophic plaques with follicular plugging, were observed over her upper back. According to the medical history, two years prior to presentation, she was diagnosed with genital and perianal lichen sclerosus (LS), which responded well to topical application of clobetasole and remained stable until today.

Dermoscopic examination of the tongue revealed a well demarcated, linear, dense, white, homogenous area. Papillae projections, clearly observed in unaffected surrounding skin, were hardly seen in the affected area (Fig. 1B). Dermoscopy of lesions located on the trunk revealed whitish plaques with comedo-like openings in the center and an erythematous halo at the periphery (Fig. 1C). Subsequent punch biopsy and histological examination confirmed the clinical diagnosis of LS (Fig. 2). The patient remains under treatment with intermittent short courses of topical steroids,

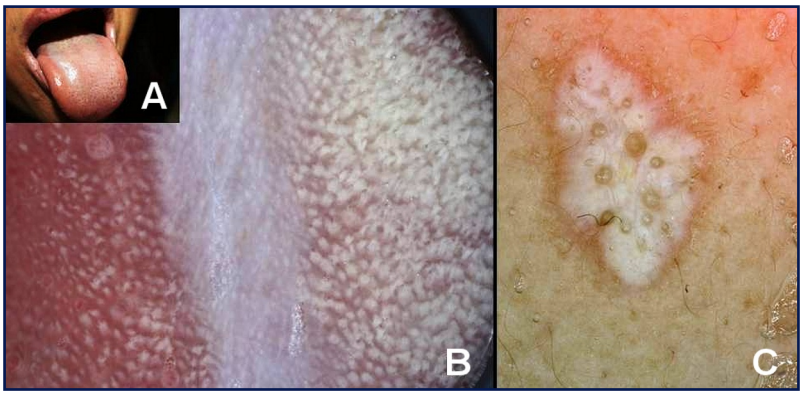

Figure 1

Linear, whitish plaque at the dorsum of the tongue (A), dermoscopy showed a well demarcated, white, homogenous area and atrophic papillae in the affected site (B), and whitish plaques with comedo-like openings in the center and an erythematous halo at the periphery of a trunk lesion (C).

resulting in adequate control of disease activity, but minimal improvement of the already established atrophy.

LS is an uncommon chronic cutaneous disorder of uncertain aetiology, affecting predominantly women's genitalia and perianal skin. Involvement of the oral mucosa during the course of the disease is extremely rare,[1] while tongue lesions are even scarcer.[2,3] To the best of our knowledge, only 26 well established cases of oral LS, have been published in the English literature, with only 5 of them reporting tongue involvement. Among the latter group, all the individuals were young to middle-aged females. Oral symptoms were recorded in only 2 out of these 5 cases, while coexistence of genital, skin and oral lesions, as in our patient, was reported only once.

Oral LS may involve the buccal, labial and gingival mucosa, palate, tonsillar pillars, tongue, and lip vermilion. The lesions typically appear as white macules or plaques of variable size, although reticular striae and superficial ulceration have also been reported. In our patient, the clinical presentation of oral LS was very unusual, strikingly resembling scleroderma "en coupe de sabre". However, personal medical history in combination with extragenital lesions and dermoscopic images favored the diagnosis of LS, which was finally confirmed histologically.

A whitish plaque with comedo-like openings in the center has been previously described as the dermoscopic pattern of 4 cases of extragenital LS.[4] A peripheral erythematous halo was present in 1 out of 4 cases and authors suggested that it represents a marker of activity of the disease. In our case of LS dermoscopy of the trunk lesions revealed strikingly similar findings. Concerning the tongue lesion, this is the first — to our knowledge — description of dermoscopy of LS in the specific location. The well demarcated, linear, dense, white, homogenous area seen under dermoscopy, possibly correlates to the histological dense, homogenous fibrosis affecting the upper dermis in long standing lesions of LS.

Clinical differentiation of oral LS and other oral diseases appearing as white atrophic plaques is almost impossible without using histology. In this context, dermoscopy might represent an additional tool, contributing to the final diagnosis, and thus avoiding an ablative procedure at this site-sensitive localization.

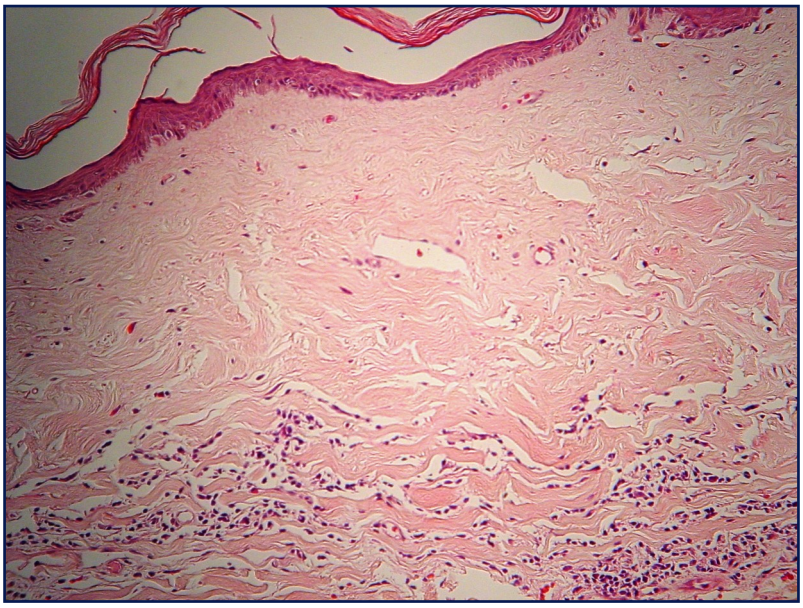

Figure 2

Hyperkeratosis overlying atrophic epidermis and sclerosis of the dermis, in combination with a band of lymphocytic infiltrate underneath, confirmed the diagnosis of LS.

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