11-1-2013

Inverse lichen planus

Michael D Lee
*Thomas Jefferson University*, mdlee@mdlee.com

Laurel R Schwartz
*Thomas Jefferson University*

Let us know how access to this document benefits you

Follow this and additional works at: [https://jdc.jefferson.edu/dcbfp](https://jdc.jefferson.edu/dcbfp)

Part of the *Dermatology Commons*

Recommended Citation
[https://jdc.jefferson.edu/dcbfp/40](https://jdc.jefferson.edu/dcbfp/40)

This Article is brought to you for free and open access by the Jefferson Digital Commons. The Jefferson Digital Commons is a service of Thomas Jefferson University’s Center for Teaching and Learning (CTL). The Commons is a showcase for Jefferson books and journals, peer-reviewed scholarly publications, unique historical collections from the University archives, and teaching tools. The Jefferson Digital Commons allows researchers and interested readers anywhere in the world to learn about and keep up to date with Jefferson scholarship. This article has been accepted for inclusion in Department of Dermatology and Cutaneous Biology Faculty Papers by an authorized administrator of the Jefferson Digital Commons. For more information, please contact: JeffersonDigitalCommons@jefferson.edu.
As submitted to:

*Skinmed*

And later published as:

Inverse Lichen Planus


PMID: 24517041

**A Case of Inverse Lichen Planus Title Page**

Author #1 = Michael D. Lee, M.D.

Author #2 = Laurel R. Schwartz, M.D.

Author Affiliations = Thomas Jefferson University Hospital
A Case of Inverse Lichen Planus

Lichen planus (LP) is a pruritic, papular eruption characterized by its violaceous color and polygonal shape. It is most commonly found on the flexor surfaces of the upper extremities, on the genitalia, and on the mucous membranes. We herein report a classic case of LP in an inverse distribution.

Report of a Case

A 61 year old African American female presents to the ER with a rash. She is a poor historian but states it started one week ago and is located in her axilla, neck, and inframammary regions. She reports no modifying factors, notes it is very itchy, denies any attempted treatment.

On physical exam, we see violaceous, shiny, polygonal papules coalescing into plaques in the axilla, neck, and inframammary regions. A punch biopsy from the R shoulder area reveals a band-like infiltrate of lymphocytes, which obscures the dermo-epidermal junction, associated with an epidermis that is altered by jagged epidermal hyperplasia, foci of hypergranulosis, compact orthokeratosis, and presence of necrotic keratinocytes. This is consistent with a diagnosis of lichen planus in an “inverse” distribution.

The patient was treated with Prednisone 20mg qday x 7 days, then 10mg qday x 7 days and Triamcinolone Cream to be applied BID x 1 week with minimal benefit. She is currently commencing narrowband UVB treatment as an outpatient.

Comment

A literature search with the search term “Inverse Lichen Planus” was not fruitful. A MEDLINE/Pubmed search produced 2 articles, one discussing the entity of inverse lichen planus pigmentosus and a historic article discussing annular inverse lichen planus in patients from subtropical countries. Our patient does not clinically resemble previously published cases.

Lichen planus is a disease with classic morphology and the diagnosis of inverse lichen planus appears to have been rendered when lichen planus affects certain locations. However, there does not appear to be significant literature specifically addressing the entity of inverse lichen planus.
