

Zosteriform Lichen Planus as the Presenting Feature of Generalized Lichen Planus; a Case Report

Dear Editor

A 40-year-old man was visited at our clinic with a history of pruritic cutaneous papules in a zosteriform pattern from 3 months ago. The skin lesions were located unilaterally on the right side of his thorax. On examination, there were multiple shiny, erythematous, violaceous and slightly scaly papules limited to right T7 dermatome (Figure.1). General physical examination was unremarkable and mucous membranes were intact. A biopsy was taken and the specimen exhibited hyperkeratosis, focal increases in the granular cell layer, and irregular acanthosis with a saw tooth appearance, liquefactive degeneration of the basal cell layer and a band-like lymphocytic infiltrate at the dermo-epidermal junction and a number of Civatte bodies. He was treated with potent topical steroids. After 2 months, he came back with generalized lesions and typical mucosal lesions. This time, he was treated with systemic steroids. After 2 months, pruritus subsided and post inflammatory hyperpigmentation was formed, but mucosal lesions persisted.

Lichen planus (LP) is an idiopathic inflammatory disease of the skin and mucous membrane. It is characterized by pruritic violaceous papules that favor the extremities¹.

Linear LP refers to LP with a unilateral linear distribution. This variant may present as an example of the Wolf's isotopic response on the site of healed zoster². In very rare instances, linear LP presents in a segmental fashion corresponding to one dermatome and is termed zosteriform LP. In extremely rare cases, zosteriform or linear distributions appear de novo on previously normal, non-traumatized skin, as in our patient. Although case reports of de novo dermatomal LP have been reported³, this entity is controversial. Happle argued that the term *zosteriform lichen planus* has been applied inappropriately in cases who have developed lesions de novo in the lines of Blaschko, rather than in true dermatomes⁴. Some authors believe that true zosteriform LP only exists in cases who have developed lesions on the sites of healed herpes zoster⁵.



Figure 1: Multiple shiny, erythematous, violaceous and slightly scaly papules limited to right T7 dermatome

In our patient, the distribution of lesions was limited to T7 dermatome. The patient denied prior history of herpes zoster. The linear eruption seemed to follow a true dermatome rather than in the S-shape pattern of the lines of Blaschko on the trunk.

Although it is difficult to differentiate the two, these atypical distribution patterns may provide clues to the pathogenesis of a condition with a currently unknown etiology. (*Iran J Dermatol* 2009;12: 35-36)

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