Bullous Lichen Planus treated with Oral Minipulse Therapy: A Rare Case Report

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ABSTRACT
Oral Lichen planus (OLP) is a common mucocutaneous disorder with a multifactorial aetiology, affecting the women more commonly than men. Most OLP are asymptomatic, except the atrophic and erosive forms. Till date many treatment modalities are implicated to treat this disorder, but no therapy is considered as the single most effective, without side-effects and remission of the lesion. As the treatment of OLP is challenging to the oral practitioners, here we report a case of successful management of extensive, symptomatic bullous and erosive oral lichen planus with a novel treatment protocol- oral minipulse therapy with betamethasone.

CASE REPORT
A 35-year-old female patient reported to the department with a chief complaint of burning sensation of the oral cavity since four months. The burning sensation was continuous and preceded by eruption of fluid filled blisters that used to burst with in few seconds. Her medical history was non contributory and on general examination multiple papules were seen on the face and scalp, which were associated with itching and loss of hair on the scalp. Black healed pigmented papules were seen on the face and scalp, which were associated with itching and loss of hair on the scalp. On intraoral examination diffuse white linear striae with areas of erosions and pigmentation were seen on the right and left buccal mucosa [Table/Fig-3]. Fine linear striae and areas of erosions were seen on the right & left lateral borders of the tongue, with intact bullae seen on the left lateral and ventral aspect of the tongue [Table/Fig-4]. Based on the clinical findings, a provisional diagnosis of bullous lichen planus was considered with the differential diagnosis of pemphigus vulgaris and bullous pemphigoid. The patient’s haematological investigations, renal and liver function tests were within the normal limit. Following written informed consent, an incisional biopsy was performed and histopathological report was suggestive of lichen planus. The patient was evaluated and was advised betamethasone oral minipulse therapy comprising 5mg of betamethasone taken as a single daily dose orally for two consecutive days every week for three months, followed by tapering the dose from 5mg to 4 mg in the fourth month, 3mg in the fifth month, and 2mg in the sixth month. Treatment was stopped after six months and patient was followed up for the next three months. The visual analogue scale (VAS) score was recorded on every visit of the patient. Following the therapy there was remission of the lesions on the face, scalp, buccal mucosa and tongue [Table/Fig-5-7]. The patient is currently under follow up since 1½ year with no recurrence of the lesions.

DISCUSSION
Lichen Planus (LP) is a relatively common chronic inflammatory, papulosquamous and presumably autoimmune disease that affects the skin, mucous membranes, nails, and the scalp [1]. The term “Lichen planus” was first introduced by Erasmus Wilson in 1869 [2]. It is derived from the Greek word “leichen”- tree moss and Latin word “planus”- flat [1]. The oral lesions of the disease was first observed by Louis Frederick Wickham and he gave a clear and detailed description of the peculiar striae and dots found on the surface of a lichen planus papule named as Wickham striae in 1895 [3]. Darier gave the first formal description of the histopathologic characteristics of the disease [1], 0.5-1% of the world’s population and 1-1.5% of Indian population were affected by the lichen planus lesions [4]. It is mostly seen in the 5th and 6th decade of life and has a predominance of women over men [2]. The different aetiological factors considered for LP are genetic background, dental materials, drugs, infectious agent, autoimmunity, immunodeficiency, food allergy, stress, habits, trauma, diabetes, hypertension, malignant neoplasm and bowel diseases [5]. The pathogenesis of LP is thought of from four mechanisms antigen specific cell-mediated immune response (heat shock proteins, CD4+ T-helper cells, CD8+ cytotoxic T-cells) non-specific mechanism (epithelial basement membrane, mast cells, chemokines, matrixmetalloproteinases) autoimmune response, humoral immunity (circulating autoantibodies to desmoglin 1 and 3) [6]. Patients with OLP frequently have concomitant disease in one or more extra-oral sites. Approximately 15% of patients develop cutaneous lesions. The classic appearance of skin lesions described by the six P’s: planar, plaque, puritic, purple, polygonal, and papular. Typically cutaneous lesions develop after the appearance of oral lesions and severity of oral lesions does not correlate with cutaneous lesions. Lichen planopilaris represents LP involvement of
sculpt and hair follicles causing a scarring alopecia. The combination of follicular LP with scarring alopecia of scalp and no scarring alopecia of axilla and pubis or other areas is known as Graham Little syndrome. Intra-orally the red and white components of lesion can be part of reticular, papular, plaque-like, atrophic, erosive and bullous types [6]. In the present case the patient presented with reticular, erosive and bullous forms.

The characteristic clinical aspects are sufficient to make a correct diagnosis if classic lesions are present. An oral biopsy with histopathologic study is recommended to confirm clinical diagnosis and also to exclude dysplasia and malignancy. The value of direct immunofluorescence for confirmation of disease is well accepted, especially with non-diagnostic histopathologic features and for desquamative gingivitis [6]. To date no cure for OLP or dermal counterpart. The treatment goal is 2-fold, that is, alleviation of symptoms, monitoring of dysplastic and also to exclude dysplasia and malignancy. The value of direct immunofluorescence for confirmation of disease is well accepted, especially with non-diagnostic histopathologic features and for desquamative gingivitis [6]. To date no cure for OLP or dermal counterpart. The treatment goal is 2-fold, that is, alleviation of symptoms, monitoring of dysplastic and also to exclude dysplasia and malignancy. The value of direct immunofluorescence for confirmation of disease is well accepted, especially with non-diagnostic histopathologic features and for desquamative gingivitis [6].

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**REFERENCES**


