Oral Atrophic Lichen Planus: Diagnosis and Management

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Lichen planus is a chronic T-cell mediated autoimmune disease, which affects the oral mucosa, skin, genital mucosa, scalp and nails. Oral lichen planus, the mucosal counterpart affects 0.5-2.0% of the general population and often seen in the fifth to sixth decades of life. The lesion is frequently seen in women. Since it is considered a potentially malignant disorder, early diagnosis with timely management and regular follow-up is very important to avoid further complications. This paper reports a case of atrophic lichen planus, highlights the classic picture of atrophic lichen planus, discusses the differential diagnoses and timely management and follow-up.

Keywords: Early diagnosis, Lichen planus, Oral, Therapy, Topical

INTRODUCTION

Lichen planus is considered as a chronic inflammatory disease affecting the skin and mucous membranes. Oral lichen planus (OLP) can occur in association with cutaneous lichen planus or alone.1,2 Approximately, 2% of the population are affected with OLP and is more prevalent in women. It mostly occurs in the fifth to sixth decades of life. It is seen clinically as reticular, papular, plaque-like, erosive, atrophic or bullous types.3-6 The buccal mucosa, lips, gingivae, floor of the mouth, and palate are usually affected, in a descending order of frequency. OLP is considered to have some degree of malignant tendency and is watched carefully for the same reason.7

CASE REPORT

A 63-year-old male presented with a chief complaint of burning sensation of his right and left buccal mucosa since 1 year. He reported that the burning sensation increases on eating spicy food. He was a smoker for the past 30 years. He was hypertensive and under medication. On intraoral examination, left buccal mucosa revealed a white lesion with fine lacy radiating lines measuring 2 cm × 3 cm. Similar greyish white areas were also observed in the left retromolar pad region (Figure 1). Right buccal mucosa showed a reddish white lesion with lacy fine radiating lines (Wickham’s striae) as well as in the retromolar pad region extending up to the upper buccal vestibule (Figure 2). The lesion on the right side was tender on palpation. However, there were no areas of shallow ulceration. Both sides the lesions were non-scrapable. Rest of the mucosa had a blackish pigmentation. He had no history of skin lesions. Based on the history and classic features of the lesion, the case was diagnosed as atrophic lichen planus. Patient was advised to undergo all required dental treatments such as oral prophylaxis and restorations. He was prescribed with 0.1% triamcinolone acetonide for topical application. The patient was reviewed after 3 weeks, and there was improvement in symptoms and the lesions subsided. Hence, biopsy was not performed in this case as there was a good response to treatment.

DISCUSSION

Lichen planus is a chronic T-cell mediated autoimmune disease, which affects the oral mucosa, skin, genital mucosa, scalp, and nails.3 OLP, the mucosal counterpart affects 0.5-2.0% of the general population and often seen in the fifth to sixth decades of life. The lesion is frequently seen in women.4,5 Since it is considered a potentially malignant disorder, early diagnosis with timely management and regular follow-up is very important to avoid further complications. However, the incidence of malignant transformation in OLP has been fairly low.6,7 Biopsy is mandatory to rule out dysplasia or malignancy. However,
CONCLUSION

Lichen planus is a chronic immune-mediated mucocutaneous lesion. Classically found on the buccal mucosa and gingiva. Atrophic lichen planus holds a high risk of malignant transformation. This paper highlights the classic picture of atrophic lichen planus and timely management. Prognosis was better post-medication. Nevertheless, it seems prudent to monitor this patient with atrophic lichen planus in the long-term.

REFERENCES


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