Dermoscopy is a non-invasive tool that allows us to recognize key structures of lichen planus, which is useful for its diagnosis, follow-up and prognosis.

Case reports

Case 1
A 50-year-old female patient with no relevant history was seen in the hospital due to a pruritic erythematous papule with months of evolution on the anterior side of her right lower limb associated with asymptomatic confluent whitish papules on buccal mucosa. Two weeks later it had evolved with an eruption of pruritic violaceous plaques in the neck area. Dermoscopy of the lesion on the patient’s thigh revealed small pinpoint vessels associated with whitish striations (projections) with a “fern leaf” aspect on an erythematous background (Figure 1).

Pathological examination revealed: sawtooth acanthosis, orthokeratotic hyperkeratosis, hypergranulosis, hydropic degeneration of the basal layer, and band-like lymphocytic infiltrate compatible with lichen planus.

Case 2
A 36-year-old female patient, with no medical history, sought medical attention due to multiple alopecic areas on the scalp of uneven distribution, erythema and follicular plugging.

A trichoscopy revealed multiple irregular cicatricial alopecic areas with perifollicular whitish-gray scaling associated with perifollicular whitish-gray scaling.
Mycological exam, X-ray of both hands, routine laboratory tests and HBV, HCV and HIV serologies were unremarkable.

Pathological examination of the nail bed and plate (Protocol 133239, Dr. Casas) revealed: hyperkeratosis, para- with erythema, arboriform vessels, absence of follicular openings, and follicular plugging (Figures 2, 3).

Pathological examination (Protocol 14-03006, Dr. Calb) revealed: hair follicles with vacuolar degeneration of follicular wall basal cells and numerous perifollicular lymphocytes; the histological image was compatible with lichen planopilaris.

Case 3
A 59-year-old male patient with no medical history was seen in the hospital due to an active and progressive onychodystrophy of the first, fourth and fifth fingers of both hands, and the third finger of the left hand, of 1 year’s evolution. Within the nail, there was pterygium, thinning, and destruction of the nail plate, longitudinal ridging, fissuring, onycholysis and subungual hyperkeratosis. The rest of the physical examination was unremarkable (Figure 4).

On dermoscopy, we observed chromonychia, subungual hyperkeratosis, onycholysis, and destruction of the nail plate (Figure 5).

Mycological exam, X-ray of both hands, routine laboratory tests and HBV, HCV and HIV serologies were unremarkable.

Pathological examination of the nail bed and plate (Protocol 133239, Dr. Casas) revealed: hyperkeratosis, para-
Cutaneous lichen planus

The classic skin lesion consists of a flat-topped polygonal papule that is slightly erythematous to violaceous. A thin and adherent scale can be observed on top of it. On the surface there are reticular or pinpoint whitish structures, known as Wickham striae (WS), pathognomonic of this entity [1].

Dermoscopy findings consist of polymorphic pearly whitish structures that correspond to WS with arboriform “fern leaf” projections. At the borders linear vessels (radial capillaries) and erythematous globules may be observed (Figure 1), WS dermoscopic patterns [2] (Table 1):

- Reticular (the most common)
- Circular
- Radial streaming
- Leaf venation: characterized by delicate secondary striae branching from the centered WS venation, linked together at either end, mimicking the crystal structure of snow
- Starry sky/white dots: clustered, follicular white dots

At dermoscopy, the WS is the diagnostic key to differentiate lichen planus from other entities such as the pityriasis rosea and psoriasis [3,4,5].

Lichen planopilaris

Lichen planopilaris (LPP) is characterized by keratotic follicular papules that coalesce, forming plaques. At the final stage, the scalp shows multiple cicatricial alopecic areas with irregular aspect, perifollicular erythema and absence of follicular openings with follicular plugging [6].

Trichoscopy reveals multiple irregular cicatricial alopecic areas with perifollicular whitish-gray scaling associated with erythema, arboriform vessels, absence of follicular openings and follicular plugging (Figures 2, 3).

Dermoscopic findings vary according to the stage of evolution and the degree of disease activity. In early stages, perifollicular inflammation leads to the appearance of whitish-gray scales (peripilar casts) associated with perifollicular erythema, characterized by the presence of arboriform ves-

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*New dermoscopic patterns

Nail lichen planus
The clinical manifestations of nail lichen planus are thinning, fragility, and destruction of the plate nail, longitudinal ridging, fissuring, onycholysis, trachyonychia, chromonychia and subungual hyperkeratosis [10] (Figure 4) (Table III).

Dermoscopic findings demonstrate the compromise of the matrix that leads to the thinning and consequent fragility of the nail plate with fissuring, pitting, and its progression to trachyonychia, longitudinal ridging, dorsal pterygium, erythematous patches in the lunula, eritronychia, melanonychia and atrophy.

Lichen planus pigmentosus inversus
Lichen planus pigmentosus inversus is an uncommon variant of lichen planus pigmentosus involving predominantly folds, characterized by the presence of well-defined, brownish-purple oval macules, whose size varies from few millimeters to several centimeters and which may adopt a linear configuration. The lesions tend to be bilateral and asymptomatic, although some patients report mild pruritus. They heal belatedly, leaving an area of atrophic and hyperpigmented skin [12].

Dermoscopic patterns (Table IV):
• Diffuse: characterized by diffuse, structureless, brownish areas probably associated with epidermal pigmentation
• Dotted: fine or coarse gray-blue or brown dots or globules related to dermal melanophages
• Mixed: combining diffuse brownish areas with dotted structures

Dermoscopic findings are of prognostic value, since those lesions with a dotted pattern tend to be persistent because the pigment is localized deeper [13].

Conclusion
We describe the key dermoscopic findings of lichen planus and the different clinical variants, highlighting that dermoscopy can improve the diagnosis and follow-up of patients with this dermatosis.

References