

Case Report

A Case Report: Lichen Planus Hypertrophicus

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ABSTRACT

Lichen planus hypertrophicus (LPH) is an ongoing provocative and resistant interceded illness that influences the skin, nails, hair, and mucous membranes. It is portrayed by polygonal, level bested, violaceous papules and plaques with overlying, reticulated, fine white scale (Wickham's striae), normally influencing dorsal hands, flexural wrists and lower arms, trunk, front lower legs and oral mucosa. Although there is an expansive clinical scope of LP indications, the skin and oral depression stay as the significant locales of involvement. The reason is obscure, yet it is believed to be the consequence of an immune system measure with an obscure introductory trigger. There is no fix, yet various drugs and techniques have been utilized in endeavors to control the indications.

1. Introduction

Lichen planus hypertrophicus is a cell-interceded safe reaction of obscure root. It very well might be found with different illnesses of adjusted invulnerability, for example, ulcerative colitis, alopecia areata, vitiligo, dermatomyositis, morphea, lichen sclerosis, and myasthenia gravis. An uncommon sort of lichen planus, familial bullous lichen planus, could be quality related. It could be set off by diuretics and antimalarials, metal fillings (causing oral lichen planus), stress, and contamination. Lichen planus (see the picture beneath) has been discovered to be related with hepatitis C infection disease [1-6]. LPH is a pruritic emission normally connected with hepatitis C. Sores are typically papular, purple (violaceous shading), polygonal, and incidentally found (eg. on the distal furthest points). LPH may likewise influence the genitalia or mucous films. It is in all probability an immunologically interceded response, however the pathophysiology is indistinct. An affiliation is noted between lichen planus and hepatitis C infection disease [2-6]. ongoing dynamic hepatitis, and essential biliary cirrhosis[7]. In one meta-examination, 16% of patients with LP had hepatitis C contamination [3]. This affiliation has been appeared to exist in all districts of the world, counting North America [4]. A workup for hepatitis C should be considered in patients with far and wide or irregular introductions of lichen planus. Beginning or fuel of lichen planus has additionally been connected to distressing events[8]. The accurate reason for

lichen planus isn't known, in spite of the fact that it is immunologically interceded. The starting antigen is indistinct; notwithstanding, Langerhans cells measure the antigen to T lymphocytes, bringing about an epidermotropic invade. Histologically, the irritation is depicted as a lichenoid invaded, destroying the dermo-epidermal intersection. A few patients with lichen planus have a positive family ancestry. It has been noticed that influenced families have an expanded recurrence of human leukocyte antigen B7 (HLA-B7). Others have discovered a relationship between idiopathic lichen planus and human leukocyte antigen DR1 (HLA-DR1) and human leukocyte antigen DR10 (HLA-DR10); along these lines, lichen planus might be impacted by a hereditary inclination. No critical contrasts in frequency for lichen planus are noted among male and female patients, yet in ladies, lichen planus may present as desquamative incendiary vaginitis[9]. More than 66% of lichen planus patients are matured 30-60 years; in any case, lichen planus can happen at any age[10]. The guess for lichen planus is acceptable, as most cases relapse inside year and a half. A few cases repeat. In lichen planus, decay and scarring are seen in hypertrophic sores and in injuries on the scalp. Cutaneous lichen planus doesn't convey a danger of skin disease, however ulcerative sores in the mouth, especially in men, do have a low pace of dangerous change. Be that as it may, the harmful change pace of oral lichen planus is low (< 2% in one report)[11]. The principal line medicines of cutaneous lichen planus are skin steroids, especially class I or II treatments. A subsequent option would be fundamental steroids for side effect control and potentially more fast

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goal. Numerous experts favor intramuscular triamcinolone 40-80 mg each 6 two months. Oral metronidazole has been demonstrated to be a successful treatment for certain patients^[12]. Oral acitretin has been demonstrated to be powerful in distributed studies^[13]. Numerous different medicines, including mycophenolate mofetil at 1-1.5 g twice every day, are of dubious adequacy, inferable from the lack of involvement. In a randomized twofold blinded investigation, sulfasalazine at up to 2.5 g/day for about a month and a half indicated improvement in sores (>80%) and pruritus (>90%) in patients with summed up lichen planus^[14].

2. Materials and Methods

The Patient visited MGM Hospital with purplish skin lesions and other associated symptoms. His and Guardians' consent was sought and explained about this case report publication. The Protocol and Written acceptance of them was submitted and got approved from Institutional Human Ethics Committee (IHEC).

3. Case Report

A Male Patient of 35 years old came to Dermatology ward of MGM Hospital with chief complaints of purplish rash on foot. He works in flower shop (Allergic to flowers and chemicals used in shop). Laboratory values were Hb-16.0g%, WBC-12,500/cmm, RBC-5.34L/cmm, PLT: 2.51L/cmm, RBS: 200mg/dl, FBS: 92mg/dl, PLBS: 146 mg/dl, Histopathology/ Cytology - report Punch biopsy for right foot lesion. Microscopic appearance - H & E stained section revealed skin lined by Keratinised stratified squamous epithelium showing Acanthosis, Papillomatosis, Hypergranulosis & Hyperkeratosis. There is lymphocytic infiltration at the base of ridges. Patient was assessed to have Lichen Planus Hypertrophicus. The patient was treated with Paracetamol, Chlorpheniramine maleate, vitamin A & D supplementation, Oint., Betamethasone in addition with liquid paraffin.



Figure 1: Patient with lichen planus hypertrophicus purplish lesions on 1st toe and ankle.

4. Discussion

This example is portrayed by hyperkeratotic thick pruritic red-earthy colored to purple-dim plaques with follicular highlight. Hypertrophic CLP usually includes the furthest points, particularly the interphalangeal joints and the foremost legs in a balanced circulation. This structure is otherwise called "lichen planus verrucosus"^[15]. Incidentally, lichen planus is known to happen with different conditions. Like Lupus erythematosus cover

condition. Sores of this disorder share highlights of both lupus erythematosus and lichen planus. Sores are generally huge and hypopigmented, atrophic, and with a red to blue tone and insignificant scaling. Telangiectasia might be available^[16, 17]. Lichen sclerosus cover condition, sharing highlights of lichen planus and lichen sclerosus^[16]. Cutaneous lichen planus injuries commonly resolve inside a half year to a year. Notwithstanding, some variation, for example, the hypertrophic variation may endure for quite a long time whenever left untreated or unmonitored^[15]. It is discovered that cutaneous lichen planus doesn't convey a danger of skin disease.

5. Conclusion

The treatment given to this patient is as indicated by standard rules and he is encouraged to follow the treatment routine likewise until complete fix of the sickness. Early finding and brief treatment can diminish the danger and seriousness of inconveniences and forestall the spread of injuries. Patients should be firmly checked for inconveniences and unfavorable occasions.

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Conflict of Interest

The author(s) confirm that this article content has no conflict of interest.

Authors Contribution

Vineeth Reddy G worked in the Hospital in collection of data, Counseling the patient and their family, etc., Anila Reddy T designed the documents required for the work. Sharavana bhava B.S. discussed and conceived the idea of doing this work and prepared the Protocol.

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