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A 12 Years Old Case of Lichen Planus, Successfully Treated with Acitretin, Apremilast and Normal Saline

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ABSTRACT

A 27 years old young unmarried man presented with diffuse pruritic skin lesion on his dorsal surface of both feet. He was suffering for last 12 years. Both the lesions were very pruritic, violaceous, hyperkeratotic, dark colored and little bit oozy due to severe scratch. There was no other similar lesion or the mucosal involvement. His nails and hair were also normal. Patient was in irregular treatment and took topical steroid ointment and antihistamine but not much improvement. According to clinical presentation patient was diagnosed as Lichen planus. No biopsy was taken because the patient did not consent to take biopsy. We did hematological examination and found CBC within normal limit, SGPT and Creatinine found normal, IgE was little bit higher than normal limit. The patient was initially treated with Normal Saline soak 2 times daily and Acitretin 25 mg daily for 2 months with topical steroid. Patient shows better response. After 2 months patient was unable to carry on the actretin therapy due to high treatment cost. After that we started apremilast 30 mg daily for 2 months then we started 30 mg apremilast on alternate days for 3 months. We checked his liver and kidney function by checking the blood parameter which was normal. Patient's condition was good enough but not totally cured. Then we continued the apremilast treatment another 2 months at the same dose. After 11 months patient was totally cured and shows no major adverse effect except weakness.

Keywords: Lichen planus, Apremilast, Acitretin, Pruritic, Violaceous

Abbreviations: LP: Lichen Planus; NS: Normal Saline; SGPT: Serum Glutamic Pyruvic Transaminase; CBC: Complete Blood Count

INTRODUCTION

Lichen planus, a papulosquamous disease, in its classical presentation is characterized by pruritic violaceous papules most commonly on the extremities. It also is accompanied by involvement of oral and genital mucous membrane. Course of LP is generally self-limited for a period of several months to years, but it may last long. Persistant LP is a premalignant condition. Lichen planus is non-contagious.

CASE REPORT

A 27 years old young unmarried man presented with diffuse pruritic skin lesion on his dorsal surface of both feet. He was suffering for last 12 years. Both the lesions were very pruritic, violaceous, hyperkeratotic, dark colored and little bit oozy due to severe scratch. There was no other similar lesion or the mucosal involvement. His nails and hair were also normal. Patient was in irregular treatment and took topical steroid ointment and antihistamine but not much improvement. According to clinical presentation patient was diagnosed as Lichen planus. No biopsy was taken because the patient did not consent to take biopsy. We did hematological examination and found CBC within normal limit, SGPT and S. Creatinine found normal, IgE was little bit higher than normal limit. The patient was initially treated with Normal Saline soak 2 times daily and Acitretin 25 mg daily for 2 months with topical steroid. Patient shows better response. After months patient was unable to carry on the actretin therapy due to high treatment cost. After that we started apremilast 30 mg daily for 2 months then we started 30 mg apremilast on alternate days for 3 months. We checked his liver and kidney function by checking the blood parameter which was normal. Patient's condition was good enough but not totally cured. Then we continued the apremilast treatment another 2 months at the same dose. After 11 months patient was totally cured and shows no major adverse effect except weakness.

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DISCUSSION

Lichen planus (LP) is a chronic mucocutaneous inflammatory disease. Lichen planus was first described by Erasmus Wilson in 1869. It involves skin, mucous membrane, hair, nail. Skin lesions are accompanied with severe pruritus [1-4]. The pathogenesis remains unclear but it thought to be an autoimmune phenomenon. Diagnosis of Lichen planus is usually clinical. However histological evidence is also important [5]. Cutaneous Lichen planus may spontaneously resolve, often within a year [6]. The use of acitretin has been proved highly effective in Lichen planus. Some authors consider acitretin as a first line therapy at a dose of 0.5-0.7 mg/kg until remission is achieved and at a dose of 0.3-0.5mg/kg thereafter, either as monotherapy or in combination with topical or systemic corticosteroid [7]. Acitretin a second generation retinoids, which activates certain retinoic acid receptor, subtypes to control epidermal maturation and skin inflammation. However, acitretin is highly teratogenic, thus a strict contraception has to be applied up to three years after treatment. Mucocutaneous side effects, like xerosis cutis, mucosae, hair loss, dyslipidemia and elevation of liver enzymes are reversible after discontinuation [8]. Systemic corticosteroids are considered as a second line therapy for Lichen planus [9]. 3 recalcitrant cases of oral lichen planus that were effectively treated with apremilast, a drug recently approved for psoriasis and psoriatic arthritis [10]. Ten patients with biopsy-proven LP received 20 mg of apremilast orally twice daily for 12 weeks with 4 weeks of treatment-free follow-up. The primary efficacy end point was the proportion of patients achieving a 2-grade or more improvement in the Physician Global Assessment (PGA) after 12 weeks of treatment [11]. It has been seen that 15%-20% of patients with LP demonstrate a relapsing and remitting course, often resistant to most conventional modalities of treatment.

CONCLUSION

Though persistent Lichen planus is a premalignant condition, it can be successfully treated with acitretin and apremilast with topical corticosteroid.

REFERENCES

1. Wolf R, Ruzicka T, Rupec RA (2010) Pleomorphismusdes lichen ruber – Klinische variationsbreite, pathogenese under therapies. The Chameleon's many faces – clinical spectrum, pathogenesis and therapy of *Lichen planus*. Akt Dermatol 36: 180-185.
2. Le Cleach L, Chosidow O (2012) *Lichen planus*. N Engl J Med 366: 723-732.
3. Brebmer F, Haenssle HA, Schon MP, Emmert S (2011) Response of recalcitrant *Lichen planus* to alitretinoin in 3 patients. J Am Acad Dermatol 65: 58-60.
4. Alsenaid A, Lang A, Ruzicka T, Braun-Falco M, Wolf R (2013) *Lichen planus* with associated myasthenia gravis - Successful treatment with acitretin. Eur J Dermatol 23: 909-910.
5. Vazirnia A, Cohen PR, Philip R (2014) Acitretin for the management of generalized cutaneous *Lichen planus*. Dermatol Online J 20: 2.
6. Asch S, Goldenberg G (2011) Systemic treatment of cutaneous *Lichen planus*: An Update. Cutis 87: 129-134.
7. Gunther S (1975) *Lichen ruber planus* and *Lichen ruber verrucosus* of the skin: Therapeutic results using vitamin A acid in 98 patients. Z Hautkr 50: 59-68.
8. Alamri A, Alsenaid A, Ruzicka T, Wolf R (2016) Hypertrophic *Lichen planus* – Successful treatment with acitretin. Dermatol Ther 29: 173-176.
9. Kossard S, Artemi P (2000) Acitretin for hypertrophic *Lichen planus* like reaction in a burn scar. JAMA Dermatol 136: 591-594.
10. https://doi.org/10.1016/j.jaad.2012.07.014 68:255-261
11. Bubna AK (2016) Apremilast: A dermatologic perspective. Department of Dermatology, Sri Ramachandra University, Chennai, Tamil Nadu, India. Indian J Drugs Dermatol 2: 75-82.