Multiple and extensive lichen planus-like keratoses: an underestimated cutaneous eruption observed in patients with intense sun damage

Benign lichenoid keratosis or lichen planus-like keratosis (LPLKs) is a fairly common lesion that seems to represent a lichenoid reaction to a pre-existing benign cutaneous lesion, such as solar lentigines, seborrheic keratoses or actinic keratoses.1–3 LPLKs is often a solitary papule located on the trunk and extremities. This lesion is usually observed in fair-skinned women in the fifth or sixth decades of life and is clinically characterized by a single, 3 to 15 mm in diameter deep brown to bluish-black papule.4 The observation of multiple LPLKs, giving rise to numerous (dozens to hundreds) lichenoid, pruritic, red to reddish-brown, scaly papules or plaques has rarely been reported.4–6

We have recently had the opportunity to study three patients (two males and one female, with ages ranging from 65 to 85 years) presenting multiple (20–40), recurrent, nonconfluent, tiny, red, papular slightly keratotic lesions on the anterior aspect of the trunk, back, legs and on the external aspects of both arms (figs 1 and 2a). The patients had a fair complexion and had experienced intense sun exposure during their youth. The adjacent photo-exposed skin showed actinic lentigines. Each individual lesion tended to resolve spontaneously, but new lesions seemed to appear in other areas, giving rise to the clinical appearance of a persistent eruption. The differential diagnosis was established between Grover’s disease, folliculitis, and disseminated superficial actinic porokeratosis. Several biopsy specimens from each patient were taken. All biopsy specimens revealed hyperkeratosis, and hypergranulosis, as well as a band-like infiltrate of mononuclear cells producing necrosis of keratinocytes (fig. 2b). Topical corticosteroids were prescribed with a good response in all patients. However, recurrent crops of lesions have subsequently been observed in two patients.

Barranco was the first to report multiple LPLKs in 1985.6 He reported 14 patients presenting dozens to hundreds, lichenoid, pruritic, red to reddish-brown lesions on the anterior aspect of the trunk, back, legs and on the external aspects of both arms (figs 1 and 2a). The patients had a fair complexion and had experienced intense sun exposure during their youth. The adjacent photo-exposed skin showed actinic lentigines. Each individual lesion tended to resolve spontaneously, but new lesions seemed to appear in other areas, giving rise to the clinical appearance of a persistent eruption. The differential diagnosis was established between Grover’s disease, folliculitis, and disseminated superficial actinic porokeratosis. Several biopsy specimens from each patient were taken. All biopsy specimens revealed hyperkeratosis, and hypergranulosis, as well as a band-like infiltrate of mononuclear cells producing necrosis of keratinocytes (fig. 2b). Topical corticosteroids were prescribed with a good response in all patients. However, recurrent crops of lesions have subsequently been observed in two patients.

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plaques in photodistributed areas, which simulated photodermatoses. Multiple LPLKs usually developed in fair-skinned adult people. The lesions frequently disappeared spontaneously within 2–6 weeks and showed a dramatic response to topical corticosteroids. However, lesions that persisted for months or even years were also observed.

Our cases illustrate that multiple LPLKs in elderly fair-skinned patients with severe photodamaged skin may be manifested as a diffuse, persistent eruption, without a clear photodistributed pattern, clinically mimicking Grover’s disease or folliculitis. Histopathological features were very close to those observed in lichen planus. However, lichen planus could be easily ruled out on the basis of clinical appearance and quick response to topical corticosteroids. Although histological evidence of solar lentigines was not observed, evident clinical actinic lentigines could be noted close to all of our patients’ lesions. Therefore, the possibility that multiple LPLKs may represent an autoinvolutive lichenoid inflammatory stage of several lesions developing on sun-exposed skin (actinic keratoses, actinic lentigines, seborrhoeic keratoses) cannot be ruled out.

Because we have encountered three cases of multiple LPLKs in a 1-year period, we believe that it is probable that these lesions are much more common than the literature seems to indicate. We consider that multiple LPLKs should be added to the list of diseases that show erythematous papular eruptions in elderly patients with intense actinic damage.

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References

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**Grand mal seizure induced by interferon-α-2b**

Interferon alpha (IFN-α) is well established in the adjuvant therapy of high-risk melanoma. The typical adverse