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## Case Presentation

### Facial actinic lichen nitidus successfully treated with hydroxychloroquin: a case report

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## Abstract

**Introduction :** Lichen nitidus is an unusual condition with chronic evolution. It arises as multiple tiny, shiny papules with a flat surface. Many clinical variants have been reported. We describe a new case of facial actinic lichen nitidus. Our patient responded rapidly to corticosteroids and hydroxychloroquine.

**Case report:** A 23-year-old woman with photodistributed eruptions recurring during the summer with improvement during the winter presented to our institution. Clinical exam revealed pinhead sized flat and flesh-colored papules on her face. Koebner phenomenon was not observed. Palms, soles, nails, and mucosa were normal. Histologic examination of a cutaneous biopsy showed a well circumscribed lymphohistiocytic infiltrate in the papillary dermis in a “claw clutching a ball” pattern suggestive of lichen nitidus. The diagnosis of actinic lichen nitidus was made. Treatment included photoprotection, topical corticosteroids once daily for 6 weeks, and hydroxychloroquine for 6 months. Remission of lesions was obtained after 4 weeks.

**Conclusion:** Actinic lichen nitidus is rare. The true prevalence of this disease and the effectiveness of its various therapies is difficult to evaluate because it is usually asymptomatic and resolves without sequelae.

**Key words:** Actinic lichen nitidus, lichen nitidus, photodistributed eruptions.

## INTRODUCTION

Actinic lichen nitidus is a photodistributed variant of lichen nitidus that appears to be more common in dark-complexioned individuals with a history of significant sun exposure during the summer months. This condition generally presents as clusters of small, pinpoint, round, or polygonal-shaped, skin-colored papules with slightly raised, shiny surfaces. Sixteen cases have been reported, mostly in children or young adults [2–3]. The lesions may improve with sun protection and topical steroids. Recurrences are common during subsequent summer seasons when the lesions tend to become more persistent [1]. In contrast, classic lichen nitidus is a chronic inflammatory condition that progresses slowly and can go into remission, but is not seasonal. It is commonly seen in pediatric patients and young adults in both sun-exposed and non exposed areas including the groin, abdomen, thighs, and forearms [3]. Confusion exists in the literature regarding the nomenclature of this entity. It has been previously reported as summertime actinic lichenoid eruption and lichen nitidus actinicus [1,2,3] and it appears to be an under-recognized disease in the North of Africa. We report a patient with facial actinic lichen nitidus who responded rapidly to corticosteroids and hydroxychloroquine.

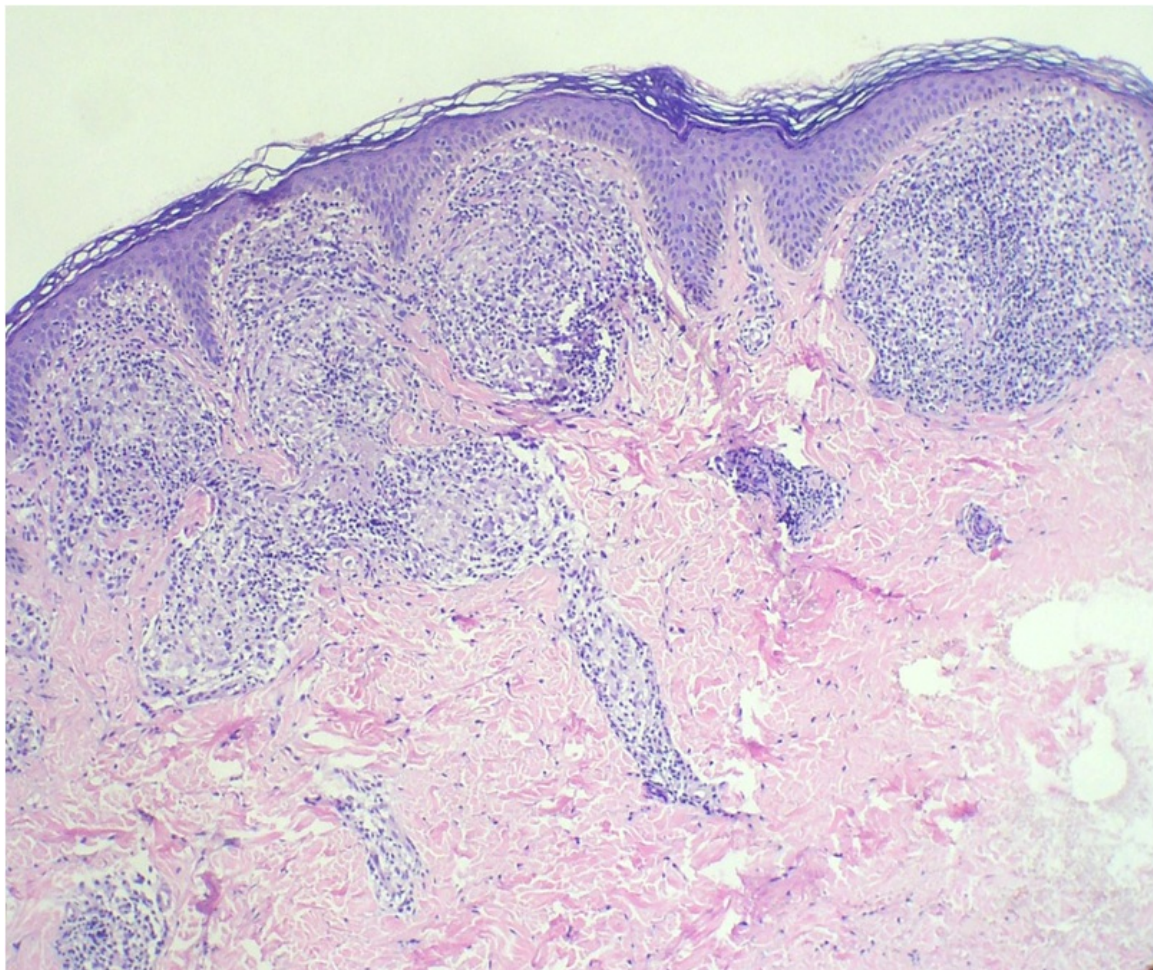
## Case synopsis

A 23 year-old woman, resident in Casablanca, presented with a two year history of photodistributed eruptions that appeared during summer and improved during the winter. Clinical examination revealed pinhead sized flat and flesh-colored papules symmetrically distributed, on her forehead, cheeks, nose and nasolabial folds, upper eyelids, and area of the upper lip (Figure 1,2). Koebner phenomenon was not observed. Palms, soles, nails, and mucosa were normal. There was no relevant family history.

The diagnoses of actinic folliculitis, sarcoidosis, and mucinosis (lichen myxoedematosus) were considered. Histologic examination of a cutaneous biopsy showed a well circumscribed lymphohistiocytic infiltrate and a few giant cells immediately in the papillary dermis in a “claw clutching a ball” below a thinned epidermis, suggestive of lichen nitidus (Figure 3). Absence of a follicular infiltrate, sarcoidal granuloma, and mucin ruled out other items in the differential diagnosis and the diagnosis of actinic lichen nitidus was made. Baseline lab investigations including anti-nuclear antibody were within normal limits. Treatment included photoprotection, clobetasol propionate 0.05%, once daily for 6 weeks, and hydroxychloroquine, 200mg twice daily for 4 weeks and then a maintenance dose of 200mg per day for a total of 6 months. Remission of the lesions was obtained after 4 weeks (Figure 4).



**Figure 1 and 2.** Many skin-colored, flat, shiny papules measuring about 1 mm in diameter were distributed on the face.



**Figure 3.** Well-circumscribed lymphohistiocytic infiltrate with giant cells, embraced by rete ridges. (hematoxylin & eosin 100).





**Figure 4.** One month after starting topical steroids and oral hydroxychloroquine, most of the papules had completely disappeared.

## DISCUSSION

This case corroborates previous reports about typical actinic lichen nitidus. Lesions are pinhead sized discrete papules with a flat or dome shaped shiny surface on photodistributed areas. The condition appears and is exacerbated during the summer months and shows histological features of lichen nitidus [1]. Actinic Lichen nitidus preferentially affects individuals of darker skin types (Fitzpatrick skin types IV and V) [4] and has been described in persons of African American, Middle Eastern, and Indian descent [1,6].

Actinic lichen nitidus was originally reported by Bedi in 1978 as summertime actinic lichenoid eruption in 25 Indian patients [1]. In 1998, Hussain suggested that the term “actinic lichen nitidus” be used because it is more descriptive and suggests a parallel of classic lichen planus and classic lichen nitidus with actinic lichen planus and actinic lichen nitidus [2,3]. Histopathology can confirm the diagnosis and reveals a typical lichenoid tissue reaction, distinguished by the often-described image of a "claw clutching a ball." The ball represents a well-circumscribed area of lymphohistiocytic infiltrate near the epidermis and the claw represents elongated rete ridges near the margins [7,8]. Although the cause of the eruption is not clear. It is possible that actinic lichen nitidus is a reaction pattern to sunlight in genetically predisposed people [5]. Sun protection appears to be more important therapeutically than topical steroids. Our patient responded rapidly to a combination of topical corticosteroids and hydroxychloroquine.

## CONCLUSION

We hope this case will highlight the existence of this entity and alert the dermatology community to a disease that is seen in our practices, but is under-recognized. We also call attention to the rare facial photodistributed actinic type that has, to our knowledge, been described in only 5 cases previously [1,8,9].

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