



## BLASCHKOID LICHEN PLANUS IS A RARE AND PROBABLY UNDER-RECOGNIZED VARIANT OF LICHEN PLANUS

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### ABSTRACT

**Introduction:** Lichen planus (LP) is a chronic inflammatory dermatosis characterized by violaceous, flat-topped papules and plaques. It has several clinical variants, of which Blaschkoid lichen planus (BLP) is an uncommon presentation. BLP is characterized by lesions following the embryonic lines of Blaschko, often producing linear, curvilinear, whorled, or S-shaped patterns. Differentiation from linear LP is important, as the latter may result from Koebnerization or other mechanisms and does not necessarily follow Blaschko lines. BLP may also clinically resemble other Blaschkoid dermatoses, particularly lichen striatus, making clinicopathological correlation essential. Most reported cases demonstrate unilateral involvement, while bilateral or extensive Blaschkoid distribution is less frequently described.

**Case report:** 12 yr old female presented with mildly pruritic lesion over chest, left arm and left forearm for 3-4 months. The eruption initially appeared over left side of chest then gradually spreading to involve left arm and left forearm. There was no history of preceding trauma or other dermatological condition. No history of varicella either and patient was not on any medication. Upon closer inspection, several violaceous papules and plaques with a clear hyperkeratotic edge were found closely arranged in a linear pattern along the lines of Blaschko (LB) on the chest and left side upper limb. The child's developmental milestones were normal, and a thorough systemic examination was also normal. Differential diagnoses considered were porokeratosis and LP. Skin biopsy from the right forearm showed an epidermis with hyperkeratosis and orthokeratosis showing basal cell vacuolation. Superficial dermis reveals melanophages and lympho-histiocytic infiltrate. In view of the characteristic Blaschkoid distribution, violaceous lichenoid morphology and supportive histopathological findings, a diagnosis of Blaschkoid lichen planus was made, and the patient was treated with topical steroids.

**Conclusion:** Blaschkoid lichen planus is a rare and probably under-recognized variant of LP, particularly in children. Recognition of the characteristic Blaschkoid distribution, together with the typical lichenoid morphology and supportive histopathological findings, is essential for diagnosis. Careful differentiation from lichen striatus and other linear dermatoses is important, particularly in the pediatric population. The present case is noteworthy because of its occurrence in a 12-year-old child and the characteristic unilateral Blaschkoid distribution, highlighting the variable clinical presentation of this uncommon variant.

**Keywords:** Blaschkoid Lichen Planus, Lichen Planus, Lines of Blaschko, Lichen Striatus, Linear Lichen Planus.

### CASE REPORT

12 yr old female presented with mildly pruritic lesion over chest, left arm and left forearm for 3-4 months. The eruption initially appeared over left side of chest then gradually spreading to involve left arm and left forearm.



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lympho-histiocytic infiltrate. In view of the characteristic Blaschkoid distribution, violaceous lichenoid morphology and supportive

histopathological findings, a diagnosis of Blaschkoid lichen planus was made, and the patient was treated with topical steroids.

### CLINICAL PHOTOGRAPHS



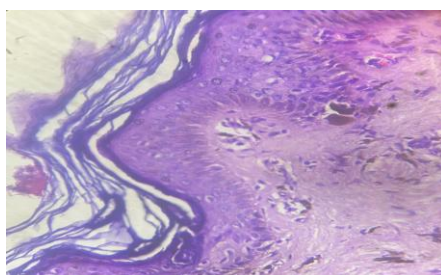
**Figure 1. Clinical photograph** Violaceous papules and plaques arranged in a linear pattern along the lines of Blaschko over the chest and left upper limb.



**Figure 2. Clinical photograph**

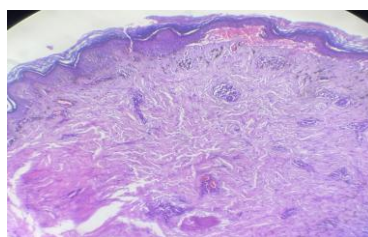
Linear arrangement of violaceous papules and plaques following the lines of Blaschko over the left upper limb.

### HISTOPATHOLOGY



**Figure 3. Histopathology**

Hyperkeratosis and orthokeratosis with basal cell vacuolation; superficial dermis shows melanophages and lymphohistiocytic infiltrate.



**Figure 4. Histopathology**

Hyperkeratosis, basal cell vacuolation, melanophages and lymphohistiocytic infiltrate, supportive of a lichenoid/interface process

### DISCUSSION

Blaschkoid lichen planus (BLP) is an uncommon clinical variant of lichen planus characterized by lesions distributed along the lines of Blaschko. The terminology surrounding linear lichen planus has historically been inconsistent, with terms such as linear lichen planus, zosteriform lichen planus, and Blaschkoid lichen planus being used variably. Kabbash et al. described three adolescents with

linear lesions distributed along the lines of Blaschko and proposed the term “lichen planus, Blaschko subtype,” emphasizing that this pattern represents a distinct distributional variant of LP. [1] Criscito et al. subsequently highlighted the importance of distinguishing Blaschkoid LP from other forms of linear LP and suggested that the term “Blaschkoid” is useful when the lesions clearly conform to the characteristic developmental patterns of Blaschko

lines. [2]

Lichen planus is relatively uncommon in childhood, with only approximately 2–3% of affected individuals being younger than 20 years. Linear or Blaschkoid involvement is particularly uncommon, with some reports estimating that it accounts for less than 0.2% of LP cases. [3] In the present case, the occurrence of a Blaschkoid eruption in a 12-year-old girl therefore represents an uncommon pediatric presentation. Previous pediatric cases have also demonstrated violaceous or keratotic papules distributed along the Blaschko lines, with histopathology confirming LP. [1,3]

The characteristic distribution along the lines of Blaschko is thought to be related to cutaneous mosaicism. One proposed mechanism is a postzygotic genetic alteration resulting in a clone of keratinocytes that is more susceptible to the development of LP. Such a mechanism may explain the restriction of lesions to specific developmental patterns despite the systemic nature of the underlying immune-mediated disease. [7] The presence of lesions following the Blaschko lines, together with the absence of preceding trauma or other local dermatoses, supports a true Blaschkoid distribution in our patient rather than linear lesions secondary to Koebnerization. Linear LP may also present with S-shaped or other characteristic patterns on the trunk and limbs, which can sometimes be mistaken for a zosteriform eruption. [4]

Clinically, BLP usually presents as violaceous, flat-topped or scaly papules and plaques arranged in linear, curvilinear, whorled, or S-shaped configurations corresponding to the Blaschko lines. [1,2] The lesions in our patient showed violaceous papules and plaques with a hyperkeratotic surface arranged in a linear Blaschkoid pattern over the chest and upper limb. Similar keratotic violaceous papules following Blaschko lines have been described in pediatric cases of linear LP. [3] The unilateral distribution observed in our patient is also consistent with previously reported cases, in which lesions were confined predominantly to one side of the body. [4]

An important differential diagnosis in a child with a linear Blaschkoid eruption is lichen striatus. The distinction between lichen striatus and linear LP can occasionally be difficult because of their overlapping clinical and histopathological features, and their relationship has historically been debated. [5] Lichen striatus typically presents in children as a unilateral linear band of small papules, most often involving an extremity, whereas LP tends to demonstrate more characteristic violaceous, polygonal or flat-topped papules and plaques. Histopathologically, both disorders may show lichenoid inflammation and basal vacuolar alteration; however, lichen striatus characteristically

demonstrates involvement of adnexal structures, particularly eccrine units, whereas this feature is generally absent in LP. [6]

A comparative clinicopathological study by Zhou et al. demonstrated that both lichen striatus and linear LP show predominantly CD3+ and CD68+ inflammatory cells, with CD8+ cells frequently located near the dermoepidermal junction. However, increased epidermal proliferation and more extensive expression of keratin 16 and involucrin were observed in linear LP compared with lichen striatus. [6] In our case, the histopathology demonstrated hyperkeratosis, basal cell vacuolation, melanophages, and a lymphohistiocytic infiltrate, findings supportive of a lichenoid/interface process. The absence of reported adnexal involvement and the characteristic clinical morphology and distribution favored Blaschkoid LP over lichen striatus.

The histopathological features of linear LP are generally similar to those of conventional LP and include hyperkeratosis, focal hypergranulosis, irregular acanthosis with a saw-tooth pattern, basal cell vacuolar degeneration, and a dense band-like lymphocytic infiltrate at the dermoepidermal junction. [7] In pediatric cases, vacuolar and lichenoid interface dermatitis with pigmentary incontinence has also been described. [3] Although the biopsy in our patient did not demonstrate every classical histological feature of LP, the presence of basal vacuolar alteration, melanophages, and lymphohistiocytic infiltration, when correlated with the characteristic Blaschkoid morphology, supported the diagnosis.

Other important differentials for a Blaschkoid eruption include inflammatory linear verrucous epidermal nevus (ILVEN), linear psoriasis, linear Darier disease, Blaschkitis, and porokeratosis. [2,3,7] Porokeratosis was considered in our patient because of the clinically apparent hyperkeratotic edge; however, the absence of a characteristic cornoid lamella on histopathological examination made this diagnosis less likely. Similarly, the morphology and histopathology were not suggestive of ILVEN, which generally presents as persistent pruritic verrucous plaques and demonstrates alternating orthokeratosis and parakeratosis histologically. [3]

The absence of a history of trauma, preceding dermatological disease, herpes zoster, or medication exposure in our patient further supports the diagnosis of primary Blaschkoid LP. This distinction is clinically relevant because linear LP may result from Koebnerization, whereas lesions that strictly follow Blaschko lines suggest a developmental mosaic pattern. [2,3,7] Recognition of this distinction is particularly important in children, in whom lichen striatus and other Blaschkoid dermatoses are more common

diagnostic considerations.

For localized disease, topical corticosteroids remain an appropriate initial treatment. Pediatric cases of linear LP have demonstrated good clinical response to topical corticosteroids, although residual post-inflammatory hyperpigmentation may persist after resolution of active lesions. [3] Our patient was therefore treated with topical corticosteroids.

## CONCLUSION

In conclusion, Blaschkoid lichen planus is a rare and probably under-recognized variant of LP, particularly in children. Recognition of the characteristic Blaschkoid distribution, together with the typical lichenoid morphology and supportive histopathological findings, is essential for diagnosis. Careful differentiation from lichen striatus and other linear dermatoses is important, particularly in the pediatric population. The present case is noteworthy because of its occurrence in a 12-year-old child and the characteristic unilateral Blaschkoid distribution, highlighting the variable clinical presentation of this uncommon variant.

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