Lichen planus After Genital Herpes Simplex Virus Type 2 Infection

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Lichen planus (LP) is a papulosquamous disease which involves glabrous skin, mucous membranes, the scalp and nails. The cause of the disease is unknown. However, several conditions including viral infections [1-3] have been postulated. We present a patient who developed LP on the penile shaft after herpes simplex virus type 2 (HSV-2) infection.

A 38-year-old male patient was referred for evaluation of slightly itchy blisters on the penile shaft that occurred 24 h previously. Past medical history revealed the occurrence of these lesions at the same site 1 month ago that healed without any treatment. Dermatologic examination disclosed grouped, pinpoint-sized vesicles on the lateral aspect of the penile shaft which were suggestive of HSV-2 infection. Clinical diagnosis was confirmed by a positive Tzanck preparation, monoclonal antibodies for HSV-2 and a positive viral culture. The patient was started on oral acyclovir, and the lesions cleared within a week. However, 5 days later, the patient returned with pruritic flat-topped violaceous papules at the same site. A clinical diagnosis of LP was made. Similar lesions were observed on the flexural aspects of the wrists. The buccal mucosa was also involved. Histopathologic examination of a biopsy specimen revealed findings consistent with LP.

Laboratory investigations including liver function tests, serum hepatitis B surface antigen, anti-hepatitis-B antibody, serum antibodies to hepatitis C virus, immunoglobulin levels, C3, C4, antithyroid, antigastric antiparietal, anti-smooth-muscle, antimicrosomal and antinuclear antibodies and immune complexes were all normal or negative. Oral griseofulvin was started in a dose of 500 mg/day. The lesions subsided within 20 days. The patient was free of HSV-2 infection and LP at the time this manuscript was submitted.

Although the cause of LP is unknown, several conditions have been associated with the disease like drugs, malignancies and hepatic disease [1-3]. Viral agents have also been suggested. Patients with viral hepatitis B and C infections could subsequently develop LP [2, 3]. To our knowledge, an association with HSV-2 infection in the context of a Koebner-like phenomenon has not been reported. The development of LP following a recent HSV-2 infection seems to be more than a pure coincidence. Since LP is considered to be a reflection of a cell-mediated immune reaction triggered by several factors [3], we may suggest that a recent HSV-2 infection could have given rise to a local cell-mediated immune injury which resulted in LP in a susceptible individual.

References
Meralgia paraesthetica is an uncommon neurologic disorder usually caused by compression of the lateral femoral cutaneous nerve. This nerve leaves the pelvic cavity at the anterosuperior iliac spine below the inguinal ligament and superficial to the sartorius muscle. In its course it is vulnerable to entrapment, generally related with obesity, pregnancy or unknown causes [1]. Meralgia paraesthetica has also been described to appear as a result of neuromas [2], malignant tumours of the psoas muscle [3], metastatic carcinomas in the second lumbar vertebra [4] or following coronary bypass surgery [5], due to compression arising from prolonged supine position on the operating table.

Meralgia paraesthetica is clinically characterized by a disturbed sensation at the anterolateral side of the thigh. Patients can complain of pain, numbness, itching or dysaesthesia, and the perception of pinprick and touch is often diminished or lost. In some cases they refer a burning pain that can be unbearable. The femoral cutaneous nerve is only sensitive so the motor function remains uninvolved and the reflexes are normal. Electrophysiological tests and somatosensory evoked potentials can be useful as diagnostic procedures [6].

Many treatments have been advocated for meralgia paraesthetica [2]. Analgesia can be provided by nerve block or local infiltrations. Surgical procedures include neurolysis, transposition or decompression of the nerve and mobilization of the suprainguinal ligament. The possible efficacy of topical capsaicin in the treatment of meralgia paraesthetica has not been previously reported, to our knowledge.

A 54-year-old man was referred for evaluation of dysaesthesia in the anterolateral right thigh. His medical history included partial epileptic crisis due to a congenital arachnoid cyst in the left parietotemporo-occipital area which had been treated with carbamazepine for the last 3 years. He also suffered from aquagenic pruritus which was well controlled with the administration of hydroxyzine before showers. He complained of paraesthesias, numbness, itching and burning sensations localized on the anterolateral aspect of the right thigh of 2 months’ evolution. Physical examination did not reveal any cutaneous abnormality, and the results of complete blood cell counts and biochemical parameters were normal. The sensory response of both femorocutaneous nerves could not be evoked on electrophysiological examination. The patient was instructed to apply topical 0.025% capsaicin cream five times daily on the lateral aspect of his right thigh. This treatment was followed by a marked relief of his symptoms in 5 days. When the medication was stopped, for financial reasons, the symptoms returned within approximately
20 days. Capsaicin 0.025% cream and placebo were applied five times a day for 15 days each, with a wash-out period of 7 days in a double-blinded placebo-controlled therapeutic trial, showing the efficacy of topical capsaicin treatment, which has been thereafter supplied to the patient to continue his treatment.

Topical capsaicin has been used in several dermatologic and peripheral pain disorders such as neuralgia postherpetica, notalgia paraesthetica, brachioradial pruritus, diabetic neuropathy, postmastectomy neuroma, reflex

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