Skin Appendage Disord 2017;3:188–189
DOI: 10.1159/000475554

Digital Lichen Striatus: Two Case Reports, One with Onychodystrophy

Uwe Wollina

Department of Dermatology and Allergology, Municipal
Hospital Dresden, Academic Teaching Hospital of the Technical
University of Dresden, Dresden, Germany

Keywords

Lichen striatus · Onychodystrophy · Fingers ·
Papulosquamous dermatoses · Lines of Blaschko

To the Editor,

Lichen striatus (LS) belongs to the group of papulosquamous dermatoses following Blaschko's lines. LS is a relatively uncommon inflammatory dermatosis. Hosamane et al. [1] investigated the histopathology of 150 patients with papulosquamous diseases. They found a single case of LS among them. It can affect any part of the body but is rare on fingers and toes only. Even less common is LS affecting nails. Only 30 cases of LS-associated nail dystrophy have been published [2].

We wish to report on two patients, one with onychodystrophy. The first patient was a 17-year-old female who reported

about linear thickening of the skin on her 5th finger of the left hand. She had no medication. Pruritus was denied. On examination, we observed a papulosquamous, slightly hyperpigmented inflammatory dermatosis limited to the medial extensor surface (Fig. 1). Her personal medical history and her family history were unremarkable.

The second patient was a 5-year-old girl with a linear skin eruption on the 3rd and 4th finger of the left hand. She had been treated with topical corticosteroids before without any improvement. On examination, we observed a linear papulosquamous skin eruption on the extensor side of her left 3rd and 4th fingers (Fig. 2). There was nail involvement of the lateral part of the fingernail on her 3rd finger with longitudinal ridging, splitting, and hyperkeratotic cuticle. Medical history of the girl and her family was unremarkable. Microscopic evaluation of skin biopsies revealed in both cases parakeratotic papules, epidermal acanthosis, partial loss of granular layer, and an interface dermatitis with a mild lymphohistiocytic infiltrate.

LS is a self-limiting disease, usually unilateral with a slight female predominance. The pathogenesis is not well understood. However, LS has been observed after medical drug therapy such as interferon and tumor necrosis factor- α inhibitors [3, 4]. Hyperpigmentation develops during its course as a kind of post-inflammatory ashy dermatosis. The disease does not well respond to topical corticosteroids or topical calcineurin inhibitors. Moisturizers and a wait-and-see strategy can be recommended. This was our recommendation in both patients. In more extensive cases, oral acitretin may be successful [5].

Fig. 1. Lichen striatus in a 17-year-old female.

Fig. 2. Lichen striatus with onychodystrophy in a 5-year-old girl.

Statement of Ethics

The patients provided informed consent for the publication of the case, and our study complies with the human rights.

Disclosure Statement

The author declares no conflicts of interest.

References

- 1 Hosamane S, Pai M, Philipose TR, Nayarmoole U: Clinicopathological study of non-infectious erythematous papulosquamous skin diseases. *J Clin Diagn Res* 2016;10:EC19–EC22.
- 2 Krishnegowda SY, Reddy SK, Vasudevan P: Lichen striatus with onychodystrophy in an infant. *Indian Dermatol Online J* 2015;6:333–335.
- 3 Mask-Bull L, Vangipuram R, Carroll BJ, Tarbox MB: Lichen striatus after interferon therapy. *JAAD Case Rep* 2015;1:254–256.
- 4 Lora V, Kanitakis J, Latini A, Cota C: Lichen striatus associated with etanercept treatment of rheumatoid arthritis. *J Am Acad Dermatol* 2014; 70:e90–e92.
- 5 Errichetti E, Stinco G, Trevisan G, Patrone P: Lichen striatus associated with psoriasis vulgaris treated with oral acitretin. *Indian Dermatol Online J* 2014;5:501–503.