More Melanin, More Pigment– A Skin of Colour Dilemma

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BACKGROUND

Ashy dermatosis (AD) and lichen planus pigmentosus (LPP) are both macular pigmentation of uncertain aetiology, commonly affecting patients with Fitzpatrick phototype III-V skin of both sexes with predilection for women. AD was first described by Ramirez of El Salvador in 1957 referring to these patients as 'ashen ones' and was later called 'erythema dyschromicum perstans'. Later in 1970s, Bhutani *et al* described detailed cases of Indian patients with similar disease to AD accompanied by histopathology showing pigment incontinence and termed this 'lichen planus pigmetosus'.[1]

Histopathological features overlap[2] therefore clinical presentation and features of AD and LPP (Table 1) aid to differentiate the two entities.

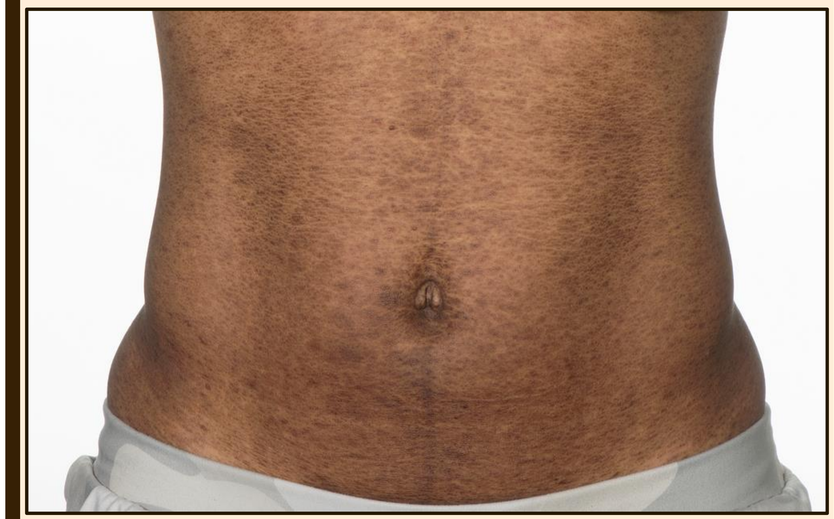
Case Report

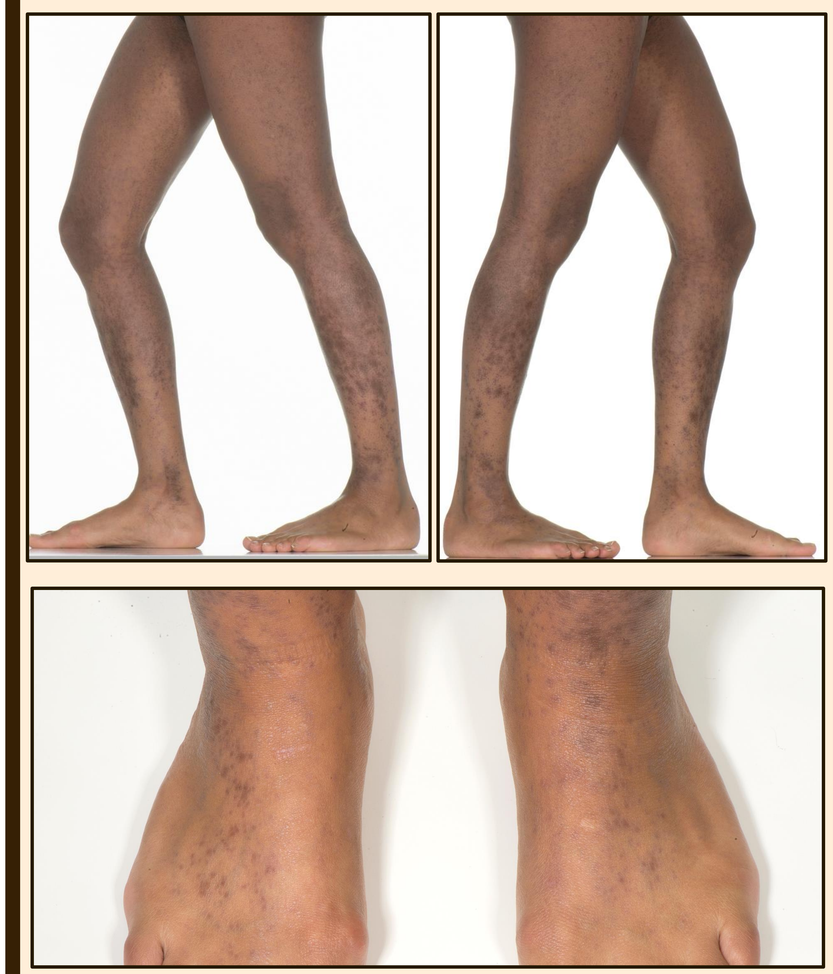
A fit and well 38-year-old Afro-Caribbean female presented with a five-month history of a rash which started as a red patch on her thigh and later became widespread on the face and body. There was initial pruritus with the appearance of redness however the rash then quickly evolved to an asymptomatic purplish hue before settling on a grey-brown appearance. Skin examination revealed an extensive widespread grey-brown lichenoid macular pigmentation, across the body, trunk and limbs extending up the neck and onto sides of the face (*Figure 1*). There was no nail or mucosal involvement. Apart from a weak positive ANA, laboratory investigations were unremarkable. Histopathology findings are shown in *Figure 2*.

Table 1: Distinguishing clinical features between AD and LPP however these features can be overlapping.

AD	LPP
Insidious onset	Exacerbations and remissions
Symmetrically distributed	No specific distribution
Slate-grey patches of varying size and shape	Grey macules and patches with purplish colour
Affects skin cleavage lines on the trunk, proximal extremities and face	**Commonly on the face, neck, and flexures**

Figure 1: Clinical Images





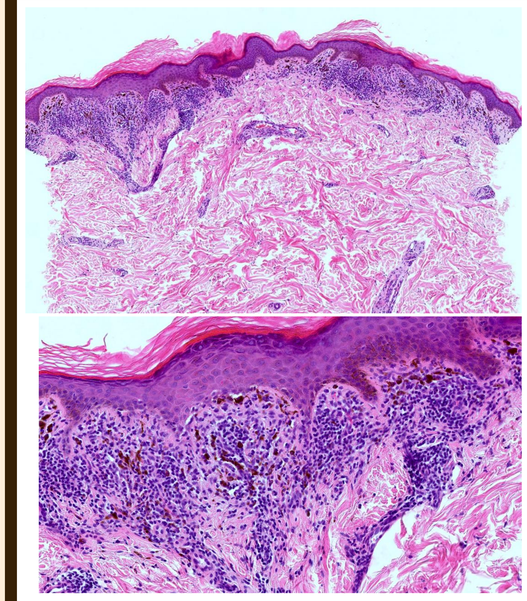


Figure 2: Histology showed lichenoid inflammatory pattern with interface changes and pigment incontinence

Discussion

Hyperpigmentation is a significant cosmetic concern in these patients which is often permanent. Thorough medical and drug history, a full examination and detailed infection screening can highlight alternative causes whilst histology can exclude other diagnoses.

There is no gold standard treatment. Evidence for clofazimine is present with one clinical trial in patients with AD although topical tacrolimus, oral dapsone and narrowband ultraviolet B (NBUVB) are of ongoing interest.[3,4] NBUVB has been proposed as a treatment option for our patient.

Importantly, increasing clinician awareness regarding associated psychosocial impact, patient counselling and further research is needed to recognise aetiology, unusual presentations and successful treatment options.

Take away point: This is a unique presentation of a case of AD/LPP overlap which presented with grossly widespread disease. There is still debate over the classification of these two conditions and no effective first line treatment.

References

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