Lichen Sclerosus et Atrophicus and Schamberg Disease

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Slowly progressive depigmentation; asymptomatic petechiae; a mildly pruritic, crusty rash--do you know the cause of the disorders pictured here?

Case 1:

For several months, a 56-year-old woman has noticed slowly progressive thickening of the skin on her volar wrists and shoulders that is associated with pruritus and loss of pigment. There is no personal history of trauma and no family history of similar lesions. She has taken the same statin for the past 3 years.

Can you identify this condition?

A. Vitiligo.
B. Lichen planus.
C. Lichen sclerosus et atrophicus.
D. Necrobiosis lipoidica.
E. Scleroderma.

(Answer on next page.)

Case 1: A biopsy confirmed the diagnosis of lichen sclerosus et atrophicus, C, a condition of unknown origin that is more common in girls before puberty and women after menopause. Characteristic early lesions are flat-topped white papules that become smooth and atrophic. The disease has a predilection for the anogenital area but may also affect the trunk and upper extremities. Potent topical corticosteroids effectively relieve the symptoms.

Vitiligo is not pruritic. Lichen planus can produce pruritic purple papules in the same areas affected by lichen sclerosus et atrophicus and has also been associated with atrophy. A biopsy may be required to establish the diagnosis. Necrobiosis lipoidica typically affects the shins and is characteristically yellow to orange. Scleroderma presents as sclerotic changes and whitening of the skin of the fingers.

Case 2:

For the past 1 to 2 weeks, a 52-year-old man has an asymptomatic eruption on the lower legs. He has not been bitten by a tick; he has no fever, chills, or aching joints; and he has not started any new
medications.

What type of outbreak is this? **A.** Leukocytoclastic vasculitis.  
**B.** Benign pigmented purpura.  
**C.** Thrombocytopenia.  
**D.** Stasis dermatitis.  
**E.** Lichen planus.

**(Answer on next page.)**

**Case 2:** This patient has **benign pigmented purpura (Schamberg disease), B,** a lymphocytic capillaritis that affects the lower extremities. The leakage of red blood cells from the capillaries produces "cayenne pepper" spots that evolve into patches of brownish pigmentation from hemosiderin deposits. There is no satisfactory treatment for this benign, self-limited condition. Leukocytoclastic vasculitis is usually palpable and painful, but a biopsy is sometimes required to differentiate it from benign pigmented purpura. Thrombocytopenia generally produces purpuric, rather than petechial, lesions. Stasis dermatitis produces hyperpigmentation from hemosiderin deposition; however, the patches are more diffuse and there are no pinpoint spots. Lichen planus produces polygonal pruritic purple papules--not petechiae--on the lower extremities.

**Case 3:**
A 14-year-old girl who plays on the school volleyball team has a mildly pruritic rash that has been spreading on 1 thigh for the past 6 days. She has a remote history of seasonal allergies but no history of trauma.  
What is your clinical impression? **A.** Nummular eczema.  
**B.** Impetigo.  
**C.** Candidiasis.  
**D.** Tinea corporis.  
**E.** Herpes simplex virus infection.

**(Answer on next page.)**

**Case 3:** This patient has **impetigo, B,** a culture of exudate identified *Staphylococcus aureus* as the culprit organism. The combination of micronicks from shaving and exposure during volleyball precipitated the infection in this atopic patient. She was successfully treated with oral antibiotics. Nummular eczema, candidiasis, and tinea corporis generally present with scaling, rather than the crusting serum seen here. Some inflammatory tinea infections produce a vesicular or pustular eruption, but these typically present initially as solitary lesions. Herpes simplex virus infections manifest initially as small vesicles before serum crusts develop. In the crusting stage, herpes lesions may be confused with those of impetigo. A viral culture or coverage with oral antiviral antibiotics
Case 4:
A 24-year-old woman wants to know whether the birthmark on her shoulder poses the risk of skin cancer and, if so, whether she should have it removed.
What does this look like to you? A. Mongolian spot.
B. Nevus of Ota.
C. Nevus of Ito.
D. Nevus spilus.
E. Café-au-lait spot.

(Answer on next page.)

Case 4: This is a nevus of Ito, C, which has the same features as nevus of Ota. Both are usually present at birth or shortly thereafter and are attributable to elongated melanocytes in the upper portion of the dermis. About 80% of affected persons are female. Nevus of Ito usually appears on the upper trunk; nevus of Ota favors the face. Because malignant transformation is rare, treatment (generally with lasers) is for cosmetic purposes.
Mongolian spots are found over the sacrum and are associated with trisomy 20 mosaicism. Nevus spilus consists of a background tan macule in which more darkly pigmented raised or flat speckles are distributed. Café-au-lait spots are uniformly pale brown macules.

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