Progressive Extragenital Lichen Sclerosus Successfully Treated With Narrowband UV-B Phototherapy

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REPORT OF A CASE

A 76-year-old woman with hypertension and hepatitis C presented with a 10-year history of sclerotic, atrophic, ivory-white plaques with violaceous borders on the upper part of her trunk and on her arms, waistline, and anogenital areas (Figure 1). The plaques were gradually extending and becoming more pruritic. A biopsy revealed findings diagnostic of lichen sclerosus (LS), including an atrophic epidermis, homogenized upper dermis, and sparse chronic inflammation in the middle dermis, below the homogenized collagen.

The patient experienced a modest response to topical tacrolimus therapy, followed by more substantial improvement with topical clobetasol propionate therapy. However, several months later, she returned with worsening pruritus and enlargement of the plaques on her neck, waist, and arms. The anogenital lesions were stable. A trial of calcipotriene ointment applied to the midchest region did not produce any appreciable benefit.

CLINICAL CHALLENGE

Lichen sclerosus is a chronic inflammatory disease that presents as white, atrophic plaques characteristically involving the anogenital area of prepubertal and postmenopausal women. The cause of LS is unknown, but most studies suggest that it is multifactorial. Recently, immunoreactivity to extracellular matrix protein 1 has been demonstrated in up to 74% of cases. Extragenital lesions occur in 15% to 20% of patients. They may be localized or widespread and typically affect the neck, inframammary area, shoulders, wrists, and inner part of the thighs. In contrast to genital LS, which is accompanied by itching, burning, and dysuria, extragenital LS is typically asymptomatic. However, progressive disease may cause discomfort and pruritus.

There is no known cure for LS, but therapy is often initiated with the hope of relieving symptoms and preventing disease progression. Therapeutic success is variable. Standard treatments include topical corticosteroids and calcineurin inhibitors, such as tacrolimus.

SOLUTION

In 2002, Kreuter et al described 10 patients who were successfully treated for extragenital LS with UV-A1 phototherapy. Since a UV-A1 source was not available to us, we initiated thrice-weekly therapy with narrowband UV-B (NBUV-B). This regimen resulted in almost complete resolution of pruritus after only 3 phototherapy sessions. Therefore, the patient discontinued all topical therapy. The plaques stopped expanding, and after 1 month they were less discolored and significantly less indurated. Within 3 months, the abdominal plaques had nearly cleared (Figure 2), and the other affected areas continued to improve, with loss of active violaceous changes at their periphery. The frequency of phototherapy was decreased to twice weekly and then discontinued at the request of the patient. Three months after discontinuation of phototherapy, the patient had no relapse of pruritus or enlargement of existing sclerotic areas. She reported that she was very pleased with the therapy and had not reinitiated any other treatments for this condition.

COMMENT

We describe a patient with progressive, severely symptomatic, extragenital LS that did not respond to mul-
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REFERENCES


Clinicians, residents, and fellows are invited to submit cases of challenges in management and therapeutics to this section. Cases should follow the established pattern. Manuscripts should be prepared double-spaced with right margins nonjustified. Pages should be numbered consecutively with the title page separated from the text (see Instructions for Authors for information about preparation of the title page). Clinical photographs, photomicrographs, and illustrations must be sharply focused and submitted as separate JPEG files with each file numbered with the figure number. Material must be accompanied by the required copyright transfer statement (see authorship form [http://archderm.ama-assn.org/misc/authorship.pdf]). Preliminary inquiries regarding submissions for this feature may be submitted to George J. Hruza, MD (ghruza@aol.com). Manuscripts should be submitted via our online manuscript submission and review system (http://manuscripts.archdermatol.com).

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Figure 2. After 3 months of narrowband UV-B therapy. Near-resolution of the lichen sclerosus on the abdomen.