

Oral Bullous Lichen Planus – A Case Report

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Abstract

Oral bullous lichen planus (BLP) is a rare and challenging variant of lichen planus affecting the oral mucosa. A 40-year-old female patient was diagnosed with Bullous lichen planus and treated with hydroxychloroquin, triamcinolone acetonide, levamisole, prednisolone and benzydamine oral rinse. Her main complaint was a burning feeling in her mouth that was linked to generalised pruritis, and skin lesions. The patient has not had any lesions during their year-long follow-up. The incidence of oral bullous lichen planus and its treatment are still poorly understood in Bangladesh. With regard to our local context, this report seeks to advance knowledge of this condition.

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Introduction

Lichen planous disease is a long-term inflammatory condition that affects the skin and mucous membranes. It is one of dermatological conditions affecting the oral cavity and affect between 1% and 2% of the general population, with most cases occurring in women. Such conditions are most likely to develop between the ages of 30 and 60.^{1,2}

Bullous lichen planus (BLP) is comparatively a rare variant of lichen planus. The majority of the patients with BLP have multifocal involvement and lesions.³

BLP is generally related to burning sensation and pain. Presence of bullae is visible in association with the white striae. Clinically, at instances BLP can be provided as erosive lichen planus because the fragile bullae fashioned can effortlessly get ruptured, which makes it hard to diagnose. If the erosive factor is severe, epithelial separation from the underlying mucosa may also occur, which ends up in bullae formation.⁴

Case Report

A 40-year-old Bangladeshi female presented with painful oral lesions that included vesicles and bullae predominantly on the buccal mucosa and tongue in the outpatient department (OPD), Community Based Medical College, Bangladesh (CBMC,B) Hospital (Fig. 1). The patient reported difficulty in eating and discomfort. Clinical

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examination revealed erosive lesions. Some Medical test was performed, and histopathological examination confirmed the diagnosis of BLP. The patient had no known systemic diseases, and relevant laboratory investigations were within normal limits.

For the management of oral BLP, initially we used oral hydroxychloroquine 200 mg twice daily for 120 days, intramuscular injection triamcinolone acetonide 1 ampoule daily for 90 days, triamcinolone acetonide oral paste twice daily on the affected areas for 60 days, oral levamisole 150 mg once daily for 3 days, oral prednisolone 20 mg twice daily for 15 days, benzydamine oral rinse 0.15%, oral famotidine 20 mg once daily for 10 days.

Regular follow-up visits and patient education on oral hygiene were crucial components of our management strategy. Maintaining all these, after 4th visit, the left and right buccal mucosal lesions almost healed (Fig. 2).

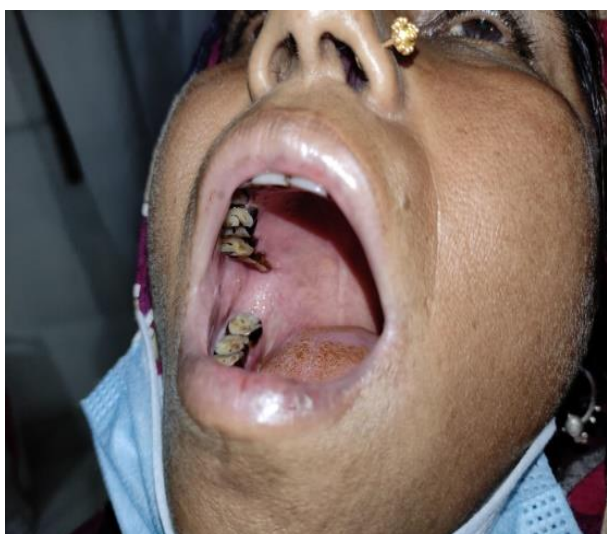


Fig. 1: Oral bullous lichen planus: before treatment



Fig. 2: After treatment: healed buccal mucosal lesion

Discussion

Lichen planus is a type of chronic inflammatory autoimmune disease where autoantibodies produced against the basal keratinocytes. The exact cause of lichen planus is not well understood. LP can be triggered by various factors such as, genetic factors, diabetes, dental environment, medicine, immunodeficiency, various infectious agent, malignant neoplasm, habits, autoimmunity, food allergy, trauma, hypertension, and bowel diseases.^{5,6} Lichen planus is characterized by flattened papules, polygonal papules, pruritic papules, violaceous papules, and grayish white scaly patches.

The affected sites typically include the flexor surfaces of the wrist, the forearms, the dorsal surfaces of the hands, the shins, and the genitals.⁷

There are various therapeutic choices available for treating OLP. Typically, non-erosive OLP can be effectively managed by using potent corticosteroids (CS) in topical form, such as clobetasol propionate 0.05%. Intralesional injection of triamcinolone may be beneficial in the

treatment of erosive OLP.⁸ Various systemic therapies have been suggested as effective for severe erosive OLP or refractory forms. These include systemic CS, apremilast, hydroxyl-

-chloroquine (HCQ), and systemic retinoids.⁹ Based on various clinical experience, the most widely used recommended therapies for OLP are listed below (Table-I):

Table-I: Recommended therapies for oral lichen planus¹⁰

Clinical phenotype	Topical therapy		Systemic therapy	
	Non-erosive OLP	Topical corticosteroids	Usually not necessary	
	Intralesional corticosteroids			
	Tacrolimus 0.1%*			
		First Line	Second Line*	Compassionate use*
Erosive OLP	Topical corticosteroids	Oral corticosteroids	Hydroxychloroquine	Sekukinumab
	Tacrolimus 0.1%	Corticosteroids i.v.	Methotrexate	Guselkumab
		Alitretinoin*	Apremilast	JAKI
	PDT*		Azathioprine	

JAKI: Janus-Kinase inhibitor; OLP: Oral Lichen Planus; PDT: Photodynamic Therapy.

*Off-label in Germany

Recently, evidence showed the efficacy of anti-IL-17, anti-IL-12/IL-23, and anti-IL-23 monoclonal antibodies to be highly potent in treating refractory erosive OLP; however, more studies were warranted regarding the safety and tolerability of some of the therapies, e.g., guselkumab in large-scale patients.¹¹

Conclusion

Oral bullous lichen planus (BLP) represents a diverse range of patients suffering from mucosal disease. It is crucial to identify and eliminate various factors associated with the disease. In order to provide relief, the majority of patients can benefit from the use of topical steroids either alone or in conjunction with other immuno-

-modulatory topical agents. As this disease is very rare in Bangladesh, the report aims to contribute to the understanding of this condition locally, highlighting the significance of our customized management approaches.

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