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PICTURE OF THE MONTH

Lichen Aureus

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A 12-y-old boy presented with 18 mo history of asymptomatic, progressively enlarging, flat bright red lesions of sudden onset over left leg which eventuated to reddish-brown in color in 3 mo (Fig. 1a). Few similar lesions appeared over right leg and dorsal feet during ensuing period. His family/medical history and systemic examination were normal. Laboratory investigations including hemogram, erythrocyte sedimentation rate, serum biochemistry, co-agulogram, urinalysis, chest x-ray, and doppler studies were normal. Histologic examination revealed features of lichen aureus (Fig. 1b, c). The lesions were observed to develop characteristic golden-yellow hue a month later.

Lichen aureus, progressive pigmented purpuric dermatosis (Schamberg's disease), pupura annularis telangiectaticum (Majocchi's disease), pigmented purpuric lichenoid dermatosis (Gougerot and Blum syndrome) and eczematoid-like purpura of Doucas and Kapetankis are common varieties of pigmented purpuric dermatoses (PPDs). They are chronic and relapsing skin disorders characterized by purpuric and pigmented patches. They perhaps represent different clinical patterns with more or less similar histopathologic features of perivascular infiltrate of lymphocytes and macrophages, extravasation of erythrocytes and/or hemosiderin deposition. However, histological features are not specific and the final diagnosis depends upon clinico-pathologic correlation. Clinically, the lesions are seen mostly over legs and occasionally over the trunk, upper extremities, buttocks, or face. Lichen aureus, a localized, persistent and intensely purpuric variant of PPD, eventually develops characteristic golden-brown-yellow color. Majocchi's disease and lichen aureus are predominantly seen in children while others may occur at any age affecting males more often. However, they are infrequent in adolescents and preadolescents. Venous hypertension, gravitational dependency, capillary fragility, alcoholism, contact allergy to dyes, clothing, and drugs (aspirin, acetaminophen, chlordiazepoxide, glipizide, hydralazine, meprobamate, reserpine, thiamine, interferon-α) are stated provocative factors for this dermatosis of obscure etiology. PPDs may reportedly be associated with thyroid dysfunction, rheumatoid arthritis, diabetes mellitus, hematological disorders, lupus erythematosus, hepatic diseases, porphyrias, hyperlipidemias, or malignancies while relationship between lichen aureus and mycosis fungoides remains controversial. Purpuric contact dermatitis, stasis pigmentation, leukocytoclastic vasculitis, traumatic/thrombocytopenic purpura, scurvy, and drug hypersensitivity are important differentials. Laboratory investigations including complete coagulogram are needed to exclude associated disorders/purpuras. Topical corticosteroids, pimecrolimus, oral pentoxifyllin, calcium dobesilate, rutoside, ascorbic acid, griseofulvin, psoralen photochemotherapy or cyclosporine have been used without proven long-term benefits. However, withdrawal of suspected provocative factors will help.

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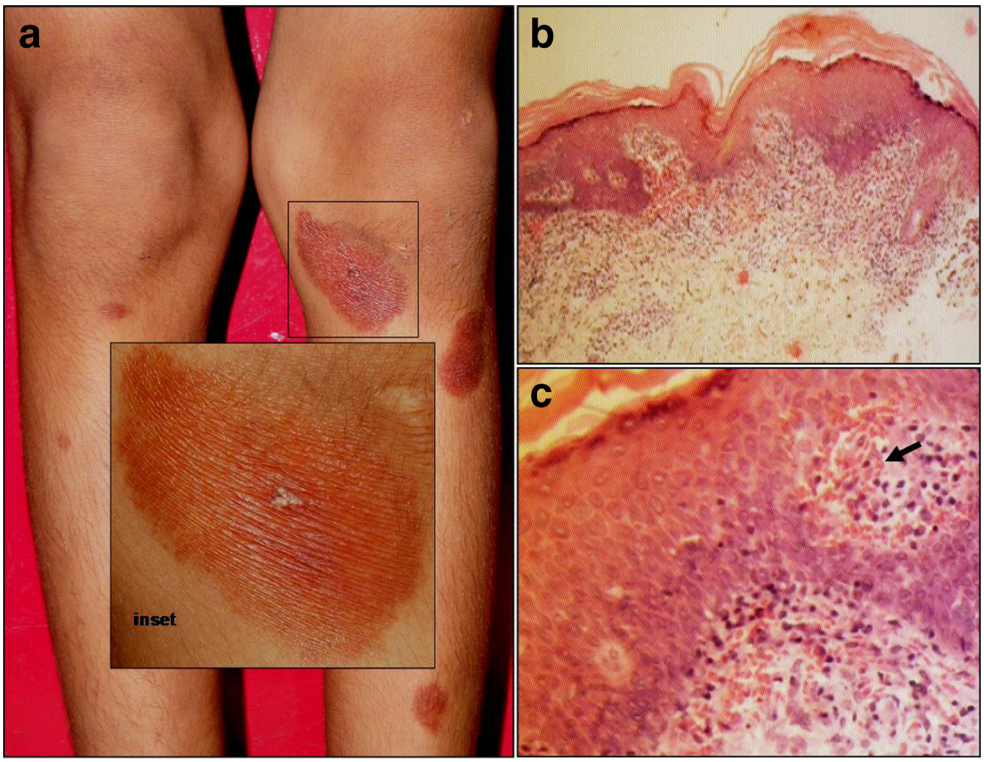

Fig. 1 **a** Bright reddish-brown lichenoid patches of variable sizes over lower limbs; more so on left leg. Inset shows the same lesion after a month. Note characteristic golden yellow hue (of sun; aureus), fine epidermal wrinkling as the lesion became less active, and milia formation at biopsy site in the centre. **b** & **c** Histology shows hyperkeratosis, mild acanthosis and spongiosis, predominantly perivasular mononuclear cell infiltrate in the upper dermis with erythrocyte extravasation (*arrow*) and hemosiderin (pigment) deposition [Stain, H& E; **b** x10; **c** x40]