A Graham-Little-Piccardi-Lassueur syndrome accompanied by lichen planus pigmentosus

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Graham-Little-Piccardi-Lassueur syndrome (GLPLS) is a rare variant of lichen planopilaris characterised by non-cicatricial hair loss of pubis and axilla, keratotic papules that are like keratosis pilaris follicles located on the trunk and extremities and cicatricial alopecia on the scalp [1]. However, it is not necessary for these three features to coincide. In this case, we aimed to present a 58-year-old patient with GLPLS accompanied by lichen planus pigmentosus unlike the usual GLPLS.

A 58-year-old woman admitted to the hospital with a 2 years' history of pruritus and spots which began on the scalp and axilla and then spread to the neck and chest. Shortly after these complaints, she reported alopecia involving her scalp, axillae and genitalia. She was postmenopausal for 5 years. She did not have any problem in her past medical history and family history. She was not taking any medication. Dermatological examination revealed locally brown and erythematous reticular patches on the axilla and both lateral necks and under the breasts. There were rare vellus type hair on the scalp, axilla and genital area without atrophy and nails were natural. Oral mucosa, genital mucosa and other system examinations were normal. Her laboratory findings including hemogram and biochemical values were also normal. The biopsies were taken from the lesions on the scalp and trunk with a pre-diagnosis of lichen planus. Histopathological examination revealed superficial perivascular, lichenoid interphase changes and melanophages in the lesion taken from the trunk and perifollicular lymphocytic infiltration in the lesion taken from the scalp. The patient was diagnosed as GLPLS according to the clinical and histopathological evaluation. After diagnosis, the patient received acitretin 25 mg/day and also topical hydrocortisone butyrate 2 × 1 therapy for the trunk lesions (Figures 1, 2).

At 3-month follow-up of the patient, we determined the regression of the lesions on the axilla, both lateral necks and under the breasts with a post inflammatory pigmentation.

The disease was originally defined in 1914 by Piccardi, who described a case of progressive cicatricial scalp alopecia, non-cicatricial alopecia in the axilla and pubic area, and follicular papules on the trunk and extremities [2]. Later, in 1915, Graham Little published a similar condition defined as "folliculitis decalvans et atrophicans". For this reason, the disease is called as GLPLS. The disease is accepted as a form of lichen planus due to histopathological and immunofluorescence findings and clinical similarity [3, 4].

The condition is often observed in postmenopausal women and the ages of 30–70 years. It is see rarely in men [5]. Scarring alopecia of the scalp is often the first manifestation; but rarely, the chronological course of the clinical manifestations of GLPLS may vary. In our patient, scalp lesions were first manifestations similar to most cases, too [6].

In addition, our patient had lichen planus pigmentosus, unlike other clinical presentations we were used to see in GLPLS.

Lichen planus pigmentosus is a rare variant of lichen planus characterized by hyperpigmented, brown macules in sun-exposed areas and flexural folds, which is often not associated with GLPLS [7, 8].

Although the aetiology of the syndrome is unknown; autoimmunity, genetic factors, HBV vaccination, vitamin A deficiency, hormone dysfunction and androgen insensitivity syndrome are implicated [9–11]. Any pathology was

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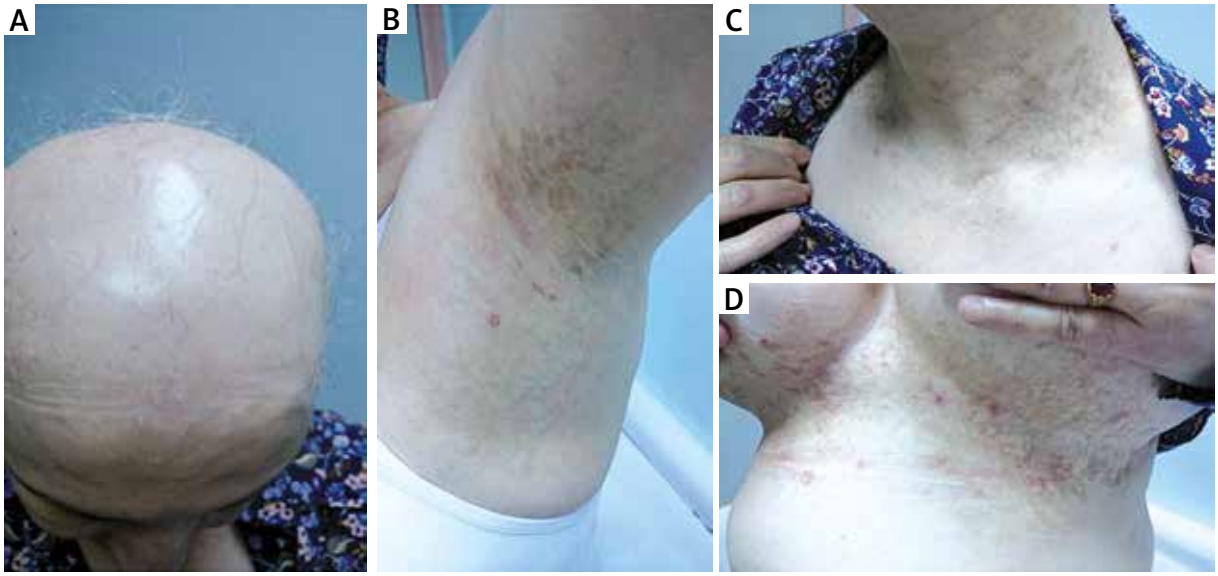

Figure 1. There were rare vellus type hair on the scalp (**A**) and axilla (**B**) without atrophy. There were brown and locally erythematous reticular patches on the axilla (**B**) and both lateral necks (**C**) and under the breasts (**D**)

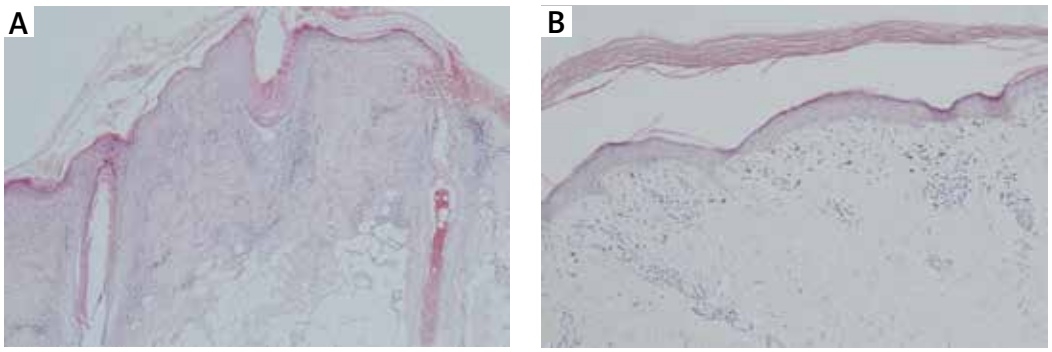

Figure 2. Histopathological examination revealed perifollicular lymphocytic infiltration in the lesion taken from the scalp (**A**) (H&E, 4×) and superficial perivascular, lichenoid interphase changes and melanophages in the lesion taken from the trunk (**B**) (H&E, 10×)

detected in both systemic examination and laboratory examinations of our patient.

In conclusion, GLPLS is a chronic and difficult disease to treat. Topical, systemic or intralesional steroids, retinoids, hydroxychloroquine, phototherapy, cyclosporine, tacrolimus, tetracycline, griseofulvin, thalidomide, dapsone and mycophenolate mofetil may be used in the treatment [12]. Chosen treatment and response varies from patient to patient. In conclusion, this case is reported because of a rare GLPLS case with lichen planus pigmentosus.

Conflict of interest

The authors declare no conflict of interest.

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