Answer to Dermacase *continued from* ***page 766***

3. Lichen nitidus

Lichen nitidus is among the 3 most common lichenoid cutaneous eruptions in children.[1] It is a relatively rare chronic skin rash that most commonly develops, without sex or racial predilection, in children between 1 and 6 years of age.[1-3] The prevalence is unknown because of its uncommon occurrence. The lesions usually persist for a long time, but some will spontaneously regress.[1]

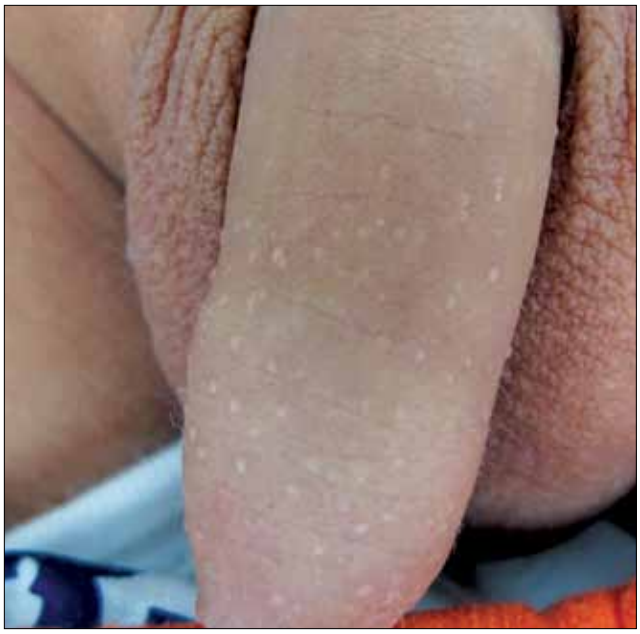
Clinically, lichen nitidus is characterized by asymptomatic, flesh-coloured, shiny, sharply demarcated, pinpoint- to pinhead-sized (1- to 2-mm) papules with fine scales.[1-3] The most commonly affected sites are the genitalia, chest, abdomen, and upper extremities,[1-3] but a generalized form has also been reported.[2,3] Rare cases might display grayish, flat papules on the oral mucosa and nail pitting.[1] As in lichen planus, linear lesions caused by isomorphic response (Köbner phenomenon) are found in almost all patients.[4,5] Unlike lichen planus, lichen nitidus is usually asymptomatic, with infrequent reports of pruritus.[2] However, coexistence of lichen nitidus and tiny papules of lichen planus in the same patient is possible, and the lesions might be indistinguishable from one another. The pathogenesis of lichen nitidus is unclear, and no associated laboratory findings or systemic involvement have been established. However, lichen nitidus is regarded as a T cell–triggered inflammatory response.

Diagnosis

Lichen nitidus is diagnosed based on clinical presentation, and biopsy is usually indicated in cases of atypical morphology and distribution. Histology of lichen nitidus is pathognomonic and shows focal granulomas containing lymphohistiocytic cells in the papillary dermis. Rete ridges grow downward in a manner resembling a claw clutching a ball.[1,2] Unlike lichen planus, results of immunofluorescence are negative in lichen nitidus. The differential diagnosis includes prurigo nodularis and other lichenoid dermatoses such as lichen striatus, lichen planus, or lichen spinulosus.

Treatment

The absence of symptoms and benign course render treatment of lichen nitidus unnecessary. In most patients,



lichen nitidus usually regresses spontaneously without intervention. However, treatment is needed if the patient experiences pruritus or when the lesions are cosmetically undesirable.[3] Topical glucocorticoids might yield good results.[1] In addition, systemic glucocorticoids might also be helpful and hasten resolution of more generalized or extensive disease. Astemizole, UVA and UVB phototherapy, and psoralen-UVA treatment have also been used successfully in more problematic disease.[2,3,6,7]

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Competing interests
None declared

References

1. Tilly JJ, Drolet BA, Esterly NB. Lichenoid eruptions in children. *J Am Acad Dermatol* 2004;51(4):606-24.
2. Arizaga AT, Gaughan MD, Bang RH. Generalized lichen nitidus. *Clin Exp Dermatol* 2002;27(2):115-7.
3. Kim YC, Shim SD. Two cases of generalized lichen nitidus treated successfully with narrow-band UV-B phototherapy. *Int J Dermatol* 2006;45(5):615-7.
4. Pinkus H, Shair HM. Koebner phenomenon in lichen nitidus. *AMA Arch Dermatol Syphilol* 1952;65(1):82.
5. Maeda M. A case of generalized lichen nitidus with Koebner's phenomenon. *J Dermatol* 1994;21(4):273-7.
6. Randle HW, Sander HM. Treatment of generalized lichen nitidus with PUVA. *Int J Dermatol* 1986;25(5):330-1.
7. Ocampo J, Torne R. Generalized lichen nitidus. Report of two cases treated with astemizol. *Int J Dermatol* 1989;28(5):49-51.