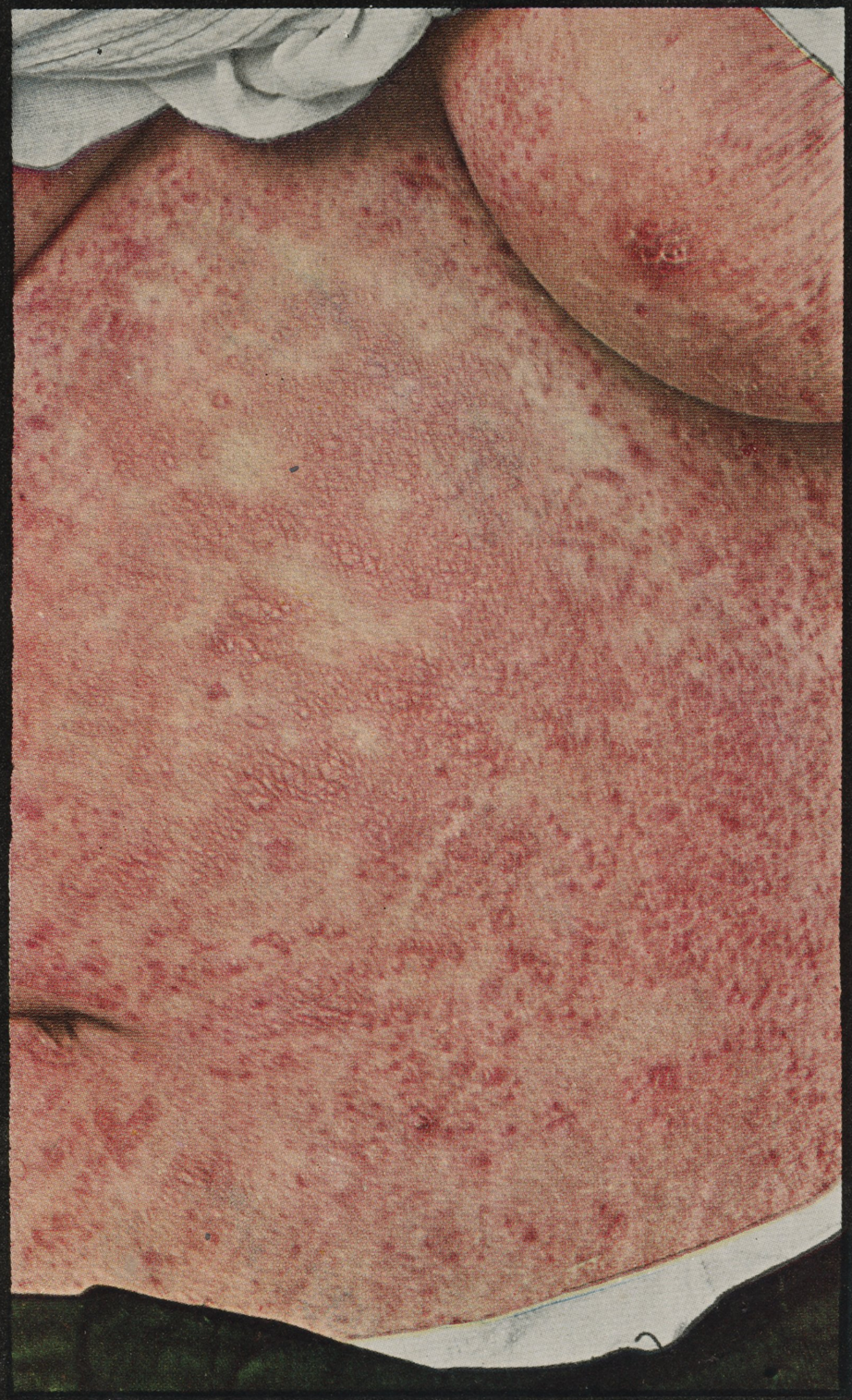

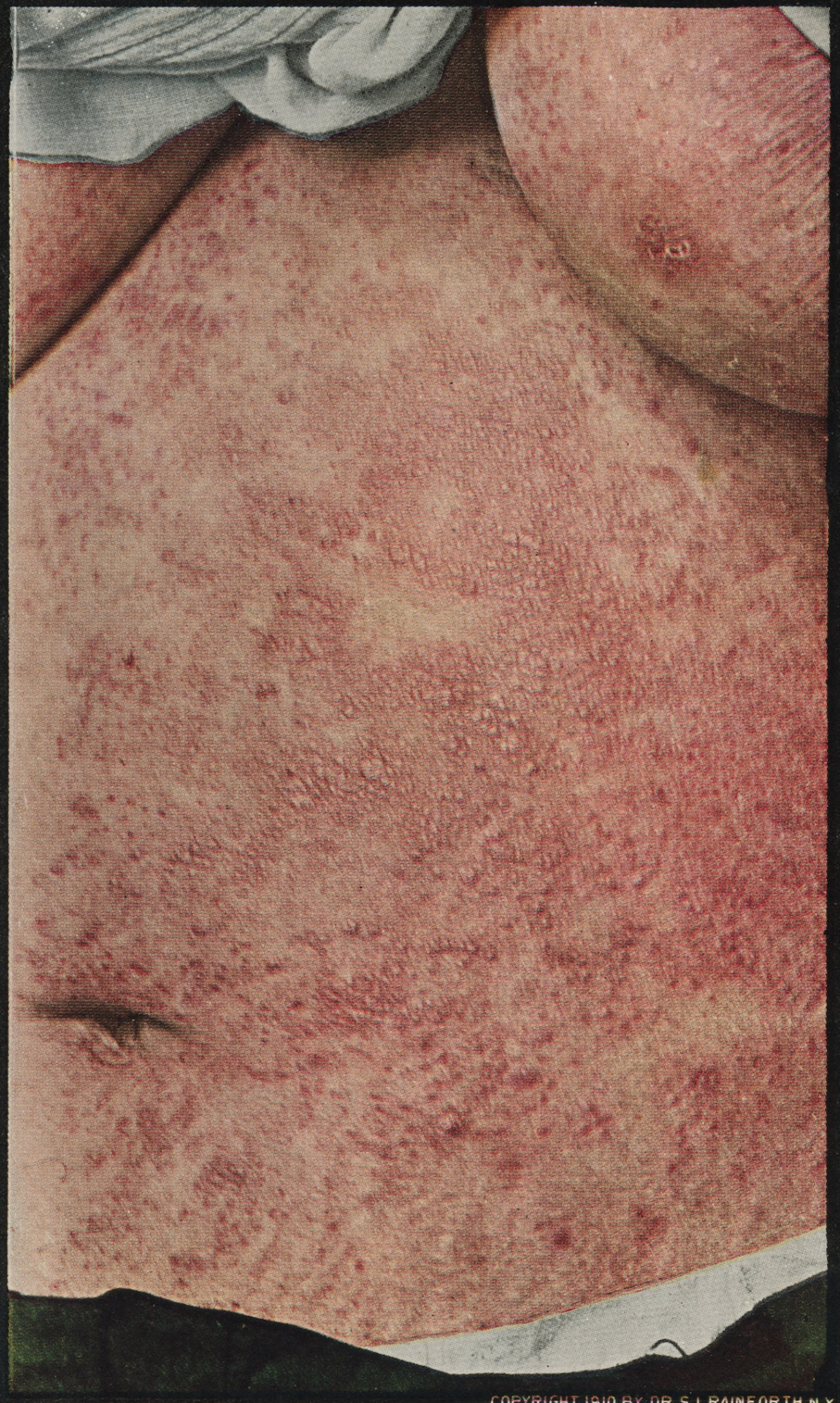

LICHEN PLANUS

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Synonym: Lichen ruber planus.

Lichen planus is a chronic inflammatory dermatosis, the elementary lesions of which consist of small polygonal, flat, glistening, red or bluish red papules, some slightly umbilicated, which tend to coalesce and form irregular and raised slightly scaling patches. Papules which are at first about the size of a pinhead often increase by peripheral growth. Involution may proceed in the center or at one edge of a large papule or of a small patch and result in the formation of rings or crescentic figures. New papules often appear along a scratch. On a fully developed patch is to be made out a network of delicate gray striae which is characteristic of the disease. While the earliest rash is sometimes of a rose red color the larger, older lesions nearly always shade into a violaceous or purple hue. Where the eruption has disappeared a brownish pigmentation is left to be slowly absorbed. Rarely there is atrophy of the skin. *Lichen verrucosus* is the form which occurs most frequently upon the legs. The patches become more elevated, infiltrated, rough and scaly. Individual papules may be hard to find, but the gray striations are well marked. Such lesions persist indefinitely, with but slight variation, and are resistant to treatment. The favorite localities for lichen planus are the flexor surfaces of the wrists and forearms, the shins and about the malleoli, and the genitals, especially the scrotum, glans and prepuce. The disease is uncommon on the face, palms and soles, but any part of the body may be attacked, even the mucous membranes on which the lesions appear as white plaques of thickened epithelium. The disease never becomes universal; even in extreme cases there are always some free areas. Lichen planus is infrequently met with among children. Itching is usually intense; it may be slight, but is very rarely entirely absent. The disease is very chronic, persisting for months even under treatment. It disappears slowly, often with recrudescences and relapses. **DIAGNOSIS:** The polygonal papules and the gray striations are pathognomonic. Large patches may resemble *psoriasis,* but the distribution is different, scaling is much less marked and the scales are much more adherent; the purple color is peculiar to lichen; psoriasis spreads by peripheral extension, lichen by the accretion of new papules; psoriasis rarely itches, intensely. A patch of *eczema* is almost always moist at some time in its development, while oozing never occurs in lichen planus; moreover, the papules of eczema are rounded or acuminate and frequently associated with vesicles or pustules. **TREATMENT:** Attention to hygiene is of importance. Internally arsenic, in full doses, is often of value. Mercury also seems to help. The two may be administered together in the form of Donovan's solution. Externally antipruritic remedies should be employed. Tarry preparations are the best, as for example five per cent oil of cade in zinc oxid ointment; the percentage of the oil should be increased as the patient is found to become more tolerant. Indolent patches on the legs may require an even stronger remedy, such as a four to eight per cent chrysarobin ointment.