LICHEN PLANOPILARIS IN CHILDREN: REPORT OF TWO CASES

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Abbreviation **LPP** = lichen plano-pilaris.

Case 1. A 5-year-old male patient presented with vertex alopecia associated with pruritus for 2 years. The history did not reveal a history of trauma. Physical examination revealed cicatricial alopecia with perifollicular erythema (Fig. 1) and trichoscopy showed absence of the follicular ostium, with evident perifollicular erythema (Fig. 2). Lichen plano-pilaris (LPP) was diagnosed and treatment with topical corticosteroids was started.

Case 2. A 9-year-old male patient presented with a 1-year history of vertex alopecia, in the absence of trauma. Physical examination revealed cicatricial alopecia (Fig. 3) and trichoscopy showed absent follicular ostium and perifollicular desquamation (Fig. 4). LPP was diagnosed and treatment with topical corticosteroids was initiated.

Discussion. Cicatricial alopecia occurs rarely in children and, unlike adults, is typically secondary rather than primary (1). Lichen plano-pilaris (LPP) is the most common cause of primary cicatricial alopecia in adults (2). Although there is significant medical literature on LPP, data on children are lacking, given its rarity in this age group.



Fig. 2

Fig. 1, 2: Lichen plano-pilaris (case 1) in a 5-year-old boy (Fig. 1). Trichoscopy shows absence of the follicular ostium (Fig. 2).





Fig. 4

Fig. 3, 4: Lichen plano-pilaris (case 2) in a 9-year-old boy (Fig. 3). Trichoscopy shows absence of the follicular ostium and perifollicular desquamation (Fig. 4).

LPP in children presents diagnostic and therapeutic challenges, due to the rarity and poor knowledge of this pathology in the pediatric population. Furthermore, its treatment is made more difficult by the limited approval of drugs for children under 18 years of age (1). LPP usually develops between the ages of 40 and 60, with a female predominance (3). However, a systematic review found that male children represented the majority of the study group (60%); the mean age was 11 years – range 8-16 - (3). These findings have raised the possibility of hormonal factors in the pathogenesis of the disease.

The typical presentation of LPP in children is characterized by scarring, perifollicular erythema and desquamation (3). Lesions are most frequently located at the vertex (4), as in adult (5). In children, LPP must be differentiated from other forms of patchy alopecia, such as tinea capitis, trichotillomania, aplasia cutis, alopecia areata and congenital triangular alopecia. Trichoscopy of LPP may show perifollicular erythema and desquamation, blue-gray dots, and absence of the follicular ostium (6-8). Histopathology shows perifollicular fibrosis, lymphocytic inflammation of the perifollicular interface, pigmentary incontinence, cytoid bodies, and scarring in the dermis; although not mandatory for diagnosis, it helps confirm the diagnosis (3).

The literature on the treatment of pediatric LPP is limited. Topical corticosteroids are the most commonly used in the treatment of pediatric LPP; however, other topical treatments have also been reported, including calcineurin inhibitors, minoxidil, tocilizumab; intralesional corticosteroids and systemic medications such as oral corticosteroids, methotrexate, cyclosporine, tetracyclines, mycophenolate, and IV immune globulin have also been used (3).

Conclusion. The current work was presented to remind physicians that pilar localization of lichen is rare in children, but should be considered in cases of cicatricial alopecia.

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