Published online: 2019-09-26

Case Report

Esophageal lichen planus: A rare and under-recognized disorder

Md Nadeem Parvez, Vijay Rai, Enam Mursheed Khan[1], Mahesh Kumar Goenka

Departments of Gastroenterology and [1]Histopathology, Apollo Gleneagles Hospital, Kolkata, West Bengal, India

Abstract

Lichen planus (LP) is a chronic idiopathic disorder involving the skin and mucosal surfaces. Although oral mucosal involvement is common, esophageal LP (ELP) is uncommon and also under-reported. Here, we present a case of ELP who was symptomatic with dysphagia for a year, but was untreated. Increasing awareness of this condition can help identify more cases and increase our understanding of this uncommon but interesting condition.

Key words

Dysphagia, esophageal lichen planus, esophageal ulceration

Introduction

Esophageal ulcerations have various etiologies, common being reflux esophagitis and candidiasis. Esophageal involvement in lichen planus (LP) is rare, which can manifest as difficult to treat esophageal ulcerations or strictures. LP is an idiopathic disorder that presents mainly with cutaneous and mucous membrane manifestations. Esophageal LP (ELP) was first described by Al-Shihabi and Jackson.[1] Till now, there are only few case reports or case series reported in medical literature.[2-4]

Case Report

A 59-year-old gentleman from Assam was referred to our outpatient department with progressive dysphagia and odynophagia for the last 1 year. He underwent upper gastrointestinal (UGI) endoscopy several times and was noted to have esophageal ulcerations. He received several courses of oral fluconazole along with proton-pump inhibitors based on the suspicion of esophageal candidiasis.

Address for correspondence:
Dr. Mahesh Kumar Goenka, Institute of Gastrosciences, Apollo Gleneagles Hospital, 58 Canal Circular Road, Kolkata, West Bengal, India.
E-mail: mkgkolkata@gmail.com

Access this article online

Website: www.jdeonline.in

DOI: 10.4103/0976-5042.180099

Quick Response Code

However, his symptoms did not improve. The patient was nondiabetic. His retroviral and hepatitis C viral serology was nonreactive. There was no history of other drug intake. At our center, at UGI endoscopy, there were diffuse ulcerations with pseudomembranes throughout the esophagus [Figure 1]. There was peeling of the mucosa away from the esophagus wall leaving a friable, inflamed surface that bled on contact. The mucosa was noted to be easily sloughed with the endoscope. Biopsies from the proximal and distal esophagus were taken. Oral examination showed presence of violet and white lacy patches over buccal mucosa. However, no lesions were seen over the skin or nails.

Histopathology of the esophageal biopsy revealed a band-like, dense lymphoid infiltrate in the lamina propria with mucosal ulceration. No evidence of candida or malignancy was seen [Figure 2]. Based on his clinical features, endoscopic findings, and histopathological features, a diagnosis of oral LP with esophageal involvement was made. He was started on oral prednisolone 40 mg with gradual tapering. On follow-up, his dysphagia significantly improved. Relook UGI was done after 3 months of steroid therapy which showed dramatic improvement in the esophageal lesions [Figure 3]. The patient is on regular follow-up with gradual tapering steroid dose.

How to cite this article: Parvez M, Rai V, Khan EM, Goenka MK. Esophageal lichen planus: A rare and under-recognized disorder. J Dig Endosc 2016;7:33-5.

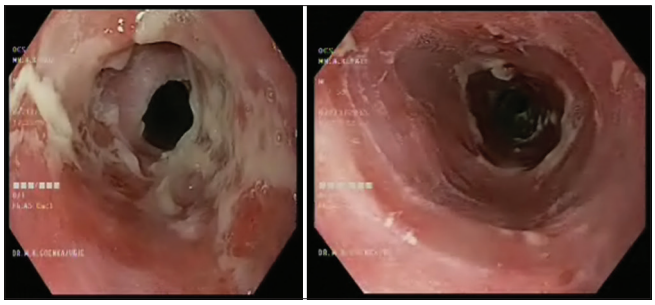

Figure 1: Endoscopic image of the esophagus prior to treatment: Diffuse ulcerations with pseudomembranes throughout the esophagus. There was peeling of the mucosa away from the esophagus leaving a friable, inflamed surface that bled on contact

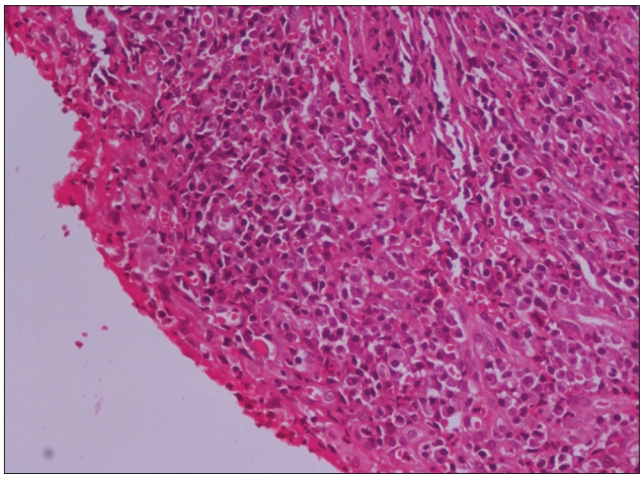

Figure 2: Histopathology of esophageal biopsy showing band-like lymphocytic infiltrate involving the superficial lamina propria and basal epithelium

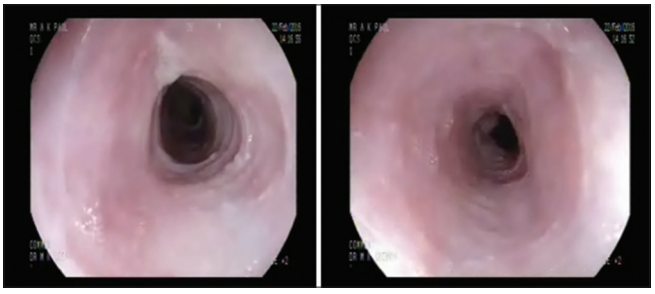

Figure 3: Endoscopic image of the esophagus after 3 months of treatment with oral steroids. There is a significant healing of the mucosal ulcerations and erythema

Discussion

LP is an idiopathic disorder that presents with cutaneous and mucous membrane manifestations. Esophageal involvement in LP is under-reported. It is a rare and under-recognized disorder, leading to a delay in diagnosis and a lack of standardized management. Diagnosis is important because of the tendency of ELP to cause persistent dysphagia resulting from esophagitis and stricture formation.[2] As in our case, the patient had persistent dysphagia for a long time. Esophageal symptoms may precede, occur in conjunction with, or develop after the diagnosis of mucocutaneous LP.[3] Patients with ELP may present with dysphagia, odynophagia, and food impaction (due to stricture) with usually long duration of symptoms. In a case series, dysphagia was the predominant symptom (83%), followed by odynophagia (50%) and food impaction (33%). The mean duration of symptoms prior to diagnosis was 2.6 years (range: 1–5).[4] ELP may be misdiagnosed as reflux esophagitis or candida esophagitis, which may lead to a delay in diagnosis.

Endoscopy plays a diagnostic and therapeutic role in these patients. Endoscopic findings include white papules, pinpoint erosions, esophageal pseudomembranes, inflamed mucosa, or strictures. The findings may be mistaken for candida esophagitis, reflux esophagitis, and eosinophilic esophagitis.[5,6]

Biopsies are necessary to differentiate ELP from other disorders. The most characteristic histologic finding in ELP is a band-like or lichenoid lymphocytic infiltrate involving the superficial lamina propria and basal epithelium. These are associated with basal keratinocyte degeneration, which often include necrotic keratinocytes with anucleate remnants (Civatte bodies).[7]

Systemic corticosteroids are considered the first-line treatment of ELP. Topical fluticasone propionate has recently been used, with mixed results. It has the advantages of rapid action, minimal absorption, and less side effects compared to systemic steroids.[5]

Our patient was started on oral prednisolone and had marked improvement in his symptoms. There was significant healing of esophageal lesion on repeat endoscopy. This case is reported with the intent to understand this rare and under-reported, commonly missed, treatable cause of esophageal lesion.

Financial support and sponsorship
Nil.

Conflicts of interest
There are no conflicts of interest.

References

1. Al-Shihabi BM, Jackson JM. Dysphagia due to pharyngeal and oesophageal lichen planus. J Laryngol Otol 1982;96:567-71.
2. Abraham SC, Ravich WJ, Anhalt GJ, Yardley JH, Wu TT. Esophageal lichen planus: Case report and review of the literature. Am J Surg Pathol 2000;24:1678-82.
3. Fox LP, Lightdale CJ, Grossman ME. Lichen planus of the esophagus: What dermatologists need to know. J Am Acad Dermatol 2011;65:175-83.
4. Franco DL, Islam SR, Lam-Himlin DM, Fleischer DE, Pasha SF. Presentation, diagnosis, and management of esophageal lichen planus: A series of six cases. Case Rep Gastroenterol 2015;9:253-60.
5. Donnellan F, Swan MP, May GR, Kandel G, Marcon NE, Kortan PP.

Fluticasone propionate for treatment of esophageal lichen planus. A case series. Dis Esophagus 2011;24:211-4.

6. Chryssostalis A, Gaudric M, Terris B, Coriat R, Prat F, Chaussade S. Esophageal lichen planus: A series of eight cases including a patient with esophageal verrucous carcinoma. A case series. Endoscopy 2008;40:764-8.
7. Chandan VS, Murray JA, Abraham SC. Esophageal lichen planus. Arch Pathol Lab Med 2008;132:1026-9.