

Methotrexate Supplemented with Steroid Ointments for the Treatment of Severe Erosive Lichen Ruber

Elisabet Nylander Lundqvist¹, Ylva Britt Wahlin² and Per-Åke Hofer^{1,3}

Departments of ¹Dermatology and Venereology, ²Odontology, School of Dentistry and ³Pathology, University Hospital, SE-901 85 Umeå, Sweden. E-mail: Elisabet.NylanderLundqvist.us@vll.se

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Sir,

Erosive lichen ruber is a disease with severe symptoms (1, 2) which affect the quality of life of patients in many ways. The main symptoms consist of pain, bleeding and a feeling of rawness caused by desquamation of the surface epithelium and adhesions caused by healing with scar formation causing even more symptoms. The syndrome often similarly affects the mouth and the genital area (2, 3), but it may also cause changes in several other organs (4, 5). Although the aetiology is unknown, it is thought to be associated with autoimmune diseases (6, 7). As the disease affects both the oral and the genital area, physicians and dentists have to collaborate closely. Treatment of erosive lichen ruber is difficult and complicated and there is no treatment available that cures the disease once and for all (6, 7). There are no large randomized clinical trials concerning treatment of this disease (8), and no controlled studies evaluating the efficacy of oral corticosteroids in mucous lichen (8). It is stated that there is no accessible treatment superior to steroid ointments in oral lichen (8), and corticosteroids locally and/or orally are the most frequently used treatment (2, 9, 10). Supplementary treatment is necessary for patients with erosive lichen with insufficient effect of treatment and persisting severe symptoms and signs. Our data show that oral methotrexate in a dosage of 10–15 mg/week is a well-tolerated and successful treatment in patients severely affected by erosive lichen ruber.

CASE REPORTS

We describe 4 patients (3 women and 1 man) with clinical signs of erosive lichen ruber. They were all diagnosed after referral to us, and the diagnosis was verified by biopsies. They all had complicated symptoms that severely affected their daily lives, e.g. they were not able to eat and drink what they wished, the women were unable to have intercourse and they suffered pain when urinating. Treatment was initiated with steroid ointments in all patients.

Patient 1

This 30-year-old woman had a history of erosive lichen ruber lasting about 10 years. Her symptoms were localized to the oral cavity, vulva and vagina. After some years she gradually developed colitis, causing bleeding

and pain; endometriosis was also diagnosed and treated. At first, the erosive lichen was treated with steroid ointments. She was also given cyclosporin, which brought about some improvement but had to be withdrawn because of side effects.

Treatment with methotrexate (10 mg/week) was initiated, with the patient gradually improving; after 9 months the dose was increased to 15 mg/week, with further improvement of the symptoms. After 13 months she was given oral steroids, as supplement, for a short period. At follow-up, 17 months after starting treatment with methotrexate, her oral mucosa was almost completely healed and in the vulva and the vagina there was only a small, eroded area. Methotrexate was stopped 2 months afterwards. One year later the patient contracted symptoms of colitis and a year and a half later she gradually got symptoms from erosive lichen ruber, although less severely than previously.

Patient 2

This 60-year-old woman with a disease history of more than 10 years and many different treatments had been tested before referral. Her symptoms were mainly located to the vulva and the mouth, where the ulcers caused burning at urination and made eating difficult. Initially, she was given steroid ointments and oral steroids combined with azathioprine. The symptoms from the mouth and oesophagus became worse, making eating very difficult. After treatment for oral candidosis her eating problem vanished. Methotrexate started at a dosage of 10 mg/week, plus local steroid ointments, was increased after 7 months to 15 mg/week, but was stopped after 17 months when the patient was free of symptoms in the vulva but still had some mild, oral symptoms. After 4 years, her symptoms and signs are still in a fairly stable phase, requiring only local steroid ointments.

Patient 3

A 45-year-old woman with more than 10 years of symptoms in the mouth and genital area. Initially, she was treated with oral steroids combined with azathioprine and, later, steroid ointments. Methotrexate was started at a dosage of 10 mg/week and improvement was seen after 2 months. After 6 months she had very few symptoms from the genitalia but some from the oral cavity. After 21 months, treatment was stopped,

and the patient received a short treatment with steroids. Since then, topical steroids intermittently have been sufficient.

Patient 4

A 55-year-old man was referred after almost 4 years of symptoms. At referral he was suffering from erosive disease involving the whole oral mucosa, with redness, soreness and ulcers in the buccal and gingival area and the tongue. He had previously been treated for lymphoma, and the erosive lichen started one year before treatment of the malignant disease. The patient could not eat and swallow properly because of the eroded mucosa in the oral cavity and because of stenosis of the oesophagus. He also had mild genitoanal symptoms. Initially, he was treated with oral steroids and local steroid ointments, which brought some improvement. Methotrexate was given to increase the patient's quality of life, initially 10 mg/week increasing to 15 mg/week after about 4 weeks. He also continued with his moderate dose of prednisone orally and steroid ointments locally. After about 3 months the symptoms ceased and the patient began to live a normal life, eating whatever he liked and working full-time. Owing to stenosis, this patient had undergone dilatation of the oesophagus twice; this has not been repeated since starting methotrexate. Treatment with methotrexate was withdrawn after 14 months. The patient claimed he had never been as healthy since his disease began.

Methotrexate treatment was started again after 4–5 months because the symptoms gradually worsened and he had increasing problems with eating and swallowing. The symptoms gradually diminished, and 3 months later he was almost fully recovered again.

DISCUSSION

Treatment of patients with severe erosive lichen is always complicated and not always successful. The need for supplementary treatment to increase quality of life is therefore great. We carried out an open trial with methotrexate supplemented with steroid ointments for severe erosive lichen. Four patients were given metho-

trexate in a dosage of 10–15 mg/week for about 17 months and they all got remarkably better. Treatment also included help with their oral hygiene, which also is of great importance to diminish the symptoms.

We conclude that methotrexate in a dosage of 10–15 mg/week was a well-tolerated and effective treatment for severe erosive lichen. The delay of onset of effect is several weeks, which is why it is necessary to encourage and motivate the patients to continue treatment until full effect is reached. Side effects were almost negligible among these patients, but there is need for extra observation. We emphasize the need for a large, controlled trial concerning treatment of erosive lichen.

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