

cannot be used to differentiate between the hypertrophic and profundus types of LE. Differentiation between the two forms should be based on histopathological criteria.

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## Plantar Lesions of Lichen sclerosus et atrophicus Accompanied by Erythralgia

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This 52-year-old man had several duodenal ulcers between 1950 and 1954 and deep venous thrombosis in the right leg in 1968. Hyperlipemia was found in 1972 and he had been treated with clofibrate and niceritrol which normalized the serum lipid levels.

In February 1976 intensely tender lesions appeared in the arches of both feet. These spread slowly during the following 6 months to reach their

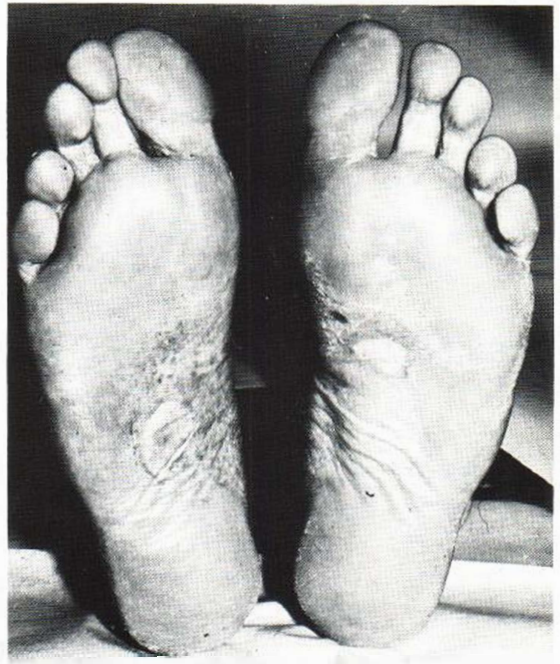


Fig. 1. Lichen sclerosus et atrophicus. Papules vesicles and purpuric scaling lesion surround the lesion on the right foot. Sequelae of a post-thrombotic syndrome.

present size (Fig. 1). During the same period the patient experienced cyclically a painful erythematous swelling of the soles of the feet. This was precipitated by long walks or by hot baths. The pain interrupted his sleep and he could not stand for 2–3 days after the onset of these symptoms. The swelling and erythema subsided within a week but returned after about 2 weeks (Fig. 2) and continued in this fashion for almost a year.

On admission in September 1976 the lesions on the soles of the feet corresponded to those of lichen sclerosus et atrophicus, with hyperkeratotic scales surrounded by erythema. There were no other such skin lesions on his body. Mainly on the right sole and on the tibial aspect of the foot, eczematous lesions with vesicles and purpuric papules and scaling could be seen. There was tenderness to palpation at the site of perforators on the right leg. At one visit the patient showed his right foot during a period of pain. The sole of the foot was swollen by a protruding edema and the plantar skin was red and cyanotic. Severe pain was elicited even by a light touch. The scaling lesion was in the centre of the edema.

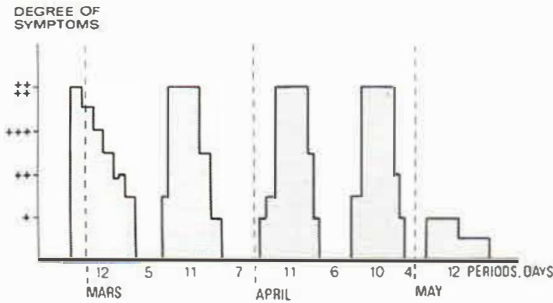


Fig. 2. The patient's arbitrary scores of complaints caused by periods of erythralgia.

Laboratory examinations revealed no abnormalities in routine tests on the blood and urine. Serum triglycerides and cholesterol levels were normal, but had at the most reached 5 and 12 mmol/l, respectively. Autoantibodies were not found. A standard patch test was negative.

Histological examination of the lesion on the left foot revealed a thin epidermis with hydropic degeneration of the basal layer, hyperkeratosis and a subepidermal edema below which an infiltrate of lymphocytes was present.

X-ray examination of the feet proved normal. Oscillometry and plethysmography showed normal arterial circulation in both legs. Capillar microscopy of the toes gave normal results.

*Subsequent course.* In January 1977, 3 g aspirin per day was prescribed. The painful erythema disappeared and the dosis could be reduced without any recurrence during the next 6 months. A leg ulcer appeared in the vicinity of the medial ankle. Hyperkeratotic plugs appeared within the keratotic lesions which gave discomfort on walking. Topical keratolytic and steroid treatment was sufficient to alleviate these complaints.

*Comments.* The clinical and histological diagnoses were lichen sclerosus et atrophicus (LSA), erythralgia (E) and a post-thrombotic syndrome of the right leg. LSA has been reported once on the feet, in twin sisters (1) and seems to affect the palms and soles only very rarely (2). Boneu et al. (3) and Redding (4) have associated the effect of aspirin with its depression of the aggregation of platelets in thrombocythemia. This mechanism would seem to be a possible cause of the beneficial effect obtained in this case with normal thrombocyte levels. On the other hand no effect of aspirin on LSA could be ascertained.

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### Chronic Hypertrophic Vulvitis— A Condition with Similarities to Cheilitis Granulomatosa (Melkersson-Rosenthal Syndrome)

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*Abstract.* Two cases of chronic hypertrophic vulvitis are described, showing histological changes identical with cheilitis granulomatosa.

*Key words:* Vulvitis; Cheilitis granulomatosa; Melkersson-Rosenthal syndrome

The syndrome consisting of relapsing swelling of the lips, paresis of the facial nerve and sometimes fissured tongue was first described by Melkersson (2) and Rosenthal (5). The disease is sometimes complicated by paresis of other cranial nerves, mostly the trigeminal nerve, and disturbance of the salivary gland function leading to hypo- or asialia in more than 50% of cases (4). The cheilitis granulomatosa, which is the cutaneous component of the syndrome, usually has a typical histological appearance.

Besides involvement of the lips, alterations indistinguishable from cheilitis granulomatosa have been found in the eye lids (1). In the present paper we describe two patients with vulvar lesions, which were histologically identical with cheilitis granulomatosa.