Chronic Active Hepatitis
and Lichen planus
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Abstract. A retrospective study on 62 patients affected by
lichen planus revealed a prevalence of chronic active
hepatitis in 13.5% of them.

Key words: Lichen planus; Chronic active hepatitis; Cir­
rhosis

Patients presenting with erosive lichen planus of
oral mucosa have been reported as frequently hav­
ing severe hepatic disease, usually with features of
chronic active hepatitis (CAH) (1). In addition, 2
patients have been described as having erosive
lichen planus along with penicillamine-treated
primary biliary cirrhosis (2).

We have investigated 62 patients who had or still
have non-erosive lichen planus and found that a
high proportion of them had histological and
haematological features of CAH.

MATERIAL AND METHODS
In the period 1965-80, 62 patients entered our Clinic for
treatment of non-erosive lichen planus. Only 15 (24%)
had some abnormalities in their blood tests for liver function.
All 62 patients were summoned for reinvestigation by
means of routine blood tests and liver biopsy. 37 patients
responded and 18 did not. 7 patients had died in the
meantime.

RESULTS
Of the 18 patients who did not respond, 5 (28%) had
some abnormality in their liver tests; one of them
had also liver cirrhosis, revealed by sonography.

Of the 37 respondents, 16 were found to have no
abnormality whatsoever in their liver tests, while 15
had fewer than three tests impaired. Conversely, 6
patients had more than three abnormal tests and
were referred for liver biopsy.

Liver histopathology revealed CAH in 5 cases
(13.5%) (Table I). The hepatitis B surface antigen
(HBsAg) was absent. CAH patients were therefore
classified in the type A-C CAH subgroups, i.e. in
the autoimmune HBsAg negative CAH (subgroup
A) and in the cryogenic CAH with no pathogenetic
indicators (subgroup C), according to the McKay
classification (3).

The causes of death of the deceased patients
were also investigated and in one case an ante-mortem
biopitc diagnosis of CAH (14.3%) was found.
Another patient had died of hepatic coma but nec­
ropsy had not been performed (Table II).

COMMENT
The global prevalence of chronic hepatitis/cirrhosis
in the Central-Southern European population has
been estimated as 0.25-0.5 %, while that of types
A-C CAH is as low as 0.1 % (3). Even though a
larger population should be screened, the occur­
rence of CAH in 13.5% of lichen planus patients is
impressive.

Table I.

<table>
<thead>
<tr>
<th>Pat.</th>
<th>Sex</th>
<th>Age</th>
<th>SGOT</th>
<th>SGPT</th>
<th>AP</th>
<th>GT</th>
<th>ASM-ANA</th>
<th>G</th>
<th>IgG</th>
<th>IgM</th>
<th>Histopathology</th>
</tr>
</thead>
<tbody>
<tr>
<td>B. V.</td>
<td>m</td>
<td>26</td>
<td>87</td>
<td>240</td>
<td>52</td>
<td></td>
<td></td>
<td>22.5</td>
<td>300</td>
<td>175</td>
<td>CAH (modest)</td>
</tr>
<tr>
<td>C. F.</td>
<td>m</td>
<td>55</td>
<td>94</td>
<td>90</td>
<td>120</td>
<td>51</td>
<td></td>
<td>17.0</td>
<td>423</td>
<td>98</td>
<td>CAH, slight, steatosis, marked siderosis</td>
</tr>
<tr>
<td>F. F.</td>
<td>f</td>
<td>61</td>
<td>30</td>
<td>56</td>
<td>240</td>
<td>19</td>
<td></td>
<td>23.0</td>
<td>925</td>
<td>245</td>
<td>CAH, marked steatosis</td>
</tr>
<tr>
<td>L. C.</td>
<td>f</td>
<td>53</td>
<td>43</td>
<td>60</td>
<td>265</td>
<td>60</td>
<td></td>
<td>32.9</td>
<td>2876</td>
<td>158</td>
<td>CAH</td>
</tr>
<tr>
<td>C. A.</td>
<td>f</td>
<td>65</td>
<td>144</td>
<td>183</td>
<td>120</td>
<td>71</td>
<td></td>
<td>22.5</td>
<td>2334</td>
<td>95</td>
<td>CAH, initial cirrhosis</td>
</tr>
<tr>
<td>B. P.</td>
<td>m</td>
<td>44</td>
<td>45</td>
<td>67</td>
<td>94</td>
<td>73</td>
<td></td>
<td>17.9</td>
<td>130</td>
<td>210</td>
<td>Steatosis, slight portal infiltration</td>
</tr>
</tbody>
</table>

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Table II.

<table>
<thead>
<tr>
<th>Pat</th>
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<th>Age</th>
<th>Causes of death</th>
</tr>
</thead>
<tbody>
<tr>
<td>M. S.</td>
<td>m</td>
<td>57</td>
<td>Ictus cerebri</td>
</tr>
<tr>
<td>L. P.</td>
<td>m</td>
<td>70</td>
<td>Colonic cancer in ulcerative colitis</td>
</tr>
<tr>
<td>R. I.</td>
<td>f</td>
<td>70</td>
<td>Breast cancer, diabetes</td>
</tr>
<tr>
<td>F. D.</td>
<td>f</td>
<td>85</td>
<td>Heart failure</td>
</tr>
<tr>
<td>N. L.</td>
<td>f</td>
<td>88</td>
<td>Angiomyocardial sclerosis, bladder cancer</td>
</tr>
<tr>
<td>G. M.</td>
<td>f</td>
<td>74</td>
<td>Hepatic coma</td>
</tr>
<tr>
<td>G. M.</td>
<td>f</td>
<td>61</td>
<td>Bronchopneumonia, heart failure, cirrhosis (ante-mortem biopsy CAH)</td>
</tr>
</tbody>
</table>

Table III. Normal-values

<table>
<thead>
<tr>
<th>SGOT</th>
<th>SGPT</th>
<th>AP</th>
<th>GT</th>
<th>IgG</th>
<th>IgM</th>
</tr>
</thead>
<tbody>
<tr>
<td>15-45 U/l</td>
<td>70-210 U/l</td>
<td>70-210 U/l</td>
<td>5-25 U/l</td>
<td>800-1500 mg%</td>
<td>80-170 mg%</td>
</tr>
</tbody>
</table>

Lichen planus is a chronic skin disease that has rarely been associated with internal disorders. Its association with CAH may be more than fortuitous, as both diseases share a similar histopathology reminiscent of graft-vs-host reaction and may have the same autoimmune pathogenesis.

REFERENCES


Balantitis circumscripta plasmacellularis (BCP) is a rare disorder which generally consists of a single red, shiny, smooth patch (3, 9, 12). It can also involve the prepuce, the vulva, the oral mucosa and the conjunctiva, for which reason it has also been named "plasmocytosis circumorificialis" (1, 4, 6, 11). Clinically, BCP should be distinguished from the erythroplasia of Queyrat and other erythroplasiform lesions (3, 9, 12). BCP is brown-red, purplish, and shows irregular borders and telangiectases (3, 4, 5, 9).

The histological features are also characteristic (3, 8, 9): a band-like inflammatory infiltrate of the upper dermis, mainly plasmocytic, dilated capillaries, and deposits of hemosiderin. The presence of lymphoid follicles is rare (4, 5).

This report describes the ultrastructural findings of a typical case of BCP. To the best of our knowledge, this is the first electron microscopic study of this disorder.

CASE REPORT

A 74-year-old man was seen for a 4-year-old asymptomatic lesion on the glans penis. Physical examination revealed a red, shiny, smooth, sharply-defined 15 mm patch, localized on the left side of the external urinary meatus (Fig. II). There was no inguinal lymphadenopathy; on the right side there was a hernia. Routine blood and urine