

## Erosive Lichen Planus of the Scalp and Hepatitis C Infection

Sir,

Lichen planus (LP) is a common dermatological condition and it has been reported in all races.<sup>1</sup> The exact etiology of LP is not fully understood, but it has been associated with disease processes, such as viral infections. It has been suggested that direct action of the virus or an induced immunological response may have a critical role in induction of lesions.<sup>2</sup> Hepatitis C virus is a single-stranded RNA virus. It is estimated that 0.16% of Iranian general population are infected with the virus.<sup>3</sup> Correlation between HCV infection and LP has been widely reported in the literature. Here, we report an exceptional clinical presentation of erosive LP of the scalp associated with hepatitis C and to our knowledge, there is the second case that has been reported.

A 51-year-old man was admitted to the department of dermatology for ulcerated lesions on the scalp and localized alopecia. The serology tests were positive for HCV infection. Fasting blood sugar was 250 mg/dl. The patient had received INF-alpha and hyperglycemia was detected after interferon therapy. He underwent a 3 mm punch biopsy. Histologically there was epidermal ulceration with more typical changes of LP such as basal cell damage, pigment incontinence and band like inflammatory infiltrate at the margin of the ulcer (Figures 1 and 2). The diagnosis was erosive LP. The lesions regressed with treatment (20 mg prednisolone daily for 6 weeks) and growth of scalp hair returned.

While it has been suggested that LP may be triggered by HCV, no clear evidence of viral infection has been found at the lesions. In one recent study, a high prevalence of HCV infection in patients with oral lichen planus has been detected.<sup>4</sup> On the other hand, many researchers found no correlation between chronic HCV infection and LP.<sup>5</sup> The wide international variation in the prevalence of HCV-infection in patients with lichen planus seems to be related partly to geographic differences in HCV infection and selection of patients such as gender and age in the population. Some genetic factors such as the HLA-DR6 may have a critical role.<sup>4</sup> Difficulties in making a definite diagnosis for LP make interpretation even more complex. The situation is further complicated by the heterogeneous nature of the response to interferon therapy.

It seems that it is too premature to reach a definite conclusion. We propose that serology for hepatitis C virus should be carried out in patients with lichen planus.

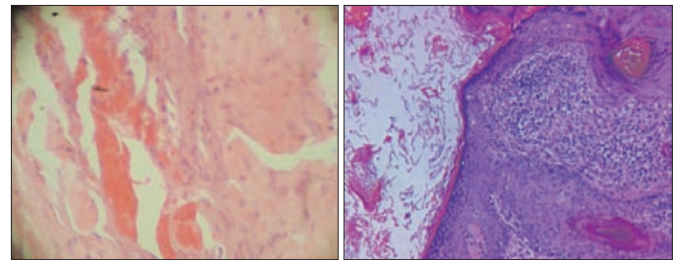


Figure 1: Section shows ulcerative area (H&E X 40)

Figure 2: Shows typical lichenoid reaction pattern at the margin of the ulcer (H&E X10).

### REFERENCES

1. Mogaddam MR, Anamzade F. Survey of relationship between hepatitis C and lichen planus among dermatology outpatients of Imam Hospital of Ardabil city. *J Pak Assoc of Dermatologists* 2010; **20**:19-22.
2. Boorghani M, Gholizadeh N, Zenouz AT, Vatankhah M, Mehdipour M. Oral lichen planus: clinical features, etiology, treatment and management; a review of literature. *J Dent Res Dent Clin Dent Prospect* 2010; **4**:3-9.
3. Alavian SM, Ahmadzad-Asl M, Lankarani KB, Shahbabaie MA, Ahmadi AA, Kabir A. Hepatitis C Infection in the general population of Iran: a systematic review. *Hepat Mon* 2009; **9**:211-23.
4. Nagao Y, Sata M. A retrospective case-control study of hepatitis C virus infection and oral lichen planus in Japan: association study with mutations in the core and NS5A region of hepatitis C virus Nagao and Sata. *BMC Gastroenterol* 2012; **12**:31.
5. Rahnama Z, Esfandiarpour I, Farajzadeh S. The relationship between lichen planus and hepatitis C in dermatology outpatients in Kerman, Iran. *Int J Dermatol* 2005; **44**:746-8.

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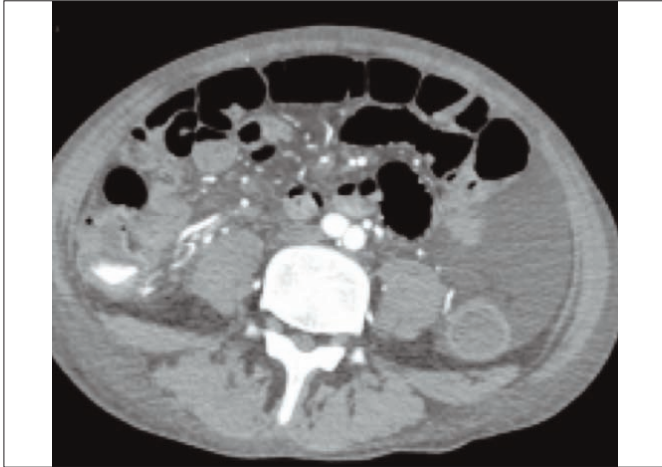
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## Angiodysplasia in Patient with Chronic Kidney Disease

Sir,

Angiodysplasia (AD), is the most common cause of recurrent lower-intestinal hemorrhage in patients with renal failure accounting for 19 – 32% of lower gastrointestinal bleeds in those with chronic kidney disease compared with 5 – 6% lower gastrointestinal bleeds in the general population.<sup>1,2</sup>



**Figure 1:** Arterial phase of multiphasic CT abdomen showing pooling of high density contrast in caecum.

A middle aged patient known case of end stage renal disease, maintained on hemodialysis for the last 4 years, presented in emergency with complaint of fresh rectal bleeding. He denied any weight change. The family history was non-contributory. No vascular abnormalities of the nasal or oral mucosa were seen. The only significant physical finding on admission was pale conjunctivae. Fresh rectal bleeding was detected on digital rectal examination. Abdomino-pelvic ultrasonography showed normal findings. Last hemodialysis was done 2 days back.

His blood pressure was 90/60 mmHg and pulse rate was 90 beats per minute. His haemogram revealed dropping haemoglobin from 12 g/dl to 8 g/dl in 8 hours suggesting the possibility of active lower gastrointestinal bleeding. After stabilizing the patient urgent multiphasic CT scan abdomen and pelvis with contrast was done which showed a gradual pooling of contrast in lumen of caecum (Figure 1). As the patient was hemodynamically unstable, an emergency angiography was carried out which demonstrated the leakage of contrast from the caecal branch of ileocolic artery along with a tuft of small vessels around it and early filling of vein during arterial phase signifying the angiodysplastic lesion of gastrointestinal tract. A successful embolization of

ileocolic artery was done by coil embolization of the ileocolic artery.

Diagnosis of angiodysplasia is usually challenging, and its clinical presentation is variable, its diagnosis depends on endoscopy, multidetector CT scan and angiography. <sup>99m</sup>Tc-labelled red blood cell scintigraphy may reveal active haemorrhage. On multidetector CT, high attenuation material can be seen within the bowel on the initial non-contrast scan, extravasated contrast is usually within 10 Hounsfield units of a large artery in the same MDCT slice. In this patient, pooling of high density contrast was identified in the caecum. Angiography has sensitivity ranging from 58% to 86% with frequently observed findings of early opacification of a draining vein, vascular tuft during arterial phase or dilated draining vein.<sup>3</sup> However, diagnosis requires observation of extravasations of contrast material to the gastrointestinal lumen. In our case, a tuft of small vessels were seen around the leaked contrast and early and persistent opacification of vein was seen during arterial phase on conventional angiography.

In this case the diagnosis was based on the CT scan and angiographic findings and the angiographic coil embolization of the lesion played a significant role in emergency management of angiodysplasia.

### REFERENCES

1. Fouch PG. Angiodysplasia of gastrointestinal tract. *Am J Gastroenterol* 1993; **88**:807-18.
2. Siddique K, Ali Q, Mirza S, Malik AZ. Massive lower gastrointestinal haemorrhage in a patient with colonic angiodysplasia. *Int J Surg* 2009; **20**. [Epub ahead of print].
3. Chin ML, Liu GL, Liu CS, Chen CY. Angiodysplasia mimicking colon carcinoma, colonoscopy, double contrast barium enema, and CT findings. *Am J Roentgenol* 2007; **188**:456-8.

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