

Letter to the Editor

The Use of Oral Terbinafine or Topical Ciclopirox for Lichen Planus

Dear *Cutis*[®]:

Lichen planus (LP) is a common inflammatory disease that affects the skin, hair, nails, and mucous membranes and has a characteristic clinical and histologic appearance. Damaged basal keratinocytes and a bandlike lymphocytic infiltrate high in the papillary dermis are present on histopathology. The cause of this inflammatory response is unknown, but the presence of LP-specific antigens on affected keratinocytes^{1,2} or exogenous antigens, such as an infectious agent, could be responsible. The unknown nature of LP has complicated clinical management. A multitude of drugs, including griseofulvin,¹ have been used with varying success. We report 2 cases of cutaneous LP that resolved following antifungal treatment.

A 39-year-old man had biopsy-proven LP on his antecubital fossae, neck, and forearms. He was treated with clobetasol ointment twice daily. On follow-up 9 months later, he stated that the topical therapy was not effective, but the LP had cleared when he was treated by his primary care physician with a 3-week course of oral terbinafine for tinea cruris. Six months after clearance with terbinafine, the LP recurred. Although he had no evidence of a fungal infection at this 6-month follow-up visit, we treated him again with oral terbinafine for 3 weeks to observe if his LP would resolve. A year later, he reported that the LP began to resolve within 3 days of restarting oral terbinafine and had resolved within a few weeks. On physical examination, there was only postinflammatory hyperpigmentation where his LP had been located.

A 61-year-old woman on no new medications presented with a 2-month history of biopsy-proven LP that was progressively worsening and involved her sacral area, medial thighs, and popliteal fossae. She had no oral lesions and denied pruritus or discomfort. In addition, a potassium hydroxide-positive rash was present on her soles. Because of the asymptomatic nature of her LP and tinea pedis as well as the anecdotal efficacy of griseofulvin and terbinafine, a decision was made to treat her tinea pedis with twice daily ciclopirox cream and

urea cream 40% while observing the effect of this therapy on her LP. At her scheduled 3-month follow-up, she reported that her tinea pedis resolved with topical ciclopirox therapy and very shortly thereafter she stopped developing new LP lesions and her preexisting LP began to fade. On physical examination, her LP had resolved, leaving only postinflammatory hyperpigmentation.

The self-resolving nature of LP and the small sample size of this report and prior studies that investigated the efficacy of antifungals for the treatment of LP are obvious confounding variables when evaluating the efficacy of antifungals for the treatment of LP.^{3,4} However, the description of these 2 cases combined with the historical success of griseofulvin³ and itraconazole⁴ as well as evidence that LP is not due to an inherent change in epidermal cells⁵ should lead dermatologists to continue to search for a causative antigen and effective therapy for this common condition.

Sincerely,
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The authors report no conflict of interest.

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