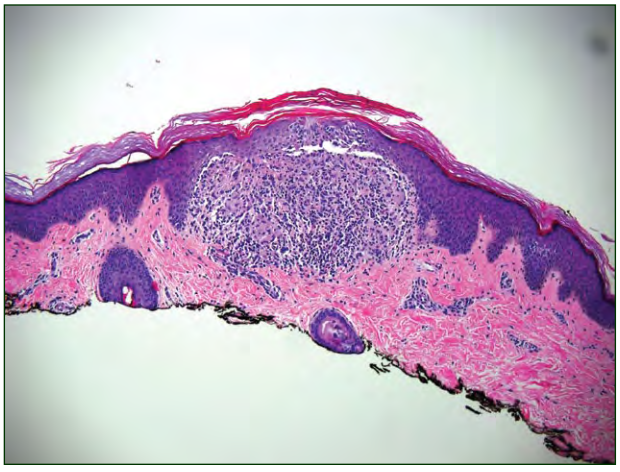
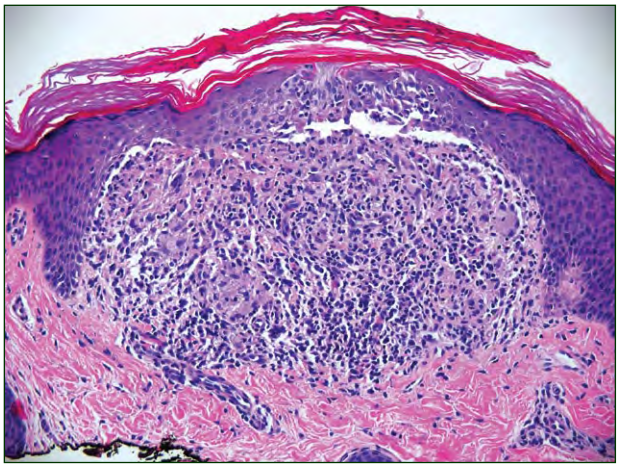


H&E, original magnification ×20.



H&E, original magnification ×40.

The best diagnosis is:

a. fixed drug eruption
b. lichen nitidus
c. lichen planus
d. lupus
e. syphilis

PLEASE TURN TO PAGE 297 FOR DERMATOPATHOLOGY DIAGNOSIS DISCUSSION

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The authors report no conflict of interest.
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Lichen Nitidus

Lichen nitidus clinically presents as multiple shiny, pinhead-sized, flesh-colored, dome-shaped papules typically involving the genitalia, upper extremities, and torso, though it also can be generalized. Lichen nitidus is a chronic eruption that classically appears in children and young adults. Although the eruption usually is asymptomatic, itching and/or a burning sensation occasionally have been reported.[1] Histologically, there is a sharply circumscribed inflammatory infiltrate within the dermis that generally spans approximately 4 to 5 dermal papillae. The borders are marked by extensions of epidermal ridges, giving a ball-in-claw appearance (Figure 1). The infiltrate is composed of lymphocytes and epithelioid histiocytes. The overlying epidermis is parakeratotic with basal cell hydropic degeneration and cytoid bodies (Figure 2).[1,2]

Lichen planus presents with a broader lichenoid and lymphocytic infiltrate with wedge-shaped hypergranulosis and saw-toothed rete ridges (Figure 3).

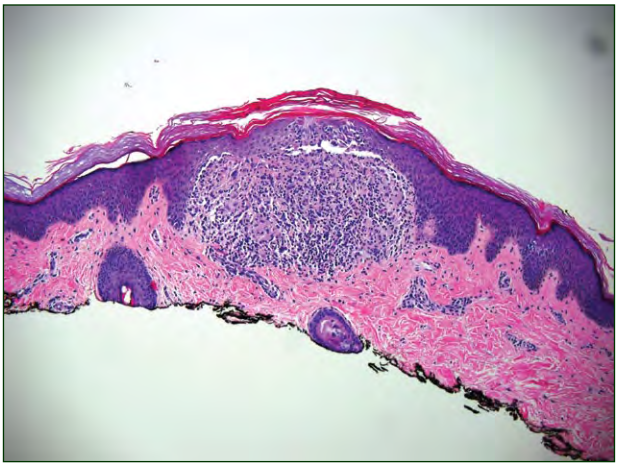

Figure 1. Sharply circumscribed inflammatory infiltrate within the dermis, giving a ball-in-claw appearance of lichen nitidus (H&E, original magnification ×20).

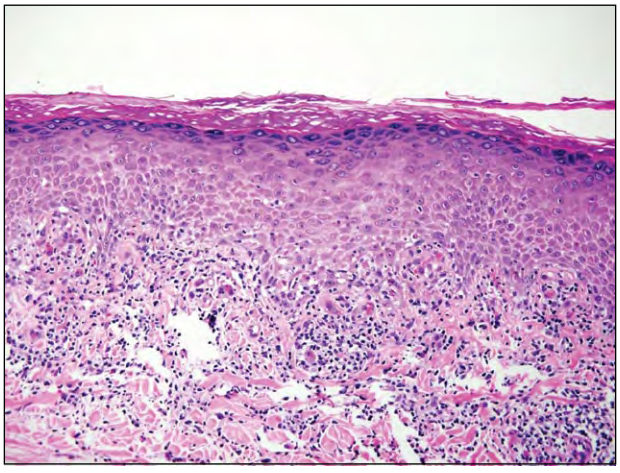

Figure 3. Wedge-shaped hypergranulosis, saw-toothed rete ridges, and bandlike lymphocytic infiltrate of lichen planus without parakeratosis or eosinophils (H&E, original magnification ×40).

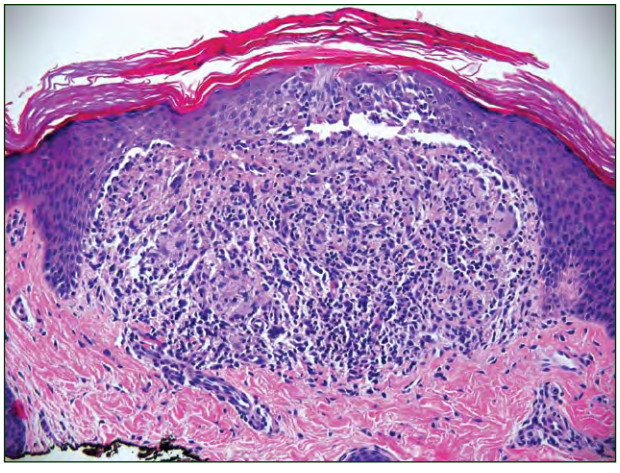

Figure 2. Higher magnification showing parakeratosis, basal cell hydropic degeneration, and mixed cellular dermal infiltrate of lichen nitidus (H&E, original magnification ×40).

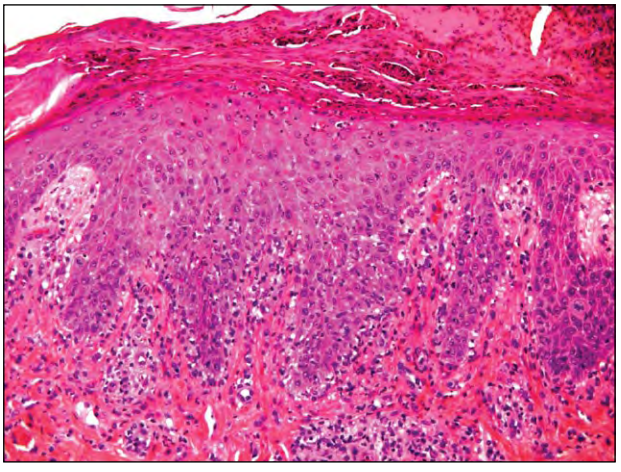

Figure 4. Elongated rete ridges, plasma cells, and neutrophilic crust of syphilis (H&E, original magnification ×40).

Lichen planus typically does not have parakeratosis or eosinophils. Syphilis can show elongated rete ridges and interface change, but neutrophils typically are seen in the stratum corneum and plasma cells usually are present within the infiltrate (Figure 4). Lupus involves a superficial and deep perivascular and periadnexal lymphoid infiltrate with interstitial mucin and focal vacuolar change (Figure 5). Basement membrane thickening and follicular hyperkeratosis also can be observed. Fixed drug eruptions generally present with a normal stratum corneum, interface change, melanoderma, and eosinophils within the infiltrate (Figure 6).[2,3]

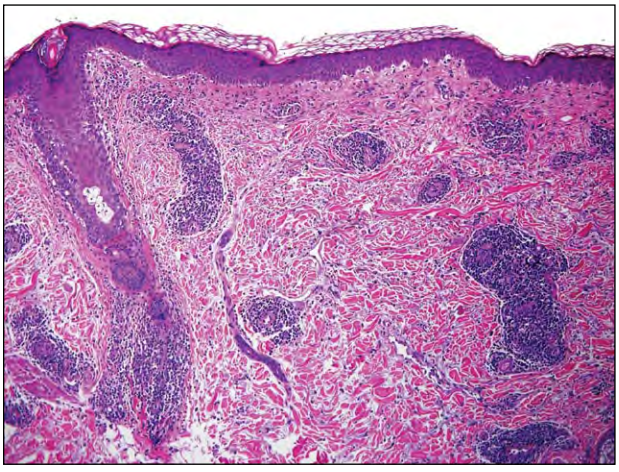

Figure 5. Superficial and deep perivascular and periadnexal lymphoid infiltrate with interstitial mucin and focal vacuolar change of lupus (H&E, original magnification ×20).

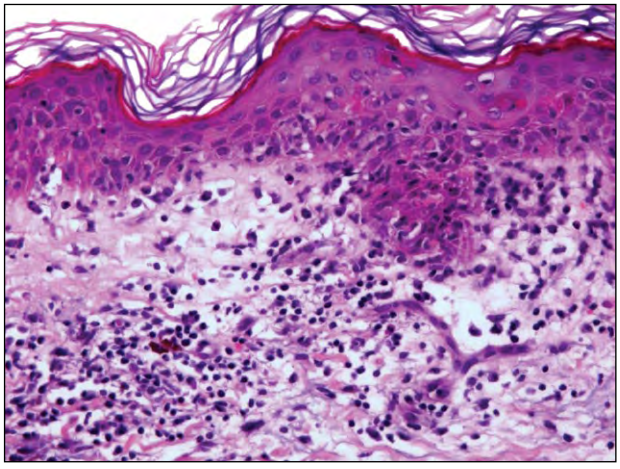

Figure 6. Acute, basket weave, orthokeratotic stratum corneum; interface dermatitis; and melanoderma of a fixed drug eruption (H&E, original magnification ×20).

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