From: "ROOT" <root@sctimst.ac.in>
To: "ROOT" <root@sctimst.ac.in>
Date: 12/08/2024 08:08 AM
Subject: Student CPC

Greetings from AIIMS, Rishikesh !!

The next student CPC is scheduled on **Aug 12, 2024** in **CPD Hall**, AIIMS Rishikesh from **8:00 AM to 9:00 AM**.

You can also join online through the following Webex link:

Meeting link:

https://aiimsrishikesh.webex.com/aiimsrishikesh/j.php?MTID=m1fc9f1acd35b59a23b32f948da2b8b2c

Monday, Aug 12, 2024, 8:00 AM | (UTC+05:30) Chennai, Kolkata, Mumbai, New Delhi

Meeting number: 2513 627 6447

Meeting password: 120824

The Clinical handout of the case to be discussed is attached herewith.

Thanks & Regards
Regional Resource Centre
Dept of Telemedicine
AIIMS Rishikesh

Student CPC

Department of Dermatology, Venereology & Leprosy (12/8/24)

Age: 14 year/Female	**Clinician in-charge:** Dr. Sushantika	**Pathology in-charge:** Dr. Prashant Durgapal
OPD: Dermatology	**Clinician discussant (Resident):** Dr. Shivani Vasisht	**Pathology discussant:** Dr. Gayathri

PRESENTING COMPLAINTS

- Raw ulcerated itchy lesions in the groin (left side), axilla, perianal region X 1 year
- Violaceous to brown itchy lesions on the nape of neck X 1 year

HISTORY OF PRESENTING ILLNESS

The patient was asymptomatic 1 year back, when she developed a single dark-colored raised lesion in the groin region (left side), which was insidious in onset, gradually increased in size, associated with severe itching (enough to hamper sleep). After 2 months, developed ulceration over the centre of lesion, which was associated with purulent discharge (non-foul smelling, dirty yellow in color) since 20 days. It was not associated with pain, bleeding, fever. After 3 months, similar dark-colored lesions developed over axilla (bilaterally) and perianal area, which gradually increased in size and number and developed ulceration in few of the lesions. These lesions were not associated with purulent discharge/ bleeding/pain. One year back, she developed violaceous to brown itchy lesions on nape of neck, which was insidious in onset, gradually increased in size and number with no h/o ulceration over these lesions. There was no history of evening rise of temperature/cough/family or personal history of tuberculosis/significant weight loss/recurrent infections/ similar lesions at sites of trauma/ oral discomfort on spicy food intake.

PAST/PERSONAL/FAMILY HISTORY

No significant past/personal/family history.

TREATMENT HISTORY

Took some medications (oral and topical) from various local practitioners (no documentation available) x 6 months (on/off), with no significant improvement in symptoms.

EXAMINATION

General condition-

Conscious and oriented, vitally stable

No pallor/ icterus/ cyanosis/ clubbing/ pedal edema

B/L inguinal lymphadenopathy+ (~1cm)

Systemic examination- WNL

Mucocutaneous examination-

Well-defined non-tender, non-indurated plaques of size approx.10 x 6 cm on left inguinal fold, approx. 3 x 2 cm and 1 x 1 cm in gluteal cleft, approx. 0.5 x 0.5 cm to 3 x 4 cm in axilla, with irregular hyperpigmented verrucous borders and central ulceration.

Multiple well-defined flat-topped hyperpigmented plaques of size ranging from approx. 1 x 1 cm to 3 x 2 cm 6 cm on nape of neck.

White lacy reticulate striae on buccal mucosa.

Wickham striae on dermoscopy

Conjunctival/nasal/anal/genital mucosa - WNL

Nails/scalp- WNL

INVESTIGATIONS

CBC/LFT/KFT/Viral markers/RBS/Fasting lipid profile/CXR- normal

Mantoux - Negative

Pus C/S- MRSA - sensitive to tetracycline, vancomycin and linezolid

Skin biopsy- CBNAAT- negative, HPE- non specific dermatitis

COURSE AND MANAGEMENT

Patient presented to Dermatology OPD with above mentioned complaints. Routine investigations were done. Biopsy from the inguinal and axillary lesion were sent, which came out to be non-specific dermatitis. Based on history, examination, dermoscopy, investigations and histopathology, a diagnosis of Inverse Erosive Lichen Planus was made. After control of secondary infection, the patient was started on Tab Prednisolone 30 mg 1 tab OD x 2 weeks → 20 mg 1 tab OD x 2 weeks, antihistaminics and topical super-potent corticosteroids, with resolution of lesions with hyperpigmentation in 2 months.

FINAL DIAGNOSIS

Inverse Erosive Lichen Planus

TREATMENT PLAN

In subsequent followup, Patient started on Cap Isotretinoin 20 mg 1 cap HS and topical Tacrolimus 0.1% LA HS.

Attachments:

File: Clinical Summary.docx	Size: 17k	Content Type: application/vnd.openxmlformats-officedocument.wordprocessingml.document