



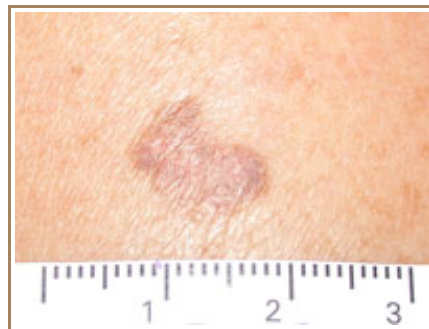
## Lichenoid keratosis

### What is lichenoid keratosis?

Lichenoid keratosis is usually a solitary lesion that looks similar to a [lentigo](#), Bowen's disease (in situ [squamous cell carcinoma](#)), or superficial [basal cell carcinoma](#). Histopathology (the microscopic structure and changes of the lesion) resembles that of [lichen planus](#) with some slight differences. The lesions appear to develop from a regressing existing lesion such as a lentigo or [seborrhoeic keratosis](#) as on close examination remnants of these former lesions may be evident.

Lichenoid keratosis is also known as benign lichenoid keratosis, solitary lichen planus, lichen planus-like keratosis and involuting lichenoid plaque.

#### Lichenoid keratoses



### Who gets lichenoid keratosis?

Lichenoid keratosis is an uncommon lesion with most cases usually discovered by doctors performing careful skin examinations. Most lesions develop in patients aged between 30–80 years and affect females more than males by 2:1. The condition is most commonly seen in Caucasians and rarely affects Asians, African Americans or Hispanics.

### What are the clinical features of lichenoid keratosis?

The clinical features of lichenoid keratosis vary somewhat in relation to their histopathological findings and how long they have been present. These attributes have been used to define several clinical subtypes of lichenoid keratosis.

Classic, bullous or atypical subtype	
Clinical features	<ul style="list-style-type: none"> <li>• Acute rapidly developing lesion (present for &lt;3 months)</li> <li>• Erythematous or pinkish papule or plaque</li> <li>• <a href="#">Dermoscopy</a> may show remnants of pigment network, subtle blotches of brown colour, clusters of grey dots plus dotted, irregular linear and other shaped telangiectatic blood vessels</li> </ul>

Histopathology	<ul style="list-style-type: none"> <li>• Classic variant shows epidermal acanthosis with a band-like lichenoid lymphocytic infiltrate. Presence of epidermal parakeratosis distinguishes these lesions from typical lichen planus.</li> <li>• Bullous variant shows intraepidermal or subepidermal bullous cavities with dense lymphocytic infiltrate and increased number of necrotic basilar layer keratinocytes.</li> <li>• Atypical variant shows similar histology to classic type with scattered enlarged CD-3, CD-30 (+) lymphocytes with hyperchromatic, irregular nuclei.</li> </ul>
<b>Early or interface subtype</b>	
Clinical features	<ul style="list-style-type: none"> <li>• Subacute lesions present for 3 months to one year</li> <li>• Erythematous to dusky-red or hyper-pigmented brown lesion</li> <li>• Depending on the age of lesion, dermoscopy may show features of a solar lentigo or flat seborrheic keratosis with moth-eaten borders, fingerprinting, milia-like cysts, comedo-like openings, plus small foci of melanophages (grey dots).</li> </ul>
Histopathology	<ul style="list-style-type: none"> <li>• Single lymphocytes aligned along the dermoepidermal junction without epidermal acanthosis and adjacent lentigo</li> </ul>
<b>Late regressed or atrophic subtype</b>	
Clinical features	<ul style="list-style-type: none"> <li>• Lesions have been present for more than one year</li> <li>• May be violaceous (violet-coloured) papules or irregularly distributed lesions with shades of brown or grey</li> </ul>
Histopathology	<ul style="list-style-type: none"> <li>• Epidermal atrophy with papillary dermal scarring, patchy lymphocytic infiltrates and melanin incontinence</li> </ul>

Other features of lichenoid keratosis found in all subtypes are:

- Solitary lesion is present in 90% of cases of lichenoid keratosis. A small number (<10%) of patients develop 2 or 3 lesions.
- Lesion most commonly found on the upper trunk, followed by the distal upper extremities, and less commonly on the head and neck.
- Lesion ranges from a few millimetres to one centimetre or more in size.
- Surface may be smooth, scaly or warty.
- Often symptomless or may be slightly itchy or have mild stinging sensation.

## What is the management of lichenoid keratosis?

Initially the lesion is examined using [dermoscopy](#). For lesions that are considered low-risk dermoscopic images can be taken and used in follow-up sessions over time to check for any significant changes.

### Dermoscopy of lichenoid keratoses



Because clinical examination and dermoscopy may not be able to differentiate between lichenoid keratosis and other solitary erythematous lesions that could be melanocytic, non-melanocytic benign, malignant or inflammatory, a [skin biopsy](#) may be necessary to confirm diagnosis of suspicious lesions. Complete excision rather than an incisional biopsy is recommended.

Once the diagnosis of lichenoid keratosis is confirmed, the patient should be advised about the benign nature of the lesion and offered medical or surgical treatment to remove any remaining lesion. This may be treatment with [liquid nitrogen](#), electro-surgery or [curettage](#). In some cases the remaining lesion can be left alone.

To date there have been no reports of lichenoid keratosis turning into malignant skin tumours.

#### Related information

##### References:

[Lichen Planus-Like Keratosis. The Doctor's Doctor](#)

##### On DermNet NZ:

- [Lichen planus](#)
- [Lentigines](#)
- [Seborrhoeic keratosis](#)

##### Other websites:

##### Books about skin diseases:

See the [DermNet NZ bookstore](#)

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DermNet does not provide an on-line consultation service.

If you have any concerns with your skin or its treatment, see a [dermatologist](#) for advice.

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