Denosumab

Lichen planus: 2 case reports

In a case report consisting of two patients, two patients were described of whom a 54-year-old man and a 56-year-old woman developed lichen planus (LP) during treatment with denosumab for osteoporosis [not all routes and dosages stated; duration of treatments to reactions onset not stated].

The 54-year-old man (case 1) presented with a 5-week history of a erythematous, pruritic, plaque-like eruption that affected the popliteal fossae and inner thighs. It was reported that he had a history of osteoporosis and had been given the first dose of SC denosumab 60mg around 4 weeks before appearance of the eruption. Physical examination showed slightly scaly, erythematous to violaceous plaques on both inner thighs, groins and the popliteal fossae. A 4-mm punch biopsy was obtained from the right groin. Histopathological analysis revealed an interstitial and perivascular infiltrate of lymphocytes and scattered histiocytes in the upper dermis. Lymphocytes were observed to extend into the basal layer of the epidermis with attributed basal vacuolar damage and occasional Civatte body formation. The epidermis was mildly hyperkeratinised with hypergranulosis. The findings were concordant with lichenoid inflammation. Based on the clinical picture and history, a diagnosis of probable lichenoid drug eruption secondary to denosumab was confirmed. His treatment with denosumab was discontinued and received an unspecified steroid. Subsequently, the eruption receded over 2–3 months and left an area of post-inflammatory hyperpigmentation.

The 56-year-old woman (case 2) presented with a 2-month history of a pruritic rash over her lower wrists and legs with lesions affecting the buccal mucosa. It was reported that she had a history of osteoporosis, and had received denosumab for the first time 3 months previously. Physical examination revealed erythematous to violaceous papules on the elbows, wrists and ankles. Examination of the mouth showed a bilateral, white, lacy reticular eruption on the buccal mucosa. Punch biopsy revealed a very prominent lichenoid interface change with dermal oedema and inflammation with intraepidermal vesicle formation consisting of scarce scattered lymphocytes and occasional eosinophils. These findings were consistent with bullous LP. She received a high-potency unspecified steroid and denosumab was discontinued. Four months later, her skin was clear.

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