Sir, Lichen planus pigmentosus (LPP) usually affects the face and neck of dark-skin phototype individuals having overexposure to sunlight. There are also a few known atypical clinical variants. Here, we document a unique case of LPP affecting both upper and lower eyelids bilaterally presenting as “raccoon eyes.”

A 35-year-old male presented with asymptomatic dark slate-gray hyperpigmentation over both eyelids on both sides for the past 1 year. There was no history of trauma, pre-existing dermatosis, or topical and/or systemic medications before the onset of pigmentation. Local cutaneous examination revealed well-defined dark slate-gray hyperpigmented patches chiefly involving both the right and left upper eyelids and medial aspect of both lower eyelids extending to the infraorbital area [Figure 1a and b]. Few brownish-black hyperpigmented patches with atrophic centre were also present on the right side of forehead. Nails and mucosa were normal on examination.

Histopathologic examination of the punch biopsy specimen taken from lower eyelid lesion demonstrated moderately dense superficial perivascular lichenoid lymphocytic infiltrate along with melanophages in papillary dermis with wedge-shaped hypergranulosis and compact orthohyperkeratosis. The dermoepidermal junction showed focal basal cell vacuolization, and scattered necrotic keratinocytes and colloid bodies were seen at the interface [Figure 2]. Based on the clinicopathologic correlation, bilateral eyelid pigmentation was diagnosed as LPP and the atrophic hyperpigmented patches on forehead were considered as lichen planus too (atrophic variant) because LPP is well known to coexist with other cutaneous lesions of LP.

LPP is a relatively common pigmentary disorder seen in individuals of Fitzpatrick skin type III–V living in tropical countries such as India, middle-east, and Latin America.[1] It chiefly affects the face, neck, and upper limbs with ill-defined slate-gray to brownish-black hyperpigmented homogenous patches.[1]

There are certain rare clinical forms of LPP such as LPP inversus (flexural involvement), blaschkoid, zosteriform, segmental, and mucosal forms reported in literature.[2] In this article, a unique presentation of LPP has been noted which involved both upper and lower eyelids bilaterally, masquerading as “raccoon eyes.” Previously, only 19 cases of LP were reportedly seen to involve eyelid regions, summarized in a recently published article, and none of those cases were the LPP variant of LP.[3] Of note, we could find a single case having ill-defined patches of LPP with periocular distribution in a female.[4]

Considering the peculiar involvement of eyelid area, its differential diagnosis includes only a few conditions such as dermal melanocytosis, post-inflammatory hyperpigmentation secondary to atopic dermatitis, allergic contact dermatitis, Riehl’s melnosis or pigmented cosmetic dermatitis (PCD), fixed drug eruption (FDE), and tear trough associated with ageing.[5] Among these, PCD is the most important differential diagnosis occurring secondary to application of cosmetics containing allergens.
such as balsam of Peru, cinnamates and lanolin, or some pigments.[1] Considering that patch testing is not a very useful method to differentiate these two conditions, detailed history, morphology and color of the lesions, and histopathologic demonstration of classical findings of LPP confirm the diagnosis.

Treatment modalities for LPP include topical application of mild or potent steroids, tacrolimus, oral administration of dapsone, retinoic acid derivatives, cyclosporine, and phototherapy.[3] For cases of LPP of eyelids, tacrolimus should be used for topical application to avoid ocular side effects of topical steroids.

Description of such a unique case further expands the dimension of clinical variants of LPP, warranting its consideration as an important differential diagnosis in all doubtful cases.

Declaration of patient consent

The authors certify that they have obtained all appropriate patient consent forms. In the form the patient(s) has/have given his/her/their consent for his/her/their images and other clinical information to be reported in the journal. The patients understand that their names and initials will not be published and due efforts will be made to conceal their identity, but anonymity cannot be guaranteed.

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Conflicts of interest

There are no conflicts of interest.

Anup K. Tiwary, Piyush Kumar

Department of Dermatology and Venereology, Government Medical College and Hospital, Haldwani, Uttarakhand, 1Department of Dermatology, Katihar Medical College and Hospital, Katihar, Bihar, India

Address for correspondence:
Dr. Anup K. Tiwary,
House No. 12, Diamond Building, Government Medical College, Haldwani, Uttarakhand, India.

E-mail: anup07tunnu07@gmail.com

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