Introduction
Lichen striatus is an uncommon, self-limiting linear dermatosis that predominantly affects children of 5–15 years of age. It is diagnosed based upon its appearance and morphological expression along the lines of Blaschko. It usually appears as a sudden eruption of small skin-colored or pink lichenoid papules forming a continuous or interrupted, linear band on the limbs or trunk. The papules are usually asymptomatic, flat topped, smooth or scaly and evolve within several days to weeks. In dark-pigmented individuals, it may appear as a band-like area of hypopigmentation. The lesions may extend from a few centimeters to involve the full length of an extremity. It is usually unilateral and single, although, bilateral or multiple parallel bands have been documented. To the best of our knowledge, only four cases of bilateral lichen striatus have been previously reported in the literature.

Case Report
A 5-year-old girl presented with a hypopigmented linear band on the left upper extremity since 1 month. The lesions first appeared on the inner aspect of the left forearm and later extended linearly to involve the posterior aspect of the arm and trunk on the same side. Further, her parents had also noticed hypopigmented pin head-sized asymptomatic raised lesions on the contralateral forearm in the last 5 days. The lesions were not itchy. Nails were uninvolved. There were no features suggestive of atopy. Skin biopsy from the right forearm showed mild hyperkeratosis, spongiosis, vacuolar alteration of basal layer and lymphocytic exocytosis with a mild-to-moderate perivascular mononuclear infiltrate and melanin incontinence in the dermis. A distinctive feature of lichen striatus is a dense infiltrate extending deep into the dermis around the hair follicles and eccrine sweat glands and ducts in some cases, which was absent.

Abstract
Lichen striatus is a self-limiting dermatosis presenting with sudden eruption of lichenoid papules along the lines of Blaschko. A 5-year-old girl presented with asymptomatic hypopigmented linear lesions over both upper limbs. The histopathological examination revealed spongiosis, vacuolar alteration of the basal layer and lymphocytic exocytosis with a mild-to-moderate perivascular mononuclear infiltrate in the dermis. Lichen striatus was diagnosed based upon the characteristic clinical and histopathological findings. The pathogenetic mechanism of bilateral lichen striatus is unknown at present, however, a somatic mutation in two different clones of cells can be a possibility.

Keywords: Bilateral, Blaschko, lichen striatus

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in our case. It was diagnosed as a case of lichen striatus based upon the characteristic clinical and histopathological findings. Emollients were prescribed for treatment and the lesions resolved within 3 months leaving no sequelae.

Discussion
The pathogenesis of lichen striatus is elusive, however, various etiological factors have been implicated. The most commonly accepted hypothesis is that of environmental stimuli acting in a genetically predisposed individual. Linear dermatoses such as lichen striatus follow the lines of Blaschko, which are embryonic in origin. A somatic mutation in early embryogenesis results in formation of an abnormal clone of cells, which on subsequent exposure to an environmental stimulus results in formation of lichen striatus.

Others believe that it is secondary to an autoimmune response mediated by T cells. Atopy has been reported to be a predisposing factor. Drugs, such as adalimumab and etanercept, BCG and hepatitis B vaccination, UV exposure from a tanning bed, minor trauma, insect bite, and viral infections, such as varicella, influenza, and human herpes viruses 6 and 7 have been reported as triggers.

The histopathological findings are nonspecific and vary depending on the stage of evolution. Usually a superficial perivascular lymphohistiocytic infiltrate is seen, which may

| Authors            | Age  | Clinical features                                                                 | Histopathology                                                                 | Treatment and follow up                          |
|--------------------|------|----------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--------------------------------------------------|
| Kurokawa et al. (2004) | 25 years | Bilateral lichen striatus on the lower extremities since fourteen years | Lichenoid tissue reaction with foci of spongiosis and perivascular and perieccrine duct inflammatory cell infiltration | Treated successfully with topical corticosteroid ointment application for 10 days |
| Aloï et al. (1997) | 5 years | Linear dermatosis along the Blaschko lines distributed asymmetrically and bilaterally on the face, neck, trunk, and limbs of 1-month duration | Atrophic epidermis with foci of spongiosis, parakeratosis, and lymphocytic exocytosis and lichenoid infiltrate with patchy perivascular and perianadrnal infiltrate | Emollients were given. Lesions regressed with residual hypopigmentation in 16 months |
| Patri (1983)       | 8 years | Pink-violet papules in linear and arciform arrangement on the trunk, arms, neck, buttocks, and right leg | Mild acanthosis, edema and a moderate lymphocytic infiltrate obscuring the dermal-epidermal junction and in perivascular areas | Follow up not mentioned |
| Mopper et al. (1971) | 2 years | 12 linear lesions were present involving the arms, back, chest and buttocks since 2 months | Acanthotic and parakeratotic epidermis with destruction of basal layer and few dyskeratotic cells. heavy infiltrate was present in the papillae and around subpapillary vessels with focal extension to deeper areas | No treatment was given and complete resolution in 3 months was seen without any sequelae |
extend focally into the lower part of epidermis causing vacuolar alteration of basal layer with melanin incontinence. The epidermal reaction pattern may include spongiosis, focal parakeratosis, and lymphocyte exocytosis.[10]

The course of LS is self-limiting, usually regressing spontaneously within 3–12 months, thus requiring symptomatic treatment only. The patient should be reassured and emollients and topical steroids may be used to relieve dryness and pruritus. Post-inflammatory hypopigmentation or hyperpigmentation can develop as a sequelae.[1]

Our patient had lesions which corroborated with the clinical and histopathological findings in lichen striatus, however, they were distributed bilaterally. To the best of our knowledge, only four cases of bilateral LS have been described previously [Table 1].[1-3,11] Although the pathogenesis is unknown at present, a somatic mutation in two different clones of keratinocytes can be a possibility.

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Conflicts of interest
There are no conflicts of interest.

References
1. Kurokawa M, Kikuchi H, Ogata K, Setoyama M. Bilateral lichen striatus. J Dermatol 2004;31:129-32.
2. Aloi F, Solaroli C, Pippione M. Diffuse and bilateral lichen striatus. Pediatr Dermatol 1997;14:36-8.
3. Patri P. Bilateral lichen striatus. G Ital Dermatol Venereol 1983;118:101-3.
4. Mittal R, Khaitan BK, Ramam M, Verma KK, Manchanda M. Multiple lichen striatus-An unusual presentation. Indian J Dermatol Venereol Leprol 2001;67:204.
5. Taieb A, El Youbi A, Grosshans E, Maleville J. Lichen striatus: A Blaschko linear acquired inflammatory skin eruption. J Am Acad Dermatol 1991;25:637-42.
6. Brennand S, Khan S, Chong AH. Lichen striatus in a pregnant woman. Australas J Dermatol 2005;46:184-6.
7. Lora V, Kanitakis J, Latini A, Cota C. Lichen striatus associated with etanercept treatment of rheumatoid arthritis. J Am Acad Dermatol 2014;70:90-2.
8. Ciconte A, Bekhor P. Lichen striatus following solarium exposure. Australas J Dermatol 2007;48:99-101.
9. Ishikawa M, Ohashi T, Yamamoto T. Lichen striatus following influenza infection. J Dermatol 2014;41:1133-4.
10. Gianotti R, Restano L, Grimalt R, Beni E, Alessi E, Caputo R. Lichen striatus - A chameleon; an histopathological and immunohistological study of forty-one cases. J Cutan Pathol 1995;22:18-22.
11. Mopper C, Horwitz DC. Bilateral lichen striatus. Cutis 1971;8:140-1.