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Actinic Lichen planus: A Photodistributed dermatosis in an outdoor worker

Dr Laasyaa Reddy B[1*], Dr Subhashree Bangaru M[2], Dr Kavya Prabha Manoharan[3]

[1]Postgraduate, Department of Dermatology, Venereology and Leprosy, Sree Balaji Medical College and Hospital, Chennai (Corresponding author)

[2]Postgraduate, Department of Dermatology, Venereology and Leprosy, Sree Balaji Medical College and Hospital, Chennai

[3]Postgraduate, Department of Dermatology, Venereology and Leprosy, Sree Balaji Medical College and Hospital, Chennai

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KEYWORDS

Actinic lichen planus; photodistributed dermatosis; lichen planus actinicus; dermoscopy; Wickham striae; histopathology

ABSTRACT:

Actinic lichen planus is a rare photodistributed variant of lichen planus that predominantly affects sun-exposed skin, especially in individuals with darker skin phototypes living in tropical and subtropical regions. Ultraviolet radiation is considered an important precipitating factor, and lesions often present as asymptomatic or mildly symptomatic annular, hyperpigmented, violaceous, or dyschromic plaques over the face and other exposed sites. We report a 42-year-old male outdoor worker who presented with progressively enlarging dark lesions over the face for five months. Cutaneous examination revealed multiple well-defined annular plaques over the bilateral cheeks and forehead with a violaceous to hyperpigmented center surrounded by a striking hypopigmented rim. Dermoscopy showed a diffuse brown background, multiple gray-brown dots and globules, fine reticular white lines corresponding to Wickham striae, and peripheral hypopigmentation. Histopathological examination demonstrated epidermal atrophy, basal cell vacuolar degeneration, a dense band-like lymphocytic infiltrate at the dermoepidermal junction, and pigment incontinence with numerous dermal melanophages, confirming actinic lichen planus. The patient was started on broad-spectrum sunscreen and a mid-potency topical corticosteroid with advice regarding strict photoprotection. This case highlights the characteristic clinicodermoscopic and histopathological profile of actinic lichen planus and emphasizes the need to consider this uncommon entity in the differential diagnosis of chronic photodistributed facial pigmentation.

Introduction

Actinic lichen planus is a rare photodistributed variant of lichen planus that predominantly affects sun-exposed skin, particularly in individuals with darker skin living in tropical and subtropical regions. Lichen planus overall is an uncommon inflammatory dermatosis and recent population-based data have estimated a standardized overall prevalence 1%–2%. (1,2) Actinic lichen planus represents only a small and distinctly uncommon subset of these cases. Ultraviolet radiation is considered an important triggering factor, and lesions usually occur over photo-exposed areas such as the face, forehead, neck, and forearms. Clinically, it presents as asymptomatic or mildly symptomatic hyperpigmented, violaceous, annular, or dyschromic patches and plaques, often without the mucosal or nail involvement classically associated with conventional lichen planus.(3) Because of its unusual morphology and photodistribution, it may mimic discoid lupus erythematosus, melasma, lichen planus pigmentosus, and other photodermatoses, making clinicopathological correlation important for accurate diagnosis. In this context, the present case evaluated in the Department of Dermatology, Venereology and Leprosy, Sree Balaji Medical College and Hospital, Chennai was a rare case of actinic lichen planus in an outdoor worker presenting with characteristic photodistributed annular facial plaques, dermoscopic Wickham striae, and confirmatory histopathology.

Case Report

A 42-year-old male outdoor worker presented with progressively enlarging dark lesions over the face for the past five months. The lesions were insidious in onset and gradually increased in size over time. There was no history of itching, burning sensation, pain, blisters, oral lesions, genital lesions, or nail changes. The patient noted that the lesions were more prominent over areas of

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maximal sun exposure. There were no similar involvement over covered parts of the body. He denied any preceding drug intake, topical application, constitutional symptoms, or prior similar episodes. On cutaneous examination, multiple well-defined annular plaques were noted symmetrically over the bilateral cheeks and forehead, corresponding to chronically photo-exposed facial skin [Figure 1]. The individual lesions showed a violaceous to hyperpigmented center with a surrounding conspicuous hypopigmented rim, producing a striking annular appearance. The surface was smooth to minimally elevated without appreciable scale, crusting, erosion, or ulceration. No other lesions were observed in sun non exposure areas. Examination of the oral mucosa, scalp, genital mucosa, and nails was normal. Dermoscopy of the lesion showed a diffuse brown background, multiple gray-brown dots and globules, fine reticular white lines corresponding to Wickham striae, and peripheral hypopigmentation. Routine laboratory investigations were within normal limits. A punch biopsy was obtained from a representative plaque. Histopathological examination revealed epidermal atrophy, basal cell vacuolar degeneration, and a dense band-like lymphocytic infiltrate along the dermoepidermal junction. Marked pigment incontinence with numerous dermal melanophages was also seen. Based on the photodistributed clinical morphology, the absence of mucosal and nail involvement, the dermoscopic finding of Wickham striae, and the characteristic lichenoid histopathology, a diagnosis of actinic lichen planus was made. The patient was started on topical corticosteroid and sunscreen along with advice regarding strict photoprotection and reduction of occupational sun exposure.

Discussion

Actinic lichen planus is regarded as a photosensitive variant of lichen planus in which ultraviolet radiation serves as an important provoking factor. Meads et al. described it as a photodistributed dermatosis occurring predominantly in patients with dark complexions and noted that sunlight appears to trigger lesion development in many cases.(4) The distribution in our patient was therefore highly characteristic. MacFarlane and Verbov reported that actinic lichen planus typically localizes to light-exposed areas and emphasized the diagnostic importance of confinement to photo-exposed skin.(5) The morphology in our patient closely resembles the pattern described by Bouassida et al., who, in their series of 32 cases, identified annular, pigmented, and dyschromic lesions as the main morphological presentations of actinic lichen planus, thereby supporting the annular hyperpigmented-to-violaceous plaques with peripheral hypopigmentation seen in our case.(6) A helpful clinical clue in this variant is the relative absence of the intense pruritus, mucosal lesions, and nail changes that are more typical of conventional lichen planus. Choi et al., while reporting isolated actinic lichen planus of the lower lip, reiterated that actinic lichen planus tends to occur on light-exposed skin in patients with dark skin and may present without the broader mucocutaneous involvement seen in classic disease.(7) Singh et al. showed that dermoscopy is useful in diagnosing actinic lichen planus, especially because the white reticular lines of Wickham striae point toward its lichenoid nature.(8) The other dermoscopic findings in our patient were also similar to those reported by Kothari et al., who described a diffuse light-brown background, pigment pseudonetwork, and peripheral pigment changes in skin of colour.(9)

The differential diagnosis of a chronic pigmented facial plaque is broad. Alhawsawi et al. reported actinic lichen planus of the forehead mimicking lentigo maligna and stressed that this entity can simulate facial melanotic disorders and other photo-aggravated dermatoses, thereby requiring histopathological confirmation.(10) Histopathology remains the diagnostic cornerstone. Đorđević et al. described pigmented actinic lichen planus with basal vacuolar degeneration, lichenoid inflammatory infiltrate, pigment incontinence, and melanophages, closely resembling the biopsy findings in our patient.(11)

Management focuses on reducing ultraviolet provocation and controlling inflammation. Jansen et al. reported successful treatment of lichen planus actinicus with acitretin and topical corticosteroids, reinforcing that photoprotection and topical anti-inflammatory therapy remain appropriate first-line approaches in localized disease.(12)

Conclusion

This case illustrates the characteristic clinical, dermoscopic, and histopathological profile of actinic lichen planus in an outdoor worker with photodistributed

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facial lesions. The combination of asymptomatic annular hyperpigmented-to-violaceous plaques over sun-exposed skin, Wickham striae on dermoscopy, and lichenoid interface dermatitis with pigment incontinence on histopathology strongly supports the diagnosis. Awareness of this uncommon variant is important because it may mimic several pigmentary and photosensitive disorders, and early recognition allows appropriate photoprotection and anti-inflammatory treatment.

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Figure 1: Multiple well-defined hyperpigmented to violaceous annular plaques with surrounding hypopigmentation over the bilateral cheeks and forehead

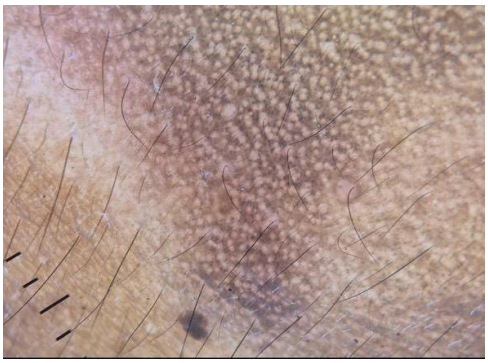

Figure 2: Dermoscopy showing a diffuse brown background, multiple gray-brown dots and globules, fine reticular white lines corresponding to Wickham striae, and peripheral hypopigmentation