

CASE REPORT

BULLOUS LICHEN PLANUS DEVELOPING AFTER TWO DECADES OF CLASSICAL MU- CUTANEOUS LICHEN PLANUS

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ABSTRACT:

Patients of lichen planus rarely suffer from a vesiculobullous variant. In this disease clear watery vesicles appear on the preexisting lesions of lichen planus and do not involve the normal skin. Lichen planus pemphigoids and bullous pemphigoid are difficult to diagnose on clinical and histopathological basis. I report a 60-year-old woman with a 30 years history of clinical and histopathological diagnosis of lichen planus. She gives history of widespread lesions involving the skin of all the body. She has also a history of oral lesions/ulcerations of lichen planus. From past 5 years she develops vesiculobullous eruptions on the lesions of lichen planus. Biopsy showed classical lichenoid changes with subepidermal blister formation. After the clinical evaluation and histopathological correlation, the diagnosis of bullous lichen planus was confirmed. All the other causes of vesicular bullous disorders were excluded. This case is important because the dermatologists may not consider this rare variant of lichen planus while making the diagnosis especially when there is a longstanding history of lichen planus.

Keywords: Lichen planus, Bullous lichen planus, Vesiculobullous, Subepidermal blister, Histopathology

INTRODUCTION:

An autoimmune chronic inflammatory disease, lichen planus involves not only the skin of the whole body but also involves the nails, hair/scalp and oral mucosa.^{1,2} The lesions are pain topped, pink, itchy and pink. They are common in women,^{3,4} The inner sides of forearms, back sides of hands, knees and feet are usually commonly involved. However, the oral mucosal involvement is also not uncommon. The disease rarely progresses to malignancy. Seasonal changes, hormonal change, and anxiety may trigger the onset of formation of new crops of the disease. The relapses and remissions vary from person to person and there is not a specific time period that has been established to date. Similarly, the time period for which the lesions stay on the body also varies in different patients⁵

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INVESTIGATION

Routine hematological and biochemical investigations were normal. However, CRP was mildly el-

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Received: 05 Nov 2025; Revised: 25 Nov 2025; Accepted: 21 Mar 2026

evated (07 mg/L). Skin biopsy from a representative lesion demonstrated hyperkeratosis and wedge-shaped hyper granulosis, irregular acanthosis, vacuolar degeneration of the basal cell layer, and a dense band-like lymphocytic infiltrate at the dermo epidermal junction. Subepidermal blister formation arising from extensive basal cell degeneration was also present. Taken together, these findings were consistent with bullous lichen planus.

DIFFERENTIAL DIAGNOSIS

The differential included drug-induced bullous eruption, insect bite reaction, erythema multiforme, bullous pemphigoid, lichen planus pemphigoids, and other autoimmune vesiculobullous disorders. What favored bullous lichen planus was the localization of the blisters, exclusively within established lichen planus lesions, combined with the characteristic histopathological picture. Clinical evaluation and ancillary investigations excluded the alternatives.

TREATMENT

Management followed standard principles for lichen planus. Topical corticosteroids were prescribed for symptomatic lesions. Given the extent of cutaneous involvement and the persistence of oral disease, systemic therapy was also considered. Supportive oral care measures were recommended alongside.

OUTCOME AND FOLLOW-UP

The patient continued under regular dermatological review. The diagnosis of bullous lichen planus was maintained on the basis of clinical evolution and histopathological findings. Treatment produced symptomatic improvement, though intermittent disease activity persisted, a pattern consistent with the chronic, relapsing nature of the condition.

DISCUSSION

In bullous lichen planus, blistering is a consequence of severe liquefactive degeneration of basal keratinocytes.² It is very important to distinguish between the bullous eruption of lichen planus which do not arise on normal skin but only arise on the previously affected skin by lichen planus. The condition may also be associated with the presence of autoantibodies in the blood as the disease is an autoimmune disorder.³ The autoantibodies may also be formed against the basement membrane. That is why it is important to make a confirmatory diagnosis on the basis of clinical, histopathological and immunological basis.⁵



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