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LETTER TO THE EDITOR

Oesophageal lichen planus: Clinical, endoscopic and fibroscopic characteristics

Dear Editor,

Lichen planus (LP) is a chronic inflammatory mucocutaneous disease of unknown aetiology.[1] Oesophageal involvement is rare but likely underdiagnosed.[2,3] We conducted a study to define the clinical, endoscopic and histological characteristics and evolutionary profile of oesophageal lichen planus (ELP) (Figure 1).

A standardized questionnaire was sent to members of GEMUB (Oral Mucosa Study Group or Groupe d'Etude de la Muqueuse Buccale) in September 2022, completed by March 2023. It involved dermatologists, oral surgeons and maxillofacial surgeons. This retrospective, multicentre national study included patients with confirmed ELP diagnosed through clinical, endoscopic and histological criteria. All patients consented to the use of medical records. Data included demographic information, medical history, associated lichen planus sites, treatments and ELP features observed during gastroscopies, documented in patient records.

We included 30 patients with ELP. The majority were female (93%) with a median age of 62 years (range: 34–88). Almost all patients had extra-oesophageal lichen planus, particularly oral lichen planus (96.6%) and vulvar lichen planus (76.6%), with 12 of them exhibiting the erosive form of LP, the vulvovaginal gingival (VVG) syndrome.

Common symptoms at diagnosis included dysphagia (96%) and odynophagia (60%). The oesophagus proximal segment was the most affected (60%). Initial fibroscopic signs indicated stenosis, mucosal denudation and tearing (58%), along with less common findings (mucosal fragility, erosions and ulcerations, trachealization and hyperkeratotic pseudomembrane).

Patients were treated with corticosteroids, along with other immunosuppressors. Dilatations were performed for oesophageal stenosis. During follow-up fibroscopy, oesophageal stenosis was detected in 11 patients (35%) after a median of 7 years from the initial diagnosis.

Seven patients (23%) experienced malignant transformation with a median of 10.5 years post-ELP diagnosis, resulting in four epidermoid carcinomas and three dysplasias. Most neoplasia cases were non-smokers and non-alcoholic. Treatments included chemotherapy, surgery and radiotherapy.

ELP often coexists with oral (96.6%) and vulvar lichen planus (76.6%), similar to findings by Peta Fox et al. (89% oral, 42% vulvar) and Shaeur et al. (52% vulvar). ELP was associated with vulvar lichen planus in 23 of 28 women and possibly VVG syndrome in 12 cases. Common symptoms were dysphagia and odynophagia, warranting digestive fibroscopy. ELP lesions were typically in the proximal oesophagus (60%), unlike reflux esophagitis, which affects the distal third. Fibroscopy often showed oesophageal stenosis and mucosal detachment, signs of ELP.

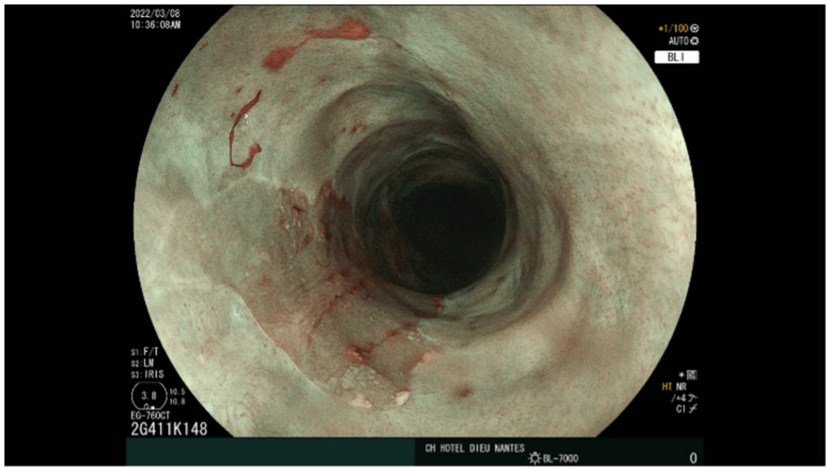

FIGURE 1 A virtual chromoendoscopy of oesophageal lichen planus.

Thirty-six per cent ($N = 11$) developed new oesophageal stenosis within 7 years, requiring repeated dilatations despite corticosteroid treatment. Long-term follow-up is crucial due to the 23% risk of neoplasia, higher than in previous studies (6.1% and 5.5%), likely due to longer follow-up (median 10 years). Most malignancies were detected via systematic follow-up fibroscopy, underscoring its importance.

Limitations include the retrospective nature, small sample size, inclusion bias towards patients with oral LP and memory bias favouring severe cases. The direct immunofluorescence test, useful for differentiating lichen planus from other diseases, was used in five patients.

Oesophageal lichen planus is a poorly recognized condition among dermatologists and gastroenterologists. To avoid a diagnosis delay in patients with oral lichen planus, physicians should systematically inquire about the presence of oesophageal symptoms on examination (particularly dysphagia and odynophagia). Particular vigilance is required in middle-aged women with associated vulvar lichen. If oesophageal symptoms are present, a fibroscopy should be performed as soon as possible. ELP should not be underestimated due to its significant risk of malignant transformation. Long-term follow-up with regular fibroscopies is recommended, even in asymptomatic patients. Although fibroscopies can be complicated in cases of oesophageal stenosis, they are necessary for proper monitoring and appropriate management. Gastroenterologists should be vigilant with oesophageal symptoms, especially in the proximal oesophagus, and conduct biopsies carefully to avoid misdiagnosis.

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The authors have no relevant financial interests to disclose.

CONFLICT OF INTEREST STATEMENT

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DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author.

ETHICAL APPROVAL

This study received approval by the institutional review board GNEDS (Nantes Group of Ethics in the Field of Health).

ETHICS STATEMENT

The patients in this manuscript have given written informed consent to publication of their case details.

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