It is difficult to diagnose on clinical examination. Tropical antifungals are usually ineffective in treating Tinea capitis and Tinea facei. Systemic griseofulvin, for six weeks, is the treatment of choice in children. Erroneous treatment with steroid results in Tinea incognito, a less clearly defined pustular folliculitis.

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An eight-year-old boy presented with moderately itchy, violaceous papules on both legs and forearms of 2 months duration. There was no mucosal, nail or hair involvement. Koebner’s phenomenon, defined as appearance of new lesions along the line of trauma or scratch was positive (Fig. 1). Lesional biopsy revealed hyperkeratosis, focal hypergranulosis, irregular acanthosis and diffuse basal cell degeneration with dense upper dermal lymphocytic infiltrate, characteristic of Lichen planus. Topical application of a potent topical steroid, clobetasol propionate (0.05%) twice daily with systemic antihistamine led to marked decrease in itching and subsequent resolution of lesion with residual hyperpigmentation in 6 weeks period.

Lichen Planus

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Fig. 1. Violaceous papules both legs with positive Koebner’s phenomenon (arrow).
Lichen planus (LP) is a pruritic dermatosis of unknown etiology that affects skin, oral and genital mucous membranes, nails and hair. The classic form presents with symmetrically distributed, violaceous, papules commonly involving the flexor aspects of wrists, legs and lower back. LP is mostly self limiting and resolves after a variable period ranging from few months to years, leaving behind hyperpigmentation and/or scarring. Differential diagnoses in children include lichenoid drug eruption, psoriasis, plane warts and pityriasis rosea. LP is uncommon in children accounting for less than 2-3% of all adults cases.

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