SAS Journal of Medicine
Abbreviated Key Title: SAS J Med
ISSN 2454-5112
Journal homepage: https://saspublishers.com

OPEN ACCESS

Dermatology Venerology

Bullous Lichen Planus: A Rare Variant of Lichen Planus in Children

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DOI: https://doi.org/10.36347/sasjm.2026.v12i06.004 | **Received:** 28.04.2026 | **Accepted:** 01.06.2026 | **Published:** 03.06.2026

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Abstract **Case Report**

Bullous lichen planus is an exceptionally rare vesiculobullous variant of lichen planus in children and represents a significant diagnostic challenge because of its clinical overlap with infectious and autoimmune blistering disorders. We report the case of an 8-year-old girl presenting with a chronic generalized pruritic vesiculobullous eruption evolving for one year and not responding to multiple courses of antibiotics. Dermatological examination revealed widespread flaccid vesicles and bullae associated with post-bullous erosions arising on hyperpigmented macules involving the trunk, limbs, flexural regions, and external genitalia. Simultaneously, slate-gray pigmentation of the face and neck was also noted. Histopathological examination revealed acanthosis, orthokeratotic hyperkeratosis, subepidermal blister formation, and a dense lichenoid inflammatory infiltrate at the dermo-epidermal junction, consistent with bullous lichen planus. Direct immunofluorescence was negative. Systemic corticosteroid therapy with prednisone at 1 mg/kg/day resulted in marked clinical improvement. Bullous lichen planus is considered a hyper-reactive form of lichen planus secondary to severe basal keratinocyte degeneration leading to dermo-epidermal cleavage. Because of its rarity and polymorphic presentation, diagnosis is frequently delayed, particularly in pediatric patients. Histopathology remains essential for distinguishing this condition from bullous impetigo, dermatitis herpetiformis, pemphigus, and other vesiculobullous dermatoses. This case emphasizes the importance of early recognition of bullous lichen planus in children presenting with chronic blistering eruptions in order to avoid misdiagnosis, unnecessary treatments, and prolonged disease evolution.

Keywords: Bullous lichen planus; Pediatric lichen planus; Vesiculobullous eruption; Lichenoid dermatosis; Subepidermal blistering.

INTRODUCTION

Lichen planus is a chronic inflammatory dermatosis characterized histopathologically by a lichenoide interface dermatitis affecting the skin, mucous membranes, hair follicles, and nails [1]. Although relatively common in adults, pediatric lichen planus remains distinctly uncommon and accounts for only a small fraction of childhood dermatosis [2]. Among its numerous clinical variants, bullous lichen planus represents one of the rarest and most diagnostically challenging forms, particularly in children [3].

Bullous lichen planus is characterized by the sudden appearance of vesicles and bullae caused by extensive vacuolar degeneration of basal keratinocytes and intense lichenoid inflammation leading to dermoepidermal cleavage. [4]. Clinically, this condition may closely mimic infectious and autoimmune blistering disorders, including bullous impetigo, dermatitis herpetiformis, bullous pemphigoid, and pemphigus vulgaris, often resulting in delayed diagnosis and inappropriate therapeutic management [5]. The rarity of pediatric cases further contributes to under-recognition by clinicians outside specialized dermatological settings [3].

Histopathological examination remains the diagnostic gold standard, typically demonstrating hyperkeratosis, basal cell vacuolar degeneration, dense lichenoid lymphocytic infiltrates, and subepidermal blister formation [1,4]. Early clinicopathological correlation is essential to establish an accurate diagnosis and initiate effective treatment before the development of extensive pigmentary sequelae.

We report a rare and extensive case of generalized bullous lichen planus in an 8-year-old girl presenting with a chronic pruritic vesiculobullous

eruption associated with diffuse hyperpigmentation, highlighting the clinical, histopathological, and therapeutic challenges of this exceptional pediatric presentation.

CASE REPRESENTATION

An 8-year-old girl, born from a non-consanguineous marriage, with no significant past medical history or prior medication exposure, was referred to our dermatology department for a generalized pruritic vesiculobullous eruption evolving progressively over one year. The patient had previously received several courses of systemic antibiotics for a presumed infectious dermatosis without clinical improvement.

Cutaneous examination revealed multiple flaccid vesicles and bullae associated with extensive post-bullous erosions arising on diffuse hyperpigmented macules involving the chest, abdomen, back, upper and lower extremities, flexural areas, and external genitalia (Figure1). Diffuse slate-gray pigmentation of the face and neck was observed along with the blistering eruption (Figure2). No mucosal, scalp, or nail involvement was identified. The patient's general condition remained stable.

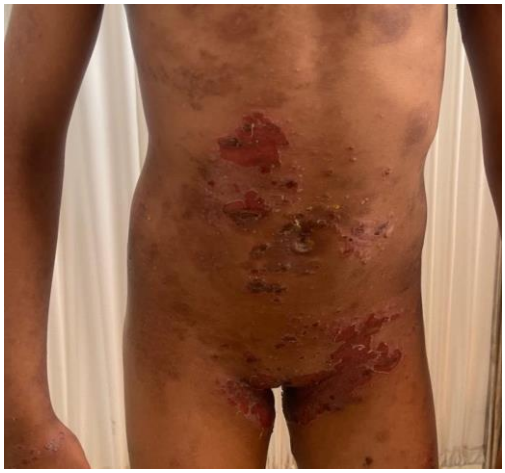

Figure 1: Vesiculobullous lesions and post-bullous erosions on hyperpigmented macules

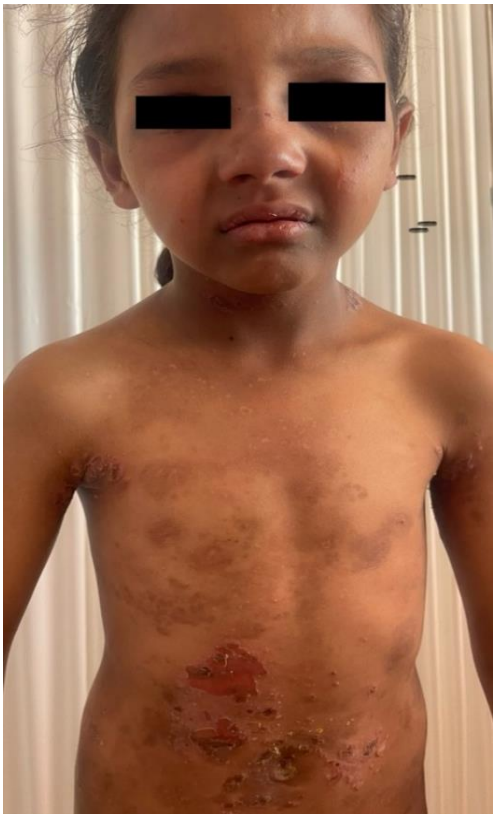

Figure 2: Diffuse slate-gray pigmentation of the face and neck with the blistering eruption

Routine laboratory investigations, including complete blood count, inflammatory markers, liver enzymes, and renal function tests, were within normal ranges. Histopathological examination of a lesional skin biopsy demonstrated marked acanthosis, lamellar orthokeratotic hyperkeratosis, subepidermal blister formation, vacuolar degeneration of the basal layer, and a dense lichenoid lymphocytic infiltrate along the dermoepidermal junction, strongly supporting the diagnosis of bullous lichen planus. Direct immunofluorescence was negative, excluding autoimmune blistering disorders.

Based on the clinicopathological correlation, a diagnosis of generalized bullous lichen planus was established. The patient was treated with systemic prednisone at a dose of 1 mg/kg/day associated with supportive topical care. Rapid clinical improvement was observed, with regression of bullous lesions, healing of erosions, and marked reduction in pruritus.

DISCUSSION

Bullous lichen planus is an exceptionally rare vesiculobullous variant of lichen planus resulting from intense lichenoid inflammation and extensive degeneration of basal keratinocytes leading to dermo-epidermal cleavage [1,4]. Unlike lichen planus pemphigoides, in which autoantibodies target basement membrane zone antigens, bullous lichen planus characteristically develops over pre-existing lichenoid lesions and lacks a true autoimmune subepidermal blistering mechanism [4,6]. Pediatric involvement remains extremely uncommon, with only isolated observations reported in the literature, which explains the limited familiarity of clinicians with this disorder and the frequent diagnostic delay [3,4].

Clinically, bullous lichen planus is characterized by the coexistence of tense or flaccid vesiculobullous lesions with classical lichenoid papules or residual hyperpigmented macules [1,8]. In some cases, extensive post-inflammatory pigmentation may dominate the clinical picture and obscure the underlying diagnosis. The polymorphic presentation frequently mimics infectious and autoimmune blistering diseases, including bullous impetigo, dermatitis herpetiformis, bullous pemphigoid, and pemphigus vulgaris [5,7]. In our patient, the chronic evolution and failure of repeated antibiotic therapies illustrate the diagnostic challenge posed by this rare condition and emphasizes the importance of considering inflammatory dermatoses in persistent vesiculobullous eruptions unresponsive to anti-infectious treatment.

Histopathological examination remains the cornerstone of diagnosis. Typical findings include orthokeratotic hyperkeratosis, acanthosis, vacuolar degeneration of the basal layer, Civatte bodies, dense band-like lymphocytic infiltrates at the dermo-epidermal junction, and subepidermal blister formation [1,4,8]. Direct immunofluorescence is generally negative or nonspecific, allowing exclusion of immunobullous diseases and reinforcing the diagnosis of bullous lichen planus [4,6]. In the present case, the clinicopathological correlation was decisive for establishing the diagnosis and excluding autoimmune blistering disorders.

Because of the rarity of bullous lichen planus, no standardized therapeutic guidelines currently exist [5]. Topical and systemic corticosteroids remain the first-line treatment and are associated with rapid clinical improvement in most reported cases [5,7]. Alternative therapies such as dapsone, acitretin, cyclosporine, and phototherapy have been successfully used in refractory forms [5,8]. Our patient showed a remarkable response to systemic corticosteroid therapy with significant regression of bullous lesions and progressive healing of erosions.

This case highlights the importance of early recognition of bullous lichen planus in children presenting with chronic vesiculobullous eruptions. Prompt clinicopathological assessment is essential to avoid prolonged misdiagnosis, unnecessary treatments, and persistent pigmentary sequelae. Increased awareness of this rare pediatric presentation among dermatologists and non-dermatologists may contribute to earlier diagnosis and improved therapeutic outcomes.

CONCLUSION

This report illustrates bullous lichen planus as a rare but important cause of chronic vesiculobullous eruptions in children. Diagnosis relied on characteristic clinicopathological features, including subepidermal blistering with lichenoid interface dermatitis and negative direct immunofluorescence. Systemic corticosteroid therapy led to marked clinical improvement. We emphasize that early recognition and histopathological confirmation are essential to avoid misdiagnosis, inappropriate treatments, and prolonged disease course.

REFERENCES

1. Boyd AS *et al.,*1991. Lichen planus. *Journal of the American Academy of Dermatology*, 25(4), 593–619.
2. Kanwar AJ *et al.,*2010. Lichen planus in childhood: report of 100 cases. *Clinical and Experimental Dermatology*, 35(3), 257–262.
3. Dhar S *et al.,*1998. Bullous lichen planus in childhood. *Pediatric Dermatology*, 15(5), 381–382.
4. Le Cleach L *et al.,*2012. Lichen planus. *New England Journal of Medicine*, 366(8), 723–732.
5. Usatine RP *et al.,*2011. Diagnosis and treatment of lichen planus. *American Family Physician*, 84(1), 53–60.
6. Weston G *et al.,*2015. Update on lichen planus and its clinical variants. *International Journal of Women's Dermatology*, 1(3), 140–149.

7. Sengupta S *et al.,*2016. Bullous lichen planus: a rare presentation. *Indian Dermatology Online Journal*, 7(6), 550–552.

8. Breathnach SM *et al.,*2010. Lichen planus and lichenoid disorders. In: Burns T et al (eds). *Rook's Textbook of Dermatology*, 8th ed. Wiley-Blackwell.