Section: DVL

Original Research Article

LICHEN PLANUS AND ITS CLINICAL VARIANTS: A RETROSPECTIVE OBSERVATIONAL STUDY AT A TERTIARY CARE HOSPITAL OF JHARKHAND

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ABSTRACT

Background: Lichen planus is a chronic immune-mediated mucocutaneous disorder with diverse clinical variants involving the skin, mucosa, scalp, nails, and other appendages. Its heterogeneous presentation makes clinicomorphological evaluation important for accurate diagnosis, demographic profiling, and early recognition of complications, particularly in persistent mucosal disease. The study aimed to evaluate lichen planus and its clinical variants in a tertiary care hospital of Jharkhand, with objectives to assess variant-wise distribution, demographic patterns, gender association, and common age-group involvement.

Materials and Methods: This retrospective observational study included 590 clinically diagnosed cases of lichen planus. Cases were categorized into lichen planus hypertrophicus, mucosal lichen planus, cutaneous lichen planus, lichen planopilaris, and miscellaneous variants. Demographic variables including sex and common age group were recorded. Data were analyzed using frequencies, percentages, and p-values to determine distribution patterns and gender associations.

Results: Cutaneous lichen planus was the most common variant, observed in 256 cases (43.4%), followed by mucosal lichen planus in 109 cases (18.5%), lichen planopilaris in 93 cases (15.8%), lichen planus hypertrophicus in 85 cases (14.4%), and miscellaneous variants in 47 cases (8.0%). Overall, females constituted 321 cases (54.4%) and males 269 cases (45.6%). Lichen planus hypertrophicus showed significant male predominance (64.7%, $p = 0.006$), while lichen planopilaris showed significant female predominance (66.7%, $p = 0.002$). The overall association between clinical type and gender was statistically significant ($p = 0.001$).

Conclusion: Lichen planus showed a broad clinicomorphological spectrum, with cutaneous disease predominating. Significant gender-based differences were observed across variants, emphasizing the need for variant-specific clinical assessment and individualized management.

Keywords: Lichen planus; Clinical variants; Cutaneous lichen planus; Lichen planopilaris; Gender distribution.

INTRODUCTION

Lichen planus is a chronic inflammatory mucocutaneous disorder that affects the skin, oral mucosa, genital mucosa, scalp, and nails, and is regarded as a prototypical interface dermatitis mediated by immune mechanisms. It was first described in the nineteenth century and remains one of the most extensively studied dermatological and oral diseases due to its varied clinical presentation and potential complications. The disease primarily involves stratified squamous epithelium and is characterized histopathologically by a band-like lymphocytic infiltrate at the dermoepidermal

junction with basal cell degeneration.[1] Clinically, it manifests with distinctive violaceous, flat-topped papules on the skin and white reticular or erosive lesions on mucosal surfaces, reflecting its polymorphic nature.[2]

Lichen planus is considered an immune-mediated disorder in which cytotoxic CD8+ T lymphocytes target basal keratinocytes, leading to apoptosis and chronic inflammation.[3] The exact etiopathogenesis remains unclear, but both antigen-specific and non-specific immune mechanisms are implicated. Triggering factors such as viral infections (notably hepatitis C), drugs, dental materials, psychological stress, and genetic susceptibility have been associated with disease onset or exacerbation. The condition typically follows a chronic course with periods of remission and relapse, particularly in mucosal variants, which tend to be more persistent and resistant to treatment.[4]

Epidemiologically, lichen planus affects approximately 0.5% to 2% of the general population worldwide, making it relatively uncommon but clinically significant.[5] Oral lichen planus, the most frequent mucosal form, shows a global pooled prevalence of around 0.89% to 1.01% in the general population.[6] The disease predominantly affects middle-aged adults between 30 and 60 years and exhibits a clear female predilection.[7] In the Indian population, prevalence rates as high as 2.6% have been reported, indicating a relatively higher burden in this region. Such epidemiological variations may be influenced by environmental factors, lifestyle habits such as tobacco use, and differences in diagnostic criteria.[8]

Clinically, lichen planus is notable for its heterogeneity, with manifestations varying depending on the site of involvement. Cutaneous lichen planus presents with pruritic, polygonal, violaceous papules and plaques, often exhibiting Wickham's striae, a network of fine white lines on the lesion surface.[2] These lesions commonly involve the flexor surfaces of the wrists, ankles, and lower back. Mucosal involvement, particularly oral lichen planus, is characterized by bilateral symmetrical lesions affecting the buccal mucosa, tongue, and gingiva. Oral lesions may present as asymptomatic white reticular patterns or as symptomatic erythematous and ulcerative lesions associated with burning sensation and discomfort.[8]

The classification of lichen planus into its clinical variants is essential for accurate diagnosis, prognosis, and management. Broadly, the disease is categorized into cutaneous, mucosal, and appendageal forms, each with distinct clinical characteristics.[1] Among mucosal variants, oral lichen planus is further classified into six major types: reticular, papular, plaque-like, atrophic, erosive, and bullous forms. The reticular type is the most common and typically presents as lace-like white striae, whereas erosive and atrophic forms are symptomatic and associated with significant morbidity.[9]

The papular variant appears as small white pinpoint lesions that may coalesce into reticular patterns, while plaque-like lichen planus resembles leukoplakia and is often seen on the dorsum of the tongue. Atrophic lichen planus is characterized by erythematous areas due to epithelial thinning, and the erosive form presents with painful ulcerations that significantly impair oral function.[8] The bullous variant, though rare, manifests as vesicles or bullae that rupture to form erosions. In addition to these classical forms, oral lichen planus is also broadly categorized into hyperkeratotic (asymptomatic) and erosive (symptomatic) patterns, reflecting differences in clinical severity and patient experience.[4]

Beyond oral and cutaneous forms, several distinct clinical variants of lichen planus have been described. Lichen planus pigmentosus is characterized by hyperpigmented macules, particularly in sun-exposed or flexural areas, and is more common in individuals with darker skin tones. Hypertrophic lichen planus presents as thickened, hyperkeratotic plaques, usually on the lower limbs, and is often associated with intense pruritus. Lichen planopilaris affects hair follicles and can lead to scarring alopecia, while nail lichen planus may result in longitudinal ridging, thinning, or even permanent nail loss. Linear, annular, and actinic variants further highlight the morphological diversity of this disease, emphasizing its broad clinical spectrum.[10]

An important clinical consideration in lichen planus, particularly in oral variants, is its potential for malignant transformation. Oral lichen planus is classified as a potentially malignant disorder, with reported transformation rates ranging from approximately 0.5% to 2%, and pooled estimates around 1.14%.[8] The risk is higher in erosive and atrophic forms, especially when associated with risk factors such as tobacco use, alcohol consumption, and chronic irritation. This underscores the importance of regular follow-up and early detection of dysplastic changes.[11]

Lichen planus significantly impairs quality of life due to chronic symptoms, cosmetic disfigurement, and functional limitations. Painful oral lesions interfere with eating, speech, and hygiene, while cutaneous forms cause pruritus and psychological distress. This chronic, immune-mediated disorder presents with diverse clinical variants involving skin, mucosa, and appendages. The spectrum ranges from asymptomatic reticular lesions to erosive and disfiguring forms, necessitating accurate diagnosis, long-term management, and vigilant monitoring to prevent complications, including potential malignant transformation in mucosal involvement.[12]

The aim of the study is to evaluate lichen planus and its clinical variants in terms of clinical presentation and distribution, while the objectives are to assess the morphological patterns across cutaneous, mucosal, and appendageal forms and to analyze demographic characteristics and site-wise involvement, correlating

different variants with their clinical features and disease severity for improved diagnosis.

MATERIALS AND METHODS

A hospital-based retrospective observational study was conducted in the Department of Dermatology, Venereology and Leprosy, Rajendra Institute of Medical Sciences, Ranchi, over 12 months from January 2024 to December 2024. A total of 590 clinically diagnosed cases of lichen planus were included. Patients were classified into cutaneous, mucosal, lichen planopilaris, hypertrophic, and miscellaneous variants. Demographic variables including age, sex, and common age-group distribution were recorded for each subtype. Diagnosis was primarily clinical. Data were systematically collected, tabulated, and analyzed using frequencies and percentages to assess clinical variant distribution and demographic patterns among the study population.

RESULTS

Table 1: Distribution of Types of Lichen Planus (n = 590)

Clinical Type	Number of Cases	Percentage (%)
Lichen Planus Hypertrophicus (LPH)	85	14.4
Mucosal Lichen Planus	109	18.5
Cutaneous Lichen Planus	256	43.4
Lichen Planopilaris (LPP)	93	15.8
Miscellaneous	47	8.0
Total	590	100

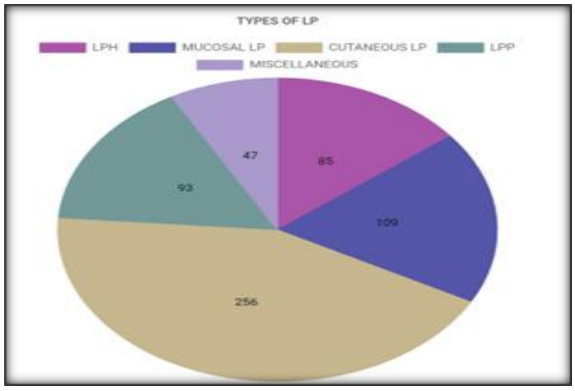

Figure 1: Distribution of Clinical Variants of Lichen Planus Among Study Participants.

The cutaneous lichen planus constituted the predominant clinical variant (43.4%), indicating that skin involvement remains the most frequent presentation in this tertiary care cohort. Mucosal involvement was the second most common (18.5%), highlighting a substantial burden of mucosal disease with potential functional implications. Hypertrophic lichen planus (14.4%) and lichen planopilaris (15.8%) showed comparable distribution, reflecting significant representation of chronic and appendageal variants. Miscellaneous forms accounted for 8.0%, demonstrating the heterogeneity of clinical presentations and reinforcing the need for variant-specific diagnostic and management approaches.

The lichen planus hypertrophicus showed a clear male predominance, with males accounting for 64.7% compared to 35.3% females. This gender disparity was statistically significant (p = 0.006), indicating a true association rather than random variation. The findings suggest that hypertrophic variants may have a higher predilection in males within this population. Overall, the significant p-value reinforces gender as an important epidemiological factor influencing the distribution of LPH.

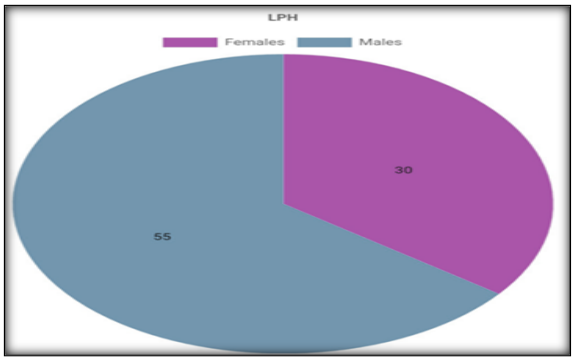

Figure 2: Gender-wise Distribution of Lichen Planus Hypertrophicus (LPH).

Table 2: Gender Distribution in Lichen Planus Hypertrophicus (LPH) (n = 85)

Gender	Number of Cases	Percentage (%)	p-value
Male	55	64.7	
Female	30	35.3	0.006
Total	85	100	

Table 3: Gender Distribution in Mucosal Lichen Planus (Oral + Genital) (n = 109)

Gender	Number of Cases	Percentage (%)	p-value
Female	59	54.1	
Male	50	45.9	0.32
Total	109	100	
Common age group affected: 41–50 years			

The mucosal lichen planus showed a slight female predominance (54.1%) compared to males (45.9%); however, this difference was not statistically significant (p = 0.32), indicating no true gender association. The distribution suggests a relatively balanced gender involvement for mucosal variants in this cohort. The most commonly affected age group was 41–50 years, highlighting a mid-life predominance of mucosal disease. Overall, these findings emphasize that age plays a more consistent role than gender in mucosal lichen planus presentation.

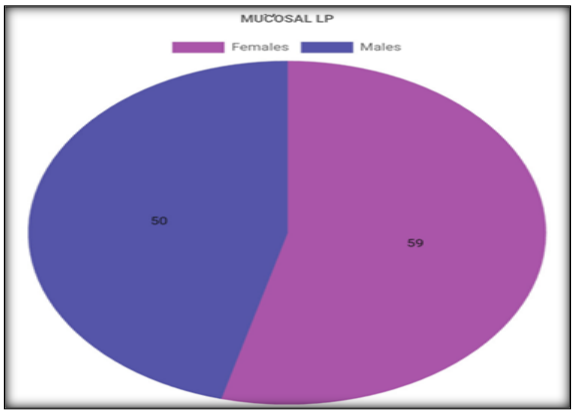

Figure 3: Gender-wise Distribution of Mucosal Lichen Planus.

Table 4: Gender Distribution in Cutaneous Lichen Planus (n = 256)

Gender	Number of Cases	Percentage (%)	p-value
Female	142	55.5	
Male	114	44.5	0.08
Total	256	100	
Common age group affected: 20–40 years			

The cutaneous lichen planus demonstrated a higher proportion of females (55.5%) compared to males (44.5%), suggesting a female predominance; however, this difference did not reach statistical significance (p = 0.08). This indicates that the observed gender variation may be due to chance rather than a true epidemiological association. The most commonly affected age group was 20–40 years, reflecting a predilection for younger to middle-aged adults. Overall, age appears to be a more consistent determinant than gender in cutaneous lichen planus distribution.

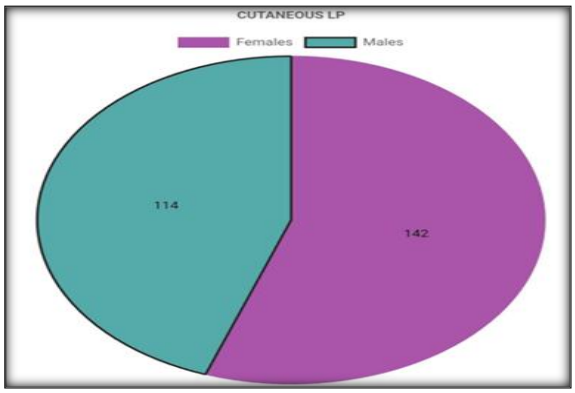

Figure 4: Gender-wise Distribution of Cutaneous Lichen Planus.

The lichen planopilaris showed a marked female predominance, with females constituting 66.7% compared to 33.3% males. This difference was statistically significant (p = 0.002), indicating a true gender-based predisposition for LPP in this cohort. The findings suggest that appendageal involvement, particularly scalp disease, is more common among females. The most affected age group was 21–30 years, highlighting an earlier age predilection compared to other variants.

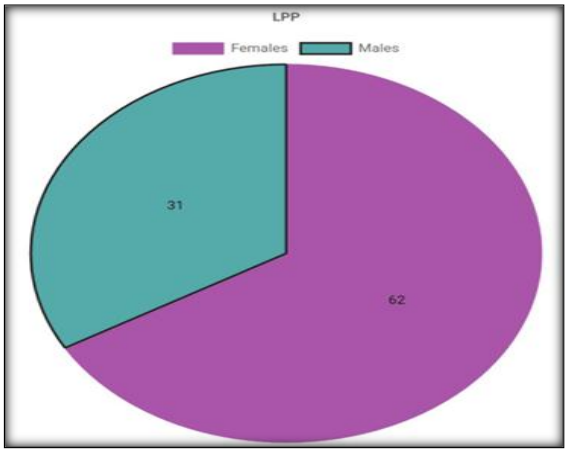

Figure 5: Gender-wise Distribution of Lichen Planopilaris (LPP).

Table 5: Gender Distribution in Lichen Planopilaris (LPP) (n = 93)

Gender	Number of Cases	Percentage (%)	p-value
Female	62	66.7	
Male	31	33.3	0.002
Total	93	100	
Common age group affected: 21–30 years			

Table 6: Gender Distribution in Miscellaneous Cases (n = 47)

Gender	Number of Cases	Percentage (%)
Female	28	59.57
Male	19	40.42
Total	47	100

The miscellaneous variants of lichen planus showed a higher proportion of females (59.57%) compared to males (40.42%), suggesting a female predominance in this heterogeneous group. However, in the absence of a reported p-value, statistical significance cannot be established, and the observed difference should be interpreted cautiously. The distribution indicates a possible trend toward greater female involvement across less common variants. Overall, these findings highlight variability in gender patterns within atypical presentations of lichen planus.

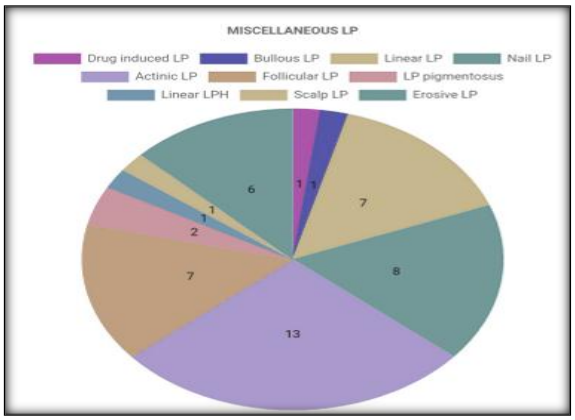

Figure 6: Distribution of Miscellaneous Variants of Lichen Planus.

Table 7: Distribution of Miscellaneous Lichen Planus Cases (n = 47)

Gender	Number of Cases	Percentage (%)	p-value
Female	28	59.57	
Male	19	40.42	0.18
Total	47	100	

In our study, miscellaneous lichen planus variants showed a higher proportion of females (59.57%) compared to males (40.42%), suggesting a female predominance. However, this difference was not statistically significant (p = 0.18), indicating that the observed variation may be due to chance. The findings reflect a relatively balanced gender distribution within this heterogeneous group. Overall, gender does not appear to have a significant influence on miscellaneous variants of lichen planus in our cohort.

Table 8: Association Between Types of Lichen Planus and Gender (n = 590)

Type of LP	Male n (%)	Female n (%)	Total	p-value
LPH	55 (64.7)	30 (35.3)	85	0.006
Mucosal LP	50 (45.9)	59 (54.1)	109	0.32
Cutaneous LP	114 (44.5)	142 (55.5)	256	0.08
LPP	31 (33.3)	62 (66.7)	93	0.002
Miscellaneous	19 (40.4)	28 (59.6)	47	0.18
Total	269 (45.6)	321 (54.4)	590	

In our study, a statistically significant association was observed between types of lichen planus and gender (p = 0.001), indicating that distribution of clinical variants is influenced by gender. Lichen planus hypertrophicus showed male predominance (64.7%), whereas mucosal (54.1%), cutaneous (55.5%), lichen planopilaris (66.7%), and miscellaneous variants (59.6%) demonstrated female predominance. These findings suggest distinct gender-based patterns across different clinical forms of the disease. Overall, female patients constituted a higher proportion (54.4%) compared to males (45.6%), reinforcing gender as an important epidemiological determinant in lichen planus variants.

DISCUSSION

In our study, cutaneous lichen planus was the predominant variant (43.4%), followed by mucosal LP (18.5%), lichen planopilaris (15.8%), hypertrophic LP (14.4%), and miscellaneous forms (8.0%), confirming that LP presents as a broad clinicomorphological spectrum. This pattern correlates with Vani et al. (2024), who reported classical LP as the commonest variant (29.5%) followed by mucosal LP (12.45%) among 257 cases. Poudel et al. (2025), in 44 cases, similarly found cutaneous and oral LP as the most common variants, followed by lichen planopilaris. Thus, our findings reinforce cutaneous predominance with clinically relevant mucosal and appendageal involvement.[13,14]

In our study, lichen planus hypertrophicus showed significant male predominance, with males constituting 64.7% compared with 35.3% females, and this association was statistically significant (p = 0.006), suggesting a true gender-linked distribution rather than random variation. This finding closely correlates with Wankhade et al. (2023), who reported hypertrophic LP more frequently in males (73.9%) than females (26.12%). Gupta et al. (2021) also reported overall male predominance in LP, with 59% males and 41% females, although not statistically significant (p = 0.3). Thus, our result reinforces male predilection specifically in hypertrophic LP.[15,16]

In our study, mucosal lichen planus showed slight female predominance, with females constituting 54.1% compared with 45.9% males; however, this difference was not statistically significant (p = 0.32),

indicating no true gender association. This balanced pattern partly correlates with Siriwardena et al. (2025), who reported female predominance in 3734 oral LP cases with a male: female ratio of 1:1.6, and maximum cases in the 41 to 50-year age group. Ślebioda et al. (2024) similarly reported female predominance among 186 OLP patients, with nearly 70% females. Thus, our findings support mid-life predominance, while gender influence appears weaker in our cohort.[7,17]

In our study, cutaneous lichen planus showed female predominance, with females constituting 55.5% compared with 44.5% males; however, this difference was not statistically significant (p = 0.08), suggesting no definite gender association. This finding closely correlates with Malhotra et al. (2025), who reported 60% females and 40% males among 50 cutaneous LP cases, with maximum cases in the 20 to 40-year age group (52%). Parihar et al. (2015) similarly observed 54.5% females and 45.5% males among 145 cutaneous LP cases, with most patients aged 20 to 40 years. Thus, our findings support age as a stronger determinant than gender.[18,19]

In our study, lichen planopilaris showed marked female predominance, with females constituting 66.7% compared with 33.3% males, and this association was statistically significant (p = 0.002), indicating a true gender-based predisposition for appendageal LP. This finding is strongly supported by Kerkemeyer et al. (2018), who reported 29 females among 32 LPP patients, confirming marked female predominance. Babahosseini et al. (2019), in a large retrospective series of 291 LPP patients, also supports the established female predilection of LPP. However, while literature commonly reports LPP in women aged 40 to 60 years, our cohort peaked earlier at 21 to 30 years, suggesting possible population-specific variation in age at presentation (20, 21).

In our study, miscellaneous variants of lichen planus showed female predominance, with females constituting 59.57% compared with 40.42% males; however, as no p-value was available, this trend should be interpreted cautiously. This pattern closely correlates with Poudel et al. (2025), who reported 26 females (59%) and 18 males (41%) among 44 LP-variant cases, including uncommon variants such as erythema dyschromicum perstans, lichen planopilaris, hypertrophic LP, and actinic/pigmentosus LP. Vani et al. (2024) similarly reported 149 females (58%) and 108 males (42%) among 257 cases, with multiple and uncommon variants observed. Thus, our findings suggest possible female predominance across heterogeneous LP variants, though statistical confirmation is required.[13,14]

In our study, miscellaneous lichen planus variants showed female predominance, with females constituting 59.57% compared with 40.42% males; however, this difference was not statistically significant (p = 0.18), indicating that gender did not independently influence this heterogeneous group. This finding correlates with Vani et al. (2024), who reported 149 females (58%) and 108 males (42%) among 257 LP cases, including uncommon variants such as linear, bullous, annular, atrophic, nail, and mixed LP. Poudel et al. (2025) similarly reported a female-slanted distribution with a male:female ratio of 1:1.4 among 44 LP-variant cases. Thus, our findings suggest a female trend, but not a statistically proven gender association.[13,14]

In our study, a statistically significant association was observed between clinical variants of lichen planus and gender (p = 0.001), indicating that variant distribution was influenced by sex. Overall, females constituted a higher proportion (54.4%) than males (45.6%), with female predominance in mucosal LP (54.1%), cutaneous LP (55.5%), lichen planopilaris (66.7%), and miscellaneous variants (59.6%), while lichen planus hypertrophicus showed male predominance (64.7%). This pattern correlates with Vani et al. (2024), who reported 149 females (58%) and 108 males (42%) among 257 LP cases, with multiple clinical variants documented. Poudel et al. (2025) similarly found overall female predominance, with 26 females (59%) and 18 males (41%) among 44 LP-variant cases, and demonstrated variant-wise gender differences. Thus, our findings reinforce gender as an important epidemiological determinant in the clinical spectrum of LP.[13,14]

CONCLUSION

This study demonstrates that lichen planus presents a broad clinicomorphological spectrum, with cutaneous variants being the most predominant, followed by mucosal and appendageal forms. A significant association with gender was observed, with hypertrophic lichen planus showing male predominance and lichen planopilaris showing strong female predominance, while other variants did not exhibit statistically significant gender differences. Overall, females constituted a slightly higher proportion of cases. These findings emphasize the relevance of recognizing variant-specific distribution patterns and demographic influences, which are essential for accurate diagnosis, tailored therapeutic strategies, and timely identification of complications, particularly in mucosal variants with potential for chronicity and malignant transformation.

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