

Dermatological Conditions in Skin of Color is a column that provides insight on the different presentations, misdiagnoses, and other challenges that patients with skin of color can present with at the dermatology office.

Lichen Planus in Skin of Color: Three Clinical Pearls for Recognition and Evaluation

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Lichen planus (LP) is a T cell–mediated inflammatory disorder that can affect the skin and mucous membranes. Although often self-limited, LP can cause considerable morbidity from pruritus, dyspigmentation, and painful mucosal disease.¹ The estimated prevalence of LP in the United States (US) ranges from approximately 0.19% to 0.39%, with prevalence increasing with age.² Recognition of LP in patients with skin of color (SOC) can be challenging because classic descriptions do not always reflect its appearance in more deeply pigmented skin. This review highlights 3 clinical considerations that could improve recognition and evaluation of LP in patients with SOC.

LOOK BEYOND “PURPLE”

LP is classically described by the “5 Ps:” planar, purple, polygonal, pruritic papules, and plaques. Although useful as a mnemonic, reliance on “purple” as a defining feature might contribute to underrecognition in patients with more deeply pigmented skin. In SOC, LP can appear violaceous, dark brown, gray-brown, or gray-black.¹

When color is less characteristic, greater attention to morphology and secondary features can aid recognition. Wickham striae—lacy, reticular white lines that might overlie LP lesions—are a characteristic clinical feature of LP.³ In patients with darker skin phototypes, the appearance of Wickham striae can vary, and dermoscopy can facilitate their recognition and

provide an additional diagnostic clue when LP is suspected.^{4,5}

Postinflammatory hyperpigmentation (PIH) can also be prominent and persistent in patients with SOC.⁶ When active lesions are subtle or have resolved, look for residual violaceous, brown, or gray-brown macules in areas where the patient reports a preceding pruritic eruption. The distribution of residual pigmentary change can provide an important clue to previously active disease.

When the clinical presentation is atypical or the diagnosis remains uncertain, a skin biopsy should be considered. Histopathologic evaluation, interpreted in conjunction with the clinical presentation, can help confirm LP and distinguish it from other lichenoid and pigmentary disorders.^{1,3}

TAKE A CAREFUL MEDICATION HISTORY

Lichenoid drug eruptions can closely resemble idiopathic LP, making a detailed medication history an important component of the diagnostic evaluation. Several medication classes have been associated with lichenoid eruptions, including antihypertensives, diuretics, antimalarials, nonsteroidal anti-inflammatory drugs, and other commonly prescribed agents.^{1,7}

Medication exposure might warrant particular consideration in some patients with SOC because several of these drug classes are used to treat conditions whose prevalence

differs across racial and ethnic populations. For example, hypertension is more prevalent among Black adults in the US than among US adults overall.⁸ Diagnosed diabetes is also more prevalent among American Indian/Alaska Native, Black, and Hispanic adults than among White adults.⁹ Systemic lupus erythematosus, for which antimalarial therapy is frequently prescribed, disproportionately affects Black women.¹⁰ These epidemiologic differences do not themselves confer an increased risk of lichenoid drug eruption but might influence exposure to medications associated with lichenoid reactions.

Importantly, the temporal relationship between medication initiation and disease onset might not be immediately apparent. In a review of 323 cases of lichenoid drug eruption, the mean latency between medication initiation and eruption was 15.7 weeks, with a reported range of 0.1 to 208 weeks.⁷ Therefore, medication review should extend well beyond recently initiated therapies when evaluating a patient with a new lichenoid eruption.

RECOGNIZE LICHEN PLANUS PIGMENTOSUS

Lichen planus pigmentosus (LPP) is an uncommon variant of LP characterized by acquired dark brown, slate-gray, or gray-black macular pigmentation. Although its true prevalence remains unknown, LPP is predominantly reported in individuals with darker skin phototypes and has been

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particularly described in South Asian, Middle Eastern, and Latin American populations.^{11,12}

LPP commonly involves sun-exposed areas, particularly the face and neck, although flexural involvement might also occur. Unlike classic LP, clinically apparent inflammation might be minimal or absent. The condition is often asymptomatic, although some patients report pruritus. Its clinical course can be chronic and unpredictable, with periods of progression and stabilization.^{11,12}

Consider LPP in patients with acquired brown-to-gray macular pigmentation involving the face, neck, other sun-exposed areas, or flexural folds—particularly when visible inflammation is minimal or absent. The differential diagnosis might include PIH, erythema dyschromicum perstans, melasma, and pigmented contact dermatitis. When the diagnosis is uncertain, clinicopathologic correlation might be helpful.^{11,12}

CONCLUSION

Recognizing LP in patients with SOC requires looking beyond its classic descriptions. Greater attention to variations in clinical appearance, a thorough medication history, and recognition of pigmentary variants such as LPP can help clinicians identify disease that might otherwise be overlooked. Maintaining awareness of these

nuances—and considering biopsy when the diagnosis remains uncertain—can support timely and accurate diagnosis.

REFERENCES

1. Boch K, Langan EA, Kridin K, et al. Lichen planus. *Front Med (Lausanne)*. 2021;8:737813.
2. Leasure AC, Cohen JM. Prevalence of lichen planus in the United States: a cross-sectional study of the All of Us research program. *J Am Acad Dermatol*. 2022;87(3):686–687.
3. Usatine RP, Tinitigan M. Diagnosis and treatment of lichen planus. *Am Fam Physician*. 2011;84(1):53–60.
4. García-García B, Munguía-Calzada P, Aubán-Pariente J, et al. Dermoscopy of lichen planus: vascular and Wickham striae variations in the skin of colour. *Australas J Dermatol*. 2019;60(4):301–304.
5. Sławińska M, Żółkiewicz J, Behera B, et al. Dermoscopy of inflammatory dermatoses (inflammoscopy) in skin of color—a systematic review by the International Dermoscopy Society “Imaging in Skin of Color” Task Force. *Dermatol Pract Concept*. 2023;13(4 Suppl 1):e2023297S.
6. Lawrence E, Syed HA, Al Aboud KM. Postinflammatory hyperpigmentation. In: StatPearls. StatPearls Publishing. Updated 25 Nov 2024. Accessed 21 Sep 2026. <https://www.ncbi.nlm.nih.gov/books/NBK559150/>
7. Maul JT, Guillet C, Oschmann A, et al. Cutaneous lichenoid drug eruptions: a narrative review evaluating demographics, clinical features and culprit medications. *J Eur Acad Dermatol Venereol*. 2023;37(5):965–975.
8. Fryar CD, Kit BK. QuickStats: age-adjusted percentage of adults aged ≥18 years with hypertension, by sex and race and ethnicity—United States, August 2021–August 2023. *MMWR Morb Mortal Wkly Rep*. 2024;73:1110.
9. National Diabetes Statistics Report. Centers for Disease Control and Prevention. Accessed 22 Sep 2026. <https://usdss.cdc.gov/diabetes/report.html>
10. Izmirly PM, Parton H, Wang L, et al. Prevalence of systemic lupus erythematosus in the United States: estimates from a meta-analysis of the Centers for Disease Control and Prevention National Lupus Registries. *Arthritis Rheumatol*. 2021;73(6):991–996.
11. Beso AP, Chhangte MZ, Dey B, Verma S. Lichen planus pigmentosus: a clinicopathological study from Northeast India. *Cureus*. 2024;16(11):e74627.
12. Robles-Méndez JC, Rizo-Frías P, Herz-Ruelas ME, et al. Lichen planus pigmentosus and its variants: review and update. *Int J Dermatol*. 2018;57(5):505–514. **NPPA**