Multiple Purpuric Plaques on the Left Leg in a 12-year-old Boy
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CASE REPORT
A 12-year-old boy visited our clinic due to multiple persistent erythematous plaques on the left leg. History of trauma, operation or drug intake before the appearance of the skin lesions was absent.

Physical examination revealed dusky red plaques with central purpuric change and peripheral brownish hue (Fig. 1). Older lesions turned to yellow-brownish and persisted unchanged. There was mild tenderness, but no itching. The lesions seemed to follow the course of the greater saphenous vein and its main branches (Fig. 2). Skin biopsy was done and showed as Fig. 3 and 4.

Fig. 1
Close-up view of the lesions revealed dusky red plaques with peripheral brownish hue.

Fig. 2
Erythematous to purpuric plaques over the inner aspect of left thigh following the greater saphenous vein and its branches which are marked with blue lines.

Fig. 3
Lichenoid infiltration of mononuclear cells and lymphocytic vasculitis of the superficial dermal capillaries were seen. (H & E, 100X)

Fig. 4
A lot of extravasated erythrocytes and some pigmented granules in the upper dermis. (H & E, 400X)
**DIAGNOSIS:** Segmental Lichen Aureus

Lichen aureus is a chronic capillaritis which occurs more frequently in male and in young to middle-aged people, but cases of women and children had also been reported. The typical presentation is one or few golden or rusty-colored patches over the lower extremities, but lesions on upper limbs, trunk, and face have also been reported. Due to the gradual metabolism of the extravasated erythrocytes in the tissue, the color of the lesion may vary from golden-brown, orange, yellow, brown, to purple. Most reported cases are asymptomatic, but itching and burning sensation are sometimes associated. The etiology is not well-understood, but T lymphocytic proliferation, capillary fragility, venous insufficiency and hormonal changes have been mentioned.

Our case was remarkable because of the distinctive segmental distribution. There were reports of segmental lichen aureus distributed along the deep veins, superficial veins and lines of Blaschko. Our case of segmental lichen aureus seemed to follow the course of the greater saphenous vein and its main branches (Fig. 1). Although Duplex scan of bilateral legs was arranged, the data of the deep veins were normal and symmetric in both legs.

Shelley et al. described three patients with localized large patches of lichen aureus on areas of perforating veins with underlying prominent varicose veins. Although the distribution of the presenting lichen aureus case seemed aggregated over some areas of perforating veins, no varicose veins or other detectable deep vein anomaly was detected.

In conclusion, we herein present a pediatric case of lichen aureus with the distribution along the greater saphenous vein. This particular presentation might indicate the special role of venous system in the pathogenesis of lichen aureus.

**REFERENCES**