

Violaceous and confluent papules on the body of the penis

Pápulas violáceas e confluentes no corpo do pênis

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A male patient, 25 years old, without comorbidities, presented with violaceous and confluent papules on the penis for the last 5 months (Fig. 1), there were no lesions in other areas of the body. The patient had been treated previously with antibiotic and antifungal therapies without success. He denied the ingestion of any other drugs or other symptoms. The histopathology revealed a band-like inflammatory infiltrate along the dermoepidermal junction (Fig. 2), establishing the diagnosis of lichen planus (LP). Therefore, the patient was treated with desonide cream twice a day for 30 days, resulting in a complete resolution of the lesions (Fig. 3).

LP is a common, pruritic, inflammatory disease of skin, hair, and mucous membranes with a prevalence of 0.5-1%. It is universal, with similar sex distribution and higher frequency after the third decade of life^{1,2}. Studies have shown a relationship between LP and autoimmune diseases, genetic predisposition, and infections³. The diagnosis is based on clinical features and confirmed by histopathology, which typically reveals hyperkeratosis, irregular acanthosis with a saw-tooth pattern, and a band-like inflammatory infiltrate in

the superficial dermis composed of lymphocytes and histiocytes⁴. In the genital area, LP can be presented by four patterns: classic, atrophic-erosive, annular, or arciform-linear. In classic LP, red to brown papules or non-scaling plaques are observed. In the atrophic-erosive variant, the glans is involved, with symptoms of itching, burning, and potential sexual dysfunction. The annular subtype is characterized by plaques with violaceous to white borders and a hyperpigmented center. In the arciform-linear pattern, lesions take on this specific shape³. The use of medium-potency topical steroids should be the first choice for isolated non-erosive lesions in the genital area, due to their low systemic toxicity and local efficacy^{3,4}. Regarding prognosis, in men, scarring can lead to phimosis, requiring surgery in some cases, and although controversial, malignant transformation has been described in the literature. Therefore, regular follow-up of the patient is important³. In this case, there was no recurrence of the lesions, considering the current clinical follow-up of 1 year. This case underscores the importance of considering LP among non-venereal genital dermatoses.

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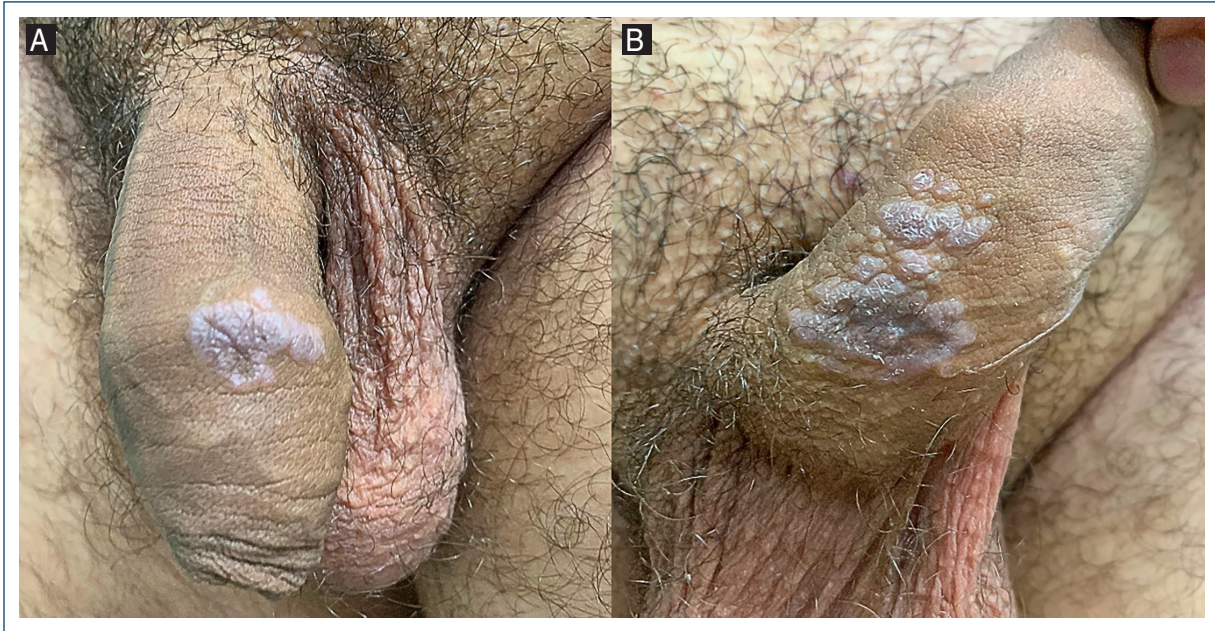


Figure 1. A and B: clinical lesions on the right and left sides of the penis.

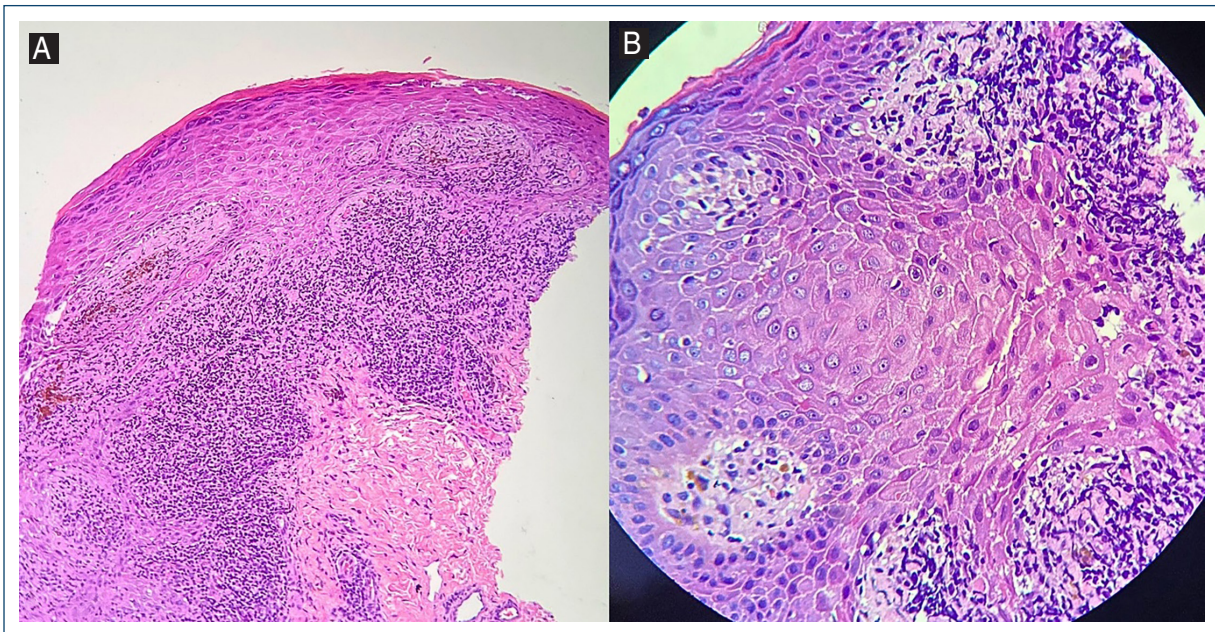


Figure 2. A: parakeratosis, vacuolar alteration of the basal layer, band-like inflammatory infiltrate composed of lymphocytes and melanophages in the superficial dermis (H&E, 4 \times). **B:** spongiosis and predominance of mononuclear inflammatory infiltrate (H&E, 40 \times).

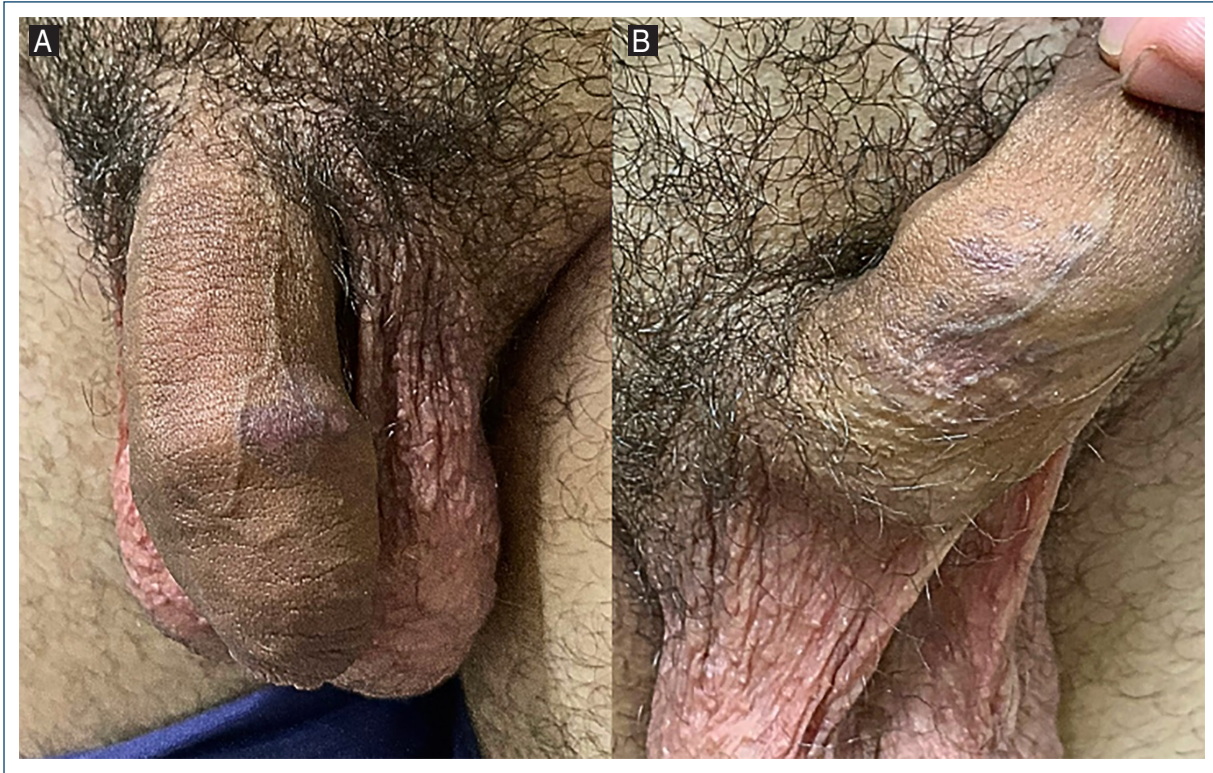


Figure 3. A and B: clinical improvement of penile lesions after appropriate treatment.

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Conflicts of interest

None.

Ethical considerations

Protection of humans and animals. The authors declare that no experiments involving humans or animals were conducted for this research.

Confidentiality, informed consent, and ethical approval. The authors have followed their institution's

confidentiality protocols, obtained informed consent from patients, and received approval from the Ethics Committee. The SAGER guidelines were followed according to the nature of the study.

Declaration on the use of artificial intelligence.

The authors declare that no generative artificial intelligence was used in the writing of this manuscript.

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