<table>
<thead>
<tr>
<th><strong>Title</strong></th>
<th>Alternative treatment using topical tacrolimus for erosive oral lichen planus resistant to steroids</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Author(s)</strong></td>
<td>Li, C; Zheng, L</td>
</tr>
<tr>
<td><strong>Citation</strong></td>
<td>Hong Kong Dental Journal, 2012, v. 9 n. 1, p. 39-42</td>
</tr>
<tr>
<td><strong>Issued Date</strong></td>
<td>2012</td>
</tr>
<tr>
<td><strong>URL</strong></td>
<td><a href="http://hdl.handle.net/10722/159231">http://hdl.handle.net/10722/159231</a></td>
</tr>
<tr>
<td><strong>Rights</strong></td>
<td>Hong Kong Dental Journal. Copyright © Hong Kong Academy of Medicine Press.; This work is licensed under a Creative Commons Attribution-NonCommercial-NoDerivatives 4.0 International License.</td>
</tr>
</tbody>
</table>
CASE REPORT

Alternative treatment using topical tacrolimus for erosive oral lichen planus resistant to steroids

ABSTRACT
Lichen planus is a T-cell–mediated immunological disorder causing inflammatory lesions on the skin and oral mucosa. The etiology of lichen planus remains unknown, and the current therapeutic strategy is primarily to manage the symptoms. Although topical steroids are commonly used in the treatment of lichen planus, there are lesions refractory to steroids that require different treatment options. This report is of a patient with bilateral erosive oral lichen planus of the buccal mucosa. The lesions did not respond to high-potency topical steroids, so they were treated with topical tacrolimus 0.1% ointment, a potent topical immunosuppressant. All the erosive lesions healed, and the associated pain and bleeding disappeared after 6 weeks of treatment.

Key words: Lichen planus, oral; Steroids; Tacrolimus

Introduction
Lichen planus is a T-cell–mediated immunological disorder causing inflammatory lesions on the skin and oral mucosa. The reported prevalence of oral lichen planus (OLP) varies from 0.5 to 3.0% of the population 1,2. Clinically, OLP can manifest as reticular, papular, plaque-like, erythematous, erosive or bullous subtypes 3. To establish a clinical diagnosis of OLP, reticular or papular textures have to be present.

A biopsy for histopathological examination is usually required for accurate diagnosis and to exclude potential malignancy. As the etiology of OLP remains unknown, the current therapeutic strategy is primarily to manage the symptoms. Although topical steroids are commonly used in the treatment of OLP, there are lesions refractory to steroids that require different medications such as immunosuppressive drugs 4,5.

This report is of a patient with bilateral erosive OLP of the buccal mucosa, which was refractory to high-potency topical steroids and required an alternative treatment approach.

Case report
A 48-year-old woman was referred by a general dental practitioner to the Oral Medicine Consultation Clinic at The Prince Philip Dental Hospital, The University of Hong Kong,
Corticosteroids, retinoids, and calcineurin inhibitors are commonly used in the management of symptomatic OLP. Retinoids are potentially effective for treating OLP, but are probably inferior to topical corticosteroids. A single-blind randomized study compared a medium-strength topical corticosteroid (triamcinolone acetonide) with ciclosporin and demonstrated no differences in efficacy between the two drugs. Another randomized, comparative, double-blind study reported that clobetasol, a high-potency topical corticosteroid, is more effective than ciclosporin in inducing clinical improvement. Triamcinolone has been found to be significantly less effective than clobetasol. Although numerous studies on the management of OLP have been published, there is a lack of randomized placebo-controlled trials that examine the efficacy of various drug treatments for OLP, and there is insufficient evidence to support the superior effectiveness of any specific treatment. Recommendations for the treatment of OLP are based mainly on clinical experiences.

The choice of drug for treating OLP depends on the severity of discomfort, the site of the lesions, and the general health of the patients. Triamcinolone acetonide 0.1% has been widely used by dental practitioners to manage symptomatic OLP because it is safe and readily available in dental clinics. Triamcinolone acetonide has intermediate potency, and is one of the few topical corticosteroids manufactured in a dental paste formula. Treatment with triamcinolone acetonide is quite effective when lichen planus presents as an erythematous lesion or small erosion. However, for extensive erosive lesions, triamcinolone acetonide is usually not sufficient or takes too long to control the symptoms. Some studies have advocated highly potent topical corticosteroids such as clobetasol propionate in favor of those with intermediate potency. After the symptoms are controlled using high-potency corticosteroids, either the frequency of administration can be reduced or a medium-potency corticosteroid can be substituted to maintain the effect.

Although topical steroids are commonly used for managing OLP, some refractory lesions do not respond to corticosteroid treatment. Immunosuppressive drugs are an alternative option for treating these refractory lesions. Tacrolimus is a calcineurin inhibitor that shares the same cellular target as ciclosporin. Both ciclosporin and oral
Figure 1  Erosive lichen planus at the (a) left and (b) right buccal mucosa

Figure 2  After 6 weeks of treatment with tacrolimus, intraoral examination revealed normal appearance at both the (a) left and (b) right buccal mucosa

tacrolimus are approved for use in organ transplantation as part of the immunosuppressive regimen. The immunosuppressive action of tacrolimus is 10 to 100 times more potent than ciclosporin. Tacrolimus ointment 0.1% and cream 0.1% have received approval from the US Food and Drug Administration (FDA) on the basis of their demonstrated efficacy in the treatment of atopic dermatitis refractory to conventional treatment. Systemic administration of tacrolimus has also been used for prevention of GVHD and for treating psoriasis.

Tacrolimus has been used successfully for managing inflammatory diseases of the skin, and has been used alternatively in the treatment of severe erosive OLP that does not respond to corticosteroids. This patient had been treated with triamcinolone, but the symptoms failed to improve before she attended the Oral Medicine Consultation Clinic. After a diagnosis of OLP was confirmed by incisional biopsy, treatment with clobetasol propionate 0.05% ointment, a highly potent topical corticosteroid, was started. There was no improvement after 3 weeks of treatment, so clobetasol propionate was replaced by tacrolimus 0.1% ointment. After 3 weeks, the intensity of the pain and the size of the ulceration were remarkably reduced, and all the lesions and associated symptoms disappeared after 8 weeks of treatment. This patient provides evidence that tacrolimus could be used as an alternative treatment for managing severe erosive OLP refractory to potent steroids.

Some studies have shown that tacrolimus has a lower risk for development of oral candidiasis than potent topical steroids. However, some reports have raised a concern
that long-term use of tacrolimus may induce squamous cell carcinoma of the skin and oral mucosa. The US FDA issued a public health advisory to inform health care professionals and patients of the potential cancer risk based on animal experiments and case reports of a small number of patients in 2005. The FDA requested that the labeling of tacrolimus include a boxed warning about the potential cancer risk, and recommended that: (1) continuous long-term use of tacrolimus, in any age-group, should be avoided; (2) application should be limited to the areas of the lesions; (3) treatment is not indicated for use in children younger than 2 years; and (4) only tacrolimus 0.03% is indicated for use in children aged 2 to 15 years. Currently, the potential for tacrolimus to cause cancer remains theoretical and unknown. The American Academy of Dermatology Association Task Force Committee stated that there is no solid proof that tacrolimus causes skin cancer, and recommended that tacrolimus should remain as treatment for inflammatory diseases. The European Dermatology Forum concurs with this advice.

In summary, tacrolimus 0.1% is an effective drug for treating severe erosive OLP. Tacrolimus should only be used as second-line treatment for lesions that are refractory to potent steroids. Continuous application should not exceed 8 weeks.