Dear Editor,

A 30-year-old man, in relatively good health, presented with progressive asymptomatic golden lesions on his left fourth finger and palm. He reported that these lesions had started to develop as a pea-sized honey-colored macule at the left proximal fourth finger 6 months previously and enlarged gradually. In the recent 2 months, he noticed the appearance of similar lesions at the left distal fourth finger, which then spread proximally to the distal palmar crease of the left palm. He denied history of any trauma or drug histories prior to the onset of skin lesions. On physical examination, one bean-sized, irregular, golden brown patch located at the medial aspect of the left proximal fourth finger and few brownish confluent papules at the medical aspect of the left distal fourth finger were found (Figure 1A). Some coppery confluent papules were also found from the volar aspect of the palm, from the left fourth proximal interphalangeal joint to the distal palmar crease (Figure 1B). All these lesions followed the venous drainage in a linear fashion. Histopathologic examination showed a dense band-like lymphohistiocytic infiltrate on the superficial dermis (Figure 2A). Marked extravasation of erythrocytes was also found but there was no evidence of vasculitis (Figure 2B). Iron-stained section showed the presence of hemosiderin-laden macrophages (Figure 2C). Based on the clinical and histologic findings, segmental lichen aureus was diagnosed. Topical desoximetasone ointment (0.25%) two times daily for 2 months produced no improvement and the lesions extended to the lateral aspect of the left fifth finger (Figure 1C). Oral pentoxifylline (400 mg) two times daily was subsequently administered; however, he was lost to follow-up.

In reviewing the English literature, we have found reports of only 11 patients with lichen aureus in a segmental, linear, or zosteriform pattern (Table 1). The pathomechanism of lichen aureus remains unknown, but several possible pathomechanisms of pigmented purpuric dermatosis have been proposed, including increased venous pressure or stasis, capillary fragility, infection, drugs, and involvement of T-cell immunity. As to our case, the pattern closely followed the venous drainage of hand circulation. Including the present case, four cases of segmental lichen aureus displayed this pattern, suggesting that segmental lichen aureus is a hemosiderin “tattoo,” resulting from impaired local venous return. The persistence of the tattoo pigment has to do with altered hemodynamics that favor continued microscopic extravasation of red cells in a delimited area.

There is a controversy between segmental lichen aureus and unilateral linear capillaritis (ULC). ULC was first reported in 1992 by Riordan et al. The differences between ULC and segmental lichen aureus are as follows: (1) lesions of ULC often resolve within 2 years, unlike the typical chronic course of lichen aureus; and (2) histopathologically, only a focal superficial perivascular lymphocytic inflammation is interspersed with mild extravasated erythrocytes in ULC. However, both entities follow linear or segmental distribution and an individual lesion of ULC is similar to lichen aureus. Therefore, we propose that ULC might represent a milder form of segmental lichen aureus, which may explain why spontaneous resolution is much often seen in ULC.

Treatment of segmental lichen aureus can be challenging. Without treatment, it is considered to be a highly chronic dermatosis; only two cases showed partial spontaneous resolution. In general, potent oral and topical corticosteroids are ineffective, although two cases showed good response to topical 0.1% methylprednisolone aceponate ointment. Pulsed-dye laser and oral pentoxifylline in combination with prostacyclin have shown variable success.

Figure 1 (A) Irregular-shaped golden brown patches and papules on the left proximal and distal fourth fingers (the arrow indicates the biopsy site). (B) Some coppery confluent papules at the volar aspect of the palm from the left fourth proximal interphalangeal joint to the distal palmar crease. (C) The lesions spread to the lateral aspect of the left fifth finger despite treatment with topical steroids for 2 months.
In conclusion, we presented a case of segmental lichen aureus in the acral part. This case implies that the possible pathomechanism of segmental lichen aureus is attributed to the impaired local venous circulation. However, further investigations are needed to confirm this hypothesis.

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**References**