Grinspan’s syndrome in a diabetic woman

Síndrome de Grinspan en una mujer con diabetes

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Case report

50 years old woman, with type 2 diabetes mellitus of 23 years of evolution and an adequate metabolic control during the last 9 years (glycosylated hemoglobin of 6.3-6.6%). She did not show any complication of her diabetes, but suffered from a diffuse proliferative glomerulonephritis with arteriolar hyalanosis, proteinuria and arterial hypertension since 1992. Moreover, the patient was also diagnosed with glaucoma, hyperuricemia and mixed hyperlipemia. According to the treatment with metformin, repaglinide, NPH insulin, simvastatin, ezetimibe, irbesartan 800 mg/day and acetylsalicylic acid.

The patient started with lesions in the oral cavity that caused her discomfort when having her meals. She has been previously treated with antifungal wash and by systemic route, but considering the inefficiency of said treatment she attended an odontology site. After a complete exploration of the oral mucosa, some lesions were observed that had a hyperkeratotic aspect in reticulated pattern, with the basis slightly erythematous of approximately 4 cm of surface, localized on both jugal mucosa. The patient also showed similar lesions in the lateral borders of the tongue. In this localization, the lesions alternated the reticular pattern with an erosive pattern. The presumption diagnosis was of oral lichen planus. This diagnosis was confirmed through an incisional biopsy in the left jugal mucosa. Considering the diabetes triad, arterial hypertension and lichen planus that the patient showed, the case report was classified as Grinspan’s syndrome.1 She has been treated with triamcinolone acetonide 0.1% in aqueous solution, three times daily during one month, achieving an evident improvement.

Though Grinspan described the syndrome, several authors point out that this association is merely casual and suggest that the main frequency of lichen planus in patients with diabetes and arterial hypertension might be due to the use of several of drugs used in these entities. In this case, it has to do with lichenoid reactions and not lesions of the lichen planus in itself.2 However, in the diabetic patients, especially those with T1D, a higher frequency of some clinical forms of lichen planus can be observed, mainly the atrophic and erosive forms with a higher tendency to be localized on the tongue. The most usual localizations are the jugal mucosa, the gum and the tongue. It is generally asymptomatic, though there is a chronic form, named erosive bullous lichen, which presents very painful lesions. The treatment includes topical and systemic corticoids (in the serious and mucocutaneous forms), retinoids, cyclosporine and phototherapy. Notwithstanding the controversy as regards to its premalignant nature, the follow-up of the lesions is considered essential.3

References