INTRODUCTION

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Lichen planus (LP) is an inflammatory mucocutaneous condition with characteristic violaceous polygonal flat-topped papules and plaques. Pruritus is often severe. Skin lesions may be disfiguring, and involvement of the oral mucosa or genital mucosa in severe cases may be debilitating. Oral lichen planus (OLP) may predispose to the development of squamous cell carcinoma within lesions. Involvement of the scalp and nails may also occur. While most cases of lichen planus are idiopathic, some may be caused by the ingestion of certain medication (e.g., gold, antimalarial agents, penicillamine, thiazide diuretics, beta blockers, non-steroidal anti-inflammatory drugs, quinidine and angiotensin-converting enzyme inhibitors) or linked to hepatitis C virus infection **(Katta, 2000)**. Other common hypotheses involve immunological abnormalities, neurological changes, or emotional stress (**Pawlotsky et al., 1995**a).

Hepatitis C virus (HCV) is a blood-borne agent transmitted by apparent and inapparent parenteral procedures representing a frequent cause of liver disease world-wide. Both acute and chronic HCV infection may affect the liver as well

as various non-hepatic tissues. Numerous extrahepatic disorders have been recognized in association with HCV infection among which dermatological diseases occupy central part. Cutaneous necrotizing vasculitis, mixed cryoglobulinemia, porphyria cutanea tarda and lichen planus are the major skin diseases frequently associated with HCV infection **(Loustaud-Ratti and Lunel, 2000 and Hadziyannis, 1998)**.

HCV was demonstrated to be the leading cause of non-A, non-B hepatitis. Not only HCV is able to determine chronic hepatitis in most patients, often leading to hepatocellular carcinoma, but has also been shown to be strictly associated with a number of immunologically-mediated diseases **(Gattoni et al., 1997)**.

A high prevalence of chronic hepatitis of unknown origin has been reported in patients with LP **(Gruppo Italiano, 1990)**.

Jubert et al. (1994) suggested a relationship between LP and chronic infection with hepatitis C virus.

Several cases of LP associated with HCV infection have been described. The reported prevalence rates of anti-HCV antibodies in patients with LP show wide geographical variation. An association of HCV-associated disorders with

certain HCV geno/subtypes has not been investigated so far **(Imhof et al., 1997)**. An increased prevalence of hepatitis C virus related hepatitis has been reported in patients with (LP) **(Dupond et al., 1998)**.