

Dermato-venereological Quiz

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A 19-year-old male patient present with 2 years history of progressive mildly pruritic skin rash over his face. The rash started as few pruritic papules and pustules over his right cheek. Papules and pustules then coalesce to form plaque with peripheral extension and central clearing with pigmentation. He consulted multiple general practitioners and had been treated as acne, fungal infection and eczema. The skin lesion increased in size and new lesions developed over his glabellar region and left cheek (Figures 1 & 2). This patient is a student and enjoy good past health. There is no family history of similar skin problem. He has no pet raised at home. He has no habit of using hair dye or other hair styling product. The skin lesions do not worsen on sunlight exposure. He has no other systemic symptoms. The other parts of body are spared and other physical examination is unremarkable. Incisional skin biopsy was performed over the left cheek and histopathological examination showed intraepidermal perifollicular inflammatory infiltration predominantly eosinophils with few polymorphs and mononuclear cells (Figures 3 & 4).

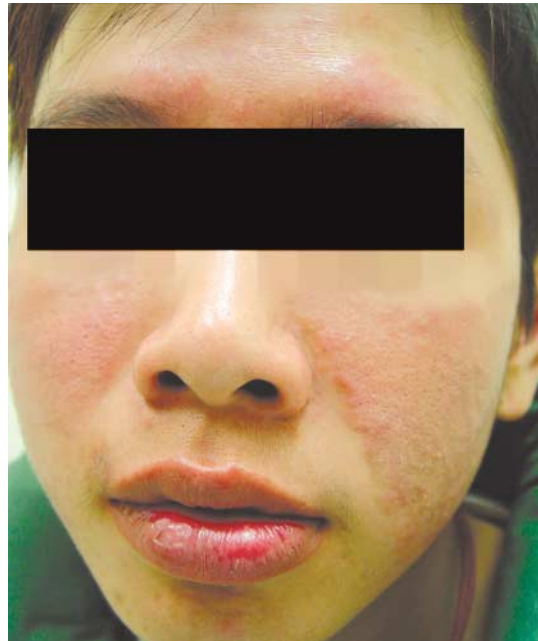


Figure 1.



Figure 2.

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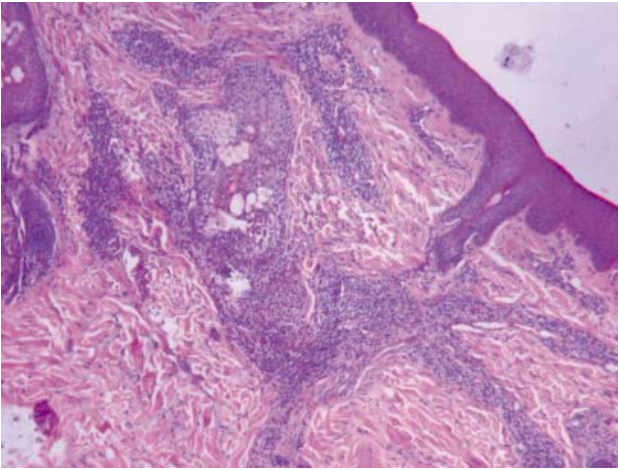


Figure 3. H&E stain, Original magnification x 16.

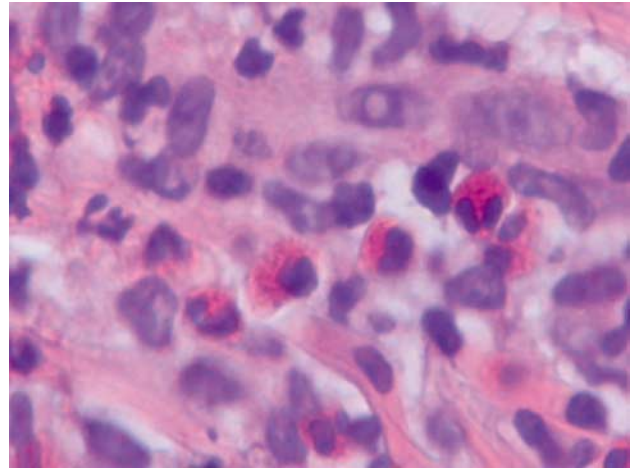


Figure 4. H&E stain, Original magnification x 160.

Questions

1. What is your diagnosis?
2. What are the differential diagnoses for this disorder?
3. What investigations will you offer?
4. What are the treatment options for this skin disorder?
5. What is the prognosis?

Answers to Dermato-venereological Quiz on pages 94-95

1. The diagnosis of this patient is classic form of eosinophilic pustular folliculitis (EPF). EPF classic form was first described by Ofuji in 1970. It has a male predilection. Classic EPF presents as chronically recurrent crops of sterile follicular papulopustules with peripheral extension and central clearing. The disease can affect the face, trunk and limbs. Usually there are no other systemic symptoms. The aetiology of this disease is unknown.
2. The differential diagnoses for EPF include other acneiform dermatoses such as acne vulgaris, bacterial and fungal folliculitis, subcorneal pustular dermatosis.
3. Fifty percent of classic EPF cases have eosinophilia. Mild to moderate leucocytosis may also be seen. Autoimmune markers such as antinuclear factor can be checked. Pustular content can be sent for microbiological examination. HIV serology should be checked in case of any suspicion. Incisional skin biopsy for histopathological examination will show folliculitis with predominant eosinophilic infiltration.
4. In the present juncture, no established treatment schemes exist for classic EPF. A number of options have been tried with various results. No controlled treatment trials have been performed for this condition. Oral indomethacin consistently appears to be most beneficial, at least in the classic form of the disease. Other treatment alternatives reported to be useful include topical tacrolimus, dapsone, minocycline, isotretinoin, UVB, colchicine and cyclosporine. Oral antihistamine such as cetirizine or hydroxyzine can be used to alleviate itchiness.
5. Classic EPF usually has a chronic course with period of remission and exacerbation. However, some patients have achieved long-lasting remissions with indomethacin alone or in combination with dapsone.