Forceps for Milia Extraction

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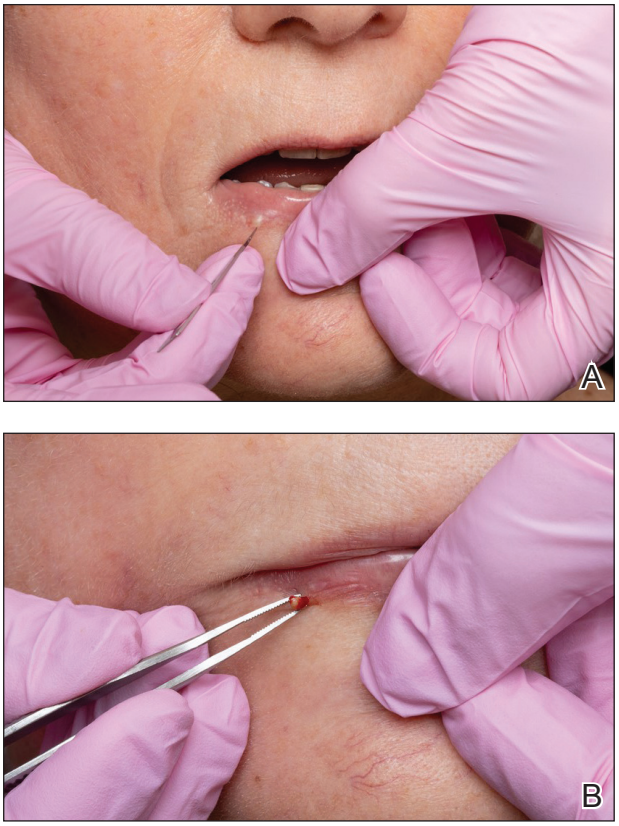
PRACTICE **POINTS**

- Milia are common benign lesions that are cosmetically undesirable to some patients.
- Although some methods of milia removal can be painful, removal with forceps is quick and effective.

To the Editor:

Several techniques can be used to destroy milia including electrocautery, electrodesiccation, and laser therapy. Manual extraction of milia uses a scalpel blade, needle, or stylet followed by the application of pressure to the lesion with a curette, comedone extractor, paper clip, cotton-tipped applicator, tongue blade, or hypodermic needle.[1-4] Many of these techniques fail to stabilize milia, particularly in sensitive areas such as around the eyes or mouth, which can make extraction challenging, inefficient, and painful for the patient. We report a novel technique that quickly and effectively removes milia with equipment commonly used in the practice of clinical dermatology.

A 74-year-old woman presented with an asymptomatic papule on the right lower vermilion border of several years' duration. Physical examination of the lesion revealed a 3-mm, firm, white, dome-shaped papule. Clinical features were most consistent with a benign acquired milium. The patient desired removal for cosmesis. The area was cleaned with an alcohol swab, the surface of the milium was nicked with a No. 11 blade (Figure, A), and then tips of nontoothed Adson forceps were used to gently secure and



A, Epidermal surface of milium after nick with a No. 11 blade. B, Tips of nontoothed Adson forceps with applied pressure at the base of the milium.

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pinch the base of the papule (Figure, B). The intact cyst was quickly and effortlessly expressed through the epidermal nick. The patient tolerated the procedure well, experiencing minimal pain and bleeding.

Histologically, milia represent infundibular keratin-filled cysts lined with stratified squamous epithelial tissue that contains a granular cell layer. These lesions are classified as primary or secondary; the former represent spontaneous occurrence, and the latter are associated with medications, trauma, or genodermatoses.[2] Multiple milia are associated with conditions such as Bazex-Dupré-Christol syndrome, Rombo syndrome, Brooke-Spiegler syndrome, oro-facial-digital syndrome type I, atrichia with papular lesions, pachyonychia congenita type 2, basal cell nevus syndrome, basaloid follicular hamartoma syndrome, and hereditary vitamin D–dependent rickets type 2.[5-9] The most common subtype seen in clinical practice includes benign primary milia, which tends to favor the cheeks and eyelids.[2]

Although these lesions are benign, many patients seek extraction for cosmesis. Milia extraction is a common procedure performed in dermatology clinical practice. Proposed extraction techniques using destructive methods include electrocautery, electrodesiccation, and laser therapy, and manual methods include nicking the surface of the lesion with a scalpel blade, needle, or stylet and then applying tangential pressure with a curette, comedone extractor, paper clip, cotton-tipped applicator, tongue blade, or hypodermic needle.[1-4] Topical retinoids have been proposed as treatment of multiple milia.[10] Many of these techniques do not use equipment common to clinical practice, or they fail to stabilize milia in sensitive areas, which makes extraction challenging. We describe a case with a new manual technique that successfully extracts milia in an efficient and safe manner.

REFERENCES

1. Parlette HL III. Management of cutaneous cysts. In: Wheeland RG, ed. *Cutaneous Surgery*. WB Saunders; 1994:651-652.
2. Berk DR, Bayliss SJ. Milia: a review and classification. *J Am Acad Dermatol*. 2008;59:1050-1063.
3. George DE, Wasko CA, Hsu S. Surgical pearl: evacuation of milia with a paper clip. *J Am Acad Dermatol*. 2006;54:326.
4. Thami GP, Kaur S, Kanwar AJ. Surgical pearl: enucleation of milia with a disposable hypodermic needle. *J Am Acad Dermatol*. 2002; 47:602-603.
5. Goeteyn M, Geerts ML, Kint A, et al. The Bazex-Dupré-Christol syndrome. *Arch Dermatol*. 1994;130:337-342.
6. Michaëlsson G, Olsson E, Westermark P. The Rombo syndrome: a familial disorder with vermiculate atrophoderma, milia, hypotrichosis, trichoepitheliomas, basal cell carcinomas and peripheral vasodilation with cyanosis. *Acta Derm Venereol*. 1981;61:497-503.
7. Gurrieri F, Franco B, Toriello H, et al. Oral-facial-digital syndromes: review and diagnostic guidelines. *Am J Med Genet A*. 2007;143A:3314-3323.
8. Zlotogorski A, Panteleyev AA, Aita VM, et al. Clinical and molecular diagnostic criteria of congenital atrichia with papular lesions. *J Invest Dermatol*. 2001;117:1662-1665.
9. Paller AS, Moore JA, Scher R. Pachyonychia congenita tarda. a late-onset form of pachyonychia congenita. *Arch Dermatol*. 1991;127:701-703.
10. Connelly T. Eruptive milia and rapid response to topical tretinoin. *Arch Dermatol*. 2008;144:816-817.