Infundibulofolliculitis of the Neck

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Disseminate and recurrent infundibulofolliculitis is an uncommon eruption that typically presents on the trunk and proximal extremities of young black men. A case of a young girl with infundibulofolliculitis limited to the neck is presented and reviewed, and a proposal for renaming it is considered.

Disseminate and recurrent infundibulofolliculitis is a variably symptomatic eruption that most frequently occurs on the trunk and proximal extremities of young black men.[1] Although several reports have indicated possible neck involvement, in this case, lesions were limited to the neck.

Case Report

A 15-year-old girl of Colombian and Norwegian descent presented with an approximate 1-year history of asymptomatic lesions of the neck. She was concerned about the appearance of the lesions but did not experience any pruritus or burning sensation of the neck. Personal and familial history did not include asthma or allergic rhinitis. She denied wearing occlusive clothing on the neck and applying agents to treat the eruption. A year earlier, she had received a diagnosis of xerosis, which responded to treatment with ammonium lactate solution. Follicular prominence was appreciated on the chest at that initial visit but not on a subsequent examination.

Now, uniform dome-shaped flesh-colored follicular papules were distributed circumferentially around the neck and extended from the clavicles to the mandibles. The papules, which seemed to follow skin tension lines, ran parallel with each other (Figure 1). The major differential diagnosis was infundibulofolliculitis and juxtaclavicular beaded lines. Results of a biopsy were positive for a perivascular and peri-infundibular mononuclear infiltrate with exocytosis and spongiosis of the follicular infundibular epithelium (Figure 2), which confirmed the diagnosis of infundibulofolliculitis. Prednicarbate ointment was prescribed, but there has been no follow-up examination.

Comment

Hitch and Lund[2] were the first to describe disseminate and recurrent infundibulofolliculitis. Their patient was a 27-year-old black man with a follicular eruption that resembled cutis anserina and was distributed on the torso, neck, and proximal extremities. The second reported case, presented by Thew and Wood,[3] involved a 15-year-old black boy with skin lesions that were virtually identical clinically and histologically to those described in the first case report. The boy's lesions were on the back of the neck, shoulders, chest, back, abdomen, upper part of the buttocks, and proximal extremities. Wolf and Tolmach[4] reported the case of a 19-year-old black woman with disseminated lesions involving the torso and neck. They described the neck lesions as being "flat confluent papules symmetrically distributed over the supraclavicular regions and continuing over the collar bones, arranged parallel along the cleavage lines of the skin, resembling beaded strands." To date, their description is the most detailed one of neck involvement for this disorder. Their patient and this patient had virtually identical presentations, though this patient did not have truncal lesions. Several other authors have reported cases in which necks were affected as part of the disseminated process.[5-11] To the best of my knowledge, a neck-limited presentation of this condition is novel.

Follicular prominence is often appreciated in atopic patients, especially black atopic patients.[12] At 14 years of age, this patient had received a diagnosis of xerosis and follicular prominence, which are suggestive of an underlying atopic diathesis; at 15 years of age, she no longer had these conditions. In addition, she had never complained of pruritus, and neither she nor her family had had any classic features of atopic dermatitis, such as lichenification.

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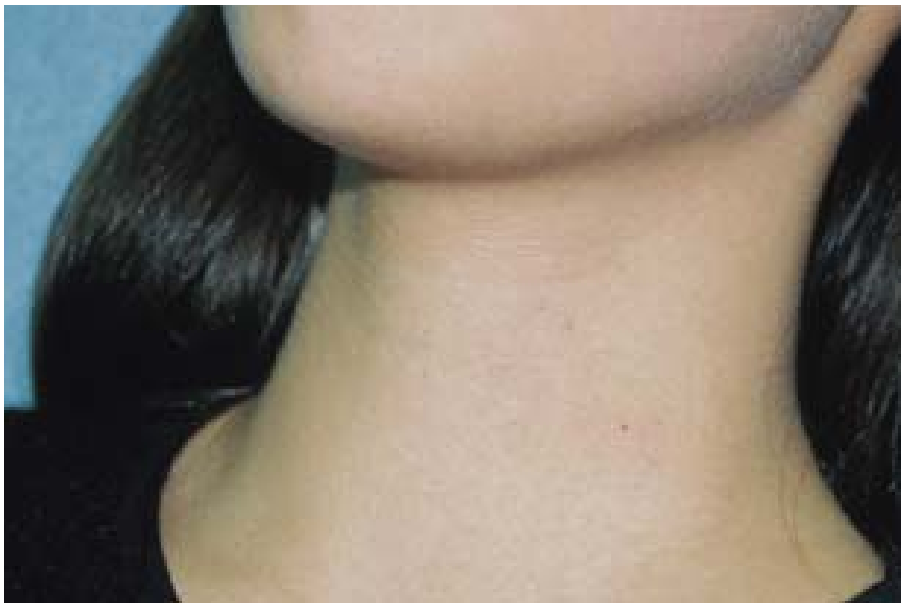

Figure 1. Minute follicular papule on the neck. Note the parallel arrangement of lesions following the cleavage line—an arrangement that has been likened to "beaded strands."

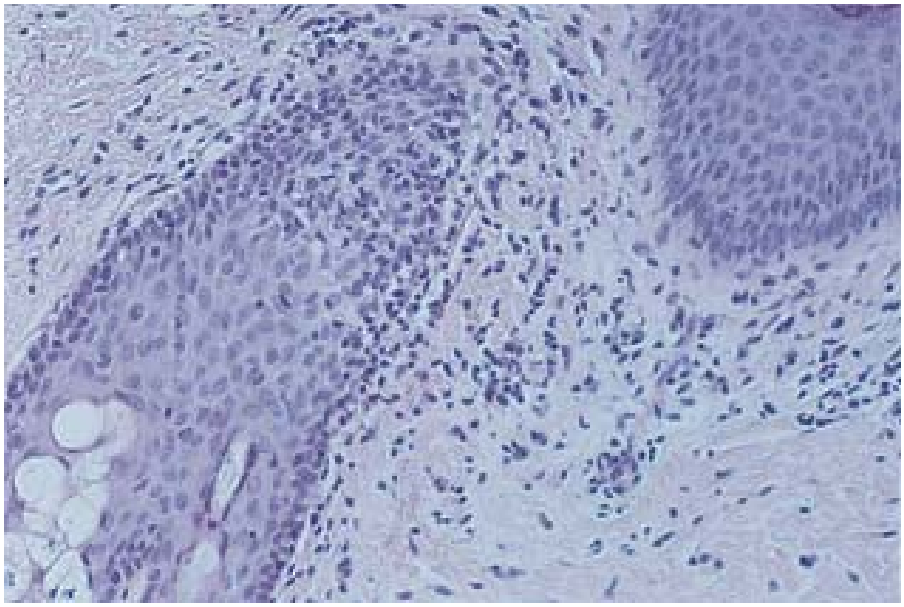

Figure 2. Exocytosis of mononuclear cells accompanied by spongiosis in the follicular epithelium (H&E, original magnification ×100).

The differential diagnosis for infundibulofolliculitis is follicular eruptions, including keratosis pilaris, lichen planopilaris, lichen scrofulosorum, infectious folliculitides such as follicular syphilis, Darier disease, Kyrle disease, perforating folliculitis, phrynoderma, and juxtaclavicular beaded lines. All these conditions were excluded on the basis of the patient's clinical presentation and histopathology.

Given the inconsistent reporting of environmental and systemic precipitants, the etiology of infundibulofolliculitis remains an enigma. As the disease may be self-limited[13] and typically is characterized by recurrent remissions and exacerbations, efficacy of therapeutic agents may be difficult to assess.[1] Use of topical steroids, soap-free cleansers, topical salicylic acid, and doxycycline is often not effective.[2] Oral vitamin A therapy was beneficial in 5 of 6 cases reported by Owen and Wood.[6] Aroni et al[1] reported a case treated successfully with isotretinoin. Ravikumar et al[8] used psoralen and ultraviolet A light (PUVA) to clear infundibulofolliculitis in a patient with pruritic lesions.

This patient was unusual in that her lesions were limited to the neck. Because other cases have been self-limited and lesion distribution may be limited to a singular anatomic unit, perhaps *disseminate*

and recurrent infundibulofolliculitis is not the appropriate term for all cases. In this patient's case, a more precise classification, *infundibulofolliculitis of the neck,* seems appropriate. Garcia[11] reported the case of a 21-year-old black man with lesions that had persisted for 6 years—a history suggestive of chronic and not recurrent disease. Using *infundibulofolliculitis* as an umbrella term would allow other types to be specified accordingly. Most cases, then, would be referred to as *infundibulofolliculitis* and would be classified *disseminated* and *recurrent*. Only further study of the pathogenesis, natural history, and atypical presentations of this condition will determine if such a reclassification is justified.

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