Diffusely Scattered Linear Folliculopapular Eruption

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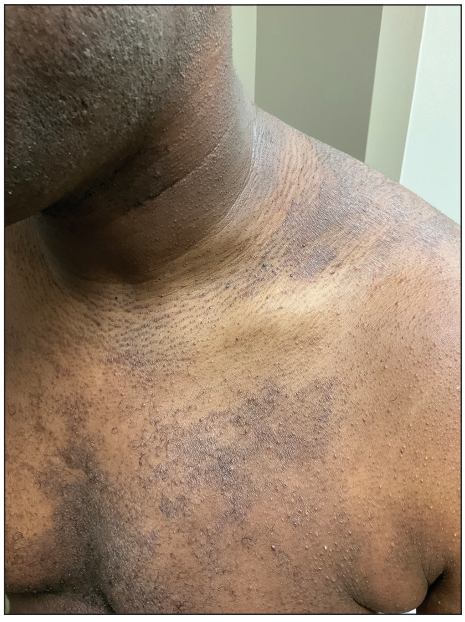

A 31-year-old man with a darker skin tone and a history of childhood eczema presented with papules on the trunk and upper arms of several years' duration. The papules were persistent and were generally asymptomatic but occasionally pruritic. The patient previously had self-treated with over-the-counter lotions and topical hydrocortisone with no appreciable changes. On physical examination, a hyperpigmented patch with follicular monomorphic papules was noted across the upper back along with confluent papules and plaques predominantly on the trunk and upper arms. Additionally, the patient had several monomorphic papules in a linear distribution on the neck. Review of systems and examination of the remaining skin were unremarkable. A biopsy from a representative papule on the left upper back was performed.

WHAT'S YOUR **DIAGNOSIS?**

a. confluent and reticulated papillomatosis
b. disseminate and recurrent infundibulofolliculitis
c. follicular eczema
d. juxtaclavicular beaded lines
e. pityrosporum folliculitis

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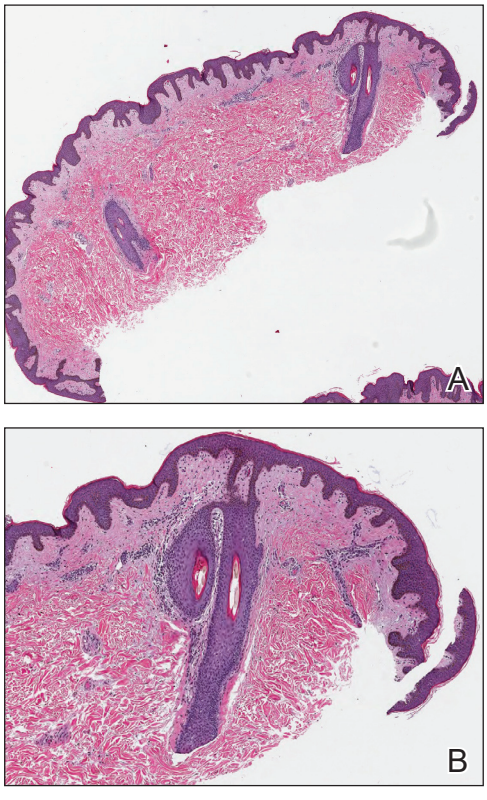
THE **DIAGNOSIS:** Disseminate and Recurrent Infundibulofolliculitis

Histopathology demonstrated a lymphocyte-predominant infundibular infiltrate with mild spongiosis and lymphocytic exocytosis; a mild, superficial perivascular infiltrate also was present. The surrounding skin was largely normal with no notable papillomatosis, acanthosis, or hyperkeratosis (Figure 1). The clinical presentation and histopathologic findings led to the diagnosis of disseminate and recurrent infundibulofolliculitis (DRIF). The patient was started on a 2-week course of once-daily ammonium lactate lotion 12% and urea cream 40% and twice-daily triamcinolone ointment 0.1%. The patient was instructed to take a 1-week break before this regimen was repeated. Isotretinoin 0.5 mg/kg/d for 2 to 4 months was considered and will be an option if there is no improvement at follow-up.

Disseminate and recurrent infundibulofolliculitis is a rare noninfectious folliculitis that initially was described by Hitch and Lund[1] in 1968. Males of African descent are most commonly affected by DRIF, but the condition is not limited to this population.[2,3] It manifests as asymptomatic, flesh-colored, monomorphic, follicular papules distributed on the trunk and proximal extremities. Pustules can be present, and hair may be seen protruding from them. As the name suggests, DRIF is associated with histopathologic changes that are prominent at the infundibulum of hair follicles.[3,4] Disseminate and recurrent infundibulofolliculitis can persist for months to years because it often is resistant to treatment. Treatments include topical monotherapies such as corticosteroids, calcineurin inhibitors, or retinoids; combination topical treatments; antibiotics; and isotretinoin.[2] Recurrent remission and exacerbation occurs in many patients.[3]



FIGURES 1. A and B, Histopathology demonstrated a lymphocytepredominant infundibular infiltrate with mild spongiosis and lymphocytic exocytosis. A mild superficial perivascular infiltrate also was present. The surrounding skin was largely normal without notable papillomatosis, acanthosis, or hyperkeratosis (H&E, original magnification ×40 and ×100).

The classic manifestations of DRIF, including follicular, monomorphic, flesh-colored papules distributed on the neck, trunk, and proximal upper extremities, were seen in our patient (Figure 2). These findings along with the skin biopsy identifying a lymphocytic infundibular infiltrate led to the diagnosis of DRIF. The papules associated with DRIF can be recurrent or chronic. The lesions in this patient were chronic and persistent.

Despite limited evidence, it has been suggested that DRIF may be a manifestation of atopic dermatitis in patients with darker skin tones. In our case, the patient had a history of childhood eczema. Other hypotheses have proposed that DRIF could be a nonspecific reaction to a currently unknown antigen. A causative infectious agent has not been identified, although the search continues. There is speculation that DRIF could be an overt expression of normal follicular prominence, but the presence of occasional pustules and lymphocyte-predominant infundibular infiltrate negates that.[3]

Confluent and reticulated papillomatosis was included in the differential for our patient and manifests as asymptomatic hyperpigmented papules and plaques frequently occurring on the upper trunk, neck, and axilla; however, these lesions have a peripheral netlike configuration, as the name suggests. Additionally, this condition is thought to have an infectious component (*Dietzia papillomatosis*) and responds to antibiotic treatment.[5] Follicular eczema also was high in the differential diagnosis but usually is seasonal and pruritic, and histopathology typically shows the features of spongiotic dermatitis. It also would respond well to topical steroids.[6] Another condition high on the differential was juxtaclavicular beaded lines, which also manifests as flesh-colored follicular papules distributed on the upper trunk; however, histopathology usually shows features of hyperplastic pilosebaceous units along with spongiosis and exocytosis.[7] Pityrosporum folliculitis initially was considered, but the patient only endorsed occasional pruritus. Additionally, no fungal elements were observed.

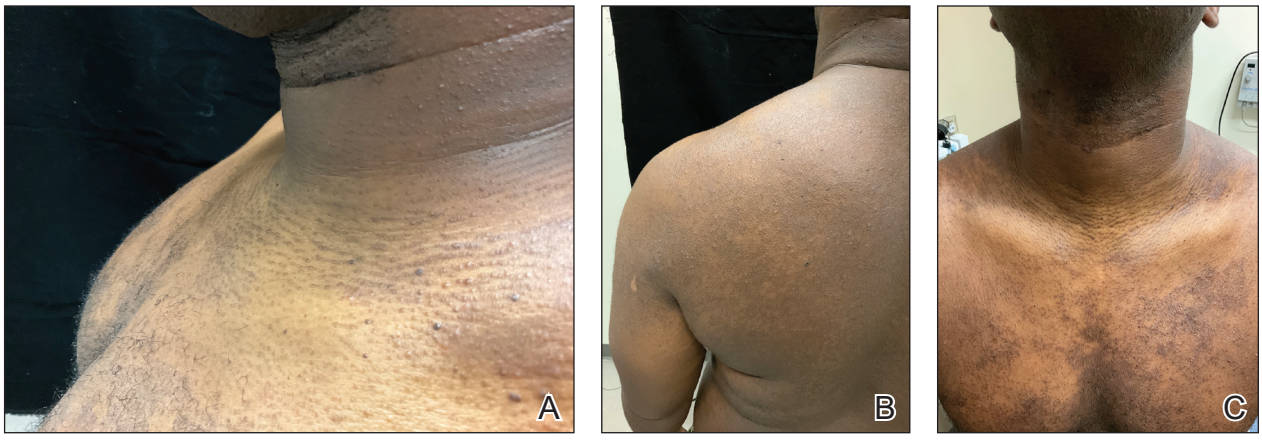


FIGURE 2. A-C, Bilateral monomorphic eruption consisting of numerous 1- to 2-mm, follicular round papules affecting the neck, back, chest, and proximal upper extremities.

Currently, there are no definitive treatments for DRIF. The topical treatments available include midpotency corticosteroids, tretinoin, calcineurin inhibitors, 12% lactic acid, and 20% to 40% urea. The systemic therapies are high-dose oral vitamin A (100,000 IU/d), isotretinoin, and psoralen plus UVA.[8-10]

REFERENCES

1. Hitch JM, Lund HZ. Disseminate and recurrent infundibulo-folliculitis: report of a case. *Arch Dermatol.* 1968;97:432-435.
2. Ma BC, Sahni VN, Sahni DR, et al. Disseminate and recurrent infundibulofolliculitis: an under-recognized yet treatable entity. *J Drugs Dermatol*. 2021;20:1353-1354. doi:10.36849/jdd.6173
3. Nair SP, Gomathy M, Kumar GN. Disseminate and recurrent infundibulo-folliculitis in an Indian patient: a case report with review of literature. *Indian Dermatol Online J.* 2017;8:39-41. doi:10.4103/2229-5178.198775
4. Rekha S, Kumar V, Rao P, et al. Disseminate and recurrent infundibulo-folliculitis. *Indian J Dermatol*. 2019;64:404-406. doi:10.4103/ijd.IJD_77_18
5. Jones AL, Koerner RJ, Natarajan S, et al. Dietzia papillomatosis sp. nov., a novel actinomycete isolated from the skin of an immunocompetent patient with confluent and reticulated papillomatosis. *Int J Syst Evol Microbiol*. 2008;58(pt 1):68-72. doi:10.1099/ijs.0.65178-0
6. Cohen PR. Follicular contact dermatitis revisited: a review emphasizing neomycin-associated follicular contact dermatitis. *World J Clin Cases*. 2014;2:815-821. doi:10.12998/wjcc.v2.i12.815
7. Butterworth T, Johnson WC. Justa-clavicular beaded lines. *Arch Dermatol.* 1974;110:891-893.
8. Calka O, Metin A, Ozen S. A case of disseminated and recurrent infundibulo-folliculitis responsive to treatment with isotretinoin. *J Dermatol.* 2002;29:431-434.
9. Goihman-Yahr M. Disseminate and recurrent infundibulofolliculitis: response to psoralen plus UVA therapy. *Int J Dermatol.* 1999;38:75-76.
10. Hinds GA, Heald PW. A case of disseminate and recurrent infundibulofolliculitis responsive to treatment with topical steroids. *Dermatol Online J.* 2008;14:11.