ACNE, ROSACEA, AND RELATED DISORDERS (INCLUDING HIDRADENITIS SUPPURATIVA)

ACNE NECROTICA (NECROTIZING LYMPHOCYTIC FOLLICULITIS): A VARIOLIFORMIS CASE REPORT

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Background: Acne necrotica, is a chronic necrotizing folliculitis, rarely described in literature, with unknown etiology; characterized by inflammatory papulonodules lesions, follicular eruption which rapidly necrotize and leaves superficial depressed scars. Classification and pathogenesis are still controversial. We present a case of acne necrotica in its varioliformis variant.

Observation: A 51-year-old male patient presented with a 3-month history of asymptomatic facial lesions, he admitted manipulating some lesions. Past medical history included systemic lupus erythematosus, in use of hydroxychloroquine sulfate. Physical examination revealed 1-2mm umbilicated erythematous follicular papules with hemorrhagic crusts and some depressed superficial scars on the face. Histopathology revealed perifollicular dermatitis with follicle necrosis and signs of epidermal excoriation; lymphocytic and perifollicular histiocytic infiltration. Fite-Faraco stain was negative. Correlation of clinical with histopathological diagnosis confirmed acne necrotica. Systemic tetracycline and topical fusidic acid cream were initiated, with a favorable response to treatment in a 2 months follow-up.

Key message: Acne necrotica, despite being initially recognized in the last century, over the last 30 years there has been a lack of literature. Miliaris and varioliformis forms are distinguished. The miliar form is a type of folliculitis of the scalp caused by P. acnes, this variant can present 2mm pustular lesions with burning pruritus. The varioliform, a 2-5mm papulonecrotic lesions with predominance in face, scalp, and neck. S. aureus and/or P. acnes have been implicated as responsible. Cultures have tended to be negative. A disseminated form has been rarely described, affecting the trunk, limbs, head and neck. Diagnosis is made by clinical and histological correlation presenting necrotizing lymphocytic folliculitis. Differential diagnosis should consider acneiform lesions, rosacea, prurigo nodularis, dermatitis artefacta, excoriated eczema, etc. Treatment includes systemic and topical antibiotics, or systemic retinoid therapy. Treatment must be prolonged for weeks or months even though it can be unsatisfactory in most of the cases.