Net Letter

Confluent and reticulated papillomatosis: Successful treatment with minocycline

Sir,

Confluent and reticulated papillomatosis of Gougerot and Carteaud (CRP) is an uncommon but distinctive icthyosiform dermatosis seen in young adults and characterized by persistent brown, scaly macules, papules, patches and plaques, localized predominantly on the neck, intermammary, interscapular regions and axillae where they tend to be confluent and become reticulated toward the periphery. A variety of topical and systemic treatment approaches have been reported like keratolytics, antimicrobials, antibiotics and retinoids. Minocycline has been suggested as a first-line treatment. We report two patients with confluent and reticulated papillomatosis who were successfully treated with minocycline.

A 34-year-old man presented with multiple asymptomatic pigmented lesions over the back, chest, shoulders and upper arms of six months duration. He used ketoconazole and selenium sulfide shampoos for six weeks with no improvement in the lesions. Except for obesity, his general physical and systemic examination did not reveal any findings. On dermatological examination, hyperpigmented scaly macular lesions are present on the upper back, shoulders, upper arms and inframammary regions which are confluent in the center and reticulate at the periphery. [Figure 1a]. 10% KOH wet mount test from scrapings showed fungal hyphae. Skin biopsy for histopathological examination revealed epidermal hyperplasia with lamellated orthohyperkeratosis and thickened granular layer. Dermis showed mild papillomatosis and superficial perivascular lymphocytic infiltrate. Diagnosis of confluent and reticulated papillomatosis was made and patient was started on oral minocycline 100 mg OD, with complete clearing of lesions in 15 days [Figure 1b].

A 25-year-old female presented with asymptomatic pigmented lesions over the back of one year duration. Except for anemia and obesity, her general and systemic examination did not reveal any findings. Dermatological examination revealed hyperpigmented scaly macular lesions which are confluent in the center and reticulate at the periphery in the interscapular area [Figure 2a]. 10% KOH wet mount test from scrapings showed fungal hyphae. Skin biopsy revealed epidermal hyperplasia with lamellated ortho hyperkeratosis

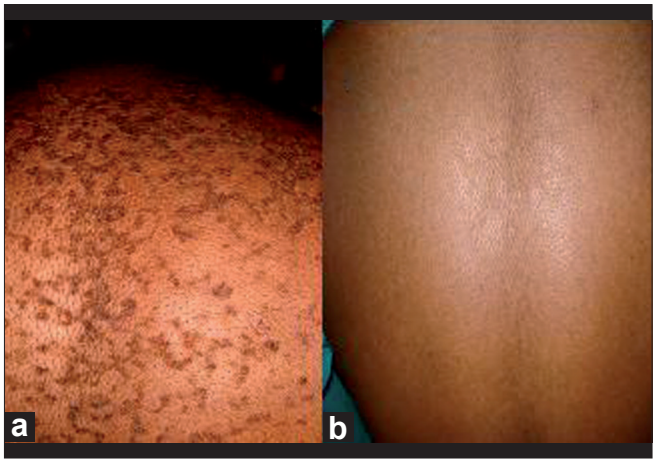

Figure 1: (a) Multiple hyperpigmented macules which are confluent in the center and reticulate at the periphery involving the upper back. (b) Complete resolution of lesions over the back with minocycline

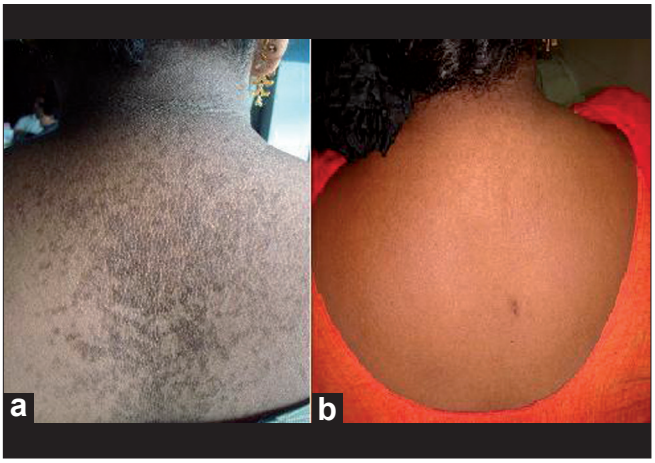

Figure 2: (a) Hyperpigmented macular scaly lesions over the interscapular area which are confluent in the center and reticulate at the periphery. (b) Complete clearance of lesions with oral minocycline

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CRP was first described in 1927 by Gougerot and Carteaud. Many etiologies have been proposed. Proposed causes include obesity, disturbance of keratinization,[1] exposure to ultraviolet light, endocrine imbalance and infection with Pityrosporum ovale or abnormal host response to Malassezia furfur.[1] Disease begins on an average, in the late teens or early twenties, with equal sex distribution. There is no standard therapy for CRP. Minocycline was first used for the treatment of CRP in 1965 by Carteaud. It was found to be highly effective in most of the patients.[2-4] Tetracycline derivatives possess anti-proliferative and anti-inflammatory action and they also inhibit Propionibacterium acnes lipase activity, collagenase activity and complement activation system.[2] Oral fluconazole 150 mg per week for one month is also effective and also topical 1% clotrimazole cream. Various other treatment modalities which have been used are topical tretinoin, topical calcipotriol, oral etretinate and isotretinoin and various other oral antibiotics like fusidic acid, erythromycin, clarithromycin. Treatment with oral azithromycin is also successful.[5]

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