

## FOLLICULAR OCCLUSION TRIAD

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One 40-year-female was diagnosed as a case of follicular occlusion triad (FOT) as she had hidradenitis suppurativa, acne conglobata and perifolliculitis capitis abscedens et suffodiens since 7 years. Partial improvement occurred within 20 days of treatment with co-trimoxazole and haematinics but relapse occurred after 5 days of stopping antibiotics.

**Key Words :** Acne conglobata, Hidradenitis suppurativa

### Introduction

The 3 diseases named hidradenitis suppurativa, acne conglobata and perifolliculitis capitis abscedens et suffodiens have similar pathogenesis and histopathology as they represent a chronic, recurrent, deep seated folliculitis resulting in abscesses, sinus tracts and scarring.<sup>1</sup> Defects in cell mediated immunity exist in some cases and predispose to infective element.<sup>2</sup> The common initial event in FOT is follicular occlusion.<sup>3</sup> Histopathologically early lesions show perifolliculitis with extensive infiltration by neutrophils, lymphoid cells, histiocytes, plasma cells and giant cells with resultant destruction of appendages. Sinus tracts lined by epidermis and extensive fibrosis is seen in chronic cases. A case of acne conglobata has previously been reported in Indian literature.<sup>4</sup>

### Case Report

One 40-year-female suffered from generalized bilaterally symmetrical, mildly pruritic, tender, follicular papules, follicular pustules, 3 to 5cm fluctuating nodules, 2 to 5cm plaques on the

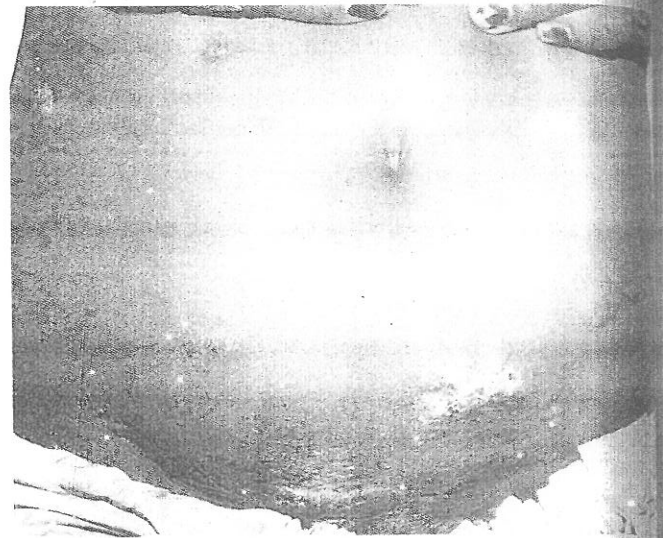


Fig. 1. Numerous plaques with multiple sinuses discharging pus in the groins and over pubes

buttocks, pubes (Fig. 1), groins, back over breasts, chest, axillae, scalp, neck and extensor aspect of thighs and forearms since 7 years. Plaques and nodules had multiple, small, superficial ulcers with yellowish-pinkish granulation tissues, yellow crusts and multiple interconnected sinuses discharging pus and mucoid discharge. Some plaques were annular as sinuses were more towards the periphery. Intermingled multiple 2 to 6 cm, at places linear hypertrophic scars and keloids were seen (Fig. 2). Polyporous comedones were present on upper back, axillae, buttocks and chest. 1 to 2 cm perifollicular pits with central hair were seen on the face.

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Fig. 2. Multiple hypertrophic scars and keloids intermingled with plaques discharging pus and polyporous comedones on the breasts

to 3 lymph nodes, 1cm in diameter, tender, non-matted, mobile were palpable in groins. Family history for similar disease and diabetes was negative. Menstrual cycles were normal and menstruation had no adverse effect. Weakness and giddiness were felt at the time of eruption of multiple lesions and partial relief occurred with different antibiotics. Hair, nail, mucosae, general physical, systemic examinations were normal. Age of youngest child was 8 years. Pus discharge, pain and tenderness decreased after 20 days treatment with co-trimoxazole but relapse occurred after 5 days of withdrawing.

Haemoglobin was 9.5 gms%, TLC was 11,500/ cmm, DLC was P 73, L20, E5 and M2. ESR was 60 mm. TSP were 7 gms%, ALB 4 gms% and GLB 3 gms%. Pus smears revealed Gram positive, coagulase negative cocci lying in groups or chains. Repeated cultures of pus, Rh factor, LE cell phenomenon, Mantoux test were negative. Urine, stools, STS, blood-

urea, FBS, SGPT and SGOT were normal. Histopathology of plaque showed intense neutrophilic and lymphohistiocytic perifollicular infiltration with destruction of some hair follicles and adnexa. Neutrophilic abscesses and granulation tissue with congested capillaries, infiltration by lymphocytes, histiocytes, plasma cells and prominent foreign body giant cells in areas of hair destruction were seen.

## Comments

Hidradenitis suppurativa, acne conglobata and mild to moderate perifolliculitis capitis abscedens et suffodiens were seen in a female of FOT. Genetic defect could be an important factor as perifollicular pits of face resembling Dowling Degos disease were associated in our patient and this association most probably has not been reported earlier. Primary bacterial infection may not be responsible for FOT as repeated cultures were negative, though it can lead to chronicity, destruction of adnexa and scarring. Most probably this is first case of FOT to be reported from India.

## References

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