

MILIA EN PLAQUE

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Milia en plaque is an unusual presentation of milia. The exact pathomechanism and reason for postauricular localization is not yet understood. Faster resolution of lesions after usage of trichloroacetic acid alongwith topical tretinoin was encouraging and may be used as adjunct in treatment of milia.

Key Words : Milia, Trichloroacetic acid

Introduction

Milia are small subepidermal keratin cysts which are quite common at all ages from infancy onwards. Primary milia are white or yellowish, rarely more than 1-3 mm in diameter occurring usually on the face in the areas of vellus hair follicles.¹ Sometimes they appear following minor trauma to normal or diseased skin or after use of topical corticosteroids, 5-fluorouracil; such milia are referred to as secondary milia and are morphologically similar to primary milia. Hubler et al² reported 2 cases of numerous milia occurring in a plaque type distribution in the post auricular area under the name 'milia en plaque'. Since then it has been reported only twice in literature.^{3,4}

Two more cases of milia en plaque are described.

Case Report

Case I: A 25-year-old man presented with multiple milia and comedones located unilaterally in the left post-auricular area for the last 2 years. He denied wearing glasses as well as regular application of topical corticosteroids, emollients or spraying of perfumes onto the affected area. Examination

revealed 1x2 cm size plaque composed of multiple yellowish globular papules and a few open comedones (Fig.1). Histopathological



Fig. 1. Multiple milia and comedones in left post-auricular area.

examination of a punch biopsy specimen revealed numerous keratin filled cysts that were consistent with milia (Fig.2). Treatment with topical tretinoin (0.05%) twice a day resulted in resolution of the lesions gradually over 4 months.

Case II: A 38-year-old man had a mildly pruritic plaque in the left retro-auricular area of 4 years duration. He denied use of spectacles, emollients, perfumes, tar ointments or corticosteroid preparations on the affected area. Examination revealed a similar clinical appearance as in case 1. Though the number of comedones was less. There was no clinical

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Fig. 2. Photomicrograph showing multiple keratin filled cysts (H&E x 40).

evidence of solar elastotic changes in the sun exposed areas. Histopathological findings were similar to case 1. He was treated with topical tretinoin (0.05%) twice a day. In addition, application of 30% trichloroacetic acid (TCA) using a 26 G needle was done once a week. The lesions cleared within three weeks.

Discussion

Milia are keratinised cysts that may arise from the infundibulum of the vellus hair follicles, sebaceous glands, or eccrine sweat ducts. Closed comedones closely resemble milia in acne. Our patients had similar clinical presentation as the earlier cases.^{2,4} Secondary causes for formation of comedones could not be identified.

The aetiopathogenesis of milia en plaque is not known. Our patients were neither using topical steroids⁴ nor 5-fluorouracil⁵ which have been implicated in milia formation. They also denied the use of any non-steroidal anti-inflammatory agent. Local treatment with topical tretinoin (0.05%) led to improvement in the first patient as has been described in earlier cases. Application of 30% trichloroacetic acid with a 26 G sterile needle helped in quicker resolution of the lesions in the second patient.

We recommend usage of TCA along with topical tretinoin for faster clearance of milia en plaque and milia.

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