Folliculitis decalvans with exclusive beard involvement

Sir,

Folliculitis decalvans is an inflammatory chronic disease of the hair which evolves irreversibly in atrophy and scarring alopecia. It represents approximately 11% of all the cases of primary scarring alopecia and usually occurs in young- and middle-aged adults.[1] Clinically, it presents with pustules, erosions and scaly-crusty lesions localized to the scalp. Anecdotally, folliculitis decalvans can affect other hairy body areas as well. Herein, we report a case of folliculitis decalvans with exclusive involvement of the beard.

A 45-year-old man was referred for erythematous-pustular lesions which appeared bilaterally on the cheeks, in the beard area. The lesions appeared 6 months ago and were associated with scarring alopecia [Figures 1a and b]. Similar lesions were not observed elsewhere on the body. Trichoscopy of the beard area showed tufted hair, perifollicular scales and few follicular pustules.

Considering a clinical suspicion of dermatophytic infection, he had previously been empirically treated with with terbinafine 250 mg per day, itraconazole 50 mg per day and topical antiseptics with no response. To exclude a fungal etiology, we performed a direct and cultural mycological examination that yielded negative result.

Moreover, a skin biopsy for histopathological evaluation showed exudative-necrotic and angiogenic inflammation together with epidermal erosion, folliculitis and perifolliculitis, as well as an intraepidermal pustule. The infiltration was mainly composed of neutrophils, eosinophils and plasma cells [Figures 2a and b]. Histochemical periodic acid-Schiff (PAS) staining was negative for fungal infection.

Based on the clinical features and histologic findings, a diagnosis of folliculitis decalvans of the beard was made and oral doxycycline 200 mg daily was started, alongwith topical antiseptic treatment. After six weeks of treatment, no signs of inflammatory lesions nor extension of scarring were observed and the patient remained disease free for the following four months of follow-up.

Folliculitis decalvans is a form of scarring alopecia primarily involving the scalp. Histologic features show an acute suppurative folliculitis with a dense perifollicular lymphocytic and neutrophilic infiltrate which leads to abscesses formation and fibrotic replacement. The etiology is not fully understood, but *S. aureus*, and a genetic predisposition, seem to play a pivotal pathogenic role.[2]

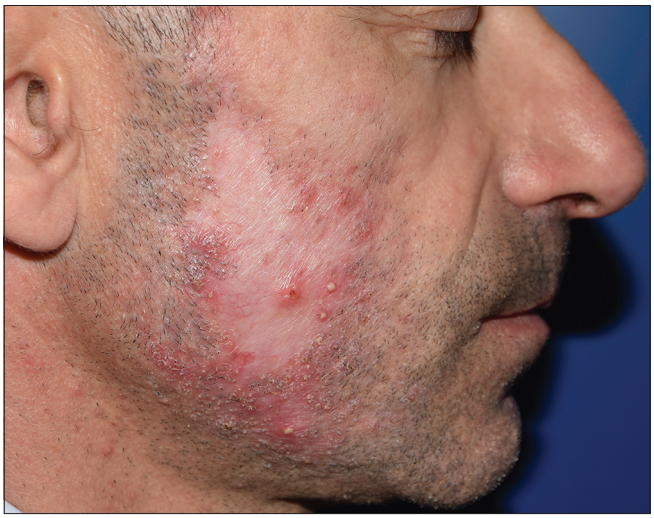

Figure 1a: Folliculitis decalvans of the beard before treatment: central scarring alopecia area surrounded by scaly-crusty lesions and pustules of the right cheek

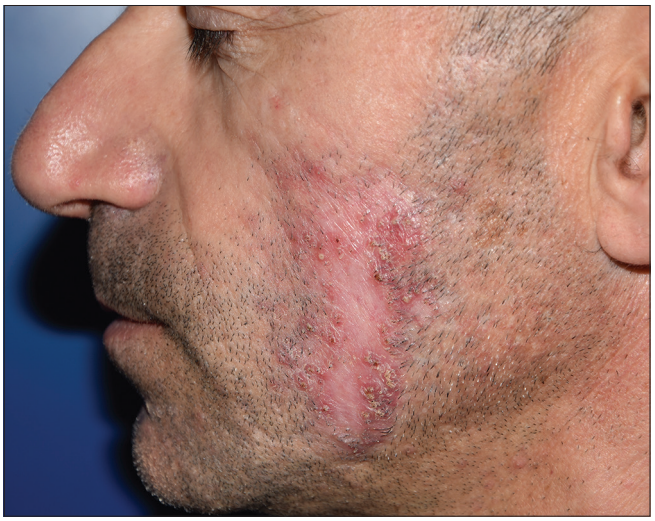

Figure 1b: Folliculitis decalvans of the beard: detail of the left cheek

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Table 1: Differential diagnosis of pustulosis of the beard

Diseases	Morphology of the lesions	Sites of involvement	Histopathological features
Folliculitis decalvans	Follicular pustules surrounding oval patches	Scalp; rarely beard, axillae, pubis, thighs	Follicular neutrophilic abscesses; granulomatous folliculitis with lymphocytes, plasma cells and giant cells
Tinea barbae	Papules, follicular pustules with exudation and crusts	Beard	Parakeratosis, spongiosis, perivascular neutrophilic and eosinophilic infiltration
Sycosis barbae	Follicular papules or pustules centered on hair, raised plaques, crusts and scales	Beard, scalp; rarely axillae, pubis and limbs	Neutrophilic infiltration of follicle wall, chronic granulomatous perifollicular infiltration by lymphocytes, plasma cells, histiocytes and foreign body giant cells
Pseudofolliculitis barbae	Papules, pustules, post-inflammatory hyperpigmentation	Beard; rarely other areas with terminal hairs	Neutrophilic perifollicular infiltration, epidermal microabscesses; infiltration of lymphocytes, plasma cells, histiocytes and foreign body giant cells
Eosinophilic folliculitis	Follicular pustules and erythematous plaques with centrifugal extension	Face, trunk, limbs	Inflammatory dermal and follicular infiltration composed of eosinophils, neutrophils and mononuclear cells
Dermatitis cruris pustulosa et atrophicans	Follicular pustules, scales, shiny edema, follicular atrophy	Usually lower third of legs; rarely thighs, forearms, face	Parakeratosis, neutrophilic infiltration of hair follicle ostium, subcorneal pustule containing neutrophils and lymphocytes

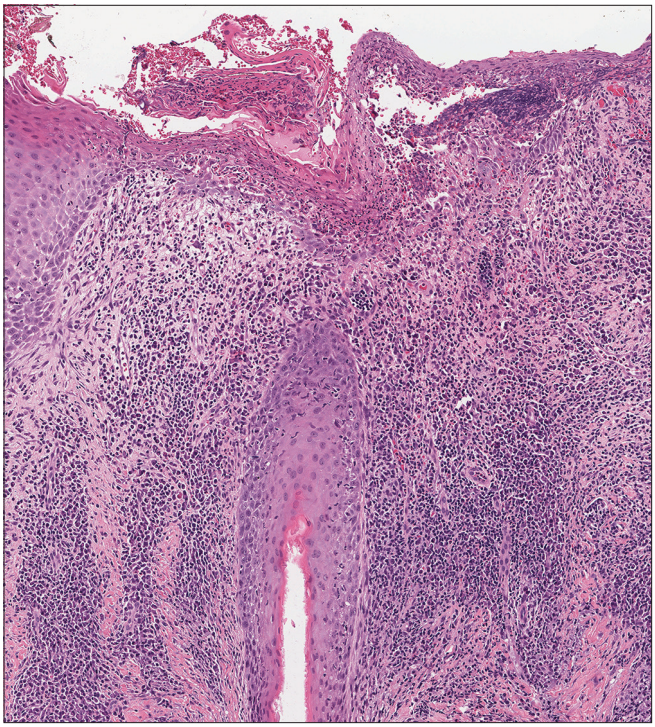

Figure 2a: Follicular and perifollicular infiltration surrounding a hair follicle (H and E, ×100)

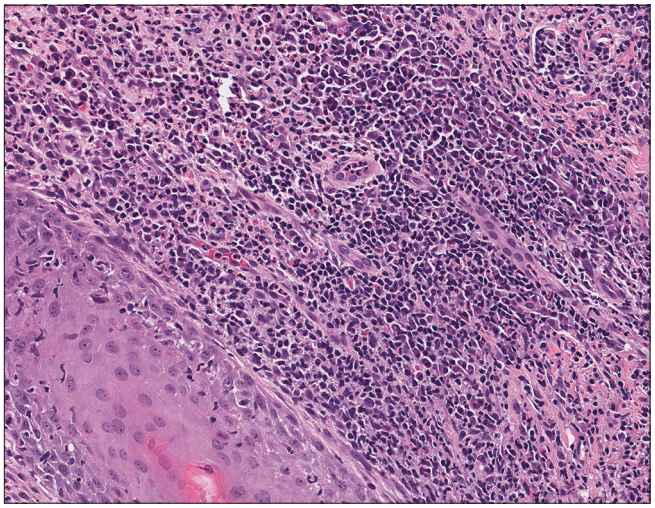

Figure 2b: Detail of perifollicular infiltration showing the presence of plasma cells, neutrophil and eosinophil granulocytes (H and E, ×400)

In literature, cases of folliculitis decalvans involving unusual sites such as groin, axillae and beard were anedoctically reported; in particular, only two cases of folliculitis decalvans of the beard have been reported, both in association with scalp involvement.[2-4] Cases of folliculitis decalvans with exclusive involvement of the beard have not been reported yet. The differential diagnosis of cases with isolated beard involvement, as the one described herein, includes pseudofolliculitis barbae, sycosis barbae, dermatitis cruris pustulosa et atrophicans, eosinophilic folliculitis and fungal infection, among others [Table 1].[2,5] Histopathologic examination is mandatory to achieve a clear-cut diagnosis, thus avoiding empirical and ineffective treatments.[6]

To conclude, folliculitis decalvans of the beard is a very rare entity, but more likely underdiagnosed. Awareness of this variant of the disease is important to provide an early diagnosis and an effective treatment and preventing disfiguring sequelae in a very sensitive area like the face.

Declaration of patient consent

The authors certify that they have obtained all appropriate patient consent.

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Conflicts of interest
There are no conflicts of interest.

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Cutaneous acrometastasis from an undifferentiated pleomorphic sarcoma with giant cells

Sir,

We present a case of a 56-year-old man who underwent amputation in July 2017 for an undifferentiated pleomorphic sarcoma affecting his left foot. Follow-up computed tomography scan in September 2017 showed bilateral pulmonary metastases and several chemotherapy regimens were required due to progression of the disease. One year later the patient was referred to dermatology for a painful periungual lesion of two months duration, with 1.2 centimeters in diameter, located on the fifth finger of his right hand. It had an angiomatous appearance and history of bleeding on trivial local trauma was reported [Figure 1]. A biopsy was performed under clinical suspicion of a pyogenic granuloma. Microscopic examination revealed a multinodular tumor with hemorrhagic and necrotic areas located in dermis [Figure 2a], consisting of highly pleomorphic and anaplastic medium-sized mononuclear cells [Figure 2b] and multinucleated giant cells [Figure 2c]. Scarce spindle cells were seen on the periphery of the lesion without storiform pattern. Vascular invasion was observed. There was minimal non-specific and patchy staining for actin and for VE-1 (BRAF), with negative mutation for said proto-oncogene in complementary studies. Immunohistochemically, negativity was observed for cytokeratins (AE1/AE3), melanocytic markers (HMB45 and Melan-A), CD31, D2-40 and CD1a. The giant cells and scattered mononuclear cells were positive for CD68 [Figure 2d]. It had a high mitotic index (almost 35%). The features were similar to those of the primary tumor and the lesion was diagnosed as a metastatic undifferentiated pleomorphic sarcoma with giant cells. Dacarbazine treatment was initiated (250 mg/m^2/day as a continuous infusion for 4 days every 3 weeks), achieving a complete remission of the cutaneous metastasis [Figure 3]. Three months later the initial lesion reappeared [Figure 4a] along with additional ones [Figure 4b]. He died 10 months after the onset of the acral cutaneous metastasis.

Soft tissue sarcomas are infrequent, and undifferentiated pleomorphic sarcomas with giant cells (historically referred as giant cell-rich malignant fibrous histiocytoma) are extremely

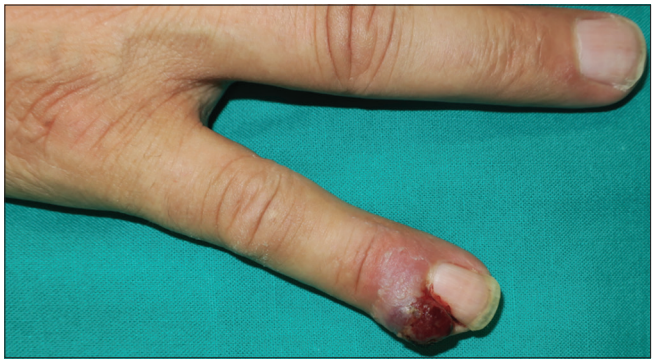

Figure 1: Angiomatous periungual nodule on the fifth finger of the right hand masquerading as pyogenic granuloma

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