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FOLLICULITIS DECALVANS

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Two cases of folliculitis decalvans presenting with cicatricial alopecia over the scalp are reported for its rarity and clinical interest.

Key Words : Folliculitis, Alopecia

Introduction

Folliculitis decalvans (FD) is a type of chronic folliculitis leading to progressive cicatricial alopecia. This entity was first described by Quainquad (1889). Various terminologies like Lupoid sycosis (Brocq 1888), Ulerythema sycosiforme (Unna 1889), Epilating folliculitis of the glabrous skin (Arnozan 1892 and Dubreuilh 1894) essentially imply the same process.[1,2] Similar lesions involving the hairy regions of the lower limbs are termed as Folliculitis depilans, Folliculitis cruris et atrophicans.[3] It is believed that all these entities are variants of a single syndrome.

In folliculitis decalvans small round or oval patches of scarring delimited by perifollicular pustules are seen over the hairy skin. Usually asymptomatic, slow intermittent extension of the lesion occurs over many years resulting in extensive cicatricial alopecia.[1] Herewith we report two cases of folliculitis decalvans involving the scalp for its clinical rarity and interest.

Case Report

Case 1: A 48-year-old female patient presented with progressiv loss of scalp hair for one year duration. Initially she noticed few follicular pustules over the frontal region which gradually spread to other parts of scalp leaving behind bald areas. On examination, scarring alopecia was present over the frontal, temporal and parietal regions. Periphery of the patch showed erythema, follicular pustules and crusting.

Case 2: A 35-year-old female patient came with pustular eruption over the scalp leading to hair loss of 8 years duration. Examination revealed follicular pustules and crusting on the border of the cicatricial alopecic area spread over both the temporal and frontal regions.

In both the patients rest of the cutaneous system including other hairy areas was normal. Hair root examination for fungus was negative. Gram's staining of the pus revealed neutrophils with few grouped Gram positive cocci. Pus culture from lesion and nasal mucosa of case 1 revealed *Staph aureus* with identical antibiotic sensitivity patterns, whereas culture of pus and nasal swab from case 2 revealed normal skin flora. Skin biopsy from the active border in both cases showed changes compatible with folliculitis decalvans viz, chronic mixed inflammatory cell infiltrate comprising of lymphocytes, neutrophils, plasma cells and epitheloid cells around the hair follicles and sebaceous glands.

Both the patients were started on topical fusidic acid ointment. Both cases

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improved well without any new pustular lesion.

Discussion

Though this entity is clinically well described, the aetiology is not clearly known. In most cases pus culture revealed *Staph aureus* as in our patient (Case 1). However the pathogenic importance of this organism is doubtful. Some authors consider a hypersensitivity reaction of the skin which explains its persistence or chronicity.[4] It seems probable that a local failure in the immune response or in leucocyte function may be the essential abnormality in most cases.[5]

This condition is very resistant to treatment, hence the unfavourable prognosis. The lack of therapeutic response in contrast to other pyogenic folliculitis is one of the outstanding features and clearly places this form in a special category. Many treatment protocols have been tried. Eradication of nasopharyngeal sepsis and treatment of the lesions with a combination of topical fucidin and steroid may be useful.[5]

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