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Pressure-induced facial follicular papules: 15 cases of an under-recognised dermatosis

Sir,

Repetitive prolonged pressure and friction results in cutaneous changes such as knuckle pads from boxing and prayer sign on the forehead. Relieving pressure/friction is an important element of treatment. The association with pressure appears under-recognised in a follicular facial eruption leading to inadequate management. We describe 15 patients with this distinctive eruption that, once identified, can be easily treated by a simple change in posture.

We evaluated ten men and five women, aged 10–59 years who presented to the department of dermatology at the All India Institute of Medical Sciences, New Delhi, with asymptomatic, hyperpigmented papules on the face that appeared insidiously over a period of two months to 20 years.

There were tiny, closely aggregated keratotic papules on a background of ill-defined dark brown pigmentation [Figure 1]. In three patients, there were a few slightly larger, yellowish-white to dark brown comedones. Papules were noted on the cheek in eight (53.3%) patients, chin in four (26.6%), left mandibular jawline in two (13.2%) and both the jawline and neck in one (6.6%). The eruption was bilateral in two and unilateral in nine patients with the left side affected in eight and the right in one; it was located centrally on the chin in the remaining four patients [Table 1]. All patients were right handed.

Seven (46.6%) patients had a history of atopy; there were no other cutaneous or systemic illnesses. Thirteen (86.7%) patients were in the habit of resting their face on their hand for long periods while studying or watching television. In all these patients, the papules corresponded exactly to the area of the face that rested on the palm.

Dermoscopy was done in four patients, out of which two revealed coiled hair shafts in the affected area. There were no follicular plugs. Two patients consented for skin biopsy. The histopathological findings included focally compact hyperkeratosis, papillomatosis and mild acanthosis with one biopsy showing a keratotic follicular plug [Figure 2].

All patients were advised to stop resting their face on their hand and prescribed topical tretinoin 0.05% for application at night. There was near complete resolution in patients who were compliant with instructions [Figure 3 and Table 1].

The development of grouped follicular papules exclusively on portions of the face rested on the palm for several hours a day with resolution when posture was changed provides strong evidence for prolonged pressure as the cause of this eruption. Patients rested their face on the hand in slightly different ways and this resulted in papules at different places but the distribution

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Figure 1a: Demonstrating the resting position of face against palm (Case 6)

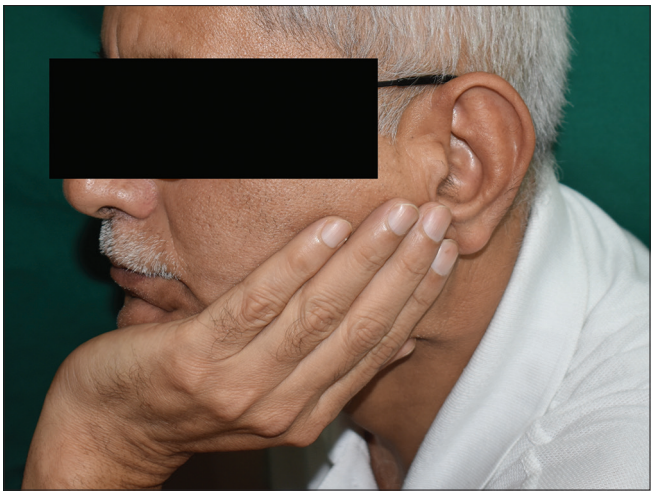

Figure 1b: Demonstrating the resting position of face against palm (Case 8)

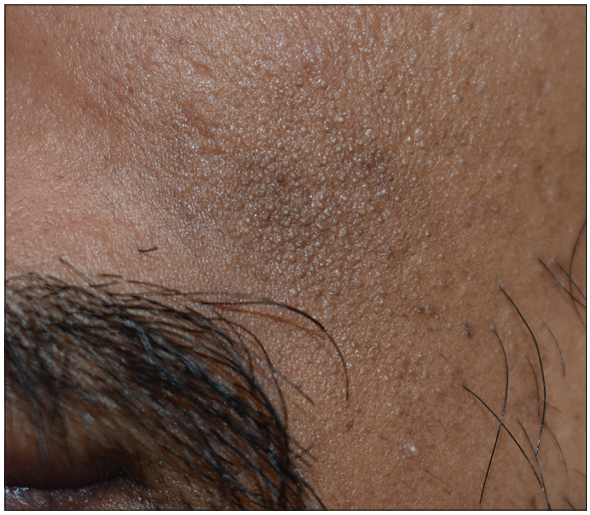

Figure 1c: Follicular papules and pigmentation at the corresponding site (Case 6)

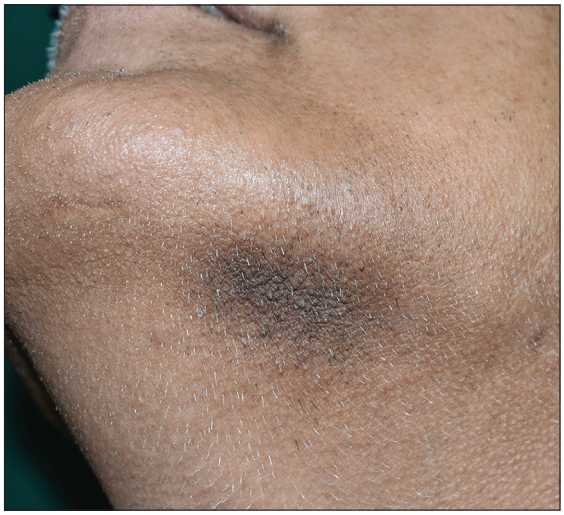

Figure 1d: Follicular papules, pigmentation and slight thickening of skin at the corresponding site (Case 8)

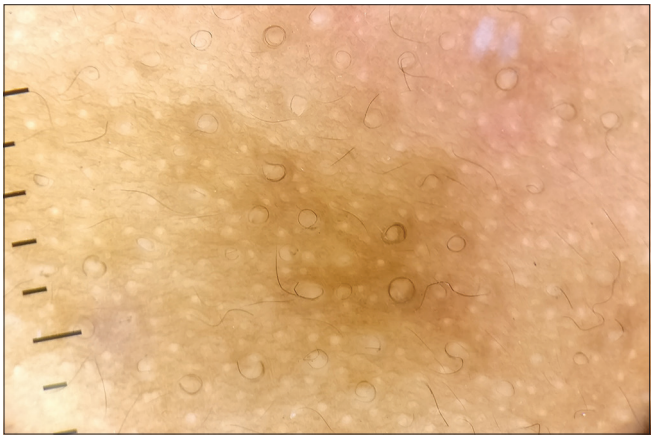

Figure 2a: Case 9: Polarized dermoscopy (×10) showing ill-defined area of yellowish to dark brown discolouration in the centre surrounded by a zone of light brown pigmentation and mild erythema and multiple coiled hair shafts in the affected area

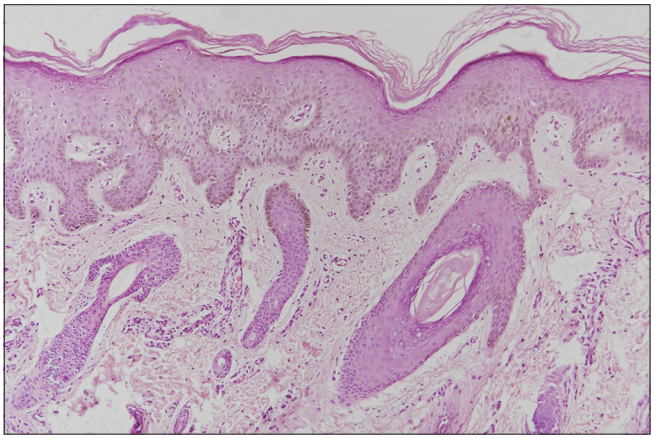

Figure 2b: Biopsy from a keratotic papule showing focally compact hyperkeratosis, papillomatosis, mild acanthosis and follicular plugging (haematoxylin and eosin, ×100)

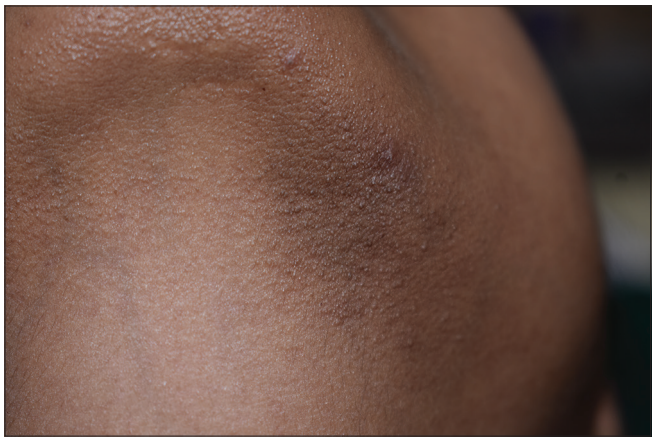

Figure 3a: Multiple tiny, closely aggregated follicular papules involving the left jawline, at the baseline

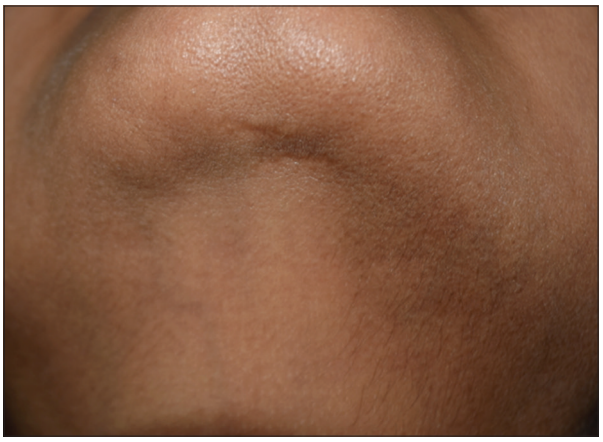

Figure 3b: Marked improvement after 6 months of application of tretinoin (0.05%) cream and avoidance of friction (Case 5)

Table 1: Clinical features and treatment response of patients

Age (year)	Gender	Site involved	Duration	Occupation	Activity associated with prolonged pressure	History of atopy	Duration of treatment	Improvement (%)	Duration of follow-up
17	F	Chin	One year	Student	Studying	Yes	NA	NA	Baseline
18	M	Left cheek	Six years	Student	Studying, watching television	No	Six months	Nearly complete	Six months
19	F	Chin	Five years	Student	Studying, general posture while conversing	Yes	Six months	Complete	Six months
21	F	Chin	Four months	Student	Listening to lectures	No	NA	NA	Baseline
27	F	Left mandibular area	Two years	Student	Studying, watching television	Yes	Six months	Nearly complete	Six months
29	M	Left cheek	Two years	Student	Studying, watching television	No	Three months	Marked	Three months
30	M	Left cheek	Six years	Student	Studying, reading, watching television	No	One month	Slight	One month
59	M	Left mandibular area	20 years	Professor	Studying, reading	No	Two weeks	Marked	Six months
12	F	Left mandibular area, left side of neck	Two months	Student	Studying, watching television	Yes	One month	Marked	One month
21	M	Left cheek	Two years	Medical student	Studying	Yes	NA	Marked	One month
22	M	Left cheek	One year	Student	Studying	NA	One month	Marked	One month
22	M	Cheeks, more on left	Ten years	Student	Studying, watching television	Yes	One month	Marked	One month
10	M	Chin	One year	Student	None reported	No	One month	Marked	One month
27	M	Cheeks, more on right	Three years	Student	Studying	Yes	NA	NA	Baseline
17	M	Right cheek	One year	Student	None reported	No	NA	NA	Baseline

*NA: Not available

always corresponded to the site of contact with the palm. These papules lacked erythema and were monomorphic, unlike acne where pustules, comedones and/or inflammatory papules can be seen. In the initial few cases, the differentials of keratosis pilaris, lichen spinulosus and trichostasis spinulosa were considered.

Padilha-Goncalves described traumatic anserine folliculosis, a similar eruption in 11 patients who had a history of prolonged friction on the chin, jawline and neck. Patients were aged four–21 years and the author suggested that the delicate skin of adolescents was predisposed to the effects of chronic friction,[1] though we saw the eruption in older people, too. The condition is probably not uncommon as we saw 15 patients over a period of nine months in our department.[1-11]

Interestingly, patients readily accepted the explanation of pressure/friction when it was pointed out to them but they were not themselves aware of the causal relation. Removal of pressure, along with a topical retinoid or keratolytic agent, led to gradual resolution over several weeks.

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None.

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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Clinical profile of leprosy among domestic and migrant patients diagnosed at a tertiary referral centre in North Kerala: A ten-year retrospective data analysis

Sir,

Despite India achieving the status of 'elimination of leprosy as a public health problem', pockets of endemicity exist within the country. In the era of migrant labour and population movement, this raises concerns regarding the success of national leprosy eradication programme.

Leprosy is highly endemic in the states of Chhattisgarh, Bihar, Jharkhand, and Odisha.[1,2] In recent years, Kerala has witnessed a steady influx of migrant labourers from these areas for job opportunities, who have contributed significantly to the economy of the state.[3] In this retrospective analysis (2009-2018), we compared the clinical profile of leprosy among domestic cases and migrant patients diagnosed at our centre. Migrant population includes individuals from other states residing in Kerala for less than eight years.

We reviewed the physical case-records of patients who received leprosy treatment from our institute as per the World Health Organization criteria.[4] We included defaulters and patients with relapse, and excluded incomplete case records. Institutional Ethics Committee approval was obtained.

Using a pre-set proforma, we collected information on patient demography, clinical profile, laboratory parameters and treatment details (paucibacillary or multibacillary regimen as per the World Health Organization recommendation).[4] As per institutional policy, all patients underwent slit skin smear examination (from ear lobe, from representative skin lesion and normal skin) for acid-fast bacilli. All patients with skin lesions underwent a skin biopsy. We categorized the disease in each patient based on the Indian Association of Leprologists classification.[5]

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