

both the external ears within a period of 1 month. She had no history of preceding trauma, insect bite, ear discharge, eczema, vesicular lesions, photosensitivity, or drug intake (oral or topical). There was no history of similar complaints in siblings or any other family members. Examination revealed multiple superficial, firm, discrete, white, dome shaped papules of size 1-3 mm present on both the external ears and a few scattered lesions over the pre auricular and postauricular areas, without any background scarring [Figure 1]. Histopathology revealed a cyst within the superficial dermis lined by stratified squamous epithelium with a granular layer containing eosinophilic concentric lamellae of keratin, diagnostic of milium [Figure 2]. There was no evidence of vellus hair cell in the cyst cavity.

Milia are common benign keratinous cysts that occur most commonly on the face, particularly over eyelids



Figure 1: Multiple milia present over both external ears

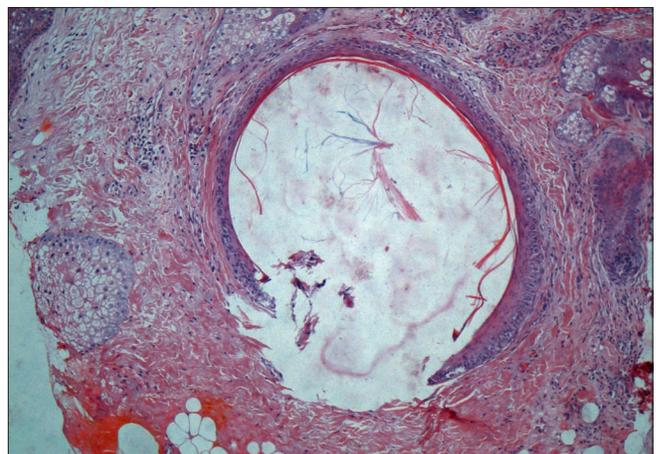


Figure 2: Subepidermal cyst lined by stratified squamous epithelium containing eosinophilic concentric lamellae of keratin, suggestive of milium (H and E, x100)

Multiple eruptive milia over both external ears

Sir,

A 13-year-old Indian girl presented with history of sudden eruption of asymptomatic white papules on

and the cheeks.^[1] Milia may be primary or secondary. Primary milia arise spontaneously and may be present at birth. They occur as single or multiple, randomly arranged papules distributed over the face in adults; with occasional involvement of upper trunk and arms commonly seen in newborns.^[1] Secondary milia arise as a cutaneous reaction to traumatic stimuli or pathologically altered integument and are localized to the involved body site, e.g., following dermabrasion, radiotherapy, second degree burns, autologous skin transplantation, allergic contact dermatitis, prolonged use of topical steroids, topical 5-fluorouracil, anti-inflammatory drugs and acitretin therapy.^[1] In addition, they have been reported after the clearance of bullous disorders, or in association with certain genodermatoses. Eruptive milia appear briskly, usually within 1 month, and are most frequently distributed on the head, neck, and trunk. The lesions are usually asymptomatic. Langley *et al.*^[1] have proposed a classification to encompass the reported cases of multiple eruptive milia.^[1] According to this classification, eruptive milia could either present spontaneously without a known cause, as part of an autosomal dominant familial condition, or as part of a genodermatoses, such as Rombo syndrome, basaloid follicular hamartoma syndrome, or Gardner syndrome.^[1,2] Milia may develop from the proliferation of pluripotent cells located in any epithelial structure.^[3] In addition, subsequent retention of keratin debris plays a role in the formation of secondary milia.^[3] The exact cause of formation of primary milia and multiple eruptive milia is unknown. On the face, both primary and multiple eruptive milia most commonly derive from the external root sheath of vellus hair follicles,^[3] whereas in other locations secondary milia more often derive from eccrine ducts.^[4] Milia should not be confused with eruptive vellus hair cyst which presents as multiple flesh colored, follicular papules ranging in size from 1 to 5 mm. Histopathology reveals a cystic structure usually seen in the mid-dermis lined by squamous epithelium. It contains laminated keratinous material and varying numbers of transversely and obliquely cut vellus hairs.^[5] In contrast, histopathology of a milium reveals a cyst in superficial to mid dermis lined by stratified epithelium with granular layer, containing laminated keratin and no vellus hair in the cavity.^[3]

To the best of our knowledge, till date ten cases of multiple eruptive milia have been described with only one case report of eruptive milia on the external

ears from Korea.^[6] None is reported from India. Our patient is the first case of spontaneous eruptive milia present over the external ear from India as no other underlying cause was elicited. Many modalities have been used to treat milia including excision, curettage, electrodesiccation, topical tretinoin, epilating needle, Er:YAG laser, and oral minocycline.^[1]

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