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CASE AND RESEARCH LETTERS

Dermatitis of the Face and Neck: Response to Itraconazole[☆]



Dermatitis de cara y cuello. Respuesta a itraconazol

To the Editor:

We report the case of a 36-year-old woman with a personal history of seasonal rhinitis and atopic dermatitis (AD) dating from childhood. She consulted for worsening of AD accompanied by severe lesions caused by scratching on the trunk and limbs. The initial physical examination revealed a SCORAD severity score of 47 and major involvement of the skinfolds and trunk. The results of a laboratory workup were normal, with an immunoglobulin (Ig) E level of 240 IU (N < 100 IU). Before consulting, the patient had received various topical corticosteroids, emollients, and systemic corticosteroids (0.5-1 mg/kg/d), with which she achieved a partial response. She received treatment at another center with ciclosporin 3 mg/kg/d, which had to be suspended because of hypertension that was difficult to control despite the addition of amlodipine 20 mg/d. Successive treatment with azathioprine 50 mg/d, methotrexate 15 mg/wk, and mycophenolate mofetil 1.5 g/d had to be suspended because of gastrointestinal intolerance to the first 2 drugs and lack of response to the third. Treatment with narrowband UV-B was not considered, because the patient was unable to attend the sessions. During the switch to mycophenolate mofetil, the clinical expression of AD varied, with intense edema and erythema on the face and neck (Fig. 1). Therefore, the initial diagnosis proposed was head and neck dermatitis. We carried out a prick test with inhaled allergens from the standard series. The results were positive for *Alternaria* species, *Cladosporium* species, and cat dander and negative for gastrointestinal allergens, latex, and *Anisakis* species. The evaluation was completed with prick testing to *Malassezia* species and *Candida* species. The results were positive for the former and negative for the latter (tested with 20 healthy controls in the last 2 cases). Histopathology was consistent with AD. Treatment was started with itraconazole 100 mg/12h for 1 month, which was tapered until 5



Figure 1 Erythema and edema on the face and neck at the initiation of treatment with itraconazole.

months of treatment had been completed. The patient's lesions improved considerably (Fig. 2).

The prevalence of adult AD ranges from 0.3% to 14%, with the most widely accepted range being that of 1%-3%.¹ In adults, pruriginous eczema affecting the face, neck, and upper thorax is known as head and neck dermatitis. It is associated with intense pruritus and a major alteration of the patient's quality of life. Curiously, the activity of AD at other sites is usually minimal or moderate. In terms of etiology and pathology, it has been associated with hypersensitivity (but not overgrowth) caused by different

[☆] Please cite this article as: Ruiz-Villaverde R, Sánchez-Cano D, López-Delgado D. Dermatitis of the Face and Neck: Response to Itraconazole. Actas Dermosifiliogr. 2018;109:829–831.



Figure 2 Response to therapy after 5 months of treatment.

subspecies of the lipophilic mold *Malassezia* (*Malassezia furfur*, *Malassezia restricta*, *Malassezia sympodialis*, and *Malassezia globosa*). Increased colonization by *Malassezia* species of specific areas of the body has been observed in pubertal patients and young adults. In this case, the areas affected were the same as those affected in head and neck dermatitis, compared with healthy skin and compared with healthy persons.²

The host immune response to *Malassezia* species was assessed using prick testing, determination of specific IgE, and patch testing.³ Most studies have not simultaneously compared the response to *Candida* species, staphylococci, streptococci, and *Trichophyton* species. In the immune response, it seems that stimulation of B lymphocytes plays a more important role than delayed T lymphocyte-mediated hypersensitivity. Similarly, some studies correlate the severity of head and neck dermatitis with specific IgE levels to *Malassezia* species.^{4,5} This hypersensitivity is greater in patients with allergic rhinoconjunctivitis or asthma,⁶ as observed in the present case.

With respect to therapy, there is no well-defined protocol to enable a suitable approach to this condition. Outcome with topical antifungal agents does not seem to be satisfactory. Systemic therapy has focused on the use of ketoconazole 200 mg/d or itraconazole 100-400 mg/d, and it

is necessary to wait a month before results appear in most patients.

Series that present a more extensive cohort of patients^{7,8} apply different itraconazole schedules over periods ranging from 7 days to 2 months. It seems reasonable to initiate treatment at 100-200 mg/d and to evaluate the effect of therapy at 1 month in order to reduce to a minimum therapeutic dose that could be used over a longer period.⁹ The main reported adverse effects were flushing and headache, which resolved after interruption of treatment and enabled treatment to be reintroduced. Routine laboratory testing is not necessary in the absence of baseline liver disease or of associated contraindications. Case reports have shown that the condition can be controlled and therapy can subsequently be combined with other immunosuppressants, such as azathioprine, thus leading to a successful outcome.¹⁰

Conflicts of Interest

The authors declare that they have no conflicts of interest.

Acknowledgments

We are grateful to the allergologist Dr. Rafael Mayorgas for his contribution to the tests used to determine the etiology of the case reported.

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Facial Papules in Frontal Fibrosing Alopecia: Good Response to Isotretinoin[☆]



Pápulas faciales en alopecia frontal fibrosante con buena respuesta a isotretinoína

To the Editor:

Most authors consider frontal fibrosing alopecia (FFA) to be a variant of lichen planopilaris owing to histopathological similarities. However, there are clear clinical differences between the 2 entities. One rare manifestation of FFA is facial papules (FP), for which no effective treatment has been described to date. We present 2 cases of women with FFA and FP who were treated with oral isotretinoin, to which the FP responded well.

Case 1

The patient was a white woman aged 47 years with a 5-year history of FFA with frontotemporal hairline recession, eyebrow loss, and histologically confirmed (Table 1) FP (Fig. 1A), as well as associated mild perifollicular erythema (PE) on the cheeks and diffuse pigmented macules (PM). From the outset the patient was treated with hydroxychloroquine, which resulted in stabilization of the FFA. Owing to an increase in the number of FP over the following years she was prescribed isotretinoin (10 mg/d), to which she showed an excellent response beginning 1 month after starting treatment and persisting up to 6 months (Fig. 1B).

Case 2

The patient was a 40-year-old woman who had been diagnosed 3 years earlier with FFA and associated FP on the forehead, temples, and cheeks (Fig. 1C). Biopsy of the FP revealed findings similar to those described for Case 1 (Fig. 2). Treatment with hydroxychloroquine and topical corticosteroids resulted in partial improvement of the alopecia, but had no effect on the FP or itching, for which concomitant isotretinoin treatment (10 mg/d) was

prescribed. An improvement in the patient's facial signs was observed after 1.5 months, with a decrease in both the number and extension of FP (Fig. 1D).

FFA is a form of primary lymphocytic scarring alopecia that mainly affects postmenopausal women and causes recession of the frontotemporal/occipital hairline, often accompanied by eyebrow loss, and in some cases affects other hairy areas of the body. Histology shows a perifollicular lichenoid infiltrate located predominantly in the isthmus and infundibulum, as well as lamellar fibrosis of variable severity.^{1–5} Vellus, intermediate, and/or terminal hair follicles are affected.^{5,6}

The reported incidence of follicular involvement outside the scalp varies widely between studies of FFA, and reports of FP in FFA are scarce.² In the first cases of FP described by Donati et al² and Abbas et al,⁷ papules developed due to inflammatory involvement of facial hair follicles.^{2,6} Data on the incidence of FP in FFA are scarce, ranging from 3% to 22%.^{6,8–10} Incidence appears to be higher in men and premenopausal women.^{6,9} FP is usually asymptomatic,² and may be accompanied by an intense burning or itching sensation.⁶ Clinically, it manifests as noninflammatory, monomorphic, skin-colored follicular papules, the random distribution of which results in a cobblestone-like pattern, which is most evident in the temporal areas and on the cheeks. FP may be associated with erythema and follicular keratosis,^{3,6} and loss or absence of facial hair.² Involvement of adjacent areas such as the submandibular or retroauricular areas may be observed. Other facial lesions associated with FFA include perifollicular or diffuse erythema with a reticular pattern,⁶ glabellar red dots, depression of the frontal veins, and PM,^{5,6} which can be caused by incontinentia pigmenti or postinflammatory epidermal pigmentation.⁶ Recognition of FP can be difficult; it is more easily observed in premenopausal women, probably because it presents during the initial stages of the disease, although this assumption has not been corroborated.

Some authors have proposed that this condition resolves spontaneously with time.⁶ However, a review of the literature and our own experience suggest that it can persist for years, is associated with a worse FFA prognosis, and serves as a marker indicating the need for systemic treatment.⁵ Specific treatment, which is currently unavailable, may be required in patients with FP that is very extensive or symptomatic. While isolated reports have described treatment of FP with systemic corticosteroids and antimalarial drugs,² the efficacy of these treatments is unclear. There are no data on FP treatment using topical or oral retinoids, although a good response to retinoid treatment was reported in patients with lichen planopilaris.² Our patients showed a good response to low-dose isotretinoin, which was selected

[☆] Please cite this article as: Flores-Terry MÁ, García-Arpa M, Franco-Muñoz M, González-Ruiz L. Pápulas faciales en alopecia frontal fibrosante con buena respuesta a isotretinoína. *Actas Dermosifiliogr.* 2018;109:831–833.