Steroid-Induced Folliculitis and Pityrosporum Folliculitis

December 01, 2005
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An asymptomatic acneiform eruption; persistent, mildly pruritic papules; a pustular rash that resists antibiotics--can you identify the disorders pictured here?

**Case 1:**
This asymptomatic acneiform outbreak erupted on the upper chest of a 24-year-old woman after she was hospitalized for an asthma exacerbation. Her medications include a nonsedating antihistamine, an oral leukotriene inhibitor, and a nonsteroidal inhaled bronchodilator. What does this look like to you?

**A.** Adverse drug reaction.
**B.** Steroid-induced folliculitis.
**C.** Stress-induced acne from hospitalization.
**D.** Staphylococcal folliculitis.
**E.** *Pityrosporum* folliculitis.

**Case 1:** The patient has **steroid-induced folliculitis**, B, attributable to high doses of corticosteroids that she received in the hospital. These outbreaks are abrupt and usually monomorphous. Discontinuation of the corticosteroids results in a slow resolution of the eruption. Adverse drug reactions are usually symptomatic and more widespread. Acne can flare as a result of stress in a patient with a history of acne, but this patient had no such history. Staphylococcal infections are usually tender, and *Pityrosporum* folliculitis is generally pruritic.

**Case 2:**
For several months, a 25-year-old woman has been bothered by a persistent, slightly pruritic acneiform eruption on the upper trunk and proximal arms. She has tried oral antibiotics, topical erythromycin, topical clindamycin, and topical benzoyl peroxide, but the eruption has not resolved. The patient is otherwise healthy and has taken the same oral contraceptive for years. What is your clinical impression?

**A.** *Pityrosporum* folliculitis.
**B.** Antibiotic-resistant acne.
**C.** Hormonal acne.
D. Environmental acne (such as from occlusive clothing or perspiration).
E. Miliaria rubra.

**Case 2:** The patient has *Pityrosporum folliculitis, A,* a monomorphous eruption that preferentially affects young women. It manifests with asymptomatic or slightly pruritic follicular papules and pustules on the upper back and chest, upper arms, and neck. Treatment choices include antifungal body washes, sulfur-based antibiotic washes, and oral antifungal antibiotics. Acne typically presents with the simultaneous appearance of papules, pustules, and comedones. Miliaria rubra results from eccrine sweat duct occlusion caused by heat, humidity, or exertion. It features papules and vesicles accompanied by a stinging sensation.

**Case 3:**
A 10-year-old boy presents with a tender, pruritic eruption on the buttocks that started while he was at camp and has persisted for 2 months. He is otherwise healthy. Which condition best explains the patient's symptoms?
A. Keratosis pilaris.
B. Staphylococcal folliculitis.
C. Acne.
D. Gram-negative folliculitis.
E. Lichen simplex chronicus.

**Case 3:** Culture results showed that the patient had *staphylococcal folliculitis, B.* Cephalosporin antibiotics are generally effective; however, in the case of resistant organisms or a gram-negative infection, the appropriate antimicrobial agent will need to be given. Keratosis pilaris is asymptomatic and generally less inflammatory than this patient's outbreak. Acne does not erupt on the buttocks. Lichen simplex chronicus is a neurodermatitis that occurs more commonly in adults and would not typically affect the buttocks.
Case 4:
A 58-year-old man presents with rosacea that has been gradually worsening during the past several months. Oral tetracyclines and topical metronidazole have been ineffective. The patient denies any precipitating factors.

A potassium hydroxide (KOH) evaluation was done. To what diagnosis do the results point?
A. Antibiotic-resistant rosacea.
B. Exacerbation from Demodex folliculorum.
C. Contact dermatitis to metronidazole.
D. Actinic keratosis.
E. Cutaneous lupus erythematosus.

Case 4: A biopsy confirmed the results of the KOH evaluation, which showed the increased presence of *D folliculorum*, B. This mite has been implicated in exacerbations of rosacea, and therapy directed at decreasing the density of the mite population (such as a topical sulfur-based antibiotic) has resulted in clinical improvement.
No organism is known to cause rosacea; hence, there is no antibiotic-resistant form of this condition. Contact dermatitis, actinic keratosis, and cutaneous lupus erythematosus do not produce pustules. Moreover, contact dermatitis is usually associated with pruritus.

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