during the early phase (Fig 1). Besides removal of the causes of hypoxia, therapy with high-potency topical corticosteroids was used.

In all, 91.7% of the patients experienced complete healing after a mean period of 3 months. During the late phase of PA, after 1 month, the regrowth of hairs of the same length was clinically evident. Trichoscopy revealed yellow-brown crusts, dilated infundibula, and diffuse circle hairs. These hairs have a thin and regularly coiled short stem with a tapered end.

Only a 6-year-old girl with a large scalp ulcer after hypoxia during scalp surgery developed scarring alopecia, showing permanent adnexal damage and absence of follicular ostia (yellow dots on trichoscopy).

When trichoscopy is performed on PA, other hair loss conditions, such as alopecia areata (AA), should be differentiated.[3,4] Black dots indicate acute transient damage to anagen hair follicles, being typical but not specific of AA.[5] On the other hand, exclamation point hairs are exclusive to AA. Dystrophic hairs and black dots are also common in tinea capitis, but the absence of comma hairs, Morse code–like hairs and hair casts, scaling, and inflammation suggests a PA diagnosis. Trichotillomania may present with black dots and dystrophic hairs, but in addition it shows hairs of different lengths and flame hairs on trichoscopy. The patient's history usually orients the diagnosis. Circle hairs are common in the regrowing phases of various alopecic conditions, including chemotherapy-induced alopecia and AA.[5]

In conclusion, PA is reversible if promptly recognized. Preventive measures are recommended in hospitalized and surgical patients. The patient's history and trichoscopy may help with the diagnosis. We suggest considering circle hairs as a favorable prognostic finding of reversible PA. The histopathologic features of PA and the role of topical corticosteroids should be further investigated.

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*Funding sources: None.*

*Conflicts of interest: None disclosed.*

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https://doi.org/10.1016/j.jaad.2019.02.050

## Chronic nonscarring scalp folliculitis: Retrospective case series study of 34 cases

*To the Editor:* Scalp folliculitis (SF) has different presentations with varying intensity: chronic nonscarring SF (CNSSF), folliculitis decalvans, tufted folliculitis, acne keloidalis nuchae, and dissecting cellulitis. Few articles describe the clinical features and therapeutic management of CNSSF.

We conducted a retrospective study searching for CNSSF and reviewed hospital records from January 2016 to December 2017 at our institution. Patients with clinical features of other forms of scarring folliculitis were excluded. We recorded sex, age, disease duration, lesion location, culture results, biopsy findings, therapies, and follow-up data until May 2018.

We retrieved data on 34 men aged 22 to 49 years (mean, 34.9 years). Disease onset was between 2 months and 30 years before diagnosis (mean 59 months). The locations of the papules and pustules were as follows: 80% occipital, 35% vertex, 26% temporal, and 20% parietal, as lesion spread could affect several areas in the same patient. In all, 17 patients (50%) had skin pustule cultured. Saprophyte flora (a mix of *Staphylococcus spp* [excluding *S aureus*], *Propionibacterium spp,* and *Micrococcus spp* without predominance of any of them) grew in 12 of the 17 cultures (70.5%), *S aureus* grew in 1 culture (6%), *Staphylococcus epidermidis* grew

1 culture (6%), and 3 cultures (17.5%) were sterile. A total of 10 patients (29%) had cutaneous biopsy performed; all presented with neutrophilic folliculitis with preserved sebaceous glands; 4 patients had *Malassezia* spores and one had *Demodex folliculorum*. All 34 patients received doxycycline, 100 mg daily for 12 weeks, as first-line therapy, with only 4 failing the therapy; withdrawal led to a rapid relapse in the remaining 30. Eight patients took rifampin plus clindamycin (each drug was administered in a dose of 300 mg twice daily for 10 weeks); during that time, all 8 patients cleared but again experienced rapid relapse upon withdrawal of the drugs. A total of 18 patients were treated with isotretinoin, 10 to 20 mg daily; all achieved complete response, except for 1 who had few active lesions. Eight patients continued receiving isotretinoin therapy and cleared or almost cleared, with 6 of them taking 10 mg on a nondaily basis (every 2-5 days) and 2 taking 10 mg daily; the other 10 stopped taking isotretinoin after 6 to 12 months and remain clear after 1 to 28 months of follow-up. The cumulative dose ranged from 2000 to 9000 mg.

Our series is the third largest. Lee[1] described 80 patients, 48 of whom had SF, and Hersle[2] reported 40 more patients. Strikingly, all the patients in our series were men; in contrast, in Lee's series, 4 of 48 patients were women, and in Hersle's study, the ratio of men to women was 3:1. The lesions were almost always on the occipital area; generalized lesions were rare. In our study, 85% of cultures were negative or with saprophyte flora; in contrast, in Lee's study, 30% of cultures were positive for *S aureus*. Antibiotics did not provide further improvement compared with that in patients with negative cultures.[1] We agree with Lee about the inflammatory hypothesis of SF rather than the infectious hypothesis on account of sterile cultures and better response to isotretinoin than to antibiotics. Moreover, the temporary clearing with anti-inflammatory doxycycline doses in the majority of patients also supports the inflammatory hypothesis, although the number of patients is too low to verify this. We do not believe that either saprophyte flora or other isolations have a causative role in the disease. One of the study limitations is lack of a trial with topical therapy. Clindamycin solution, benzoyl peroxide wash, and topical steroids may be beneficial. In conclusion, in this condition, we propose starting doxycycline, 100 mg daily, for 3 months, and then if relapse occurs, administering isotretinoin, 10 mg daily, for 3 months and tapering to the lowest dose (every 2-5 days) that maintains remission. Withdrawals after 6 or more months if clearing is achieved may lead to long disease-free intervals. Using long-term, low-dose isotretinoin could be a limitation in countries in which prescribing is highly regulated.

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*Funding sources: None.*

*Conflicts of interest: None disclosed.*

*Presented as a poster at the 46th Congress of the Spanish Academy of Dermatology and Venereology, Palma de Mallorca, Spain, May 9-12, 2018.*

*Reprints not available from the authors.*

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https://doi.org/10.1016/j.jaad.2019.02.065

## A new 1-sided nail brace for ingrown toenails of lesser toes

*To the Editor:* Ingrown toenails usually affect the big toe but might also occur on the lesser toes. Surgery with phenolization of the lateral matrix horn is the most commonly performed treatment.[1] However, poor cosmetic outcomes after surgery are not uncommon for lesser toes because the nail plates are smaller. Nail brace application is a noninvasive treatment for ingrown toenails.[2,3] However, the currently reported 2-sided nail braces are usually too bulky for the curved nails of the lesser toes.

Consequently, we propose the use of a 1-sided nail brace consisting of a spring wire and a plastic pad. This nail brace has been reported to have good efficacy for ingrown toenails of big toes.[3] The length of the wire can be adjusted according to the size of the nail. The wire is shaped into a hook and attached