Dermoscopy of pityrosporum folliculitis

To the Editor: We read with great interest the article by Prindaville et al[1] describing a retrospective analysis of *Pityrosporum* folliculitis. Dermatoses caused by *Malassezia* yeast are common but probably underreported in tropical countries.[2,3] In cases of *Pityrosporum* folliculitis, the diagnosis is usually confused with acne vulgaris. Both can present simultaneously, and therefore it is of the utmost importance to identify the coinfection of *Malassezia* for complete cure. Dermoscopy, as a noninvasive auxiliary tool, can be useful to identify and diagnose the presence of *Pityrosporum* folliculitis.

In our observation of 15 cases (6 men and 9 women) of *Pityrosporum* folliculitis, diagnosed clinically and confirmed on potassium hydroxide mount, monomorphic follicular papules or pustules were seen in all cases. Scaling, on naked eye examination, was seen in 5 cases. While most of the patients consulted for erythema and pigmentation, itching was reported by 6 patients. For dermoscopic evaluation, patients with positive potassium hydroxide were included. Dermoscopy was performed with a universal serial bus dermoscope. Dermoscopy revealed the presence of folliculocentric papules and pustules with surrounding erythema in all cases (Fig 1, *A*). Scaling, which was not clinically apparent, became apparent on dermoscopy in 11 cases (73.3%). The scales were predominantly perilesional and dirty white in color (Fig 1, *B*). Keratosis pilaris–like features were seen in 8 cases (53.3%), where the hair follicle was seen to be coiled/looped with surrounding erythema and scaling as is seen in the dermoscopy of keratosis pilaris (Fig 2, *A*).[4] Hypopigmentation of the involved hair shaft was seen in 9 cases (60%; Fig 2, *B*). The hypopigmentation probably resulted from invasion of the hair shaft by yeast spores.[5] Dermoscopy of the resolving lesions

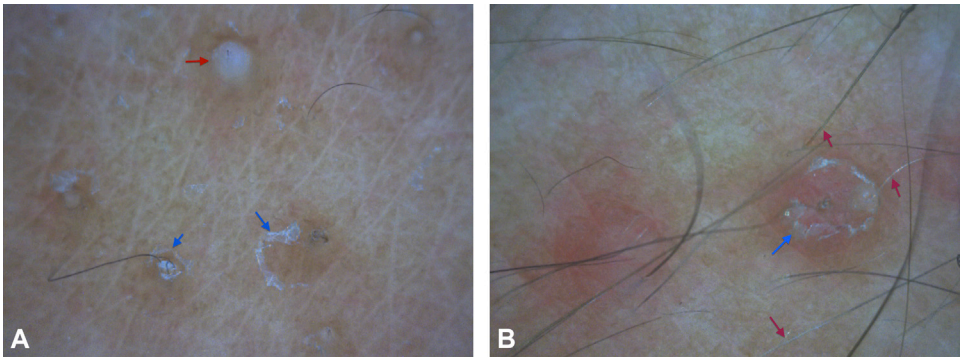

Fig 1. **A**, Dermoscopy showing follicular pustule (red arrow) and scaling (blue arrow). **B**, Dirty white perilesional scaling with surrounding erythema (blue arrow). Note the hypopigmentation of the base of the involved hair shafts (red arrow) (Dinolite AM413ZT staining; original magnification, ×50; polarizing).

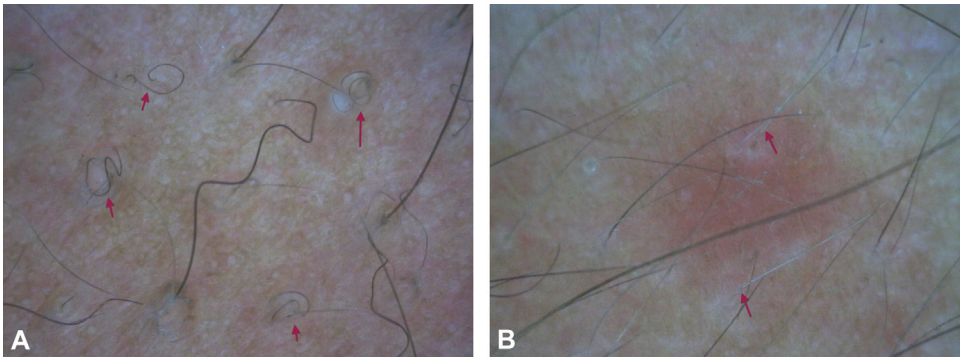

Fig 2. **A**, Coiled/looped hairs (red arrows). **B**, Hypopigmentation of the involved hair follicles suggestive of invasion by yeast spores (red arrow) (Dinolite AM413ZT staining; original magnification, ×50; polarizing).

Table I. Dermoscopic characteristics of acne lesions and *Pityrosporum* folliculitis

Lesions	Dermoscopic features
Inflammatory acne	Round-structured lesions with well-defined white center with thin brown borders and erythematous periphery
Pustular acne	Well to ill-defined dull white to yellowish raised lesions with erythematous borders
Comedonal acne	Brown-yellow hard central plug with sparse inflammation
Pityrosporum folliculitis	Folliculocentric papule and pustules with surrounding erythema; dirty white perilesional scales; coiled/looped hairs with perifollicular erythema and scaling; hypopigmentation of involved hair follicles; perilesional brownish discoloration in resolving lesions

was nonspecific and revealed lesional brownish discoloration. Culture and histopathology were not done in our cases.

The clinical presentation of acne vulgaris and *Pityrosporum* folliculitis can be confusing, and therefore dermoscopic evaluation may aid in an appropriate diagnosis (Table I).[6] The pathogenesis of *Pityrosporum* folliculitis is still not completely understood, but studies suggest it to be an infection of the hair follicle by the *Malassezia* genus and subsequent inflammation.[5] The dermoscopic features of this entity seem to correlate with the current understanding of its etiopathogenesis.

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REFERENCES

1. Prindaville B, Belazarian L, Levin NA, Wiss K. Pityrosporum folliculitis: a retrospective review of 110 cases. *J Am Acad Dermatol*. 2018;78:511-514.
2. Thayikkannu AB, Kindo AJ, Veeraraghavan M. *Malassezia*—can it be ignored? *Indian J Dermatol*. 2015;60:332.
3. Jacinto-Jamora S, Tamesis J, Katigbak ML. Pityrosporum folliculitis in the Philippines: diagnosis, prevalence, and management. *J Am Acad Dermatol*. 1991;24:693-696.
4. Thomas M, Khopkar US. Keratosis pilaris revisited: is it more than just a follicular keratosis? *Int J Trichology*. 2012;4:255-258.
5. Gaitanis G, Magiatis P, Hantschke M, Bassukas ID, Velegraki A. The *Malassezia* genus in skin and systemic diseases. *Clin Microbiol Rev*. 2012;25:106-141.
6. Alfaro-Castellon P, Mejia-Rodriguez SA, Valencia-Herrera A, Ramirez S, Mena-Cedillos C. Dermoscopy distinction of eruptive vellus hair cysts with molluscum contagiosum and acne lesions. *Pediatr Dermatol*. 2012;29:772-773.

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