

## Letter to the Editor

## Perifolliculitis capitis abscedens et suffodiens accompanied by marginal keratitis

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Perifolliculitis capitis abscedens et suffodiens (PCAS) or dissecting cellulitis (DC) is clinically characterized by severe destructive folliculitis leading to scarring alopecia, often associated with fluctuated nodules and abscesses, sinus tracts, fistula and recurrent Gram-negative infections [1, 2]. Dissecting cellulitis was first described by Spitz in 1903. The most frequently affected areas are the vertex and the occipital part of the scalp [3]. This disease has been considered to be a part of the follicular occlusive triad or tetrad. It is believed that retention of material dilates follicles and causes them to rupture. After dilatation followed by rupture, keratin and organisms from the damaged hair follicles can initiate a neutrophilic and granulomatous response. Bacterial infection is most likely secondary in the course of the disease. The most frequently isolated organisms are coagulase-positive *Staphylococcus aureus* [3–5]. It has been reported to occur with pyoderma vegetans [6], marginal keratitis [7], and pityriasis rubra pilaris [8]. The pathophysiology is believed to involve follicular blockage in all these conditions [3, 7]. The presence of marginal keratitis is a common complication in many conditions and can develop as a result of longstanding staphylococcal blepharoconjunctivitis [9, 10]. Only one case of PCAS with marginal keratitis has been reported, in 2001 [7]. In this article, we report the second case of PCAS with marginal keratitis in the literature.

A 38-year-old man was admitted to our department with a 10-year history of coalescing, suppurating and crusted nodules on the occipital, parietal and vertex scalp areas with scarring alopecia. The patient was healthy with no history of nodulocystic acne on his face, back and chest. He had no hidradenitis suppurativa. In the past, the patient had been treated with various medical treatments including dapsone, isotretinoin, systemic and local antibiotics such as ciprofloxacin, tetracycline, and amoxicillin, but the results were unsatisfactory and the lesions repeated. Seven years and three years ago, he had received a 2-month course of oral prednisolone 60 mg/day and 8-month isotretinoin treatments respectively, without any satisfactory results. The patient reported decreased vision in his left eye, redness and photophobia. His complaints had begun 3 months earlier and he had been treated unsuccessfully with several lubricating eye drops; corneal infection was suspected at times. He had no history of contact lens wear or ocular surgery. In the dermatological examination, there were boggy, fluctuant, draining tracts, multiple crusted nodules and patches of alopecia on the scalp areas,



**Figure 1.** Boggy, fluctuant, draining tracts, multiple crusted nodules and patches of alopecia on the scalp



**Figure 2.** Marginal infiltrates with mild hyperemia of the bulbar conjunctiva

most prominently in the occipitoparietal areas (Figure 1). In ophthalmologic examination of the patient, the left eye showed marginal infiltrates with mild hyperemia of the bulbar conjunctiva (Figure 2), and limbitis in two foci at the 5–8 o'clock positions was found. Fundoscopic examination was normal and marginal keratitis was diagnosed. Complete blood cell count, erythrocyte sedimentation rate, serum biochemistry profile, urine analysis, serum albumin, and electrolytes were within normal limits. Repeated cultures of scalp abscesses for bacteria and fungi were negative. The skin biopsy specimen from the scalp lesion showed histopathological features characteristic of chronic folliculitis and perifolliculitis with an extensive infiltrate composed of neutrophils, lymphocytes, and histiocytes leading to destruction of root sheaths. Marginal keratitis was diagnosed and he was prescribed topical steroids.

Perifolliculitis capitis abscedens et suffodiens is a chronic, relapsing, suppurative and inflammatory disease of the scalp that, if left untreated, eventually results in extensive scarring alopecia. Its aetiology and pathogenesis are not completely understood [11]. Perifolliculitis capitis abscedens et suffodiens has been associated with the follicular occlusion triad or tetrad [2, 3]. This association suggests a common pathogenic mechanism of abnormal follicular keratinization and occlusion, secondary bacterial infection, and follicular destruction and a granulomatous inflammatory response [5, 11].

Marginal keratitis, which is an immune-mediated corneal disorder, can develop as a result of longstanding staphylococcal blepharoconjunctivitis. It is characterized by peripheral corneal infiltration and ulceration [9, 10].

Only 1 case of PCAS associated with marginal keratitis has been reported, in 2001. In this article, we have reported the second case of PCAS with marginal keratitis in the literature.

### Conflict of interest

The authors declare no conflict of interest.

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