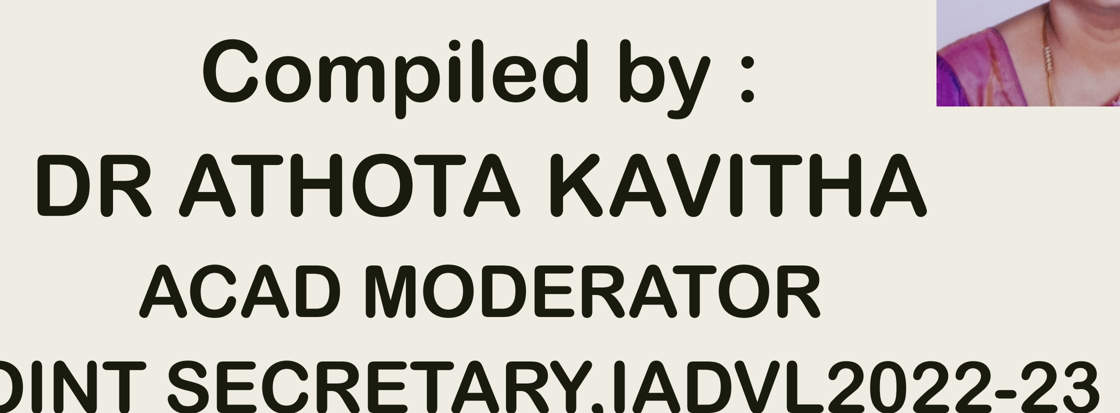

Compiled by :

DR ATHOTA KAVITHA

ACAD MODERATOR

JOINT SECRETARY,IADVL2022-23

ACNE & APPENDAGEAL DISEASES

SIG ACNE & APPENDAGEAL DISEASES (IADVL ACADEMY)

(ACAD DISCUSSION 2022)

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ACAD CASE-SIG ACNE AND APPENDAGEAL DISEASES

DR USHA N KHEMANI

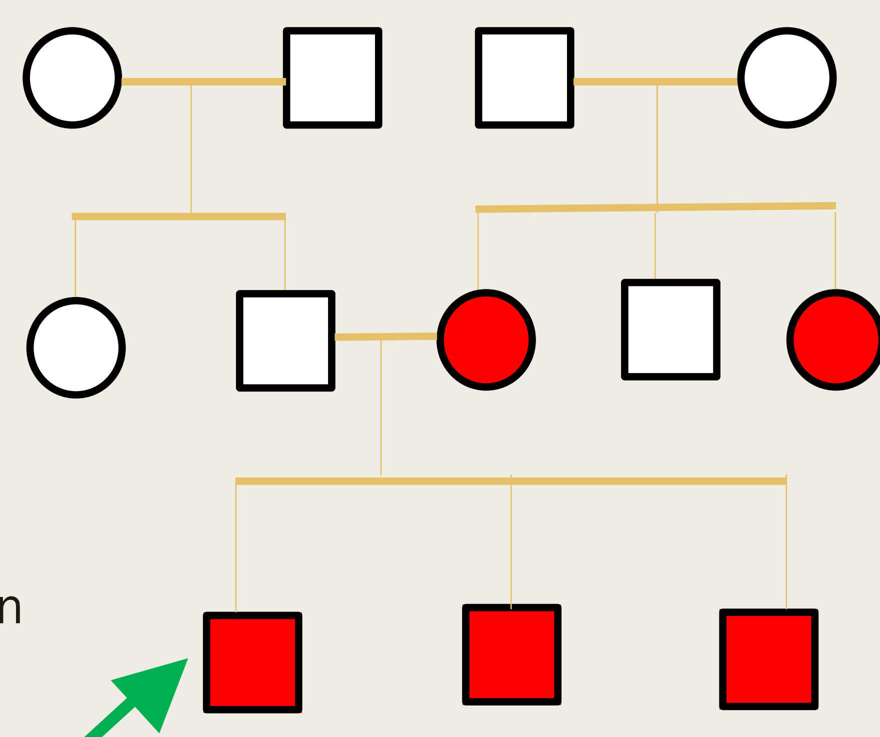
ASSOCIATE PROFESSOR

GRANT GOVERNMENT MEDICAL COLLEGE

MUMBAI

CASE 1

- A 27 years/male came with chief complaint of-
  - Raised lesions over face since 9 years.
  - H/O similar complaints in family present

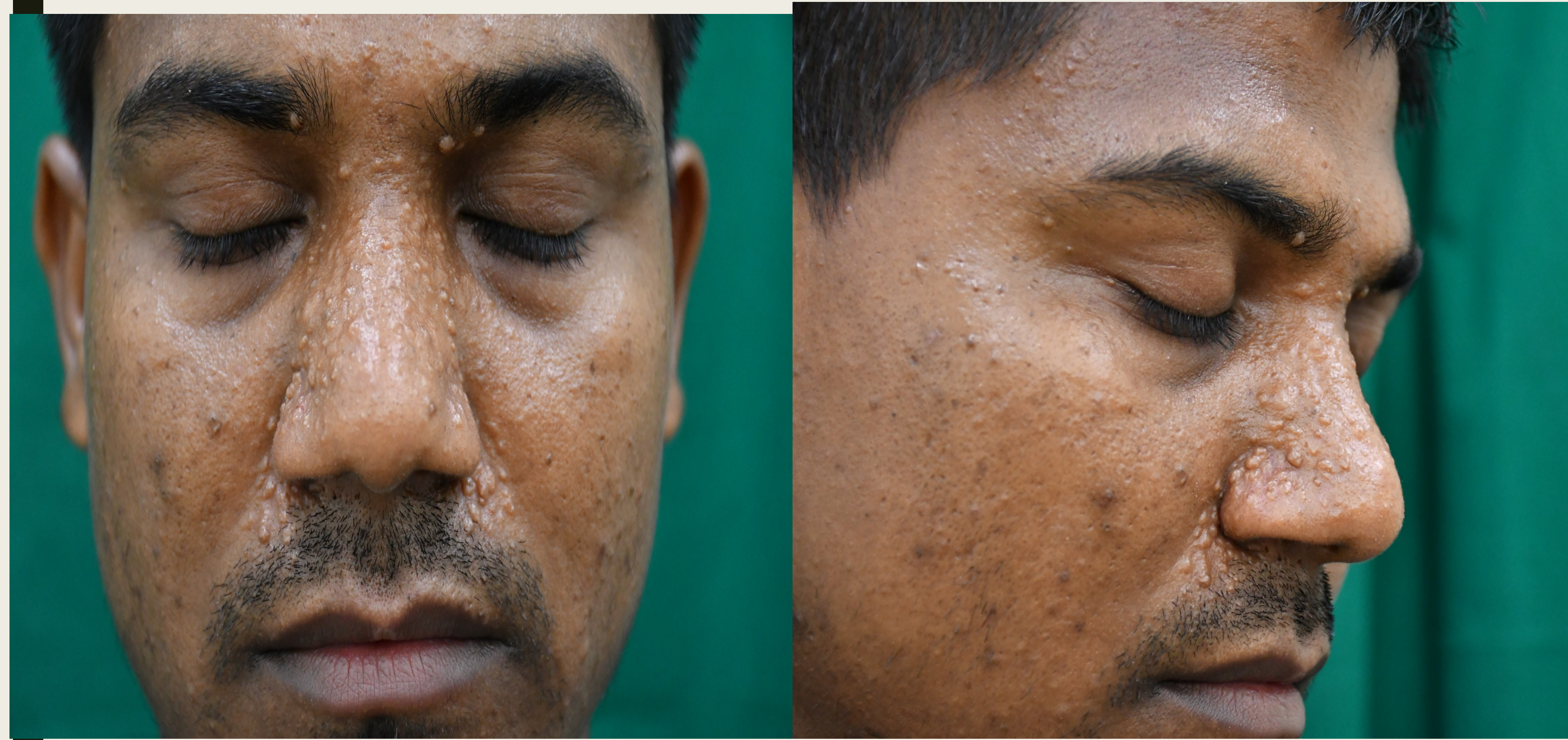


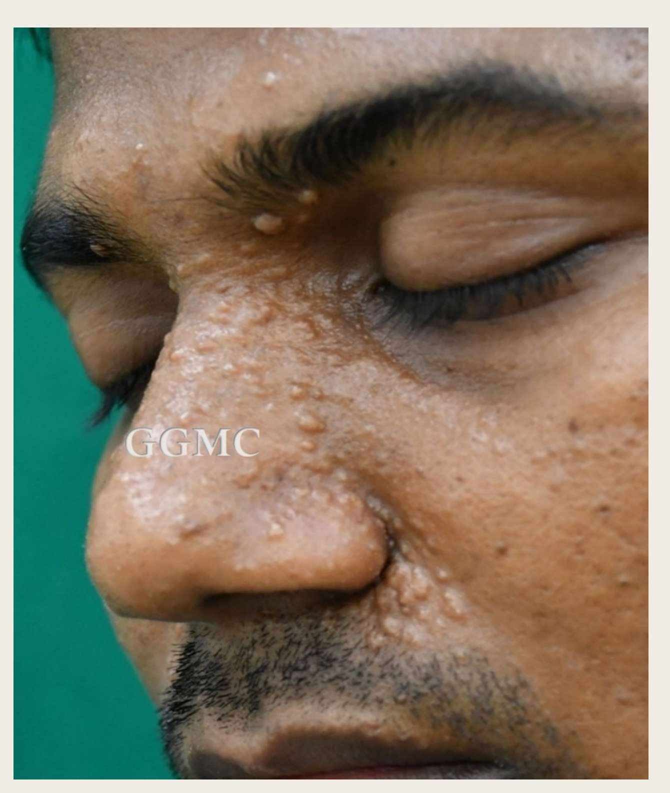
General Examination : Normal

Cutaneous Examination :

Multiple skin coloured to yellowish discrete, non tender, firm dome shaped papules in

centrofacial distribution over nose, eyelids, nasolabial fold and upper lip

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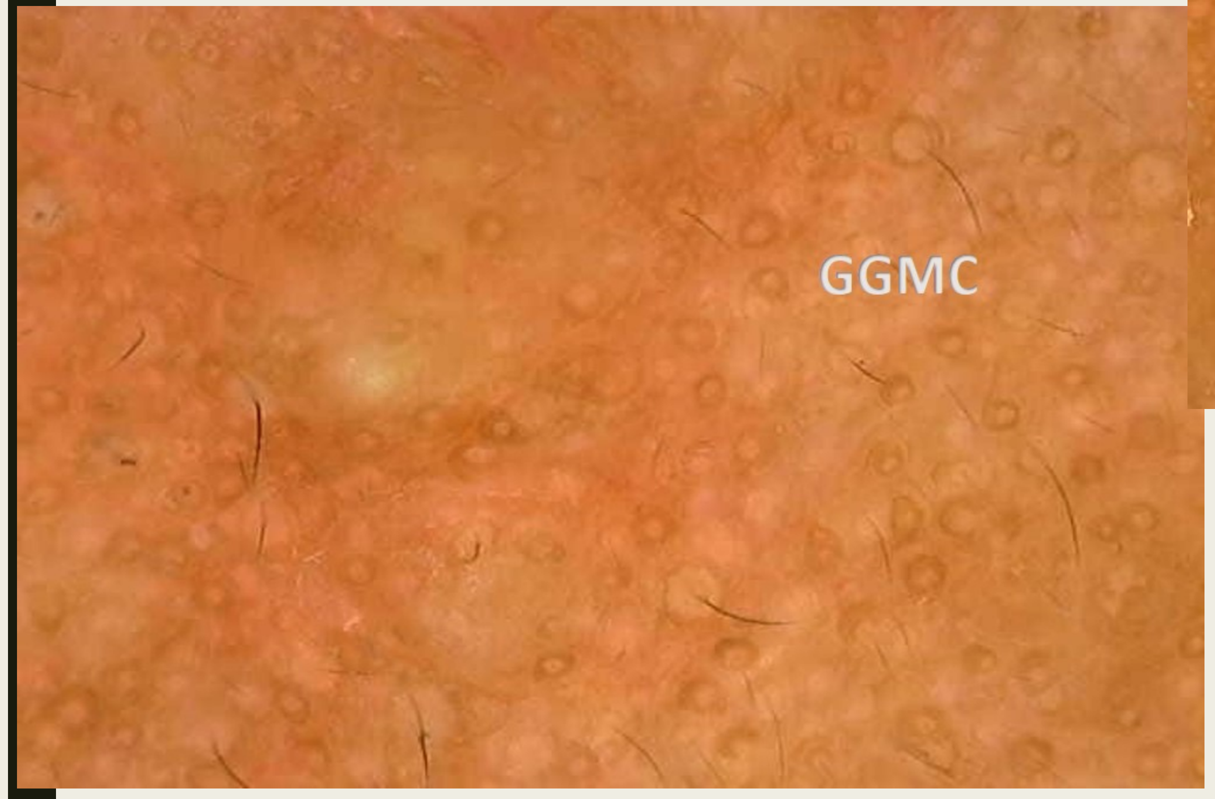
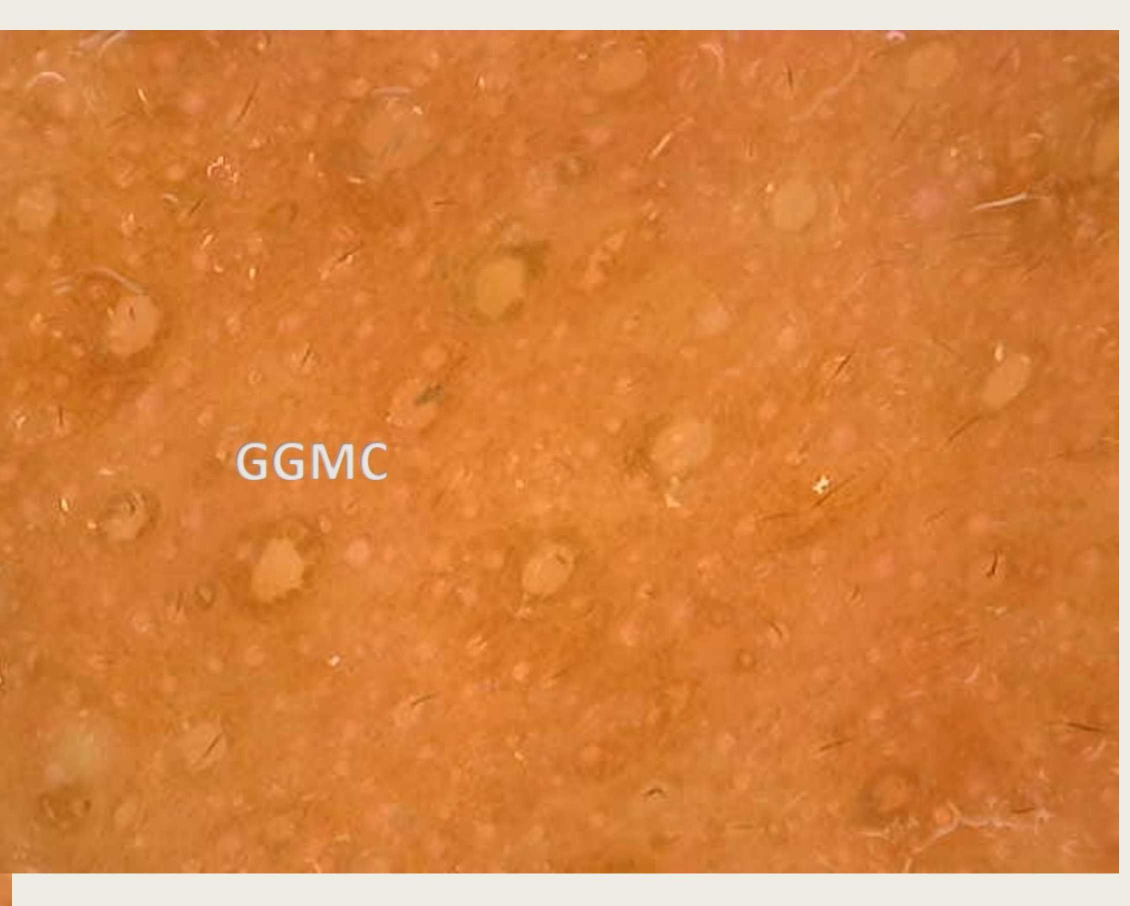
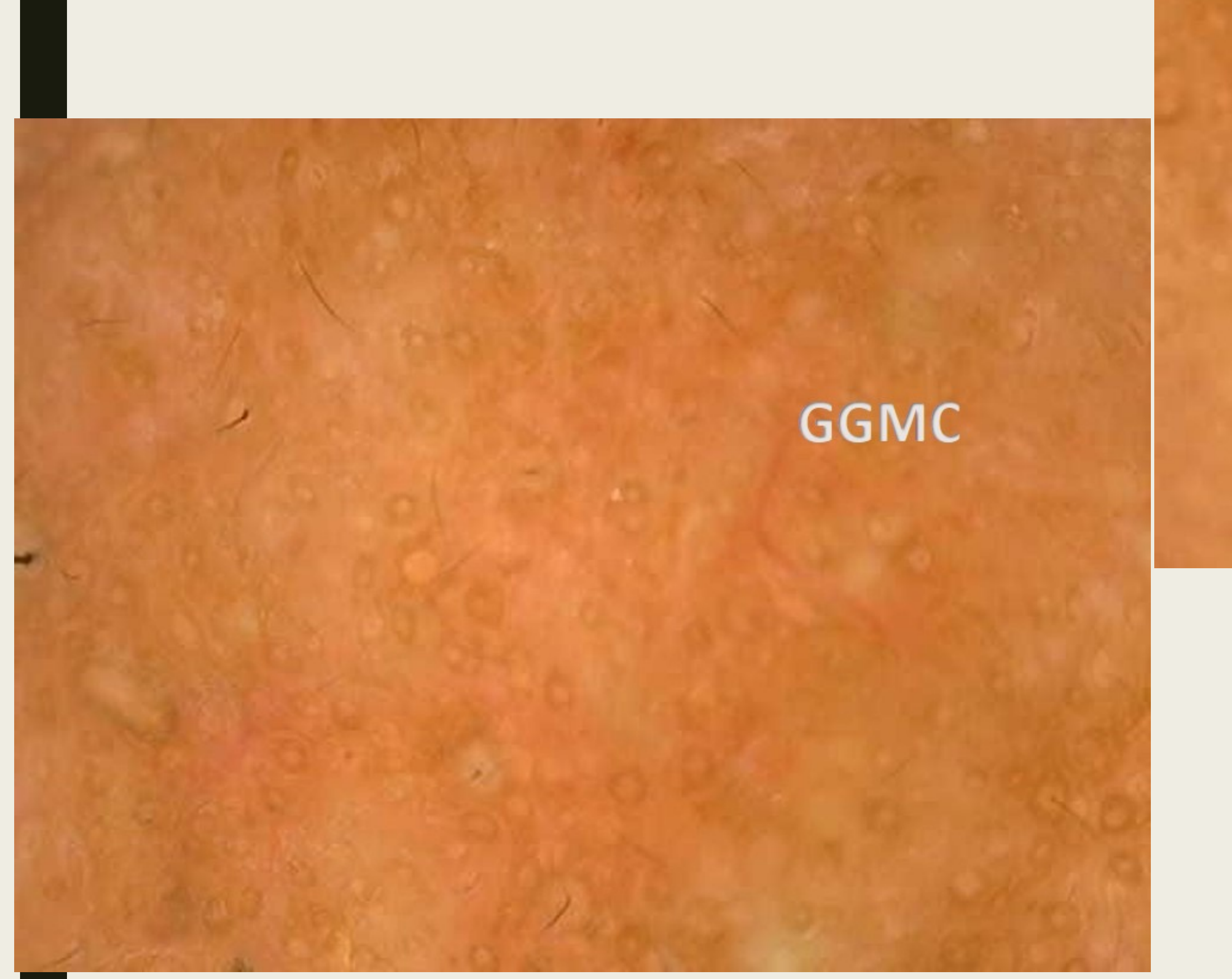
CASE 1

DERMOSCOPY







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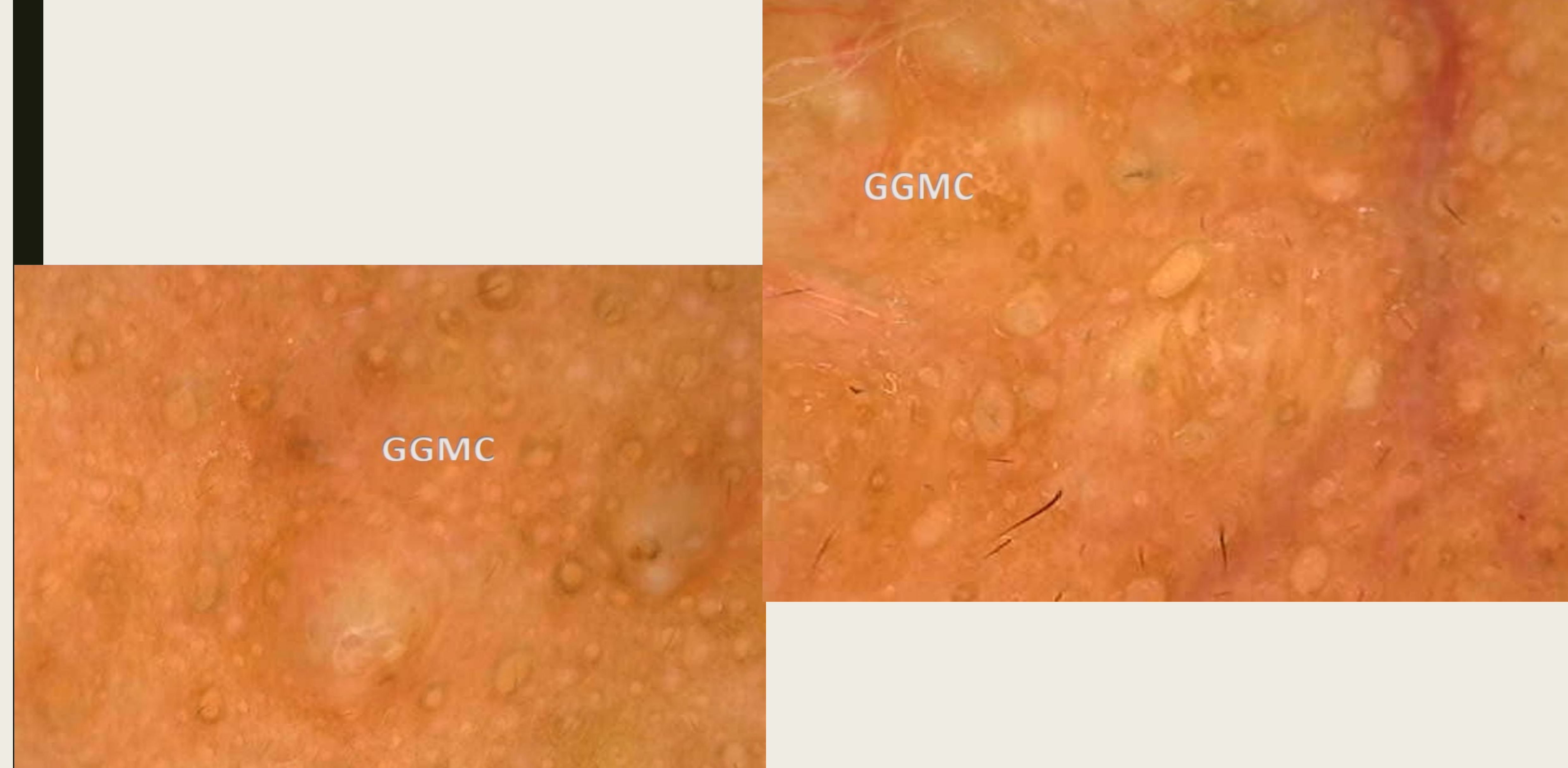
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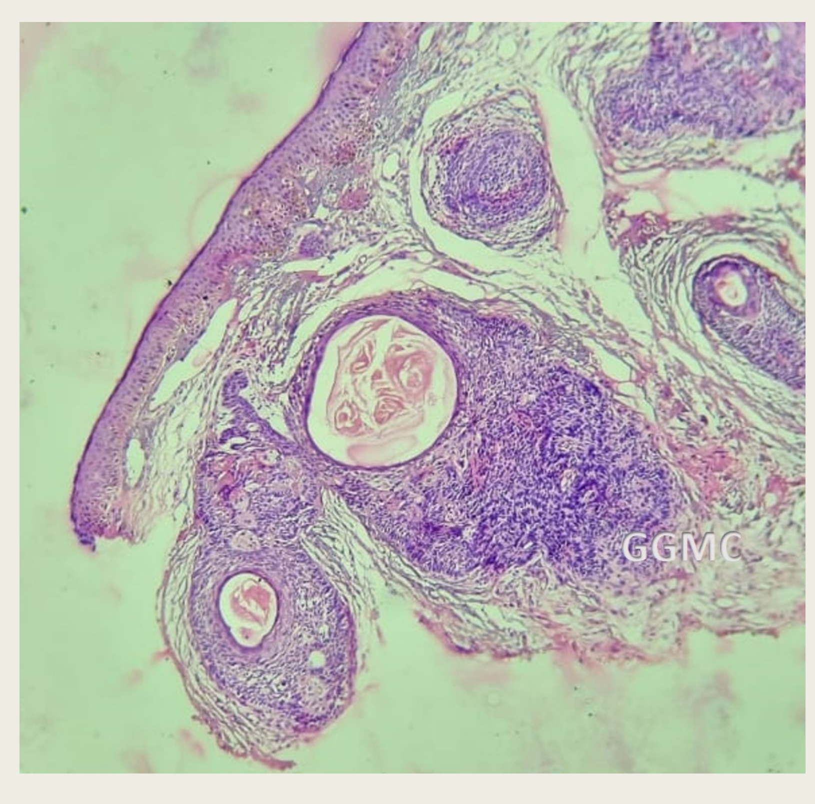
HISTOPATHOLOGY



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GGMC

Familial Trichoepithelioma

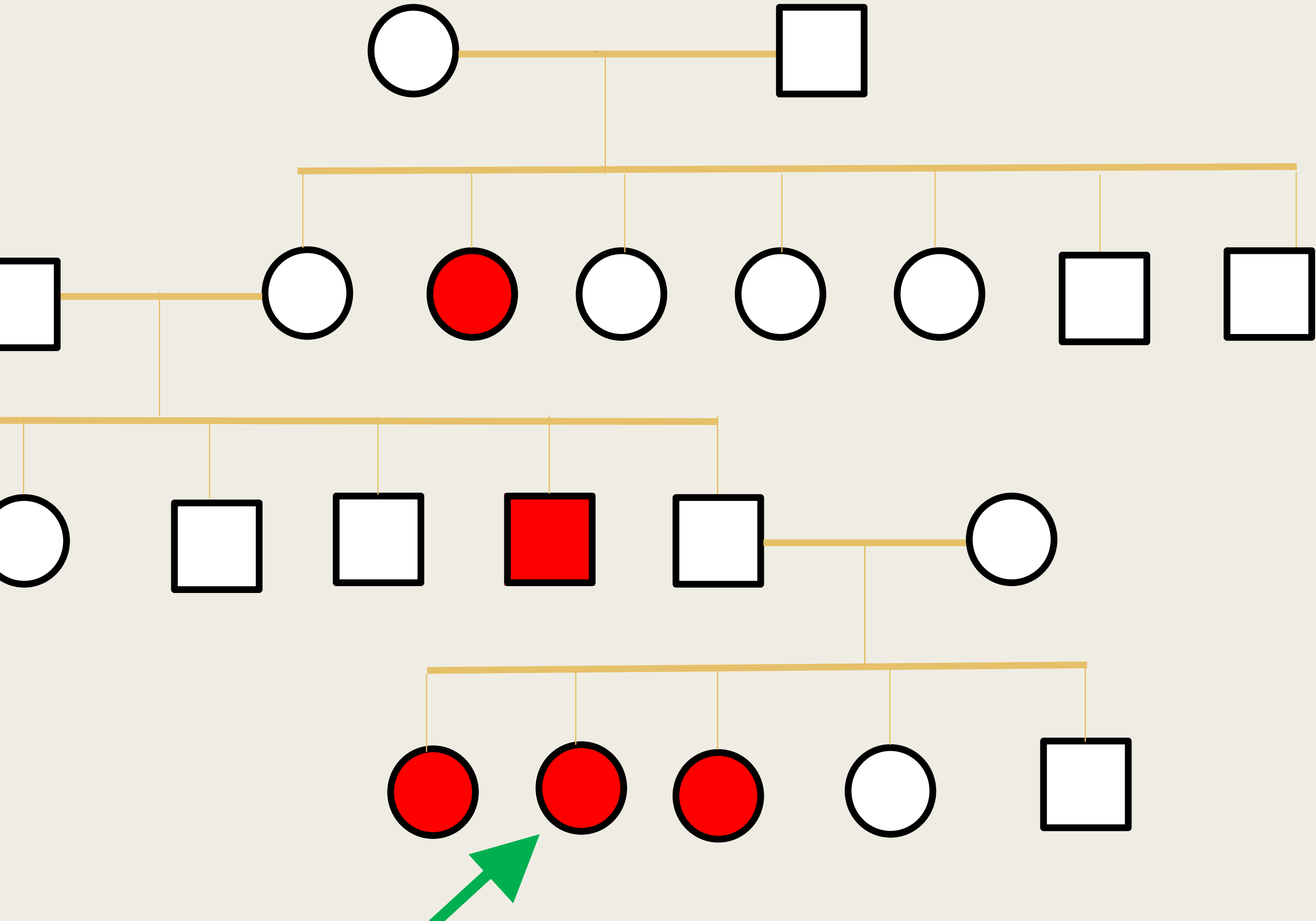
- Patient is undergoing surgical Co2 treatment and is under follow-up.

CASE 2

- 27 year/ female came with chief complaints of-

➢ Raised lesions over face and Upper extremities since 12 years asymptomatic

- CUTANEOUS EXAMINATION
- Multiple skin coloured to brownish hyperpigmented discrete to few confluent papules present over the forehead, bilateral cheek, bilateral temple area, chin, nose, forearms and wrist



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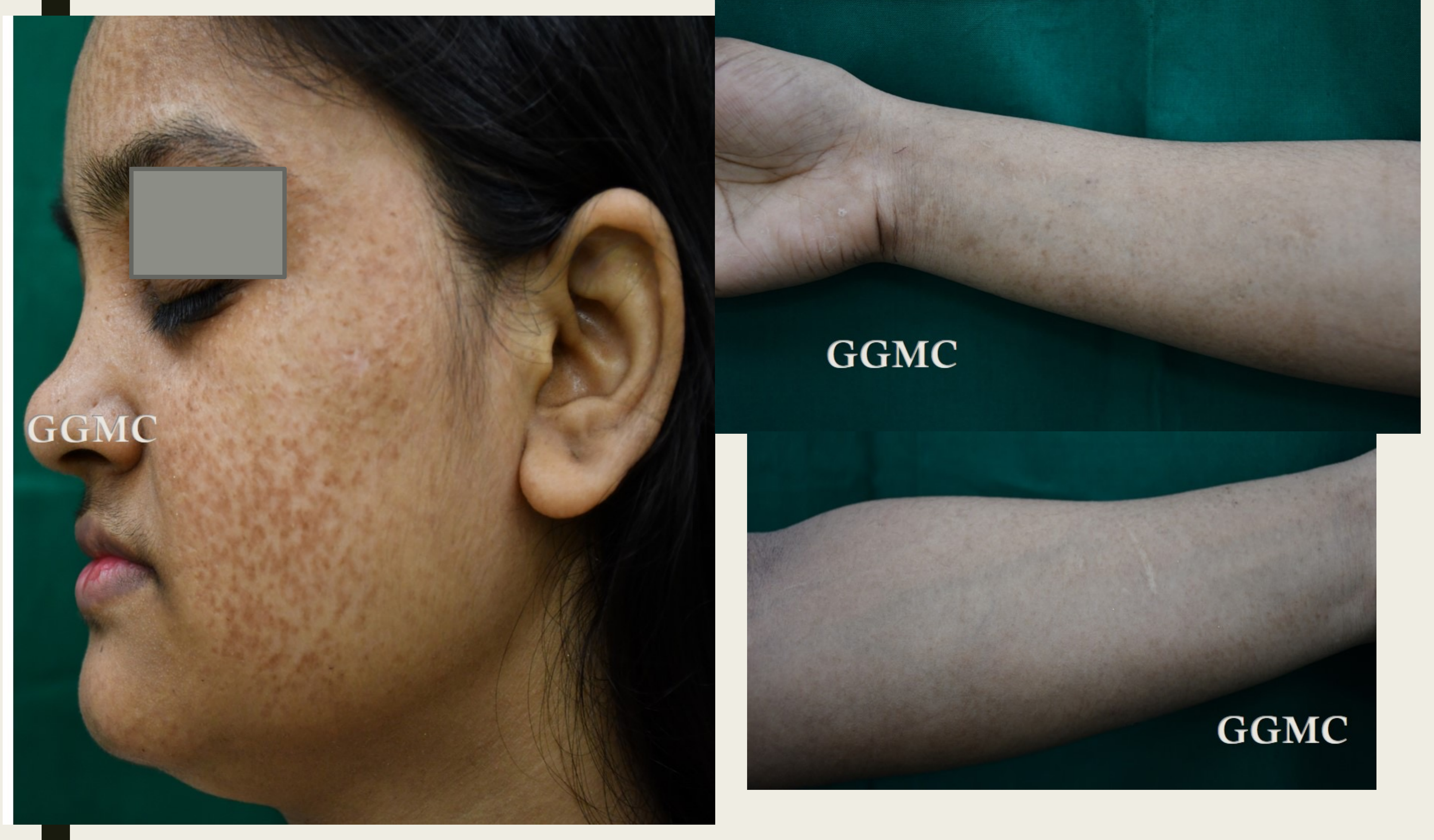
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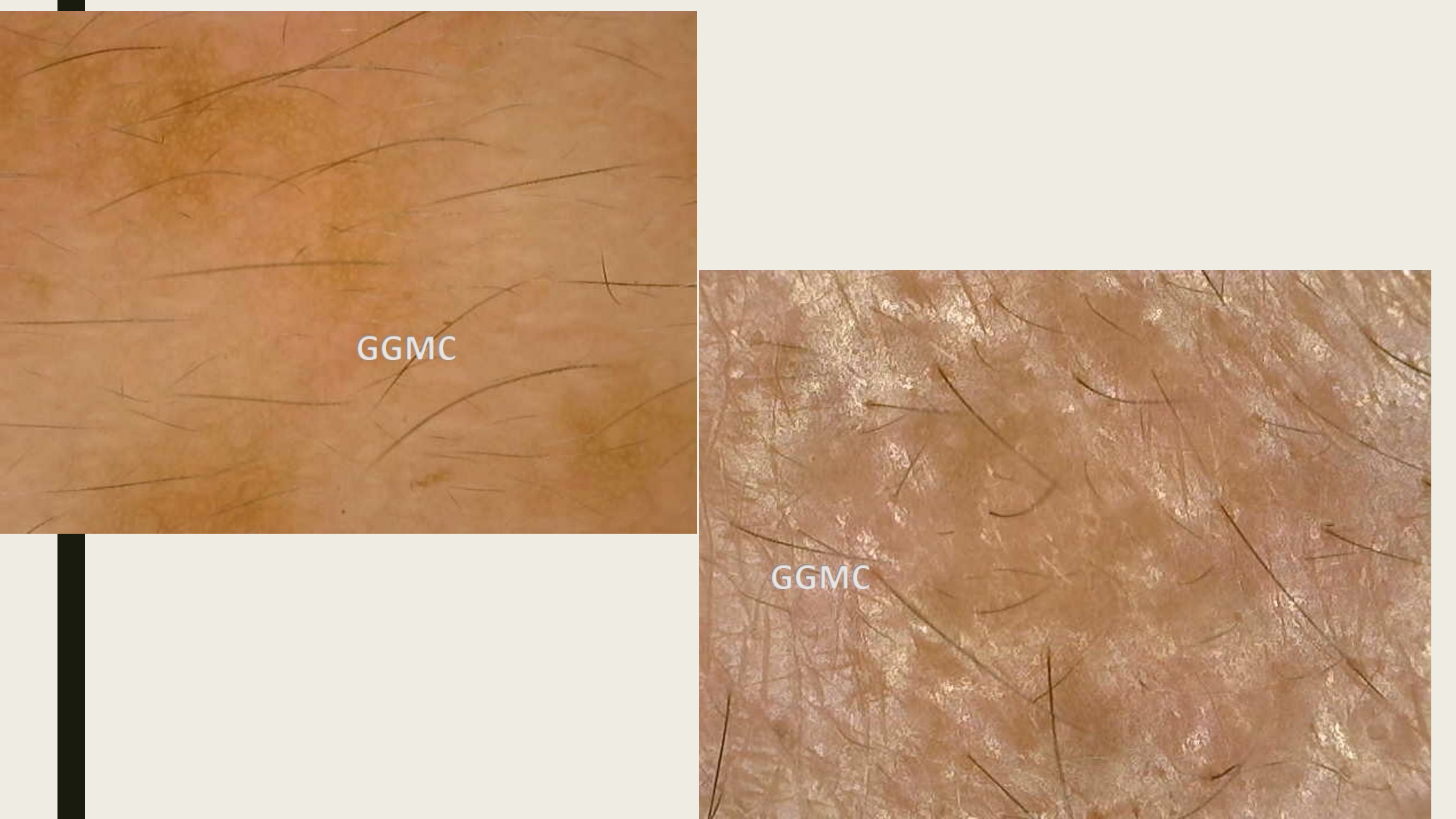
CASE 2

DERMOSCOPY

GGMC

GGMC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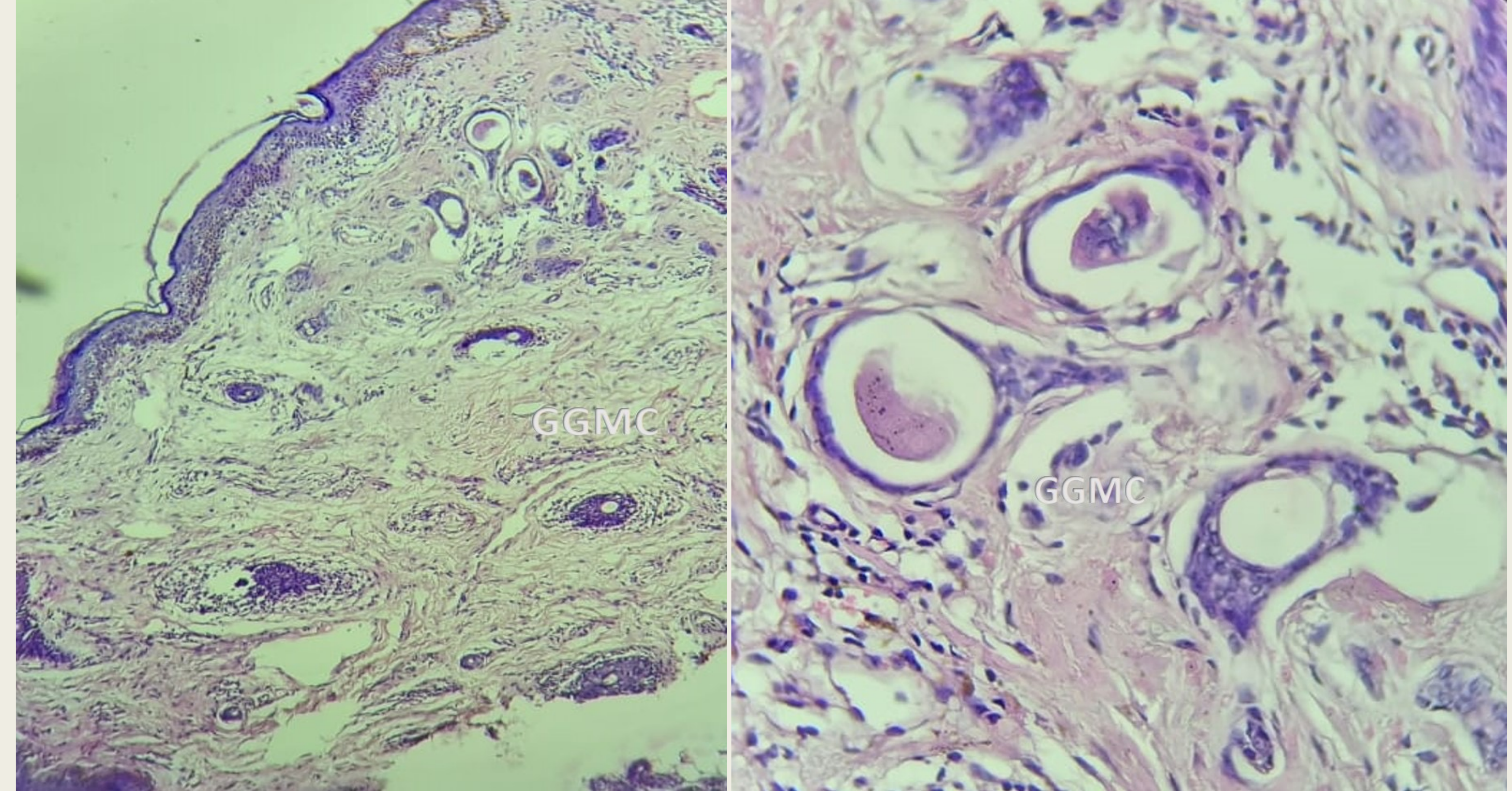
HISTOPATHOLOGY



Familial Eruptive Syringoma

- Trated with fractional CO_2 one sitting and is lost for follow up.

CASE 3

- 54 year/female came with chief complaints of-

- ➢ Raised lesions over face since 10 years

H/O summer exacerbation present

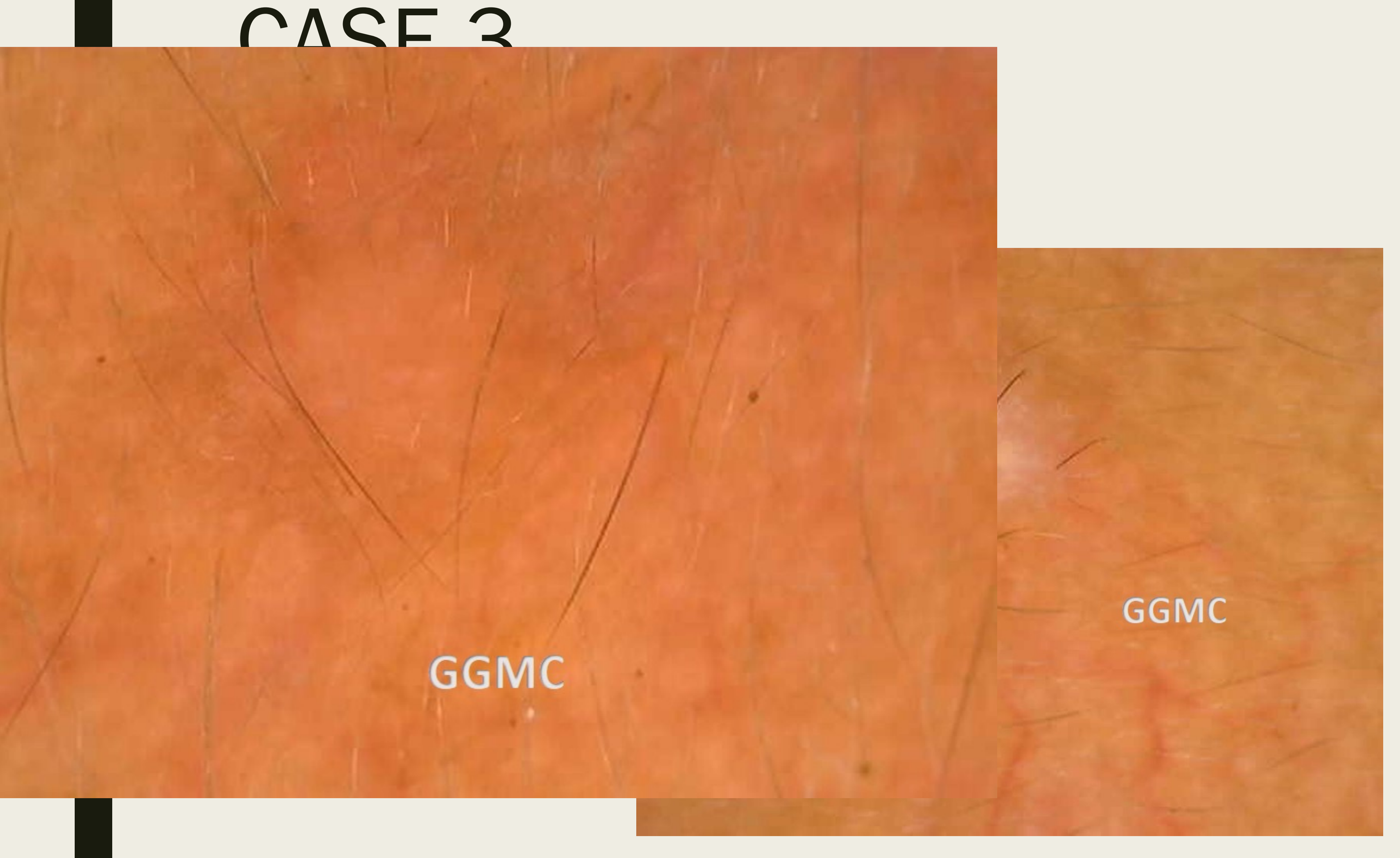
- Cutaneous examination-

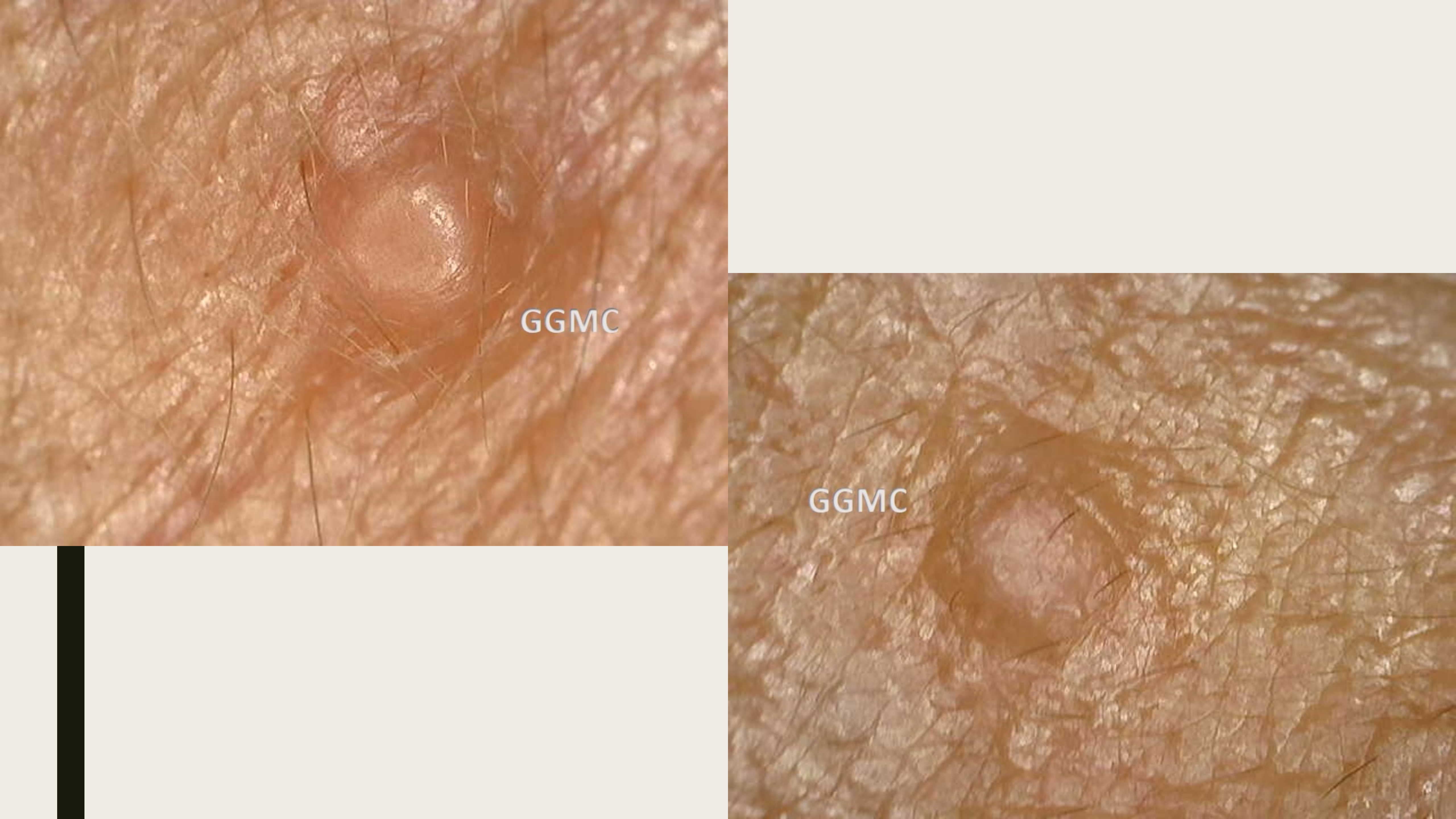
Multiple transluscent shiny papules over bilateral cheeks and periorbital area

GGMC
GGMC

DERMOSCOPY

CASE 3

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HISTOPATHOLOGY

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TREATMENT WITH ATROPINE 0.1% Solution

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TREATMENT WITH ATROPINE 0.1% Solution

Eccrine Hidrocystoma

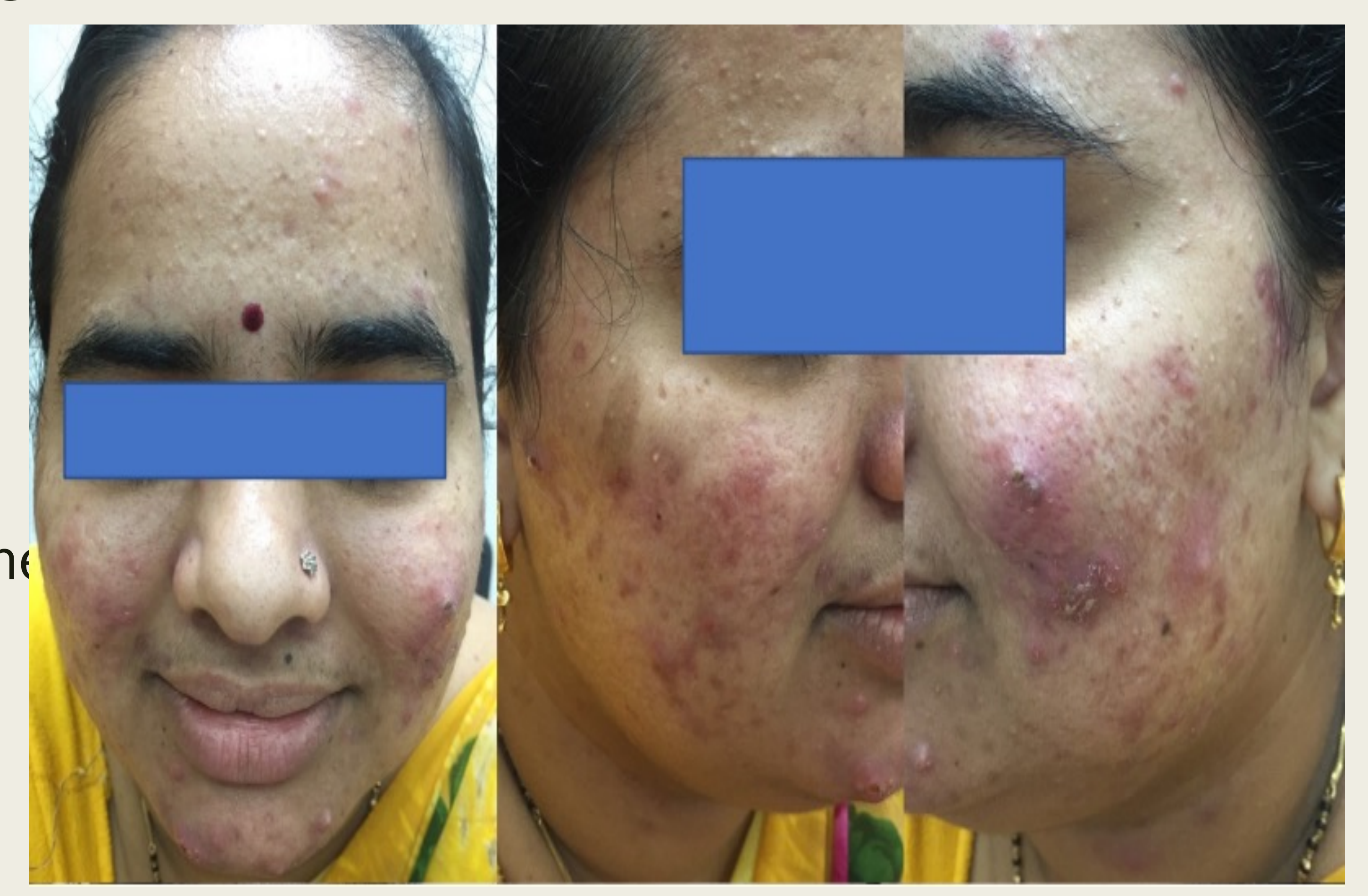
- Treated with 1% Atropine solution (eye drops)and had a significant improvement.It was given twice daily for 1 month and is being continued on alternate nights for 1 month.Follow up photos are posted above.

Dr Aseem Sharma MD, DNB, MBA, FAGE Member, SIG Acne

3[illegible]/F

- Homemaker
- Adult Acne (Persistent)
- Clinical Pictures attached
- Additional historical pointers?

■ Cystic adult acne with macular erythe



Hi Everyone
Clinical picture shows
*Adult female acne with inflammatory papules, pustules ,nodules ,closed comedons and scars and Erythema.
*Also shows s/o androgen excess.

*Oily skin
*Hair loss
Questions to be asked are to elicit history
*Duration of acne
*Persistant erythema
*Menstrual irregularity to R/O PCOS
*Obstratic history
*Check for Obesity/Diabetus
*Any Hormonal suppliments
*Diet and Lifestyle
*Medication in the past
Thank you for sharing.
Regards
Dr. Sarita Tippannawar

- yes Dr Vinita, she used Mometasone off and on for 4 years in all. He family was complete in her late twenties. Tubal ligation done. No surgery involving the uterus / ovaries. She had never takAny other drug History
- To look for other signs of hyperandrogenism
  Free and Total testosterone, S DHEA,FSH,LH.
-
  OCPs prior to presentation.

- Updating with the further clinical presentation.
- Adult acne (persistent) cystic with macular erythema and PIH
- FPHL (Gd 3 Sinclair)
- Hirsutism (low FG scoring - limited to the face)
- Acanthosis Nigricans
- Definitive signs of hyperandrogenism seen clinically.
- The next step is investigating the patient.
- She also has a fair amount of P. folliculitis which is evident from her clinical pictures
- Also ask for a history of conception/infertility, how many children, any abortions, premenstrual severe pain

- Oily - yes ; recent increase in the same (I thought of Seborrhoea worsened by ? androgens)
- *Hair loss - Yes, she has patterned hair loss - shall send the grade tomorrow morning
- Questions to be asked are to elicit history
- *Duration of acne - Persistent since she was 16; hence I mentioned persistent adult acne
- *Persistant erythema - h/o applying mometasone (not from my side!!) - this was even more evident in person
- *Menstrual irregularity to R/O PCOS - None reported
- *Obstratic history - P2L2, both FTNDs, No ovulation inducers / progesterone supplemets or injections, all WNL
- *Check for Obesity/Diabetus - Have done. Shall send these tomorrow morning when I reveal investigations
- *Any Hormonal supplements - None till she presented to me
- *Diet and Lifestyle
- *Medication in the past - Oral minocycline, Topical benxoyl peroxide, multiple AHA-BHA based serums, toners, face washes and creaOily

- Oily skin - yes ; recent increase in the same (I thought of Seborrhoea worsened by ? androgens)
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- xcellent point. Post steroid use - demodicidosis is what I had thought of but superadded P lliculitis is a good addition.

- xcellent point. Post steroid use - demodicidosis is what I had.

Additional Pointers

- Associated androgen excess, FPHL Gd 3 Sinclair, Hirsutism, Seborrhoea
- No menstrual irreg
- P2L2A0 – FTND
- No ovulation inducers / conception aids / progesterone use
- Tubal ligation done
- h/o using mometasone cream off and on for 3 years
- Obese lady; BMI – 31.06
- Acanthosis Nigricans

Prior Treatment:

- Oral minocycline
- Topical benxoyl peroxide
- Multiple AHA-BHA based serums, toners, face washes and

creams

Labs:

- Prolactin – 167
- Serum Insulin (F) – 29
- BS (F/PP) – 134/168
- DHEAS / Total Testosterone / AMH – WNL

Management Approach:

Orals

- T Metformin 500mg 1-0-1 after food (serial upgrade to 2g/day) - She was quite hesitant to take the same.
- Cap Isotretinoin 20mg 0-0-1 after food
- T Spironolactone 50mg 0-0-1
- T Cabgolin 0.5 mg once weekly x 8 weeks

Topicals

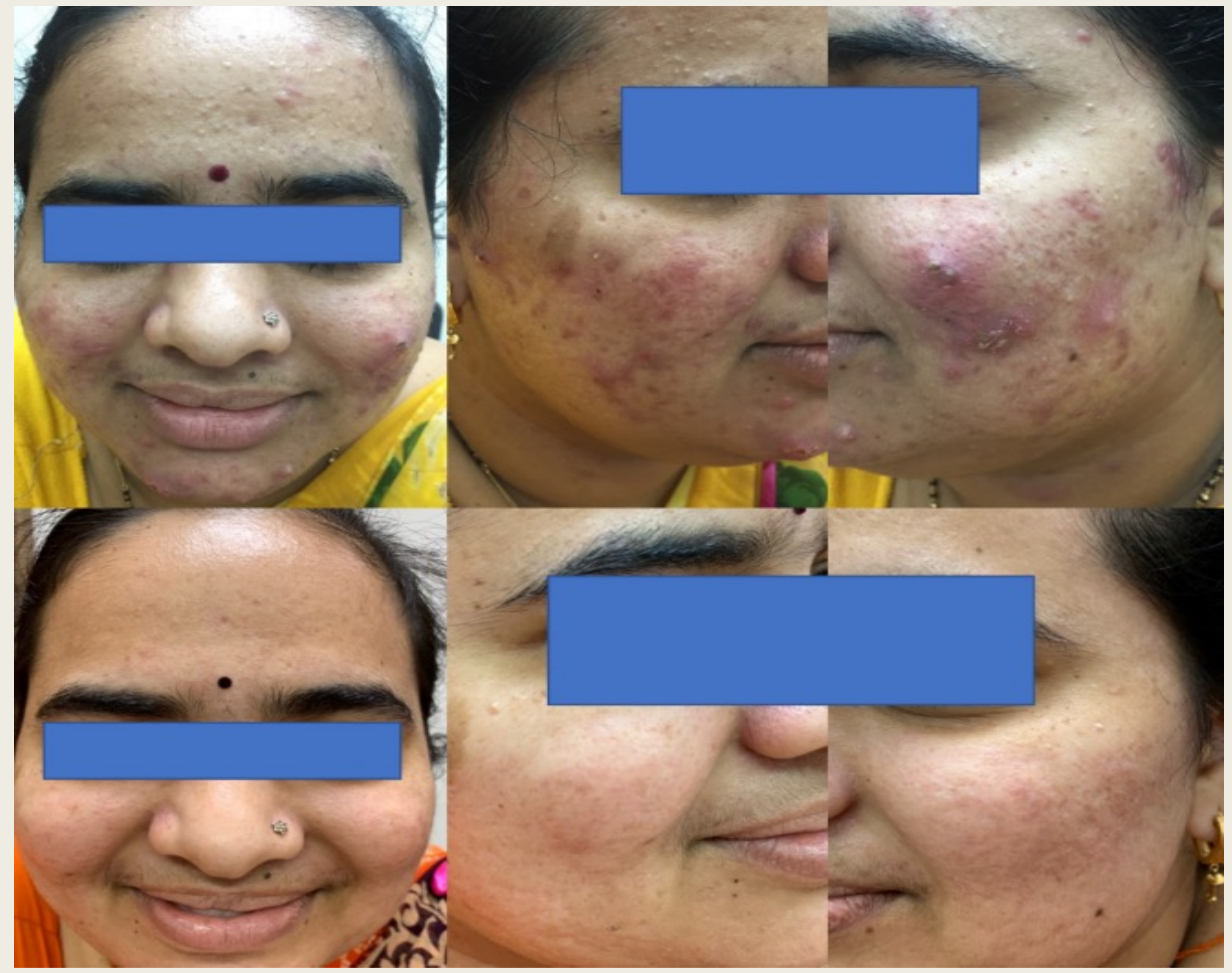
- Sunscreen
- Azelaic Acid liposomal
- Moisturizers
- Minoxidil 5% once daily

LSM

- Diet / Exercise

- Result after

4 months



- DR NINA MADNANI
- Visiting Consultant
- PD Hinduja National Hospital & Sir HN Reliance Foundation Hospital

13 yr old female

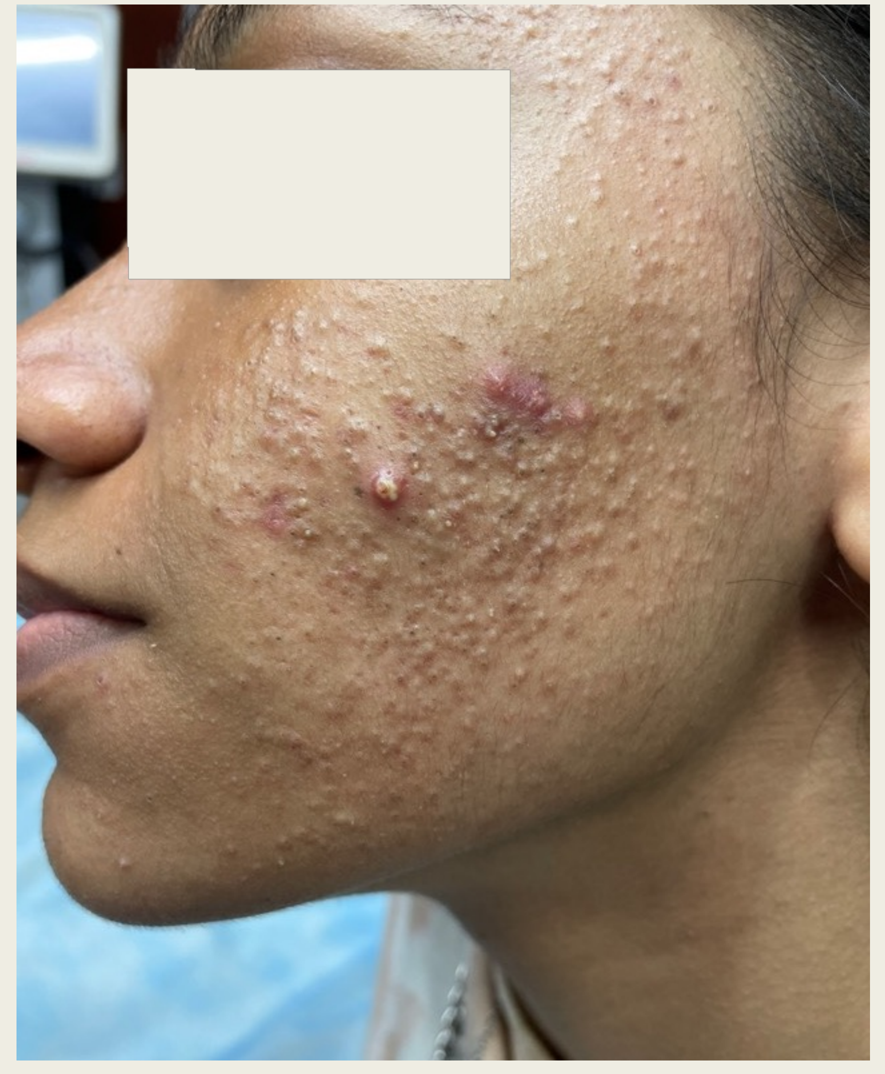
- “Boils” on the face since 2 yrs
- Had done several home remedies like channa atta, Multani matti with no relief.
- Started Rakth Doshantak 1 TBSF daily since 6 months with no relief.

How would you proceed?

Relevant history?

In terms of investigation?

Management?



History - Menarche?, Menstrual history, Oil application over scalp or face, Application of any other creams over face, dandruff in scalp

Investigations - None at baseline

Management -
Topical adapalene, benzoyl peroxide with systemic Azithromycin; Comedone extraction
Mild face wash - DR Shikha Gupta

.
She has profuse comedones, few papules ..
Menstrual history, occlusive cosmetics and any OTC application in history
Investigation

s needed only if abnormal menstrual history for now
She needs, apart from topicals and short course antibiotics, comedones extraction - to prevent scars as well as reduce new inflammatory lesions -Dr Nirmaladevi P

- at 13 year of age i would like to take following history: As the lesions are **monomorphic** (microcomedones) will think of following history:
- 1. history of application of any whitening or brightening creams
- 2.History of intake of any oral drugs for some other ailments(Oral steroids, AKT, antidepressants)
- 3.history of bronchial asthma (many times rota-inhaler chronic use do perpetuate acneiform eruptions.
- 4.History of use of facial scrubs or toner or cosmetics.

- Treatment: will counsel the patient that it will take a longer time to resolve.
- will give low dose oral Retinoid along with topical keratolytic and antibacterial combination (Adapalene + Benzoylperoxide) .
- will advise short contact therapy .
- manual removal of comedones. if this doesnot help then will use electrolysis needle of RF machine or 26no. needle to open the comedones and express the contents.

- Yes this is a common scenario we see as "adolescent acne".
- Further details of history which need to be asked
- Questions which need to be asked as a lot of you mentioned:
- Age of menarche
- Menses regularity
- Pre-period flare?
- Applications used including home remedies, oils etc
- Facials cleanups?
- Scalp oiling? Frequency of shampooing? Dandruff?
- H/o TB meds or other acneigenic medication?
- H/o acne in sibling?
- Family history of PCOS?

Here are further details related to the history taken: 13 yr old,Menarche at 9 (4 yrs ago),Irregular menses, skips few months at a time-irregularly irregular

Severe abdominal pain during menses-has to skip school

Face flares up if periods missed and starts getting painful boils

Has to apply oil on scalp for school

Shampoos once a week

No H/o any medications, asthma or TB

No home remedies done

Elder sibling Age 18 has similar acne but not concerned

Mother still has occasional breakouts and scarring

Now question:

Would you like to do investigations?

If yes-why?

if no-Why

Nina Madnani

- Lets look at some literature:
- DHEAS levels and free testosterone levels may be higher in adolescent girls with acne, and may correlate with the severity of acne, although often levels are normal.
- In a study by , Lucky et al , DHEAS and testosterone levels were found to be above the 90th percentile in 29% and 28%, respectively, for girls with severe comedonal acne; only 20% had low sex hormone-binding globulin values. They concluded that measurement of androgens, therefore, should be reserved for girls with acne and other evidence of androgen excess (e.g., irregular menses, hirsutism, or clitoromegaly).
- So, this patient had irregular menses, acne, and mild temporal thinning with widening of her parting)
- Her sexual characteristics were developed, but she did not have clitoromegaly.
- She did not have KPs or acne elsewhere.
- No hirsutism.

- Hence with acne and hyperandrogenism, the following tests were done:
- TSH
- Prolactin
- DHEAS
- Testosterone
- SHBG.
- USG pelvis.

- Although a recent study checked 25(OH) D levels with AMH levels in a cohort of adolescents with PCOS and found "We have identified that AMH is significantly higher in adolescent females with PCOS (6.7 ng/mL v 3.6 ng/mL), and our values are consistent with previously published reports that suggest AMH “cutoffs” around 6.26–7 ng/mL Simpson S, Seifer DB, Shabanova V, Lynn AY, Howe C, Rowe E, Caprio S, Vash-Margita A.
- The association between anti-Müllerian hormone and vitamin 25(OH)D serum levels and polycystic ovarian syndrome in adolescent females. Reprod Biol Endocrinol. 2020 Nov 21;18(1):118.)
- In the Australian guidelines for PCOS, they recommend when the combination of hyperandrogenism and ovulatory dysfunction is present, ultrasound examination of the ovaries is not necessary for diagnosis of PCOS in adult women; it requires the combination of hyperandrogenism and ovulatory dysfunction in young women within 8 years of menarche, with ultrasound examination of the ovaries not recommended, owing to the overlap with normal ovarian physiology; and adolescents with some clinical features of PCOS, but without a clear diagnosis, should be regarded as "at risk" and receive follow-up assessment.
- Teede HJ, Misso ML, Boyle JA, Garad RM, McAllister V, Downes L, Gibson M, Hart RJ, Rombauts L, Moran L, Dokras A, Laven J, Piltonen T, Rodgers RJ, Thondan M, Costello MF, Norman RJ; International PCOS Network. Translation and implementation of the Australian-led PCOS guideline: clinical)

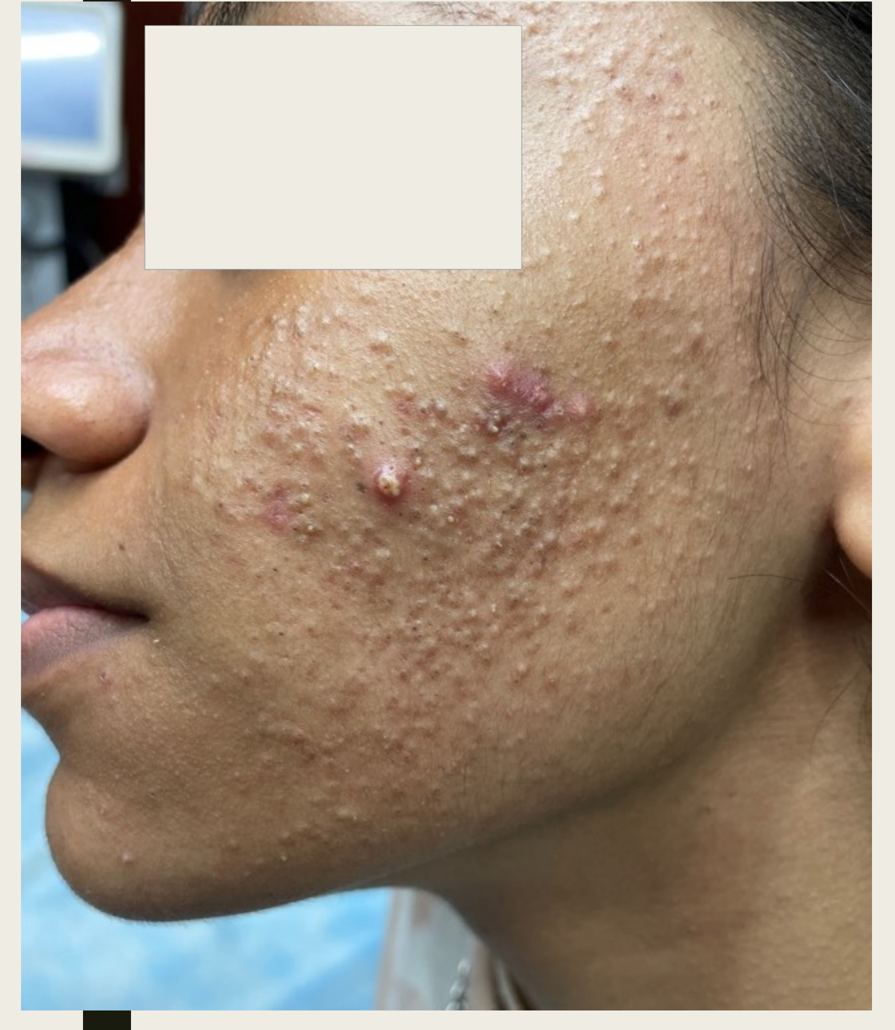
- So my patient values were as follows: Her BMI was on the lower percentile and BP normal
  - Testosterone –0.96 ng/ml (<0.6 ng/ml)
  - DHT – 345 pg/ml (24 - 368ng/ml)
  - DHEAS – 145 mcg/dl (35 – 430ug/dl)
  - TSH – 1.2 mIU/ml
  - PRL – 10.9 mg/ml (<20ng/ml)
  - 17OHP – 0.8 ng/ml (0.2 – 2.5 ng/ml)
  - FBS-105 mg/dL PLBS-81 mg/dL
  - Fasting insulin-20µIU/mL
  - So patient had hyper androgenemia/hyperandrogenism with oligomenorrhoea,
  - Other causes of hyperandrogenism ruled out
  - Conclusion: This was a case of PCOS
  - Rt ovary : 51.6 x 23.8mm Volume: 27.9ml
  - Lt ovary: 38.5 x 33.1mm Volume 22.4ml
  - ›Both ovaries multiple cysts, surrounding a dense stroma
  - Consistent with a diagnosis of PCOD

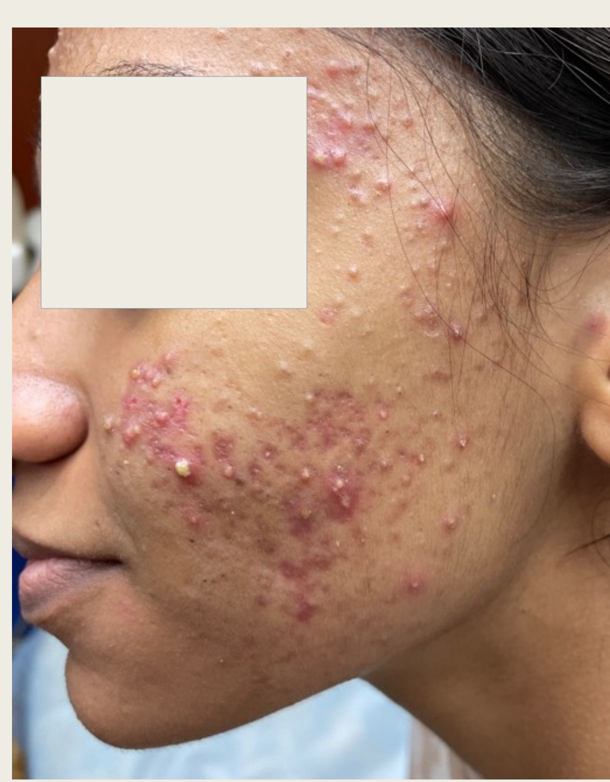
- The use of statins may be relevant for those with obesity and metabolic syndrome.

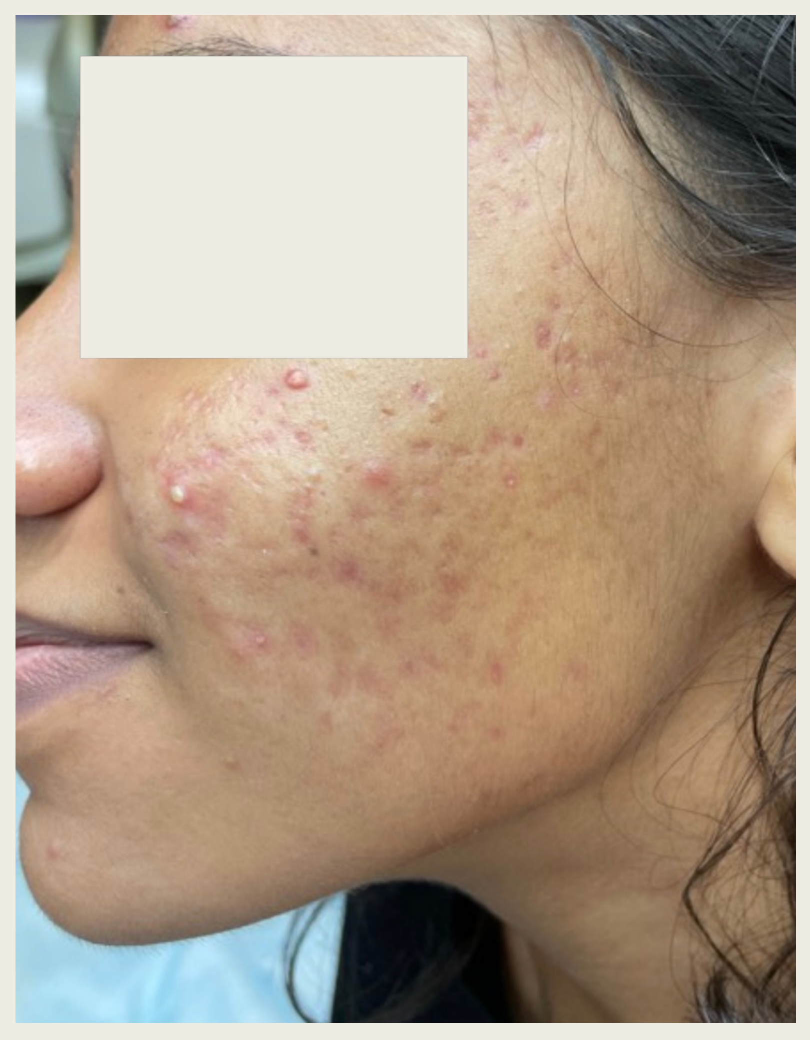
- Goodman NF, Cobin RH, Futterweit W, Glueck JS, Legro RS, Carmina E; American Association of Clinical Endocrinologists (AACE); American College of Endocrinology (ACE); Androgen Excess and PCOS Society. AMERICAN ASSOCIATION OF CLINICAL ENDOCRINOLOGISTS, AMERICAN COLLEGE

- Yes with such large polycystic ovaries ideally she needs to be started on OCPs preferably Diane 35, at least for 6 months.
- Also as others suggested: Comedone extraction, salicylic acid peels, topical retinoids/BP, oral antibacterial agents
- That is the required ideal treatment.
- in practice, patient families are not cooperative.
- The parents refused to take OCPs., the parents refused any procedures including comedone expression
- They wanted only treatment which was non-hormonal.
- So I started her on Doxycycline 100 mg bid, and Retino-A 0.025) with skin care.
- A month later she came with a flare of inflammatory lesions (expected).
- A lot of hand holding, Aziderm 20% was added in the day, and a month later she started getting better.
- After 6 weeks I stopped the doxycycline, added 5mg isotretinoin to modulate her scarring, and started 20% sali peels, and she cleared up well.
- For her periods, Tab deviry 10mg twice a day for 5 days if cycle goes beyond 45 days to precipitate the periods.
- Learning for me from this case:
- Often, the ideal protocols which are recommended may not be aceepted by parents for their children
- We need to find alternatives and Also she needs to be monitored for her progress

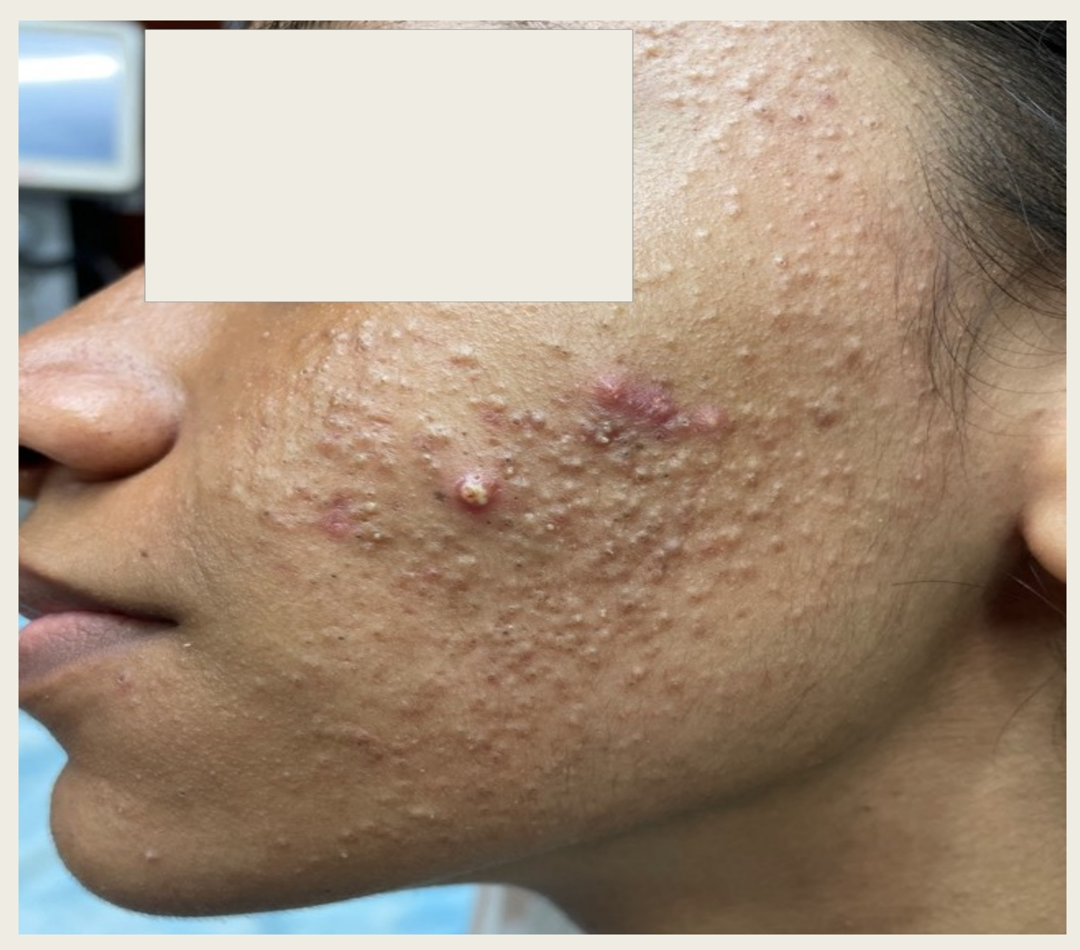
With retinO-A and doxycycline

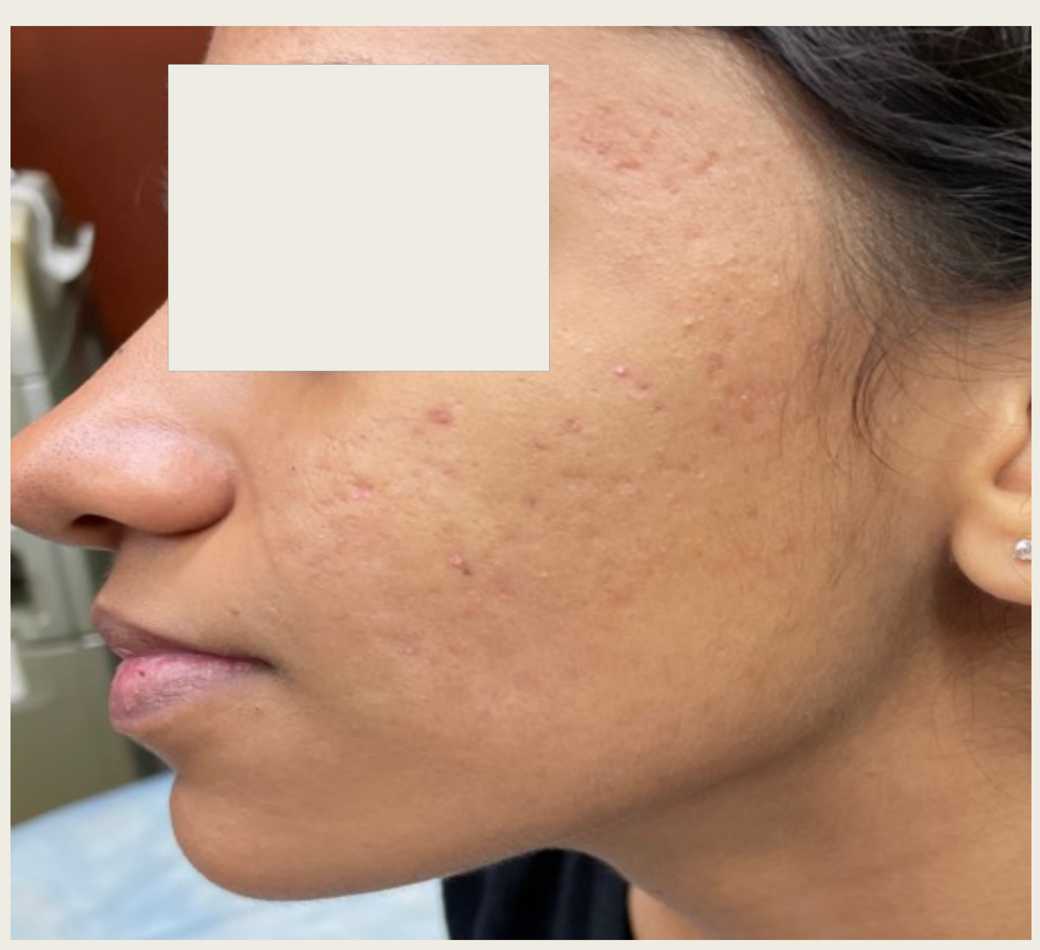






Beginning to End



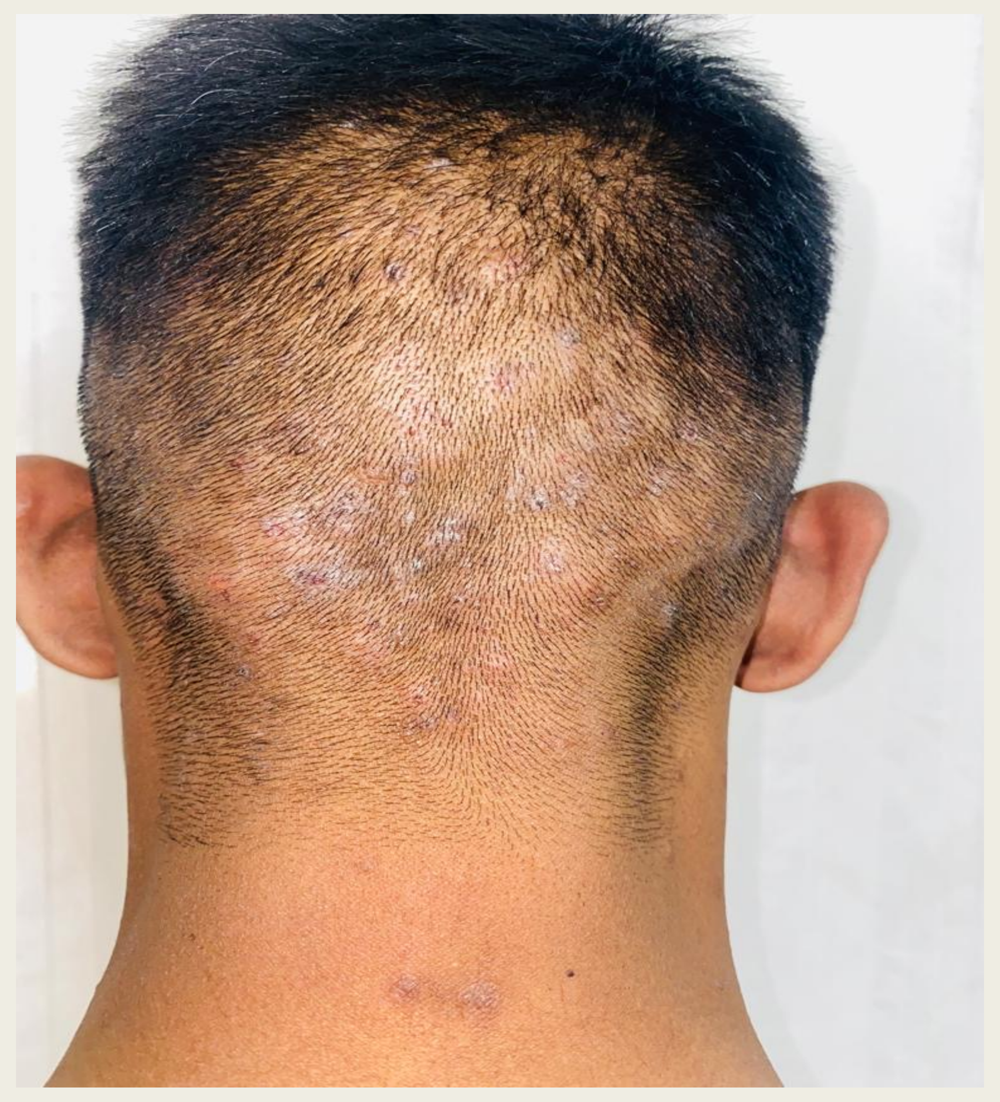


- Adolescent acne is very common and generally does not require investigations, but when we see severe cases, it warrants investigation especially since she had in addition scalp thinning, scalp seborrhoea, irregular periods (signs of hyperandrogenism).
- Endocrine reference and gynaec ref is useful, but very often parents do not want to meet several physicians.
- It is our job to counsel well, and get the patient through this disabling condition.

- DR RASHMI MAHAJAN
- PROF & HOD Sumandeep Vidyapeeth,Dhiraj Hospital
- Vadodara

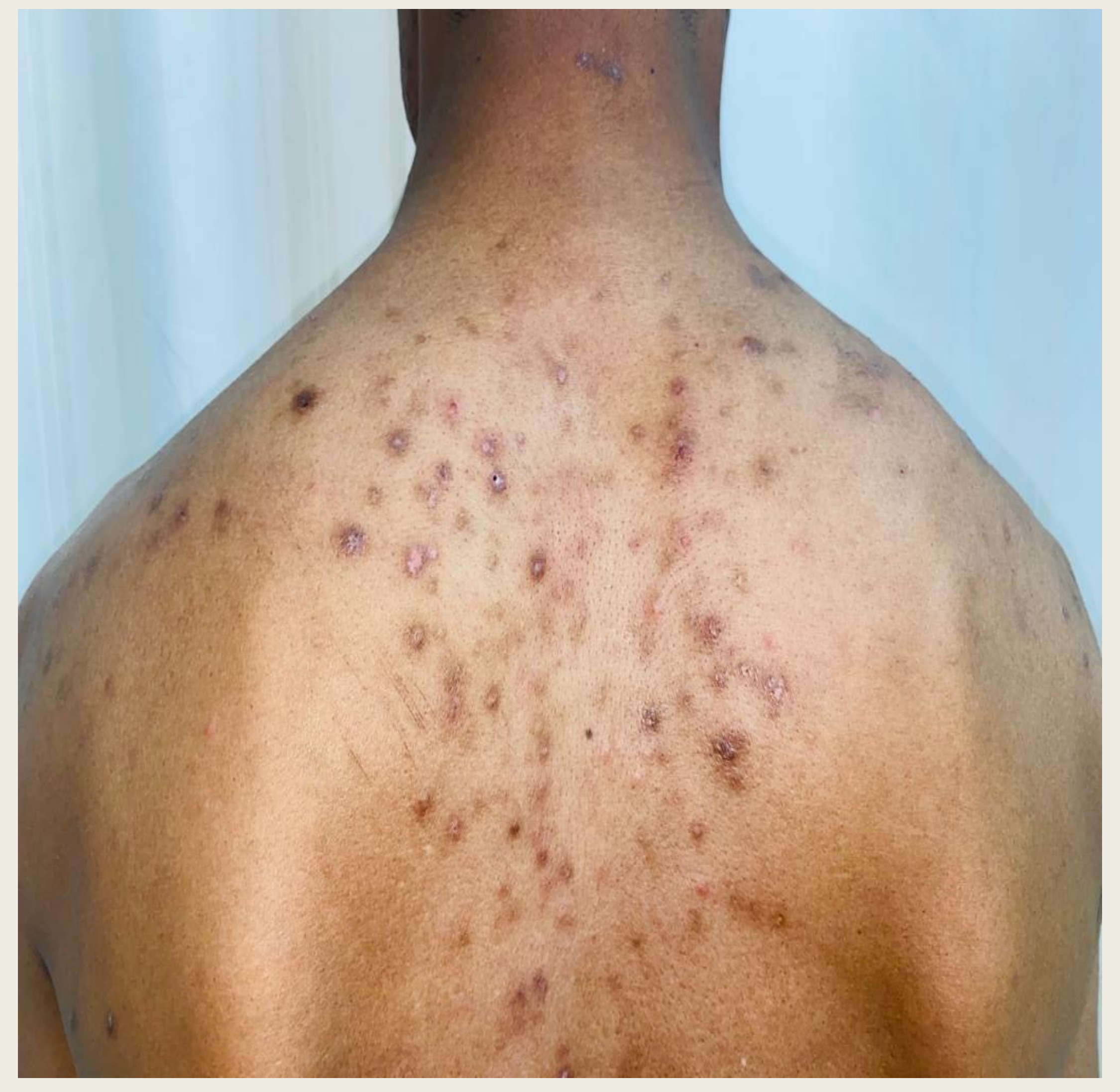
Case

- 35 year old male
- Complaints of itching with skin lesions over face and trunk since 2 months.



O/E:

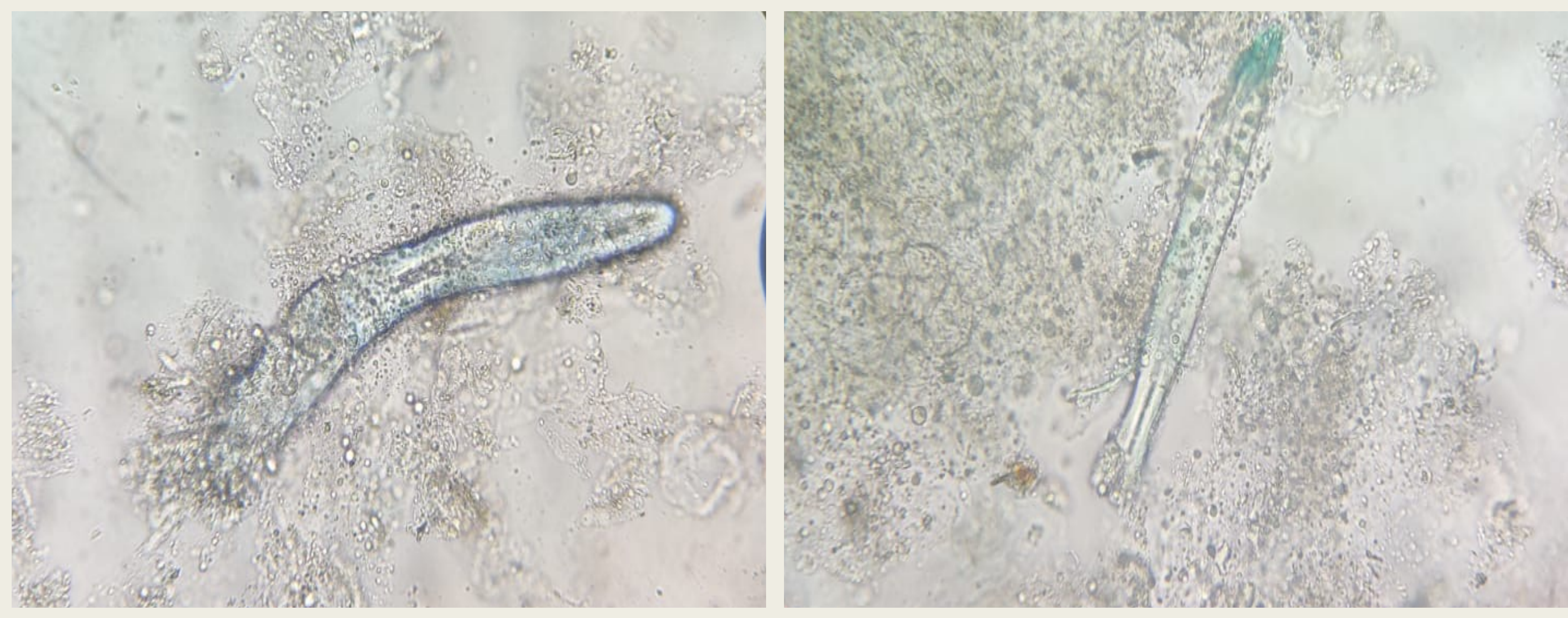
Multiple erythematous papules and excoriated papules present in seborrheic distribution



O/E:
Multiple skin coloured with hyperpigmented papules, few areas of crusting over scalp, upper back and chest.

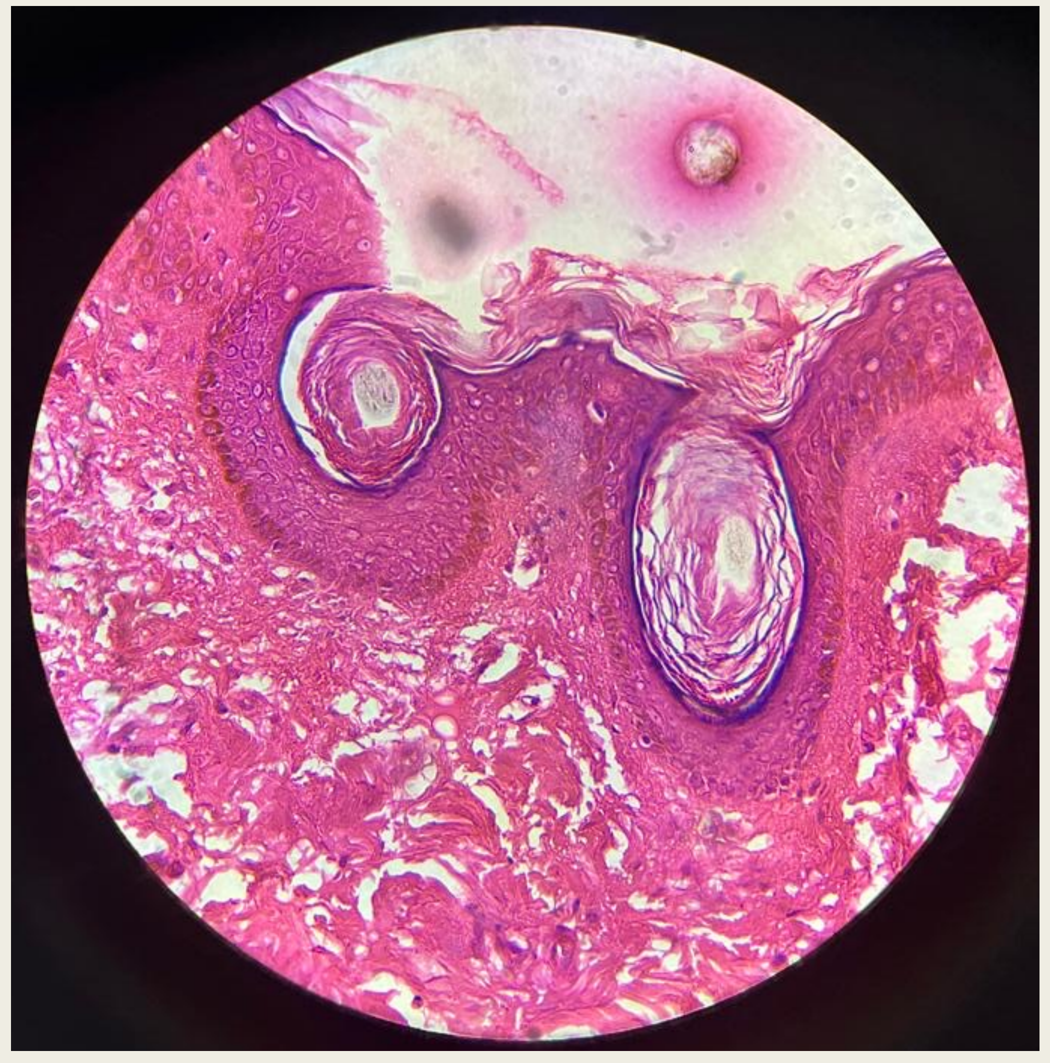
Diagnosis?

On KOH Mount



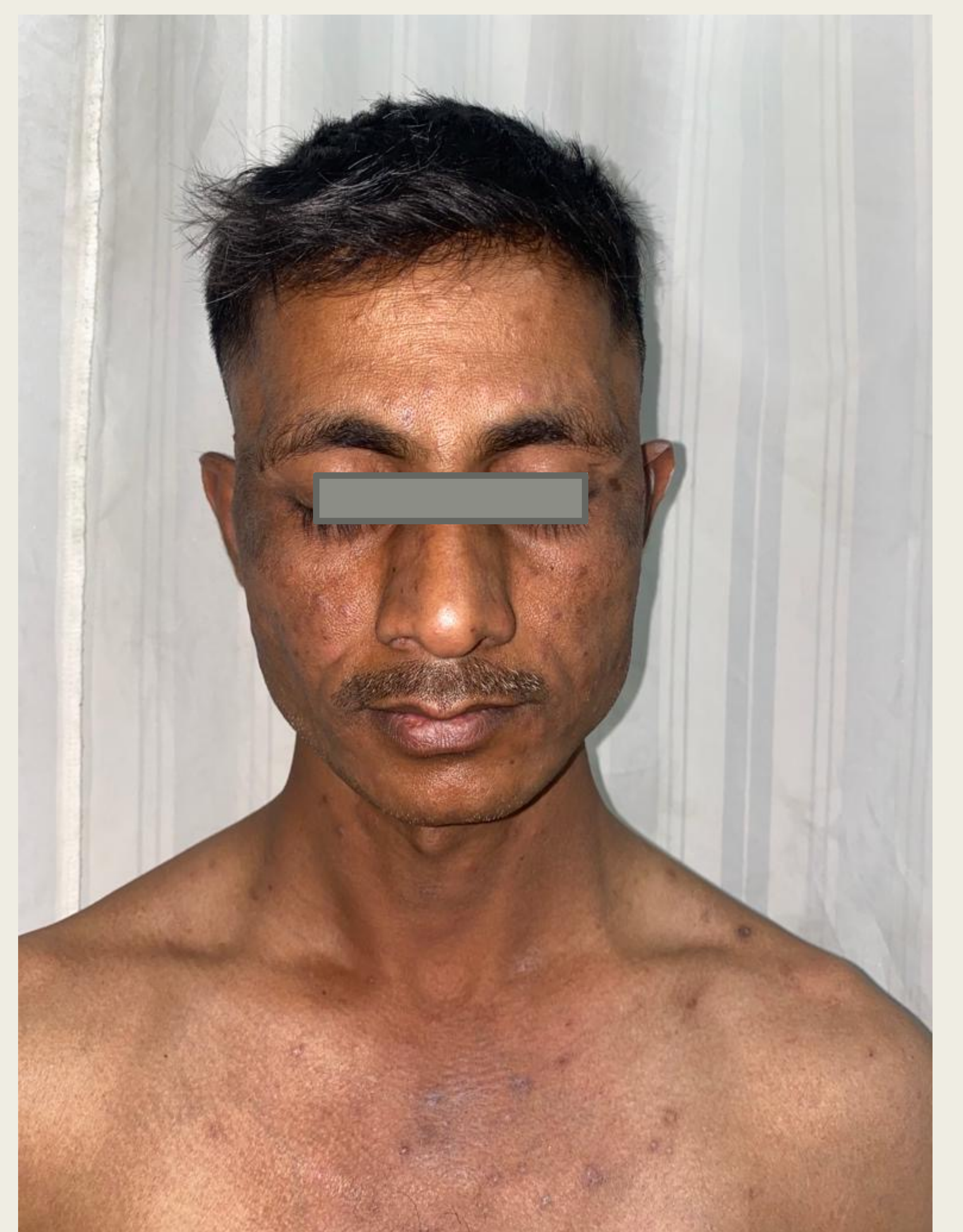
Demodex mite seen

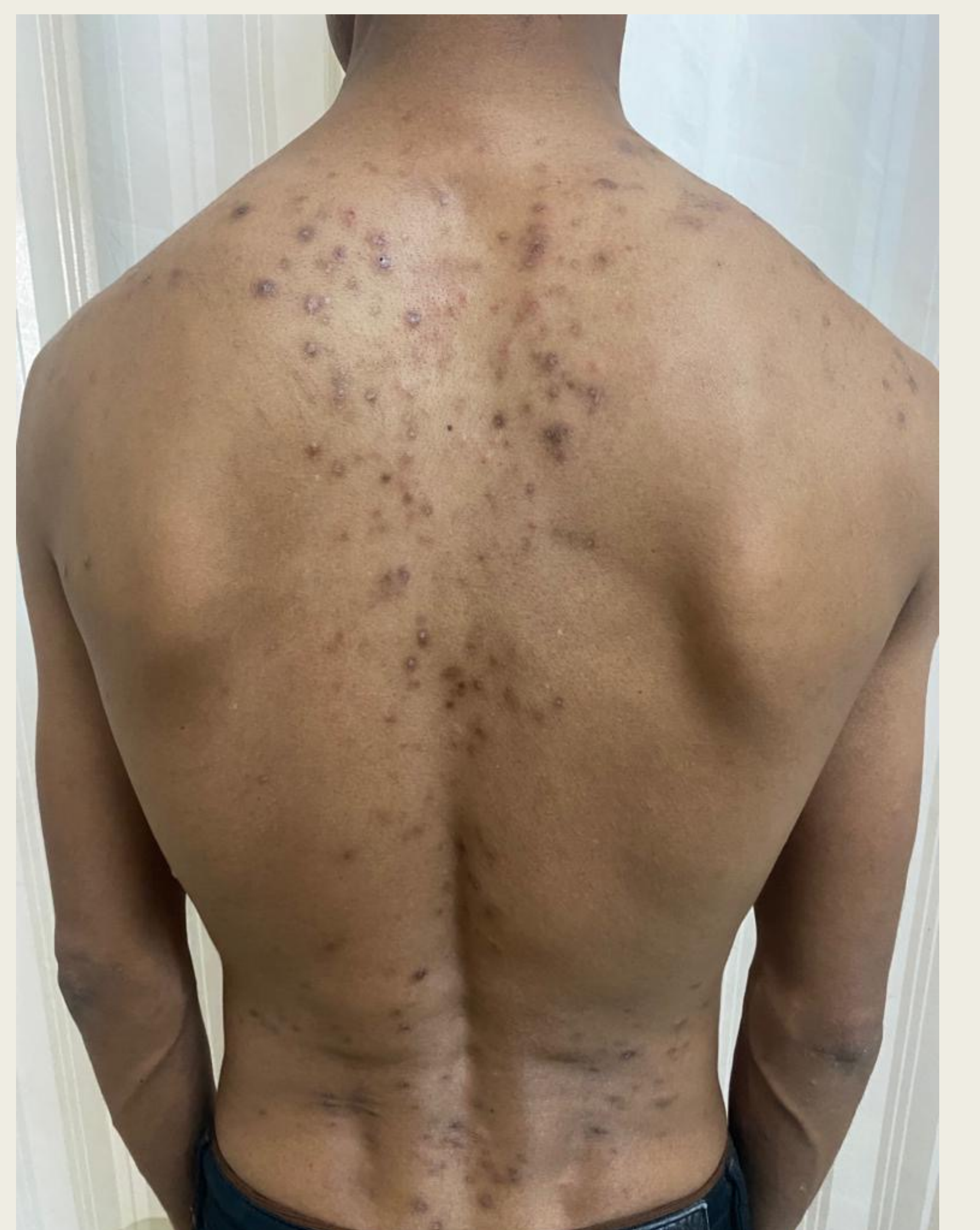
ON HISTOPATHOLOGY

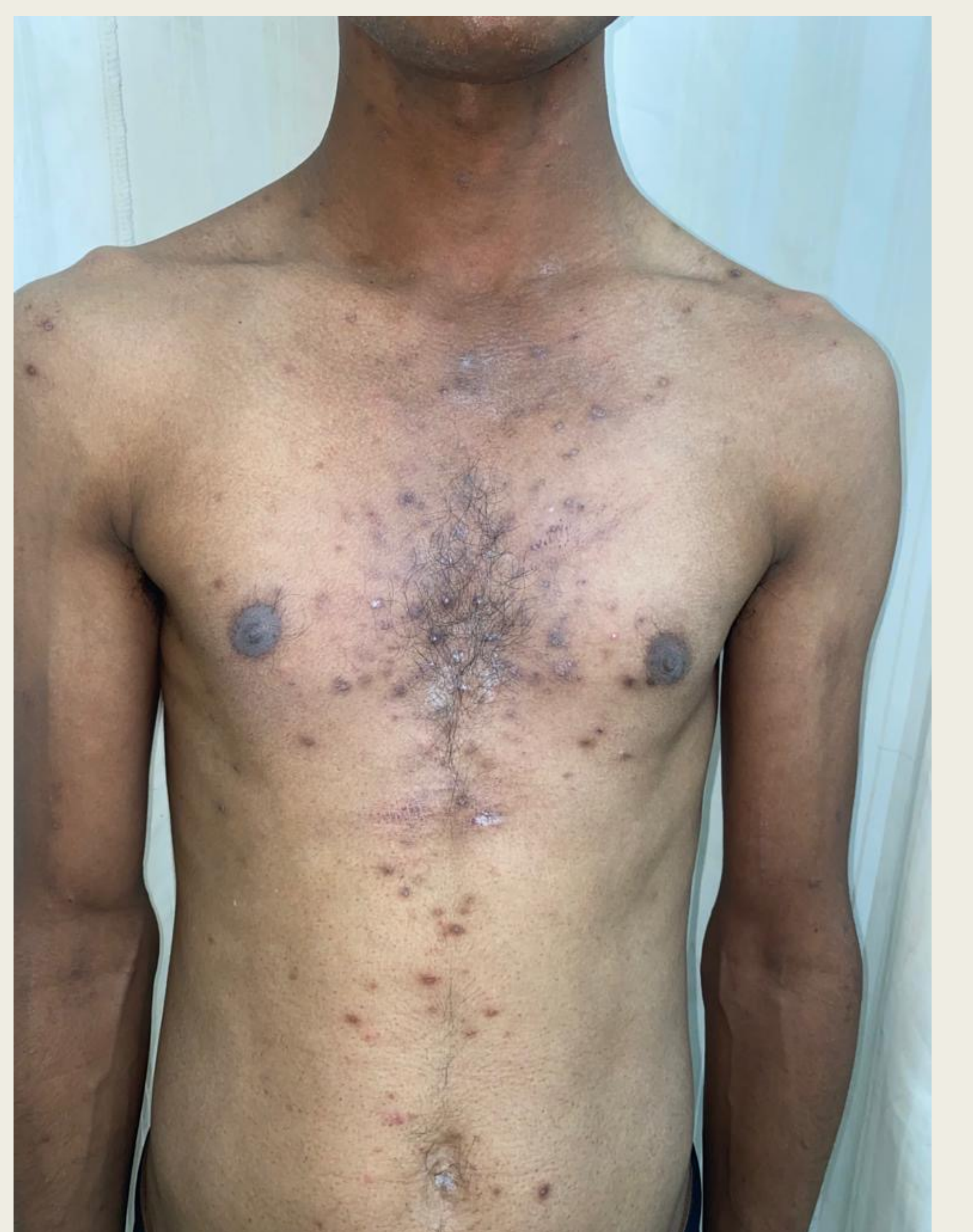


Thin epidermis with mild parakeratosis is seen. Rete pegs are short and blunt. Mild periadnexal inflammatory infiltrate is seen in the dermis. No demodex mite seen.

- The possibility of Demodex folliculitis was considered and scraping was taken. A skin biopsy was done. Biopsy reveals no specific features. However a simple scraping mounted with 10% KOH revealed Demodex mites.
- A final diagnosis of Demodicosis was made.The patient was treated with oral ivermectin 12 mg ,with topical application of permethrin 5% cream .Cap Doxycycline 100mg twice daily was continued.ART was started. However the patient was lost to follow up.
- Demodex folliculorum is a saprophytic parasitic mite of the pilosebaceous follicle and sebaceous gland. It should be considered in a rosacea like or papulopustular eruption that fails to respond to a standard therapy.
- Clinical features include itching, follicular papules and pustules, conglobate and nodulocystic lesions and blepharitis. It has been implicated in rosacea, non specific facial dermatitis, steroid rosacea, androgenetic alopecia, madarosis, lupus miliaris disseminatus faciei and dissecting folliculitis. It is commonly seen in immunocompromised patients with HIV, diabetes and hemopoietic malignancies. Demonstration of the mite on skin biopsy and surface scrapings is confirmatory for diagnosis.
- Treatment includes permethrin cream, crotamiton cream, topical and oral metronidazole and oral ivermectin.







THANK YOU.