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A case of unilateral inflamed plaques with comedones of the face

Marco A. Chessa[1], Federica Filippi[1], Francesca Ferrara[1], Annalisa Patrizi[1], Carlotta Baraldi[1]

1 Dermatology, Department of Experimental, Diagnostic and Specialty Medicine, University of Bologna, Italy

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Corresponding author: Federica Filippi, MD, Dermatology, Department of Experimental, Diagnostic and Specialty Medicine, University of Bologna, Via Massarenti 1, 40138, Bologna, Italy. Email: federicafilippi8@gmail.com

Introduction

We report on a case of a 82-year-old woman referred to us with a 2-month history of comedones and multiple yellow-colored cysts, ranging from 0.5 to 5 mm in diameter, located within erythematous plaques on her right malar region (Figure 1a). The left side was spared (Figure 1b). The patient had a history of smoking. She had been a factory worker indoors for 40 years and she denied significant sun exposure.

Case Presentation

Dermatoscopy showed yellowish lobular-like structures with rare peripheral telangiectasia (Figure 1c). Actinic keratosis, lentigo solaris and seborrheic keratosis were also detected on her face, mainly on her forehead, nose and periorbital areas. A punch biopsy was performed and histopathology revealed massive dermal elastosis and cystic-like spaces. The cystic-like spaces were lined by a flattened epithelium and were filled with layered horny material. The sebaceous glands were atrophic (Figure 1d).

Considering clinical, dermoscopic and histological findings was diagnosed unilateral Favre-Racouchot disease (FRD).

Discussion

FRD is characterized by nodules and cysts associated with the clinical signs of actinic-related skin damage and solar elastosis of the face. In 1888 Thin et al. described grouped comedones occurring in solar-damaged skin of elderly individuals for the first time. In 1951, Favre and Racouchot extended this description to include nodular elastosis and cysts [1].

FRD occurs in up to 6% of patients aged from 40 to 60 years, and most are Caucasian men [1]. Sun exposure, smoking, and therapeutic radiation are considered important risk factors.

In this disease, 3 pathogenetic steps are described: 1) loss of functional elastic tissue network and reduction of tensile strength; 2) distension of the infundibular canal of the sebaceous follicles; and 3) retention of sebum with consequent comedones formation [1].

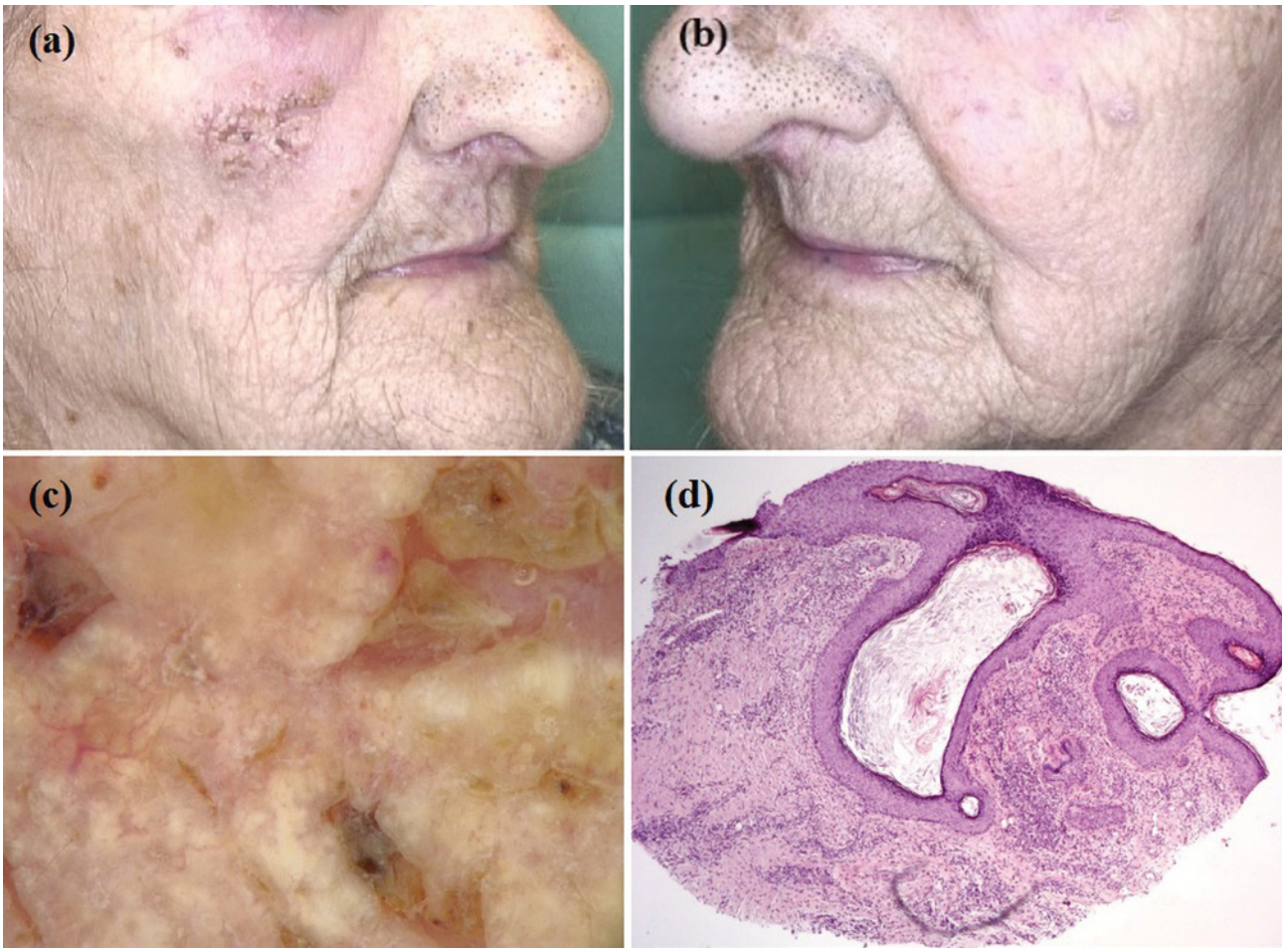

Figure 1. (a) Inflamed plaque with comedones and yellow cysts localized on right malar region; (b) left side of face was spared by Favre-Racouchot disease; (c) yellowish lobular-like structures with rare telangiectasia were detected at dermatoscopy; (d) thinning of the epidermis, massive dermal elastosis and cystic-like spaces. The sebaceous glands are atrophic (H&E 4×). [Copyright: ©2018 Chessa et al.]

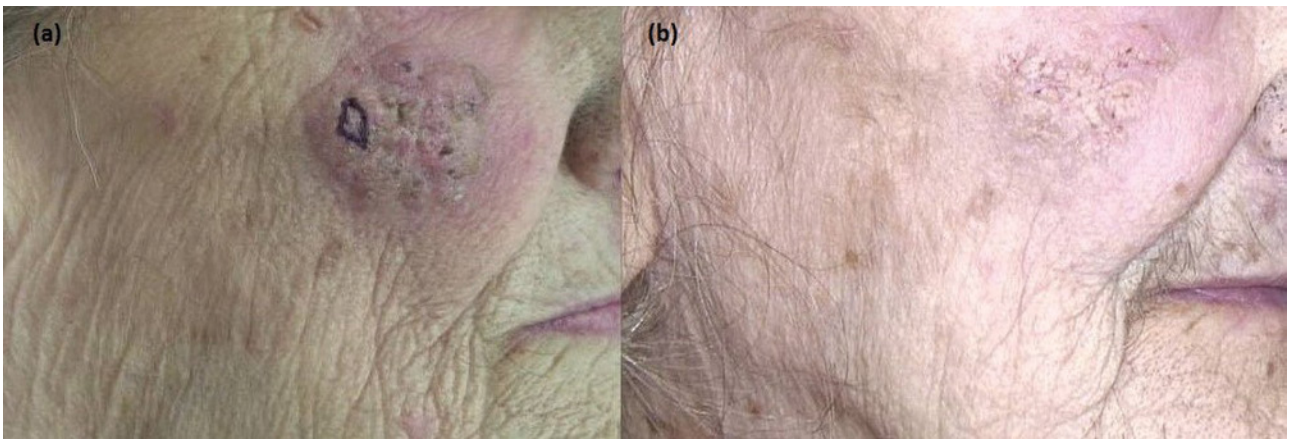

Figure 2. (a) Inflamed plaque with comedones on the right malar region; the black rectangle indicates the site where the skin biopsy was performed; (b) reduction of inflammation with improvement of the skin appearance after application of fusidic acid and tretinoin 0.05% for 2 months. [Copyright: ©2018 Chessa et al.]

Clinically, the skin involved is characterized by slowly progressive waxy and soft plaques with open or closed comedones. The surrounding skin may be thickened and shows deep furrows, isolated papules, nodules and rough and waxy plaques from 2 to 6 cm in diameter.

The skin areas usually involved are the lateral canthi of the eyes, the malar regions, as in our patient, temples, cheeks or neck and the posterior auricular skin. Usually, this disease has a symmetrical distribution even though some cases of unilateral FRS have been reported in the literature [2].

Clinical and histopathological findings usually play a pivotal role in coming to the diagnosis and ruling out chloracne, sebaceous adenoma, and syringoma [1].

The dermoscopic features of FRD have not been reported in the literature before. Histopathologically, FRD is characterized by an alteration of the pilosebaceous unit; dilated infundibulum and large, round cystic like spaces are present. Regression or absence of sebaceous glands is often detected. In addition, solar elastosis could be pronounced, but it may also be slight or absent [1].

Sunscreen and cessation of smoking can arrest the progression of the disease. Besides these measures, pharmacological and surgical approaches could be effective.

Conclusion

Our patient refused both surgical and laser therapy, so a topical treatment was started. Fusidic acid and tretinoin 0.05% creams were applied on the lesion once a day for 2 months, achieving a reduction of inflammation and a clinical improvement of the disease (Figure 2 a,b).

References

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