ACNE CONGLOBATA OF THE SCALP

Khalil I Al-Hamdi1,2,3, Anwar Qais Saadoon2

1Department of Medicine, Basra Medical College, 2Division of Dermatology, Al-Sadr Teaching Hospital, 3Basra Training Center of Iraqi and Arab Board in Dermatology and Venereology, Basra, Iraq

ABSTRACT

Acne conglobata (AC) is a rare form of severe and chronic nodulocystic acne. It is characterized by nodulocystic lesions, borrowing, interconnecting abscesses, scars, in addition to grouped comedones. AC usually appears on the trunk and may extend to the buttocks. It can also appear, to a lesser extent, on the face, neck, shoulders, proximal arms, abdomen, and thighs. To the best of our knowledge, AC of the scalp has not been reported in the literature. Herein, we are reporting a case of AC of the scalp, emphasizing its clinical and trichoscopic features and how to differentiate it clinically from similar scalp conditions, especially alopecic and aseptic nodules of the scalp and dissecting cellulitis of the scalp.

Key words: Acne conglobata of the scalp, alopecic and aseptic nodules of the scalp, comedones, dissecting cellulitis of the scalp

INTRODUCTION

Acne conglobata (AC) is a rare, chronic, and severe form of acne, first described by Lang in 1902 and Spitzer in 1903.1–3 It is characterized by nodulocystic lesions, draining sinuses, interconnecting deep-seated abscesses with seropurulent discharge, grouped and polyporous comedones, and atrophic or hypertrophic scars.3 Systemic symptoms are usually absent. It occurs mainly in young males and is usually located on the back, chest, or buttocks. It can also appear on the forehead, cheeks, neck, shoulders, upper arms, abdomen, and thighs.3 To the best of our knowledge, AC of the scalp has not been reported in the literature.

CASE REPORT

A 23-year-old Iraqi male presented in our outpatient clinic at Al-Sadr Teaching Hospital with a 9-month history of nodular scalp lesion on the vertex accompanied by multiple scars and blackheads. The patient had recurrent episodes of the same lesion, which usually appeared as single or multiple nodules, enlarging in size to reach 2–3 cm in diameter, accompanied by the hair loss on the surface, and when resolved, leaving areas of scarring or nonscarring alopecia, with regrowth often occurs within 2–3 months. Puncture of the nodule usually reveals seropurulent material. The patient has a history of acne vulgaris controlled with oral isotretinoin. There were no other skin conditions or joint pain. Systemic symptoms were absent.

Examination of the patient’s scalp showed a fluctuating, skin-colored, and dome-shaped nodule, 2 cm in diameter, on the vertex, accompanied by hair loss on the surface, with

Access this article online
Website: www.ijtrichology.com
DOI: 10.4103/ijt.ijt_117_19
Quick Response Code:
Al-Hamdi and Qais Saadoon: A young male with scalp acne conglobata

regrowth of a few hairs. There were also multiple atrophic scars and three areas of alopecia, 1–2 cm in diameter, resulting from resolved nodules. A close observation of the scalp showed multiple grouped comedones distributed over the vertex and occipital areas [Figure 1].

Trichoscopic examination of the nodule revealed a honeycomb pattern, black dots, white dots, vellus hairs, broken hair shafts, and violaceous areas [Figure 2a]. Trichoscopy of other vertex and occipital areas showed multiple grouped comedones [Figure 2b].

A biopsy from the nodule showed follicular plugging, ruptured pilosebaceous apparatus with mixed inflammatory infiltrate (perifollicular and in the deep dermis) [Figure 3]. Cultures of the punctured material were negative. The patient tried oral isotretinoin without improvement. However, new lesions have not developed after 2 months of treatment with oral doxycycline, 100 mg/day, with improvement of the already presented lesions.

DISCUSSION

AC occurs usually as nodulocystic lesions on the back, chest, or buttocks. It can less commonly be located on the face, neck, shoulders, upper arms, abdomen, or thighs. Herein, we are reporting a case of AC located on the scalp. Other diseases that affect the scalp and present as nodulocystic lesions must be differentiated from AC of the scalp, in particular, alopecic and aseptic nodules of the scalp (AANS) and dissecting cellulitis of the scalp (DCS). AANS carry a good prognosis and may even resolve spontaneously or after treatment. It can be differentiated clinically from AC of the scalp by the absence of the scars or scarring alopecia. Comedones are usually absent in AANS. DCS and AC can be parts of a follicular occlusion tetrad, along with hidradenitis suppurativa and pilonidal sinus. Grouped comedones are absent in DCS, and the trichoscopic examination usually shows yellow structureless areas and three-dimensional yellow dots over a dystrophic hair shaft, especially in the late stage of the disease. These findings are absent in cases of AC of the scalp.

![Figure 1](image1.png)  
**Figure 1:** Superior view of the patient’s scalp shows a dome-shaped nodule with multiple atrophic scars and comedones. Note the multiple grouped comedones (inset)

![Figure 2](image2.png)  
**Figure 2:** (a) Trichoscopy of the nodular lesion reveals a honeycomb pattern, few black dots, white dots, vellus hairs, broken hair shafts, and violaceous areas. (b) Trichoscopy of the vertex and occipital areas shows multiple grouped comedones
Al-Hamdi and Qais Saadoon: A young male with scalp acne conglobata

International Journal of Trichology / Volume 12 / Issue 1 / January-February 2020 37

Figure 3: Histopathology shows ruptured pilosebaceous unit with perifollicular mixed inflammatory infiltrate, (H and E; x4). Note the mixed inflammatory infiltrate (inset, x40)

Financial support and sponsorship
Nil.

Conflicts of interest
There are no conflicts of interest.

REFERENCES
1. Lang H. Hautkrankheiten. Wiesbaden; JF Bergmann; 1902. p. 504.
2. Spitzer L. Dermatitis Follicularis et Perifollicularis Conglobata. Dermatol Z 1903;10:109.
3. Canpolat F, Kurmuş GI, Göñül M. Acne conglobata. Ro J CED 2017;2:68-73.
4. Yiu ZZ, Madan V, Griffiths CE. Acne conglobata and adalimumab: Use of tumour necrosis factor-α antagonists in treatment-resistant acne conglobata, and review of the literature. Clin Exp Dermatol 2015;40:383-6.
5. Shirakawa M, Uramoto K, Harada FA. Treatment of acne conglobata with infliximab. J Am Acad Dermatol 2006;55:344-6.
6. Vega J, Sánchez-Velicia L, Pozo T. Efficacy of etanercept in the treatment of acne conglobata. Actas Dermosifiliogr 2010;101:553-4.
7. Sand FL, Thomsen SF. Adalimumab for the treatment of refractory acne conglobata. JAMA Dermatol 2013;149:1306-7.
8. Vasanth V, Chandrashhekar BS. Follicular occlusion tetrad. Indian Dermatol Online J 2014;5:491-3.
9. Ross EK, Tan E, Shapiro J. Update on primary cicatricial alopecias. J Am Acad Dermatol 2005;53:1-37.

Declaration of patient consent
The authors certify that they have obtained all appropriate patient consent forms. In the form the patient(s) has/have given his/her/their consent for his/her/their images and other clinical information to be reported in the journal. The patients understand that their names and initials will not be published and due efforts will be made to conceal their identity, but anonymity cannot be guaranteed.