To the Editor:

Pityrosporum folliculitis is not uncommon in Sri Lanka

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Piryrosporum folliculitis is an itchy skin eruption mostly involving upper back, shoulders and chest. Sometimes forearms, arm and face are also involved The typical rash consists of small itchy, dome shaped skin coloured or erythematous papules with intermingling small pustules[1-4]. Pruritus, absence of comedones and rarity of facial involvement are some features that differentiate pityrosporum folliculitis from acne. However when acne and pityrosporum folliculitis coexist it may pose a diagnostic problem. This condition affects adolescents and adults of either sex. It has been reported commonly in Asian countries especially in the South East Asian region. It is common among young adults in Singapore (Kumarasinghe 2003, personal observation). However in Sri Lanka it is often under recognized. This condition is often misdiagnosed as truncal acne.

Diagnosis is mostly clinical; based on the typical clinical features as described above. It can be confirmed with scrapings from the base of a follicular pustule. The smear made from the scrapings is stained with Gram stain and examined with a light microscope under oil emersion. Spores are seen as round bodies stained in dark pink.

Management should be aimed at avoiding predisposing factors and suppression of overgrowth of the yeast. Local application of antifungals (such as topical ketoconazole) with oral antifungals; ketaconazole 200mg daily for 2 weeks or itraconazole 100mg bd for 2 weeks are recommended. The response is better when combined with ketoconazole shampoo twice a week up to 3 months. Sometimes, recurrences occur. Therefore it is important to control the predisposing factors where possible.

In this condition, the yeast *Pityrosporum ovale* descends into hair follicles and multiplies. This yeast tends to grow in hot, humid and sweaty conditions. Occlusive clothing, oily skin, being over-weight are possible predisposing factors of this condition. The factors which lead to suppression of host resistance, like diabetes mellitus and oral steroids also can aggravate or precipitate this condition. This condition can also occur when the patients are on oral antibiotics like tetracycline, due to competitive overgrowth of the yeast.

Associated conditions include pityriasis versicolor (due to overgrowth of same organism) and acne (as increased oil also promotes acne.)

Case history I

A 16 year old school girl presented with an itchy papular rash on trunk and upper limbs of two weeks duration. She gave a history of practicing ballet dancing for few months prior to appearance of the rash. While practicing, she had to wear a tight fitting costume which made her uncomfortable due to intense sweating. A clinical diagnosis of pityrosporum folliculitis was made. After treatment with oral itraconazole 200mg daily for 2 weeks and ketoconazole and zinc pyrithion shampoo, her condition improved.

Case history II

A 34 year old male patient who was on prednisolone for a neuralgic pain was referred from the Rehabilitation Hospital, Ragama with an itchy erythematous papular eruption on the trunk of 3 weeks duration. On examination he had numerous follicular papular lesions involving the trunk (Fig 1). Scrapings from one of the lesions revealed bunches of Gram positive fungal spores suggestive of Malassezia spores. He was treated with oral itraconazole 200 mg daily for 2 weeks with ketoconazole shampoo washes every other day. His condition improved dramatically after 2 weeks of treatment.

In conclusion pityrosporum folliculitis needs to be recognized and treated appropriately.

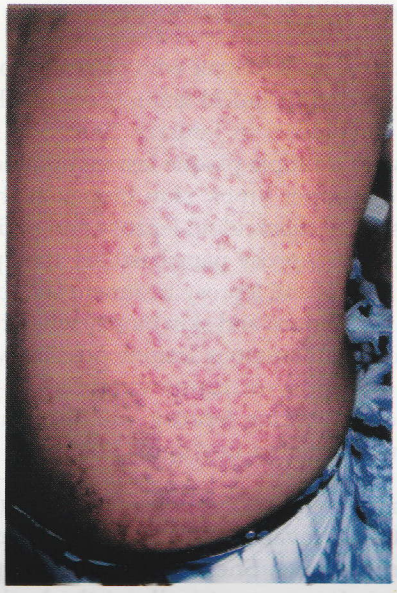

Figure 1. *Before treatment – inflamed follicular papules on the trunk.*

References

1. Back O, Faergemann J, Hornqvist R. Pityrosporum folliculitis: a common disease of the young and middle-aged. *J Am Acad Dermatol* 1985; **12**: 56-61.

2. Aditya KG, Roma B, Robin B. Skin disease associated with Malassezia species. *J Am Acad Dermatol* 2004; **51**: 280-3.

3. Ford G. Pityrosporum folliculitis. *Int J Dermatol* 1984; **23**: 320-1.

4. Jacinto-Jamora S, Tamesis J, Katigbak ML. Pityrosporum folliculitis in the Philippines: diagnosis, prevalence and management. *J Am Acad Dermatol* 1991; **24**: 693-6.

K M G D Rajapaksha, *Medical Officer,* **D M Hewage,** *Registrar in Dermatology,* **S P W Kumarasinghe,** *Consultant Dermatologist, North Colombo Teaching Hospital, Ragama.*