Read Item - Follicular mucinosis

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Abstract: Doctor's resource on Follicular mucinosis

Follicular mucinosis

Follicular mucinosis occurs in two forms: a primary idiopathic form and a secondary form. The secondary form is most commonly associated with lymphoma, especially mycosis fungoides, but it is also associated with chronic discoid lupus erythematous, angiolymphoid hyperplasia with eosinophilia and verruca vulgaris. The clinical features of primary and secondary cases are indistinguishable.

Primary follicular mucinosis can occur at any age from early childhood onwards, but is most common between 10 and 40 years. Secondary follicular mucinosis tends to occur in an older age group.

Follicular mucinosis consists of grouped, sometimes itchy, follicular papules and erythematous, boggy plaques that occur mainly on the head and face, but they can occur anywhere. Some may ulcerate. Characteristically the plaques are devoid of hair and patulous follicular openings are visible to the naked eye. The follicles are sometimes studded with horny plugs, and mucin can be expressed from the affected follicles. Hair loss is not obligatory and for this reason the name follicular mucinosis is preferred to the original name alopecia mucinosa. Linear lesions following Blaschko?s lines have been described.

In the secondary group the lesions may be widely disseminated on the trunk and limbs. Untreated the plaques often resolve spontaneously within 2 months to 2 years, but in older patients they may be more persistent. Some 15 to 20% of these chronic cases are associated with mycosis fungoides.

All cases require a biopsy to confirm the diagnosis and to look for histological evidence of mycosis fungoides. The histology is characteristic and demonstrates reticular degeneration of hair follicles and sebaceous glands associated with copious mucin (hyaluronic acid), especially in the outer root sheath of the hair follicle. A variable dermal inflammatory infiltrate is present and should be studied carefully for evidence of mycosis fungoides. In many cases the features of mycosis fungoides are subtle. In such cases only regular follow-up of the patient will distinguish primary from secondary causes of follicular mucinosis.

Many cases spontaneously improve and topical or intralesional steroids may hasten this. Superficial radiotherapy helps cases secondary to mycosis fungoides. Widespread pruritic lesions may benefit from low dose systemic steroids or occasionally dapsone. Patients for whom radiotherapy is undesirable are very difficult to treat and follicular mucinosis can run a prolonged course.