CASE REPORT

A 51-year-old married woman presented with a 6-month history of an asymptomatic eruption on the trunk. On examination, there were numerous pearly semi-translucent erythematous papules, varying in diameter from 2 to 4 mm (Fig. 1). The skin eruptions appeared to be located with a follicular-centric distribution. There were no central umbilication although occasional lesions had a hair growing through the center. According to the patient's statement, the lesions suddenly appeared on the anterior chest and spreaded rapidly over the whole trunk. She had been treated toward bacterial folliculitis but in vain at local clinics. The patient had a regular sexual partner. She did not have atopic dermatitis. However, she has a noteworthy habit of taking saunas for 10 years and taking spas for one year. Serological examination of HIV was performed which showed a negative result. Peripheral blood T-cell subsets were normal. A skin biopsy was taken from a papule on the anterior abdomen (Fig. 2 and Fig. 3). After being treated with three courses of cryotherapy with liquid nitrogen, the lesions cleared without scarring or recurrence.

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**DIAGNOSIS: Molluscum Folliculitis**

**DISCUSSION**

The common clinical presentations of molluscum contagiosum are well known to dermatologists. However, folliculitis due to the virus is an infrequently reported entity and might be considered a sign of immunosuppression.

Molluscum contagiosum virus (MCV) occurs predominantly in preadolescent children, sexually active adults, participants in sports with skin-to-skin contact, and in individuals with impaired cellular immunity. Individuals with impaired cellular immune function may have widespread lesions. Individual lesions may last 2 to 4 months, and the development of new lesions by autoinoculation is common. Most cases resolve spontaneously in 6 to 9 months, but some may persist for years, especially in immunocompromised patients.

Viral folliculitis due to MCV has been termed as "molluscum folliculitis". There have been few reported cases of MCV involving follicular structures. The virus enters through breaks in the epidermis or in the infundibular portion of the hair follicle. Mechanical trauma is especially relevant to the clinical presentation of molluscum folliculitis.

Reed and Parkinson found that areas of hair bulb differentiation were common at the periphery of a molluscum contagiosum lesion, and that the lesion occasionally was associated with areas of sebaceous gland differentiation. They suggested that the virus-infected cells were capable of differentiating into abortive hair follicles and sebaceous glands (follicular neogenesis). However, Brandrup and Asschenfeldt found the appearance of arrector pili muscles and argued for the primary follicular nature.

They suggested that molluscum folliculitis characteristically proliferates within the follicular epithelium. In our patient, primary follicular origin was supported by the fact that arrector pili muscles were noticed near MCV infected lesions.

Our patient was likely to be infected by MCV during taking saunas or spas. Although the patient did not have abnormal immune functions, habits of taking saunas and spas may increase the incidences of skin-to-skin contact and mechanical trauma. This may play a part in the development of molluscum folliculitis in our case. A relationship between outbreaks of molluscum contagiosum and swimming schools had been described. However, the relationship between molluscum folliculitis and saunas or spas has not reported yet.

**REFERENCE**