SHORT COMMUNICATION
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Eruptive vellus hair cyst syndrome or exuberant atypical keratosis pilaris?

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Dear Editor,

A generally healthy 35-year-old man presented with complaints of trunk skin lesions since his early childhood. He reported no symptoms and lesions were stable so far. Clinical examination revealed slightly hyperchromic, multiple, and disseminated perifollicular small papules on the anterior aspect of the trunk (Figure 1). No lesions were found at any other place on full-body skin examination. Eruptive vellus hair cyst (EVHC) syndrome was considered as a main diagnostic hypothesis, but the patient declined to undergo a skin biopsy for diagnostic confirmation. Treatment with a compounding cream of 20% urea plus 5% salicylic acid was prescribed and the patient reported moderate improvement after 3 months of use.

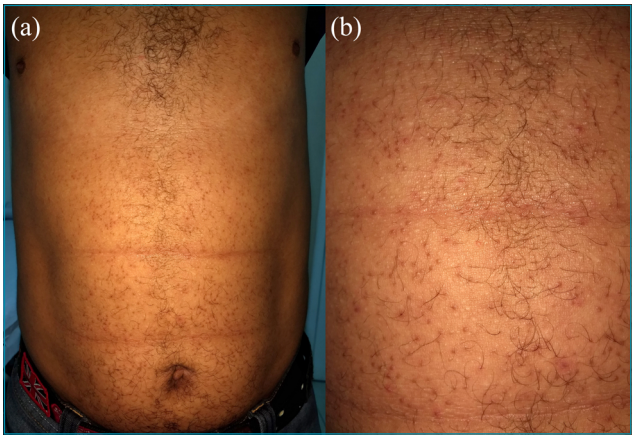

Figure 1. (a) shows the patient's frontal aspect of the trunk, covered by slightly hyperchromic, multiple, and disseminated perifollicular small papules on the anterior aspect of the trunk; (b) presents a closer view of skin lesions.

EVHC, firstly described by Esterly et al. is considered a rare condition that affects equally different genders and ethnicities1-3. There is a predilection to adolescents and young adults2, as in the current report. Even though most reports present sporadically, some believe its pathogenesis comes from autosomal dominant inheritance and follicular occlusion by keratin and folding of multiple vellus hairs2-4. Clinical features are as described in our patient and can affect limbs, face, abdomen, gluteal and genital region, as well as the trunk2,4. Keratin-17 mutations were described on EVHC patients5.

Clinical differential diagnosis of EVHC includes keratosis pilaris, acneiform eruptions, steatocystoma multiplex, milia, contagious mollusk, and folliculitis2-5. Definitive diagnosis is confirmed by skin biopsy exam1-5. Our patient did not want to undergo a skin biopsy because of personal concerns with scar raising. Thus, the exact diagnosis of the current case remains unclear.

As for clinical practice, though, we considered an exuberant and atypical form of keratosis pilaris as the main differential diagnosis for the current case, given its presentation. Both conditions are benign skin lesions and may be managed with topical keratolytic agents, such as urea, retinoids, salicylic acid, and lactic acid2,4,5. Laser, surgical and oral treatment is also described, but with limited results5.

This communication aims to stress that even though without a precise and definitive diagnosis, the current case

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examples a patient with skin lesions that invasive investigation would not lead to a better therapeutic decision or prognostic statement. We agree that microscopic examination of lesions would enrich this report. However, authors consider it noteworthy to say that complementary investigation should be done wisely, and patients' choices on refusing procedures must be respected, as well as daily practice skin conditions investigation should be oriented by well-established clinical, therapeutic and prognostic criterion. Additionally, we have to say that EHVC may be considered as a rare syndrome due to underdiagnosed, histopathological-confirmed cases, as the current communication.

AUTHOR'S CONTRIBUTIONS

BOR: Conceptualization of the study, Literature review, Dermatological examination, Drafting, Reviewing, Editing the final paper. **HVCS:** Literature review, Drafting, Reviewing, Editing the final paper. **JDF:** Supervision, Dermatological examination, Editing the final paper.

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