

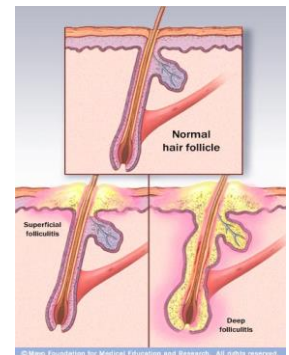
## Folliculitis Highlights

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Taken From:  
<http://www.shorthillsderm.com/blog/wp-content/uploads/2014/11/What-is-Folliculitis.jpg>

- **Definition:**
  - Inflammation of the hair follicle caused by either chemical/physical irritation or viral/bacterial infection
  - Folliculitis is the smallest and most minor
  - Furuncles are larger, carbuncles larger than that, and boils even larger (3)
- **Common associations:**
  - **Diabetes, immunosuppression, shaving**
- **Diagnosis:**
  - Based on appearance and history
  - Usually seen on scalp, face, legs, back, chest, axilla
  - Folliculitis is usually not tender compared to carbuncles and furuncles
  - If someone has had recent contact w/ hot tub or DM, consider pseudomonas as potential bacteria (3)
  - May see hyper- or hypopigmentation post infection
- **Tx:**
  - Warm compresses 3 times/day
  - Antibiotics as treatment of recurrent infections is controversial as increased antibiotic use may lead to increased resistance
    - Topical mupirocin for moderate folliculitis, more severe infections may require antibiotics
    - For tx of strep: dicloxacillin or cefadroxil; tx of strep infections helps to prevent PSGN but no effect on rheumatic fever (3)
    - For tx of pseudomonas: fluoroquinolones or carbapenems or other anti-pseudomonal options
    - For tx staph (particularly MRSA): 7-10 day course of Bactrim, clindamycin, doxycycline, vancomycin, linezolid,... other antibiotics reserved for more severe infections. (5)
  - Many people carry MRSA in their nares. Between 10-35% are persistent carriers and 20-75% intermittent carriers. (4)
    - Should we treat carriers? (Mashhood AA, 2006) recommends nasal swab testing in all patients with recurrent “furunculosis” aka boils aka abscesses. If positive, patients should receive prophylactic antibiotics as infection resolves.
    - Recommended courses: (1) rifampin 5-10d course in combination w/ other antibiotics or alone (7) (2) mupirocin nasal ointment twice daily for 5d may temporarily eradicate *S. aureus* in the nares and hence prevent subsequent infections (1)
- Folliculitis kinda...



Taken from  
[http://riversideonline.com/source/images/image\\_popup/sn7\\_hairfollicle.jpg](http://riversideonline.com/source/images/image_popup/sn7_hairfollicle.jpg)

- Pseudofolliculitis barbae: usually affects men of African descent. Seen in bearded areas secondary to shaving, results in ingrown hairs and keloid formation. Management includes avoidance of shaving or using a spacer to prevent ingrown hairs. (2)
- Hidradenitis suppurativa: (8)
  - Usually affects people of African descent
  - Occurs in areas similar to folliculitis but more penchant for intertriginous areas such as inner thighs, groin, buttocks
  - Can manifest as everything from folliculitis to abscesses, fistulas, keloids
  - Usually see recurrence – people have multiple infections/year
  - May result from defects in innate follicular immunity and overreaction of CONS
  - Mild HS can be tx w/ topical clindamycin or dapsone
  - Stage 1-2: rifampin + oral clindamycin or minocycline
  - Advanced stages may require immunosuppressants, intralesional steroids, de-roofing of fluctuant nodules, surgical excision and CO2 laser ablation for definitive mgmt.
- Eosinophilic folliculitis: seen in patients w/ AIDS; pruritic and usually seen on the trunk



Taken from:

<http://www.skindsight.com/images/dx/webTeen/hidradenitis>

- Take-home Points

- Mild Folliculitis: tx w/ warm compresses 3 times/day
- Moderate folliculitis: use topical mupirocin
- More severe folliculitis: consider antibiotics, but have discussion with patients about risks/benefits
  - Benefits: potential temporary eradication of specific organism targeted by antibiotic
  - Risks: side effects of antibiotics (diarrhea, nausea, vomiting, photosensitivity), recurrence of infections, increased antibiotic resistance
- Discuss w/ patients the pros/cons of nasal swab testing for MRSA w/ their primary care physician

### References / Further Reading

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