

Nonfamilial bilateral axillary nevus comedonicus in a 24-year-old lady – a case report

J. Chowdhury, A.K. Roy, S. Das, S. Hansda

Department of Dermatology, Nil Ratan Sircar Medical College & Hospital, Kolkata

Abstract Nevus comedonicus is a rare hamartoma of the pilosebaceous unit. Bilateral involvement is relatively uncommon and is usually associated with other non-cutaneous anomalies. We report a case of non-familial nevus comedonicus affecting both axillae and ears only in a 24-year-old lady without any other anomalies.

Key words

Nevus comedonicus, axillary, bilateral.

Introduction

Nevus comedonicus is rare hamartoma of the pilosebaceous unit. It clinically appears as a collection of discrete, dilated follicular ostia plugged with hyperpigmented keratinaceous material.¹ Most of the cases present at birth or in early childhood. When associated with other systemic anomalies it is known as nevus comedonicus syndrome. We present a case of non-familial bilateral axillary nevus comedonicus without any systemic anomalies in a 24-year-old lady.

Case Report

A 24-year-old lady presented with asymptomatic blackish lesions over both her ears and axillae **Figure 1** and **2**. She observed the lesions since last 2 years. On examination multiple grouped comedo-like black keratin filled pits and comedones were present in both the axillae and single comedones were noted in front of both the

ears. There were no double comedones. There was no sinus tract or scarring. There were no lesions elsewhere in the body, and mucosae, hair and nail were unaffected. Thorough systemic and laboratory investigations revealed no abnormality. There was no familial history of similar lesions. Acne vulgaris, childhood flexural comedones, nevus comedonicus, lichen planus were kept as differential diagnosis. Histopathological examination from both axillary and ear lesion showed epidermis with deep invagination filled with keratin. The dermis showed rudimentary appendages (**Figure 3**). Thus diagnosis of nevus comedonicus was made.

Discussion

Nevus comedonicus, also known as nevus follicularis keratosis, nevus acneformis unilateralis, nevus zoniforme, is a hamartoma of the pilosebaceous unit. There is improper formation of hair matrix cells and sebaceous gland. It was first described by Kofmann in 1895.¹ It presents as multiple comedo-like dilated pores filled with black keratinous plug. It

Address for correspondence

Dr. J. Chowdhury (MD Dermatology)
RMO-cum-Clinical Tutor
Department of Dermatology
Nil Ratan Sircar Medical College 7 Hospital
Kolkata
Email: author-joyeeta_chowdhury@yahoo.co.in



Figure 1 Comedones in both axillae



Figure 2 Comedones in front of both ears

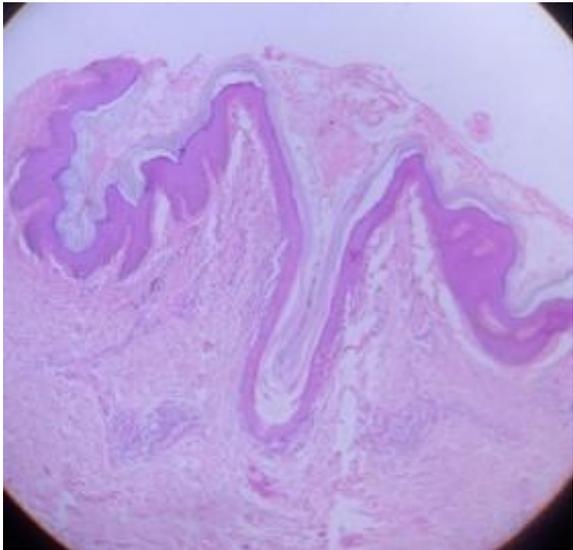


Figure 3 Histopathology from both axillary and ear lesions [H&E stain] showed epidermis with deep invagination filled with keratin [400x]. The dermis had rudimentary appendages

commonly affects face, trunk and upper extremities,^{2,3} but involvement of palms, soles, and penis has also been reported.⁴

The pattern of involvement may be linear, nevoid, unilateral, zosteriform and uncommonly bilateral.⁵

Onset may be at birth, childhood or adolescence. Lesions may have an inflammatory or noninflammatory course. Complications in inflammatory variety include cyst, abscess, sinus and result in scarring. Nevus comedonicus when associated with skeletal, cardiac anomalies, cataract, etc. is known as nevus comedonicus syndrome. Mosaicism or changes in the juxtaepidermal mesenchymal tissue during embryogenesis gives rise to nevus comedonicus.⁶ Treatment of uncomplicated lesions are topical tretinoin, dermabrasion, laser ablation or surgical excision.

Our patient started noticing these lesions for 2 years. They were asymptomatic. The ear lesions developed later. Acne vulgaris, childhood flexural comedones and lichen planus were kept as differential diagnosis. But there were no acne lesions on face or back. Childhood flexural comedones was ruled out as there were no double comedones and the disease appeared late.⁷ There was no sinus tract or scar, hence hidradenitis suppurativa was also excluded. There were no other associated anomalies. The histopathology was suggestive.

Nevus comedonicus is a rare clinical presentation. Till date near about hundred cases have been reported. Earlier extensive nevus comedonicus was reported.^{8,9} Yadav *et al.*¹⁰ also reported a case of bilateral axillary nevus comedonicus syndrome in a 13-year-old boy with other cutaneous areas of involvement. Previous reports of bilateral nevus comedonicus were associated with other systemic abnormality. In our case the onset was in early 20s and non-familial and only skin was affected with bilateral axillary and ear involvement, without any systemic anomaly.

Conclusion

Such bilateral axillary nevus comedonicus without systemic involvement has not been reported earlier in literature, hence this case reported.

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