Asymptomatic Plaques on the Bilateral Postauricular Areas in a 50-year-old Man

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Case report

A previously healthy 50-year-old fisherman had asymptomatic erythematous lesions on the bilateral postauricular areas for 18 months. He denied the history of applying any topical agents or taking any systemic drugs. There was no history of photosensitivity, burn, irradiation and local trauma in the areas. None of his family had a similar problem. The skin examination showed multiple white, 1 to 2 mm papules within erythematous plaques on the bilateral postauricular areas (Fig. 1). A biopsy was taken and the tissue specimen was stained with H & E stain (Fig.2).

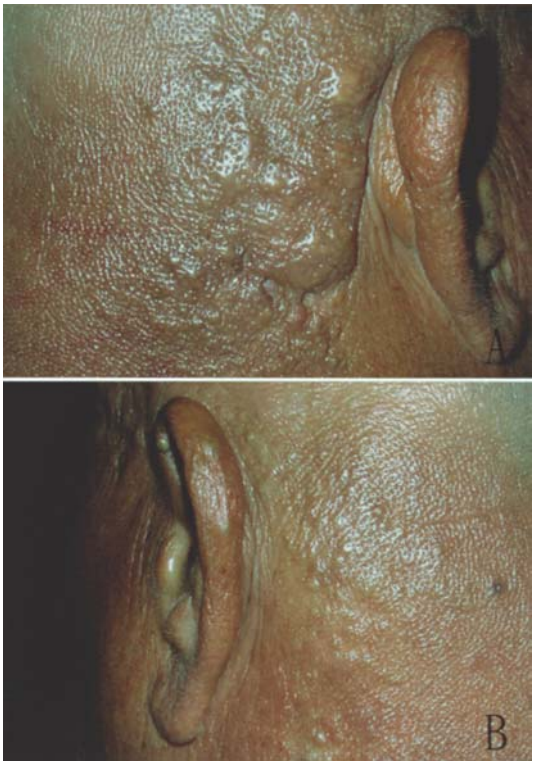

Fig. 1
A: Right, B: Left.

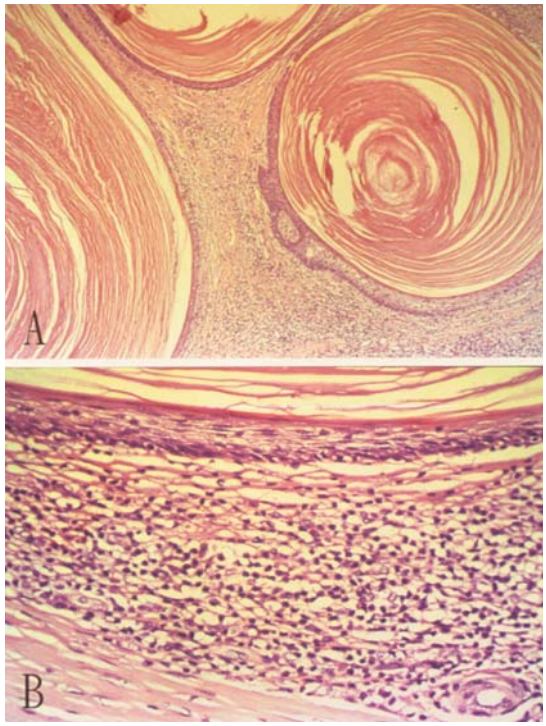

Fig. 2
A (H & E, x40), B (H & E, x200).

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Diagnosis: *Milia en plaque*

Discussion

Since Hubler *et al*.'s naming as "Milia en plaque" (MEP) in 1978,[1] up to date 18 cases have been reported in the related English literature. MEP is a rare type of primary milia consisting of grouped milia on an erythematous base.[2] Histologically MEP is characterized by keratin-filled small cysts, surrounded by mild to dense mononuclear infiltrates.[3]

According to review of the 18 cases in the related English literature, MEP affected males and females aged between 14 and 84 years.[2] The eruption was usually asymptomatic although mild pruritus and burning sensation have been reported occasionally.[2] The majority of cases have presented with erythematous plaques of 1 month to 2 years duration. Sites near to or in the ears have been the most common.[2] In addition, pericystic inflammation composed mainly of lymphocytic infiltrates, correlating with erythematous appearance of the lesions, has been found consistently in almost all.[2] By the above data, the presentation of our case fitted into the classic MEP.

The etiology remains unknown.[2] Once local or systemic external causes have been excluded, the principal condition in the differential diagnosis is Favre-Racouchot disease. The disease, also known as nodular elastosis with cysts and comedones, occurs on facial sun-exposed skin and is characterized by huge open comedones, predominantly on the temples of some older persons.[4] It is differentiated by its topography and associated actinic damage.[5] Follicular mucinosis should also be considered. It can be accompanied by cysts and comedones, but the histological findings with mucinous follicular deposits are different from MEP.[5]

Treatment for MEP is limited.[2] In general, responders to simple extraction or topical tretinoin showed a superficial location of the milia on histologic examination, and minocycline administration, 100 mg/day over 2~3 months, was advisable in cases of dense inflammatory infiltrates of the dermis.[2] In our case, treatment with oral minocycline, 200 mg/day, reduced the inflammation, and superficial larger milia were evacuated with a comedo extractor. The condition was improved four months later.

Reference

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