

**Reply to: “Histopathology of facial papules in frontal fibrosing alopecia and therapeutic response to oral isotretinoin”**



*To the Editor:* We thank Pirmez et al for their comments<sup>1</sup> to our article entitled *Yellow facial papules associated with frontal fibrosing alopecia: A distinct histologic pattern and response to isotretinoin*.<sup>2</sup> We intend to provide an explanatory response for additional clarification.

The authors stated that they were the first to report that histopathologic features of facial papules are not limited to perifollicular inflammation. However, this claim is a misunderstanding; we submitted our research letter on this topic, and it was accepted for publication in April 2017. Furthermore, we presented a poster<sup>3</sup> in 2016 and an oral presentation<sup>4</sup> in September 2015 unveiling our preliminary findings on this distinct histologic pattern and response to low-dose isotretinoin.

We have specifically mentioned yellow facial papules because they are different from the facial papules that Pirmez et al cited without distinguishing them from the papules described by Abbas et al,<sup>5</sup> Donati et al,<sup>6</sup> and Lopez-Pestana et al.<sup>7</sup> Vano-Galvan et al<sup>8</sup> found facial papules in 14% of their 355 cases but suggested them to be a sign of vellus hair follicle involvement by lichenoid inflammation followed by perifollicular fibrosis and compared them with the papules of follicular lichen planus. We have stressed the difference between the aforementioned simple facial papules and the yellow facial papules; yellow facial papules involve large sebaceous glands lacking vellus hair follicles and lichenoid inflammation.

Pirmez et al highlighted structural changes involving elastic fibers, which the authors thought affected the pathogenesis of facial papules, although their picture does not reveal an impressive reduction of elastic fibers.<sup>9</sup> In our research, we did not find any change in elastic fibers among the 10 patients enrolled.

We have acknowledged the relatively low number of patients enrolled and treated with oral low-dose isotretinoin (10 mg every other day) for  $\geq 12$  months, which yielded a visible reduction of the yellow facial papules and was associated with a reduction of skin roughness after a median of 2 months. Pirmez et al<sup>9</sup> used higher doses of isotretinoin (20 mg/day for the first month, then titrated to 0.5 mg/kg/day for the following 2 months) in 3 patients and noticed an improvement by the second week of treatment and,

at 3 months follow-up, discontinued isotretinoin therapy.

We agree that further research and extended follow-up are needed to confirm the usefulness of isotretinoin. Particularly regarding the possible reversibility of its effects, 3 months of treatment might not be enough. In addition, we wonder if such a high daily dose of isotretinoin would trigger hair loss as a possible side effect.

Histologic features of the facial papules are critical to support this therapy; as we have reported, yellow facial papules present a distinct histologic pattern, which might represent an intermediate step between an initial perifollicular lichenoid inflammation and the ultimate epidermal atrophy without hair follicles but with large sebaceous glands remaining.

Ana Filipa Pedrosa, MD,<sup>a,b,c</sup> Ana Filipa Duarte, MD,<sup>a</sup> Eckart Haneke, MD, PhD,<sup>a,d</sup> and Osvaldo Correia, MD, PhD<sup>a,b</sup>

*From the Centro de Dermatologia Epidermis, Instituto CUF, Porto, Portugal<sup>a</sup>; Faculty of Medicine, University of Porto, Portugal<sup>b</sup>; Department of Dermatology and Venereology, Centro Hospitalar São João EPE, Porto, Portugal<sup>c</sup>; and Department of Dermatology, Inselspital, University of Bern, Bern, Switzerland<sup>d</sup>*

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*Correspondence to:* Ana Filipa Pedrosa, MD, Centro de Dermatologia Epidermis, Instituto CUF, Porto, Portugal, Rua Fonte das Sete Bicas, 170.

*E-mail:* [anabastospedrosa@gmail.com](mailto:anabastospedrosa@gmail.com)

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