Gram-Negative Folliculitis and Candidal Folliculitis

January 01, 2006
By David L. Kaplan, MD [1]

For 2 months, a 19-year-old woman has had a slightly tender acneiform eruption on the trunk that spread to the extremities.

Case 1:

For 2 months, a 19-year-old woman has had a slightly tender acneiform eruption on the trunk that spread to the extremities. She has not changed her bathing habits or taken any new medications. She has used the same oral contraceptive for 3 years.

What type of outbreak is this?
A. Staphylococcal folliculitis.
B. Gram-negative folliculitis.
C. Follicular eczema.
D. Keratosis pilaris.
E. Pityrosporum folliculitis.

Case 1: A culture grew Serratia marcescens; this confirmed the diagnosis of Gram-negative folliculitis, B. When questioned, the patient said that she used a loofah, which presumably spread the infection. An antibiotic was prescribed, and the eruption cleared. Staphylococcal infections are more tender than this patient's eruption. Keratosis pilaris—which can affect the trunk—is asymptomatic. Follicular eczema and Pityrosporum folliculitis are pruritic.

Case 2:

For several weeks, a 34-year-old man has been bothered by an acneiform eruption in his mustache. He has seasonal allergies, for which he uses a corticosteroid nasal spray and an oral nonsedating antihistamine. He is otherwise healthy.

What is the most likely cause of the eruption?
A. Staphylococcal folliculitis.
B. Rosacea.
C. Candidal folliculitis.
D. Steroid folliculitis.
E. Herpes simplex virus infection.

Case 2: A culture confirmed the diagnosis of candidal folliculitis, C, which most likely arose because the corticosteroid nasal spray created an environment hospitable to infection. The patient was successfully treated with a topical antifungal cream. Staphylococcal folliculitis is a possibility, as is steroid folliculitis (if the spray drips onto the skin). Rosacea does not confine itself to the upper lip. Herpes simplex virus infection would not last for several weeks.

Case 3: Two days earlier, a pruritic acneiform rash erupted on the face, scalp, and upper trunk of a 28-year-old man. The patient has a low-grade fever. He is otherwise healthy and has not taken any new medications. What does this look like to you?
A. Varicella.
B. Staphylococcal folliculitis.
C. Pityrosporum folliculitis.
D. Contact dermatitis.
E. Herpes simplex virus infection.

Case 3: The patient has varicella, A. This infection is often more severe in adults than in children; patients may benefit from oral antiviral therapy. Staphylococcal and disseminated herpes simplex virus infections are typically painful. Pityrosporum folliculitis does not usually erupt on the face, and contact dermatitis does not generally present as discrete lesions.
Case 4: Painful pustules arose several days earlier on the trunk and buttocks of a 43-year-old woman. She is otherwise healthy, takes no medications, and cannot recall any precipitating factors. What is your clinical impression?
A. Gram-negative folliculitis.
B. Staphylococcal folliculitis.
C. Candidal folliculitis.
D. Methicillin-resistant Staphylococcus aureus (MRSA) infection.
E. Herpes simplex virus infection.

Case 4: A culture grew Pseudomonas aeruginosa, which supported the diagnosis of Gram-negative folliculitis, A. The patient recalled that she had used a hot tub—the likely source of the infection. The clinical clue was the confinement of the eruption to the area in contact with the seat of the hot tub. The patient was successfully treated with ciprofloxacin. Staphylococcal infection and MRSA infection resemble gram-negative infection and would need to be differentiated by culture. Candidal folliculitis is unlikely in a healthy host. Herpes simplex virus infection would appear as grouped vesicles in a unilateral distribution.

Source URL:
http://www.diagnosticimaging.com/printpdf/gram-negative-folliculitis-and-candidal-folliculitis/page/0/

Links: