pears, too. A smooth, clean facial complexion can be brought about. Duration of treatment is 4–6 months and longer if desired. The very low dose is not associated with systemic toxicity, and laboratory values remain normal. Beneficial effects can be enhanced by concomitant use of topical retinoids. Broad-spectrum sunscreens of SPF 15 or more are recommended to every patient with solar comedones.

References


Acne Aestivalis (Mallorca Acne)

This variant in the repertoire of acneiform eruptions is a stranger in every aspect. Everything about it is unusual and indeed inexplicable. An undisputed etiological factor is ultraviolet radiation, either from solar exposure or artificial sources.

Acne aestivalis is a seasonal disorder. It starts in spring, peaks in summer, and disappears completely in fall. The key features were well described in the original publication by Hjorth and co-workers in 1972. After a long dark winter, sun-hungry Scandinavians flew into the bright Mediterranean sun in spring, mostly to the island of Mallorca. Enthusiastic sunbathing provoked an acneiform eruption which persisted throughout their vacation and in the weeks thereafter at home. The victims were equally women and men, between 20 and 40 years old, generally with no prior history of acne vulgaris.

The distribution of acne aestivalis is unusual. In contrast to acne vulgaris, the face is mostly spared. The lesions concentrate on the upper parts of the arms, shoulders, back, and chest. The typical lesions are monomorphic, dome-shaped, hard, follicular papules, usually not more than 2-4 mm in diameter, with a surrounding inflammatory reaction. Comedones and pustules are generally absent. The papules spring up suddenly within 1-3 days and last for many weeks, finally involuting without scarring. Clinically and histologically, the lesions resemble those of steroid acne and evolve in the same way. A segment of the follicular epithelium becomes necrotic, and a sharply limited abscess develops at the site of rupture. Following epithelial re-encapsulation of the abscess, the follicle becomes hyperkeratotic, but the quantity of corneocytes is generally too small to be visible as a comedo.

An eruption identical to acne aestivalis occurs in patients receiving UV-A radiation for the phototherapy of chronic dermatoses, or undergoing treatment with 8-methoxypsoralen and UV-A radiation (PUVA), suggesting that the action spectrum lies in the long-wave ultraviolet region. How this happens is a mystery. Like patients with polymorphous light eruption, subjects prone to acne aestivalis react the same way year after year. Indeed, in our
Solar Comedones

Above: These open and closed comedones around the eyes and on the cheeks of aging Caucasians, ungraciously called senile comedones, are but one of many pathological changes caused by excessive exposure to sunlight. In the elderly they become large enough to look like cysts situated on a background of yellow, thickened, elastotic skin.

Below: The oval lesion on the far left is a horn-filled cyst lined by a thin epithelium. With serial sectioning, an opening is always found, as in two other comedones. These are simply closed and open comedones. They are hard to press out and contain fewer bacteria than acne comedones, and the sebaceous acini have regressed to epithelial buds and sprouts, usually restless with variable hyperplastic growths.