CASE REPORT
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MILIA EN PLAQUE

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Abstract

Discrete milia are common whereas milia en plaque is rarely encountered entity. Althoughreason for postauricular localization in not yet understood, repeated trauma could be predisposing factor.

Key words: Milia , Retroauricular, Middle age

Introduction

Milia are subepidermal keratin cysts that can be seen in all age groups from neonate to elderly. Milia can be primary or secondary to various skin disorders. It frequently appears over cheeks and eyelids.[1] Although discrete milia are common, milia en plaque is rarely encountered. Here, we are reporting two patients where milia en plaque found on retro-auricular skin.

Case 1

A 32-year old male, farmer by occupation, presented to dermatology OPD with multiple skin coloured lesions on retro-auricular skin, present for last three years. Patient denied use of eye glasses, any topical cream or any possible trauma. Clinical examination revealed 3 x 2 cm size plaque composed of multiple yellowish papules on retroauricular skin (Figure 1a,b). Fig 1a,b

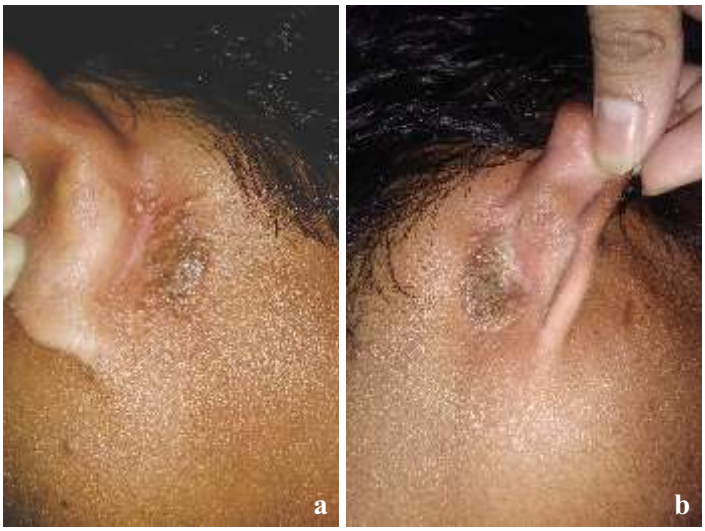

Figure 1a : Erythematous plaque studded with multiple shiny yellow colored milia over left retroauricular area.
1b : Milia en plaque at right retroauricular space

Histopathological examination revealed multiple concentric lamellar keratin filled cysts lined by keratinized stratified squamous epithelium in dermis (Figure 2a). Mature or fully developed cysts were lined by single layer whereas evolving cyst lined by multiple layers. Peri-cystic and peri-appendegeal mononuclear cell infiltration was noted[1] (Figure 2b). Diagnosis of milia en plaque was made and patient was asked for local application of tretinoin 0.025% cream. Patient was however loss to follow up.

Case 2

A 35-year-old woman, presented with closely aggregated milia on left retroauricular skin (Figure 3). Lesions were present for last six months. She gave history of wearing large ear-ring for 1 years. Cutaneous Examination showed 2x2 cm skin colored plaque composed of multiple milia with shiny yellowish surface. Patient did not give consent for histopathological examination. On the basis of morphological examination, diagnosis of milia en plaque was made.

Discussion

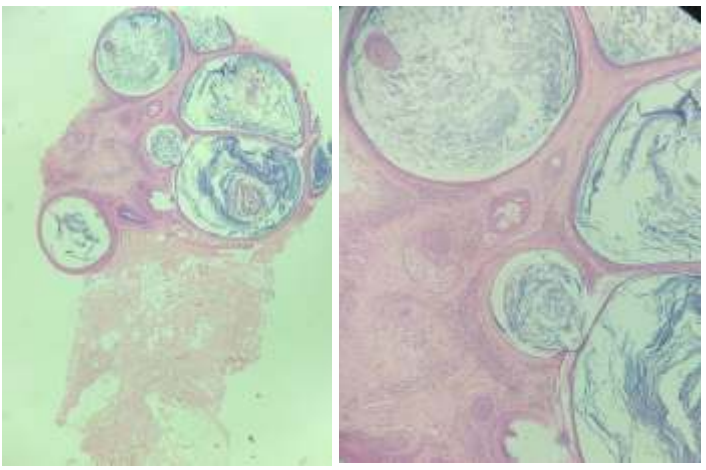

Figure 2a : 10x view of HPE of milia en plaque with multiple lamellar keratin filled cyst in superficial and deep dermis.
2b : 40x view of multiple cyst lined by single or multiple layer with peri-cystic and peri-appendegeal mononuclear cell infiltration

Milia can be considered primary appearing spontaneously, or secondary, caused by skin disease, trauma, or medications.

Primary milia are small epidermoid cyst, 1-4mm in diameter , arise from lowest part of infundibulum of vellus hair follicle at the level of sebaceous gland. They are fixed and persistent. Primary milia may occur congenitally or shortly after birth in up to 50% newborns. Favourable sites are the face, especially nose, scalp, proximal extremities and upper trunk. They resolve over weeks.[2]

Secondary milia arises from eccrine duct or hair follicle, in order

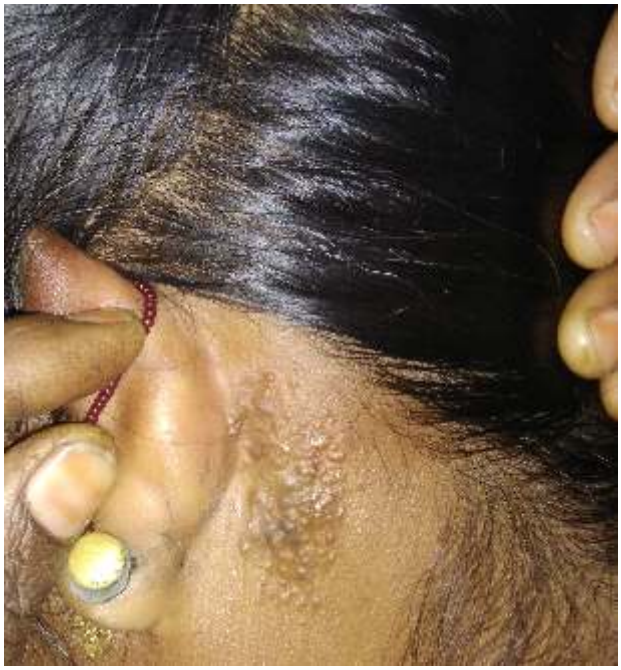

Figure 3 : Skincolored plaque with grouped milia forming milia en plaque over left retroauricular area.

to re-epithelise the eroded epidermis. They are transient and spontaneously disappear. Milia on palate are called Epstein pearls. Secondary milia can develop as a result of blistering skin disease, they also tend to occur after trauma such as dermabrasion, chemical peeling, ablative laser, skin grafting and radiotherapy[2]. Long term use of topical corticosteroids and occlusive moisturizer can cause milia. Cyclosporine and 5-FU have been associated with development of milia.[3]

Milia en plaque is an inflammatory variant of milia. It shows predilection for the head and neck area, especially periauricular and periorbital area[4].This condition is more common in middle aged women.[2]

In both our cases lesions of Milia en plaque were present on retro-auricular skin.

First case mentioned here, had no prior risk factors like pre-existing skin lesions or any chronic trauma. It is possible that in second patient, history of wearing large ear rings might have acted as precipitating factor.

Milia en plaque is not common and reported only sparingly in literature. This prompted us to report these cases.

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