DISSECTING CELLULITIS OF THE SCALP

What are the aims of this leaflet?

This leaflet has been written to help you understand more about dissecting cellulitis (DCS) of the scalp. It tells you what it is, what causes it, what you can do about it, and where you can find out more about it.

What is dissecting cellulitis of the scalp?

DCS is a rare condition affecting the hair follicles (hair roots) within the skin on the scalp. The hair follicles on the head become blocked, causing pus-filled spots and lumps to develop. These may become red and swollen (inflamed). The hair follicles in the affected areas are destroyed by inflammation, leaving permanent scarring and permanent bald patches (alopecia) of different size.

The condition is sometimes called “perifolliculitis capitis abscedens et suffodiens” or “Hoffman’s Disease”. It is commonest in adult men of Afro-Caribbean descent, but can affect any race, sex, or age.

What causes dissecting cellulitis of the scalp?

The cause of DCS is not fully understood. People who have DCS may also have other conditions causing spots, cysts, and abscesses. These include hidradenitis suppurativa, pilonidal cysts, and a severe form of acne called acne conglobata. In all these conditions, the hair follicles become blocked and swell up. Eventually, they burst underneath the skin, causing inflammation and pus formation. Spots and cysts in DCS are not caused by bacterial infections, but they may become infected with bacteria over time (secondary infection).

DCS is thought to be more common in people of Afro-Caribbean descent due to their tightly curled, thicker hair type, and damage to the scalp caused by hair shaving. Research suggests a link between DCS and tobacco smoking.

Is dissecting cellulitis of the scalp hereditary?

It is not usually hereditary, but it can rarely run in families, which suggests that genes may play a role in this condition.

What are the signs and symptoms of dissecting folliculitis of the scalp?

DCS starts with blocked hair follicles, which may develop into painful spots and boggy/swollen lumps that may ooze pus (discharge) spontaneously. In severe cases, there may be abscesses or channels (called sinus tracts) filled with pus that cause areas of hair loss and scarring. The condition tends to start at the top of the head and spread to the back of the head; it can sometimes be very extensive and affect the whole scalp.

How is dissecting cellulitis of the scalp diagnosed?

A Dermatologist can usually diagnose DCS by looking at the scalp. They may take swabs of the pus to test for infections. If there is any doubt about the diagnosis, a scalp biopsy may be required. A dermatology doctor or nurse will remove one or two small pieces of skin from the scalp under local anaesthetic. These are examined under the microscope to help confirm the diagnosis.

Can dissecting cellulitis of the scalp be cured?

No. There is no cure for DCS, but various treatments can be used to control the condition and limit further hair loss, pain, and discharge. It is important to realise that hair will not regrow in scarred areas, so the hair loss is permanent. The condition does slowly tend to resolve but this is unpredictable and may take several years.

How can dissecting cellulitis of the scalp be managed?

There are several ways your doctor may try to manage the condition. Often, a combination of topical and tablet treatments will be needed.

Topical Steroids

Topical steroids are creams, ointments, foams, gels, or lotions that are applied directly onto the affected areas, and work by reducing inflammation in the scalp.

Topical antimicrobials

These work by decreasing the bacterial level on the skin and include antiseptic washes such as chlorhexidine or iodine, and topical antibiotics such as clindamycin in cream or lotion form.

Tablets

- Antibiotic tablets fight inflammation, and work quickly. Examples include erythromycin, tetracyclines, clindamycin, and rifampicin. Long courses (up to several months) of antibiotics are often needed to avoid relapse.
- Steroid tablets are sometimes used for short-term management to reduce inflammation. Steroid tablets cannot be used long-term due to their side effects.
- Dapsone (an antibacterial medicine) can be given for longer term treatment but requires regular monitoring blood tests (see Patient Information Leaflet on dapsone for more information).
- Retinoids are another commonly used long-term medicine. These reduce the hair follicle blockage that causes DCS. Retinoids are made from Vitamin A and include isotretinoin and acitretin. Retinoids are not suitable for women who are pregnant or trying to conceive as they may cause catastrophic damage to the unborn child and increase the chance of miscarriage. Retinoids require monitoring blood tests and can only be prescribed by a Dermatologist. For further information on isotretinoin and acitretin, please refer to the relevant BAD Patient Information Leaflet.

Surgery

Surgery is sometimes needed to incise (cut open) large abscesses (boils or collections of pus) or excise (cut out) persistent areas of inflammation. If a large area of skin is removed, a graft may be required. This will leave scarring.

Other treatments

- Steroid injections are sometimes given into affected areas to reduce inflammation. This has fewer side-effects and complications than steroid tablets but can be a painful procedure.
- Laser hair removal has been attempted to control the disease as the process mainly occurs around the hair follicles. This treatment may lead to permanent hair loss.
- Adalimumab and inflixamab are injectable drugs known as “biologics” that block or reduce Tumour Necrosis Factor-α (TNF- α) in the body. TNF-α contributes to inflammation in many diseases including psoriasis and hidradenitis suppurativa. Small studies of biologics have shown that

they may be helpful in DCS, but they are not currently licenced or funded for DCS within the UK.

- Photodynamic therapy (light treatment) has been reported successful in a few patients with this disease (see photodynamic therapy leaflet). A "sensitising" treatment is applied to the scalp before exposing the area to light treatment. The main side effects are temporary pain and crusting.
- Oral zinc sulphate. Small studies have reported that zinc supplements may help with inflammation in DCS and hidradenitis suppurativa. Your Dermatologist may suggest a trial of high dose zinc in addition to your other medication.

What if I need a wig?

Wigs and hairpieces may be helpful if the disease has been controlled and has left considerable hair loss. These can either be bought privately or prescribed by an NHS Consultant (a financial contribution is usually required).

Self-care (What can I do?)

- Try not to pick and squeeze the spots as this will aggravate them.
- Use regular antiseptic wash/shampoo and avoid oil-based hair toiletries and pomades (waxes).
- Take prescribed treatment as directed by your dermatologist. Because medication works slowly, it may take several months before any improvement can be seen.
- Flare ups of DCS are common when treatments are stopped. It is important to discuss any issues with your Dermatology Specialist before stopping your medication.
- There is no evidence that food or diet affects this condition, so a normal healthy diet is recommended (NHS Choices website).
- If you smoke, try to quit tobacco smoking.

Where can I get more information about dissecting cellulitis of the scalp?

Web links to patient support groups:

Alopecia Help & Advice (Scotland)
Web: www.alopeciascotland.co.uk

Alopecia UK
Tel: 0800 101 7025

Web: www.alopecia.org.uk
E-mail: info@alopecia.org.uk

Web links to detailed leaflets:

https://dermnetnz.org/topics/perifolliculitis-capitis-abscedens-et-suffodiens

https://www.uptodate.com/contents/dissecting-cellulitis-of-the-scalp#H192597780

Information about entitlement to free wigs is given in NHS leaflet HC11.

Please note that the British Association of Dermatologists provides web links to additional resources to help people access a range of information about their skin condition. The views expressed in these external resources may not be shared by the Association or its members.

This leaflet aims to provide accurate information about the subject and is a consensus of the views held by representatives of the British Association of Dermatologists: individual patient circumstances may differ, which might alter both the advice and course of therapy given to you by your doctor.

This leaflet has been assessed for readability by the British Association of Dermatologists' Patient Information Lay Review Panel

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