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About authors:

Zhetishev Rashid Abdulovich, MD, DMSc, Professor, Head of the Department of Pediatric Diseases, Obstetrics and Gynecology; tel.: +79287168045; e-mail: rashid.zhetishev@yandex.ru

Golovkina Olga Alexandrovna, student; tel.: +79892941770; e-mail: ogolovkina63@gmail.com

Uzdenova Zalina Mukhtarovna, student; tel.: +79889213826; e-mail: zali.uzdenova@mail.ru

Karova Diana Aivarovna, student; tel.: +79631693884; e-mail: diana.karova.99@mail.ru

Zhetisheva Irina Salihovna, CMSc, Associate Professor of the Department of Hospital Therapy; tel.: +79280809239, e-mail: rashid.zhetishev@yandex.ru

Arkhestova Diana Ruslanovna, CMSc, Associate Professor of the Department of Pediatric Diseases, Obstetrics and Gynecology; tel.: +79604300070, e-mail: diana_z.a@mail.ru; ORCID: 0000-0002-5490-4166

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DISSECTING HOFFMAN'S CELLULITIS: CLINICAL CASE WITH SUCCESSFUL THERAPEUTIC RESPONSE

Kulakova T. B., Odinets A. V.

Stavropol State Medical University, Russian Federation

ПОДРЫВАЮЩИЙ Фолликулит Гоффмана: Клинический случай с успешным терапевтическим исходом

Т. Б. Кулакова, А. В. Одинец

Ставропольский государственный медицинский университет,
Российская Федерация

The article presents our clinical observations and results of Hoffman folliculitis detonation treatment in a 25-year-old patient with hair loss lesions on the scalp, in which the area is dense inflammatory, Hyperemic, painful knots with fluctuation and pus content. Timely prescribed adequate therapy led to the regression of dense nodules, which led to the cosmetic recovery of scalp hair in areas of pronounced inflammation.

Keywords: *dissecting cellulitis, scalp, dissecting Hoffman's folliculitis, alopecia, isotretinoin, treatment*

Представлены собственное клиническое наблюдение и результаты лечения подрывающего фолликулита Гоффмана у пациента 25 лет с очагами выпадения волос на коже волосистой части головы, в области которых определялись плотные воспалительные гиперемизированные болезненные узлы с флюктуацией и гнойным содержимым. Вовремя назначенная адекватная терапия привела к регрессу плотных узлов, в результате чего достигнуто косметически приемлемое восстановление волос на коже волосистой части головы в местах выраженного воспалительного процесса.

Ключевые слова: *рассекающий фолликулит, подрывающий фолликулит Гоффмана, алоpecia, изотретиноин, лечение*

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ALT – alanine aminotransferase
AST – aspartate aminotransferase

GGT – gamma-glutamyltransferase

Folliculitis dissection (Cellulite dissection) or Hoffman folliculitis – a rare scar alopecia that occurs predominantly in men aged 18 to 40. It is characterized by inflammatory nodes, abscesses, fistula tracts, and scalp scarring due to a chronic inflammatory process involving neutrophils [1, 2].

Hoffman splitting follicle belongs to the group of diseases with follicular occlusion and can be combined with conglobate acne, supporting darier, pilonidesinus (epithelial coccygeal duct), with the possibility of subsequent malignant development [3, 4]. The pathogenesis undermining folliculitis is not fully understood. However, there is a link between this disease and follicular occlusion, seborrhea, androgen exposure, and secondary bacterial infection (*S. aureus*) [5]. Hoffman folliculitis leads to excessive accumulation of keratin in hair follicles, resulting in the expansion and destruction of the latter, neutrophilic inflammatory process, and secondary infection with *S. aureus* and *S. epidermidis* [1, 5, 6]. The histological picture is characterized by follicular occlusion of keratin corks with follicular and perifollicular neutrophil infiltration with an admixture of lymphocytes, histiocytes, and plasmacytes. At later stages, abscesses, fibrosis, and scar tissue are formed. Foreign body pellets may be included in response to the destruction of hair follicles [5]. The most commonly used treatment for Hoffmann's undermining folliculitis is systemic isotretinoin. Several case reports were successfully treated by oral administration of rifampicin concomitantly with isotretinoin [7, 8]. According to some reports [3, 5], oral antibiotics (doxycycline, azithromycin, and rifampicin) constitute the first line of treatment for mild Hoffman folliculitis. Isotretinoin treats severe cases that do not respond to antibiotic therapy.

Biology is rarely used to treat Hoffman's folliculitis but shows a high probability of remission. One of the disadvantages of treatment with biological drugs is their high cost. In the treatment of Hoffman folliculitis, photodynamic therapy and excision with a carbon dioxide laser can be used. X-ray hair removal and surgical excision showed reasonable remission rates but may be complicated by severe complications [6].

They are taking into account the peculiarities of the Hoffman Disruptive Folliculite Clinic, where, in the absence of appropriate therapy, erythematous papuloculic elements are converted into purulent nodes, atrophic, hypertrophic or keloid scars in the area where scar alopecia is subsequently determined. Often with disfiguring effects in the form of multiple scars such as cerebral packets. The purpose of this clinical observation was to assess the results of the timely use of systemic isotretinoin.

Clinical case. Patient V., 25 years old, applied to the Regional Clinical Dermatovenereologic Dispensary (Stavropol) in December 2021 with complaints of nodular rashes with purulent contents on the skin of the scalp, which were accompanied by soreness and slight itching, worsening sleep due to soreness of inflammatory elements, and a decrease in the quality of life. In the

inflammatory foci, hair began to fall out. Also, during the examination of the patient, painless rashes (comedones, papules, pustules, nodes, and scars) on the skin of the back were detected.

It is known from the anamnesis that the patient considered himself ill for three months, when for the first time, without connection with any provoking factors on the skin of the parietal area of the head, rashes appeared. Untreated. The patient reported that such rashes were in 2018, slightly painful and without the formation of large knots, taking amoxiclav orally for 14 days – with a regression rash on the scalp. In addition, the patient was given 5 % minoxidil-containing medication for 4–6 months to improve hair growth in lesions.

Objectively. General condition satisfactory. Constitution correct. Weight – 65 kg. Peripheral lymph nodes are not enlarged or painless; the skin above them does not change. Didn't have hemodynamic or respiratory diseases. The abdomen is soft and painless. Physiological functions are normal.

There are covers and visible mucous membranes (except lesions) of physiological color and moisture and turgor. There were no injuries, surgeries, or blood transfusions. Bad habits – smoking, alcohol denies. Allergic history is not burdened.

Local status. The pathological process is localized on the skin of the parietal zone of the scalp and back skin. On the skin of the scalp, it is represented by foci of hair loss ranging in size from 0.7–0.8 cm to 1.0–3.5 cm, in the area of which inflammatory hyperemic nodes are determined ranging in size from 0.5–0.5 cm to 1.2–2.5 cm, protruding above the surrounding tissues, painful on palpation, with fluctuation (Fig. 1). On the skin of the head there are hyperseborrhea and scales, which are also located on the hair shafts. On the skin of the face, there are a few papula-pustular elements 0.4–0.5 cm in diameter and open comedones. On the skin of the back, there are open and closed comedones, papules, pustules with a hyperemic base, knots, and scars. Nail plates are visual without features.

The trichoscopic picture in the foci of hair loss is represented by empty follicular openings, areas without follicular openings, black dots, and broken hair (Fig. 2).

A laboratory examination in a clinical blood test revealed a slight increase in hemoglobin 175 g/l (reference

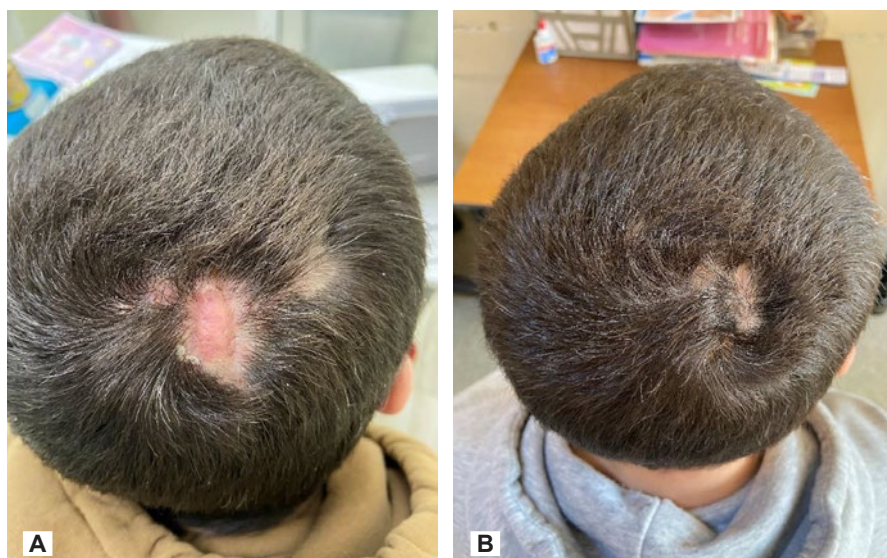


Fig. 1. Nodules on the scalp before treatment (A) and restoration of scalp hair 9 months after treatment (B)

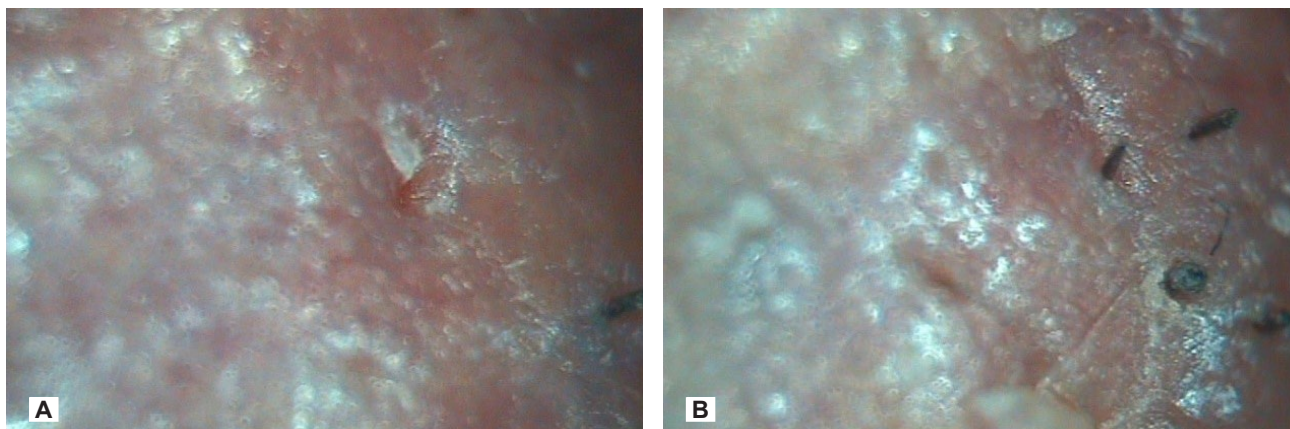


Fig. 2. Empty follicles (A), black dots (B), broken hair during trichoscopy of the affected areas of the skin of the scalp

values 132–173 g/l), slight erythrocytosis in peripheral blood up to $5.8 \times 10^{12}/l$ (reference values $4.3\text{--}5.7 \times 10^{12}/l$), slightly increased hematocrit 52 % (reference values 39–49 %), other parameters are within the normal range. Blood biochemical parameters (ALT, AST, total bilirubin, creatinine, urea, total cholesterol, glucose, insulin, C-peptide, GGT, alkaline phosphatase, total protein, albumin) are within the age norm. Serum iron and urinalysis were within normal limits.

Considering the pronounced clinic of inflammatory process on the scalp – foci of hair loss with dense, painful, purulent nodes with fluctuations that can lead to scar alopecia, the formation of hypertrophic and keloid scars, there were indications of systemic antibiotic therapy followed by systemic treatment of isotretinoin.

Treatment. Doxycycline 100 mg 2 times a day after meals for 14 days. After the end of doxycycline therapy, systemic isotretinoin was prescribed at a dose of 0.5 mg/kg per day, with a gradual increase in the dose of the drug to 0.6 mg/kg per day. The course dose was 150 mg/kg of body weight; the duration of treatment was ten months.

During therapy with systemic isotretinoin, liver enzymes (AST, ALT), bilirubin, and creatinine were analyzed. After one month from the start of taking the drug, the indicators of the general blood test, such as a slight increase in hemoglobin and hematocrit, a slight increase in hemoglobin and hematocrit, a slight increase in erythrocytosis, detected a month before the start of therapy with systemic isotretinoin, returned to normal.

The pathological process on the scalp and back was dynamically resolved. For 3–4 months, the back skin was practically cleaned of comedones, papules, and pustules. On the scalp, the nodes dynamically regressed, and the node remained on the scalp skin, which decreased in size in the following months of therapy. Areas of alopecia remained in areas where there were inflammatory dense nodes. Since six months of isotretinoin treatment, hair growth has resumed in areas of alopecia.

After ten months of taking isotretinoin on the skin of the parietal area of the patient's scalp, the pathological lesions dissipated, the hair growth was almost completely restored (Fig. 1), and rashes on the back skin regressed. While taking isotretinoin, the patient noted the phenomena of cheilitis, which was successfully stopped by using a lip balm based on dexpanthenol; dryness of the skin was reduced by using emollients.

After completing the course of systemic isotretinoin, the patient was prescribed zinc picolinate tablets at a dose of 22–25 mg, topically – a cream containing 0.1 % adapalene.

Conclusion. The clinical observation's importance is that timely prescribed adequate therapy led to the regression of dense nodes, resulting in a cosmetically acceptable hair restoration on the skin of the scalp in places of a pronounced inflammatory process. The decisive factor in this is an adequately selected therapy regimen: a broad-spectrum antibiotic and a transition to long-term use of systemic isotretinoin.

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About authors:

Kulakova Tatyana Borisovna, CMSc, Assistant of the Department of Dermatovenereology and Cosmetology with a course additional professional education;
tel.: +79197450833; e-mail: lerova_t@mail.ru; ORCID: 0009-0009-5031-9574

Odinets Aleksey Vasilievich, MD, PhD, Professor, Head of the Department of Dermatovenereology and Cosmetology with a course additional professional education;
tel.: +79624498959; e-mail: odinets1@yandex.ru; ORCID: 0000-0003-3257-4343

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THE CASE OF CARDIAC RUPTURE AND THE DEVELOPMENT OF A FALSE LEFT VENTRICULAR ANEURYSM IN A PATIENT WITH MYOCARDIAL INFARCTION

Gladkikh N. N., Yagoda A. V., Znamenskaya I. A., Rybas A. V.

Stavropol State Medical University, Russian Federation

СЛУЧАЙ РАЗРЫВА СЕРДЦА И РАЗВИТИЯ ЛОЖНОЙ АНЕВРИЗМЫ ЛЕВОГО ЖЕЛУДОЧКА У БОЛЬНОГО С ИНФАРКТОМ МИОКАРДА

Н. Н. Гладких, А. В. Ягода, И. А. Знаменская, А. В. Рыбас

Ставропольский государственный медицинский университет, Российская Федерация

The article presents the clinical observation of a rare complication of an acute myocardial infarction – a rupture of the left ventricle wall with the development of a false aneurysm in an 84-year-old patient who suffered some diseases that had a myocardial infarction, Bypass surgery for multiple coronary stenosis with severe structural and functional heart disease (calcification, combined aortic defect, relative valve failure, tiny fraction of left ventricular discharge, pulmonary hypertension). The cause of the recurrent heart attack that caused the rupture was the occlusion of one of the left coronary arteries. High diagnostic efficiency of EchoCG, contrast of MSCT and non-specific electrocardiographic pattern of complication was demonstrated.

Keywords: myocardial infarction, cardiac rupture, false aneurysm

Приведено клиническое наблюдение редкого осложнения острого инфаркта миокарда – разрыва стенки левого желудочка с развитием ложной аневризмы у больного 84 лет, коморбидного по ряду заболеваний, перенесшего инфаркт миокарда, операцию шунтирования по поводу множественных коронарных стенозов, имеющего тяжёлые структурно-функциональные нарушения сердца (кальциноз, сочетанный аортальный порок, относительную недостаточность клапанов, низкую фракцию выброса левого желудочка, легочную гипертензию). Причиной приведшего к разрыву повторного инфаркта послужила окклюзия одного из шунтов левой коронарной артерии. Продемонстрированы высокая диагностическая эффективность ЭхоКГ, контрастного МСКТ, неспецифичность электрокардиографической картины осложнения.

Ключевые слова: инфаркт миокарда, разрыв сердца, ложная аневризма

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APTT – activated partial thromboplastin time
BMI – body mass index
BP – blood pressure
CABG – coronary artery bypass grafting
CT – computed tomography
DB – diagonal branch
ECG – electrocardiogram
EchoCG – echocardiography
HR – the number of heartbeats
LCA – left coronary artery

LV – left ventricle
LVEF – left ventricle ejection fraction
MCBS – mammarcoronary bypass surgery
MI – myocardial infarction
MSCT – multispiral computed tomography
PLBRCA – posterolateral branch of the right coronary artery
RCA – right coronary artery
RIVA – right interventricular artery
SBPPA – systolic blood pressure in the pulmonary artery