Letter

Don't miss the clue in the crease: Recognition of childhood flexural comedones

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To the Editor

A 21-month-old girl was referred to our pediatric dermatology clinic for evaluation of a skin lesion in the left axilla, first noted by her parents 2 months prior. The lesion had gradually enlarged but remained asymptomatic, without associated pain or pruritus. There was no history of similar lesions elsewhere and no known family history of similar findings. Dermatologic examination of the left axilla revealed a double-headed open comedone without erythema, edema, or drainage (**Figure 1**). Based on the morphology, location, and patient age, a diagnosis of childhood flexural comedones (CFC) was favored.

CFC is a rare and likely underrecognized dermatologic finding, classically presenting as comedones in intertriginous areas during early childhood.[1] The entity was first described in 2007, and the term was coined based on its clinical features in a cross-sectional study of 40 affected children.[1] Since then, a small number of case reports have expanded understanding of its clinical spectrum, though much remains unknown.

CFC presentations range from solitary, unifocal lesions[1,2] to multiple, double-headed comedones in multifocal distributions, including the axillae, groin, and neck.[3,4] Although typically found in intertriginous areas, lesions have also been reported in non-flexural sites, such as the face and periauricular skin.[4,5] Onset may occur anytime from infancy to adolescence. No gender predilection has been established; however, factors such as friction and genetic predisposition may contribute to pathogenesis.[1] Some reports suggest possible associations with a family history of acne or hidradenitis suppurativa, as well as a personal history of molluscum contagiosum, neurofibromatosis type 1, and atopic dermatitis.[1,2] Additionally, CFC has been hypothesized to increase the risk of subsequent pilosebaceous disorders, including acne vulgaris and hidradenitis suppurativa;[1,3,4] however, further longitudinal studies are needed to clarify these associations.

Figure 1. *Double-orifice comedone in the left axilla of a 21-month-old girl, without surrounding erythema, drainage, or edema.*

Differential diagnoses include nevus comedonicus, familial dyskeratotic comedones, and idiopathic disseminated comedones.[1,5] The intertriginous distribution of CFC helps distinguish it from other entities. Dermoscopy may also aid identification, revealing features such as cuneiform or multi-orifice comedones and double-ended pseudo-comedones.[5] Management is typically conservative: observation is appropriate for asymptomatic lesions, while extraction or topical retinoids may be considered for symptomatic or cosmetic concerns.[5]

This report adds to the limited literature on CFC and underscores the importance of recognition and long-term monitoring. In particular, CFC may be a precursor lesion for hidradenitis suppurativa, a condition in which delayed diagnosis can significantly influence quality of life. Continued reporting of such cases with long-term follow-up will be essential to better elucidate the condition's natural history, range of presentations, and clinical associations.

Potential conflicts of interest

The authors declare no conflicts of interest.

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