

Actinic Folliculitis (Formerly Acne Aestivalis and Mallorca Acne): A Report of 18 Patients and Review of the Literature

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In 1972, Hjorth et al. (1) coined the term *acne aestivalis/Mallorca acne* to describe an acneiform eruption that occurred in a group of 40 patients, 37 of them were females, aged 20–40 years, with a negative medical history of acne. The eruption appeared 15–30 days after sun exposure, without the use of sunscreens. It was characterized by papules, with rare comedones and pustules, located on the face, neck, shoulders, upper trunk and upper limbs. Histopathological picture was characterized by follicular keratosis. The arms eruption lasted 3–6 months.

The name of *acne aestivalis* was subsequently used by other authors (2–7). The term *solar acne* or *acne solaris* was also suggested (8). It was hypothesized that *acne aestivalis* was, simply, acne aggravated by sunlight (9). In 1985, Nieboer suggested the name of *actinic superficial folliculitis* (10). The latter was used by other authors (11–13), although the name *actinic folliculitis* and *recurrent photosensitive pustular eruption* were also suggested (14–19).

Review of the literature revealed that, on the basis of clinical presentations and histopathological pictures, all these 3 entities, *acne aestivalis/Mallorca acne*, *actinic superficial folliculitis* and *actinic folliculitis*, are the same disease. As the term of *acne aestivalis/Mallorca acne* is rather old, we agree to name this entity *actinic folliculitis* (AF).

We present 18 patients with AF: to our knowledge, this is one of the largest caselists reported so far.

CASE REPORTS

From 1987 to 2025, we observed 18 Caucasian patients, 5 males and 13 females, with an age ranging from 19 to 37 years (mean age: 22.3 years) with AF. Four patients (2 males and 2 females) were affected by acne. According to medical history, latency time from sun exposure to the appearance of the first skin lesions ranged from 12 to 72 h. Patients' characteristics are reported in **Table I**. In all patients the eruption was characterized by roundish, erythematous papules and pustules, of a few millimetres in diameter, located on the face (**Fig. 1a, b and c**), neck (**Fig. 1b**), shoulders (**Fig. 2a and b**), chest (**Fig. 2b**) and upper portion of the back. In addition, the upper limbs were involved in 2 patients (**Fig. 2c**). Nine patients complained of mild itching. In 12 patients, AF was recurrent. Laboratory tests were carried out in all patients: in 4 of them, mild leukocytosis and increase in erythrocyte sedimentation rate were detected. In 4 patients, bacteriological examinations of pustular lesions were negative for aerobic and anaerobic bacteria. In 8 patients, patch tests and photopatch tests with the SIDAPA baseline series (Società Italiana di Dermatologia Allergologica, Professionale e Ambientale) were negative. Three patients were subjected to biopsy. Histopathological examination was superimposable in all patients: it showed foci of necrosis in the upper dermis and a perivascular and perifollicular infiltrate consisting of neutrophils, lymphocytes and histiocytes. Ten

Table I. Actinic Folliculitis: patients' characteristics in our case series

N.	Gender	Age, years	Time to onset, hours	Time to remission	Recurrences	Therapy
1	F	19	18–36	3 weeks	Yes	Adapalene/benzoyl peroxide gel
2	M	22	24	3 weeks	Yes	Adapalene/benzoyl peroxide gel
3	F	25	18	4 weeks	No	Adapalene/benzoyl peroxide gel
4	F	23	24	4 months	Yes	Retinaldehyde cream
5	F	17	12–24	4 weeks	Yes	Adapalene/benzoyl peroxide gel
6	M	23	32	3 weeks	No	Adapalene/benzoyl peroxide gel
7	M	26	24	2 months	No	Retinaldehyde cream
8	F	19	18–36	4 weeks	Yes	Adapalene/benzoyl peroxide gel
9	M	20	24–72	2 months	No	Retinaldehyde cream
10	M	21	12–18	4 weeks	Yes	Adapalene/benzoyl peroxide gel
11	F	24	24	2 months	No	Retinaldehyde cream
12	F	27	24	3 weeks	Yes	Adapalene/benzoyl peroxide gel
13	F	20	18–24	3 weeks	No	Tretinoin cream
14	F	19	12–18	3 weeks	Yes	Tretinoin cream
15	F	37	36	3 weeks	Yes	Adapalene/benzoyl peroxide gel
16	F	21	24	4 weeks	Yes	Adapalene/benzoyl peroxide gel
17	F	18	36	3 weeks	Yes	Tretinoin cream
18	F	21	24	3 weeks	Yes	Tretinoin cream

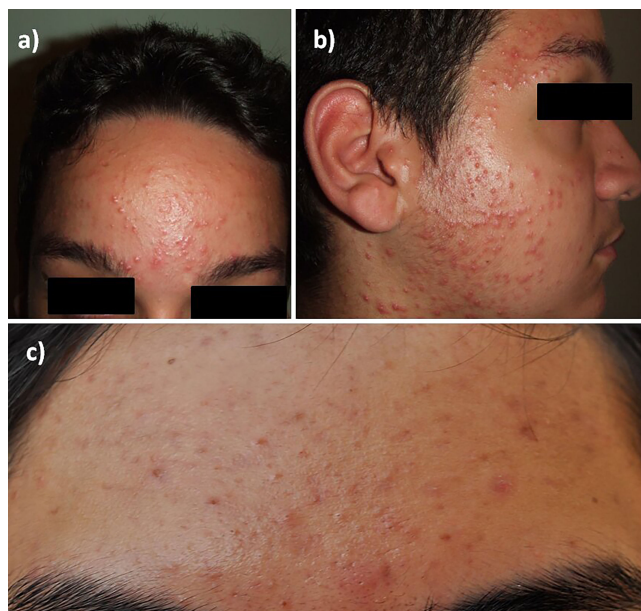


Fig. 1. Different patients with actinic folliculitis: Erythematous papules on the forehead (A,C); Erythematous papules on the temple, cheek and neck (B).

patients were treated with the fixed combination 0.1% adapalene/2.5% benzoyl peroxide gel, 4 patients with 0.005% retinaldehyde cream and 4 patients with 0.05% tretinoin cream. In all patients, complete remission was observed within 4 months (Table I).

DISCUSSION

AF mainly occurs in adult females (2, 4, 10, 14–18), although some males were observed (4, 10–14). Seborrhea (4) and the use of oily sunscreens that cause obstruction of the follicles (8) were suggested as possible predisposing factors; although, in the caselist by Hjorth et al. (1), sunscreens were not used. In addition, we cannot exclude the role of hot-humid weather, hyperhidrosis and sweating.

Latency time from the sunlight exposure to the appearance of the first skin lesions is extremely changeable: from 15 min to 3 weeks (18), to 4–6 h (16), 4–24 h (17), 6–24 h (15), 24–36 h (10, 12, 13), 48–72 h (11), up to 15–30 days (1). As previously mentioned, in our group of patients, time to onset ranged from 12 to 72 h.

AF is characterized by follicular, erythematous papules (1, 2, 4, 5, 8, 9, 14, 15, 17, 18) and pustules (1, 5, 9–18), with rare comedones (1, 5, 9), located on the face (1, 3, 5, 9, 15–18), neck (1, 3–5, 10, 11, 18), shoulders (1, 3, 5, 8, 10–14), chest (3–5, 8, 12, 13, 17, 18), upper portion of the back (3, 4, 10–13, 18) and upper arms (1, 3–5, 8, 10, 11, 14, 17, 18). Rare locations are breasts (10), buttocks (3), thighs (18) and legs (3). The lesions are sometimes accompanied by itching (8, 18). Based on this clinical picture, AF

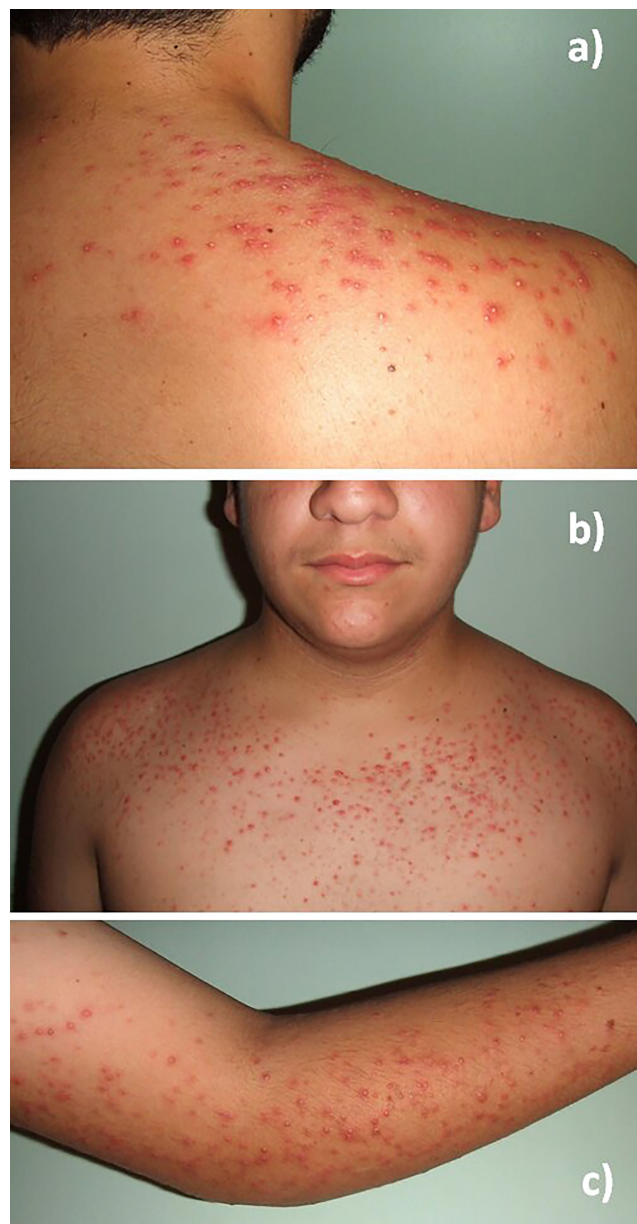


Fig. 2. Different patients with actinic folliculitis: Erythematous papules and pustules on the shoulder (A); Erythematous papules on the shoulders and chest (B); Erythematous papules and pustules on the upper limb (C).

was considered similar to steroid acne (2, 5) or a clinical variant of polymorphous light eruption (5). A recently reported clinical entity, which was named *acute and recurrent pustulosis*, differs from AF for several reasons: it occurs almost exclusively in young women; sun exposure is not always the trigger; it is characterized almost exclusively by pustules; time to resolution is very short; treatment is unnecessary; it is almost always recurrent (20). Several drugs were used for the treatment of AF, such as benzoyl peroxide (4, 5), tretinoin (2, 4, 5), adapalene (17), topical corticosteroids (8) and isotretinoin (15, 17). Remission occurs at very variable times: from 3 days (15), to 5–7 days (11, 13), to 7–

10 days (10, 17), to 3 months (14), to 3–6 months (1, 4). Recurrences are rather common (13, 17): some authors suggested, in patients with recurrent AF, a prophylaxis with UVA (5) or UVB (5), either alone (5) or in combination (5) or narrow-band-UVB (18) or PUVA (5). In summary: a) AF is an acneiform eruption induced by the exposure to sunlight; b) Caucasian, adult females are more frequently involved; c) latency time is extremely variable, from a few hours to weeks; d) erythematous papules and pustules, located on the face, neck, shoulders, chest, upper portion of the back and upper arms are the most frequently observed lesions; e) several drugs are effective, although remission occurs from a few days to some months; f) recurrences are rather common and g) prophylaxis with phototherapy is helpful.

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IRB approval status: In accordance with the guidelines of our institutions ethics committee, and given the nature of the study, formal approval was not required.

The authors have no conflicts of interest to declare.

REFERENCES

- Hjorth N, Sjölin KE, Sylvest B, Thomsen K. Acne aestivalis--Mallorca acne. *Acta Derm Venereol* 1972; 52: 61–63.
- Mills OH Jr, Kligman AM. Acne aestivalis. *Arch Dermatol* 1975; 111: 891–892.
- Sjölin KE. Acne aestivalis. A histopathological study. *Acta Derm Venereol Suppl* 1979; 59: 171–176.
- Petrizzellis V, Scardigno A, Velon A. Contributo alla conoscenza dell'acne aestivalis. *G Ital Dermatol Venereol* 1986; 121: 55–60.
- Plewig G, Jansen T. Acneiform dermatoses. *Dermatology* 1998; 196: 102–107. <https://doi.org/10.1159/000017841>
- Jansen T. Was hat sie sich in Nordafrika gefangen? *MMW - Fortschritte Der Medizin* 2015; 157: 5–5. <https://doi.org/10.1007/s15006-015-2788-9>
- Rippke F, Wendt G, Bohnsack K, Dörschner A, Stäb F, Hölzle E, et al. Results of photoprovocation and field studies on the efficacy of a novel topically applied antioxidant in polymorphous light eruption. *J Dermatolog Treat* 2001; 12: 3–8. <https://doi.org/10.1080/095466301750163491>
- Padilha-Gonçalves A, Alvimar Ferreira J. Solar acne. *Med Cutan Ibero Lat Am* 1977; 5: 271–274.
- Allen HB, LoPresti PJ. Acne vulgaris aggravated by sunlight. *Cutis* 1980; 26: 254–256.
- Nieboer C. Actinic superficial folliculitis; a new entity? *Br J Dermatol* 1985; 112: 603–606. <https://doi.org/10.1111/j.1365-2133.1985.tb15271.x>
- Labandeira J, Suarez-Campos A, Toribio J. Actinic superficial folliculitis. *Br J Dermatol* 1998; 138: 1070–1074. <https://doi.org/10.1046/j.1365-2133.1998.02283.x>
- Jaeger C, Hartschuh W, Jappe U. Actinic superficial folliculitis. *J Eur Acad Dermatol Venereol* 2003; 17: 562–565. <https://doi.org/10.1046/j.1468-3083.2003.00816.x>
- LaBerge L, Glassman S, Kanigsberg N. Actinic superficial folliculitis in a 29-year-old man. *J Cutan Med Surg* 2012; 16: 191–193. <https://doi.org/10.1177/120347541201600310>
- Verbov J. Actinic folliculitis. *Br J Dermatol* 1985; 113: 630–631. <https://doi.org/10.1111/j.1365-2133.1985.tb02392.x>
- Norris PG, Hawk JL. Actinic folliculitis--response to isotretinoin. *Clin Exp Dermatol* 1989; 14: 69–71. <https://doi.org/10.1111/j.1365-2230.1989.tb00889.x>
- Veysey EC, George S. Actinic folliculitis. *Clin Exp Dermatol* 2005; 30: 659–661. <https://doi.org/10.1111/j.1365-2230.2005.01899.x>
- Rahman S, Powell J, Al-Ismail D. First reported cases of actinic folliculitis treated successfully with topical retinoid. *Clin Exp Dermatol* 2020; 45: 716–718. <https://doi.org/10.1111/ced.14179>
- Butt S, Dawe R, Blair R, Ibbotson S. A new approach to actinic folliculitis: prophylactic narrowband ultraviolet B phototherapy. *Clin Exp Dermatol* 2021; 46: 675–679. <https://doi.org/10.1111/ced.14518>
- Brokamp G, Chung CG. Recurrent photosensitive pustular eruption in a young woman. *JAMA Dermatol* 2022; 158: 204–205. <https://doi.org/10.1001/jamadermatol.2021.5383>
- Porter AP, James WD. Acute and recurrent pustulosis: consolidating uncommon cases of follicular pustulosis induced by UV light and other triggers. *Int J Womens Dermatol* 2023; 9: e100. <https://doi.org/10.1097/JW9.000000000000100>