TB MED 287

TECHNICAL BULLETIN, MEDICAL

Pseudofolliculitis of the Beard and Acne Keloidalis Nuchae

HEADQUARTERS, DEPARTMENT OF THE ARMY

16 July 2025

*TECHNICAL BULLETIN

NO. MED 287

HEADQUARTERS
DEPARTMENT OF THE ARMY
WASHINGTON, DC
16 July 2025

Pseudofolliculitis of the Beard and Acne Keloidalis Nuchae

Applicability. This technical bulletin, medical applies to the Regular Army, the Army National Guard/Army National Guard of the United States, and the U.S. Army Reserve, unless otherwise stated.

Proponent and exception authority. The proponent of this technical bulletin, medical is The Surgeon General. The proponent has the authority to approve exceptions or waivers to this pamphlet that are consistent with controlling law and regulations. The proponent may delegate this approval authority, in writing, to a division chief within the proponent agency or its direct reporting unit or field operating agency in the grade of colonel or the civilian equivalent. Activities may request a waiver to this technical bulletin, medical by providing justification that includes a full analysis of the expected benefits and must include formal review by the activity's senior legal officer. All waiver requests will be endorsed by the commander or senior leader of the requesting activity and forwarded through their higher headquarters to the policy proponent. Refer to AR 25–30 for specific requirements.

Suggested improvements. Users are invited to send comments and suggested improvements on DA Form 2028 (Recommended Changes to Publications and Blank Forms) directly to the U.S. Army Medical Logistics Command (ELML-MMP), 693 Neiman St., Fort Detrick, MD 21702-5001.

*This bulletin supersedes TB MED 287, dated 10 December 2014.

TABLE OF CONTENTS

CHAPTER 1

INTRODUCTION

Section I
General

1–1. Purpose
This technical bulletin provides information with respect to the diagnosis and medical management of pseudofolliculitis of the beard and acne keloidalis nuchae (AKN). It is specifically intended to assist medical officers and other healthcare providers in the proper management of Soldiers who are afflicted with these conditions.

1–2. References and forms
See appendix A.

1–3. Explanation of abbreviations and terms
See the glossary.

1–4. Records management (recordkeeping) requirements
The records management requirement for all record numbers, associated forms, and reports required by this publication are addressed in the Records Retention Schedule–Army (RRS–A). Detailed information for all related record numbers, forms, and reports are located in Army Records Information Management System (ARIMS) RRS–A at https://www.arims.army.mil. If any record numbers, forms, and reports are not current, addressed, and/or published correctly in ARIMS/RRS–A, see DA Pam 25–403 for guidance.

CHAPTER 2

Pseudofolliculitis Barbae

2–1. Introduction

a. Synonyms. Pseudofolliculitis barbae (PFB) is also known as pili incarnati, chronic scarring pseudofolliculitis of the beard, and ingrown hairs of the beard.

b. Definition. PFB is a common inflammatory condition of the face and neck caused by shaving in predisposed individuals with naturally curly hair. Papules, pustules, and nodules characterize this inflammatory foreign body reaction resulting from penetration of the epidermis by the tip of the growing curved hair.

c. Epidemiology. Curly hair tends to grow back into the skin more than straight or wavy hair. Although PFB can occur in any group, it occurs primarily in those with a genetic predisposition for curly hair. The PFB process is not sex dependent and can occur in any skin area subjected to regular shaving, plucking, waxing, or other traumatic means of hair
removal. PFB can occur in women, including those with endocrine disorders in which beard hair growth may occur.

d. Military considerations.

(1) Army regulations provide guidance and limitations on Soldiers' grooming practices, including having. Since PFB only becomes apparent following a period of regular traumatic removal of the hair–shaving, pulling, and plucking–the majority of individuals with this condition have had insufficient cause to develop the problem before entering military Service.

(2) The medical management of PFB almost always necessitates wearing a beard during some phase of treatment. The commander is acutely aware of the bearded Soldier when he appears in sharp contrast to his clean-shaven counterpart. This can create problems if there is a gap in communication regarding medical necessity. Clear, consistent approach to treatment combined with appropriate communication with chain of command allow both compliance with Army regulation and proper care of the military patient.

e. Medical management. Under medical management of PFB almost always necessitates wearing a beard during some phase of treatment. The commander is acutely aware of the bearded Soldier when he appears in sharp contrast to his clean-shaven counterpart. This can create problems if there is a gap in communication regarding medical necessity. Clear, consistent approach to treatment combined with appropriate communication with chain of command allow both compliance with Army regulation and proper care of the military patient.

f. Other considerations

(1) Due to the pathophysiology of PFB, it is unusual for individuals with straight hair to develop this condition.

(2) Differential diagnoses for PFB include traumatic folliculitis from shaving (a form of irritant contact dermatitis colloquially known as 'razor burn), which may accompany and worsen PFB; bacterial folliculitis, and, less commonly, warts or molluscum contagiosum.

2–2. Pathogenesis

Like many medical conditions, the presentation of PFB is a combination of genetic risk factors and environmental exposures. Curly hair is a well-known risk factor. The main environmental exposure is shaving. When at-risk individuals shave and cut their hair below a minimum length, the curled hair either penetrates through the hair follicle (intrafollicular) or the skin next to the hair follicle (transfollicular) (see fig 2–1). Additional risk factors for intrafollicular penetration are stretching of the skin during shaving (a 'barber close shave') and plucking of individual hairs. The hair penetrating the skin causes an inflammatory reaction that produces papules. Large cysts may occur if left untreated, containing one or more curled hairs. The resulting inflammatory response can lead to post-inflammatory hyperpigmentation, which should resolve once the condition is adequately treated. More permanent but less common complications are hypertrophic scar and keloid formation. Pustules, if present, are often of normal skin flora, although uncommonly, a secondary bacterial infection can ensue.

.

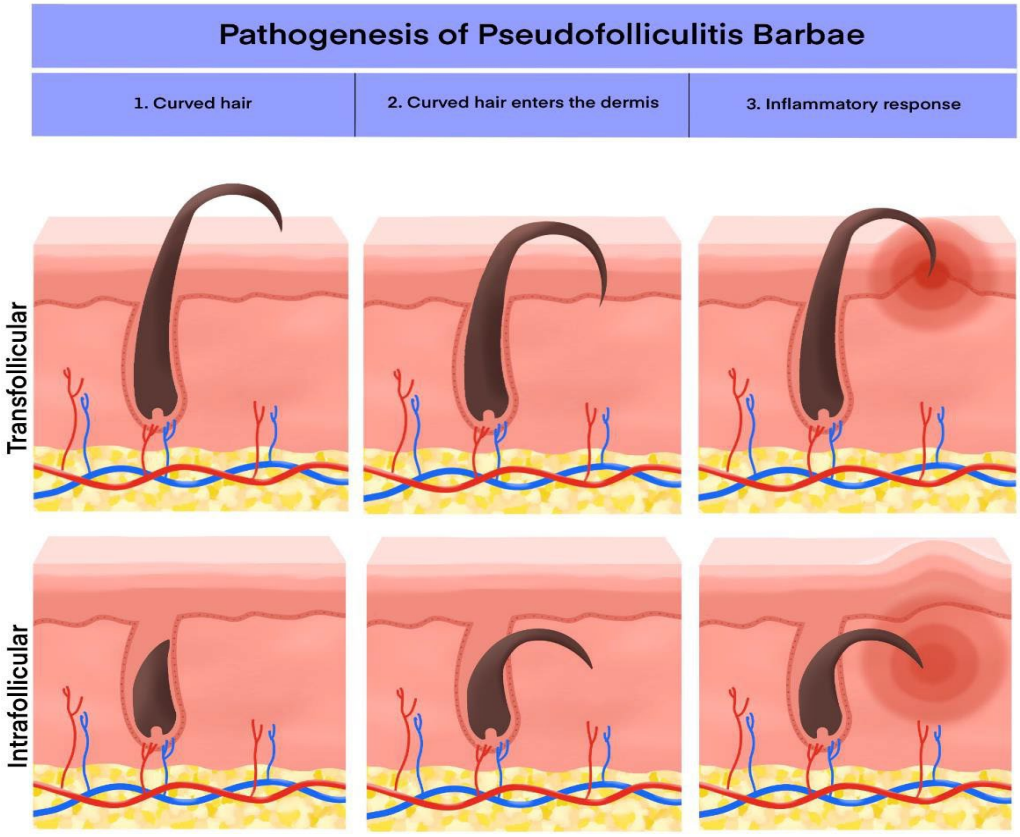

Figure 2–1. Pathogenesis of Pseudofolliculitis Barbe

2–3. Clinical approach to the patient

The PFB papules are subjected to irritation and denudation with shaving, increasing inflammation and patient discomfort. The submandibular area is particularly prone to PFB because of the density and often sharply angled direction of hair growth, leading to a more traumatic shaving cut. Treatment is directed toward clearing the dermatitis and instituting measures to prevent recurrence. The management is related to the severity of the condition and varies to the extent of the disease. Rarely, large, disfiguring scars or keloids may develop in the affected areas.

2–4. Shaving techniques

While there is no one correct way to shave, there are principles that can limit irritation and decrease the risk of follicular penetration.

a. Adequate time for shaving. One of the most important management methods is to allow adequate time to prepare the hair and the skin for shaving. Shaving without adequate preparation will result in more trauma to the hair follicle and the skin. Experts recommend that Soldiers shave at night, thus allowing adequate time to execute the pre-shave, shave, and post-shave phases properly. This may result in the Soldier showing the beginnings of a "5 o'clock shadow" shortly after noon the following day.

b. Dislodgement. When present, visibly embedded hairs should be lifted by inserting a toothpick under the loop just before shaving. Measures for more general treatment utilizing this principle include the use of a dry washcloth or facial sponge across the affected areas in a clockwise and counterclockwise circle to help release embedded hair tips.

c. Hydration of the face. The Soldier should wash their face with warm water. This procedure allows for hairs to swell and lift. If time allows a longer presoak with a hot, wet washcloth for 5 minutes will maximize pre-hydration of the face. During this phase, dislodgement, as noted above, can be performed.

d. Pre-shave and shave foam, gel, or cream. Once the face is adequately hydrated, the Soldier may apply one of several pre-shave medications and allowed to remain for a couple of minutes. A shaving gel is then applied directly over the pre-shave to the wet face and allowed to soften the hair and hydrate the skin for 4 minutes.

e. Razors. The single-blade system has a foil guard to protect against shaving too closely and against nicking existing papules. Multi-bladed razors with lubricating strips are also acceptable as the blades are closer together, making it more difficult for a papule to enter between them. Electric razors, set to avoid too close a shave, can alternatively be used. Whichever razor system is selected, Soldiers should replace razors frequently to avoid shaving with a dull razor. If there is pain or a pulling sensation while shaving, the Soldier should replace the blades immediately.

f. Shaving technique. Soldiers should use smooth, light shaving strokes in the direction of hair growth to avoid hair pulling and limit the closeness of the shave. They should not shave over in the same area more than once. The skin of the face and neck should not be stretched beyond normal. The razor should be rinsed with cool water between strokes.

g. Post-razor hydration. It is critical to hydrate the irritated surface after shaving. It is recommended to wash off the remaining shaving gel with warm water, apply a post-shave hydrating lotion to the wet face, allow it to remain on the face for 1–2 minutes, and then pat dry.

h. Waterless shaving. This method, also known as dry shaving, utilizes any one of several shaving lotions/gels or waterless soaps. After the face is washed and dried, the lotion is applied, and a razor shave is performed. No pre-shave or shave gel is applied in this method. The remaining lotion is washed off after the shave is complete. This method is particularly useful in areas where water supplies are limited (that is, deployment and field environments).

i. Depilatories. In general, depilatory use is limited due to the time required for use, skin irritation, and odor. This is particularly true for powder chemical depilatories. Lotion depilatories are easier to apply/remove and better tolerated.

j. The break period. Affected Soldiers should periodically refrain from shaving to allow recovery of the facial skin. If duty allows, the Soldier should refrain from shaving on weekends or off-duty days. This will give the facial skin time to recover and allow additional therapies to take effect.

2–5. Medical treatments

a. Medical management does not remove the impact of shaving, nor should it be expected to cure PFB completely. However, in the proper context medical treatments can address symptoms and improve PFB enough to allow Soldiers to continue daily shaving.

(1) *Topical retinoids.* Prescription topical retinoids include tretinoin and its less irritating derivative, adapalene. Retinoids normalize epidermal turnover and are thought to make the skin more resilient. The Soldier should be advised to make sure the beard area is completely dry before applying tretinoin at bedtime and use only a "pea" sized amount to cover the beard area to curb irritation.

(2) *Topical benzoyl peroxide or benzoyl peroxide/clindamycin.* Benzoyl peroxide has keratolytic and antimicrobial properties, and topical clindamycin is an antibiotic with anti-inflammatory properties. Topical benzoyl peroxide wash is typically used twice a day. Topical benzoyl peroxide/clindamycin is a leave-on gel used once to twice a day. Soldiers should be advised that benzoyl peroxide bleaches fabric if not washed off thoroughly.

(3) *Topical steroids.* Topical steroids can help temporarily with superficial inflammation and are useful to treat irritation and contact dermatitis from shaving. Only low-potency steroids should be used, and duration should be limited to minimum time to cease irritation.

(4) *Antibiotics.* Severely inflamed lesions may benefit from oral doxycycline, which has antibacterial and anti-inflammatory properties. Although the pustules of PFB are usually of normal skin flora, a secondary bacterial infection can sometimes ensue. Topical clindamycin or oral doxycycline can be helpful in these cases. If a bacterial infection is suspected, culture and sensitivity testing should be performed on samples taken from the pustules.

b. Shaving profile. The single most effective treatment for PFB is the cessation of shaving. Virtually all individuals with PFB will require a profile for the face and neck area at some point in therapy. The length of the hair required to prevent PFB is typically one-eighth to one-fourth inch, or the length provided by a number 1 and number 2 guard on a clipper. When a temporary or permanent shaving profile is initiated, the Soldier should be thoroughly counseled on this treatment option, including hair clipper use, which guards to use, and how long the hair can be.

c. Laser hair removal. LHR (reduction) with the long-pulse 1,064 nm neodymium-doped yttrium aluminum garnet (also known as Nd:YAG) laser has been shown to improve PFB in individuals with darker hair/skin tone. Lighter hair/skin tones are best treated with the Alexandrite 755nm laser. LHR can be an excellent treatment in those with mild to severe PFB, but it will not help treat hairs that are gray, red, and blonde. Usually, 4–6 treatments spaced 4–6 weeks apart are given with periodic touch-up treatments. Patients should be made aware that LHR can result in patchier growth of beard hair in the long term. These lasers are usually available in military treatment facilities where dermatology services are provided. In accordance with the TRICARE Operations Manual, laser therapy is covered in the civilian sector for PFB of the face and neck when there is an operational need and no locally available laser.

d. Indications for referral to dermatology. A dermatology referral is not required for initial management of PFB or to place permanent shaving profiles. For those requiring referral to dermatology, a history of tried medical treatment and photos are an essential. The referred Soldier often holds an active shaving profile by the time they see a dermatologist and may lack evidence of active disease. Concern for other causes for presenting symptoms is another reason for referral to dermatology. Finally, referral to dermatology for LHR is appropriate following failed first line medical treatment.

2–6. Guidelines for treatment in relation to clinical severity

a. Mild condition (few, scattered papules with scant hair growth of the beard area – generally considered to be in Phase I – Control of Mild Case). The initial phase of treatment focuses on a trial of shaving using the techniques described above. Medicated after-shave creams should still be used daily. Patients who do not see improvement after 4–6 weeks will need follow up for further treatment guidance in phase 2 below. Patients with PFB may experience flares during the course of their disease, and a temporary profile can be helpful during those times.

b. Moderate or severe condition (heavier beard growth, scattered or numerous papules – generally considered to be in Phase II – Control of Moderate to Severe Cases and Those Unresponsive to Phase I) or mild condition refractory to treatment). For moderate or severe PFB, with scattered or numerous papules, or mild PFB refractory to treatment, a topical medication such as tretinoin 0.025% cream or gel, benzoyl peroxide 5% and clindamycin 1percent gel, or a combination can be used. A course of oral doxycycline can be added for those with a lot of inflammation. These patients will benefit from a longer temporary shaving profile, up to 60 days. An initial worsening may appear the week following the discontinuation of shaving since all hair tips are available for entry into the skin. After several weeks, the ingrown hairs should grow out of the papules and allow the topical medications to work uniformly on the entire skin surface. At the end of the profile, shaving should be restarted, and a follow-up appointment should be made 2–3 weeks after resumption of shaving.

c. Chronic / Progressive disease (Generally considered to be in Phase III – Control of Severe Cases Unresponsive to Phase II or Phase IV – Control of Cases Unresponsive to Phase III or Recurring Frequently). Soldiers who demonstrate progression of the disease despite following treatments as detailed above may benefit from referral to dermatology for laser therapy. Consultation with dermatology can provide advanced treatment options and valuable information for the patient's informed decision.

d. Post-inflammatory hyperpigmentation, scars, and keloids may complicate PFB. Post- inflammatory hyperpigmentation is the most common complication of PFB and should resolve with successful treatment. Although uncommon, resultant hypertrophic scars and keloids are permanent, and the presence of these should prompt treatment starting in phase II or III for long-term management.

e. Medical Retention Decision Point (MRDP) - Rarely, PFB may be associated with the formation of chronic large, disfiguring keloids in the beard area that are recalcitrant to treatment. If these lesions interfere with performance of duty or use of protective equipment, it may indicate that the Soldier has reached MRDP. For further details on MRDP and referral to the Disability Evaluation System (DES) (see AR 40–501, AR 40–502, and AR 635–40).

2–7. e-Profile considerations

a. General. Patients with PFB frequently experience flares during the course of their disease, and a temporary profile can be helpful during those times. The Department of the Army (DA) Form 3349–SG (Physical Profile Record), functions as a means of communication between the medical provider and the Soldier's commander, informing the latter of the member's physical condition and restrictions. For specific details on preparation of DA Form 3349–SG, see Department of the Army Pamphlet (DA Pam) 40–502.

The e-Profile system provides standardized templates for shaving restrictions which providers can individualize to address the specific Soldier's needs and phase of care.

b. Designation. A Soldier with PFB will not ordinarily require a restriction in duty or assignment. DA Pam 40–502, describes the use of a physical, upper, lower, hearing, eyes, psychiatric (PULHES) "P–2" designation for shaving profiles.

c. Wording. The e-Profile system offers pre-populated templates that address common concerns from commanders. Consistent with guidance in AR 40–502 and DA Pam 40–502, providers can then edit these templates to reflect the individual Soldier's unique needs. As an example, instructions to commanders' text for the DA Form 3349-SG could read:

> "Soldier is actively undergoing medical care for a skin condition. In addition to other treatments, the medical team recommends an exception to policy for Army grooming standards for the duration of this profile. The Soldier is authorized to use electric or manual clippers daily, NOT electric or blade razors, to maintain a beard length of 1/8–1/4 inch. The beard must maintain a neatly trimmed, uniform, and clean appearance with no styling such as goatees or handlebar mustaches, and so forth. The Soldier will continue to wear the beard when training/simulation requires use of a protective mask. However, when in actual danger of exposure to a toxic environment where protective mask wear is required for the safety of the Soldier and the unit, on order from the commander, the Soldier must shave the beard."

d. The existence of a beard does not prevent performance of most military duties but can interfere with the safe employment of a protective mask. Most training environments that require a protective mask present minimal risk to the Soldier and the unit. In these situations, it is best to allow the Soldier to continue to function within the limits of his profile to ensure he is fully familiar with the use of the protective mask while reducing risk of setbacks in his PFB treatment. Some tactical situations may present significantly greater imminent risk of chemical or biological threat to the Soldier and unit. In those scenarios, the standard profile text allows commanders to order Soldiers to shave their beards to improve protective mask function.

2–8. Summary

PFB is a chronic, reoccurring condition that affects the Soldier populations largely due to the grooming standards required of Soldiers. There are a variety of treatment options which may necessitate a temporary or permanent profile to reduce complications from PFB. Each individual Soldier's treatment plan can be tailored to maximize ability to meet military standards while reducing risks of complications.

CHAPTER 3

ACNE KELOIDALIS NUCHAE

3–1. Introduction

a. Synonyms. AKN is also known as keloidal acne, dermatitis papillaris capilliti, and folliculitis keloidalis.

b. Definition. AKN is a chronic inflammatory and scarring disorder of the hair follicles, affecting the posterior scalp, upper neck, and occasionally the crown of the scalp. It is characterized by multiple firm papules and sometimes pustules. The papules occasionally coalesce into keloid-like plaques. Patients may experience varying degrees of pruritus and irritation.

c. Epidemiology. This disorder affects predominantly males with tightly curled hair although it can affect females and other groups. It is most frequent before the age of 25 and can be triggered by a closely shaven ‘high and tight’ hair style.

d. Military considerations. While the medical management of AKN often necessitates wearing a longer hairstyle, hair can still be maintained at an acceptable length and not detract from proper military appearance.

3–2. Pathogenesis

AKN occurs most commonly in men with tightly curled hair similar to that of PFB. Unlike PFB it is unclear what factors contribute to the inflammatory process, but it is likely multifactorial in nature. Along with irritation of the localized skin, as can be seen in short haircuts, an autoinflammatory response to intrafollicular antigens has been proposed. There is likely a strong genetic component to this condition, although this has yet to be elucidated. There have been no specific bacterial organisms implicated in this process; however, secondary bacterial infection may occur, often complicating the management and contributing to the progression of the disorder.

3–3. Clinical approach to the patient

The papulebs, once developed, are chronic and difficult to treat. In addition to the ‘high and tight’ style of military haircut, AKN can also be exacerbated from irritation by the top of the shirt or jacket collar. Treatment is directed towards eliminating the contributing factors, halting the development of any further scarring, and decreasing the existing scar formation.

3–4. Management techniques

a. Close shaving. The first step in management is to advise the Soldier to allow their hair to grow to a longer, yet militarily acceptable, length instead of a closely trimmed "high and tight" hair style.

b. Antibiotics. The use of antibiotics should be reserved for the treatment of a known bacterial infection. Depending on the severity of the infection, topical clindamycin or oral antibiotics can be used. Oral doxycycline is often a good choice as it is one of the more skin-specific classes of antibiotics and has both antibiotic and anti-inflammatory properties. Before beginning any antibiotic regimen, culture and sensitivity testing should be performed on samples taken from the affected scalp.

c. Steroids. Topical steroids are of great value in the treatment of AKN. A high potency topical steroid such clobetasol 0.05% foam or solution should be applied once to twice daily to the affected areas. Topical steroids can be applied in 2–week cycles to minimize effects of chronic steroid use. Intralesional steroid injections, given monthly or every 6 weeks (depending on the severity of the scarring) are helpful in decreasing scar formation. Triamcinolone acetonide is given as the recommended course, beginning at concentrations of 20 milligrams/milliliter (mg/ml) in very severe cases, or 10 mg/ml in less severe cases, and decreasing gradually to 3 mg/ml strength as the scars subside. Commonly, intralesional injections of the 10 mg/ml strength are used for maintenance therapy.

d. Wide excision. For cases that are either severe or unremitting, wide excision of the scars, with healing by secondary intention, is recommended. Recent studies have shown excellent results. While some scar formation is unavoidable, the resulting scar is much more cosmetically acceptable than the scarring of the preoperative condition. This technique should be reserved for dermatologists and surgeons. It should not be performed in individuals who are prone to the development of keloids. The Soldier will be placed on appropriate convalescent leave during the post-operative phase of this treatment with a corresponding e-Profile.

e. Profiles. Wearing protective headgear or garments with high collars may irritate AKN lesions. Avoiding such garments may be beneficial in allowing Soldiers to heal. A DA Form 3349–SG e-Profile can be used to document this duty limitation for the duration of the treatment period. Both providers and commanders should be mindful of individual Soldier safety when limiting use of protective equipment.

f. Medical Retention Decision Point. Rarely, AKN may lead to the formation of chronic large, disfiguring keloids in the posterior scalp and nape of neck area that are recalcitrant to treatment or that may render a Soldier unfit for further military service. Examples of findings suggestive that a Soldier has reached MRDP include a permanent inability to wear protective headgear; keloids that are so extensive and adherent that they interfere with the performance of duty; or chronic lesions of a nature that requires frequent medical care or interferes with the satisfactory performance of military duty. For further details on MRDP and referral to the Disability Evaluation System (see AR 40–501, AR 40–502, and AR 635–40).

3–5. Summary

Currently, the mainstay of treatment for AKN consists of changing the Soldier's hairstyle from one that is too closely shaven to one that is longer but still militarily acceptable. Topical and intralesional steroids are the most commonly used techniques for treatment and currently have a good success rate. However, this disorder is chronic and often recurrent. For those disorders that are severe or resistant to other forms of treatment, wide excision with healing by secondary intention is recommended. The Soldier should be initially evaluated by a dermatologist, and a strategy for therapy can be devised. After evaluation by a dermatologist, the treatment regimen can be administered by healthcare providers who are familiar with the disorder.

APPENDIX A

REFERENCES

Unless otherwise indicated, Department of the Army publications are available on the Army Publishing Directorate website at https://armypubs.army.mil/.

Section I

Required Publications

AR 40–501
Standards of Medical Fitness (Cited in para 2–6*e*.)

AR 40–502
Medical Readiness (Cited in para 2–6*e*.)

AR 635–40
Disability Evaluation for Retention, Retirement, or Separation (Cited in para 2–6*e*.)

DA Pam 40–502
Medical Readiness Procedures (Cited in para 2–7*b*.)

Section II

Related Publications

AR 11-34
The Army Respiratory Protection Program

AR 670-1
Wear and Appearance of Army Uniforms and Insignia

.

Section III

Prescribed Forms

This section contains no entries.

Section IV

Referenced Forms

Unless otherwise indicated, Department of the Army forms are available on the Army Publishing Directorate website at https://armypubs.army.mil/.

DA Form 3349-SG
Physical Profile record (Cited in para 2–7*a*.)

Section IV

Bibliography

Bolognia JL, Jorizzo JL, Schaffer JV. Dermatology. 3 e. Philadelphia: Elsevier Saunders 2012, pp. 579-583, 1580.

Brauner GH, Flandemeyer KL. Pseudofolliculitis barbae, 2: Treatment. Int Dermatol 1977;16:520.

Burns T, Breathnach S, Cox N, Griffiths C. Rook's Textbook of Dermatology. 8e.

Chichester, West Sussex, UK: Wiley-Blackwell 2010, pp. 9.9, 28.50, 30.26, 78.12.

Coquilla RH, Lewis CW. Management of pseudofolliculitis barbae. Mil Med 1995; 160(5): 263-269.

Craig GE. Shaving in relationship to disease of the bearded area of the face. Arch Dermatol 1955;71:11-13.

Goldsmith LA, Katz SI, Gilchrest BA, Paller AS, Leffell DJ, Wolff K. Fitzpatrick's Dermatology in General Medicine. 8e New York: McGraw-Hill Medical, 2012, pp. 1000, 2134.

Greidanus TG. Pseudofolliculitis of the beard. http://emedicine.medscape.com/article/1071251, retrieved 13 March 2014.

James, WD, Berger TG, Elston DM. Andrew's Diseases of the Skin. 11 e. London: Elsevier Saunders 2011, pp. 238-239, 758-759.

Kelly P. Surgical Therapy for Acne Keloidalis. At the 100th Annual Scientific Assembly of the National Medical Association, Atlanta, Georgia, 31 July 1995.

Kelly AP. Pseudofolliculitis barbae and acne keloidalis nuchae. Dermatol Clin 2003; 21: 645-653.

Letada P. Acne keloidalis nuchae, http://emedicine.medscape.com/article/1072149, retrieved 13 March 2014.

Perry PK, Cook-Bolden FE, Rahman Z, Jones E, et. al. Defining pseudofolliculitis barbae in 2001: A review of the literature and current trends. J Am Acad Dermatol 2002;46:S113-119.

Schulze R, Meehan KJ, Lopez A, Sweeney K, et al. Low-fluence 1,064-nm laser hair reduction for pseudofolliculitis barbae in skin types IV, V, and VI. Dermatol Surg 2009;35:98-107.

Sperling LC, Homoky C, Pratt L, Sau P. Acne keloidalis is a form of primary scarring alopecia. Arch Dermatol Apr 2000;136(4):479-84.

Strauss JS, Kligman AM. Pseudofolliculitis of the beard. Arch Dermatol 1956;74:533-542.

Winter H, Schissel D, Parry DAD., Smith TA, et al. An unusual Ala12Thr polymorphism in the 1A α-helical segment of the companion layer-specific keratin K6hf: Evidence for a risk factor in the etiology of the common hair disorder pseudofolliculitis barbae. J Invest Dermatol 2004;122:652-657.

Yurechko S, Carter K, ETG, PF/Toxic Chambers Group. Quantitative fit factor test on the effects of beard growth on military respirator performance. RDCB-DET-C, U.S. Army Edgewood Chemical Biological Center, September 2009.

GLOSSARY and TERMS

Section I

Abbreviations and Acronyms

AKN
Acne keloidalis nuchae

AR
Army regulation

DES
Disability Evaluation System

LHR
Laser Hair Removal

mg
milligram(s)

ml
milliliter(s)

MRDP
Medical Retention Decision Point

PFB
pseudofolliculitis barbae

PHA
Periodic Health Assessment

Section II

Terms
This section contains no entries.

TB MED 287

16 July 2025

By Order of the Secretary of the Army:

RANDY A. GEORGE
General, United States Army
Chief of Staff

Official:

MATTHEW L. SANNITO
Acting Administrative Assistant to the
Secretary of the Army
2519805

DISTRIBUTION:
Active Army, Army National Guard, and United States Army Reserve. Distributed in electronic media only(EMO).

PIN: 009980-000