for clinical management because no large series have been published and no treatment protocol has been established. Systemic therapies such as retinoids, methotrexate, and cyclosporine, among others, either alone or in combination, have traditionally achieved mixed results.[5] However, the market introduction of biological therapies provided new options for the treatment of this variant of psoriasis.

Experience with biological therapy for the treatment of erythrodermal psoriasis is limited to the use of etanercept and infliximab (Table). Infliximab has been used in 2 isolated cases,[6,7] and a small series of 4 patients,[8] whereas etanercept has only been analyzed in a prospective study of 10 patients.[9] The clinical response was good in the patients treated with infliximab, although in 4 out of 6 the degree of response was not reported. In addition, except for 1 case,[6] the others were receiving methotrexate at the same time. The response was good in 80 % of patients treated with etanercept (50 % with a PASI 75 response and 30 % with PASI 50 response), but no other concomitant medications.

It is difficult to draw comparative conclusions between infliximab and etanercept, due to the limited number of case studies published, as well as the different doses and the use of concomitant treatments. However, etanercept and infliximab appear to be clearly superior to classic systemic therapy for psoriatic erythroderma, due to their fast action, greater efficacy, and few adverse effects. More cases are nevertheless needed to establish the most appropriate dosage and treatment.

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Evaluation of Dermatological Services Implemented in the Primary Care Setting

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To the Editor:

In light of the interesting article published by Macaya-Pascual et al,[1] we felt it appropriate to describe the results of a study conducted in our referral area.

In 2004 a service list for dermatology was prepared and distributed jointly by the Dermatology Department at the Hospital Universitario Germans Trias i Pujol and primary health care representatives in order to streamline the specialist care offering and reduce the waiting list. Among other points, this list expressly recommended that referrals be restricted when treatment was requested for clearly benign lesions—skin tags, seborrheic keratoses, dermal nevi, cherry angiomas, and liver spots—that present no diagnostic doubts or complications. Implementation was assessed by a cross-sectional study conducted in November and December 2005 of the first 200 consecutive visits referred to specialists from primary care. The endpoints assessed included whether the reason for consultation was considered "indicated" or "not indicated" in the opinion of the dermatologist consulted, using the previously agreed service list as a reference. As a whole, 72/200 (36 %) of the initial visits assessed were considered "not indicated" by the dermatologist. In this group, 72 % (52/72) of the visits included reasons for consultation agreed

in the service list not to be eligible for referral.

Despite the limited scope of the study in terms of data collection and with no prior study that could be used as a reference, the results suggest that consensus and subsequent distribution of the service list in the referral area would have some impact on referrals of trivial, extremely widespread lesions that account for almost 1 of 3 consultations.

The factors that lead to a high prevalence of consultations for trivial lesions in the public health care system and their medium-term and long-term consequences on dermatologists' activity are unquestionably complex and deserve lengthy and careful discussion. However, this situation not only requires funding, as Macaya-Pascual et al[1] pointed, but could largely explain the long waiting lists commonly seen in dermatology outpatient clinics. Unlike the private sector, resource allocation in the public health care system is not proportional to demand and market laws, but is governed by political criteria and health plans or medium-term and long-term strategies.[2] Under these circumstances, the waiting list is far from helpful for dermatologists and often turns into a severe care overload that limits the time that professionals should devote to truly ill patients—who must also endure a bloated waiting list—and to the practice of all the various elements of the specialty.[3]

Therefore, it appears appropriate for dermatologists to claim reasonable restrictions on the treatment of trivial, highly prevalent skin lesions in the public health care system or, if considered appropriate, adjustment of human and material resources to the demand, so as to allow quality care. In addition to requiring sufficient agreement and consensus among professionals from the various Spanish autonomous communities—the Academia Española de Dermatología y Venereología (Spanish Academy of Dermatology and Venereology, AEDV) could be an appropriate institutional setting for discussion in this case—it would be desirable to identify and use health care management indicators and have the necessary agreement and cooperation among those responsible for primary care.[4]

Lastly, as Macaya-Pascual et al[1] rightly concludes, none of this takes into consideration the meager percentage of total invoicing for the visits that goes to the dermatologists, who would blanch with envy at the most miserly entrepreneur in the private sector.

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Adalimumab-Induced Urticaria

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To the Editor:
The use of biological agents is a safe, effective treatment in certain diseases, mainly dermatological and rheumatological diseases.

In particular, adalimumab (Humira), a recombinant human monoclonal antibody that inhibits tumor necrosis factor-α (TNF-α), has begun to be used in the treatment of rheumatoid arthritis, ankylosing spondylitis, and psoriatic arthritis.

Skin reactions to this antibody are uncommon, around 1 % according to clinical studies,[1,2] and include, among others, allergic rash, anaphylactic reaction, fixed drug eruption, nonspecific drug reaction, and urticaria. This last entity is extremely rare, with only 1 case reported in 2006, in a 41-year-old woman with a long history of plaque psoriasis who presented lesions consistent with acute urticaria in the neck and arms, in which onset occurred within hours of each administration of adalimumab.[2]