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]

Other skin reactions have been identified. In 2004 a case of erythema multiforme-like reaction was described in a patient with rheumatoid arthritis.[3] Lesions appeared at the injection site and on the palms and soles after the sixth dose of adalimumab, but improved after discontinuation of this drug. In 2006, Boura et al[4] reported the case of a 72-year-old woman diagnosed with rheumatoid arthritis who presented lesions consistent with eosinophilic cellulitis (Wells syndrome) in the area of the first injection.

In addition to those reports, we describe the case of a 32-year-old man diagnosed with ankylosing spondylitis who had presented an inadequate response to conventional therapy. The rheumatology department initiated treatment with subcutaneous adalimumab (at doses of 40 mg every 2 weeks), leading to improvement of the symptoms. After administration of the third dose, the patient reported the sudden onset of very severe pruritus in the lower back, accompanied by a slight burning sensation and general malaise, with no other associated symptoms or intake of any other medication. The pruritus later spread to the rest of the trunk and to the junctions of the limbs. The physical examination revealed multiple confluent erythematous-edematous lesions forming large plaques on the back and the anterior region of the trunk, and with smaller patches on both flanks (Figure). The lesions were described as evanescent by the patient. The symptoms were not accompanied by difficulty with breathing or by edema of the lips, tongue, or eyelids. Based on a diagnosis of acute urticaria, oral antihistamines and corticosteroids were prescribed, with improvement of the symptoms and disappearance of the lesions within a few days.

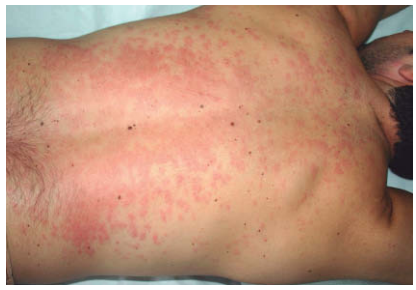

Figure. Plaque of confluent erythematous lesions in the lumbar area.

The rheumatology department did not prescribe new doses of adalimumab, and the patient has remained asymptomatic to date.

The urticaria was attributed to the administration of adalimumab, in view of the absence of other potential causal factors in the patient.

A noticeable increase in the use of biological agents should be expected to result in new reports of skin reactions associated with their use.

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