are ordered at baseline and every 6 months during follow-up for asymptomatic patients.[1,3] A full physical examination, complete blood count and biochemistry, and abdominal ultrasound as well as a chest radiograph are usually ordered annually for at least 3 years.[3] Bone marrow should be biopsied if infiltration is suspected, although some authors believe the procedure should be routine.[1]

Because LCH in the adult is so rare, optimum treatment has not been established. The prognosis is good for patients with LCH confined to a single organ or system,[3,6] but they should be followed closely.[3,10] Local treatments (surgery, topical corticosteroids, or corticosteroid infiltrations) can be used. Multiple, ulcerated, or resistant lesions can be treated with systemic corticosteroids, phototherapy, radiotherapy, interferon, and various chemotherapeutic regimens.[6,9] It has been suggested that ulceration may affect the prognosis, although to date the reported outcomes have been inconsistent.[1]

Conflicts of Interest

The authors declare that they have no conflicts of interest.

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Nail Psoriasis Treated With Certolizumab Pegol in Patients With Psoriatic Arthritis: Preliminary Observation☆

Psoriasis ungueal tratada con certolizumab pegol en pacientes con artritis psoriásica: conclusión preliminar

To the Editor:

Nail psoriasis is a common complaint in psoriasis. It can be a sign of severe disease and must be taken into account when choosing a treatment aimed at reducing pain, functional disability, and emotional stress. An estimated 90% or so of patients with psoriasis will develop nail psoriasis at some stage in their lifetime, although the condition is uncommon in the pediatric population (prevalence, 7%-13%).[1]

Nail psoriasis can have a major impact on patient quality of life, as it can cause intense pain or interfere with the ability to pick up small objects or perform fine motor movements. We present our experience with 8 patients (4 men and 4 women) with a mean (SD) age of 59.8 (8) years with psoriatic arthritis (PsA) and severe nail damage treated with certolizumab pegol (CZP) monotherapy using the standard dosage of 400 mg at weeks 0, 2, and 4, followed by 200 mg every 2 weeks. CZP is a TNF inhibitor formed

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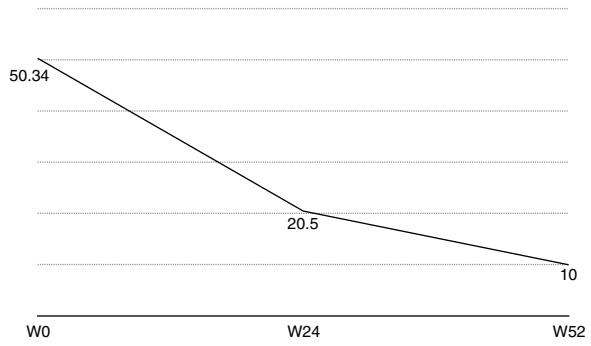

Figure 1 Nail Psoriasis Severity Index graph. W indicates week.

by the Fab' fragment of a humanized antibody. It was approved by the European Medicines Agency in 2009 for the treatment of active PsA in adults in whom disease-modifying antirheumatic drugs (DMARDs) do not produce an adequate response or are contraindicated. Despite our small sample, the aim of this study was to evaluate the efficacy and safety of CZP in the treatment of nail psoriasis. We included adults aged 18 years or older with a clinical and instrumental diagnosis (confirmed by ultrasound and/or magnetic resonance imaging) of nail psoriasis and PsA of over 6 months' duration who did not respond to or tolerate conventional DMARDs, including methotrexate, azathioprine, and leflunomide. We also included patients previously treated with other biologic drugs (tumor necrosis factor and/or interleukin 12/23 inhibitors). Patients were evaluated using the Nail Psoriasis Severity Index (NAPSI), the Health Assessment Questionnaire for patients with spondyloarthritis (spA-HAQ), the Derma-

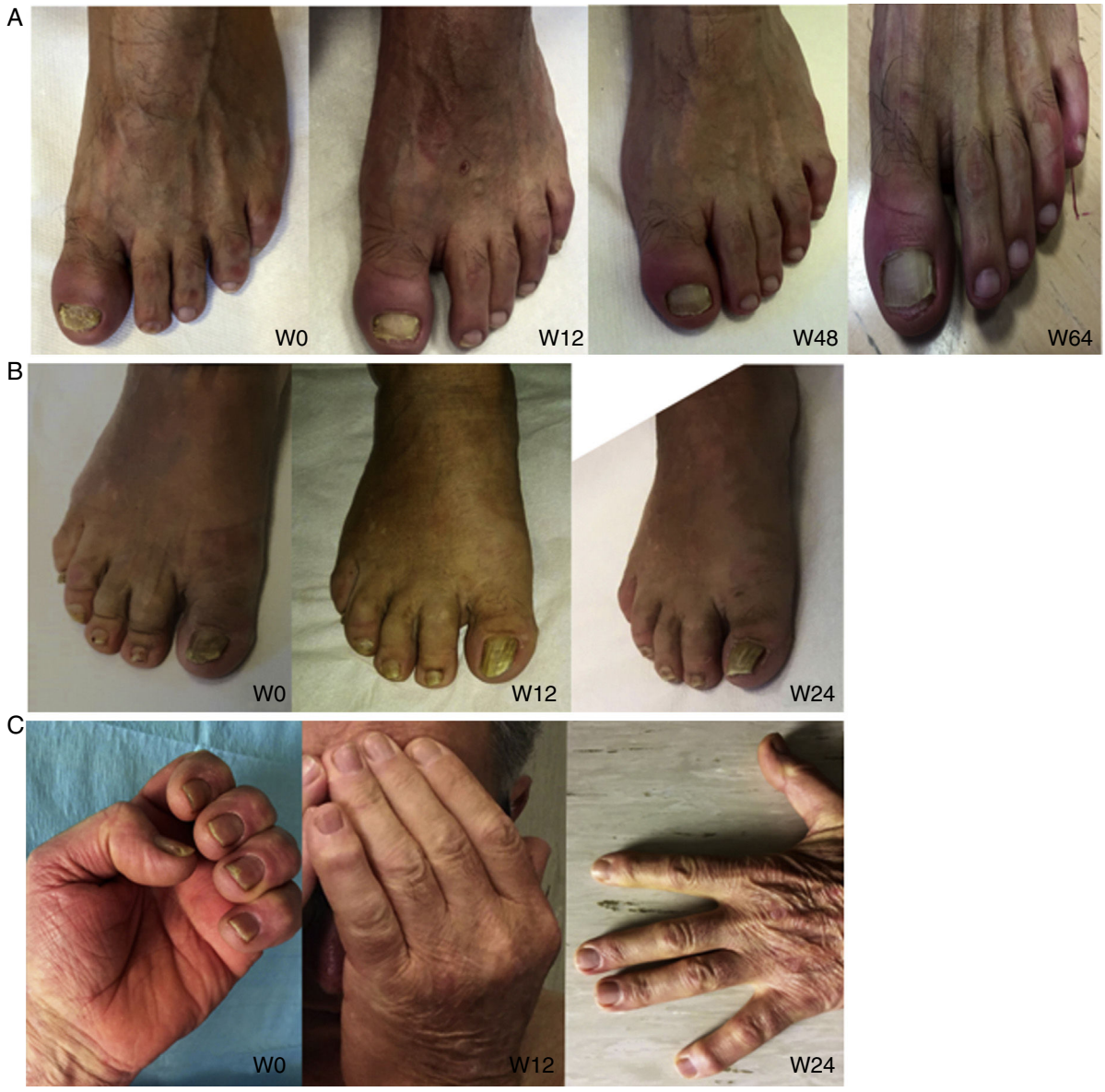

Figure 2 Typical whitening seen in 3 patients with nail psoriasis. W indicates week.

tology Life Quality Index (DLQI), and the Disease Activity Score based on the 44 swollen joint count (DAS-44) correlated with erythrocyte sedimentation rate (ESR) in the first hour (DAS44-ESR) at weeks 0, 24, and 52.[2] The nails were also photographed at each visit to allow objective disease evaluation. The mean NAPSI score improved from 50.34 at baseline to 20.5 at week 24 and 10 at week 52 (Figs. 1 and 2). Mean DAS44-ESR also improved in patients with PsA, with a reduction from 4.4 (0.6) at baseline to 1.9 (0.5) at week 24 and 0.7 (0.5) at week 52. The mean DLQI score improved from 26 at baseline to 8 at week 24 and 5 at week 52. There was also an improvement in mean SpA-HAQ score, with a reduction from 1.65 at baseline to 0.75 at week 24 and 0.35 at week 52. Although Psoriasis Area and Severity Index assessment was not an objective in our study, we noticed a reduction in mean score from 5.1 (5.7) at baseline to 0.8 (1.2) at week 24. This score remained at 0.8 up to week 52. Improvement in nail psoriasis became evident after 4 doses (week 8). The improvement continued up to week 24 and was maintained for the rest of the year (up to week 52).

Taken together, the results of our study show that CZP improved the clinical manifestations of psoriasis over the course of 1 year and is a safe, well-tolerated treatment for refractory nail psoriasis. The efficacy and safety of CZP in the treatment of PsA has been studied in the RAPID-PsA trial. This is a phase 3, multicenter, double-blind, placebo-controlled trial in which patients were randomized to CZP 200 mg every 2 weeks (Q2W), 400 mg every 4 weeks (Q4W), or placebo to evaluate effects on the signs and symptoms of PsA over a period of 24 weeks. The results at 24 weeks for the group of patients with nail psoriasis at baseline (73.3%) showed a change in the modified NAPSI of −1.6 for the Q2W group and −2.0 for the QW4 group versus −1.1 for the placebo group ($P = .003$ and $P < .001$, respectively).[3] Our results are consistent with other findings that have shown that CZP offers rapid and considerable improvement in psoriatic nail disease.

Conflicts of Interest

The authors declare that they have no conflicts of interest.

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An Unusual Presentation of Cutaneous Leishmaniasis: The Role of Skin Ultrasound☆

Leishmaniasis cutánea de presentación inusual. Papel de la ecografía cutánea

To the Editor:

Cutaneous leishmaniasis (CL) manifests as a papule or nodule that forms in response to the bite of mosquitoes that carries this parasitosis. These lesions tend to grow to form a well-defined plaque with a raised violaceous border that may ulcerate, leading to subsequent formation of a crust. Atypical presentations of CL are increasingly common, and pose a diagnostic challenge.

Diagnosis is based on histological and microbiological findings (ie, a positive result in polymerase chain reaction [PCR] analysis of blood or tissue). However, skin ultrasound can be a useful complementary technique for CL diagnosis and a tool to monitor treatment response in CL patients.

We describe 2 cases of CL with an unusual, erysipeloid presentation, and the corresponding ultrasound findings.

Case 1

A 62-year-old man with a personal history of hepatic porphyria cutanea was seen for a lesion covering a large portion of the external aspect of the shoulder and upper left arm. The lesion had appeared 2 months earlier and was occasionally suppurative. The patient had been previously treated for suspected cellulitis with multiple oral antibiotics, without improvement. Physical examination revealed an indurated, erythematous plaque (9 × 7 cm) with poorly defined borders that was hot to the touch (Fig. 1A). Histology revealed non-necrotizing granulomatous dermatitis and the presence of *Leishmania* bodies within the cytoplasm of the histiocytes. Skin ultrasound (SonoScape, 15-MHz linear probe) was performed to evaluate the extent of the lesion

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