Sustained Remission of Extramammary Paget Disease Following Treatment with Imiquimod 5% Cream☆

Remisión mantenida de la enfermedad de Paget extramamaria tras tratamiento con imiquimod al 5% en crema

To the Editor:

The recent report by Hiraldo-Gamero et al.[1] on the use of 5% imiquimod cream to treat extramammary Paget disease (EMPD) confirms the growing interest in this new nonsurgical treatment option for this disease. In 2009 we reported the results obtained in the treatment of 3 cases of EMPD of the vulva with clinical and pathologic features similar to those described by Hiraldo-Gamero.[2]

The 3 patients, aged 66, 58, and 82 years, had vulvar lesions up to 5 cm in diameter (Fig. 1). In all 3 cases, the results of multiple biopsies (Fig. 2) revealed exclusively intraepidermal involvement, and exhaustive screening ruled out the possibility of underlying malignancy. Bearing in mind the comorbid conditions present in each case, treatment with imiquimod was chosen to avoid the risks associated with surgical excision, the approach traditionally used to treat such tumors. The regimen used was once daily application of 5% imiquimod cream for 3 weeks followed by application on alternate days for a further 13 weeks. All 3 patients completed treatment despite episodes of inflammation and moderate pain. Control biopsies were performed at 6 and 12 months. The 3 patients were followed up clinically every 3 months for 1 year after treatment and every 6 months thereafter. At the time of writing, they have completed a follow-up period of 53 months and remain in complete remission (Fig. 3). Green et al.,[3] who recently reviewed reports

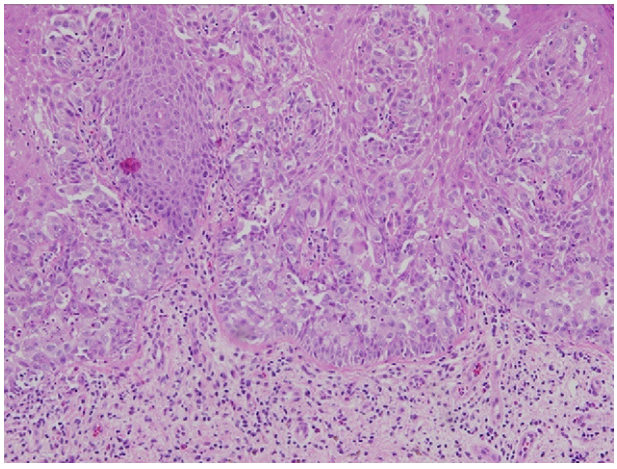

Figure 2 Cells with abundant clear cytoplasm and pleomorphic nuclei (Paget cells) distributed throughout the full thickness of the epidermis. Immunohistochemical stains were positive for carcinoembryonic antigen, epithelial membrane antigen, and cytokeratin 7.

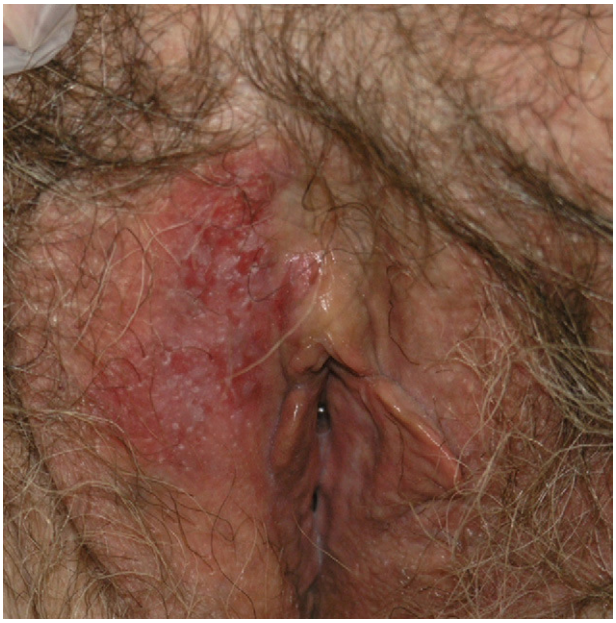

Figure 1 Erythematous plaque with whitish patches and erosions on the right labium majus of the vulva.

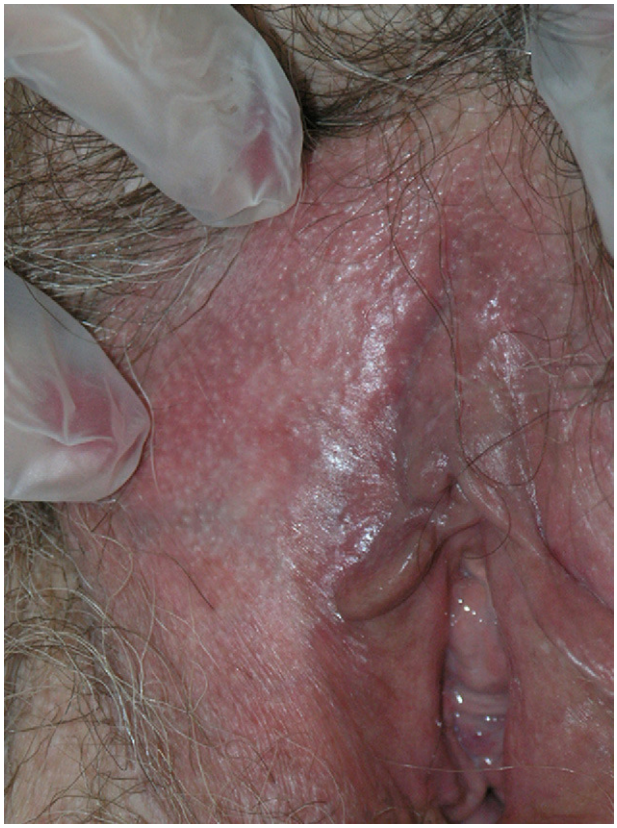

Figure 3 Complete resolution of the lesions 3 months after completion of treatment.

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in the literature on the use of imiquimod in EMPD, found complete remission of the disease in 21 of the 27 reported cases (78%). The factors that influence the success or failure of imiquimod therapy in this setting have not yet been clearly established. Factors that might explain the variability of response to treatment include the size of the lesion, its variable thickness in different areas, and the presence of extensive adnexal involvement.

We agree with Hiraldo-Gamero that the small number of published cases makes it difficult to draw conclusions concerning the efficacy and safety of 5% imiquimod cream in selected cases of EMPD. Our report provides additional evidence on the medium-term safety of this treatment and represents the longest follow-up period free of disease reported in the dermatologic literature.

References

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Exacerbation of Atopic Dermatitis in a Patient Treated With Infliximab☆

Exacerbación de dermatitis atópica en paciente tratado con infliximab

To the Editor:

Biologic agents are now being used to treat chronic inflammatory diseases, mainly those of rheumatic, dermatologic, or gastrointestinal origin. This development has led to a reassessment of the diagnosis and therapeutic management of their associated adverse effects, which can include relapses of certain pre-existing diseases that a patient may have; although these relapses have been successfully treated in some cases, they have been difficult to control in others.[1] We present the case of a patient with infliximab-treated ulcerative colitis who developed a relapse of atopic dermatitis, and we review the cases reported in the literature.

The patient was a 30-year-old man with a past history of ulcerative colitis on treatment with infliximab; the disease had been refractory to treatment with mesalazine and azathioprine. After the fifth infusion he developed widespread, intensely pruritic eczema that did not respond to topical corticosteroids or oral antihistamines.

The patient had a history of atopic dermatitis (AD) since childhood, but denied rhinitis or extrinsic asthma. The AD lesions had always developed in flexures (cubital and popliteal fossae) and had responded to corticosteroids and topical calcineurin inhibitors, without requiring systemic treatment or phototherapy.

On physical examination, erythema and fine desquamation were observed on the face, trunk, and in the limb flexures; almost 50% of the body surface area was affected (Fig. 1). There were no alterations of vital signs and respiratory function was not affected.

Additional tests did not reveal eosinophilia or elevation of immunoglobulin (Ig) E or acute phase reactants (C-reactive protein, erythrocyte sedimentation rate). Moderate spongiosis and a predominantly lymphocytic perivascular infiltrate were observed on histology. The absence of necrotic keratinocytes, the minimal damage to the basal layer, and the deep lymphocytic infiltrate with no eosinophils, together with the clinical manifestations, were more suggestive of a relapse of his AD than of a toxic dermatitis.

As a precaution it was decided to interrupt treatment with infliximab and start prednisone 0.5 mg/kg/d in a slowly tapering regimen. Control of the skin condition was achieved in 3 weeks (Fig. 2).

The etiology and pathogenesis of AD is characterized by an acute phase with an inflammatory pattern involving type 2 helper T (T_H2) cells (often with elevated IgE levels and eosinophil counts), and a chronic phase with a T_H1 inflammatory pattern. It is therefore to be expected that the anti-tumor necrosis factor (TNF) agents used in psoriasis would improve the chronic forms of AD but that there would be no clear response in the acute phase.[3]

In the chronic phase of AD there is elevation of serum TNF-α, which is released initially by mast cells and subsequently by the T_H lymphocytes and keratinocytes. The release of the cytokine further stimulates the inflammatory

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