

Successful Treatment of Recalcitrant Chronic Foot Eczema with Alitretinoin[☆]

Tratamiento exitoso de un eczema crónico recalcitrante de las plantas con alitretinoína

In recent years, little attention has been paid to chronic foot eczema if we consider the numerous publications dedicated to eczema of the hands. However, chronic foot eczema is also a common problem and it can limit activity in some patients. The introduction of new therapeutic options, such as alitretinoin, for the management of chronic hand eczema resistant to conventional therapy led us to choose this drug in a patient with recalcitrant chronic foot eczema.

A 49-year-old woman with a history of atopy and allergies to various nonsteroidal anti-inflammatory drugs was seen in our outpatient department for a 5-year history of eczema affecting both feet. She had been treated with emollients, high-potency topical corticosteroids, and several cycles of oral corticosteroids, which had achieved a slight improvement (Fig. 1). The eczema gave rise to constant itching associated with pain that sometimes disturbed her sleep and had caused occasional periods off work.

Standard patch testing following the guidelines of the Spanish Contact Dermatitis and Skin Allergy Research Group (GEIDAC) was positive for chromium, thiomersal, and the caines. Skin biopsy showed a subacute spongiotic dermatitis and microbiology cultures were negative.

After failure of therapy with topical calcineurin inhibitors (tacrolimus and pimecrolimus), treatment was started with oral ciclosporin at a dosage of 3 mg/kg/d in 2 daily doses, with a poor response at 12 weeks. In addition, the patient used chrome-free shoes. She was then treated with acitretin, 25 mg/d, which was discontinued after 1 month due to hypertriglyceridemia in the follow-up blood tests; there had been no response. In view of this lack of improvement, off-label use of alitretinoin was requested and treatment was started at a dosage of 30 mg/d, with a good response after the first week of treatment; complete clearance of the lesions was achieved at 1 month (Fig. 2), and it was therefore decided to discontinue treatment. No adverse effects and no alterations of the blood tests were detected. During the third month of follow-up without treatment, the patient presented a further outbreak, and alitretinoin treatment was restarted at a dosage of 30 mg/d, which was continued until remission was achieved. She was subsequently administered the same dosage on alternate days, and continued on this regimen for 6 months, maintaining almost complete clearance of the lesions and with a marked improvement in her quality of life.

There are geographical variations in the incidence of chronic foot eczema, and in a large proportion of cases it appears to be related to atopic eczema.¹

In general, there is a high prevalence of dermatoses affecting the feet. However, certain aspects, such as their repercussions on quality of life, have not been sufficiently investigated. In a large study, a considerable percentage of



Figure 1 A, Appearance of the eczema on the soles of the feet. B, Lateral view.

patients with dermatoses of the feet were found to have pain, discomfort on walking, and even a feeling of embarrassment and limitation of the activities of daily living.²

Treatment is usually similar to that of chronic hand eczema and includes emollients, topical corticosteroids, and calcineurin inhibitors; systemic treatments have included corticosteroids, traditional retinoids, ciclosporin, and UV radiation.

Alitretinoin (9-cis-retinoic acid) is an isoform of isotretinoin (13-cis-retinoic acid), a retinoid that was specifically developed and approved for the treatment of chronic hand eczema. The exact mechanism of action of alitretinoin in chronic eczema is unknown, but it may interfere with at least 2 stages of the inflammatory process. In the early phases, it could interfere with chemokine production, reducing leukocyte migration, and it may also act within the leukocytes themselves, altering leukocyte activation modulated by antigen-antibody presentation.³

The efficacy of alitretinoin in chronic hand eczema resistant to topical corticosteroids has been demonstrated in a large double-blind study⁴; the dosage that achieved the best response was 30 mg/d, which achieved clearance for up to 24 weeks in 48% of patients, compared with 28% of patients for the 10 mg/d dosage and 17% of patients for placebo; the mean response time was 12.1 weeks. Those results are consistent with the results of a recent case series published in Spain.⁵ In the study by Ruzicka et al.⁴ recurrence of the

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Figure 2 Complete resolution after 4 weeks of treatment with alitretinoin.

lesions occurred in up to a third of patients who initially responded to alitretinoin after 24 weeks of follow-up. A recent study reported that a second course of treatment with alitretinoin at a dosage of 30 mg/d in patients who relapsed achieved clearance in up to 80% of cases, with good tolerance⁶; this would indicate that this medication could be used for long-term management of chronic hand eczema. Alitretinoin is therefore a useful and probably cost-effective treatment for this condition.⁷

We have presented the case of a patient with chronic foot eczema that did not respond to various traditional treatments. Alitretinoin achieved complete clearance of the eczema. Alitretinoin could be a useful alternative for the management of patients with chronic foot eczema.

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Dermatosis Neglecta or Terra Firma-Forme Dermatitis[☆]

Dermatosis neglecta o terra firma-forme dermatosis

Dermatosis neglecta, or terra firma-forme dermatosis, is a clinical entity whose etiology has still not been fully defined.

It is characterized by the presence of asymptomatic, dirt-like hyperpigmented plaques with a slightly papillomatous surface; these plaques cannot be removed with ordinary cleansing but disappear completely on swabbing with 70% ethyl or isopropyl alcohol. We report a new case of this entity.

The patient was a 10-year-old girl with no relevant past medical history. Her mother brought her to our unit for assessment of a persistent asymptomatic skin rash that had appeared several months earlier. Physical examination revealed brownish, reticulated, macular areas that were slightly papillomatous to the touch in some zones. The lesions were distributed symmetrically on the

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