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. 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, and a small series of 4 patients, whereas etanercept has only been analyzed in a prospective study of 10 patients. 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, 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.

References

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., 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...
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

References