Table 2. Initial Features on Presentation

<table>
<thead>
<tr>
<th>Initial Presentation</th>
<th>Affected Patients/Total Patients, No. (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fever</td>
<td>18/23 (78)</td>
</tr>
<tr>
<td>Malaise</td>
<td>20/24 (83)</td>
</tr>
<tr>
<td>Cutaneous eruption</td>
<td>26/26 (100)</td>
</tr>
<tr>
<td>Gastrointestinal symptoms</td>
<td>8/26 (31)</td>
</tr>
<tr>
<td>Respiratory symptoms</td>
<td>6/26 (23)</td>
</tr>
<tr>
<td>Lymphadenopathy</td>
<td>19/26 (73)</td>
</tr>
<tr>
<td>Abnormal liver function</td>
<td>16/24 (67)</td>
</tr>
</tbody>
</table>

Figure. Breakdown of initial diagnoses over the study period.

Comment. The clinical presentation of DRESS is heterogeneous. The constellation of fever, constitutional symptoms, eruption, and multiple-organ involvement led the initial consulting doctors in our study to consider an infectious illness as the primary diagnosis in 13 of 26 patients. Infection was also implicated in an additional 6 patients, although other differential diagnoses were considered. Drug hypersensitivity was deemed as the most likely diagnosis in only 7 patients (27%), and an initial diagnosis of DRESS was never made.

The initial misdiagnosis of DRESS led to an average diagnostic delay of 1.7 days. This short delay is likely attributed to the fact that in our institution, liaison inpatient dermatology services are available 24 hours a day. On analyzing the diagnostic accuracy over the study period, we found that an increasing proportion of cases were considered to have an underlying drug cause. This improvement most likely reflects our efforts to educate our medical colleagues about the drug-induced dermatoses and dissemination of information on DRESS in particular.

Our study further illustrates how difficult the diagnosis of DRESS can be. A close cooperation between dermatologists and other hospital physicians may decrease the delay in diagnosis as well as bring about a greater awareness of this syndrome.

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Enhancing Patients’ Satisfaction and Sun-Protective Behaviors Using the ABC Method of Physician-Patient Communication

The incidence and mortality rates from skin cancer have been rapidly increasing in the United States in recent decades, particularly among individuals aged 15 to 39 years, emphasizing the need for individuals to establish habits of sun protection. Despite knowing the dangers associated with UV light (UVL) exposure, many individuals do not practice sun-protection behaviors. Physician-patient communication, along with the availability of appropriate information, is necessary to elicit essential behavior change and consequential use of sun protection among patients. Research has shown that communication methods using motivational interviewing measures for a patient-centered approach have positively improved numerous health-related habits and behaviors.

To optimize physician-patient communications about UVL protection, Mallett and colleagues developed...
The focus of the present study was to evaluate the effects of the ABC intervention on patient outcomes to determine if this technique is associated with improvement in patient satisfaction and immediate intentions to enhance their sun-protective behaviors.

Methods. Participants consisted of 60 patients from 2 research sites (30 per site; 75% women). Data were collected during the late summer, and the institutional review board at each site approved the research protocol. The Milton S. Hershey Medical Center at The Pennsylvania State University served as the treatment site because the dermatologists there were already trained to perform the ABC intervention; the Northwestern University Faculty Foundation (NWFF) served as the control site. Participants included adult individuals who were scheduled to receive a skin examination during their appointment and did not meet any exclusion criteria. Exclusion criteria consisted of (1) a history of psoriasis; (2) a complicated presenting problem that required the full duration of the office visit; and/or (3) a demonstrated communication barrier (eg, mental disability). Participants in each condition completed identical surveys after their office visit was complete to assess patient satisfaction with the visit, their intentions to use sunscreen, and their perception of information about sun protection communicated by their dermatologist.

Treatment Group. Participants who had an appointment that included a skin examination were recruited the day of their office visit. Prior to the examination, a research assistant obtained the patient’s consent to participate in the study. Participants agreed to fill out a brief, 5-minute survey at the end of their visit and have their appointment audio recorded to document the delivery of the intervention. After the visit, participants were escorted to a designated area to complete the anonymous survey. Participants received a $20 gift card for their time.

Control Group. Participants in the control group were approached by research assistants after their visit and asked to complete the same brief anonymous survey as the treatment group. Control participants received a routine skin examination and engaged in treatment-as-usual physician-patient communication, since the NWFF dermatologists had no previous exposure to or training in the ABC invention. Control participants did not receive additional compensation.

Results. Response rates were consistent across sites (97% for both treatment and control). Patients in the treatment group reported significantly higher intentions to increase overall sunscreen use and to use sunscreen before outdoor activities compared with the control group, and patients in the treatment group were also significantly more satisfied with their physician communication practices than the controls (Table 1). Treatment-group patients also reported that their dermatologists were more likely to cover each of the 6 components of the ABC intervention than patients who received usual care (Table 2).

Comment. The findings of the study demonstrate that patients who received the ABC intervention from dermatologists trained in delivering this innovative communication method reported higher satisfaction with their care and had stronger intentions to increase sunscreen use and practice sun-protective behaviors than patients who received traditional physician care and communication. These findings, coupled with previous reports of dermatologists’ positive experiences with the ABC intervention and ability to maintain good fidelity over time,4 show promise for a brief and sustainable physician-
delivered intervention to enhance both patient satisfaction with care and UV protective behaviors in a dermatologic setting. Future studies will examine the efficacy of the ABC method on enhancing patients’ sun-protective behaviors to assess how physicians’ use of the intervention positively influences patients’ actions over time.

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Effects of Anti-Tumor Necrosis Factor Therapy on Body Composition and Insulin Sensitivity in Patients With Psoriasis

Epidemiologic studies have shown an association between psoriasis and cardiovascular diseases. An interesting but unproven hypothesis ascribes this association to the psoriatic march, the process by which inflammatory mediators released in the course of the psoriatic autoimmune reaction cause insulin resistance, which ultimately leads to atherosclerosis.1

Tumor necrosis factor (TNF) is a proinflammatory cytokine that impairs response to insulin in adipocytes and muscle cells via inhibition of tyrosine kinase activity of the insulin receptor, activation of peroxisome proliferator-activated receptor-δ, and changes in secretion of adipokines.2 For the present study, we investigated the effect of anti-TNF treatment on insulin resistance and body composition in patients with psoriasis.

Methods. Eligible participants were anti-TNF–naïve male patients with psoriasis recalcitrant to other systemic treatments and UV-B therapy. They also had a PASI (Psoriasis Area and Severity Index) or a DLQI (Dermatology Life Quality Index) of 10 or higher. The selection of the TNF agent was left to the treating dermatologist. Patients were asked to maintain their usual physical activity and to stay on their usual diet during the 12-week study period. Approval was granted by the scientific ethical committee (approval No. H-D-2009-040).

Insulin sensitivity was determined by a 2-hour hyperinsulinemic euglycemic clamp. Body composition was estimated by dual-energy x-ray absorptiometry. Peak oxygen uptake was assessed during a progressive exercise test. Patients completed the International Physical Activity Questionnaire. A sample size of 18 was required to detect an increase of 15% or more in insulin sensitivity (1-sided α = 0.05 and power=0.91). An interim analysis after 9 completed patients was performed to indicate a trend for a difference. A P < .20 was needed to justify study continuation. A more detailed description of methods is available in the eAppendix (http://www.archdermatol.com).

Results. The interim analysis did not indicate a trend; therefore, the study was terminated. Baseline patient characteristics are summarized in Table 1. Truncal fat percentage was negatively correlated with insulin sensitivity (r = −0.78; P = .01) and positively correlated plasma leptin (r = 0.88, P = .002). After 12 weeks of therapy (infliximab=5, adalimumab=4), there were no significant changes in insulin sensitivity or levels of fasting glucose, hemoglobin A1c, or C-peptide. Body fat increased by 6.5%, and truncal fat increased by 11.4%. Leptin concentrations significantly decreased after anti-TNF treatment (Table 2).

Comment. It is known that anti-TNF therapy increases body weight in patients with psoriasis. In line with our results, Renzo et al3 observed a gain in the body fat of 8.6% in patients with psoriasis after 24 weeks of anti-TNF therapy. It is known that TNF stimulates lipolysis.