higher in prolonged DRESS (5 of 7 [71%] vs 2 of 25 [8%]; P = .002). Liver enzyme level increase and lymphocyte count were higher at baseline in prolonged DRESS (Table). Likewise, mononucleosis-like atypical lymphocytosis was found in 4 cases of prolonged DRESS (57%), compared with 5 cases in “usual” DRESS (20%) (P = .08). Strikingly, minocycline as a culprit drug was observed in 3 of 7 cases in prolonged DRESS, whereas it was never involved in the other cases (P = .007). There was no evidence of a significant difference between the 2 groups regarding the use of corticosteroids for management of patients with DRESS. Last, no significant difference in viral reactivation frequency was found between the 2 groups.

Discussion | Seven of 32 patients (22%) had prolonged evolution lasting more than 90 days, lasting until day 180 (n = 4) and even up to 1 year (n = 3). Comparative analysis showed a predominance of minocycline use in patients of non-European ethnicity, more frequent pustular eruption, more severe hepatic cytolyis, and higher lymphocyte count at baseline in the prolonged evolution group. Several pharmacogenetic studies have shown an association between HLA types, ethnicity, and severe drug reaction, arguing for ethnicity as an additional key factor in the occurrence of adverse drug reactions. In this respect, in a series of minocycline-induced DRESS, all patients were of non-European ethnic origin with Fitzpatrick skin phototypes V and VI, and minocycline was reported to be detected in the plasma and/or skin of some patients up to 17 months after minocycline withdrawal. Drug accumulation in the skin of predisposed patients could explain prolonged evolution of DRESS and in particular the persistence of cutaneous involvement. In a previous study, we showed that drug use was able to reactivate EBV or HHV-6 in vitro. Minocycline, although not tested, might also reactivate herpesviruses or unidentified viruses. In addition, a previous report linked HHV-6 reactivation and severity and duration of symptoms, as well as occurrence of flares. In the present study, no difference was found regarding the role of viral reactivation in the persistence of symptoms. However, more pronounced lymphocytosis, presence of mononucleosis, and more severe hepatic cytolyis suggest a more important viral-dependent reaction in prolonged DRESS.

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Pulmonary Gas Exchange After Foam Sclerotherapy

Foam sclerotherapy (FS) is a safe and effective procedure. Indeed, transient ischemic attacks and pulmonary complications are usually mild, although stroke and pulmonary embolism events have occasionally been reported. It has been speculated that gas microemboli, passing through the heart, may reach the lungs or, through a right-to-left shunt, the cerebral arteries. However, no treatment modification could completely prevent the cephalic dissemination of air bubbles. In an analogy with decompression sickness, a venous gas microembolization should lead to some loss of gas exchange surface, with consequent gas exchange abnormalities and reduction in the transfer factor of the lung for carbon monoxide (TLco). The aim of this proof-of-concept study was to verify whether TLco worsens after FS treatment.

Methods | Eleven consecutive voluntary patients, scheduled to undergo FS for varicose veins, were enrolled in the study. The study was approved by the local ethics committee. Written informed consent was obtained from participants. Exclusion cri-
The pathogenesis might be related to endothelin-1, inligible, dry cough and chest tightness are frequently reported. Though the onset of pulmonary embolism following FS is negligible, dry cough and chest tightness are frequently reported. Neurological adverse effects of FS have been reported within a few minutes from the foam injection. Therefore, we might have underestimated some pulmonary effect owing to the time needed for the patient to dress and be transferred to the RFT examination. Nevertheless, no sign or symptom was reported by our patients in this timeframe.

**Conclusions** | Bubble microembolism either is not a typical effect of FS or has only a minimal impact on gas exchanges. Other mechanisms may account for FS-related respiratory adverse effects.

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The Characterization of Indoor Tanning Facilities in Florida

Commercial tanning beds have been available for cosmetic use for many decades, and current estimates suggest that 1 million people use tanning beds daily despite their placement in the highest cancer risk category and use being restricted in many states. Indoor tanning is linked to melanoma and non-melanoma skin cancer development, especially with use before age 35 years. Interestingly, use by teenage girls is as high as 40%, and overall, 20% of 18- to 29-year-old individuals have indoor tanned in the last year. Because indoor tanning use is associated with increased morbidity and mortality, the availability of devices to certain demographics may have significant public health consequences. Classification of providing facilities may facilitate more directed health or regulatory interventions.

Methods | The requirement for institutional review board approval was waived by the University of Miami Miller School of Medicine. Information regarding registered tanning facilities was obtained from the Florida Department of Health including business name, telephone number, and zip code. Further information on the facility type and the services offered was abstracted from the internet and direct contact with facilities.

The facilities were categorized by the services offered and were assigned to the following groups: tanning only, beauty, hair, nail services, fitness facilities, residential facilities, spa, wellness, massage services, and other. Residential facilities were assessed for whether the tanning services were unlimited and complimentary to residents.

Results | In October 2012, 1261 facilities were licensed indoor tanning facilities by the Florida Department of Health. Table 1 gives the numbers of indoor tanning facilities by type. There is 1 tanning salon per 15 113 people and 1.16 tanning facilities per every 50 square miles (129.5 km²). For comparison, numbers of other types of prevalent, frequently visited businesses within the state of Florida were tabulated (Table 2).

Discussion | Recently, availability of indoor tanning facilities has drastically increased, and this business has become one of the fastest growing industries. Despite tanning bed exposure being labeled as “carcinogenic to humans,” increasing use by adolescents is a concern. The prevalence of indoor tanning likely varies by sex, age demographic, social influences, attitudes, and the proximity of tanning facilities to schools and homes. The prevalence of indoor tanning facilities in Florida compared with commonly frequented businesses in our study has alarming implications.

Florida has the second highest incidence of melanoma in the country and does not restrict tanning device use by age. The link between indoor tanning use and skin cancer development has strengthened. Melanoma is the most lethal skin cancer, and its incidence in young women and girls has recently more than doubled. Our group previously reported geographic clustering of late-stage melanoma cases in Miami Dade County, and whether a causal relationship exists may warrant further evaluation and stringent regulation.

Interestingly, this study uncovered many indoor tanning facilities operating within residential facilities in Florida marketing services to university students, offering use of tanning devices with residence. Of the 94 residential locations providing indoor tanning services in Florida, 88 (94%) provide complimentary tanning with residence, only limiting use to once daily. Because the targeted demographic is at particular risk for subsequent skin cancer development, the implications are substantial. Moreover, many Florida tanning facilities are located at fitness centers and businesses marketing “wellness” services. The association of indoor tanning with these amenities falsely implies that indoor tanning promotes health rather than carcinogenic effects.

Further investigation of the impact of indoor tanning facility type, geographic location, and use on skin cancer incidence may promote regulation of these carcinogenic devices and guide health interventions. Moreover, efforts to restrict false advertising and complimentary indoor tanning may be warranted.

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