verse event was likely to be directly related to therapy, a grade 1 injection-site reaction. Complete blood cell counts and serum chemistry analyses were assessed at every visit, and no clinically significant abnormalities were identified.

By day 56, 5 of 8 patients (63%) had an improved PASI score of 25, 3 of 8 (38%) had a PASI score of 50, and 1 of 8 (13%) had a PASI score of 75 (Figure 1). The mean (SD) PASI score decreased from 12.4 (2.9) at day zero to 8.1 (3.4) on day 56 ($P = .02$). Of the individual PASI components, erythema was affected most during this study, with a mean (SD) reduction of 36% (14%) noted on day 56 ($P = .03$). Figure 2 shows a clinical response from a patient who achieved a PASI score of 75.

Discussion | Although this study is limited by its small size and lack of a control group, the clinical responses and high tolerability that were observed are encouraging. With a half-life of 8 days and a dosage schedule of every 3 weeks, a steady-state concentration was not achieved. As with currently approved biological agents used to treat psoriasis, which are given in intervals of about 1 half-life for each drug, we anticipate that an increased dosage frequency may result in higher PASI responses.

No anti-MABp1 antibodies were detected during the study period. This is consistent with observations that used MABp1 in a larger study of patients with cancer. Although a larger dermatology cohort will be required to confirm this finding, the lack of antidrug antibodies in this population may lead to improved long-term results and fewer adverse effects.

Although this study has certain limitations, treatment with MABp1 showed a promising therapeutic response in patients with psoriasis. We anticipate that the clinical responses observed in this trial can be further improved with increased dosage frequency and/or a higher dose. The results presented here indicate that targeting IL-1α has a strong potential therapeutic value in treating psoriasis and may provide a novel future treatment of this often devastating disease.

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Accepted for Publication: December 7, 2014.

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Acquisition, analysis, or interpretation of data: All authors.

Drafting of the manuscript: All authors.

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Administrative, technical, or material support: Coleman.

Study supervision: All authors.

Conflict of Interest Disclosures: Dr Stecher reports being employed by and having stock options from XBiotech USA. Dr Gudjonsson reports being a consultant for XBiotech USA. No other disclosures were reported.

Funding/Support: This study was supported in part by XBiotech USA.

Role of the Funder/Sponsor: XBiotech USA had a role in the design and conduct of the study; collection, management, analysis, and interpretation of the data; preparation, review, or approval of the manuscript; and decision to submit the manuscript for publication.

Trial Registration: clinicaltrials.gov Identifier: NCT01384630


Implementation of Store-and-Forward Teledermatology and Its Associated Effect on Patient Access in a Veterans Affairs Dermatology Clinic

Dermatology is one of the specialties in the US Department of Veterans Affairs (VA) health care system that has the highest demand. To address this issue, many VA facilities have implemented the use of store-and-forward teledermatology (SFT). At the beginning of 2013, the VA Medical Center in Tampa, Florida, implemented the broader use of SFT services to improve veteran access to dermatologic care. In previous studies, SFT has been proven to decrease time to intervention and decrease clinic-based visits. However, its effect on patient access to the main dermatology clinic (MDC) has been less well studied. To determine if SFT is positively associated with improved patient access to the MDC, we retrospectively compared January 1 through May 31, 2012, during which SFT was not being heavily used, with January 1 through May 31, 2013, when SFT was fully implemented. In 2012, there were 1557 new patient clinic visits and 28 SFT encounters. In 2013, there were 1508 new patient clinic visits and 608 SFT encounters.

Methods | The research service at the James A. Haley Veterans’ Hospital (Tampa, Florida) deemed this project to qualify as a quality assurance and quality improvement activity; hence, this study was exempt from institutional review board approval. The clinical database was queried for percentage of no-shows, average new and established patient wait times, capacity, and percentage of new patients being seen within 30 days. Variables were compared for the 2 time intervals using the unpaired $t$ test. The effect of completed consultations on each variable was determined using linear regression and analysis of variance. Significance was set at $P < .05$. Statistical analysis was performed using Microsoft Excel Data Analysis software (Microsoft Corp).

Results | There was a significant decrease in the percentage of no-shows (7.91% to 6.16%, $t = 3.87; P < .05$) and new patient wait times (32.9 days to 9.75 days, $t = 17.05; P < .001$) between the 2 time periods, but not for established patient wait times.
(4.14 days to 1.49 days, \( t = 0.95; P = .37 \)) or clinic capacity, defined as the sum of appointment slots allocated to a given clinic or location (1612.6 to 1722.8, \( t = -1.139; P = .29 \)). There was a significant correlation between the quantity of SFT consultations completed and the percentage of new patients being seen at the MDC within 30 days \( (R^2 = 0.88; P < .05) \), new patient wait times \( (R^2 = 0.95; P < .001) \), and percentage of no-shows \( (R^2 = 0.74; P = .001) \), but not with established patient wait times \( (R^2 = 0.10; P = .36) \).

Discussion | In previous studies, SFT decreased the time for dermatologic intervention and unnecessary consultations.\(^3\)\(^-\)\(^4\) A recent literature review revealed programs that had 2 of 4 critical factors (effective preselection, high-quality photographic images, high-quality dermoscopic images if pigmented lesions are evaluated, and supportive infrastructure and culture) had filtering percentages near 50%.\(^5\) Our analysis suggests that SFT may improve patient access to the MDC by decreasing the percentage of no-shows and the average wait time for new patients. Interestingly, the quantity of SFT consultations completed was directly associated with an increase in the percentage of new patients being seen at the MDC within 30 days, a decrease in the rate of no-shows, and a decrease in new patient wait times. To determine if these effects were confounded by a change in capacity, we analyzed capacity for both time intervals and found no statistical difference. Our study is limited by the observational pre-post study design, lack of a control group, relatively small number of patients, short follow-up, and veteran population being studied. The differences in the results of the pre-post study outcomes may not be causally related to the selected SFT intervention and may be related to one or a number of other factors entirely. Additional studies will be needed to establish the clinical significance of our observation.

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Accepted for Publication: November 30, 2014.

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Conflict of Interest Disclosures: Dr Park is an attending physician in the Surgical Service, James A. Haley Veterans’ Hospital and Clinics, Tampa, Florida. Dr Fabri is an attending physician in the Surgical Service, James A. Haley Veterans’ Hospital and Clinics. No other disclosures were reported.

Funding/Support: This study was supported in part by the resources and the use of facilities at the James A. Haley Veterans’ Hospital, Tampa, Florida.

Role of the Funder/Sponsor: The funding source had no role in the design and conduct of the study; collection, management, analysis, and interpretation of the data; preparation, review, or approval of the manuscript; and decision to submit the manuscript for publication.

Disclaimer: The contents of this article do not represent the views of the US Department of Veterans Affairs or the United States government.

Additional Contributions: We are indebted to Suzette M. Maynard, James A. Haley Veterans’ Hospital, for her time and help with data extraction. She was not compensated for her contribution.


Low Filaggrin Monomer Repeats in African American Pediatric Patients With Moderate to Severe Atopic Dermatitis

The severity of atopic dermatitis (AD) and intragenic filaggrin \((FLG;\) OMIM 135940) copy number variant (CNV) genotypes were assessed in African American pediatric patients, a health disparities group that is disproportionately affected with AD.\(^4\)

Methods | The study was approved by Washington University School of Medicine’s institutional review board. Eligibility criteria for recruited pediatric patients were (1) age 3 months to 18 years, (2) United Kingdom Working Party’s Diagnostic Criteria for Atopic Dermatitis,\(^2\) (3) African American ethnicity (self-reported), (4) moderate to severe AD (SCORAD index, ≥25),\(^3\) and (5) written informed assent or consent. Common European \(FLG\) R501X and 2282del4 mutations and intragenic \(FLG\) CNV (3 alleles of either 10, 11, or 12 \(FLG\) monomer repeats), upon high-quality DNA assessment, were genotyped\(^4\) and correlated with AD severity.

Results | Thirty-nine pediatric African American patients with AD were recruited with a mean (range) age of 6.7 (0.4-15) years (Table 1). Thirty-five patients reported a first-degree family member with atopy, and 30 patients reported AD onset before age 2 years. Of the 31 patients who were 4 years or older at the time of visit, a history of asthma and allergic rhinitis and/or hay fever was reported in 24 (77%) and 16 (52%), respectively. Food allergies were reported as well (51% [\( n = 20 \)]) most commonly peanut (\( n = 10 \)) and fish and/or shellfish (\( n = 10 \)) that were not coincident. All but 1 were either being treated with or had been prescribed topical triamcinolone ointment, 0.1%.