of cutaneous cancers; the addition of voriconazole appears to accelerate UV-induced skin damage. While our patient had been on a long-term treatment regimen of low-dose corticosteroids, she was relatively immunocompetent, suggesting that immunocompetent individuals may also be at risk for photocarcinogenic effects of voriconazole.

Posaconazole appears to have a more favorable adverse effect profile than voriconazole. In a case series of 3 patients with voriconazole-associated SCC, posaconazole was replaced in 2 of 3 patients, with improvement of the photosensitivity reaction. While the present patient did not cease developing SCCs, tumor burden and quality of life improved. Considering that posaconazole has a favorable adverse effect profile, it should be considered more often for patients who are at risk of cutaneous cancer development.

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Erythema Dyschromicum Perstans Response to Isotretinoin

Erythema dyschromicum perstans (EDP), also called ashy dermatosis, is a rare acquired and chronic dermatosis, characterized by asymptptomatically and progressively hyperpigmented macules of various size on the trunk, face, and extremities. Its exact cause is unknown, and its treatment remains controversial. We describe a 48-year-old Chinese man with EDP who was successfully treated with low-dose isotretinoin over a period of 7 years.

Figure. Clinical Views of Skin Lesions Before and 4 Months After Beginning Isotretinoin Treatment

A, Discrete and confluent ashy-gray macules and patches over the neck, forehead, face, and cheek. B, After 4 months of isotretinoin treatment, the lesions over the neck, forehead, face, and cheek have substantially improved.
Report of a Case | The patient first presented in 2008 at age 41 years with a 3-year history of a diffuse asymptomatic ashy-gray dermatosis. The lesions initially appeared erythematous with nonscaling palpable borders, and within 3 months it had evolved to ashy-gray patches. There were no identifiable triggers or associated family history. Cutaneous examination revealed ashy-gray patches of varying sizes symmetrically distributed throughout the body (Figure, A), while the mucosa, palms, soles, and nails were spared. Laboratory findings, including complete blood cell count, thyroid function tests, biochemical profiles, urinalysis, and autoantibody assays, were unremarkable. A biopsy specimen from a lesion on the right upper abdomen showed thinned epidermis, superficial and perivascular lymphocytic infiltrate with linear interface change, and pigment incontinence in the papillary dermis with macrophages.

Clinical and histopathological findings were thought to be most consistent with EDP, and the patient, who weighed 78 kg, was subsequently treated with isotretinoin, 20 mg/d. Within the first 4 months of therapy, the dermatosis improved 90%, and no new lesions were noted (Figure, B). A second lesional biopsy specimen taken 4 months after treatment began, and from a site adjacent to the baseline biopsy, revealed punctate vacuolar degeneration of the basal layer, mild lymphohistiocytic infiltrate, and melanophages in the superficial dermis with sparse pigment incontinence. Isotretinoin treatment was discontinued after clinical improvement.

Two months after isotretinoin treatment was stopped, the dermatosis recurred at baseline level, and the patient was restarted on the isotretinoin regimen, 20 mg/d; the lesions faded again. Then the isotretinoin dose was tapered to 10 mg/d. During the subsequent 7 years of follow-up, the patient took isotretinoin, 10 mg/d, intermittently without any adverse effects except for dry face skin. During this time, the eruption recurred once after discontinuation of isotretinoin treatment for a number of months (patient could not recall exact timing) and disappeared again after retreatment with isotretinoin, 10 mg/d. The periodical laboratory tests during the 7 years of follow-up showed normal serum lipid profiles and biochemical profiles.

Discussion | Generally a rare cutaneous condition, EDP is more commonly reported in Latin American and Asian patients. While EDP may occur at any age, it is more commonly seen in patients younger than 30 years.1 The pathogenesis of EDP remains to be determined, but previously reported associations include infections, medications, and thyroid disease.2 However, most cases are considered to be idiopathic.

Erythema dyschromicum perstans has an insidious onset and usually presents with asymptomatic, symmetrically distributed ashy-gray patches. While the histopathologic presentation is not diagnostic, the active border is characterized by lichenoid dermatitis with vacuolization of the basal layer and perivascular mononuclear infiltrates. The inactive areas of these patches have features similar to postinflammatory hyperpigmentation with melanophages in the dermis. The differential diagnosis includes lichen planus pigmentosus, idio-

pathic eruption, and postinflammatory hyperpigmentation, fixed pigmented erythema, and Addison disease.

Some treatments for EDP have been tried with minimal success, including antibiotics, corticosteroids, vitamins, antihistamines, chloroquine, clofazimine, dapson, and laser therapy.3-5 The present case indicates that isotretinoin may be a potential option for treatment. The possible mechanism may be mainly isotretinoin’s anti-inflammatory and immunomodulatory effects.6 Unfortunately, the lesions tended to recur when the treatment was stopped. The reasons remain unknown. The present result indicates that long-term, low-dose systemic isotretinoin (<0.5 mg/kg) may be an effective option in the treatment of EDP in the appropriate patient.

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Refractory Subcutaneous Sweet Syndrome Treated With Adalimumab

Subcutaneous Sweet syndrome (SSS) is a rare febrile neutrophilic dermatosis, distinct from classic Sweet syndrome. There is insufficient literature guidance regarding treatment options for SSS besides corticosteroids or effective alternatives if steroids fail to manage disease.