Financial Disclosure: None reported.

Methods. In a bilateral paired, single-blinded, randomized study, 10 patients (7 women and 3 men; age range, 23–54 years) with idiopathic focal axillary hyperhidrosis were treated with botulinum toxin type B (BT-B) (NeuroBloc; Eisai Europe Limited, Hatfield, Herts, England) and botulinum toxin type A (BT-A) (Botox; Allergan Inc, Irvine, California).

Results. All patients reported a reduction in axillary sweat production. Mean (SD) pretreatment sweat production rates and areas were similar bilaterally: rates, 217.0 (22.8) mg per 5-minute interval for BT-A and 206.0 (21.9) mg per 5-minute interval for BT-B; area, 31.4 (5.8) cm² for BT-A and 31.0 (8.1) cm² for BT-B. After BT injections, patients responded to treatment until month 6. At 1 and 2 weeks and 1, 3, and 6 months after treatment, sweat weight and area decreased significantly more in the BT-B side than in the BT-A side (P < .01).

Patients’ treatment satisfaction scores were significantly higher for the BT-B than for BT-A treatment (P < .05) until month 3 (Table). According to patients’ subjective reports, treatment began acting earlier in the BT-B side than in the BT-A side: mean (SD) time to ini-

Abbreviations: BT-A, botulinum toxin, type A; BT-B, botulinum toxin, type B; NA, not applicable.

The scale score ranged from −4 to +4 and included patients’ description of a 0% reduction or increase in sweating (unchanged) or a mean (SD) reduction of 25% (1%), 50% (2%), 75% (3%), or 100% (4%).

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Table. Changes in Gravimetric Sweat Production, Colorimetric Areas of Sweat Production, and Satisfaction Scores for Axillae Treated With BT-A and BT-B

<table>
<thead>
<tr>
<th>Measurement Interval</th>
<th>Sweating Weight, %</th>
<th>P Value</th>
<th>Sweating Area, % Area</th>
<th>P Value</th>
<th>Satisfaction Score b</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>BT-A</td>
<td>BT-B</td>
<td></td>
<td></td>
<td>BT-A</td>
<td>BT-B</td>
</tr>
<tr>
<td>0 d</td>
<td>100</td>
<td>100</td>
<td>NA</td>
<td>NA</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>1 wk</td>
<td>68.0 (32.1)</td>
<td>14.9 (20.3)</td>
<td>.01</td>
<td>16.9 (6.2)</td>
<td>6.9 (7.4)</td>
<td>.049</td>
</tr>
<tr>
<td>2 wk</td>
<td>16.6 (9.2)</td>
<td>4.1 (7.2)</td>
<td>.04</td>
<td>10.4 (5.9)</td>
<td>3.7 (2.2)</td>
<td>.04</td>
</tr>
<tr>
<td>1 mo</td>
<td>13.1 (7.7)</td>
<td>4.3 (4.1)</td>
<td>.049</td>
<td>14.5 (6.5)</td>
<td>6.1 (4.6)</td>
<td>.047</td>
</tr>
<tr>
<td>3 mo</td>
<td>66.3 (38.4)</td>
<td>30.6 (24.3)</td>
<td>.03</td>
<td>29.5 (8.9)</td>
<td>17.4 (4.9)</td>
<td>.02</td>
</tr>
<tr>
<td>6 mo</td>
<td>90.7 (10.1)</td>
<td>56.4 (25.4)</td>
<td>.02</td>
<td>49.0 (8.4)</td>
<td>29.2 (5.4)</td>
<td>.002</td>
</tr>
</tbody>
</table>

Abbreviations: BT-A, botulinum toxin, type A; BT-B, botulinum toxin, type B; NA, not applicable.

The scale score ranged from −4 to +4 and included patients’ description of a 0% reduction or increase in sweating (unchanged) or a mean (SD) reduction of 25% (1%), 50% (2%), 75% (3%), or 100% (4%).

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**Neurogenic Rosacea: A Distinct Clinical Subtype Requiring a Modified Approach to Treatment**

Rosacea is generally categorized into 4 distinct clinical subtypes: erythematotelangiectatic, papulopustular, phymatous, and ocular.1 Granulomatous rosacea, rosacea fulminans, and perioral dermatitis have been described as additional variants.2 Herein we describe 14 patients with rosacea and prominent neurologic symptoms, who represent another distinct subset of rosacea meriting a unique approach to management.

**Methods.** Patients with prominent neurologic symptoms in addition to classic features of rosacea were identified during routine appointments at a major teaching hospital. Details regarding medical history, disease symptoms and triggers, and response to treatments were obtained via clinic visits and telephone interviews. The study was approved by the institutional review board of the University of California, San Francisco.

**Results.** Twelve of the 14 patients were women, and 12 were white. Mean age at disease onset was 38 years. Prominent symptoms included burning or stinging pain (100% [14 of 14]), erythema (100% [14 of 14]), and flushing (93% [13 of 14]), sometimes accompanied by facial edema (50% [7 of 14]), telangiectasias (50% [7 of 14]), pruritus (43% [6 of 14]), and papules (36% [5 of 14]). Important symptom triggers included heat (93% [13 of 14]), sunlight (93% [13 of 14]), hot showers (79% [11 of 14]), stress (71% [10 of 14]), exercise (64% [9 of 14]), and alcohol consumption (57% [8 of 14]). Use of makeup (50% [7 of 14]), eating spicy foods (43% [6 of 14]), touching skin (36% [5 of 14]), drinking hot beverages (29% [4 of 14]), cold weather (21% [3 of 13]), and humidity (14% [2 of 13]) were less reliable triggers. Notably, 71% of patients experienced relief from cooling via fans or cold compresses or ice applied to the face or held in the mouth (10 of 14). Figure 1 depicts typical examination findings in these patients.

A notably high percentage of patients had neurologic (43% [6 of 14]) or neuropsychiatric (30% [7 of 14]) conditions, including complex regional pain syndrome, es-