in size from 2 to 10cm, most often found on the upper trunk, cervical area, and proximal aspect of the limbs, besides other locations such as face and oral mucosa.[1] Lesions are usually asymptomatic, but can be very painful and present with hypertrichosis and hyperhidrosis.[2] It must be differentiated from other conditions, such as congenital hemangioma, infantile hemangioma, vascular malformations, pyogenic granuloma and, in adults, kaposiform hemangioendothelioma and Kaposi sarcoma. To differentiate between other tumors or to assess the area involved, imaging as ultrasound or magnetic resonance can be used..[3] Histopathology of TA shows many lobules of tufts spread across the dermis with a "cannonball" appearance, crescent-shaped spaces around the vascular tufts and similar spaces in the tumor stroma.[2,4,5] Immunohistochemistry can be strongly positive for *Ulex uropaeus* I lectin and EN4, besides CD31 and CD34, and rarely positive for smooth muscle actin and negative staining for GLUT1.[3,4] The main treatment option for tufted angioma is surgical excision. Other therapeutic modalities have been reported, such as cryotherapy, laser, topical or systemic corticosteroids and chemotherapy. Some authors believe the lesion should only be monitored due to the possibility of spontaneous regression of these cases.[3,5] ❑

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Effectiveness and safety of infliximab for 11 years in a patient with erythrodermic psoriasis and psoriatic arthritis*

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Dear Editor,

Psoriasis is a chronic skin condition that affects 0.5 to 5% of the population. It is characterized by erythematous, scaly plaques, typically affecting the extensor surfaces of the knees and elbows, scalp, intergluteal cleft and sacrum.[1] Around 40% of psoriasis patients have psoriatic arthritis, which leads to physical limitations, decreased quality of life, and increase in patient mortality.[2,3]

Erythrodermic psoriasis is a rare form of psoriasis, characterized by generalized erythema with variable scaling. It is associated with severe morbidity and even mortality, since it can cause hyper or hypothermia leading to decreased cardiac output and affecting liver and renal functions. Erythrodermic psoriasis results from worsening of a previous case of psoriasis or it can develop as the initial presentation of psoriasis. Its treatment is still a challenge and is not yet standardized due to lack of scientific evidence regarding therapeutic recommendations. Traditional systemic therapies include methotrexate, cyclosporine and oral retinoid.[4,5,6]

Tumor necrosis factor alpha (TNF-alfa) is a key mediator in the pathogenesis of psoriasis, because it is involved in keratinocyte proliferation, endothelial cell regulation and T lymphocyte recruitment.[3] Based on the important role of TNF-alpha in the pathogenesis of psoriasis, the first biologic drugs emerged, which changed radically the treatment for patients with moderate to severe psoriasis.[2] Infliximab was the first biologic drug used for treatment of psoriasis, approved by the Food and Drug Administration (FDA) in 2006.[7]

Erythrodermic psoriasis treatment with traditional systemic medications (methotrexate, cyclosporine and oral retinoid), although effective, is frequently associated with therapeutic failure or intolerance, with the need of alternative strategies. Recently, TNF

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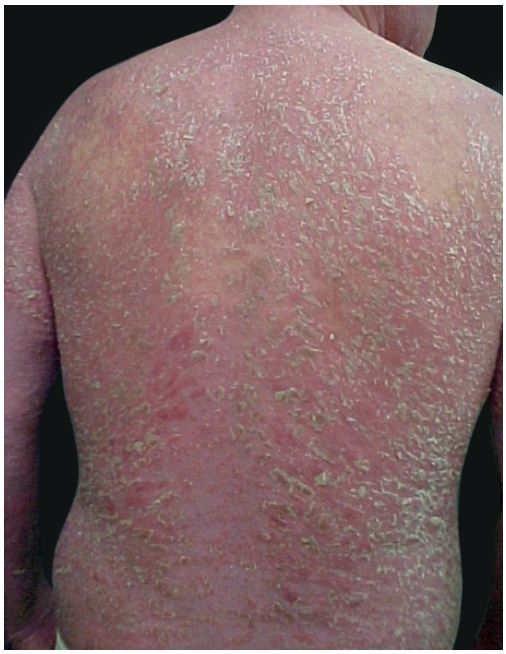

Figure 1: Patient with psoriatic exfoliative erythroderma

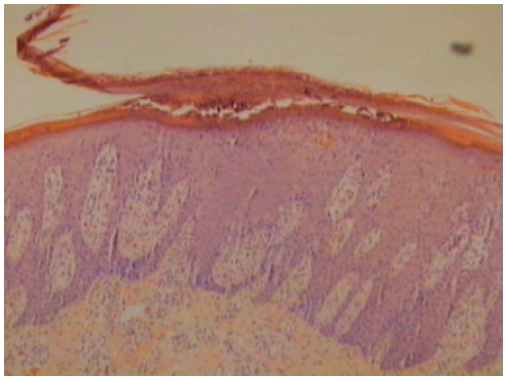

Figure 2: Skin biopsy showing parakeratosis and pustule in the stratum corneum, regular acanthosis and suprapapillary thinning. Hematoxylin & eosin, X100

inhibitor biologic drugs have been used in the treatment of erythrodermic psoriasis with good results.[4] We report a case of a patient with erythrodermic psoriasis and psoriatic arthritis that had excellent results using infliximab after 11-year follow up.

Male, 55-year-old patient developed moderate to severe plaque psoriasis 30 years ago. His PASI (Psoriasis Area and Severity Index) was above 10 and he progressed with joint involvement about two months after the appearance of the lesions.

The patient was treated for 18 years at another medical service with topical medications and oral corticosteroids, with periods of remission and exacerbation of the lesions, but with progression of his psoriatic arthritis leading to deformities of the small joints and affecting the hip and knee joints.

Twelve years ago, the patient was referred to our service with psoriatic exfoliative erythroderma and intense arthralgia (Figure 1). He was admitted and treatment was started with methotrexate 12.5 mg/week for one week and then 25 mg/every week. Biopsy of the lesions confirmed the diagnosis of psoriasis (Figure 2). After three months of treatment, the patient had improvement of the erythroderma and joint pain, but his lesions remained widespread.

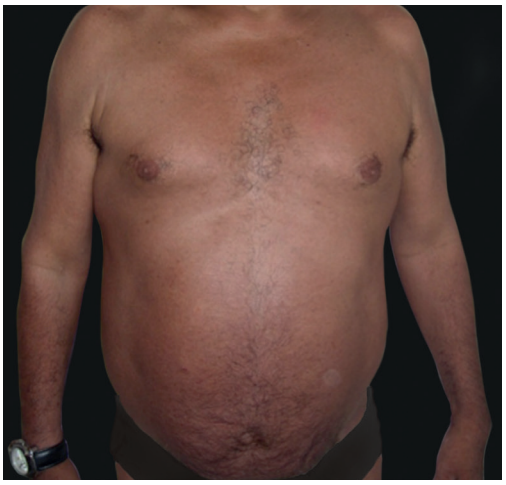

Figure 3: Ten years after beginning treatment with infliximab

We opted to start infliximab 5 mg/kg/day in three loading doses (weeks 0, 2 and 6) and maintenance doses every eight weeks thereafter. After the second dose, the patient's lesions improved significantly. Methotrexate was discontinued after the seventh dose of infliximab and the patient had variable PASI between 0 and 4 after methotrexate discontinuation (Figure 3).

Since then, infliximab was maintained at 5 mg/kg/day every eight weeks until now, completing 11 years using the medication. His PASI is zero for four years, the patient went back to walking normally soon after the introduction of infliximab and has no joint pain (he only remains with the bone resorption sequelae in the distal phalanges of his hands).

Throughout 11 years of treatment with infliximab, there was no complication or side effect. There are limited data about the efficacy of infliximab in Dermatology. In the available studies, infliximab is well tolerated, with no increase in side effects over time.[8]

In the reported case, we observed the long-term effectiveness of the medication, for there was no reduction in the therapeutic potential in 11 years. ❑

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Phototherapy: experience from a reference service*

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Dear Editor,

Phototherapy is a treatment method that uses ultraviolet radiation (UVR).[1,2] The extensive use of phototherapy in dermatology, the growing number of dermatoses that benefit from this therapeutic modality, and the scarcity of data in the literature regarding the profile of a phototherapy sector in a reference dermatology center, motivated this study.

This is an observational and descriptive study carried out at the phototherapy sector of the Dermatology Service at the Hospital Universitário de Taubaté, in the state of São Paulo, Brazil, from January to December 2014.

We included both male and female patients, with no age restrictions, attended in the study period, by any dermatosis and who agreed to participate in the study by signing an informed consent form. Exclusion criteria were incomplete forms and individuals with less than 10 phototherapy sessions.

Data were collected using a standard form and complemented with an interview. Our dependent variable was phototherapy, and the independent variables included demographic parameters and parameters related to dermatosis and phototherapy.

This study was approved by the Research Ethics Committee of the institution (No. 109816).

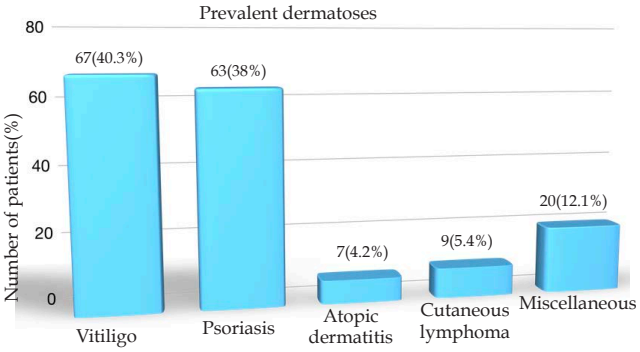
A total of 166 individuals were included, out of which more than 65% were females.

The mean age of the sample (at the time of the interview) was 43.1 years (SD = 20.5), ranging from 6 to 86 years, with a predominance of individuals over 40 years of age.

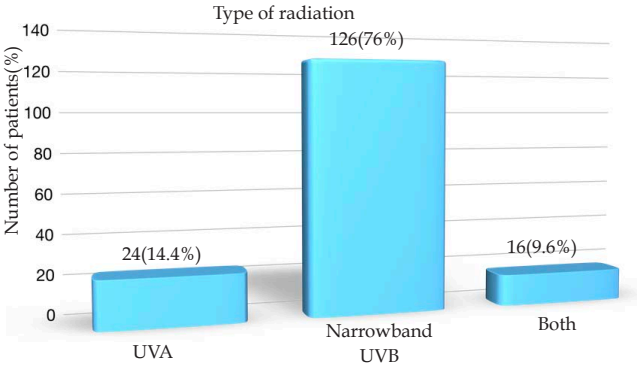
Skin phototype III was prevalent in the sample.

Vitiligo and psoriasis were among the most prevalent dermatoses treated in this sector (Graph 1).

Regarding phototherapy, most patients underwent narrowband ultraviolet B radiation (UVB) (Graph 2). Cabin was the most used phototherapy equipment.



Graph 1: Distribution of the most prevalent dermatoses treated in the phototherapy sector



Graph 2: Sample distribution according to the type of ultraviolet radiation used

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