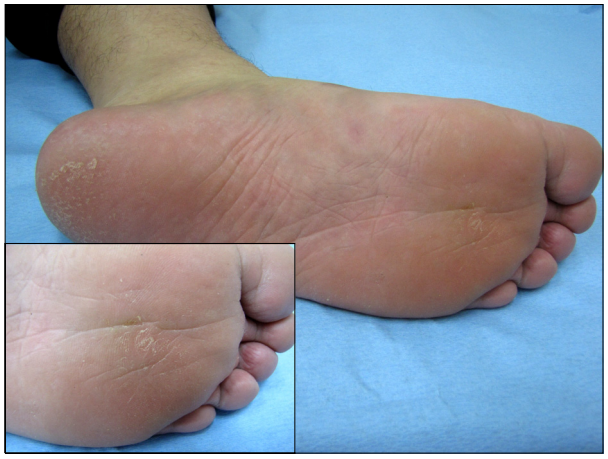

Fig. 2. Six weeks later following biopsy, the wart had completely disappeared (inset: close-up view).

large plantar wart regression, following a small biopsy. In conclusion, wart regression can be achieved if the HPV-specific immunity can be stimulated. Therefore, inducing and boosting such a response is critical for the treatment of warts. I report here on a case of a rapidly regressed large plantar wart, following a biopsy without any additional treatment.

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Refractory Atopic Dermatitis in Childhood: Improvement with Methotrexate?

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Dear Editor:

A 5-year-old boy had suffered from generalized severe atopic dermatitis (AD) for 3 years, and his symptoms were not controlled by first-line therapeutics, that is, topical corticosteroids, topical calcineurin inhibitors, and oral antihistamines. Initially, we tried cyclosporine (5 mg/kg/d)

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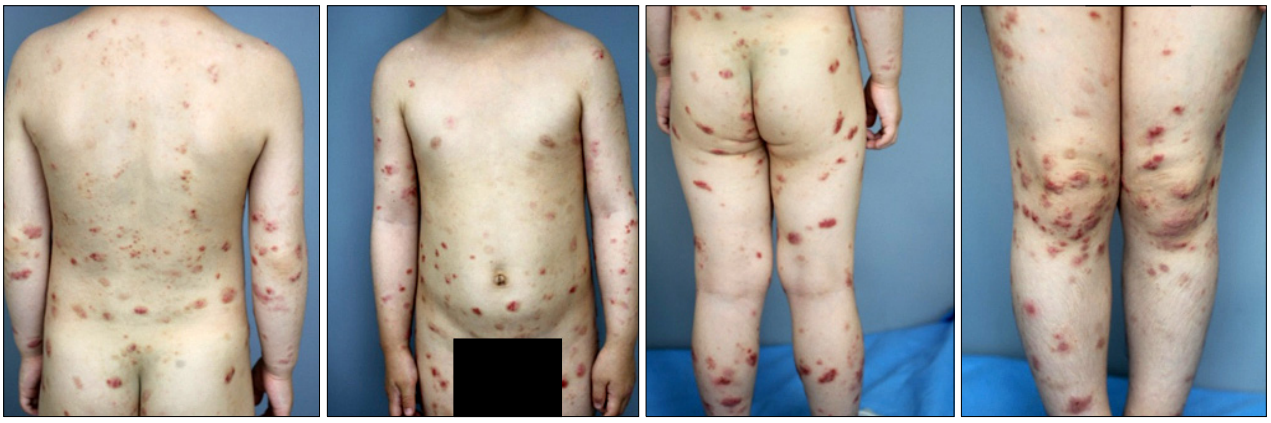

Fig. 1. Generalized multiple, intensely pruritic, excoriated erythematous scaling papules, and plaques, refractory to treatment with first-line treatment modalities and ciclosporin.

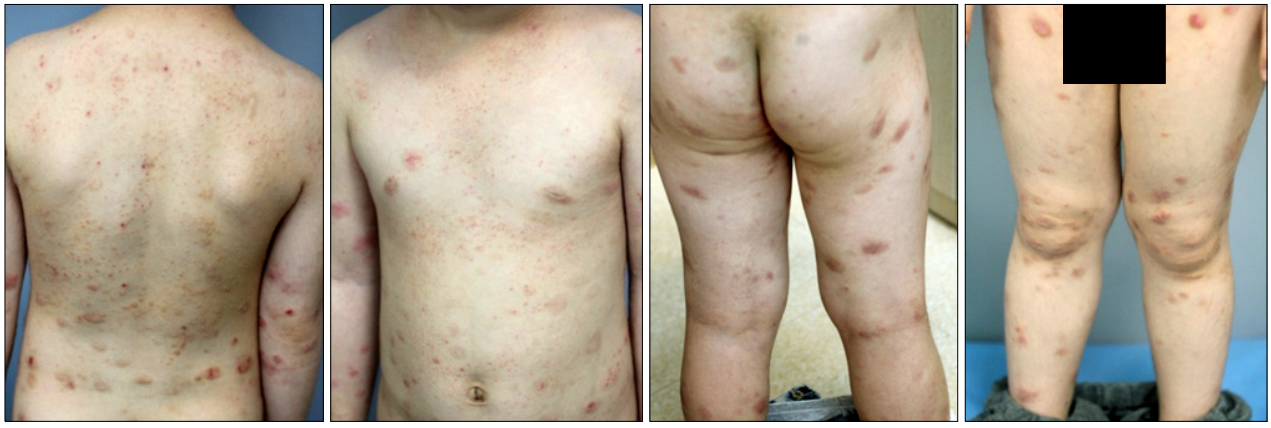

Fig. 2. Seven weeks after initiation of treatment with methotrexate, substantial improvement of the patient's atopic eczema was noted.

for 3 months, but his condition proved recalcitrant (Fig. 1), and he complained of hypertrichosis of the eyebrows. Accordingly, cyclosporine was discontinued, and methotrexate (MTX) (7.5 mg/wk p.o. as 2.5 mg every 12 hours over 24 hours) started. In addition, folic acid (1 mg) was administered daily to reduce the risk of adverse reaction to MTX, and the disease severity was monitored using the severity scoring for atopic dermatitis (SCORAD) scoring system. After 7 weeks, the skin lesions markedly improved (Fig. 2), and this was reflected by his SCORAD score, which was reduced by more than 50% (from 61 to 28). We then reduced MTX to 7.5 mg biweekly and discontinued MTX after 10 additional weeks. Rebound phenomenon was not observed, and the clinical improvement steadily continued for 3 months. No adverse clinical events occurred and no laboratory abnormalities were noted.

AD is a common, chronic inflammatory skin disease, characterized by intense pruritus and dry skin indicative of a defective skin barrier. Patients with moderate-to-severe disease, refractory to treatment with the first-line treatment modalities, such as topical corticosteroids or topical calcineurin inhibitors, require second-line treatment, such as phototherapy or systemic immunosuppressant administration[1]. However, a proportion of patients has a contraindication for these treatments or discontinues treatment because of ineffectiveness or side effects. It is therefore important to search for alternative, safe second-line treatments and expand the armamentarium of therapeutic options available for the treatment of patients with moderate-to-severe AD[2].

MTX is a highly effective treatment for chronic inflammatory conditions, such as psoriasis and rheumatoid arthritis[2], and many studies have concluded that MTX is as effective as cyclosporine for the treatment of psoriasis[3]. For the treatment of AD, an international consensus committee for the management of AD recommended MTX for third-line use in recalcitrant disease[4]. However, although MTX has been reported to be of value in the treatment of recalcitrant adult AD2, peer reviewed evi-

dence is insufficient. In particular, there is no performed study or reported case on the use of MTX to treat AD in childhood, and thus, this case report is the first to describe the successful use of MTX in childhood AD. MTX has been served as a good treatment modality for more than 40 years in the pediatric dermatologic field and is considered the systemic treatment of choice for childhood psoriasis[5]. MTX has a track record of safe and effective long-term use in childhood psoriasis and juvenile idiopathic arthritis[5]. Given these facts, we believe that MTX offers an effective, safe, tolerable, and preferred therapeutic option for childhood AD as well as for childhood psoriasis despite a lack of peer reviewed evidence.

Further well-designed studies are needed to confirm the efficacy, doses, dosing schedules, safety, and side effects on short-term and long-term use of MTX in childhood AD.

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Eruptive Penile Syringomas Spreading to the Pubic Area and Lower Abdomen

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Dear Editor:

Syringomas are common benign neoplasms of eccrine differentiation. They often occur at the eyelids, upper cheeks, neck, axilla, abdomen and vulva. Penile syringomas are rare, with only 12 reported cases in the English literature to date. All of the reported cases were confined to the penis, and this is the first case of penile syringoma spreading to the pubic area and lower abdomen.

A 33-year-old Korean male was presented to our clinic with asymptomatic papules on the pubic area, lower abdomen (Fig. 1A), as well as dorsal and lateral aspects of the penile shaft (Fig. 1B). The scrotum and glans were spared. The lesion occurred eruptively about 3 years ago. Physical examination found soft purplish papules measuring 1～3 mm in diameter on the penile shaft, pubic area and lower abdomen. He had no family history of similar lesions. Histologic examination of punch biopsies from the pubic area and penis revealed multiple comma or tadpole-shaped ductal structures and few milia-like structures within the superficial dermis (Fig. 2). The ductal

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