Clinical, Cosmetic and Investigational Dermatology

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RESPONSE TO LETTER

Pityriasis Rosea and Immunosuppressive Drugs [Response to Letter]

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Dear editor

I hope this message finds you well. I am writing to address the inquiries raised by scholars regarding our recently published article on the successful use of abrocitinib for treating persistent pityriasis rosacea (PPR). The scholars believe that our diagnostic process does not definitively exclude guttate psoriasis (GP). In fact, GP and PPR share many clinical and histological similarities but also exhibit some distinctions.[1] For instance, GP tends to have a longer disease course compared to PPR. Additionally, GP more commonly affects the scalp than PPR. Additionally, the skin lesions of PPR typically exhibit a typical centripetal distribution and align parallel to the Langer lines, characteristics that are not observed in GP. The onset of GP is often associated with bacterial infections, accompanied by precursor symptoms like pharyngitis and tonsillitis, whereas PPR is typically an immune response following viral infection. The lesions of PPR may exhibit itching symptoms, whereas the lesions of GP typically does not cause significant itching. Furthermore, in terms of disease progression, PPR and GP differ. While GP may achieve partial remission with treatment, most patients eventually progress to plaque-type psoriasis. In contrast, PPR is a self-limiting disease with a variable duration. Histologically, GP is characterized by hyperkeratosis and dilated papillary dermal capillaries at a higher frequency than PPR, with clustering of Langerhans cells in the epidermis. Conversely, PPR exhibits a higher probability of extravascular red blood cells and a greater number of dermal CD1a-positive cells and Langerhans cells compared to GP.[1] However, the patient's refusal of biopsy prevented us from definitively excluding other diagnoses, which is a limitation of our study.

Regarding the question of unreported systemic symptoms, I can responsibly inform the scholars that we conducted detailed inquiries with the patient and confirmed the absence of fever, fatigue, headache, insomnia, or other systemic symptoms during the illness period. Additionally, there were no signs of oral involvement. It is important to note that while most patients with PPR experience systemic symptoms and oral involvement, this occurrence is not 100%,[2] and there remains a small subset of individuals with PPR who do not exhibit these symptoms during the course of the disease.

As for why signs of human herpesvirus 6 (HHV-6) and/or human herpesvirus 7 (HHV-7) reactivation testing was not conducted, I must clarify that in our country, these tests are not part of the standard hospital diagnostic protocols, and we do not have the capability to offer this examination to patients. Furthermore, based on our literature review, there is a positive correlation between viral load and the appearance of systemic symptoms.[3] Given that our patient did not exhibit any systemic symptoms, we deemed the testing for signs of human HHV-6 and/or human HHV-7 reactivation to be unnecessary.

Finally, these scholars have cited a literature report describing cases of herpesvirus infection following the use of abrocitinib, leading them to advise caution when using abrocitinib in patients with PPR.[4] Firstly, the article they referenced involved patients who continuously used abrocitinib for twelve weeks. Secondly, among 156 patients receiving abrocitinib at 100mg for 12 weeks and 154 patients receiving abrocitinib at 200mg for 12 weeks, only 5 and 6 patients, respectively, experienced herpesvirus infections.[4] It's important to note that during the treatment period, patients were not living in completely sterile environments, and further investigation is required to establish the correlation between viral infections and the use of abrocitinib. Moreover, herpesvirus infection is transient, and PPR is the result of an ongoing immune response following viral infection, with the viral infection mostly resolved by the time symptoms appear. We consider the use of abrocitinib at this stage to be safe and effective, and the facts have indeed confirmed our assessment.

Received: 10 May 2024
Accepted: 17 May 2024
Published: 30 May 2024

Disclosure

The authors report no conflicts of interest in this communication.

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https://doi.org/10.2147/CCID.S477678