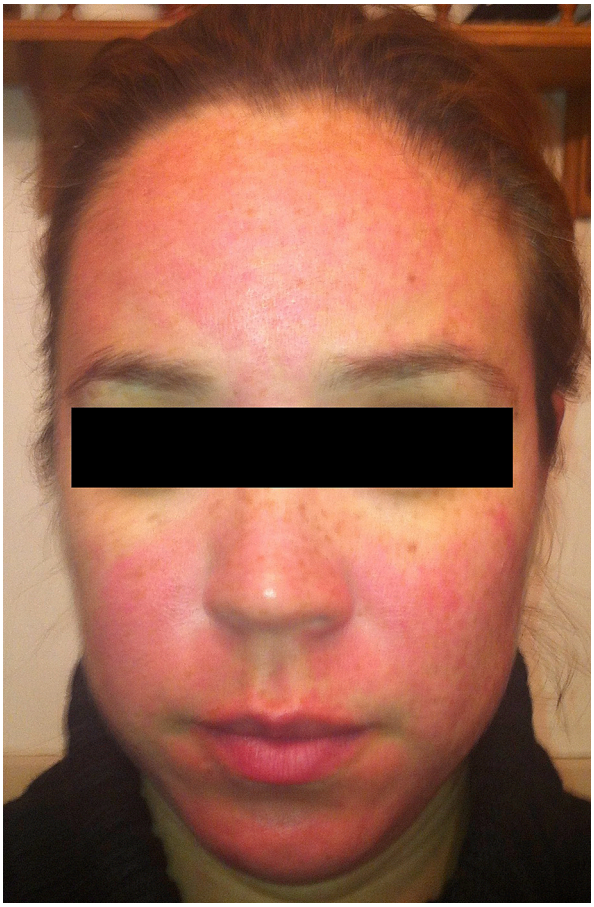

Fig 2. Rosacea, patient 1. Twelve hours after application of brimonidine tartrate to forehead, cheeks, nose, and chin. Erythema is present in all of the areas where the medication was applied.

alpha-adrenergic agonist nasal sprays (eg, oxymetazoline and xylometazoline).[4] This reaction directly opposes the goal of therapy.

Counseling about the potential for worsening erythema, use of a test area, and limiting use to special occasions may be warranted. Viewing images of this adverse reaction prior to use may alleviate patient distress.

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Acne fulminans successfully treated with cyclosporine and isotretinoin

To the Editor: Acne fulminans (AF) is a rare and very severe form of acne characterized by the sudden onset of painful, ulcerative pustules and associated systemic symptoms. Recommended treatment is a combination of oral steroids and isotretinoin. We report the case of a male patient with poor response to this treatment who was successfully treated with the combination of oral cyclosporine and isotretinoin.

A 15-year-old white male patient with severe acne flare was referred to our hospital. Diagnosis was acne vulgaris for the past 2 years, treated with topical antibiotics. Six months before the consultation, the lesions worsened and a diagnosis of acne conglobata was made. He was treated with isotretinoin 20 mg/day and prednisone 15 mg/day, but there was no clinical improvement. Isotretinoin dosage was increased to 30 mg/day, but 3 weeks later multiple reddish papulonodular and ulcerated lesions with hemorrhagic crusts suddenly developed on his face, neck, and trunk. The lesions were painful, and arthralgias and temperature up to 39°C were noted (Fig 1). Abnormal laboratory findings included elevated C-reactive protein levels (5 mg/dL; normal < 1 mg/dL) and leukocytosis (15,700 cells/mm^3) with neutrophilia (68.8%). AF was diagnosed, and treatment with prednisone 60 mg/day and isotretinoin 20 mg/day was initially successful. Nevertheless progressive worsening was observed in the following weeks while prednisone was tapered and isotretinoin increased to 30 mg/day. He was treated with potassium permanganate baths and topical antibiotics. Oral cyclosporine 5 mg/kg/day plus isotretinoin 30 mg/day was initiated and systemic steroids were stopped. After a few weeks,

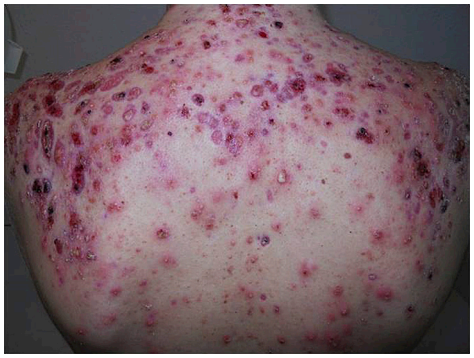

Fig 1. Acne fulminans. Initial presentation with draining pustules and crusted papules and nodules on the back.

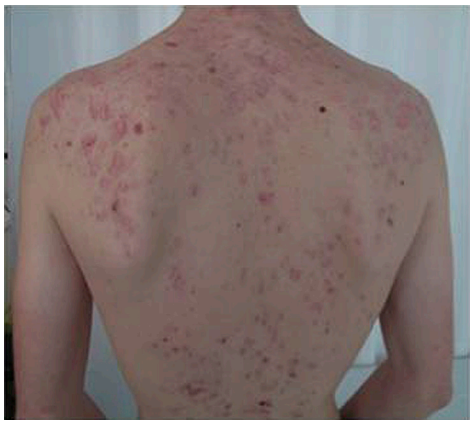

Fig 2. Acne fulminans. Complete resolution of the inflammatory lesions with residual scarring after treatment with cyclosporine and isotretinoin.

the lesions improved, and 4 months later, cyclosporine was discontinued. A total dose of isotretinoin 100 mg/kg could be completed, and he presented an almost complete resolution of the inflammatory lesions with some residual scarring (Fig 2). No significant side effects or laboratory abnormalities were observed during treatment.

AF is a rare condition that is considered the most severe form of acne. It is characterized by a sudden onset of ulcerative, crusty, painful lesions. Most patients are young teenagers with previous mild to moderate acne. It is considered a severe inflammatory disease with abscess formation and hemorrhagic crusts accompanied by high temperature, asthenia, anorexia, and often asymmetric polyarthralgias.[1] In this case, laboratory findings showed an intense neutrophilic leucocytosis and elevation of erythrocyte sedimentation rate and C-reactive protein. The etiology of AF is appears to be multifactorial.[2] The diagnosis is usually clinical. The differential diagnosis includes other disorders such as PAPA[3] syndrome and SAPHO syndrome.[4]

Oral antibiotics are usually ineffective. The combination of oral isotretinoin and systemic corticosteroids is the treatment of choice,[1] but recurrences are not unusual when steroid dose is tapered. We have found only 1 report describing a good response of AF to a combination of cyclosporine and prednisolone.[5] To our knowledge this is the first report showing a good response to cyclosporine combined with isotretinoin. Because this regimen has a very good short-term safety profile (particularly in young persons), it can be an alternative in patients with AF when systemic steroids are either ineffective or contraindicated.

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Complete pathologic response after neoadjuvant treatment with vemurafenib for malignant melanoma

To the Editor: Invasive melanoma on the left arm was diagnosed in a 32-year-old male patient. The initial diagnosis was made by skin biopsy, which revealed a nonulcerated melanoma of 3 mm depth. The patient underwent reexcision and sentinel lymph node