The immunomodulatory role of thalidomide in the treatment of MF deserves further study, particularly in view of the objective clinical response noted at 8 weeks in our patient, when all previous therapies had failed. Because analogs of thalidomide have been reported to have a lower risk of peripheral neuropathy, the potential therapeutic role of these new agents should be carefully investigated in patients with MF.

Lori Brightman, MD
Marie-France Demierre, MD, FRCPc
Skin Oncology Program
Department of Dermatology
Boston University School of Medicine
Boston, Massachusetts

Correspondence to:
Marie-France Demierre, MD, FRCPc
Skin Oncology Program
Department of Dermatology
Boston University School of Medicine
720 Harrison Avenue, DOB 801A
Boston, MA 02118

E-mail: mariefrance.demierre@bmc.org

Published online April 1, 2005.

REFERENCES


doi:10.1016/j.jaad.2005.01.104

Alefacept in the treatment of psoriatic nail disease: A small case series

To the Editor: We report findings of nail changes observed in a small series of patients receiving alefacept for chronic plaque psoriasis. Alefacept is an IgG1 fusion protein mimicking LFA-3 that is administered as a weekly intramuscular injection and has been shown to effectively treat chronic plaque psoriasis.1 The ability of alefacept to treat psoriatic nail disease has not been previously reported. In our analysis, subjects were enrolled in an open-label, multicenter study to evaluate the safety and tolerability of repeated courses of alefacept for treatment of subjects with chronic plaque psoriasis. With enrolled subjects we obtained regular photo-documentation of psoriatic nails and performed a retrospective assessment of the nail photographs by using the Nail Psoriasis Severity Index (NAPSI) grading system.2 Subjects received alefacept, 15 mg administered intramuscularly, every week for 12 weeks; they were then followed up for an additional 12 weeks of observation. During a course of therapy, subjects also had weekly assessments for CD4+ T-cell counts and the Psoriasis Area and Severity Index (PASI).

In the treatment of psoriasis, alefacept therapy shows a maximal response rate noted at 14 to 18 weeks after the first dose.1 Given these data and the slow growth of nails, we chose 18 weeks after onset of alefacept therapy as our primary end point for assessment of PASI and NAPSI scores in responders.

Six of the 12 subjects enrolled had psoriatic nail disease and completed a course of alefacept. At the primary end point, those subjects achieving improvement in PASI score of more than 50% from baseline were considered skin responders. Given a recent study considering 10% to 25% improvement in NAPSI scores as a minimal significant response3 and the longer period of 18 weeks after onset of therapy as our primary end point, we selected a 30% improvement in NAPSI score as a conservative requirement for a minimally significant response.
In our analysis, alefacept appears to induce some improvement in psoriatic nail disease, but not in all subjects with cutaneous response (Table I). Three of 6 patients had at least a 30% improvement in the NAPSI score. However, improvement of cutaneous disease did not always correlate with improvement in nail disease. One patient with the most dramatic response to alefacept showed no improvement in nail disease. This was best shown in patient E who was almost clear of plaque psoriasis, although nail pitting remained unchanged from baseline (Fig 1, C and D).

In summary, during and after receipt of alefacept, patients showed varying response, as demonstrated by improvement in both cutaneous and nail disease, cutaneous disease alone, or neither cutaneous nor nail disease. Our study has clear limitations: small sample size, an open-label and uncontrolled design, and a retrospective analysis of the primary end point. In the future, placebo-controlled studies examining larger sample sizes may detect a statistically significant benefit regarding the ability of either alefacept or other systemic agents to alleviate psoriatic nail disease.

Christopher T. Cassetty, MD
Andrew F. Alexis, MD, MPH
Jerome L. Shupack, MD
Bruce E. Strober, MD, PhD
The Ronald O. Perelman Department of Dermatology
New York University School of Medicine
New York, New York

Drs Shupack and Alexis are speakers for Amgen-Wyeth. Dr Strober is a speaker for Amgen-Wyeth, Biogen-Idec, Genentech, and Centocor.

Correspondence to: Bruce E. Strober, MD, PhD
Department of Dermatology, New York University School of Medicine, TCH-158, 560 First Ave, New York, NY 10016
E-mail: b_strober@hotmail.com

REFERENCES


A pilot study on the use of topical tazarotene to treat squamous cell carcinoma in situ

To the Editor: Tazarotene is the first of a new generation of acetylenic retinoids developed for the topical treatment of mild-to-moderate plaque psoriasis. It is a prodrug metabolized in the skin and plasma to tazarotenic acid, the active form.