Letter to the Editor

Dear *Cutis*®:

The Hu et al[1] article, "Interstitial Granulomatous Dermatitis in a Patient With Rheumatoid Arthritis on Etanercept" (*Cutis*. 2008;81:336-338), highlights a case of interstitial granulomatous dermatitis (IGD), also termed *palisaded neutrophilic and granulomatous dermatitis* in recent literature,[2] that occurred in a patient with rheumatoid arthritis treated with etanercept. The patient's lesions cleared after treatment over 2 weeks with clobetasol propionate ointment 0.05% applied twice daily without occlusion, and the patient has remained on etanercept.[1]

We report a 25-year-old man who developed IGD while being treated with etanercept for psoriasis and psoriatic arthritis (seronegative for rheumatoid factor and anticyclic citrullinated peptide antibodies). Three weeks after initiating etanercept, the patient developed tender red nodules (6–10 mm in diameter) on his bilateral shins, 2 nodules around the injection site on his arm, and plaques on his torso and knees. A punch biopsy specimen revealed a superficial and deep interstitial infiltrate of histiocytes, lymphocytes, and neutrophils consistent with IGD. Etanercept was discontinued for 13 days and the nodules became flatter, less tender, and less violaceous. The patient was informed of the association of IGD secondary to use of a tumor necrosis factor α inhibitor (etanercept).[1] Despite resuming etanercept, there was complete resolution of his IGD after 3 months. The psoriatic plaques on his torso, bilateral shins, and arms also resolved entirely, with some remaining moderately thick plaques over both knees.

Interstitial granulomatous dermatitis is an immune complex disorder that often occurs in the setting of autoimmune disease and use of a tumor necrosis factor α inhibitor.[2] Clinical presentation of IGD may vary but often manifests as painful erythematous nodules or plaques on the extremities. Histologically, the condition typically is characterized by a superficial and deep interstitial lymphohistiocytic infiltrate, variable neutrophils and eosinophils, necrobiosis of collagen, and variable mucin.[2] Both patients experienced IGD secondary to use of etanercept with subsequent clearance. In our case, resolution occurred without topical corticosteroids.

Several dermatologic conditions may resolve without any therapeutic intervention. Topical corticosteroids, which frequently are used in dermatology, are not without risk and may be associated with steroid rosacea, cutaneous atrophy with telangiectasia, hypothalamic-pituitary-adrenal axis suppression, and striae cutis distensae.[3] When used, topical corticosteroids often are credited with treatment success, though there may be no evidence for their efficacy. These successes may then be reported in the literature, which propagates their use. We should be mindful not to inappropriately credit topical corticosteroids with treatment success.

Sincerely,
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The authors report no conflict of interest.

REFERENCES

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