be aware that radiosensitization may be associated with vemurafenib administration and carefully monitor patients receiving concomitant radiotherapy, as well as patients who start vemurafenib after radiotherapy. Neither radiotherapy nor vemurafenib need be stopped if radiation dermatitis develops, in that reported cases resolved without further adverse events after topical corticosteroid administration, cessation of radiotherapy, or both.

Michael Saco, BS, and Christina Mitchell, MD

University of South Florida Morsani College of Medicine, Tampa, Florida

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Correspondence to: Christina Mitchell, MD, Assistant Professor of Dermatology, Department of Dermatology, University of Florida College of Medicine, PO Box 100279, Gainesville, FL 2610-0279

E-mail: mitchcl@dermatology.med.ufl.edu

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Treatment of epidermolysis bullosa pruriginosa using systemic and topical agents

To the Editor: A 46-year-old Hispanic woman presented to our dermatology clinic with a 6-year history of an intermittent pruritic vesicobullous eruption on her lower legs and, to a lesser extent, on her forearms (Fig 1, *A*). She had failed to respond to prior treatments, including topical and intralesional corticosteroids, mycophenolate mofetil, and phototherapy. There was no family history of a similar condition. Histologic findings showed subepidermal clefts with minimal inflammation. Direct immunofluorescence on perilesional skin was negative. A complete workup for immunobullous disease and porphyria was negative. Electron microscopy demonstrated separation of the sublamina densa with a reduced number of anchoring fibrils, which was clinically consistent with dystrophic epidermolysis bullosa pruriginosa (EBP). DNA extraction from peripheral blood followed by bidirectional *COL7A1* gene sequencing (GeneDx, Gaithersburg, MD) revealed a novel compound heterozygotic mutation; a guanine (G) to cytosine (C) splice site mutation at the beginning of intron 51 (IVS51+1 G→C) and adenine (A) to thymine (T) resulting in a codon mutation of glutamine (Gln) to leucine (Leu) at position 1924 (p.Gln1924Leu) on exon 69.

Pruritus and excoriation are critical in unmasking skin fragility in EBP. Given the pauci-inflammatory nature of EBP, we focused on the control of pruritus with the use of ketamine 0.5% and amitriptyline 2% (KA) topical gel. With regular use of KA gel, the patient described a 90% decrease in localized pruritus and blistering. Subsequently, the patient was started on sertraline for depressive symptoms. Over the 6-month period on oral sertraline and KA gel, the patient had virtually complete resolution of localized and generalized pruritus with minor relapses (Fig 1, *B*).

Effective treatment of EBP is challenging, and long-term outcomes are rarely described in the literature. Treatments reported to date include corticosteroids, antihistamines, cryotherapy, tacrolimus, cyclosporine, and thalidomide.[1] However, control of inflammation has not demonstrated consistent efficacy. Based on the structural fragility of EBP, unmasked by severe pruritus and scratching, we advocate focusing the treatment on the control of pruritus, minimizing trauma, and managing lower extremity edema. Topical KA is thought to act pre- and post-axonally in the transmission of pain and possibly pruritus. Poterucha et al[2] showed that topical KA had a 62% response rate in a wide variety of cutaneous disorders, without inducing systemic side effects.[2,3] Interestingly, the concomitant use of sertraline for mild depressive symptoms further improved the patient's generalized pruritus and EBP. Sertraline has been reported as a first-line treatment for cholestatic pruritus and implicates serotonergic mediators in the pruritus of EBP.[4] The exact mechanism of action is unknown but is thought to have a regulatory action on the transmission of itch signals.[5]

The efficacy and minimal medication risk with the combined oral and topical therapies reported here favor this approach as a primary treatment of EBP, a disease that necessitates long-term management. Additional studies are required to further validate the efficacy of systemic sertraline and topical KA for treatment of EBP and possibly other skin conditions in which pruritus plays a key pathogenic role.

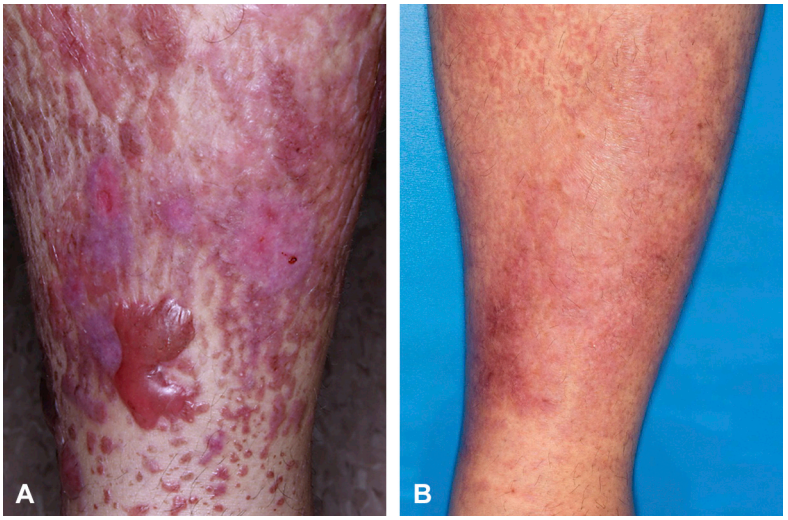

Fig 1. Epidermolysis bullosa pruriginosa. **A**, Purple polygonal flat-topped papules coalescing into large, linear plaques. Bullae occurred on the top of several of these plaques. **B**, Area shown in *A* 6 months after treatment with residual postinflammatory hyperpigmentation and scarring.

Aaron R. Mangold, MD,[a] *Christine M. Cole, MD,*[a,b] *David J. DiCaudo, MD,*[a] *Mark R. Pittelkow, MD,*[a] *and Aleksandar Sekulic, MD, PhD*[a]

Department of Dermatology,[a] *Mayo Clinic, Phoenix, Arizona, and the Center for Dermatology Care,*[b] *Thousand Oaks, California*

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Correspondence to: Aleksandar Sekulic, MD, PhD, Department of Dermatology, Mayo Clinic, 13400 E Shea Blvd, Scottsdale, AZ 85259

E-mail: sekulic.aleksandar@mayo.edu

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Orofacial granulomatosis successfully treated with mycophenolate mofetil

To the Editor: Orofacial granulomatosis (OFG) is a chronic, relapsing, potentially disfiguring inflammatory disorder of unknown etiology.[1] It is characterized by persistent enlargement of the orofacial tissues and noncaseating granulomatous inflammation on tissue biopsy in the absence of diagnosable Crohn disease or sarcoidosis.[1-3] It is thought that OFG represents a spectrum of disease ranging from localized granulomatous inflammation of the lips (cheilitis granulomatosa, Miescher cheilitis) to persistent lip or facial swelling with mucosal ulceration, recurrent facial paralysis, and lingual fissuring (Melkersson-Rosenthal syndrome).[2,3] Due to its unknown etiology and unpredictable clinical course, no definitive pharmacologic therapy is yet available.[1,2] We present a case of OFG successfully treated with mycophenolate mofetil (MMF), suggesting this treatment may be of benefit in these patients.

A 59-year-old Caucasian woman with a history of systemic lupus erythematosus, hepatitis C, and recurrent herpes labialis presented with a 4-month history of rash and swelling of her upper lip. The lesion started as a "cold sore" with occasional burning and mild pruritus. She was treated with oral steroids and amoxicillin by her primary care physician with temporary relief and was referred for further evaluation by a dermatologist. Her condition was persistent with erythema, mild scaling, and diffuse swelling of the upper lip extending to the right oral commissure and lower lip. No other oral mucosal or lingual lesions were noted and she