might contribute to healing so we would not have a real inactive control.

We could not have an equally distributed severity grading in all three groups given the small number of patients. However, distribution in the three groups was randomized. We think that this minimizes the hypothesized effect of severity in the outcome.

We do not include exclusion criteria in the title of our paper. We have found that it saves space in the journal and the title is more attractive that way.

There was no identification of bacteria in any of our patients during direct microscopy at the beginning of the study. A possible subsequent inoculation of bacteria might have an effect on treatment efficacy; however, such a complication could happen equally to all three groups so it does not have an effect on the design of the study. For the same reason we did not consider evaluating fungi inoculation in the middle of the study.

Systemic contraindications and exclusion factors have been taken into account and are mentioned in the Methods section, at the end of the first paragraph.

We appreciate the fact that our paper raised such a spirited discussion in the authors’ Journal club and we would appreciate if they tried to confirm our results using the commercial vehicles of both products.

Table 1 Comparison of efficacy between betamethasone and tacrolimus

<table>
<thead>
<tr>
<th>Cure</th>
<th>Treat</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Count</td>
<td>14</td>
<td>10</td>
</tr>
<tr>
<td>Expected count</td>
<td>12.0</td>
<td>12.0</td>
</tr>
<tr>
<td>Count</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>Expected count</td>
<td>2.0</td>
<td>2.0</td>
</tr>
<tr>
<td>Count</td>
<td>14</td>
<td>14</td>
</tr>
<tr>
<td>Expected count</td>
<td>14.0</td>
<td>14.0</td>
</tr>
</tbody>
</table>

χ² tests

<table>
<thead>
<tr>
<th>Value</th>
<th>df</th>
<th>Asymp. sig (2-sided)</th>
<th>Exact sig (2-sided)</th>
<th>Exact sig (1-sided)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pearson χ²</td>
<td>4.667</td>
<td>1</td>
<td>0.031</td>
<td></td>
</tr>
<tr>
<td>Continuity correctionb</td>
<td>2.625</td>
<td>1</td>
<td>0.105</td>
<td></td>
</tr>
<tr>
<td>Likelihood ratio</td>
<td>6.215</td>
<td>1</td>
<td>0.013</td>
<td></td>
</tr>
<tr>
<td>Fisher’s exact test</td>
<td></td>
<td></td>
<td>0.000</td>
<td>0.049</td>
</tr>
<tr>
<td>Linear-by-linear association</td>
<td>4.500</td>
<td>1</td>
<td>0.034</td>
<td></td>
</tr>
<tr>
<td>No. of valid cases</td>
<td>28</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

aTwo cells (50-0%) have expected count < 5. The minimum expected count is 2. bComputed only for a 2 × 2 table.

References


Key words: betamethasone 17-valerate, chronic paronychia, placebo, tacrolimus

Conflicts of interest: none declared.

There are no ‘safe exposure limits’ for phototherapy

DOI: 10.1111/j.1365-2133.2010.09746.x

MADAM, The British Association of Dermatologists’ guidelines on the use of biological therapy state that, ‘Phototherapy may be inappropriate in patients who have exceeded safe exposure limits (150–200 treatments for PUVA, 350 treatments for narrowband UVB)’.¹ Also, eligibility criteria for biological therapy are said to include fulfillment of severity criteria and one of the following: ‘(i) where phototherapy and alternative standard systemic therapy are contraindicated or cannot be used...”

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due to the development of, or risk of developing, clinically
important treatment-related toxicity; (ii) [patients who] are
intolerant to standard systemic therapy; or (iii) are unrespon-
sive to standard systemic therapy.1

These statements may be misunderstood. Firstly, there are
no defined ‘safe exposure limits’ for narrowband ultraviolet B
(NB-UVB) or for psoralen–ultraviolet A photochemotherapy
(PUVA). Secondly, unless there are good reasons not to do so,
it is surely prudent to offer all patients both NB-UVB and
PUVA, which are distinct therapies with their own different
mechanisms of action and adverse effect profiles, before pro-
gressing to newer treatments that are not proven to be of
greater efficacy, and which can have such serious adverse
effects as the biologicals. Both NB-UVB and PUVA are photo-
therapies (using the term broadly), but failure of response to
one of these therapies is no more an indication of lack of
response to all phototherapies than a failure to respond to aci-
tretin implies that ciclosporin (another tablet therapy) will not
work.

Action levels of cumulative numbers of NB-UVB and of
PUVA treatments, to guide discussions with patients, and to
remind us to reassess the appropriateness of therapy over the
years, can be useful. The choice of such levels is unavoidably
arbitrary. The selection of 200 treatments for PUVA can be
based on such pieces of evidence as that the incidence of
squamous cell skin cancer is increased 14-fold among those
exposed to > 200 PUVA treatments compared with the inci-
dence in those exposed to < 100 treatments.2 With NB-UVB,
the risks are less clear, with no proof, so far, that NB-UVB,
introduced in the mid-1980s, increases the risk of any skin
cancers.3 However, we can be guided by estimates, such as
that, if we accept many assumptions, 450 whole-body (no
face-shield worn) UVB exposures might moderately increase
the risk of skin cancer.4,5

Whatever levels are selected, it is important to recognize
that these are not maximum safe limits, nor are they absolute
ceiling doses or numbers of exposures. The risks, just like the
benefits, of different treatments must be considered for each
patient as an individual. For a red-haired skin phototype 1 per-
son, brought up in Australia and with a strong family history
of various skin cancers before the age of 40 years, I would be
wary of prescribing even just 100 PUVA exposures. On the
other hand, I would not deprive a 60-year-old without any
evidence of photodamage, and who typically gets 1 year of
remission from his otherwise severe psoriasis after a 20-treat-
ment course, of NB-UVB just because he has received a cumu-
lative 400 treatments. What is ‘safe’ for one individual is not
safe for another. We should remember that whatever figures
we choose these are just to guide us. Perhaps ‘action levels’ is
a better term, with less potential for causing misunderstanding,
than ‘safety limits’ or ‘ceiling doses’.

References
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narrow-band ultraviolet B phototherapy: a British Photodermatology

Key words: biological therapy, patient safety, photochemotherapy, phototherapy, psoriasis

Conflicts of interest: none declared.

Langerhans cell histiocytosis: a case study suggesting a reactive aetiology

DOI: 10.1111/j.1365-2133.2010.09765.x

MADAM, Langerhans cell histiocytosis is a group of diseases of
unknown aetiology characterized by infiltrates of bone mar-
row-derived Langerhans cells associated with eosinophils.
Much debate exists as to whether the process is neoplastic
or reactive. Here, we report a case suggesting a reactive aetio-
logy.

A series of pink and skin-coloured papules developed on
the head, neck and shoulders, but not face, of a 63-year-old
female nonsmoker with no other medical history except
increased cholesterol level treated with a statin (Fig. 1). These
papules had spread steadily over 6 months. The remainder of
the examination was unremarkable. Skin biopsy showed a
cellular infiltrate of the superficial dermis by nonclonal

Fig 1. Pink and skin-coloured papules on the trunk.