regression in the remaining lesion. The partially regressed nodule on the lateral aspect of the right thigh had a CD20-negative phenotype. Although rarely, a CD20-negative phenotype has been previously described in systemic B-cell lymphomas and in a few cases of primary or secondary cutaneous B-cell lymphomas treated with intravenous rituximab.[3-5] Loss of CD20 expression has been interpreted as a mechanism of drug resistance due to the selection of preexisting CD20-negative neoplastic cells or emergence of mutated CD20-negative clones.[3-6] The existence of a varying proportion of CD20-negative cells that do not respond to rituximab treatment should therefore be considered.[3-6]

Notably, the lesion that appeared on the left scapular region after 14 months of follow-up was CD20 positive. This finding suggests that the loss of CD20 expression in persistent or relapsing cutaneous lesions does not preclude the repeated use of anti-CD20 antibody—based therapy. Whenever possible, patients should undergo evaluation for CD20 expression before the initial or repeated treatments with anti-CD20 therapy.

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Aquagenic syringeal acrokeratoderma

To the Editor: Aquagenic syringeal acrokeratoderma is a rare acquired condition characterized by papules and translucent plaques with prominent eccrine ducts that develop after a 2- to 4-minute exposure to water. The lesions frequently appear on the palmar surface, although the dorsal surfaces of the hands and the soles of the feet can also be affected.[1-2] The condition appears to predominantly affect adolescent and young adult women, and only two cases of male patients have been reported.[1-3]

A 19-year-old female presented to our department with a 2- to 3-year history of a condition in which the skin on both of her hands, on her palms, and between her fingers had a symmetric, edematous appearance. These symptoms occurred within 1 to 2 minutes of exposure to water and occurred regardless of water temperature. The condition spontaneously resolved within minutes without side effects. The physical appearance of her palmar surfaces before immersion was normal. After inviting the patient to soak her hands in water for 60 seconds at different temperatures, small, whitish papules coalescing on the palms at the hypothenar eminence and interdigital web spaces began to appear; these showed a softening appearance. Dilated eccrine ducts were observed in bigger plaques (Fig 1). In her medical history, there was neither hyperhidrosis nor other illnesses or associated iatrogenic disease. After the patient was diagnosed with aquagenic syringeal acrokeratoderma, she commenced a 2-month trial of aluminium chloride 20% therapy, but she discontinued treatment because of a lack of clinical improvement. The patient rejected both biopsy and botulinum toxin injections when we explained to her that the diagnosis was asymptomatic and benign.

Aquagenic syringeal acrokeratoderma has been given different names since its first description in 1996 by English and McCullough.[4] The different terms were related to the clinical and histologic characteristics of the disease. Key indications for the diagnosis of aquagenic syringeal acrokeratoderma are the previously described lesions that affect adolescents and young adult women; the location of the condition on the palms and, to a lesser extent, on the soles; this condition is asymptomatic or shows mild

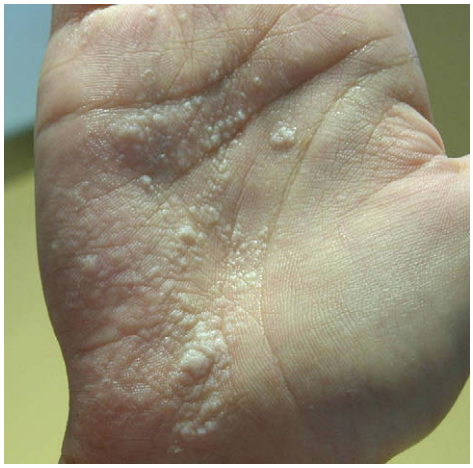

Fig 1. Lesions on the palmar surface of the patient's hand.

pain or tingling; spontaneous resolution within a few minutes; and the "hand in the bucket" sign.[2] Histologic examination shows dilated eccrine ducts and orthokeratotic hyperkeratosis. The cause of this rare condition remains unclear, but it may be related to an acquired sweat gland abnormality or a primary keratoderma. The condition may also be associated with functional and structural changes in the stratum corneum during puberty.[5] A total of 16 cases of acquired aquagenic syringeal acrokeratoderma have been reported in the European and American literature. This number has increased since the last time the same literature was studied.[3,6]

We present a new case that contributes to the knowledge of this disease. We believe that the condition has been underdiagnosed thus far, given the clinical presentation of the lesions and the spontaneous resolution.

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Treatment of juvenile pityriasis rubra pilaris with etanercept

To the Editor: Pityriasis rubra pilaris (PRP) is a rare papulosquamous disorder characterized by circumscribed follicular papules, varying degrees of erythroderma, islands of uninvolved skin, and palmoplantar keratoderma.

We report the case of a 16-year-old girl with a 4-year history of a pruritic, scaly eruption which began on her scalp and spread to the trunk and extremities after 1 year. Another physician diagnosed psoriasis and initiated treatment with etanercept 50 mg subcutaneously twice weekly after she failed to respond to topical steroids, topical retinoids, and calcipotriene.

She was first evaluated in our clinic 4 weeks after starting etanercept. The physical examination was notable for erythroderma with islands of uninvolved skin, thick hyperkeratotic plaques on her shins, follicular papules on the extremities, and desquamation of the palms and soles. A skin biopsy was performed and confirmed the diagnosis of PRP. Because the patient reported improvement on etanercept, we continued the medication at the same dose.

Four weeks later, the hyperkeratotic plaques on her shins were thinner and the erythroderma had resolved. After 4 months of therapy, she had near complete clearance (Fig 1). The dose of etanercept was tapered to 50 mg weekly for 2 months, 25 mg weekly for an additional 2 months, and then discontinued. A complete remission was maintained for 6 months before the skin disease flared. Etanercept 50 mg twice a week was restarted and near clearance was achieved after 2 months of therapy. The patient is currently maintained on etanercept 50 mg weekly. She has experienced no adverse effects.

The treatment of PRP in both adults and children remains challenging. There is no universally accepted treatment because the response rate to