Dr Murrell is an employee of St George Hospital; has been an investigator/advisor for Novartis, Sun Pharma, Janssen, and AbbVie; and is the director of a clinical trial center for dermatologic diseases. Dr Rivera-Oyola has no conflicts of interest to declare.

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Retrospective case series of isotretinoin outcomes for acne in 393 female patients at Baylor College of Medicine during 2012-2016

To the Editor: Adult acne vulgaris (in persons aged ≥25 years) has a similar pathophysiologic mechanism as teenage acne, with hormonal regulation, cosmetic products, and stress or genetic factors contributing to its pathomechanism.[1] There are a wide variety of treatments for adult acne, including isotretinoin. Interestingly, there are few randomized control trials of isotretinoin compared with other acne treatments.[2] Many studies demonstrate improvements in adolescent acne after isotretinoin treatment. However, we sought to examine its usefulness in treating acne in women. We analyzed 3800 patient charts of female patients ≥25 years of age with acne vulgaris diagnoses in the Baylor Clinic. Of these patients, 393 met the inclusion criteria of isotretinoin treatment with sufficient documentation. Data was compiled from the electronic medical records and analyzed by using IBM SPSS Statistics version 25 (Armonk, NY). The average age of our patients was 34.6 years, median age 31 years, average ± standard deviation cumulative dosage 103.83 ± 52.78 mg/kg, and duration ± standard deviation of treatment 3.9 ± 1.7 months, respectively.

The results showed that 95.4% of patients had a positive response to treatment, with 43.3% experiencing 100% clearance of their lesions and 52.2% experiencing improvement but not complete resolution. The most frequently reported side effect from treatment was cheilitis and xerosis (97.3%). The side effect frequencies are summarized in Table I. Two patients discontinued treatment because of side effects (1 because of increased joint pain and the other a melasma flare while on treatment). In addition, 5 (1.3%) patients had elevations in liver enzymes or lipid panel results requiring discontinuation of therapy.

Oral contraceptive pills (OCPs) were used as a form of contraception in 35.6% of patients. OCPs are a known therapeutic agent used to treat acne vulgaris. A χ^2 analysis revealed no difference in the response rates between patients on OCPs and those on nonhormonal contraceptive methods ($P = .763$, Pearson $\chi^2 = .540$, degrees of freedom = 2).

Limitations to our study include a lack of a standardized grading system for acne as well as a high rate of patients lost to follow-up (24.9%). Although these patients did not return for posttreatment follow-up, their last note did document their response to treatment, and these individuals were therefore included in the study.

The high response rates demonstrated by our study match other studies, suggesting that isotretinoin is useful for treating acne vulgaris in both the adolescent and adult populations (91%-97.4%).[3,4] After isotretinoin treatment, 15.5% of patients had a relapse documented at some point, lower than what was seen in a previous study (47.4%).[3] Despite the high frequency of cheilitis and xerosis, no patient elected to discontinue treatment because of these side effects. When combined with the low frequency of other side effects, isotretinoin should be considered a well-tolerated, useful option for physicians to consider when treating acne in adult female patients.

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Table I. Side effects of isotretinoin treatment

Side effect	Present, n	Absent, n	Not recorded, n	Percentage affected*
Cheilitis and xerosis	366	10	17	97.3
Nosebleeds	12	195	186	5.8
Low mood	2	208	183	1.0
Gastrointestinal disturbance	3	207	183	1.4
Muscle aches and bone pain	15	205	173	6.8
Headache	4	208	180	1.9
Vision changes	1	207	183	0.5
Elevations in liver enzymes	3	385	5	0.8
Lipid panel results outside of reference ranges	2	384	7	0.5

*Percentage affected among patients for whom data was recorded.

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Clinical features of dermatofibrosarcoma protuberans and risk factors for local recurrence after Mohs micrographic surgery

To the Editor: To date, few studies have focused on the differences in the clinical features of primary and recurrent dermatofibrosarcoma protuberans (DFSP). Some studies have reported the risk factors for local recurrence after wide local excision.[1] However, few studies have assessed the risk factors for local recurrence after Mohs micrographic surgery (MMS). To better understand the clinical features of DFSP, a retrospective cohort study, which included 197 patients, was conducted to evaluate the clinical features of primary and recurrent DFSP and the risk factors for local recurrence after MMS.

The main characteristics of our cohort are shown in Table I. Tumors appeared in men slightly more often than in women. The median age at the time of presentation was 30.8 years (range, 0.08-66 years). The median age at the time of first diagnosis was 38.0 years (range, 0.3 to 76.5 years). DFSP most commonly occurred on the chest (26.4%). In 8 patients, the lesions recurred after MMS: 1 recurrence occurred in the recurrent DFSP, and 7 recurrences occurred in the primary DFSP. No differences in sex, age at presentation, tumor size, location, or recurrence rates were noted between the primary and recurrent cases of DFSP after MMS. The mean ages at the time of first diagnosis and the interval between presentation and diagnosis in primary DFSP were significantly lower than those of recurrent DFSP ($P = .041$ and $P = .002$, respectively).

Compared with primary DFSP, fibrosarcomatous (FS) change was significantly more likely to occur in recurrent DFSP ($P = .042$). Tumor size (>5 cm) and FS change were associated with recurrence in the univariate analysis. In the multivariate analysis, FS change was the only independent predictor of recurrence (95% confidence interval, 1.990-74.794; $P = .007$) (Table II).

In contrast to previous studies suggesting an equal sex ratio,[2] our study showed that DFSP in Chinese patients was slightly more common among male than female patients. FS-DFSP is highly aggressive, with a high risk of local recurrence.[1,3] In this study, we found that FS change was an independent prognostic factor for local recurrence in both univariate and multivariate analyses. Interestingly, our data showed that FS-DFSP occurred in a large proportion of patients with recurrent DFSP relative to patients with primary DFSP. A multicenter study conducted by Huis in 't Veld et al[1] showed that patients who had tumors