This limited-sample retrospective study suggests that biologics do not affect long-term renal function in psoriasis patients with CKD. Additional studies are needed to further investigate whether early intervention with biologics can reduce progression to end-stage renal disease.

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Dupilumab for the treatment of dyshidrotic eczema in 15 consecutive patients

To the Editor: Dyshidrotic eczema is a subtype of hand/foot eczema characterized by recurrent episodes of pruritic vesicular and eczematous eruptions. Even though dyshidrotic eczema affects a limited body surface area, it is frequently refractory to superpotent topical corticosteroids and may require treatment with phototherapy or systemic immunosuppressants. Even with aggressive management, many patients do not achieve satisfactory disease control. Several case reports and small case series (≤3 patients) have reported using dupilumab in the treatment of refractory dyshidrotic eczema; however, data supporting dupilumab's use in this condition are still limited.[1-4] To highlight the role of dupilumab in dyshidrotic eczema, we report 15 consecutive patients from the Connecticut Veterans Affairs and University of Connecticut Departments of Dermatology who were treated with dupilumab for dyshidrosis.

Table I. Demographics and treatment characteristics

Demographics	No. (%)
Sex	
Men	10 (67)
Women	5 (33)
Age, y	Mean 56, range 32-76
Race	
White	14 (93)
Hispanic	1 (7)
Other	0
Treatment history	
Topical corticosteroid use	15 (100)
Systemic immunosuppressive use	7 (47)
Phototherapy use	1 (7)
Systemic immunosuppressive and phototherapy use	3 (20)
Psoriasis biologic use	7 (47)
Dupilumab-associated adverse events	
Facial redness	2 (13)
Ocular surface disease	1 (7)

Patients were excluded from this series if they had known atopic dermatitis or other eczematous eruptions elsewhere on their body. All patients initially received an atopic dermatitis dosing of dupilumab. Table I reports demographic data for these patients. All patients had previously failed topical corticosteroids, and 73% (11/15) had previously failed at least 1 oral immunosuppressive, phototherapy, or both. Forty-seven percent of patients (7/15) had previously received a diagnosis of having palmoplantar psoriasis, for which they had received other biologic medications. All patients demonstrated at least partial response to dupilumab, with decreased erythema and pruritus, whereas 6 of 15 patients (40%) had complete clearing. Ninety-three percent of patients (14/15) who began receiving dupilumab for dyshidrotic eczema are still receiving dupilumab, with an average treatment

duration of 12.5 months. Seven patients have been receiving dupilumab for more than 1 year.

One patient in our cohort had concomitant plaque psoriasis, for which he was receiving ustekinumab, 45 mg every 12 weeks, in conjunction with his dupilumab. He developed clearance of his psoriasis and near clearance of his dyshidrotic eczema and developed no treatment-related adverse events. The dosing frequency was increased to weekly for 2 partial responders. Neither of them experienced clearance of their disease while receiving this more frequent dosing regimen, nor did they develop adverse events. The one patient in our cohort who stopped dupilumab was responding appropriately but decided to discontinue because she was concerned about possible long-term adverse effects.

Dupilumab was well tolerated in our cohort, with only 3 reported adverse events. One patient developed conjunctivitis that is being managed satisfactorily with artificial tears. Two patients developed dupilumab facial redness that was refractory to treatment with topical corticosteroids, topical azoles, and topical calcineurin inhibitors. All 3 patients who developed adverse events have continued with therapy.[5]

Our series suggests that dupilumab is a generally well tolerated and frequently effective treatment for dyshidrotic eczema. Limitations include its retrospective nature and risk of misclassification bias, given lack of diagnostic criteria for dyshidrosis.

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Dupilumab treatment of nummular dermatitis: A retrospective cohort study

To the Editor: Nummular dermatitis is an idiopathic eczematous eruption characterized by pruritic, coin-shaped lesions typically involving the extremities and, less commonly, the trunk. Although topical therapy is the mainstay of management, treatment escalation may be required in severe cases. Dupilumab is a human monoclonal antibody against the interleukin 4 receptor α subunit that has shown efficacy for moderate to severe atopic dermatitis.[1] We present a retrospective cohort study of our institutional experience with dupilumab for nummular dermatitis.

After institutional review board approval, a retrospective chart review was performed of adult patients treated in the general dermatology clinic at our institution from January 1, 2017, through July 31, 2019, with the words "nummular" and "dupilumab" or "dupixent" in clinic notes. Patients receiving a diagnosis of idiopathic nummular dermatitis who had ever received dupilumab were included.

Six patients treated with dupilumab were identified (Table I). All patients did not meet the revised Hanifin and Rajka criteria for atopic dermatitis, which were used to establish a diagnosis of atopic dermatitis in the dupilumab clinical trials.[1] None of the patients had a history of flexural dermatitis or childhood atopic dermatitis. All had failed standard therapy, as well as emollition and dry skin care.

In total, 5 of 6 patients had a durable response to dupilumab, defined as a reduction in body surface area involvement sustained throughout the follow-up period of up to 2 years (Table I). The sole patient without durable response had initial improvement but discontinued treatment because of fluctuating response and the development of conjunctivitis attributed to dupilumab. No other adverse events were reported.