of cosmetics in resident training and the perceived inadequacy of cosmetics training by residents, that residents are not more motivated to gain expertise in cosmetics compared with other areas of dermatology (average, 7.2-8.0).

Our results confirm previous data that program directors and chairmen believe that training in cosmetics is less important during residency than training in noncosmetic areas of dermatology.[1,2,4,5] The important new findings in our survey are that 85% of respondents feel cosmetics has become more prominent in residency training, and 53% believe the increased emphasis on cosmetics has lessened residents' interest and expertise in medical dermatology.

Limitations of this study are that it assessed a subpopulation of dermatologists who may be biased toward medical dermatology—yet these are the people charged with educating residents, so we believe their opinions are important. Second, the response rate of 31%, although well within the accepted range for survey studies of physicians, may have affected the data.[6] Lastly, responders may have stronger feelings about the role of cosmetic dermatology than nonresponders, introducing bias.

Our study raises the concern that residents may have less interest and expertise in medical dermatology as a result of increased emphasis on cosmetics. As the field of dermatology expands, it is vitally important that residency programs consider how to offer comprehensive training in all areas of dermatology, including cosmetics, without compromising expertise in traditional aspects of dermatology such as medical dermatology.

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Case letters

Partial unilateral lentiginosis associated with nevus of Ota

To the Editor: A 25-year-old otherwise healthy female was referred to our department for the evaluation of pigmented facial lesions. Localized hyperpigmentation over the right eye had been present since birth. In the last 4 years, she noticed development of ipsilateral multiple brown lentigines extending onto the right forehead, temple, and eyelids, as well as a progressive blue-gray pigmentation on the right eyelid and tip of the nose.

The physical examination revealed multiple brown, lentigo-like macules overlying normal skin corresponding to the first and second branches of the trigeminal nerve and superimposed on a blue-gray background over the eyelid and tip of the nose (Fig 1), and a slate gray irregular pigmentation on the ipsilateral sclera. The ophthalmologic examination

Fig 1. Multiple brown, lentigo-like macules overlying areas of normal skin on the right side of the face. Note the blue-gray pigmentation on the tip of the nose.

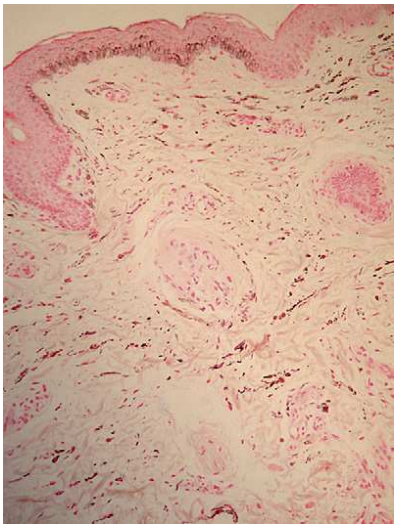

Fig 2. Hyperpigmentation of the basal layer compared with adjacent normal epidermis and slight increase in the number of melanocytes without nesting, typical for lentigo, along with dermal proliferation of melanocytes. (Silver nitrate stain; original magnification: ×20.)

was negative for Lisch nodules, the intraocular pressure was normal, and there were no conjunctival lentigo–like lesions or diffuse subepithelial pigmentation. There was no evidence of café au lait spots, axillary freckling, or neurofibromas.

A biopsy specimen was obtained from a lentigo-like macule lying over blue-gray skin on the inferior eyelid. The histopathologic examination revealed increased pigmentation of the basal layer of the epidermis with a slightly increased number of melanocytes. Haphazardly arranged within the dermis and impinging on the subcutaneous tissue was a discrete proliferation of dendritic melanocytes (Fig 2). The clinical and pathologic features allowed us to categorize these pigmentary changes as partial unilateral lentiginosis (PUL) associated with a nevus of Ota.

PUL is a pigmentary disorder characterized by multiple lentigines overlying normal skin with a unilateral segmental pattern stopping at the midline. The lesions are present at birth or noticed during childhood.[1] The long term prognosis is unknown and malignant transformation has not been reported, but a case of extensive bilateral lentiginosis with two malignant melanomas has been described.[2]

The nevus of Ota represents a hamartoma of dermal melanocytes, clinically characterized by a unilateral macular blue-gray discoloration overlying the first and second branches of the trigeminal nerve with frequent ipsilateral ocular pigmentation. PUL can usually be distinguished from a nevus of Ota by clinical features. However, Kang et al[3] has described a case involving a nevus of Ota presenting as grouped lentigo-like macules, thereby clinically resembling a PUL. The location of melanocyte proliferation in the superficial dermis may be explained by this atypical clinical pattern. Cases of PUL with ocular involvement have been reported[4,5]; in such cases, the ocular pigmentation has been brown rather than the usual blue-gray coloration of a nevus of Ota.

Dermal melanocyte proliferation is observed in the nevus of Ota, whereas an increase of pigmentation in the basal layer of the epidermis without the presence of dermal melanocytes is the pathologic hallmark of PUL.

Our patient may represent PUL associated with a nevus of Ota. The embryonic connection between PUL and a nevus of Ota may explain this association. The blue-gray ocular pigmentation in this case is thought to be a nevus of Ota; however, we could not establish if the ocular lesion is related to a nevus of Ota or a manifestation of PUL with ocular involvement.

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Apparent safe use of single dose rituximab for recalcitrant atopic dermatitis in the first trimester of a twin pregnancy

To the Editor: Rituximab, a chimeric monoclonal anti-CD20 antibody originally developed for the therapy of B-cell malignancies, has recently been suggested as an option for severe atopic dermatitis (AD),[1] particularly in patients with elevated levels of total immunoglobulin E (IgE) and/or specific IgE to environmental allergens.

We report a 30-year-old woman with allergic rhinitis, asthma, and AD since childhood, which was resistant to intensive topical therapy with steroids and tacrolimus and oral antihistamines. She had documented allergies to *Dermatophagoides* spp., latex, cow's milk proteins, egg proteins, and peaches. Serial total IgE levels in blood were consistently > 20000 kU/L (normal IgE range < 100 kU/L). She had been previously treated with systemic corticosteroids, cyclosporine, mycophenolate mofetil, and psoralen plus ultraviolet A light phototherapy (PUVA), with inconsistent and temporary results, and she continued to have persistent severe disease. The physical examination revealed lesions involving 80% of her total body surface area (TBSA). Rituximab was then proposed to the patient, after complement deficiency, immunoglobulin deficiencies, and severe infection had been ruled out; pregnancy was excluded by a negative immunologic human chorionic gonadotropin test in urine 1 week before the infusion, because her last menstruation had occurred 4 weeks earlier. A baseline complete blood cell count, total IgE level, and B lymphocyte count were obtained. Written informed consent was signed by the patient. The treatment schedule consisted of two intravenous infusions of rituximab 1000 mg 2 weeks apart.[1] However, before the second infusion, a second pregnancy test was performed, which was positive. The infusion was canceled and the pregnancy was closely monitored in a high-risk pregnancy unit. Obstetric ultrasonographies placed the date of conception 13 days before the first infusion. At week 36 of an uncomplicated pregnancy, two healthy monozygotic twins were delivered via cesarean section. Our patient had a significant decrease in her IgE levels (4000 kU/L) and TBSA decreased to 5% after the single rituximab infusion; during the 17-month follow-up period she did not experience new flares of her dermatitis and no adverse events occurred. Her closely monitored 8-month-old boys are growing and developing normally; careful hematologic and immunologic monitoring has revealed no adverse effects resulting from exposure to rituximab (B lymphocyte levels of 1250/μL and 1050/μL for each twin, respectively; IgA, IgM, IgG, and IgE levels are normal in both twins).

Data regarding the use of rituximab during pregnancy are scarce and have been limited to patients with hematologic disease: non-Hodgkin lymphoma,[2] B-cell lymphoma,[3] Burkitt lymphoma,[4] acute thrombotic thrombocytopenic purpura,[5] autoimmune hemolytic anemia,[6] and idiopathic thrombocytopenic purpura.[7] In all reported cases, no abnormalities have been found in fetal or child development with the weekly regimen of 375 mg/m^2 given as four to six infusions. Furthermore, some have suggested that rituximab therapy for lymphomas is a viable option for deferring cytotoxic therapy early during pregnancy and might help to reduce the risk of fetal malformation or abortion.[4] Because AD is a chronic, nonfatal, inflammatory disease, it is difficult to support its use in pregnant women, regardless of the risk—benefit ratio. Nonetheless, the present case is a valuable contribution in asserting the safety of the drug in this setting.

The significant and long lasting clinical improvement produced in our patient with the single infusion administered suggests that rituximab may be a promising therapy in AD. Its administration during pregnancy appears to be safe for the child, but further studies are warranted.

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