

prior to the onset of psoriasis, and none was found in 10 of our psoriasis patients with IBD. A total of 183 patients have history of IBD-related surgery in our study, whether patients have received surgical treatments was not associated with the prevalence of mucocutaneous disease. {(Spearman correlation analysis ($r = 0.094$, $P = 0.059$)). Enteral nutrition combined with mesalazine therapy may be somewhat related to the low prevalence of mucocutaneous disease in our study² {(Spearman correlation analysis ($r = -0.151$, $P = 0.002$)). However, there are limitations and our study is a cross-sectional and single-centre study. Further prospective controlled clinical trials are desirable.

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Isotretinoin treatment and peanut allergy: a new case report and review of the literature

Dear Editor,

Isotretinoin is a common and effective retinoid drug that remains the gold standard for the treatment of severe acne. The package leaflet clearly mentions its contraindication in patients with peanut and/or soya allergy. As isotretinoin is solubilized in refined soya oil, it is contraindicated in patients with soya IgE-mediated allergy. Because of possible cross-reactivity, concerns

have been raised about giving the drug to patients presenting with peanut allergy.

However, knowing the distress and discomfort caused by severe acne and the relief brought by isotretinoin, we feel that a study is needed to assess how and when this drug may be used to treat acne patients with peanut allergy. We recently treated a teenage patient safely with isotretinoin despite his peanut allergy.

The 13-year-old boy was referred for severe acne. He had a past medical history of proven peanut allergy, and a hospital groundnut reintroduction had triggered an anaphylactic shock. Yet the patient could eat soya without clinical reaction. Clinical assessment showed an acne severity score of 4 on the Global Acne Evaluation (GEA) scale with facial and dorsal mixed nodular, comedonal and inflammatory acne. Isotretinoin was the only appropriate treatment for the severity of his acne considering the risk of scars. Due to his medical allergic background, prick tests with peanut and isotretinoin were carried out. Positive reaction (6 mm wheel) was observed for peanut with good positive and negative controls. A negative reaction was observed with isotretinoin. A decision was made to carry out an oral provocation: the patient first received 1/10 of the dose followed 30 min later by 9/10, remaining under medical supervision over a period of 3 h. No medical complication occurred, and the patient was started on isotretinoin with neither immediate nor delayed allergic issues.

Although it is a widely prescribed drug, allergic reaction to isotretinoin is exceptional with only three cases of angio-oedema having been reported (with no underlying peanut allergy).^{1–3} There are currently no guidelines to what precautions or investigations are needed for peanut allergic patients.

Having reviewed the articles already published (Table 1) on the subject, we found that earlier case reports had already demonstrated successful isotretinoin introduction in patients known to be allergic to peanut, accounting, in total, for 12 patients.^{4–9} None of these patients experienced adverse allergic events. The investigations varied slightly from one case report to another, but overall, most patients underwent prick testing for peanut and isotretinoin. Specific IgE for peanut and soya were sometimes performed. The underlying rationale was to consider a possible cross-reactivity between peanut and soya. Cross-reactivity occurs when an IgE antibody against a targeted allergen recognizes and reacts against another similar allergenic source. However, little data are available on the *in vitro* and *in vivo* cross-reactivity between peanut and soya allergens. Only one patient who tolerated isotretinoin well had a positive soya IgE antibody, but had no clinical history of soya IgE-mediated allergy.¹⁰ Furthermore, the IgE titre was very low (0.389 KUI/L, considered negative <0.35 KUI/L) and might correspond to unspecific *in vitro* cross-reactivity.

These studies, and our case, seem to indicate that peanut allergy should not be considered as a definitive contraindication to isotretinoin. Nevertheless, the number of reported cases is

Table 1 Characteristics of previous published case reports

Author	Date and country of publication	Type of study	Patients <i>n</i> =	Age	Clinical manifestations to peanut exposure	Prick test	IgE peanut	IgE soya	Oral challenge and outcome
Laing <i>et al.</i>	2008, Ireland	Case report	<i>n</i> = 1	14 years	Nausea, rash, throat tightness	–	17 KU/L	–	Acitretin prescription NO REACTION
Walsh <i>et al.</i>	2008, UK	Case report	<i>n</i> = 2	16 and 24 years	Anaphylaxis Not specified	–	–	–	Oral challenge isotretinoin NO REACTION
Spierings <i>et al.</i>	2015, UK	Case report	<i>n</i> = 6	[16–19 years]	Severe anaphylactic peanut allergies	Peanut positive Soya positive Isotretinoin negative	–	–	Oral challenge of 20 mg of isotretinoin NO REACTION
Pierret <i>et al.</i>	2016, Belgium	Case report	<i>n</i> = 1	12 years	Urticaria, facial oedema, dyspnoea	Peanut 8 mm Isotretinoin negative	3.93 KU/L	<0.35 KU/L (negative)	10 and 20 mg oral challenge of isotretinoin NO REACTION
Hulstaert <i>et al.</i>	2016, Belgium	Case report	<i>n</i> = 1	18 years	Nausea, throat tightness	Peanut positive Isotretinoin negative	Ara h2 4.12 KU/L Ara h8 9.74 KU/L	–	20mg oral challenge of isotretinoin NO REACTION
Alden <i>et al.</i>	2016, UK	Case report + Small cohort	<i>n</i> = 1 <i>n</i> = 6	27 years N/A	Cashew nut allergy No peanut allergy –	– –	– –	0.04 KU/L prior to isotretinoin 1.38 KU/L after isotretinoin introduction IgE Gly m4/Gly m5/Gly m6	First dose of isotretinoin: eyelid, lip and then throat swelling Risk stratification
Alvarez-Arango <i>et al.</i>	2016, USA	Case report	<i>n</i> = 1	23 years	No clinical symptoms, positive RAST in infancy, peanut avoided	Peanut positive (4+) Soya positive (1+) Isotretinoin negative	35.7 KU/L	0.389 KU/L	Oral challenge with 2 mg, then 20 mg of isotretinoin NO REACTION

small and there are little sustainable data in the literature. Therefore, we believe that a multicentred prospective study should be set up in this field with prick testing for peanut, soya and isotretinoin, along with specific IgE antibodies, before doing the oral challenge in a hospital setting. Follow-up with clinical and biological assessment would allow us to see whether these patients subsequently develop sensitization to isotretinoin.

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'Dermohscopy' mapping: correlating dermoscopic findings with histology in Mohs micrographic surgery

Editor

Mohs micrographic surgery (MMS) is the treatment of choice for high-risk basal cell carcinoma.^{1,2} The technique combines tissue conservation with complete microscopic margin control,

leading to superior cure rates while minimizing deformity.³ MMS involves several steps that should be meticulously followed to achieve this high cure rate.⁴

Mapping is an essential step during MMS, as it allows tumours found by histological analysis to be tracked during surgery. Histological findings are typically correlated to a clinical photograph or hand-drawn map.⁵ Despite the increasing use of dermoscopy as an adjuvant tool to help identify basal cell carcinoma,^{6,7} to the author's knowledge, mapping of dermoscopic findings before MMS has not been described. The objective of this report was to describe 'dermohscopy' mapping for the correlation of dermoscopic findings with histological features in MMS for ill-defined tumours.

The first step consists of a careful evaluation of the tumour with a handheld dermatoscope. Tumour borders and 1st stage margins are then outlined with a black surgical pen. Next, reference marks are coloured similar to the Mohs map to be drawn (Figs 1 and 2). Dermoscopy photographs are taken with a device that connects the dermatoscope to a cell phone or camera. A zoom feature is usually needed for better visualization. If margins are positive for tumour on histological evaluation, the Mohs surgeon may correlate the histological findings not only with the clinical map, but also with the dermoscopy map.

The disadvantages of the technique include the effort and time required. However, with practice, the technique may be performed in 1 or 2 min. 'Dermohscopy' mapping is ideal for small to medium-sized and ill-defined tumours. Larger tumours are not good candidates due to the necessity of extensive documentation.

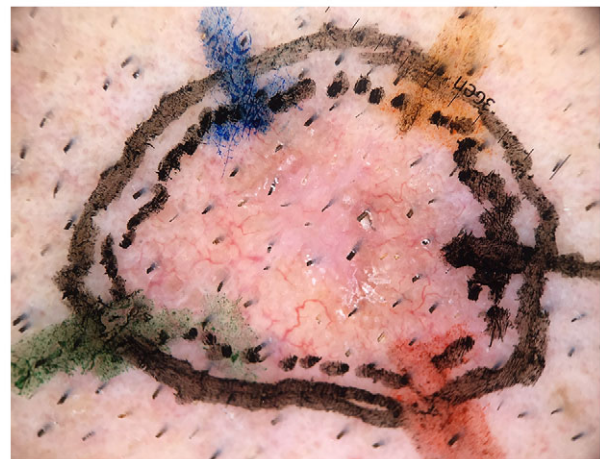


Figure 1 Dermoscopy map of an infiltrative basal cell carcinoma prior to Mohs surgery (the tumour is marked with a dotted line, and the 1st stage margin is marked with a continuous line).