Table 1
Responses to the questions asked to patients with rheumatoid arthritis.

Current treatment actual Number 93	Preference of administration route Number (%)	Reason for preference Number (%)	Talked to rheumatologist Number (%)
Oral → 12	Oral → 33 (35,5)	Convenience → 32 (34,4)	Yes → 37 (41,9)
Subcutaneous → 24	Subcutaneous → 14 (15)	Efficacy → 20 (21,5)	No → 57 (58,1)
Intravenous → 57	Intravenous → 46 (49,5)	Phobia of needle → 5 (5,4)	
		Safety → 15 (16,1)	

relationship with the nurse and the broad experience of some of the patients with the day hospital could be factors implicated in these results. Even so, almost a quarter of the patients preferred an oral or SC treatment.

In a similar study, presented at an international congress, which included 41 patients with RA, over half of them (53%) indicated that oral administration was ideal and 34% SC administration.[5] There is a great difference with our sample since only 25% of patients had biologic treatments (IV or SC). However, the majority of patients included in this study and of our patients with SC tended to choose the oral route as the ideal one for its convenience.

Almost half of our patients responded that they preferred the intravenous route, but the majority were patients who were currently receiving IV treatment (only 2 patients who were not currently receiving IV treatment preferred this administration route). The most commonly given reasons for this were the efficacy (18/44) and safety (15/44) of the IV treatment.

Communication between physician and patient is key when choosing the appropriate treatment and it is notable that over half of our patients said they had not previously spoken about this aspect of their treatment with the rheumatologist in charge of their treatment. Although this result may only apply to our centre, it highlights the importance of involving patients in all aspects of their treatment.

The patient's opinion when choosing administration route is important. Although the intravenous route is initially rejected by the majority of patients, once established many of them agree to maintaining intravenous treatment due to the higher perceived sensation of efficacy and safety. The subcutaneous route, however, although greatly increased in recent years is not the preferred route by many patients, who would mostly choose oral treatments.

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Leukocytoclastic vasculitis manifested as a Koebner phenomenon☆

Vasculitis leucocitoclástica manifestada como fenómeno de Koebner

Dear Editor,

Koebner's isomorphic phenomenon consists of the reproduction of lesions typical of a dermatosis in areas that have suffered prior trauma, identical both clinically and histopathologically to the pre-existing dermatosis.[1,2] Its pathogenesis remains little known, and is probably multifactorial, although it has been suggested that capillary changes take place in the dermis that precede all the morphological changes.[3] Although it is well known in conditions such as psoriasis or vitiligo, Koebner's phenomenon has been described in many other dermatoses.[1] Because there are so few cases published in the literature, vasculitis is included in the group of diseases that manifest this phenomenon less frequently.[1,4] We present a case of idiopathic leukocytoclastic vasculitis with a striking Koebner's phenomenon in areas of scratching.

A 53-year-old woman, with no history of interest, consulted with a 3-day history of pruriginous erythematous-purpuric lesions on both lower limbs. The lesions were palpable, and did not disappear on diascopy. On both anterior pre-tibial surfaces they grouped and converged presenting a clear linear distribution, which was more intense on the right side (Fig. 1A and B). Although the patient admitted scratching due to her pruritis, there were no signs of abrasion. When her clinical history was taken she denied any intake of mushrooms or drugs. And she reported no gastrointestinal, respiratory tract, joint pain or other symptoms in previous days. A differential diagnosis was suggested between vasculitis or purpuric gloves and socks manifested as Koebner's phenomenon, and flagellate dermatitis. Peripheral blood, urine sediment analysis and chest x-ray showed no alterations, and autoimmune studies (ANA, ANCA, C3, C4 and CH50), and serologies (HBV, HCV and HIV) were negative. Skin biopsy reported leukocytoclastic vasculitis, and direct immunofluorescence study was negative.

Small-vessel leukocytoclastic vasculitis of the skin is mediated by a type III hypersensitivity reaction, and is due to the development of circulating immune complexes and their deposit in vessels

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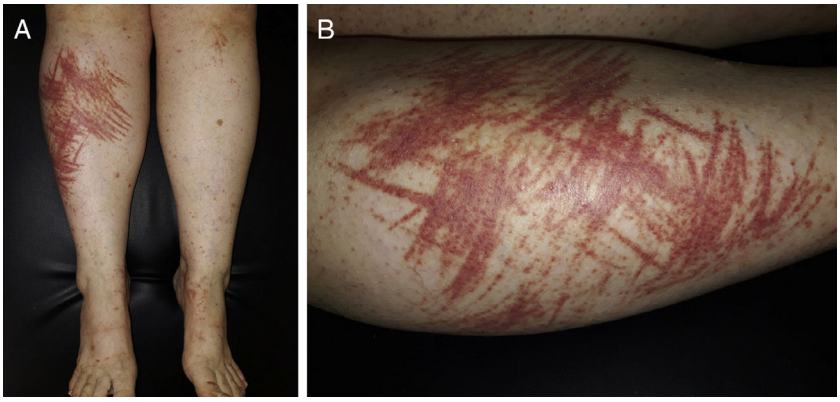

Fig. 1. (A) Palpable purpuric lesions on both lower limbs, grouped in a linear and confluent distribution. (B) Detail of the lesions on the right pre-tibial area.

of the superficial plexus, which causes inflammation and necrosis.[5] There are many factors that can influence deposit of immune complexes in the vascular wall, such as the permeability of the vessels, the size and nature of the immune complex, hydrodynamic forces, etc.[4,6] In the case of our patient, we believe that scratching was the trigger that activated deposit of immune complexes in the vessels of the superficial plexus of the damaged skin.

Despite the particular form of presentation of this case, with marked linear distribution of the lesions, leukocytoclastic vasculitis with Koebner's phenomenon was suggested as the first diagnostic option, given the analysis of the elementary lesion as a guide sign (palpable purpura that did not disappear on diascopy), the fact that the studies were normal, and that there was no history of mushroom intake.

We present a case of leukocytoclastic vasculitis with marked and infrequent Koebner's isomorphic phenomenon in areas of scratching. This case highlights the importance of detailed clinical history taking and analysis of elementary lesions, to guide a diagnosis of dermatosis with an atypical pattern of presentation.

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