

Dr. Claudepierre and Dr. Thomas reply

To the Editor:

We thank Prof. Toussirof for providing data on new-onset psoriasis in patients taking rituximab (RTX) for rheumatoid arthritis (RA)¹. His case report is well documented, with a dermatologist confirmation and a typical illustration of psoriasis, although no biopsy was performed. In this case, a link between RTX therapy and new-onset psoriasis is suggested. Nevertheless, it may also be hypothesized that emergence of psoriasis is independent of RTX treatment and is eventually triggered by the decrease of corticosteroids; indeed, data on progression of psoriasis lesion after the second course of RTX are not available, and the causality of RTX in the occurrence of psoriasis is thus at most "possible."

In our large observational prospective cohort, among 1927 patients taking RTX for RA, only 2 experienced new-onset psoriasis, including the patient in whom the diagnosis of psoriasis was established retrospectively from patient's description; further, these 2 cases had only a "doubtful" causality². Our study did not support a role for RTX therapy in new-onset psoriasis, but because of a weak incidence rate with a wide CI, we could not definitely eliminate it. We also pointed out that, in contrast to tumor necrosis factor- α antagonists, the case reports for RTX were not linked by a consistent clinical pattern, time-course, or site involvement^{3,4,5,6}. For example, the 2 new-onset psoriasis cases described in our study cleared after a few weeks, while in the case described by Toussirof, psoriasis lesions remained stable.

Thus, no firm conclusions can be drawn, and if RTX could induce psoriasis lesions, the incidence is very rare, regarding its prescription. Nevertheless, clinicians should be aware of a possible but uncertain role of B cell depletion with RTX in the development of psoriasis, in a few patients.

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