

Regarding the number of sessions per week, most patients (138 or 83.1%) reported having two sessions.

The average number of sessions at the time of the interview was 78 (SD = 62.8), ranging from 10 to 254. The sessions were performed without interruption in 90 individuals (54.2%).

Only 27 subjects (16.3%) reported adverse events. First-degree burn was the most prevalent adverse event (63%) and was caused by UVB in 81.3% of the cases.

The association of phototherapy with other treatments (topical, systemic drugs or both) was reported by 100% of the sample.

In relation to the degree of satisfaction with the treatment, more than 90% (150 individuals) of the sample were satisfied, and about 40% were very satisfied.

This is an original study designed to fill a gap in the literature by describing the profile of a phototherapy sector in a reference dermatology center. Comparative analysis of the data from this study is difficult given the paucity of similar studies.

The predominance of older individuals in our study may be justified by the presence of comorbidities or contraindications to conventional treatments, making phototherapy an excellent isolated or adjuvant therapeutic option. Powell and Gach<sup>3</sup> reported phototherapy as well tolerated, safe, and effective in their study, suggesting a likely future increase in the indication/adherence to this treatment.

The prevalence of females and low phototypes was in agreement with the findings of Casara *et al.*<sup>4</sup> and are possibly justified by a greater female concern with health and aesthetics and by the predominant ethnic profile in the region.

The prevalence of vitiligo and psoriasis as the dermatoses most treated with phototherapy was also in agreement with the literature.<sup>4,5</sup>

Our phototherapy-specific data are original, serving as the basis for future studies. The most prevalent adverse effect revealed by our study and the combined use of phototherapy with other medications are also in agreement with the literature.<sup>4</sup>

Although the accessibility to the phototherapy unit constitutes an important limiting factor to this type of treatment, the degree of satisfaction reported by patients motivates its use.

This study allowed to describe the profile of a phototherapy sector from a reference dermatology center, corroborating the literature and providing original data that could be used in future studies. □

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#### Rickettsial diseases in Brazil: report of a case with varicella-like skin lesions\*

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Dear editor,

A 66-year-old male patient began to experience headache, fever, myalgia, and general malaise three days after returning from a farmhouse in São Sebastião do Paraíso, in the state of Minas Gerais, Brazil, where he stayed for five days. After five days, the patient reported cough, dyspnea, diarrhea, and rash, and was hospitalized for evaluation. Physical examination showed a BP of 130x80 mmHg, HR of 100 BPM, RR of 21 IPM, temperature of 38.5°C, O<sub>2</sub>Sat of 90% in ambient air, and O<sub>2</sub>Sat of 94% with 3L/min via nasal cannulae. The patient was in regular state and tachypneic. Respiratory auscultation showed bilateral crepitation. Dermatological examination revealed erythematous macules, papules, vesicles, pustules, and vesiculo-crusted lesions on the trunk, back, and in the cervical region. We also observed an erythematous papule topped by a vesicle showing a necrotic spot in the right scapular region (Figure 1). Chest x-ray performed on the third day of his symptoms revealed bilat-

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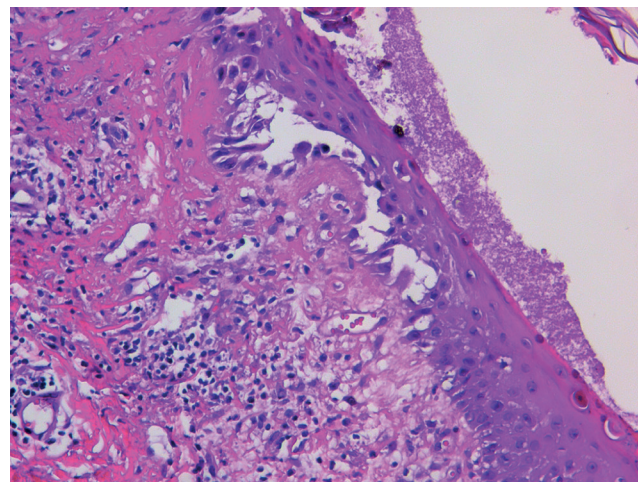
eral perihilar opacification. On the seventh day, however, another x-ray showed opacification of two thirds of the right lung. Chest tomography showed an alveolar lesion in the upper portion of the lower lobe of the right lung intermingled with air bronchogram extending to the pleural surface, in addition to paraseptal emphysema and pleural effusion. The patient had no clinical improvement after seven days of treatment with ceftriaxone (2g/daily), clarithromycin (500mg/twice daily), and acyclovir (5mg/kg/every eight hours) (Figure 2).

An interconsultation with the dermatology department was then requested. Although the patient denied having had a tick

bite during his stay in São Sebastião do Paraíso, the hypothesis of spotted fever was raised. We requested serology tests for spotted fever, viral hepatitis, herpes types 1 and 2, HIV, syphilis, and Lyme disease. We also biopsied two erythematous macules of the flanks. The patient showed positive serology results for spotted fever with anti-Proteus OX-2 antibody (1/160), anti-Proteus OX-19 antibody (1/160), and anti-Proteus OX-K antibody (1/160). Serology tests for hepatitis A, B, and C, herpes types 1 and 2, HIV, syphilis, and Lyme borreliosis were negative. Histopathological examination of the lesions showed a hydropic degeneration of basal cells with subepidermal clefts and detachment of parts of the epidermis. We also observed individual and confluent necrosis of keratinocytes with accumulation of neutrophils, fibrin, and crusts. The dermis showed perivascular and superficial inflammatory lymphomononuclear interstitial infiltrates. Vacuolar dermatitis of interface with keratinocyte necrosis was thus revealed (Figure 3). The patient was treated with doxycycline (100mg/twice daily). On the second day of treatment, he had no fever and reported decreases in headache



**FIGURE 1:** Polymorphous eruption (papules and erythematous macules, vesicles) predominantly on the trunk on the day of hospital admission. Note an erythematous papule with a raised vesicle showing a necrotic spot (arrow)



**FIGURE 3:** Hydropic degeneration of basal cells with subepidermal clefts, detachment of parts of the epidermis, individual and confluent necrosis of keratinocytes and accumulation of neutrophils, fibrin, and crusts. Dermis revealing superficial and perivascular inflammatory lymphomononuclear infiltrates (Hematoxylin & eosin, X200)



**FIGURE 2:** A and B. Maculopapular rash and varicelliform eruption. Presence of erythematous macules and papules, vesicles, and some exulcerated lesions with a necrotic center

and myalgia. At the end of doxycycline treatment for seven days, he was asymptomatic and with no cutaneous lesions. We repeated serology tests for spotted fever 30 days later, observing a drop in titration and negative results for the three antibodies: anti-Proteus OX-2 (less than 1/20), anti-Proteus OX-19 (1/80), and anti-Proteus OX-K (less than 1/80).

Spotted fever is a rickettsial disease that manifests itself as an acute, febrile infectious disease of varying severity.<sup>1,2</sup> Human rickettsial diseases already described in Brazil can be classified into three groups: classical, atypical, and new or recently described. Classical rickettsioses common symptoms include high fever with sudden onset and frequent exanthema. Atypical rickettsioses feature a poorly defined clinical picture and may go unnoticed, without clinical or laboratory diagnosis. The third group, new rickettsiosis, includes vesicular rickettsial infection (rickettsialpox), Debonel/Tibola, perimiocarditis, and rickettsia felis.<sup>3</sup>

Its diagnosis can be considered a challenge because many physicians are not familiar with the nonspecific symptoms of the early stages of the disease. The Weil-Felix method is easy to implement and inexpensive. The reaction detects antibodies in the serum of patients, which react with different strains or species of Proteus. Each species has antigenic epitopes similar to the lipopolysaccharides of the rickettsia membranes of the different groups. Its positivity indicates only the presence of an infection caused by rickettsia. The gold standard for the diagnosis of rickettsial disease is indirect immunofluorescence, which uses species-specific rickettsia antigens.<sup>4,5</sup>

This report may represent a description of a rickettsial disease not observed in Brazil to date: vesicular rickettsial disease. Characterized as a benign disease that manifests itself about a week after the bite of a parasitic mite of the mouse *Mus musculus*, the disease reveals a reddish and painless papule at the inoculation site, which becomes vesicular, associated with sudden fever with tremors, accompanied or not by vesicular exanthema similar to that of varicella.<sup>1,3,4</sup>

Perceptions of the importance of diseases caused by rickettsia in public health has been increasing. Its early diagnosis is fundamental and decisive to avoid therapy delays. The authors emphasize that clinical evaluation is still the fastest and most precious diagnostic methods and highlight the importance of a dermatologist in the hospital environment. □

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## Treatment of reaction to red tattoo ink with intralesional triamcinolone\*

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Dear Editor,

Body tattoos are becoming increasingly popular. A national survey revealed that approximately a quarter of American adults aged between 18 and 50 years had tattoos.<sup>1</sup> Dermatologists worldwide are requested for tattoo removal, counseling, and treatment for tattoo reactions. No consistently effective treatment for tattoo reactions has been reported to date.<sup>2</sup> If the tattoo reaction area is small, surgical excision, 10,600-nm CO<sub>2</sub> laser, cryosurgery, or radiofrequency ablation may be performed. However, in cases of multiple tattoos or large surface area with reaction, or ablation over the lower extremities, the risk of suboptimal scar development is high. A

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