

Besides, airborne eczema is a difficult differential diagnosis.⁴ The clinic symptoms can be varied, with a marked photodistribution and can sometimes mimic cutaneous lymphoma, especially if the patient has erythroderma.⁵ This is the only pathological condition where a collapsed MED is found.⁶ In the literature, a 2009 London study⁷ reports four cases of erythrodermic T lymphomas with severe photosensitivity mimicking chronic actinic dermatitis. The profile of their lymphocytes was CD8+ in half of the cases, skin eruption had a marked photodistribution, and the MED was collapsed. As a result, it can be questioned that malignant T cells recognize UV-induced neoAg, which in turn gives the lymphoma characteristics of chronic actinic dermatitis. Moreover, in a Japanese study⁸ of 2017, patients with erythrodermic chronic actinic dermatitis had a predominance of circulating CD8+ T cells and the authors demonstrated a potential relationship between the haematologic burden of circulating CD8+ T cells and the skin burden of skin-infiltrating CD8+ T cells.

The case of our patient is a reminder that chronic actinic dermatitis is not always an easy diagnosis.

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Metabolic syndrome and atopic dermatitis: reconsidering the definition criteria

Editor

Shalom *et al.*¹ should be congratulated for their study on the association between atopic dermatitis (AD) and metabolic syndrome (MetS) and its components (obesity, hypertension, dyslipidaemia and diabetes). The study provides new evidence on a highly conflicting topic. According to a recent systematic review, the existing data are very inconsistent,² especially concerning the association between AD and hypertension. In that study, a positive association between AD and hypertension was reported in six out of 11 included studies, an inverse association was found in three studies, and no association was reported in two studies.²

Shalom *et al.*¹ showed that the prevalence of hypertension was comparable between AD adults and the general population, whereas it was more prevalent in moderate-to-severe AD adults than general population (age and sex matched). Furthermore, MetS in AD adults was significantly less prevalent than general population, while in contrast an increased prevalence of MetS was observed in moderate-to-severe AD adults.

We would like to comment that a potential confounding factor that might be partially responsible for the above-mentioned controversies is related to the criteria used for the definition of MetS and hypertension. In the literature, the definition of MetS is not consistent, rendering difficult to compare data from studies using variable criteria. The National Cholesterol Education Program Adult Treatment Panel III (ATP III) is the most widely used.³ In this study,¹ diagnosis of hypertension was made if several measurements of a systolic blood pressure (SBP) were above 140 mmHg or a diastolic blood pressure (DBP) above 90 mmHg during at least a 1-month period of follow-up. This definition is different from ATP III criteria and does not seem to include the antihypertensive drug treatment in the definition of hypertensive subjects.

Finally, according to the new 2017 ACC/AHA guidelines for the prevention, detection, evaluation and management of high blood pressure in adults,⁴ the classification of blood pressure (BP) levels is redefined as: ‘normal BP’ when SBP and DBP are below 120/80 mmHg; ‘elevated BP’ for SBP between 120 and 129 mmHg and DBP below 80 mmHg; ‘Stage-1 hypertension’ for SBP between 130 and 139 mmHg or DBP between 80 and 89 mmHg; and ‘Stage-2 hypertension’ for SBP/DBP above 140/90 mmHg. It might be clinically relevant to further explore the relationship of AD with hypertension and MetS according to ATP III criteria and also using the new proposed BP criteria for the definition of hypertension.

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Clinical criteria and sensitivity – what should be preferred when we tackle highly conflicting issues

Response to ‘Metabolic syndrome and atopic dermatitis: reconsidering the definition criteria’

Dear Editor,

We read the letter by Alexandraki *et al.*¹ with great interest, and we thank them for their highly important comment concerning our study entitled ‘Atopic Dermatitis and the Metabolic Syndrome’.² As discussed by Alexandraki, the association between the atopic dermatitis (AD) and the metabolic syndrome (MS) is very disputable, since the current data are highly conflicting. This is true with regard to the specific association between AD and hypertension.

Our study² was aimed to explore the association in the most sensitive manner, since the burden of proof is currently upon us, as investigators claiming for such association. Therefore, our

study was designed in that spirit and we decided to choose the strictest criteria for all investigated variables in a manner that will make the association harder to appear. Although Alexandraki suggestions are correct, using their criteria would have revealed stronger association (i.e. the increase in the numbers of patients with hypertension and MS in the AD group is higher than the respective increase in the controls). Nevertheless, the sensitivity of the extracted data would have dropped following this manipulation and therefore was not in line with our aims and was not adopted when the study was designed.

Taken collectively, we feel that the report by Alexandraki *et al.* does not contradict our report. Their comment completes rather than conflict our report: while the association we observed stands in our strict criteria, it would have strengthened if Alexandraki *et al.* criteria were adopted.

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Efficacy of intravenous immunoglobulins for laryngopharyngeal lesions and upper airway obstruction in epidermolysis bullosa acquisita

Dear Editor

Epidermolysis bullosa acquisita (EBA) is a rare type of autoimmune blistering disease, which is characterized by autoantibodies against type VII collagen.¹ Patients with EBA exhibit blisters or