origin of TLE, and consider it a photodermatosis outside the CLE spectrum.[7,8] However, we believe that classification of TLE as a true lupus subtype is justified based on the evidence published to date, in particular the coexistence of TLE and DLE lesions in certain patients,[3–5,9,10] as in the present case. Our description of a case of coexisting TLE and DLE adds to the small number of such cases reported in the literature, and should help resolve some of the controversy surrounding TLE, facilitating earlier diagnosis of this entity and better management of affected patients.

Conflicts of Interest

The authors declare that they have no conflicts of interest.

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Paradoxical Arthritis Due to Ixekizumab in a Patient With Plaque Psoriasis☆

Artritis paradójica por ixekizumab en un paciente con psoriasis en placas

To the Editor:

Our patient was a 46-year-old man who had been diagnosed with plaque psoriasis 27 years earlier and reported no previous axial or peripheral joint signs. Over the preceding years he had responded poorly to narrowband ultraviolet-B phototherapy, methotrexate, cyclosporine, etanercept, adalimumab, ustekinumab, and infliximab. At the time of the consultation he had numerous generalized plaques (psoriasis area and severity index [PASI], 10). Treatment was started with subcutaneous ixekizumab at the usual dose. After the first dose of 160 mg, the patient reported generalized migratory arthralgias that intensified and became disabling after the second dose of 80 mg, prompting an emergency visit to the rheumatology service. Physical examination revealed pain and marked limitation of cervical spinal cord mobility with no involvement of the lumbar or sacroiliac spinal cord (normal response in the Schober test and negative response to sacroiliac manipulation), pain and limited mobility of the scapular and pelvic girdles, pain and mild swelling of the carpal joints, and pain without swelling in the ankles, knees, and the small joints of the fingers. The painful joint count (PJC28) was 10 (carpal joints, knees, shoulders, and second and third bilateral metacarpophalangeal joints), and the swollen joint count (SJC28) was 2 (carpal joints). Based on these findings, the patient was diagnosed with paradoxical arthritis. With the patient's consent ixekizumab treatment was discontinued, and he was treated with a tapering dose of oral prednisone (20 mg/d) for 10 days, resulting in almost complete resolution of the joint problems. Upon reaching the end of the corticosteroid regimen, the patient was treated with secukinumab at the usual dose (300 mg). After 10 months of coordinated monitoring by the dermatology and rheumatology services, the patient's psoriasis had markedly improved (PASI, 1), with no adverse effects or joint symptoms.

Ixekizumab is a humanized IgG4 monoclonal antibody that acts to neutralize IL-17A, and in clinical trials has shown high efficacy in patients with plaque psoriasis[1] and psoriatic arthritis,[2] with an acceptable safety profile[3] and no

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adverse effects on joints. In the present case, the coincidence of ixekizumab injections and the sudden onset of joint symptoms in a patient with no history of arthritis, together with the progressive disappearance of these symptoms after ixekizumab discontinuation, suggest a causal relationship between ixekizumab and this adverse effect. The literature describes several cases of so-called paradoxical psoriatic arthritis coinciding with the use of biological treatments for plaque psoriasis, including efalizumab,[4] etanercept, adalimumab,[5] infliximab, and ustekinumab,[6] but none involving IL-17 inhibitors. The appearance of paradoxical psoriatic arthritis in this case underscores the pathogenic complexity of this disease.

In conclusion, despite the absence from the literature of any reports of adverse joint effects caused by ixekizumab, we describe a case of paradoxical arthritis that was associated with ixekizumab treatment, discontinuation of which was ultimately required. Long-term follow-up studies will be necessary to determine the frequency and causality of this adverse effect.

Conflicts of Interest

The authors declare that they have no conflicts of interest.

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