1 culture (6%), and 3 cultures (17.5%) were sterile. A total of 10 patients (29%) had cutaneous biopsy performed; all presented with neutrophilic folliculitis with preserved sebaceous glands; 4 patients had *Malassezia* spores and one had *Demodex folliculorum*. All 34 patients received doxycycline, 100 mg daily for 12 weeks, as first-line therapy, with only 4 failing the therapy; withdrawal led to a rapid relapse in the remaining 30. Eight patients took rifampin plus clindamycin (each drug was administered in a dose of 300 mg twice daily for 10 weeks); during that time, all 8 patients cleared but again experienced rapid relapse upon withdrawal of the drugs. A total of 18 patients were treated with isotretinoin, 10 to 20 mg daily; all achieved complete response, except for 1 who had few active lesions. Eight patients continued receiving isotretinoin therapy and cleared or almost cleared, with 6 of them taking 10 mg on a nondaily basis (every 2-5 days) and 2 taking 10 mg daily; the other 10 stopped taking isotretinoin after 6 to 12 months and remain clear after 1 to 28 months of follow-up. The cumulative dose ranged from 2000 to 9000 mg.

Our series is the third largest. Lee[1] described 80 patients, 48 of whom had SF, and Hersle[2] reported 40 more patients. Strikingly, all the patients in our series were men; in contrast, in Lee's series, 4 of 48 patients were women, and in Hersle's study, the ratio of men to women was 3:1. The lesions were almost always on the occipital area; generalized lesions were rare. In our study, 85% of cultures were negative or with saprophyte flora; in contrast, in Lee's study, 30% of cultures were positive for *S aureus*. Antibiotics did not provide further improvement compared with that in patients with negative cultures.[1] We agree with Lee about the inflammatory hypothesis of SF rather than the infectious hypothesis on account of sterile cultures and better response to isotretinoin than to antibiotics. Moreover, the temporary clearing with anti-inflammatory doxycycline doses in the majority of patients also supports the inflammatory hypothesis, although the number of patients is too low to verify this. We do not believe that either saprophyte flora or other isolations have a causative role in the disease. One of the study limitations is lack of a trial with topical therapy. Clindamycin solution, benzoyl peroxide wash, and topical steroids may be beneficial. In conclusion, in this condition, we propose starting doxycycline, 100 mg daily, for 3 months, and then if relapse occurs, administering isotretinoin, 10 mg daily, for 3 months and tapering to the lowest dose (every 2-5 days) that maintains remission. Withdrawals after 6 or more months if clearing is achieved may lead to long disease-free intervals. Using long-term, low-dose isotretinoin could be a limitation in countries in which prescribing is highly regulated.

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A new 1-sided nail brace for ingrown toenails of lesser toes

To the Editor: Ingrown toenails usually affect the big toe but might also occur on the lesser toes. Surgery with phenolization of the lateral matrix horn is the most commonly performed treatment.[1] However, poor cosmetic outcomes after surgery are not uncommon for lesser toes because the nail plates are smaller. Nail brace application is a noninvasive treatment for ingrown toenails.[2,3] However, the currently reported 2-sided nail braces are usually too bulky for the curved nails of the lesser toes.

Consequently, we propose the use of a 1-sided nail brace consisting of a spring wire and a plastic pad. This nail brace has been reported to have good efficacy for ingrown toenails of big toes.[3] The length of the wire can be adjusted according to the size of the nail. The wire is shaped into a hook and attached

Fig 1. A patient with severe ingrown toenails. The patient received nail brace treatment for both sides of the big toenails and both sides of 3 lesser toenails.

Fig 2. Ingrown toenails after treatment. The shapes of the ingrown toenails were restored after 6 months of nail brace treatment.

to 1 side of the nail rim, and the pad is glued onto the nail. The nail brace exerts a bending force via the restoring torque of the wire, facilitating correction of deformed nails.

We retrospectively collected the treatment data on patients with ingrown toenails of lesser toes who were treated at the Dermatology Clinic of Wan Fang Hospital, Taipei Medical University, Taipei, Taiwan, between June 1, 2017, and May 31, 2018. This study was approved by the joint institutional review board of Taipei Medical University.

A total of 10 patients with 19 ingrown toenails (11 second toes, 4 third toes, and 4 fourth toes) and 28 affected sides (10 unilaterally and 9 bilaterally affected toes) were recruited. Of these 10 patients, 2 were men and 8 were women, and their mean age was 50.1 plus or minus 15.3 years (range, 27-80 years). All affected sides achieved at least 90% improvement based on the Physician's Global Assessment (Figs 1 and 2). The mean treatment duration and follow-up period (after nail brace removal) were 122.5 plus or minus 73.3 days (range, 30-259 days) and 174.5 plus or minus 100.8 days (range, 33-427 days), respectively. The treatment duration for unilaterally affected toes was much shorter than that for bilaterally affected toes (68.6 days vs 182.3 days). Bilaterally affected toes required a longer treatment duration because they were treated first on the 1 side and then on the other side because of limited space on the nail plates. No recurrence was noted during the entire follow-up period.

Compared with conventional 2-sided nail braces, the wire length of 1-sided nail braces can be more easily adjusted and the braces require less space on the nail plates, which is particularly useful for treating ingrown nails of lesser toes. In conclusion, this novel 1-sided nail brace was easily operated and showed good efficacy along with a low recurrence rate for treating ingrown toenails of lesser toes.

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Patients left behind: Rare dermatologic conditions miss the orphan drug development boom

To the Editor: Orphan drugs are those indicated for the treatment of uncommon conditions and are granted 7 years of exclusivity by the US Food and Drug Administration. As a result of this designation, there has been a considerable increase in rare disease research, pharmaceutical development, and market expenditures[1]; however, we hypothesize that rare dermatologic diseases have been relatively neglected.