## Reply to: "Comment on 'Folliculitis decalvans: Effectiveness of therapies and prognostic factors in a multicenter series of 60 patients with long-term follow-up'"

*To the Editor*: We have read the letter by Litaiem et al[1] and thank them for their interest and critical appraisal of our report on the effectiveness of therapies for patients with folliculitis decalvans (FD).[2]

Regarding their comment about the absence of significant statistical differences between treatment regimens with rifampicin and clindamycin versus isotretinoin in multivariate analyses, we think that it is caused by the small sample size, which decreases the statistical power. As we have already commented, one of the main limitations of our study, despite of being a multicenter study, was the difficulty of recruitment of patients with FD with a minimum period of 5 years of follow-up, because the incidence of FD is low.

Oral isotretinoin is a classic therapy for FD.[3] The largest published series[2,4] described a lower effectiveness of oral isotretinoin compared with oral antibiotics in FD. Some reports show the potential usefulness of oral isotretinoin at higher doses (usually ≥40 mg/day).[5] It should be taken in account for recalcitrant cases with early relapses after stopping the treatment. Nevertheless, in our opinion, these higher doses produce several side effects, such as xerosis, epistaxis, and hypercholesterolemia, that make compliance with treatment more difficult.

On the other hand, we agree with Litaiem et al[1] that resistance to antimicrobials is a problem of increasing importance. *Staphylococcus aureus* is not isolated in scalp pustules from all patients with FD, so we believe that the mechanism of oral antibiotics in the treatment of FD is due not only to the to the antimicrobial effect, but also to the antiinflammatory properties of these drugs.[2]

Finding therapeutic alternatives for FD to be used in combination with topical and intralesional treatments is a challenge for dermatologists. New local therapeutic approaches will hopefully decrease the number of cycles of oral drugs. Recently, the use of photodynamic therapy for the treatment of FD has been described with promising results in select patients.[6,7] In addition, the tumor necrosis factor inhibitors adalimumab and infliximab have been used in recalcitrant cases of FD.[8] Ongoing and future studies about cutaneous microbiota in patients with FD could give us more clues about its pathogenesis, opening new lines of research for finding new therapies.

In conclusion, FD is a therapeutic challenge, and the combination of treatments is necessary to reduce outbreaks. We believe that oral isotretinoin at doses ≥0.4 mg/kg daily may be an interesting option for patients who are resistant to oral antibiotic and intralesional steroids or patients who have early clinical relapses. However, the safety profile of high-dose oral isotretinoin may be troublesome and should be discussed with the patients.

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