chloramphenicol and cycloheximide resulted diagnostic for *Trichophyton (T.) mentagrophytes*. Consequently, the diagnosis of Kerion Celsi caused by *T. mentagrophytes* was made. Treatment with oral griseofulvin (1 g/die) once daily resulted in almost complete remission within three weeks. Therapy was continued for 6 weeks and no recurrence of the infection at the 9-weeks follow-up occurred (Figure 1D). Nevertheless, a scarring alopecia resulted after healing. Kerion is a severe inflammatory form of TC, with a T-cell-mediated hypersensitivity reaction against dermatophyte fungi.[3] Our case is interesting also for the patient's age: TC occurs primarily in prepubertal children, while limited data are reported on adults.[4] Because of these clinical features, kerion is often misdiagnosed and confused with a bacterial infection, thus delaying proper treatment, and allowing the spread of infection.[5] A culture for fungi is the gold standard to confirm the diagnosis, supported also by dermoscopic and Wood's lamp examinations.[4] Treatment can be challenging and established clinical guidelines for kerion are still missing. Systemic antifungal therapy is needed for treatment, with griseofulvin, terbinafine, fluconazole or itraconazole being the treatments of choice.[6] Thus, purulent plaque and nodules of the scalp often constitute a diagnostic challenge to the dermatologist. Due to the possible complications of kerion, such as scarring alopecia and spread of infection, we want to highlight the importance of including fungal infection in the differential diagnosis for dermatologic illnesses of the scalp, even in adult patients, in order to avoid misdiagnosis, delayed treatment and unnecessary invasive procedures (*e.g.*, surgical drainage).

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Primary malignant melanoma of uterine cervix

Mucosal melanomas account for less than 0.03% of all newly diagnosed cancers and only 2% of those are discovered in female genital tract.[1] Vulva and vagina are the most frequent site of malignant melanoma in the female genital tract while the development in the uterine cervix is rarer.[2, 3] We report the case of a 68-year-old patient, in follow-up for a previous vulvar squamous cancer (pT1b N0 G2) and with a medical history of type II diabetes mellitus, hypertension and obliterating arteriopathy of the lower limbs with previous amputation of the right forefoot. One year after the radical vulvectomy and bilateral inguinal lymphadenectomy, she presented with genital bleeding and for this reason she has undergone gynecological evaluation and cervical smear (Papanicolaou test), with detection of epithelial cell abnormalities, deposing for a malignancy. Speculum examination was not clear, so a biopsy of the uterine cervix was taken. The histopathology showed a neoplastic tissue characterized by atypical cellular elements of medium and large size, conspicuous nucleoli,

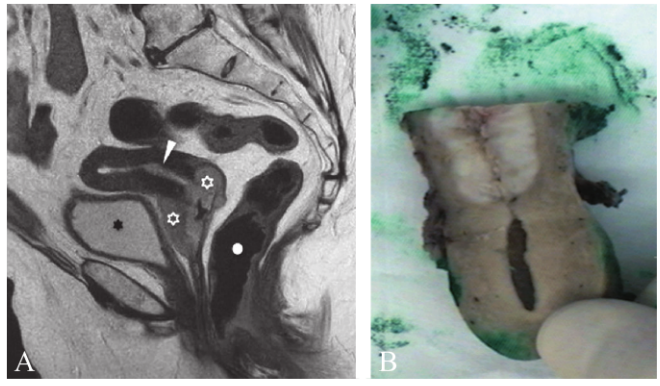

Figure 1.—A) Sagittal T2 weighted image. Bladder (black star). Rectum (white dot). The image shows well-defined malignant solid tissue diffusely involving the cervix of the uterus (empty stars) with direct invasion into the cervical lumen (arrowhead). The cervix uteri shows an overall thickening due to the tumor mass. The fornixes of the vagina are almost completely obliterated by the mass, with only a small area of the upper vaginal lumen patent. B) Horizontal section of postoperative uterine specimen.

abnormal mitotic figures and focal cytoplasmic accumulation of melanin-like pigment. Immunohistochemical profile of the specimen was positive for S-100, vimentin and Ki-67, negative for cytokeratin AE/E3 and cytokeratin CD31, CD34, CD10. Morphological and immunohistochemical findings were compatible with malignant melanoma. The patient underwent an extensive search for melanocytic lesion of skin in the suspicion of metastatic cutaneous melanoma, which was negative. Radiological evaluation showed that there was no evidence of extra cervical disease on a computed tomography (CT) scan of head, chest and abdomen but, on magnetic resonance imaging (MRI) imaging, a massive lesion occupying the cervix (39×30×55 mm) was identified (Figure 1A). There was no evidence of parametrial involvement, lymph node swellings in the groin or at the level of the external iliac nodes. The patient underwent a total hysterectomy and bilateral salpingo-ophorectomy, with dissection of para-iliac and obturator lymph nodes and no signs of peritoneal spread of disease were observed. Histology and immunohistochemistry confirmed the diagnosis of malignant melanoma (pT4b, N0, M0 – FIGO II) of uterine cervix, infiltrating the soft tissue near cervix (Figure 1B). The histological sample showed ulceration, the mitotic count was up to 6 per 10 high-powered fields and BRAF mutation was negative (Figure 1A, B). After surgery, the patient refused other treatments and/or follow-up. Two months later, due to a worsening of symptoms, a CT scan of the abdomen was performed, showing the presence of liver, lung and bones metastases and, unfortunately, the patient died the following month. To date, primary melanomas of the female genital tract are a rare entity with biologically aggressive characteristics. Optimal management consists of individualized surgery, clinical- radiological integration, adjuvant therapy and close follow-up, although aggressive biological behavior makes melanocytic mucosal neoplasm highly lethal.[4]

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The antidrug antibodies detection: a valuable tool for clinical response loss in psoriatic patients?

The efficacy of anti-TNF-α agents in psoriatic patients is well-documented.[1, 2] However, a substantial proportion of these patients do not respond to anti-TNF-α therapy.[3, 4] One of the supposed reasons has been attributable to antidrug antibodies (aDAbs).[3-5] Here, we evaluated if the detection of aDAbs at week (W)-12 could have a predictive value over time in psoriatic patients treated with anti-TNF-α agents.

Our study comprised 85 naïve subjects to biologics. Inclusion criteria were both sexes, age ≥18 years, diagnosis of psoriasis (Pso) (PASI≥10) with or without psoriatic arthritis (PsA). The latter was classified according to CASPAR criteria. Patients were treated with adalimumab (ADL) or etanercept (ETN). Both treatments were administered following the recommended dosing schedules for plaque psoriasis. Patients were followed up to W-104 with planned assessments at W-0, W-12, W-52 and W-104. At W-12, a peripheral blood sample was taken from each patient. Quantification of serum anti-ADL or anti-ETN Abs was checked by ELISA (Progenika-Biopharma; Bilbao, Spain).

Non-responders (NRS) were defined as not achieving a 50% reduction of PASI from baseline at W-12 or having a loss of PASI50 treatment response during the study follow-up period.

Responders (RS) were defined as having a 75% reduction of PASI from baseline at W-12, whereas partial responders as patients achieving an improvement of PASI from baseline comprised between 50% and 75% at W-12.

Descriptive statistics were calculated for each variable using frequencies and percentage for categorical variables, whereas mean±standard deviation for continuous ones. Efficacy data were analyzed using the "as-observed" approach to manage missing val-