In August 2021, we proposed treatment with benralizumab prescribed at a US Food and Drug Administration–approved dose of 30 mg via subcutaneous injection every 4 weeks for the first 3 doses, and then every 8 weeks. Rapid and complete resolution of her cutaneous lesions occurred during the induction phase of therapy, with minimal relapse once maintenance therapy was initiated at 8-week intervals (Figure 1, B). Biopsy results from February 2022 showed perivascular and interstitial lymphocytic inflammation with a substantial decrease of eosinophils compared with the previous biopsy (Figure 2, C and D). As of last follow-up, the patient continued to receive treatment without pruritus and with limited lesions arising when the next dose time approached.

Discussion | Eosinophilic annular erythema is a benign, unusual condition, with approximately 60 cases reported in the literature. To our knowledge, there are no treatment guidelines, with only few cases responding to different drugs, including oral corticosteroids, indomethacin, doxycycline, hydroxychloroquine, methotrexate, dapsone, nicotinamide, or narrowband UV-B phototherapy. Relapse of EAE has been reported once these therapies are discontinued.1

Although the pathogenesis of EAE is not fully understood, dysregulated tissue eosinophilia plays an important role. Interleukin 5 is produced by Th2-type lymphocytes, mast cells, natural killer cells, and eosinophils themselves. It causes migration of eosinophils from the bone marrow into the bloodstream. Interleukin 5 also promotes, together with Th2 cell-derived cytokines IL-4 and IL-13, eosinophil activation and tissue recruitment. By binding to IL-5Rα, it activates Janus kinase 2/signal transducer and activator of transcription 5 and tissue recruitment. By binding to IL-5Rα, it activates Janus kinase 2/signal transducer and activator of transcription 5 and

Therefore, drugs targeting Th2-type cytokines are potential first-line therapies for EAE. There are 2 case reports in which complete response was achieved with dupilumab, a dual IL-4 and IL-13 inhibitor.4,5 Another patient accomplished resolution with treatment with mepolizumab, an IL-5 inhibitor.1 Finally, there is 1 case report of a patient with severe asthma and cutaneous EAE who, after initiating treatment with benralizumab for her asthma, experienced improvement of her cutaneous lesions.5 While further research is needed, antibodies targeting the IL-5 signaling pathway could be an effective therapy for patients with recalcitrant EAE.

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CORRECTION

Error in Author Affiliations and Funding/Support: In the Original Investigation titled “Effect of Reflectance Confocal Microscopy for Suspect Lesions on Diagnostic Accuracy in Melanoma: A Randomized Clinical Trial,” published in the July 2022 issue, an affiliation for Prof Stanganelli was misstated. The correct affiliation is Skin Cancer Unit, Istituto Scientifico Romagnolo per lo Studio dei Tumori (IRSTR) IRCCS, Meldola, Italy. Additionally, a project code was added to the Funding/Support section. This article has been corrected.