BACKGROUND

Grover’s disease (GD) is a rare papular disorder with an incompletely characterized etiology. Corticosteroids yield resolution in roughly 64% of patients; however, rapid relapses often occur upon tapering.¹ There is a dearth of evidence for use of steroid-sparing immunosuppressive agents such as methotrexate (MTX) for GD.² Systemic retinoids are supported by a 100% response rate in a four-patient case series (75% complete clearance).³

METHODS

A retrospective review of patients treated with MTX or acitretin for GD at Wake Forest University School of Medicine between 2013-2020 was performed. Patients without biopsy-proven disease and patients without follow-up evaluation were excluded. Outcomes were classified as: complete clearance, partial response (reduced pruritus, fewer/flatter papules, less erythema), no response.

RESULTS

Fifteen GD patients treated with MTX or acitretin were identified. Patients presented with severely pruritic (100%) erythematous papules (100%) on the trunk (100%) and upper extremities (67%), with occasional burning pain (13%). Disease existed a mean 33 months before acitretin initiation (median dose 25 mg weekly, median duration 13 months), and a mean 6 months before MTX initiation (median dose 8.75 mg weekly, median duration 13 months). No acitretin responders flared upon discontinuation (median 6.5 months post-cessation), and both did not respond to subsequent MTX therapy. Four MTX responders flared during therapy and both did not respond to subsequent MTX therapy. Two MTX responders flared upon discontinuation (median 6.5 months post-MTX cessation; median follow-up evaluation period 26 months). No acitretin responders flared (median follow-up evaluation period 3 months). MTX and acitretin were well tolerated; one MTX patient (10%) complained of fatigue, and one acitretin patient (20%) experienced dry lips.

RESULTS CONTINUED

(70% vs 20% acitretin). Two MTX responders flared during therapy and both did not respond to subsequent MTX therapy. Four MTX responders flared upon discontinuation (median 6.5 months post-MTX cessation; median follow-up evaluation period 26 months). No acitretin responders flared (median follow-up evaluation period 3 months). MTX and acitretin were well tolerated; one MTX patient (10%) complained of fatigue, and one acitretin patient (20%) experienced dry lips.

CONCLUSIONS

Although this study is limited by a small sample size, non-standardized outcome measures, and flares which may occur as natural fluctuation of the disease, it appears MTX and acitretin may provide some disease control for patients with severe, persistent, and/or recalcitrant GD.

REFERENCES