



Figure 1. Patient's chest x-ray before (A) and after (B) corticosteroid treatment.

found and the patient's current situation was accepted as LON associated with rituximab. The number of neutrophils was normalized spontaneously, 6 days after admission but the depletion of Blymphocytes continued one more year. At this time the percent of T helpers (CD4) was low and of T suppressors was high. The patient is in complete remission 32 months after the last dose of R-CHOP with no pulmonary, neurologic or hematologic toxicity except the percent of T helper cells which is still just under the normal level.

Rituximab is generally well tolerated, whether given alone or with chemotherapeutic agents. When used alone, during rituximab treatment or 30 days after treatment, various side effects are observed in 84% of patients. However, 97% of these side effects are of grade 1 or 2 and the most commonly documented adverse events are acute, infusion-related reactions which are usually observed during the first administration. Nonetheless, these side effects aren't seen in 55% of patients on subsequent administration. However, with the increasing uses of rituximab, the rare late side effects started to be reported more frequently. LON, delay in the recovery of B lymphocyte function, infections, progressive multifocal leukoencephalopathy, hepatitis B virus reactivation, interstitial pneumonitis, and COP are some of them [4,5]. Although LON and COP have been reported increasingly more often, the pathogenetic mechanisms and risk factors are unclear [4,5].

In conclusion, as rituximab is being used more widely, and for extended periods of time, it is rather certain that a greater number of late side effects are to be expected in the future. Therefore, physicians need to be aware of rituximab-related late onset toxicities.

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Case detection rates of basal cell carcinoma by gender and age in Greek population

Dear Editor,

Basal cell carcinoma (BCC) is the most common cancer in humans, deriving from non keratinizing cells that originate in the basal layer of the epidermis. If left untreated, BCC can become invasive and may result in substantial tissue damage. Metastasis is a rare event [1]. A paucity of studies from Mediterranean climates prompted us to undertake the present study.

A cross-sectional methodology was used to analyse data (1995-

2002) from an outpatient setting of a dermatologic teaching clinic of a general state hospital. In Greek dermatology departments, outpatients are self-referred and ask directly for primary health care. Preoperatively, the diagnosis in obvious cases was clinical, whereas in patients with less typical lesions a histopathological confirmation was imperative.

The overall denominator and reference population consisted of 50,237 Greek dermatologic outpatients, aged 35 days to 96 years, consecutively examined by dermatologists. Males were 20,909 (41.6%) and females 29,328 (58.4%) (Table 1). The study includ-

Age group (years)	Men		Women		
	n/exam	BCC (%)	n/exam	BCC (%)	Significance
≤30	9681	4 (0.04)	12311	5 (0.04)	
31-50	4435	11 (0.25)	7741	12 (0.15)	
51-55	1012	9 (0.88)	1595	11 (0.7)	_
56-60	963	24 (2.5)	1570	17(1.1)	p=0.01, 1.2 CR2.3 < 4.6
61-65	1376	34 (2.5)	1831	23 (1.2)	p=0.01, 1.1 <or2.0<3.5< td=""></or2.0<3.5<>
66-70	1295	48 (3.7)	1756	60 (3.4)	*
71-75	1072	46 (4.3)	1284	54 (4.2)	_
76-80	558	28 (5.0)	693	37 (5.3)	—
>80	517	39 (7.5)	557	32 (5.7)	_
Total	20909	243 (1.2)	29328	251 (0.85)	p=0.009, 1.06 <mhwor1.3<1.5< td=""></mhwor1.3<1.5<>

Table 1. Case detection rates of basal cell carcinoma by gender and age

n/exam: number of patients examined, BCC (%): number of basal cell carcinoma cases (per cent), MHWOR: Mantel-Haenzel weighted odds ratio (OS) and Cornfield 95% confidence limits

ed only first-time referrals. Mantel-Haenszel x^2 stratified analysis was used to compare detection rates by age and gender without confounding effects [2]. Case detection rates actually represent relative incidence trends.

In our series (n=494) median age was 67 years for men (range 17-95) and 70 years for women (range 16-95), in agreement with northern countries with cold climates where the majority of cases with BCC is also over 60 years [1]. These findings are very near to an overall estimation of median age (67 years) [3].

In line with international trends, overall the disease was found to be statistically more common in males (Table 1), probably as a result of increased exposure to the sun but with a lower ratio (1.3 instead of 2.0) [3].

Up to the middle of the 6th decade of life (55 years), BCC affected equally both sexes at rather low rates. Despite male prevalence in most of the age group strata, only from 56 up to 65 years the difference reached significance, detection rates being about twice as high than those in females, implying also a shorter latency period. In elderly patients (>66 years) both sexes were equally affected with highest morbidity rates.

Including our series, relative frequencies increased steadily with advancing age [1,3]. The peak incidence was observed in the group of >80 years.

There was no significant difference of our findings with literature data. BCC incidence is influenced by the geographic latitude, since residence below 40° N latitude has been implicated as a risk factor in disorders resulting from interaction of solar radiation and the skin [4]. The latitude of Greece is between 41°44'58" and $34^{\circ}45' \cdot 02''$ N. However, a decreased ultraviolet radiation susceptibility has been noted in southern Europeans as a function of pigmentary determinants of cutaneous sun sensitivity and skin type ≥ 3 predominance predominates in the Greek population [5]. Similarities with our findings might be explained by the interaction of these events.

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