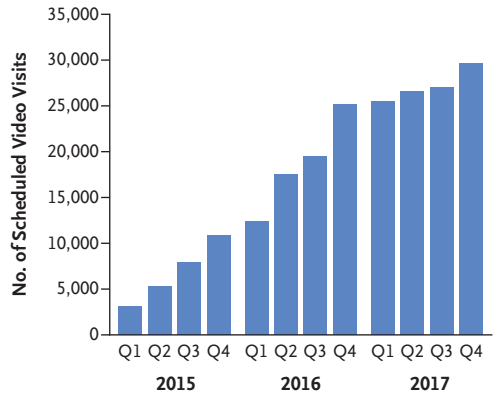

Figure 1. Growth in Scheduled Video Visits, 2015–2017 (210,383 Total Visits).

Video visits could be conducted by all clinicians (including medical doctors, osteopathic physicians, nurse practitioners, and physician assistants), with growing implementation by departments or through individual adoption over time. All the patients were potentially eligible for a video visit. The most common documented reasons for video visits included skin problems (e.g., acne, rash, and dermatitis), medication management, test results, and follow-up.

clinicians with less than 5% of total patients, amounting to less than 1% of all office visits. Further research is needed to examine continued adoption over time. Still, together with positive patient-reported experiences,[5] our findings show the feasibility and growing adoption of video visits integrated with ongoing clinical care.

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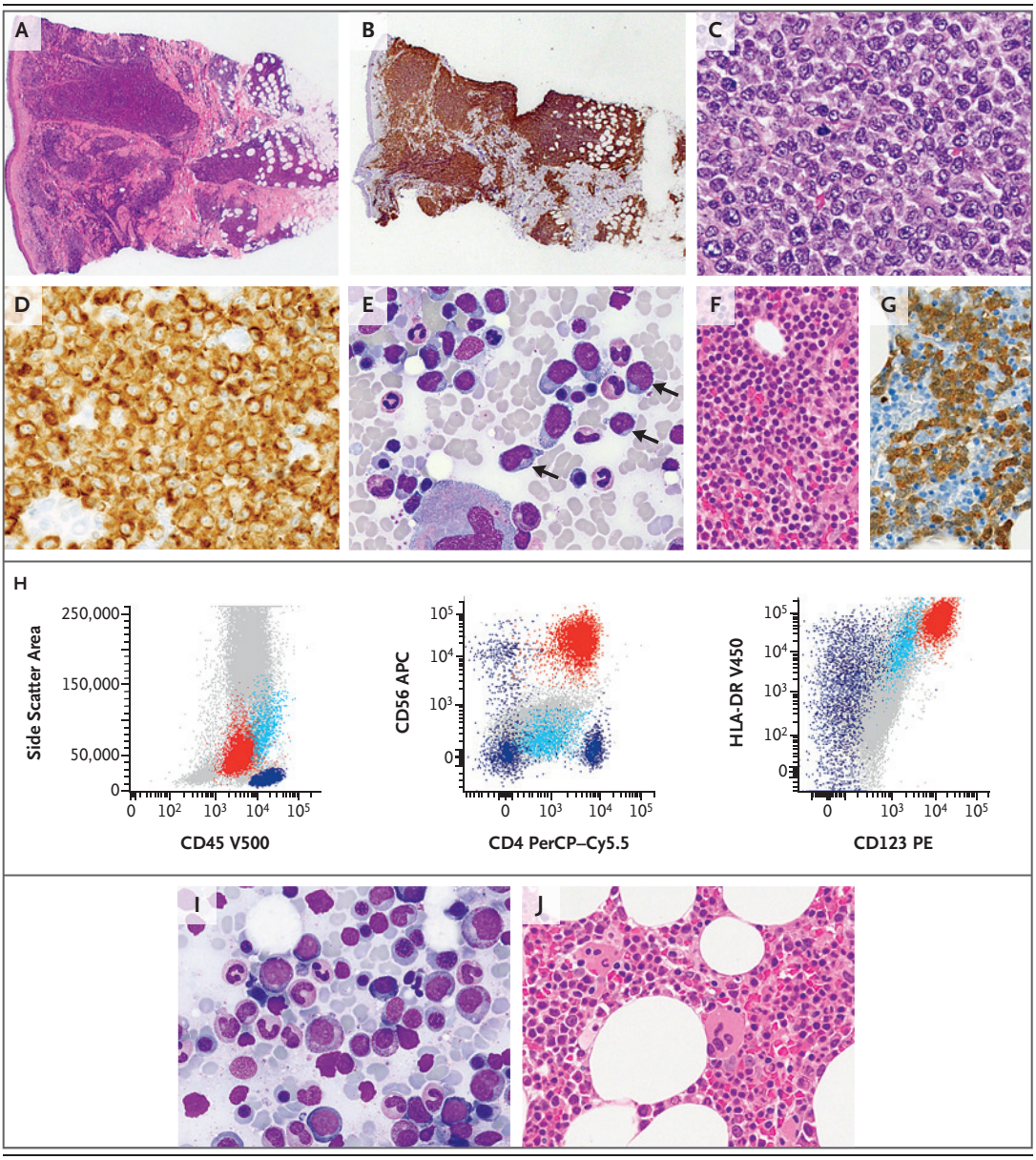
Venetoclax in a Patient with a Blastic Plasmacytoid Dendritic-Cell Neoplasm

TO THE EDITOR: A blastic plasmacytoid dendritic-cell neoplasm is a rare tumor with very aggressive clinical behavior and no established treatment.[1] Available treatment options include aggressive multiagent chemotherapeutic regimens. Treatment for relapsed disease is largely ineffective, and the prognosis for patients with refractory disease is poor.

A 62-year-old woman presented with a large necrotic plaque on her left cheek that was confirmed on biopsy to be a classic blastic plasmacytoid dendritic-cell neoplasm (Fig. 1A and 1B). Positron-emission tomography–computed tomography (PET-CT) showed a large left buccal lesion with a left cervical lymph node that measured 30×30 mm and had a standardized uptake value of 4.5, but it did not show other disease. Because of concern regarding local disease progression, she underwent complete surgical excision of the lesion and the cervical lymph nodes (Fig. 1C and 1D). Analysis of a bone marrow specimen showed involvement with a blastic plasmacytoid dendritic-cell neoplasm (Fig. 1E through 1H).

The patient declined to receive standard therapy or to participate in research protocols. She agreed to receive bortezomib (at a dose of 1.3 mg per square meter of body-surface area) weekly and simvastatin (20 mg) daily. These agents are



reported to have synergistic in vitro activity in this disease[2]; bortezomib was also shown to be active in a mouse xenograft model.[2] Treatment was discontinued in our patient after 8 weeks because of neuropathy.

Immunohistochemical studies of the original lesion showed that expression of CD274 (also called programmed death ligand 1 [PD-L1]) and CD279 (programmed cell death protein 1 [PD-1]) was mostly negative (<10%), but there was extensive strong BCL2 expression (Fig. 1D). Accordingly, venetoclax at a dose of 400 mg daily was initiated, and a bone marrow biopsy specimen obtained after 4 weeks showed no evidence of disease (Fig. 1I and 1J). PET-CT after 6 months showed complete remission, as did follow-up examinations of bone marrow specimens obtained at 6 months and 9 months.

Although BCL2 is not expressed in normal plasmacytoid dendritic cells, it is overexpressed in most blastic plasmacytoid dendritic-cell neoplasms.[3,4] Our case underlines the probable pathogenetic role of BCL2 in blastic plasmacytoid dendritic-cell neoplasms and the potential

Figure 1 (facing page). Morphologic Characteristics and Immunophenotype of a Blastic Plasmacytoid Dendritic-Cell Neoplasm.

The punch biopsy specimen obtained from the patient's left cheek and stained with hematoxylin and eosin shows a dense dermal infiltrate extending into the subcutis but sparing the epidermis (Panel A, low magnification). Immunohistochemical analysis was positive for expression of CD56 (Panel B, immunoperoxidase staining, low magnification). Sheets of medium-to-large cells in the subcutaneous tissue in the resection specimen stained with hematoxylin and eosin show oval nuclei, vesicular chromatin, and small nucleoli (Panel C, high magnification). Immunohistochemical analysis was strongly positive for expression of BCL2 (Panel D, immunoperoxidase staining, high magnification). Wright–Giemsa staining of neoplastic cells (Panel E, arrows) in the staging bone marrow–aspirate smears shows scant-to-moderate basophilic cytoplasm and eccentric nuclei (high magnification). A staging bone marrow–biopsy specimen stained with hematoxylin and eosin shows a focally dense mononuclear-cell infiltrate (Panel F, medium magnification). The T-cell leukemia–lymphoma 1 (TCL1) immunostain highlights the interstitial infiltrate that accounted for 30 to 40% of the bone marrow cellularity (Panel G, TCL1 immunoperoxidase staining, medium magnification). Flow-cytometry dot plots of the staging bone marrow specimen show an abnormal population (red) positive for CD45 (dim), CD4, CD56, CD123 (bright), and HLA-DR (bright), with monocytes (blue) and lymphocytes (purple) highlighted for contrast; gray denotes the remaining cells (Panel H). APC denotes allophycocyanin, PE phycoerythrin, PerCP–Cy5.5 peridinin chlorophyll protein–cyanine 5.5, V450 violet dye (peak emission, 448 nm; BD Horizon), and V500 violet dye (peak emission, 500 nm; BD Horizon). Wright–Giemsa staining of a bone marrow–aspirate smear obtained after the patient received venetoclax (at a dose of 400 mg daily for 4 weeks) showed that the smear was negative for disease (Panel I, high magnification), and a biopsy specimen stained with hematoxylin and eosin revealed only trilineage hematopoiesis without tumor (Panel J, medium magnification).

therapeutic role of the anti-BCL2 venetoclax in their treatment. Although we think that venetoclax contributed most of the therapeutic efficacy, we cannot rule out the contribution of bortezomib and simvastatin in the induction of remission (the patient declined to undergo bone marrow biopsy after she received the initial treatment, before the initiation of venetoclax).

The long duration of response in our patient is particularly notable. It is also considerably different from the response in two other patients, in whom venetoclax induced skin and nodal response but only partial or no bone marrow response, resulting in a very short survival.[5]

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Safety Trials of Long-Acting β_2-Agonists

TO THE EDITOR: The analysis of safety trials of long-acting β_2-agonists (LABAs) by Busse et al. (June 28 issue)[1] concluded that adding a LABA to an inhaled glucocorticoid was safe. However, patients with previous life-threatening reactions were excluded from the analysis. My colleague and I had previously reported on two boys, 10 and 15 years of age, who received a LABA with an inhaled glucocorticoid and who had life-threatening bronchospasm not prevented with a short-acting β_2-agonist (SABA) until the LABA was discontinued.[2] Loss of the bronchoprotective effect of a SABA from regular use of a LABA has been reported previously[3,4] and is not prevented by the simultaneous use of an inhaled glucocorticoid.[5,6] Although there may be a limited subgroup of patients at risk for the serious adverse effect seen in our previous report, it is highly unlikely that