Irish Association of Dermatologists
&
Australasian College of Dermatologists

Autumn Meeting

4 - 5 October 2012
Malahide Grand Hotel, Dublin

Welcome Message from the President Dr Pat Podmore

As a result of the sterling efforts of both Jacqui and Olivia I feel we can proudly welcome our Australian Colleagues to what is bound to be an exciting, enjoyable and important meeting. Skin cancer and specifically melanoma are topics which take dermatology out of the realms of "Cinderella speciality" as I think sometimes we are still cast. My own sons medical student included tease me that "Dermatologist" is Greek for fake doctor!!!

As always our programme carries high calibre speakers and I hope the welcome that we will all extend will ensure that they also enjoy their contribution to this historical joint meeting. The venue I know will be conducive to refreshing old and forging new friendships. Our programme of necessity is very busy but I hope we will still all have plenty of opportunities to share experiences and learn from each other's practices of dermatology.

Of further historical significance this meeting will be the inaugural clinical registrars' symposium at which we will award the Rogers Prize for the first time. I know we all agree that this has been a tremendous idea of Sarah's and will ensure over future years our meetings cover all aspects of our speciality.

With each meeting we try to ensure that as an Association we remain at the forefront of clinical practice and experience. This meeting is no exception and looking at the topics that our speakers are going to address, once again I know we will leave with that precious gift of increased knowledge in current research and innovative treatments of dermatological oncology.

Yours sincerely

Pat Podmore
President IAD

Irish Association of Dermatologists
Autumn Meeting 2012

THE AUSTRALASIAN COLLEGE OF DERMATOLOGISTS

Irish Association of Dermatologists & Australasian College of Dermatologists

Autumn Meeting

4th & 5th October 2012
The Grand Hotel, Malahide, Co. Dublin

Thursday 4th October 2012

9.30am **Registration**

10.45am **LEO Pharma Satellite Symposium**
'Actinic Keratosis and Non-Melanoma Skin Cancer'

12.30pm **LUNCH/EXHIBITION**

Programme

2.00pm **Prof Julia Newton - Bishop**
'The sun, genes, vitamin D and melanoma'

Professor of Dermatology,
Section of Epidemiology and Biostatistics,
Leeds Institute of Molecular Medicine,
University of Leeds,

2.45pm **Dr Pippa Corrie**
'First fruits from metastatic melanoma targeted therapy'

Consultant and Associate Lecturer
in Medical Oncology
Cambridge University Hospitals NHS Foundation Trust (Addenbrooke's Hospital)

3.30pm **COFFEE/EXHIBITION**

4.00pm **Dr Karyn Lun**
'Antipodean adventures in non-melanoma skin cancer'

Consultant Dermatologist
Queensland Institute of Dermatology, Brisbane and the Princess Alexandra Hospital, Brisbane.

5.00pm **IAD Business Meeting**

7.30pm **GALA DINNER**
(Kindly subsidised by LEO Pharma)

Friday 5th October 2012

Programme

9.30am **Registrars' Symposium Rogers Prize**

11.00am **COFFEE**

11.30 **Case presentations**

1.00pm **LUNCH**

THE AUSTRALASIAN COLLEGE
OF DERMATOLOGISTS

L E O

LEO Pharma Satellite Symposium
"Actinic Keratosis and Non-Melanoma Skin Cancer"

at
Irish Association of Dermatologists and
Australasian College of Dermatologists Joint Meeting

October 4th 2012
The Grand Hotel, Malahide

10:45	**Dr Fergal Moloney, Chairperson** **Meeting open**
10:50	**Dr Gillian Murphy** ***The Scope of Actinic Keratosis and Non-Melanoma Skin Cancer***
11:15	**Dr Gunther Hofbauer** ***Treating the field to address sub-clinical lesions in Actinic Keratosis***
11:40	**Dr Steve Shumack** ***New emerging therapies in Actinic Keratosis and Non-Melanoma Skin Cancer***
12:05	**Panel Q&A and discussion**
12:30	**Dr Fergal Moloney, Chairperson** **Meeting close**

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Biographical Sketches

Dr Pippa Corrie

Dr Pippa Corrie was appointed in 1996 as Consultant Medical Oncologist at Cambridge University Hospitals NHS Foundation Trust and was made University of Cambridge Associate Lecturer in 1999. She founded the Cambridge Cancer Trials Centre (currently its Deputy Director) and West Anglia Cancer Research Network (Clinical Lead for Research between 2001 and 2011), a flagship UK regional research network. Her specialist interests are melanoma and pancreatic cancer. She chairs the NCRI Melanoma Clinical Studies Group and is Chief Investigator of the CRUK funded UK adjuvant melanoma trial, AVAST-M.

Dr Karyn Lun

Medical graduate of University of Qld, worked as a general practitioner for 5 years before training in dermatology in Brisbane and London. Attained Fellowship of the Australasian College of Dermatologists in 2002. Completed Fellowship in Mohs surgery, advanced cutaneous surgery and laser surgery at the Skin and Cancer Foundation Australia in Sydney in 2004, gaining membership of the American College of Mohs Surgery.

Since 2005, working as a consultant dermatologist at Princess Alexandra Hospital, Greenslopes Private Hospital and Qld Institute of Dermatology as well as in private rooms.

Prof Julia Newton-Bishop

Section of Epidemiology and Biostatistics, Leeds Institute of Molecular Medicine,
St James's Hospital/University of Leeds
Leeds

Finding skin cancer genes

Professor Julia Newton-Bishop works in the Section of Biostatistics and Epidemiology of the Leeds Institute of Molecular Medicine. She studies people with family histories of melanoma - the most dangerous form of skin cancer - and has made many significant discoveries.
Her team has found several inheritable faults in a gene called CDKN2A that increase the risk of melanoma and, possibly, pancreatic cancer.

Nature or nurture?

Professor Newton-Bishop's team is also looking at how our lifestyle choices interact with our genes to affect our risk of cancer. The team is studying how sun exposure and melanoma genes jointly affect a person's chances of getting skin cancer.
The researchers are also running a large study to look for more melanoma genes that specifically affect a patient's chances of survival. Another aim of this project is to find out if there are crucial differences between melanomas that start in different areas of the body.

Professor Newton-Bishop and her team of researchers are experts in their field and their work should pave the way for new treatements for melanoma

Irish Association of Dermatologists

Spring Meeting 2012

Aidan Egan GSK, Philomena O'Brien IDNA, Sheila Gleeson IDNA & Nicola Early GSK

Aidan O'Kane, Anne McKeon, Pat Houlihan Dermal & Dr Brid O'Donnell

Annamma Raju IDNA & MSD

Christine McMillan & Pamela Todd

Dr Aneta Kecler-Pietrzyk & Szymon Pietrzyk

Dr Charles Shepherd Guest Speaker & Dr Pat Podmore

Dr Clifford McMillan, Dr Susannah Hoey, Dr Clare Devereux & Dr David Todd

Dr Collette McCourt, Dr Helen Hunter, Dr Pat Podmore, Dr Muireann Roche, Dr Gemma McIntyre, Dr Donal O'Kane

Dr Collette McCourt, Dr Muriel Sadlier, Dr Maeve Lynch, Dr Muireann Roche, Dr Gemma McIntyre & Dr Eleanor Higgins

Irish Skin Foundation, Geraldine Clare, Biography

The Irish Skin Foundation, a newly formed charity with the aim of supporting people with skin disease in Ireland, has appointed Geraldine Clare, former Chief Executive of the leading mental health charity Aware, as its CEO. Geraldine's experience in patient advocacy and disease awareness will be instrumental in implementing the goals of the new charity.

A management accountant by profession, Geraldine worked at senior management level in the corporate sector for a number of years before moving to the voluntary sector in 2000.
Much of her leadership experience was gained in Aware, where she worked to deliver and develop support services including a telephone helpline, peer support group meetings, and an educational programme in secondary schools.

The challenge of stigma and being an advocacy for services has been a constant feature of her work, not only in the area of mental health, but extending to the broader disability arena through her involvement with the Disability Federation of Ireland.
More recently Geraldine has worked with ARC Cancer Support, which offers support services and programmes for those with a cancer diagnosis and their families.

Her experience and skills leave her well placed to lead the Irish Skin Foundation through its formative years, and beyond.

'Best Poster Award Spring 2012
Presented by Dr Pat Podmore, IAD President & Maurice Leonard, Abbott
to Dr Bart Ramsey – accepting on behalf of winner Dr Dmitri Wall

Registrar's Symposium Rogers Prize

Time	No	Title	Author(s)
		Rogers Prize	
9.30	001	**Case control study to assess cardiovascular risk factors and intima-media thickness in patients predisposed to keloid scarring**	Eustace K[1], Gray C[2], Clowry J[1], Malone C[3], Mc Donnell C[2], Moloney F. J.[1]
9.45	002	**Who dies from melanoma? A population-based study of Irish patients**	Mary Bennett[1], Paul Walsh[2], Harry Comber[2], Sandra Deady[2], Michelle Murphy[1]
10.00	003	**Diagnostic and Treatment Centres for Melanoma – Are they of benefit?**	Foley C[1], Beausang E[2], McMenamin M[3], Leonard N[3], O rmond P[1], Wynne B[1]
10.15	004	**An Electronic Health Record for Dermatology: A survey of the experiences and requirements of Irish Dermatologists.**	Wall D, Hackett C, Ahmad K, Ramsay B.
10.30	005	**Immobilisation of full thickness skin grafts using a multi-layered polyurethane foam dressing**	Eustace K, Barry RBM
10.45	006	**Overview of Dermatology Hospital Services in a Tertiary US Medical Centre.**	Eoin Storan[1], Mark Davis[2]
		Case Presentations	
11.30	007	**Orbital Exenteration secondary to invasive Non-Melanoma Skin Cancer.**	E Storan, B Moran, B Wynne, P Ormond.
11.40	008	**First report of Kaposi's sarcoma in ciclosporin treated atopic dermatitis; implications for screening pre immunosuppression?**	Wall D, Moran B, Irvine AD.
11.50	009	**Spontaneous regression of metastatic squamous cell carcinoma of unknown primary**	Foley C1, McMenamin M2, Ormond P1, Irvine AD1
12.00	0010	**Spontaneous Resolution of Keratoacanthoma Centrifugum Marginatum**	RH EL-KHAYAT, C McGrath, SE HOEY
12.10	0011	**Multifocal primary cutaneous anaplastic large cell lymphoma.**	S Verma, N Ralph, G Gullo, K Sheahan, P Collins.
12.20	0012	**Malignant eccrine spiradenoma(MES) - A case report of this rare cutaneous adnexal tumour.**	O'Callaghan DM,McInerney N, Kelly JL
12.30	0013	**Fluorescence in situ hybridization (FISH) analysis as an adjunct to the diagnosis and management of melanoma: A case report.**	O'Callaghan DM, Jones DM, Tan M
12.40	0014	**Muir-Torre syndrome and diagnostic error: lessons learned.**	Wall D, Hackett C, Ahmad K, Ramsay B.

Irish Association of Dermatologists

Spring Meeting 2012

Burrows Cup 1st Prize, Presented by Dr Pat Podmore, IAD President to Dr Nigel Burrows, accepting on behalf of Dr Suzanne Clements

Dr Collette McCourt, joint 2nd prize Burrows Cup & Dr Pat Podmore

Dr Dermot McKenna, Dr Pauline Marren & Dr Kashif Ahmad

Dr Cal Condon & Dr Nick Walsh

Dr Donal O'Kane, Dr Helen Hunter, Dr Collette McCourt & Dr Paul Collins

Dr Emma Shudell & Colm Murphy Galderma

Dr Gillain Murphy, Prof Edel O'Toole & Dr Pat Podmore

Dr Kara Healon, Dr Claire Reid & Dr Eleanor Higgins

Dr Kara Heelan & Dr Catherine Foley

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President,
Consultant Dermatologist
Altnagelvin Hospital
Derry

Dr Olivia Dolan
Hon Secretary,
Consultant Dermatologist
Royal Victoria Hospital
Belfast

Dr David Alderdice
Hon Treasurer,
Consultant Dermatologist
Ulster Hospital
Dundonald
Belfast

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Beaumont Hospital
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Dr Trevor Markham
Consultant Dermatologist
University College Hospital
Galway

Dr Rosemarie Watson
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St James Hosp & OLHSC Crumlin
Dublin

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University Hospital, Cork

Dr Paul Collins,
Consultant Dermatologist,
St Vincent's University Hospital, Dublin

Dr Olivia Dolan
Consultant Dermatologist,
Royal Victoria Hospital, Belfast

IAD Past Presidents

1965/7 Dr R. Hall, Belfast,

who was followed by:

1967/9 Dr D.O'C Donelan

1969/71 Dr J.M. Beare

1971/3 Dr D.M. Mitchell

1973/5 Dr D.B. Buckley

1975/7 Prof D. Burrows

1977/9 Dr F.O.C. Meenam

1979/81 Dr Agnese M.T. Kelly

1981/3 Dr Count H. Viani

1983/5 Dr Grace Allen

1985/7 Dr Marjory Young

1987/9 Dr Roddy Matthews

1989/91 Dr David O'Gorman

1991/3 Dr Rory Corbett

1993/5 Prof Sarah Rogers

1995/7 Dr E.A. Bingham

1997-9 Dr. Fergus Lyons

1999-01 Dr Clifford McMillan

2001-3 Prof Frank Powell

2003-5 Dr Raymond Fulton

2005-8 Prof Louise Barnes

2008-9 Dr Hilary Jenkinson

2009-11 Dr Gillian Murphy

2012 Dr Pat Podmore

Registrars' Symposium (Rogers Prize)
Oral presentations

ORAL ABSTRACT 01
Case control study to assess cardiovascular risk factors and intima-media thickness in patients predisposed to keloid scarring

Author(s): Eustace K[1], Gray C[2], Clowry J[1], Malone C[3], Mc Donnell C[2], Moloney F. J.[1]

Institution(s): [1] Department of Dermatology, Mater Misericordiae Hospital, Dublin 7
[2] Department of Vacular Surgery, Mater Misericordiae Hospital, Dublin 7
[3] Department of Ophthalmology, Royal College of Surgeons in Ireland, Dublin 2.

Abstract:
Background: Both keloid scarring and cardiovascular events occur more frequently in individuals with darker skin types. Signalling pathways, in particular those involving transforming growth factor-beta 1, involved in keloid pathogenesis also play a role in the development of atheromatous plaques. Common carotid artery (CCA) wall intimal medial thickness (IMT) is a surrogate measure of atherosclerosis.

Objective: We hypothesise that keloid prone patients may demonstrate a tendancy to subclinical atherosclerosis and that keloid may provide an early marker to identify individuals at higher risk of cardiovascular events.

Methods: Dermatologist confirmed keloid patients were age, gender and ethnic group matched with controls with non-keloid scars from dermatology or plastic surgery clinics. Baseline parameters recorded included age, gender, skin type, smoking history and family history of ischaemic heart disease. The mean of three blood pressure (BP) measurements were recorded, fasting lipids, glucose and CRP were obtained. Carotid IMT was measured at four different sites on the far wall of the right and left CCA, by the same Vascular Technologist using the same high resolution B-Mode Duplex Ultrasound system.

Results: 38 study participants in total were recruited, 19 keloid patients and 19 matched non-keloid controls. The mean +/- SEM age of the keloid group was 33.37 ± 3.097 years and for the control group was 34.26 ± 3.273 years, with a female preponderence of 63.16%. Three keloid patients were known hypertensives on treatment compared to none in the control participant group. There were no diabetic patients in either group. Hypercholesterolemia (>5mmol/L) and hypertriglyceridemia (>1.7mmol/L) was documented in four and two patients from the keloid group compared to eight and one patient in the control group. Six keloid patients had a reduced HDL level <1mmol/L for males and <1.2mmol/L for females, compared with only two in the control participant group. There was no overall statistical difference between the mean systolic and diastolic BP's, lipid profile, CRP and glucose values of both groups. There was also no statistically significant difference in mean IMT measurements from the right CCA (p=0.2481) and left CCA (p=0.1677) between the keloid and control groups.

Conclusion: This pilot case-control study identified no significant difference in mean IMT of keloid patients when compared with non-keloid controls. These findings will guide sample size calculation for future studies and suggest a larger study population with an older mean age may be required to confirm the study hypothesis.

ORAL ABSTRACT 02
Who dies from melanoma? A population-based study of Irish patients

Author(s): Mary Bennett[1], Paul Walsh[2], Harry Comber[2], Sandra Deady[2], Michelle Murphy[1]

Institution(s): Department of Dermatology, South Infirmary-Victoria University Hospital, Cork, Ireland[1], National Cancer Registry, Cork, Ireland[2]

Abstract:
Background
Historically, studies have shown that the incidence of melanoma tends to be higher among patients from more affluent backgrounds (1). Interestingly, survival from melanoma also tends to be higher in that group (1). Gender has also been shown to influence survival, with women having better outcomes in some studies. In this study we sought to identify factors that were significantly influencing patient survival.

Methods
We assessed disparities in cause-specific survival for melanoma patients diagnosed in Ireland during 1994-2008, and selected results are presented here. Descriptive statistics on incidence, stage and survival were calculated, and survival variations were assessed by Cox modelling.

Results
We found that in situ melanomas were less frequent proportionately in the most deprived compared to the least deprived group (29% v 32%), as were stage I melanomas (42% v 47% of invasive cases). Five-year survival from invasive melanoma averaged 81% for the most deprived compared with 86% for the least deprived group overall (age-/sex-adjusted hazard ratio 1.33, 95% CI 1.11-1.58); in men, 71% v 79% (HR 1.47, CI 1.16-1.84); in women, 88% v 90% (HR 1.17, CI 0.89-1.52). Deprivation-related disparities in survival appeared to improve over the study period, and appeared less marked for women. Significant disparities remained for the most deprived group after adjustment for stage, overall (HR 1.22, CI 1.01-1.45) and in men (HR 1.35, 1.06-1.72).
A high proportion of deaths from melanoma occurred among farm owners, farm managers and horticulturists or their spouses.

Discussion
We found significantly poorer survival outcome for those from the most deprived areas, particularly in males and those in the 50-99 year age group. Stage explained about a third of excess mortality risk in the highest deprivation stratum. Several other factors may be at play here, including other unidentified prognostic, lifestyle or treatment-related factors. Occupation may reflect some of these factors. It is important when planning a national cancer strategy, screening programmes and public education to consider these potential discrepancies in incidence and survival and tailor campaigns to those at greatest risk.

(1) MacKie RM, Hole DJ. Incidence and thickness of primary tumours and survival of patients with cutaneous malignant melanoma in relation to socioeconomic status. BMJ. 1996 May 4;312(7039):1125-8.

ORAL ABSTRACT 03
Diagnostic and Treatment Centres for Melanoma – Are they of benefit?

Author(s): Foley C[1], Beausang E[2], McMenamin M[3], Leonard N[3], Ormond P[1], Wynne B[1]

Institution(s): Departments of Dermatology[1], Plastic Surgery[2] and Histopathology[3], St. James's Hospital, James's Street, Dublin 8

Abstract:
Every year in , over 700 new cases of melanoma are diagnosed and there are 100 melanoma related deaths. With the launch of the national cancer control programme (NCCP) general practitioner (GP) melanoma guidelines in October 2011 we present a comparative analysis of 2 centres – one (SJH) adherent to NCCP guidelines where suspicious pigmented lesions are referred intact to a consultant dermatologist or plastic surgeon and on diagnosis discussed at a skin cancer multidisciplinary team (MDT), versus the midlands where there is very limited access to a consultant dermatologist and melanoma heretofore has been managed on an ad hoc basis by general surgeons and GPs with no MDT.

We analysed the data for prognostic indicators of 25 primary invasive melanomas in 25 patients who had their initial procedure and diagnosis in the midlands – in a GP surgery, Tullamore General Hospital, Mullingar Regional Hospital or Midland Regional Hospital Portlaoise – between August 2010 and May 2012 and compared the results to an audit of all melanomas (142) treated in SJH in 2011. The demographics of the two groups were similar. Melanomas in patients who had their diagnostic procedure in the midlands had a higher average Breslow depth (4.27mm vs 2.04mm), higher incidence of mitoses (80% vs 47.2%) and higher incidence of ulceration (48% vs 13.53%) when compared to patients treated in SJH initially. Additionally 6 of 15 cases where the histology was reviewed in SJH had changes made to the report, in 3 of these patients this led to a change in management.

According to NCCP guidelines a patient who presents with signs and symptoms suggestive of melanoma should be referred to a consultant dermatologist or consultant plastic surgeon. Lesions suspicious of melanoma should not be removed in primary care. The prognosis for melanoma is closely related to the thickness of the tumour. Patients referred with melanoma from the midlands have worse prognosis when compared to those patients who are referred to a dedicated diagnostic and tertiary skin cancer centre, SJH.

ORAL ABSTRACT 04
An Electronic Health Record for Dermatology: A survey of the experiences and requirements of Irish Dermatologists.

Authors: Wall D, Hackett C, Ahmad K, Ramsay B.
Department of Dermatology, University Hospital Limerick.

Abstract:
Introduction: A 2011 report on behalf of the Health Service Executive noted that "support in the form of an Integrated Electronic Patient Record is now acknowledged as the number one innovative change required by the clinical services" in Ireland"[1]. In this regard, at the Spring meeting of the Irish Association of Dermatologists, 2012, we presented designs for an electronic health record to serve Dermatology patients. Regarding successful implementation of optimised Electronic Health/Patient Records (EHR/EPR), the literature suggests that involvement of clinical staff in design and implementation is essential[2].

Aims: To assess the opinions of physicians working in Dermatology in Ireland regarding their experience and requirements of a Dermatology EHR.

Methods: We created a survey using the online survey tool, Survey Monkey®, and invited full and trainee members of the Irish Association of Dermatologists to participate. We also encouraged those within Irish dermatology departments involve their physician colleagues.

Results: Of 61 respondents, 54% (33) were consultants (both public, private, HSE and NHS) and 29.5% (18) specialist registrars/residents. 62.3% had no experience with EHRs, 23% had some form of EHR integrated with their practice and 3.3% had a fully paperless practice. Regarding factors most important to development of an EHR, ease of data input and integration with current electronic hospital systems ranked most highly. In respect to how helpful respondents felt that an EHR could be, safety was seen as the most significant benefit that could be realised through the use of an EHR, followed by building a national network and providing an ability to demonstrate the work performed by a dermatology department. The concept of a National web based EHR was addressed by 26 of the 61 respondents with almost unanimous strong support. A free comment section answered by 14 participants reflected a generally positive sentiment that EHRs were inevitable and practice changing tools. Concern regarding the cost, complexity of set up and security of the system were, however, expressed by a few.

Conclusion: EHRs will be fundamental in the evolution of medicine. This survey addresses the opinions and concerns of potential Irish dermatology users of such systems and provides valuable information to ensure the representation of their interests in such systems.

References:1.Shannon, T. National Clinical Programmes:Aligning Process Improvements with Information Technologies Strategic Framework proposal. 2011;1–50.
2. Silow-Carroll S et al. Using electronic health records to improve quality and efficiency: the experiences of leading hospitals. Issue brief (Commonwealth Fund) [Internet]. 2012 Jul;17(July):1–40.

ORAL ABSTRACT 05
Immobilisation of full thickness skin grafts using a multi-layered polyurethane foam dressing

Author(s): Eustace K, Barry RBM

Institution(s): Dermatology Department, St. Vincent's University Hospital, Elm Park, Dublin 4

Abstract: Successful engrafting of full-thickness skin grafts is dependent on adequate neovascularisation of the graft from the underlying vascularised wound bed. Immediate postoperative immobilisation of the skin graft is essential. Such immobilisation is frequently achieved by either a tie-over bolster dressing though this can be cumbersome and easily dislodged. Adhesive pressure dressings are an alternative method of immobilisation but their success is user-dependent. Recently, an alternative multi-layered polyurethane foam dressing technique was described and this has proven to be a simple, comfortable, reliable and reproducible method of immobilising skin grafts[1]. We describe the technique as well as our experience of using this method of graft immobilisation.

Following complete extirpation of the tumour, a full-thickness skin graft is harvested from a suitable donor site. The graft is sutured in place using an absorbable, synthetic braided 6-0, polyglactin 910 suture. The graft is coated with either a topical antibiotic or petrolatum. A template, which is the exact size and shape of the underlying skin graft, is cut from a foam polyurethane dressing and placed directly onto the graft. A second layer of foam polyurethane is then placed over the first layer. The second layer should be approximately 4-5 millimetres larger in diameter than the first layer. This second layer is then sutured into the skin using a non-absorbable suture. The entire foam pressure dressing is then left in place until removal of sutures. The multi-layered nature of this dressing ensures adequate and uniform pressure of the entire graft. Furthermore, patients have found this dressing to be comfortable and easy to manage. We illustrate the surgical technique with clinical examples.

[1]Nakamura M, Ito E, Kato H, Watanabe S *et al*. A multilayered polyurethane foam technique for skin graft immobilisation. Dermatol Surg. 2012 Feb;38(2):224-9

ORAL ABSTRACT 06
Overview of Dermatology Hospital Services in a Tertiary US Medical Centre.

Abstract:
Background: There is a paucity of data describing dermatology inpatient hospital services and dermatology day hospital centres for the treatment of adult and paediatric patients with severe skin disease.

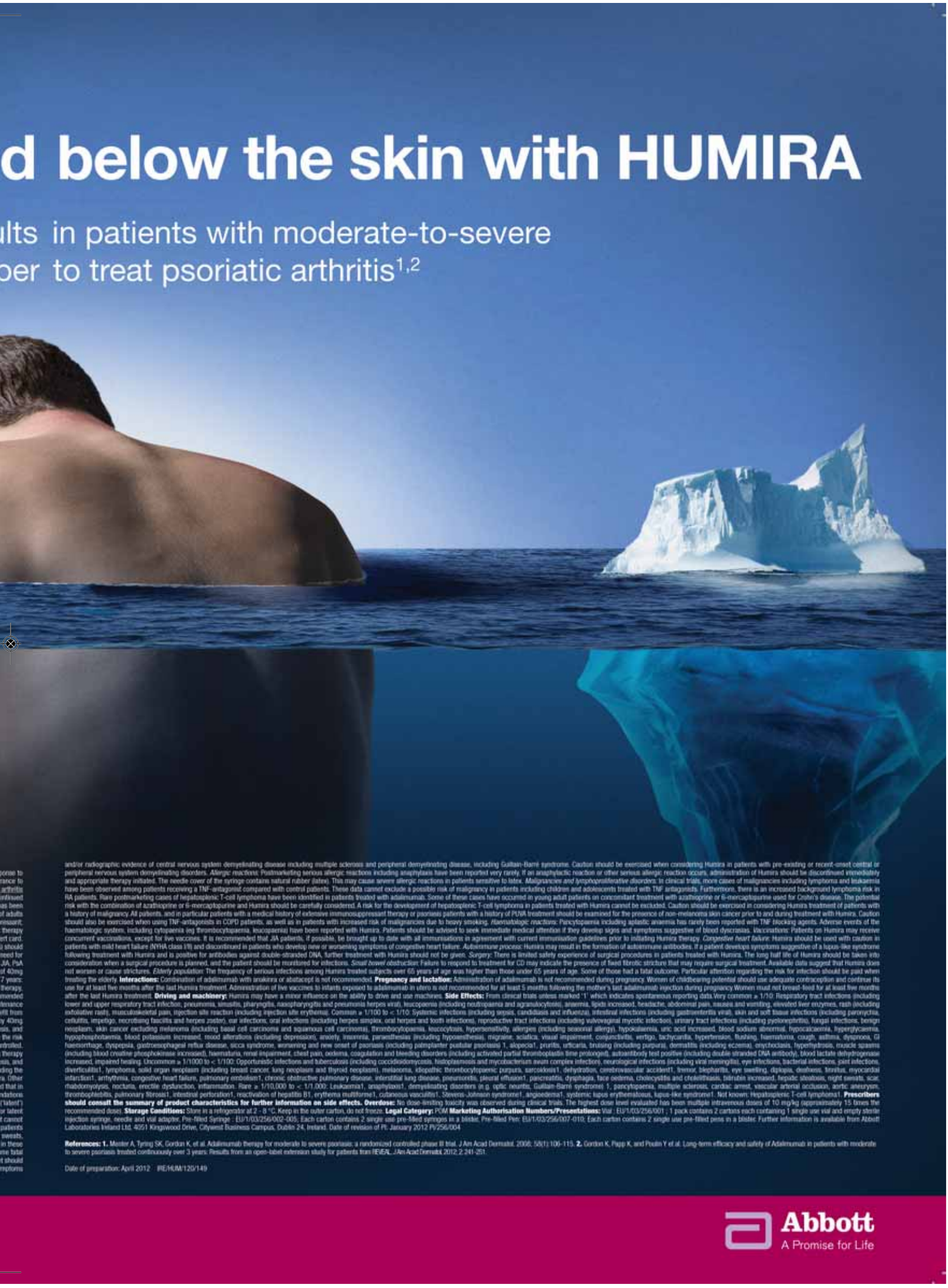
Aims: To describe the activities of a dermatology-run inpatient hospital service and day hospital service in treating patients with severe skin disease in a large tertiary referral centre in the United States.

Methods: We performed a retrospective chart review of the adult (age ≥18 years) inpatient hospital service, looking at patient demographics (including age, sex, ethnicity, location), length of stay and admission diagnosis over an 11-year period from 2000-2010. Data from the first 5.5 years was compared to data from the second 5.5 years to evaluate for any trends. Similarly, for the paediatric (Age <18) inpatient hospital service we recorded patient demographics, length of stay, admission diagnosis and treatment rendered over 24 months between 2009-2010.

Dermatology day hospital: patient demographics, admission diagnosis, duration of treatment and treatment rendered over a 12 month period in 2010 were recorded.

Results: Adult Inpatients: 1,732 patients had 2,216 admissions over the 11 years study period. 38% of patients treated were from the local state of Minnesota. Length of stay decreased from 4 days to 3 days (P<0.01) across the 2 study periods. Admissions for psoriasis decreased from 20.7% to 13.0% (P<0.01) and admissions for for dermatitis increased from 41.6% to 47.6%; (P<0.01).
Paediatric inpatients: 97 patients had 108 admissions between 2009-2010. Indications for admission included atopic dermatitis (86.1%), psoriasis (3.7%), and eczema herpeticum (2.8%). The main treatment provided was wet dressings (97.2%).
Day Treatment Centre: 211 patients had 235 admissions in 2010. Indications for admission included dermatitis (139 admissions [59.2%]), psoriasis (58 admissions [24.7%]), and mycosis fungoides (8 admissions [3.4%]). The main treatment interventions were wet dressings (195 admissions [83.0%]) and traditional Goeckerman treatment (38 admissions [16.2%]).

Conclusions: In the adult inpatient group, rates of admission for psoriasis decreased, which may be due to therapeutic advances including the introduction of biologics. Over 60% of patients treated were from outside the local state implying people are willing to travel for inpatient care. The majority of



and/or radiographic evidence of central nervous system demyelinating disease including multiple sclerosis and peripheral demyelinating disease, including Guillain-Barré syndrome. Caution should be exercised when considering Humira in patients with pre-existing or recent-onset central or peripheral nervous system demyelinating disorders. *Allergic reactions:* Postmarketing serious allergic reactions including anaphylaxis have been reported very rarely. If an anaphylactic reaction or other serious allergic reaction occurs, administration of Humira should be discontinued immediately and appropriate therapy initiated. The needle cover of the syringe contains natural rubber (latex). This may cause severe allergic reactions in patients sensitive to latex. *Malignancies and lymphoproliferative disorders:* In clinical trials, more cases of malignancies including lymphoma and leukaemia have been observed among patients receiving a TNF-antagonist compared with control patients. These data cannot exclude a possible risk of malignancy in patients including children and adolescents treated with TNF antagonists. Furthermore, there is an increased background lymphoma risk in RA patients. Rare postmarketing cases of hepatosplenic T-cell lymphoma have been identified in patients treated with adalimumab. Some of these cases have occurred in young adult patients on concomitant treatment with azathioprine or 6-mercaptopurine used for Crohn's disease. The potential risk with the combination of azathioprine or 6-mercaptopurine and Humira should be carefully considered. A risk for the development of hepatosplenic T-cell lymphoma in patients treated with Humira cannot be excluded. Caution should be exercised in considering Humira treatment of patients with a history of malignancy.All patients, and in particular patients with a medical history of extensive immunosuppressant therapy or psoriasis patients with a history of PUVA treatment should be examined for the presence of non-melanoma skin cancer prior to and during treatment with Humira. Caution should also be exercised when using TNF-antagonists in COPD patients, as well as in patients with increased risk of malignancies due to heavy smoking. *Haematologic reactions:* Pancytopaenia including aplastic anaemia has rarely been reported with TNF blocking agents. Adverse events of the haematologic system, including cytopaenia (eg thrombocytopaenia, leucopaenia) have been reported with Humira. Patients should be advised to seek immediate medical attention if they develop signs and symptoms suggestive of blood dyscrasias. *Vaccinations:* Patients on Humira may receive concurrent vaccinations, except for live vaccines. It is recommended that JIA patients, if possible, be brought up to date with all immunisations in agreement with current immunisation guidelines prior to initiating Humira therapy. *Congestive heart failure:* Humira should be used with caution in patients with mild heart failure (NYHA class I/II) and discontinued in patients who develop new or worsening symptoms of congestive heart failure. *Autoimmune process:* Humira may result in the formation of autoimmune antibodies. If a patient develops symptoms suggestive of a lupus-like syndrome following treatment with Humira and is positive for antibodies against double-stranded DNA, further treatment with Humira should not be given. *Surgery:* There is limited safety experience of surgical procedures in patients treated with Humira. The long half life of Humira should be taken into consideration when a surgical procedure is planned, and the patient should be monitored for infections. *Small bowel obstruction:* Failure to respond to treatment for CD may indicate the presence of fixed fibrotic stricture that may require surgical treatment. Available data suggest that Humira does not worsen or cause strictures. *Elderly population:* The frequency of serious infections among Humira treated subjects over 65 years of age was higher than those under 65 years of age. Some of those had a fatal outcome. Particular attention regarding the risk for infection should be paid when treating the elderly. **Interactions:** Combination of adalimumab with anakinra or abatacept is not recommended. **Pregnancy and lactation:** Administration of adalimumab is not recommended during pregnancy. Women of childbearing potential should use adequate contraception and continue its use for at least five months after the last Humira treatment. Administration of live vaccines to infants exposed to adalimumab in utero is not recommended for at least 5 months following the mother's last adalimumab injection during pregnancy.Women must not breast-feed for at least five months after the last Humira treatment. **Driving and machinery:** Humira may have a minor influence on the ability to drive and use machines. **Side Effects:** From clinical trials unless marked '1' which indicates spontaneous reporting data.Very common ≥ 1/10: Respiratory tract infections (including lower and upper respiratory tract infection, pneumonia, sinusitis, pharyngitis, nasopharyngitis and pneumonia herpes viral), leucopaenia (including neutropaenia and agranulocytosis), anaemia, lipids increased, headache, abdominal pain, nausea and vomiting, elevated liver enzymes, rash (including exfoliative rash), musculoskeletal pain, injection site reaction (including injection site erythema). Common ≥ 1/100 to < 1/10: Systemic infections (including sepsis, candidiasis and influenza), intestinal infections (including gastroenteritis viral), skin and soft tissue infections (including paronychia, cellulitis, impetigo, necrotising fasciitis and herpes zoster), ear infections, oral infections (including herpes simplex, oral herpes and tooth infections), reproductive tract infections (including vulvovaginal mycotic infection), urinary tract infections (including pyelonephritis), fungal infections, benign neoplasm, skin cancer excluding melanoma (including basal cell carcinoma and squamous cell carcinoma), thrombocytopaenia, leucocytosis, hypersensitivity, allergies (including seasonal allergy), hypokalaemia, uric acid increased, blood sodium abnormal, hypocalcaemia, hyperglycaemia, hypophosphotaemia, blood potassium increased, mood alterations (including depression), anxiety, insomnia, paraesthesias (including hyposesthesia), migraine, sciatica, visual impairment, conjunctivitis, vertigo, tachycardia, hypertension, flushing, haematoma, cough, asthma, dyspnoea, GI haemorrhage, dyspepsia, gastroesophageal reflux disease, sicca syndrome, worsening and new onset of psoriasis (including palmplantar pustular psoriasis1, alopecia1, pruritis, urticaria, bruising (including purpura), dermatitis (including eczema), onychoclasis, hyperhydrosis, muscle spasms (including blood creatine phosphokinase increased), haematuria, renal impairment, chest pain, oedema, coagulation and bleeding disorders (including activated partial thromboplastin time prolonged), autoantibody test positive (including double stranded DNA antibody), blood lactate dehydrogenase increased, impaired healing. Uncommon ≥ 1/1000 to < 1/100: Opportunistic infections and tuberculosis (including coccidioidomycosis, histoplasmosis and mycobacterium avium complex infection), neurological infections (including viral meningitis), eye infections, bacterial infections, joint infections, diverticulitis1, lymphoma, solid organ neoplasm (including breast cancer, lung neoplasm and thyroid neoplasm), melanoma, idiopathic thrombocytopaenic purpura, sarcoidosis1, dehydration, cerebrovascular accident1, tremor, blepharitis, eye swelling, diplopia, deafness, tinnitus, myocardial infarction1, arrhythmia, congestive heart failure, pulmonary embolism1, chronic obstructive pulmonary disease, interstitial lung disease, pneumonitis, pleural effusion1, pancreatitis, dysphagia, face oedema, cholecystitis and cholelithiasis, bilirubin increased, hepatic steatosis, night sweats, scar, rhabdomyolysis, nocturia, erectile dysfunction, inflammation. Rare ≥ 1/10,000 to < 1/1,000: Leukaemia1, anaphylaxis1, demyelinating disorders (e.g. optic neuritis, Guillain-Barré syndrome) 1, pancytopaenia, multiple sclerosis, cardiac arrest, vascular arterial occlusion, aortic aneurysm, thrombophlebitis, pulmonary fibrosis1, intestinal perforation1, reactivation of hepatitis B1, erythema multiforme1, cutaneous vasculitis1, Stevens-Johnson syndrome1, angioedema1, systemic lupus erythematosus, lupus-like syndrome1. Not known: Hepatosplenic T-cell lymphoma1. **Prescribers should consult the summary of product characteristics for further information on side effects. Overdose:** No dose-limiting toxicity was observed during clinical trials. The highest dose level evaluated has been multiple intravenous doses of 10 mg/kg (approximately 15 times the recommended dose). **Storage Conditions:** Store in a refrigerator at 2 - 8 °C. 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References: 1. Menter A, Tyring SK, Gordon K, et al. Adalimumab therapy for moderate to severe psoriasis: a randomized controlled phase III trial. J Am Acad Dermatol. 2008; 58(1):106-115. **2.** Gordon K, Papp K, and Poulin Y et al. Long-term efficacy and safety of Adalimumab in patients with moderate to severe psoriasis treated continuously over 3 years: Results from an open-label extension study for patients from REVEAL. J Am Acad Dermatol. 2012; 2:241-251.

Date of preparation: April 2012 IRE/HUM/120/149

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paediatric inpatient admissions were for the treatment of atopic dermatitis with wet dressings.

The majority of admissions to the day treatment centre were for the management of dermatitis with wet dressings, and for the management of psoriasis with the Goeckerman treatment.

Case Presentations

ORAL ABSTRACT 07
Orbital Exenteration secondary to invasive Non-Melanoma Skin Cancer.

Author(s): E Storan, B Moran, B Wynne, P Ormond.

Institution(s): St. James's Hospital, Dublin

Abstract:
Case 1: A 35-year-old gentleman presented to ophthalmology in early 2008 with a large ulcerating nodule of the right medial canthus that had been present for several months. Biopsy revealed an infiltrative squamous cell carcinoma (SCC) and he proceeded to wide local excision with reported clear margins. In November 2008, he developed cutaneous recurrence of the SCC at the right pre-auricular area and a positive regional lymph node. He underwent parotid and neck dissection and Mohs micrographic surgery (MMS). Clear soft tissue margins were achieved and received post-operative radiotherapy in early 2009. His SCC recurred in late 2009 at the right medial canthus. MR head and neck revealed infiltration of tumour into the right orbit and extraocular muscles and he underwent exenteration of his right eye and ethmoidectomy with simultaneous intraoperative MMS. He proceeded to chemotherapy and is currently under observation.

Case 2: An 82-year-year old lady presented in late 2009 with a several years history of an ulcerating nodule at the right lower eyelid. Biopsy revealed invasive basal cell carcinoma (BCC) with squamous differentiation. MR of the orbits showed extensive tumour involvement of the upper and lower eyelids of the right eye with extension to the maxillary sinus. She underwent right parotidectomy, selective right neck dissection and right orbit exenteration after MMS revealed involvement of the right orbit.

Case 3: An 84-year-old lady was seen at dermatology clinic in early 2008 with an ulcerating nodule of her right medial canthus present for over a year. She proceeded to MMS in May 2008 that revealed widely invasive squamous cell carcinoma. Clear soft tissue margins were achieved. In early 2009 she re-presented with recurrence of a nodule at her right medial canthus and associated right eye pain. CT orbits showed tumour infiltration around the medial canthus with extension into the right orbit and nasal cavity and bony destruction of the maxillary sinus. She underwent modified radical neck dissection, maxillectomy and right orbit exenteration with selective intraoperative MMS.

Case 4: A 64-year-old gentleman presented in January 2008 with a 4-year history of an enlarging ulcerating plaque on his right cheek. MR head was performed and revealed local invasion and destruction of the right zygoma and maxillary antrum and infiltration of tumour into the right orbit. Incisional biopsy revealed infiltrative SCC. He underwent right-sided neck dissection, maxillectomy, zygomectomy and exenteration of the right orbit with selective MMS.
These cases describe the rarely reported serious complications of non-melanomatous skin cancer and the importance of multidisciplinary management.

ORAL ABSTRACT 08
First report of Kaposi's sarcoma in ciclosporin treated atopic dermatitis; implications for screening pre immunosuppression?

Author(s): Wall D, Moran B, Irvine AD.

Institution(s): Department of Dermatology, St James's Hospital, Dublin.

Abstract:
A 42 year old Congolese man, resident in Ireland for 11 years, was treated with ciclosporin (CSA) for recalcitrant, biopsy proven, lichenified eczema of the beard area. Within 8 weeks of treatment, painful, hyperpigmented nodules and plaques appeared within a previously patchy, lichenified area on the left thigh and spread to both lower limbs. Kaposi's sarcoma (KS) was histologically confirmed and immunostaining was positive for HHV8 (HIV serology negative). Doxorubicin was commenced and CSA stopped with subsequent improvement. Shortness of breath and chest discomfort however raised the suspicion of doxorubicin-induced cardiomyopathy (currently under investigation), but treatment has continued in view of deteriorating control of the patient's KS.

Discussion:
Histopathology is identical across the 4 subtypes of KS, differentiated on clinical grounds into, AIDS-associated, classic, iatrogenic and endemic, of which our case is a cross-over of the latter two. The link between CSA and KS has been well documented in other conditions, but never previously in the context of atopic dermatitis (AD).
2 cases of AD-associated KS have been described, with recent oral corticosteroid and Azathioprine therapy respectively (both HIV-negative)[1,2]. We therefore suggest a role for HHV8 screening in at risk populations with AD, and possibly other dermatological conditions, prior to systemic immunosuppression.

References:
Salem H a, El Sohafy M, Abd El Gawad M. Kaposi's sarcoma in an atopic dermatitis patient: a case report and a review of literature. Pediatric dermatology [Internet]. 2011;28(5):547–9.
Vandercam B, Lachapelle JM, Janssen P et al. Kaposi's sarcoma during immunosuppressive therapy for atopic dermatitis.Dermatology 1997;194:180–182.

ORAL ABSTRACT 09
Spontaneous regression of metastatic squamous cell carcinoma of unknown primary

Author(s): Foley C[1], McMenamin M[2], Ormond P[1], Irvine AD[1]

Institution(s): Departments of Dermatology[1] and Histopathology[2], St. James's Hospital, James's Street, Dublin 8

Abstract:
(Your abstract must use style and must fit in this space) A 74 year old lady presented with a rash on her right leg in October 2011. She had multiple dermal nodules between the knee and the ankle. A biopsy of one of the nodules showed intact skin with underlying poorly differentiated squamous cell carcinoma (SCC), confirmed by positive staining for epithelial membrane antigen (EMA) and cytokeratins. Full skin examination, including breasts, external genitalia and oral mucosa, did not reveal any obvious primary cutaneous lesion. She was seen by otorhinolaryngology and had no abnormality on upper airway endoscopy.

Her case was discussed with radiology, who suggested going straight to PET-CT to evaluate the extent of disease and possibly identify a primary. PET-CT showed more than 12 cutaneous 18-fluorodeoxyglucose (FDG) avid nodules below the knee in the right leg and low grade uptake within two morphologically normal right inguinal nodes. There was no evidence of distant metastases. Histopathology on fine needle aspirate from one of the inguinal nodes showed no evidence of metastatic disease.

After discussion at the skin cancer multidisciplinary team meeting she was referred to plastic surgery for an above knee amputation. She was seen by plastic surgery, medical oncology and radiation oncology but declined all treatment.
When seen in outpatients in February 2012, all of the lesions on the right leg had resolved and there were no suspicious cutaneous lesions elsewhere or lymphadenopathy. A repeat PET-CT showed no abnormality in the right lower limb or elsewhere. She attended a healer in the intervening period and had the affected leg blessed with Padre Pio's glove. In July, 9 months after initial presentation she is well with no cutaneous lesions.

While SCC of the skin is common, metastatic SCC of unknown primary is rare. Spontaneous regression of SCC has been previously described with primaries in the lung, oesophagus and oral cavity. The mechanism of this phenomenon is poorly understood.

ORAL ABSTRACT 10
Spontaneous Resolution of Keratoacanthoma Centrifugum Marginatum

Author(s): RH El-Khayat,C McGrath, SE Hoey

Institution(s): Department of Dermatology, Royal Victoria Hospital, Belfast City

Abstract:
An 87 year old lady with advanced Alzheimer`s disease presented in 2009 with an 8 month history of a lesion on the dorsal aspect of her right hand. It started as a small pimple then gradually increased in sized. It failed to respond to cryotherapy carried out by the general practitioner. At the initial review there was a 6×6 cm annular lesion with peripheral coalescing multiple large nodules and central healing. A 4 mm diagnostic punch biopsy was inconclusive. It showed no evidence of malignancy.

The lesion continued to increase in size reaching 10× 10 cm, 5 month later. Two subsequent 3 diagnostic punch biopsies were performed (2 from periphery and one from the centre). Again these were also inconclusive. They showed no evidence of dysplasia, malignancy or granulomatous inflammation. Fungal stains and Mycobacterium culture were both negative.

This case was discussed at our local MDT. A further four incisional biopsies from different sites within the lesion were carried out. Of those two were suggestive of squamous cell carcinoma. However, the lesion began to involute spontaneously. This was associated with a number of inflammatory episodes at which the right lower arm became red and inflamed. Given the spontaneous involution and the advanced dementia a 'watch and wait' policy was implemented, with the patient closely followed up and monitored. Eventually the lesion at the dorsal aspect of the right hand cleared and this site remains clear after 12 month follow up.

In our case the combination of the clinical picture, histopathopathological finding and serial medical photography support the diagnosis of spontaneous resolution of a keratoacanthoma centrifugum marginatum (KCM).

KCM with less than 40 cases reported worldwide is a rare variant of Keratoacanthoma. It typically shows no tendency for spontaneous resolution[1,2]. Therefore, our case is very unusual and interesting.

References:
Miedzinski F, Kozakiewicz J, keratoacanthoma centrifugum- a special variety of Keratoacanthoma. Hautarzt 1962;13:348-352
Attili S, Attili VR, keratoacanthoma centrifugum Marginatum arising in vitiligo : a case report. Dermatol Online J 2006;12:18

ORAL ABSTRACT 11
Multifocal primary cutaneous anaplastic large cell lymphoma.

Author(s): S Verma, N Ralph, G Gullo, K Sheahan, P Collins.

Institution(s): St Vincents University Hospital, Departments of Dermatology, Oncology and Pathology

Abstract:
A 70-year old man presented with widespread skin tumours for more than one year. He had a multiple lesions on the left lateral thigh and recently developed smaller lesions on the popliteal fossa, arms and scalp. The lesions on the left thigh were tender, malodorous and weeping. He was systemically well and denied any weight loss or night sweats.

His medical history was significant for atopic dermatitis, ichthyosis vulgaris, asthma and hay fever. His medications included a salbutamol inhaler. He was a retired civil servant and an active smoker.

Examination showed grouped violaceous eroded tumours on the left thigh, the largest of which measured 19 x 9 cms, and with evidence of underlying muscle loss. There were smaller satellite tumours on the arms, popliteal fossa and scalp, and clinical evidence of inguinal lymphadenopathy.

Skin biopsy showed a dermal infiltrate composed of sheets of large cells with an irregular appearance with small reactive lymphocytes at the periphery. There was abundant mitotic activity, but no epidermotropism. Immunohistochemistry was positive for CD45, CD4, and CD 30. CD8, CD20, CD3, CD56, as well as CD138 and S100 were negative.
Investigations showed an elevated LDH, alkaline phosphatase, ESR and CRP. Whole body CT showed multiple skin tumours of the left thigh with subcutaneous fat invasion, bilateral inguinal lymphadenopathy and a single enlarged necrotic right paratracheal lymphnode. There was no evidence of visceral or CNS involvement. Bone marrow aspirate, immunophenotyping and CSF exam were normal.

A diagnosis of primary cutaneous anaplastic large cell lymphoma (pALCL) was confirmed. He was commenced on CHOP chemotherapy and initially had a dramatic reduction of tumour size on his left thigh with resolution of satellite lesions elsewhere. At the completion of treatment, he had a residual fungating tumour on the left thigh. Restaging with PET CT post treatment confirmed residual activity in the left thigh, with borderline enlarged inguinal lymphadenopathy and paratracheal lymph nodes. He was treated with palliative radiotherapy and had a clearance of the tumour on the left thigh. However continued to make new tumours elsewhere. pALCL has a favourable prognosis, but poor prognostic features include older age at diagnosis, extensive single limb involvement and extracutaneous disease.

1. Woo DK, Jones CR, Vanoli-Storz MN,et al. Prognostic factors in primary cutaneous anaplastic large cell lymphoma: characterization of clinical subset with worse outcome. Arch Dermatol. 2009 Jun;145(6):667-74.

ORAL ABSTRACT 12
Malignant eccrine spiradenoma(MES) - A case report of this rare cutaneous adnexal tumour.

Author(s): O'Callaghan DM,McInerney N, Kelly JL

Institution(s): NUI Galway

Abstract:
Description: Malignant eccrine spiradenoma (MES) is an exceptionally rare tumour of cutaneous adnexal origin. Most cases have originated from transformation of a long standing benign spiradenoma. We report a new case of this rare tumour in a 55 yr old female who presented with a swelling on her right forearm for eighteen years. Histologically the tumour showed typical features of a benign spiradenoma transitioning with areas of adenocarcinoma. Immunohistochemistry showed diffuse strong staining for cytokeratin 7 and AE1/3 in the tumour cells. BMA was also positive. Imaging studies did not reveal any metastastic disease. Surgical management with wide local excision was undertaken and the patient is under surveillance. With this case we wish to highlight a classical presentation of MES, an eccrine carcinoma which behaves in a very aggressive manner with a high rate of local recurrence, potential for distant metastasis and mortality.

References:
1. Granter SR, Seeger K, Calonje E, Busam K, McKee PH. Malignant eccrine spiradenoma (spiradenocarcinoma): a clinicopathologic study of 12 cases. Am J Dermatopathol. 2000 Apr;22(2):97-103.
2. CA. Storm, and JT Seykora, Cutaneous Adnexal Neoplasms J Clin Pathol 2002;118(Suppl 1):S33-S49

ORAL ABSTRACT 13
Fluorescence in situ hybridization (FISH) analysis as an adjunct to the diagnosis and management of melanoma: A case report.

Author(s): O'Callaghan DM, Jones DM, Tan M

Abstract:
We present a case of a 65yr old female who had an unusual nodule excised from her upper lip and upon histological examination by multiple dermatopathologists ambiguity remained as to whether this lesion should be classified as a naevoid melanoma or an atypical naevus. This case was particularly challenging as the patient reported the lesion had been longstanding and unchanged and further surgery would have significant cosmetic implications. Several studies have supported the use of fluorescence in situ hybridization (FISH) analysis as an aid to characterization of challenging melanocytic lesions.A melanoma FISH analysis was performed in this case and strongly supported the diagnosis of melanoma. The patient subsequently underwent wide local

excision with flap reconstruction. We report this case to highlight this novel and highly sensitive and specific technique as an adjunct to the diagnosis and management of melanoma.

References:

1. Gerami P, Zembowicz A. Update on fluorescence in situ hybridization in melanoma: state of the art. Arch Pathol Lab Med. 2011 Jul;135(7):830-7.
2. Gerami P, Wass A, Mafee M, Fang Y, Pulitzer MP, Busam KJ. Fluorescence in situ hybridization for distinguishing nevoid melanomas from mitotically active nevi. Am J Surg Pathol. 2009 Dec; 33(12):1783-8

ORAL ABSTRACT 14

Muir-Torre syndrome and diagnostic error: lessons learned.

Author(s): Wall D, Hackett C, Ahmad K, Ramsay B.

Institution(s): Department of Dermatology, University Hospital Limerick.

Abstract:
We present a case of a 65yr old female who had an unusual nodule excised from her upper lip and upon histological examination by multiple dermatopathologists ambiguity remained as to whether this lesion should be classified as a naevoid melanoma or an atypical naevus. This case was particularly challenging as the patient reported the lesion had been longstanding and unchanged and further surgery would have significant cosmetic implications. Several studies have supported the use of fluorescence in situ hybridization (FISH) analysis as an aid to characterization of challenging melanocytic lesions.A melanoma FISH analysis was performed in this case and strongly supported the diagnosis of melanoma. The patient subsequently underwent wide local excision with flap reconstruction. We report this case to highlight this novel and highly sensitive and specific technique as an adjunct to the diagnosis and management of melanoma.

References:

Gerami P, Zembowicz A. Update on fluorescence in situ hybridization in melanoma: state of the art. Arch Pathol Lab Med. 2011 Jul;135(7):830-7.
Gerami P, Wass A, Mafee M, Fang Y, Pulitzer MP, Busam KJ. Fluorescence in situ hybridization for distinguishing nevoid melanomas from mitotically active nevi. Am J Surg Pathol. 2009 Dec; 33(12):1783-8

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Poster Presentations

No.	Title	Author(s)
P001	**Patient satisfaction in a pigmented lesion clinic**	SJ O'Shea, M Dunphy, C Buckley Waterford Regional Hospital
P002	**Basal Cell Carcinoma in young adults.**	A.Kecler–Pietrzyk, E Storan, P. Ormond Department of Dermatology, St.James Hospital, Dublin
P003	**Contact allergy in Non-Actinic Cheilitis**	O'Gorman S.1, Torgerson R2. 1Department of Internal Medicine, Mayo Clinic Rochester, MN, USA 2Department of Dermatology, Mayo Clinic Rochester, MN, USA
P004	**Lessons in underestimating Basal Cell Carcinomas**	Wen Lyn Ho, Eoin Storan, Benvon Moran, Patrick Ormond Department of Dermatology, St James Hospital, Dublin
P005	**Dermatological Diagnosis of Muir Torre Syndrome**	Eoin Storan, Bairbre Wynne St. James's Hospital, Dublin
P006	**A case of Dermatofibrosarcoma Protuberans**	Presenter: Dr Gemma McIntyre Dermatology FTSTA3 Royal Victoria Hospital on behalf of Dr Rory Corbett
P007	**Are the new ACCS stageing criteria for cutaneous squamous cell cancers being used in histology reports?**	R Fitzgerald, C Maguire, P Collins, B Kirby, A Lally St Vincent's Univerity Hospital, Dublin
P008	**Allergic Contact Dermatitis of the Vulva**	O'Gorman S.1, Torgerson R2. 1Department of Internal Medicine, Mayo Clinic Rochester, MN, USA 2Department of Dermatology, Mayo Clinic Rochester, MN, USA
P009	**The solitary purple nodule.**	SJ O'Shea, S O'Gorman, GM Murphy Beaumont Hospital, Dublin 9.
P010	**Malignant Melanoma Database 2012**	Dr Michael Lavery; Dr Patricia Podmore Department of Dermatology, Altnagelvin Area Hospital, Derry
P 011	**Beware of the "Irritated Seborrhoeic Keratosis"**	O'Gorman S.1, O'Shea S.1, Murphy G1. 1 Department of Dermatology, Beaumont Hospital, Dublin, Ireland.
P012	**Adult Dermatology Hospital Consults at a U.S Tertiary Referral Centre**	Eoin Storan1, Mark Davis2, Departments of Internal Medicine1 and Dermatology2, Mayo Clinic, Rochester, MN, USA

POSTER PRESENTATIONS

POSTER ABSTRACT 001
Patient satisfaction in a pigmented lesion clinic

Author(s): SJ O'Shea, M Dunphy, C Buckley

Institution(s): Waterford Regional Hospital

Abstract:
The demand for rapid access pigmented lesion clinics (PLC) is increasing. The positive effects of such clinics has already been shown.[1] Full skin examination (FSE) can lead to detection of other significant lesions that might otherwise go undiagnosed.[2] Some centres routinely provide FSE, while in others, the referred lesion is examined in isolation. Little is known about patient satisfaction. The study aim was to compare patient satisfaction among those who had FSE or single lesion examination (SL).

Following ethical approval, a questionnaire was distributed to two groups of adult patients attending a PLC. The first (n=50) had FSE and the second (n=50) was offered examination of referred lesion (SL). Patients were assigned to FSE automatically if referred with multiple lesions, expressed concern about >1 lesion, or if considered to be high risk, e.g. previous skin cancer. For equality, SL group was also offered FSE after the questionnaire.

One hundred (95%) patients responded; 68 were female. Mean age was 41 (range 18-75) years. Mean score for satisfaction with clinical examination was 9.35±1.25/10 and 9.65±0.83/10 for SL and FSE, respectively. There was no significant difference in scores between the two groups (Mann Whitney, p=0.15).

24% were surprised to have FSE. Of those who had FSE, whether assigned or following SL examination with subsequent FSE, 96% considered it to be beneficial. Just 4% FSE and 20% SL (n=10; 9 of whom declined further examination) would have preferred to have examination of referred lesion alone. Benefits of FSE quoted included: reassurance/peace of mind (33%), other moles checked (20%), other lesions noted/treated (3%).

Of those assigned to SL, 54% declined to have rest of skin examined. Reasons given were: 'not needed' (n=6), 'no other moles/lesions' (n=6), 'not worried' (n=4), 'don't have time' (n=3), 'not prepared/no prior notice' (n=2), 'advice of GP/GP checks moles regularly' (n=1), 'seen before' (n=1), 'don't want to' (n=1).

This study shows that patient satisfaction is similar among patients offered SL or FSE, however, most patients consider FSE worthwhile. It may be beneficial to provide notice to patients of possible FSE in advance of attendance at clinic.

References

Field S, Deady S, Fitzgibbon J, Murphy M, Comber H. Improved malignant melanoma prognosis at a consultant-delivered multidisciplinary pigmented lesion clinic in Cork. *Ir Med J.* 2010; 103 (2):40-3.

Moran B, McDonald I, Wall D, O'Shea SJ, Ryan C, Ryan AJ, Kirby B. Complete skin examination is essential in the assessment of dermatology patients: findings from 483 patients. *Br J Dermatol.* 2011; 165 (5):1124-6.

POSTER ABSTRACT 002
Basal Cell Carcinoma in young adults.

Author(s): A.Kecler–Pietrzyk, E Storan, P. Ormond

Institution(s): Department of Dermatology, St.James Hospital, Dublin

Abstract:
The incidence of non - melanoma skin cancers is increasing in young adults. The histological subtypes and sites involved is less well known in this subgroup. We analysed patients under 45 years old diagnosed with Basal cell carcinoma in our hospital over a 10 year period.

Objectives: To investigate the sex- and age-specific incidence of basal cell carcinoma in a young adult population attending our hospital and describe the histological type, size and depth of these tumours, and the time between appearance and presentation to their doctor.

Method : Retrospective chart and histopathological reports based analysis of BCCs diagnosed in patients younger than 45 years of age, over a 10 year period between 2001 – 2011. Histological parameters were analysed in those diagnosed between 2006 and 2011.

Results: 6790 BCCs were diagnosed in 5911 patients in the study period. 547 patients with 633 BCCs were under the age of 45 which constituted 9.25 % of all BCCs. The incidence of basal cell carcinoma doubled during the study period, and more women were diagnosed with BCC then men. 391 BCCs were diagnosed between 2006-11: 85.68 % of these were a single histological type, 14.32 % were mixed. Nodular BCCs were the most common (45.01 %), followed by superficial (21.22%), mixed (14.32%), sclerosing (11.25%), micronodular (4%) and infiltrating (4%). More male patients (55%) had nodular BCCs. Women were more often diagnosed with superficial subtype (25.23%) then men (16.57%). Aggressive subtypes were found in 15 % of males and 22.86 % of females. The commonest site affected was the face: 68.21% of lesions with nodular subtype diagnosed in 56.25% of cases. 47.5% lesions on the trunk were found to be superficial. Infiltrating and sclerosing subtypes were found most commonly on face in women but on non-facial sites in men.The mean tumour diameter was 8.1 mm and mean depth was 2.05 mm, being larger and deeper in men. Mean time from patients noticing a lesion to initial presentation to primary health care professional was 19.8 months in women, 38.2 months in men.

Conclusion: BCCs in young adults are not uncommon, although traditionally thought to affect older age groups. Increased incidence of BCCs in this subgroup was noticed over the period of study. More women under the age of 45 are diagnosed with BCCs than men, and they are more often diagnosed with high – risk BCCs. Tumours tended to be bigger and deeper in men. Mean time of presentation with a skin lesion was twice as long in men.

POSTER ABSTRACT 003
Contact allergy in Non-Actinic Cheilitis

Author(s): O'Gorman S.[1], Torgerson R[2].

Institution(s): [1]Department of Internal Medicine, Mayo Clinic Rochester, MN, USA
[2]Department of Dermatology, Mayo Clinic Rochester, MN, USA

Abstract:
Background and Objectives:
Recalcitrant non-actinic cheilitis may be an indication of contact allergy. We performed a retrospective review of patch-testing results in patients with non-actinic cheilitis to determine the prevalence of allergic contact cheilitis in this group and to identify which allergens are most relevant.

Materials and Methods:
Using a database, from three geographically distinct sites, we identified patients with cheilitis, who were patch tested between April 2001 and August 2011. Additional data were obtained from the electronic medical records. Patch testing was in line with accepted universal methods; application on day 1, allergen removal and initial reading on day 3 and final reading on day 5.

Results:
91 patients were included in our study. 76.9% were female and the mean age was 51 years. 45% had a final diagnosis of allergic contact cheilitis (ACC). The allergens of most significance were Fragrance mix, Myroxylon Pereirae resin, Dodecyl gallate and Octyl gallate and Benzoic acid. Nickel was the most relevant metal allergen.

Conclusions:
Contact allergy is an important consideration in recalcitrant cheilitis. Fragrances, antioxidants and preservatives dominated the list of relevant allergens. Nickel and gold appeared among our list of top ten allergens. 45% of the patients in our series had a final diagnosis of allergic contact cheilitis

POSTER ABSTRACT 004
Lessons in underestimating Basal Cell Carcinomas

Author(s): Wen Lyn Ho, Eoin Storan, Benvon Moran, Patrick Ormond

Institution(s): Department of Dermatology, St James Hospital, Dublin

Abstract:
Basal cell carcinomas (BCC) represent an extremely common skin cancer. Traditional teaching focuses on the "benign" nature of BCCs. However, BCCs can have devastating consequences. This is usually one of two reasons, the physician underestimating its aggressive potential or some patients denying or ignoring the existence of these tumours. Here we present two cases where these factors culminated in poor prognostic metastatic tumours. First case demonstrating the former reason is a 70 year old man who was treated by a general surgeon for a medial canthal BCC which had been present for a year. A year after excision, the lesion recurred. He was referred to dermatology for MOHs surgery which did not clear the tumour due to involvement of bone. He subsequently had nasal frontal bone excised and reconstructed with a forehead flap for closure of defect. A few months later, this was re-excised to remove area of residual BCC. He then presented 8 mths later with diplopia. CT orbit showed BCC eroding the posterior wall of frontal sinus extending into the right cranial fossa and frontal lobe. He currently awaits neurosurgical review and oncology opinion with a possibility of commencing, Vismodegib, the new hedgehog pathway inhibitor.

Second case is an 84 yr old man who presented with a large ulcerating BCC on his right cheek. This was narrowly excised from the deep margin. Six months later, a subcutaneous nodular swelling appeared on the lateral aspect of his scar associated with facial nerve weakness. Re-excision of tumour including parotidectomy showed a sclerosing, infiltrating BCC with evidence of severely atypical squamous component extending to margins. There was perineural invasion with tumour present in the periosteum of bone fragment. He received radiotherapy treatment with 10 fractions/44Grays.Two years later, he developed a recurrence on the same site. PET-CT scan showed right infratemporal lesion with multiple metastatic pulmonary nodules. Endobronchial biopsy confirmed metastatic BCC. Given his poor performance status, he was not a suitable candidate for chemotherapy. He received palliative care and died a few months later.

BCCs are easily treated in early stages. The larger the tumour grows, the more extensive the treatment needed. Although metastases derived from BCCs are exceedingly rare, it is vital for physicians to be aware of this potential. On the other hand, BCCs which develop in the elderly grows slowly thus making them "ideal candidate" for a neglected tumour. Unfortunately, for advanced aggressive tumours, despite the choice of best possible treatment modalities, a rather unfavourable prognosis and high recurrence rate are to be anticipated.

POSTER ABSTRACT 005
Dermatological Diagnosis of Muir Torre Syndrome

Author(s): Eoin Storan, Bairbre Wynne

Institution(s): St. James's Hospital, Dublin

Abstract:
A 61 year-old female with a background history of endometrial cancer in 1996 and breast cancer in 2010, both currently in remission, presented to dermatology for evaluation of a 6-month history of an ulcerated nodule on her lower abdominal wall. Given the concern for squamous cell carcinoma, shave excision was performed which revealed a

sebaceous carcinoma. Tumour cells showed loss of expression of the mismatch repair proteins MLH2 and MLH6 strongly indicating a diagnosis of Muir Torre syndrome. She underwent wide local excision of the abdominal nodule. She proceeded to PET CT to investigate for further occult malignancies and this revealed a moderately FDG-avid 2.3cm subcutaneous soft tissue nodule on the right buttock but no evidence of visceral malignancy. Her physical exam showed an ulcerated nodule on her right buttock, which was excised by wide local excision. Histology revealed a second sebaceous carcinoma. Over the subsequent weeks, she underwent excisional biopsies of sebaceous adenomata from her right arm and back in addition to an excisional biopsy of a sclerosing basal cell carcinoma from her nose.

Genetic testing confirmed heterozygous pathogenic deletion of the MSH2 gene, consistent with a diagnosis of Muir Torre syndrome. Given this woman's history of visceral malignancy and sebaceous neoplasms of the skin, she was diagnosed with Muir Torre syndrome. Family screening is currently underway.

Muir Torre Syndrome is an autosomal dominant hereditary cancer syndrome characterised by the combination of sebaceous neoplasms of the skin (sebaceous adenoma, sebaceous epithelioma, or sebaceous carcinoma) and a visceral malignancy (usually gastrointestinal or genitourinary carcinomas). It is believed to be a variant of hereditary polyposis colorectal cancer syndrome. It affects MLH1 and MLH2 which results in DNA mismatch repair.

This patient will require annual screening for breast, urogential and gastrointestinal malignancy in addition to a 6-monthly skin examination by a dermatologist.

POSTER ABSTRACT 006
A case of Dermatofibrosarcoma Protuberans

Author(s): Dr Gemma McIntyre Dermatology FTSTA3 Royal Victoria Hospital on behalf of Dr Rory Corbett

Abstract:
Clinical History:
Miss PG is a 41 year old lady who was referred to dermatology on 5/7/2012 with a lesion below her right breast which had been present from her teens. During her second pregnancy in October 2011 she noticed that the lesion had become more raised and painful. Following the birth of her baby it had settled again to its original appearance; however she continued to experience some tenderness over the lesion on touch and had been using daily dressings to cover it. She denied ever having had any trauma to the particular site. She had no similar lesions elsewhere and was otherwise in very good health.

Examination:
On examination there was a 3x2.5cm fibrotic area on the right lower ribcage consisting of a 2x2cm soft blue/red nodule which was compressible centrally with a surrounding more macular, atrophic area with a violaceous edge. The lesion was tender on palpation.

Management:
A 4mm diagnostic skin biopsy was performed of the lesion and histology showed features in keeping with a dermatofibrosarcoma protuberans. Her case was discussed at our local Skin MDM on 2/8/12 and she has been red flagged to plastic surgery to undergo wider excision which is scheduled for 14/09/2012.

Discussion:
Dermatofibrosacroma protuberans is an uncommon skin tumour arising in the deeper layers of the skin (the dermis). The cause is unknown, but an injury to the affected skin may be a predisposing factor. It usually presents in early or middle life between 20 and 50 years of age, but all ages may be affected. Males are affected slightly more than females. The absence of symptoms often leads to a delay in diagnosis. Treatment consists of wide excision of the lesion although there is no published guidance in the UK on management. Different margins are suggested by different sources. The tumour metastasises in 5% of cases, but local recurrences arise in 11-20% cases, usually within 3 years of initial surgery so follow-up is very important.[1] I present this as an interesting case and present the findings of a 10 year review of all dermatofibrosarcoma protuberans presenting within the Belfast trust.

References:
DermNet NZ (2011). Dermatofibrosarcoma protuberans. Available at: http://www.dermnetnz.org/lesions/dfsp.html (Accessed 1/9/12).

POSTER ABSTRACT 007
Are the new ACCS stageing criteria for cutaneous squamous cell cancers being used in histology reports?

Author(s): R Fitzgerald, C Maguire, P Collins, B Kirby, A Lally

Institution(s): St Vincent's Univerity Hospital, Dublin

Abstract:
Cutaneous squamous cell cancer (cSCC) is the second commonest form of skin cancer. Morbidity and mortality, as in melanoma, depends on certain tumour characteristics. To adequately assess the potential risk of a tumour, the ACCS issued a new system for the grading of cSCCs in January 2011. Tumours are classified as low- or high-risk based on the presence of two or more high-risk characteristics, including size greater than 2cm, depth greater than 2mm, site lip or ear, Clarke level, and presence of perineural and lymphovascular invasion. Tumours are deemed adequately resected if the histological margin is greater than 1mm. This audit sought to establish whether or not the new criteria are being applied in histology reports in the authors' own institution. 138 cSCCs were reported between February and July 2011. 14/138 (10.1%) were shave excised, 124/138 (89.9%) were excised. 71/138 (51.4%%) were on the on the head, while 4/138 (2.9%) were on the neck. Of head and neck cancers, 2.3% (1.4% of all tumours) were on the lip, 11.5% (7.2% of all tumours) were on the ear. The rest were

on the leg (21/138, 15.2%), hand (11/138, 8.0%), trunk (7/138, 5.1%, arm (9/138, 6.5%, anus (2/138, 1.4%), shoulder (1/138, 0.7%). Differentiation was reported in 119/138 (86.2%). 57/119 (48%) were moderately differentiated, 51/119 (42.9%) were well differentiated, 10/119 (8.4%) were poorly differentiated and 1 was graded as moderately-poorly differentiated. In 110/138 (79.7%), tumour size was provided. 23/110 (20.9%) were >2cm size, 87/110 (63%) were <2cm in size. In 94/138 (68.1%), depth was mentioned. 17/94 (12.3%) were <2mm in depth, while 77/94 (87.7%) were greater than 2mm in depth. Presence or absence of lymphovascular invasion was reported in 78/138 (56.5%) of all tumours. In 1/78 (1.3%) lymphovascular invasion was present, whereas in 77/78 (98.7%) lymphovascular invasion was absent. Perineural invasion was reported in 81/138 (58.7%). It was present in 6/81 (7.4%), and absent in 92.6% (75/81). Clarke level was documented in 76/138 (55.8%). 25/76 (32.9%) were level 5, 31/76 (40.8%) level 4, 16/76 (21%) level 3, 2/76 (2.6%) level 2, and 2/76 (2.6%) level 1. Stage, was given in 81/138 (58.7%). 32/81 (39.5%) were stage T2, 48/81 (59.3%) T1, and 10/81 (1.2%) T3. Excluding shave excisions, a complete excision rate of 82.9% was seen in histology reports where information on completeness of excision was provided. This audit demonstrates that in the majority of histology reports, detail on important criteria such as high-risk characteristics was provided. Factors that could improve reports include a multidisciplinary meeting for cSCCs and improved resources for histopathology. Limitations of this study are the small sample size and that the sampling period started immediately after the new criteria were issued.

POSTER ABSTRACT 008
Allergic Contact Dermatitis of the Vulva

Author(s): O'Gorman S.[1], Torgerson R[2].

Institution(s): [1]Department of Internal Medicine, Mayo Clinic Rochester, MN, USA
[2]Department of Dermatology, Mayo Clinic Rochester, MN, USA

Abstract:
Background and Objectives:
Allergic contact dermatitis (ACD) of the vulva can arise as a primary condition or can develop secondary to topical agents. We aimed to describe the incidence of ACD in patients presenting with vulvar symptoms and to identify the allergens of most significance.

Patients and Methods:
Using a database of the patch testing results from three geographically distinct sites, we identified patients tested to a gynecologic series between 2003 and 2010. Patients had patch testing to the standard European battery and a gynecologic series. Patch testing was in line with accepted universal methods; application on day 1, allergen removal and initial reading on day 3 and final reading on day 5.

Results:
Ninety patients were included. Thirty-five (38.9%) had a relevant positive result. The top five standard series allergens to cause a relevant reaction were the Natural Fragrance Mix 2%, Balsam of Peru, Benzocaine 5%, Fragrance Mix 8% and Quaternium 15 1%. The most common gynecologic series allergen to cause a relevant reaction was Terconazole.

Conclusions:
Allergic contact dermatitis is a frequent finding in patients presenting with vulvar symptoms. We identified a relevant positive result to patch testing in 38.9%. We found fragrances, medicaments and preservatives to be of most relevance.

POSTER ABSTRACT 009
The solitary purple nodule.

Author(s): SJ O'Shea, S O'Gorman, GM Murphy

Institution(s): Beaumont Hospital, Dublin 9.

Abstract:
A 66-year-old woman presented to the Emergency Department with a one year history of an enlarging lesion on the right abdomen. She was assessed urgently by Dermatology.
On examination, there was a 3cm ulcerated, fungating, purple nodule on the right flank. Full skin examination was otherwise normal and there was no lymphadenopathy.

Histology of the excised nodule showed melanoma within the dermis, invading into the subcutaneous fat, with a depth of 21mm. It was impossible to determine whether the neoplasm was connected to the epidermis due to overlying epidermal ulceration.

This case illustrates both a clinical and histological conundrum. The clinical presentation was blurred by the lack of obvious pigmentation within the lesion and the late presentation. This made it difficult to decide clinically whether this was an ulcerated, primary, amelanotic, melanoma or a cutaneous metastasis of melanoma. The lack of other suspicious lesions and lymphadenopathy on clinical examination could support the view that this was a primary melanoma. Alternatively, it could be viewed as a solitary, cutaneous melanoma metastasis, of unknown primary.

The histology was also striking. There was a well-circumscribed nodule within the dermis without apparent connection with the epidermis, but as the overlying epidermis was ulcerated this could not be definitively proven. There were abundant mitoses within the tumour which was Clarks V and 21mm in depth. Immunohistochemistry was positive for S100 and Mel A. There were no satellite nodules and no lymphovascular invasion.

Was this a nodular melanoma in which the epidermis had ulcerated due to rapid tumour growth or was this a melanoma metastasis with incidental epidermal ulceration?

International guidelines neglect this issue. The patient will be managed as if the lesion is a primary, though the histological appearance is somewhat more in favour of a solitary metastasis. It has also been argued that dermal and subcutaneous melanoma is a distinct type of primary melanoma and it has been observed that patients with solitary, cutaneous melanoma metastases fare better than those with other types of distant metastatic disease which poses questions about differences in the biologic behaviour of such tumours. [1, 2]

References

Bowen GM *et al*. Solitary melanoma confined to the dermal and/or subcutaneous tissue. Arch Dermatol. 2000; 136: 1397-99.
Swetter SM *et al*. Primary dermal melanoma. Arch Dermatol. 2004; 140: 99-103.

POSTER ABSTRACT 010
Malignant Melanoma Database 2012

Author(s): Dr Michael Lavery; Dr Patricia Podmore

Institution(s): Department of Dermatology, Altnagelvin Area Hospital, Derry

Abstract:
Study aims:
To design and test the efficacy of a clinical malignant melanoma database. This database would not only contain all pertinent information, be readily accessible to every clinician to ensure optimal clinical treatment of each patient, but would also facilitate future clinical research. This database would be available at out-patient clinics and multi-disciplinary meetings and have input from Dermatologists, Surgeons, Histo-pathologists and Oncologists.

Methods:
We performed a retrospective study by collating a list of all patients diagnosed in the 'Western Trust' in 2011 with cutaneous malignant melanoma – data obtained from histology and oncology departments. A proforma sheet was then prepared, which detailed the recommended clinical guidelines. The medical notes were obtained from medical records at Altnagelvin Hospital, Derry

Results:
The result of this clinical study was the production of a complete malignant melanoma database for all patients diagnosed in 2011, with all information being transferred to this proforma sheet, which is based on current management guidelines.

This database, available on the computer (and a copy in patient's notes in case of system failure), will ensure clinicians have prompt access to relevant information, in case medical notes are not available, in addition to optimising time management - as medical notes will not have to be sifted through, during a busy clinic.

It will also ensure optimal patient satisfaction, regarding management, as patients can be referred to tertiary centres for further treatment, but their medical notes, containing important information regarding the proposed management in the tertiary centre, always remain there. This database will ensure that the review clinician has relevant management details from any centre, to hand.
Moreover this database ensures the clinician is alerted to whether the current guidelines are being adhered to.

POSTER ABSTRACT 011
Beware of the "Irritated Seborrhoeic Keratosis"

Author(s): O'Gorman S.[1], O'Shea S.[1], Murphy G[1].

Institution(s): [1] Department of Dermatology, Beaumont Hospital, Dublin, Ireland.

Abstract:
A 66-year-old lady was treated with cryotherapy for an irritated seborrhoeic keratosis on her left thigh. Three years later she represented for evaluation of a rapidly enlarging nodule in the same location. She was otherwise well, with no personal history of malignancy. On examination there was a three-centimetre fungating nodule on the patient's left thigh. There was no lymphadenopathy. A punch biopsy from the lesion revealed an invasive poorly differentiated carcinoma of unclear origin. The lesion was excised and the histology was consistent with an eccrine porocarcinoma. A one-centimeter wide excision of the scar was performed. A CT scan of the chest, abdomen and pelvis showed no evidence of metastasis. Eccrine porocarcinoma is a rare skin cancer that arises from the intraepidermal ductal portion of the eccrine sweat glands. It is a slow growing tumour, often present for years before diagnosis. It typically develops in a benign eccrine poroma, which may mimic a seborrhoeic keratosis, pyogenic granuloma, squamous cell carcinoma or viral wart. In approximately 20% of cases local recurrence or regional metastasis occurs. It is estimated that in 12% of cases distant metastasis are seen.

POSTER ABSTRACT 012
Adult Dermatology Hospital Consults at a U.S Tertiary Referral Centre

Author(s): Eoin Storan[1], Mark Davis[2]

Institution(s): Departments of Internal Medicine[1] and Dermatology[2], Mayo Clinic, Rochester, MN, USA

Abstract:
Background: Dermatology consultations are frequently requested by inpatient hospital services. As inpatient dermatology services decline in the United States, dermatology hospital consultations are becoming increasingly important.

Objective: To describe the spectrum of skin diseases and the health care subspecialties requesting dermatology hospital consultation.

Abstract PO12 (continued)

Methods: We performed a retrospective chart review of adult inpatient (age, ³18 years) dermatology hospital consultations from January 1, 2010, through December 31, 2010. We examined patient demographic characteristics, consult requesting services, and consult diagnoses.

Results: Among dermatology services, 614 patients had 674 separate inpatient dermatology consultations during 2010. Of these patients, 55.9% were male (mean age, 59 years). In total, 205 consultations (30.4%) were requested by the internal medicine subspecialty, 137 (20.3%) by haematology-oncology subspecialty, and 93 (13.8%) by surgical subspecialty. The most common conditions seen by the hospital dermatology consult service were skin infections (n=125; 18.5%); dermatitis (n=120; 17.8%); drug eruptions (n=87; 12.9%); chronic wounds and ulcers (n=55; 8.1%); cutaneous neoplasms (n=39; 5.8%); graft-vs-host disease (n=37; 5.5%); ecchymosis, purpura simplex, or petechia (n=26; 3.8%); intertrigo (n=21; 3.1%); and urticaria (n=20; 3.0%).

Conclusion: The majority of consults received by the dermatology hospital consult service were for the management of common skin diseases, such as cutaneous infections, dermatitis, and drug eruptions. Most consults were requested by internal medicine, haematology-oncology, and surgical services. These data identify the spectrum of skin disease seen by each subspecialty.

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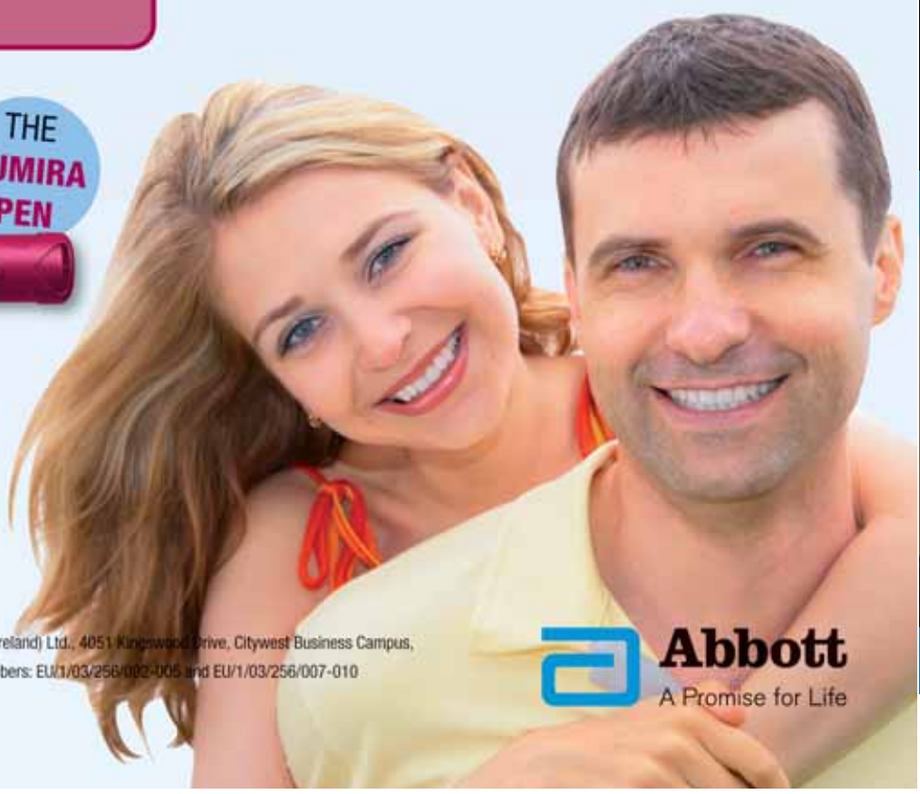

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