IAD
IRISH ASSOCIATION OF DERMATOLOGISTS

AUTUMN MEETING

Thursday 6th & Friday 7th October 2016

Hilton Hotel, Templepatrick, Co Antrim

Welcome Message from the President Dr Kevin McKenna

Welcome to the Autumn meeting of the IAD 2016 at the Hilton Hotel, Templepatrick. I hope you all had a great summer and are looking forward to the year ahead. This venue is well known to IAD members and the meeting should be both interesting and educational.

The theme of this meeting is therapeutics. Our guest speakers include Professor Catherine Nelson-Piercy, Professor Eli Sprecher and Dr Ian Coulson. We look forward to their presentations which will cover topics including the use of drugs in pregnancy, disorders of pigmentation and aspects of medical dermatology.

At the Registrars Symposium our junior colleagues have the opportunity to compete for the Rogers' Prize. This is the fourth year this prestigious prize has been awarded. I would like to thank the scientific committee for all their hard work in selecting abstracts for this meeting.

I would like to thank the members of the Executive Committee and Jacqui Carroll for their support and also our pharmaceutical colleagues who so generously sponsor our meetings.

I look forward to meeting you all.

Yours sincerely,

Dr Kevin McKenna
President
Irish Association of Dermatologists

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Biographical Sketches

Dr Gary Meenagh.
Dr. Meenagh studied medicine at Queen's University Belfast, Northern Ireland, where he graduated with Honours and trained in Rheumatology at Musgrave Park Hospital and at the University of Ancona, Italy. In 2005 he was awarded a Doctorate of Medicine from Queen's University Belfast. He received a Diploma in Clinical Education from Queen's University Belfast in 2013.
He is a Fellow of the Royal College of Physicians (London)and a Fellow of the Royal College of Physicians of Ireland. He is a member of the British Society for Rheumatology and theIrish Society for Rheumatology.

He is a member of the organising committee for the Advanced Rheumatology Sonography website promoting the diffusion of musculoskeletal ultrasound within rheumatology in Europe.

Currently he acts as an Educational Supervisor for Queens University Belfast overseeing the training needs of junior doctors at Antrim Hospital.

Dr. Meenagh has a wide research portfolio including osteoarthritis, systemic lupus erythematosus and early inflammatory arthritis. He continues to collaborate with co-workers at the University of Ancona, Italy publishing articles regularly on musculoskeletal ultrasound in rheumatology.

Professor Kingston Mills
Kingston Mills is Professor of Experimental Immunology, School of Biochemistry and Immunology, Trinity College Dublin (TCD). He is Head of The Centre for the Study of Immunology at Trinity Biomedical Sciences Institute and Theme Champion for Immunology, Inflammation and Infection at TCD. He is a graduate of TCD and trained at as a Postdoctoral Fellow at University College London and the National Institute for Medical Research, Mill Hill, London, before joining the Scientific Staff of NIBSC, Herts, UK. He returned to Ireland in 1993 to take up an academic position at National University of Ireland, Maynooth. He was appointed to a Personal Chair at Trinity College Dublin in 2001 and was Head of the School of Biochemistry and Immunology from 2008-2011. He heads an active research team focusing on T cells in infection, autoimmunity and cancer. He is co-founder of Opsona Therapeutics and TriMod Therapeutics, biotech companies focusing on the development of immunotherapeutics for inflammatory diseases and cancer.

Irish Association of Dermatologists Autumn Meeting 2016

IAD Irish Association of Dermatologists

Celgene

Celgene Sponsored Symposium

From Bench to Bedside: Understanding the Clinical Potential of Targeted Small-Module Therapies in Psoriatic Disease

Thursday 6th October 2016
Hilton Hotel, Templepatrick

9.30am	**REGISTRATION, Tea & Coffee**
10.30 - 10.35am	**Opening Remarks** **Chair: Dr Kevin McKenna, Consultant Dermatologist, Belfast City Hospital** *From Bench…: What Research Has Taught us About Intracellular Pathways of Inflammation and How We Can Manipulate them to Control Inflammatory Disease*
10.35 - 11.05am	**Professor Kingston Mills** **Professor of Experimental Immunology, Trinity College Dublin.** *An overview of Molecular and Cellular pathways of inflammation and their role as therapeutic targets* *…To Bedside: Understanding the Multiple Inflammatory Manifestations of Psoriatic Disease and the Therapeutic Potential of Targeted Small-Molecule Therapies*
11.05am - 11.50am	**Dr Gary Meenagh** **Consultant Rheumatologist, Northern Trust Belfast** *Psoriatic Disease*
11.50 - 12.20pm	**Case Studies** *(Psoriasis and Psoriatic Arthritis)*
12.20 - 12.30pm	**Q & A**

IAD Irish Association of Dermatologists

Autumn Meeting

Thursday 6th & Friday 7th October 2016
Hilton Hotel, Templepatrick, co Antrim

Thursday 6th October 2016

9.30am	REGISTRATION
10.30am-12.30pm	Celgene Sponsored Satellite Symposium
12.30pm - 2.00pm	LUNCH, EXHIBITION & REGISTRATION
	IAD Autumn Meeting – Theme "Therapeutics"
2.00pm - 2.45pm	Professor Catherine Nelson-Piercy Consultant Obstetric Physician, Professor of Obstetric Medicine, St Thomas' Hospital London *'A Dermatologists guide to drugs during conception and pregnancy'*
2.45pm - 3.30pm	Professor Eli Sprecher Professor and Chair Department of Dermatology, Tel Aviv Sourasky Medical Centre *'Pigmentation disorders of the skin'*
3.30pm - 4.00pm	COFFEE & EXHIBITION
4.00pm - 4.45pm	Dr Ian Coulson Consultant Dermatologist, East Lancashire NHS Trust, Burnley General Hospital *"A taste of Lancashire in Medical Dermatology"*
5.00pm - 6.00pm	IAD Business Meeting
7.30pm	IAD CONFERENCE DINNER

Friday 7th October 2016

9.30 - 11.00am	Registrars' Symposium - Rogers Prize
11.00am	COFFEE & EXHIBITION
11.30 - 1.00pm	Case presentations
1-1.15	Presentation of prizes
1.15pm - 2.00pm	LUNCH & CLOSE

Biographical Sketches

Dr Ian Coulson Biography

After schooling in Durham City, Dr. Coulson qualified in Medicine in 1978 from St. Thomas's Hospital Medical School London, and commenced training in dermatology after gaining higher qualifications in general internal medicine in 1981. After working at the national skin hospital, St. John's Hospital for Diseases of the Skin in London, he had posts as Registrar and Senior Registrar at St. George's Hospital in South London. During this period he was awarded the Registrars' Prize by St. John's Hospital Dermatological Society in 1986. He had research interests in the mechanisms of inflammation in atopic eczema and has written over 60 clinical and research papers.

He commenced Consultant practice in North East Lancashire in 1990, and has broad interests in all areas of clinical dermatology and skin surgery. He was skin cancer network chairman for the North Lancashire, South Cumbria area between 2005 to 2010.

He has lectured widely and regularly presents research material both at the American Academy of Dermatology and British Association of Dermatologists Annual meetings. He was awarded jointly the Bristol Cup prize for best poster presentation in 2006, and silver prize in 1999 at the BAD. He is enthusiastic about the teaching of dermatology and has produced a nationally used elearning module covering the core undergraduate medical curriculum, as well as practical patient information material available on YouTube.

He co-edited a new text book of dermatological treatment, entitled "Treatment of Skin Disease" published in 2002, and this became global dermatology best seller in 2004; the book is a continued success with edition 4 due for release in 2013. He was therapy section editor of the British Journal of Dermatology between 2004 and 2009.

He co-wrote 3 chapters for the internationally renowned Rook's Textbook of Dermatology. When President of the Dowling Club (tenure summer 2007-8), a national foundation for dermatology trainees with an international membership, he took 50 dermatologists to South Africa.

Between 2012-13, he will preside over the North of England Dermatological Society.

Spare moments are dedicated to recreational cycling (a veteran of 2 London to Paris rides); he is an under appreciated guitarist!.

Professor Catherine Nelson-Piercy

Catherine Nelson-Piercy is a Consultant Obstetric Physician at Guy's and St. Thomas' Hospitals Trust and Queen Charlotte's and Chelsea Hospital in London. In 2010 she was awarded the title of Professor of Obstetric Medicine at King's College London. Her undergraduate studies were at King's College, Cambridge University and St Bartholomew's Hospital. She trained as a physician, and was taught Obstetric Medicine by Professor Michael de Swiet.

Professor Nelson-Piercy is the immediate past President of the International Society of Obstetric Medicine (ISOM). She is founding co-editor in chief of the journal 'Obstetric Medicine: the medicine of pregnancy.'
Professor Nelson-Piercy has been involved in the development of several evidence-based National Guidelines notably for "Contraception in Women with Heart Disease", BTS / SIGN "Asthma in Pregnancy" and RCOG Green top guidelines on "Reducing the risk of thromboembolism during pregnancy, birth & the puerperium" and 'Management of nausea vomiting of pregnancy and hyperemesis gravidarum". She has over 200 publications and has edited five books and written the successful Handbook of Obstetric Medicine, now in its fifth edition. She is also one of the central physician assessors for the UK Confidential maternal deaths enquiry.

Irish Association of Dermatologists Autumn Meeting 2016

Biographical Sketches

Professor Eli Sprecher

Eli Sprecher, MD, PhD serves as a Member of Clinical Advisory Board-International at PsoriasisDX, LLC. Dr. Sprecher serves as the Director of the Department of Dermatology at the Tel Aviv Sourasky Medical Center, Israel, he is also Director of the Center for Translational Genetics of the Rappaport Family Institute for Research in the Medical Sciences at the Technion-Israel Institute of Technology, Israel. Dr. Sprecher is Associate Editor for the Journal of Investigative Dermatology, Section Editor for the British Journal of Dermatology and is on the Advisory Editorial Board for the Clinical and Experimental Dermatology.

Dr. Sprecher's large library of published research has merited worldwide recognition. His work has been honored with the Belgian Government Prize (1981), the Rector's Prize from the Hebrew University (1983), the Dean's Prize from the Hebrew University (1983 - 1987), the Senta Foulkes Research Award (1994), the Tsipora Friedman Research Award (1998), the Israel Society of Dermatology Research Award, the Everett C. Fox Award from the American Academy of Dermatology (2002), the Bill Reed Award (2002), the Henry Taub Prize for Academic Excellence from Technion - Israel Institute of Technology (2006), and the Alfred Marchionini Award from the International Society of Dermatology (2007). Dr. Sprecher graduated with a B.Med. and M.D. in Medicine from the Hebrew University of Jerusalem, a Ph.D. in Molecular Virology from the Hebrew University of Jerusalem, and completed a fellowship program in Genetics of Skin Diseases at the Thomas Jefferson University of Philadelphia.

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DATE FOR DIARY...

IAD Spring Meeting 2017

MELANOMA

Thursday 27th, Friday 28th & Saturday 29th April

Stormont Hotel & Belfast City Hospital

Registrars' Symposium - Rogers Prize

01. 9.30am **A novel use of reflectance confocal microscopy (RCM) to detect Pagetoid Melanocytosis (PM)**
L Griffin, L Roche, S McCarthy, M Lynch, K Ahmad, C Hackett, N Leonard, B Ramsay. Department of Dermatology, University Hospital Limerick.

02. 9.40am **Prospective Randomised Trial comparing Electroporation to Surgery for primary BCC Treatment**
AJP Clover1, S Salwa2, J McKiernan1, C Buckley1, M Bourke2, EJ Kelly1, ST O'Sullivan1, D Soden2
1 Department of Plastic Surgery, Cork University Hospital, Cork, Ireland
2 Cork Cancer Research Centre, University College Cork, Cork, Ireland
Corresponding author: D Soden

03. 9.50am **Methotrexate for Severe Childhood Atopic Dermatitis: Real Life Experience in a Tertiary Centre**
V. Dvorakova, G. O'Regan. A. Irvine
Our Lady's Children's Hospital, Crumlin.

04. 10.00am **Enhancing medical student's dermatology skills through the use of precision teaching**
C. McGrath, G. Gormley, C. McCourt, A. Corry, K. Dillenburger, K. Douvani. Belfast Trust. Queens University Belfast.

05. 10.10am **The burden of chronic itch-a questionnaire based evaluation of clinical characteristics, associated**
I. McDonald, A. Gábor Szollosi, B. Kirby, M. Steinhoff. Charles Institute of Dermatology UCD.
St Vincent's University Hospital

06. 10.20am **Trends in Preservative Contact Allergy In Cork**
R. O'Connor, S. McCarthy, M. Murphy, J. Bourke.
SIVUH Cork

07. 10.30am **Can Referral Management Enhance Access to Paediatric Dermatology Services?**
E.Gilhooley, S. Collins. Our Lady of Lourdes Hospital, Drogheda.

08. 10.40am **Utility of lymphocyte transformation testing in the diagnosis of drug hypersensitivity.**
J. Boggs, M. Keogan, M. O'Kane. Department of Dermatology, Connolly Hospital Blanchardstown/ Beaumont Hospital

09. 10.50am **Analysis of 10 years of phototherapy data from one centre and its implications**
S. Mohamed*1,2, D. R. Wall*2, 3, B. Q. Huang1, M. Greenwood4, A. D. Irvine2,3,5, M-T. Kechadi1, N. O'Hare3,5, A-M. Tobin4
* Indicates joint first authors.
Insight Centre for Data Analytics, University College Dublin, The Irish Skin Foundation, Charles Institute UCD, University College Dublin, St James's Hospital, Dublin, The Adelaide and Meath Hospital, Incoporating the National Children's Hospital, Tallaght, Trinity College Dublin,

Orals - Abstracts

■ A novel use of reflectance confocal microscopy (RCM) to detect Pagetoid Melanocytosis (PM)

L Griffin, L Roche, S McCarthy, M Lynch, K Ahmad, C Hackett, N Leonard, B Ramsay.
Department of Dermatology, University Hospital Limerick.

Introduction: MM diagnosis by RCM usually relies on detecting pagetoid cells in 5 of 6 criteria using horizontal vivablock technique.1 However, the vivastack function on RCM works as a rapid, non invasive in vivo punch biopsy recording a series of 34 high resolution consecutive images on a single spot (0.5x0.5mm) from the surface through the epidermal layers. Using this we observed striking pagetoid spread in invasive MM and decided to study if this finding helps distinguish MM from other lesions.

Methodology and results: We studied 60 patients attending our pigmented lesion clinic with suspicious lesions where a clinical decision to excise had been made and RCM vivastack images were taken. The RCM operator was unaware of the eventual histologic diagnosis. The prescence of PM, its level of onset and cessation were measured and expressed as a percentage of the total vivastack of images.

All 22 patients who were histologically confirmed to have benign diagnoses had no PM. 2 out of 6 patients with spitz naevi had PM reflecting the heterogenous nature of this tumour. 6 of 8 patients with dysplastic naevi (DN) had PM. 3 out of 4 patients with lentigo maligna had PM. Of the 22 patients with invasive MM PM occurred within the 1st 10 frames in 18 patients with mainly rounded/pleomorphic PM. The percentage PM stack involvement ranged from 26% for amelanotic melanoma to 97% in a patient with 2.3 mm breslow MM.

Conclusions: RCM visualises the epidermis in its physiologic state in contrast to retraction bias from fixation, tissue staining and sectioning seen in histopathology. RCM vivastack enables the operator to focus it on the most dermatoscopically suspicious areas of the lesion taking less than 30 seconds to capture the stack images. It is easier to identify PM by CFM as there at least 34 images in contrast to histology. CFM requires no special stains and injures no cells.

No patients with benign lesions had PM. The presence of PM confirms significant melanocytic pathology. Stack analysis allows enhanced recognition of vertical growth phase of melanoma. The novel finding of this study is that if there is no PM on stack function it is likely one is dealing with a benign lesion.

1. Pellacani G et al. Reflectance-mode confocal microscopy for the in vivo chracterisation pf pagetoid melanocytosis in melanomas and naevi. JID 2005 125: 532-537

■ Prospective Randomised Trial comparing Electroporation to Surgery for primary BCC Treatment

AJP Clover1, S Salwa2, J McKiernan1, C Buckley1, M Bourke2, EJ Kelly1, ST O'Sullivan1, D Soden2
1 Department of Plastic Surgery, Cork University Hospital, Cork, Ireland
2 Cork Cancer Research Centre, University College Cork, Cork, Ireland

Corresponding author: D Soden

Introduction: Basal Cell Carcinoma (BCC) is the most common cutaneous malignancy with incident rates increasing throughout the world. Surgery remains the primary treatment standard for these tumours due to its excellent overall curative outcome. Electroporation in combination with local chemotherapy injection has demonstrated efficiency for the treatment of BCC but has not been assessed in a prospective randomised setting. This study hypothesised that Electroporation had an equal outcome over 5 years to surgery and could offer a cosmetic benefit to patients due to the fact that in contrast to other ablative technologies electroporation preserves healthy tissue structures.

Method: A prospective randomised control trial was established to determine the efficiency of Electroporation and local bleomycin injection as a primary treatment modality for BCC with the current standard of surgery as the control arm. Initial response rates to treatment were assessed and recurrence rate over a one, three and five year period

Results: In total 86 patients with 105 lesions were enrolled, treated and completed minimum follow up of 1 year (Electroporation group 45 patients - 60 lesions; Surgery 41 patients - 45 lesions). All patients responded to their primary treatment modality, however 5 patients in the ECT group required a second Electroporation treatment and 2 patients in the surgical group required further excision. There were no recurrences in either group for the first two years of follow up. At the year 5 follow up the results demonstrate a disease free progression of 94% (47/50) (10 lost to follow up) in those lesions treated with Electroporation and 94% (31/33) (12 lost to follow up) in those treated with surgery (P = 0.37).

Discussion: Electroporation involves the delivery of very short (millisecond) electrical pulses directly to target tissue. We have demonstrated in this clinical study that in combination with the low dose injection of bleomycin it is an extremely effective treatment for primary BCC. Significantly it has also proven to have a durable curative effect that is comparable with surgery at five years of follow up.

This data also demonstrates that electroporation can be a useful utility in the management of BCC lesions with its preservation of healthy tissue structures providing additional cosmetic advantages in the treatment of lesions located in sensitive regions of the body.

It should be noted that the suitability of electroporation for widespread BCC treatment has to date been reduced by the discomfort generated by delivery of the electrical pulses. This has required administration of local anesthesia and sedation to patients. However technological improvements with the electroporation generator system have recently been achieved which have eliminated the muscular contractions and pain induced allowing for more widespread application of the technology. In addition recent research has demonstrated efficacy with the use of CaCl2 as a replacement for bleomycin further enhancing its application.

Orals - Abstracts

Methotrexate for Severe Childhood Atopic Dermatitis: Real Life Experience in a Tertiary Centre

V. Dvorakova, G. O'Regan. A. Irvine
Our Lady's Children's Hospital, Crumlin.

Background: Atopic dermatitis (AD) affects up to 20% of children. While the majority of patients are adequately controlled with emollients, topical corticosteroids, topical calcineurin ihibitors or phototherapy, children with moderate-to-severe AD often require systemic treatment.

Objectives: To evaluate methotrexate (MTX) efficacy and safety in real life use in a paediatric population with severe AD attending a tertiary referral centre.

Methods: A retrospective chart review was undertaken of all children who received MTX for severe AD at our tertiary referral centre from November 2010 to August 2015.

Results: 47 children were commenced on MTX for AD during this time period. Mean IGA at 3-5 months' follow-up improved from 4.25 to 2.8, with further improvement to 1.9 in the group of patients that contiued therapy beyond 10 months of treatment. Changes in CDLQI mirrored changes in IGA with improvement in mean CDLQI of 14.4 at the start of the treatment to a mean CDLQI 7.5 at 3-5 months' follow up. The continued improvement in disease control beyond medium-term therapy was confirmed by a further improvement in CDLQI to 6.6 in patients that continued MTX beyond 10 months of treatment. The treatment was well tolerated in our cohort.

Conclusions: MTX appears to be a safe treatmet for paediatric severe atopic dermatitis. Its therapeutic effects continue to improve beyond medium-term treatment period as reflected by further improvement in IGA and CDLQI scores in patients who continued MTX therapy beyond 10 months of treatment.

Enhancing medical student's dermatology skills through the use of precision teaching

C. McGrath, G. Gormley, C. McCourt, A. Corry, K. Dillenburger, K. Douvani. Belfast Trust & Queens University Belfast.

Dermatology is often considered to be underrepresented in undergraduate medical curricula and students nearing graduation may lack confidence in assessing and diagnosing skin conditions. Therefore new teaching methods are required to enhance medical student's acquisition of dermatological skills and knowledge. Precision Teaching (PT), is a pedagogical strategy stemming from behaviour analysis that can be used to improve learners' knowledge retention. This teaching method uses frequent, brief, timed measures of student performance on specific learning points, in this case reviewing multiple dermatological images, with the aim of improving speed and accuracy sufficient to ensure retention and improve learning efficiency. Already established in other educational fields, PT has only recently been applied to medical education. In this study we aimed to determine the impact of PT (using dermatology flashcards) on dermatology diagnostic skills compared to traditional teaching alone.

Third year medical students were invited by email to participate in this study. During their one-week attachment, consenting third year medical students completing placements on two hospital sites were randomly allocated either to the intervention group (PT+ traditional teaching) or the control group (traditional teaching). For our PT method, we designed 50 dermatology image flashcards. Repeated practice with the flashcards during timed periods of one minute took place 2-3 times per teaching day and students' data on accuracy were recorded. Pre and post-training tests, in the form of a 30 question picture quiz, were carried out to determine whether students' diagnostic skills improved as a result of the training.

A total of 135 participants were recruited over the academic year, 70 were randomised to the intervention group and 65 to the control group. Statistical analysis was carried out using analysis of covariance to take into account the differing baseline level of students. Primary analysis of the 'change score' (comparing pre- and post-test scores) demonstrated a statistically significant improvement of 8.8% (95% CIs 4.9-12.7 $p<0.001$) in the intervention group compared with the control group. This was independent of the teaching week or hospital site. Interestingly, secondary analysis of the intervention group demonstrated a 'dose' effect: the post-test score increased by an average of 1.61% per additional 'try' (95% CIs 0.97 to 2.25). Our study highlights that Precision Teaching has a positive effect on enhancing diagnostic and recognition skills. It is an effective and quick adjunctive teaching method that educators could use in their blended approach of teaching dermatology.

The burden of chronic itch-a questionnaire based evaluation of clinical characteristics, associated

I. McDonald, A. Gábor Szollosi, B. Kirby, M. Steinhoff. Charles Institute of Dermatology UCD, St Vincent's University Hospital

Itch is the most common symptom in dermatology associated with a significant impact on patient's quality of life. With new therapeutic options on the horizon it is important to clinically differentiate our "itchy" patients, evaluating this symptom independently and with objective measures.

Aims: 1) Characterize clinical features of itch in a cohort of patients attending the dermatology department. 2) Evaluate the impact of itch on quality of life, sleep and mental health. 3) Evaluate the efficacy of treatments as reported by patients.

Methods: Patients with a diagnosis of prurigo nodularis (PN), atopic dermatitis (AD), psoriasis (PSO) and pruritus of undetermined origin (PUO) were recruited from the dermatology OPD of SVUH. A pruritus questionnaire was developed, incorporating the itch VAS. The DLQI, PSQI and HADS were also used.

Results: 73 patients were recruited. Itch was a symptom for more than 5 years in 62.67% of patients. 45.9% reported "always" feeling itchy. Bedtime was the most bothersome time (36.49%) while heat and stress were the commonest exacerbating factors. The mean VAS was 6.69 indicating moderate to severe itch. This was greatest in patients with PN (7.50) and lowest in patients with psoriasis (5.89) with a significant difference in severe and very severe itch between the two groups (83.3% vs 47.2%, $P<0.05$). The VAS for itch

was found to be a significant predictor of DLQI, PSQI, and HADS. Importantly it remained a significant predictor of DLQI independent of PASI (regression coefficient B=1.881, p<0.05). 77.73% of patients had abnormal sleep patters (PSQI score › than 5). The mean PSQI was highest in patients with PUO and lowest in patients with psoriasis. 34.7% of patients had a borderline or abnormal HADS for anxiety. This was proportionally greatest in patients with PN (50%). Most patient's felt that topical and systemic treatments were only partially effective (71.67% and 72.73% respectively) while phototherapy was found to be the most efficacious of therapeutic options overall.

Conclusion: In this patient cohort itch was found to be a chronic and pervasive symptom. There was significantly less severe itch in patients with psoriasis where it had less impact on sleep than the other groups. Measurement of itch by VAS was an important predictor of DLQI and was independent of PASI. Systemic and topical treatment efficacy remains partial for most patients. This highlights the unmet medical need in pruritus management and the need for its evaluation independent of other disease measures.

■ Trends in Preservative Contact Allergy In Cork

R. O'Connor, S. McCarthy, M. Murphy, J. Bourke. SIVUH Cork

Several epidemics of preservative contact allergy have emerged, namely formaldehyde in the 1960s, MCI/MI in the 1980s, methyldibromo glutaronitrile in the 1990s, and the recent epidemic of MI following European Union (EU) approval in 2005 allowing MI to be used in stronger concentrations in leave-on and rinse-off cosmetic products.

The aim of our study was to evaluate the trends in preservative allergy in our dermatology unit in Cork. Over a nineteen-year period (1997 to 2015) we analyzed the patch test results of 2,636 patients who were investigated for a contact allergy. The reports were reviewed via access to four patch test databases. Over this time period the incidence of allergy to parabens, formaldehyde and formaldehyde releasers have fallen. Isothiozolinone allergy has risen sharply and these results are in keeping with European figures. In 2015 we were surprised at persistent high rates of positive patch tests to methylisothiazolinone (MI) (15.4%) given recent recommendations from the Scientific Committee for Consumer Safety (SCCS). We examined over a thousand cosmetic products in local supermarkets and pharmacies and found MI still to be present in wash off products and some wipes but also were surprised to find it in 'leave-on' products (moisturizer, sunblock). This may explain the current high rates of positive patch tests to MI in Ireland. The incidence of sodium metabisulphite allergy has also increased but this is difficult to explain. From 1997 to 2009 418 patients were patch tested to sodium metabisulphite as part of the medicament series and all had a negative result. From 2010 to 2015 776 patients were patch tested and 42 had positive results to sodium metabisulphite (5.4%). Of those 42 patients only 3 results were of confirmed relevance. This recent increase in sodium metabisulphite contact allergy is difficult to explain.

■ Can Referral Management Enhance Access to Paediatric Dermatology Services?

Gilhooley E., Collins S.
Our Lady of Lourdes Hospital, Drogheda, Co Louth.

Paediatric dermatology encompasses a variety of dermatoses ranging from common inflammatory skin diseases to the rare genodermatoses. The National Clinical Care Programme (NCCP) for dermatology has recently issued referral exclusions for benign and self-limited conditions. In the setting of limited resources and excessive waiting times we sought to determine referral patterns to our department that serves a 400,000 catchment area.

An analysis of all paediatric referral letters received over a six-month period triaged as non-urgent was conducted. Referral letters were examined for inclusion of information for appropriate triage, diagnosis and details of first line treatments.

Of 464 referrals, 20% were for atopic dermatitis (AD) [91/464], 19% pigmented lesions [89/464], 16% viral warts [73/464], 10% non-specific rash [46/464], 7% acne vulgaris [34/464], and 28% other (other lesions, hair disorders, fungal infections and other inflammatory disorders).

AD represented the commonest diagnosis. 78% were referred for AD control [71/91] and 22% requesting allergy testing [20/91]. 31% provided details of severity: recurrent infections, sleep disruption and school absenteeism. None recorded psychological impact. Details of first line treatment was recorded in 69% [63/91]. Pigmented lesions represented 19% [89/464] of referrals, mean age of 10years. 85% [76/89] reported new and changing moles. 15% [13/89] were referred for general mole checks, none reported a family history of melanoma. 16% were referred for management of viral warts. 45% [33/73] recorded multiple warts, 47% [34/73] detailed failed treatments. 14% requested surgical excision. Acne accounted for 9% of referrals, at a mean age of 15 years. 29% [9/34] of referrals included information on severity/presence of scarring, 9% of psychological impact.

We determined that 55% of all referrals received were for 3 conditions: atopic dermatitis, pigmented lesions and viral warts. The education of primary care providers in the first line management of atopic eczema along with referral criteria to secondary care is required. The rarity of melanoma in childhood is not reflected in referral patterns suggesting low awareness amongst primary care and/or the public who would benefit from education in this regard. The exclusion of viral warts as per the NCCP criteria has to potential to reduce referrals significantly. Our data demonstrates that a detailed breakdown of referrals, by diagnostic categories, can provide valuable data for identifying the educational needs of primary care providers. In addition, referral management may be enhanced, with the objective of promoting access by clinical priority.

■ **Utility of lymphocyte transformation testing in the diagnosis of drug hypersensitivity.**

J. Boggs, M. Keogan, M. O'Kane. Department of Dermatology, Connolly Hospital Blanchardstown/Beaumont Hospital

Adverse cutaneous reactions to drugs are common, affecting 2-3% of hospitalised patients. An estimated 1 in 1000 hospitalised patients develop a serious cutaneous drug reaction. Diagnosis of drug hypersensitivity may be complex, particularly Type IV reactions which are delayed in onset (days to weeks) following exposure to the culprit drug. Reactions can take many different forms, varying from inconvenient to life threatening, morphology is diverse and multiple drugs may be suspected. Type IV reactions may be evaluated with various diagnostic tests including lymphocyte transformation testing (LTT), which aims to detect circulating drug specific memory T cells which proliferate upon drug stimulation. We aimed to evaluate whether LTT helped to define the incriminating drug in our patients with drug reactions.

All patients who had LTT performed under Dermatology care between 03/2009- 03/2016 were identified from a patient database (n=34). Retrospective review of their medical records was performed. Of 34 patients, (21 female, 13 male), with mean age of 52.8 years (range 18-85); 97% presented with a skin eruption and 20% had systemic symptoms at presentation. The predominant morphology was maculopapular (29%); 30/34 patients were hospitalised. The mean duration between drug exposure and onset of reaction was 10.9 days. Of the 56% that underwent biopsy, 79% had histology consistent with a drug eruption. The average number of drugs requested for LTT per patient was 3 (range 1-9 drugs). 76% (26/34) had a positive LTT. 69% (18/26) had positive LTT reactions to an antibiotic, of which the majority were Beta-lactams, comprising 61% (11/18). 7/34 patients had a Severe Cutaneous Adverse Reaction (SCAR), all 7 had a positive LTT. The causative drugs were withdrawn once the diagnosis of drug reactions were made in 82% (28/34), followed by significant improvement in 82% of patients. There were 2 fatalities secondary to multi-organ failure and 1 patient required haemodialysis. Two known accidental re-challenges occurred, both with more severe recurrences of the skin eruption, with one patient developing DRESS.

In conclusion we found that a positive LTT was a valuable contribution in the diagnosis of drug allergy and in identifying the drug involved. However as sensitivity of LTT is limited, a negative LTT cannot exclude a drug hypersensitivity. False negatives may occur with mistiming of the test and in patients on high dose systemic prednisolone. Nevertheless we feel that LTT is a useful test in the armamentarium of the dermatologist when faced with this challenging situation.

■ **Analysis of 10 years of phototherapy data from one centre and its implications**

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Introduction: Since its introduction to mainstream dermatology in the 1970s, phototherapy has flourished and is considered amongst the first line treatments for a number of conditions, though moderate to severe psoriasis is the main indication.1,2
Concerns regarding skin cancer development, and adverse events that have seen phototherapy become a common source of legal claims in dermatology, have emphasised the importance of fastidious monitoring of its delivery.3,4
Many hospitals rely on paper records for this purpose, though electronic systems have been developed to capture data entry at a patient level. This study aimed to analyse the AMNCH phototherapy Puvamate database to identify treatment, outcome and safety trends at a hospital level. A further aim was to identify the datapoints required to fully digitise phototherapy in a manner supportive of care delivery and monitoring of its safety.

Methodology: After obtaining ethical approval, the AMNCH database was professionally anonymised. The data was processed and mined using advanced data mining techniques. Models to find associations between treatment and adverse event occurrence and clusters of patients were implemented and reviewed with clinicians.

Results: Treatment records over 12 years and 955 patients were analysed. 3% of records had inconsistencies requiring their exclusion from analysis. The most common indications for phototherapy were psoriasis and eczema. Side effects were encountered in 12% of treatments.

Conclusion: This study demonstrates the value of phototherapy to dermatology and the richness of the data recorded during its delivery. An initial dataset to inform the development of user-centric software to digitise phototherapy delivery was also identified. It is suggested that such software, if widely adopted, could be capable of informing and supporting a national phototherapy network to efficiently and safely deliver phototherapy, while providing data to advocate for resources and facilitate research.

References:

1 Parrish JA et al. Photochemotherapy of Psoriasis with Oral Methoxsalen and Longwave Ultraviolet Light. New England Journal of Medicine 1974; 291: 1207-11.
2 Lee E et al. UVB phototherapy and skin cancer risk: a review of the literature. International journal of dermatology 2005; 44: 355-60.
3 Hearn RMR et al. Incidence of skin cancers in 3867 patients treated with narrow-band ultraviolet B phototherapy. British Journal of Dermatology 2008; 159: 931-5.
4 Ong S, Coulson I. Legal claims in English dermatological practice. British Journal of Dermatology 2011; 164: 217-9.

Case Presentations

01. 11.30am **Resolving hepatic hemangiomas and hypothyroidism after treatment with propranolol and levothyroxine**
V. Cambell, R. Beckett, N. Abid, S. Hoey.
Department of Dermatology, Royal Victoria Hospital, Belfast. Department of Endocrinology, Growth and Diabetes, Royal Belfast Hospital for Sick Children

02. 11.40am **A case of paraneoplastic elastosis perforans serpiginosa associated with ovarian malignancy**
C. Quinlan, J. Boggs, M. Finan, N. Mulligan, M. O'Kane, N. Ralph.
Mater Misericordiae University Hospital, Dublin. Connolly Hospital, Blanchardstown, Dublin. Mater Misericordiae University Hospital, Dublin.

03. 11.50am **High-grade follicular lymphoma in a patient receiving adalimumab and methotrexate for pityriasis rubra pilaris**
E Nic Dhonncha,1 K Fadalla,2 C Murray,3 P Gou,3 D Gibbons,3 A Fabre,3 B Moriarty,1 P Collins1
Departments of 1Dermatology, 2Haematology and 3Histopathology, St. Vincent's University Hospital, Dublin

04. 12.00pm **Back to the bible**
I. Timoney, L. Timoney, N. Allen, E. Storan, A-M. Murphy. Dermatology, University Hospital Galway. Dermatology, Queen Elizabeth University Hospital, Glasgow. Infectious Disease, University Hospital Galway.

05. 12.10pm **Epithelioid Angiosarcoma Arising on the Back of a Young Caucasian Male**
A. Kelly, G. Murphy, C. Gulmann. Beaumont Hospital Dublin.

06. 12.20pm **Abatacept: a novel treatment in severe limited scleroderma and morphoea**
S. McCarthy, L.Roche, L. Griffin, N. Leonard, M. Lynch, C. Hackett.
Dermatology Department, University Hospital Limerick. Pathology Department, St James' Hospital, Dublin

07. 12.30pm **Subcutaneous Sweet's syndrome in pregnancy**
J. Boggs, M. Sabah, M. Redmond, F. Moloney, M. O'Kane.
Connolly Hospital Blanchardstown/Beaumont Hospital. Connolly Hospital Blanchardstown. Beaumont Hospital. Connolly Hospital Blanchardstown/Mater Hospital. Connolly Hospital Blanchardstown/Beaumont Hospital.

08. 12.40pm **Febrile ulceronecrotic Mucha-Habermann disease**
Muriel Sadlier, Grainne O'Regan, Fiona Browne
Department of Dermatology, Our Lady's Children's Hopsital Crumlin, Dublin.

09. 12.50pm **Systemic and cutaneous amyloid presenting with palmar bullae**
Roche L, Leen E, Quinn J, Keogan M, O'Kane M
Connolly Hospital Blanchardstown, Beaumont Hospital Dublin

Oral Case Presentations Abstracts

■ **Resolving hepatic hemangiomas and hypothyroidism after treatment with propranolol and levothyroxine**

V. Cambell, R. Beckett, N. Abid, S. Hoey.
Department of Dermatology, Royal Victoria Hospital, Belfast. Department of Endocrinology, Growth and Diabetes, Royal Belfast Hospital for Sick Children.

Infantile hepatic hemangiomas (IHH) particularly the diffuse subtype, can in severe cases be associated with hepatic and cardiac failure, compartment syndrome, and consumptive hypothyroidism. Early recognition and treatment of these pathologies is paramount in order to minimise the risk of longterm sequelae. Thyroid hormones are crucial for growth and neurodevelopment, with three to five IQ points lost for each month hypothyroidism remains untreated in the first year of life. This developmentally sensitive period parallels the proliferative phase of hemangiomas, and highlights a window of opportunity to screen for, and aggressively treat hypothyroidism in the context of diffuse IHH.

We report a female twin conceived through in-vitro fertilization who presented aged eight weeks with systemic compromise and hepatomegaly in the absence of large or obvious cutaneous infantile hemangiomas (IH). Abdominal ultrasound showed innumerable hypoechoic nodules and increased vascularity within the liver, confirmed on CT and MRI. AFP was markedly elevated with associated derangement of her LFTs and coagulation profile. Findings were consistent with a diagnosis of diffuse infantile hepatic hemangiomatosis. Subsequent to this, assessment of her thyroid function confirmed consumptive hypothyroidism. She was promptly treated with levothyroxine 9.6 micrograms/kg/day and oral propranolol at an initial dose of 1mg/kg once daily in two divided doses, escalated to 2mg/kg after five days. Treatment was well tolerated with no adverse effects, and rapid improvement in her clinical parameters.

This case reiterates the importance of investigating for consumptive hypothyroidism in an infant diagnosed with IHH, particularly when there is systemic compromise in the absence of cutaneous clues. Consultation with endocrinology for specialist management is imperative if growth and intellectual retardation are to be prevented. In accordance with a growing body of evidence, we advocate propranolol as a single agent for IHH, supported by thyroid replacement when appropriate. More research is needed to fully understand the pathophysiology underlying systemic decompensation in diffuse IHH, and to understand the exact mechanism of action of propranolol when used as a first line treatment.

■ **A case of paraneoplastic elastosis perforans serpiginosa associated with ovarian malignancy**

C. Quinlan, J. Boggs, M. Finan, N. Mulligan, M. O'Kane, N. Ralph.
Mater Misericordiae University Hospital, Dublin. Connolly Hospital, Blanchardstown, Dublin. Mater Misericordiae University Hospital, Dublin.

Introduction: Elastosis perforans serpiginosa is a rare skin disorder in which there is transepithelial elimination of elastin fibres.1 There have been no previous reports of elastosis perforans serpiginosa occurring as a paraneoplastic phenomenon. We report a case of paraneoplastic elastosis perforans serpiginosa in the setting of ovarian cancer.

Case Report: A 42-year-old female presented with proximal muscle weakness, difficulty swallowing and an erythematous eruption on the chest and shoulders. The clinical impression was of dermatomyositis. Myositis panel revealed positive anti-nuclear antibody and positive anti-transcription intermediary factor-1y. She also had a cutaneous eruption affecting the flexures, which consisted of superficial erosions on an erythematous base.

She was treated with three days of pulsed methylprednisolone at a dose of 1g daily, followed by oral prednisolone at a dose of 1mg/kg/day. As there was no clinical improvement, she received 5 days of intravenous immunoglobulin (IVIG) at a dose of 400mg/kg/day. Muscle weakness improved significantly, however the skin eruption was persistent.

Skin biopsy showed increased amount and size of dermal elastic fibres with fragmented fibres being eliminated through transepidermal channels. Verhoeffs-van gieson (VEG) stain was performed and this demonstrated transepidermal elimination of elastin fibres.

MRI pelvis findings showed likely ovarian malignancy, extensive peritoneal metastases and extensive metastatic lymphadenopathy. Biopsy of the omentum revealed poorly differentiated adenocarcinoma.

The patient was diagnosed with stage IV high grade serous papillary ovarian carcinoma and commenced on neo-adjuvant chemotherapy with weekly taxol and 3-weekly carboplatin. On review at cycle 1 day 16 of treatment her skin eruption had almost fully healed.

Discussion: Elastosis perforans serpiginosa (EPS) is a rare skin disorder in which there is transepithelial elimination of elastin fibres. It belongs to the group of perforating disorders of which there are 4 classic types; EPS, perforating folliculitis, Kyrles disease and reactive perforating collagenosis. Reactive perforating collagenosis has been reported, rarely, in association with malignancy.2

In our case the onset of symptoms shortly before diagnosis of underlying malignancy and the rapid response of the skin following chemotherapy are consistent with a paraneoplastic dermatosis. The failure of the skin to respond to high dose steroids and IVIG also supports this proposal.

In conclusion, we present a case of paraneoplastic elastosis perforans serpiginosa in association with ovarian malignancy. To our knowledge this is the first case of paraneoplastic elastosis perforans serpiginosa reported.

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2. Yazdi S et al Acquired reactive perforating collagenosis associated with papillary thyroid cancer. Clin Exp Dermatol 2010 March;35(2):152-5

Oral Case Presentations Abstracts

■ **High-grade follicular lymphoma in a patient receiving adalimumab and methotrexate for pityriasis rubra pilaris**

E Nic Dhonncha,1 K Fadalla,2 C Murray,3 P Gou,3 D Gibbons, 3 A Fabre,3 B Moriarty,1 P Collins1
Departments of 1Dermatology, 2Haematology and 3Histopathology, St. Vincent's University Hospital, Dublin

In April 2014, a 52-year-old male presented with an itchy erythematous facial eruption, which subsequently spread to involve his trunk and limbs. He had a history of hypertension for which he took telmisartan and amlodipine.

Examination revealed erythroderma with islands of sparing, follicular hyperkeratotic papules and palmoplantar hyperkeratosis, consistent with pityriasis rubra pilaris (PRP). Histopathology supported the diagnosis. Acitretin 40mg OD was started and adalimumab 40mg weekly subcutaneously was added four weeks later. Within 3 months, a significant clinical improvement was noted. The dose of adalimumab was reduced to 40mg on alternate weeks and methotrexate 15mg weekly replaced acitretin therapy. In February 2015, his skin was almost clear and treatment was continued with no adverse effects. At routine clinical review in February 2016, he reported a 2-month history of a right-sided neck swelling in the absence of B symptoms. Examination revealed palpable neck nodes and a left-sided axillary swelling. Adalimumab and methotrexate were withdrawn. Laboratory tests were normal apart from lymphopenia. Urgent CT scan revealed a 3.2cm mass originating from the superior right parotid gland with four other enhancing soft tissue parotid mass lesions and a 5.1cm left sided axillary mass. Excisional lymph node biopsy from the left axilla diagnosed a high-grade follicular lymphoma. Seven months later he has received 6 cycles of RCHOP to which he is responding well. His skin remains clear to date.

PRP is a rare papulosquamous disorder and treatment is challenging. Established therapeutic options include acitretin, methotrexate, ciclosporin and phototherapy. More recently, several case reports have noted the efficacy of anti-TNFα agents in PRP, either as monotherapy or in combination with acitretin or methotrexate.1,2 Although PRP has been reported in association with solid and haematologic malignancies in case reports, it has not been described in association with follicular lymphoma which occurred in our patient while receiving adalimumab and methotrexate.

References:

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2. Eastham AB, Femia AN, Qureshi A, Vleugels RA. Treatment options for pityriasis rubra pilaris including biologic agents: A retrospective analysis from an academic medical centre. JAMA Dermatol 2014; 150:92-94.

■ Back to the bible

I. Timoney, L. Timoney, N. Allen, E. Storan, A-M. Murphy. Dermatology, University Hospital Galway. Dermatology, Queen Elizabeth University Hospital, Glasgow. Infectious Disease, University Hospital Galway.

A 27-year-old female presented to her general practitioner with a two-year history of a gradually extending rash. This consisted of several erythematous annular plaques, involving much of the right arm.

There was no response to various topical treatments including steroids and anti-fungals. She continued to develop new similar, smaller plaques on the right arm as well as on her wrists, knees, face and back.

She was systemically well and otherwise asymptomatic. She had no significant medical history. She was originally from Bangladesh and had moved to Ireland nine years previously.

On examination, large annular erythematous plaques with well-defined raised borders, subtle surface scale and central clearing were present on the right arm. Similar, smaller plaques were noted elsewhere on the body. Hypo-aesthesia was demonstrated in affected areas.

A punch biopsy was taken from the right forearm. Histopathology showed non-necrotizing epithelioid granulomas throughout the dermis and extending into the subcutaneous tissue. Granulomas were seen within and destroying subcutaneous nerves.

The case was discussed at the Hospital for Tropical Diseases in London histopathology meeting and the opinion of a leprosy specialist was sought. Histological features were diagnostic of leprosy, most probably borderline leprosy (BB) subtype.

Discussion: Leprosy was first described in antiquity. It is rarely seen in Ireland with this being only the third reported case for decades.

Infection is caused by the bacillus Mycobacterium leprae. Clinical manifestation of the disease is determined by the nature of the host immune response, with poor cell mediated immunity resulting in lepromatous leprosy.

Global prevalence of leprosy has reduced by almost 90% in the last two decades however it continues to afflict developing countries where it remains a huge source of stigma.

The disease mainly affects the skin, peripheral nerves and the eyes. Peripheral neuropathy results in the classical, biblical deformities associated with leprosy.

The patient was commenced on dapsone and rifampicin. It is expected that skin lesions will resolve; indeed, they have improved significantly. Nerve damage is unfortunately permanent.

The cultural diversity we now enjoy in Ireland can present diagnostic challenges. It is necessary to be mindful of prevalent diseases in the countries from which patients have emigrated, particularly when faced with unusual or non-resolving symptoms.

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Psoriatic arthritis

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Psoriasis

HUMIRA is indicated for the treatment of moderate to severe chronic plaque psoriasis in adult patients who are candidates for systemic therapy.[1]

Some patients may not be suitable for Humira. You are strongly advised to read the prescribing information (PI) below.

Prescribing Information (PI) Humira (adalimumab) 40 mg solution for injection in pre-filled pen or pre-filled syringe or paediatric vial containing 40 mg solution for injection. Refer to Summary of Product Characteristics (SmPC) for full information.

Presentation: Each single dose pre-filled pen (0.4 ml), pre-filled syringe (0.4 ml) or vial (0.8 ml) contains 40 mg of adalimumab. **Indications:** Rheumatoid arthritis (RA), adults: In combination with methotrexate (MTX) for moderate to severe, active RA with inadequate response to disease-modifying anti-rheumatic drugs (DMARDs) including MTX. In combination with MTX for severe, active and progressive RA when not previously treated with MTX. Can be given as monotherapy if intolerance to or when continued treatment with MTX is inappropriate. Reduces rate of progression of joint damage on X-ray and improves physical function, in combination with MTX. Polyarticular juvenile idiopathic arthritis (pJIA), paediatrics 2 years and above: In combination with MTX, for active pJIA with inadequate response to one or more DMARDs; or monotherapy if intolerance to or when continued treatment with MTX is inappropriate. Enthesitis-related arthritis (ERA), paediatrics 6 years and above: For active ERA with inadequate response or intolerance to conventional therapy. Ankylosing spondylitis (AS), adults: For severe active AS with inadequate response to conventional therapy. Axial spondyloarthritis without radiographic evidence of AS (nr-axSpA), adults: For severe nr-axSpA with objective signs of inflammation (elevated CRP and/or MRI), and an inadequate response to or intolerance to nonsteroidal anti-inflammatory drugs (NSAIDs). Psoriatic arthritis (PsA), adults: For active and progressive PsA with inadequate response to DMARDs. Reduces rate of progression of peripheral joint damage on X-ray in polyarticular symmetrical subtypes of the disease and improves physical function. Psoriasis, adults: For moderate to severe chronic plaque psoriasis who are candidates for systemic therapy. Psoriasis, paediatrics 4 years and above: For severe chronic plaque psoriasis with inadequate response, or if topical therapy and phototherapies are inappropriate. Hidradenitis suppurativa (HS), adults: For active moderate to severe hidradenitis suppurativa (acne inversa) in patients with an inadequate response to conventional systemic HS therapy. Crohn's disease (CD), adults: For moderately to severely active CD with inadequate response, contraindication or intolerance to corticosteroid and/or an immunosuppressant therapy. Crohn's disease (CD), paediatrics 6 years and above: For moderately to severely active CD with inadequate response, contraindication or intolerance to conventional therapy including primary nutrition therapy and a corticosteroid, and/or an immunomodulator. Ulcerative colitis (UC), adults: For moderately to severely active UC with inadequate response, contraindication or intolerance to conventional therapy including corticosteroids and 6-mercaptopurine (6-MP) or azathioprine (AZA). Uveitis, adults: For the treatment of non-infectious intermediate, posterior and panuveitis in adult patients who have had an inadequate response to corticosteroids, in patients in need of corticosteroid-sparing, or in whom corticosteroid treatment is inappropriate. **Dosage and administration:** A specialist physician experienced in diagnosis and treatment of the indicated condition, to initiate and supervise treatment. Provide patients with special alert card. Patients may self-inject after proper injection training, with physician approval and appropriate medical follow-up. Optimise other concomitant therapies. RA, adults: 40 mg dose every other week. Concomitant MTX should be continued. During monotherapy, patients may require 40 mg each week if they have experienced a decrease in clinical response. Treatment beyond 12 weeks should be reconsidered if no clinical response in that time. Consider need for dose interruption, e.g. before surgery or if serious infection occurs. Reintroduction after 70 day dose interruption gave same magnitudes of clinical response and similar safety profile as before dose interruption. pJIA, paediatrics 2 years and above: Treatment beyond 12 weeks reconsidered if no clinical response in that time. pJIA, paediatrics 2-<4 years: 24 mg/m² body surface area up to 20 mg maximum single dose every other week (see SmPC for height/weight dosing chart). pJIA, paediatrics 4-12 years: 24 mg/m² body surface area up to 40 mg maximum single dose every other week (see SmPC for height/weight dosing chart). pJIA, paediatrics 13 years and above: 40 mg every other week regardless of body surface area. ERA, paediatrics 6 years and above: 24 mg/m² body surface area up to 40 mg maximum single dose every other week (see SmPC for height/weight dosing chart). AS, nr-axSpA and PsA, adults: 40 mg every other week. Treatment beyond 12 weeks should be reconsidered if no clinical response in that time. Psoriasis, adults: 80 mg induction dose at week 0, 40 mg every other week from week 1. Treatment beyond 16 weeks should be reconsidered if no clinical response in that time. Beyond 16 weeks, patients with inadequate response can increase dosing frequency to 40 mg every week. If adequate response is achieved with an increased dosing frequency, the dose may subsequently be reduced to 40 mg every other week. If there is inadequate response to the increased frequency, carefully reconsider treatment. Psoriasis, paediatrics 4 years and above: 0.8 mg/kg body weight (maximum 40 mg/dose) weekly for the first 2 doses then every other week (see SmPC for weight dosing chart). Treatment beyond 16 weeks should be reconsidered if no response in that time. HS, adults: 160 mg initially at Day 1 (given as four 40 mg injections in one day or as two 40 mg injections per day for two consecutive days), followed by 80 mg two weeks later at Day 15 (given as two 40 mg injections in one day). Two weeks later (Day 29) continue with a dose of 40 mg every week. Antibiotics may be continued if necessary. Concomitant topical antiseptic wash on HS lesions should be used on a daily basis. Treatment beyond 12 weeks should be reconsidered in a patient with no improvement in that time. Reintroduction after interruption: 40 mg every week. Evaluate periodically the benefit and risk of continued long-term treatment. CD, adults: Induction: 80 mg Week 0 and 40 mg at Week 2. For a more rapid response: 160 mg at Week 0 (either as 4 injections in 1 day or 2 injections/day for 2 consecutive days) and 80 mg at Week 2; risk of adverse events higher during induction. Maintenance: 40 mg every other week. If decrease in clinical response, can increase dose to 40 mg weekly. Corticosteroids may be tapered in maintenance phase in accordance with clinical guidelines. Patients with no response by Week 4 may benefit from continued therapy to Week 12. Treatment beyond 12 weeks should be reconsidered if no clinical response in that time. CD, paediatrics 6 years and above < 40 kg: Induction: 40 mg Week 0, 20 mg at Week 2. For a more rapid response: 80 mg Week 0 (2 injections in 1 day), 40 mg at Week 2; risk of adverse events higher during induction. Maintenance: 20 mg every other week. If insufficient response, consider 20 mg every week. Treatment beyond 12 weeks should be reconsidered if no clinical response in that time. CD, paediatrics 6 years and above ≥ 40 kg: Induction: 80 mg Week 0, 40 mg at Week 2. For a more rapid response: 160 mg at Week 0 (4 injections in 1 day or 2 injections/day for 2 consecutive days), 80 mg at Week 2; risk of adverse events higher during induction. Maintenance: 40 mg every other week. If insufficient response, consider 40 mg every week. Treatment beyond 12 weeks should be reconsidered if no clinical response in that time. UC, adults: Induction: 160 mg at Week 0 (as 4 injections in 1 day or 2 injections/day for 2 consecutive days) and 80 mg at Week 2. Maintenance: 40 mg every other week. During maintenance, corticosteroids may be tapered in accordance with clinical guidelines. If insufficient response, consider 40 mg every week. Treatment beyond 8 weeks should be reconsidered if no clinical response in that time. Uveitis, adults: 80mg induction dose at week 0, maintenance dose; 40 mg every other week starting at week 1. Treatment can be initiated in combination with corticosteroids and/or with other non-biologic immunomodulatory agents. Concomitant corticosteroids may be tapered in accordance with clinical practice starting two weeks after initiating treatment with Humira. **Contraindications:** Active tuberculosis (TB), severe infections (e.g. sepsis), and opportunistic infections; moderate to severe heart failure (NYHA class III/IV); hypersensitivity to adalimumab or any excipients.

Warnings and precautions: Clearly record trade name and batch number of administered product to improve traceability of biological products. ***Infections:*** Patients are more susceptible to serious infections especially if impaired lung function. Monitor for infections, including TB, before, during and for 4 months after treatment. Do not initiate treatment with an active infection, until it is controlled. Consider risk/benefit prior to treatment in patients exposed to high risk of TB or endemic mycoses. Evaluate new infections during treatment and monitor closely. Stop treatment if new serious infection or sepsis, and treat appropriately. Exercise caution in patients with a history of recurring infections or who are predisposed to infections. ***Serious infections:*** Serious infections, including those with hospitalisation or death, reported in patients receiving treatment. ***TB:*** Consult SmPC for details. Reactivation and new onset TB, both pulmonary and extra-pulmonary (disseminated) reported. Screen all patients before therapy initiation for active or latent TB. If latent TB suspected, consult physician with appropriate expertise and follow local treatment recommendations for prophylaxis prior to initiation of Humira. Despite prophylaxis, TB reactivation has occurred on Humira. If active TB is diagnosed, do not initiate treatment. ***Other opportunistic infections:*** Opportunistic infections observed in patients receiving Humira. Stop treatment in patients with signs and symptoms of such infections. Consult with physician with appropriate expertise for diagnosis and administration of empiric antifungal therapy in these patients. ***Hepatitis B reactivation:*** Reactivation has occurred in chronic carriers (surface antigen positive) tested for HBV infection before initiating treatment. HBV carriers should consult a specialist physician and be closely monitored for reactivation of HBV infection throughout therapy and for several months following termination of treatment. If reactivation occurs stop treatment and initiate appropriate anti-viral and supportive treatment. ***Neurological events:*** Caution in patients with pre-existing or recent-onset central or peripheral nervous system demyelinating disorders. Rare association with new onset or exacerbation of symptoms and/or radiographic evidence of central and peripheral demyelinating disease. Discontinuation of treatment should be considered if any of these disorders develop. Neurologic evaluation should be performed in patients with non-infectious intermediate uveitis prior to initiation of treatment and regularly during treatment, to assess for existing or developing central demyelinating disorders. ***Allergic reactions:*** Reports of serious allergic reactions including anaphylaxis received. For serious allergic or anaphylactic reaction stop Humira immediately and initiate appropriate therapy. ***Malignancies and lymphoproliferative disorders:*** A possible risk of malignancy, including lymphomas and leukaemia, in all patients, including paediatric patients, treated with TNF antagonists. Examine all patients, especially those with a medical history of extensive immunosuppressant or PUVA treatment, for non-melanoma skin cancer prior to and during treatment; caution in COPD patients, and in patients with increased risk for malignancy due to heavy smoking. Consider the potential risk with the combination of AZA or 6-MP and Humira (hepatosplenic T-cell lymphoma has occurred). Risk of hepatosplenic T-cell lymphoma cannot be excluded. Caution in patients with a history of malignancy. Risk of developing dysplasia or colon cancer is unknown. Patients with UC, history of dysplasia or colon carcinoma to be screened for dysplasia before and during treatment. ***Haematologic reactions:*** Adverse events of the haematologic system reported with Humira. Patients should seek immediate medical attention if signs and symptoms of blood dyscrasias. ***Vaccinations:*** Patients may receive concurrent vaccinations, except for live vaccines. Bring paediatric patients up to date with all immunisations prior to Humira treatment. ***Congestive heart failure:*** See contraindications. Caution is advised with mild heart failure (NYHA class I/II). Discontinue treatment for new or worsening symptoms of congestive heart failure. ***Autoimmune processes:*** Autoimmune antibodies may form. Stop treatment if development of a lupus-like syndrome with positive antibodies against double-stranded DNA. ***Surgery:*** Consider the long half-life of Humira for planned surgical procedures. Monitor for infections. ***Small bowel obstruction:*** Failure to respond to treatment for CD may indicate the presence of fixed fibrotic stricture requiring surgical treatment. ***Elderly patients:*** Serious infections were higher in patients over 65 years of age, some of whom had a fatal outcome. Consider risk of infections. **Interactions:** Combination of adalimumab with other biologic DMARDs (e.g. anakinra and abatacept) or other TNF-antagonists is not recommended. **Fertility, pregnancy and lactation:** Not recommended during pregnancy. Women of childbearing age to use adequate contraception, and continue its use for at least 5 months after the last treatment. Women must not breast feed for at least 5 months after the last treatment. **Side effects:** *Very common ≥ 1/10*: Infections, leucopaenia, anaemia, lipids increased, headache, abdominal pain, nausea and vomiting, elevated liver enzymes, rash (including exfoliative rash), musculoskeletal pain, injection site reaction. *Common ≥ 1/100 to < 1/10*: skin cancer excluding melanoma (including basal cell carcinoma and squamous cell carcinoma), benign neoplasm, leucocytosis, thrombocytopaenia, hypersensitivity, allergies (including seasonal allergy), hypokalaemia, uric acid increased, blood sodium abnormal, hypocalcaemia, hyperglycaemia, hypophosphatemia, dehydration, mood alterations (including depression), anxiety, insomnia, paraesthesias, migraine, nerve root compression, visual impairment, conjunctivitis, blepharitis, eye swelling, vertigo, tachycardia, hypertension, flushing, haematoma, asthma, dyspnoea, cough, GI haemorrhage, dyspepsia, gastroesophageal reflux disease, sicca syndrome, worsening or new onset of psoriasis (including palmoplantar pustular psoriasis), urticaria, bruising (including purpura), dermatitis (including eczema), onychoclasis, hyperhidrosis, alopecia, pruritus, muscle spasms (including blood creatine phosphokinase increased), renal impairment, haematuria, chest pain, oedema, pyrexia, coagulation and bleeding disorders, autoantibody test positive, blood lactate dehydrogenase increased, impaired healing. **Serious, including fatal, side effects have been reported** including infections/sepsis, intestinal perforation, opportunistic infections, TB, endemic mycoses, demyelinating disease, malignancies including lymphoma, (including hepatosplenic T-cell lymphoma), leukaemia and skin cancer (including melanoma and Merkel cell carcinoma), cytopenias, worsening heart failure, myocardial infarction, pulmonary embolism, pleural effusion, pulmonary fibrosis, cerebrovascular accident, interstitial lung disease, Stevens-Johnson syndrome, angioedema, anaphylaxis, sarcoidosis, hepatitis, liver failure and worsening of symptoms of dermatomyositis. **Other less common and rarely reported side effects are listed in the SmPC. Basic NHS price:** £704.28 (for 2 pens or 2 syringes or 2 vials). **Legal category:** POM. **Marketing Authorisation numbers**: EU/1/03/256/001, EU/1/03/256/013, EU/1/03/256/017. **Further information**: available from AbbVie Ltd., Maidenhead, SL6 4UB, United Kingdom. **Date of revision of PI**: July 2016, PI/Humira(combined)/36.

References: 1. Humira Summary of Product Characteristics, AbbVie Limited **2.** Mease. P.J. et al Adalimumab for the treatment of patients with moderately to severely active psoriatic arthritis. 2005 *Arthritis and Rheumatism*, 52, 3279-3289.

Adverse events should be reported. Reporting forms and information can be found at www.mhra.gov.uk/yellowcard. Adverse events should also be reported to AbbVie on ukadverseevents@abbvie.com

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Date of preparation: June 2016

AXHUD161207

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■ Epithelioid Angiosarcoma Arising on the Back of a Young Caucasian Male

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Introduction: Epithelioid angiosarcoma is a rare and unique subtype of angiosarcoma in which the malignant endothelial cells have an epithelioid appearance. This subtype can histologically mimic non-vascular malignancies and can make diagnosis extremely challenging. Traditionally, angiosarcoma is a disease of older men, arising on sun-damaged skin often on the scalp and forehead. Epithelioid angiosarcomas have an aggressive clinical course and often demonstrate early nodal and solid organ metastasis thus early recognition and diagnosis is critical. We describe the case of an atypical angiosarcoma in a young man and highlight the importance of rethinking diagnoses and sampling lesions, which are not resolving.

Case: A forty-year-old Caucasian male was sent by his family doctor to the emergency department with a non-resolving and repeatedly infected sebaceous cyst. After incision and drainage of the lesion it was evidently not cystic and he was referred to dermatology.

On examination a 2.5 cm by 2.5 cm wide and 1.5 cm in height, solid, violaceous nodule on the right scapula was seen with an area of surrounding erythema. The lesion was indurated and painful to touch.

Biopsy of the nodule showed an ulcerated poorly differentiated malignant tumor with spindle cells and multiple mitoses. No pigment was seen and the cells stained positive for CD31 and S100. Four mapping biopsies of the surrounding erythema were then performed which showed inflammation and no tumor cells. A staging CT TAP was performed two weeks later that showed by now a 3.4 by 4.2 cm soft tissue mass arising from the subcutaneous tissues in the posterior right supra scapula area.

On review, three weeks post initial presentation the lesion had almost doubled in size, now measuring 5cm by 4.5cm, highlighting the aggressive nature of this tumour.

Following discussion at the skin cancer multidisciplinary meeting, a decision was made to treat with neo-adjuvant radiotherapy followed by excision.

Conclusion: Epithelioid angiosarcoma is a rare tumour, which can mimic benign and other malignant lesions, as a result correct diagnosis can be severely delayed. Despite the diagnostic challenges early detection is essential due to the aggressive nature and poor prognosis associated with this tumour. In this case, the tumour presented mimicking sebaceous cyst, which was not resolving. This case is an excellent description of a rare malignancy and also highlights the importance of rethinking diagnoses and sampling lesions that are not resolving.

■ Abatacept: a novel treatment in severe limited scleroderma and morphoea

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Limited scleroderma and morphoea can have significant morbidity. Early treatment is essential to avoid this. The aetiology of both conditions is poorly understood however new insights into the key role of effector T-cells in scleroderma, in particular Th-17, suggest T-cell directed therapies are expected to have promising effects. We describe four cases and their response to abatacept, a CTLA-4 antibody.

Case 1: A 60-year-old female with a nine-month history of progressive hardening of the skin of the right breast on a background of invasive ductal right breast cancer treated with lumpectomy and radiotherapy. Woody induration of the right breast with an inflammatory violaceous edge was noted and a diagnosis of morphoea profundus was made clinically and on histology. Despite initial reluctance to start immunosuppression, due to her history of malignancy, methotrexate in combination with corticosteroids was commenced due to progression of disease. This failed to control her condition and she was commenced on abatacept, which halted progression.

Case 2: A 40-year-old male with a six-month history of skin tightness of the hands and feet. There was sclerosis, with failure of extension of the hands and feet, and fixed flexion of the neck. A diagnosis of limited scleroderma was made. The patient completed three days of intravenous methylprednisolone therapy followed by a reducing course of steroids and methotrexate. Abatacept was commenced with significant improvement in symptoms.

Case 3: A 58-year-old female with extensive sclerosis of the lumbosacral spine and abdomen and a diagnosis of deep morphoea was made. The patient developed adenocarcinoma of the colon requiring a right hemi-colectomy and radiotherapy. Initial treatment with plaquenil failed and her condition progressed. With much consideration she was commenced her on immunosuppression with corticosteroids, methotrexate, and abatacept with significant improvement.

Case 4: A 65-year-old female presented with skin tightening of the wrists and forearms consistent with severe linear morphoea. Progression was noted and she was commenced on abatacept with excellent response.

Abatacept is a fusion protein of the extracellular domain of CTLA-4 and human IgG1that binds to the antigen-presenting cell, inhibiting T-cell function and used in the treatment of rheumatoid and juvenile arthritis. Small case series of treatment with abatacept have shown promise in systemic sclerosis with case reports suggesting success in localised scleroderma. We have found abatacept very effective in preventing the progression of sclerosing process in all four cases. It shows promise in the treatment of both systemic sclerosis and localized scleroderma.

■ Subcutaneous Sweet's syndrome in pregnancy

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A 31 year old woman at 29 weeks gestation developed a large left breast mass, fever, painful swollen joints and a tender eruption of the skin over a period of 5 days. There was no personal or family history of skin, joint or autoimmune disease. Previous pregnancies were uneventful. She originated from Pakistan, had no foreign travel in 7 months and denied sick contacts or new medications.

On examination she was tachycardic with persistent high grade pyrexia. Tender erythematous subcutaneous nodules and plaques were observed on the limbs with marked swelling of the hands and feet. She had bilateral conjunctival injection, later confirmed as nodular episcleritis. A 10cm firm, non-fluctuant, non-tender mass was palpable in the left breast. Investigations revealed peripheral neutrophilia and elevated inflammatory markers. Broad spectrum antibiotics were commenced for presumed breast abscess with disseminated infection, with no effect on pyrexia, skin, neutrophilia or inflammatory markers over the following 5 days. Breast ultrasound confirmed an irregular mass, suggestive of partially treated abscess or malignancy; 6 core biopsies were performed. Histology revealed a dense acute and chronic mixed inflammatory collection with no evidence of malignancy and negative PAS, Gram and ZN stains. Foetal wellbeing was confirmed by ultrasound. Deep skin biopsy of a limb nodule demonstrated normal epidermis and dermis, with extensive lobular inflammation in the subcutis, comprising a dense neutrophilic infiltrate with microabscesses. No granulomas, giant cells or leucocytoclastic vasculitis were noted; stains for infective organisms were negative. A diagnosis of subcutaneous Sweet's syndrome was made and prednisolone 40mg commenced; fever and tachycardia resolved within 16 hours and pain and swelling of the hands and feet improved over the following 24 hours. The breast mass resolved slowly over the following weeks. A CT TAP and Haematology review postpartum out-ruled malignancy.

Subcutaneous Sweet's syndrome is a rare variant of acute febrile neutrophilic dermatosis in which the pathologic changes are either localised within the adipose tissue only, or involve both the dermis and the subcutaneous fat.1 Although Sweet's syndrome may rarely be associated with pregnancy, to our knowledge there are no previous reports of subcutaneous Sweet's syndrome in association with pregnancy.

1 Cohen PR. Sweet's syndrome – a comprehensive review of an acute febrile
neutrophilic dermatosis. Orphanet Journal of Rare Diseases 2007, 2:34

■ Febrile ulceronecrotic Mucha-Habermann disease

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Febrile ulceronecrotic Mucha-Habermann disease (FUMHD) is a rare severe variant of pityriasis lichenoides characterized by the sudden onset of fevers and papulonecrotic skin lesions. We describe a 12-year-old boy who presented with classical pityriasis lichenoides et varioliformis acuta (PLEVA) that rapidly evolved to FUMHD. He presented with a 2-week history of haemorrhagic red-brown papules and plaques, concentrated on the trunk and proximal extremities, that were impetiginized and painful. He was admitted for intensive topical care (paraffin gel, fusidic acid/beclomethasone, potassium permanganate baths) and intravenous antibiotics (flucloxacillin and benzylpenicillin). This resulted in significant reduction in pain and partial resolution of the skin lesions. He was discharged on oral erythromycin.

Three weeks after the initial onset of PLEVA however he developed high fevers (39.5°C) associated with myalgia, malaise, and a confluent lace-like erythematous eruption on his trunk. Flexural accentuation was noted with extensive painful erosions and fissures present in the axillae, groin, and neck. Painful oral ulcers also developed. Inflammatory markers and white cell count were persistently normal. He had a mild and self-limiting transaminitis on both admissions. Serology for EBV IgM, CMV, parvovirus B19, varicella, hepatitis B&C, HIV, and HSV1&2 were negative. Bacterial cultures from impetiginized sites on first presentation grew E. coli, but were negative on the subsequent admission. Viral skin cultures were also negative. Sequential histology showed severe interface dermatitis with prominent vacuolar change, necrotic keratinocytes, and parakeratotic scale consistent with PLEVA. His fever settled within 48 hours after administration of intravenous flucloxacillin, benzylpenicillin, and acyclovir. He was commenced on oral methotrexate 15mg/week, and topical steroids were withdrawn. His skin and general condition have improved with no new skin lesions developing.

Pityriasis lichenoides represents a group of uncommon acquired inflammatory skin disorders that include acute (PLEVA, FUMHD) and chronic (PLC) variants. Its aetiology is unknown, although both hypersensitivity to foreign antigens and T-cell dyscrasia have been postulated. FUMHD is a potentially lethal form of PL with mortality rates of up to 25% reported. Children and adolescents tend to have a more favourable prognosis. There is no established standard treatment. Systemic steroids, oral antibiotics (erythromycin, tetracycline), phototherapy, methotrexate, intravenous immunoglobulins, and anti-TNF agents have all been reported to be effective in case reports and small case series.

Reference:

Nofal A, Alakad R, Assaf M, Nofal E. A fatal case of febrile ulceronecrotic Mucha-Habermann disease in a child. JAAD Case Reports. 2016;2(2):181-185.

■ Systemic and cutaneous amyloid presenting with palmar bullae

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A 74-year-old man presented with marked palmar erythema and haemorrhagic bullae on minor trauma, confined to both palms. He described onset of tender, red palms after a day of physical work several weeks previously. Blisters would develop filled with 'black fluid' at sites of mild trauma. There was no associated pruritus; skin elsewhere was uninvolved. He was under investigation for myeloma; he had IgG lambda paraproteinaemia (18.8g/L) with immune paresis and serum free light chain ratio of 0:1, lambda›kappa. Bone marrow trephine showed 60% plasma cells. Inflammatory markers were raised. Three serum samples were negative for cryoglobulins.

Examination revealed significant fragility of palmar skin, five circumscribed blood filled bullae were noted on the palmar skin and a sixth appeared as he untied his shoelace. We also noted an atypical pigmented lesion at the right jawline.
Perilesional skin biopsies taken from a bulla on the right palm revealed a split in the corneal layer, no inflammatory cell infiltrate and mild epidermal spongiosis, essentially nonspecific. Direct immunofluorescence was grossly abnormal with very bright positivity of IgG and lambda throughout the dermis raising the possibility of a paraprotein. There was clumpy positivity (C3, IgM, fibrin and kappa) along the dermo-epidermal junction and in dermal papillae, suggesting additional deposition of immunoreactants. We suspected myeloma-associated bullous amyloid as a cause of his blistering, however no amyloid was seen on Congo red stain. Since biopsy of the pigmented lesion on the jawline had revealed cytological atypia, further excision was performed some weeks later and Congo red staining was requested on that skin specimen. Histology revealed a junctional melanocytic lesion with Congo red stain highlighting extensive dermal vascular amyloid deposition. When he returned for histology results his palmar blistering had improved on corticosteroids prescribed for his myeloma, however he had developed periocular pinch purpura and subsequent echocardiogram revealed findings typical of cardiac amyloidosis.

Our patient was diagnosed with cutaneous bullous amyloidosis in association with systemic amyloid light chain (AL) amyloidosis on a background of multiple myeloma.

There is considerable variability in the cutaneous manifestations of amyloidosis and bullous lesions are rare. Palmoplantar bullae formation as a presenting feature of systemic amyloidosis has not been previously reported. Diagnosis of cutaneous amyloid can be challenging and ultrastructural methods may be required for confirmation. In this case, amyloid deposition was detected serendipitously on subsequent naevus excision remote from affected skin.

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1 Department of Dermatology, Royal Victoria Hospital, Northern Ireland

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Poster Presentations

■ **Deeper than a contact reaction...**

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Pyoderma gangrenosum (PG) is a rare inflammatory neutrophilic dermatosis that is often misdiagnosed. It is uncommon in infants and children accounting for only 4% of cases (1).

A one year old male in-patient in paediatric ICU ventilated for bronchopneumonia was referred with areas of ulceration on his neck and axilla. These corresponded to sites of recent removal of central and arterial lines. The working diagnosis from the referring doctors was a contact allergic dermatitis to the dressing used to secure the lines. He had a complicated past medical history including chromosomal duplication disorder and visual impairment. On examination he had areas of deep ulceration with a violaceous undermined border in keeping with the classical appearance of PG. This was supported by a skin biopsy which showed a neutrophilic infiltrate both in the deeper dermis and subcutaneous fat particularly at the edge of the biopsy; the epidermis was intact. Topical clobetasol propionate was commenced and a dramatic improvement was noted within 24 hours. The central line was re-sited to the left side and a few days later a similar lesion appeared, again with a good response to topical therapy. Blood results showed a markedly elevated WCC 29.7- a differential WCC showed toxic granulation in neutrophils with myeloid left shift; immunoglobulins showed an elevated IgG 23 and IgA 4.86. The elevated WCC made us consider a possible leukaemic trigger, however, with treatment of the underlying infection, the patient's WCC settled. Furthermore, 1 month later he was re-admitted with pneumonia requiring IV antibiotics but fortunately did not develop any further lesions.

PG in children is more likely to have an atypical distribution involving the head and neck (26.6%) or buttocks (15%), and in a similar fashion to adults, it is also associated with systemic illness such as ulcerative colitis, leukaemia, Crohn's disease, IgA deficiency. Another interesting feature in this case is the presence of pathergy. Pathergy is a term used to describe the induction or exacerbation of PG at sites of iatrogenic or incidental trauma. It is seen in 31% of patients with PG.

In summary, we present this case with classic features of PG in an uncommon age group.

References:
(1) Graham JA, Hansen KK, Rabinowitz LG, Esterly NB. Pyoderma gangrenosum in infants and children. Paediatric Dermatology. 1994;11(1):10-7.

■ **What's behind this rash? A case series of 6 patients with drug-induced subacute lupus erythematosus**

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Introduction: Drug induced subacute lupus (DISCLE) is thought to be one of the commonest forms of drug induced lupus. The number of medications recognised to cause it is certainly increasing but frequently reported culprits include anti-hypertensives, proton-pump inhibitors and anti-fungals. Considering medications as a trigger and stopping offending drugs could prevent a patient from a prolonged rash and potentially toxic treatments, however, it is difficult to differentiate between drug induced and idiopathic subacute lupus given their similar clinical, histological and autoantibody profiles. Frequent polypharmacy, particularly in older patients, with multiple potential DISCLE-inducing medications causes further confusion for clinicians.

Methods: As part of a departmental retrospective review of our cutaneous lupus patients we identified six who developed DISCLE which cleared when the offending drugs were stopped.

Results: Our six patients developed classical scaling, annular/ polycyclical rash affecting photosensitive sites. All had biopsies for histology, showing interface dermatitis, and 5 had immunofluorescence. 5/6 were anti-Ro positive. Medication histories revealed Lansoprazole, Naproxen, Capcitabine, Anastrazole and recent Terbinafine use in two patients; one of the latter was also prescribed Naproxen in preceding months. All such drugs were stopped and gradual clearance of rashes was observed, alongside transient use of topical, in all, and oral steroids in one. Photographs are available for 3 of these cases.

Discussion: This review highlights the importance of a careful drug history in managing new subacute lupus patients and demonstrates the resolution of rash following cessation of triggering medication. Our cases were similar to previously reported drug classes; however, we found only 6 other examples of Capcitabine and 1 of Anastrazole DISCLE thus adding further robust evidence for their potential culpability in subacute lupus.

Conclusion: Management can be simplified for this group of patients by readily identifying a drug trigger, stopping it, and perhaps short-term use of topical or oral steroids. We agree that more persistent or difficult-to-treat cases may actually present a case of idiopathic lupus being exacerbated by a drug.

Acute genital swelling heralding C1 esterase inhibitor deficiency in a child.

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A healthy 5-year-old presented to the emergency department with acute genital swelling. He had a history of joint swelling treated as presumed septic arthritis which resolved a few days later. He had mild atopic dermatitis and asthma. He had no relevant family history. Examination revealed profound non-pitting oedema of the penile shaft and foreskin with partial narrowing of the distal urethral meatus. His full blood count, routine biochemistry and inflammatory markers were all normal or negative. His genital swelling subsided slightly a few hours later. A provisional diagnosis of angioedema was made based on his clinical presentation and preliminary investigation results. His remaining investigation results showed a reduced C4 level, C1 esterase inhibitor level and functional C1 esterase inhibitor activity. A diagnosis of type 1 hereditary angioedema (HAE), most likely arising de novo was made. He was treated with tranexamic acid (50mg/kg/day) which has resulted in less severe and infrequent episodes.

Angioedema is a localised and self-limiting soft tissue swelling as a result of transient increase in vascular permeability which is either mediated by mast cell or bradykinin. HAE most commonly affects the skin on the extremities with the onset of symptoms usually in childhood. A child presenting with acute genital swelling could pose a diagnostic challenge to clinicians. Other causes of genital swelling reported in childhood included cellulitis, idiopathic lymphoedema, metastatic Crohn's, juvenile dermatomyositis and fixed drug eruptions. Non-cutaneous involvement of HAE such as the gastrointestinal tract, brain, kidney and pancreas often causes a delay in the diagnosis. The 2 most common types of HAE are type 1, with reduced C1 esterase inhibitor (C1-INH) protein and functional levels and type 2 HAE with normal C1-INH protein levels but reduced C1-INH functional levels.

The treatment strategy of HAE should include management of acute attacks and prophylaxis. It is a bradykinin-mediated angioedema which does not improve with antihistamines, glucocorticoids or epinephrine. Approved therapies for paediatric patients are limited but recent studies support the use of self administered plasma derived C1-INH at home. Tranexamic acid and attenuated androgens have been used as long term prophylaxis with some benefit in symptom control. C1-inhibitor concentrates, higher doses of tranexamic acid or attenuated androgens have been recommended for short term prophylaxis.

■ **A retrospective review on the management of hidradenitis suppurativa**

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Background: Hidradenitis suppurativa (HS) is a chronic inflammatory disease characterised by abscesses and nodules developing into sinuses with scarring and contractures in severe cases. It can be debilitating and psychologically distressing, greatly impacting on quality of life. There is a lack of published guidelines on HS. This review was designed to assess current management in the Belfast Trust.

Methods: A retrospective review of both paper and electronic charts was performed on 33 patients including five on biological therapy over one year. Hospital numbers were retrieved from the coding department in Royal Victoria Hospital.

Results: Seventy-five percent of patients were female with disease duration ranging from <1 to >20 years. Co-morbidities documented included; obesity (45%), Crohn's disease (15%) and diabetes (3%). Eighty percent received weight reduction advice, 48% smoking cessation advice and 39% received British Association of Dermatologist's patient information leaflet on HS. 61% had at least one cardiovascular risk factor. The most common site of involvement was the axilla (70%), groin (61%) and submammary regions (15%). Only 2 patients had a Hurley stage documented. Tetracyclines were used as first line in 60% of cases whilst Rifampicin/Clindamycin combination was used as second line in 21%. Thirteen percent received oral retinoids, a better response was noted with 6-9 month duration of treatment. Twenty percent of patients received dapsone with good effect. Six percent received oral immunosuppressants - One patient used methotrexate in addition to infliximab with good effect, one patient used ciclosporin at 3mg/kg with good response, 5 patients required biological treatment, with 3 cases required combination with another agent including doxycycline, acitretin and methotrexate. All 5 patients had a DLQI >10 and Hurley stage 3 disease.

Discussion: The management parallels the findings of a survey performed on UK dermatologists' management of HS published in 2015. Improvement in documentation of severity assessment, DLQI, weight reduction/ smoking cessation advice, as well as providing information leaflets is needed. Association with cardiovascular disease is recognised in HS and as such a risk assessment for modifiable cardiovascular risk factors should be undertaken in all patients. A checklist has been designed to improve future documentation. Up to date guidelines on the management of HS are awaited.

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■ **Springing up in two shakes of a lamb's tail**

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A 56-year-old farmer presented to ENT and was referred for a dermatology opinion that day following ENT review. He had a 2-week history of a rapidly enlarging lesion on his nose at a site of recent trauma. He denied any associated pruritus or pain. He was systemically well. He had no past medical or dermatological history of note, and took no regular medications. On examination he had a well demarcated, crusted, exophytic, firm, non-tender, nodule on the right side of his nose measuring 2cm, with surrounding cellulitis extending to involve 80% of his nose. An incisional punch biopsy was taken which showed hyperkeratosis with eosinophilic cytoplasmic inclusions, probably representative of viral inclusions, suggestive of orf. The surrounding cellulitis responded rapidly to a one-week course of oral flucloxacillin and co-amoxiclav. With conservative management only, the lesion had significantly reduced in size within 3 weeks, and had completely resolved within 10 weeks.

Orf is a zoonotic parapoxvirus that is endemic in sheep and goats worldwide. Transmission to humans occurs when abraded skin comes into contact with infected animals or contaminated objects. Orf is most common during spring and summer months, co-inciding with lambing season. The true prevalence of orf infection is almost certainly underestimated, as it is a self-limiting condition and can be easily recognised by people at risk who do not always seek medical care. Orf typically occurs on the fingers and hands. Rarely, as in our case, the disease presents on the face. The main differential diagnosis in our case was a very rapidly growing squamous cell carcinoma, an excision of which would have required extensive surgery. Histologically, orf is char-

acterised by the appearance of hyperkeratosis and eosinophilic inclusion bodies in the cytoplasm of vacuolated epidermal cells in the upper epidermis. The disease course consists of 6 clinical stages each lasting approximately 1 week. Orf is usually self-limiting and no specific treatment is indicated. The natural history of the disease in an immunocompetent patient is spontaneous resolution without scarring within 4-6 weeks. Reported complications include secondary bacterial infection, erythema multiforme or lymphangitis.
Taking an accurate history and having high index of suspicion are both crucial for diagnosing orf. Awareness of orf at unusual sites is important to allow for prompt diagnosis of this benign condition, and avoidance of over treatment.

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■ Acute generalised exanthematous pustulosis presenting without pustules: A variant revealed on biopsy.

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Acute generalized exanthematous pustulosis (AGEP) is a severe cutaneous adverse reaction (SCAR) that presents with the simultaneous development of a high-grade fever and erythematous plaques and papules studded with numerous pinpoint pustules following administration of a medication. AGEP is often diagnosed clinically, and confirmed on biopsy, as the appearance of these small sterile pustules is characteristic. We present two cases of AGEP who failed to develop clinically evident pustules, with the diagnosis made on biopsy, and one case of delayed onset of pustulosis.

An 83-year old female was referred to dermatology with a widespread erythematous rash of the trunk and limbs. She was admitted with an NSTEMI and had sustained a fractured left hip following a fall at home. During the course of her treatment she had received teicoplanin, ceftriaxone and metronidazole. She had erythema of the trunk and limbs with vesiculation at the flanks with epidermal detachment. Nikolsky sign was positive and no pustules were noted. Clinically a diagnosis of toxic epidermal necrolysis (TEN) was suspected and a biopsy was undertaken. The patient responded readily to conservative measures and her histology suggested AGEP, with no evidence of epidermal necrosis.

An 84-year old male was referred with a six-week history of an erythematous eczematous rash of the trunk and limbs on a background of progressive pro-lymphocytic leukaemia. His treatment included idealisib, a phosphoinositide 3-kinase inhibitor, and rituximab, which were stopped three months later due to progression of the rash. He presented with widespread macular erythema without pustules. Histology showed a large subcorneal pustule and dermal oedema confirming a diagnosis of AGEP, likely secondary to idealisib.

An 86-year old male was reviewed with a five-day history of a widespread erythematous rash of the trunk and limbs with epidermal detachment and no pustules. The patient was recently treated with five days of flucloxacillin for an infected sacral pressure ulcer. A clinical diagnosis of toxic epidermal necrolysis was made and a biopsy was undertaken. Four days after admission the patient developed widespread pustules over 90% of the body surface area. The biopsy confirmed subcorneal pustule formation and neutrophil polymorphs in the upper dermis in keeping with AGEP. The patient died of sepsis.

Cases of TEN-like AGEP have been described in the literature, with absence of the characteristic pustules. Furthermore, confluent pustules may mimic the bullae formation of TEN. We describe these atypical cases to demonstrate the spectrum of presentations of AGEP.

■ A case of multicentric reticulohistiocytosis

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A 62-year-old Caucasian female was admitted to hospital under the general medical team with a 3-month history of weight loss, fatigue and joint pain. Haematological investigations demonstrated an iron deficiency anaemia. She had significant lower limb oedema with an associated albumin level of 17 g/l (35-50). Erythrocyte sedimentation rate (ESR) was elevated at 17 mm/hr (1-15). Rheumatoid factor, anti-cyclic citrullinated peptide, anti-nuclear antibody and anti-neutrophilic cytoplasmic antibody were all negative. She underwent multiple investigations including a CT thorax abdomen pelvis, colonoscopy, capsule endoscopy and bone marrow biopsy, all of which were normal. X-rays of her hands demonstrated a bilateral erosive arthopathy.

On examination it was noted she had papules and nodules over her metacarpal and elbow joints. A right knee aspirate demonstrated macrophages, lymphocytes, neutrophils and scant negatively bifringent crystals. Given the atypical appearance of the papules and nodules, dermatology were consulted.
Full skin examination demonstrated non-tender pink and fleshy coloured papules on the distal aspect of her fingers and encircling her right helical rim. There were firm pink nodules on the extensor surface of her left elbow, as well as mild periungal telangiectasia along her fingernails. There was no palpable lymphadenopathy. Biopsies from both a papule and nodule were performed.

Histopathological examination showed a prominent dermal-based histiocytic lesion comprised of histiocytic cells with abundant eosinophilic cytoplasm. There was no significant associated lymphocytic or plasma cell infiltrate, neutrophilic component or granulomas seen. The lesional cells expressed CD68 and melan A. CD1a, S100 or HMB45 were all negative, consistent with the diagnosis of multicentric reticulohistiocytosis (MRH).

Reticulohistiocytoses are a rare group of non-langerhans cell histiocytoses. MRH is an aggressive systemic condition primarily affecting the skin and joints. It typically presents with a symmetrical erosive polyarthritis and cutaneous papules. There is a predominance in middle-aged Caucasian females. Internal organs are rarely affected, however up to 30% of cases are associated with internal malignancy. The condition may rapidly progress to cause a destructive arthritis, leaving patients crippled with significant joint pain and deformity. There may be associated constitutional symptoms including fever, malaise and weight loss, as well as anaemia and raised ESR.

Different treatments have been reported including methotrexate, prednisolone, cyclosporine, azathioprine and bisphosphonates. Non-steroidal anti-inflammatory drugs can be useful for associated arthritis. A review published in 2016 concluded that methotrexate was the most effective initial treatment. Anti-TNF agents have recently been reported as effective.

■ Airborne contact urticaria resulting from occupational exposure to sodium benzoate

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SIVUH Cork

A 32-year old gentleman presented to the dermatology department with a history of transient erythema and burning of his face while working on a new process at work introduced a few months previously. He was employed as a process operator at a pharmaceutical plant for three years and recently started a new role within the plant. He was sieving sodium benzoate while wearing a hairnet, mask and nitrile gloves. The environment was quiet dusty. One morning shortly after starting the procedure he became hot and red and quickly moved outside. His face and neck became red and he attended the general practitioner. The reaction settled over an hour and half. No other staff members were affected but the process was only new in the company and only carried out every few months. An urticarial reaction to sodium benzoate was diagnosed on clinical grounds. Other workers were also at risk of developing a similar reaction and we recommended full protective PPE, an enclosed method for carrying out the procedure and improved ventilation of the area. There have been no reported problems since that time.

There is only one report of a similar reaction from the US, also in a pharmaceutical plant, where three workers exposed to airborne contact with sodium benzoate developed transient urticaria (Nethercott JR, Lawrence MJ, Roy AM, Gibson BL, Airborne contact urticaria due to sodium benzoate in a pharmaceutical manufacturing plant, J Occup Med. 1984 Oct;26(10);734-6)

■ Omalizumab: A New Therapeutic Option for Aquagenic Pruritus

R. O'Connor, S. McCarthy, J. Bourke, M. Murphy.
SIVUH Cork

Aquagenic pruritus is a rare skin condition characterised by intense itch, burning or stinging sensation after contact with water without visible skin changes. The pathogenesis is unknown. Anti-histamines are the mainstay of treatment but other reported therapeutic options include phototherapy and immunosuppression.

A 57-year-old male patient presented with a 10-year history of generalised pruritus that was precipitated by contact with water. The itch started immediately after showering. It severely impacted on his activities of daily living and he was unable to wash or swim. It was not associated with urticarial wheals or skin changes. His medical history included multiple sclerosis, depression, hypertension and mild psoriasis. He was systemically well and investigations revealed a normal haemoglobin, B12, folate, ferritin, renal and liver profile. Coeliac screen was also negative. Previous treatment included antihistamines to which he reported an initial partial response but then lost effectiveness. Given his history of intractable itch triggered by contact with water, a modified itch provocation test was performed which was positive and a diagnosis of aquagenic pruritus was made. He was initially treated with ketotifen 1mg OD and montelukast was added with no improvement in symptoms. He was subsequently treated with narrowband UVB and completed 26 exposures. He reported an initial improvement in pruritus on phototherapy but as treatment was weaned to once weekly his symptoms relapsed. As the pruritus was having a very significant impact on his quality of life we commenced him on ciclosporin 100mg BD, which after one month was further increased to 150mg BD. Within two months of commencing treatment with ciclosporin his pruritus was markedly improved and he remained itch free while on treatment. However, he developed severe hypertension which necessitated discontinuation of ciclosporin. His intense pruritus reoccurred which was unresponsive to high dose antihistamines. He was commenced on omalizumab 300mg subcutaneously every four weeks. Visual analogue scale for pruritus was performed before and after starting treatment with omalizumab and he reported resolution of his symptoms within 2 weeks of the initial dose. He is tolerating the medication well with no adverse events and his aquagenic pruritus remains in remission.

We report the first case of aquagenic pruritus refractory to conventional therapies that was successfully treated with omalizumab.

■ AN AUDIT OF TRANSPLANT CLINICS 2014

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Background: Post-transplant patients are known to have 50-100x increased risk of developing SCC compared to the normal population. In addition, skin tumours are often multiple and may behave more aggressively.1 Harwood et al. noted a cumulative incidence of NMSC at 5, 10, 20 and 30 years of 11%, 25%, 54% and 74% respectively in post-transplant patients.2 Statistically significant risk factors include skin phototype, ultraviolet radiation exposure, age at transplant and the duration of transplant. Specialist dermatology clinics for organ transplant recipients have been shown to significantly improve compliance with photo protection and levels of skin cancer awareness.3 Therefore, a new dermatology service was initiated in the Belfast City Hospital in 2013 specifically for immunosuppressed transplant patients with a background of skin cancer. The new clinics were developed due to a large cohort of renal transplant patients in the general dermatology clinics who had complex skin cancer management requirements.

Aims: To improve the quality of care for patients including:
•Education of their risk and of precautions instituted for prevention of skin cancer
•Early and successful management of pre-malignant lesions
•Early diagnosis and treatment of skin cancers, comparing standards outlined in NHS cancer care guidelines 2007

Methods: Retrospective audit of 33 patients on immunosuppression who attended a transplant clinic in 2014.

Results:
•Average length of time on immunosuppression = 19.8 years
•Average age of patient = 61.6 years
•73% had previous skin cancer (BCC/SCC/MM)
•73% prescribed vitamin D
•76% patients received appropriate information leaflets
•63% patients had AK
•39% had Bowens
•42% patients had new diagnosis of skin cancer
•18% had BCC all treated with excision, 83% within 62 days
•27% had SCC, 13 T1a, 6 T2a and 1 T4
•95% SCCs excised within 62 days
•62% skin cancers excised on same day

Conclusion/ Recommendations:
•Majority of skin cancers (62%) excised on same day.
•95% of SCCs excised within 62 days.
•Audit findings highlight the need to improve advice and prescription of sun protection, provision of PILs and monitoring/ prescription of vitamin D.
•? role for a specific key worker to help coordinate more complex skin cancer patients

References
1. Skin cancers after organ transplantation. Euvrard S et al. N Engl J Med. 2003;348:1681–91
2. A Surveillance Model for Skin Cancer in Organ Transplant Recipients: A 22-Year Prospective Study in an Ethnically Diverse Population C. A. Harwood et al. American Journal of Transplantation Vol13 Issue 1 p119-129 January 2013
3. Specialist dermatology clinics for organ transplant recipients significantly improve compliance with photoprotection and levels of skin cancer awareness. Ismail F1 et al. 2006 Nov;155(5):916-25

■ Challenges in Triaging Paediatric Acne Vulgaris Referrals to a Secondary Care Dermatology Department

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Acne vulgaris is a common inflammatory skin condition affecting up to 90% of teenagers. The psychological impact of acne is subjective and often considerable. Dermatology services nationally are under resourced and subject to long delays in access, currently up to 15 months for paediatric referrals to our institution. Waiting list management can be enhanced by improving appropriateness of referrals and with the inclusion of clinical information relevant for triage. The AAD and EADV have recently issued or updated existing acne management guidelines that provide evidence based referral guidelines for clinical practice (1). In order to identify measures to improve access we analysed our paediatric acne referrals designated as routine, for documentation of first line/primary care management. We examined the inclusion of information necessary for appropriate triage.
Over a 6-month period a total of 464 paediatric referrals were triaged as routine. 7% (34/464) of referrals were made in relation to acne. 29% (9/34) included information on severity/presence of scarring while 9% detailed psychological impact. Regarding documentation of therapies commenced in primary care, topical agents were listed in 62% of referrals (21/34). The most commonly used were combination topical retinoid and antibiotic products (41%), topical retinoid (26%), monotherapy with topical antibiotic (21%) and benzoyl peroxide in 9%. Dermatology input was requested following a single oral antibiotic in 68% and further to two courses in 12%. Duration of antibiotic course was detailed in 9% of referrals (3/34).
Discussion: Current acne guidelines recommend avoiding antibiotic monotherapy, limitation of oral antibiotic therapy duration and the use of concomitant topical retinoids. Monotherapy with topical and oral antibiotics was commonly practiced while topical retinoids were prescribed in a quarter of patients. Appropriateness of referral for isotretinoin was difficult to determine as less than a third recorded an assessment of severity, scarring and details of antibiotic usage. Details of psychological impact were found in less than 10%.
Conclusion: In the setting of delayed access and increasing referrals from primary care to secondary paediatric dermatology services, the inclusion of relevant triage information is fundamental in ensuring services are accessed by clinical priority. Algorithms for management, referral criteria and pathways have the potential to reduce unnecessary referrals and improve patient care. National educational initiatives to promote internationally accepted acne clinical care pathways and referral criteria are required.

1) Guidelines of care for the management of acne vulgaris. Zaenglein AL et al.J Am Acad Dermatol. 2016 May;74(5):945-73.e33. doi:10.1016/j.jaad.2015.12.037.

■ Sweet's Syndrome presenting in IBD, a rarity?

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Background: Almost one third of patients with Inflammatory Bowel Disease will suffer dermatological complications. Sweet's syndrome has been described as a rare extra intestinal manifestation of Crohn's Disease. This was first described in 1964 by Robert Douglas Sweet in the British Journal of Dermatology as an acute febrile neutrophilic dermatosis, its eponym, Gomm Button disease. It is characterized by the acute onset of fever, neutrophilia and tender erythematous skin lesions (papules, nodules, and plaques) predominantly affecting the upper extremities, face and neck. In addition to painful and oedematous nodules and plaques, vesicles, bullae, or pustules may also be present.Regardless of the aetiology, typical histopathological findings include a diffuse infiltrate consisting predominantly of mature neutrophils located in the upper dermis. We present a case series of patients presenting with Sweet's syndrome on a background of inflammatory bowel disease.

Methods: We retrospectively collected data on our adult patients with Sweet's Syndrome presenting on a background of IBD (both Crohn's Disease and Ulcerative Colitis) who attended our dermatology and gastroenterology service by means of chart review. Clinical photography was also carried out with informed consent.

Conclusions: Although Sweet's syndrome occurring in IBD has been described as a rare extra intestinal manifestation of IBD we found this to be a relatively common presentation to our service. In addition, Sweet's Syndrome has been described as occurring

more frequently in patients with Crohn's Disease, however, in our series Sweet's Syndrome was equally as common in both UC and CD. Overall there was a notable female predominance. In all but one of our patients, IBD was quiescent at the time of onset of Sweet's Syndrome. One case was attributed to treatment with Azathioprine, an important entity in Sweet's Syndrome occurring in IBD. Overall, this case series highlights the importance of a multidisciplinary approach in treating patients with Sweet's Syndrome occurring in the setting of IBD. With prompt diagnosis and management, Sweet's Syndrome responds well to intensification of immunosuppression, with some patients requiring only topical corticosteroid agents. Overall our case series outlines the most common presenting features of Sweet's Syndrome in IBD and also that most patients present with Sweet's Syndrome in the setting of established IBD, however, one must have a low threshold for screening for underlying IBD in all patients with Sweet's syndrome.

■ Unilateral hyperhidrosis as a presenting symptom in Ross' syndrome

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A 50 year old woman was referred by her G.P with a three year history of hyperhidrosis, confined to her right hand side. Symptoms were progressing and significantly impacting her quality of life. Hyperhidrosis occurred at ambient temperatures and was exacerbated by minimal exertion, increase in temperature and anxiety. It was unilateral and segmental. Skin in unaffected areas was anhidrotic. Previous trials of beta-blockers and clonidine had been unsuccessful in ameliorating her condition. She had no other symptoms of autonomic dysfunction.

The patient was seen previously in the ophthalmology department having been referred with incidentally-noted anisocoria. She was diagnosed with bilateral Adie's pupils (confirmed with denervation hypersensitivity to pilocarpine) and had been discharged. She had no other significant past medical history.

On full skin examination, hyperhidrosis was noted in the right face and neck, right flank and right lower limb with these areas being notably moist to touch. Remaining skin was anhidrotic. Opthalmological examination showed slow pupillary reaction to light, with normal reaction to accommodation. Neurological examination demonstrated loss of deep tendon reflexes.

Investigations revealed urinary and plasma catecholamines/metanephrines, thyroid function tests, cortisol, urinary 5-hydroxyindoleacetic acid, C reactive protein and lactate dehydrogenase were all within normal limits. Follicle-stimulating hormone and luteinising hormone indicated the patient was peri-menopausal. CT Brain and MRI Brain were normal.

The unilateral, segmental hyperhidrosis coupled with the bilateral tonic pupils and deep tendon reflex loss led to a diagnosis of Ross syndrome. The patient was referred to the dermatology department for further management.

Discussion: Ross syndrome is a rare dysautonomic syndrome characterised by a triad of: unilateral or bilateral anhidrosis, deep tendon hypo- or areflexia and Adie's tonic pupil/pupils– which typically show slow reaction to light, but normal response to accommodation. One of the most common presenting and troubling symptoms is segmental compensatory hyperhidrosis. The exact mechanism is unknown, however it has been postulated that peripheral autonomic nervous system degeneration may be contributory. Since first described in 1958, as few as 50 cases of Ross syndrome have been reported in the literature Patients typically present to neurology and dermatology.
The aim of management is to control disabling hyperhidrosis with a range of treatment strategies including medications (clonazepam, propantheline), iontophoresis, botulinum toxin and endoscopic thoracic sympathectomy having been tried with varying results.

■ Paediatric psoriasis is associated with multiple co-morbidities and impaired quality of life

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Introduction: Considerable advances in therapy and knowledge of associated co morbidities of adult psoriasis have occurred over the last 2 decades yet a paucity of studies exists for paediatric disease. Psoriasis is a chronic inflammatory condition that is typically described as having bimodal onset with the first peak between ages 16 and 22 and the second between 57 and 62 years. Childhood disease is considered to have an irregular disease course with a tendency to be difficult to treat. Experiences from our adult patients with severe disease suggest that early onset in childhood may be a predicting factor for recalcitrant disease. We completed a literature review of childhood onset psoriasis which highlighted an increased rate of psychiatric disorders and poorer quality of life compared to controls, with younger children more severely affected. A higher prevalence of co-morbidities, such as Crohn's disease, hyperlipidaemia, hypertension and obesity was seen compared to healthy controls. To date differences in age groups used and methods defining severity in published literature have made studies on severity of childhood onset disease too heterogonous to draw conclusion from.

Methodology and results: A search of our letters database confirmed 69 cases of patients less than 16 with a definite diagnosis of psoriasis. Females were more commonly affected (n=41) with a female: male ratio of 1.46:1. Plaque psoriasis predominated (55%), followed by guttate (19%), flexural (13%), scalp (10%) and napkin (3%). 37% had moderate-severe disease with four patients (7.2%) requiring systemic treatment with methotrexate, 22 patients (32%) referred for phototherapy and one requiring treatment with a Biologic agent. Almost two thirds of the moderate-severe group required long-term follow up (61.50%).A positive family history was recorded in 38% of patients. Co-morbidities were detailed for 14% of the patients (2 arthritis, 1 Crohns disease, 2 alopecia areata, 1 asthma, 1 congenital heart disease). 11% made reference to significant impact on quality of life primarily affecting the child's ability to participate in school.

Conclusions: Our experience demonstrates a significant impact in children when affected with psoriasis with 37% requiring systemic therapy or phototherapy, the majority still attending our

service. Unlike children with atopic eczema those with psoriasis have significant co morbidities prompting us to re think the way we monitor these patients and consider screening for risk factors for metabolic syndrome as we do in adult psoriasis. Collaboration with our paediatric colleagues and longitudinal studies in this age group are required.

■ Audit of Cutaneous Allergy Service in a Regional Dermatology Department

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Background: Allergic contact dermatitis (ACD) is a delayed type hypersensitivity reaction accounting for 4-7% of dermatological consultations. Diagnosis is by meticulous history taking and interpretation of appropriate cutaneous allergy tests.

Objectives: To review the Cutaneous Allergy Service in our University Tertiary Centre in 2015 to confirm compliance with the British Society of Cutaneous Allergy minimum standards guidelines (BSCA) and to identify current allergen prevalence and trends in our catchment area patient population (800,000)
Methods: Cutaneous allergy testing was performed one week each month for 10 months during that calendar year. Information was obtained from each patient's final clinic report.

Results: Patients were seen on days 0, 2, and 4 by a Consultant Dermatologist. Patches were applied on day 0 by a trained dermatology nurse. BSCA protocols were followed in preparation and procedural methodology. Results were read and interpreted by the same Consultant Dermatologist. Data on 96 patients, 41 male and 55 female, was available for analysis. The median age in our cohort was 45 years (range 7-87 years). The majority of referrals, 75%, were from consultant dermatologists within our department. The remainder came from GP referrals (15%) and non-dermatology hospital consultants (10%). The most common sites affected were face (36%) and hands (26%). All patients were tested to the BSCA standard series and to a range of other allergens as deemed individually appropriate. A positive reaction was documented in 54% of patients. Allergens of current clinical relevance were diagnosed in 65% (35/54) of patients with a positive reaction. The most common allergens in our cohort were nickel (20%), fragrances (17%) and Balsam of Peru (10%) followed by preservatives MCI/MI (9%), MI (7%) and PPD (3%).

Conclusion: Allergic contact dermatitis remains a prevalent condition affecting males and females across all age groups. Our prevalence figures reflect our referral base ie. 75% of patients are selected referrals from dermatologists. This is determined by limited available resources. As confirmed internationally, positive reactions to nickel, fragrances and Balsam of Peru remain amongst the most common allergens causing ACD. The prevalence of positive reactions to PPD and MCI/MI and MI may be beginning to show a downward trend compared to recent previous years. If this downward trend continues , can it be attributed to increasing patient awareness with increased avoidance of these allergens or does it reflect a tardy response finally emerging from our cosmeceutical industry.

■ Recalcitrant cutaneous sarcoidosis, with response to daylight photodynamic therapy.

Conor Broderick1, Catherine Quinlan1, Christian Gulmann1, Marina O'Kane1
1. Beaumont Hospital Dublin

A 37 year-old Zimbabwean woman with type V skin presented to Dermatology with a two year history of symmetrical, uncomfortable papules and plaques on her face, ears and neck. Her past medical history was significant for HIV and chronic hepatitis B co-infection, multiple opportunistic infections, including pulmonary tuberculosis and cryptococcal meningitis, iron-deficiency anaemia and multiple laparotomies for ovarian cysts and adhesional small bowel obstruction. Her medications included efavirenz, lamivudine/zidovudine, fluconazole and co-trimoxazole. Previous treatments included topical clobetasol. Examination revealed juicy, symmetrical, erythematous and skin-coloured papules and plaques, which subsequently developed dyspigmentation. The lesions were both annular and umbilicated in parts.

Skin biopsy confirmed cutaneous sarcoidosis, with numerous upper dermal granulomata and occasional focal necrosis, with a background mild chronic inflammatory infiltrate. Special stains and cultures were negative for mycobacteria, fungi, cryptococcus and spirochetes. Repeat biopsies were consistent with sarcoid. Investigations showed an undetectable HIV viral load, CD4 count of 250-300, normal serum angiotensin-converting enzyme and adjusted calcium and negative Mantoux test. Chest imaging demonstrated bihilar and mediastinal lymphadenopathy and pulmonary function tests indicated a restrictive pattern. Respiratory review deemed there to be no requirement for ongoing oral steroids. She was evaluated by rheumatology who confirmed sarcoid dactylitis, treated with non-steroidal anti-inflammatories. Ophthalmological assessment excluded ocular sarcoidosis.

Trials of topical clobetasol propionate and tacrolimus were moderately effective but led to skin atrophy, intralesional trimacinolone was ineffective. Her skin would respond well to intermittent 6-week courses of oral prednisolone but she developed Cushingoid facies and suffered rapid relapses on discontinuation. Oral methotrexate (10mg/week) was poorly tolerated and discontinued (leukopenia and monitoring difficulties) and hydoxychloroquine (200mg BD) was ineffective. Anti-TNF agents were considered an unacceptable risk given her history of pulmonary tuberculosis, chronic hepatitis B infection and cryptococcal meningitis. Given her significant disfigurement, psychological distress and limited therapeutic options, and being aware of case reports (1,2,3) citing success with photodynamic therapy (PDT) treatment, a test patch of conventional PDT (methyl-aminolevulinate; Metvix and Aktilite) to the right cheek successfully flattened a plaque leaving cosmetically acceptable post-inflammatory hyperpigmentation, which faded with time. This was followed with daylight PDT with further flattening of lesions, most markedly on her maxillary prominences and forehead. She will have further sessions of daylight PDT. There are no reported cases of daylight PDT being used to treat cutaneous sarcoidosis.

1) Karrer, S et al; Arch. Dermatol. 2002
2) Wilsmann-Theis, D et al; Dermatology. 2008
3) Penrose, C et al; J Am Acad Dermatol. 2011

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Spring Meeting Guest Speakers

IAD President Dr Kevin McKenna & guest speaker Dr Sandy McBride

Guest speaker Dr Sandy McBride & Prof Brian Kirby

Dr Kevin McKenna & guest speaker Prof Brian Kirby

Dr Anne-Marie Tobin & guest speaker Dr Sandy McBride

Dr Kevin McKenna & guest speaker Prof Chris Griffiths

Past & Present IAD Presidents Dr Rosemarie Watson & Dr Kevin McKenna

Dr's Ian McDonald & Genevieve Kelly

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IAD Dinner
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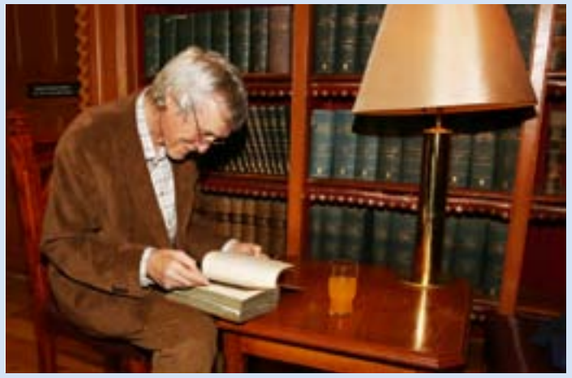
















abbvie Spring Symposium

Prof Brian KirbY

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Spring Symposium

Dr Michelle Murphy, Prof Brian Kirby, Janneke Huizinga and Barbara Horvatt

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UVELLE


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TOUGH ON
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IMPORTANT TO PATIENTS
DUAC


Cosentyx
secukinumab
THE AIM IS CLEAR


soolantra


OUR
CLEA
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Taltz

IAD SPRING MEETING WINNERS

Dr Kevin McKenna presenting to Dr Gemma McIntyre, Burrows Cup runner up

Dr Kevin McKenna presenting to Dr Maeve Lynch 1st place poster prize

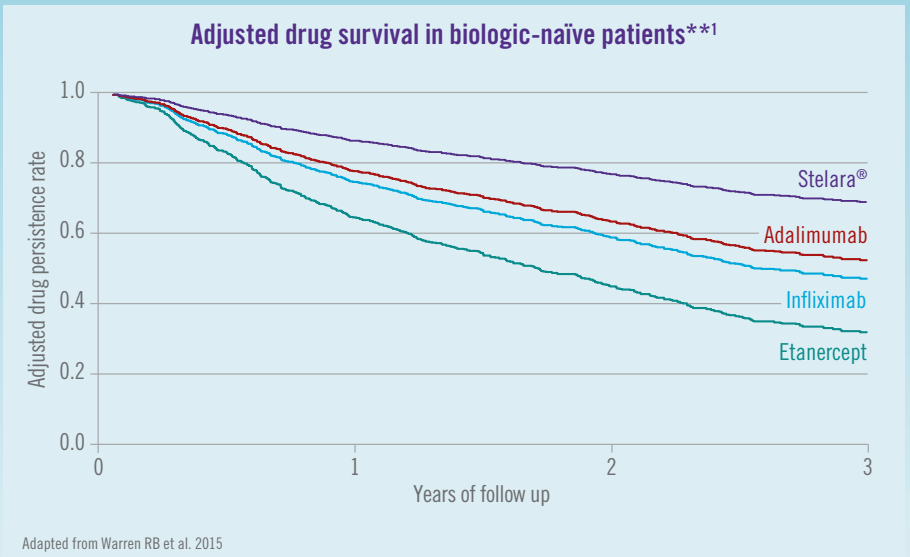
Dr Maeve McAleer Burrows Cup Winner presented by Dr Kevin McKenna

IAD SpR's

Real-world patients remain on Stelara® longer compared to anti-TNF therapies[1,2]

Newly published BADBIR* data shows better drug persistency for Stelara compared to anti-TNF therapies[1]

- Predictors of discontinuation were analyzed using a multivariate Cox proportional hazards model.[1]
- Compared to adalimumab[$]:
  - Stelara was a **predictor of drug survival**
  - Infliximab[†] and Etanercept[‡] were both predictors of discontinuation.



Adapted from Warren RB et al. 2015

* BADBIR (British Association of Dermatologists Biologic Interventions Register) is a prospective, longitudinal, pharmacovigilance register for the UK and the Republic of Ireland. Over 3,500 biologic-naïve patients are enrolled, with a median 1.4 years of follow-up.[1]

** Study limitations: BADBIR is primarily used as a pharmacovigilance register, therefore limitations include: the intention behind concomitant medication; potential variability in classifying reason for drug withdrawal across centres; recall and reporting bias may occur with patient-reported characteristics; non-randomisation may introduce selection bias; unmeasured confounders cannot be ruled out; patient adherence was not measured; the infliximab cohort is small.[1]

$ Adalimumab was the reference standard to which the other biologics were compared with because it was the most commonly prescribed biologic in the registry.

† Infliximab was a predictor for discontinuation overall and due to adverse events.

‡ Etanercept was a predictor for discontinuation overall and due to ineffectiveness

STELARA® solution for injection PRESCRIBING INFORMATION
ACTIVE INGREDIENT(S): Ustekinumab
Please refer to Summary of Product Characteristics (SmPC) before prescribing.
INDICATION(S): Plaque psoriasis adults: Treatment of moderate to severe plaque psoriasis in adults who failed to respond to, or who have a contraindication to, or are intolerant to other systemic therapies including ciclosporin, methotrexate or PUVA. **Plaque psoriasis paediatrics:** Moderate to severe plaque psoriasis in adolescent patients from the age of 12 years and older, who are inadequaely controlled by, or are intolerant to, other systemic therapies or phototherapies. **Psoriatic arthritis:** Alone or in combination with methotrexate for the treatment of active psoriatic arthritis in adult patients when the response to previous non-biological disease-modifying anti-rheumatic drug (DMARD) therapy has been inadequate. **DOSAGE & ADMINISTRATION:** Under the guidance and supervision of a physician experienced in diagnosis and treatment of psoriasis or psoriatic arthritis. Subcutaneous injection. Avoid areas with psoriasis. Self-injecting patients or caregivers ensure appropriate training Physicians are required to follow-up and monitor patients. **Plaque psoriasis, adults & elderly:** Patients <100kg, 45 mg at week 0 followed by a 45 mg dose at week 4, then every 12 weeks. Patients >100 kg, 90 mg at week 0 followed by a 90 mg dose at week 4, then every 12 weeks (45 mg was less effective in these patients). **Plaque psoriasis paediatrics (12 years and older):** Patients <60 kg, 0.75 mg/kg at week 0, followed by 0.75 mg/kg at week 4 then every 12 weeks thereafter. Patients ≥60-<100kg, 45 mg at week 0 followed by 45 mg at week 4, then every 12 weeks. Patients >100 kg, 90mg at week 0, followed by 90mg at week 4, then every 12 weeks. **Psoriatic arthritis, adults & elderly:** 45 mg at week 0 followed by a 45 mg dose at week 4, then every 12 weeks. Alternatively, 90 mg may be used in patients with a body weight >100 kg. Consider discontinuation if no response after 28 weeks. **Children <12 years:** Not recommended. **Renal & Hepatic impairment:** Not studied. **CONTRAINDICATIONS:** Hypersensitivity to product; clinically important, active infection. **SPECIAL WARNINGS & PRECAUTIONS: Infections:** Potential to increase risk of infections and reactivate latent infections. Caution in patients with a chronic infection or history of recurrent infection, particularly TB. Patients should be evaluated for tuberculosis prior to initiation of STELARA. Consider anti-tuberculosis therapy prior to initiation of STELARA in patients with past history of latent or active tuberculosis. Patients should seek medical advice if signs or symptoms suggestive of an infection occur. If a serious infection develops, they should be closely monitored and STELARA should not be administered until infection resolves. **Malignancies:** Potential to increase the risk of malignancy. No studies in patients with a history of malignancy or in patients who develop malignancy while receiving STELARA. Monitor all patients, in particular those older than 60, patients with a medical history of prolonged immunosuppressant therapy or those with a history of PUVA treatment for non-melanoma skin cancer. **Concomitant immunosuppressive therapy:** Caution, including when changing immunosuppressive biologic agents. **Hypersensitivity reactions:** Serious hypersensitivity reactions (anaphylaxis and angioedema) reported, in some cases several days after treatment. If these occur appropriate therapy should be instituted and, STELARA discontinued immediately. **Latex sensitivity:** Needle cover contains natural rubber (latex), may cause allergic reactions. **Immunotherapy:** Not known whether STELARA affects allergy immunotherapy. **Serious skin conditions:** Exfoliative dermatitis has been reported following treatment. Discontinue STELARA if a drug reaction is suspected. **SIDE EFFECTS: Common:** dental infections, upper respiratory tract infection, nasopharyngitis, dizziness, headache, oropharyngeal pain, diarrhoea, nausea, pruritus, back pain, myalgia, arthralgia, fatigue, injection site erythema, injection site pain, antibodies to ustekinumab. **Other side effects include:** cellulitis, serious hypersensitivity reactions (including anaphylaxis, angioedema), skin exfoliation, exfoliative dermatitis. Studies show adverse events reported in ≥12 year olds with plaque psoriasis were similar to those seen in previous studies in adults with plaque psoriasis. **Refer to SmPC for other side effects. FERTILITY:** The effect of ustekinumab has not been evaluated. **PREGNANCY:** Should be avoided. Women of childbearing potential: Use effective contraception during treatment and for at least 15 weeks post-treatment. **LACTATION:** Limited data in humans. **INTERACTIONS:** *In vitro*, STELARA had no effect on CYP450 activities. **Vaccinations:** Live vaccines should not be given concurrently with STELARA, and should be witheld for at least 15 weeks after last dose of STELARA. STELARA can resume at least 2 weeks after such vaccinations. No data on secondary transmission of infection by live vaccines in patients receiving STELARA. **Concomitant immunosuppressive therapy:** Psoriasis: The safety and efficacy of STELARA in combination with other immunosuppressants, including biologics, or phototherapy have not been evaluated. **Refer to SmPC for full details of interactions. LEGAL CATEGORY:** Prescription Only Medicine. **PRESENTATIONS, PACK SIZES, MARKETING AUTHORISATION NUMBER:** 45 mg: 1 x vial. EU/1/08/494/001, 45mg: 1 x 0.5ml pre-filled syringe. EU/1/08/494/003. 90mg: 1 x 1.0ml pre-filled syringe. EU/1/08/494/004. **MARKETING AUTHORISATION HOLDER:** JANSSEN-CILAG INTERNATIONAL NV, Turnhoutseweg 30, B-2340 Beerse, Belgium. **FURTHER INFORMATION IS AVAILABLE FROM:** Janssen-Cilag Ltd, 50 – 100 Holmers Farm Way, High Wycombe, Buckinghamshire, HP12 4EG UK.

Adverse events should be reported. Healthcare professionals are asked to report any suspected adverse events via: HPRA Pharmacovigilance, Earlsfort Terrace, IRL - Dublin 2, Tel: +353 1 6764971, Fax: +353 1 6762517, Website: www.hpra.ie, E-mail: medsafety@hpra.ie

Adverse events should also be reported to Janssen-Cilag Ltd on +44 1494 567447.

Prescribing information last revised: 06/2015

References: 1. Warren RB et al. J Inv Dermatol. Accepted article: June 2015; doi: 10.1038/jid.2015.208. 2. Menter A et al. P1705: Poster presented at the AAD Annual Meeting, 20-24 March 2015; San Francisco, California.
3.Stelara Summary of Product Characteristics, available at www.medicines.ie

Date of preparation: March 2016 I PHIR/STE/1015/0007a