

abbvie

GALDERMA

NOVARTIS
PHARMACEUTICALS

Lilly

janssen
PHARMACEUTICALS



IAD
IRISH ASSOCIATION
OF DERMATOLOGISTS

SPRING MEETING

Thursday 27th, Friday 28th & Saturday 29th April 2017
Stormont Hotel, Belfast & Belfast City Hospital

THE AIM IS CLEAR

TARGET IL-17A

Cosentyx®

• The first and only fully human IL-17A inhibitor approved for the treatment of adults with moderate to severe plaque psoriasis and psoriatic arthritis¹

Cosentyx 300mg:

- Demonstrated superior efficacy against both ustekinumab and etanercept up to 52 weeks^{2,3}
 - 79% of psoriasis patients achieved almost clear skin at week 16²
 - Sustained efficacy up to 3 years⁴
- Rapid and sustained relief from joint and skin symptoms of PsA⁵⁻⁷

 **Cosentyx**®
secukinumab

COSENTYX® (SECUKINUMAB) PRESCRIBING INFORMATION. Please refer to the Summary of Product Characteristics before prescribing. Indication: Cosentyx is indicated for: the treatment of moderate to severe plaque psoriasis in adults who are candidates for systemic therapy; the treatment of active psoriatic arthritis in adult patients, alone or in combination with methotrexate (MTX), when the response to previous disease-modifying anti-rheumatic drug (DMARD) therapy has been inadequate. Presentations: Cosentyx 150 mg solution for injection in pre-filled syringe; Cosentyx 150 mg solution for injection in pre-filled pen. Dosage & Method of Administration: Psoriasis: The recommended dose is 300 mg via subcutaneous injection. Dosing is given at weeks 0, 1, 2 and 3, followed by monthly maintenance dosing starting at Week 4. Each 300 mg dose is given as two subcutaneous injections of 150 mg. If possible, areas of the skin that show psoriasis should be avoided as injection sites. Psoriatic Arthritis: For patients with concomitant moderate to severe plaque psoriasis or who are anti-TNF α inadequate responders (IR), the recommended dose is 300 mg by subcutaneous injection with initial dosing at Weeks 0, 1, 2 and 3, followed by monthly maintenance dosing starting at Week 4. Each 300 mg dose is given as two subcutaneous injections of 150 mg. For other patients, the recommended dose is 150 mg by subcutaneous injection with initial dosing at Weeks 0, 1, 2 and 3, followed by monthly maintenance dosing starting at Week 4. Consideration should be given to discontinuing treatment in patients who have shown no response up to 16 weeks of treatment. Some patients with an initial partial response may subsequently improve with continued treatment beyond 16 weeks. Safety and efficacy in patients below the age of 18 years have not been established. Contraindications: Severe hypersensitivity reactions to the active substance or to any of the excipients. Clinically important, active infection. Warnings & Precautions: Infections: Cosentyx has the potential to increase the risk of infections. In clinical studies, most of these were mild or moderate upper respiratory tract infections such as nasopharyngitis and did not require treatment discontinuation. Nonserious mucocutaneous candida infections were more frequently reported for secukinumab than placebo in the psoriasis clinical studies. Caution in patients with a chronic infection or a history of recurrent infection. Advise patients to seek medical advice if signs or symptoms suggestive of an infection occur. If a patient develops a serious infection, the patient should be closely monitored and Cosentyx should not be administered until the infection resolves. Cosentyx should not be given to patients with active tuberculosis. Anti-tuberculosis therapy should be considered prior to initiation of Cosentyx in patients with latent tuberculosis. Crohn's disease: Caution in patients with Crohn's disease - exacerbations of Crohn's disease, in some cases serious, were observed in clinical studies. Patients who are treated with Cosentyx and have Crohn's disease should be followed closely. Hypersensitivity reactions: Rare cases of anaphylactic reactions have been observed. If anaphylactic or other serious allergic reactions occur, discontinue immediately and initiate appropriate therapy. Vaccinations: Live vaccines should not be given concurrently with Cosentyx. Patients receiving Cosentyx may receive concurrent inactivated or non-live vaccinations. Latex-Sensitive Individuals: The removable needle cap of the Cosentyx pre-filled syringe and the pre-filled pen contains a derivative of natural rubber latex. Concomitant immunosuppressive therapy: Combination with immunosuppressants, including biologics, or phototherapy - have not been evaluated. Interactions: Live vaccines should not be given concomitantly with Cosentyx. No interaction studies have been performed in humans. The formation of some CYP450 enzymes are suppressed by increased levels of cytokines during chronic inflammation. Thus normalisation of CYP450 levels may be anticipated during secukinumab treatment, with accompanying lower exposure of CYP450

metabolised co-medications. Therefore, a clinically relevant effect on CYP450 substrates with a narrow therapeutic index, where the dose is individually adjusted (e.g. warfarin) cannot be excluded. On initiation of secukinumab therapy in patients being treated with these types of medicinal products, therapeutic monitoring should be considered. No interaction was seen when Cosentyx was administered concomitantly with methotrexate and/or corticosteroids in arthritis studies. Fertility, Pregnancy and Lactation: Women of childbearing potential: Women of childbearing potential should use an effective method of contraception during treatment and for at least 20 weeks after treatment. Pregnancy: It is preferable to avoid the use of Cosentyx in pregnancy, due to lack of adequate data. Breast feeding: Clinical decision on continuation of breast feeding during secukinumab treatment (and up to 20 weeks after discontinuation) in nursing mothers must be made, taking into account the benefit of breast feeding to the child and the benefit of Cosentyx therapy to the woman. It is not known if secukinumab is excreted in human breast milk. Fertility: The effect of secukinumab on human fertility has not been evaluated. Adverse Events: Very Common ($\geq 1/10$): Upper respiratory tract infection. Common ($\geq 1/100$ to $< 1/10$): Oral herpes, rhinorrhoea, diarrhoea. Rare ($\leq 1/10,000$ to $< 1/1,000$): Anaphylactic reactions. Infections: In the placebo controlled period of clinical studies in plaque psoriasis, infections were reported. The majority of infections consisted of non-serious and mild to moderate upper respiratory tract infections, such as nasopharyngitis, which did not necessitate treatment discontinuation. There was an increase in mucosal or cutaneous candidiasis, but the cases were mild or moderate in severity, non-serious, responsive to standard treatment and did not necessitate treatment discontinuation. Serious infections occurred in a small proportion of patients in both the Cosentyx and placebo groups. Over the entire treatment period (up to 52 weeks), infections were reported in 47.5% of patients treated with Cosentyx (0.9 per patient year of follow up). Serious infections were reported in 1.2% of patients treated with Cosentyx (0.015 per patient years of follow up). Infection rates observed in psoriatic arthritis clinical studies were similar to those observed in the psoriasis studies. Neutropenia: Neutropenia was more frequently observed with secukinumab than with placebo, but most cases were mild, transient and reversible. The frequency of neutropenia in psoriatic arthritis is similar to psoriasis. Rare cases of neutropenia CTCAE Grade 4 were reported. Immunogenicity: Less than 1% of patients treated with Cosentyx developed antibodies to secukinumab up to 52 weeks of treatment. Other Adverse Effects: Please consult the Summary of Product Characteristics for a detailed listing of all adverse events before prescribing. Legal Category: POM. MA Number & List Price: EU/1/14/980/005 - 150 mg pre-filled pen x 2 £1,218.78; EU/1/14/980/003 - 150 mg pre-filled syringe x 2 £1,218.78. PI Last Revised: December 2015 [COS15-C128]. Full prescribing information, including a SmPC is available from: Novartis Pharmaceuticals UK Limited, Frimley Business Park, Frimley, Camberley, Surrey, GU16 7SR. Telephone: (01276) 692255. Fax: (01276) 692508. References: 1. Cosentyx Summary of Product Characteristics, April 2016. 2. Blauvelt A et al. Secukinumab demonstrates superior sustained efficacy vs. ustekinumab in clearing skin of subjects with moderate to severe plaque psoriasis: 52-week results from the CLEAR study. Abstract presented at the 74th Annual Meeting of the American Academy of Dermatology. 2016 March 4-8; Washington DC. 3. Langley RG, et al. N Eng J Med 2014; 371 (4) 326-338. 4. Bissonnette R, et al. Secukinumab maintains high levels of efficacy through three years of treatment. Abstract presented at EADV 2015; 7th-11th October; Copenhagen, Denmark. 5. Kavanaugh A, et al. Ann Rheum Dis 2015;74(S2):345-6. Poster THU0411 at European League Against Rheumatology (EULAR), 10 June, 2015, Rome, Italy. 6. Kavanaugh A, et al. Arthritis Rheum 2015;57(S10):2573. Oral presentation 2146 at the American College of Rheumatology (ACR), 9 November 2015, San Francisco, USA. 7. Mease P & McInnes I. Rheumatology and Therapy. 2016;3:5. doi:10.1007/s40744-016-0031-5. Date of Preparation: August 2016. COS16-C143

ADVERSE EVENT REPORTING: 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 Novartis Pharmaceuticals UK Ltd on 01276 69 8370 or via medinfo.uk@novartis.com

Welcome Message from the President Dr Kevin McKenna



Welcome to the Spring meeting of the IAD 2017 at the Stormont Hotel, Belfast and Belfast City Hospital. It gives me particular personal pleasure to host this meeting in my home city and hospital. I hope you find the meeting both stimulating and educational.

The theme of this meeting is malignant melanoma. We have the Thursday afternoon dedicated to a Dermoscopy session under the direction of Professor Colin Fleming. Guest speakers for the Friday include Professor Julia Newton-Bishop, Professor Catherine Harwood, Dr Veronique Bataille and Dr Judith Carser. We look forward to the presentations from these international leaders in the field of melanoma.

Our junior colleagues will have the opportunity to compete for the prestigious Burrows Cup at the Registrars Symposium. I would like to thank our Scientific Committee for all their hard work towards organising the programme for this meeting.

I would like to take the opportunity to thank our secretary Dr Art O'Hagan and Jacqui Carroll for all their hard work and support. Special thanks to Dr Gillian Gibson who is stepping down a treasurer for keeping our finances in such good shape.

I hope you enjoy the meeting and our opportunity to visit Parliament Buildings, Stormont for our IAD Conference Dinner.

Yours sincerely,

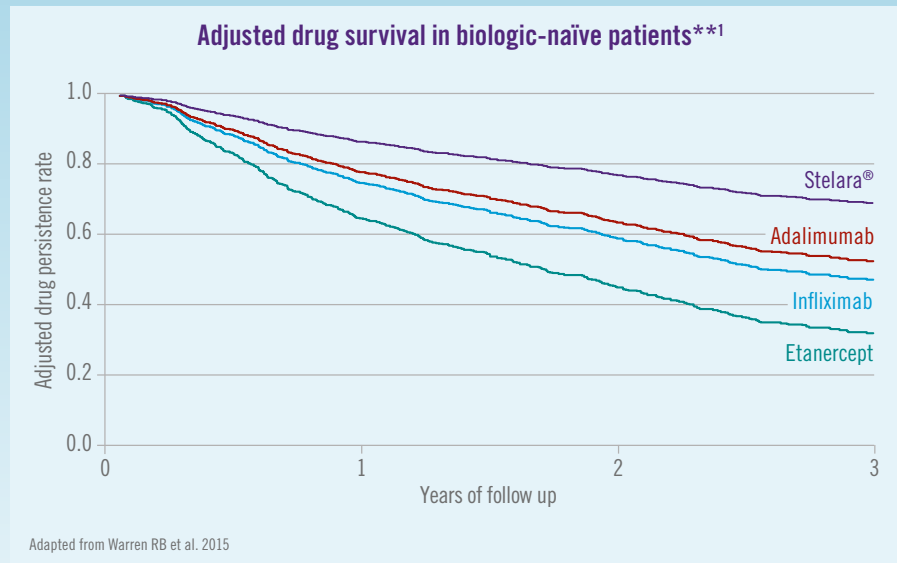
Dr Kevin McKenna
President
Irish Association of Dermatologists

Real-world patients remain on Stelara® longer compared to anti-TNF therapies^{1,2}

BADBIR* data shows greater long-term persistency for Stelara® compared to any other anti-TNF therapies¹



- 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.



* 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® 45 mg and 90 mg solution for injection and 130 mg concentrate for solution for infusion. 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 12 years of age, who are inadequately controlled by, or are intolerant to, other systemic therapies or phototherapies. **Psoriatic arthritis:** Alone or in combination with methotrexate for treatment of active psoriatic arthritis in adult patients when response to previous non-biological disease-modifying anti-rheumatic drug (DMARD) therapy has been inadequate. **Crohn's Disease:** Treatment of adult patients with moderately to severely active Crohn's disease who had inadequate response with/lost response to/were intolerant to either conventional therapy or TNF α antagonist or have contraindications to such therapies. **DOSAGE & ADMINISTRATION: Adults:** Under guidance and supervision of a physician experienced in diagnosis and treatment of psoriasis/psoriatic arthritis/Crohn's disease. **Psoriasis or psoriatic arthritis:** Subcutaneous (s.c.) 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. **Crohn's Disease:** Initial single intravenous infusion dose based on body weight (260 mg or 390 mg or 520 mg) diluted in 0.9% w/v sodium chloride solution and given over at least one hour. At week 8 after intravenous dose, 90 mg s.c. dose is given; followed by every 12 weeks (or 8 weeks based on clinical judgement). Consider discontinuation if no response at 16 weeks. Immunomodulators and/or corticosteroids may be continued but consider reducing/discontinuing corticosteroids if responding to STELARA.

If therapy interrupted, resume s.c. every 8 weeks if safe/effective. **Children: <12 years** - Not recommended for psoriasis. **<18 years** - Not recommended for psoriatic arthritis and Crohn's disease. **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, closely monitor and STELARA should not be administered until infection resolves. **Malignancies:** Potential to increase risk of malignancy. No studies in patients with 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. **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 reported following treatment. Discontinue STELARA if drug reaction is suspected. **SIDE EFFECTS: Common:** upper respiratory tract infection, nasopharyngitis, dizziness, headache, oropharyngeal pain, diarrhoea, nausea, vomiting, pruritus, back pain, myalgia, arthralgia, fatigue, injection site erythema, injection site pain. **Other side effects:** 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 withheld 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:** Safety and efficacy of STELARA in combination with other immunosuppressants, including biologics, or phototherapy have not been evaluated. Psoriatic arthritis: concomitant MTX did not appear to affect STELARA. **Crohn's disease:** concomitant immunosuppressive or corticosteroid therapy did not appear to affect STELARA. **Refer to SmPC for full details of interactions. LEGAL CATEGORY:** Prescription Only Medicine. **PRESENTATIONS, PACK SIZES, MARKETING AUTHORISATION NUMBER(S):** 45 mg, 1 x vial, EU/1/08/494/001, 45 mg, 1 x 0.5 ml pre-filled syringe, EU/1/08/494/003, 90 mg, 1 x 1.0 ml, pre-filled syringe, EU/1/08/494/004, 130 mg, 1 x vial, EU/1/08/494/005. **MARKETING AUTHORISATION HOLDER:** JANSSEN-CILAG INTERNATIONAL NV, Turnhoutseweg 30, B-2340 Beerse, Belgium. **FURTHER INFORMATION IS AVAILABLE FROM:** Janssen-Cilag Limited, 50 - 100 Holmers Farm Way, High Wycombe, Buckinghamshire, HP12 4EG UK. **Prescribing information last revised:** 11/2016

Adverse events should be reported. Healthcare professionals are asked to report any suspected adverse events via: HPR 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 Limited on +44 1494 567447 or at dsafety@its.jnj.com.**

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: April 2017 | PHIR/STE/0217/0001



IAD Directors

Dr Keith Armstrong,
Royal Victoria Hospital,
Belfast.

Dr Colin Buckley
Whitfield Clinic,
Cork Rd,
Waterford.

Dr Gillian Gibson,
Bon Secours Hospital,
College Road,
Cork.

Dr Kevin McKenna,
Belfast City Hospital,
Belfast.

Dr Art O'Hagan,
Craigavon Area Hospital,
Armagh.

Dr Gillian Murphy,
Beaumont Hospital,
Dublin 9

Dr Rosemarie Watson,
Our Lady's Children's Hospital,
Crumlin,
Dublin 12

Scientific Committee

Dr Clare Devereux
Consultant Dermatologist
Antrim Area Hospital,

Dr Susannah Hoey
Consultant Dermatologist
Royal Victoria Hospital, Belfast

Dr Dermot McKenna
Consultant Dermatologist
Sligo Regional Hospital

Dr Fergal Moloney - Chair
Consultant Dermatologist
Mater Hospital, Dublin

Dr Donal O'Kane
Consultant Dermatologist
Royal Victoria Hospital, Belfast

Dr Anne-Marie Tobin
Consultant Dermatologist
Tallaght Hospital, Dublin

IAD Past Presidents

1965/7 Dr R. Hall, Belfast,
who was followed by:

1967/9 Dr D.O'C Donelan

1969/71 Dr J.M. Beare

1971/3 Dr D.M. Mitchell

1973/5 Dr D.B. Buckley

1975/7 Prof D. Burrows

1977/9 Dr F.O.C. Meenam

1979/81 Dr Agnese M.T. Kelly

1981/3 Dr Count H. Viani

1983/5 Dr Grace Allen

1985/7 Dr Marjory Young

1987/9 Dr Roddy Matthews

1989/91 Dr David O'Gorman

1991/3 Dr Rory Corbett

1993/5 Prof Sarah Rogers

1995/7 Dr E.A. Bingham

1997-9 Dr. Fergus Lyons

1999-01 Dr Clifford McMillan

2001-3 Prof Frank Powell

2003-5 Dr Raymond Fulton

2005-7 Prof Louise Barnes

2007-9 Dr Hilary Jenkinson

2009-11 Dr Gillian Murphy

2011-13 Dr Pat Podmore

2013-2015 Dr Rosemarie Watson

2015-Present Dr Kevin McKenna

SOOLANTRA® TOUGH ON ROSACEA KIND TO SKIN



A ONCE-DAILY TOPICAL THAT TREATS INFLAMMATORY LESIONS OF ROSACEA IN ADULTS

- More effective than metronidazole cream (0.75%)¹
- Significant improvements as early as week 2²
- A generally well tolerated topical for everyday use³



REFERENCES

1. Taieb A *et al.*, *Br J Dermatol* 2015;172:1103–10.
2. SOOLANTRA Summary of Product Characteristics. March 2015.
3. Stein Gold L *et al.*, *J Drugs Dermatol* 2014;13(11):1380–86.

SOOLANTRA® 10mg/g Cream Prescribing Information (UK & IRE)

Presentation: 10mg/g ivermectin cream **Indications:** Topical treatment of inflammatory lesions of rosacea (papulopustular) in adult patients. **Dosage and Administration:** One application per day for up to 4 months. The treatment course may be repeated. Treatment should be discontinued after 3 months if no improvement. Apply a pea sized amount to each of the 5 areas of the face: forehead, chin, nose, each cheek. Cutaneous use only. Apply only to the face, avoiding the eyes, lips and mucosa. Hands should be washed immediately after application. There is no data on use in patients under 18 years. Cosmetics may be applied after the medicinal product has dried. **Contraindications:** Hypersensitivity to the active substance or any excipients. **Precautions and Warnings:** Soolantra has not been studied in patients with renal or hepatic impairment. Caution should be exercised in patients with severe hepatic impairment. Contains cetyl alcohol and stearyl alcohol which may cause local skin reactions (e.g. contact dermatitis), Methyl parahydroxybenzoate (E218) and propyl parahydroxybenzoate (E216) which may cause allergic reactions (possibly delayed) and propylene glycol which may cause skin irritation. **Interactions:** No interaction studies have been performed. Concomitant use of Soolantra with other topical or systemic medicinal products for the treatment of rosacea has not been investigated. In vitro studies have shown

that ivermectin is primarily metabolised by CYP3A4. Consequently, caution is advised when ivermectin is administered concomitantly with potent CYP3A4 inhibitors as the plasma exposure may be significantly increased. **Pregnancy and Lactation:** Soolantra is not recommended during pregnancy. A risk to a suckling child cannot be excluded; a decision must be made whether to discontinue breast-feeding or to discontinue/abstain from Soolantra therapy taking into account the benefit of breast-feeding for the child and the benefit of therapy for the woman. **Undesirable Effects:** In clinical trials the most common adverse reactions were typically mild to moderate in severity, and usually decreased when treatment was continued. Adverse reactions include: Common (≥1/100 to <1/10) Skin burning sensation; Uncommon (≥1/1,000 to <1/100) Skin irritation, pruritus, dry skin. **Packaging Quantities and Cost:** 30g UK £18.29 IRE €22.00 **MA Number:** PL 10590/0063, PA 590/28/1 **Legal Category:** POM **Full Prescribing Information is Available From:** Galderma (UK) Ltd, Meridian House, 69-71 Clarendon Road, Watford, Herts, WD17 1DS, Telephone: +44 (0) 1923 208950 Fax: +44 (0) 1923 208998 **Date of Revision:** December 2015

Date of preparation: May 2016

Code: S00/088/0516

Adverse events should be reported.
For the UK, Reporting forms and information can be found at www.mhra.gov.uk/yellowcard.
For Ireland, Suspected adverse events can be reported via HPRAs 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 Galderma (UK) Ltd.



Galderma Sponsored Symposium

Stormont Hotel, Belfast
Thursday 27th April 2017

5.30pm	Registration & Light refreshments
6.30pm	Welcome <i>Chaired by: Dr David Alderdice</i> <i>Consultant Dermatologist, Ulster Hospital Dundonald, Belfast</i>
6.40pm	Acne management in an era of antibiotic stewardship <i>Dr Sandra Minor</i> <i>Consultant Dermatologist, St Richards Hospital, Chichester</i>
7.10pm	Rosacea management in an era of antibiotic Stewardship <i>Dr Geraldine Morrow</i> <i>Consultant Dermatologist, Beacon Hospital, Dublin</i>
7.40pm	Daylight PDT: "A walk in the park?" <i>Dr Sandra Minor</i> <i>Consultant Dermatologist, St Richards Hospital, Chichester</i>
8.10pm	Questions & Discussion
8.30pm	Close & Fork Supper

This meeting has been sponsored by Galderma (UK) Ltd

ANTHELIOS XL

With La Roche-Posay Thermal Spring Water

COMFORT CREAM SPF50+ / PPD 39

VERY HIGH UVB AND UVA SUN PROTECTION SPECIFICALLY DESIGNED FOR SENSITIVE SKIN. CLINICALLY PROVEN IN 19 PUBLISHED CLINICAL TRIALS.

INDICATIONS

- Skin which is sensitive to the sun.
- Very broad UVB and high UVA protection, with long lasting photostability.

TEXTURE THAT ENCOURAGES PATIENT COMPLIANCE

- Very water resistant.
- Easy to apply, non-greasy, easily absorbed texture.
- Does not leave white marks.
- Available in tinted formula.

ACTIVE INGREDIENTS

PATENTED FILTERING SYSTEM MEXOPLEX®

1. New synergy of filters: MEXORYL® SX + TINOSORB®S.
2. Innovating photostabiliser: ELDEW®.
3. Now with added anti-oxidant Baicalin for increased protection against long UVA.

MINIMALIST FORMULA

- Tolerance tested under dermatological control



NON-PERFUMED
NO PARABENS
NON-COMEDOGENIC

If you care for somebody,
**BECOME A
SKIN CHECKER**
have a look at their beauty spots.
www.laroche-posay.ie/skinchecker



LA ROCHE-POSAY. COMMITTED TO DERMATOLOGY



SPRING MEETING

Thursday 27th, Friday 28th & Saturday 29th April 2017
Stormont Hotel, Belfast & Belfast City Hospital

THURSDAY 27th APRIL: Dermoscopy Session

Prof Colin Fleming, Consultant Dermatologist, Clinical Director, Specialist Services, Oncology, Haematology and Renal. Honorary Reader, Ninewells Hospital and Medical School Dundee.

2.00pm	Quiz
2.25pm	Refresher; key concepts
2.50pm	Update on terminology
3.20pm	Coffee
3.35pm	Real life workshop
4.00pm	Lentigo maligna
4.25pm	Acral dermoscopy
4.45pm	Unusual melanomas workshop
5.05pm	Last man stands
5.15pm	Finish

Galderma Sponsored Symposium – Theme ‘ACNE’

5.30pm	Registration & Light Refreshments
6.30-8.30pm	Galderma Symposium
8.30pm	Fork Supper

FRIDAY 28th APRIL: IAD Spring Meeting – Theme ‘Melanoma’

8.00am	Registration
9.00-10.30am	Registrars’ Symposium – Burrows Cup
10.15-11.15am	Exhibition
11.15am-12.00pm	Prof Julia Newton-Bishop, Professor of Dermatology, University of Leeds “What determines survival from melanoma?”
12.00-12.45pm	Prof Catherine Harwood, Consultant Dermatologist, Barts and the London School of Medicine & Dentistry “Melanoma and immunosuppression”
12.45-2.15pm	Exhibition
2.15-3.00pm	Dr Veronique Bataille, Consultant Dermatologist, West Hertfordshire Trust “Melanoma susceptibility, what is the trade off?”
3.00-3.45pm	Dr Judith Carser, Consultant Medical Oncologist, Cancer Centre, Belfast Health & Social Care Trust “Current Systemic therapies in metastatic melanoma”
3.45-5.00pm	Exhibition
4.30pm	Presentation of Burrows Cup & Poster Prizes
5.00-6.00pm	IAD Business Meeting
7.30pm	IAD CONFERENCE DINNER, Parliament Buildings, Stormont Estate

SATURDAY 29th APRIL 2017: Clinical Meeting Belfast City Hospital, Out Patients Department

Hosted By: Dr Suzanne Clements, Dr Andrea Corry, Dr Helen Hunter, Dr Olga Kerr, Dr Collette McCourt, Dr Kevin McKenna.

8.30am	Patients arrive
9.00am	Review of Patients
10.15am	Coffee
10.45am	Discussion of Cases
12.15pm	Lunch

Biographical Sketches

Prof Colin Fleming

Prof Colin Fleming is a Consultant Dermatologist, Mohs' Surgeon, Honorary Reader and Clinical Director in the dermatology department at Ninewells Hospital and Medical School, Dundee. He was an undergraduate at Glasgow University where he also studied for a BSc(Honours) in Immunology, and subsequently developed an interest in skin cancer research and treatment through working in Australia, Glasgow and Lisbon.



He has been a Consultant in Tayside since 1999 and has set up multiple services for skin cancer patients, including the NOSCAN Macmillan Mohs service. He has research interests in diagnosis and treatment of skin cancer, and has over 80 publications in skin cancer, skin surgery and general dermatology. He has been a leading proponent of dermoscopy in the UK for the last 20 years, and has taught dermoscopy in numerous courses and lectures. He is a ex-board member of the European Association of Dermato-Oncology, a fellow of the American Society for Mohs Surgery, and former President of the British Society of Dermatological Surgery.

Dr Sandra Minor

Dr Sandra Minor graduated from Queen's University, Belfast and subsequently trained in dermatology in Belfast, St John's Institute, London and Portland, Oregon. Soon after gaining a consultant post in Antrim she moved to Carson City ,Nevada where she lived and worked for 18 years. She returned to UK in 2001 and since then has worked at St Richard's hospital, Chichester and in private practice.

Dr Geraldine Morrow

Dr. Geraldine Morrow is a Consultant Dermatologist at Beacon Hospital, Dublin. She is a Graduate of UCD in 1985. She trained in Dermatology at the Mater Hospital and St. Anne's Skin and Cancer Hospital, Dublin. Her special areas of interest include Acne, Rosacea and Occupational Dermatology. She has lectured in Dermatology in UCD on the Higher Diploma courses in Occupational Health and the Masters in Sports Medicine and has also examined on these courses. She also lectures regularly for ICGP CME groups.

Professor Julia Newton-Bishop

Professor Julia Newton-Bishop is a dermatologist who worked for many years (till 2015) in the Leeds Specialist Melanoma Multidisciplinary Team which manages poor prognosis melanoma for the Yorkshire region of the UK. She is also a clinician scientist and Professor of Dermatology at the University of Leeds, UK. She leads the melanoma research group within the Section of Epidemiology and Biostatistics, Leeds Institute of Cancer and Pathology, University of Leeds, lead by Tim Bishop. The research group uses genetics to understand susceptibility to melanoma and survival from melanoma and for the last year Julia has been working in melanoma research full time. She is a fellow of the Academy of Medical Sciences in the UK.



Biographical Sketches

Dr Catherine Harwood

Catherine Harwood is a Consultant Dermatologist in the Centre for Cell Biology and Cutaneous Research, Blizard Institute, Barts and the London School of Medicine and Dentistry, Queen Mary University of London and Barts Health NHS Trust. She qualified in Medicine from the University of Cambridge and St Thomas's Hospital Medical School, London. Her training in dermatology was at Westminster Hospital, St John's Institute of Dermatology, St George's Hospital and Barts and the London NHS Trust. Her main clinical and research interests are related to skin cancer, particularly in immunosuppressed individuals.



Dr Veronique Bataille

Dr Veronique Bataille trained at the Louvain Medical School in Brussels and graduated in July 1985 with magnum cum laude. She then worked in many teaching hospitals in London and started her dermatology training at St John's Institute of Dermatology at St Thomas Hospital in 1989. She then moved to the Imperial Cancer Research Fund in Holborn and the Royal London Hospital as a clinical research fellow where she completed her PhD on the genetic epidemiology of skin and eye melanoma in 1995 under the supervision of Professors Julia Newton Bishop, Jack Cuzick and Tim Bishop.



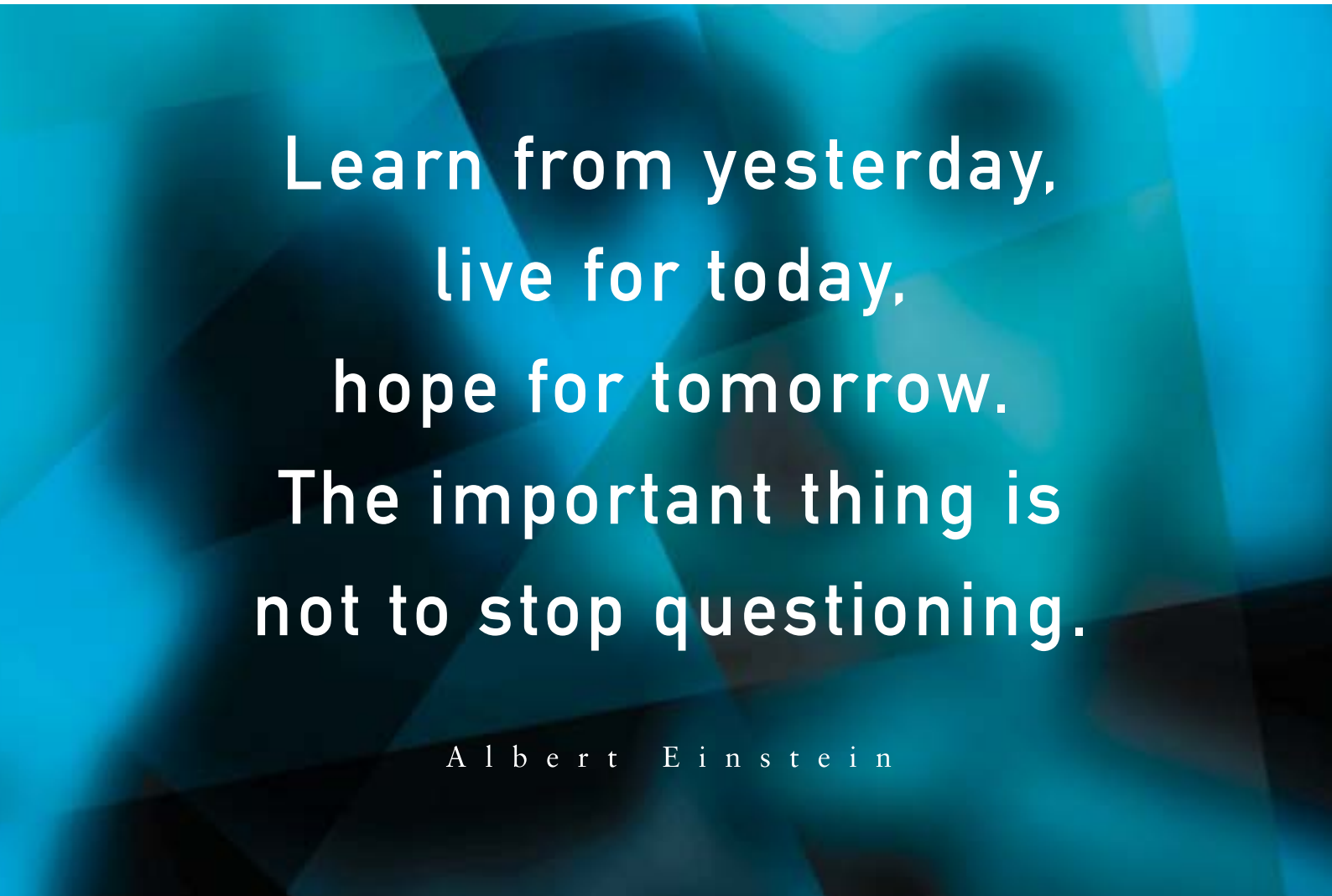
Dr Bataille became an accredited consultant dermatologist in 1996. In 1996, she was appointed Senior Lecturer and Honorary Consultant Dermatologist at Barts and the London School of Medicine and Dentistry where she continued her interest in the genetics of melanoma and other skin cancers. Since 2004, Dr Bataille has been working at the West Hertfordshire Trust where she is also providing specialised care for patients with skin cancers where she works with Dr Paul Nathan in the multi-disciplinary melanoma clinic at the Mount Vernon Cancer Centre. Dr Bataille is also in charge of the skin programme at the Twin Research Unit at Kings College London looking at the genetics of common skin diseases.

Dr Bataille has published extensively in many dermatology, genetic and cancer journals over the last 20 years and has presented many abstracts at national and international meetings. She regularly writes reviews and book chapters on skin cancer and reviews manuscripts for many dermatology journals. She is assistant editor for the Acta Dermatologica and Venereologica, European Journal of Cancer, BMJ case reports dermatology and Research Notes for BIOMED Central.

Dr Judith Carser

Dr Judith Carser graduated from Queens University, Belfast and trained in medical oncology in Northern Ireland. Since completing training in 2010 I have taken up consultant posts at Clatterbridge Cancer Centre, Wirral as well as Southern Health & Social Care Trust, Northern Ireland. I currently provide a regional service at the Cancer Centre, Belfast Health & Social Care Trust for melanoma and testicular cancers as well as leading the Trust Acute oncology service.





Sponsors & Date for Your Diary

IAD would like to thank the following sponsors and exhibitors for their generous support

- Abbvie
- Galderma
- Janssen-Cilag
- Lilly
- Novartis
- Almirall
- Beiersdorf
- Bioderma
- Celgene
- Hospira
- La Roche-Posay
- Leo Pharma
- T & R Derma
- Alliance
- Dermacea
- Dermal
- Irish Skin Foundation
- Fannin
- Johnson & Johnson
- Mylan
- Ovelle
- Sanofi - Genzyme

Unmet needs require new solutions to old problems, which is why we push ourselves to see challenges from different perspectives, constantly questioning and forging new paths toward solutions, both in the lab and in our communities.

Committed to improving the lives of patients worldwide®

UK-CELG160205
Date of Preparation: November 2016



DATE FOR DIARY...
IAD Autumn Meeting 2017
'INTERNAL MEDICINE'
Thursday 12th & Friday 13th October
Radisson Blu Hotel, Farnham Estate, Cavan



Skinnies are a unique range of specialist medical garments for the treatment and management of serious conditions affecting the skin. Our range is:

- **Skinnies Silk** (antimicrobial protection)
- **Skinnies Viscose** (wet or dry wrapping)
- **Skinnies WEB** (dressing retention)

All Available On Prescription

Dermacea Ltd (Skinnies) Tel:01562 884898 Fax: 0121 259 0292

Email: infor@skinniesuk.com Web: www.skinniesuk.com



Irish Dermatology Nurses Association Ltd.

**Friday 28th April 2017
14th IDNA Annual Meeting**

8.30- 9.00 am	Registration
9.00- 9.45	IDNA BUSINESS MEETING
9.45-10.30 am	P. COWAN (BHSCT) "DOWN UNDER"
10.30-11.15am	Coffee & Exhibition
11.15am-12.00pm	Carrie Wingfield MOHS SURGERY FOR NURSES
12.00-12.45pm	IAD Bursary Presentations Bernie Finneran " Dermoscopy for Beginners" Eilish Ryan " Phototherapy: Lessons Learnt"
12.45-2.15pm	Lunch & Exhibition
2.15- 3.00 PM	Speaker to be confirmed
3.00-3.45 pm	MICHELE MCCALLUM (BHSCT) DERMATOLOGY WOUNDS CASE STUDIES
3.45-4.30pm	Coffee & Exhibition
4.30pm- 5.00	DR EMMA MACK Development of an Outpatient APP

NEW

Registrars' Symposium Oral Case Presentations Burrows Cup Friday 28th April 2017

Oral 01. 9.00am

Circulating Mucosal Associated Invariant T cells are depleted in melanoma and show an exhausted prof
L. Nestor, K. Molloy, J. Clowry, C. Gallagher, A.Salim, M. Connolly, A.M. Tobin.
Tallaght Hospital, Dublin.

Oral 02. 9.10am

Missed Opportunities for Melanoma Detection in Secondary Care
Authors: C. Quinlan¹, S. McCracken², E.Tierney¹, C. Heffron³, J. Fitzgibbon³, C. Murphy^{2,4}, J.F. Bourke¹, M. Murphy^{1,2}

Oral 03. 9.20am

Myositis-specific antibodies and immunotype-phenotype correlation in Irish dermatomyositis patients:
Authors: Fatima Awdeh , Rebecca Hellen , Qamar Rhazali , Marina O'Kane.
Insttution: Beaumont Hospital

Oral 04. 9.30am

Photoprotective behaviours in an Irish at risk Inflammatory Bowel Disease Population
C. Gallagher¹⁺³, A. Ridge², D. Kevans², D. McNamara³, AM Tobin¹
Dermatology Department Tallaght Hospital. Gastroenterology Department St James's Hospital/ Trinity Academic Gastroenterology Group

Oral 05. 9.40am

Hidradenitis suppurativa is driven by insulin resistance rather than hyperandrogenism in the setting of polycystic ovarian syndrome
S Kirthi¹, M Connolly¹, C Gallagher¹ ,LA Behan², J Gibney², AM Tobin¹
1.Department of Dermatology, Tallaght Hospital
2.Department of Endocrinology, Tallaght Hospital

Oral 06. 9.50am

Medication adherence among psoriasis patients on systemic and biologic treatment
Roisin Hambly,¹ Aine Kelly,¹ Eimear Gilhooley,¹ Eilis Nic Dhonna,¹ Aizuri Murad,¹ Rosalind Hughes,¹ Aoife Lally,^{1,2} Brian Kirby,^{1,2}
1. The Charles Centre, Department of Dermatology, St Vincent's University Hospital, Elm Park, Dublin.
2. University College Dublin School of Medicine and Medical Sciences, Dublin.

Oral 07. 10.00am

A re-evaluation of teenage sunbed use following the introduction of banning legislation for under 18 year olds.
Stephanie Menzies, Selene Daly, Miriam Fitzgerald, Dermot McKenna.
Department of Dermatology, Sligo University Hospital



Always read the label/leaflet before use

- **Doublebase Emollient Gel** is specially formulated to provide the emollient advantages associated with an ointment, with the cosmetic acceptability of a cream.
- Clinically proven to provide effective protection against dryness.
- Recommend your patients purchase **Doublebase Emollient Gel** to help manage their dry skin.



Not your average emollient...

Essential Information

Doublebase™ Emollient Gel

Therapeutic ingredients: Isopropyl myristate 15% w/w, liquid paraffin 15% w/w. **Presentation:** White opaque gel. **Uses:** Highly moisturising and protective hydrating gel for regular and frequent use in the management of dry skin conditions such as eczema, psoriasis or ichthyosis. **Directions:** Adults, the elderly, infants and children: Apply directly to dry skin as often as needed. It may also be applied before washing, showering or bathing to prevent further drying of the skin. **Contra-indications, warnings, side effects etc:** Do not use if sensitive to any of the ingredients. In the rare event of a reaction stop treatment. **Ingredients:** Isopropyl myristate, liquid paraffin, glycerol, carbomer, sorbitan laurate, triethylamine, phenoxyethanol, purified water. **Pack size and trade price:** 100g tube €3.42. **Legal category:** Class I medical device. **Further information is available from the manufacturer:** Dermal Laboratories, Tatmore Place, Gosmore, Hitchin, Herts, SG4 7QR, UK. **Date of preparation:** November 2016. 'Doublebase' is a trademark.

Adverse events should be reported to Dermal.



DEGPRO01/JAN17

Restoring the Quality of Life.

Metoject® 50 mg/ml Solution for Injection, pre-filled syringe, in Everyday Life

Metoject® –
The 50 mg/ml methotrexate injection available in:

- 7.5mg / 0.15ml single syringe
- 10mg / 0.20ml single syringe
- 15mg / 0.30ml single syringe
- 20mg / 0.40ml single syringe
- 25mg / 0.50ml single syringe

Distributed in Ireland by:
Fannin Ltd
Fannin House
South County Business Park
Dublin 18
Ph: +353 1 290 7000
Fax: +353 1 290 7111

FN/2016/108/00
Date of Preparation: March 2017

Metoject 50 mg/ml solution for injection, pre-filled syringe (refer to full Summary of product Characteristics before prescribing).
Qualitative and quantitative composition: 1 ml of solution contains 50 mg methotrexate (as methotrexate disodium). 1 pre-filled syringe of 0.15ml (0.20ml, 0.40 ml, 0.50ml) contains 7.5 mg; 15 mg; 20 mg; 25 mg methotrexate. Excipients: sodium chloride, sodium hydroxide, water for injections. **Therapeutic indications:** Active rheumatoid arthritis in adult patients; severe recalcitrant disabling psoriasis, which is not adequately responsive to other forms of therapy such as phototherapy, PUVA, and retinoids; severe psoriatic arthritis in adult patients. **Posology and method of administration:** Should only be prescribed by physicians who are familiar with the various characteristics of the medicinal product and its mode of action. **Adults, rheumatoid arthritis:** The recommended initial dose is 7.5 mg of Metoject once weekly, administered either subcutaneously, intramuscularly or intravenously. Depending on the individual activity of the disease and tolerability, the dose may be increased gradually by 2.5 mg per week. A weekly dose of 25 mg should not be exceeded. **Psoriasis vulgaris, psoriatic arthritis:** Test dose of 5-10 mg should be administered parenterally, one week prior to therapy to detect idiosyncratic adverse reactions. The recommended initial dose is 7.5 mg of methotrexate once weekly, administered either subcutaneously, intramuscularly or intravenously. The doses to be increased gradually but should not, in general, exceed a weekly dose of 25 mg of methotrexate. **Elderly:** Dose reduction should be considered due to reduced liver and kidney function as well as lower folate reserves. If changing from oral methotrexate a reduction in dose may be required due to the variable bioavailability of methotrexate by the oral route. **Contraindications:** Hypersensitivity to methotrexate or any of the excipients; liver insufficiency; alcohol abuse; severe renal insufficiency (creatinine clearance <20ml/min); pre-existing blood dyscrasias; (bone marrow hyperplasia; leukopenia; thrombocytopenia); significant anaemia); serious, acute or chronic infections such as tuberculosis, HIV, other immunodeficiency syndromes; ulcers of the oral cavity and known active gastrointestinal ulcer disease; pregnancy, breastfeeding, concurrent vaccination with live vaccines. **Special warnings and precautions for use:** Patients must be clearly informed that Metoject has to be administered once a week. Patients undergoing therapy should be subject to appropriate supervision. Because of the risk of the possibility of severe or even fatal toxic reactions, the patient should be fully informed by the physician of the risks involved and the recommended safety measures. **Interactions with other medicines:** Special care should be taken with Methotrexate and Alcohol, other haematotoxic medicinal products, antibiotics, other medicinal products with high plasma protein binding, probenecid, weak organic acids, pyrazoles, non-steroidal anti-inflammatory agents, medicinal products with adverse reactions on the bone marrow, medicinal products which cause folate deficiency, folic acid, other antirheumatic medicinal products, sulphasalazine, Mercaptopurine, proton-pump inhibitors, theophylline, caffeine or theophylline-containing beverages. **Fertility, pregnancy and lactation:** methotrexate is contraindicated during pregnancy and is excreted in breast milk and there is a risk for the infant. Methotrexate can be genotoxic, all women are advised to consult a genetic counselling centre, if possible already prior to therapy. Men should seek advice about the possibility of sperm preservation before starting therapy. **Effects on ability to drive and use machines:** Metoject has minor or moderate influence on the ability to drive and use machines. **Undesirable effects:** The following headings are used to organise the undesirable effects in order of frequency. Very common (≥1/10), common (≥ 1/100 to < 1/10), uncommon (≥ 1/1,000 to < 1/100), rare (≥1/10,000 to < 1/1,000), very rare (<1/10,000), not known (cannot be estimated from the available data). The most relevant undesirable effects are suppression of the haematopoietic system and gastrointestinal disorders. **Very common:** Stomatitis, dyspepsia, nausea, loss of appetite, common: oral ulcers, diarrhoea. **Uncommon:** pharyngitis, enteritis, vomiting, rare: gastrointestinal ulcers, very rare: hematemesis, haematemesis, toxic megacolon. **Skin and subcutaneous tissue disorders:** common: Exanthema, erythema, pruritus, uncommon: photosensitisation, loss of hair, increase in rheumatic nodules, herpes zoster, vasculitis, herpetiform eruptions of the skin, urticaria. **Rare:** increased pigmentation, acne, acanthosis. **Very Rare:** Stevens-Johnson syndrome, toxic epidermal necrolysis (Lyell's syndrome), increased pigmentation of the nails, acute paronychia, furunculosis, telangiectasia. **General disorders and administration site conditions:** Rare: Allergic reactions, anaphylactic shock, allergic vasculitis, fever, conjunctivitis, infection, sepsis, wound-healing impairment, hypogammaglobulinaemia. **Very Rare:** local damage of injection site following intramuscular or subcutaneous administration. **Metabolism and nutrition disorders:** uncommon: Precipitation of diabetes mellitus. **Nervous system disorders:** Common: headache, tiredness, drowsiness, uncommon: dizziness, confusion, depression, Very rare: impaired vision, pain, muscular asthenia and paraesthesia in the extremities, changes in sense of taste, convulsions, meningism, paralysis, unknown: Leukoencephalopathy. **Eye disorders:** Rare: Visual disturbances. **Very Rare:** retinopathy. **Hepatic and biliary disorders:** Very common: Elevated transaminases, Uncommon: cirrhosis, fibrosis and fatty degeneration of the liver, decrease of serum albumin, Rare: acute hepatitis. **Very Rare:** hepatic failure. **Cardiac disorders:** Rare: Pericarditis, pericardial effusion, pericardial tamponade, **Vascular disorders:** Rare: Hypotension, thromboembolic events. **Respiratory, thoracic and mediastinal disorders:** Common: Pneumonia, interstitial alveolitis, pneumonitis often associated with eosinophilia, Rare: pulmonary fibrosis, pneumocystis carinii pneumonia, shortness of breath and bronchial asthma, pleural effusion. **Blood and lymphatic system disorders:** Common: Leukopenia, anaemia, thrombopenia, Uncommon: pancytopenia, Very rare: agranulocytosis, severe courses of bone marrow depression, **Renal and urinary disorders:** uncommon: Inflammation and ulceration of the urinary bladder renal impairment, disturbed micturition, Rare: renal failure, oliguria, anuria, electrolyte disturbances. **Reproductive system and breast disorders:** Uncommon: Inflammation and ulceration of the vagina Very rare: Loss of libido, impotence, gynaecomastia, oligospermia, impaired menstruation, vaginal discharge. **Musculoskeletal and connective tissue disorders:** uncommon: Arthralgia, myalgia, osteoporosis, **Neoplasms benign malignant and unspecified (incl. cysts and polyps):** Very rare: Reports of individual cases of lymphoma which subsided in a number of cases once treatment with methotrexate had been discontinued. **Overdose:** Calcium folinate is the specific antidote for neutralising the toxic undesirable effects of methotrexate. **Legal classification:** POM. **Marketing Authorisation Holder:** Medac Gesellschaft für Klinische Spezialpräparate MbH, Theaterstr.6,22880 Wedel, Germany. **Marketing authorisation number:** PA 623/14/1. **Date of Revision of PI:** February 2017. **MARKETED IN IRELAND BY:** FANNIN LTD, FANNIN HOUSE, LEOPARDSTOWN, DUBLIN 18.

For a copy of the SmPC or further medical information, please contact medical@dccvital.com
Adverse events should be reported to Fannin Ltd, Pharmacovigilance at +353 868394447 or medical@dccvital.com

Reporting of suspected adverse reactions
Reporting suspected adverse reactions after authorisation of the medicinal product is important. It allows continued monitoring of the benefit/risk balance of the medicinal product. Health care professionals are asked to report any suspected adverse reactions 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 REF: IE17/05/SmPC - APR2015

Orals - Abstracts

■ Oral 01. 9.00am

Circulating Mucosal Associated Invariant T cells are depleted in melanoma and show an exhausted prof

L. Nestor, K. Molloy, J. Clowry, C. Gallagher, A.Salim, M. Connolly, A.M. Tobin. Tallaght Hospital, Dublin.

“Circulating mucosal associated invariant T cells are depleted in melanoma and show an exhausted profile with increased expression of PD1: a prospective cohort study”

Manipulation of the immune response invoked by melanoma by the CTLA-4 inhibitor (Ipilimumab) lead to the development of one of the first effective treatments for melanoma. Ipilimumab blocks the inhibitory receptor CTLA-4 expressed on cytotoxic T cells activated by antigen presenting cells, facilitating their function to destroy melanoma cells. Less is known of innate cytotoxic T cells in the setting of melanoma including invariant NKT cells (iNKT), Mucosal Associated Invariant T cells (MAIT) and gamma/delta T cells. We undertook a prospective study of circulating iNKT, MAIT and gamma/delta T cells in patients diagnosed with melanoma.

Following ethical approval, patients undergoing excision of a suspicious pigmented lesion were invited to take part. Controls were also recruited who did not have melanoma or dysplastic lesions. Blood samples were drawn and peripheral blood monocytes extracted and analyzed at the Institute of Molecular Medicine, Trinity College Dublin by flow cytometry. Samples were analyzed for numbers of the following CD3, CD8, MAIT, NK, iNKT, gamma delta T cells. We also looked at the activation and exhaustion profiles of all of these subsets. Differences between patients diagnosed with melanoma and dysplastic lesions and controls were analyzed using Graph Pad Prism (Mann-Whitney Test for non-parametric data (p < 0.05))

In total 8 patients were recruited, six diagnosed with melanoma and two with dysplastic naevi and 15 controls. Circulating MAIT cells were significantly reduced in patients with dysplastic lesions compared to controls (2.1% vs 2.5%, p = 0.04). Levels of NK, iNKT and gamma/delta T cells were similar among both cohorts. Circulating MAIT cells had significantly increased surface expression of PD1 in patients with melanoma/dysplastic lesions compared to controls (55% vs 11%, p < 0.0001) and significantly increased expression of TIMMAIT- PD1 (55% vs 10%, p < 0.0001).

Our results indicate defects in the innate immune system of patients with early stage melanoma. Reduced circulating MAIT cells have previously being described in patients with mucosal- associated cancer and our study is the first to describe this phenomenon in melanoma. Therapeutic blockade of PD-1 is one of the most effective therapeutic strategies in metastatic melanoma and our results indicate that blockade may have protective effects on innate immune cells.

■ Oral 02. 9.10am

Missed Opportunities for Melanoma Detection in Secondary Care

Authors: C. Quinlan¹, S. McCracken², E.Tierney¹, C. Heffron³, J. Fitzgibbon³, C. Murphy^{2,4}, J.F. Bourke¹, M. Murphy^{1,2}

Affiliations:

1. Department of Dermatology, South Infirmity Victoria University Hospital, Cork
2. School of Medicine, University College Cork
3. Department of Histopathology, Cork University Hospital, Cork
4. Department of Medical Oncology, Bon Secours Hospital, Cork

Introduction: Early detection of melanoma is associated with improved survival.¹⁺² There has been significant emphasis on the role of general practitioners in melanoma screening strategies.³⁻⁶ However, the role of secondary care providers in the detection of melanoma has been rarely explored.

Aim: To identify inpatient and outpatient episodes in patients with intermediate and thick melanomas in the 5 years and 1 year prior to their diagnosis.

Methods: A multicentre, retrospective case review was conducted at Cork University Hospital, South Infirmity Victoria University Hospital Cork, Mercy University Hospital Cork, Bon Secours Hospital Cork and University Hospital Kerry. Databases at the five hospitals were reviewed. All patients with a Cork/Kerry address with primary cutaneous melanomas of greater than or equal to 1mm Breslow depth from January 2013 to December 2014 diagnosed or reviewed by CUH pathology department were included. Data from the patient record enquiry for the 5 years prior to diagnosis was collected for each patient at each clinical site. This included inpatient admissions, day case admissions, outpatient clinics and emergency department attendances.

Results: 106 patients were included with a mean age of 63 years. The median Breslow depth was 2.3mm. 32 (30%) of the melanomas were located on the head/neck region. Of the 106 patients, 67% (n=71) had a secondary care interaction in the 5 years prior to their melanoma diagnosis and 42.5% (n=45) in the year prior to diagnosis. Most of these hospital encounters were in the outpatient clinic (57.5%), but almost one third (31%) had an inpatient admission in the five years prior to diagnosis and 10%(n=11) in the year prior to diagnosis.

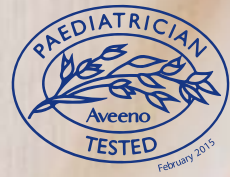
The three specialties with the most interactions in the year prior to diagnosis were ophthalmology (n=20), orthopaedics (n=18) and emergency medicine (n=16).

Discussion: A significant opportunity exists to improve early detection of intermediate and thick melanomas in secondary care. Patients with intermediate and thick melanomas are being seen in secondary care facilities in the years prior to their diagnosis. Education and awareness campaigns directed at secondary care providers should be implemented to encourage them to perform skin assessment as part of clinical examination.

References:

1. Marks. R. Prevention and Control of Melanoma; The Public Health Approach. Ca Cancer J Clin. 1996;46: 199-216

Gently cleanse & protect everyday sensitive skin



Aveeno
Baby®
Naturally Beautiful Babies



2. Schuchter. L. et al. A prognostic model for predicting 10-year survival in patients with primary melanoma. *Annals of Internal medicine.* 1996;125(5):369-75
3. Baade. P.D. et al The relationship between melanoma thickness and time to diagnosis in a large population-based study. *Archives of dermatology.* 2006;142(11):1422-7
4. Richard. M.A. et al Delays in diagnosis and melanoma prognosis (II):the role of doctors. *International journal of cancer.* 2000;89(3):280-5
5. Argenziano. G. et al. Total body skin examination for skin cancer screening in patients with focused symptoms. *J Am Acad Dermatol.* 2012;66(2):212-9
6. Aitken. J.F. et al. Clinical whole body skin examination reduces the incidence of thick melanomas. *International journal of cancer.* 2010;126(2):450-8

■ **Oral 03. 9.20am**
Myositis-specific antibodies and immunotype-phenotype correlation in Irish dermatomyositis patients

Authors: Fatima Awdeh , Rebecca Hellen , Qamar Rhazali , Marina O’Kane. Institution: Beaumont Hospital

Myositis autoantibodies are categorized as either myositis-specific antibodies (MSA); or myositis-associated antibodies (MAA; mostly occurring in myositis-overlap syndromes). There is growing interest in the prognostic role of MSA in dermatomyositis (DM)¹. In addition newer immune targets for MSAs have been identified in distinct phenotypes of DM¹. Current understanding of their significance in dermatomyositis is incomplete due to small numbers of studied patients. This pilot is part of a larger study aiming to evaluate relationships between clinical phenotype, MSA serotypes and prognosis, in Irish DM patients.

Patients with DM attending dermatology at a university hospital were identified from a database. We included patients aged 18 and over with diagnosis of DM, meeting Bohan and Peter criteria for DM or Sontheimer’s criteria for clinically amyopathic DM (CADM). Chart review, extended MSA panel, and skin examination were performed at subsequent review appointments. Clinical data was collected as part of routine medical care; all were examined by a consultant dermatologist for the presence/ absence of 13 cutaneous signs, to confirm documented or emerging clinical phenotype. Cutaneous signs were divided into those specific to DM (eg Gottrens papules/sign, heliotrope) and those occurring in DM but not specific to the disorder. Extended MSA panel included anti-Mi-2 (directed against chromatin remodeler enzyme, Mi-2), anti-transcription intermediary factor-1gamma (TIF-1gamma), anti-small ubiquitin like modifier enzyme (SAE), anti- nuclear matrix protein-2 (NXP-2) and anti-melanoma differentiation associated gene-5 (MDA-5).

Evaluation is complete in 14 patients (2 men,12 women, mean age 60). 11/14 patients had DM; 3/14 had CADM. Three DM patients had positive MSAs; no CADM patient had positive MSAs. The most frequently occurring MSAs were anti-TIF-1γ and NXP-2, accounting for 21% of antibody positive patients (7% anti-NXP-2; 14% anti-TIF-1γ). The patients positive for anti-TIF-1γ and/or anti-NXP-2 did not express any other MSA or MAA; 2 patients expressed both antibodies. The two patients with classical DM who were anti-TIF-1γ positive both had small cell lung cancer. Patients with anti-TIF-1γ

antibodies had severe and extensive cutaneous involvement in addition to typical DM features. Despite small numbers in this pilot study, the above findings are consistent with recent MSA literature¹ Dermatomyositis is rare. Extended MSA panel testing in the assessment of all patients presenting with DM may facilitate better understanding of immunotype-phenotype correlations and prognostic implications.

(These are interim results)

¹ Daly ML, Gordon PA, Creamer D. Cutaneous Features of Dermatomyositis associated with Myositis Specific Antibodies. *Br J Dermatol* 2016 DOI: 10.1111/bjd.15020

■ **Oral 04. 9.30am**
Photoprotective behaviours in an Irish at risk Inflammatory Bowel Disease Population

C. Gallagher¹⁺³, A. Ridgez, D. Kevans², D. McNamara³, AM Tobin¹ Dermatology Department Tallaght Hospital. Gastroenterology Department St James’s Hospital/ Trinity Academic Gastroenterology Group

Azathioprine and TNF-α inhibitors are widely used immunosuppressants in Inflammatory Bowel Disease (IBD). It has been reported that such treatments increase the risk of developing all types of skin cancer. Patients on combination therapy have been shown to have up to five times the relative risk of non-melanoma skin cancer. The British Association of Dermatology (BAD) has published preventative guidelines for patients on immunosuppression, but specific gastroenterology recommendations are lacking. Our aims were to examine skin cancer risk factors, attitudes towards sun exposure and preventative strategies adopted in an Irish at risk IBD cohort.

A prospective pilot cohort study. Following ethical approval and informed consent, a self-assessment questionnaire was given out to patients attending our IBD clinic over a twelve week period. Clinical data was recorded including diagnosis, immunosuppressants, skin cancer risk factors and photoprotective behaviours.

To date, 244 patients completed the questionnaire. Patients were excluded as follows; 23 (9%) with indeterminate colitis or an unconfirmed diagnosis and 79 (32%) not on azathioprine or TNF-inhibitors.

The majority of patients were a high risk phenotype with light coloured eyes (51%(n=73)), >30 freckles (52% (n=75)), fair skin (50% (n=71)), or had blonde/red hair (31% (n=45)). Of interest, ten (7%) patients had a personal history and 15 (10%) gave a family history of any type of skin cancer. With regard to other risk factors; 54 (38%) had previous blistering sunburn, 31 (22%) used sunbeds and 37 (26%) worked outdoors.

With reference to BAD recommended preventative measures, the majority of our cohort (63% (n=90)) wore sun cream, but failed to take other important measures; staying in the shade at high risk times (59%(n=84)), re-applying sun cream every 2 hours (50%(n=71)), and wearing a hat (26% (n=38)).

In addition, while 51% (n=73) knew what changes to look for in a suspicious mole, only 43% (n=62) performed regular self-skin checks.

That Enstilar® moment

NEW
Enstilar®
 calcipotriol/betamethasone dipropionate
 CUTANEOUS FOAM

Discover what the NEW foam spray Enstilar® can do for your plaque psoriasis patients

Extraordinary Delivery

Visit www.enstilar.co.uk

Abbreviated Prescribing Information for Enstilar® 50 micrograms/g + 0.5 mg/g cutaneous foam Please refer to the full Summary of Product Characteristics (SmPC) (www.medicines.org.uk/emc) before prescribing.
Indication: Topical treatment of psoriasis vulgaris in adults.
Active ingredients: 50 µg/g calcipotriol (as monohydrate) and 0.5 mg/g betamethasone (as dipropionate).
Dosage and administration: Apply by spraying onto affected area once daily. Recommended treatment period is 4 weeks. The daily maximum dose of Enstilar should not exceed 15 g, i.e. one 60 g can should last for at least 4 days. 15 g corresponds to the amount administered from the can if the actuator is fully depressed for approximately one minute. A two-second application delivers approximately 0.5 g. As a guide, 0.5 g of foam should cover an area of skin roughly corresponding to the surface area of an adult hand. If using other calcipotriol-containing medical products in addition to Enstilar, the total dose of all calcipotriol-containing products should not exceed 15 g per day. Total body surface area treated should not exceed 30%. Safety and efficacy in patients with severe renal insufficiency or severe hepatic disorders have not been evaluated. Safety and efficacy in children below 18 years have not been established. Shake the can for a few seconds before use. Apply by spraying, holding the can at least 3 cm from the skin, in any orientation except horizontally. Spray directly onto each affected skin area and rub in gently. Wash hands after use (unless Enstilar is used to treat the hands) to avoid accidentally spreading to other parts of the body. Avoid application under occlusive dressings since systemic absorption of corticosteroids increases. It is recommended not to take a shower or bath immediately after application.
Contraindications: Hypersensitivity to the active substances or any of the excipients. Erythrodermic and pustular psoriasis. Patients with known disorders of calcium metabolism. Viral (e.g. herpes or varicella) skin lesions, fungal or bacterial skin infections, parasitic infections, skin manifestations in relation to tuberculosis, perioral dermatitis, atrophic skin, striae atrophicae, fragility of skin veins, ichthyosis, acne vulgaris, acne rosacea, rosacea, ulcers and wounds.
Precautions and warnings: Adverse reactions found in connection with systemic corticosteroid treatment, e.g. adrenocortical suppression or

impaired glycaemic control of diabetes mellitus, may occur also during topical corticosteroid treatment due to systemic absorption. Application under occlusive dressings should be avoided since it increases the systemic absorption of corticosteroids. Application on large areas of damaged skin, or on mucous membranes or in skin folds should be avoided since it increases the systemic absorption of corticosteroids. Due to the content of calcipotriol, hypercalcaemia may occur. Serum calcium is normalised when treatment is discontinued. The risk of hypercalcaemia is minimal when the maximum daily dose of Enstilar (15 g) is not exceeded. Enstilar contains a potent group III-steroid and concurrent treatment with other steroids on the same treatment area must be avoided. Skin on the face and genitals are very sensitive to corticosteroids. Enstilar should not be used in these areas. Instruct the patient in the correct use of the product to avoid application and accidental transfer to the face, mouth and eyes. Wash hands after each application to avoid accidental transfer to these areas. When lesions become secondarily infected, they should be treated with antimicrobial therapy. However, if infection worsens, treatment with corticosteroids should be discontinued. When treating psoriasis with topical corticosteroids, there may be a risk of rebound effects when discontinuing treatment. Medical supervision should therefore continue in the post-treatment period. Long-term use of corticosteroids may increase the risk of local and systemic adverse reactions. Treatment should be discontinued in case of adverse reactions related to long-term use of corticosteroid. There is no experience with the use of Enstilar in guttate psoriasis. During Enstilar treatment, physicians are recommended to advise patients to limit or avoid excessive exposure to either natural or artificial sunlight. Topical calcipotriol should be used with UVR only if the physician and patient consider that the potential benefits outweigh the potential risks. Enstilar contains butylhydroxytoluene (E321), which may cause local skin reactions (e.g. contact dermatitis), or irritation to the eyes and mucous membranes.
Pregnancy and lactation: There are no adequate data from the use of Enstilar in pregnant women. Enstilar should only be used during pregnancy when the potential benefit justifies the potential risk. Caution should be exercised when prescribing Enstilar to women who breast-feed. The patient should be instructed not to use Enstilar on the breast when breast-feeding.

Side effects: There are no common adverse reactions based on the clinical studies. The most frequently reported adverse reactions are application site reactions. **Calcipotriol:** Adverse reactions include application site reactions, pruritus, skin irritation, burning and stinging sensation, dry skin, erythema, rash, dermatitis, psoriasis aggravated, photosensitivity and hypersensitivity reactions, including very rare cases of angioedema and facial oedema. Systemic effects after topical use may appear very rarely causing hypercalcaemia or hypercalciuria. **Betamethasone (as dipropionate):** Local reactions can occur after topical use, especially during prolonged application, including skin atrophy, telangiectasia, striae, folliculitis, hypertrichosis, perioral dermatitis, allergic contact dermatitis, depigmentation and colloid milia. When treating psoriasis with topical corticosteroids, there may be a risk of generalised pustular psoriasis. Systemic reactions due to topical use of corticosteroids are rare in adults; however, they can be severe. Adrenocortical suppression, cataract, infections, impaired glycaemic control of diabetes mellitus, and increase of intra-ocular pressure can occur, especially after long-term treatment. Systemic reactions occur more frequently when applied under occlusion (plastic, skin folds), when applied on large areas, and during long-term treatment.
See SmPC for a full list of side effects.
Precautions for storage: Do not store above 30°C. Extremely flammable aerosol. Pressurised container. May burst if heated. Protect from sunlight. Do not expose to temperatures exceeding 50°C. Do not pierce or burn, even after use. Do not spray on an open flame or other ignition source. Keep away from sparks/open flames. No smoking.
Legal category: POM.
Marketing authorisation number and holder: PL 05293/0008. LEO Pharma A/S, Ballerup, Denmark.
Basic NHS price: £39.68/60 g
Last revised: May 2016
Further information can be found in the Summary of Product Characteristics or from: LEO Pharma, Horizon, Honey Lane, Hurley, Berkshire SL6 6BJ. e-mail: medical-info.uk@leo-pharma.com
 © Registered trademark
 UK 1070/00024g Date of preparation: May 2016

Reporting of Suspected Adverse Reactions

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 Drug Safety at LEO Pharma by calling +44 (0)1844 347333 or e-mail medical-info.uk@leo-pharma.com

LEO®

ALL LEO TRADEMARKS MENTIONED BELONG TO THE LEO GROUP



Our pilot study highlights gaps in our at risk IBD cohort's education regarding skin cancer risk and prevention associated with immunosuppression therapy and warrants further investigation. Ideally educational interventions to enhance patient awareness should be undertaken and assessed.

■ Oral 05. 9.40am

Hidradenitis suppurativa is driven by insulin resistance rather than hyperandrogenism in the setting of polycystic ovarian syndrome

S Kirthi¹, M Connolly¹, C Gallagher¹, LA Behanz², J Gibney², AM Tobin¹

1. Department of Dermatology, Tallaght Hospital
2. Department of Endocrinology, Tallaght Hospital

Studies have documented higher rates of polycystic ovarian syndrome in patients with HS, suggesting that hyperandrogenism may drive HS. Polycystic ovarian syndrome is also associated with insulin resistance and in study of our patients with HS, approximately 78% of female patients were insulin resistant. In order to elucidate the role of insulin - resistance and hyperandrogenism in patients with PCOS and HS, we carried out a prospective cohort study in our outpatient department.

Following ethical approval, successive female patients attending the HS clinic were screened for clinical signs of polycystic ovarian syndrome (acne, hirsutism, androgenetic alopecia) and fasting blood samples were drawn for measurement of testosterone, dihydroepiandrosterone (DHEAS), androstenedione and sex hormone binding globulin (SHBG). Insulin and glucose were also measured to generate the HOMA-IR as a measure of insulin resistance. Patients diagnosed with HS and PCOS according to the Rotterdam criteria were compared to HS only patients with age (+/- 3 years) and BMI (+/- 3 kg/m²) matched, and also patients with PCOS only, recruited from the endocrinology outpatient department. Data were analysed using GraphPad Prism, a p value < 0.05 was considered significant. Fifteen patients diagnosed with HS and PCOS (mean age 30, mean Hurley stage 2, mean BMI 35.6 kg/m²) were compared with 30 patients with HS (mean age 31 years, mean Hurley 2, mean BMI 34) who had no signs of PCOS. Patients with HS and PCOS had significantly higher HOMA-IR compared to their counterparts with HS only (6.3 vs 1.7, p = 0.007). They also had higher levels of testosterone (1.3 nmol/L vs 0.9nmol/L, p = 0.04). Levels of DHEAS, androstenedione and SHBG were similar, p = 0.3, 0.08 and 0.9 respectively. When these patients were compared to patients diagnosed with PCOS without signs of HS, HOMA-IR were 6.3 vs 3.8, p = 0.6. Patients with HS and PCOS had significantly lower levels of testosterone than those with PCOS only (1.3nmol/L vs 3.4nmol/L, p = 0.006) and adrostenedione (19.6nmol/L vs 14.1nmol/L , p = 0.03) and similar levels of DHEAS and SHBG (p = 1.0 for both).

Our data suggest that the key driver of HS in patients with PCOS is not hyperandrogenism but insulin resistance. Our study also suggests that hormone measurements in our patients appear superfluous compared to gauging patients' insulin status.

■ Oral 06. 9.50a

Medication adherence among psoriasis patients on systemic and biologic treatment

Roisin Hambly¹, Aine Kelly¹, Eimear Gilhooley¹, Ellis Nic Dhonncha¹, Aizuri Murad¹, Rosalind Hughes¹, Aoife Lally^{1,2}, Brian Kirby^{1,2}
 1. The Charles Centre, Department of Dermatology, St Vincent's University Hospital, Elm Park, Dublin.
 2. University College Dublin School of Medicine and Medical Sciences, Dublin.

Medication adherence is "the extent to which a patients' behaviour in taking their medication corresponds to agreed recommendations by their healthcare provider". Patients with high adherence to medications have better outcomes. Systemic treatments for psoriasis are expensive and knowledge on adherence would be beneficial. The aim of our study was to assess adherence to systemic agents in psoriasis and to identify predictors of adherence.

Following ethical approval, validated self-report questionnaires were completed by patients with moderate/severe psoriasis on systemic therapy, including Patient Global Assessment (PtGA), Hospital Anxiety and Depression Scale (HADS), Dermatology Life Quality Index (DLQI) and the 8-item Morisky Medication Adherence Scale (MMAS). There were 106 participants, 59% male and mean age 47.9 years (range 18-80). Thirty-two percent had psoriatic arthritis. Twelve percent were smokers and the mean disease duration was 24 years (range 1-51). Thirteen percent reported that psoriasis was clear; 37% almost clear; 26% mild; 21% moderate, and 3% severe.

The medications were adalimumab (30%), etanercept (23%), methotrexate (20%), fumaric acid esters (18%) and others (9%). Fifty-one percent of participants were also taking prescribed medications for other conditions (mean 3.6, range 1-12). The mean anxiety score on the HADS was 6.3 (range 0-18), the mean depression score was 3.4 (range 0-16) and the mean DLQI was 3.2 (range 0-27). Fifty percent reported never missing a dose of their psoriasis medication for any reason. The reasons for missing doses included forgetting (49%), unwell (26%), too busy (15%), running out of medication (11%), psoriasis under control (13%), medication too expensive (8%) and side-effects (10%).

Ninety-one percent had taken the most recent dose of their psoriasis medication. Twenty-seven percent reported not taking their medication on one or more occasions over the previous 3 months. Using the MMAS, 76% of participants were classified as high adherers, 17% medium and 7% low adherers. In a study of 1,367 patients with hypertension using the MMAS, 15.9% were high adherers, 52% medium and 32.1% low adherers.

There was no significant difference in adherence based on gender (p=0.105) or age (p=0.146). There was an inverse relationship between adherence and anxiety scores (r=-0.267, p=0.008, n=97) and depression scores (r=-0.217, p=0.033, n=97). There was no correlation between adherence and DLQI values (p=0.15, n=97) Adherence to systemic medication for psoriasis appears higher than for other chronic conditions. High levels of anxiety and depression may be a negative predictor of adherence to these medications.

Skin improved¹

Structural joint damage inhibited²

My time to holiday with friends

Psoriatic arthritis

HUMIRA is indicated for the treatment of active and progressive psoriatic arthritis in adults when the response to previous disease-modifying anti-rheumatic drug therapy has been inadequate. HUMIRA has been shown to reduce the rate of progression of peripheral joint damage as measured by X-ray in patients with polyarticular symmetrical subtypes of the disease and to improve physical function.¹

Psoriasis

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

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

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 and adolescents from 12 years of age:** 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 vial 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 vial 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 vial 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. **HS, adolescents from 12 years of age weighing at least 30 kg:** 80 mg initially at week 0 (given as two 40 mg injections on day one), 40 mg injection in week 1 followed by 40 mg every other week. In adolescent patients with inadequate response to Humira 40 mg every other week an increase in dosing frequency to 40 mg every week may be considered. Antibiotics may be continued if necessary. Concomitant topical antiseptic wash on HS lesions should be used on a daily basis. If no improvement after 12 weeks refer to SmPC for guidance. **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 $\geq 1/10$: infections, leucopenia, anaemia, lipids increased, headache, abdominal pain, nausea and vomiting, elevated liver enzymes, rash (including exfoliative rash), musculoskeletal pain, injection site reaction. Common $\geq 1/100$ to $< 1/10$: skin cancer excluding melanoma (including basal cell carcinoma and squamous cell carcinoma), benign neoplasm, leucocytosis, thrombocytopenia, hypersensitivity, allergies (including seasonal allergy), hypokalaemia, uric acid increased, blood sodium abnormal, hypocalcaemia, hyperglycaemia, hypophosphatemia, dehydration, mood alterations (including depression),

anxiety, insomnia, paraesthesia, 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), onychoclasia, 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:** December 2016, PI/Humira(combined)/37.

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 AbbVieAdverseEvents@abbvie.com

For the Republic of Ireland adverse events should be reported to HPRRA Pharmacovigilance, Earlsfort Terrace, Dublin 2. Tel. +353 16764971; Fax +353 16762517; Email medsafety@hpra.ie. Adverse events should also be reported to AbbVieonIREpharmacovigilance@abbvie.com

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.

Date of preparation: March 2017

AXHUD161207(1)

Desunin®

Cholecalciferol 800IU Tablets & 4000IU Tablets



DESUNIN®:

- Available in 800IU tablets and 4000IU tablets
- Daily flexible dosing of 800IU - 4000IU Vitamin D₃
- Prescription only medicine

Desunin® 800IU is indicated for the treatment and prevention of Vitamin D deficiency in adults and adolescents¹

Desunin® 4000IU is indicated for the treatment of Vitamin D deficiency in adults and adolescents²

ABBREVIATED PRESCRIBING INFORMATION

Desunin® 800IU Tablets

Please consult the Summary of Product Characteristics (SPC) for full prescribing information.

Presentation: Tablet: White to light yellow, biconvex, 7 mm in diameter. **Indication:** Prevention and treatment of vitamin D deficiency in adults and adolescents. Vitamin D deficiency is defined as serum levels of 25-hydroxycholecalciferol (25(OH)D) < 25 nmol/l. In addition to specific osteoporosis treatment of patients who are at risk of vitamin D deficiency, preferably in combination with calcium. **Dosage and Administration:** Recommended dose: One tablet per day. Higher doses can be necessary in treatment of vitamin D deficiency, where the dose should be adjusted dependent upon desirable serum levels of 25-hydroxycholecalciferol (25(OH)D), the severity of the disease and the patient's response to treatment. The daily dose should not exceed 4000IU (five tablets per day). Pediatric population: The safety and efficacy of Desunin in children under 12 years have not been established. **Dosage in hepatic impairment:** No dose adjustment is required. **Dosage in renal impairment:** Desunin should not be used in patients with severe renal impairment (see full SPC section 4.3). **Method of administration:** The tablets can be swallowed whole or crushed. The tablets can be taken with food. **Contraindications:** Diseases and/or conditions resulting in hypercalcaemia or hypercalcaemia. Nephrolithiasis. Nephrocalcinosis. Hypervitaminosis D. Hypersensitivity to the active substance or to any of the excipients listed in section 6.1 of full SPC. **Warnings and precautions:** Desunin should be prescribed with caution to patients suffering from sarcoidosis due to risk of increased metabolism of vitamin D into its active form. These patients should be monitored with regard to the calcium content in serum and urine. During long-term treatment, serum calcium levels should be followed and renal function should be monitored through measurements of serum creatinine. Monitoring is especially important in elderly patients on concomitant treatment with cardiac glycosides or diuretics (see section 4.5) and in patients with a high tendency to calculus formation. In case of hypercalcaemia (exceeding 300 mg (7.5 mmol)/24 hours) or signs of impaired renal function the dose should be reduced or the treatment discontinued. Desunin should be used with caution in patients with impairment of renal function and the effect on calcium and phosphate levels should be monitored. The risk of soft tissue calcification should be taken into account. In patients with severe renal insufficiency, vitamin D in the form of cholecalciferol is not metabolised normally and other forms of vitamin D should be used. The content of vitamin D (800 IU) in Desunin should be considered when prescribing other medicinal products containing vitamin D. Additional doses of vitamin D should be taken under close medical supervision. In such cases it is necessary to monitor serum calcium levels and urinary calcium excretion frequently. Desunin contain sucrose and isomalt. Patients with rare hereditary problems of fructose intolerance, glucose-galactose malabsorption or sucrase-isomaltase insufficiency should not take this medicine. **Interactions:** Thiazide diuretics reduce the urinary excretion of calcium. Due to the increased risk of hypercalcaemia, serum calcium should be regularly monitored during concomitant use of thiazide diuretics. Concomitant use of phenytoin or barbiturates may reduce the effect of vitamin D since the metabolism increases. Excessive dosing of vitamin D can induce hypercalcaemia, which may increase the risk of digitalis toxicity and serious arrhythmias due to the additive inotropic effects. The electrocardiogram (ECG) and serum calcium levels of patients should be closely monitored. Glucocorticoid steroids may increase vitamin D metabolism and elimination. During concomitant use, it may be necessary to increase the dose of Desunin tablets. Simultaneous treatment with ion exchange resins such as cholestyramine or laxatives such as paraffin oil may reduce the gastrointestinal absorption of vitamin D. **Fertility, pregnancy and lactation:** **Fertility:** There are no data on the effect of Desunin on fertility. However, normal endogenous levels of vitamin D are not expected to have any adverse effects on fertility. **Pregnancy:** Desunin should be used during pregnancy, only in the case of a vitamin D deficiency. Desunin is not recommended during pregnancy in patients without a vitamin D deficiency as the daily intake should not exceed 600 IU vitamin D. Studies in animals have shown reproductive toxicity of high doses of vitamin D (see section 5.3). There are no indications that vitamin D at therapeutic doses is teratogenic in humans. **Breast-feeding:** Vitamin-D can be used during breast-feeding. Vitamin D₃ passes into breast milk. This should be considered when giving additional vitamin D to the child. **Undesirable effects:** Immune system disorders - Hypersensitivity reactions such as angio-oedema or laryngeal oedema. Metabolism and nutrition disorders - Hypercalcaemia and hypercalcaemia. Skin and subcutaneous disorders - Pruritus, rash and urticaria. Consult the Summary of Product Characteristics for full list of side effects. **Legal Category:** POM **Marketing Authorisation Holder:** Meda Health Sales Ireland Limited, Unit 34/35, Block A, Dunboyne Business Park, Dunboyne, Co Meath, Ireland. **Marketing Authorisation Number:** PA1332/044/001 **Date of first authorisation:** 8th June 2012 **Date of revision of text:** July 2016

Desunin® 4000IU Tablets

Please consult the Summary of Product Characteristics (SPC) for full prescribing information.

Presentation: Tablet: White to light yellow, oblong, 16 mm in diameter, with a line score. The score line is only to facilitate breaking for ease of swallowing and not to divide into equal doses. **Indication:** Treatment of vitamin D deficiency in adults and adolescents. Vitamin D deficiency is defined as serum levels of 25-hydroxycholecalciferol (25(OH)D), the severity of the disease and the patient's response to treatment. The daily dose should not exceed 4000 IU (one tablet per day). Pediatric population – the safety and efficacy of Desunin in children under 12 years have not been established. **Dosage in hepatic impairment:** No dose adjustment is required. **Dosage in renal impairment:** Desunin should not be used in patients with severe renal impairment. The tablets can be swallowed whole or crushed. The tablets can be taken with food. **Contraindications:** Diseases and/or conditions resulting in hypercalcaemia or hypercalcaemia. Nephrolithiasis. Nephrocalcinosis. Hypervitaminosis D. Hypersensitivity to the active substance or to any of the excipients listed in section 6.1 of full SPC. **Warnings and precautions:** Desunin should be prescribed with caution to patients suffering from sarcoidosis due to risk of increased metabolism of vitamin D into its active form. These patients should be monitored with regard to the calcium content in serum and urine. During long-term treatment, serum calcium levels should be followed and renal function should be monitored through measurements of serum creatinine. Monitoring is especially important in elderly patients on concomitant treatment with cardiac glycosides or diuretics (see section 4.5) and in patients with a high tendency to calculus formation. In case of hypercalcaemia (exceeding 300 mg (7.5 mmol)/24 hours) or signs of impaired renal function the dose should be reduced or the treatment discontinued. Desunin should be used with caution in patients with impairment of renal function and the effect on calcium and phosphate levels should be monitored. The risk of soft tissue calcification should be taken into account. In patients with severe renal insufficiency, vitamin D in the form of cholecalciferol is not metabolised normally and other forms of vitamin D should be used. The content of vitamin D (4000 IU) in Desunin should be considered when prescribing other medicinal products containing vitamin D. Additional doses of vitamin D should be taken under close medical supervision. In such cases it is necessary to monitor serum calcium levels and urinary calcium excretion frequently. Desunin contain sucrose and isomalt. Patients with rare hereditary problems of fructose intolerance, glucose-galactose malabsorption or sucrose-isomaltase insufficiency should not take this medicine. **Interactions:** Thiazide diuretics reduce the urinary excretion of calcium. Due to the increased risk of hypercalcaemia, serum calcium should be regularly monitored during concomitant use of thiazide diuretics. Concomitant use of phenytoin or barbiturates may reduce the effect of vitamin D since the metabolism increases. Excessive dosing of vitamin D can induce hypercalcaemia, which may increase the risk of digitalis toxicity and serious arrhythmias due to the additive inotropic effects. The electrocardiogram (ECG) and serum calcium levels of patients should be closely monitored. Glucocorticoid steroids may increase vitamin D metabolism and elimination. During concomitant use, it may be necessary to increase the dose of Desunin tablets. Simultaneous treatment with ion exchange resins such as cholestyramine or laxatives such as paraffin oil may reduce the gastrointestinal absorption of vitamin D. **Fertility, pregnancy and lactation:** **Fertility:** There are no data on the effect of Desunin on fertility. However, normal endogenous levels of vitamin D are not expected to have any adverse effects on fertility. **Pregnancy:** Desunin should be used during pregnancy, only in the case of a vitamin D deficiency. Desunin is not recommended during pregnancy in patients without a vitamin D deficiency as the daily intake should not exceed 600 IU vitamin D. Studies in animals have shown reproductive toxicity of high doses of vitamin D (see section 5.3). There are no indications that vitamin D at therapeutic doses is teratogenic in humans. **Breast-feeding:** Vitamin-D can be used during breast-feeding. Vitamin D₃ passes into breast milk. This should be considered when giving additional vitamin D to the child. **Undesirable effects:** Immune system disorders - Hypersensitivity reactions such as angio-oedema or laryngeal oedema. Metabolism and nutrition disorders - Hypercalcaemia and hypercalcaemia. Skin and subcutaneous disorders - Pruritus, rash and urticaria. Consult the Summary of Product Characteristics for full list of side effects. **Legal Category:** POM **Marketing Authorisation Holder:** Meda Health Sales Ireland Limited, Unit 34/35, Block A, Dunboyne Business Park, Dunboyne, Co Meath, Ireland. **Marketing Authorisation Number:** PA1332/044/004 **Date of first authorisation:** 11th December 2015 **Date of revision of text:** July 2016

REFERENCES

1. Desunin® 800IU Summary of Product Characteristics.
2. Desunin® 4000IU Summary of Product Characteristics.

Adverse Events

Adverse Events should be reported to Meda Health Sales Ireland Limited on 01 802 6624 or PV@meda.ie.

■ Oral 07. 10.00am

A re-evaluation of teenage sunbed use following the introduction of banning legislation for under 18 year olds.

Stephanie Menzies, Selene Daly, Miriam Fitzgerald, Dermot McKenna. Department of Dermatology, Sligo University Hospital

Indoor tanning is associated with an increased risk of skin cancer. The risk is higher in frequent users and in those using sunbeds at a younger age. In a previous study of Irish teenagers, we showed that 7.5% of respondents had used a sunbed with a higher rate in Dublin (11.2%). In 2014, legislation was introduced in Ireland to ban the use of sunbeds in teenagers <18 years old.

The purpose of the present study was to reassess sunbed usage among teenagers 14-18 years old two years after the introduction of the ban. We assessed (i) sunbed usage rates; (ii) sunburn history; (iii) sun-protection habits; (iv) attitudes towards sun and sunbed exposure. The same secondary schools as before were visited and the teenagers completed an anonymous questionnaire. Numbers completing the questionnaire, age and male/female ratio were similar to the original study.

The results showed that more teenagers are using sunbeds following the ban (8.8%). Teenagers in Dublin continue to have a higher rate of sunbed use (14%) compared to other regions. After the ban there was an increase in sunbed usage in tanning shops (pre-ban, 21%; post-ban, 54%) and at home (pre-ban, 18%; post-ban, 41%). Only a minority of teenagers report being consented prior to treatment (pre-ban, 9%; post-ban, 15%). The majority did not wear eye protection (65%), resulting in eye problems in 11%. In the present study, 50% had experienced burning due to sunbed use, most frequently occurring on the face (33%) and chest (22%). A minority (2%) of teenagers used Melanotan.

Sunburn due to ambient exposure was reported by 91% of teenagers with 43% experiencing ≥ 5 burns. Sunscreen was seldom used at home (34%) compared to when holidaying abroad (84%). The majority of teenagers believe that a tan looks healthy (66%) and makes you look more attractive (67%). Conversely, the majority also acknowledged that tanning is harmful (82%), dangerous (72%) and associated with wrinkles (74%).

Our findings show that there has been no reduction of sunbed use in teenagers following the introduction of legislation banning its use in under 18's. This may be due to lack of enforcement of legislation, in addition to an increasing trend for sunbed use at home.

References:



1. Fitzgerald et al. Ambient and sunbed ultraviolet radiation exposure: exposure rates, protection habits and attitudes of Irish teenagers aged 14-18 years before introduction of national sunbed legislation. Br J Dermatol (2015) 173(Suppl. S1), pp3-10

elave
ABSOLUTE PURITY

BABY SAFE SKIN CARE



TREAT
SKIN
RIGHT

Available in pharmacies nationwide. Buy online at elaveskincare.com  

Poster Presentations

Poster 01

Introducing a Dermatology Handover system within the Belfast and South Eastern Health and Social Care Trust.
Skillen LA, Brennan R, O'Kane D, Hoey S.
Department of Dermatology, Belfast Health and Social Care Trust.

Poster 02

A review of all patients recruited to BADBIR prior to 2014 in the Belfast Trust.
Skillen LA, McKenna K.
Department of Dermatology, Belfast City Hospital.

Poster 03

The development of lentigines in chronic plaque psoriasis
L. Nestor, O. Molloy, L. Jennings, A. Lally, S. Rogers, B. Kirby.
Department of Dermatology, St Vincent's University Hospital Dublin.

Poster 04

What Is Your Skin Type?
A Havelin, C Feighery,
Department of Dermatology, Our Lady of Lourdes Hospital, Drogheda.

Poster 05

An Audit of Compliance with TB Screening Procedures prior to treatment of Psoriasis with Biologic.
Dr. Aine Kelly, Dr. Aoife Lally, Prof. Brian Kirby
St. Vincent's University Hospital, Dublin.

Poster 06

Laboratory Monitoring during Isotretinoin Treatment of Acne: How much is enough?
Dr Niamh Byrne, Dr Cliona Feighery, Dr Sinead Collins
Dermatology Department, Our Lady of Lourdes Hospital Drogheda, Co. Louth, Ireland

Poster 07

Narrowband UVB phototherapy outcomes – a single-centre retrospective review
J Clowry, L Nestor, K Molloy, A Salim, M Connolly, AM Tobin

Poster 08

A single-centre review of methotrexate in the management of severe adult atopic dermatitis
J Clowry, L Nestor, K Molloy, A Salim, M Connolly, AM Tobin

Poster 09

Remission of refractory cutaneous Crohn's disease with combination ertapenem and biologic therapy
J Clowry, L Nestor, K Molloy, A Salim, M Connolly, AM Tobin

Poster 10

Referral of invasive melanoma to a Melanoma Multidisciplinary Team Meeting in Cork University Hospital
R. O'Connor¹, C.M.R Fahy², S. McCarthy¹, J. Bourke¹, M. Murphy¹
¹Department of Dermatology - South Infirmary Victoria University Hospital Cork
²Department of Dermatology – Royal United Hospital NHS Foundation Trust, Bath, UK

Cetraben.

Helping patients to **completely** understand emollient therapy.



Cetraben's approach to Complete Emollient Therapy:

- Providing a clinically effective, uniquely formulated and comprehensive emollient range that users prefer
 - 96% of patients with problematic skin prefer Cetraben cream to their previous emollient¹
 - Cetraben ointment ranked as the most preferred ointment versus leading brands²
- An ongoing commitment to the development of innovative tools and support materials to help HCPs and patients better manage problematic dry skin conditions

To find out what Cetraben can do for you and your patients and to order samples, please visit www.cetraben.co.uk

SLS, lanolin and paraben free



1. Preference study, September 2013. Data on file. 2. Preference study, August 2014. Data on file.

ABBREVIATED PRESCRIBING INFORMATION:

Cetraben® Ointment Presentation: An opaque white ointment. **Main ingredients:** White soft paraffin 35.0% w/w, Light liquid paraffin 45.0% w/w. **Indications:** An emollient used to moisturise and soften dry skin in eczema, dry cases of psoriasis and other dry skin conditions. Also used as a skin cleanser or bath additive. **Dosage and Administration:** Adults, the elderly and children: As an emollient: Apply to the affected areas as often as required. Smooth gently into the skin, following direction of the hair growth. As a bath additive: Melt about 4g in hot water in a suitable container then add to the bath. As a soap substitute: Take a small amount of the ointment and lather it under warm water and use as required when washing or in the shower. Pat skin dry. **Contraindications:** Hypersensitivity to any of the ingredients. **Precautions:** For external use only. May cause local skin reactions. Avoid contact with eyes. Baths and showers may become slippery when used. If this product comes into contact with dressings and clothes, it can be more easily ignited with a naked flame. Keep away from fire when using this product. Do not use if you are allergic to any of the ingredients listed. Talk to your doctor before use if the skin is badly cracked, infected or bleeding. **Pregnancy and breastfeeding:** Unlikely to have any ill effect when used as directed. If unsure, talk to your doctor or pharmacist. **Side effects:** None known. **Pack size:** 50g, 125g & 450g. **Trade Price:** 125g: £3.49 450g: £5.39 **Medical Device:** Class I. **Manufacturer:** Thornton & Ross Limited, Huddersfield, HD7 5QH, UK. **Date of preparation:** 05.11.2015.

Cetraben® Emollient Bath Additive Light Liquid Paraffin Please refer to Summary of Product Characteristics before prescribing. **Presentations:** Bath additive – Clear liquid containing light liquid paraffin 82.8% w/w. **Indications:** Symptomatic relief of red, inflamed, damaged, dry or chapped skin, especially when associated with endogenous or exogenous eczema. **Dosage:** Bath additive – Adults: Add one or two capfuls; Children: add half/one capful to a warm water bath or apply with a wet sponge to wet skin before showering. **Contra-indications:** Hypersensitivity to any of the ingredients. **Special Warnings and Precautions:** Care should be taken if allergy to any of the ingredients is suspected. Care should also be exercised when entering or leaving the bath. Avoid contact with the eyes. **Side Effects:** Very rarely, mild skin reactions have been seen **Marketing Authorisation Numbers:** Cetraben Emollient Bath Additive: PL 06831/0260 **Basic NHS Price:** £5.75 **Legal Category:** GSL **Date of Preparation:** November 2015. **Further Information is available from:** Genus Pharmaceuticals Ltd, Linthwaite, Huddersfield, HD7 5QH, UK. Cetraben® is a registered trademark. CETBA.APLV11.

Cetraben® Cream Presentation: A thick white cream. **Main ingredients:** White soft paraffin 13.2% w/w, Light liquid paraffin 10.5% w/w. **Indications:** An emollient, moisturising and protective cream for the symptomatic relief of red, inflamed, dry or chapped skin, especially when associated with eczema. **Dosage and Administration:** Adults, the elderly and children: Apply to dry skin areas as often as required and rub in. **Contraindications:** Hypersensitivity to any of the ingredients. **Precautions:** For external use only. May cause local skin reactions. Avoid contact with eyes. Talk to your doctor before use if the skin is badly cracked, infected or bleeding. Do not use if allergic to any of the ingredients. Children under 1 year should be treated under medical supervision. **Pregnancy and breastfeeding:** Using Cetraben Cream during pregnancy and breastfeeding is unlikely to have any ill effects. If unsure, talk to your doctor or pharmacist. **Side effects:** Mild allergic skin reactions. **Pack size:** 50g, 150g, 500g, 1050g Rx packs, 50ml, 200ml & 500ml (with 475ml fill) OTC packs. **Trade Price:** 50g: £1.40 150g: £3.98 500g: £5.99 1050g: £11.62 50ml OTC: £3.00 200ml OTC: £4.80 500ml (with 475ml fill) OTC: £7.25 **Medical Device:** Class I. **Legal Manufacturer:** Thornton & Ross Limited, Huddersfield, HD7 5QH, UK. **Date of preparation:** 13.05.2016.

Cetraben® Lotion Presentation: A smooth white lotion. **Main ingredients:** White soft paraffin 5.0% w/w, Light liquid paraffin 4.0% w/w. **Indications:** For the relief of the symptoms of eczema, dermatitis and other dry skin conditions. **Dosage and Administration:** Adults, the elderly and children: Apply to the skin and gently rub in until absorbed. Use as often as required, or as directed by your doctor or pharmacist. **Contraindications:** Hypersensitivity to any of the ingredients. **Precautions:** For external use only. Do not swallow. Avoid contact with eyes. May cause local skin reactions. Talk to your doctor before use if the skin is badly cracked, infected or bleeding. Do not use if allergic to any of the ingredients. **Pregnancy and breastfeeding:** Using Cetraben Lotion during pregnancy and breastfeeding is unlikely to have any ill effects. If unsure, talk to your doctor or pharmacist. **Side effects:** Mild allergic skin reactions. **Pack size:** 200ml & 500ml Rx packs, 50ml, 200ml & 500ml (with 475ml fill) OTC packs. **Trade Price:** 200ml: £4.00 500ml: £5.64 50ml OTC: £3.00 200ml OTC: £4.80 500ml (with 475ml fill) OTC: £7.25 **Medical Device:** Class I. **Legal Manufacturer:** Thornton & Ross Limited, Huddersfield, HD7 5QH, UK. **Date of preparation:** 05.11.2015.

Adverse events should be reported. Reporting forms and information can be found at www.yellowcard.mhra.gov.uk. Adverse events should also be reported to Medical Information on 0870 851 207

Thornton & Ross
DERMATOLOGY

Poster Presentations

Poster 1

Introducing a Dermatology Handover system within the Belfast and South Eastern Health and Social Care Trust.
Skillen LA, Brennan R, O’Kane D, Hoey S.
Department of Dermatology, Belfast Health and Social Care Trust.

Background: Handover of care is one of the most perilous procedures in medicine, and when carried out improperly can be a major contributory factor to subsequent error and harm to patients. Handover theory to date has been centred round hospital at night care for acute specialties. Dermatology as a specialty involves complex chronic disease processes and acute emergency presentations, therefore requiring a handover system that allows for this.

Within the trusts, there are 8 registrars providing 24 hour on call to 6 hospitals. This provides a challenge for patient review and follow up arrangements. Handover within dermatology had been informal with phone call or an informal chat to handover patient care. This was flagged by the GMC as an issue needing addressed within the department.

Aim: To introduce a specialty specific, time efficient handover system for the dermatology on call service within the Belfast/South Eastern Trusts within 4 months.

Method: An electronic survey questionnaire was sent to all CMTs, SPRs and Consultants involved in out of hour cover to get baseline data on how the current system worked and what improvements could be made. 44% of staff had been in a situation on call that could have been avoided through better communication between medical staff.

Changes made to the handover process include introduction of formal handover meetings, a template was created to allow access to “at risk” patients available to all on call staff through PDSA cycles. This was approved by the trusts available through a shared computer drive to ensure data protection.

A further electronic survey was sent out to review the implementation of the new handover procedures.

Results: 86% of staff preferred the new system that was introduced. 88% of the weekly handover were updated. Only 27% of updated emails were sent out on a Monday after on call weekend. Access to the shared drive to view and update the handover template was 77%.

Discussion: The new handover system has proved to be efficient and favoured by the medical staff involved in handover. Figures show that the new system is working. Improvements can be made in access to the shared drive for staff rotating into the department and ensuring that the update template is emailed to all staff after weekend on call. Effective communication lies at the heart of good medical practice. This Quality Improvement project shows that small changes can improve communication and efficiency.

Poster 02

A review of all patients recruited to BADBIR prior to 2014 in the Belfast Trust.
Skillen LA, McKenna K.
Department of Dermatology, Belfast City Hospital.

Background: The British Association of Dermatologists’ Biologic Interventions Register (BADBIR) was set up to follow up all patients receiving biologic therapy for psoriasis in the UK and ROI. Its aim is to investigate the long-term safety for patients treated with biologic agents, compared with conventional systemic therapy. The Belfast Trust has been recruiting patients since 2010.

Aim: To review all patients recruited to BADBIR until 31/12/2013 with an aim to determine key demographics in our local cohort of biologic patients and compare to national and international data. Also to assess baseline disease severity, response to biologic therapy with PASI 75 and compare to UK data and international data.

Method: A retrospective review of data for patients recruited to BADBIR prior to 31/12/13. This included BADBIR review, and medical chart review.

Results: 93 patients were identified. 62% were male, 38% female. Mean age was 48.5yrs. 30% of patients suffered from hypertension, 16% hypercholesterolaemia, 4% T2 Diabetes, 3% IHD, 19% Psoriatic Arthropathy and 20% depression. 84% were on adalimumab, 7% etanercept and 9% ustekinumab. 66.25% achieved PASI 75 at 3 months. 77% achieved PASI 75 at 6 months. There were no serious adverse events.

Discussion: Psoriasis affects 2-3% of the UK population. A small proportion of those patients require systemic and biological therapy to control their disease. Recruiting patients to BADBIR offers a system by which population data and outcomes can be collected, analysed and then compared with UK and international data.

Poster 03

The development of lentiginos in chronic plaque psoriasis
L. Nestor, O. Molloy, L. Jennings, A. Lally, S. Rogers, B. Kirby.
Department of Dermatology, St Vincent’s University Hospital Dublin.

Psoriasis vulgaris is a common T cell mediated cutaneous disorder. In 20% of patients it follows a severe, recalcitrant course. Previous studies have reported the development of lentiginos as an unusual form of post inflammatory hyperpigmentation in psoriasis.(1). It has been suggested that the proposed mechanism of this pigmentation is an abnormal reaction to UV light (2,3). There are reports of lentiginos arising within psoriatic plaques in the absence of phototherapy. We report a case series [n=12] of patients with longstanding severe chronic plaque psoriasis.

A retrospective study was carried out on twelve patients over a three month period. The study was approved by the Medical

The Irish Skin Foundation (ISF) is a national charity supporting people with skin disease.

ISF HELPLINE

The ISF Helpline now provides direct, accessible and specialist advice about skin conditions to the public:

Contact the **IRISH SKIN FOUNDATION HELPLINE**
 **(01) 486-6280**

ADVOCACY

Demand for access to dermatology services is growing. People with skin disease need improved access to better resources services and affordable treatment options. The ISF is advocating for change and ensures that the voice of patients is heard by government and policy makers.

WEBSITE AND NEWSLETTERS

Our website and quarterly newsletters provide a growing range of information about skin conditions, news, life stories, resources and booklets.



AWARENESS AND HEALTH PROMOTION

Levels of public awareness of skin diseases are low. The wider aspects of having a skin disease (e.g. psychological effect or the impact of treatment) are only beginning to be understood. Awareness campaigns and education play a crucial role in changing attitudes, dispelling prejudices, and reducing stigma and feelings of isolation.

DERMATOLOGY EDUCATION

We run an annual Dermatology Study Day for community, public health, community and hospital-based nurses, pharmacists and others involved in providing skin care aims to improve access to dermatology education.

Saturday 13th May 2017
Ashling Hotel, Parkgate St, Dublin 8

IRISH SKIN FOUNDATION

ISF DERMATOLOGY STUDY DAY

- Wound management & burns
- Treatment of eczema
- Urticaria
- Treatment of acne
- Skin infections & infestations
- Non-melanoma skin cancers

Eventbrite

Irish Skin Foundation
 Charles Institute UCD
 University College Dublin
 Dublin 4
 D04 V1W8

t: 01-486-6280 e: info@irishskin.ie w: www.irishskin.ie
 Charity Regulatory Authority Number: 20078706

Follow us on  @Irishskin.ie on  @ISFcharity and watch videos on our  YouTube Channel

Foundation partners



Poster Presentations

Research Ethics Committee of St Vincent's University Hospital. Written informed consent was obtained. Selected patients who were found to have lentigines confined to post inflammatory psoriatic plaques were asked to participate. The lesions were photographed and punch biopsies of the lentigines were taken. The specimens were stained by Haematoxylin and eosin and analyzed by a consultant histopathologist. Histology showed increased melanocyte proliferation with pigment incontinence in the dermal epidermal junction.

We describe the development of lentigines within resolving psoriasis plaques in twelve patients with severe disease. There are only three reports of this to date in the literature. Similar to our study, all had severe psoriasis of long duration that required systemic therapy. Histology was not however, performed in these case reports. This study was carried out on patients who had not had phototherapy for over ten years, and lentigines were present on non-sun exposed sites in some of our patients. They were also confined to the area of skin affected by the now resolved psoriatic plaque.

Our study suggests that this change is a form of post inflammatory hyperpigmentation. A recent study by Prinz et al in 2015 reports that melanocytes are target cells of the HLA-C*06:02 molecule that mediates T cell responses in psoriasis. We speculate that the formation of these "lentigines" may reflect potential autoimmunity directed against melanocytes in these patients. It would not explain, however, why this phenomenon appears uncommon.

■ Poster 04 What Is Your Skin Type?

A Havelin, C Feighery,
 Department of Dermatology,
 Our Lady of Lourdes Hospital, Drogheda.

Introduction: The Fitzpatrick Skin Type Classification is the most commonly used measure of skin type. It is a scale of six skin types based on individuals' self-reported tanning and burning propensities after moderate sun exposure (fig.1). Clinically, it is used to estimate minimum erythema dose for phototherapy. It is also used as a standard for self-assessment of sun sensitivity in questionnaire based surveys.

Objectives:

1. To determine the accuracy of self-reported skin types.
2. To determine whether we could improve patients' estimation of their skin type.

Methods: Data was obtained from 74 patients attending pigmented lesion clinics over a four week period. All patients filled out a questionnaire requiring them to categorize their skin type (I-VI). Group 1 (33 patients) based their decision on their tanning and burning propensities only (Fig1). Group 2 (41 patients) were shown images of individuals with different skin types and their corresponding skin colour, ethnicity, tanning and burning propensities.

Results: Of the 74 patients assessed, only 24 (32%) selected their correct skin type. The correlation between physicians' assessments and self-reported skin types was higher for Group 2 (18/41)(44%) than Group 1 (6/33) (18%). The vast majority of patients (66%) underestimated their skins' sensitivity to the sun.

Conclusion: Patients are not aware of their skin type. The use of additional descriptions and visual aids improved the accuracy of patients' self assessment but the results remain suboptimal. This could have public health implications as self-reported questionnaires are commonly used to collect data. Skin type is an important risk factor for the development of skin cancers. Patients with skin types I- III are at an increased risk of sun damage, melanoma and non-melanoma skin cancers. The majority of patients under-estimated their skins' sensitivity to UV light. This alarming finding highlights the need to increase skin type awareness and the associated UV risk among the Irish population.

Fig.1 Fitzpatrick Skin Types I-VI:

- Type I Always burn and never tan
- Type II Burn easily and then tan
- Type III Tan after initial burn
- Type IV Burn minimally, tan easily
- Type V Rarely burn, tan darkly
- Type VI Never burns, always tan darkly

■ Poster 05 An Audit of Compliance with TB Screening Procedures prior to treatment of Psoriasis with Biologic.

Dr. Aine Kelly, Dr. Aoife Lally, Prof. Brian Kirby
 St. Vincent's University Hospital, Dublin.

The BAD guidelines for treatment of psoriasis with anti- TNF, IL 12/23 and IL17 recommend screening for latent TB. It is common practice in Dermatology centres to perform both a chest Xray and an Interferon Gamma Release Assay (IGRA) at the time of screening. The IGRA is approximately 96% sensitive and 99% specific for the diagnosis of latent TB. A chest X-ray is approximately 73-79% sensitive and 60-63% specific.

We assessed clinician compliance with TB screening in 107 psoriasis patients prior to commencing biologic therapy. We used the BAD guidelines on biologic therapy in psoriasis as our audit standard. We also looked at the incidence of latent TB, incidence of positive chest X ray results in those who were negative for latent TB (as per respiratory physician) and the consequence of these positive findings.

Of the one hundred and seven patients, the charts were unavailable for six. Thirty patients had a tuberculin skin test and seventy-one patients had IGRAs. Eleven patients (10.2 %) had documented TB risk factors. Five patients (4.6%) had a positive TST or IGRA (4 TST and one IGRA). All five patients with a positive TST or IGRA received chemoprophylaxis for latent TB. Sixteen patients (15 %) had granulomas of unknown significance on chest X-ray. Ten of these sixteen patients were referred to respiratory medicine for an opinion. Twelve of these sixteen

patients went on to have further imaging and procedures. Compliance with tuberculosis screening with chest X-ray and IGRA was one hundred per cent at our hospital. Compliance with documentation of TB risk factors was poor at 10.2%. Five percent of psoriasis patients screened were diagnosed with latent TB. There was no diagnosis of latent TB made from a positive chest X-ray finding. All latent TB diagnoses were based on a TST or IGRA positivity. There were seven C.T. thoraces, bronchoscopies and repeat chest X-rays done due to a false positive chest X-ray. No additional diagnoses of latent TB were made after these procedures.

The audit suggests that chest X-ray is both insensitive and non-specific as a screening tool for latent TB. In our study, chest X-ray screening led to unnecessary expensive tests that are potentially hazardous. Further studies should be performed to delineate the safest and most cost efficient screening algorithm for TB infection prior to biologic therapy.

■ Poster o6

Laboratory Monitoring during Isotretinoin Treatment of Acne: How much is enough?

*Dr Niamh Byrne, Dr Cliona Feighery, Dr Sinead Collins
Dermatology Department, Our Lady of Lourdes Hospital Drogheda, Co. Louth, Ireland*

Introduction: Isotretinoin is gold standard therapy for severe acne. Due to teratogenicity pregnancy prevention measures are required. Requirement for laboratory monitoring is less clear. The manufacturer's SPC recommends monitoring lipids and liver function at weekly or biweekly intervals until the response to isotretinoin has been established. The European Dermatology Forum recommends monitoring liver enzymes and lipids, before treatment, one month after starting and every three months thereafter. Recent studies including a large meta-analysis propose that monitoring of FBCs is not required and that a baseline LFT and lipid profile and once more during therapy is adequate (1,2). The aim of this study was to establish laboratory monitoring practices in our centre, determine the rate of blood abnormalities and ascertain the clinical consequence of any abnormalities.

Methods: A retrospective review was conducted of 50 patients who received at least one course of isotretinoin for the treatment of acne from January 2015 to January 2017. Patient demographics, laboratory results, interval of testing and isotretinoin dose were recorded.

Results: The mean age was 21yrs (12 -53 yrs), 58% were male. In total, 35 patients (70%) had an FBC measured at baseline, 24 (48%) had at least one FBC measured during treatment. There were no abnormalities in FBC detected in any patient. Lipid abnormalities occurred most frequently, 5 patients (10%) had a lipid abnormality detected at baseline and 14 (28%) developed an abnormality during treatment. No lipid abnormality required isotretinoin adjustment or discontinuation. One patient developed a raised ALT [94 IU/l (normal range: 24 - 68)], which normalized within one month. Four patients (8%) developed a raised GT [mean: 57 IU/l (normal range: 6 - 30)]. Three patients (6%) had an isolated raised fasting bilirubin level [mean: 23 µmol/l (normal range: 8.4 - 20.5)].

Discussion: A standardized approach to laboratory monitoring of isotretinoin would eliminate unnecessary testing and reduce costing. Our study demonstrates that laboratory monitoring of isotretinoin in our department would benefit from rationalisation. Hansen et al recommend measuring a baseline lipid profile and LFTs and repeating once while on the target dose (1). Our data suggest that adopting this approach would be safe and cost effective.

[1]Hansen TJ, Lucking S, Miller JJ et al. Standardized laboratory monitoring with use of isotretinoin in acne. *JAAD*. 2016 Aug 31;75(2):323-8.

[2]Lee YH, Scharnitz, Muscat J et al. Laboratory monitoring during isotretinoin therapy for acne: a systematic review and meta-analysis. *JAMA dermatol*. 2016 Jan 1;152(1):35-44.

■ Poster o7

Narrowband UVB phototherapy outcomes – a single-centre retrospective review

J Clowry, L Nestor, K Molloy, A Salim, M Connolly, AM Tobin

Systemic and biologic therapies are rapidly evolving areas of research and development in cutaneous inflammatory diseases including psoriasis and atopic dermatitis (AD). We sought to determine whether narrowband ultraviolet B phototherapy (NBUBV; 311 - 313nm) remains an effective treatment option, 30 years following its introduction.

We present a retrospective review of outcomes with in-office NBUBV phototherapy for AD in a tertiary-referral centre. We reviewed records for all AD patients treated with NBUBV phototherapy from 2006 - 2016. Data collected included age, sex, minimal erythema dose (MED), cumulative dose, number of treatment courses, adverse events and outcome. All patients were 18 years or older with generalised skin involvement and had failed first-line topical regimens.

A total of 36 patients, 15 females (42%) and 21 males (58%) were included. Twenty-two patients (61%) had a single treatment course, 9 patients (25%) had two courses and 5 (14%) patients had three courses. Seventy-eight percent (n = 28) used topical corticosteroids during treatment. An MED was recorded in 81% (n = 29) ranging from 0.2 - 0.77 J/cm². Treatment limiting adverse events included herpes simplex (n = 1), polymorphic light eruption (n = 3), photo-aggravated atopic dermatitis (n = 2) and grade 3 erythema (n = 1). Two patients did not complete therapy for personal reasons. There were no reported melanoma or non-melanoma skin cancers.

Seventy-two percent (n = 26) were clear or almost clear following their first treatment course, reflecting previously reported outcomes¹. The median number of exposures for the first course was 28 (range 6-40) and the median cumulative dose was 25.78 J/cm² (range: 1.39 - 110.67 J/cm²). The median interval between patients' first and second treatment courses was 310 days (range: 140 - 1384) and 963 days (range: 86 - 3577) between courses 2 and 3. Twenty-two percent (n = 8) progressed to systemic therapy at a median of 273 days post completion of phototherapy (range: 5 - 1385).

Emerging therapies in AD offer great hope for refractory disease, however this study serves as a reminder of the impressive treatment outcomes with NBUBV phototherapy. The results reflect the commitment to maintaining the highest standards in phototherapy units and support the continued funding of these departments in a challenging era for the health service.

1. George SA et al. Narrow-band (TL-01) UVB air-conditioned phototherapy for chronic severe adult atopic dermatitis. *Br J Dermatol* 1993; 128: 49-56.

■ Poster o8

A single-centre review of methotrexate in the management of severe adult atopic dermatitis

J Clowry, L Nestor, K Molloy, A Salim, M Connolly, AM Tobin

Methotrexate is commonly prescribed in the management of atopic dermatitis. This is a single-centre retrospective review of treatment outcomes amongst a patient cohort >18 years old. Cases were identified from laboratory records from January 2014 - December 2016.

Twenty-five patients with severe atopic dermatitis were included; thirteen females (52%) and twelve males (48%). Median age was 36 years (range 22 - 64). Previous treatments included topical therapies, antihistamines, narrow-band ultraviolet B phototherapy (n = 17, 68%), azathioprine (n = 4, 16%), mycophenolate mofetil (n = 1, 4%) and ciclosporin (n = 4, 16%). Prior oral prednisolone was documented in nineteen cases (76%) and hospital admissions for atopic dermatitis were recorded in ten (40%). Four patients (16%) had attended tertiary psychiatry services in the context of their cutaneous disease.

Methotrexate was commenced at 5-10mg weekly with folic acid supplementation and titrated up to a maximum 25mg. Median treatment duration was 13 months (range 1.5 - 44). Adjunctive oral therapies included prednisolone, acyclovir and antibiotics. Six patients (24%) required tapering dose prednisolone at the outset of treatment, n = 2 (8%) required short course prednisolone for an acute flare and n = 1 (4%) required maintenance prednisolone.

A four-point Physician's Global Assessment score (PGA) was used to assess outcome. A PGA score of 1 indicated disease clearance and PGA 4 corresponded with treatment failure. Two patients were lost to follow-up and nineteen cases (76% overall) had a PGA ≤3. Sixteen patients (64%) remained on methotrexate, of whom four (16% overall) had a PGA score of 1. Reasons for discontinuation included family planning (n = 1), lack of efficacy (n = 2), combined lack of efficacy and adverse effects (n = 3), neutropenic sepsis (n = 1) and remission (n = 2). Methotrexate was otherwise well tolerated, however 32% (n = 8) reported nausea. Transient mild elevations in liver function tests were recorded in nine cases (36%).

This review demonstrates favourable response rates to methotrexate in atopic dermatitis. Given the psychological impact of

severe disease, this well-established systemic therapy should be considered early in the management of moderate-to-severe and monitored using patient and clinician-based assessments.

■ Poster o9

Remission of refractory cutaneous Crohn's disease with combination ertapenem and biologic therapy

J Clowry, L Nestor, K Molloy, A Salim, M Connolly, AM Tobin

We present two cases of severe cutaneous Crohn's disease, both refractory to standard treatments. These patients had a history of prolonged hospital admissions, but responded dramatically to an extended course of community administered intravenous (IV) ertapenem, added to their biologic regimens.

The first case is a thirty-three year old female with a lifelong history of Crohn's. She had intractable vulval disease with persistent pain, discharge, lymphoedema and fissuring. She had failed multiple courses of combination oral and intravenous antibiotics, dapsone, adalimumab and infliximab. The severity of her condition necessitated long-term oral steroid use, resulting in secondary Cushing's syndrome. Ustekinumab 90mg every two weeks was beneficial as a steroid-sparing agent however did not adequately control her symptoms. Ertapenem 1g daily was added with an immediate clinical response resulting in reduced pain, oedema and discharge. It was withdrawn four months later when the patient's pain had fully resolved, fissures had almost completely healed and discharge was minimal. She remains in remission on maintenance rifampicin and ustekinumab.

The second case, is also a thirty-three year old female with a ten year history of severe Crohn's disease. She was reviewed with perianal fistulating disease from the vagina to natal cleft with recurrent cellulitis. This had a profound impact on her quality of life and was unresponsive to a similarly exhaustive list of immunomodulatory therapies. Vedolizumab 300mg IV eight weekly was introduced with some benefit, but her cutaneous fistulating disease remained problematic. Ertapenem 1g daily was added with a significant reduction in pain and discharge and was withdrawn after a twelve week course.

Ertapenem is an intravenous beta-lactam antibiotic indicated for use against gram-positive, gram-negative and a wide range of anaerobic pathogens. Its pharmacokinetic profile favours convenient community-based once daily dosing and its antimicrobial spectrum against anaerobes is of particular benefit in discharging, fistulating Crohn's. In inflammatory bowel disease, it has only been reported to date as an oral therapy for chronic antibiotic-refractory pouchitis (CARP), given its poor oral absorption and selective gastrointestinal activity. Optimal duration of therapy is unclear, and necessitates balancing disease control with concerns regarding clostridium difficile infections and antibiotic resistance. Nevertheless, it is a potentially transformative agent in a select group of refractory cases.

1.Madirrala V et al Successful faecal coliform sensitivity-based oral ertapenem therapy for chronic antibiotic-refractory pouchitis: a case series. *Eur J Gastroenterol Hepatol*. 28(3), 277-80.

Eucerin®

SKIN SCIENCE THAT SHOWS



Expert sun protection
for your skin's individual needs

■ Poster 10

Referral of invasive melanoma to a Melanoma Multidisciplinary Team Meeting in Cork University Hospital

R. O'Connor¹, C.M.R Fahy², S. McCarthy¹, J. Bourke¹, M. Murphy¹
¹Department of Dermatology - South Infirmery Victoria University Hospital Cork

²Department of Dermatology – Royal United Hospital NHS Foundation Trust, Bath, UK

Introduction: The incidence of melanoma is rapidly rising in Ireland with over 700 new cases diagnosed each year. The NCCP guidelines suggest that all melanomas are referred for discussion to a Melanoma MDT. The Southwest Melanoma MDT meeting is a dynamic meeting held twice monthly at Cork University Hospital (CUH).

Aim: In this study we examined how many primary invasive melanomas diagnosed at CUH in 2014 were discussed at the melanoma MDT. We compared our results to a similar study performed in 2012.

Methods: Reports were obtained from all cases of primary invasive melanoma diagnosed at the Department of Pathology, CUH from January – December 2014. By analyzing records of MDT minutes, these cases were compared to those referred for discussion at the Melanoma MDT from January 2014 – June 2015.

Results: In 2014, 129 cases of primary invasive melanoma were diagnosed at CUH. 120 (93%) cases were discussed at the MDT. In 2012, 123 cases of invasive melanoma were diagnosed at CUH and 106 (86%) cases were discussed.

737 cases of melanoma were discussed at the Melanoma MDT in CUH from Jan – Dec 2014. Some cases were reviewed on multiple occasions as clinical situations evolved.

Dermatology had 66 cases of IM of which 65/66 were referred to the MDT. This reflects an improvement of 2% from 2012. Plastic Surgery referred 18/22, an improvement of 8% from 2012. Numbers of IM from other specialties include general surgery, N=9, 9/9 referred, GP N=14, 12/14 referred; maxillofacial surgery N=1, 1 referred; ENT N=1, 0 referred.

9 cases were never referred for discussion to the MDT from various specialties including Plastic Surgery, N=4, ENT N=1, GP N=2, Dermatology N=1 and Colorectal surgery N=1.

36 cases of melanoma were referred from external institutions for review at the Southwest Melanoma MDT.

Discussion: Although the above results reflect an overall improvement in the number of cases referred for discussion to the melanoma MDT at Cork University Hospital, not all invasive melanomas diagnosed at this institution are being referred for discussion. It is likely that the percentage of melanomas referred to MDTs from institutions without an in-house MDT is even lower. The mechanism for referring melanomas to MDTs nationally needs to be evaluated and streamlined.



IAD
IRISH ASSOCIATION
OF DERMATOLOGISTS

Autumn Meeting



Dr Garry Meenagh & Dr Ian Coulson



Dr Catherine Quinlan & Dr Lisa Roche



Dr's Louise Cunningham, Julianne Clowry & Alison Havelin



Prof Eli Sprecher, Prof Catherine Nelson-Piercy Guest speakers
& Dr Kevin McKenna, IAD President



Dr Rosemarie Watson & Prof Louise Barnes IAD



Dr's David Middleton, Victoria Campbell & Emma Mack



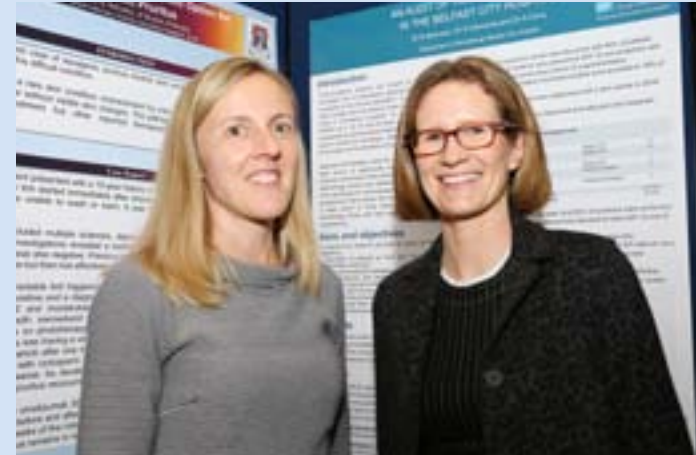
Dr Laura Skillen & Dr Donal O'Kane



Dr Art O'Hagan, Honorary Secretary IAD & Guest speaker
Dr Ian Coulson



Roisin O'Connor, Ian McDonald, Conor McGrath, Laoise Griffin,
Eimear Gilhooly, Jennifer Boggs & Veronika Dvorakova



Dr Helen Hunter & Dr Julia Tolland



Dr Maeve Lynch & Dr Oonagh Molloy



Dr Nicola Cooke, Dr Collette McCourt & Dr Helen Hunter



Dr Fergal Moloney, Dr Anousha Yazdabai & Dr Patsy Lenane



Suzanne Clements, Cliona Feighery, Louise Barnes, Rose-
marie Watson & Muireann Roche



Christine McMillan, Julie Handley & Rosemary Black



Ms Clémence Rudolph Biderma & Dr Colin Buckley IAD



Celgene Group Dr Conor Broderick IAD, Dr Kevin McKenna President IAD, Celgene guest speakers Prof Kingston Mills & Dr Gary Meenagh



Mr Richard Best & Dr Olivia Dolan



Dr Kevin McKenna addresses the Symposium



Dr Gary Meenagh, Celgene symposium Guest Speaker



Dr Laoise Griffin, Dr Siobhan McCarthy & Dr Lisa Roche



Laoise Griffin, Roisin O'Connor, Sibhan McCarthy, Kevin McKenna, Lisa Roche & Catherine Quinlan



Celgene Satellite Symposium



Prof Kingston Mills, Celgene Symposium Guest Speaker



Dr Nazish Mansoor, Dr Conor Broderick & Dr Catherine Quinlan









HUMIRA
adalimumab
destination you™

The joy
of being
connected

Humira (adalimumab) 40 mg solution for injection in pre-filled pen or pre-filled syringe or padlock: Humira (adalimumab) 40 mg solution for injection in pre-filled pen or pre-filled syringe or padlock is indicated for the treatment of active and severe hidradenitis suppurativa (HS) in adults and adolescents from 12 years of age with an inadequate response to conventional systemic HS therapy. Humira (adalimumab) 40 mg solution for injection in pre-filled pen or pre-filled syringe or padlock is not suitable for HUMIRA. You are strongly advised to read the prescribing information (PI) below.

Humira (adalimumab) 40 mg solution for injection in pre-filled pen or pre-filled syringe or padlock: Humira (adalimumab) 40 mg solution for injection in pre-filled pen or pre-filled syringe or padlock is indicated for the treatment of active and severe hidradenitis suppurativa (HS) in adults and adolescents from 12 years of age with an inadequate response to conventional systemic HS therapy. Humira (adalimumab) 40 mg solution for injection in pre-filled pen or pre-filled syringe or padlock is not suitable for HUMIRA. You are strongly advised to read the prescribing information (PI) below.

Humira (adalimumab) 40 mg solution for injection in pre-filled pen or pre-filled syringe or padlock: Humira (adalimumab) 40 mg solution for injection in pre-filled pen or pre-filled syringe or padlock is indicated for the treatment of active and severe hidradenitis suppurativa (HS) in adults and adolescents from 12 years of age with an inadequate response to conventional systemic HS therapy. Humira (adalimumab) 40 mg solution for injection in pre-filled pen or pre-filled syringe or padlock is not suitable for HUMIRA. You are strongly advised to read the prescribing information (PI) below.

IAD AUTUMN MEETING WINNERS



1st Poster Prize, Winner Dr Conor Broderick & IAD President Dr Kevin McKenna



1st Prize Case Presentation winner Dr Victoria Campbell & IAD President Dr Kevin McKenna



1st Rogers prize winner Dr Laoise Griffin & IAD President Dr Kevin McKenna



2nd Rogers prize winner Dr Veronika Dvorakova & IAD President Dr Kevin McKenna

The first approved treatment in adults and adolescents from 12 years for moderate to severe Hidradenitis Suppurativa^{1,2}

Feeling good about myself

There are no clinical trials with HUMIRA in adolescent patients with HS. The efficacy of adalimumab is predicted based on the demonstrated efficacy and exposure-response relationship in adult HS patients. Please see the Summary of Product Characteristics for more details.²

Fewer abscesses^{3,4}

Hidradenitis Suppurativa (HS): HUMIRA is indicated for the treatment of active moderate to severe hidradenitis suppurativa (HS) in adults and adolescents from 12 years of age with an inadequate response to conventional systemic HS therapy. HUMIRA is not suitable for HUMIRA. You are strongly advised to read the prescribing information (PI) below.

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

Humira (adalimumab) 40 mg solution for injection in pre-filled pen or pre-filled syringe or padlock: Humira (adalimumab) 40 mg solution for injection in pre-filled pen or pre-filled syringe or padlock is indicated for the treatment of active and severe hidradenitis suppurativa (HS) in adults and adolescents from 12 years of age with an inadequate response to conventional systemic HS therapy. Humira (adalimumab) 40 mg solution for injection in pre-filled pen or pre-filled syringe or padlock is not suitable for HUMIRA. You are strongly advised to read the prescribing information (PI) below.

Humira (adalimumab) 40 mg solution for injection in pre-filled pen or pre-filled syringe or padlock: Humira (adalimumab) 40 mg solution for injection in pre-filled pen or pre-filled syringe or padlock is indicated for the treatment of active and severe hidradenitis suppurativa (HS) in adults and adolescents from 12 years of age with an inadequate response to conventional systemic HS therapy. Humira (adalimumab) 40 mg solution for injection in pre-filled pen or pre-filled syringe or padlock is not suitable for HUMIRA. You are strongly advised to read the prescribing information (PI) below.

Humira (adalimumab) 40 mg solution for injection in pre-filled pen or pre-filled syringe or padlock: Humira (adalimumab) 40 mg solution for injection in pre-filled pen or pre-filled syringe or padlock is indicated for the treatment of active and severe hidradenitis suppurativa (HS) in adults and adolescents from 12 years of age with an inadequate response to conventional systemic HS therapy. Humira (adalimumab) 40 mg solution for injection in pre-filled pen or pre-filled syringe or padlock is not suitable for HUMIRA. You are strongly advised to read the prescribing information (PI) below.

THE SKIN ITSELF

INSPIRED BIODERMA
TO INCREASE
ITS NATURAL DEFENCES
FACING THE SUN.



Photoderm MAX Aquafuide SPF 50+

THE VERY HIGH SUN PROTECTION AS LIGHT AS WATER,
WITH A DRY TOUCH FINISH

The Cellular Bioprotection® patent preserves and stimulates the ability of the skin cells to develop their own natural defences against the sun. Anti-UVA/UVB action provides protection against the immediate dangers of solar radiation. Skin is protected from the inside and out. It is preserved, respected and more resistant to the sun. In a lasting way.