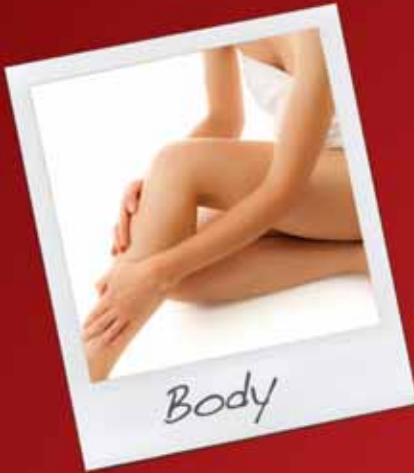




**Irish Association of Dermatologists  
&  
Australasian College of Dermatologists**

# **Autumn Meeting**

**4 - 5 October 2012  
Malahide Grand Hotel, Dublin**



Body



Scalp



# Dovobet® Gel



**For the treatment of scalp  
and/or  
mild to moderate body psoriasis**



**Dermatology**  
IN FOCUS  
dermatologyinfocus.ie



**MyPsoriasis.ie**



**LEO Pharma**  
Cashel Road, Dublin 12

www.leo.ie

**Name and address of P.A. holder:** LEO Pharmaceutical Products Ltd. A/S (LEO Pharma A/S), Industriparken 55, DK-2750 Ballerup, Denmark.  
**P.A. Number:** PA 1025/1/2. Available only on prescription. Full prescribing information is available from LEO Pharma, Cashel Rd., Dublin 12.  
**Telephone:** 01 4908924 or email: [medicalinfo.ie@leo-pharma.com](mailto:medicalinfo.ie@leo-pharma.com). **Date of preparation:** February 2012. Further information is available on request or within the relevant SmPC.

**LEO®** © LEO Pharma February 2012. IE/Derm/2012/09. ALL TRADEMARKS MENTIONED BELONG TO THE LEO GROUP.

## Irish Association of Dermatologists Autumn Meeting 2012

### Welcome Message from the President Dr Pat Podmore



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

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

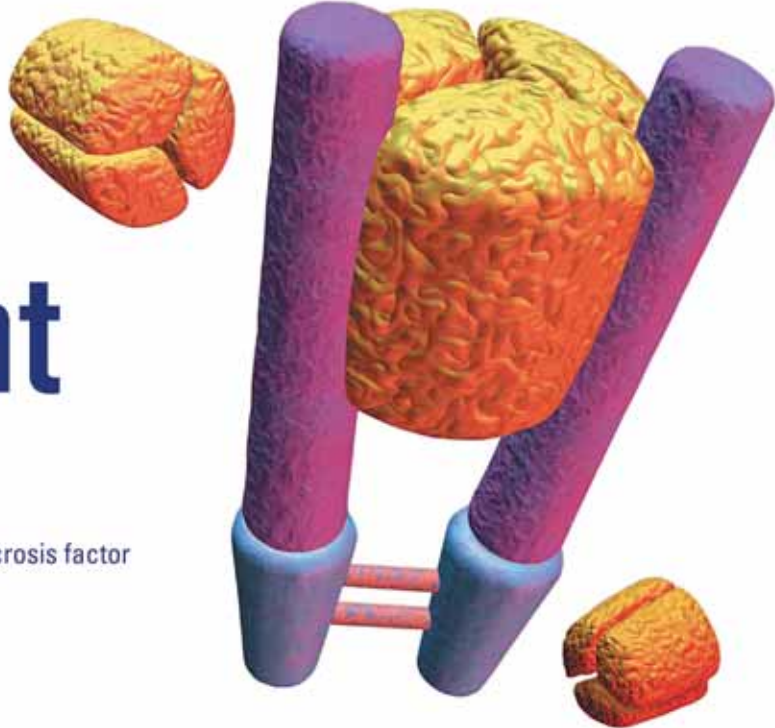
Of further historical significance this meeting will be the inaugural clinical registrars' symposium at which we will award the Rogers Prize for the first time. I know we all agree that this has been a tremendous idea of Sarah's and will ensure over future years our meetings cover all aspects of our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

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

Yours sincerely

**Pat Podmore**  
President IAD

# ENBREL is Different



## A unique mechanism of action

- Enbrel is the only fully human soluble tumour necrosis factor (TNF) receptor <sup>1,2,3,4,5,6</sup>
- It works differently than MAB's <sup>1</sup>

## No neutralising antibodies<sup>7</sup>

- Enbrel is not associated with the production of neutralising antibodies in humans

## Enbrel has a short half life (<3 days)<sup>8</sup>

- The half-life of anti-TNF agents should be taken into account if a treatment break is required

## Efficacy

- Registry data and Cochrane Review data support efficacy & safety of Enbrel <sup>7,8</sup>



**ABBREVIATED PRESCRIBING INFORMATION** Before prescribing Enbrel® please refer to full Summary of Product Characteristics (SmPC).  
**Presentation:** Enbrel Pre-filled Syringe: Enbrel 25 mg and 50 mg solution for injection in pre-filled syringe. Each pre-filled syringe contains either 25 mg or 50 mg etanercept. Enbrel Pre-filled Pen (MYCLIC®): Enbrel 50 mg solution for injection in pre-filled pen. Each pre-filled pen contains 50 mg etanercept. Enbrel Powder: Enbrel 25 mg powder and solvent for solution for injection. Each vial contains 25 mg etanercept and each pre-filled syringe contains 1 ml water for injections. Enbrel Paediatric: Enbrel 10 mg powder and solvent for solution for paediatric use. Each vial contains 10 mg etanercept and each pre-filled syringe contains 1 ml water for injections. Enbrel 25 mg/ml powder and solvent for solution for injection for paediatric use. Each vial contains 25 mg etanercept and each pre-filled syringe contains 1 ml bacteriostatic water for injections. **Uses:** Adults: Moderate to severe active rheumatoid arthritis (RA), in combination with methotrexate, when response to DMARDs, including methotrexate (unless contraindicated), has been inadequate. Enbrel can be given as monotherapy in the case of intolerance to methotrexate or when continued treatment with methotrexate is inappropriate. Severe, active and progressive RA without prior methotrexate treatment. Enbrel alone or with methotrexate has been shown to reduce the rate of progression of joint damage measured by X-ray and to improve physical function. Patients with moderate to severe plaque psoriasis (PP) who failed to respond to, or who have a contraindication to, or are intolerant to other systemic therapy including cyclosporine, methotrexate or PUVA. Active and progressive psoriatic arthritis (PsA) when response to DMARDs has been inadequate. Enbrel has been shown to improve physical function in PsA patients, and to reduce the progression rate of peripheral joint damage as measured by X-ray in patients with polyarticular symmetrical subtypes of PsA. Severe active ankylosing spondylitis (AS) when response to conventional therapy has been inadequate. Children aged 2-17 years (25 mg only): Active polyarticular juvenile idiopathic arthritis (JIA) when inadequate response to, or intolerant of methotrexate. Children aged 6-17 years: Chronic severe psoriasis when inadequately controlled by, or intolerant to, other systemic therapies or phototherapies. **Dosage:** By subcutaneous injection. Adults: RA – 25 mg twice weekly or 50 mg once weekly PP - 25 mg twice weekly or 50 mg once weekly for up to 24 weeks, or 50 mg twice weekly for up to 12 weeks followed by 25 mg twice weekly or 50 mg once weekly for a further 12 weeks if needed. Continuous therapy may be appropriate for some adult patients. Discontinue if no response after 12 weeks. For re-treatment: 25 mg twice weekly or 50 mg once weekly for up to 24 weeks. AS and PsA – 25 mg twice weekly or 50 mg once weekly. Children aged 2-17 years: JIA in children aged 2-17 years – 0.4 mg/kg (maximum per dose 25 mg) twice weekly with an interval of 3 – 4 days. Discontinuation of treatment should be considered in patients who show no response after 4 months. Children aged 6-17 years: Plaque psoriasis in children aged 6-17 years – 0.8 mg/kg (maximum per dose 50 mg) once weekly for up to 24 weeks. Discontinue if no response after 12 weeks. For re-treatment: 0.8 mg/kg (maximum per dose 50 mg) once weekly for up to 24 weeks. **Contra-indications:** Hypersensitivity to any of the ingredients, sepsis or risk of sepsis, active infections. Enbrel Paediatric (25 mg): Must not be given to premature babies or neonates as the bacteriostatic water for injections contains benzyl alcohol. **Warnings and Precautions:** Enbrel should be initiated and supervised by specialist physicians experienced in the diagnosis and treatment of RA, JIA, PsA, AS, PP or Paediatric PP. Patients treated with Enbrel should be given the Patient Alert Card. Use carefully in patients predisposed to, or with history of, infection due to

underlying diseases other than RA (e.g. advanced or poorly controlled diabetes) or with history of blood dyscrasias, pre-existing or predisposition to demyelinating disease or congestive heart failure. Cases of active tuberculosis have been reported, therefore all patients should be evaluated for both active and inactive TB prior to being treated with Enbrel. If active TB is diagnosed, Enbrel should not be initiated. Caution should be used when administering Enbrel to patients identified as carriers of hepatitis B virus and there have been reports of worsening hepatitis C in patients receiving Enbrel. Use with caution in patients with a history of hepatitis C. Whether treatment with Enbrel might influence the development and course of active and/or chronic infections is unknown. Concurrent administration of Enbrel and anakinra has been associated with increased risk of serious infections and neutropenia, and is therefore not recommended. In clinical studies, concurrent administration of abatacept and Enbrel resulted in increased incidences of serious adverse events, and is therefore not recommended. Use caution when considering combination therapy with sulfasalazine. Reports of various malignancies have been received in the post-marketing period, therefore with current knowledge, a possible risk for the development of lymphomas, leukaemia or other haematopoietic or solid malignancies in patients treated with a TNF-antagonist cannot be excluded. Malignancies, some fatal, have been reported among children, adolescents and young adults (up to 22 years of age) treated with TNF-antagonists (initiation of therapy < 18 years of age) in the postmarketing setting. Melanoma and non-melanoma skin cancer (NMSC) have been reported in patients treated with TNF-antagonists, including Enbrel. Post-marketing cases of Merkel cell carcinoma have been reported very infrequently in patients treated with Enbrel. Periodic skin examination is recommended for all patients, particularly those with risk factors for skin cancer. Enbrel has not been studied in combination with other systemic therapies or phototherapy for the treatment of psoriasis. Monitor closely if patient develops new infection during treatment. Discontinue treatment if serious infection or allergic reaction develops or if blood dyscrasias are confirmed. Caution should be used in patients who have moderate to severe alcoholic hepatitis and Enbrel should not be used in patients for the treatment of alcoholic hepatitis. Discontinue temporarily if significantly exposed to varicella virus. Live vaccines should not be given concurrently with Enbrel. Paediatric patients should have received all vaccines recommended in current immunization guidelines prior to starting Enbrel. Treatment with Enbrel may result in the formation of autoantibodies. Enbrel is not recommended for the treatment of Wegener's granulomatosis. There have been reports of hypoglycaemia in Enbrel patients receiving medication for diabetes, necessitating a reduction in anti-diabetic medication in some of these patients. There have been reports of Inflammatory Bowel Disease (IBD) in JIA patients being treated with Enbrel. Caution should be exercised when treating the elderly and with particular attention to occurrence of infections. Enbrel Paediatric (25 mg): Contains benzyl alcohol as an excipient, which may cause toxic and/or anaphylactic reactions in infants and children up to 3 years old. **Pregnancy & Lactation:** Enbrel is not recommended in pregnant or breast-feeding women. **Undesirable Effects:** Adults: The most commonly reported adverse reactions are injection site reactions, infections, allergic reactions, development of autoantibodies, itching, and fever. See SmPC for less commonly reported side effects. TNF-antagonists, such as Enbrel, affect the immune system and their use may affect the body's defenses against infection and cancer. Serious infections affect fewer than 1 in 100 patients treated with Enbrel. Reports have included fatal and life threatening infections and sepsis. Various

malignancies have also been reported with use of Enbrel, including cancers of the breast, lung, skin and lymph glands (lymphoma). Serious haematological, neurological and autoimmune reactions have also been reported. These include rare reports of pancytopenia and very rare reports of aplastic anaemia. Central and peripheral demyelinating events have been seen rarely and very rarely, respectively, with Enbrel use. There have been rare reports of lupus, lupus-related conditions, and vasculitis. Rate of new malignancies was similar to that expected for the population studied. Fatalities associated with serious infections, pancytopenia, aplastic anaemia and interstitial lung disease have also been reported. **Paediatrics:** Generally as for adults, except the following were more common: headaches, nausea, vomiting and abdominal pain. In addition the following were reported as severe events: varicella, appendicitis, gastroenteritis, depression/personality disorder, cutaneous ulcer, oesophagitis/gastritis, group A streptococcal septic shock, type I diabetes mellitus and soft tissue and post operative wound infection. There have been post-marketing reports of IBD in JIA patients, including cases indicating a positive re-challenge. **Legal Category:** POM. **Package Quantities:** Enbrel Pre-filled Syringe: Each carton contains 4 pre-filled syringes containing either 25 mg or 50 mg of Enbrel and 4 alcohol swabs. Enbrel Pre-filled Pen (MYCLIC): Each carton contains 4 pre-filled pens containing 50 mg of Enbrel and 4 alcohol swabs. Enbrel Powder: Each carton contains 4 vials of Enbrel 25 mg powder, 4 pre-filled syringes of water for injections, 4 needles, 4 vial adaptors and 8 alcohol swabs. Enbrel Paediatric (10 mg): Each carton contains 4 vials of Enbrel 10 mg powder, 4 pre-filled syringes of water for injections, 4 needles, 4 vial adaptors and 8 alcohol swabs. Enbrel Paediatric (25 mg): Each carton contains 4 vials of Enbrel 25 mg powder, 4 pre-filled syringes of bacteriostatic water for injections, 8 empty plastic syringes, 20 needles and 24 alcohol swabs. **European Marketing Authorisation Numbers:** Enbrel Pre-filled Syringe 25 mg: EU/1/99/126/013 Enbrel Pre-filled Syringe 50 mg: EU/1/99/126/017 Enbrel Pre-filled Pen (MYCLIC) 50 mg: EU/1/99/126/020 Enbrel Powder 25 mg: EU/1/99/126/003 Enbrel Paediatric 10 mg: EU/1/99/126/022 Enbrel Paediatric 25 mg: EU/1/99/126/012. **European Marketing Authorisation Holder:** Pfizer Limited, Ramsgate Road, Sandwich, Kent, CT13 9NJ, UK. For full prescribing information see the Summary of Product Characteristics. **Further information is available on request from:** Pfizer Healthcare Ireland, 9 Riverwalk, National Digital Park, Citywest Business Campus, Dublin 24, telephone: +353 1 467 6500. **Medical Information:** 1 800 633 363. **API Reference Number:** EN\_3\_0. **Date of Prescribing Information:** January 2012.

**References:** 1. Enbrel SPC July 2010 2. Remicade SPC 3. Humira SPC 4. Orelvea SPC 5. Mabthera SPC 6. Simponi SPC 7. Singh J et al. CMAJ: 2009;DOI:10.1503 8. Herland ML et al. Arthritis & Rheumatism: Vol 62, no 1, January 2010.

**Date of preparation:** February 2012  
**ENB/2012/015**

**Pfizer Specialty Care**

# Irish Association of Dermatologists Autumn Meeting 2012



THE AUSTRALASIAN COLLEGE  
OF DERMATOLOGISTS

## Irish Association of Dermatologists & Australasian College of Dermatologists

### Autumn Meeting

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

#### Thursday 4th October 2012

9.30am **Registration**

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

12.30pm **LUNCH/EXHIBITION**

#### Programme

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

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

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

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

3.30pm **COFFEE/EXHIBITION**

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

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

5.00pm **IAD Business Meeting**

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

#### Friday 5th October 2012

#### Programme

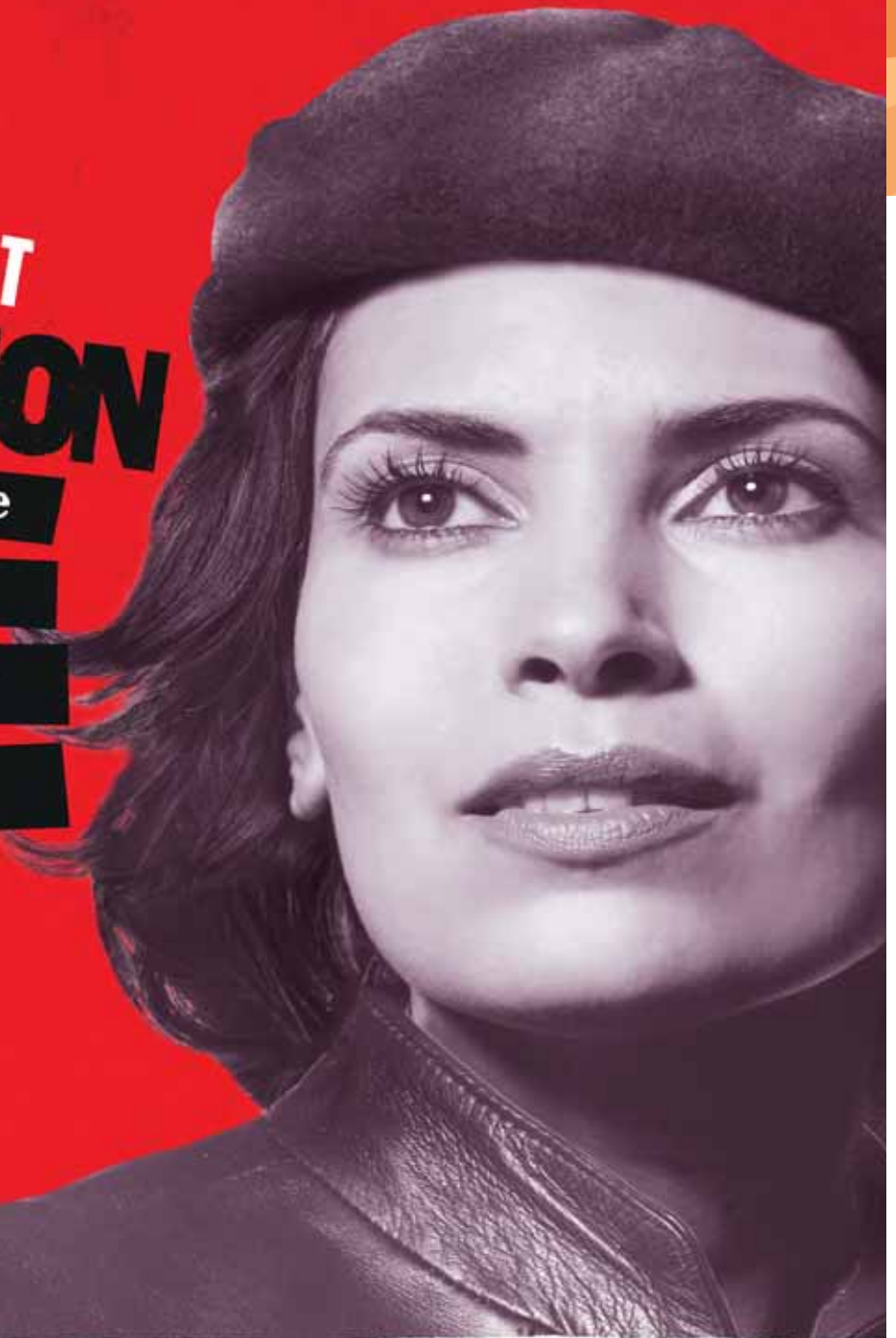
9.30am **Registrars' Symposium Rogers Prize**

11.00am **COFFEE**

11.30 **Case presentations**

1.00pm **LUNCH**

There's a **QUIET**  
**REVOLUTION**  
 going on in the  
 treatment of  
 papulopustular  
 rosacea.



**Efracea is different to other rosacea treatments.**

Working only at **anti-inflammatory levels**, Efracea has no antimicrobial action<sup>1</sup> but is still highly effective in the treatment of inflammatory lesions.<sup>2</sup> Efracea has been reviewed by the Cochrane Collaboration to be an effective treatment for papulopustular rosacea.<sup>3</sup>

The revolution has begun.

ONCE-DAILY  
**EFRacea**<sup>®</sup>  
 (doxycycline) 40mg modified-release,  
 hard capsule

**References:** 1. Fowler JF Jr. *Expert Rev Dermatol* 2007;2(5):523-531. 2. Del Rosso JQ, Webster GF, Jackson M et al. *J Am Acad Dermatol* 2007;56(5):791-802. 3. Van Zuuren EJ, Kramer S, Carter B et al. *The Cochrane Collaboration – Interventions for rosacea (review)* 2011.

**Efracea Abbreviated Prescribing Information (UK & Ireland). Presentation:** Modified-Release hard capsule containing 40mg Doxycycline (as monohydrate) **Indications:** Reduction of papulopustular lesions in adults with facial rosacea. **Dosage and Administration:** Adults – 40mg (1 capsule) in the morning with adequate amounts of water. Evaluate after 6 weeks, if no effect seen, consider stopping treatment. In clinical trials, patients treated for 16 weeks. **Contraindications:** Hypersensitivity to the active substance any of the excipients or other tetracyclines. Children up to 12 years. Patients suspected to have achlorhydria or who have had surgery that bypasses/excludes the duodenum. Second and third trimesters of pregnancy. **Precautions and Warnings:** Efracea must not be used to treat infections caused by doxycycline sensitive organisms. To avoid Oesophageal irritation/ulceration take with adequate fluids & swallow whilst sitting/standing in an upright posture. Higher doses may increase incidence of vaginal candidiasis and emergence of resistant intestinal bacteria. Caution in patients with hepatic impairment, receiving potentially hepatotoxic medicinal products or suffering from Myasthenia Gravis. Avoid excessive sunlight/UV light. Risk of developing Pseudomembranous colitis. Not to be used in ocular rosacea. May cause permanent tooth discolouration, enamel hypoplasia and in premature infants, decreased fibula growth. Not to be used by Patients with fructose intolerance, glucose-galactose malabsorption or sucrase-isomaltase insufficiency. **Interactions:** Absorption may be affected by simultaneous administration of aluminium, zinc, calcium, magnesium, iron preparations, activated charcoal, cholestyramine, bismuth chelates & succralfate, & products which increase gastric pH. Such products or foodstuffs should be taken 2 to 3 hours after Efracea. Rifampicin, barbiturates, carbamazepine, diphenylhydantoin, primidone, phenytoin and chronic alcohol abuse & cyclosporin

may decrease the half life of doxycycline. Avoid concomitant use with isotretinoin, penicillin, beta-lactam antibiotics, methoxyflurane, sulphonylurea oral antidiabetic agents and anticoagulants of the dicoumarol type. Concurrent use with oral contraceptives has resulted in a few cases of breakthrough bleeding/pregnancy. **Undesirable Effects:** Common adverse reactions reported during Efracea clinical trials: Nasopharyngitis, Sinusitis, Fungal infection, Anxiety, Sinus headache, Hypertension, Diarrhoea, Upper abdominal pain, Dry mouth, Back pain, increases in ASAT, Blood pressure, blood LDH, & blood glucose. Other adverse reactions reported for tetracyclines: Very rare: Anogenital candidiasis, Haemolytic anaemia, Brown-black microscopic discolouration of thyroid tissue, Bulging fontanelle in infants, Exacerbation of systemic lupus erythematosus, Exfoliative dermatitis, angioneurotic oedema, glossitis, dysphagia, enterocolitis, oesophagitis and oesophageal ulceration. Rare: Thrombocytopenia, neutropenia, eosinophilia, Hypersensitivity reactions including anaphylaxis, Benign intracranial hypertension, Pericarditis, Nausea, vomiting, diarrhoea, anorexia, Hepatotoxicity, Maculopapular and erythematous rashes, skin photosensitivity, urticaria, increased blood urea. **Packaging Quantities and Cost:** 56 capsules, UK – £29.78 (NHS), Ireland – €33.39 **MA Number:** PL 10590/0056, PA 590/25/1 **Legal Category:** POM **Full Prescribing Information is Available From:** Galderma (UK) Limited, Meridian House, 69-71 Clarendon Road, Watford, Herts, WD17 1DS, UK. Tel: +44 (0)1923 208950 Fax: +44 (0)1923 208998. **Date of Revision:** September 2011. Copyright © 2012 Galderma (UK) Ltd.

Adverse events should be reported. Reporting forms and information can be found at [www.mhra.gov.uk/yellowcard](http://www.mhra.gov.uk/yellowcard). Adverse events should also be reported to Galderma (UK) Ltd

Date of Preparation: January 2012

DOX001/0112

**GALDERMA**  
 Committed to the future  
 of dermatology

# Irish Association of Dermatologists Autumn Meeting 2012



THE AUSTRALASIAN COLLEGE  
OF DERMATOLOGISTS



## LEO Pharma Satellite Symposium “Actinic Keratosis and Non-Melanoma Skin Cancer”

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

October 4th 2012  
The Grand Hotel, Malahide

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





# Irish Association of Dermatologists Autumn Meeting 2012

## Biographical Sketches

### Dr Pippa Corrie

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



### Dr Karyn Lun

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



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

### Prof Julia Newton-Bishop

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



### Finding skin cancer genes

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

### Nature or nurture?

Professor Newton-Bishop's team is also looking at how our lifestyle choices interact with our genes to affect our risk of cancer. The team is studying how sun exposure and melanoma genes jointly affect a person's chances of getting skin cancer.

The researchers are also running a large study to look for more melanoma genes that specifically affect a patient's chances of survival. Another aim of this project is to find out if there are crucial differences between melanomas that start in different areas of the body.

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



# Irish Association of Dermatologists Spring Meeting 2012



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



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



Annamma Raju IDNA & MSD



Christine McMillan & Pamela Todd



Dr Aneta Kecler-Pietrzyk & Szymon Pietrzyk



Dr Charles Shepherd Guest Speaker & Dr Pat Podmore



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



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



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



## Irish Association of Dermatologists Autumn Meeting 2012

### Irish Skin Foundation, Geraldine Clare, Biography

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



A management accountant by profession, Geraldine worked at senior management level in the corporate sector for a number of years before moving to the voluntary sector in 2000.

Much of her leadership experience was gained in Aware, where she worked to deliver and develop support services including a telephone helpline, peer support group meetings, and an educational programme in secondary schools.

The challenge of stigma and being an advocacy for services has been a constant feature of her work, not only in the area of mental health, but extending to the broader disability arena through her involvement with the Disability Federation of Ireland.

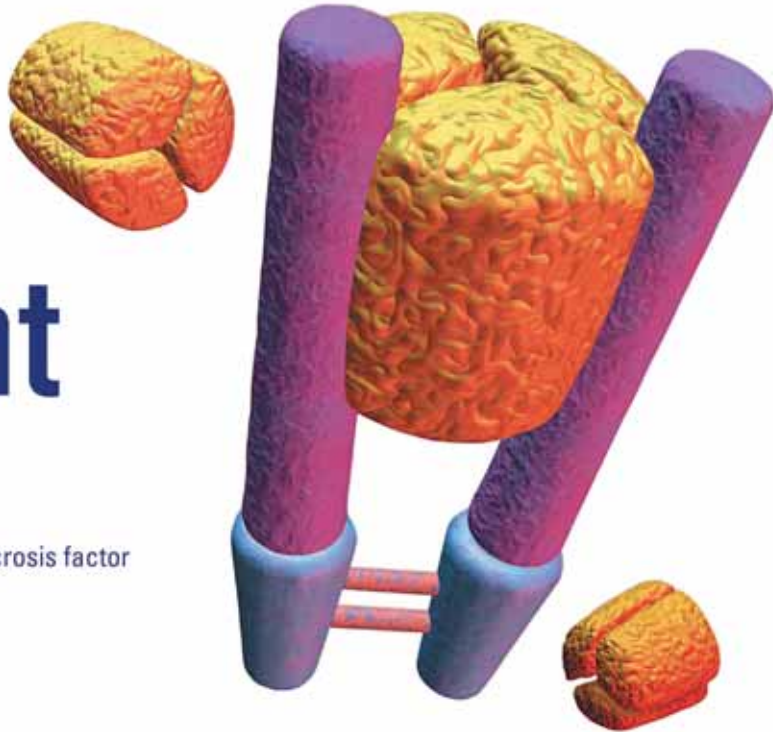
More recently Geraldine has worked with ARC Cancer Support, which offers support services and programmes for those with a cancer diagnosis and their families.

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



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

# ENBREL is Different



## A unique mechanism of action

- Enbrel is the only fully human soluble tumour necrosis factor (TNF) receptor <sup>1,2,3,4,5,6</sup>
- It works differently than MAB's <sup>1</sup>

## No neutralising antibodies<sup>1</sup>

- Enbrel is not associated with the production of neutralising antibodies in humans

## Enbrel has a short half life (<3 days)<sup>1</sup>

- The half-life of anti-TNF agents should be taken into account if a treatment break is required

## Efficacy

- Registry data and Cochrane Review data support efficacy & safety of Enbrel <sup>7,8</sup>



**ABBREVIATED PRESCRIBING INFORMATION** Before prescribing Enbrel® please refer to full Summary of Product Characteristics (SmPC).  
**Presentation:** Enbrel Pre-filled Syringe: Enbrel 25 mg and 50 mg solution for injection in pre-filled syringe. Each pre-filled syringe contains either 25 mg or 50 mg etanercept. Enbrel Pre-filled Pen (MYCLIC®): Enbrel 50 mg solution for injection in pre-filled pen. Each pre-filled pen contains 50 mg etanercept. Enbrel Powder: Enbrel 25 mg powder and solvent for solution for injection. Each vial contains 25 mg etanercept and each pre-filled syringe contains 1 ml water for injections. Enbrel Paediatric: Enbrel 10 mg powder and solvent for solution for injection for paediatric use. Each vial contains 10 mg etanercept and each pre-filled syringe contains 1 ml water for injections. Enbrel 25 mg/ml powder and solvent for solution for injection for paediatric use. Each vial contains 25 mg etanercept and each pre-filled syringe contains 1 ml bacteriostatic water for injections. **Uses:** Adults: Moderate to severe active rheumatoid arthritis (RA), in combination with methotrexate, when response to DMARDs, including methotrexate (unless contraindicated), has been inadequate. Enbrel can be given as monotherapy in the case of intolerance to methotrexate or when continued treatment with methotrexate is inappropriate. Severe, active and progressive RA without prior methotrexate treatment. Enbrel alone or with methotrexate has been shown to reduce the rate of progression of joint damage measured by X-ray and to improve physical function. Patients with moderate to severe plaque psoriasis (PP) who failed to respond to, or who have a contraindication to, or are intolerant to other systemic therapy including ciclosporin, methotrexate or PUVA. Active and progressive psoriatic arthritis (PsA) when response to DMARDs has been inadequate. Enbrel has been shown to improve physical function in PsA patients, and to reduce the progression rate of peripheral joint damage as measured by X-ray in patients with polyarticular symmetrical subtypes of PsA. Severe active ankylosing spondylitis (AS) when response to conventional therapy has been inadequate. Children aged 2-17 years (25 mg only). Active polyarticular juvenile idiopathic arthritis (JIA) when inadequate response to, or intolerant of methotrexate. Children aged 6-17 years: Chronic severe psoriasis when inadequately controlled by, or intolerant to, other systemic therapies or phototherapies. **Dosage:** By subcutaneous injection. Adults: RA – 25 mg twice weekly or 50 mg once weekly PP - 25 mg twice weekly or 50 mg once weekly for up to 24 weeks, or 50 mg twice weekly for up to 12 weeks followed by 25 mg twice weekly or 50 mg once weekly for a further 12 weeks if needed. Continuous therapy may be appropriate for some adult patients. Discontinue if no response after 12 weeks. For re-treatment: 25 mg twice weekly or 50 mg once weekly for up to 24 weeks. AS and PsA – 25 mg twice weekly or 50 mg once weekly. Children aged 2-17 years: JIA in children aged 2-17 years – 0.4 mg/kg (maximum per dose 25 mg) twice weekly with an interval of 3 – 4 days. Discontinuation of treatment should be considered in patients who show no response after 4 months. Children aged 6-17 years: Plaque psoriasis in children aged 6-17 years – 0.8 mg/kg (maximum per dose 50 mg) once weekly for up to 24 weeks. Discontinue if no response after 12 weeks. For re-treatment: 0.8 mg/kg (maximum per dose 50 mg) once weekly for up to 24 weeks. **Contra-indications:** Hypersensitivity to any of the ingredients, sepsis or risk of sepsis, active infections. Enbrel Paediatric (25 mg): Must not be given to premature babies or neonates as the bacteriostatic water for injections contains benzyl alcohol. **Warnings and Precautions:** Enbrel should be initiated and supervised by specialist physicians experienced in the diagnosis and treatment of RA, JIA, PsA, AS, PP or Paediatric PP. Patients treated with Enbrel should be given the Patient Alert Card. Use carefully in patients predisposed to, or with history of, infection due to

underlying diseases other than RA (e.g. advanced or poorly controlled diabetes) or with history of blood dyscrasias, pre-existing or predisposition to demyelinating disease or congestive heart failure. Cases of active tuberculosis have been reported, therefore all patients should be evaluated for both active and inactive TB prior to being treated with Enbrel. If active TB is diagnosed, Enbrel should not be initiated. Caution should be used when administering Enbrel to patients identified as carriers of hepatitis B virus and there have been reports of worsening hepatitis C in patients receiving Enbrel. Use with caution in patients with a history of hepatitis C. Whether treatment with Enbrel might influence the development and course of active and/or chronic infections is unknown. Concurrent administration of Enbrel and anakinra has been associated with increased risk of serious infections and neutropenia, and is therefore not recommended. In clinical studies, concurrent administration of abatacept and Enbrel resulted in increased incidences of serious adverse events, and is therefore not recommended. Use caution when considering combination therapy with sulfasalazine. Reports of various malignancies have been received in the post-marketing period, therefore with current knowledge, a possible risk for the development of lymphomas, leukaemia or other haematopoietic or solid malignancies in patients treated with a TNF-antagonist cannot be excluded. Malignancies, some fatal, have been reported among children, adolescents and young adults (up to 22 years of age) treated with TNF-antagonists (initiation of therapy < 18 years of age) in the postmarketing setting. Melanoma and non-melanoma skin cancer (NMSC) have been reported in patients treated with TNF-antagonists, including Enbrel. Post-marketing cases of Merkel cell carcinoma have been reported very infrequently in patients treated with Enbrel. Periodic skin examination is recommended for all patients, particularly those with risk factors for skin cancer. Enbrel has not been studied in combination with other systemic therapies or phototherapy for the treatment of psoriasis. Monitor closely if patient develops new infection during treatment. Discontinue treatment if serious infection or allergic reaction develops or if blood dyscrasias are confirmed. Caution should be used in patients who have moderate to severe alcoholic hepatitis and Enbrel should not be used in patients for the treatment of alcoholic hepatitis. Discontinue temporarily if significantly exposed to varicella virus. Live vaccines should not be given concurrently with Enbrel. Paediatric patients should have received all vaccines recommended in current immunization guidelines prior to starting Enbrel. Treatment with Enbrel may result in the formation of autoantibodies. Enbrel is not recommended for the treatment of Wegener's granulomatosis. There have been reports of hypoglycaemia in Enbrel patients receiving medication for diabetes, necessitating a reduction in anti-diabetic medication in some of these patients. There have been reports of Inflammatory Bowel Disease (IBD) in JIA patients being treated with Enbrel. Caution should be exercised when treating the elderly and with particular attention to occurrence of infections. Enbrel Paediatric (25 mg): Contains benzyl alcohol as an excipient, which may cause toxic and/or anaphylactic reactions in infants and children up to 3 years old. **Pregnancy & Lactation:** Enbrel is not recommended in pregnant or breast-feeding women. **Undesirable Effects:** Adults: The most commonly reported adverse reactions are injection site reactions, infections, allergic reactions, development of autoantibodies, itching, and fever. See SmPC for less commonly reported side effects. TNF-antagonists, such as Enbrel, affect the immune system and their use may affect the body's defenses against infection and cancer. Serious infections affect fewer than 1 in 100 patients treated with Enbrel. Reports have included fatal and life threatening infections and sepsis. Various

malignancies have also been reported with use of Enbrel, including cancers of the breast, lung, skin and lymph glands (lymphoma). Serious haematological, neurological and autoimmune reactions have also been reported. These include rare reports of pancytopenia and very rare reports of aplastic anaemia. Central and peripheral demyelinating events have been seen rarely and very rarely, respectively, with Enbrel use. There have been rare reports of lupus, lupus-related conditions, and vasculitis. Rate of new malignancies was similar to that expected for the population studied. Fatalities associated with serious infections, pancytopenia, aplastic anaemia and interstitial lung disease have also been reported. Paediatrics: Generally as for adults, except the following were more common: headaches, nausea, vomiting and abdominal pain. In addition the following were reported as severe events: varicella, appendicitis, gastroenteritis, depression/personality disorder, cutaneous ulcer, oesophagitis/gastritis, group A streptococcal septic shock, type 1 diabetes mellitus and soft tissue and post operative wound infection. There have been post-marketing reports of IBD in JIA patients, including cases indicating a positive re-challenge. **Legal Category:** POM. **Package Quantities:** Enbrel Pre-filled Syringe: Each carton contains 4 pre-filled syringes containing either 25 mg or 50 mg of Enbrel and 4 alcohol swabs. Enbrel Pre-filled Pen (MYCLIC): Each carton contains 4 pre-filled pens containing 50 mg of Enbrel and 4 alcohol swabs. Enbrel Powder: Each carton contains 4 vials of Enbrel 25 mg powder, 4 pre-filled syringes of water for injections, 4 needles, 4 vial adaptors and 8 alcohol swabs. Enbrel Paediatric (10 mg): Each carton contains 4 vials of Enbrel 10 mg powder, 4 pre-filled syringes of water for injections, 4 needles, 4 vial adaptors and 8 alcohol swabs. Enbrel Paediatric (25 mg): Each carton contains 4 vials of Enbrel 25 mg powder, 4 pre-filled syringes of bacteriostatic water for injections, 8 empty plastic syringes, 20 needles and 24 alcohol swabs. **European Marketing Authorisation Numbers:** Enbrel Pre-filled Syringe 25 mg: EU/1/99/126/013. Enbrel Pre-filled Syringe 50 mg: EU/1/99/126/017. Enbrel Pre-filled Pen (MYCLIC) 50 mg: EU/1/99/126/020. Enbrel Powder 25 mg: EU/1/99/126/003. Enbrel Paediatric 10 mg: EU/1/99/126/022. Enbrel Paediatric 25 mg: EU/1/99/126/012. **European Marketing Authorisation Holder:** Pfizer Limited, Ramsgate Road, Sandwich, Kent, CT13 9NJ, UK. For full prescribing information see the Summary of Product Characteristics. **Further information is available on request from:** Pfizer Healthcare Ireland, 9 Ryerwalk, National Digital Park, Citywest Business Campus, Dublin 24, telephone: +353 1 467 6500. **Medical Information:** 1 800 633 363. **API Reference Number:** EN\_3\_0. **Date of Prescribing Information:** January 2012.

**References:** 1. Enbrel SPC July 2010 2. Remicade SPC 3. Humira SPC 4. Orencia SPC 5. Mabthera SPC 6. Simponi SPC 7. Singh J et al CMAJ: 2009;DOI:10.1503 8. Herland M, et al Arthritis & Rheumatism: Vol 62, no 1, January 2010.

**Date of preparation:** February 2012  
**ENB/2012/015**

**Pfizer Specialty Care**

# Irish Association of Dermatologists Autumn Meeting 2012

## Registrar's Symposium Rogers Prize

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



# Irish Association of Dermatologists Spring Meeting 2012



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



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



Dr Dermot McKenna, Dr Pauline Marren & Dr Kashif Ahmad



Dr Cal Condon & Dr Nick Walsh



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



Dr Emma Shudell & Colm Murphy Galderma



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



Dr Kara Healon, Dr Claire Reid & Dr Eleanor Higgins



Dr Kara Healan & Dr Catherine Foley



# Irish Association of Dermatologists Autumn Meeting 2012

## IAD Executive

**Dr Pat Podmore,**  
President,  
Consultant Dermatologist  
Altnagelvin Hospital  
Derry

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

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

## Members of Executive

Dr Gillian Murphy  
Consultant Dermatologist  
Beaumont Hospital  
Dublin

Dr Trevor Markham  
Consultant Dermatologist  
University College Hospital  
Galway

Dr Rosemarie Watson  
Consultant Dermatologist  
St James Hosp & OLHSC Crumlin  
Dublin

## Scientific Committee

Dr Johnny Bourke,  
Consultant Dermatologist South Infirmery Victoria  
University Hospital, Cork

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

Dr Olivia Dolan  
Consultant Dermatologist,  
Royal Victoria Hospital, Belfast

## IAD Past Presidents

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

**1967/9** Dr D.O'C Donelan

**1969/71** Dr J.M. Beare

**1971/3** Dr D.M. Mitchell

**1973/5** Dr D.B. Buckley

**1975/7** Prof D. Burrows

**1977/9** Dr F.O.C. Meenam

**1979/81** Dr Agnese M.T. Kelly

**1981/3** Dr Count H. Viani

**1983/5** Dr Grace Allen

**1985/7** Dr Marjory Young

**1987/9** Dr Roddy Matthews

**1989/91** Dr David O'Gorman

**1991/3** Dr Rory Corbett

**1993/5** Prof Sarah Rogers

**1995/7** Dr E.A. Bingham

**1997-9** Dr. Fergus Lyons

**1999-01** Dr Clifford McMillan

**2001-3** Prof Frank Powell

**2003-5** Dr Raymond Fulton

**2005-8** Prof Louise Barnes

**2008-9** Dr Hilary Jenkinson

**2009-11** Dr Gillian Murphy

**2012** Dr Pat Podmore

# Irish Association of Dermatologists Autumn Meeting 2012

## Registrars' Symposium (Rogers Prize) Oral presentations

### ORAL ABSTRACT 01

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

**Author(s):** Eustace K<sup>1</sup>, Gray C<sup>2</sup>, Clowry J<sup>1</sup>, Malone C<sup>3</sup>, Mc Donnell C<sup>2</sup>, Moloney F. J.<sup>1</sup>

**Institution(s):** <sup>1</sup> Department of Dermatology, Mater Misericordiae Hospital, Dublin 7

<sup>2</sup> Department of Vascular Surgery, Mater Misericordiae Hospital, Dublin 7

<sup>3</sup> Department of Ophthalmology, Royal College of Surgeons in Ireland, Dublin 2.

#### Abstract:

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

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

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

**Results:** 38 study participants in total were recruited, 19 keloid patients and 19 matched non-keloid controls. The mean +/- SEM age of the keloid group was 33.37 ± 3.097 years and for the control group was 34.26 ± 3.273 years, with a female preponderance of 63.16%. Three keloid patients were known hypertensives on treatment compared to none in the control participant group. There were no diabetic patients in either group. Hypercholesterolemia (>5mmol/L) and hypertriglyceridemia (>1.7mmol/L) was documented in four and two patients from the keloid group compared to eight and one patient in the control group. Six keloid patients had a reduced HDL level <1mmol/L for males and <1.2mmol/L for females, compared with only two in the control participant group. There was no overall statistical difference between the

mean systolic and diastolic BP's, lipid profile, CRP and glucose values of both groups. There was also no statistically significant difference in mean IMT measurements from the right CCA (p=0.2481) and left CCA (p=0.1677) between the keloid and control groups.

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

### ORAL ABSTRACT 02

#### Who dies from melanoma? A population-based study of Irish patients

**Author(s):** Mary Bennett<sup>1</sup>, Paul Walsh<sup>2</sup>, Harry Comber<sup>2</sup>, Sandra Deady<sup>2</sup>, Michelle Murphy<sup>1</sup>

**Institution(s):** Department of Dermatology, South Infirmarary-Victoria University Hospital, Cork, Ireland<sup>1</sup>, National Cancer Registry, Cork, Ireland<sup>2</sup>

#### Abstract:

##### Background

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

##### Methods

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

##### Results

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

A high proportion of deaths from melanoma occurred among farm owners, farm managers and horticulturists or their spouses.



# Irish Association of Dermatologists Autumn Meeting 2012

## Discussion

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

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

## ORAL ABSTRACT 03

### Diagnostic and Treatment Centres for Melanoma – Are they of benefit?

**Author(s):** Foley C<sup>1</sup>, Beausang E<sup>2</sup>, McMenamin M<sup>3</sup>, Leonard N<sup>3</sup>, Ormond P<sup>1</sup>, Wynne B<sup>1</sup>

**Institution(s):** Departments of Dermatology<sup>1</sup>, Plastic Surgery<sup>2</sup> and Histopathology<sup>3</sup>, St. James's Hospital, James's Street, Dublin 8

#### Abstract:

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

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

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

## ORAL ABSTRACT 04

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

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

#### Abstract:

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

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

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

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

Dry skin, very dry  
and atopic skin

# TriXéra<sup>+</sup> selectiose



*Finally my skin feels happy...*

TriXéra<sup>+</sup> Selectiose's special combination of lipids and Avène Thermal Spring water, helps to

- strengthen the skin barrier
- restore moisture
- reduce itching

Selectiose a unique active ingredient helps to calm and protect against skin reactions and irritations.

Skin feels soft, soothed and supple again.

FOR BABIES, CHILDREN  
AND ADULTS

Fragrance-free  
Paraben-free

\* PFDC Patented



# EAU THERMALE Avène

Available in selected pharmacies nationwide.

[www.eau-thermale-avene.com](http://www.eau-thermale-avene.com)

IE.AVE.12.03.15

Distributed by



Pierre Fabre

Avène, the Hydrotherapy Center for sensitive skin



[www.avenecenter.com](http://www.avenecenter.com)

# Irish Association of Dermatologists Autumn Meeting 2012

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

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

## ORAL ABSTRACT 05

### Immobilisation of full thickness skin grafts using a multi-layered polyurethane foam dressing

**Author(s):** Eustace K, Barry RBM

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

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

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

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

## ORAL ABSTRACT 06

### Overview of Dermatology Hospital Services in a Tertiary US Medical Centre.

#### Abstract:

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

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

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

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

**Results:** Adult Inpatients: 1,732 patients had 2,216 admissions over the 11 years study period. 38% of patients treated were from the local state of Minnesota. Length of stay decreased from 4 days to 3 days ( $P < 0.01$ ) across the 2 study periods. Admissions for psoriasis decreased from 20.7% to 13.0% ( $P < 0.01$ ) and admissions for for dermatitis increased from 41.6% to 47.6%; ( $P < 0.01$ ).

Paediatric inpatients: 97 patients had 108 admissions between 2009-2010. Indications for admission included atopic dermatitis (86.1%), psoriasis (3.7%), and eczema herpeticum (2.8%). The main treatment provided was wet dressings (97.2%).

Day Treatment Centre: 211 patients had 235 admissions in 2010. Indications for admission included dermatitis (139 admissions [59.2%]), psoriasis (58 admissions [24.7%]), and mycosis fungoides (8 admissions [3.4%]). The main treatment interventions were wet dressings (195 admissions [83.0%]) and traditional Goeckerman treatment (38 admissions [16.2%]).

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



# Target psoriasis on and below the surface

HUMIRA achieves rapid and sustained results in chronic plaque psoriasis and also goes deeper to



**Humira (adalimumab) 40mg solution for injection in pre-filled pen or pre-filled syringe and Humira 40mg/0.8ml solution for injection for paediatric use. Refer to Summary of Product Characteristics for full information.**

**Presentations:** Each 0.8ml single dose pre-filled pen, pre-filled syringe or vial contains 40mg of adalimumab. **Indications:** Rheumatoid arthritis (RA); Humira in combination with methotrexate is indicated for the treatment of moderate to severe, active RA in adult patients when the response to disease-modifying anti-rheumatic drugs (DMARDs) including methotrexate has been inadequate. Humira is also indicated for the treatment of severe, active and progressive RA in adults not previously treated with methotrexate. Humira can be given as monotherapy in case of intolerance to methotrexate or when continued treatment with methotrexate is inappropriate. Humira has been shown to reduce the rate of progression of joint damage as measured by X-ray and to improve physical function, when given in combination with methotrexate. Polyarticular juvenile idiopathic arthritis (JIA). Humira in combination with methotrexate is indicated for the treatment of active JIA, in children and adolescents aged 4 to 17 years who have had an inadequate response to one or more DMARDs. Humira can be given as monotherapy in case of intolerance to methotrexate or when continued treatment with methotrexate is inappropriate. Humira has not been studied in children less than 4 years. Psoriatic arthritis (PsA); Humira is indicated for the treatment of active and progressive PsA 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. Ankylosing spondylitis (AS); Humira is indicated for the treatment of adults with severe active AS who have had an inadequate response to conventional therapy. Crohn's disease (CD); Humira is indicated for treatment of severe, active CD, in patients who have not responded despite a full and adequate course of therapy with a corticosteroid and/or an immunosuppressant, or who are intolerant to or have medical contraindications for such therapies. Psoriasis (Ps); Humira is indicated for the treatment of moderate to severe chronic plaque psoriasis in adult patients who failed to respond to or who have a contraindication to, or are intolerant to other systemic therapy including cyclosporine, methotrexate or PUVA. **Dosage and administration:** Humira treatment should be initiated and supervised by specialist physicians experienced in the diagnosis and treatment of RA, RA, PsA, AS, CD, or Ps. Patients treated with Humira should be given the special alert card. After proper training in injection technique, patients may self-inject with Humira if their physician determines that it is appropriate and with medical follow-up as necessary. During treatment with Humira, other concomitant therapies (e.g., corticosteroids and/or immunosuppressive agents) should be optimised. RA, PsA or AS: 40mg administered every other week as a single dose via subcutaneous injection. RA: In monotherapy some patients who experience a decrease in their response to Humira may benefit from an increase in dose intensity to 40mg every week. There may be a need for dose interruption, for instance before surgery or if a serious infection occurs. Available data suggest that re-introduction of Humira after discontinuation for 70 days or longer resulted in the same magnitudes of clinical response and similar safety profile as before dose interruption. For RA, PsA and AS, available data suggest that the clinical response is usually achieved within 12 weeks of treatment. Continued therapy should be carefully reconsidered in a patient not responding within this time period. JIA: Age 4 to 12 years: 20mg/m<sup>2</sup> body surface area to a maximum single dose of 40mg administered every other week via subcutaneous injection. The volume for injection is based on the patients' height and weight (see SmPC for height and weight dosing chart). A 40mg paediatric vial is available for patients who need to administer less than the full 40mg dose. Age 13 to 17 years: 40mg administered every other week via subcutaneous injection regardless of body surface area. CD: The recommended Humira induction dose regimen for adult patients with severe CD is 80mg at Week 0 followed by 40mg at Week 2. In case there is a need for a more rapid response to therapy, the regimen 160mg at Week 0 (plus can be administered as four injections in one day or as two injections per day for two consecutive days), 80mg at Week 2, can be used with the awareness that the risk for adverse events is higher during induction. After induction treatment, the recommended dose is 40mg every other week via subcutaneous injection. Alternatively, if a patient has stopped Humira and signs and symptoms of disease recur, Humira may be re-administered. There is little experience from re-administration after more than 8 weeks since the previous dose. During maintenance treatment, corticosteroids may be tapered in accordance with clinical practice guidelines. Some patients who experience decrease in their response may benefit from an increase in dose intensity to 40mg Humira every week. Some patients who have not responded by Week 4 may benefit from continued maintenance therapy through Week 12. Continued therapy should be carefully reconsidered in a patient not responding within this time period. Psoriasis: The recommended dose of Humira for adult patients is an initial dose of 80mg administered subcutaneously, followed by 40mg subcutaneously given every other week starting one week after the initial dose. Continued therapy beyond 16 weeks should be carefully reconsidered in a patient not responding within this time period. **Contraindications:** Active tuberculosis or other severe infectious such as sepsis, and opportunistic infections, moderate to severe heart failure (NYHA class III/IV) and hypersensitivity to adalimumab or any of the excipients. **Precautions and Warnings:** Infections: Patients being TNF-blockers are more susceptible to serious infections. Impaired lung function may increase the risk for developing infections. Patients must therefore be monitored closely for infections, including tuberculosis, before, during and for 4 months after treatment with Humira. Treatment with Humira should not be initiated in patients with active, chronic or localised infections until infections are controlled. In patients who have been exposed to tuberculosis and patients who have travelled in areas of high risk of tuberculosis or endemic mycoses, such as histoplasmosis, coccidioidomycosis, or blastomycosis, the risk and benefits of treatment with Humira should be considered prior to initiating therapy (see Opportunistic infections). Patients who develop a new infection while undergoing treatment with Humira should be monitored closely and undergo a complete diagnostic evaluation. Administration of Humira should be discontinued if a patient develops a new serious infection or sepsis, and appropriate antimicrobial or antifungal therapy should be initiated until the infection is controlled. Physicians should exercise caution when considering the use of Humira in patients with a history of recurring infection or with underlying conditions which may predispose to infections, including the use of concomitant immunosuppressive medications. Serious infections, including sepsis, due to bacterial, mycobacterial, invasive fungal, parasitic, viral, or other opportunistic infections such as listeria, and pneumocystis have been reported in patients receiving Humira. Other serious infections seen in clinical trials include pneumonia, pyelonephritis, septic arthritis and septicemia. Hospitalisation or fatal outcome associated with infections has been reported. Tuberculosis: There have been reports of tuberculosis in patients receiving Humira. It should be noted that in the majority of these reports, tuberculosis was extra-pulmonary, i.e. disseminated. Before initiation of therapy with Humira, all patients must be evaluated for both active or inactive (latent) tuberculosis infection. Appropriate screening tests, should be performed in all patients. Local recommendations may apply. If active tuberculosis is diagnosed, Humira therapy must not be initiated. If latent tuberculosis is suspected, a physician with expertise in the treatment of tuberculosis should be consulted and the benefit/risk balance of therapy with Humira should be considered. If inactive (latent) tuberculosis is diagnosed, appropriate treatment must be started with anti-tuberculosis prophylaxis therapy before the initiation of Humira, and in accordance with local recommendations. In patients who have several or significant risk factors for tuberculosis and have a negative test for latent tuberculosis, anti-tuberculosis therapy should also be considered before the initiation of Humira. Use of anti-tuberculosis therapy should also be considered before the initiation of Humira in patients with a past history of latent or active tuberculosis in whom an adequate course of treatment cannot be confirmed. Some patients who have previously received treatment for latent or active tuberculosis have developed active tuberculosis while being treated with Humira. Other opportunistic infections: Opportunistic infections, including invasive fungal infections have been observed in patients receiving Humira. These infections have not consistently been recognised in patients taking TNF-blockers and has resulted in delays in appropriate treatment, sometimes resulting in fatal outcomes. For patients who develop the signs and symptoms such as fever, malaise, weight loss, sweats, cough, dyspnoea, and/or pulmonary infiltrates or other serious systemic illness with or without concomitant shock, an invasive fungal infection should be suspected and administration of Humira should be promptly discontinued. Diagnosis and administration of empiric antifungal therapy in these patients should be made in consultation with a physician with appropriate expertise. Hepatitis B (HBV) reactivation: Reactivation of hepatitis B (HBV) has occurred in patients receiving a TNF-antagonist including Humira, who are chronic carriers of this virus (i.e. surface antigen positive), with some fatal outcomes. Patients should be tested for HBV infection before initiating treatment. Patients that test positive should have a consultation with a physician. In patients who develop HBV reactivation, Humira should be stopped and effective anti-viral therapy with appropriate supportive treatment should be initiated. Carriers of HBV should be closely monitored for signs and symptoms of active HBV infection throughout therapy and for several months following termination of Humira. Neurological events: Humira has been associated, in rare cases, with new onset or exacerbation of clinical symptoms

**HUMIRA**  
adalimumab  
THINK DEEP, STRIKE DEEP





# Irish Association of Dermatologists Autumn Meeting 2012

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

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

## Case Presentations

### ORAL ABSTRACT 07

#### Orbital Exenteration secondary to invasive Non-Melanoma Skin Cancer.

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

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

#### Abstract:

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

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

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

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

### ORAL ABSTRACT 08

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

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

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

#### Abstract:

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

#### Discussion:

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

#### References:

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

# Irish Association of Dermatologists Autumn Meeting 2012

## ORAL ABSTRACT 09

### Spontaneous regression of metastatic squamous cell carcinoma of unknown primary

**Author(s):** Foley C<sup>1</sup>, McMenamin M<sup>2</sup>, Ormond P<sup>1</sup>, Irvine AD<sup>1</sup>

**Institution(s):** Departments of Dermatology<sup>1</sup> and Histopathology<sup>2</sup>, St. James's Hospital, James's Street, Dublin 8

#### Abstract:

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

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

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

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

## ORAL ABSTRACT 10

### Spontaneous Resolution of Keratoacanthoma Centrifugum Marginatum

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

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

#### Abstract:

An 87 year old lady with advanced Alzheimer's disease presented in 2009 with an 8 month history of a lesion on the dorsal aspect of her right hand. It started as a small pimple then gradually increased in sized. It failed to respond to cryotherapy carried out by the general practitioner. At the initial review there was a 6x6 cm annular lesion with peripheral coalescing multiple large nodules and central healing. A 4 mm diagnostic punch biopsy was inconclusive. It showed no evidence of malignancy.

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

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

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

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

#### References:

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

# Irish Association of Dermatologists Autumn Meeting 2012

## ORAL ABSTRACT 11

### Multifocal primary cutaneous anaplastic large cell lymphoma.

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

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

#### Abstract:

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

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

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

Skin biopsy showed a dermal infiltrate composed of sheets of large cells with an irregular appearance with small reactive lymphocytes at the periphery. There was abundant mitotic activity, but no epidermotropism. Immunohistochemistry was positive for CD45, CD4, and CD 30. CD8, CD20, CD3, CD56, as well as CD138 and S100 were negative.

Investigations showed an elevated LDH, alkaline phosphatase, ESR and CRP. Whole body CT showed multiple skin tumours of the left thigh with subcutaneous fat invasion, bilateral inguinal lymphadenopathy and a single enlarged necrotic right paratracheal lymphnode. There was no evidence of visceral or CNS involvement. Bone marrow aspirate, immunophenotyping and CSF exam were normal.

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

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

## ORAL ABSTRACT 12

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

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

**Institution(s):** NUI Galway

#### Abstract:

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

#### References:

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

## ORAL ABSTRACT 13

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

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

#### Abstract:

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



# Irish Association of Dermatologists Autumn Meeting 2012

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

#### References:

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

#### ORAL ABSTRACT 14

#### Muir-Torre syndrome and diagnostic error: lessons learned.

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

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

#### Abstract:

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

#### References:

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

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

#### Sponsors

Abbott Ltd  
Janssen-Cilag Ltd  
Pfizer Healthcare Ltd  
Leo Pharma Ltd  
Almirall Ltd  
Bayer Ltd  
Beiersdorf Ltd  
Cosmetique Active  
Dermal Labs Ltd  
Fannin Healthcare  
Galderma Ltd  
Genus Ltd  
GSK Ltd  
Johnson & Johnson  
L'Oréal (UK) Ltd  
Meda Ltd  
Ovelle Ltd  
Pharmed Ltd  
Reckitt Benckiser Ltd  
Sanofi-Aventis Ltd  
Quintiles Ltd

#### DATE FOR DIARY

#### IAD Spring Meeting

26-27 April 2013

Hilton Hotel Belfast & Royal Hospitals  
Belfast



Jacqui Carroll & Dara O'Mahony

LA ROCHE-POSAY  
LABORATOIRE DERMATOLOGIQUE



# ANTHELIOS XL

MELT-IN CREAM SPF 50+/PPD 42

With La Roche-Posay thermal spring water



Reinforced protection and tolerance

> Higher UVA protection

ANTHELIOS XL  
MELT-IN CREAM

PPD 42

> 6-hour guaranteed photostability

> Even more minimalist formula

**Octocrylene-free**  
-32% of chemical filters

Patented filtering system MEXOPLEX®

> Synergy of filters: Mexoryl®SX + Tinosorb®S

> Innovating photostabiliser: Eldew®

Non-comedogenic.

Fragrance-free/Paraben-free.

Tested under dermatological control.

Also available in tinted version

At your side in the prevention of skin cancer in Ireland.

[www.SOSsaveourskin.ie](http://www.SOSsaveourskin.ie)



# Irish Association of Dermatologists Autumn Meeting 2012

## Poster Presentations

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



*Sun Protection from Oz..*  
*..no Worries*



*Sensitive Skin range now available*

RECOMMENDED BY DERMATOLOGISTS

# Irish Association of Dermatologists Autumn Meeting 2012

## POSTER PRESENTATIONS

### POSTER ABSTRACT 001

#### Patient satisfaction in a pigmented lesion clinic

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

**Institution(s):** Waterford Regional Hospital

#### Abstract:

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

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

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

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

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

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

#### References

Field S, Deady S, Fitzgibbon J, Murphy M, Comber H. Improved malignant melanoma prognosis at a consultant-delivered multidisciplinary pigmented lesion clinic in Cork. *Ir Med J.* 2010; 103 (2):40-3.  
Moran B, McDonald I, Wall D, O'Shea SJ, Ryan C, Ryan AJ, Kirby B. Complete skin examination is essential in the assessment of dermatology patients: findings from 483 patients. *Br J Dermatol.* 2011; 165 (5):1124-6.

### POSTER ABSTRACT 002

#### Basal Cell Carcinoma in young adults.

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

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

#### Abstract:

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

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

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

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

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

# Irish Association of Dermatologists Autumn Meeting 2012

## POSTER ABSTRACT 003

### Contact allergy in Non-Actinic Cheilitis

**Author(s):** O'Gorman S.<sup>1</sup>, Torgerson R<sup>2</sup>.

**Institution(s):** <sup>1</sup>Department of Internal Medicine, Mayo Clinic Rochester, MN, USA

<sup>2</sup>Department of Dermatology, Mayo Clinic Rochester, MN, USA

#### Abstract:

##### Background and Objectives:

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

##### Materials and Methods:

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

##### Results:

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

##### Conclusions:

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

## POSTER ABSTRACT 004

### Lessons in underestimating Basal Cell Carcinomas

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

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

#### Abstract:

Basal cell carcinomas (BCC) represent an extremely common skin cancer. Traditional teaching focuses on the "benign" nature of BCCs. However, BCCs can have devastating consequences. This is usually one of two reasons, the physician underestimating its aggressive potential or some patients denying or ignoring the existence of these tumours.

Here we present two cases where these factors culminated in poor prognostic metastatic tumours. First case demonstrating the former reason is a 70 year old man who was treated by a general surgeon for a medial canthal BCC which had been present for a year. A year after excision, the lesion recurred. He was referred to dermatology for MOHs surgery which did not clear the tumour due to involvement of bone. He subsequently had nasal frontal bone excised and reconstructed with a forehead flap for closure of defect. A few months later, this was re-excised to remove area of residual BCC. He then presented 8 mths later with diplopia. CT orbit showed BCC eroding the posterior wall of frontal sinus extending into the right cranial fossa and frontal lobe. He currently awaits neurosurgical review and oncology opinion with a possibility of commencing, Vismodegib, the new hedgehog pathway inhibitor.

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

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

## POSTER ABSTRACT 005

### Dermatological Diagnosis of Muir Torre Syndrome

**Author(s):** Eoin Storan, Bairbre Wynne

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

#### Abstract:

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

## Irish Association of Dermatologists Autumn Meeting 2012

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

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

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

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

### **POSTER ABSTRACT 006** **A case of Dermatofibrosarcoma Protuberans**

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

#### **Abstract:**

##### **Clinical History:**

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

##### **Examination:**

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

#### **Management:**

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

#### **Discussion:**

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

#### **References:**

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

### **POSTER ABSTRACT 007**

#### **Are the new ACCS staging criteria for cutaneous squamous cell cancers being used in histology reports?**

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

**Institution(s):** St Vincent's University Hospital, Dublin

#### **Abstract:**

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

## Irish Association of Dermatologists Autumn Meeting 2012

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

### POSTER ABSTRACT 008 Allergic Contact Dermatitis of the Vulva

**Author(s):** O'Gorman S.<sup>1</sup>, Torgerson R.<sup>2</sup>.

**Institution(s):** <sup>1</sup>Department of Internal Medicine, Mayo Clinic Rochester, MN, USA  
<sup>2</sup>Department of Dermatology, Mayo Clinic Rochester, MN, USA

#### **Abstract:**

##### **Background and Objectives:**

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

##### **Patients and Methods:**

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

#### **Results:**

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

#### **Conclusions:**

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

### POSTER ABSTRACT 009 The solitary purple nodule.

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

**Institution(s):** Beaumont Hospital, Dublin 9.

#### **Abstract:**

A 66-year-old woman presented to the Emergency Department with a one year history of an enlarging lesion on the right abdomen. She was assessed urgently by Dermatology.

On examination, there was a 3cm ulcerated, fungating, purple nodule on the right flank. Full skin examination was otherwise normal and there was no lymphadenopathy.

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

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

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

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



## Irish Association of Dermatologists Autumn Meeting 2012

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

### References

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

### POSTER ABSTRACT 010 Malignant Melanoma Database 2012

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

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

### Abstract:

#### Study aims:

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

#### Methods:

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

#### Results:

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

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

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

Moreover this database ensures the clinician is alerted to whether the current guidelines are being adhered to.

### POSTER ABSTRACT 011 Beware of the "Irritated Seborrhoeic Keratosis"

**Author(s):** O'Gorman S.<sup>1</sup>, O'Shea S.<sup>1</sup>, Murphy G.<sup>1</sup>.

**Institution(s):** <sup>1</sup> Department of Dermatology, Beaumont Hospital, Dublin, Ireland.

### Abstract:

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

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

**Author(s):** Eoin Storan<sup>1</sup>, Mark Davis<sup>2</sup>

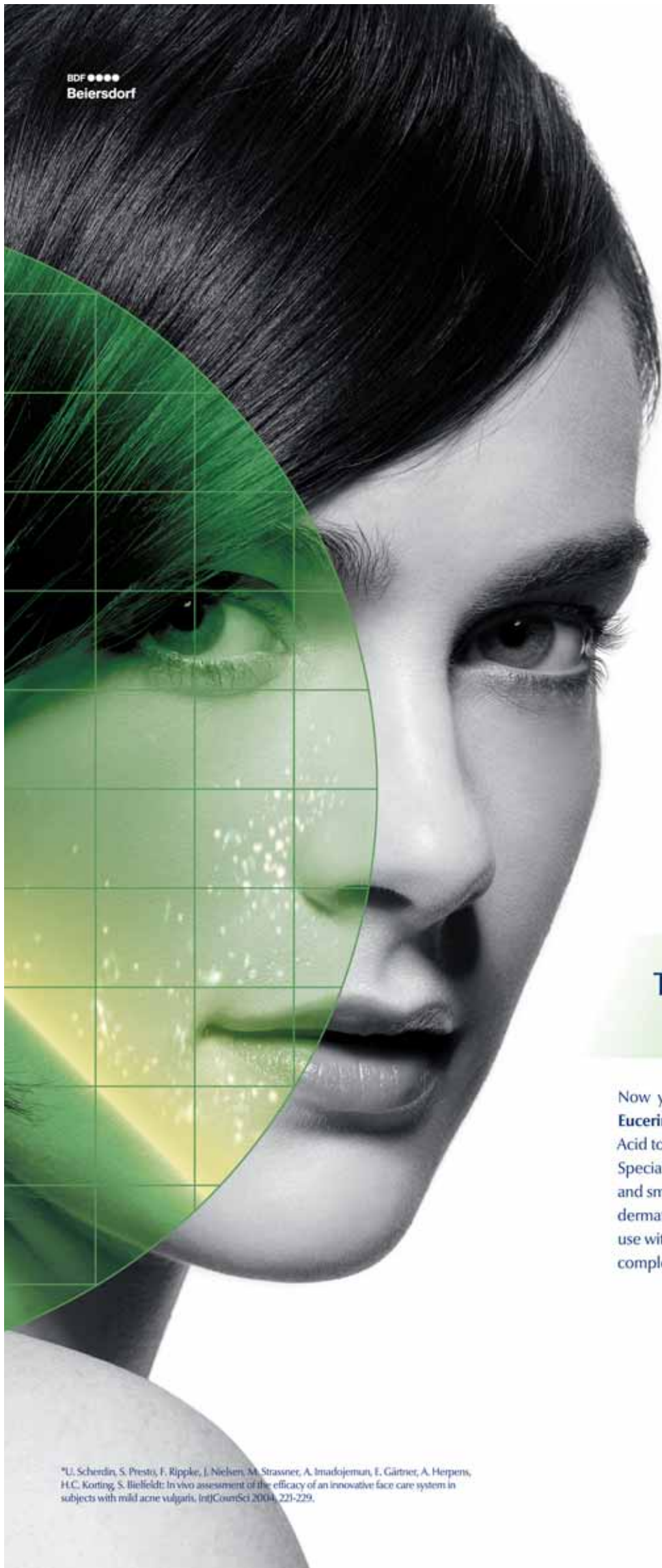
**Institution(s):** Departments of Internal Medicine<sup>1</sup> and Dermatology<sup>2</sup>, Mayo Clinic, Rochester, MN, USA

### Abstract:

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

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

BDF ●●●●●  
Beiersdorf



clinically  
proven

NEW



## The Skincare Solution For Acne-Prone Skin

Now you can care for acne-prone skin without drying it out. **Eucerin® DermoPURIFYER** is a unique skin care range with Lactic Acid to effectively, yet gently help unclog pores and fight bacteria. Specially developed for daily cleansing to give your skin a clean and smooth look. A daily skin care regime is recommended by dermatologists and has been clinically proven to be suitable for use with medical treatments and helps give a noticeably clearer complexion with regular use.\*

[www.eucerin.ie](http://www.eucerin.ie)

# Eucerin®

SKIN SCIENCE THAT SHOWS  
PHARMACIES NATIONWIDE

\*U. Scharidin, S. Presti, F. Rippke, J. Nielsen, M. Strassner, A. Imadojerman, E. Gärtner, A. Herpens, H.C. Korting, S. Bielefeld: In vivo assessment of the efficacy of an innovative face care system in subjects with mild acne vulgaris. *IntJCosmSci* 2004, 221-229.

# Irish Association of Dermatologists Autumn Meeting 2012

Abstract PO12 (continued)

**Methods:** We performed a retrospective chart review of adult inpatient (age,  $\geq 18$  years) dermatology hospital consultations from January 1, 2010, through December 31, 2010. We examined patient demographic characteristics, consult requesting services, and consult diagnoses.

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

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



Dr Mary Bennett & Dr Dmitri Wall Winner  
Best Poster Prize Spring 2012



LEO Pharma



Maria McElwee, Galderma & Dr Rami Hamadeh



Maurice Leonard, Oliver Kinlough  
& Katherina McCormack Abbott



# The rediscoverLIFE programme

## Enhancing the patient's experience

### At Home Nurse Service

The rediscoverLIFE At Home Nurse Service provides support to patients who require initial or follow-up training with HUMIRA self-injection in the comfort of their own home.



### Patient Pack

The rediscoverLIFE patient pack is a HUMIRA education and support pack providing advice on managing their treatment and the disease.



### Waste Disposal Service

The free of charge rediscoverLIFE waste disposal service enables the safe disposal of used HUMIRA pens and pre-filled syringes.



### Newsletter

The rediscoverLIFE Newsletter is designed to support and provide information to HUMIRA patients in Ireland.



THE  
HUMIRA  
PEN



# HUMIRA

Full prescribing information is available on request from Abbott Laboratories (Ireland) Ltd., 4051 Kingswood Drive, Citywest Business Campus, Dublin 24, or in the SmPC. Legal Category: POM. Marketing Authorisation Numbers: EU/1/03/256/002-005 and EU/1/03/256/007-010  
Date of preparation: April 2009. IMMUN/HUM/2009/055

 **Abbott**  
A Promise for Life





# Irish Association of Dermatologists Spring Meeting 2012



Dr Karoline Adamzik & Dr Muriel Sadlier



Dr Kashif Ahmad, Dr Grainne O'Regan, Dr Sarah Landy,  
Dr Rosemary Black & Dr Dermot McKenna



Dr Maeve Lynch, Dr Brian Kirby & Dr Sally O'Shea



Dr Maeve Lynch, Dr Karen Eustace & Dr Nuriah Ismail



Fannin Healthcare



Fiona Carroll, Fiona Reid & Susan Maguire



IAD Executive Committee



Jacquí Carroll, Dr Caoimhe Fahy &  
Annette O'Sullivan Reckitt Benckiser





# Irish Association of Dermatologists Spring Meeting 2012



Dr Mike Badminton Guest Speaker & Dr Gillian Murphy



Dr Nicola Ralph, Dr Catriona Hackett & Dr Caoimhe Fahy



Dr Olivia Dolan & Mr Richard Best



Greg Patterson, GENUS Pharma



Dr Rosemarie Watson & Prof Edel O'Toole



Dr Nicola Ralph, Fiona Carroll, Dr Paul Collins,  
Fiona Reid & Sheila Ryan IDNA



Dr Nigel Burrows Guest Speaker & Dr Pat Podmore

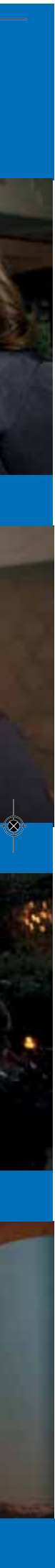


Dr Pat Podmore, Dr Kevin McKenna,  
Dr Paul Collins & Mr Richard Best



Dr Sarah Landy & Carol Ramsey Janssen-Cilag





$$\begin{array}{r} 365 \\ -4^* \\ \hline 361 \end{array}$$

That's **361** days to  
focus on life... not psoriasis

#### Stelara® offers:

##### Clearance

- Superior efficacy to etanercept 50mg twice weekly at 12 weeks<sup>1</sup>
- Treatment benefit maintained in responders through 3 years<sup>2</sup>

##### Convenience

- Four doses per year, after 2 induction doses<sup>3</sup>

##### Confidence

- The Stelara® psoriasis clinical trial safety database contains over 3000 patients treated to date, some to up to 4 years and continues to demonstrate a favorable benefit risk profile.<sup>4</sup>

\*4 = maintenance therapy after 2 induction doses.



**Stelara®**  
(ustekinumab)

**STELARA® solution for injection in pre-filled syringe** **PRESCRIBING INFORMATION ACTIVE INGREDIENT(S)**: Ustekinumab. Please refer to Summary of Product Characteristics (SmPC) before prescribing. **INDICATION(S)**: 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 and PUVA. **DOSAGE & ADMINISTRATION**: Under the guidance and supervision of a physician experienced in diagnosis and treatment of psoriasis. Subcutaneous injection. Avoid areas with psoriasis. For self-injecting patients ensure appropriate training, follow-up and monitoring during treatment. 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). Consider discontinuation if no response after 28 weeks. Children <18 years: Not recommended. Renal & Hepatic impairment: Not studied. **CONTRAINDICATIONS**: Hypersensitivity to product, clinically important, active infection. **SPECIAL WARNINGS & PRECAUTIONS**: Infections: Potential to increase risk of infections and reactivate latent infections. Caution in patients with a chronic infection or history of recurrent infection, particularly TB. Patients should be evaluated for tuberculosis prior to initiation of STELARA. Consider anti-tuberculous therapy prior to initiation of STELARA in patients with past history of latent or active tuberculosis. Patients should seek medical advice if signs or symptoms suggestive of an infection occur. If a serious infection develops, they should be closely monitored and STELARA should not be administered until infection resolves. **Malignancies**: Potential to increase the risk of malignancy. No studies in patients with a history of malignancy or in patients who develop malignancy while receiving STELARA. **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, discontinue STELARA immediately and institute appropriate therapy. Immunotherapy: Not known whether STELARA affects allergy immunotherapy. **Latex sensitivity**: Needle cover contains natural rubber (latex), may cause allergic reactions. **SIDE EFFECTS**: Serious side effects: Serious infections, malignancies. Very common: upper respiratory tract infection, nasopharyngitis. Common: hypersensitivity reactions (rash, urticaria), cellulitis, viral upper respiratory tract infection, depression, dizziness, headache, pharyngolaryngeal pain, nasal congestion, diarrhoea, pruritus, back pain, myalgia, arthralgia, fatigue, injection site erythema, antibodies to ustekinumab. Uncommon: herpes zoster infection, injection site reactions. **Rare**: serious hypersensitivity reactions (including anaphylaxis, angioedema), facial palsy. 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: The safety and efficacy of STELARA in combination with other immunosuppressants, including biologics, or phototherapy have not been evaluated. **LEGAL CATEGORY**: Prescription Only Medicine. **PRESENTATIONS, PACK SIZES, PRODUCT LICENCE NUMBER**: STELARA 45mg: 1 x 0.5ml pre-filled syringe. EU/1/08/494/003. STELARA 90mg: 1 x 1.0ml pre-filled syringe. EU/1/08/494/004 **MARKETING AUTHORISATION HOLDER**: JANSSEN-CILAG INTERNATIONAL NV, Turnhoutseweg 30, B-2340 Beerse, Belgium. **FURTHER INFORMATION IS AVAILABLE FROM**: Janssen-Cilag Ltd, 50 – 100 Holmers Farm Way, High Wycombe, Buckinghamshire, HP12 4EG UK. © Janssen-Cilag Ltd 2012. Prescribing information last revised: 20/03/2012 **PIVER**: 200312

**References**: 1. Griffiths CE et al. NEJM. 2009; 362: 118-128. 2. Kimball et al. Long-term efficacy of ustekinumab in patients with moderate-to-severe psoriasis: results from the PHOENIX 1 trial through up to 3 years. Br J Dermatol. Apr 2012 166; 861-872. 3. Stelara® (ustekinumab) Summary of Product Characteristics. 4. Reich K et al. J Drugs Dermatol. 2012 Mar 1; 11(3): 300-12.

**Date of Preparation**: April 2012 IRE/UK/2012/0054



**janssen**  
PHARMACEUTICAL COMPANY  
of Johnson & Johnson