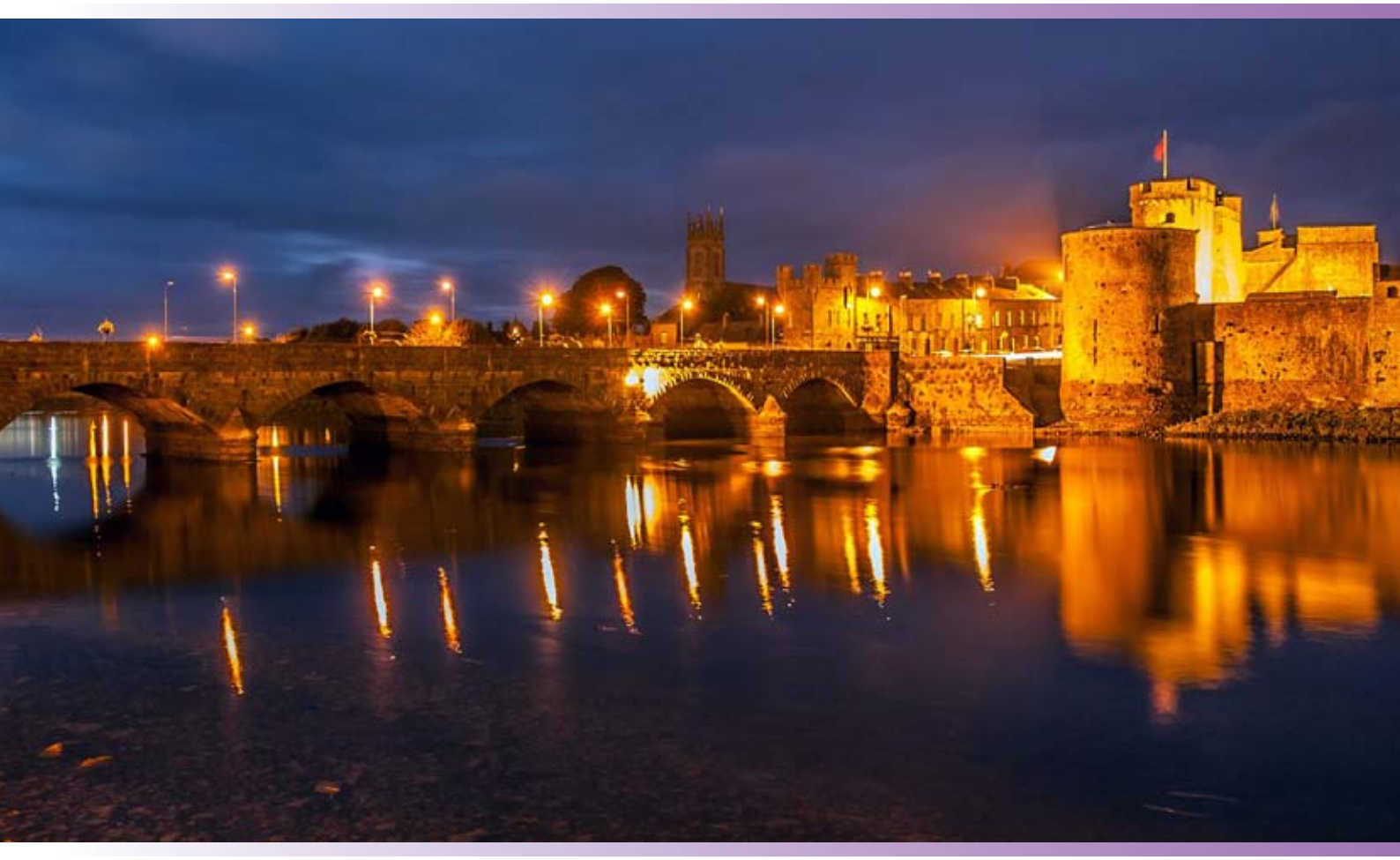

IAD
Irish Association of Dermatologists

SPRING MEETING

Thursday 26th, Friday 27th & Saturday 28th April 2018

Limerick Strand Hotel & University Hospital Limerick

Welcome Message from the President Dr Trevor Markham

Welcome to the Spring meeting of the IAD 2018 at the Strand Hotel, Limerick and Midwestern University Hospital. It gives me particular personal pleasure to return to Limerick, " my home town" to host this meeting. In this year of Grand Slam success it is fitting for the IAD to be held in the spiritual home of Irish Rugby!

The meeting kicks off on Thursday evening with our symposium. Dr Kate Russo will speak on the hot topic of resilience. Our main meeting begins on Friday with our registrars competing for the prestigious Burrows Cup at the Registrars Symposium. I would like to thank our Scientific Committee for all their hard work towards organising the programme for this meeting.

The theme of this meeting this year is paediatrics. Guest speakers for the Friday include Professor Celia Moss, Professor Daniel Bradley, Prof Alan Irvine and Dr Fiona Browne. We look forward to learning about the latest developments in paediatric dermatology.

I would like to take the opportunity to thank our secretary Dr Art O'Hagan and Jacqui Carroll for all their hard work and support. Special thanks to Dr Fergal Moloney, Dr Donal O Kane and Dr Ann Marie Tobin for their help in organising the symposium. Finally I would like to acknowledge all the hard work of the Dermatology team at Midwestern University Hospital in the preparation of our clinical meeting on Saturday. We all look forward to visiting the state of the art Dermatology unit at MWUH.
I hope you enjoy the meeting and I look forward to catching up with everyone over the next few days.

Yours sincerely,

Dr Trevor Markham
President
Irish Association of Dermatologists

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2017-Present Dr Trevor Markham

IAD
IRISH ASSOCIATION OF DERMATOLOGISTS

Agenda for IAD Symposium Thursday 26th April 2018 Limerick Strand Hotel

6.00pm	Registration, Light snacks & Tea/Coffee
7.00pm	Opening address
7.15pm	Dr Kate Russo Clinical Psychologist and Associate Fellow of the British Psychological Society "Striving and thriving"
8.20pm	Questions & Discussion
8.30pm	Close & Fork Supper

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IAD
Irish Association of Dermatologists

SPRING MEETING

Thursday 26th, Friday 27th & Saturday 28th April 2018
Limerick Strand Hotel & University Hospital Limerick

THURSDAY 26th APRIL

Symposium kindly sponsored by Abbvie

'Managing Resilience'

6.00pm	Registration & Light Refreshments
7.00-8.30pm	Symposium **Dr Kate Russo** *'Striving & Thriving'*
8.30pm	Fork Supper

FRIDAY 27TH APRIL

Theme "Paediatrics"

8.00am	Registration
9.00-10.30am	Registrars' Symposium – Burrows Cup
10.30-11.15am	Coffee & Exhibition
11.15am-12.00pm	**Professor Celia Moss OBE**, Consultant Dermatologist, Birmingham Children's Hospital; Honorary Professor, University of Birmingham UK. *"Paediatric Dermatology – lessons learnt"*
12.00-12.45pm	**Professor Daniel Bradley** Smurfit Institute of Genetics, Trinity College Dublin *"Ancient genomes and the origins of Irish human variation"*
12.45-2.15pm	Lunch & Exhibition
2.15-3.00pm	**Professor Alan Irvine**, Consultant Dermatologist, Our Lady's Children's Hospital Crumlin *'Atopic Dermatitis: 3 Mechanisms, 3 Opportunities'*
3.00-3.45pm	**Dr Fiona Browne**, Consultant Dermatologist, Our Lady's Children's Hospital Crumlin & Children's University Hospital Temple Street *'Referrals from the Neonatal Unit'*
3.45-4.30pm	Coffee & Exhibition
4.30pm	Presentation of Burrows Cup & Poster Prizes
5.00-6.00pm	IAD Business Meeting
7.30pm	IAD CONFERENCE DINNER - Strand Hotel Limerick

SATURDAY 28TH APRIL 2017

Clinical Meeting – University Hospital Limerick
Out Patients Department
Hosted By:
Dr Bart Ramsay, Dr Kashif Ahmad, Dr Caitriona Hackett, Dr Maeve Lynch & Sheila Ryan ANP

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

Biographical Sketches

Dr Kate Russo

Dr Kate Russo is a Clinical Psychologist and Associate Fellow of the British Psychological Society, specialising in health and wellbeing. Based in Belfast for the last 20 years, she contributes to national and international projects to improve the lives of those living with chronic medical conditions. She is a former Assistant Course Director of the Doctoral training programme in Clinical Psychology at Queen's University Belfast, and spent 15 years working in the NHS embedded in several medical teams, including cystic fibrosis, rheumatology, orthopaedics, and pain. She has undertaken a number of projects across Ireland with Abbvie, including training teams in motivational interviewing and working with Dermatology and Gastroenterology.

Alongside her professional career, Kate travels the world as an eclipse chaser, and also as a workshop facilitator on board cruise ships. Having now published three eclipse-related books, she is in demand worldwide as an authority on the total eclipse experience and is featured extensively in the media. She encourages everyone to live life to their full potential.

Professor Celia Moss OBE

Celia Moss is a Consultant Dermatologist at Birmingham Children's Hospital (BCH) and Honorary Professor of Paediatric Dermatology at the University of Birmingham. She trained in Medicine at Oxford University and University College Hospital, London (qualified 1975), and in Dermatology in Newcastle-upon-Tyne. Previous national appointments include Chair of the British Society for Paediatric Dermatology, Chair of the UK NHS Clinical Reference Group for Specialised Dermatology, and Convenor for Dermatology at the Royal College of Paediatrics and Child Health. She is a member of the Advisory Boards of the British Journal of Dermatology and several national patient support groups. She lectures, advises and publishes widely on Genetic and Paediatric dermatology, and has contributed chapters to the major UK and US textbooks. She was surprised to be awarded the British Association of Dermatologist's Sir Archibald Gray Medal and an OBE in 2016 and to be featured in the Medical Women's Federation Centenary booklet 2017. Now semi-retired, she and her husband (Prof Robin Ferner, Clinical Pharmacologist) travel frequently, supporting colleagues overseas, particularly in India. She has three grown up children, none of them doctors.

Professor Dan Bradley

Dan Bradley spent his early years on an Irish farm waiting to get away and broaden his horizons. After a degree in genetics from Cambridge University and PhD in medical genetics from Trinity College Dublin he subsequently started to work on the genetics of each species present on that farm, including Irish humans, and has done for over 20 years. With his colleagues he has combined analysis of ancient and modern cattle to inform on the origins of these and other domesticates and pioneered the molecular genetic analysis of Irish populations, particularly co-analysis with surnames. Current collaborative research interests include: ancient genomes of domestic animals from bones and parchment; human genetic variation and history including ancient DNA; the genetics of susceptibility to motorneuron disease; and the genetics of infectious disease susceptibility in cattle. He holds a Personal Chair in the Smurfit Institute of Genetics, Trinity College Dublin, is a member of the RIA and is the holder of an ERC Advanced Grant.

Professor Alan Irvine MD DSc FRCP

Alan completed Dermatology Training in Belfast, Northern Ireland with post residency fellowships in Great Ormond Street Children's Hospital, London and Children's Memorial Hospital Chicago, as a Fulbright Scholar. He has been a Consultant Dermatologist in Our Lady's Children's Hospital/ St. James's Hospital, Dublin, Ireland since October 2002. His department in OLCHC provides multidisciplinary care for 10, 000 children per annum from across Ireland and is a national centre for management of severe atopic dermatitis. Alan is a Professor in Dermatology, Trinity College Dublin. He has published more than 200 peer-reviewed articles mostly on atopic dermatitis and genodermatoses; he has published several papers recently on the role of Staph aureus in atopic dermatitis. Alan is a Section Editor of the Journal of Investigative Dermatology and an Associate Editor of Allergy. His international awards for research include the 2006/2007 Paul Gerson Unna Prize from the German Dermatology Society, the 2013 Jerry Dolovich Memorial Lecture of the AAAAI, the 2015 Dr Sydney Watson Smith Lecture of the Royal College of Physicians of Edinburgh and the 2016 RW Goltz Memorial Lecture from the University of Minnesota. He is an Honorary Professor in the School of Life Sciences, University of Dundee.

Dr Fiona Browne

Dr Fiona Browne is a Consultant Dermatologist at Crumlin Children's Hospital and Children's University Hospital, Temple Street.

She qualified in medicine from Queen's University Belfast in 2001, having previously completed a research fellowship with Prof Judah Folkman at Harvard Medical School, Boston. She trained in Dermatology in Leeds and completed a post CCT fellowship in Paediatric Dermatology with Prof Celia Moss at Birmingham Children's Hospital where she then worked as Consultant from 2011 to 2015.

She has a specialist interest in Epidermolysis Bullosa and leads the adult Epidermolysis Bullosa service at St James Hospital Dublin.

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DATE FOR DIARY...

IAD Autumn Meeting 2018

Psychodermatology

Thursday 4th & Friday 5th October

Slieve Donard Hotel, Newcastle, Co. Down

IDNA
Irish Dermatology Nurses Association Ltd.

15h Annual Irish Dermatology Nurses Association Ltd Meeting
The Strand Hotel, Limerick Friday 27th April 2018

08.30 - 0915	Registration
09.15 - 09.45	Opening Remarks /IDNAL Business meeting and AGM Business meeting will include Election of new commitee. Update on DCU Dermatology Programme
09.45 - 10.30	Child protection in dermatology....examining the overlap Heulwen Wyatt, Clinical Nurse Specialist in Paediatric Dermatology Aneurin Bevan University Health Board, Newport, Gwent, UK
10.30 - 11.15	Coffee/ Exhibition
	City of Dublin Skin & Cancer Hospital Charity Bursary Winners (Presentation 1)
11.15 - 11.45	Experience of establishing a nurse led melanoma screening service Evelyn Power, Dermatology Nurse Specialist, University Hospital Limerick, Limerick
11.45 - 12.00	Experience of establishing a phototherа[y satelite service in North-Tipperary Aisling O'Shaughnessy, Alma Hourigan, Dr Berbie Byrne, Sheila Ryan, ULHG, Limerick.
12.00 - 12.45	Wound Management Helen Meagher, Tissue Viability CNS, University Hospital Limerick, Limerick
12.45 - 14.15	Lunch / Exhibition
14.15 - 15.00	Early detection of skin cancer-a research approach Professor Steven Ersser, Professor in Clinical Nursing Research, University of York, York, UK
15.15 - 15.45	Experience of establishing a phototherapy satelite service and a patient self-administered phototherapy service in Scotland Linda Malcolm and Celia Sprot, NHS Tayside, Scotland, UK.
	City of Dublin Skin & Cancer Hospital Charity Bursary Winners (Presentation 2)
15.45 - 16.30	Managing Junctional Epidermolysis Bullosa, generalised severe (JEB-gs) in the Community. Challenges, Achievements and Lessons learnt AnnMarie Ormonde , EB Clinical Nurse Specialist, Our Lady's Children's Hospital Crumlin, Dublin
16.30 - 16.40	Closing Remarks and Meeting Close
19.30	IAD Drinks Conference Dinner - Strand Hotel, Limerick

Registrars' Symposium
Oral Case Presentations Burrows Cup
Friday 27th April 2018

Oral 01. 9.00am
Pregnancy on biologics for treatment of dermatological conditions in a university teaching hospital
JME Boggs, L Griffin, K Ahmad, C Hackett, B Ramsay, M Lynch. Department of Dermatology, University Hospital Limerick

Oral 02. 9.10am
Risk of Secondary Malignancies in 4229 Patients with Mycosis Fungoides or Sezary Syndrome
R. Almukhtar, R. Soine, B. Lee, E. McBurney
Louisiana State University, Department of Dermatology, New Orleans, LA, USA

Oral 03. 9.20am
Post-transplant skin cancer incidence has halved, for both BCC & SCC, since the turn of the century.
S. Menzies, G. O'Callaghan, E. O'Leary, S. Deady, C. MacEochagain, B. Gadallah, S. Ni Raghallaigh, P. Lenane, A. Lally, D. Houlihan, P.G. Morris, D.J. Sexton, A. McCormick, J.J. Egan, J.P. O'Neill, P.J. Conlon, F.J. Moloney.
Mater Misericordiae University Hospital, National Cancer Registry Ireland, St Vincent's Hospital & Beaumont Hospital.

Oral 04. 9.30am
A multi-centre audit of occupational dermatoses in the Republic of Ireland
A Flynn,1 A Mooney,2 S McCarthy,1 L Roche,3 E Nic Dhonncha, 3 O Molloy,4 R O'Connor,5 S Menzies,6 L Cunningham, 7 M Sadlier,8 E Gilhooley,9 J Boggs,10 C Harnett,11 J Bourke1
1South Infirmary-Victoria University Hospital, Cork
2Centre for Occupational and Environmental Health, The University of Manchester, UK
3University Hospital Galway
4Beaumont Hospital, Dublin
5Adelaide Meath and National Children's Hospital, Dublin
6Mater Hospital, Dublin
7St. Vincent's University Hospital, Dublin
8St. James's Hospital, Dublin
9Sligo University Hospital
10University Hospital Limerick
11Our Lady of Lourdes Hospital Drogheda

Oral 05. 9.40am
Friend or foe?
C. Gallagher, C. Cotter, R. O'Connor, S. Kirthi, A .Salim, M. Connolly, A O'Brien, AE Hogan & AM Tobin Tallaght University Hospital

Oral 06. 9.50am
Experience of Dupilumab in the treatment of atopic eczema: a case series
A.Alani, O. Dolan, D. O'Kane
Dermatology Department, Royal Victoria Hospital, Belfast Social Health and Care Trust

Oral 07. 10.00am
Obstructive Sleep Apnoea in Hidradenitis Suppurativa patients
A. Kelly, S. Kirthi, C. Ryan, R. Hughes, B. Kirby.
St Vincent's University Hospital Dublin

Oral 08. 10.10am
An open prospective study to assess short incubation time white LED light photodynamic therapy for the treatment of superficial basal cell carcinoma.
R. Hellen, E. Nic Dhonncha, A. Havelin, A. Kavanagh, B. Moriarty*, P. Collins*. (* joint senior authors)
The Charles Centre, Department of Dermatology, St. Vincent's University Hospital, Dublin

Oral 09. 10.20am
Incidence of genital and perianal muco-cutaneous adverse events in a cohort of patients on isotretinoin
L. Cunningham, S. Menzies, E. Shudell, F. Moloney, N. Ralph.
Mater Misericordiae University Hospital, Dublin

Oral Case Presentation Abstracts

Oral 01. 9.00am
Pregnancy on biologics for treatment of dermatological conditions in a university teaching hospital
JME Boggs, L Griffin, K Ahmad, C Hackett, B Ramsay, M Lynch.
Department of Dermatology, University Hospital Limerick

The effect of biologics on pregnancy outcomes has not been adequately studied to quantify accurately. The British Association of Dermatologists guidelines advise that the risks and benefits of continuing vs. stopping therapy should be discussed on a case-by-case basis in women who become pregnant. We reviewed all pregnancies on biologics in our Department.

Patients who became pregnant whilst on biologics were identified from our departmental Filemaker-Pro database. A retrospective chart review was performed.

Eleven patients, over a mean of 4.3±2.7 years, became pregnant on biologics (mean age 32.4±4.1 years), leading to 17 pregnancies. Biologics were prescribed for psoriasis and psoriatic arthritis (PsA) (n=5), hidradenitis suppurativa (HS) (n=2), psoriasis (n=1), psoriasis, PsA and HS (n=1), psoriasis and Crohn's disease (CD) (n=1), HS and CD (n=1). Nine pregnancies were unplanned. The mean duration on a biologic prior to conception was 21.4±28.5 months. A decision was made to continue treatment in 8 pregnancies, all of whom had extracutaneous inflammatory diseases (PsA, HS or CD) in addition to psoriasis in 6. Biologics were discontinued in patients with psoriasis and PsA (n=5), psoriasis (n=2) and HS (n=2). There were 12 healthy live births and 2 pregnancies are ongoing. Three miscarriages occurred, 2 in patients continued on biologics (adalimumab n=1, secukinumab n=1). Of the 9 pregnancies during which biologic treatment was discontinued, 7 developed disease flares: psoriasis (n=4), psoriasis and PsA (n=2) and HS (n=1). Biologic therapy was recommenced in 6 of 8 patients (one pregnancy ongoing) in the postpartum period, 4 of whom experienced secondary failure. Of the 5 patients who had healthy live births while on biologics (2 miscarriages, 1 ongoing) 3 had documentation advising delay of live vaccinations of the infant for 6 months.

The 8 of 17 pregnancies continued on biologics had PsA, CD or HS in addition to psoriasis in 6. Controlling severe systemic inflammatory diseases during pregnancy is important to maintain maternal and foetal health and uncontrolled disease may impact on a patient's ability to conceive. When treatment was discontinued during pregnancy this led to disease flares frequently. Of those continued on biologics during pregnancy clear documentation with regard to live vaccinations in the infant is essential. Our findings support the complexity of dealing with pregnancies on biologics and that continuing vs. stopping therapy should be assessed individually. Registry data in the future should inform us of the safety of biologic therapy with respect to maternal and foetal health.

Oral 02. 9.10am
Risk of Secondary Malignancies in 4229 Patients with Mycosis Fungoides or Sezary Syndrome
R. Almukhtar, R. Soine, B. Lee, E. McBurney
Louisiana State University, Department of Dermatology, New Orleans, LA, USA

Introduction: Mycosis fungoides (MF) is an extra-nodal, non-Hodgkin cutaneous T-cell lymphoma. Sezary syndrome (SS) is the leukemic form of cutaneous T-cell lymphoma and is manifested typically with erythroderma, generalized lymphadenopathy, and circulating Sezary cells. Few studies suggested increased risk of secondary malignancies in those patients. However, such increased risk has never been well characterized or studied.
Aim: To assess risks for developing a second malignancy in patients with MF or SS.

Methods: A cohort of patients with MF and SS was formed from thirteen population-based US cancer registries utilizing the Surveillance, Epidemiology, and End Results Program (SEER-13). Patients were diagnosed and followed up from 1992 to 2014. Relative risk was estimated using the standardized incidence ration (SIR), which was calculated using age-, sex-, race-, and calendar year- matched incidence rates for the general population.

Results: 4229 patients with MF or SS were included from the SEER-13 cohort. Of those, 556 developed a second malignancy (SIR = 1.27, P< 0.05). 23 patients developed melanoma (SIR=1.32, P> 0.05), however risk was not significantly higher compared to the age- sex- race- calendar year- matched general population. 14 patients developed chronic lymphocytic leukemia (CLL) (SIR= 2.58, P<0.05). The risk for all other type of leukemias was not significantly increased. 13 patients developed Hodgkin's lymphoma (HL) (SIR=11.18, P<0.05), and 98 developed non- Hodgkin's lymphoma (NHL) (SIR=5.28, P<0.05). 82 developed lung cancer (SIR= 1.33, P <0.05). Risk of a second malignancy of all other individual sites was analyzed and didn't reach statistical significance. Non-melanoma skin cancers were excluded as they were not reported in the SEER-13 database.

Conclusions: An analysis of nationwide cancer registries of US patients with MF or SS showed an overall increase of a second malignancy in those patients by 27% compared to the age-, sex, race-, calendar year- matched general population. There was a significantly increased risk of CLL, NHL, HL, and lung cancer. There was no increased risk of malignancy in any other location. Providers managing patients with MF or SS must be aware of increased risk and screen those at risk accordingly.

Oral 03. 9.20am
Post-transplant skin cancer incidence has halved, for both BCC & SCC, since the turn of the century.
S. Menzies, G. O'Callaghan, E. O'Leary, S. Deady, C. MacEochagain, B. Gadallah, S. Ni Raghallaigh, P. Lenane, A. Lally, D. Houlihan, P.G. Morris, D.J. Sexton, A. McCormick, J.J. Egan, J.P. O'Neill, P.J. Conlon, F.J. Moloney.
Mater Misericordiae University Hospital, National Cancer Registry Ireland, St Vincent's Hospital & Beaumont Hospital.

Rates of non-melanoma skin cancer (NMSC) in the general population are increasing. Furthermore, organ transplant recipients (OTRs) are older and surviving longer post-transplantation. Despite this, recent evidence suggests a declining incidence in SCC in the modern era of transplantation. Given that national incidence figures in many countries document SCC only, there is limited data on the effect of changing immunosuppressive regimens on BCC risk.

Since 1994, the Irish National Cancer Registry (NCRI) has registered all histologically confirmed first SCC and BCC. Datasets from the Irish national transplant centres for renal, heart, liver and lung were matched to NCRI data from 1994-2014. Standardized incidence ratios (SIRs; observed/expected cases) were calculated, comparing

patients transplanted in different years in blocks of 5-year follow-up post transplantation.

A total of 4,617 OTRs were included [3,391 (74%) renal, 756 (16%) liver, 269 (6%) cardiac and 201 (4%) lung transplants]. The majority were male (63%). The relative risk of BCC has halved, over the same period of post-transplantation follow-up, for patients transplanted after 1999 compared to those transplanted before 1999 (pre-1999 SIR range 12.6-14.6; post-1999 SIR range 5.8-7.6). A similar trend was seen for risk of SCC (pre-1999 SIR range 44.1-52.0; post-1999 SIR range 12.5-27.8). This reduced risk has persisted, was similar across different OTRs and continues to trend downwards.

We also identified cohorts of OTRs who had exclusively developed BCC or SCC/SCC in situ. A history of NMSC was noted in 1,039 (22.5%) patients with 469 (10.2%) having SCC only and 246 (5.3%) having BCC only. A statistically significant difference between gender was demonstrated in the SCC only and SCC/BCC group (11.1% male, 8.5% female p=0.006; 8.8% male, 3.9% female p=0.0001 respectively). A higher rate of SCC only was seen following heart and renal transplantation (12.6%, 11.1% respectively), whereas the lowest rate was seen following lung transplantation (3.5%). The risk of SCC only increased as time from transplantation increased, however, the risk of BCC only was stable over time.

This study is the first to show that there has been a fall in the risk of BCC following solid organ transplantation over the last 2 decades. This mirrors the reduced risk of SCC documented in this and other studies. A major factor contributing to the reduced risk of NMSC post-transplantation is likely to be changes in immunosuppression regimens used since ~2000, whereby lower doses and non-thiopurine based immunosuppressive regimens have been more widely used.

Oral 04. 9.30am

A multi-centre audit of occupational dermatoses in the Republic of Ireland

A Flynn,1 A Mooney,2 S McCarthy,1 L Roche,3 E Nic Dhonncha,3 O Molloy,4 R O'Connor,5 S Menzies,6 L Cunningham,7 M Sadlier,8 E Gilhooley,9 J Boggs,10 C Harnett,11 J Bourke1
1South Infirmary-Victoria University Hospital, Cork
2Centre for Occupational and Environmental Health, The University of Manchester, UK
3University Hospital Galway
4Beaumont Hospital, Dublin
5Adelaide Meath and National Children's Hospital, Dublin
6Mater Hospital, Dublin
7St. Vincent's University Hospital, Dublin
8St. James's Hospital, Dublin
9Sligo University Hospital
10University Hospital Limerick
11Our Lady of Lourdes Hospital Drogheda

The incidence of occupational dermatitis in Ireland is unknown. At present, cases of occupational dermatitis presenting to Dermatology departments in Ireland are recorded by the University of Manchester (EPIDERM - ROI), but the uptake nationally is variable. The aim of this study was to record occupational skin disease presenting to Dermatology departments in the Republic of Ireland (ROI) over a period of one month, and compare with figures from EPIDERM-ROI.

We identified a registrar working in each Dermatology department throughout the ROI to collect data within their department. All patients attending Dermatology departments during the month of November 2017 with a diagnosis of occupational dermatitis were included. Data was collected by the registrar in each department on patient age, gender, clinical diagnosis, suspected agent, occupation and geographical location.

During the month of November 2017 there were 38 cases of occupational dermatitis recorded from nine Dermatology departments across the ROI. The mean age was 44 years (range 20-64 years) and 58% (22/38) were male. 45% (17/38) had a diagnosis of allergic contact dermatitis, 37% (14/38) had irritant contact dermatitis, and 13% (5/38) had both. The most common occupations were healthcare (18%), cleaner (16%) and food services (16%).

In one month we have recorded 38 cases of occupational dermatitis presenting to Dermatology departments across the ROI. Figures for 2017 are not yet available for EPIDERM-ROI. Just 2 cases of occupational dermatitis were reported during November 2016 almost 1/20th the figure we recorded in November 2017. We estimate this equates to an annual incidence of more than 400 cases presenting to dermatologists. In 2016, 24 cases were reported for the whole year to EPIDERM-ROI. From our study we have shown that what is being recorded in EPIDERM is significantly lower than what is occurring nationally. Our figures suggest that the true rate presenting to dermatology departments is approximately 20 times greater than recorded by EPIDERM-ROI.

Routine data collection on occupational disease, including skin disease, is important to determine incidence of disease and particular trends in such incidence. Results presented here suggest that currently EPIDERM-ROI is underreporting. Therefore, it is important to improve this scheme by increasing participation and encourage reporting.

References:
1. Money A, Carder M, Agius R. The incidence of work-related ill-health as reported to The Health and Occupation Research (THOR) network by physicians in the Republic of Ireland between 2005 and 2016.

Oral 05. 9.40am

Friend or foe?

C. Gallagher, C. Cotter, R. O'Connor, S. Kirthi, A .Salim, M. Connolly, A O'Brien, AE Hogan & AM Tobin
Tallaght University Hospital

Background and aims: Mucosal- associated invariant T (MAIT) cells are a novel subset of innate-like T cells. They are major players in the human immune system representing 2-10% of the human T-lymphocyte population. They are robust producers of effector cytokines such as IFN-γ, TNF-α and IL-17 an inflammatory mediator implicated in the pathogenesis of several inflammatory chronic diseases. Their presence in human skin has only recently been recognised with limited data in the literature. Our aims were therefore to characterize the frequencies and function of circulating and skin resident MAIT cell frequencies in the cohorts of psoriasis, hidradenitis suppurativa (HS) and eczema patients.

Methods: Consecutive patients with a diagnosis of psoriasis, hidradenitis suppurativa and eczema who attended the dermatology department in Tallaght Hospital were included. Following signed consent, clinical history and exam, a blood sample and a 6 mm punch biopsy was taken from both involved and uninvolved skin. CD45 positive cells where isolated from both the skin biopsies and peripheral blood samples. Enumeration and functional characterization of MAIT cells in the skin and blood was then performed by multi-colour intracellular flow cytometry. Immune parameters were correlated with disease severity index.

Results: MAIT cell frequencies where reduced in peripheral blood samples compared to age and sex matched healthy controls. MAIT cells where enriched in the skin biopsies of the psoriasis and HS patients when compared to matched blood samples. Cytokine analysis demonstrated an significant increase in the frequencies of IL-17 producing MAIT cells in the skin of both the psoriasis and HS cohorts when compared to matched peripheral blood. To investigate the drivers of MAIT cell IL-17 production, we investigated cell-cell interactions and found IL-17 production by MAIT cells to be dependent on monocyte interactions.

Conclusion: We show that IL-17+ MAIT cells are enriched in the skin of psoriasis and HS, but not eczema patients. Furthermore we show that IL-17 production by MAIT cells is dependent on interactions with monocytes. IL-17 is a pro-inflammatory cytokine which has been implicated in the pathogenesis of several chronic human diseases including a recent report in psoriasis. Collectively our data suggests that MAIT cells are contributing to the inflammatory milieu in psoriasis and HS, and their interactions with monocytes may represent a novel therapeutic target.

Oral 06. 9.50am

Experience of Dupilumab in the treatment of atopic eczema: a case series

A.Alani, O. Dolan, D. O'Kane
Dermatology Department, Royal Victoria Hospital, Belfast Social Health and Care Trust

Background: Atopic eczema (AE) is a chronic pruritic inflammatory skin condition with an overall prevalence of approximately 1.5 million adults across the UK and Ireland. The pathogenesis is complex but skin barrier dysfunction and an up-regulation of Th2 cytokines (including IL-4 and -13) are central. Treatment strategies include topical emollients, corticosteroids and calcineurin inhibitors with phototherapy and systemic therapies considered for recalcitrant disease. Although methotrexate, azathioprine and oral steroids are commonly used systemic options, ciclosporin was the only licensed systemic agent of severe eczema until recently. Dupilumab (600mg subcutaneously week 0 followed by 300mg fortnightly) is an interleukin (IL)-4 receptor alpha antagonist that blocks IL-4 and IL-13 signaling.

Objectives: Five adult patients with severe AE have received at least 3 months of dupilumab in our Centre via the UK Medicines and Healthcare Products Regulatory Agency (MHRA), Early Access to Medicines Scheme (EAMS). The objective of this retrospective study was to detail both clinician, patient experience and treatment outcomes to date.

Methods: Treatment response was assessed using Investigator's Global Assessment (IGA), Eczema Area Severity Index (EASI) and Disability of Life Quality Index (DLQI) scores at baseline and follow-up. Clinical notes were reviewed for additional detail on response and tolerability.

Results: Of the five treated patients, three were male and two female. The age range was 24-63 years with a mean age of 41 years. All patients had failed to respond to 2-4 previous conventional systemic therapies. The EASI, IGA and DLQI improved by a mean of 6-point, 1-point and 6-point reduction respectively, from baseline. In relation to reported side-effects to dupilumab, one patient reported two episodes of conjunctivitis, however, none of our patient experienced herpetic infections or significant ocular problems to necessitate temporary or permanent interruption of treatment. All patients received written information on potential side-effects and ocular self-care at baseline. One patient has discontinued treatment due acute episodes of facial flushing, while the other 4 remain on treatment with sustained response.

Conclusion: This small case series highlights the clinical efficacy of dupilumab in a subset of our most severe eczema patients who have had longstanding recalcitrant disease. After many years without treatment developments, a golden era for eczema patients is potentially ahead with new targeted therapies emerging, offering patients hope of leading a normal life with eczema.

Oral 07. 10.00am

Obstructive Sleep Apnoea in Hidradenitis Suppurativa patients

A. Kelly, S. Kirthi, C. Ryan, R. Hughes, B. Kirby.
St Vincent's University Hospital Dublin

Introduction: Obstructive sleep apnoea (OSA) is an independent risk factor for cardiovascular disease. The prevalence of OSA in psoriasis patients is higher than healthy control populations. The prevalence in Hidradenitis Suppurativa (HS) is unknown.

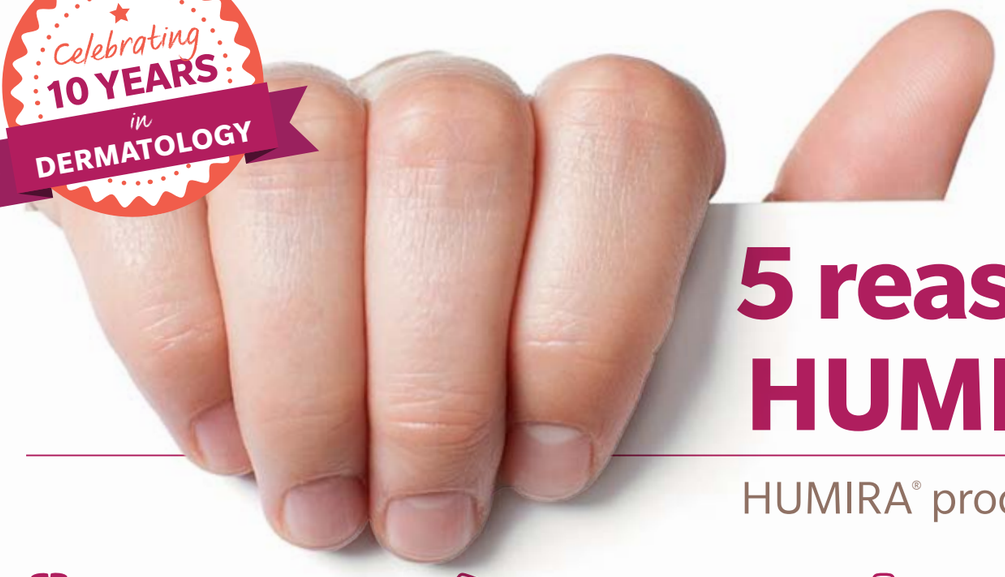
Objective: To assess the prevalence and characteristics of obstructive sleep apnoea in HS and psoriasis patients.

Method: We recruited 38 HS patients and 39 psoriasis patients. Disease severity was recorded with the Hidradenitis Suppurativa Score, Hurley Stage and PASI. Patients completed three validated screening questionnaires for OSA (Berlin, Stop BANG and Epworth questionnaire- sensitivity levels 84%, 93%, and 58%; specificity levels 38%, 35% and 60% respectively). Patients had neck circumference, waist circumference, BMI, blood pressure, lipid profile, insulin level and CRP recorded.

Results: Fifty percent of HS patients and 34% of psoriasis patients had a high probability of sleep apnea using the Berlin and Stop BANG questionnaires. Forty one percent of HS patients had an Epworth score of ›8 compared to 26.3% of psoriasis patients. Those patients with more severe HS had a higher risk of OSA (Odds ratio 4.6 (p=0.02)). Obese patients had a significantly higher risk for OSA (Odds ratio 14.0, p=0.03). Patients with higher CRP in both the psoriasis and HS group were more likely to be high risk for OSA according to Stop BANG than patients with lower CRP (Chi Sq=4.187, p=0.04, HS group; Chi Sq= 3.97, p=0.05, psoriasis group).

Conclusion: HS patients are at higher risk for OSA than psoriasis patients. HS patients should be opportunistically screened for OSA in order to identify and treat modifiable cardiovascular disease risk factors.

Celebrating 10 YEARS in DERMATOLOGY



HUMIRA® adalimumab
destination you™

5 reasons to choose HUMIRA® in Psoriasis and PsA

HUMIRA® product label contains data from a **global clinical trial in nail psoriasis**[1]

SKIN

Sustained PASI 90 long-term efficacy results supported by real-world data

61% of biologic-naïve patients achieved PASI 90 at 6 months[2]

75% of those PASI 90 responders sustained PASI 90 at 12 months[2]

JOINTS

Rapid and sustained efficacy in joint symptoms in PsA patients

58% of HUMIRA® patients achieved ACR20 by week 12[3]

57% of HUMIRA® patients achieved ACR20 at 2 years based on an LOCF analysis[4]

NAILS

Significant mNAPSI improvement in nail psoriasis at week 26

47% vs 3%, HUMIRA® and placebo respectively ($p<0.001$)[1]

SAFETY

One of the largest published global safety analysis for an anti-TNF

including 71 global clinical trials and more than 23,000 patients[5]

The most commonly reported adverse reactions are infections, injection site reactions, headache and musculoskeletal pain[1]*

PERSISTENCY

Persistency demonstrated in long-term studies of patients with psoriasis

41% of all-treated patients remained on therapy at the 8 year ESPRIT analysis†[6]

FOUR INDICATIONS IN DERMATOLOGY INCLUDING[1]

- Psoriasis in adults
- Paediatric Plaque Psoriasis (from age 4)
- Psoriatic Arthritis (PsA) in adults
- Hidradenitis Suppurativa in adults and adolescents (from age 12)

*** Please see the Summary of Product Characteristics for more information**

† Relates to patients who received at least 1 dose of HUMIRA in the registry and does not include new prescription patients (i.e. patients newly initiated on HUMIRA within 4-weeks prior to registry enrolment).

ACR: American College of Rheumatology | **LOCF:** Last Observation Carried Forward | **PASI:** Psoriasis Area Severity Index | **TNF:** Tumor Necrosis Factor | **mNAPSI:** Modified Nail Psoriasis Severity Index

Prescribing Information: Humira (adalimumab) 40mg solution for injection in pre-filled pen or pre-filled syringe, Humira 80mg solution for injection in pre-filled pen and Humira 40mg/0.8ml solution for injection (vial). Refer to Summary of Product Characteristics (SmPC) for full information. Presentation and method of administration: Each single dose 0.4 ml pre-filled pen, 0.4 ml pre-filled syringe or 0.8 ml vial contains 40mg of adalimumab for subcutaneous injection. Each single dose 0.8 ml pre-filled pen contains 80 mg of adalimumab for subcutaneous injection. **Indications and Dosage:** Humira 80 mg pen and Humira 40 mg vial are only approved for use in specific indications with a therapeutic requirement, **please refer to SmPCs for full information.** Humira treatment should be initiated and supervised by specialist physicians experienced in the diagnosis and treatment of conditions for which Humira is indicated. Ophthalmologists are advised to consult with an appropriate specialist before initiation of treatment with Humira. 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 immunomodulatory agents) should be optimised. **Rheumatoid arthritis (RA), adults:** In combination with methotrexate (MTX) for moderate to severe, active RA with inadequate response to disease-modifying anti-rheumatic drugs (DMARDs) including MTX. In combination with MTX for severe, active and progressive RA when not previously treated with MTX. Can be given as monotherapy if intolerance to or when continued treatment with MTX is inappropriate. Reduces rate of progression of joint damage on X-ray and improves physical function, in combination with MTX. Dosage: 40 mg single dose every other week (EOW). Concomitant MTX should be continued. In monotherapy, patients may require 40 mg every week if they experience a decrease in clinical response. Treatment beyond 12 weeks should be reconsidered if no clinical response in that time. Consider need for dose interruption, e.g. before surgery or if serious infection occurs. Reintroduction of Humira after discontinuation for 70 days or longer gave same magnitudes of clinical response and similar safety profile as before dose interruption. **Polyarticular juvenile idiopathic arthritis (pJIA), paediatrics 2 years and above:** In combination with MTX, for active pJIA, with inadequate response to one or more DMARDs. Can be given as monotherapy if intolerance to or when continued treatment with MTX is inappropriate. Dosage: 10 kg to <30 kg 20 mg EOW. If ≥ 30 kg: 40 mg EOW. Treatment beyond 12 weeks should be reconsidered if no clinical response in that time. **Enthesitis-related arthritis (ERA), paediatrics 6 years and above:** For active ERA with inadequate response or intolerance to, conventional therapy. Dosage: 15 kg to < 30 kg: 20 mg EOW. If ≥ 30 kg: 40 mg EOW. **Ankylosing spondylitis (AS), adults:** For severe active AS with inadequate response to conventional therapy. Dosage: adults: 40 mg single dose EOW. Treatment beyond 12 weeks should be reconsidered if no clinical response in that time. **Axial spondyloarthritis without radiographic evidence of AS (nr-axSpA), adults:** For severe nr-axSpA with objective signs of inflammation (elevated CRP and / or MRI), and an inadequate response to, or intolerance to nonsteroidal anti-inflammatory drugs. Dosage: 40 mg single dose EOW. Treatment beyond 12 weeks should be reconsidered if no clinical response in that time. **Psoriatic arthritis (PsA), adults:** For active and progressive PsA with inadequate response to DMARDs. Reduces rate of progression of peripheral joint damage on X-ray in polyarticular symmetrical subtypes of the disease and improves physical function. Dosage: 40 mg single dose EOW. Treatment beyond 12 weeks should be reconsidered if no clinical response in that time. **Psoriasis (Ps), adults:** For moderate to severe chronic plaque psoriasis in candidates for systemic therapy. Dosage: 80 mg initial dose at Week 0, followed by 40 mg EOW from Week 1. Treatment beyond 16 weeks should be reconsidered if no clinical response in that time. Beyond 16 weeks, patients with inadequate response can increase dosing frequency to 40 mg every week (refer to SmPC). If adequate response is achieved with an increased dosing frequency, dose may subsequently be reduced to 40 mg every other week. **Psoriasis, paediatrics 4 years and above:** For severe chronic plaque psoriasis with inadequate response to or if topical therapy and phototherapies are inappropriate. Dosage: 15 kg to < 30 kg: 20 mg dose initially followed by 20 mg EOW starting one week after initial dose. If ≥ 30 kg: 40 mg dose initially followed by 40 mg EOW starting one week after initial dose. Treatment beyond 16 weeks should be reconsidered if no clinical response in that time. **Hidradenitis suppurativa (HS), adults and adolescents from 12 years of age:** For active moderate to severe HS (acne inversa) in patients with an inadequate response to conventional systemic HS therapy. Dosage: HS, adults: 160 mg dose initially at Day 1, followed by 80 mg two weeks later at Day 15. Two weeks later (Day 29) continue with a dose of 40 mg every week. Reintroduction after treatment interruption: 40 mg every week. Dosage: HS, adolescents from 12 years and ≥30 kg: 80 mg initial dose at Week 0, followed by 40 mg EOW from Week 1. If there is inadequate response to 40 mg EOW, an increase in dosing frequency to 40 mg every week may be considered. Treatment interruption: Humira may be re-introduced as appropriate. Adults and adolescents from 12 years of age: Antibiotics may be continued if necessary. Concomitant topical antiseptic wash on HS lesions is recommended to be used on a daily basis. Treatment beyond 12 weeks should be reconsidered if no improvement in that time. Evaluate periodically the benefit and risk of continued long-term treatment. **Crohn's disease (CD), adults:** For moderately to severely active CD with who have not responded despite a full and adequate course of therapy with a corticosteroid and/or an immunosuppressant, intolerance to or medical contraindications for such therapies. Dosage: Induction: 80 mg dose at Week 0, followed by 40 mg at Week 2. For a more rapid response: 160 mg at Week 0, followed by 80 mg at Week 2; risk of adverse events higher during rapid induction. Maintenance: 40 mg dose EOW. During maintenance, corticosteroids may be tapered in accordance with clinical guidelines. If decrease in clinical response, can increase dosing frequency to 40 mg every week. Patients with no response by Week 4 may benefit from continued maintenance therapy to Week 12. Treatment beyond 12 weeks should be reconsidered if no clinical response in that time. **Paediatric Crohn's disease (CD), 6 years and above:** For moderately to severely active CD with inadequate response to, intolerance to or contraindication for conventional therapy including primary nutrition therapy and a corticosteroid, and/or an immunomodulator. Dosage: < 40 kg: Induction: 40 mg dose at Week 0, followed by 20 mg at Week 2. For a more rapid response: 80 mg at Week 0, followed by 40 mg at Week 2; risk of adverse events higher during rapid induction. Maintenance: 20 mg dose EOW. If insufficient response, consider an increase in dosing frequency to 20 mg every week. If ≥ 40 kg: Induction: 80 mg dose at Week 0, followed by 40 mg at Week 2. For a more rapid response: 160 mg dose at Week 0, followed by 80 mg at Week 2; risk of adverse events higher during rapid induction. Maintenance: 40 mg dose EOW. If insufficient response, consider an increase in dosing frequency to 40 mg every week. Treatment beyond 12 weeks should be reconsidered if no clinical response in that time. **Ulcerative colitis (UC), adults:** For moderately to severely active UC with inadequate response to, intolerance to or contraindication for conventional therapy including corticosteroids and 6-mercaptopurine (6-MP) or azathioprine (AZA). Dosage: Induction: 160 mg dose at Week 0, followed by 80 mg at Week 2. Maintenance: 40 mg dose EOW. During maintenance, corticosteroids may be tapered in accordance with clinical guidelines. If insufficient response, consider an increase in dosing frequency to 40 mg every week. Treatment beyond 8 weeks should be reconsidered if no clinical response in that time. **Uveitis, adults:** For non-infectious intermediate, posterior and panuveitis with inadequate response to corticosteroids, in patients in need of corticosteroid-sparing, or in whom corticosteroid treatment is inappropriate. Dosage: 80 mg initial dose at Week 0, followed by 40 mg EOW from Week 1. Treatment can be initiated in combination with corticosteroids and/or with other non-biologic immunomodulatory agents. Concomitant corticosteroids may be tapered in accordance with clinical practice starting two weeks after initiating treatment with Humira. Evaluate on a yearly basis the benefit and risk of continued long-term treatment. **Paediatric Uveitis, 2 years and above:** For chronic non-infectious anterior uveitis with inadequate response or intolerance to conventional therapy, or in whom conventional therapy is inappropriate. Dosage: < 30 kg: 20 mg dose EOW in combination with MTX. Optional 40 mg loading dose one week prior to start of maintenance therapy. No clinical data in use of loading dose < 6 years of age (see SmPC). If ≥ 30 kg: 40 mg dose EOW in combination with MTX. Optional 80 mg loading dose one week prior to start of maintenance therapy. Evaluate on a yearly basis the benefit and risk of continued long-term treatment. **Contraindications:** Hypersensitivity to the active substance or any of the excipients (see SmPC). Active tuberculosis (TB) or other severe infections such as sepsis and opportunistic infections; Moderate to severe heart failure (NYHA class III/IV). **Warnings and precautions:** Clearly record trade name and batch number of administered product to improve traceability of biological medicinal products. ***Infections:*** Patients taking TNF-antagonists are more susceptible to serious infections especially if impaired lung function. Monitor for infections, including TB, before, during and for 4 months after treatment. Do not initiate treatment with an active infection, until it is controlled. Consider risk/benefit prior to treatment in patients exposed to high risk of TB or who have travelled in areas of high risk of TB or endemic mycoses. Evaluate new infections during treatment and monitor closely. Stop treatment if new serious infection or sepsis, and treat appropriately. Exercise caution in patients with a history of recurring infections or who are predisposed to infections, including the use of concomitant immunosuppressive medications. ***Serious infections:*** Serious infections, including those with hospitalisation or death reported in patients receiving treatment. ***TB:*** Consult SmPC for details. Reactivation and new onset TB, both pulmonary and extra-pulmonary (disseminated) reported. Screen all patients before therapy initiation for active or latent TB. Appropriate screening tests (i.e. tuberculin skin test and chest X-ray) should be performed in all patients. If active TB is diagnosed Humira therapy must not be initiated. If latent TB is suspected, consult a physician with appropriate expertise and follow local treatment recommendations for prophylaxis prior to initiation of Humira. Despite prophylaxis TB reactivation has occurred on Humira. ***Other opportunistic infections:*** Opportunistic infections observed in patients receiving Humira. Stop treatment in patients with signs and symptoms of such infections. Consult with physician with appropriate expertise for diagnosis and administration of empiric antifungal therapy in these patients. ***Hepatitis B Reactivation:*** Reactivation of HBV has occurred in chronic carriers (surface antigen positive). Patients should be tested for HBV infection before initiating treatment. HBV carriers should consult with a specialist physician and be closely monitored for reactivation of HBV infection throughout therapy and for several months following termination of Humira. If reactivation occurs stop treatment and initiate appropriate anti-viral and supportive treatment. ***Neurological events:*** Caution in patients with pre-existing or recent-onset central or peripheral nervous system demyelinating disorders. Discontinuation of treatment should be considered if any of these disorders develop. Neurological evaluation should be performed in patients with non-infectious intermediate uveitis before therapy initiation and regularly during treatment, to assess for pre-existing or developing central demyelinating disorders. ***Allergic reactions:*** Reports of serious allergic reactions including anaphylaxis received. For serious allergic or anaphylactic reaction, stop Humira immediately and initiate appropriate therapy. ***Malignancies and lymphoproliferative disorders:*** A possible risk of malignancy, including lymphoma and leukaemia, in all patients including paediatric patients, treated with TNF antagonists. Examine all patients, especially those with a medical history of extensive immunosuppressant or PUVA treatment for non-melanoma skin cancer prior to and during treatment, caution in COPD patients, and in patients with increased risk of malignancy due to heavy smoking. Consider the potential risk with the combination of AZA or 6-MP and Humira (hepatosplenic T-cell lymphoma has occurred). Risk of hepatosplenic T-cell lymphoma cannot be excluded. Caution in patients with a history of malignancy. Risk of developing dysplasia or colon cancer is unknown. Patients with UC, history of dysplasia or colon carcinoma to be screened for dysplasia before and during treatment. ***Haematologic reactions:*** Adverse events of the haematologic system reported with Humira. Patients should seek immediate medical attention if signs and symptoms of blood dyscrasias develop while on treatment. ***Vaccinations:*** Patients may receive concurrent vaccinations, except for live vaccines. Bring paediatric patients up to date with all immunisations prior to Humira treatment ***Congestive heart failure:*** See contraindications. Caution is advised in mild heart failure (NYHA class I/II). Discontinue treatment for new or worsening symptoms of congestive heart failure. ***Autoimmune processes:*** Autoimmune antibodies may form with Humira. Stop treatment if development of a lupus-like syndrome with positive antibodies against double-stranded DNA. ***Surgery:*** Consider the long half-life of Humira for planned surgical procedures. Closely monitor for infections. ***Small bowel obstruction:*** Failure to respond to treatment for CD may indicate the presence of fixed fibrotic stricture requiring surgical treatment. ***Elderly:*** Serious infections were higher in patients over 65 years of age, some of which had a fatal outcome. Consider risk of infections in these patients. **Interactions:** Antibody formation was lower when Humira was given together with MTX in comparison with use as monotherapy. Combination of Humira with other biologic DMARDS (e.g. anakinra and abatacept) or other TNF-antagonists is not recommended. **Fertility, pregnancy and lactation:** Not recommended during pregnancy. Women of childbearing potential should use adequate contraception and continue its use for at least five months after the last Humira treatment. No administration of live vaccines to infants exposed to Humira in utero for 5 months following mother's last Humira treatment during pregnancy. Women must not breast-feed for at least five months after the last Humira treatment. **Adverse Reactions:** *Very common ≥ 1/10:* Respiratory tract Infections (including lower and upper respiratory tract infection, pneumonia, sinusitis, pharyngitis, nasopharyngitis and pneumonia herpes viral), leukopenia (including neutropenia and agranulocytosis), anaemia, lipids increased, headache, abdominal pain, nausea and vomiting, elevated liver enzymes, rash (including exfoliative rash), musculoskeletal pain, injection site reaction (including injection site erythema). **Serious, including fatal, adverse reactions have been reported.** including infections/sepsis, TB, opportunistic infections, allergic reactions (including anaphylaxis), HBV reactivation and malignancies (including leukaemia, lymphoma and hepatosplenic T-cell lymphoma). Serious haematological, neurological and autoimmune reactions have also been reported. These include rare reports of pancytopenia, aplastic anaemia, central and peripheral demyelinating events and reports of lupus, lupus-related conditions and Stevens-Johnson syndrome. **Prescribers should consult the SmPC for the complete list of reported side effects. Legal Category:** POM. **Marketing Authorisation Numbers:** EU/1/03/256/001, EU/1/03/256/013, EU/1/03/256/017, EU/1/03/256/021. **Further information:** available from AbbVie Limited, 14 Riverwalk, Citywest Business Campus, Dublin 24.

HCPs are asked to report any suspected adverse reactions via HPRA Pharmacovigilance, Earlsfort Terrace, IRL - Dublin 2; Tel: +353 1 6764971; Fax: +353 1 6762517. Website: www.hpra.ie; E-mail: medsafety@hpra.ie.

Date of revision of PI: December 2017, PI/256/020

References: 1. Humira Summary of Product Characteristics, available at www.medicines.ie. **2.** Data on File IREHUD170739 Analysis of sustained PASI response, BADBIR data cut 2016. **3.** Mease PJ, *et al.* Adalimumab Effectiveness in Psoriatic Arthritis Trial Study Group. Adalimumab for the treatment of patients with moderately to severely active psoriatic arthritis: results of a double-blinded, randomized, placebo controlled trial. Arthritis Rheum. 2005;52(10):3279-3289. **4.** Mease PJ, *et al.* Adalimumab for long-term treatment of psoriatic arthritis: 2 year data from the Adalimumab Effectiveness in Psoriatic Arthritis Trial (ADEPT). Ann Rheum Dis. 2009;68(5):702-709. **5.** Burmester GR, *et al.* Adalimumab: long-term safety in 23 458 patients from global clinical trials in rheumatoid arthritis, juvenile idiopathic arthritis, ankylosing spondylitis, psoriatic arthritis, psoriasis and crohn's disease. Ann Rheum Dis. 2013;72(4):517-524. **6.** D Thaci *et al.* Long-term Safety and Effectiveness of Adalimumab for Moderate to Severe Psoriasis: Results from the Eight-Year Interim Analysis of the ESPRIT registry. Presented at the Fall Clinical Dermatology Conference - 36th Anniversary, Las Vega, Nevada, October 12 – 15, 2017.

abbvie

Oral 08. 10.10am

An open prospective study to assess short incubation time white LED light photodynamic therapy for the treatment of superficial basal cell carcinoma.

R. Hellen, E. Nic Dhonncha, A. Havelin, A. Kavanagh, B. Moriarty, P. Collins*. (* joint senior authors)*
The Charles Centre, Department of Dermatology, St. Vincent's University Hospital, Dublin

Twenty percent of patients treated with conventional MAL-PDT for superficial BCC (sBCC) in our unit suffer severe pain and 33% moderate pain according to prospective visual analogue scores. Our primary aim was to determine if white light MAL-PDT using a modified protocol (wl-PDT) could address this with equal efficacy and cosmesis.

Consecutive patients with confirmed histopathology <1mm in depth were recruited. Lesions were measured then photographed at baseline and follow up. Patients were treated with MAL-PDT (two treatments, one week apart) using the Maquet Power LED 500 theatre light (405-800nm, 140,000 lux) with an equivalent red light dose of 75 J/cm2 at a rate of 55 mW/cm2.1 Pain was measured using a visual analogue scale at 1, 30, 60, and 90 minutes. Patients were unaware of the score. Adverse effects were recorded. Clinical response was assessed at day 28 and 3-monthly for 1 year. Cosmetic outcome was assessed at each visit. Suspected recurrence was confirmed with histopathology. Data was analysed using IBM SPSS v21. Twenty-eight patients (13 women, 15 men) with 36 lesions were recruited. The mean age of patients was 63.64 years (SD 2.62). The median lesion size was 15mm (IQR 8.75). Sites treated were trunk (n=16), lower limb (n = 10), head and neck (n = 7) and upper limb (n = 3). During treatment 1, the median pain score was 0/100 (IQR 0). During treatment 2, the median pain score was 0/100 (IQR 5). Response rate at day 28 following treatment was 100%. Recurrence rates were 3/36 (8.3%) at 3 months, 6/36 (16.6%) at 6 months, 10/36 (27.8%) at 9 months and 11/36 (30.6%) at 1 year. Recurrences were a small focus within the sBCC measuring 1-3 mm which were not apparent after biopsy. There was no relationship between lesion site, size, treatment-related erythema or erosion and recurrence rate at 1 year. Cosmetic outcome was reported as excellent in 14/22 (63.63%) and good in 8/22 (36.36%) at 1 year. Treatment was effective and pain free with good cosmesis. The recurrence rate is similar to that recorded in an open study using daylight PDT at 1 year.2

1. Manley M et al. Quantifying the radiant exposure and effective dose in patients treated for actinic keratoses with topical photodynamic therapy using daylight and LED white light. Phys Med Biol. 2018 Jan 25;63(3):035013.
2. Wiegell SR et al. Daylight-mediated photodynamic therapy of basal cell carcinomas–an explorative study. JAEDV. 2014:Feb 1;28(2):169-75.

Oral 09. 10.20am

Incidence of genital and perianal muco-cutaneous adverse events in a cohort of patients on isotretinoin

L. Cunningham, S. Menzies, E. Shudell, F. Moloney, N. Ralph.
Mater Misericordiae University Hospital, Dublin

Isotretinoin, a pro-drug for all-trans retinoic acid, is a very effacious treatment for acne vulgaris. Common muco-cutaneous side-effects include cheilitis and xerosis and it is highly teratogenic necessitating the need for strict contraceptive practices and pregnancy testing in females. Uncommonly reported muco-cutaneous adverse effects are dermatitis, fissures and bleeding affecting the genital and perianal skin (1, 2).

In a questionnaire-based study, we evaluated the presence of these symptoms in a cohort of patients attending our department being prescribed isotretinoin therapy. We also aimed to assess the impact of isotretinoin therapy on their sexual health and well-being. Ethics approval was obtained to carry out the study. Inclusion criteria included age greater than 16 years and minimum 3 months treatment.

Sixty-five patients completed the questionnaire from April 2017 to date. Forty-two were female. The average age of respondents was 24 years; range 17 – 48. The average dose (mg/kg) at the time of completion of questionnaire was 0.7 (range 0.3 – 1) for 56/65 patients.

Of the female respondents, 14 reported a history of dry skin and/or eczema prior to commencement of treatment. Thirty-two reported being sexually active. The most commonly employed contraceptive measures was the combination of the oral contraceptive pill and barrier method (20 patients). One patient abstained from intercourse on treatment to avoid pregnancy.

Thirteen patients (31%) reported vulval dryness on treatment leading to vulval discomfort in 9 patients. Eight patients reported dyspareunia. This led to the avoidance of intercourse in 5 patients. Two patients reported intracoital bleeding, 5 reported vulval fissures (2 whilst using an exercise bike) and 10 reported the new or increased need for lubricating agents. Seven reported bleeding not occurring during intercourse.

Thirteen of 65 (20%) patients reported perianal dermatitis, 16 reported fissures (25%) and 13 reported perianal bleeding on treatment. Seven male patients had reported a pre-treatment history of dry skin and/or eczema.

The findings of our study suggest that muco-cutaneous adverse events affecting the genital and perianal skin are more common than generally appreciated. Patients should be advised of the possibility to develop them and the potential benefit of regular emollient use on treatment.

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2. Topal IO. Dyspareunia and vaginal bleeding associated with isotretinoin: a rare complication. J Sex Med. 2013;10(10):2604.

Poster Presentations
IAD Spring Meeting 2018

Poster 01
Surgical management of cutaneous squamous cell carcinoma in Mid-west Ireland
O. Dhomhnallain, C. Hackett, B. Ramsay, M. Lynch, K. Ahmad.
University Hospital Limerick

Poster 02
An audit comparing pain scores during conventional and white light topical methyl aminolaevulinic acid photodynamic therapy in the treatment of superficial basal cell carcinoma and squamous cell carcinoma in situ.
R. Hellen, E. Nic Dhonncha, A. Havelin, L. Fleming, A. Kavanagh, B. Moriarty, P. Collins.
The Charles Centre, Department of Dermatology, St Vincent's University Hospital Dublin.

Poster 03
The New Biologic Era in Atopic Dermatitis - how many patients will need them Nationally?
E. Tierney, M. Lynch, C. Hackett, K. Ahmad, B. Ramsay.
University Hospital Limerick

Poster 04
Melanotan II user perceptions and experience: a qualitative study of online discussion forums
E. Gilhooley, S. Daly, D. McKenna.
University Hospital Sligo.

Poster 05
Success in Triaging Melanomas – A Retrospective Review of Referrals to the Pigmented Lesion Clinic in Our Lady of Lourdes Hospital Drogheda July to October 2017
N. Kearney, C. Harnett, E. Allison, C. Feighery, M. Roche.
Our Lady of Lourdes Hospital, Drogheda

Poster 06
Audit on Systemic Treatment of Palmoplantar Psoriasis
A. Flynn, R. Harrington, O. Molloy, T. Markham
University Hospital Galway

Poster 07
Incidence trends and clinicopathological characteristics of melanoma at Galway University Hospital
Q.Razali1, L.Roche1, E. Nic Dhonncha1, C. Brodie2, M. Laing1, 1Dermatology Department, 2Pathology Department, Galway University Hospital

Poster 08
Audit of influenza and pneumococcal vaccine uptake and timing amongst dermatology patients on immunosuppressant therapies
L. Cunningham, J. Barlow, B. Moriarty, R. Hughes, B. Kirby, E. Feeney, A. Lally.
St Vincent's University Hospital, Dublin.

Poster 09
Self-reported Cutaneous Side Effects of Anti-TNF Therapy in Inflammatory Bowel Disease Patients
A. Ridge, C. Gallagher, C. Judge, J. Campion, D. McNamara, D. Kevans
Department of Gastroenterology St James's Hospital, Dublin.
Department of Dermatology, AMNCH, Tallaght, Dublin 24.
Department of Gastroenterology AMNCH, Tallaght., Dublin 24.
Trinity Academic Gastroenterology Group, Trinity College, The University of Dublin.

Poster 10
Infantile haemangioma of the lip: a case series
A. Alani, S. Hoey.
Dermatology Department, Royal Victoria Hospital, Belfast Social Health and Care Trust

Poster Presentation Abstracts

Poster 01

Surgical management of cutaneous squamous cell carcinoma in Mid-west Ireland

O. Dhomhnallain, C. Hackett, B. Ramsay, M. Lynch, K. Ahmad.
University Hospital Limerick

Surgical excision remains the gold standard for the management of cutaneous squamous cell carcinoma (SCCs). There are no national guidelines for management of non-melanoma skin cancer (NMSC) in Ireland at this point. British Associations of Dermatologists guidelines suggest 5mm radial margins for low-risk and 6mm for high-risk SCCs. A skin cancer multidisciplinary meeting (MDM) was introduced in University Hospital Limerick in 2014.
Aim: Aim of this study was to quantify the incomplete excision rate for cutaneous SCCs during two time periods: 2012 and 2015 (before and after the MDM was introduced). We also assessed if histopathology reports of cutaneous SCCs described excision margins adequately.

Methods: Pathology Department provided a computer-generated list of all cutaneous SCCs excised in 2012 and 2015. Data collected included demographics, tumour characteristics, histological margins and completeness of excision.

Results: We identified 311 SCCs in 2012 and 274 in 2015. The average age of patients was 75 years (range 33-99) in 2012 and 76 years (range 25-97) in 2015. Most common site was head/neck in 230 (73%) in 2012 and 203 (74%) in 2015. In 2012, most number of SCC excised was by ENT and Maxillofacial Surgeons 93, General Surgeons 66, General Practitioners (GP's) 54 and Dermatologists 52. In 2015, most number of SCC excised was by ENT and Maxillofacial Surgeons 114, Dermatologists 62 and GP's 37. There were 36 (11%) incompletely excised SCCs in 2012. Eighteen of 36 (50%) patients had re-excision of incompletely excised SCCs with clear margins. There were 35 (12%) incompletely excised SCCs in 2015 and 13 (37%) SCCs were re-excised with clear margins. There were no differences in tumour size between incompletely and completely excised tumours. Incomplete excisions were performed by GP's (33%), ENT and Maxillofacial Surgeons (27%), General Surgeons (19%) and Dermatologists (11%) in 2012. Incomplete excisions were performed by ENT and Maxillofacial Surgeons (46%), GP's (17%), General Surgeons (14%) and Dermatologists (9%) in 2015. Analysis of histology results showed precise excision margins were not specified in 63 of 311 (20%) in 2012 and 32 of 274 (12%) cases in 2015.

Conclusions: In summary our analysis demonstrates that despite recommended surgical margins for SCCs the incomplete excision rate remains higher than expected: 11.5% in 2012 and 2015. Precise excision margins were not specified in 16% of reports in 2012 and 2015. The proportion of incompletely excised SCCs in primary care reduced 2012 to 2015.

Poster. 02

An audit comparing pain scores during conventional and white light topical methyl aminolaevulinic acid photodynamic therapy in the treatment of superficial basal cell carcinoma and squamous cell carcinoma in situ.

R. Hellen, E. Nic Dhonncha, A. Havelin, L. Fleming, A. Kavanagh, B. Moriarty, P. Collins.
The Charles Centre, Department of Dermatology, St Vincent's University Hospital Dublin.

Topical 5 methyl-aminolaevulinic acid photodynamic therapy (MAL-PDT) is an effective treatment for diffuse actinic keratoses (AK), superficial basal cell carcinoma (sBCC) and squamous cell carcinoma in situ (SCCis). Pain is a limiting factor. We report pain scores recorded with conventional PDT (c-PDT) and compare them to those recorded during white light PDT (wl-PDT) in patients with sBCC and SCCis.

Pain scores, using a visual analogue scale (VAS), are recorded in our standard protocol. Data on pain scores in c-PDT for sBCC and SCCis was retrieved from phototherapy notes. Patients with biopsy proven sBCC or SCCis were prospectively treated using a modified protocol with MAL applied for 30 minutes followed by two hours exposure with a broad spectrum visible source (Maquet 500 LED white light 75 J/cm2 at a dose rate of 55 mW/cm2) as previously described.1 Patients received two treatments one week apart. Age, gender, lesion size, lesion site, lesion type and VAS pain scores in treatment 1 and treatment 2 were recorded. Data was analysed using IBM SPSS V21.

One hundred and thirty six patients with 154 lesions were included. There were 102 lesions (51 SCCis, 51 sBCC) treated with c-PDT and 52 lesions (16 SCCis, 36 sBCC) treated with wl-PDT. Pain scores were significantly different with a median score of 43.75/100 (IQR 37.13) in the c-PDT group and 0/100 (IQR 3.63) in the wl-PDT group ($p < 0.001$). In the c-PDT group, 45/102 (44.1%) reported mild pain, 37/102 (36.3%) reported moderate and 20/102 (19.6%) reported severe pain. There was a weak positive correlation between lesion size and pain score ($r = 0.325$, $p = 0.001$). Pain scores differed significantly depending on lesion site ($p = 0.043$). The trunk and upper limb were the most painful sites. There was a modest positive correlation ($r = 0.454$, $p < 0.001$) between pain scores during treatments 1 and 2. Pain score in treatment 2 increased by 0.466/100 for each point scored during treatment 1. Pain is significantly reduced during wl-PDT using a modified protocol compared with c-PDT for the treatment of sBCC and SCCis and so is an option for patients experiencing severe pain.

1. O'Gorman SM, Clowry J, Manley M, et al. Artificial White Light vs Daylight Photodynamic Therapy for Actinic Keratoses: A Randomized Clinical Trial. JAMA Dermatol. 2016;152(6):638-44.

Poster. 03

The New Biologic Era in Atopic Dermatitis - how many patients will need them Nationally?

E. Tierney, M. Lynch, C. Hackett, K. Ahmad, B. Ramsay.
University Hospital Limerick

Background: Some patients with atopic dermatitis (AD) suffer from severe disease, often with only partial control, in spite of systemic therapies. Pharmacoeconomics may determine how accessible the forthcoming new biologic era for AD will be.

continued >>

Aims: We aimed to quantify the number of children and adults in our patient population with severe AD (i.e. those who failed topical treatments and phototherapy and currently on systemic therapy) and use that data to extrapolate what the national therapeutic needs are likely to be for severe AD.

Methods: We used our departmental Filemaker-pro patient database to identify adults (defined as ≥15yrs) and children (defined as ≤14yrs) receiving systemic therapy for AD. We used the Irish 2016 census data for Mid-West and National population figures for adults and children. Using international prevalence of severe AD we tried to predict how many AD patients would likely benefit from biologics.

Results: There are 1,002,336 children in Ireland with 98,918 of these from the Mid-West. Given AD has a childhood prevalence of 20%, there are potentially 200,467 children affected with AD nationally, of whom 19,640 reside in the Mid-West. There are 3,687,585 adults living in Ireland, with 369,591 living in the Mid-West. The adult AD prevalence is 10%, with potentially 368,759 adults affected nationally, 36,959 of whom reside in the Mid-West. Currently we have 16 children and 16 adults taking systemic therapy - 21 of whom had failed phototherapy and 6 who had failed more than one systemic agent - most with only partial control of their AD. International epidemiological data on prevalence of severe AD is extremely sparse. Up to 33% of children with AD and 9% of adults with AD may have severe disease (1,2). If we take a very conservative range of between 1-5% of children and adults as having severe AD then nationally we could expect between 10,023 to 50,116 children and 36,876 to 184,379 adults, potentially suffering with severe AD.

Conclusions: Our current patient population is a large underestimation of those affected with severe AD because historically dermatology has been under-resourced and there still remains prolonged outpatient appointment waiting times. Skin malignancy occupies a large amount of dermatologists' workload. A consequence is that sufferers with decompensating AD remain on long waiting-lists. This Irish data on severe AD in children and adults may be of assistance to the HSE National Pharmacoeconomics Department in planning for this welcome new biological era.

Poster. 04

Melanotan II user perceptions and experience: a qualitative study of online discussion forums

E. Gilhooley, S. Daly, D. McKenna.
University Hospital Sligo.

Introduction: Melanotan II is a synthetic melanocortin receptor agonist that enhances skin pigmentation by binding to the melanocortin type 1 receptor (MCR) of melanocytes, increasing eumelanin production. As a result of its non-targeted mechanism of action, Melanotan II can influence sexual function, energy homeostasis and cardiovascular function. Illicit manufacturing has made it possible for the public to purchase this unlicensed substance through online and other unregulated sources. The covert nature of Melanotan II use makes it difficult to access information on the prevalence of use, user experience, side effects and sourcing of this unregulated substance. Cyber forums potentially offer a unique method of obtaining information from publically available online postings of Melanotan II users.

Aims: Our aim was to explore Melanotan II user experience, shared advice and side effect occurrence via the examination of discussion threads posted on U.K. and Ireland online forums.

Methods: Data were extracted retrospectively from January 2016- October 2017 using an online media monitoring service provider, OlyticoTM (Dublin, Ireland). Search terms included: Melanotan, Melanotan II, Mt, Mt2, tanning injections and Barbie drug. All discussion entries were anonymised, reviewed and categorised into themes, by one reviewer, using inductive thematic analysis.

Results: A total of 1547 references to our search terms were found. We extracted 623 discussion entries among 205 participants, following exclusion of non-English language based threads, duplicate discussions and discussion points irrelevant to Melanotan II use. The four most prominent themes were motivation towards Melanotan II use, concurrent sun bed use, advice on dosing regimens and side effects experienced. Frustration surrounding 'pale' skin tones, preparing for summer holidays and tanning for body building competitions were the main sources of motivation for using Melanotan II. Sunbed use was described as complimentary or necessary in achieving a tanned appearance. Advice surrounding dosing regimens was varied and ranged from 125mcg- 1mg daily injections. Side effects discussed included nausea, lethargy, hot flushes, spontaneous erections and the emergence of new naevi or changes with pre-existing naevi. Further themes include sources of Melanotan II procurement and administration practices and advice.

Conclusion: Due to the covert nature of Melanotan II use, the analysis of online forums provides access to and a unique insight into the motivations and experiences of Melanotan II users. The sharing of empirical dosing regimens and anecdotal administration advice may be harmful and hinder the assimilation of health care advice recommending the avoidance this unlicensed product.

Poster. 05

Success in Triaging Melanomas – A Retrospective Review of Referrals to the Pigmented Lesion Clinic in Our Lady of Lourdes Hospital Drogheda July to October 2017

N. Kearney, C. Harnett, E. Allison, C. Feighery, M. Roche.
Our Lady of Lourdes Hospital, Drogheda

Aims/objectives: We aimed to assess the success of triage of patients referred to the pigmented lesion clinic (PLC), uptake of the National Cancer Control Programme (NCCP) form among GPs in our catchment and if this form aids triage.

Methods: We identified patients seen from July to October 2017 through the PLC logbook which includes patient demographics, triage category, referral mode and outcome. We identified all melanomas diagnosed in this period by reviewing patients discussed at Melanoma MDM.

Results: 360 new patients were seen in the PLC with 100 referred via the NCCP form (27%). 65 patients were triaged as urgent (18%) with 22 referred via the NCCP form (33.8%), 194 patients were triaged as semi-urgent/soon (54%) with 61 referred via the NCCP form (31%) and 101 patients were triaged as routine (28%) with 17 referred via the NCCP form (16%).

Irish Association of Dermatologists Spring Meeting 2018

12 patients triaged as urgent were felt to have clinically suspicious lesions (18.5%) with 7 diagnosed with melanoma, including 3 in-situ (10.8%). Three patients with melanoma (33.3%) were referred by the NCCP form. Two patients triaged as semi-urgent and referred by GP letter were diagnosed with melanoma-in-situ. All referrals for patients diagnosed with invasive melanoma had a documented GP suspicion for melanoma.

There were 3 melanomas detected incidentally in general clinic, two patients were being seen with psoriasis with one on ustekinamab while another patient was referred with possible SCC.

Discussion/Conclusion: There are a large number of referrals to the PLC and without standardised criteria triage can be challenging. The NCCP introduced a pigmented lesion referral form in 2016 to assist GPs in documenting important clinical features and aid the receiving consultant in triage.

Our review was completed one year after it's introduction and revealed a 27% overall uptake. 33% of referrals triaged as urgent were referred via the NCCP compared to 16% of those triaged as routine. There are a number of possible explanations for this. We feel the most likely is that GPs who are aware of the NCCP form and guidelines may be inherently more likely to detect suspicious lesions and melanomas in their patients.

It is difficult to discern if the NCCP aids triage, however; it contains numerous prompts for pertinent information. In addition to this, using GP's clinical suspicion of melanoma as a single triage criterion for pigmented lesions represents a potential standardised approach to capture all invasive melanomas urgently.

Poster. 06

Audit on Systemic Treatment of Palmoplantar Psoriasis

A. Flynn, R. Harrington, O. Molloy, T. Markham
University Hospital Galway

Background: Palmoplantar psoriasis (PPP) is a condition that significantly affects patients' quality of life. It can be difficult to treat and many patients often fail to improve with topical therapy. Historically, there has been limited data on systemic treatment, as patients are often excluded from clinical trials of psoriasis because less than 10% of their body surface area is affected. This creates a lack of 'real-life' data when it comes to treating PPP with systemic medications. We endeavoured to find what systemic treatments were most effective and well tolerated for patients with PPP. To do this, we performed a retrospective audit on all patients attending our department with PPP on systemic medications, excluding biologic agents.

Methods: Over the past ten years we have collaborated a database for patients with a diagnosis of psoriasis on systemic treatment. Using this database, we identified patients with PPP-subtype on systemic treatment. We then collected their medical records to identify their systemic treatment. Information was collected on age, gender, medication, primary failure, secondary failure and duration of treatment.

Results: Eighteen patients with PPP who received systemic treatment within the past ten years were identified. The systemic medications prescribed were acitretin, fumaderm® and methotrexate. 56% (10/18) were female and the age range was 20 – 84 years, with a mean age of 54 years.
Ninety-four percent (17/18) were prescribed acitretin. 18% (3/17) experienced primary failure, and a further 30% (5/17) experienced secondary failure. The most common reason for discontinuing treatment was loss of effect. The mean duration of treatment was 18.9 months.

Fourty-one percent (7/17) were prescribed fumaderm®. 43% (3/7) experienced primary failure and a further 43% (3/7) experienced secondary failure, with only one patient continuing on treatment. Reasons for discontinuation included lymphopenia, joint pains and fatigue. The mean duration of treatment was 15.7 months.

Thirty-five percent (6/17) were prescribed methotrexate. No patients experienced primary failure and 50% experienced secondary failure. The mean duration of treatment was 23.4 months.

Conclusion: Overall, methotrexate appears to be the most effective medication for PPP, with 50% of patients remaining on treatment and the longest mean duration of treatment at 23.4 months. Acitretin was nearly as good, with 47% of patients remaining on treatment with a mean duration of treatment 18.9 months. Fumaderm® appears to be the least effective of the three medications, with 86% of patients experiencing either primary or secondary failure.

Poster. 07

Incidence trends and clinicopathological characteristics of melanoma at Galway University Hospital

Q.Razali1, L.Roche1, E. Nic Dhonncha1, C. Brodie2, M. Laing1, 1Dermatology Department, 2Pathology Department, Galway University Hospital

Title: Incidence trends and clinicopathological characteristics of melanoma at Galway University Hospital (GUH) and three-year comparison with National Registry Ireland (NCRI)

Background: Melanoma incidence has been increasing in light-skinned populations worldwide. Few studies have assessed the incidence of melanoma in situ and lentigo maligna in a large population-based database. The aims of this study were to describe the incidence trends of cutaneous melanoma in Galway University Hospital (GUH), to evaluate the clinicopathological features such as cancer subtype, age and gender and compare this with the National Cancer Registry.

Methods: In collaboration with Department of Pathology, GUH we collected data on melanoma diagnosis generated from APEX Laboratory Information Systems (LIS) computer system from the year 2013 until October 2017. The clinicopathological data included patients age, gender and subtype of melanoma diagnosis. Similar melanoma diagnosis data from the NCRI was also acquired for comparison purposes. The data were compared and analysed.

Results: Eight hundred and fifty-five melanomas were diagnosed in GUH from the year 2013 up to 2015. This represented 17% of melanomas in Ireland per year between these periods. A further 552 cases were diagnosed up until October 2017. Data from NCRI was complete to 2015 only so a comparison could only be performed for a 3-year period. Overall, females comprised 54%

of cases (n= 855) with a median age of 77. Lentigo maligna represented 33% of melanomas diagnosed between those periods. Our analysis showed a high incidence of lentigo maligna (LM) subtypes diagnosed throughout the three-year period and a higher percentage of LM compared to the national data. Evaluation of the yearly incidence of LM showed a rate of 37%, 30% and 32% respectively for years 2013, 2014 and 2015. When we compared this to the NCRI data the national incidence of LM over the period showed a lower incidence of LM; 2013: 21%, 2014: 20% and 2015: 20%.

Conclusion: Over a three-year period, 17% of melanomas in Ireland were diagnosed at GUH. The incidence of LM at our centre is high compared to the national average (33% versus 20%) and international average (4-15%). The incidence of LM has been consistently high over the past 3 years in our centre.

Reference
1. Swetter, S., Boldrick, J., Jung, S., Egbert, B. and Harvell, J Invest Dermatol. 2005 Oct;125(4):685-91 Increasing Incidence of Lentigo Maligna Melanoma Subtypes: Northern California and National Trends 1990–2000.

Poster. 08

Audit of influenza and pneumococcal vaccine uptake and timing amongst dermatology patients on immunosuppressant therapies

L. Cunningham, J. Barlow, B. Moriarty, R. Hughes, B. Kirby, E. Feeney, A. Lally.
St Vincent's University Hospital, Dublin.

Patients on immunosuppressive (IS) therapies have an increased risk of infection. It is recommended they have the annual influenza vaccine as well as the pneumococcal vaccine (Pneumovax) administered 5 yearly. The response to these vaccines can be attenuated whilst on therapy and it can take up to 2 weeks to mount a sufficient response. Therefore, it is recommended that they are initially given at least 2 weeks prior to commencing treatment.

This audit was carried out to assess both the uptake and timing of these vaccines amongst a cohort of patients on IS therapies attending our center as well as to assess reasons for not receiving them. Approval was granted by the audit committee to carry out a questionnaire-based study.

One hundred patients completed the questionnaire (November 2017 to February 2018), of whom 60 were male. 77/99 reported being up to date with the influenza vaccine. Only 16/92 patients had their first dose prior to commencing their IS agent, of whom 12 reported having it at least 2 weeks before. 48/78 patients reported receiving it from their GP or practice nurse, 16 from a pharmacist, 2 in another hospital department and 10 through work. The most common reported reasons for not having had the vaccine were difficulty or inconvenience attending their GP (7/23), being unaware of the recommendation for the vaccine (6/23) or forgetting (4/23). Only 1 patient cited the cost of attending their GP/practice nurse was a deterrent.

Sixty-four of 98 patients reported being up to date with the pneumococcal vaccine. Only 7 patients reporting having had their first dose pre-IS therapy and 5/7 had it at least 2 weeks pre-treatment. 61/64 received it from their GP or practice nurse. Similarly, the most commonly reported reasons for not receiving the vaccine were being unaware of the recommendation (11/35), difficulty/inconvenience attending the GP (10/35) or forgetting (7/35). 3 patients cited the cost of the GP/nurse consultation or vaccine as a reason why not.

Overall, just 24/100 patients recalled receiving written information on why they should be vaccinated. 71/85 of patients reported receiving the recommendation from the dermatology clinic.

This audit shows good uptake of both the influenza and pneumococcal vaccines. Most patients were not vaccinated pre-immune-suppression. Introduction of vaccination of these patients at point of dermatology care may lead to higher uptake and appropriate pre-immune-suppression vaccination. This is naturally limited by resource restrictions.

Poster. 09

Self-reported Cutaneous Side Effects of Anti-TNF Therapy in Inflammatory Bowel Disease Patients

A. Ridge, C. Gallagher, C. Judge, J. Campion, D. Mc Namara, D. Kevans
Department of Gastroenterology, St James's Hospital, Dublin 8
Department of Dermatology, AMNCH, Tallaght, Dublin 24
Department of Gastroenterology AMNCH, Tallaght , Dublin 24
Trinity Academic Gastroenterology Group, Trinity College, The University of Dublin

Introduction: Anti-TNF monoclonal antibodies are established induction and maintenance agents for inflammatory bowel disease (IBD). They are generally well tolerated with an extensively characterised side effect profile. While cutaneous side effects of these agents are known to occur, they are less well described and few studies have evaluated patient-reported skin side effects. Our aim was to assess the prevalence and characteristics of self-reported cutaneous side effects in an IBD cohort receiving anti-TNF therapy.

Methods: A prospective multi-centre study was conducted at two Irish Academic Medical Centres. Consecutive IBD patients with a history of anti-TNF therapy exposure were invited to complete a self-assessment questionnaire which focused on cutaneous symptoms. Clinical data was recorded including basic demographics, pre-existing skin conditions and development of cutaneous symptoms post anti-TNF therapy commencement.

Results: N=78 patients completed the study questionnaire (mean age 41years [range 18-72]; 54% male; 72% Crohn's Disease (CD), 21% ulcerative colitis (UC) and 8% IBD-U. Mean Anti-TNF therapy duration at time of questionnaire completion was 39 months [range 2-180]. 59% of subjects reported experiencing "skin changes" following the commencement of anti-TNF therapy with the reported time to development of symptoms (mean [range]) being 12 months [0 - 72]. The most common cutaneous symptoms experienced were "dry skin" (41%), "itch" (35%) and "redness" (26%). Of the 46% of subjects with a pre-existing dermatological condition, 31% described worsening of the condition after therapy commencement. Of those with pre existing psoriasis, 13% reported it worsened during therapy. Only 26% of the study cohort reported seeking medical attention for cutaneous side effects. Therapy was prescribed in a minority of patients with emollient and topical steroids use reported in 31% and 17% of study subjects respectively. Discontinuation of anti-TNF therapy was rarely required with n=1 individual reporting anti-TNF therapy discontinuation due to cutaneous side effects.

Conclusion: Cutaneous side effects of anti-TNF therapy are common and may be under-appreciated by practicing clinicians and patients. Specific questioning regarding cutaneous side effects should be undertaken when reviewing IBD patients receiving anti-TNF therapy. While common, cutaneous side effects can be successfully managed using topical therapies and uncommonly lead to a requirement for therapy discontinuation.

Poster. 10

Infantile haemangioma of the lip: a case series

A. Alani, S. Hoey.
Dermatology Department, Royal Victoria Hospital, Belfast Social Health and Care Trust

Background: Infantile haemangioma (IH) of the lip are potentially problematic and present a unique challenge because of high visible location with risk of deformity and ulceration. IH grow after birth and usually spontaneously regress, but can lead to disfigurement when located in facial areas such as the lip. We wanted to share our experience in the treatment of these problematic IH of the lip with propranolol.

Objectives: We report three patients with lip IH managed with propranolol. We document treatment course, discuss challenges and treatment options available for these patients.

Methods: This is a retrospective analysis of IH of the lip cases, managed with propranolol over the past 6 years to document the treatment course, number of propranolol courses, complications and outcome. The outcome determined by medical records was classified as good, poor or intermediate. Patients were considered, as having a poor outcome if the haemangioma resulted in anatomic deformity, functional impairment, scarring, ulceration or airway compromise. Intermediate outcome was considered in cases with some response to propranolol but patient required corrective surgery or pulsed dye laser. While a good outcome was complete involution of IH.

Results: A total of 141 patients have been treated with propranolol over the past 6 years. Three cases of IH involving the lips were identified from review of medical records. All three cases received oral propranolol at a dose of 2mgs/kg (10mgs/5ml). Age at starting oral propranolol ranged from 2- 6 weeks old with first course of propranolol duration from 9 – 27 months. In two cases, lip haemangioma required a second course of oral propranolol after 2- 8 months from completion of the first course, due to lip ulceration. In one case, a third course of propranolol was indicated due to lip haemangioma flare. All three cases involved the lower lip and in two cases, lower lip IH was linked with to a diagnosis of PHACES (posterior fossa malformations, haemangioma, arterial anomalies, cardiac defects, eye abnormalities, sternal cleft and supra-umbilical raphe syndrome). Outcomes reported in our three cases range from poor to intermediate. One case required three treatments with pulsed dye laser and corrective surgery.

Conclusion: IH are common and affect 5% of Caucasian infants. They are characterized by rapid growth during the first six-months of life, followed by a period of stabilization and eventually involute after age one. However, lip IH can be problematic and from our experience follow an unpredictable course.

LA ROCHE-POSAY SYMPOSIUM

Carlos Otalora, La Roche-Posay

Dr Anne-Marie Tobin

Dr Suzanne Clements

Jackie O'Connor & Ciara Swan,Dr Anne-Marie Tobin, Carlos Otalora, Dr Kevin McKenna, Dr Suzanne Clements, Moira Walsh & Mark Withington

Autumn Meeting Guest Speakers

Dr Daniel Creamer

Prof Sarah Rogers & Dr Nick Levell

Dr Kevin McKenna, IAD President & Dr Nick Levell

Dr Kevin McKenna, IAD President & Dr Richard Groves

PRIZE WINNERS

Rogers Plate 2017 Winning abstract
Dr Aoibheann Flynn

Pilot project on electronic photo-triage of referrals for infantile haemangiomas
A. Flynn, M. Murphy. South Infirmary Victoria University Hospital, Cork.

Background: The discovery of propranolol as an effective treatment for infantile haemangiomas (IH) has been one of the highlights of paediatric dermatology.1 IH mainly develop between 4 weeks and 3 months of age. There is evidence that a period of accelerated growth occurs between 5.5 and 7.5 weeks of life and that those treated earlier have more favourable outcomes.2 Thus, early IH need to be recognized promptly and infants with high-risk IH should be referred to specialists urgently for either initiation of treatment or close clinical observation. In an era of prolonged waiting lists, consultant dermatologists need to have mechanisms in place for urgent evaluation of infants with high-risk IH and a triage system to determine what is high-risk in order to optimise timing of consultation and management.

Methods: The aim of this project was to provide a fast-track approach for general practitioners to send a photograph of the haemangioma with the child's date of birth via Healthmail to a paediatric dermatologist. The photographs were reviewed within five working days and the general practitioner was contacted with an outcome.

Results: The project initiated November 2016. To date there have been 88 referrals. Eight of the referrals did not have a photograph attached. At photo-triage 84% (67/80) were infantile haemangioma, 10% (8/80) port-wine stain, 1% (1/80) vascular malformation and 5% (4/80) could not have a definitive diagnosis made. Age varied from less than 1 week to 57 weeks, with a mean age of 16 weeks. 31% were located on the face, 28% on the trunk, 19% limbs, 11% scalp, 5% ear, 4% genital and 2% on the neck. 46% (31/67) of the IH did not require treatment, 36% (24/67) had a routine review and 18% (12/67) required urgent review. Conclusion: This novel photo-triage study has shown to be effective at identifying high-risk infantile haemangiomas. This allowed appropriate allocation of resources, with urgent clinical reviews arranged for infants who would benefit from early intervention. Patients with low-risk IH and port-wine stains were triaged appropriately, obliterating the need for urgent clinical review and saving resources.

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2. Megha M. Tollefson, Ilona J. Frieden. Early growth of infantile haemangiomas: what parents' photographs tell us. Pediatrics 2012; 130(2) e314-320

Rogers Plate 2017 Runner-up abstract
Dr Laoise Griffin

Title: Reflectance confocal microscopy helps exclude melanoma in breast-milk line melanocytic naevi
L. Griffin1, J. Boggs1, K. Ahmad1, N. Leonard2, C. Hackett1, B. Ramsay1. 1 Dermatology department, University Hospital Limerick. 2 Pathology Department, St. James Hospital, Dublin 8.

Introduction: Pigmented lesions of the anatomic milk line often present as atypical melanocytic naevi with concerning features on dermoscopy. This cosmetically sensitive area can offer management dilemmas. In this retrospective study, we identified a cohort of milk line nevi (n=14) and compared our clinical impression from dermoscopy, to Reflectance Confocal Microscopy (RCM) criteria for melanoma and histology to see if diagnostic accuracy could be improved preoperatively.

Methods: 14 pigmented nevi from anterior chest /breast of both sexes were identified where a decision to remove the lesion had been made. Dermoscopy images had been examined by 2 clinicians pre-operatively for features of malignant melanoma (MM). RCM images for 12 lesions were examined using RCM diagnostic criteria for MM by Pellacani et al (1).

Results: The mean age of patients was 34 years, age range: 19-67 years and 10 were female. A clinical impression of MM was made in 5 and dysplastic nevus in 9 following dermoscopy. The dermoscopic findings included asymmetric pigment network, peripheral globules, pigmented streaks, dots and radial streaming. Confocal examination was variable. While most retained the regular meshwork epidermal structure we usually see in naevi, significant architectural atypia were noted. Cellular variation in melanocytic size and shape was noted. Pagetoid cells were noted in 6, yet only 2 lesions fulfilled the RCM criteria for MM pre-excision. One was a superficial spreading MM, Breslow 0.6mm and the other was other deemed to be an atypical special site breast nevus by a specialist dermatopathologist. In the remaining 12, significant regression was noted in 4 and dramatic dermal pigment incontinence in 3, but all were benign.

Conclusion: Histopathology literature has recognised a group of naevi in the milk line that are associated with atypical histological appearance with an atypical growth pattern of the loosely connecting variably sized melanocytic cells, prominent nests along sides of the rete ridges and an active junctional component (2). This, however, was only seen in one of our patients. The remaining histology was reassuring benign in 12 patients and a single malignant melanoma was diagnosed. With the spotlight now firmly on pigmented lesion clinic waiting times, it is helpful to be aware that naevi in the breast-milk line may have atypical clinical appearance but based on our series, MM is less likely in this group. RCM was helpful in determining whether patients had melanoma as the RCM criteria excluded MM in 10 out of 12 lesions (83%).

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SCHOLARSHIP RECIPIENTS

Undergraduate recipients autumn 2017, Barbara Marzario UCC & Aoife McElduff QUB

Undergraduate scholarship recipient, Aoife McElduff, Queens University Belfast & Dr Nataliia Zhovta, EADV scholarship recipient

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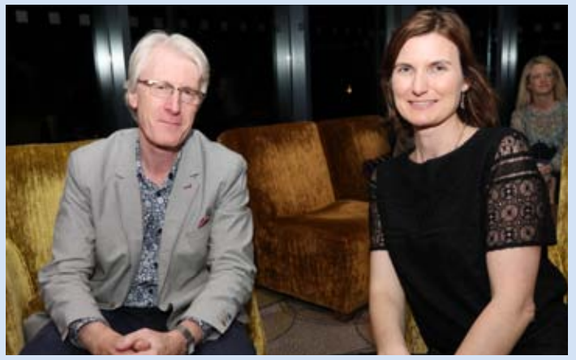
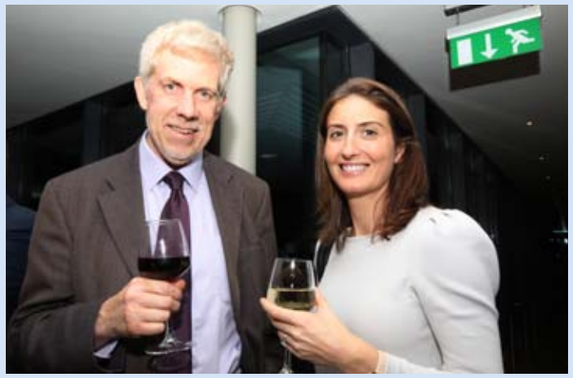
AUTUMN MEETING DINNER

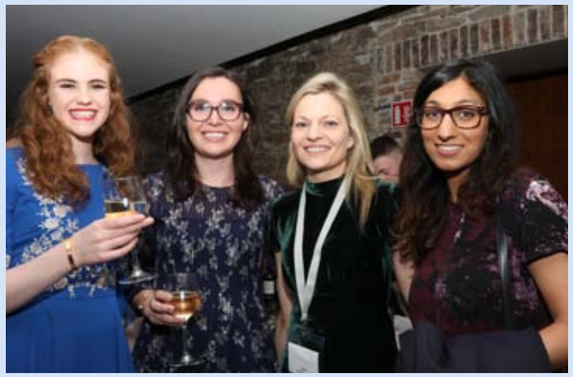


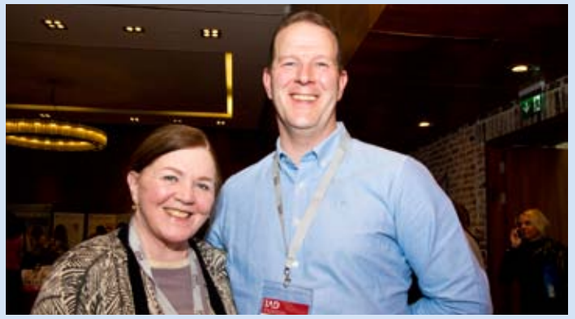











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Avène
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and protect


Protopic
Calming the atopic dermatitis flare cycle


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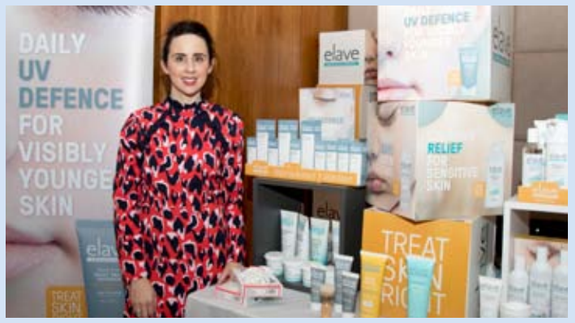
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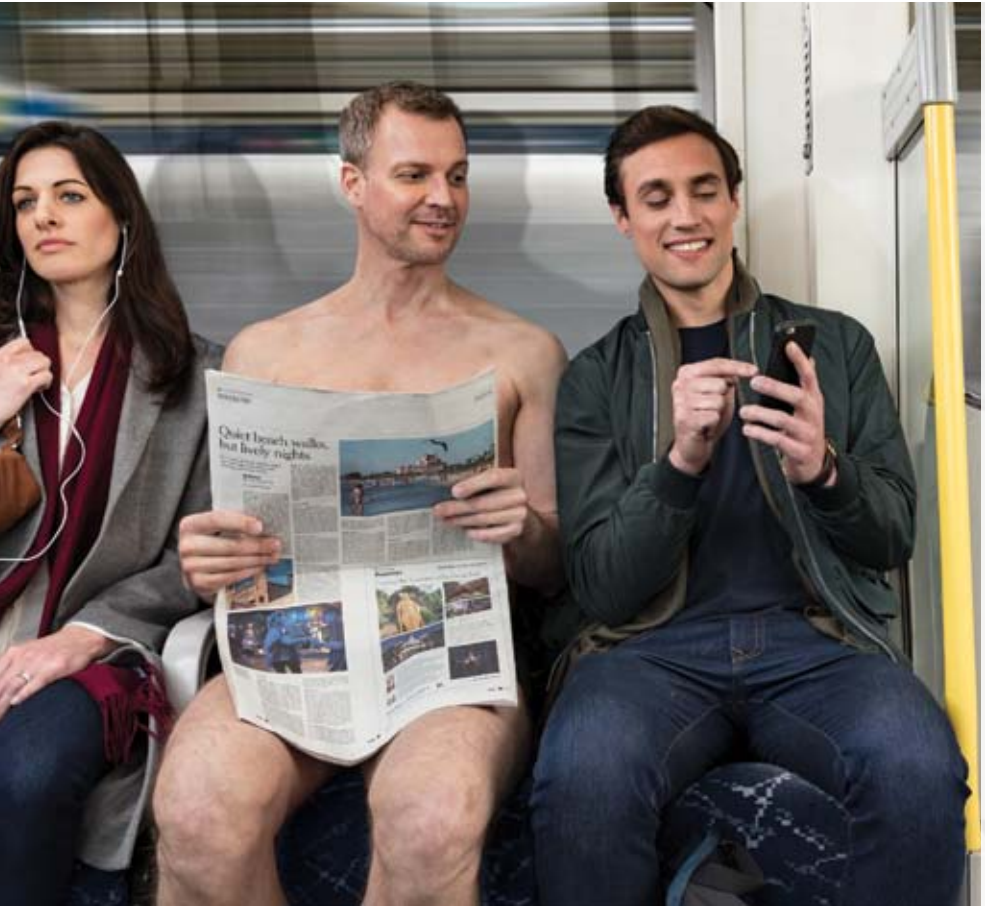

kyntheum®▼

brodalumab

What does PASI 100 mean to Simon?

Kyntheum®: Confidence starts with clearance

Kyntheum® (brodalumab) is indicated for the treatment of moderate to severe plaque psoriasis in adult patients who are candidates for systemic therapy.[1]

LEO®

- Kyntheum® targets the IL-17 pathway in a novel way, being the only biologic treatment for moderate to severe plaque psoriasis that selectively targets the IL-17 receptor subunit A[2]
- Kyntheum® is superior to ustekinumab at achieving PASI 100 at 12 weeks[30]

44% vs 22%* (AMAGINE-2)[3]

37% vs 19%* (AMAGINE-3)[3]

*P<0.001

- Patients achieving PASI 100 are less likely to experience impairment to their health-related quality of life than those with residual disease[4]
- Kyntheum® has a simple induction schedule and an acceptable safety profile[5]

Abbreviated Prescribing Information for Kyntheum®▼(brodalumab) 210 mg solution for injection in pre-filled syringe Please refer to the full ummary of Product Characteristics (SmPC) (www.medicines.ie) before prescribing.▼ This medicinal product is subject to additional monitoring. This will allow quick identification of new safety information. Healthcare professionals are asked to report any suspected adverse reactions. **Indication:** Treatment of moderate to severe plaque psoriasis in adult patients who are candidates for systemic therapy. **Active ingredient:** Each pre-filled syringe contains 210 mg brodalumab in 1.5 ml solution. 1 ml solution contains 140 mg brodalumab. **Dosage and administration**: *Posology: Adults:* The recommended dose is 210 mg administered by subcutaneous injection at weeks 0, 1, and 2 followed by 210 mg every 2 weeks. Consideration should be given to discontinuing treatment in patients who have shown no response after 12-16 weeks of treatment. Some patients with initial partial response may subsequently improve with continued treatment beyond 16 weeks. Administer by subcutaneous (SC) injection. Each pre-filled syringe is for single use only. *Elderly:* No dose adjustment recommended. *Hepatic and renal impairment:* No dose recommendations can be made. *Children and adolescents below the age of 18 years:* Safety and efficacy of Kyntheum have not been established. *Method of administration*: Kyntheum should not be injected into areas where the skin is tender, bruised, red, hard, thick, scaly, or affected by psoriasis. The pre-filled syringe must not be shaken. After proper training in SC injection technique, patients may self-inject Kyntheum when deemed appropriate by a physician. Patients should be instructed to inject the full amount of Kyntheum according to the instructions provided in the package leaflet. **Contraindications:** Hypersensitivity to the active substance or to any of the excipients. Active Crohn's disease. Clinically important active infections (e.g. active tuberculosis).**Precautions and warnings:** *Crohn's disease*: Exercise caution when prescribing Kyntheum to patients with a history of Crohn's disease. They should be followed for signs and symptoms of active Crohn's disease. If patients develop active Crohn's disease, treatment should be discontinued permanently. *Suicidal ideation and behaviour*: A causal association between treatment with Kyntheum and increased risk of suicidal ideation and behaviour has not been established. Carefully weigh the risk and benefit of treatment with Kyntheum for patients with a history of depression and/or suicidal ideation or behaviour, or patients who develop such symptoms. Patients, caregivers and families should be advised of the need to be alert for the emergence or worsening of depression, suicidal ideation, anxiety, or other mood changes, and they should contact their healthcare provider if such events occur. If a patient suffers from new or worsening symptoms of depression and/or suicidal ideation or behaviour is identified, it is recommended to discontinue treatment with Kyntheum. *Infections*: Kyntheum may increase the risk of infections. Caution should be exercised when considering the use of Kyntheum in patients with a chronic infection or a history of recurrent infection. Patients should be instructed to seek medical advice if signs or symptoms suggestive of an infection occur. If a patient develops a serious infection, they should be closely monitored and Kyntheum should not be administered until the infection resolves. Kyntheum should not be given to patients with active tuberculosis. Anti-tuberculosis therapy should be considered prior to initiation of Kyntheum in patients with latent tuberculosis. *Reduced absolute neutrophil count*: A decrease in absolute neutrophil count, generally transient and reversible, has been observed in 5.6% of patients receiving Kyntheum. *Vaccinations*: It is recommended that patients be brought up-to-date with all immunisations in accordance with local immunisation guidelines prior to initiation of treatment with Kyntheum. Live vaccines should not be given concurrently with Kyntheum.The safety and efficacy of Kyntheum in combination with immunosuppressants, including biologics, or phototherapy have not been evaluated. **Drug interactions:** Live vaccines should not be given concurrently with Kyntheum. **Fertility, pregnancy and lactation:** *Women of childbearing potential*: Use an effective method of contraception during treatment and for at least 12 weeks after treatment. *Pregnancy*: There are no or limited amount of data from the use of brodalumab in pregnant women. As a precautionary measure, it is preferable to avoid the use of Kyntheum in pregnancy. Benefit risk for exposure of the infant to live vaccines following third trimester exposure to Kyntheum should be discussed with a physician. *Breast-feeding:* It is unknown whether brodalumab is excreted in human milk. A risk to the newborns/infants cannot be excluded. Whether to discontinue breast-feeding or discontinue Kyntheum therapy should be decided, taking into account the benefit of breast-feeding for the child and the benefit of therapy for the woman. *Fertility*: No data are available on the effect of brodalumab on human fertility. **Side effects:** *Common (≥1/100 to <1/10)*: Influenza, tinea infections (including tinea pedis, tinea versicolor, tinea cruris), neutropenia, headache, oropharyngeal pain, diarrhoea, nausea, arthralgia, myalgia, fatigue, injection site reactions (including injection site erythema, pain, pruritus, bruising, haemorrhage). *Uncommon (≥1/1,000 to <1/100)*: Candida infections (including oral, genital and oesophageal infections), conjunctivitis. **Precautions for storage:** Store in a refrigerator (2°C-8°C). Do not freeze. Keep the pre-filled syringe in the outer carton in order to protect from light. Kyntheum may be stored at room temperature (up to 25°C) once, in the outer carton, for a maximum single period of 14 days. Once Kyntheum has been removed from the refrigerator and has reached room temperature (up to 25°C) it must either be used within 14 days or discarded **Legal category:** POM. **Marketing authorisation number and holder:** EU/1/16/1155/001, LEO Pharma A/S, Ballerup, Denmark. **Last revised:** September 2017.

Further information can be found in the Summary of Product Characteristics or from: LEO Pharma, Cashel Road, Dublin 12, Ireland. e-mail: medical-info.ie@leo-pharma.com

Reporting of Suspected Adverse Reactions

Reporting suspected adverse reactions after authorisation of the medicinal product is important. It allows continued monitoring of the benefit/risk balance of the medicinal product. Healthcare professionals are asked to report any suspected adverse reactions via HPRA Pharmacovigilance, Earlsfort Terrace, Dublin 2, Tel: +353 1 6764971, Fax: +353 1 6762517, Website: www.hpra.ie, e-mail: medsafety@hpra.ie

Adverse events should also be reported to Drug Safety at LEO Pharma by calling +353 1 4908924 or e-mail medical-info.ie@leo-pharma.com

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References:
1. Kyntheum® Summary of Product Characteristics.
2. Campa M, et al. *Dermatol Ther* 2016;6:1–12.
3. Lebwohl M, et al. *N Engl J Med* 2015;373:1318–1328.
4. Strober B, et al. *J Am Acad Dermatol* 2016;75:77–82.
5. Papp KA, et al. *Br J Dermatol* 2016;175(2):273–86.

Date of preparation: December 2017 MAT-14024

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