17th CONGRESS of THE BALTIC ASSOCIATION OF DERMATOVENEREOLOGISTS

ONLINE ABSTRACT BOOK

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2021

17th Congress of the Baltic Association of Dermatovenereologists

17–19 September 2021, Kaunas, Lithuania

ONLINE ABSTRACT BOOK

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17th Congress of the Baltic Association of Dermatovenereologists

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Assoc. Prof. Ruta Ganceviciene (Vilnius, Lithuania)

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CONGRESS SECRETARIAT

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PROGRAMME

Friday, 17 September 2021

10.00–18.00	Registration / INFO center working hours
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Anna Sujica (Ljubljana, Slovenia)

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Cryotherapy. Theory
Chairs: Janis Kisis (Riga, Latvia),
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Chair: Iryna Smolanka (Uzhgorod, Ukraine)

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Latvia: *Silvestrs Rubins (Riga, Latvia)*
Russia: *Eugenij Sokolovskij (Saint Petersburg, Russia)*
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Surgical treatment methods
Topical treatment in oncodermatology

Cryotherapy. Live demonstration
Chairs: Janis Kisis (Riga, Latvia), Mara Rone-Kupfere (Riga, Latvia)

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10.40–10.45	Acne fulminans in 14 years old male. A case report. *Justina Maciulyte (Kaunas, Lithuania)*
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15.30–15.45	Iatrogenic Kaposi sarcoma in a renal allograft recipient. *Jokubas Liutkus, Justina Mackeviciute, Rokas Kireilis, Jurgita Makstiene, Skaidra Valiukeviciene (Kaunas, Lithuania)*
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16.45–17.00	Classic Kaposi's sarcoma: clinical aspects and treatment options. *Ilona Hartmane (Riga, Latvia)*
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17.15–17.30	Diagnostics and monitoring of patients with melanoma. *Skaidra Valiukeviciene (Kaunas, Lithuania)*
17.30–17.45	Modern systemic therapies in melanoma and non-melanoma skin cancer. *Steffen Emmert (Rostock, Germany)*
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8.45–9.00	Acquired epidermolysis bullosa. *Lina Kuliesyte, Jonas Lauraitis, Raimundas Meskauskas, Jurate Grigaitiene (Vilnius, Lithuania)*
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10.00–10.05	Clinical features and quality of life of patients with chronic wounds. *Laura Rackauskaite (Kaunas, Lithuania)*
10.05–10.10	Diagnostic challenge of gigantic benign skin lesion. *Agne Ruminaite (Vilnius, Lithuania)*
10.10–10.15	The prevalence of rosacea and its association with serum vitamin D levels: a population based study of adults in Lithuania, Kaunas city. *Evelina Stankute (Kaunas, Lithuania)*
10.15–10.20	The management of progressive Mycosis fungoides with overlapping presentation of Sezary syndrome. *Ieva Vaitkeviciute (Kaunas, Lithuania)*
10.20–10.25	Efficiency of intralesional therapy in a rare case of lichen ruber planus hypertrophicus. *Vadims Viktorovs (Riga, Latvia)*

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10.50–11.05	Tasks and visions of IUSTI - Europe**.** *Airi Poder (Tartu, Estonia)*
11.05–11.20	Syphilis in Belarus: focus on MTCT (congenital syphilis) prevention. *Oleg Pankratov (Minsk, Belarus)*
11.20–11.35	Neurosyphilis in HIV-infected patients. *Evgeny Sokolovskiy (Saint Petersburg, Russia)*
11.35–11.50	Value of Gardnerella vaginalis genotyping in the diagnosis of bacterial vaginosis. *Alevtina Savicheva (Saint Petersburg, Russia)*
11.50–12.05	Quality in the lab and the new IVD Regulation (EU) 2017/746. *Kai Joers (Tartu, Estonia)*
12.05–12.25	European (IUSTI) guidelines for bacterial STIs. *Magnus Unemo (Orebro, Sweden)*
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13.15–13.30	What is new in contact allergy? *Wolfgang Uter (Erlangen, Germany)*
13.30–13.45	Itch: what's new. *Jacek C. Szepietowski (Wroclaw, Poland)*
13.45–14.00	Diffuse hair loss in daily practice. *Jurate Grigaitiene (Vilnius, Lithuania)*
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WORKSHOPS ABSTRACTS

The content of the abstracts presented is the responsibility of their authors and co-authors.
The abstracts are arranged according to the congress program.

Workshop I
Management of sexually transmitted infections (STI)

W 1–12. Why international collaborative projects are important? Experiences of an Eastern European Network for Sexual and Reproductive Health and Rights

Marius Domeika[1]
[1]*Forum Health MD, Sweden*

Introduction
After the fall of the Berlin wall and distortion of the Soviet Union in many previous soviet republics resources were limited and therefore previous possibility for the specialists to meet, to attend the educational courses, i.e. follow the knowledge development became impossible. At the same time absence of the evidence-based approaches formed the gap in the STI patient management between the East and West. The only possibility of improving this situation was establishing close networking between the specialists of different countries and through the collection of the evidence, elaborate evidence-based approaches for the patient management, including qualitative laboratory diagnosis and epidemiological surveillance.

Aims and Objectives
Quality assurance of the STI management in the countries of Eastern Europe, through the networking and introduction of evidenced-based aproaches.

Materials and methods
Establishment of the international network, multiple training sessions, evidence collection (mainly thorough the research studies), elaboration and national adaptation of the laboratory quality management standards, standards for the laboratory diagnosis and patient management, elaboration and adaptation of epidemiological surveillance systems.

Results
As a result of the project, an international multidisciplinary Eastern European Network for Sexual and Reproductive Health and Rights was established. Laboratory quality management standard ISO 15185 translated and nationally adapted in Lithuania, Russia, Ukraine, and Belarus. Numerous training for the implementation of the standard in the project countries were

provided. Evidence for the usage of the laboratory approaches for the diagnosis of STIs was collected and internationally and nationally published. As a result, the international guidelines for the laboratory diagnosis of STIs were produced, internationally and nationally published, adopted, and implemented. Patient management using microscopy of genital smears was suggested; the number of training courses conducted, training schools in St Petersburg and Estonia established, training materials prepared and available. Evidence-based patient management guidelines were elaborated, nationally published, and implemented in many of the project countries. Computer-based surveillance systems elaborated and in Lithuania and Belarus became national systems for the surveillance of communicable diseases. Materials for the education of the STI patients were elaborated, published, and made available in the project countries.

Conclusions

The networking situation confirmed being effective for the know-how exchange and allowed us to increase the level of understanding between the specialists from the different countries. It also speeded up the positive development of qualitative STI care in the project countries, mainly in the area of laboratory diagnosis, patient management, and epidemiological surveillance.

Key words

STI diagnosis; STI treatment; epidemiological surveillance

W 2–12. The epidemiological surveillance system of STIs in Lithuania

Orina Ivanauskienė[1], Giedrė Aleksienė[2]

[1]*Head of the Communicable Diseases Management Department at Kaunas Department of National Public Health Centre under the Ministry of Health, Chief Epidemiologist of Kaunas County, Lithuania*

[2]*Head of the Communicable Diseases Management Department, acting Director of National Public Health Center under the Ministry of Health, Lithuania*

Introduction

The epidemiological surveillance system of Sexually Transmitted Infections (STI), including the Human Immunodeficiency Viruses (HIV) infection, in Lithuania since 2003 is defined under the order of the Minister of Health.

Since 2009 the unique, National Electronic reporting system has been introduced, aiming to standardise the data collection and analysis for all communicable diseases and their agents through the country, improve the quality and timeliness of the surveillance of those diseases. Reportable STIs are four, namely syphilis, Chlamydia trachomatis, Neisseria gonorrhoeae and HIV. The agents of STIs get‘s also in to the National Electronic reporting system, but they are aggregated and are not comparable with the case.

Aims and Objectives

The aim – to stabilize the spread of STIs in Lithuania. The objectives: to access to STI health care and to ensure epidemiological surveillance and monitoring of STIs.

Materials and methods

Analysis of the national database available at www.ulac.lt and monthly data, according to the counties, available at https://nvsc.lrv.lt/.

Results

During the period of 2009-2019, the morbidity due to STIs in Lithuania has been decreasing (calculated per 100 000 population). The morbidity due to syphilis decreased from 9.6 to 4.2 cases, due to Neisseria gonorrhoeae from 11.5 to 2 cases, due to genital Chlamydia trachomatis from 11.9 to 8,9. Only the incidence of HIV infection during the same period of time changed from 0.49 in 2009 to 5.4 cases in 2019.

In 2009, Lithuanian laboratories performed 190 530 tests for HIV, 197 143 tests for syphilis, 198 331tests for Neisseria gonorrhoeae and 7 501 tests for Chlamydia trachomatis. During 2019, the number of laboratory testing for the same STIs were 241 590, 215 885, 117 284 and 8 351, respectively. Compared to the year 2019 to 2018, the absolute laboratory tests for STI has increased, for example, HIV tests has increased more than fifth.

Since 2003, the double reporting of the newly detected STI cases, namely by the physician and the laboratory, has become mandatory. The physician every week reports the individual data of STIs, so the laboratory has every month reports only for aggregated data.

W 3–12. Bed side microscopy - what do we get out of it?

Rita Butylkina[1]
[1]*LUHS Kaunas Hospital, Lithuania*

Introduction

The microscope is a symbol of science and considered a fundamental tool in dermatovenerologist and gynecologist practice for diagnosis of urogenital tract condition. Dermatologists and gynecologist are uniquely equipped amongst clinicians to make bedside diagnoses. Direct microscopy skill is highly valuable in both an inpatient and outpatient setting because it may lead to a rapid diagnosis or be a useful adjunct in the initial clinical decision-making process.

Aims and Objectives

Testing object is a vaginal wet mounts (sometimes called a vaginal smears) to find the cause of vaginitis, or inflammation of the vagina. Methylene blue stained urethral, cervical smears allow to detect inflammatory condition.

Materials and methods

Wet mount microscopy consisting of the direct microscopic observation of vaginal disccarges diluted with saline, without staining, and methylene blue stained urethral, cervical smear allows immeediate evoliution of urogenital speciments during the first doctor visit.

Results

Diagnosis trichomoniasis based on the typical movement of the Tricomona vaginalis parasite (sensitivity between 25 % and 82 %, specificity 100 %). Bacterial vaginosis is characterized by presence of clue cells and lack of lactobacilli (sensitivity 25 % - 100 %, specificity 93 % - 97 %). Candidiasis diagnosis based on visualization of pseudohyphae (sensitivity 44 % - 78 %, specificity 75 % - 88 %). Urethritis diagnosis in man based on detection ≥5 polymorphonuclears in objective field, urethritis in women – detection ≥10 polymorphonuclears in objective field, cervicitis - ≥20 polymorphonuclears in objective field plus cervical mucopurulent discharges. Detection intacelular didplocci makes suspicion of gonorrhea.

Conclusions
By examining the patient during the first visit and microscopy the samples taken in the doctor's office, it is possible to make an initial diagnosis, plan a further examination and prescribe treatment. Smear microscopy in the doctor's office allows to detect inflammatory changes in the male and female urethra, cervix and vagina. The physician can diagnose Trichomona vaginalis, Candida albicans spp. infections include bacterial vaginosis as well as diplococci.

Key words
Direct microscopy; wet mount microscopy; candidiasis; trichomoniasis; candidiasis; urethritis; vaginitis; cervicitis

W 4–12. From resistance, to the school of genital smear microscopy and how does it combine with the advanced diagnostic technologies

Alevtina Savicheva[1,2], Elena Spasibova[1,2], Kira Shalepo[1,2]
[1]*The D.O. Ott Research Institute of Obstetrics, Gynecology and Reproductology, Russia*
[2]*St. Petersburg State Pediatric Medical University, Russia*

Introduction
For nearly 20 years, the D.O. Ott Research Institute of Obstetrics, Gynecology and Reproductology, St. Petersburg, Russia had an agreement with the WHO Center for STIs collaborating with the Institute of Medical Sciences of the Uppsala University, Sweden, represented by the head of the Center, Marius Domeika. The D.O. Ott Institute has established an educational and methodological center for training obstetricians-gynecologists, dermato-venereologists, urologists and other doctors of the North-West Federal District of Russia dealing with the management of patients with STIs, according to the program “Application of methods of direct (Bed side) microscopy for the diagnosis of some STIs”. Doctors from St. Petersburg and the Leningrad Region were trained. Some physicians greeted this training positively, realizing that the physician should conduct the research in order to obtain additional information about the patient who is nearby; the quality of the smear taken is assessed; repeated sampling of material is possible; the patient immediately receives a conclusion and treatment begins immediately; closer contact with the laboratory is formed. However, there was also opposition to this training. Various arguments were

put forward - lack of time for research; you need a certificate in laboratory diagnostics; what difference does it make who is watching - a doctor or a laboratory assistant; what difference does it make for a patient - the diagnosis is at the appointment or later. Currently, in the Russian Federation, despite the introduction of molecular technologies, methods of so-called “Bed Side” diagnostics, which can be used immediately at a doctor's appointment, are increasingly being used. These methods include methods of direct microscopy of "native" preparations of vaginal discharge. This is a screening method both for the diagnosis of infections such as bacterial vaginosis, vaginitis, trichomoniasis, candidiasis, and for the interpretation of modern molecular biological methods in case of detection of opportunistic microorganisms (ureaplasma, streptococcus, staphylococcus, etc.) to make a decision - to treat or not treat.

Aims and Objectives

To substantiate the application of the method of microscopy of preparations of the separated female urogenital tract by an obstetrician-gynecologist at an outpatient appointment in the conditions of using high-tech molecular biological diagnostic methods.

Materials and methods

Based on many years of work in the Russian-Swedish project and on the basis of our own experience, the creation of training programs for obstetricians-gynecologists, venereologists, urologists on the methods of microscopic examination of the "native" preparation of the vaginal discharge, as well as the preparations of the separated cervical canal and urethra stained with methylene blue.

Results

We have developed a proprietary training program for obstetricians-gynecologists, venereologists, urologists "Evaluation of urogenital microbiocenosis by direct microscopy" within the framework of continuous medical education. Microscopy of the preparations of the detachable female urogenital tract allows you to quickly establish a diagnosis of urethritis, cervicitis, bacterial vaginosis, vulvovaginitis (candidiasis, trichomonas, bacterial) or to ascertain the physiological microbiocenosis of the vagina on the day patients seek help. The doctor, on the basis of complaints and physical examination, formulates a preliminary diagnosis, chooses

laboratory tests to determine a possible etiological agent of the disease, adequately and correctly takes clinical material, controls storage and transportation to the laboratory, interprets the results obtained. After that, he makes a final diagnosis and, if necessary, prescribes therapy. In the vast majority of medical institutions, microscopy is performed in a laboratory. The quality of laboratory analysis largely depends on the preanalytical stage, including the quality of taking clinical material.

Conclusions

The use of microscopy by an obstetrician-gynecologist, venereologist directly during the patient's appointment has a number of advantages. First of all, the diagnosis, and therefore adequate therapy, can be made already at the first visit, the quality of taking the clinical material is immediately assessed and, if necessary, there is the possibility of re-obtaining the clinical material. At the same time, a dialogue is being established between the clinic and the laboratory, which ultimately improves the quality of diagnostics.

Key words

Bed Side microscopy; urogenital infections; education; diadnostic

W 5–12. Adherence to the international STI Guidelines in Belarus

Oleg Pankratov[1], Andrew Pankratov[1]

[1]*Belarusian Medical Academy of Postgraduate Education, Belarus*

Introduction

Currently in the Republic of Belarus there is a rather favorable epidemiological situation with STI. In 2020 there were reported 763 patients with syphilis (8.1 cases/100000), 629 - gonorrhea (6.6 cases/100000), 3359 - genital chlamydial infections (35.5 cases/100000), 3923 - trichomoniasis (41.4 cases/100000), 874 - HSV (9.2 cases/100000), 1759 - HPV (18.6 cases/100000), 3110 - other infections (M. genitalium) (32.8 cases/100000).

Aims and Objectives

To present and discuss the adherence to the International STI Guidelines in Belarus.

Materials and methods

An analysis of the compliance of national STI clinical protocols and instructions and international STI guidelines has been carried out.

Results

The Belarusian-Swedish project «Optimization of the prevention and control of STI/HIV in Belarus» was carried out in Belarus in 2006-2010.

We surveyed STIs diagnostic capacities and methodological preparedness of all state-owned laboratories and their adherence to international guidelines.

The European ISO 15189 for the laboratory diagnosis was nationally adopted, legalized.

Validation of the domestic tests for syphilis diagnostics (MPR and two ELISAs) was carried out. The sensitivity of the MPR test was low (77.3%), but both ELISAs performed well (sensitivities of 99.2% and 100%, specificities of 98.7% and 99.0%, respectively).

New Instructions on diagnostics (gonococcal, chlamydial, trichomonal infections and syphilis) and Clinical Protocols on STI, based on the international experience and guidelines, were developed and after examination by the international experts have been confirmed by Ministry of Health and introduced in practical work. Clinical Protocols assumes: full conformity of diagnoses of ICD-10; adaptation of therapeutic approaches and techniques to the international standards; restriction of methods of diagnostics C. trachomatis with an exception of microscopy and IFA on revealing anti-chlamydial antibodies; wide introduction PCR in diagnostics of STI; exception of ureaplasmosis and mycoplasmosis (excluding M. genitalium). Belarus continuously monitors gonococcal AMR using WHO protocols. Aniskevich A. et al. (2021) presented the gonococcal AMR surveillance data for isolates cultured in Belarus from 2009 to 2019, quality-assured according to WHO standards. Based on the gonococcal AMR data presented in this paper, Belarus has also participated in the WHO Global GASP. In 2009–2019 the gonococcal population circulating in Belarus showed stable and high resistance to tetracycline, ciprofloxacin, and benzylpenicillin. More sporadic resistance to azithromycin and fluctuating resistance to cefixime were also found. No resistance to ceftriaxone, spectinomycin, or gentamicin was identified.

The educational-methodical manual «Sexual education of teenagers and preventive maintenance of STIs» for school teachers has been prepared in 2010, the second edition (with additions and corrections) - in 2021.

Problems: there is no benzathine benzylpenicillin in the country; STIs treatment is not always exactly according to the protocol; the national STIs treatment protocol needs to be revise.

Conclusions
Diagnosis of STIs in Belarus complies with international standards. Treatment protocols need optimization.

Key words
STIs; Belarus; diagnosis; treatment; guideline

W 6–12. Adherence to the international STI Guidelines in Estonia – waiting for the abstract

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Introduction
In Estonia there are three notifiable bacterial sexually transmitted infections (syphilis, gonorrhoeae and chlamydial infection) and one viral (HIV). The STIs are reported if a person meets clinical criteria. Laboratories have to report STIs, too. The STIs are diagnosed and managed by the recommendations of Estonian STI guidelines.

Aims and Objectives
The first Estonian STI guideline was printed under the leadership of the Estonian Union Against STI in 2003. Authors of the Estonian STI guidelines are members of the Society of Estonian Infectionists, the Society of Estonian Gynecologysts, the Society of Estonian Dermatovenerologists, the Estonian Society of Sexuology and the Estonian Society of Urologists. Guidelines were edited by dr Airi Põder (dermatovenerologist) and dr Matti Maimets (infectiologist). The STI guidelines are in printed versions and on the internet. The guidelines are have been updated periodically in 2007, 2015 and 2021. As clinicians and medical laboratories follow the Estonian STI guidelines the adherence to the guidelines is about 80-90%.
In addition to the notifiable sexually transmitted diseases, information on papillomavirus (HPV) immunization is also collected. In Estonia the HPV vaccine was included in the immunization program from 2018 when the coverage of girls born in 2003 was about 55%. In 2021 the HPV NAT testing

was included in the cervical cancer treatment guideline as the primary test for cervical cancer screening. As HPV NAT screening started this year, we will see the results in the coming years.

W 7–12. Adherence to the International STI Guidelines in Latvia

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Introduction
Several international STI guidelines exist.

Aims and Objectives
To find out which guidelines are used in Latvia.

Materials and methods
Searching Latvian governmental and non-governmental sites for STI prevention, diagnosis and treatment guidelines.

Results
The official list of the registered guidelines in Latvia does not include STI guidelines. Modern STI diagnosis like PCR is not reimbursed in Latvia. Most of the drugs listed for STI in international guidelines are generally available in Latvia.

Conclusions
At this moment there are no STI guidelines – neither national nor international – officially registered in Latvia. There is a need to produce at least national recommendations for the diagnosis and treatment of STI in Latvia.

W 8–12. Adherence to the International STI Guidelines in Russia

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Introduction
It was over two decades ago when we started working together at the SRHR project. This work brought so much joy and excitement to me, as well as much of anxiety for the highest quality of its result. Anyway, I took great

pleasure in our joint effort and creativity with the project. Yet, I do not consider it only as a kind of mutual success. I heartily believe that the project has been highly productive for all our countries.

Aims and Objectives

The memory of how it all started brings us to the following thing. Some time ago, there were national STI Clinical Guidelines (CG) for medical specialists in each country. Those guidelines were different in their structure, basic principles, and actual material. They were frequently far behind the latest tendencies of the world diagnostics and treatment practices. And each country adopted their own regulation for the procedure of developing those guidelines.

Here, I would like to highlight what has changed in the development of such CG in Russia, and what conclusions we have made.

Materials and methods

Currently, the procedure for the development of CG of STI management, as well as their structure and essence, is regulated by the order issued by the Russian Ministry of Healthcare (RMH). The developer of CG is represented by a professional dermatological society - the Russian Society of Dermatovenereologists and Cosmetologists (RSDVC). The RSDVC has created special Expert Panel Councils for each disease. The Guidelines' structure and their sections are correspondent with all the principles accepted worldwide. In order to be included into the CG, the recommended treatment and medication should be up-to-date with the latest international practices. It should be also graded in detail by the level of evidence, and it should be highly persuasive. If possible, the CG should show the graphical algorithm of a doctor's what-to-do list while diagnosing the disease and treating the patient. The innovation of the recent years has become the Guidelines' Section dedicated to the Criteria for assessing the medical care quality. This Section distinctly states all the requirements that should be strictly followed while treating the patient. These requirements are also to rely on by the entities who review a doctor's work. That may be an insurance company or the governmental supervisory body.

The CG under development are thereafter examined by the RMH. They are formally assessed on how they meet general requirements. The CG are modified, if necessary, and then examined by the RMH Scientific Council. It is only after this stage that they can be adopted as a regulatory basis for a

doctors' work. There is also a periodic revision of actual CG. It is carried out by the Expert Councils of the professional community, and this is mandatory. In case a disease is subject to the charge of various medical experts (dermatologists, gynecologists, urologists, for instance), the CG are cooperatively developed by the joint work of all professional communities. Currently, there are over 60 CG developed in Russia on various dermatological diseases and on all STIs.
After 2022, according to the Federal Law and according to all the orders of the RMH, the CG are going to become the mandatory regulatory basis for doctors. And this is the fact I would like to draw your special attention to.
In my opinion, at the very beginning of our cooperation, such kind of Guidelines was our most desirable thing. But did all our desires come true? Here, I would like to discuss the situation with the Russian Guidelines only.

Results
As an expert, I am totally satisfied with the Guidelines' structure, as well as with the criteria of treatment methods and the selection of recommended medication. As an expert, I am satisfied with the reduce of pharmaceutical industry being so influential upon developing these CG. As an expert, I like the strict and simple assessment criteria being included into the Guidelines.
What I am not satisfied with as an expert, is the following. I also consider it necessary for the Russian professional community to solve these problems as soon as possible:
- the formal language and formalized requirements of the Ministry's Guidelines often make it hard for doctors to follow them adequately. Some of Guidelines' instructions need to be either clarified verbally, or even need adopting another regulatory document illustrating their principles. It all looks like a joke about guidelines on how to follow the guidelines, but this is the thing that really is.
- the Section dedicated to the Criteria for assessing the medical care quality is no doubt a great step forward. But some of the Criteria developed by the professional community are either too easy to follow, or irrelevant to improve the quality of treating the patient. This can be mostly explained by one clear thing. The professional community is well aware of the fact that some of the Guidelines' instructions are tied to the financial aspects of treatment that can be hardly provided by the government or the patient. On the other hand, the diagnostic process cannot yet be equally well technically supplied in all parts of Russia.

- all of the instructions of the CG should form the basis for training next generation medical specialists. This should also be considered while writing and revising the curricular, manuals, etc.
- the doctors in practice are not all ready to follow the Guidelines strictly. And it does not only depend on diagnostic capabilities or medication availability, which can be greatly different in various parts of the vast country. It can also be explained by some of the older generation doctors' inertial thinking. They are more inclined to rely on their limited personal experience (they consider it more valid and correct) rather than on generalized worldwide medical community practice that is represented in the Guidelines.

Conclusions

As a conclusion I'd like to declare the following. Keeping it in mind how we worked together at the SRHR project, it would be highly appropriate to quote the great Heraclitus: «E pluribus unum». These of his words precisely render our universal mission regardless of our national borders, or any other kind of differences, as long as we are all aware of ourselves as a part of the single medical community: the doctors of the world doing their best for the healthcare of their patients.

Key words
STI Clinical Guidelines

W 9–12. Adherence to the international STI guidelines in Lithuania

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Introduction

In Lithuania various clinicians (general practitioners, urologists, gynaecologists, dermatovenereologists, infectionists, etc.) diagnose and treat STIs. Therefore it's important to make updated STI's management guidelines available for all health care specialists to designate adequate laboratory diagnosis and timely initiate appropriate treatment. The diagnosis of bacterial STI's is still suboptimal in Lithuania. And this is one of the

reasons that the incidence of reportable bacterial STIs decreased in the past decade. In 2010-2020, the reported cases of syphilis ranged 10.3 to 2, chlamydial infection 11.0 to 6, gonococcal infection 9.4 to 1 per 100,000 inhabitants.

Aims and Objectives

To discuss the adherence to the international STIs management guidelines in Lithuania.

Materials and methods

There was made the review on published updated international guidelines (mainly IUSTI) on the management of sexually transmitted infections.

Results

The participation of Lithuanian specialists in the Lithuanian-Swedish and Eastern European Network for Sexual and Reproductive Health (EE SRH Network) projects shaped the skillful attitude towards international guidelines on the STIs management. IUSTI guidelines on bacterial STI's (syphilis, gonorrhoeae, chlamydia infection, Mycoplasma genitalium infection) management are being adapted on the national level. The distribution of updated translated material among clinicians is going through the publications at the journal Lithuanian General Practitioner. The content of the Lithuanian STI management recommendations is similar to the European IUSTI management guidelines. Though theoretically there are no major discrepancies concerning diagnostics and treatment schemes, in practice there are some inequalities in the country of the performing laboratory diagnostics for different STI microorganisms. The international guidelines on the organization of a consultation for STIs indicate the necessity to offer all patients the testing for syphilis, Chlamydia trachomatis, Neisseria gonorrhoeae (NAAT), HIV. But in rural districts the main test for STIs is genital smear microscopy in laboratory as the primary level where most patients with the STIs are processed have no laboratory facilities to determine the etiological agents by performing NAATS. Also IUSTI guidelines recommend the tests which can give immediate preliminary results on STIs and facilitate the decision on treatment, but in Lithuania the bed-side microscopy is used more for training purposes and young specialists don't use it very much when graduated. The first choice antibiotics for treatment of Syphilis, Chlamydia trachomatis, Mycoplasma genitalium are

acceptable and being prescribed for patients. Uncomplicated gonorrhoeae treatment goes with chinolones more often than ceftriaxone because of inconvenient organization of administration of the latter.
Updated IUSTI guidelines and educational material on bed side microscopy (prepared during Lithuanian-Swedish project) are the main tools for undergraduate and postgraduate studies.

Conclusions
The international guidelines are followed in the University hospitals considering all it/s aspects but on the district level the discrepancies on the adherence to it are common.

Key words
Sexually transmitted infections; management; IUSTI; guidelines

Workshop II
Oncodermatology

W 10–12. Oncodermatology: clinical diagnostic and basic of dermoscopy

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Introduction
The importance of early detection of malignant skin tumours and especially melanoma cannot be overstated. When melanoma is found and treated early, the chances for long-term survival are excellent. Five – year survival rates for patients with early –stage melanoma exceed 95 %. Also non melanoma skin cancer can have a big influence on the patients quality of life and can also cause mutilation, and even metastasis with unclear prognosis for patients life. How can a doctor managed in the short time that it has for inspection, not overlook suspicious skin tumour or melanoma? Experience and knowledge are of major importance, however clinical inspection and dermoscopy are perfect diagnostic tools, helping to avoid overlooking dangerous skin lesion
- clinical diagnosis of suspicious skin lesions
The basis of early diagnosis in dermato-oncology is still a clinical examination of non- pigmented skin lesions and pigmented lesions, moles

and pigmented tumours. The most important malignant skin tumours are basal cell carcinoma (BCC), squamous cell carcinoma (SCC) and melanoma (MM).
BCC: the main characteristics are slowly growing plaque or nodule, skin coloured, pink or pigmented, varies in size from a few millimetres to several centimetres in diameter, spontaneous bleeding or ulceration.
SCC: Cutaneous squamous cell carcinoma presents clinically as an enlarging, irregular, keratinous nodule or a firm erythematous plaque that frequently ulcerates.
They usually arise within pre-existing actinic keratosis or intraepidermal carcinoma.
MM: Melanoma usually starts as a skin lesion. Occasionally it can grow in lips or genitals, rarely melanoma occurs in brain, mouth, eye or vagina. The first sign of a melanoma is usually an unusual looking mole. Melanoma may be detected at an early stage when it is only a few millimetres in diameter, but it may grow to several centimetres in diameter before it is diagnosed. Melanoma may have a variety of colours including tan, dark brown, black, blue, red and, occasionally, light grey. Some melanomas are itchy or tender. More advanced lesions may bleed easily or crust over.
Most melanomas have characteristics described by the ABCD rule. Not all lesions with these characteristics are malignant. Not all melanomas show these characteristics.
In clinical diagnosis for early detection of melanoma we usually follow the rule A (asymmetry), B (borders), C (colour), D (diameter), E (evolution). When we find three of the five mentioned criteria, it is necessary to excise the lesion.
- dermatoscopy in diagnostic of skin tumors
Dermoscopy (dermatoscopy) refers to the examination of the skin, using skin surface microscopy, and is also called ‘epiluminoscopy’ and ‘epiluminescent microscopy’. Derm(at)oscopy is mainly used to evaluate pigmented skin lesions but is ob big help also for evaluation of other benign and malignant skin tumours and early detection of malignant changes. It is a non-invasive diagnostic technique for the in vivo observation of skin lesions, allowing a better visualisation of surface and subsurface structures. This diagnostic tool permits the recognition of morphologic structures not visible by the naked eye, thus opening a new dimension of the clinical morphologic features of skin lesions. Dermoscopy can increase the precision in distinguishing the

benign from malignant skin lesions. This technique is a bridge between clinical dermatology and dermatopathology
BCC: bluish white, pink, grey, or light brown stroma, sharply defined, fine linear and branching serpentine (arborising) vessels, slight scaling and focal ulceration are typical dermoscopic features for BCC. In case of pigmented BCC absence of pigment network, structureless or leaf-like areas on the periphery of the lesion are common. More rare, blue-grey ovoid nests or blotches, also known as large clods are presented.
SCC: the dermoscopic features of cutaneous squamous cell carcinoma are not precise. Usually, white structureless areas, looped vessels, central keratin, can be observed. Pink or red background in poorly differentiated or rapidly growing tumours.
MM: structureless areas, blue-withish zones, irregular brown or black dots/globules, irregular pigmentation, irregular branched streaks, atypical pigmented network, vascular pattern (dotted, linear irregular, hairpin vessels), strongly indicates malignancy.
- quiz
15-20 skin lesions for clinical and dermoscopic diagnosis will be presented.

Part 2. Oncodermatology:
(surgical treatment methods, topical treatment in oncodermatology)
- surgical ltreatment methods:
During recent years, requests for surgical and physical treatment have increased considerably. Dermatology is and is becoming more also a surgical science. Referrals for surgical treatment now account for up to 55% of a dermatologists workload in West Europe. This is a trend that is likely to continue and the acquisition of basic dermatological skills is certain to become an increasingly important component of dermatological training. Dermatological education in the USA and in many countries in EU includes at least several months of surgical training. Surgical and physical treatment is usually very effective and patients satisfaction is high. Surgical therapy is usually by the health insurance well evaluated. New surgical techniques and technical possibilities have been developed in recent years.
Surgery: a common reason and the main treatment indications to excise a skin lesion is to remove skin cancer, such as a basal cell carcinoma, squamous cell carcinoma or melanoma. Excision of pigmented lesion is also common. There are also other reasons for surgery in daily dermatological practice: to make a diagnosis, to improve cosmetic appearance, to relieve

symptoms (if a lesion is tender or prone to being knocked), to remove an inflamed or frequently infected cyst. Aesthetic and corrective surgical procedures are also important field of dermato-surgery. The most often used is simple excision, but also grafts and flaps are usual treatment procedures in dermato-surgery.
Physical treatment methods: among "dermatological surgical" treatment of big importance and with good effect in daily dermatological practice can be placed also so called physical methods. Some of these methods are old and easy to use, others are new, more complicated and requires special training. In dermatology used methods next to real surgical therapy are: cryosurgery, electro-surgery, radiofrequency , many high energy lasers, deep chemical peels , dermabrasion Indications for physical treatment methods are: benign, pre-malignant and malignant skin lesions of different origin.
For dermatology as a medical field, it is of big importance to include surgical knowledge in the education process, in whole Europe. I am convinced that in order to maintain the integrity of dermatology as well as for the development of modern dermatology, knowledge of basic surgical techniques will be crucial. Without surgery, dermatology in future will not be complete and could lose the respect of both, patients and other medical disciplines.
- topical treatment in oncodermatology
Modern dermato-oncology includes also chemical agents for topical (local) use. They can be used as monotherapy or in combinations. Indications are, pre-cancer lesions, BCC, SCC? and in isolated cases even melanoma.
Imiquimod: is an immune response modifier. It is manufactured as a 3.75% and as 5% cream. Agent works by stimulating the immune system to release a number of chemicals called cytokines, which are important in fighting viruses and destroying cancer cells.
Imiquimod is mainly used to treat actinic keratoses, basal cell carcinoma(BCC), especially superficial BCC and sometimes low-risk nodular BCC. Intradermal SSC carcinoma and Bowen disease. Experimental it has been successful in melanoma in situ (lentigo maligna melanoma) and in combination with diphencyprone for metastatic melanoma.
Fluorouracil: topical fluorouracil 5% cream is often abbreviated to 5-FU. It is a cytotoxic agent or antimetabolite and it is toxic to living cells, especially to certain cancer or precancerous cells. It destroys sun-damaged skin cells. It is used as a mono-therapy or combined with 10% salicylic acid. Fluorouracil is a pyrimidine analogue that irreversibly binds within a cell to

thymidylate synthetase. This prevents the incorporation uracil into nuclear RNA, which destroys abnormal cancer cells. Main indications are actinic keratoses and superficial type of BCC.
Photodynamic therapy (PDT): is a treatment used mainly for superficial types of skin cancer. PDT is effective in treating actinic keratoses and superficial basal cell carcinomas. It may also be used for treatment of small, thin, low-risk nodular basal cell carcinomas outside of the head and neck area.
PDT utilises photosensitising agents, oxygen and light, to create a photochemical reaction that selectively destroys cancer cells. Photosensitising agents are drugs that are administered into the body through topical, oral or intravenous methods. In the body, they concentrate in cancer cells and only become active when light of a certain wavelength is directed onto the area where the cancer is. The photodynamic reaction between the photosensitising agent, light and oxygen kills the cancer cells.

Workshop III
Cryotherapy

W 11–12. Cryotherapy

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Introduction
Cryosurgery is one of the most common techniques used by dermatologists. It is simple, cheap procedure and allows to treat patients of different age and with different medical conditions.
The following workshop will be divided in two parts. Main topics:
I part.
1. Cryobiology and cryoimmunology. 2. Equipment. 3. Techniques. 4. Pre-operative considerations. 5 .Treatment for benign tumores, inflammatory and infectious conditions. 6. Premalignant and malignant lesions. 7. Cryoprocedures in aesthetic therapy. 8. Combination therapy (field treatment, adjuvants, synergism). 9. Post operative considerations. 10. Expected events, possible complications, common pitffals.
II part.

Demonstration of practical approach. Equipment. Live demonstration of cryo treatment or video. There will be time for Q and A.

Workshop IV
Aesthetic dermatology

W 12–12. Basic principles and safe approach to botulinum therapy of the upper third of the face

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Introduction
Botulinum toxin type A injection is the most common cosmetic procedure globally. Abobotulinumtoxin A is a potent neurotoxic agent used clinically in subtoxic doses, to target underlying muscle activity in an attempt to improve dynamic rhytids of the overlying skin. The goal in the aesthetic patient, in addition to wrinkle reduction, is to produce a new "balance" in facial dynamics between agonist and antagonist muscle groups.

Aims and Objectives
The main goal the of the seminar is to help the participants to learn:
- the basic concepts of botulinum therapy and how to use them on practice;
- how to dilute the botulinum toxin, calculate the dosages and fill the syringe;
- improve knowledge of topographic anatomy;
- how to to detect all the muscles of the upper third of the face;
- understand functional anatomy and muscular interactions;
- how to draw up an effective correction scheme for each patient individually, based on
- the anatomy;
- effective and safe injection technique for glabella, forehead and periorbital region;
- how to avoid undesirable adverse events;
- understand the cause and principle of correcting undesirable side effects.

Materials and methods
Theoretical part: 5 blocks of theory, which will allow participants to improve knowledge of topographic and functional anatomy and form the skills of

clinical thinking. Explain principles of botulinum therapy of the upper third of the face.
Practical part: live demonstration of restoration the botulinum toxin with detailed explanation of the rules for unit calculation and filling the syringe Live demonstration of the procedure on models with detailed explanation of classical rules, proper points and techniques.

Results
Participants will be able to start safe practice of botulinum therapy.

Key words
Botulinum therapy; aesthetic dermatology; botulinum toxin; facial anatomy

PLENARY SESSIONS ABSTRACTS

The content of the abstracts presented is the responsibility of their authors and co-authors.
The abstracts are arranged according to the congress program.

PL 1–53. Pathogenesis and treatment of chronic spontaneous urticaria and cholinergic urticaria

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Introduction

Both chronic spontaneous urticaria (CSU) and cholinergic urticaria (CholU) are evoked by rapid mast cell activation. The effectiveness of antihistamines and omalizumab, anti-IgE monoclonal antibody, suggests the involvement histamine and IgE in the pathogenesis of these subtypes of urticaria. In addition, severe cases of CSU may be associated with the increase of blood coagulation markers. However, action mechanism of omalizumab in these subtypes of urticaria and its relationship to the blood coagulation are still largely unknown.

Aims and Objectives

To investigate the mechanism of mast cell activation and the effectiveness antihistamines and omalizumab in the activation of skin mast cells.

Materials and methods

Blood coagulation potentials were evaluated by APTT clot waveform analysis and calibrated automated thrombography. The expression of tissue factor (TF) on cultured human endothelial cells and peripheral monocytes of patients and healthy volunteers were analyzed by real-time PCR and FACS analysis. Basophils and skin mast cells were obtained from healthy volunteers or spare skin tissues obtained by skin surgeries.

Results

The potential of blood coagulation increased in a population of CSU and CholU. The expression of TF that initiates the exogenous coagulation pathway was induced by a small amount of histamine or VEGF in synergy with lipopolysaccharide (LPS) or several inflammatory cytokines, such as TNF, IL-1□ and IL-33. On the other hand, monocytes also express TF regardless of IgE and histamine concentrations. The activated coagulating factors, including Xa and IIa specifically activate skin mast cells through the production of C5a. Approximately two thirds of patients with CholU were sensitized with MGL_1304, a major IgE antigens in human sweat, but most

CholU associated with dermal pain on sweating were not, and responded to steroid pulse therapy.

Conclusions
The pathogenesis of CSU and CholU may be classified into IgE-mediated and non-IgE-mediated ones. Developing new medications targeting inflammation and mast cell specific signaling are expected for the treatment of sever and refractory urticaria.

Key words
Urticaria; IgE, histamine; blood coagulation; complement; sweat; MGL_1304

PL 2–53. Progress of the treatment of atopic dermatitis and sweat allergy

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Introduction
Atopic dermatitis (AD) is a long-lasting inflammmatory skin disease, characterized by conituous remissions and aggravations of rash and priritus. It developes on a certain genetic background of atopic diathesis and skin bariar disfunctions. Topical steroids and calcinuerin inhibitors have been the mainstay to control inflammation. Recently developed systematic medications, targeting cytokines or intracellular signaling moleculs may well control moderate to severe AD. However, the mechanisms of aggravation in daily life, especially by sweating are not fully understood. We demonstrated that most patients with AD are sensitized with sweat components, and identified MGL_1304, a protein secreted by Malassezia (M.) globoza as a major sweat antigen for IgE.

Aims and Objectives
To further study the mechanism of aggravation of AD upon sweating and explore means for prevention.

Materials and methods
Basophil histamine releasing antigen in human sweat was purified from healthy volunteers. MGL_1304 homologues produced by major malassezia

species on human skin (M. restricta, M. M. sympodialis) and canin (M pachdermatis) were prepared as recombinant proteins. Type I hypersensitivity against MGL_1304 homologues in patients with AD and those with cholinergic urticaria (CholU) were studies by histamine release from basophils of the patients. Histamine concentrations were measured in sweat samples collected from patients with AD, cholinergic urticaria, chronic spontaneous urticaria and healthy volunteers.

Results

The semipurified sweat induced histamine release from basophils of 77% of patients with AD and 66% of CholU. The sensitivties to MGL_1304 were well correlated to those of other Malassezia homologues, especially that by M. restricata, but substantially different from those to whole Malassezia lysates. By screening natural substances approved for topical use on human skin, we picked up tannic acid which effectively inactivates histamine release activity of the semipurified sweat antigen. Randomized double-blind cross-over trials showed the efficacy of topical spray and bath additive containing tannic acid on itching of patients with AD. Histamine concentration of sweat was unexpectively higher than those in plasma, not only in patients with AD and those with CholU, but also in a certain population of healthy volunteers in association with histamine release from basophil by semi-purified sweat. Leakage of sweat into the dermis in AD and CholU observed by other groups suggests a pathogenetic role of sweat via type I allergy and/or direct action of histamine in the sweat.

Conclusions

Sweating is physiological, but may also play important roles in the pathogenesis of AD and CholU. Medications which normalize characterisitcs of sweat and barrier functions of sweat glands are candidates for new treatments of these refractory diseases.

Key words

Atopic dermatitis; sweat; MGL_1304; malassezia; cholinergic urticaria

PL 3–53. Atopic dermatitis - therapy 2021

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Introduction

Atopic dermatitis (AD) is a chronic, relapsing, inflammatory skin diseases. Prevalence of AD can reach up to 20 % in children is industrial nations.

Aims and Objectives

Search for publications on atopic dermatitis from 1980 till 2021 regarding topical and systemic treatment.

Materials and methods

Literature search of the latest publications, medical databases, guidelines was performed using phrases such as "atopic dermatitis treatment", "atopic dermatitis treatment guidelines".

Results

Topical corticosteroids and topical calcineurin inhibitors are the first-line treatment options in AD. Regular and liberla use of emollients is also recommended. Treatment choice depends on AD severity - mild, moderate, severe. Cyclosporine A and the "off label" use of methotrexate, azathioprine, mycophelate mofetil are reserved for systmeic use mostly in severe cases. Also hospitalization is indicated for severe cases. Biologics are opening a new era in AD management, with dupilumab being first in its class being internationally registered.

Conclusions

Several new topical and systemic treatments are becoming available for the treatment of AD, which can potentially improve quality of life of the patients. Antimicrobial and drug resistance, side effects from local or systemic treatments is an ever existing and increasing problem.

Key words

Atopic dermatitis; topical therapy; systemic therapy

PL 4–53. Atopic dermatitis: new treatment experience. Case report

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Introduction

Dupilumab is a fully human monoclonal antibody against interleukin (IL)-4 receptor alpha that inhibits IL-4/IL-13 signalling. It is the first biological drug approved for the treatment of moderate to severe atopic dermatitis. In a placebo-controlled, randomized phase III clinical trial (LIBERTY and CAFE) dupilumab with topical corticosteroids significantly improved signs and symptoms of atopic dermatitis and quality of life in adults with a history of inadequate response to/intolerance of cyclosporine (CsA), or for whom CsA treatment was medically inadvisable. Moreover, there is increasing real-world evidence regarding dupilumab efficacy. Meta-analysis, conducted by Halling et al., included 3303 atopic dermatitis patients, receiving dupilumab therapy for 16 weeks: the proportion of patients achieving 50%, 75%, and 90% Eczema Area and Severity Index (EASI) score improvement was 85.1%, 59.8%, and 26.8%, respectively, and the weighted mean reduction in EASI score was 69.6%. In Lithuania, Dupilumab for the treatment of severe adult atopic dermatitis, has been reimbursed since 2020, therefore we would like to present the latest results of our treatment experience with this drug.

Aims and Objectives

To evaluate efficacy and safety of dupilumab in the adult patient with atopic dermatitis.

Materials and methods

A case report.

Results

A 43 year-old female was diagnosed with atopic dermatitis from the age of 9 months. In 2018, due to worsening of skin condition (Severity scoring of atopic dermatitis index (SCORAD) - 66 points) and elevated total serum IgE levels (17348 kU/l), treatment with plasmapheresis (total of 4 procedures) was initiated - with partial clinical effect. Later in 2018, treatment with systemic methotrexate 10 mg per week subcutaneously was started, however after 32 weeks of treatment no significant effect was observed. In 2020,

treatment with cyclosporin (CsA) was initiated, starting from 2.5 mg/kg/day and subsequently increasing dosage to 4 mg/kg/day. After 28 weeks of treatment SCORAD reduced only by 30% from baseline, the patient was complaining of severe pruritus of 8 points by numeric rating scale (NRS), a hirsutism due to CsA use was observed, therefore treatment with CsA was discontinued. In January, 2021 treatment with dupilumab was initiated, starting with a 600 mg loading dose subcutaneously at baseline and followed by an injection of 300 mg dupilumab every other week. 2 weeks after onset of treatment, pruritus slightly decreased and by week 15 it reached 0 points by NRS (compared to 8 points at the baseline), SCORAD decreased by 71% compared to baseline (from 40.8 to 11.9 points respectively). The treatment is well-tolerated with no side effects observed.

Conclusions
We present a clinical case of severe adult atopic dermatitis, successfully controlled with dupilumab. This case report supports the use of dupilumab in severe atopic dermatitis refractory to treatment with conventional immunosuppressive drugs.

Key words
Atopic dermatitis; dupilumab; biologics

PL 5–53. Acne - what's new?

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Introduction
Acne is one of the most prominent diseases in out patient dermatology settings. It has also a high impact on psychosomatic comorbidity and longterm physical and psychosocial sequelae.
During the last three decades a great progress in the understanding of the pathogenesis in acne has been made. Today we accept that the sebaceous gland is a small but important endocrine and immunoactive adnexal organ of the skin. GATA-6 recently has been detected as a key regulator of the sebaceous follicle homeostasis Beside the sebaceous gland itself which is capable of transforming hormonal signals and growth factors such as IGF-1 the follicular keratinocyte also is responding with hyperproliferation to

androgens and growth factors. Follicular keratinocytes are producing IL 1 alpha as an important inflammatory mediator closely connected to the formation of the microcomedo. The presence of C. acnes as an inflammatory signal is not per se necessary in this early event. However, TLR-2 upregulation via IGF-1 via phosphokinase 1 / AKT and later via specific virulent strains of C. acnes play a key role towards the production of proinflammatory mediators followed by disturbed keratinization and inflammation.

Several other receptors on the sebocyte have a more or less active signalling role in the activation cascade such as CRH-R, GF, alpha-MSH, acetylcholine receptor, ectopeptidases such as DPP IV and aminopeptidase, neuropeptidase or vitamine D receptor and others more.

The PPAR`s gamma and alpha are closely connected to the arachidonic cascade of which downstream leukotrienes play a prominent role and can be inhibited by antagonists leading to a reduction of lipid synthesis and normalization of the lipid composition.

The role of diets incl. milk and the hyperglycemic index are currently under intensive discussion as a driver of the androgen receptor and on PPAR gamma activity via FoxO1.

Within the armamentarium of therapeutics in acne we are still missing a real breakthrough innovation but the consensus publications of the “Global Alliance for better Outcome in Acne” in 2003 ,2009 and 2018 (all JAAD) and the S3 EDF guideline and the European Expert Algorithm 2016 (both JEADV) have clarified a lot in misunderstandings and myths and have set new standards of treatment. New topical drugs such as a synthetic anti-androgen clascoterone and trifarotene, a gamma receptor ligand retinoid, have enriched the our prescriptions for acne patients. Very recently, the microbiota transplantation of certain C. acnes strains have opened a new successful option for treatment.

Key words
Acne; pathogenesis; treatment

PL 6–53. Hidradenitis suppurativa: where we are, where we go

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Introduction

Fifteen years after the 1st International Hidradenitis Suppurativa (HS) Research Symposium held March 30–April 2, 2006 in Dessau, Germany with 33 participants, there is no doubt that solid basic HS research is ongoing with rapid steps and that HS has developed deep roots among inflammatory diseases in Dermatology and beyond, recognized as "the main inflammatory skin disease than can be healed". The detection of the pilosebaceous unit as disease initiation target, the establishment of simple but accurate diagnostic criteria and the development of a combined dynamic disease severity/classification instrument (IHS4) have markedly improved the understanding and management of HS. The registration of the tumor necrosis factor-α inhibitor adalimumab in 2015 was a major step forward in HS treatment. However, it soon became evident that the effectiveness of adalimumab in daily practice is variable. A significant unmet medical need of HS patients remained, and the search for novel therapeutic targets was intensified. Research data on potential target molecules for future HS treatment detected several promising molecules currently under investigation from a pathophysiological and clinical point of view. With phase III trials ongoing, the anti-IL-17 biologics secukinumab and bimekizumab are in the most advanced stage of clinical development. In addition, targeting IL-1α with bermekimab has shown encouraging results in two clinical trials. C5a and C5aR blockade as well as inhibition of JAK1 signalling only showed clinical efficacy in the highest dosage, highlighting that careful surveillance of the balance between safety and efficacy. Short courses of i.v. clindamycin as well as oral doxycycline have been shown to exhibit equal effectiveness with the standard oral clindamycin/rifampicin regimen, leading to modifications in first line treatment. Overall a combination of medical with surgical means is still the treatment of choice in HS. To guide future drug development, more and better-defined translational data on the pathogenesis of this severe and enigmatic

inflammatory skin disease, real world data as well as drug repurposing studies are required.

PL 7–53. Update on clinical trials and hidradenitis suppurativa

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Introduction

Hidradenitis Suppurativa (HS) is a common auto inflammatory disorder that has prevalence rates, which in some countries are as high as 4%. HS is a high impact disease because of the skin manifestations the psychosocial implications and the comorbidities that are associated with these severe recurrent boyles. Although only a single gene has been linked to HS, the immuno-pathogenesis is well studied and multiple potential targets, such as TNF- α, IL-23, IL-12, IL-17, IFγ, IL-β, IL-26, CXCL-1 and 2, MMP-1, 3, and 10, have been identified.

Aims and Objectives

To review both published and non-published literature related to clinical trials for therapies under investigation for the treatment of HS.

Materials and methods

Literature review was conducted on all therapies being investigated for the treatment of HS. Also the website "clinicaltrials.gov" was searched for ongoing clinical trials in HS. The drug targets and related genes were reviewed.

Results

Presently 31 clincial trials with 25 different molecules being studied for the treatment of HS. In addition there are 5 surgical, 3-laser, and 2-wound care studies ongoing. 23 of the interventional trials are systemic agents and include compounds that targets C5a, IL-1 aka, TYK2-Jak, inhibitors, OCP, and Metformin. Multiple biologics are also under study and these agents target IL-17, IL-23, C5a, CSF, IL-1a, CD4, CXCR, and IL-1R1. Topical studies also include JAK inhibitors, as well as cannabis products. Total number of studies ongoing or completed is 111.

Conclusions
Although multiple targets are being investigated, many of these targets are not based on rational drug design. We must, therefore, stop this irrational drug (DUD) design in drug development in HS. We also need to raise the therapeutic bar to high score of 100 and treat target with an IHS4 of 0 and NRS pain score of 0.

PL 8–53. Hidradenitis suppurativa syndromes

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Introduction
Hidradenitis suppurativa (HS) is a chronic inflammatory dermatosis usually involving the skin folds characterized by a multifactorial pathogenesis, however with an important autoinflammatory component. It can also rarely present in association with other diseases as complex clinical syndromes, causing additional diagnostic and therapeutic challenges. The syndromic forms of HS are PASH (PG, acne and hidradenitis suppurativa [HS]), PAPASH (PASH associated with pyogenic sterile arthritis), PsAPASH (PASH combined with psoriatic arthritis [PsA] and PASS (PG, acne, ankylosing spondylitis, with or without HS). Different etiopathological factors contribute to the inflammation of the hair follicle and suppurative lesions in these entities, including follicular hyperkeratinization and plugging as well as activation of autoinflammatory pathways. Moreover, our group recently demonstrated that vitamin D metabolism dysfunctions seem to be play a role in PASH and PAPASH pathogenesis. We also confirmed through a Whole Exome Sequencing (WES) approach that genetic alterations of autoinflammation and keratinization process are linked to PASH etiopathogenesis, according to the hypothesis that considers syndromic HS as an Autoinflammatory Keratinization Disease. Patients with syndromic HS commonly have a severe disease course, presenting atypical skin involvement, signs of systemic inflammation and refractoriness to conventional therapies. Systematic classification of syndromic HS is based on clinical, pathogenetic and genetic grounds, but is constantly evolving due to increased disease awareness.

Syndromic HS treatment may be difficult and should be tailored on a case-by-case basis. Investigations of syndromic HS can lead to useful insights on genetics and pathogenesis, translating in new clinical approaches for sporadic HS.

Key words
Hidradenitis suppurativa; syndromic; genetics; PASH; PAPASH

PL 9–53. Rosacea. What's new?

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Introduction
Rosacea is established as a chronic, progressive, and often fluctuating between periods of exacerbation and remission cutaneous syndrome, encompassing various combinations of signs and symptoms that manifest primarily on the central face. Various novel therapeutic interventions are being investigated, some based on the increased understanding of rosacea's pathophysiology.

Aims and Objectives
This review presentation will aim to outline some of the recent findings and hypotheses for a modern understanding of rosacea pathophysiology, will touch on key diagnostic criteria, as well as will provide up-to-date, evidence-based recommendations for the management of rosacea. The precise pathophysiologic interplay of the dysregulated systems (immune, vascular, nervous) in rosacea is still poorly understood. Various novel therapeutic interventions are being investigated, some based on the increased understanding of rosacea's pathophysiology.

Materials and methods
The review lecture is based with an emphasis on the most recent cited scientific literature.

Results
Rosacea is characterized by recurrent episodes of fushing or transient erythema, persistent erythema, phymatous changes, papules, pustules, and

telangiectasia. The eyes may also be involved. The updated classification system is associated with an increased understanding of disease pathophysiology and is based on phenotypes subtyped into diagnostic features, major features, and minor/secondary features. Such classification is intended to provide clearer parameters to conduct investigations, guide diagnosis, and improve treatment. At least one diagnostic or two major phenotypes are required for the diagnosis of rosacea.

The interplay of immunologic alterations and neurovascular dysregulation are at the forefront of the proposed rosacea pathophysiology and thought to have important roles in initiating and strengthening the clinical manifestations of the disease. Nevertheless, its multifactorial pathogenesis remains to be elucidated.

An increasing number of studies showed a relationship between rosacea and systemic comorbidities. It is likely that these connections involve mechanisms that underlie chronic inflammatory conditions including inflammatory cytokines, and metabolic, immune, and endocrine changes. However, the pathophysiologic connections remain to be defined.

Because of the diverse clinical presentations of rosacea, approaches to treatment should be individualized and based on the disease severity, identified phenotype, quality-of life implications, comorbidities, trigger factors, the patient's perception and desire for treatment. Possible interventions and treatment options should be very rationally and thoughtfully selected for each patient. This is the only way to help most patients to alleviate the clinical and psychological symptoms of rosacea, despite the fact that none of these therapies is curative.

Conclusions

Recent scientific and clinical data are reshaping our understanding of rosacea from both a pathophysiologic perspective and clinical approach to therapy, introducing novel agents that can improve patient clinical outcomes, psychological status and quality of life.

Key words

Rosacea; inflammation; pathogenesis; phenotypes; comorbidities; treatment

PL 10–53. Hormone related therapy and skin disorders

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Introduction

The skin is an endocrine organ and a major target of hormones such as estrogens, androgens and cortisol. Besides vasomotor symptoms (VMS), skin and hair symptoms often receive less attention than other menopausal symptoms despite having a significant negative effect on quality of life. Skin and mucosal menopausal symptoms include dryness and pruritus, thinning and atrophy, wrinkles and sagging, poor wound healing and reduced vascularity, whereas skin premalignant and malignant lesions and skin aging signs are almost exclusively caused by environmental factors, mostly solar radiation. Hair menopausal symptoms include reduced hair growth and density on the scalp (diffuse effluvium due to follicular rarefication and/or androgenetic alopecia of female pattern), altered hair quality and structure and increased unwanted hair growth on facial areas. Hormone replacement therapy (HRT) is not indicated for skin and hair symptoms alone due to the risk-benefit balance, but wider potential benefits of HRT (beyond estrogen's effect on VMS, bone, breast, heart, blood vessels) to include skin, hair and mucosal benefits, should be discussed with women so that they will be able to make the best possible informed decisions on how to prevent or manage their menopausal symptoms.

PL 11–53. Psoriasis standards of care: newest recommendations

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Introduction

Psoriasis is a chronic immune-mediated inflammatory skin disease with a prevalence of 2-3% in adults patients. Therapeutic modalities differs according to the extend of the disease. The highest efficasy can be seen with the use of systemic treatment especially biologic therapy.

Aims and Objectives
We will discuss the newest guidelines and recommendations and we will focus on the achievement of PASI90 and PASI100.

Materials and methods
New european guidelines.

Results
The newest guidelines for the treatment of psoriasis suggest as the new treatment goal PASI90 and PASI100. Anti IL-17 and anti IL-23 drugs have a high propability of achieveing PASI90 and PASI100.

Conclusions
Psoriasis vulgaris is a very well treated skin disease in our days. In the past PASI50 was the main goal of treatment which changed by the time to PASI75 and now the newest guidelines suggest PASI90 and PASI100.

Key words
Psoriasis vulgaris; biologic therapy; guidelines; PASI90; PASI100

PL 12–53. Use of biologics in clinical practice

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Introduction
When I use biologic therapy in the treatment of psoriasis, I am guided by 3 main principles, i.e. do no harm (safety), prevent progression of disease (both skin disease and related comorbidities), and treat to target (PASI-100; both short and long term).

Aims and Objectives
Review past and current psoriasis guidelines to help guide the use of biologics in clinical practice.

Materials and methods
Review of most recently published guidelines EuroGuiDerm Part 1 and 21, as well as previous published Canadian, British, European, and American

psoriasis guidelines2 in order to present an evidence based approach to the use of biologic therapy in clinical practice.

Results

Over the past 20 years, the management of psoriasis has been transformed initially by the use of cyclosporine, and then by the introduction of biologic therapy. In 20192, we undertook the review of published guidelines to help guide practicing dermatologists to use an evidence-based approach management of psoriasis in their clinical practice. The Canadian Psoriasis Guidelines (2010 and updated 2019) has helped guide many dermatologists in the safe and effective use of biologics for the management of psoriasis. Our systematic review suggests that methotrexate can be used for long term maintenance, while cyclosporin is recommended for only short term use. In 2019 targeting TNFα and IL-12/23 had the strongest recommendations. The newer agents targeting IL-17 and 23 were being studied but were not addressed in these guidelines. In 2021, the landscape has changed dramatically. We now have updated European guidelines1, multiple head to head studies, as well as an enormous amount of real world data to guide our use of biologics in clinical practice. With the use of these high performing therapeutic agents, we continue to reach greater heights while following the guiding principles, i. e. we are seeing the majority of patients reaching treat to target of PASI-100 (70% in short term, 50% in long term); preventing the progression of the disease, i.e. with a few patients flaring or progressing to more severe psoriasis phenotypes, all while maintaining a high level of safety.

PL 13–53. Personalised treatment of psoriasis with biologics: what is important?

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Introduction

Patients are the center of interest in developing personalised medicine as one drug does not fit all. Current management approaches for the treatment of psoriasis depend largely on clinical assessment. However, a more precise approach should be taken into account as psoriasis is characterized by genetic polymorphism and patients have individual variations in genes, proteins, environment, lifestyle, concomitant diseases, etc. The increasing

development and success of biologic treatment for psoriasis has resulted in many patients achieving complete or almost complete skin responses. Nevertheless, only a proportion of patients achieve such outcomes to the first prescribed biologic and it may take time for patients to achieve expected results. There are many challenges when treating patients with psoriasis and trying to achieve best possible results. All this will be taken into account during the speech at the BADV congress in Kaunas, Lithuania.

PL 14–53. Biomarkers of psoriasis and related chronic inflammatory skin diseases

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Introduction

Papulosquamous diseases are chronic inflammatory skin diseases that have a significant negative impact on the physical, emotional, and psychosocial wellbeing of affected patients. The nosology of papulosquamous diseases is based on a descriptive morphology of clinical lesions characterized by scaly papules and plaques. Based on histopathological findings, inflammation and the abnormal proliferation of keratinocytes are the hallmark features of these diseases. The major entities in this group include psoriasis, lichen planus, and pityriasis rubra pilaris. Besides the fact that different papulosquamous disorders share several similar clinical and histopathological features, a common problem that remains for all mentioned disorders is the delay of diagnosis. The latter may reflect the fact that at early stages the presentation of cutaneous findings of different papulosquamous diseases can be highly variable and can mimic each other. Moreover, it seems that all these diseases need different disease management strategies, which necessitates a more precise understanding of pathogenesis with accurate and biomarker-based diagnosis.

PL 15–53. Psoriasis as an independent cardiovascular risk factor

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Introduction

Psoriasis is a chronic inflammatory skin disease strongly associated with both systemic and vascular inflammation as well as increased prevalence of conventional cardiovascular risk factors. Low grade systemic inflammation has been identified as a key driver in the development, progression and complications of atherosclerosis, of which the most important are myocardial infarction and stroke.

Recently, a "psoriatic march" theory has been proposed, according to which psoriasis may induce systemic inflammation leading to insulin resistance, endothelial dysfunction, and, lastly, the development of atherosclerosis and related cardiovascular comorbidities. Current evidence suggest that psoriasis and atherosclerosis might share similar immunological mechanisms involving IL-12/Th1 and IL-23/Th17 pathways, leading either to the atherosclerotic plaque growth or to its' instability. In addition, a study conducted by Elnabawi et al., revealed that the top three upregulated proinflammatory cytokines were IL-17A, IL-6, and CCL-20. Within the vasculature, CCL-20 induces lymphocyte migration and triggers changes as those activated by low- density lipoproteins. Increased levels of IL-17 may be responsible for increased recruitment and activation of the myeloid cells in the vascular intima and this results in an increased release of other proinflammatory cytokines. IL-6 along with IL-2, TNF-α and INF-γ plays a major role in the formation of inflammatory infiltrates, both in psoriatic and atherosclerotic plaques.

In Subas et al. performed literature review, the most important markers of subclinical atherosclerosis were increased coronary artery calcium score, increased total and non- calcified coronary plaque burden, high risk plaque prevalence beyond conventional cardiovascular risk factors, increased intima- media thickness of the common carotid artery, impaired flow-mediated vasodilatation of the brachial artery, elevated levels of oxidized blood lipids, serum myeloperoxidase, GlycA, low cholesterol efflux capacity, thicker epicardial fat. In comparison with healthy controls, all these

parameters were significantly more prevalent in psoriasis patients, proving that psoriasis alone is an independent cardiovascular risk factor.

Key words
Psoriasis; cardiovascular risk; systemic inflammation

PL 16–53. Severe cutaneous drug reactions

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Introduction
Severe drug reactions include AGEP, DRESS, and epidermal necrolysis. The talk will update the knowledge about management of epidermal necrolysis (Stevens-Johnson syndrome, toxic epidermal necrolysis) at the acute phase and during follow-up.

PL 17–53. Subacute cutaneous lupus erythematosus

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Introduction
Subacute Cutaneous Lupus Erythematosus (SCLE) occurs primarily in young to middle aged women. SCLE is highly photosensitive. There are two morphologic variants of SCLE: annular and papulosquamous. The differential diagnosis for SCLE also includes dermatomyositis, cutaneous T-cell lymphoma, lichen planus, tinea corporis, erythema annulare centrifugum, erythema gyratum repens, vitiligo, psoriasis vulgaris, drug eruption, granuloma annulare, urticaria, bullous diseases, and more. Many of these lesions have similar appearances, and histologic examination is often necessary for differentiation. Histologically SCLE is characterized by hydropic degeneration of the basal keratinocytes, dermal edema, hyperkeratosis, follicular plugging, and a sparse superficial inflammatory infiltrate, “dust-like particles” of IgG deposits on DIF.
Patients with SCLE usually have only mild systemic symptoms, most commonly arthritis and myalgias, while severe systemic symptoms, such as lupus vasculitis, CNS lupus, and nephritis occur in less than 10%. Immunologically, 70% of SCLE patients are anti-Ro (SS-A) positive, 70-80% are ANA positive, but positive anti-dsDNA is seen only in 5%.

Photoprotections should be used in all forms of LE including SCLE. Topical treatment is mainly with corticosteroids and calcineurin inhibitors. Systemic therapy includes antimalarials – hydroxychloroquine or chloroquine – and other immunomodulatory or suppressive drugs – dapsone, methotrexate, thalidomide. Oral retinoids can be tried in some cases. New biologic are also available for SCLE.

PL 18–53. Surgical therapy of hidradenitis suppurativa

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Introduction

Hidradenitis suppurativa (HS) is a chronic inflammatory skin disease for which surgical therapy is often the only curative treatment option, especially in the higher stages. The primary goal of surgery is the surgical removal of irreversibly destroyed tissue, which includes fistulas, severe tissue destruction, contracted scars and, last but not least, malignant processes. However, a generally accepted consensus regarding resection and reconstruction techniques does not exist to date.

Results

Various surgical techniques exist, which differ in their invasiveness and recurrence rates. The simplest excision techniques are incision and drainage. The advantage of these methods is their simplicity and rapid pain reduction for the patient. Recurrence rates are up to 100% with these methods. Other procedures with less invasiveness include deroofing and skin-tissue-sparing excision with electrosurgical peeling (STEEP). However, their use is mostly limited to Hurley stages I and II. The defects heals in secondary intention in a relatively short time. For severe cases, radical excision remains the surgical therapy of choice. Here, individually adapted, excision should be as less invasive as possible but as radical as necessary. For wound closure, secondary intention wound healing is also the goal in most cases. However, primary and secondary split-thickness skin grafts or plastic reconstructions by local flaps are also used. Ultimately, the type of wound closure depends on various factors, such as the size and location of the defect, the patient's compliance and, last but not least, the surgeon's experience. However, evidence-based recommendations on wound closure are still lacking.

Conclusions
Surgical treatment of HS should be performed within the framework of a comprehensive therapeutic concept, which, in addition to surgical therapy, also includes the various options of drug therapy.

Key words
Hidradenitis suppurativa; surgical therapy; recurrence rates; wound closure

PL 19–53. Cutaneous lupus and new treatment possibilities

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Introduction
CLE includes several cutaneous presentations with common and unique pathogenesis. Until now, the recommended treatment for CLE is local treatment with potent corticosteroids /tacrolimus and systemic treatment mainly with antimalarials plus UV-protection. The use of various DMARDs has been descibed based on case reports and support the use of dapsone for CLE, especially bullous lupus erythematosus. Research into the pathogenesis of CLE identifies a skewed type I interferon production and response in the pathogenesis of CLE lesions.

Aims and Objectives
An overview of current evidence and guidelines for the treatment of different subtypes of CLE.

Materials and methods
Literature review and description of current and upcoming treatment strategies. Based on new insights in pathogenesis, a number of potential new strategies are outlined, with emphasis of pipeline drugs targeting the interferon pathway.

Results
The pathophysiology of lesions may be similar among the CLE subtypes, and patients with a more TLR9-driven disease mechanism may have more benefit from hydroxychloroquine. Rituximab and Belimumab have efficacy in patients with systemic lupus erythematosus and severe active CLE. The significant role for type I interferons in CLE and encouraging clinical data

suggest anifrolumab as a very promising agent, and Dapirolizumab, BIIB059, Ustekinumab and Janus kinase inhibitors also have supportive early data as promising new strategies for CLE treatment.

Conclusions

Current treatment approaches can improve CLE, but there are still several unmet needs, including diagnostic accuracy, more effective and less toxic medications. Further research and clinical trials directed at CLE as a disease entity is important for patients who suffer from CLE with and without associated SLE.

Key words

Cutaneous lupus erythematosus; CLE; interferon pathway

PL 20–53. Successful adalimumab therapy in hidradenitis suppurativa and acne conglobata

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Introduction

Hidradenitis suppurativa (HS) is a chronic, inflammatory, recurrent skin disorder in which diagnosis appears to be delayed for 7.2 ± 8.7 years prolonging the burden of disease. Deep, painful nodules, tunnels (sinus tracts/fistulas), abscesses, double comedones, hypertrophic scars typically are present in groins, axilla, back, trunk, genital or perianal areas. HS is a component of the follicular occlusion tetrad along with acne conglobata (AC), dissecting cellulitis and pilonidal cyst.

Aims and Objectives

To report a case of HS with AC that was successfully treated with adalimumab.

Materials and methods

We present a case report of 31-year-old male with HS and AC who have received 1 year adalimumab therapy.

Results
Patient with a 1-year history of HS and 14 years history of AC presented to our clinic. Treatment with doxycycline 100 mg twice daily for 6 months and isotretinoin 60 mg daily for 6 months was without significant improvement. He had medical history of pilonidal sinus and was a smoker for 15 years. HS lesions were presented as fistulas and inflammatory nodules in axillary and inguinal regions (Hurley III stage, HS-PGA - 5 points, IHS4- 47 points, paint VAS-4 points and DLQI- 21 points). On the back and trunk fistular comedones, hypertrophic scars and inflammatory nodules were presented. Patient was not obese, his body mass index was 23.31 kg/m2. Blood tests showed increased white blood cell (WBC) count (15.15 10*9/l) and C-reactive protein (CRP) level (10.78 mg/L). Treatment with subcutaneous adalimumab 40 mg weekly was initiated and patient quit smoking. After 1 month of adalimumab injections, his pain decreased and purulent secretions ceased. His WBC count, CRP levels levels normalized and this response continued over the 12-month treatment period (IHS4-7 points, VAS-0, DLQI-8 point).

Conclusions
HS and AC can be recalcitrant to conventional therapies. This report provides further evidence to support the role of adalimumab in treatment-resistant cases.

Key words
Hidradenitis suppurativa acne conglobate; biologic therapy

PL 21–53. Application of infrared thermography and ultrasound in the diagnostics of hidradenitis suppurativa

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Introduction
Hidradenitis suppurativa (HS) – chronic, inflammatory, progressive skin, subcutaneous and hair follicle disease. A mean illness incidence of 6.0 per 100,000 person-years and an average prevalence of 1% has been reported in

Europe. HS is diagnosed on average 7.2 years after the onset of symptoms. Therefore non-invasive imaging methods such as infrared thermography (IT) and ultrasound (US) are used for HS diagnostics.

Aims and Objectives

The aim of this study is to evaluate the applicability of IT and US in patients with HS when lesions are located in the armpit area. Objectives: 1. To propose the methodology of IT temperature change (ΔT) assessment for the study of HS patients. 2. To determine the dependence of ΔT on the morphology of lesion in SH patients.3. To evaluate the relationship between ΔT and ultrasonic parameters.

Materials and methods

The study included 4 patients (Hurley‘s stage II-III) which calculation of inflammatory and non-inflammatory lesions, photo documentation were performed. At rest, the body temperature in the forehead area was measured with a thermometer and the temperature of the skin affected by HS was measured using a FLIR camera, and the difference ΔT between the two parameters was calculated using the methodology of Pi-Chang et al, 2006. Using the thermogram data, the highest (hottest) body temperature point was determined in the HS affected area (armpit), the position being in the area was marked by perpendicularly glued two rulers, followed by an 15-22 MHz US examination according to the defined procedure by Martorell et al, 2017. Thermograms were analyzed with FLIR TOOLS program.

Results

The scientific literature was analyzed and the methods of IT application was described, selecting the appropriate environmental and physical parameters for patients with HS. When a patient has an inflammatory lesion, the maximum temperature ranges from 34.1oC to 36.5oC and the ΔT varied from 1.9 to 3.6 (ΔT mean 3.3 (95% CI: 1.6-5.1)). In the absence of inflammatory lesions, the maximum temperature in the armpit area ranged from 33.6 oC to 36.4 oC, and the calculated ΔT value varied from 2.5 to 4.5 (ΔT mean 3.5 (95% CI: 1.1-5.8)). Lower mean ΔT (3.2 (95% CI: 1.7-4.6) and 2.3 (95% CI: 0-6.7)) were calculated when US showed peripheral and peripheral-central circulatory activity and higher mean ΔT (4.4 (95% CI) : 1.3-7.5)) was calculated, in contrast, when no active blood flow was detected by ultrasound doppler.

Conclusions
The results of the study showed a tendency that among HS patients the maximum temperature in the affected skin is higher than 34.0oC, a lower ΔT value is calculated and peripheral or peripheral-central circulatory activity is recorded in US. Therefore, ΔT indicator monitoring can be used to control the course of the disease in patients with HS.

Key words
Hidradenitis suppurativa; infrared thermography; ultrasound

PL 22–53. Locally advanced basal cell carcinoma in an elderly patient with bullous pemphigoid

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Introduction
Bullous pemphigoid (BP) is an autoimmune subepidermal blistering disorder that most commonly occurs in the elderly. Some authors have described several cases of BP associated with malignancies, but the evidence of this correlation remains controversial. A possible association between malignant neoplasms and BP is the formation of tumor-directed antibodies, which cross-react with antigens in the basement membrane zone leading to the formation of blisters [1].

Aims and Objectives
The aim is to present a rare case of locally advanced basal cell carcinoma (BCC) in an elderly patient with BP.

Materials and methods
An 84-year-old female patient was admitted to the hospital because of itchy, widespread bullae, fever (38.9 °C), and a painful 25 x 10 cm sized ulcer under both breasts. During the dermatological examination, we found tense bullae with a negative Nikolsky sign. There were no lesions in the mucosa. The patients' history revealed that the ulcer, which had never been treated before, appeared 15 years ago and the bullae began to form within the past 3 weeks. In addition, the patient's health condition was aggravated by chronic

autoimmune hemolytic anemia which was systemically treated with prednisolone and splenectomy in the hematology department 15 years ago.

Results

A punch biopsy of the bullae and histopathological analysis using hematoxylin and eosin staining showed a subepidermal blister and dense perivascular infiltrate. Direct immunofluorescence of perilesional skin displayed linear deposition of IgG and C3 along the basement membrane, consistent with BP. Histopathological analysis of the ulcer revealed multifocal nests of atypical basaloid epithelium with peripheral palisading and cleft formation, supporting the diagnosis of BCC. Additionally, cultures from the ulcer and bullae grew Staphylococcus aureus.

The patient was treated with intravenous methylprednisolone 500 mg daily for 4 days, followed by oral prednisolone taper over 13 weeks with a loading dose of 65 mg q.d. and 50 mg of daily azathioprine. Antimicrobial foam dressings with silver were used for wounds, in addition to i.v. cefazolin 1 g t.i.d. for 10 days.

With treatment, the bullous lesions disappeared and the hemoglobin in peripheral blood increased from 58 g/L to 126 g/L. Thoracic, abdominal, pelvic CTs, and thoracic MRI investigations were negative for BCC metastasis. Eventually, it was decided to treat the locally advanced BCC ulcer with radiotherapy. Radiotherapy (40.5 Gy over 9 fractions) was applied for almost 1 month and showed positive results. BP remained in remission post radiotherapy and no other malignant tumors were identified. We propose that the BP was of paraneoplastic nature due to the locally advanced BCC, with no similar reports found in literature.

Conclusions

There are conflicting results of BP association with malignancies among published case reports, reviews and meta-analyses [2,3]. Nevertheless, physicians should be aware of the existence of BP in patients with cancer, suggesting a possible need for oncological screening in early-onset BP.

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Key words
Basal cell carcinoma; locally advanced; bullous pemphigoid; treatment

PL 23–53. What your hands show. Changes of hands as clues to diagnosis

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Introduction
Many dermatoses or systemic diseases may show changes of the hands and such hand signs can lead to diagnosis.

Materials and methods
Disorders with hand-signs include collagenoses, metabolic, nutritional disorders including intoxications; moreover infections, genodermatoses, vascular disorders with disturbances of circulation, neuropathies, neoplasias and some others.

Results
In these diseases, diagnostic hints of the hands (hand-signs) may be early symptoms for sytemic or for cutaneous diseases.

Key words
Hand signs; diagnostic hints; systemic diseases

PL 24–53. The hidden face of scabies in Latvia

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Aims and Objectives

Scabies affects around 200 million people worldwide. Prevalence estimates in the recent scabies related literature range from 0.2% to 71%. Population crowding and skin-to-skin contact promotes transmission among children, homeless individuals, and displaced groups .

The treatment of scabies is now neglected in Latvia and there is a possibility, that self-treatment with 4% permethrin (5% permethrin elsewhere in the world) is present. Scabies diagnosis and treatment has a number of unresolved weaknesses, which consequences are not always evaluated.

The aim of this study is Scabies related issue update and validity of Scabies excluded from "Reportable Sexually Transmitted Diseases (STDs)" in Latvia.

Materials and methods

As of today available literature in databases, epidemiological data, regulatory documents and guidelines were gathered and our clinic experience in scabies care was evaluated.

Results

Is scabies really familiar to us - problems are caused by pure human scabies, coincidence with itchy (inducing a cutaneous hypersensitivity reaction to the mite and its products) and papulosqamous dermatoses and treated scabies.

There is no understanding in new "2020 IACS Criteria for the Diagnosis of Scabies" about necessity for microscopic diagnosis and the use of dermatoscope for visualisation.

Immunohistochemical, confocal examination, biopsy are not used.

For the treatment is used a product with 20% lower active ingredient content – 4% permethrin, that should be used longer than 5% permethrin. Therapy mainly is symptomatic, and is done without diagnosis.

Consequences: irritated skin becomes the entrance gate for infection (streptococci etc.), allergens. Sensitization occurs with the following auto-aggressive reaction, including eczema, psoriasis, glomerulonephritis, chronic renal failure and rheumatic fever.

Conclusions
Previous low cases of scabies can be explained by: the direct unavailability of a dermatologist, the absence of epidemiological reports and the replacement of diagnosis of scabies with “dermatitis”. The increase of allergic conditions can also be associated with ignored scabies. Combination therapy, new systemic (oral ivermectin, moxidectinand, isoxazolines), novel topical therapy and environmental measures has to be implemented.

PL 25–53. Scabies: what we know, what we should know?

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Introduction
Old and new modalities of transmission of scabies (scabies acquired in Chinese massage centers; contact sports and scabies);
- Where to look for the scabies mite (importance of subungual skin of fingers);
- Why is the back so rarely involved in scabies? (importance of autoinoculation);
- Nodular scabies versus postscabies prurigo;
- Scabies and nocturnal pruritus;
- Pruritus sine materia? Scabies!
- Skin bacterial superinfections in scabies (they are actually rare in Western countries);
- Old and new therapies (tretinoin? Acitretin?).

PL 26–53. Clinical plasma medicine

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Aims and Objectives
The ability to produce cold plasma at atmospheric pressure conditions was the basis for the rapid growth of plasma related application areas in biomedicine.

Materials and methods

Plasma comprises a multitude of active components such as charged particles, electric current, UV radiation, and reactive gas species which can act synergistically. Anti-itch, antimicrobial, anti-inflammatory, tissue stimulating, blood flow enhancing as well as proapoptotic effects were demonstrated in in vivo and in vitro experiments and until now no resistance of pathogens against plasma treatment was observed. The combination of the different active agents and their broad range of positive effects on various diseases, especially easily accessible skin diseases, render plasma quite attractive for applications in medicine.

Results

For medical applications two different types of cold plasma appear suitable; indirect (plasma jet, plasma torch) and direct plasma sources (dielectric barrier discharge - DBD). DBD generates a low temperature plasma under atmospheric pressure and, thus, is a suitable instrument for a non-destructive treatment of biological material. The PlasmaDerm® VU-2010 (Cinogy GmbH, Duderstadt, Germany) device is a non-invasive active medical intervention which does not reach direct skin contact. For our medical application, a non-equilibrium, weakly ionized physical DBD plasma is generated by the application of high voltages across small gaps, whereas the electrode is covered by a dielectric. This non-conducting layer avoids the transition of the gas discharge into a hot arc by limiting the current. The biological tissue itself (i.e. the skin) acts as the counter electrode. In contrast, the atmospheric pressure plasma jet (APPJ) kINPen® MED (INP Greifswald / neoplas med GmbH, Greifswald, Germany) consists of a hand-held unit for plasma generation, a DC power supply (60 V) and a gas supply unit. The APPJ is generated due to a centered electrode which is surrounded by a second round electrode and expands to the surrounding air at the end of the nozzle, driven by an argon gas flow. The argon gas flow was set to 5 standard liters per minutes (slm). The kINPen® MED is applicable primarily for small-point treatments and very useful for the treatment of small gaps. Both devices are CE-certified as a medical product to treat chronic wounds in humans, showed efficacy, and a good tolerability.

Recently, the use of plasma in cancer research and oncology is of particular interest. Plasma has been shown to induce proapoptotic effects more efficiently in tumor cells compared with the benign counterparts, leads to cellular senescence, and – as shown in vivo – reduces skin tumors. To this

end, we establish a scientific network for the investigation of the efficacy and safety of cold atmospheric plasma in dermato-oncology.

Conclusions
Hence, plasma medicine especially in dermatology holds great promise.

Key words
Cold atmospheric plasma; reactive oxygen species; reactive nitrogen species; electrical current; UV irradiation; wound treatment; skin cancer treatment

PL 27–53. Several cases of complicated trophic ulcers

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Introduction
Trophic ulcers are actual and worldwide problem, complicated trophic ulcers are very common in dermatologist practice, however direct guidelines for local and systemic treatment are not published.

Aims and Objectives
Two cases of complicated trophic ulcers. In the first case, a 49-year-old Caucasian man was admitted to the hospital. At the initial examination, the patient complained of pain in the lower extremities and wounds with exudation. Examination by an ambulance doctor revealed a massive ulcer in the medial part of the left ankles. It is known from the anamnesis that the patient has an abrasion of the skin at the site of the ulcer, the abrasion has turned into an ulcer. The patient did not control the condition of the ankles. At the dermatologist's appointment, a complete examination of the body was carried out, hyperpigmentation on both legs, varicose veins, bilateral trophic ulcer in the left ankle joint were revealed. The second case is a patient about 53 years old who was admitted to the clinic with an ulcer on the right and left ankles. The patient had a circular ulcer on the right ankle and ulcers of the lateral and medial ankles on the left leg. It is known from the history that the patient had recurrent ulcers of the lower extremities.

Materials and methods
For both patients blood analysis, microbiological swab from ulcer and venous ultrasound were performed.
After microbiological swab systemic course of antibiotics was prescribed. Every day both patients had ulcer care with combined local therapy. Local therapy began with the "wet to dry" principle and continued with local applications of antibiotics, antiseptics and corticosteroids. During all hospitalization the patient had pain therapy.

Results
Both patients were discharged from the hospital with significant improvement of local status.

Conclusions
Treatment of trophic ulcers is complicated and prolonged process, which combine local therapy with systemic medications, as well as prophylaxis.

Key words
Trophic ulcers; wound care

PL 28–53. Iatrogenic Kaposi sarcoma in a renal allograft recipient

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Introduction
Kaposi sarcoma (KS) is an endothelial tumor associated with human herpes virus 8 (HHV-8) infection. The iatrogenic form of KS arises due to immunosuppressive treatment and is most common following solid organ transplantation. Patients typically present with angiomatoid lesions on the

lower limbs and lymphedema. Currently, there are no guidelines specific for iatrogenic KS diagnostics and treatment, although a change in the immunosuppressive regimen is often employed and is associated with lesion resolution.

Aims and Objectives

We present a case of iatrogenic KS following a renal allograft, with rapid progression mandating systemic treatment.

Materials and methods

A 74-year-old female was referred to the dermatology department due to expanding itchy tumors on the right leg with a duration of 5 months. Previous treatment with local corticosteroids and H1 antihistamines was ineffective. The patient had received a cadaveric renal allograft two years before and the immunosuppressive therapy consisted of cyclosporine 175mg and methylprednisolone 4mg q.d. She was HIV negative with a normal CD4 cell count. On dermatological examination, multiple grouped red-violet nodules on the right thigh and lower leg were seen. There was associated unilateral limb edema. Peripheral lymph nodes were not palpable. On dermoscopy, red-violet structureless homogenous zones with KS-specific rainbow pattern were identified.

Results

A lesion biopsy displayed a dermal tumor composed of spindle-shaped CD31+ CD34+ cells with positive staining for HHV-8 and slit-like spaces containing erythrocytes, consistent with KS nodular stage. Computer tomography scans of the chest, abdomen and pelvis showed peritoneal carcinomatosis with multiple affected mesenteric lymph nodes up to 1.2 cm, in addition to the involved lower thoracic paravertebral, para-aortic and hepatic hilar lymph nodes up to 1.1 cm in size. Following negative cytomegalovirus DNA serology, an ultrasound guided mesenteric lymph node biopsy was performed. On histopathology, the lymph node architecture was effaced by spindle-shaped CD34+ HHV-8+ cells, confirming KS spread. After the case discussion in a multidisciplinary tumor board, sirolimus 10mg q.d. was substituted for cyclosporine. Further observation was deemed precarious and local radiotherapy unsuitable due to pre-existing lymphedema and advanced disease, thus treatment with liposomal doxorubicin was initiated.

Conclusions
Iatrogenic KS is an important disease among patients with secondary immunosuppression, which can seldom progress to systemic involvement. Early diagnosis is crucial for the timely initiation of alternative immunosuppressive regimens and further emphasizes the importance of skin cancer screening in patients with solid organ transplants.

Key words
Kaposi sarcoma; iatrogenic; immunosuppression

PL 29–53. COVID-19: The skin and more

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Introduction
Pandemics have ravished the globe periodically, often beginning with fever and rash, as recorded in the crowded walled city of Athens during the Peloponnesian War as described by Thucydides in 430 BCE. As the world now faces the first major pandemic of the 21st century, we view the "plague" in Athens in 430 BCE and the 2 pandemics of the more recent century which killed more than one million, the Spanish flu of 1918 and the Asian flu of 1957. The latter should be linked with successful vaccine development by heroic microbiologist Maurice Hilleman. We now look back and then forward to the viral infection coronavirus disease 2019 now devastating the modern world.

Aims and Objectives
The novel coronavirus SARS-CoV-2 has caused coronavirus disease-2019, known as COVID- 19, now a pandemic stressing millions of individuals worldwide. COVID-19 is a systemic respiratory infection that may have dermatologic signs and systemic sequelae, a devastating public health challenge with parallels to the two great influenza pandemics of the last century. Skin lesions linked with COVID-19 have been grouped into six categories, with three distinct indicative patterns: vesicular (varicella-like), vasculopathic, and chilblains-like (including "COVID toes" and "COVID fingers") plus the following three less suggestive patterns: dermatitic, maculopapular, and urticarial morphologies. Vasculopathic changes are the most concerning, in some patients, reflecting a devastating blood clotting

dysfunction. We discuss the ways to detect, prevent, and treat COVID-19, keeping in mind the context of possible cutaneous markers of COVID-19 to enhance detection.
The coronavirus disease 2019 pandemic has had a profound effect on our lives and nations; socioeconomic effects have been profound. Travel and meeting activities, as well as many other activities, have been severely restricted. Social unrest has become intense, with evolving political consequences worldwide. We will review cutaneous associations within a broader societal context.

Results
Dermatological implications fall into four main groupings: cutaneous manifestations of COVID-19, skin changes from COVID-19 lifestyle alterations, cutaneous adverse reactions to COVID-19 medications, and effects of COVID-19 and its therapy on primary skin diseases and their management. COVID-19 has been associated with suggestive skin manifestations which we classify into 6 categories with three distinct patterns: vesicular (varicella-like), vasculopathic, and chilblains-like ("COVID toes") plus three less indicative ones: dermatitic, maculopapular, and urticarial morphologies.

Conclusions
We recall the words of Albert Camus as a fitting end to this presentation: Did he more than foreshadow the COVID-19 pandemic in "The Plague?" In his lyrical essay, "Return to Tipasa," Camus revisits this mystical seaside Roman ruin of his childhood in Algeria, as he adjusts to the world's new normal. Camus has awakened from despair with a revitalized spirit of purpose upon returning to glorious Tipasa, Algeria. Let us hope we can greet our world with the same joy after having vanquished COVID-19.

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PL 30–53. Clinical features of cutaneous lymphomas

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Introduction
Primary cutaneous lymphomas are classified on the basis of nodal lymphoma classification. However, they present with distinct clinical features and diserve special follow up and treatment strategies.

Aims and Objectives
Even though a precise identification of the special type of lymphoproliferative disorder today needs histopathologic (goldstandard), immunologic and/or molecular workup, the major categories of cutaneous lymphomas can be differentiated on clinical profiles, i.e. on clinical features and the dynamics of their morphologies.

Materials and methods
From the broad spectrum of primary cutaneous lymphomas some prototypes with histologically and immunologically confirmed diagnoses were chosen and their typical features in terms of clinical presentation and course of the diseases are presented.

Results
Various types of clinical presentation can be put into a morphologic and diagnostic algorithm:

TYPE of skin lesions: disseminated vs solitary, patches vs plaques vs tumors; nodules vs papules; hard vs soft consistency; nodular exophytic vs flat or endophytic and subcutaneous.
SURFACE: scaling vs glossy; smooth vs cerebriform; red vs yellowish vs hemorrhagic; not ulcerated vs ulcerated.
DYNAMICS: slowly growing vs eruptive; constantly progressive vs spontaneously regressive.
Other pairs of parameters.

Conclusions
Major categories of lymphoproliferative disorders of the skin can be antissipated just on the basis of their clinical and morphological presentation in conjunction with the course of the disease. Nevertheless the golsdstandard for the diagnosis remains the histo- (T-cell pattern vs B-cell pattern) and cytomorphology with immunological and melecular phenotyping, which finally have to confirm the visual diagnosis.

Key words
Cutaneous lymphomas; clinical features; visual diagnosis.

PL 31–53. Classic Kaposi's sarcoma: clinical aspects and treatment options

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Introduction
Kaposi's sarcoma (KS) is a vascular neoplasm first descrIbed by Kaposi in 1872. KS is categorized into 4 clinical types: epidemic, iatrogenic, classic and endemic. Classic KS (CKS) typically occurs primarily in elderly men. It has a male predominance with a male to female ratio of 10-15:1. The age of onset is between 50 and 70 years. HHV-8 is identified as the causative agent of KS, it is present in 95-98% cases. CKS usually follows a protracted and indolent course.

Aims and Objectives
Describe and analyze clinical information about CKS, as well as provide data on the therapeutic potential of this disease, taking into account the patient's general health and comorbidities.

Materials and methods
Diagnostic considerations
Clinical signs: subjective and objective symptoms
Laboratory studies
Histology: typical histologic findings include proliferation of spindle cells, prominent slitlike vascilar spaces, and extravassated red blood cells
Dermoscpopy: the most common frequent patterns are cyanotic coloration, the "rainbow pattern", scaly surface.

Results
Therapeutic options for CKS based upon disease stage, progession pattern and distribution, clinical type, and immune status. Managment modalities for CKS include topical agents, systemic treatments, and instrumental methods. Clinical case presentation.

Conclusions
1. For the diagnosis of CKS, it is important to consider the epidemiological data of the patients
2. For treatment the combination of local and systenic regimens may be preferable
3. For long-term monitoring in patients with CKS should have routine physical examnations every 3-4 months to assess for new skin lesions, or symptoms suggestive of visceral involvement.

Key words
Kaposi's sarcoma. diagnostic, treatment modalities

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PL 32–53. Laser treatment of infantile capillary malformations: dermatologists role

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Introduction

In dermatological practice can vascular lesions be divided into vascular malformations and vascular tumors, namely infantile hemangiomas. Capillary malformations affect up to 0.5% of newborns and they may darken, thicken, or even enlarge if left untreated. Most of capillary malformations appear on the face and usually treatment should be started as early as possible. Early intervention with laser is associated with better outcomes and less pain. Laser treatment in younger patients is more effective and is thought to provide the best opportunity to obtain lesion clearance as dermal thickness and scatter increase with age. In infants, the surface area of the malformation is smaller in absolute size and therefore fewer pulses are required. Laser treatment at 6 to 12 weeks intervals under general anaesthesia in infants at 6 months of age remains the standard of care in order to achieve maximal improvement prior to school age. During the talk the general knowledge and clinical experience of treating infantile capillary malformations at Oslo university hospital will be shared.

PL 33–53. Diagnostics and monitoring of patients with melanoma

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Introduction

Cutaneous melanoma (CM) is the ninth most common type of cancer and the second leading cause of death. Localized CM has a 99% 5-year survival rate, but in patients with distant metastases the 5-year survival rate decreases to 20%. The incidence and mortality of CM in Lithuania has been increasing for the last three decades due to the lack of early diagnosis [1] and delay in

reimbursement of targeted therapy with BRAFi + MEKi inhibitors and anti-PD1 immunotherapy for progressive stages of disease [2].

Aims and Objectives

To review diagnostics and monitoring of CM based on own experience and recent scientific literature.

Materials and methods

Results of our clinical studies were analysed and articles containing terms for diagnostics and monitoring of CM were retrieved to generate an up-to-date view on this topic.

Results

Routinely, primary CM is diagnosed based on clinical and dermatoscopic features, but promising results were observed using spectrophotometry (SIAscopy), which shows the distribution of skin chromophores (including melanin, hemoglobin, and collagen) in the epidermis and dermis [3]. CM thickness, measured histopathologically (pT) after tumour excision based on the 8th version of AJCC classification, is an important prognostic indicator (in cases of pT >=0.8 mm) for sentinel lymph node (SLN) biopsy [1]. Our studies have shown that CM thickness before excisional biopsy can be accurately estimated using 14 MHz ultrasound when pT is >2 mm [4], and similar accuracy can be achieved for pT of less than 2 mm with a 22 MHz ultrasound probe [5,6]. CM up to 0.8 mm in pT does not need further imaging diagnostics (ID) for staging. From stage IB onwards, patient examination with lymph node sonography (LNS) is recommended, with no further ID. From stage IIC whole-body computed tomography (CT) and/or positron emission tomography (PET)-CT in combination with brain MRI should be performed. From stage III and higher, molecular testing for BRAF V600 is obligatory, including NRAS or KIT mutations according to the subtype of CM.

Conclusions

The first 5 years of patient follow-up after surgery of primary melanoma are the most important. Ultrasound has been proven to be superior to physical examination for the detection of lymph node metastases. The frequency and extent of follow-up examinations depend on the primary tumor stage. Total

skin clinical and dermatoscopic examination, including visible mucosa, and blood testing for LDH and S-100 from IIC stage are recommended.

Key words
Cutaneous melanoma; diagnostics, monitoring.

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PL 34–53. Modern systemic therapies in melanoma and non-melanoma skin cancer

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Introduction

Skin cancer is the most common cancer in man. Basal cell carcinoma is by far the most common skin cancer, however, with low mortality, followed by squamous cell carcioma. Melanoma is the most deadly skin cancer.

Aims and Objectives

Large and surgically difficult to resect or metastasized basal and squamous cell carcinomas need effective systemic medicamentous tumor thrapies. The same holds true for metastasized melanomas or stage III melanomas with lymph node micrometastases to prevent recurrence.

Materials and methods

Molecular-genetic as well as immunulogical research paved the way for new treatment targets including checkpoint inhibition and blockage of signaling cascades.

Results

For melanomas, CTLA-4 and PD-1 checkpoint inhibition antibodies were developed over the last decade. Roughly, mortality can be reduced in the metastasized stage by 50 %. In the adjuvant setting, relapse probability can be reduced by 50%. In parallel, selective inhibitors for silencing the BRAF/MEK signaling cascade have been developed. They can reduce melanoma mortality - if the BRAF mutation is present - by about 40% in the metastasized stage. In the adjuvant setting, relapse probability can be reduced by 50%.

Large and surgically difficult to resect or metastasized basal cell carcinoms can be treated with hedgehog-inhibitors with an efficacy of about 60 %. Studies using PD-1 antibodies are underway.

Large and surgically difficult to resect or metastasized squamous cell carcinomas can be treated with PD-1 antibodies with an efficacy of about 50%. The anti-EGFR antibody cetuximab is not licensed for squamous cell cancer treatment and less effective than PD-1 checkpoint inhibition.

Conclusions
Systemic therapies for advanced skin cancer have evolved with an efficacy of about 50%. Combinatorial therapies with immunogeneic enhancers may increase treatment efficacy in the future.

Key words
Basal cell carcinoma, squamous cell carcinoma, cutaneous melanoma, hedgehog inhibitors, checkpoint inhibitors, BRAF/MEK inhibitors.

PL 35–53. A Case report of 30 – year – old patient treated with skin – directed therapy for cutaneous T-cell lymphoma

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Introduction
Primary cutaneous T – cell lymphoma (CTCL) is a rare disorder especially in young patients that presents with skin lesions without extracutaneous involvement at the time of diagnosis. The European society for medical oncology has introduced guidelines on primary cutaneous lymphomas where the treatment options depend on clinical stage of the disease. For patients with early stage disease the skin – directed therapies including topical steroids, oral Methoxypsoralen plus ultraviolet A (320 – 400 nm), narrow band ultraviolet B (311 – 312 nm), topical mechlorethamine is recommended, while the use of systemic treatment for the advanced disease is still limited [1].

Aims and Objectives
We present a case report of the first patient in Baltic countries treated with topical mechlorethamine gel.

Materials and methods
A 30 – year – old male patient presented with 10 – year history of multiple well – defined patches covering less than 10 percent of skin surface

resembling atopic dermatitis resistant to the treatment. After histopathological evaluation of affected skin, the patient was diagnosed with mycosis fungoides (MF), the most common subtype of cutaneous T cell lymphoma. There was no evidence of visceral organs, lymph nodes involvement or circulating atypical cells in the blood, stage IA was evaluated. The patient was treated with high potency topical steroids and oral 8 – Methoxypsoralen plus ultraviolet A (320 – 400 nm) (total 53 procedures in 2 years). One month after skin – directed treatment new plaques were observed. The multidisciplinary council decided to prescribe topical mechlorethamine 0,016 percent gel once a day.

Results

Clinical response of MF was evaluated with scales: CAILS – 50 points, mSWAT – 9 points and BSA – 9 percent. After 4 weeks the patient developed herpes labialis, oral acyclovir was prescribed. Although, during the treatment skin irritation developed, patient discontinued mechlorethamine gel for 3 days. At the week 40 follow – up skin condition improved, CAILS – 8 points, mSWAT – 3 points, BSA – 3 percent. During the treatment, no other side effects of mechlorethamine were observed.

Conclusions

The incidence of disease is rare before 30 years of age, with an incidence rate of 0.12 per 100 000 persons per year between ages 20 and 29 years [2]. The skin directed therapies for primary cutaneous T cell lymphoma is chosen according to the stage in order to achieve the best treatment outcomes. According to published evidence and upon its availability the mechlorethamine is recommended for first line treatment of early stage (IA – IB) disease, especially when topical steroids and oral 8-Methoxypsoralen plus ultraviolet A (320 – 400 nm) did not achieve complete response [3]. Therefore, according literature and our experience mechlorethamine is safe and effective and could be used as an initial therapy which accessibility should be improved for early stages MF patients.

Key words

Mycosis fungoides, mechlorethamine.

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PL 36–53. Case report: Mycosis fungoides

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Introduction

We present an interesting case where the patients' preliminary and final diagnoses changed more than once due to the fact that clinically obvious mycosis fungoides (MF) histologically mimicked other dermatoses.

Results

In 2019, a 73-year-old woman was referred to the tertiary care Centre of Dermatovenereology due to disseminated rashes on her body and face, which appeared 5 years ago. First histological examination revealed lichen planus, so treatment with systemic glucocorticoid (GCC) therapy and UVB-311 nm phototherapy was administered. Regression of skin lesions followed quickly, however, at the end of the treatment, cutaneous condition began deteriorating

again – new facial lesions and red, infiltrated plaques developed. Mycosis fungoides was suspected once more, however, histological examination again confirmed lichen planus. This time, systemic GCC and psoralen – ultraviolet A (PUVA) phototherapy was administered and skin condition improved rapidly. Unfortunately, after a few months of remission, the skin condition worsened again. For the third time mycosis fungoides was suspected, but histological examination confirmed discoid lupus erythematosus. Based on clinical signs and histopathological symptom, final diagnosis of lichen planus – discoid lupus erythematosus overlap syndrome was made. Since sun exposure had no negative effect on skin condition, the patient successfully continued treatment with PUVA phototherapy and systemic GCC. After a brief remission, the condition of the skin deteriorated rapidly again - new plaques began forming diffusely on the skin, painful purulent nodules appeared. For the fourth time mycosis fungoides was suspected, and, finally, histological examination confirmed the patient's final diagnosis – mycosis fungoides, tumour stage.

Conclusions

Mycosis fungoides is a real diagnostic challenge for a dermatovenerologist, especially in the early stages of the disease, as it often takes many years from the onset of the disease to the exact diagnosis. MF is like a chameleon - a patient may have several types of lesions at the same time, which may vary in shape, size, colour, and arrangement. This clinical case emphasizes the importance of critical and holistic view towards the patient, since blind reliance to a single test can be misleading.

Key words

Mycosis, fungoides, cutaneous, oncology.

PL 37–53. Aquired epidermolysis bullosa

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Introduction

Epidermolysis bullosa acquisita (EBA) is a rare, chronic, autoimmune, subepidermal blistering skin disorder. The pathogenesis of EBA involves the production of autoantibodies (mainly IgG class) to type VII collagen, a major component of anchoring fibrils at the dermal-epidermal junction. Usually it develops in adult life and presents with chronic skin inflammation, formation of blisters on trauma-prone areas (e.g., arms, legs, knees, elbows, buttocks) or mucous membranes and heals with scarring. Current treatment options are limited because non-specific immunosuppressive treatments are usually given, which in many cases do not help to achieve long-term remission.

Aims and Objectives

A 48 - year - old female was referred to Vilnius University Hospital Santaros klinikos, Centre of Dermatovenereology with a chief complaint of multiple tense, heterogeneous bullae on hands, feets, intertrigous areas, eyelids small blisters in mucous membranes, as well as multiple erosions, onychodistrophy with partial anonychia and area of cicatrial alopecia on the scalp. The first blisters appeared 3 years ago in the scalp area and eventually the condition progressed: blisters began spreading throughout the body. Blisters appeared even at the site of minor trauma and were healing with scars. The patient was treated with local and systemic gluccocorticoids, antiseptics, but there was no improvement, so additional treament with azathioprine was added. Due to inssuficient effect, plasma aphereses were administered. The patient is still being treated and followed-up.

Conclusions

EBA is an aquired, very rare disease, which clinical and histological features can be difficult to distinguish from other bullous diseases. It is incurable disease, so the main goal of treatment is to stop the progression of the disease and to minimize the risk of severe complications associated with scarring. At

this time, there is no specific treatment, so systemic immunosuppressants are usually given in combination with topical agents, which often result in only partial clinical improvement. Emerging new treatment options are of crucial importance, as the quality of life of patients with this disease is very poor, making it difficult to engage in normal daily activities, work and even take care of themselves.

Key words
Epidermolysis bullosa acquisita, bullous disease, therapeutic management.

PL 38–53. Acute generalised egzantemous pustulosis and paraneoplastic erythema multiforme overlap syndrome

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Introduction

Paraneoplastic syndromes can be defined as a set of various symptoms that are unrelated to the primary tumor or its metastases. One of the manifestations can be a paraneoplastic skin syndrome which has a fairly wide range of possible erythematous (erythema multiforme), pustular (pemphigus paraneoplastica), papulosquamous rashes (acrokeratosis paraneoplastica). Furthermore, there are some cases described in which paraneoplastic skin syndromes are characterized by an overlap of various skin conditions.

Results

A 62 y.o. woman was admitted to our Dermatovenereology unit in November 2018. Her complaints were itching and redness of the skin. The lesions first appeared in February 2018 on the right arm and spread to the left arm, face, and ears in a couple of months. The condition worsened from UV exposure and heat. She presented with erythema on the cheeks, slightly erythematous, swollen earlobes, and slightly infiltrated, cyanotic erythematous, scaly plaques on both arms. Detailed laboratory tests, chest X-ray, and abdominal ultrasound were found to be within normal ranges. In addition, a skin biopsy showed changes compatible with lupus erythematosus. Subsequently, a

diagnosis of subacute cutaneous lupus erythematosus was made. Therefore, in-patient treatment consisted of emollients and intravenous dexamethasone infusions. Within a week the patient's condition markedly improved and she was discharged. She was prescribed oral prednisolone and hydroxychloroquine.

During a follow-up after two weeks, the patient's condition was still improving. The dose of prednisolone was reduced, and a follow-up visit after a month was set up. However, the patient arrived two weeks later presenting with a febrile fever, a rash that appeared suddenly on the face and spread throughout the body in a couple of days. During the examination, an occasional dry cough was noticed. The patient admitted having episodic dry cough for the past 3 months. Clinical findings included a “butterfly” shaped rash on the face, severely erythematous, swollen and scaly earlobes, multiple confluent cyanotic erythematous papules and plaques, several pustules, and small blisters throughout the skin. The patient was once again admitted to our in-patient unit. On admission, neutrophilic leukocytosis was observed, with a slight increase in ESR, CRP. During the in-hospital stay, the fever persisted, with increasing neutrophilic leukocytosis, ESR, and CRP. Furthermore, new “target–like” rashes that resembled erythema multiforme appeared. Based on the symptoms, it was decided to repeat the chest X-ray and the skin biopsy. Histological results revealed changes consistent with the diagnosis of acute generalized exanthematous pustulosis (AGEP). Moreover, a mass in the right lung was identified in the chest X-ray. Hence, a CT scan was performed, which confirmed the mass in the right lung most likely being of malignant origin. Consequently, a diagnosis of AGEP and paraneoplastic erythema multiforme overlap syndrome was made. Hence, hydroxychloroquine was discontinued, the patient was transferred to a Pulmonology department, where a transbronchial biopsy was performed and a moderately differentiated lung G2 acinar adenocarcinoma was diagnosed.

Conclusions

The path to the right diagnosis sometimes can be especially windy, however, a situation when a seemingly correct treatment fails and a patient presents with unusual or overlapping symptoms ought to always remind us to stay vigilant for a more severe underlying condition.

Key words

Erythema multiforme, AGEP, paraneoplastic overlap syndrome.

PL 39–53. Terbinafine induced cutaneous lupus erythematosus. Clinical case report

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Introduction

Drug-induced lupus erythematosus (LE) is characterized by clinical manifestations, immunopathological and serological findings similar to those of idiopathic LE, but is related to continuous drug exposure, typically resolving after the discontinuation of the responsible drug. Correspondingly to idiopathic lupus, drug-induced LE can be divided into systemic (SLE) and subacute cutaneous lupus erythematosus (SCLE) [3]. The cutaneous features of drug-induced SLE include purpura, erythema nodosum and photosensitivity, and the typical laboratory profile consists of positive ANA and anti-histone antibodies. Medications most frequently associated with drug-induced SLE are hydralazine, procainamide, isoniazid and minocycline. Drug-induced SCLE typically presents with annular polycyclic papulosquamous lesions, but blisters or target lesions mimicking erythema multiforme may also be associated with this condition. ANA and anti-Ro/SSA antibodies are usually present, whereas anti-histone antibodies are uncommonly found. Drugs reported to be associated with SCLE include calcium-channel blockers, angiotensin-converting enzyme inhibitors, thiazide diuretics, terbinafine, and tumour necrosis factor-α antagonists [3].

Materials and methods

A 68-year-old woman presented with multiple infiltrated erythematous scaly plaques on sun-exposed areas of the chest and back. The skin lesions developed in May 2020. Before the appearance of the rash, the patient was treated for onychomycosis with oral terbinafine for 4-months (February - May 2020).

During June-July of 2020, the patient was hospitalized in a regional hospital's dermatology department. Skin biopsy and histology concluded vacuolar interface dermatitis suggestive of pityriasis lichenoides et varioliformis acuta (PLEVA), with erythema exudativum multiforme as the

main differential diagnosis. Treatment with topical corticosteroids and intravenous dexamethasone 8 mg per day was begun, followed by a methylprednisolone 32 mg/day taper to cessation. Due to disease progression and advancing lesions, in August 2020 the patient was admitted to the Department of Skin and Venereal Diseases of Kaunas Clinics.
Life and medical history: Current medications included nebivolol/hydrochlorothiazide 5/12.5mg once per day (many years before the rash) for primary hypertension, betahistine 24 mg once per day for vestibular neuritis (April-May 2020), with occasional use of zopiclone 7.5 mg due to insomnia.
Skin examination: annular polycyclic erythematous plaques and macules with scaling at periphery on the face, neck, chest, back and dorsal surfaces of the arms and legs, without oral mucosa involvement.

Results
Patient's laboratory findings included normal levels of complement C3 and C4, positivity for anti-Ro/SSA antibodies (3+). Direct immunofluorescence of a skin biopsy displayed perivascular fibrinogen staining. On histology, hyperparakeratotic and atrofic epidermis was found, with apoptotic keratinocytes, vacuolisation at the basement membrane zone and perivascular lymphocytic infiltrate in the dermis. Based on clinical and histopathological findings the diagnosis of drug-induced SCLE was established, with terbinafine as the most likely cause. Treatment with oral prednisolone 30 mg daily (nine days) was started and tapered to cessation. Simultaneously, hydroxychloroquine (HC) 200 mg daily (after one month the dose was doubled to 400 mg), topical clobetasol 0,05% for the body, hydrocortisone 1 % for the face, and SPF50+ sunscreen were begun. After 6 months of treatment, no new lesions appeared, and skin hyperpigmentation on previous SCLE sites was seen. The treatment with HC was tapered off and stopped, with continued avoidance of direct sun exposure.

Conclusions
Terbinafine can induce or aggrevate SCLE [1-3] and mimic erythema exudativum multiforme or PLEVA due to similar clinical and histopathotological findings. Therefore, diagnostics of drug-induced SCLE or LE require a comprehensive medical history, in addition to immunopathological and serological screening in each suspicious case.

Key words
SCLE – subacute cutaneous lupus erythematosus, terbinafine.

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PL 40–53. Successful treatment of pemphigus vulgaris and psoriasis vulgaris with methylprednisolone pulse and methotrexate

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Introduction
Psoriasis is associated with an elevated risk of pemphigus [1]. It is one of the most prevalent T-cell-mediated diseases. In contrast, pemphigus is an autoimmune blistering disorder caused by autoantibodies against the keratinocyte cell surface. It is known that methotrexate inhibits epidermal keratinocyte proliferation and reduces T-lymphocytes count in the lesion. For bullous diseases, it is administered as a corticosteroid substitute while for psoriasis it is one of the most effective and important traditional treatment options especially for a moderate or severe form of the disease [2]. We present a case report of both these diseases and their effective management with methylprednisolone pulse and subcutaneous methotrexate.

Aims and Objectives
We present a rare case report of pemphigus vulgaris associated with psoriasis and their effective management.

Materials and methods

A 63-year-old patient presented with painful, itchy, widespread, bleeding, non-healing erosions on the whole body. Moreover, the patient has had a history of psoriasis vulgaris that began at the age of 35 years. Psoriasis was treated with topical steroids. The patient's bullous lesions had initially started on the lips and oral cavity and after four months spread to the neck and other parts of the body. More than 50% of the body surface was covered with secreting, bleeding erosions surrounded by epidermal debris. A Nikolsky's sign was positive.

Results

The affected skin biopsy with direct immunofluorescence showed a suprabasal bulla with acantholysis and intercellular IgG pattern in the epidermis and linear C3 deposits in the basal membrane. Laboratory tests revealed antibodies against desmoglein 1 and 3 and the diagnosis of the pemphigus vulgaris was made. Other laboratory data showed anemia and hypoalbuminemia. In the culture from erosions MRSA was found. The treatment with intravenous pulse of methylprednisolone (500 mg/day - 3 days) and then subcutaneous methotrexate injections (10mg/week) were prescribed, and vancomycin (15 mg/kg/every 12 hours - 7 days) had been administered. After 3 pulses of methylprednisolone, no new bullae formed, erosions decreased, and more post-inflammatory hyperpigmentation occurred.

Conclusions

Systemic glucocorticoids are the first-line treatment for pemphigus to achieve rapid control of the disease [3]. Moreover, methotrexate is a useful and well-tolerated therapy for long-term treatment with considerable steroid-sparing effect in patients with pemphigus vulgaris [4]. Methotrexate is also approved for use in psoriasis in all the guidelines reviewed [5]. The combined immunosuppressive regimen determined effective management of the coexistence of the pemphigus vulgaris and psoriasis.

Key words

Psoriasis vulgaris, pemphigus vulgaris; methylprednisolone pulse, methotrexate.

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PL 41–53. Case report of Buruli ulcer

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Introduction

Buruli ulcer is noncontagious disabling cutaneous and subcutaneous mycobacteriosis, caused by nontuberculous bacterium Mycobacterium ulcerans. It is an environmental pathogen with a unique virulence determinant–a potent locally acting toxin. The natural reservoir of the organism and the mode of transmission are unknown. The lesion usually begins on an extremity as a solitary, hard, painless, subcutaneous nodule, if untreated, some lesions ulcerate and expand by undermining the surrounding skin, followed by scarring and contractures. The diagnosis of Buruli ulcer is confirmed by is detection of M. ulcerans DNA using PCR, microscopic detection of acid-fast bacilli in lesions, cultures, and histopathology. The combination of rifampicin (10 mg/kg once daily) and clarithromycin (7.5 mg/kg twice daily) or rifampicin and streptomycin for at least 8 weeks is now the recommended treatment. The surgery only if the lesion is not responding to conservative treatment. The early diagnosis and treatment lead to better treatment options.

Aims and Objectives

A 37-year-old man complained of a painless nodule on the lateral surface of the right wrist lasting about 1.5 years. He had no fever or systemic symptoms. The treatment with topical ointments of antibiotics, antifungals, glucocorticoids was with no clinical effect. A punch biopsy of the skin was performed and it revealed non-specific inflammation. He has working contact with aquariums and basins, because he grows of sea shrimps. Skin

biopsies were taken for fungal, bacterial isolation, histological, and mycobacterial examination. The diagnosis of Mycobacterium ulcerans was confirmed by PCR test. The treatment of rifampycin 600mg one daily plus clarithromycin 500mg BD was prescribed for 8 weeks.

Conclusions
Buruli ulcer harmful cutaneous and subcutaneous disease, which diagnostic and treatment are challenging, but it is important for better disease outcomes.

Key words
Buruli ulcer, Mycobacterium ulcerans, non-tuberculous mycobacterial disease.

PL 42–53. Antimicrobial resistance of bacterial STIs in Europe

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Introduction
Antimicrobial resistance (AMR) in infectious diseases is a major public health problem globally. Of the main bacterial sexually transmitted infections (STIs), Neisseria gonorrhoeae and Mycoplasma genitalium have both developed resistance to all antimicrobials available for empirical first-line treatment. The high levels of AMR have made gonorrhoea and M. genitalium infections difficult to treat and sporadic cases of particularly M. genitalium infections have become mainly untreatable. International surveillance of AMR (and ideally also treatment failures and antimicrobial use/misuse) in N. gonorrhoeae and M. genitalium is imperative. For N. gonorrhoeae, the European Gonococcal Antimicrobial Surveillance Programme (Euro-GASP) provides crucial AMR data for refinements of national and international management guidelines and public health policies in Europe. However, no international surveillance of AMR in M. genitalium exists, and internationally recommended resistance-guided sequential

therapy for these infections also remains limited in many geographic settings. For gonorrhoea and M. genitalium infections, the development of novel therapeutic antimicrobials and ideally vaccine(s) is imperative. Nevertheless, Chlamydia trachomatis has remained susceptible to recommended first- and second-line treatments, and Treponema pallidum has only developed resistance to azithromycin, which is not recommended for therapy, and has remained susceptible to recommended first-line treatment. In the present talk, the AMR situation in Europe will be presented, reasons for AMR emergence and spread, and crucial actions to mitigate the spread of AMR will be discussed.

PL 43–53. Tasks and visions of IUSTI - Europe

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Introduction

The International Union against Sexually Transmitted Infections (IUSTI) is the oldest international organization in the field of sexual health and is founded in 1923 in Paris, whose objective is to achieve international cooperation in the control of sexually transmitted diseases, including HIV infection.

IUSTI World has four branches – IUSTI-America, IUSTI-Africa, IUSTI-Asia and IUSTI Europe.

IUSTI-Europe as organization is responsible for coordination of STI activities in Europe.

IUSTI Europe is giving its best for continuing medical education and professional development;

- is producing the STI Guidelines;
- organizes STI Training Courses, Webinars & most importantly Annual Congresses;
- is also a link between various European Governmental Organizations;
- is giving world class science to a pan European group of practitioners.

IUSTI-Europe is a link between STI-related national organizations in Europe.

To the Council of IUSTI-Europe belongs one national representative from every European country.

Ten officers are responsible for the management of the organization and the fulfillment of its objects.

IUSTI-Europe has 5 committees:
1) Committee of Education
The duties of the Committee of education are as following:
- Planning and organizing STI courses;
- Establishing the Scientific programmes;
- Management of scholarships.

2) Committee of IUSTI-Europe STI Guidelines
The duties of the Committee of IUSTI-Europe STI Guidelines are:
- Coordinating the work of STI Guidelines authors and working groups;
- Contributing to the production of protocol;
- Suggesting for suitable candidates to join the Editorial Board;
- Supervising the publication of guidelines;
- Chairing IUSTI-Europe STI Guidelines Editorial Board.

3) Committee of International Development
IUSTI-Europe also has the Committee of International Development, that is responsible for the collaboration between different international organizations.
4) Committee of Scientific Policy and Conference Management
Chair of the Committee of Scientific Policy and Conference Management is responsible for the development and maintenance of IUSTI-Europe Conferences and database of experts.
5) Committee of Communication

PL 44–53. Syphilis in Belarus: focus on MTCT (congenital syphilis) prevention

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Introduction
After an epidemic rise in the incidence of syphilis in Belarus with a peak in 1996 (210 cases/100000), there was a steady decrease in incidence until 2019 (4.7 cases/100000). In 2020 an increase was recorded to 8.4 cases/100000.

Aims and Objectives
To present and discuss the dynamics and structure of the incidence of syphilis in Belarus in 1996-2020 and congenital syphilis (CS) prevention.

Materials and methods
The analysis of the annual reports on the incidence of STIs for 1996-2020 in Belarus was carried out.

Results
The analysis of the morbidity structure, clinical forms of the disease, the sex and age of the patients, the annual proportion of manifest and latent, early and late forms of syphilis revealed significant changes: decrease in the proportion of early forms of syphilis from 99.9% in 1996 to 24.7% in 2020 (4 times) with an increase in the proportion of late and other forms from 0.1% in 1996 to 75.3% in 2020 (753 times); prevalence of latent forms of syphilitic infection (91%) over manifest (9%); the ratio of men and women with syphilis did not differ significantly, with a slight predominance of men in recent years; low, stable of syphilis rate in the age groups 0-14, 15-17 and 18-19 years; a 2-fold decrease in the proportion of patients aged 20-29, an increase in the proportion of patients aged 30-39 (1.3 times) and, especially, 40 years and older (2 times). Taking into account the rapid growth and prevalence of late forms of syphilis in the morbidity structure, we changed in 2019 the procedure for screening and diagnosing syphilis in Belarus and use the Reverse sequence lab-based serologic screening algorithm: screening – treponemal test, confirmation – non-treponemal test (quantitative), confirmation of negative non-treponemal – other treponemal test.
In 2007 WHO launched an initiative for the global elimination of CS. The overarching global goal of the present strategy is the elimination of CS as a public health problem.
Late congenital syphilis has not been registered in Belarus for more than 30 years, early congenital syphilis - since 2011.
In June 2016 Belarus was reviewed and approved for validation of EMTCT of HIV and syphilis as a public health problem by the WHO. In 2018-2019, in accordance with the WHO recommendations, in Belarus stoped using RMP, and Belarusian treponemal ELISA with a high level of sensitivity and specificity began to be used for screening for syphilis in pregnant women, with followed using of a non-treponemal test (RPR or VDRL) and other treponemal test. This algorithm is provided for by the new national clinical protocol (2019). Belarus also fulfilled the requirement to establish a National Reference Laboratory for the Diagnosis of Syphilis, which was included in the WHO/CDC program of external quality control. In 2018, the Global Validation Committee confirmed validation until 2020, but additionally

recommended to use WHO proposed definition of cases of CS in global surveillance.

Conclusions
The syphilis situation in Belarus has changed and is controversial, especially given the interruptions in the availability of penicillins and the absence of benzathine benzylpenicillin.
Obtaining and confirming the status of validation of the EMTCT of syphilis is a dynamic two-way process that requires constant active work.

Key words
Syphilis, Belarus, diagnosis, prevention.

PL 45–53. Neurosyphilis in HIV-infected patients

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Introduction
The risk of developing neurosyphilis (NS) in HIV-infected patients is 3-6 times higher than in HIV-negative patients with syphilis. The diagnosis of NS is complicated by the absence of pathognomonic clinical signs (if any) and the lack of a unified approach to assessing the parameters of cerebrospinal fluid (CSF) in HIV-infected patients with syphilis.

Aims and Objectives
To evaluate clinical and serological features of syphilis and CSF changes in the group of HIV-infected patients.

Materials and methods
A retrospective analysis of the medical records of 169 HIV-infected patients with syphilis who were followed-up at the St. Petersburg AIDS Center was carried out.

Results

93% of the study participants were males and 7% were females, the mean age was 35 years. Among men, 65% had sexual intercourse with men. 68% of the patients had the IV stage of HIV infection and 44% had received the antiretroviral therapy.

Primary syphilis was diagnosed in 1% of the study participants, secondary syphilis – in 15%, early latent – in 5%, late latent – in 14%, early NS – in 55% and late NS – in 10%. Malignant syphilis was observed in 7,7% of the cases.

48% of patients with NS complained about headaches, dizziness, impaired vision, hearing loss, insomnia, memory and concentration problems, anxiety. Clinical symptoms of the nervous system or eye involvement were found in 25% of patients with CSF abnormality. Optic neuritis was diagnosed in 15% of the cases, tabes dorsalis – in 2%, and syphilitic meningitis – in 8%.

VDRL test was positive in 96% of the study participants and treponemal tests (TT) – TPHA, ELISA, FTA – in all the patients examined. In 64% of the cases the titer of VDRL was 1:16 and higher. In patients with NS the VDRL titer was significantly higher comparing to the patients without the nervous system involvement ($p = 0,008$). No correlation between the duration of syphilis and the VDRL titer was found.

The diagnosis of NS was confirmed by positive CSF-VDRL in 7% of the patients. The other 52% of the study participants with negative CSF-VDRL and positive CSF-TT had pleocytosis > 5 cells/µl and/or CSF-protein level higher than 0,5 g/l which allows to confirm NS in them also. NS was excluded because of negative CSF-VDRL and CSF-TT in 12% of patients; among them 40% had pleocytosis and 20% had increased CSF-protein level.

Conclusions

1. Syphilis and HIV coinfection was more common in young men who had sex with men.
2. False negative VDRL was found in 4% of HIV-infected patients. No correlation between the duration of syphilis and the VDRL titer was found, but in patients with NS the titer was significantly higher comparing to those without NS.
3. Pathological changes in the CSF allowing to diagnose NS were identified in 59% of coinfected patients. However, due to the fact that HIV infection itself is accompanied by pleocytosis and increased CSF-protein level, the cut-off values of these diagnostic indicators of NS should be different

(obviously, be higher) in HIV-infected patients with syphilis comparing to HIV-negative ones. Unfortunately, at the moment there is no consensus on this matter.

Key words
Neurosyphilis, HIV infection, serological tests, cerebrospinal fluid.

PL 46–53. Value of Gardnerella vaginalis genotyping in the diagnosis of bacterial vaginosis

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Introduction
Gardnerella vaginalis is an important diagnostic marker of bacterial vaginosis (BV), a state of the vaginal microbiome characterized by the transition from a vaginal microbiome dominated by lactobacilli to a more diverse microbiome containing many aerobic and anaerobic bacterial species, including gardnerella. Gardnerella vaginalis is characterized by exceptional phenotypic and genotypic diversity. Using the universal target sequencing of the cpn60 barcode, four subgroups (A, B, C and D) were identified that correspond to the four genotypes identified by Ahmed et al.

Aims and Objectives
To assess the importance of identifying different genotypes of Gardnerella vaginalis in the diagnosis of bacterial vaginosis (BV).

Materials and methods
The study involved 299 women of reproductive age: healthy women with the first episode of bacterial vaginosis and recurrent bacterial vaginosis. Gardnerella vaginalis in the vaginal discharge was detected by real-time PCR. The detection of four genotypes of G. vaginalis was performed using real-time multiplex PCR. To quantify the amplified PCR fragments, quantitative standard samples were constructed.

Results
In 38.2% of healthy women in the vaginal biotope, any one genotype of G. vaginalis was detected, and most often it was genotype 4 (35.2%), while the concentration of G. vaginalis DNA was low (102-103). When several genotypes of gardnerella were detected simultaneously in healthy women, the DNA concentration did not exceed 104. A completely different picture was observed among women with bacterial vaginosis (BV). In the first episode of BV, genotype 4 of G. vaginalis prevailed, both as a single genotype and in combination with 1 or 2, or 3. In the recurrent course of BV, only 3-4 genotypes of G.vaginalis were detected at once, and in 78% of cases it had place is a combination of 1, 2 and 4 genotypes, and the DNA concentration was 107 - 108.

Conclusions
To diagnose BV, it is necessary to develop and put into practice a test system for detecting different genotypes of G. vaginalis by real-time PCR.

Key words
Gardnerella vaginalis, PCR, genotyps, diagnosis, bacterial vaginosis.

PL 47–53. Quality in the lab and the new IVD Regulation (EU) 2017/746

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Introduction
The International standard ISO15189 is the standard for accreditation of medical laboratories. Accreditation have been voluntary in most European countries. In May 2022, this situation will change.
The IVDD 98/79/ EC has been replaced by a regulation named the new European In Vitro Diagnostic Regulation (IVDR) EU/2017/746.
The regulation published in the Official Journal of the European Union on May 5, 2017, entered into force on May 25, 2017. The official transition period for full implementation is five years. During that time the IVD companies must to (re-)register their entire IVD portfolio under the new regulation. Medical Laboratories that are running Laboratory Developed Tests (LDT) considered now as a manufacturer in their healthcare institution. These tests should conform to the Art 5.5 requirements in the IVDR. It says

that lab can offer this tests only when CE marked alternative are not available on the market and this test have to be accredited according to ISO15189.
Till April 2021, only seven medical tests out of ~19, 000 tests got CE-approval under the IVDR and there is a lot of uncertainty around the use of LDT tests. It is going to affect all of us. We have lot to do to be ready on May 26, 2022.

PL 48–53. European (IUSTI) guidelines for bacterial STIs

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Introduction

The International Union against Sexually Transmitted Infections (IUSTI) has since many years been developing evidence-based European STI management guidelines, with main focus on testing, diagnosis, treatment, and follow up of STI patients, in strict accordance with an agreed development protocol including GRADE approach. The European STI management guidelines are intended for use of specialists in the field of STIs, but additionally patient information sheets have been developed by STI experts and peer reviewed. These European guidelines are produced and/or peer reviewed by IUSTI Europe; the European Academy of Dermatology and Venereology (EADV); the European Dermatology Forum (EDF); the European Society of Clinical Microbiology and Infectious Diseases (ESCMID); and International Society for Infectious Diseases in Obstetrics and Gynaecology (ISIDOG). The European Centre for Disease Prevention and Control (ECDC) and the European Office of the World Health Organization (WHO-Europe) also contribute to their development. In the present talk, the European guidelines for the main bacterial STIs (gonorrhoea, chlamydia, syphilis and Mycoplasma genitalium infections) will be presented and discussed.

PL 49–53. Scabies in the immunocompromised patient: a case report.

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Introduction

The patients who are hospitalized over 12 weeks have a high risk of immunorestitution disease, including scabies [1]. Scabies is a highly contagious skin infestation caused by the mite, Sarcoptes scabiei var. hominis. Diagnosis can be challenging, due to improved sanitation and similar features with other dermatological skin diseases [2].

Aims and Objectives

We report the first case in Lithuania of scabies in an allogeinic hematopoietic cell transplant (HCT) recipient, initially suspected of skin graft versus host disease (GVHD). Scabies were diagnosed 40 days after onset of symptoms.

Materials and methods

A 51 – year – old female patient with acute myeloid leukemia was hospitalized in hematologic department and underwent allogeneic hematopoietic stem cell transplant (HSCT) on March 3, 2021., she received myeloablative conditioning including total body irradiation for 3 days and cyclophosphamide for 2 days. On posttransplant day 7, the patient developed severe itching, erythematous papular rash on the face and trunk, grade 3 mucositis, febrile fever and infectious complications: Staphylococcus epidermidis sepsis, BK virus cystitis, positive urine culture for Escherichia coli and Enterococcus faecium. Treatment with broad – sprectrum antibiotics, oral methylprednisolone, topical steroids and antihistamine agents was started. During the treatment fever regressed, itching and rash slightly decreased and on hospitalization day 29, April 2, 2021 the patient was discharged. On the April 5, 2021 the patient was admitted to HSCT unit because of severe diarrhea, renal dysfunction, rash all over the body and

intense pruritus Acute GVHD reaction was suspectedLaboratory tests showed anemia (Hb 101 g/l), thrombocytopenia 78 x 10^9/l, normal white blood cell count 11,2 x 10^9/l, elevated C reactive protein 17,3 mg/l and increased creatinine 159 mcmol/l. Due to suspision of skin GVHD, but no response to the treatment with topical steroids and antihistamines, after a consultation with dermatologists skin biopsy was performed. In histological examination of affected skin hypergranulosis, apoptotic keratinocytes, vacuolar degeneration of the basal membrane, vasodilatation in dermal layer, perivascular and interstitial lymphocyte infiltration were observed. Acute skin GVHD was diagnosed. Treatment with antihistamine agents and topical steroids continued but the patient still complained of severe itching sensation and erythemous papular rash. On hospitalization day 51, a repeated dermatological consultation was requested for the evaluation of intense itching and suspected cytomegalovirus infection (CMV). The polymerase chain recation (PCR) of skin biopsy for CMV was negative. During repeated consultation of dermatologists very itchy erythematous not – lichenoid paired papules and nodules on the legs, hands, abdomen, and back were observed. Skin biopsy was repeated. Histological examination, revealed lymphocytic infiltration, histiocytes and eosinophilic granulocytes in dermal layer, as well as Sarcoptes mite in the stratum corneum.

Results

Treatment with topical 4% permethrin cream was prescribed. The patient improved with treatment, after one week complete resolution of all skin lesions was observed.

Conclusions

Scabies should be considered in immunosuppressed patients with severe itching and maculopapular rash, although diagnosis can be delayed due to resemblance with other dermatological diseases [3]. A prompt diagnosis and treatment are necessary to prevent complications, such as secondary skin infections [4]. There is relatively low indicence of such clinical cases worldwide, most commonly diagnosed in pediatric patients. First choice treatment for scabies is oral ivermectin, but in our case treatment with permethrin cream was particularly successful.

Key words

Scabies, bone marrow transplantation, adults.

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PL 50–53. What is new in contact allergy?

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Introduction
Contact allergy is common. Thousands of substances have been described as haptens, although only some 100 - 200 haptens seem to be play a major role as contact allergens. The most common 30 - 50 haptens are assembled in so-called baseline patch test series which are used, with slightly varying composition, throughout the world. However, on a case-by-case basis, patch testing with patients' own products and their breakdown may be decisive for a correct diagnosis, and the chance of subsequent allergen avoidance.

Aims and Objectives
The overview intends to present a selection of current developments in terms of contact allergy trends, also beyond the baseline series, of new exposure contexts concerning well-known allergens, and of particular, on-going problems of prevention and regulation.

Materials and methods
Selective literature search for pertinent publications published 2019-2021.

Results
The unprecedented epidemic of methylisothiazolinone (MI) contact allergy has decreased in Europe thanks to EU regulation, but not e.g. in the US. Residual exposure to MI occurs via rinse-off products, also beyond cosmetics (washing-up liquid, polishes, wall paints and similar). Another isothiazolinone preservative, benzisothiazolinone, while not permitted in cosmetics in the EU, has become a relatively common allergen, e.g. according to Spanish surveillance data. Concerning metals, a benefit of regulation of the maximum permissible level of Cr-(VI) in leather is yet to be demonstrated in European surveillance data, which also holds true for the recent adaptation of potentially eliciting nickel exposure in terms of short, repeated contact. The clinical relevance of cobalt contact allergy often cannot be elucidated, despite the availability of a spot test or hand-held XRF devices for exposure analysis. In contrast to cosmetics with their well-proven regulatory framework (scientific opinions, ingredient labelling), medical devices – although recently furnished with an amended regulation – still vastly lack information on potential allergens they release. A well-known example are (meth-)acrylates from various diabetes devices, but also many other medical devices, which is an ongoing problem owing to new products put on the market. Another common diagnostic riddle is presented by contact dermatitis due to face masks (occupationally) worn during the COVID-19 pandemic, which may often be irritant, but can also be due to contact allergy.

Conclusions
The combination of contact allergy surveillance by (inter-)national networks with carefully documented, published case reports provides an optimum basis for the detection of problematic exposures (or unsolved problems of exposure assessment as in case of cobalt) to known allergens, and newly described contact allergens, respectively. In some areas, notably medical devices, information relevant for contact allergy diagnostics (and prevention) must be improved. Concerning cosmetic allergens, with the ban of animal methods to assess toxicology of newly introduced agents, such as the murine local lymph node assay (LLNA), hazard and risk assessment and subsequent risk management solely relies on alternative (or “non-animal”)

methods; their predictive value with regard to preventing clinical disease in humans (allergic contact dermatitis) will yet have to be proven.

Key words
Contact allergy, epidemiology, medical devices, metals, patch testing, preservatives.

PL 51–53. Itch: what is new?

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Introduction
Itch is the most common symptom in dermatology, but it may also be present in patients with systemic disorders, such as end stage renal failure, hyper- or hypothyroidism, diabetes, haematological malignancies, polycytaemia vera, liver problems, HIV infection and many others. This type of itch is called systemic itch. It usually has a chronic course and presents without visible skin lesions, however scratch lesions, such as excoriations and or lichenification, may be also be seen. It is obvious that chronic systemic itch has negative impact on patients' well-being. Many patients with chronic itch considered it as the most bothersome symptom of the disease they have. Patients suffering from itch were found to have low self-image, suffer from obsessive-compulsive disorders and have difficulties in coping with aggression. Severe itch at night frequently resulted in significant sleeping problems. It was also observed, that in many diseases itch intensity significantly correlated with degree of quality of life impairment, level of stigmatization, presence and severity of depressive symptoms as well as with emotional stress. Based on available data and own experience it could be concluded that chronic itch is a devastating symptom impairing all aspects of patients' life. The therapy of systemic itch a challenge. Treatment modalities are different in various types of chronic itch. Recently several new options have been under the development. They target immune mechanisms, like dupilumab or neural system (neurokinin-1 inhibitors, opioid receptors agonists and antagonist). It seems that difelikefalin will be registered for chronic kidney disease-associated itch in the neares future. The holistic approach with psychological support should also be considered in all itchy patients.

PL 52–53. Diffuse hair loss in daily practice

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Introduction

Diffuse hair loss or telogen efluvium (TE) is one of the most common trichological diseases in a dermatologist ‘s practice. TE is a non-scaring alopecia, characterized by diffuse hair loss, which begins three months after the provoking event. Telogen efluvium represents a disturbance of the hair cycle, when synchronization of the hair growth cycle happens. As a result, more hair, about from 20 to 30 percent, simultaneously enter telogen stage, resulting in more than 20 percent of telogen hair falling out.

Acute telogen efluvium lasts up to 6 months. The main causative agents include severe infections (with or without fever), postpartum period, surgical procedures, sudden weight loss or diets, stress and discontinuation of certain medications, especially contraceptives. Chronic telogen efluvium is diagnosed when the symptoms last more than 6 months. Patients most commonly complain of persistent hair loss, which lasts for many years. Main causes of chronic hair loss include stress, iron, vitamin or mineral deficiencies, eating disorders, thyroid, renal or liver diseases. Medications also have a significant role. Vitamin A derivates, anticoagulants, statins, beta-blockers and antielipeptics are the most often mentioned in the scientific literature.

The most important diagnostic tools which aid in successful diagnosis of TE are medical history, clinical examination, hair removal (epilation) test, trichoscopy and laboratory tests. Treatment depends on the cause of the disease, and patient’s education is of major importance. Other management strategies include treatment of the underlying comorbidities, stress control, balancing nutrition. Certain dietary supplements show significantly positive results as well. Other treatment options include topical steroids, minoxidil and psychosocial support of the patient.

PL 53–53. Management of androgenetic alopecia: clinical experience

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Introduction

The treatment of hairloss is a challenge for all dermatologists. Androgenetic alopecia (AGA) is the most commonly seen type of hairloss, affecting up to 70% of men and 40% of women at some point in their lifetime. While men tipically present with distinctive alopecia pattern involving hairline recession and vertex balding, women exhibit a diffuse hair thinning over the top of their scalps.

Aims and Objectives

The aim of this presentation is to overview the recommended treatment options for androgenetic alopecia, including topical, systemic agents, injection, and surgical procedures; and its results in clinical practice in patients with long-term follow-up.

Results

In males, Norwood-Hamilton scale is used to evaluate the severity of androgenetic alopecia. Patients with Norwood I to V shloud be treated with topical minoxidil with oral finasteride and PRP injections. If improvement is observed, the treatment is continued indefinitely; also, transplantation is always possible if desirable results cannot be achieved. If no improvement is observed, finasteride can be exchanged with dutasteride; also PRP procedures, hair transplantation and hair systems are other options. Patients with Norwood VI and VII can be offered hair transplantation with managed expectations, scalp reduction surgery or a hair system.

In females, treatment choice should be based on the extent of the scalp affected. If less than 20% of the scalp is affected, initial treatment includes topical minoxidil with oral finasteride or spironolactone. If less than 50% of the scalp is affected, PRP should be added and both systemic agents should be considered. If no improvement is observed in 6 months, the dose of finasteride and spironolactone can be increased. Dutasteride is also an option in postmenopausal women. Patients with less than 90% involvement should be offered hair transplantation, camouflage products.

Conclusions

Overall, there are a number of treatment options available to people with AGA, though clinical data supporting their use is often limited. Finasteride and minoxidil are the most common medications prescribed for AGA. Hair transplantation can help restore frontal hairline and increase hair density.

Key words

Androgenetic alopecia, alopecia, hairloss, minoxidil, finasteride, PRP, hair transplant.

POSTER ABSTRACTS

The content of the abstracts presented is the responsibility of their authors and co-authors.
The abstracts are arranged in sequence alphabetically according to the surname of first author of abstract.

PO 1–11. Severe plaque psoriasis patients treated with biological drugs in 2011–2016: a retrospective study

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Aims and Objectives

To determine short- and long-term effectiveness of biologics and quality of life in patients with severe plaque psoriasis treated with biologics in 2011 – 2016.

Materials and methods

Anonymized data of 47 primary naïve patients were included prospectively and analysed using database "PsoLT". The clinical study was approved by regional biomedical ethics committee (№. BE-2-53). Treatment effectiveness was measured using Psoriasis Area and Severity Index (PASI) score and Dermatology Life Quality Index (DLQI) questionnaire. First three visits of clinical examination were performed every 3 months, correspondingly since fourth visit - every 6 months. Short-term biologic therapy effectiveness was evaluated based on 3rd visit results, long-term based on 12th visit results.

Results

For 7 patients biologics were changed, 15 were treated with combined therapy (biologic and methotrexate) and 25 with monotherapy. Subjects, who were treated with etanercept (n = 14), primary PASI mean – 20.45 (95%CI 14.34±26.56), while 13.13 (95%CI 8.85±17.41) for treated with ustekinumab (n = 8). Primary DLQI mean in etanercept and ustekinumab groups, 15 (95%CI 5.5±24.5) and 10 (95%CI 0.83±19.17) respectively. After a short-term therapy with etanercept and ustekinumab PASI means were 3.43 (95%CI 1.33±5.52) and 3.07 (95%CI 0.3±5.84) respectively. In a long-term therapy with etanercept and ustekinumab PASI means were 4.57 (95%CI 2.74±6.4) and 1.62 (95%CI 0±3.58) correspondingly. After a short-term

etanercept and ustekinumab therapy DLQI means were 2.8 (95%CI 0±6.46) and 4.2 (95%CI 0±9.27) accordingly. In a long-term therapy with etanercept and ustekinumab DLQI means were 7.4 (95%CI 0.02±14.78) and 1.6 (95%CI 0±4.46) respectively.

Conclusions
1. The short-term effectiveness of biologic therapy in patients with severe plaque psoriasis does not differ according to which biologic drug (etanercept or ustekinumab) is used. 2. Compared with etanercept, ustekinumab long-term therapy is more effective in patients with severe plaque psoriasis. 3. In patients with severe plaque psoriasis and treated with etanercept and ustekinumab life quality does not vary according to the duration of a therapy.

Key words
Psoriasis, biological drugs, therapy effectiveness, quality of life

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PO 2–11. Contact allergy in relation to body sites in patients with allergic contact dermatitis in 2019–2020

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Introduction
Allergic contact dermatitis is a common inflammatory skin disease which in long-term significantly impairs quality of life. The main task of disease control is to identify and eliminate the sensitiser (contact allergen). The most reliable method to diagnose contact allergy is a standartized allergen patch test. Therefore the anatomical site of dermatitis can help suspecting the cause of contact allergy.

Aims and Objectives
To evaluate the prevalence of contact allergy and its relation with body sites during the 2019–2020 year period for patients with chronic dermatitis. To

determine the change in the frequency of contact allergy in this study period. To evaluate the spectrum of the most common contact allergens among patients with chronic dermatitis. To determine the relation of prevalence of contact allergy with a body site among patients with chronic dermatitis.

Materials and methods

A retrospective study was performed in accordance with European Surveillance System on Contact Allergies (ESSCA) project and its standard protocol. Patch test results of European baseline series performed with 45 contact allergens in 2019-2020 were analysed at the Department of Skin and Venereal Diseases Kaunas Clinics in patients with chronic dermatitis. Data analysis was made with SPSS 25.0 statistical program.

Results

In 2019 women sensitized to contact allergens accounted for 37.8 % (95 % CI 32.5–43.2) of patients and men – 11.2 % (95 % CI 8.0–15.1), respectively in 2020 women – 32.7 % (95 % CI 25.7–40.4) and men – 13.1 % (95 % CI 8.4–19.2). Contact allergy to nickel sulfate: among women – 21.88 % (95 % CI 16.97–27.45) in 2019 and 20.0 % (95 % CI 13.25–28.28) in 2020; among men – 2.67 % (95 % CI 0.3–9.3) in 2019 and 2.08 % (95 % CI 0.1–11.1) in 2020. Contact allergy to sodium metabisulphite among men: 8.06 % (95 % CI 2.7–17.8) in 2019 and 8.33 % (95 % CI 2.3–20.0) in 2020. Sensitization of less than 0.5 % was observed for mercaptobenzothiazole, tixocortol pivalate, bronopol, imidazolidinyl urea, lidocaine, quaternium 15, hydroxyisohexyl 3-cyclohexene carboxaldehyde (HMPCC) and parthenolide. Prevalence of hand dermatitis in 2019 – 35.3 % (95 % CI 30.20–40.76), face and leg dermatitis – 31.1 % (95 % CI 26.17–36.41) and 8.5 % (95 % CI 5.69–11.29), and in 2020 – 29.8 % (95 % CI 22.96–37.29), 23.8 % (95 % CI 17.59–30.98) and 17.9 % (95 % CI 12.38–24.5).

Conclusions

During the study period contact allergy was found more frequently in women than men. Nickel sulfate compared with other allergens more often sensitizes women than men, while sodium metabisulfite – men than woman. In 2019 contact sensitization was observed in the hands (19.6 % (95 % CI 15.5–24.3) and face (14.8 % (95 % CI 11.2–19.1) more often than in the legs (4.23 % (95 % CI 2.33–6.99). Whereas in 2020, a significant relation between contact allergy and its anatomic sites was not found. The most prevalent contact

allergen in patients with hand and face dermatitis was nickel sulfate, while in patients with leg dermatitis – sodium metabisulfite.

Key words
Allergic contact dermatitis, contact allergy, European baseline series

PO 3–11. Acne fulminans in 14 years old male. A case report.

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Introduction
Acne fulminans (AF) is the rarest and most severe form of acne. The disease usually affects adolescent males and manifests in painful ulcerated nodular lesions especially on the face, chest and back that results in severe scarring. Its treatment is usually very complex and challenging due to its resistance to various treatments. Until now there are less than 200 cases of AF reported. [1,2].

Aims and Objectives
The aim is to present a severe acne fulminans case in association with panniculitis, fever, neutrophilic leukocytosis, anaemia.

Materials and methods
A 14-year-old male patient (body weight 50 kg) has a history of acne since 10 years old, and a positive family history of acne of his father. Initial treatment with isotretinoin 30 mg/d was started. During treatment the patient reported outcome according to VAS scale improved slightly (from 9 to 6 points). At the fourth month of isotretinoin use, a cellulitis like painful lesions on the patient's shins, and febrile fever appeared. The patient was admitted to the department of pediatric surgery for necrectomy of multiplex ulcerated nodules and symptomic systemic treatment with oxacillin 2g 4x/d

and metronidazole per os for 6 days. During dermatological examination we found multiplex ulcerated nodules with hemorrhagic crusts, pustules, papules on the patients chest and back. On the shins - erythematous infiltrated painful subcutaneous plaques symmetrically.

Results

In laboratory tests: CRP – 88 mg/l, leukocytosis (13,7 x 10/9) with neutrophilia, anaemia (Hb –114 g/l) was found. Staphylococcus aureus was found in the culture of lesional skin. In shins ultrasound - subcutaneous adipose tissue infiltration zones, without local fluid accumulation was observed, which is characteristic of a panniculitis. Histological examination of rashes on shins, correspondingly pustules on trunk revealed abundant infiltration with neutrophils, lymphocytes and solitary granulocytes. Clinical diagnosis of acne fulminans with panniculitis and systemic symptoms present (AF-SS) was made and it was decided to start oral corticosteroids 25-40 mg/d, to decrease isotretinoin dose to 10 mg/d and to continue this treatment for up to 12 months until lesions heal over.

Conclusions

Acne fulminans is a very severe and complex disease that requires an intense treatment [2]. It is very important to diagnose and differentiate between AF, SAPHO syndrome and neutrophilic dermatoses such as Sweet syndrome.

Key words

Acne fulminans, isotretinoin, panniculitis.

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PO 4–11. What is hidden under the diagnosis of syphilis?

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Introduction

Syphilis rarely goes alone and together with this diagnosis other sexually transmitted infections (STIs) related to risky sexual behaviour could be identified. As syphilis has a high probability with other coinfections since they share common routes of transmission and target populations, individuals diagnosed with syphilis should undergo a full STIs assessment [Janier M, 2021; Refugio ON, 2018].

Materials and methods

A 32-year-old homosexual male admitted for a complaint of generalized skin rash for 1 month. A painless ulcer in the anus was present before the lesions occurred. The anamnesis revealed that the patient was diagnosed with HIV a year ago and has been receiving antiretroviral therapy (ART). The sexual partner of the patient was previously diagnosed with HIV (2 years ago) and syphilis (1 month ago) and prescribed targeted treatment by ART and Benzathine penicillin G to cover both STIs.

As laboratory tests for syphilis were positive (RPR 1:32, TPHA 4+), the patient was diagnosed with secondary syphilis and prescribed the first-line treatment therapy by Benzathine penicillin G 2.4 million units intramuscularly on day 1 and 7. Additionally, screening for other classical STIs (gonorrhea, chlamydia, Mycoplasma genitalium) was performed. The patient was also tested for hepatitis B and C. After reactive HBV was identified (HBsAg>1000.0), a consultation of a gastroenterologist was suggested to provide the specific treatment of hepatitis B. Moreover, the Quantiferon-TB test showed a positive result, and the patient was directed to a pulmonologist for further diagnostics of tuberculosis (TB).

Conclusions

The high prevalence rates for syphilis, HIV, HBV, HCV, and TB coinfection must be considered and a full assessment of these overlapping infections should be performed to achieve complete diagnosis and provide a complex treatment as well as appropriate prophylaxis [Refugio ON, 2018; Gupta RK, 2015].

Key words
Syphilis, HIV, HBV.

PO 5–11. Validation of autoimmune bullous diseases-specific quality questionnaires

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Introduction
Autoimmune bullous diseases (AIBDs) have a significant impact on the quality of life (QOL) and psychological status of patients. Patients with AIBDs often feel pain, itching, discomfort and it has a negative impact on sleep, mood. Due to skin damage, the person feels unattractive, repulsive, and therefore begins to avoid social contact with relatives and friends. Depression and anxiety have been reported to be more common among patients with AIBDs compared to the general population. The Dermatology life Quality Index (DLQI) is designed to measure the health-related QOL of adult patients suffering form a skin disease. After analyzing the research literature, ABQOL and TABQOL questionnaires were shown to be more sensitive than DLQI for the measurement of QOL of patients with AIBDs.

Aims and Objectives
To perform the validation process on the Lithuanian version of the questionnaires related to the QOL of patients with AIBDs.

Materials and methods
The Lithuanian version of the ABQOL and TABQOL questionnaires validation was performed in 3 stages. In the first stage the ABQOL and TABQOL were translated forward-backward the original French version. Second stage: the questionnaires were distributed to the patients with AIBDs for cross cultural adaptation. Third stage: the Cronbach‘s alpha coefficient was used to assess the credibility of questionnaires. The patients inclusion criteria were: at least 18 years of age, histological or serological confirmation of AIBDs diagnosis, signed consent form.

Results
A total of 10 patients with AIBDs were recruited between March 2019 and January 2020. The age of patients ranged from 18 to 60 years (mean 42,7). Most of the patients had pemphigus vulgaris (n=5), followed dermatitis herpetiformis Duhring (n=3) and pemphigus foliaceus (n=2). Patients completed the questionnaires quickly: the average time to finish the ABQOL questionnaire was 6.6 minutes and the TABQOL - 5.7 minutes. The Cronbach's alpha coefficient for ABQOL and TABQOL questionnaires was 0.787 and 0.724 accordingly.

Conclusions
Adapted ABQOL and TABQOL questionnaires in Lithuanian language found to be suitable for the assessment of the QOL of patients with AIBDs: the study persons easily comprehended the questions and good internal consistency of questionnaires was estimated.

Key words
Autoimmune bullous diseases, ABQOL, TABQOL.

PO 6–11. Pustular tinea cutis

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Introduction
Tinea corporis is a fungal skin infection caused by a group of fungi known as Dermatophytes. Microsporum species causes numerous forms of the disease – itching, rash and nail discoloration are the most common symptoms. Infection is limited to the dead layers of the skin but predisposed by moist and warm environment. Nevertheless mostly known as ringworm in pets, it may also infect humans.

Materials and methods

A 16-year-old female presented with 3 months history of enlarging polymorphic erythematous, papulopustular changes and scaling of the skin located on the neck, chest, upper and lower extremities accompanied by itching and burning sensation. 1 month before the manifestation of the rash two hamsters were purchased by the family. The patient was treated in the other clinic with topical and oral steroids, topical and oral antibiotics with no significant effect. When admitted to our clinic diagnostic tests such as skin culture and microscopy for fungus, punch biopsy with direct immunofluorescence (DIF) were made. The tests revealed Microsporum species in skin culture, histologically PAS positive hyphae of the fungus in the stratum corneum and no radiance in DIF. The patient was prescribed with local and systemic antimycotic drugs (Naftifine 10 mg/g cream once a day and Itraconasole 200 mg per day oraly) and showed significant improvement.

Conclusions

With this case report our goal is to emphasize the importance of the accurate anamnestic data and performance of the right diagnostic tests to determine correct diagnosis and treatment plan for the patient's best outcome.

PO 7–11. Clinical Features and Quality of Life of Patients with Chronic Wounds

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Introduction

Patients with chronic wounds (CW) experience health-related changes in quality of life (QoL). Physical well-being, mental health and daily activities are affected. It has been found that the longer a wound persists and the larger it is, the poorer is the QoL of patients.

Aims and Objectives

To evaluate the clinical characteristics of CW and analyze the clinical characteristics of CW which are significant for the prognosis of QoL.

Materials and methods
An instantaneous study was conducted as the part of multicentre research of ten countries. Examination of 50 patients was performed using clinical signs of CW and Wound-QoL questionnaires and VAS pain scale. QoL was scored according to patient survey data on physical well-being, mental health and daily activities. Descriptive statistics, nonparametric tests and binary logistic regression were used for data analysis.

Results
More than half (52%) of CW are of venous origin. The duration of CW varies from 3 to 228 months, the mean – 22.6 months. The area of CW varies from 1 to 900 cm2, the mean - 69.9 cm2. The majority of CW has a flushed wound edge and/or flushed surrounding skin, respectively 80% and 82%. More than a third of CW surface is covered with fibrin (38%) and 64% of CW has an odour. The mean of wound VAS pain at rest is 4.1 (±2.6) points and when changing dressings - 5 (±3.2) points. According to the data of logistic regression analysis, the physical well-being is worsened by the wound odour 11 times (p=0.002), respectively pain at rest - 3 times (p=0.006). Mental health is worsened by wound pain during the change of dressings 2 times (p=0.005). Daily activities are aggravated 8 times by the wound odour (p=0.003), respectively 2 times by pain at rest (p=0.043). General QoL is worsened by wound odour 15 times (p<0.001) and pain at rest 2 times (p=0.026).

Conclusions
The majority of chronic wounds are venous, have a flushed edge and/or flushed surrounding skin, more than half of CW has malodour. When planning the treatment of chronic wounds, it is essential to note that wound odour worsens the patient's physical well-being, daily activities and the general quality of life more than pain at rest.

Key words
Chronic wounds, ulcers, quality of life.

PO 8–11. Diagnostic challenge of gigantic benign skin lesion

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Introduction

A giant benign epidermal proliferative lesion is a rare finding. These skin growths may mislead clinicians and pathologists mostly due to their size, as well as unusual localization, morphology, or even coexisting pathology. I report a benign case of verrucous hyperplasia, which is unique regarding to it's dimension and also seldom published in the literature.

Aims and Objectives

This case raised questions about the origin of this lesion. I describe the importance of thoroughness pathologist‘s work and diagnostic challenge which appears with gigantic skin tumors. Verrucous hyperplasia is a benign condition, but could transform into verrucous carcinoma, therefore it is crucial for the pathologist to compose specific histological features to the places where they belong.

Materials and methods

Man in his mid-50s referred to his family doctor with a complaint of a painful gigantic skin keratoma in a right lower limb amputee. One year after the second amputation surgery, patient noticed swelling and colour changes in area of a stump. He was directed to dermatologist with a clinical suspicion for allergic or contact dermatitis. On physical examination, approximately a 10x7 centimetre in diameter, pink verrucous and exophytic growth was seen in a right limb stump area. Few different doctors was afraid of performing a surgery in this risky circumstances. Few months until the final surgery, patient was suffering in a huge pain and almost could not walk with a prosthesis.

Results

After surgical skin growth excision, the patient‘s material was forward to the pathology department. Histopathology examination revealed a prominent lesion with a hyperplastic acantothic stratified squamous epithelium with exophytic papillary projections and underlying fibrovascular connective tissue. Epithelial cells shows no signs of dysplastic features or invasion. The final diagnosis of verrucous hyperplasia was made. At this moment, more

than one year after the surgical treatment, there was no recurrence at the stump area. The patient is living his life properly, he is using a new and more comfortable leg prosthesis without any difficulties.

Conclusions

Possible pitfall in this case: due to gigantic skin lesion, uncommon localization, and lack of specific dermatopathology knowledge, it could be misdiagnosed as a malignant tumor, therefore a thoroughness pathologist‘s work is essential to make a precise diagnosis.

Key words

Verrucous hyperplasia, gigantic benign skin lesion, epidermal proliferation.

PO 9–11. The prevalence of rosacea and its association with serum vitamin D levels: a population based study of adults in Lithuania, Kaunas city

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Introduction

The prevalence of rosacea in the general population of Caucasian adults in Europe differs from 2.3% to 12.3% in Germany, 5% in Russia, and 22% in Estonia. Only two studies on the relationship between serum vitamin D and rosacea prevalence have been performed, but the results are controversial. We performed the first population based study in Lithuania and investigated the prevalence of rosacea and its relationships with phenotypic traits and serum vitamin D levels in adults of Kaunas city.

Materials and methods

A cross-sectional study was performed between February 2020 and March 2020, in Kaunas city, Lithuania. Subjects were randomly selected from the Lithuanian Population Register from the Kaunas city. Persistent erythema, phymatous changes, telangiectasia, inflammatory papules and pustules on

the face were examined for each subject and the diagnosis of rosacea was established, if one or more symptoms were evaluated. Eye and hair color were recorded for each subject. Skin phototype (I-IV) was assessed in accordance with the Fitzpatrick classification. Also the body mass index was calculated. The skin examination was performed by 4 medical students and one resident who were trained by one experienced dermatovenereologist. We assessed the diagnostic validity of rosacea of each trained investigator in a sub-study of 30 volunteers. The clinical judgment regarding grading of each symptom of rosacea differed by less than 5% from the judgment of an experienced dermatovenereologist. Participants of the study were interviewed about vitamin D supplementation and ultraviolet exposure exposure. Vitamin D concentration in serum was assessed in 117 participants, excluding those who have been taking vitamin D supplements or had an ultraviolet radiation exposure during the last four weeks.

Results

247 subjects, with a mean ± SD age of 51.5 ± 10.9 years were enrolled in the study. The rosacea was confirmed for 82 (33.2%) participants. Univariate logistic regression revealed that the prevalence of rosacea is higher in subjects in the age groups of 36-45 (OR 3.6, 95% CI 1.5 - 9.2) and 46-55 (6.7, 95% CI 2.7 - 14.3), as compared to participants in the 25-35 age group. We found correlation between rosacea and obesity ($p < 0.01$). Sunscreen application 30 minutes before sun exposure decreased odds of acquiring rosacea by 3.6 times compared to not using sunscreen at all. The mean of vitamin D levels were found as 29.3 ± 19.6 nmol/L and 28.6 ± 19.3 nmol/L in patients and participants without rosacea, respectively.

Conclusions

In our study we found a higher prevalence rate of rosacea compared with other studies. The prevalence of rosacea was higher in the obese group than normal and overweight groups. Eye and hair color, skin phototype, and vitamin D level were not associated with frequency of rosacea.

PO 10–11. The management of progressive Mycosis fungoides with overlapping presentation of Sezary syndrome

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Introduction

Mycosis fungoides (MF) and Sezary syndrome (SS) are the most common clinical types of Cutaneous T – cell lymphomas (CTCLs). MF and SS have overlapping presentations and are not distinguished in the WHO/EORTC staging criteria, however they are considered separate entities. The WHO /EORTC and the International Society for Cutaneous Lymphomas consider SS to be a clinical syndrome presenting with erythrodermic skin and leukemic disease. In contrast, patients who initially present with classic skin lesions of MF (patches, plaques, and tumors) and only later meet the staging criteria for SS are referred to as leukemic MF, SS preceded by MF, or secondary SS. The National Comprehensive Cancer Network (NCCN) considers patients with SS to be anyone who meets the criteria for a high blood burden of disease (B2 disease) [1].

Materials and methods

A 78 – year – old male presented with erythroderma and severe pruritus (VAS score – 8). Histopathological examination revealed a dermal infiltrate of atypical lymphocytes with irregular cerebriform nuclei, slight epidermotropism. Immunohistochemical staining showed positivity for CD3, with elevated CD4:CD8 ratio (>10), together with expression of CD1a+ – Langerhans cells. Flow cytometry showed a presence of circulating atypical lymphocytes, increased CD4/CD8 ratio (15.71). Enlarged peripheral lymph nodes by ultrasonography were found. Based on these findings diagnosis of Sezary syndrome (cT4N1M0B2) was made.

Results

The extracorporeal photopheresis (ECP) together with topical corticosteroids and oral prednisolone (30 mg daily, gradually reducing the dose to 15 mg daily) were prescribed.

The ECP was performed by Haemonetics MCS+ apheresis system (Grifols, Spain). Treatment comprised three phases: leukapheresis, photoactivation with 8 – Methoxypsoralen (0,1 mg) with exposure to ultraviolet A radiation (2.01 J/cm2) and reinfusion of lymphocytes back to the patient. Procedure was repeated on two consecutive days, every 2–3 weeks. After this treatment positive response was obtained: BSA decreased from 90% to 10%, mSWAT decreased from 80 to 12, LDH decreased from 1177 U/l to 382 U/l. Additional treatment with oral 8 – Methoxypsoralen plus ultraviolet A (systemic PUVA) was prescribed (6 procedures in total).

However, after ECPs procedures (8 in total) multiple red plaques on the face, chest and thighs, as well as tumors in both armpits appeared. BSA reached 18 %, mSWAT increased to 49.5, even though CD4/CD8 ratio decreased to 2.1 and LDH did not increased significantly – 426 U/l. Clinicaly and histologically abnormal axillary and inguinal lymph nodes were detected. The patient was treated with Metyhlprednisolone 250 mg/d infusion (5 days). Due to rapid progession of the disease Cyclophosphamide, Doxorubicin, Vincristine, Etoposide and Prednisone (CHOEP) regime was initiated. After one cycle of chemotheraphy, patients condition continues to deteriorate: erythroderma is present again – BSA 95%, mSWAT increased to 136.5, patient has developped agranulocytosis and fever.

Conclusions

Patients with MF/SS have unfavourable prognosis and are in a grave need of effective treatment options and precise diagnostics. MF and SS diagnostics requires not only clinical and pathological examination, but also molecular tests such as T – cell receptor (TCR) clonality in blood, skin and lymph nodes. The goal of treatment of MF and SS is to reduce symptomatic morbidity and limit progression of the disease. ECP combined with other treatment modalities is the treatment of the choice for erythrodermic MF and SS. For MF stage IV – polychemotherapy is often given, although as a first line treatment it is associated with a higher risk of death [2, 3]. Increasingly, hematopoetic stem cell transplantation is being considered for patients with advanced stages, it is the only possibly curative therapy.

Key words
Cutaneous T-cell lymphoma, Mycosis fungoides, Seezary syndrome, extracorporeal photoimmunotherapy.

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PO 11–11. Efficiency of intralesional therapy in a rare case of Lichen Ruber planus hypertrophicus.

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Introduction
Lichen planus is a chronic inflammatory disease affecting the skin and mucose. Lichen ruber planus hypertrophicus is a rare type of lichen planus. It most often occurs on the lower limbs, especially around the ankles. Many patients are treated by local corticosteroids, but in some cases it has no positive result.

Aims and Objectives
5 years old female first admitted to dermatologist with a complains of erythematous papules on lateral side of right ankle, leasions persisted for one year. Patient had no trauma or previous episodes of similar lesions. Patient

did not have any specific treatment or diagnostics before appointment. Patient was prescribed local corticosteroids, but in one month no significant result was seen. Dermatologist performed intralesional injections of Triamcinolone acetonide 40 mg/ml, into each cm2 of lesion 0,1 ml of corticosteroid was injected. After first procedure in one-week significant positive effect was seen. Papules reduced in size and erythema in the base of lesion was reduced. One other procedure of intralesional injections were performed, with significant positive result.

Materials and methods

Immunology panel and blood analysis were performed, which has no changes. Punch biopsy was performed. Pathomorphologist described severe hyperkeratosis, parakeratosis, irregular epidermal hyperplasia and papillomatosis with elongation of the rete ridges. Unequal thickness of epidermis, with irregular significant hyper granulosis. Civatti bodies are seen. Fibrosis into dermis, in upper layers of dermis linear lymphohistocitar infiltration is detected, exocytosis.

Results

After two procedures of intralesional corticosteroid injections significant positive effect was noticed

Conclusions

Intralesional corticosteroid injections is effective method to treat lichen ruber planus hypertrophicus.

Key words

Lichen Ruber planus hypertrophicus, intraleasiona injections.

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