Workshop

"Top Masters in Dermatology"

Rzeszów, Poland — Sept. 12–14, 2019

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Workshop

"Top Masters in Dermatology"

Program

Thursday, 12.09.2019

17.00–17.15 — *Introduction and opening*
Adam Reich (Rzeszów, Poland)

17.15–18.00 — *Novel antifibrotic targets*
Jörg Distler (Erlangen, Germany)

18.00–18.45 — *Dr Julian Kostołowski's Lecture. Diagnosis and treatment of dermatomyositis: state-of-the art*
Victoria Werth (Pensylvania, USA)

18.45–19.30 — *Melanoma malignum — current state of diagnosis and treatment*
Rolland Gyulai (Pecs, Hungary)

19.30–21.00 — Networking symposium

Friday, 13.09.2019

09.00–09.45 — *Mohs micrographic surgery in daily routine practice*
Andrzej Bieniek (Wrocław, Poland)

09.45–10.30 — *New trends in the treatment of atopic dermatitis*
Jacek Szepietowski (Wrocław, Poland)

10.30–11.15 — *Morphea and related disorders: the past and the future*
Aleksandra Pazdrowska (Poznań, Poland)

11.15–11.45 — Coffee break

11.45–12.30 — *Psoriasis update*
Paul Sator (Wien, Austria)

12.30–13.15 — *Many shades of psoriasis*
Joanna Narbutt (Łódź, Poland)

13.15–14.00 — *New perspectives in skin carcinogenesis*
Aleksandra Lesiak (Łódź, Poland)

14.00–16.00 — Lunch

16.00–19.00 — *Take the challenge* — presentations of case reports by the workshop participants

Saturday, 14.09.2019

09.00–09.45 — *Paraneoplastic syndromes in dermatology*
Beata Bergler-Czop (Katowice, Poland)

09.45–10.30 — *Non-STI dermatoses of anogenital area*
Adriana Polańska (Poznań, Poland)

10.30–11.15 — *Chronic pruritus: disease of itself*
Adam Reich (Rzeszów, Poland)

11.15–11.30 — Coffee break

11.30–12.15 — *Quo vadis treatment of hidradenitis suppurativa?*
Łukasz Matusiak (Wrocław, Poland)

12.15–13.00 — *Introduction to the reflectance confocal microscopy*
Joanna Ludzik (Kraków, Poland)

13.00–13.45 — *How to interpret histopathological reports?*
Joanna Czuwara (Warszawa, Poland)

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Abstracts

NOVEL ANTIFIBROTIC TARGETS

Jörg Distler

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Persistent activation of fibroblasts is a common denominator of fibrotic diseases but mechanistically incompletely defined. In contrast to physiologic tissue repair responses, fibroblasts remain persistently active in fibrotic diseases and continue to release excessive amounts of extracellular matrix. While fibroblast-to-myofibroblast transition occurs only transiently increased in normal wound healing and is terminated as soon as the damage is repaired, fibroblasts remain persistently active in fibrotic diseases. We will discuss the latest approval relevant clinical trials for the treatment of fibrosis in systemic sclerosis (SSc). Moreover, we will highlight promising preclinical targets with high translational potential for the treatment of fibrosis in SSc and other fibrotic conditions.

DIAGNOSIS AND TREATMENT OF DERMATOMYOSITIS: STATE-OF-THE ART

Victoria P. Werth

Division of Dermatology at the Philadelphia Veterans Administration Hospital, United States

The Bohan and Peter's criteria defined dermatomyositis (DM) for many years. These criteria did not allow recognition of amyopathic DM patients, since patients have to have some muscle abnormalities to be recognized as even possible DM. Sontheimer's criteria for the skin findings of DM include pathognomonic findings of Gottron's papules and Gottron's sign. Characteristic findings include heliotrope, periungual telangiectasias, dystrophic cuticles, and photodistributed violaceous erythema. Secondary skin features of DM include subepidermal vesicle and/or blisters which could evolve into superficial erosion/ulcerations. Other secondary features include vasculopathy, poikiloderma (hyperpigmentation and hypopigmentation, telangiectasias, and superficial atrophy), as well as cutaneous calcinosis. The International Myositis Classification Criteria Project (IMCCP) utilized a collaborative and scientific approach to develop criteria that would allow recognition of amyopathic DM, with three skin criteria determined as important to include as criteria: heliotrope, gottron's papules, and gottron's sign. The presence of two of the three skin variables allowed recognition of patients as having dermatomyositis. A skin biopsy showing typical changes of interface dermatitis was included as part of the selection criteria for subjects used in the criteria study, and it was recommended to utilize skin biopsies in addition to the clinical criteria to avoid inclusion of mimickers of DM. Interface dermatitis is a histopathological pattern of inflammatory skin disease with the dermoepidermal junction obscured by hydropic degeneration and/or lichenoid cellular infiltrate. These new EULAR/ACR criteria allow classifying amyopathic DM in approximately 75% of patients.

There is now an ongoing collaborative effort to further refine the skin variables, so that more CADM patients can be correctly classified as DM. A pre-delphi, followed by two rounds of Delphi have narrowed potential classification criteria from 54 to 22 items that are now being tested prospectively in an international collaboration including dermatologists and rheumatologists. The variables to be tested include morphology, distribution, symptoms, presence of myositis antibodies, and contextual factors such as interstitial lung disease (ILD) and muscle weakness. The goal is to develop and validate skin criteria for dermatomyositis so as to correctly classify as many patients as possible, with the target group being patients with amyopathic dermatomyositis.

Features of DM can be helpful in terms of determining risk of ILD, with mechanics hands seen somewhat more often in patients with ILD, although prevalent in those without ILD or anti-synthetase antibodies. It is clear that anti-synthetase antibodies can be seen in patients with skin features of DM, and thus defining DM with or without anti-synthetase antibodies may help define distinct subsets. Many patients with DM or CADM and ILD do not have anti-synthetase antibodies, so there is a lot of overlap of systemic features. MDA-5 antibodies define a subset of patients who may have rapidly progressive ILD. MDA-5 patients have more lung disease, skin ulcers, palmar papules, mechanics hands, oral lesions, and alopecia. Skin ulcers in DM can be due to vasculopathy, vasculitis, excessive inflammation at the interface between the dermis and epidermis, or due to excoriations in response to pruritus. Antibodies are beginning to help define phenotypes of disease. There is however, a need for better standardization of measurement of DM autoantibodies. A recent study showed just 14% of patients with dermatomyositis had myositis specific antibodies and 21% had myositis associated antibodies when testing was done in commercial labs. Hopefully the detection rate of autoantibodies will improve with time and allow better correlation with disease phenotype.

Therapies for DM have included topicals, sun protection, antimalarials, immunosuppressives, IVIG, and for refractory cases tacrolimus, IVIG, and JAK inhibitors. There is a need for independent critical evaluation of skin manifestations of DM with reliable and validated measure of skin disease severity. There is now a validated disease severity tool, the CDASI, that is being used for clinical and translational studies in dermatomyositis where skin is an important outcome. There are a number of phase 2 trials that are examining potential new therapies for DM and looking at skin as a primary outcome that may improvement treatment options for patients with DM.

In summary, clinical findings in the skin include both primary and secondary changes. The new EULAR/ACR criteria allow identifying 75% of patients with amyopathic DM. An ongoing prospective study will further refine criteria for the patients with skin predominant disease. Histology in about 80% of cases of dermatomyositis show interface dermatitis. There are some cases that don't show that pattern and that can make the diagnosis more difficult. The key is clinical and pathological correlation. Measurement of skin outcomes in trials and other studies is now possible with the CDASI. This is facilitating new trials that include skin outcomes for DM.

MELANOMA MALIGNUM — CURRENT STATE OF DIAGNOSIS AND TREATMENT

Rolland Gyulai

Department of Dermatology, Venerology and Oncodermatology, University of Pécs, Hungary

Recent advances in melanoma genetics and immunoregulation have led to fundamental changes in our understanding of melanoma pathogenesis. These changes have also revolutionized

the therapeutic approach to patients with melanoma, resulting in new treatment paradigms and dramatically improved patient outcomes. Currently, the standard-ofcare for metastatic melanoma has evolved as either combination therapy with a BRAF and a MEK inhibitor or immunotherapy with a programmed cell-death protein 1 (PD1) immune checkpoint inhibitor. Targeted and immunotherapy approaches are now also part of the adjuvant therapeutical landscape. State-of-the-art treatment of metastatic melanoma, however, requires proper clinical, pathological, genetic and radiological evaluation of the patient before and during the therapy. In this lecture, we review the current state of the field and outline a rational approach to the diagnosis and treatment selection for patients with melanoma.

MOHS MICROGRAPHIC SURGERY IN A DAILY, ROUTINE PRACTICE

Andrzej Bieniek
Medical Center Bieniek, Wrocław, Poland

Mohs Micrographic Surgery (MMS) is a staged excision of skin tumors with complete and fast histopathologic examinations of surgical margins, enabling exact correlation of localization of pathologic structures identified in histologic picture and on body integument. It allows for complete and selective removal of neoplastic structures, thus assuring highest cure rates and possibility of conservation of healthy tissues. It is indicated in skin tumors developing through continuity.
In 1994 for the first time in Poland author with coworkers performed operations with use of "3 D-Histology" of Breuninger (Slow Mohs, Paraffin Mohs). Still, this method in our hands proved to be too time consuming. In order to speed up the course of the treatment in 1999 we introduced first operations with use of MMS in frozen sections technique (fresh tissue). At the beginning we employed the most common technique of tissue mounting "direct method — float". In spite of the great experience in "classical" histological technique our technicians were not skillful enough to produce correct MMS slides, leading frequently to: — sections taken deeply from the surface of tissue block (entering into the tumor), or — incomplete tissue sections (which did not comprise whole surgical margin). Because of difficulties and drawbacks of "direct method" many specialists developed their own techniques (author identified 16 of them). Some are efficient enough for obtaining good sections (complete, from the very surface of the tissue block). Still, after changing the position of the cryostat chuck (socket), the manual adjustment is required, what causes loss of time, and loss of tissue ("entering" the tumor — false positive results).

B-S laboratory device. That's why I decided to design a device with a new function of adjustment of the tissue block to any position of cryostat chuck in cryostat. I began my work on new device in 2004, and in 2008 Eng. Szymkowski joined me. Beside the new function it allows for creation of precise tissue block, assuring improved precision and speed of tissue mounting and sectioning. Planar adjustment is carried out in 3 steps: Step I) Preparation of the "sample block without tissue. Step II) Sectioning of "sample block" in cryostat into sections (5-10 µm thick) and taking 3 measurements: 1. Point at which section begins, 2. Depth (from the block surface) an which section encompasses whole surface of the block, 3. Diameter of the block, Step III) Regulation of handwheels with aid of an application "Block Alignment Calculator" (working in Android System and to be installed free from Google Play). The optimal alignment of the tissue block lasts usually 2 minutes. The ability to align the surface of the block to the current cutting position of the cryostat knife — in cryostats with the adjustable "socket" allows to abandon its manual adjustment. In cryostats with a fixed "socket" — it allows to correct the small inaccuracies of their factory setting and adapt to the variable position of the knife. The B-S device allows for obtaining full sections from the top layers of the tissue block (sections from preparations with a diameter of 10-40 mm were obtained at a depth of 40-210 µm, on average 111.57 µm [median 110 µm, standard deviation (SD) 44.38 µm]). This reduces risk of the "false positive results" (and the number of unnecessary excisions) — what is extremally important when treating small structures (e.g. eyelids). It allows for creation of large sections (up to 4 cm), what reduces time of tissue processing and risk of "false positives". Its operation is easy, tissue mounting proceeds in well-defined and easy-to-follow steps, what does not require extraordinary manual skills or long-lasting learning process.

Tumor mapping in MMS. The thorough graphical documentation is necessary in MMS. Formerly it was made by hand drawings: on blank paper, on ready — made schemes of different body areas, on foils attached to Polaroid photos, on print — outs of digital photos. Lately many authors introduced digital mapping systems in MMS (Papa, Lin, Alcalay, Nijssen). We employ own digital mapping system working in Windows®. The program is placed on the server with enabled access from the different participants of the treatment. By admission — surgeon introduces the textual data and draws (on the skin) clinical margins of the tumor, preliminary margins of excision, marking points in the circumference, takes a digital photograph and introduces it to program. During surgery: surgeon draws digitally exact margins of excision and marking points of the circumference. In histo-laboratory: technician draws lines of division, introduces numbering and color coding. By histologic diagnosis: surgeon and /or pathologist introduces the results of diagnosis both of the biopsy (tumor) (in textual form) and excision margins (in textual and graphical form). After completing the histological diagnosis the map is analyzed by surgeon, who in case of "positive margins" determines the area of necessary excision, performs it, draws its area onto the map, passes the case again to the technician, etc, in case of "negative margins" — closes the wound. The Digital Tumor Mapping is illustrating more precisely the tumor margins with its surroundings, cancer infiltrations, and extent of post-operative defect. During follow up visits it serves as easy to open source of information.

Telepathology in MMS. In many countries according to formal requirements, the engagement of a qualified pathologist in MMS is mandatory. Still, it's usually not easy to obtain immediate, repeated histopathological consultation "on demand". That' why many trials were undertaken on the use of "telepathology" in MMS. Professional systems are costly, have long scanning time (8-15 minutes) and produce "heavy" scans (up to 1 GB). Cheaper and simpler solutions may not be reliable enough to assure sufficient quality. We introduced manual telepathology system Microvisioneer®. Slides are analyzed by surgeon and scanned simultaneously (objective x4 — time 2-3 minutes, files 100-400 MB). Then pathologist performs "remote" examination, and makes his (secondary) diagnosis. It proved to be a reliable and fast instrument of remote histological diagnosis.

Statistics in MMS. MMS is closely related to classical surgical excision (Excision with Predetermined Margins — EPM), but the methods vary in form and width of tumor removal. Determining of the exact relations between them is difficult. Therefore we attempted to introduce the index of radicality (completeness) of tumor removal (IRTR) as well as the index of extent of post-operative defects (IED). The indexes are derived from the following

data: 1) The widest margin of excision in MMS [Marg Max MMS], 2) The mean margin of excision in MMS [Marg Mean MMS], 3) The hypothetical margin of classical excision with predetermined margins [Marg EPM]. IRTR = (Marg Max MMS)/(Marg EPM), IED = (Marg Mean MMS)/(Marg EPM)

During 668 operations of BCC with use of MMS, the following results: were obtained:

IRTR — Index of radicality of tumor removal (33.3–444%, mean 106.20%) The excision by MMS was more radical [by mean of 6.2% — not significant statistically]. In (12.57%) (index value =100%) surgical excision and MMS would be equally complete and radical (effective). In (51.64%) [IRTR] (index value below 100%) surgical excision would be effective, but made with an excess of healthy tissue (too radical). In 237 cases (35.47%) (index value over 100%) — the surgical excision would leave residual tumor.

IED — Index of extent of the defects (33.3–344.41%, mean 84.93%). Defects after MMS were smaller (by mean of 15.07% — what was statistically significant). In (11.52%) (index value = 100%) — both methods would create similar defects, in (71.10%) — (index value below 100%) — defect after MMS were smaller, in (17.36%) — (index value above 100%) — defects after MMS were bigger.

Our modifications may play a role in the everyday practice of MMS. In 1997 the first Polish Conference on Mohs Surgery was organized by the Department of Dermatology, Medical University of Wrocław. In 2017 the idea of the Courses was resumed by Centrum Medyczne Bieniek.

NEW TRENDS IN THE TREATMENT OF ATOPIC DERMATITIS

Jacek Szepietowski

Department of Dermatology, Venereology and Allergology, Wrocław Medical University, Poland

Abstract was not submitted.

MORPHEA AND RELATED DISORDERS: THE PAST AND THE FUTURE

Aleksandra Dańczak-Pazdrowska

Noninvasive Diagnostic of Skin Diseases Unit at Department of Dermatology, Poznań University of Medical Sciences, Poland

Morphea, also known as localized scleroderma, is an immune-mediated, fibrosing skin disorder which belongs to autoimmune connective tissue group of diseases and affects both children and adults. There is huge variation in the clinical presentation of morphea. The course of disease is chronic and unpredictable. It may cause tissue atrophy, dyspigmentation, but also contractures or even functional disability. There is no one, unique, generally accepted classification system. The mode of treatment depends on severity of the disease. The mildest forms can be treated topically, in more severe cases methotrexate (with or without systemic glucocorticosteroids), or phototherapy are usually recommended. However, the treatment of severe forms of morphea may be challenging. There are variety of disorders and diseases which belong to so called scleroderma spectrum disorders (term used to describing a spectrum of conditions characterized by hardening and/or thickening of the skin and adjacent tissues), which should be considered in differential diagnosis. The aim of this presentation is to summarize and to synthesize the information into a rational approach to the diagnosis and management of patients with morphea.

PSORIASIS UPDATE

Paul Sator

Department of Dermatology, Hietzing Hospital, Vienna, Austria

Psoriasis is a chronic inflammatory disease with underlying autoinflammatory pathomechanisms. A recent systematic review of the worldwide literature regarding epidemiology of psoriasis estimated that the prevalence in adults ranges from 0.51% to 11.43%.
Several comorbidities are associated with psoriasis, including psoriatic arthritis and cardiometabolic disorders. In addition to its clinical burden, psoriasis also has significant psychosocial impact. In large surveys of patients with psoriasis, respondents have reported that psoriasis can affect emotional state, interfere with daily life, and have a negative impact on work, relationships and sleep quality and quantity. Additional factors, including involvement of highly visible or bothersome areas (e.g. scalp, nails, genitals, palms and/or soles) or symptoms (e.g. itching) significantly impair QoL and impact patient-perceived severity. About 50% of patients treated by dermatologists have moderate-to-severe psoriasis, which, according to S3 guidelines, requires systemic treatment. Parameters used in daily practice to classify psoriasis as mild, moderate or severe are the Psoriasis Area and Severity Index (PASI), Dermatology Life Quality Index (DLQI) and Body Surface Area (BSA). Moderate-to-severe psoriasis is defined by a European consensus as (BSA>10% or PASI>10) and DLQI>10.
Currently, available treatments for moderate-to-severe psoriasis include phototherapy, small molecules and biologics. Biologic drugs, such as anti-tumor necrosis factor and specific monoclonal antibodies (IL-12/23, IL-17, IL-23), revolutionized treatment paradigms in psoriasis. More and more patients achieve a PASI 100 due to these potent therapies. Hence, non-invasive biomarkers are sought to predict treatment outcomes and individualize care for patients with psoriasis. Even as treatment of psoriasis becomes safer, it is important to recognize both common and uncommon adverse effects of treatment. Common adverse effects are similar across treatment options, including upper respiratory infection and injection-site reaction. Serious adverse effects occur less frequently and specific to the psoriasis treatment option, such as inflammatory bowel disease and candida infections with IL-17 inhibitors or tuberculosis with certolizumab pegol.
Data from registries provide important information of biological treatments on a high efficacy and long-term safety. Due to the approval of biosimilars the biological therapies are also more and more cost-effective.
The introduction of biologics may greatly improve patient outcomes.

MANY SHADES OF PSORIASIS

Joanna Narbutt

Department of Dermatology, Pediatric Dermatology and Oncology, Medical University of Łódź, Poland

Psoriasis is an immune-mediated, genetic disease manifesting in the skin or joints or both. Due to involvement of many organs, a diverse team of clinicians is often needed to treat the disease. Psoriasis provides many challenges including high prevalence, chronicity, disfiguration, disability, and associated comorbidity. When the role of immune function in psoriasis and the interplay between the innate and adaptive immune system had been discovered, new therapeutic options have been developed. During the lecture I will highlight the clinical diversity of psoriasis and associated comorbid diseases. I would like to

raise awareness of the complexity of this multifaceted disease, the potential of state-of-the-art therapeutic approaches, and the need for early diagnosis and comprehensive management of patients with psoriasis.

NEW PERSPECTIVES IN SKIN CARCINOGENESIS

Aleksandra Lesiak

Department of Dermatology, Pediatric and Oncological Dermatology and is a coordinator of Dermatology for Children of Medical University of Łódź, Poland

Discovered in 2002, cytoplasmic multi-protein complexes, called inflammasomes, are key regulators of the innate immune response, activated under the influence of various endo- and exogenous stressors. One of the permanent external stressors that significantly affects the homeostasis of the body is ultraviolet radiation (UVR), which, as recent research has shown, can be an inflammasome activating factor. Until now, the best-characterized inflammasomes are NLRP1(NOD-Like Receptor Family Pyrin Domain Containing 1) and NLRP3 (NOD-Like Receptor Family Pyrin Domain Containing 3). Until now, it is known that UVR can affect the function and structure of the NLRP1 and NLRP3 inflammasomes, but the exact molecular mechanisms underlying this phenomenon have not been sufficiently described. In the context of the growing incidence of non-melanoma skin cancers (NMSC), where the main risk factor is chronic exposure to UVR, it becomes necessary to determine how inflammasomes regulate the process of their formation and development. Thus, the aim of the current presentation is to describe the potential role of NLRP1 and NLRP3 inflammasomes in skin carcinogenesis

PARANEOPLASTIC SYNDROMES IN DERMATOLOGY

Beata Bergler-Czop

Chair and Clinic of Dermatology, Silesian Medical University, Katowice, Poland

A variety of cutaneous abnormalities can be seen in patients with malignant diseases, some of which are infectious, with others representing direct involvement of the skin by the underlying disorder. Yet another group of lesions can be regarded as associated markers of the malignant process, and, as such, are termed "paraneoplastic". This review considers the latter collection of conditions, grouping them by the generic type of malignancy that is usually linked to the paraneoplasia. Some of the processes show a predominant association with alimentary tract malignancies (acanthosis nigricans, acrodermatitis paraneoplastica, florid cutaneous papillomatosis, necrolytic migratory erythema, palmoplantar keratoderma, pancreatic fat necrosis, and pityriasisrotunda). Others are usually linked to a hematolymphoid malignancy (acquired ichthyosis, exfoliative erythroderma, necrobiotic xanthogranuloma, pemphigus paraneoplastica, plane xanthoma, pyoderma gangrenosum, scleromyxedema, Sweet syndrome, and leukocytoclastic vasculitis). Finally, yet another collection of paraneoplastic skin disorders can associate themselves with anatomically-diverse malignancies (Leser–Trelat syndrome, Trousseau syndrome, dermatomyositis, erythema gyratum repens, hypertrichosis lanuginosa acquisita, papuloerythroderma of Ofuji, tripe palms, and multicentric reticulohistiocytosis). Recognition of these processes by the pathologist can be a valuable step in the characterization of underlying malignant diseases.

NON STI DERMATOSES IN ANOGENITAL AREA

Adriana Polańska

Department of Dermatology and Venereology Poznań University of Medical Sciences, Poland

Anogenital area due to the specific conditions (e.g. humidity, rubbing of adjacent surfaces) and exposition to various irritants and allergens, is the common specific cutaneous localization of non-sexually transmitted dermatoses including inflammatory and infectious one. This particular localization makes the presentation of the lesions much different than within the glabrous skin. The involving of genitalia, especially in young male patients, can stigmatize them due to the attribution of the venereal origin. However, sexually transmitted infections (STI) constitutes only minority of the lesions located within that area. More common are lichen simplex, psoriasis or contact dermatitis. It should be also emphasized that involvement of anogenital area highly impairs the patients quality of life.
The aim of the lecture is to present the updated knowledge on non STI dermatoses of anogenital area, with special emphasis on inflammatory diseases like lichen simplex, lichen planus, contact dermatitis as well as lichen sclerosus. In differential diagnosis psoriasis, intertrigo and balanitis as well as infectious diseases will be discussed.

CHRONIC PRURITUS: DISEASE OF ITSELF

Adam Reich

Department of Dermatology, University of Rzeszów, Poland

Itching is defined as an unpleasant sensation that causes a desire to scratch. Itching is the most common subjective symptom of skin diseases, but it can also be present in many systemic, neurological or psychiatric diseases. According to the classification by the International Forum for the Study of Itch (IFSI), itching can be treated as acute (lasting less than 6 weeks) or chronic (lasting > 6 weeks). While short-term itching is often a defense mechanism that protects us from ectoparasites, chronic itching is a pathological phenomenon, which causes significant suffering to patients and reduces their quality of life.
Contemporary classification of pruritus is also largely based on the clinical presentation of the skin in which the patient reports the occurrence of pruritus. According to the IFSI classification, patients are grouped into 3 subgroups: group I — pruritus on lesional skin, group II — pruritus on unchanged, normally-looking skin, and group III — pruritus with secondary scratch lesions. The patient should then be classified into one of the categories of pruritus depending on its etiology: pruritus associated with skin diseases, pruritus associated with systemic diseases, neurological pruritus, psychogenic pruritus, or mixed pruritus. However, it is not uncommon, that the exact etiology cannot be defined and such cases are classified as pruritus of unknown etiology. Recently, many expert also suggested, that chronic pruritus can be considered as a disease on its own.

QUO VADIS TREATMENT OF HIDRADENITIS SUPPURATIVA?

Łukasz Matusiak

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Abstract was not submitted.

INTRODUCTION TO THE REFLECTANCE CONFOCAL MICROSCOPY

Joanna Łudzik

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Skin tumors are the most frequent type of cancer in the general population with epidemiological data showing a rising trend. Genetic and environmental risk factors play a crucial role in skin cancer development and include caucasian race, light colored skin, the number and type of naevi and a positive family history in the case of both BCC and MM. Sun burns and ultraviolet exposure are known environmental risk factors for skin cancers and it is believed that intense but intermittent sun exposure, especially on skin areas that are not usually sun-exposed, and a history of sunburns, especially in childhood and adolescence, play an important role in melanoma development. In recent years several non-invasive imaging modalities have emerged aimed at increasing accuracy of in-vivo diagnosis, of which reflectance confocal microscopy (RCM) has shown to be the most promising and popular amongst clinicians in Europe. RCM permits non-invasive (in-vivo) examination of the skin at cellular resolution from the surface down to the upper dermis enabling visualization of the relevant skin layers for skin tumor evaluation and diagnostic confirmation by enabling the visualization of tissue in its physiological state avoiding retraction bias due to fixation, staining and sectioning procedures that are a prerequisite of conventional light histopathology. Additionally, RCM permits cellular level observation of changes over time. The application of this technology is quite advantageous in the screening of malignant skin tumors as well as inflammatory diseases, monitoring of pigmentary skin disorders and cosmetology. The first description of RCM for the imaging of human skin in-vivo was in 1995 by Rajadhyaksha and colleagues and morphology of naevi and melanoma were first described in in 2001 as well as the potential for this technique to aid in detecting clinically amelanotic melanoma. The integration of digital dermoscopy imaging with the reflectance confocal microscope was proposed by Prof. Giovanni Pellacani in 2004 during his research in Modena, Italy which highlighted the ability of RCM to be a bridge between clinical naked-eye with dermoscopy examination and histopathology and was the foundation upon which RCM technology is designed and implemented today in clinical practice.

HOW TO INTERPRET HISTOPATHOLOGICAL REPORTS?

Joanna Czuwara

Department of Dermatology, Medical University of Warsaw, Poland

The interpretation of the skin biopsy is very important for the dermatological diagnosis. There are neoplastic and inflammatory dermatoses in which histopathological findings are characteristic or pathognomonic making the final diagnosis with certainty. There is also a group of diseases in which clinical-pathological correlation, location or clinical anamnesis determinate the most likely diagnosis. Also histopathological differential diagnosis is different than clinical one, and the interpretation may relay on the anatomic site and clinician experience. Another histological aspect is so called "life of lesion" in which time duration or secondary changes such as scratching or bacterial infection influence the epidermal and dermal events and dermatopathologist has to refer to the most basic event which has triggered the chain of changes for establishing the most probable entity underneath the overlying changes.

Very important point for the interpretation of histopathology is description of epidermal changes (spongiosis in eczema, exocytosis in many inflammatory diseases, acanthosis, acantholysis in different types of pemphigus and HSV/VZV infection, type of parakeratosis, dyskeratosis and interface changes) because they differentiate type of dermatoses (drug and infection induced, autoimmune, psoriasiform, cytotoxic, lichenoid and types of cutaneous lupus erythematosus among others. The composite of inflammatory infiltrate is also crucial for diseases distinction e.g. allergic, neoplastic, neutrophilic, vascular and dermal including the arrangement of skin infiltration such as perivascular, nodular, follicular or diffuse.

Helping mnemonic such 8Ls was created for differentiation of superficial and deep inflammatory cell infiltrate in the dermis to better remember the following light reactions, lymphoma, leprosy, lues, lichen striatus, lupus erythematosus, lipodidica and lepidoptera or DRUGS for dermatophyte, REM, urticarial diseases, gyrate erythemas, scleroderma and drug reactions.

Undoubtedly the interpretation of the skin biopsy is a mainstay diagnostic tool for many, if not all dermatological entities. It should be remembered that proper description of the skin lesion, not only clinical suggestion and location of the biopsy site strongly influence the quality of pathological report, but the first condition is the depth and size of the biopsy which purely depends on the clinician.

Abstracts of young dermatologists

GRANULOMA FACIALE IN A 59-YEAR-OLD MAN

Anna Ryczek, Ewa Żabska
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A 59-year-old man was admitted to the Dermatology Department in Rzeszów presenting with a 6-years history of the slowly growing tumor on the scalp. The skin lesion developed after a minor trauma. In the past the patient had been also exposed to ultraviolet radiation for several years as he worked at the outdoor construction site. Physical examination on admission revealed an erythematous tumor (diameter of 6 cm) with visible teleangiectasias. Histopathological examination showed Grenz zone, and the infiltration of neutrophils, lymphocytes and eosinophils in the deeper dermis. Based on the clinical manifestation, medical history and histology, facial granuloma (GF) was diagnosed. GF is a rare, benign, inflammatory skin disease, usually isolated. It usually occurs on the forehead, nose or cheeks. GF is most commonly seen in middle-aged Caucasian males. The treatment is difficult and includes: topical corticosteroids, tacrolimus, cryotherapy, dapson, hydroxychloroquine, colchicine, phototherapy and lasers.

SCHNITZLER SYNDROME

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Introduction: Schnitzler syndrome belongs to the group of auto-inflammatory diseases. This disorder is characterized by a chronic urticarial rash and monoclonal IgM or less frequently IgG gammopathy. It is a rare disease with about 300 cases described in the literature. Schnitzler syndrome may be associated with malignancy, as lymphoproliferative disorders develop in about 20% of patients
Case report: Here, a 67-year-old woman with chronic urticarial rash is demonstrated. The patient also manifested general symptoms such as recurrent fever, abdominal pain, arthralgia and paresthesia. The diagnosis of Schnitzler symptom was established based on the clinical picture, abnormal laboratory tests and histopathological examination of the skin lesions. Systemic glucocorticosteroids were started with a very good therapeutic effect.
Conclusions: The presented case underline a major diagnostic challenge of Schnitzler syndrome due to its rare occurrence. The proper diagnosis is essential for the identification and treatment of comorbidities, which may worsen the prognosis.

EXCISION BIOPSY FOR SUBUNGUAL MELANOMA

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A 55-year-old woman was admitted to the Dermatology Department in Rzeszów because of pigmented lesion within the nail plate of the 4th digit of the left hand. Physical examination and then dermoscopic view of the pigmented lesion revealed multicolored, slightly trapezoidal lesion involving almost 50% of nail plate, and slight dystrophy of the distal edge of the nail plate. Although the longitudinal melanonychia persisted for 2.5 years, the patient did not visit any physicians before. Considering the anamnesis and clinical manifestation, the excisional biopsy of the pigmented lesion of nail matrix was performed. Based on the histopathological examination malignant melanoma in situ was diagnosed.

PHOTOTOXIC REACTION AFTER CONTACT WITH POISON IVY — A CASE REPORT

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A 75-year-old man was admitted to the dermatology department with generalized erythemas and hives. The first skin lesions appeared one week before hospitalization, and their appearance was preceded by gardening in the USA. Based on the medical history it was revealed that poison ivy grew thereabouts. The rash improved with parenteral and topical steroids and antihistamine treatment. Poison ivy is the most common cause of allergic contact dermatitis in the USA. In Europe, as opposed to North America, poison-ivy rash is hardly known. Intense pruritus and redness develop soon after the skin is exposed to urushiol, which is found in the resin of poison ivy. Vesicles typically occur 12–48 h after exposure. The treatment for poison ivy dermatitis varies depending on the severity of the reaction and includes antihistamines and steroids.

SCLERODERMA OVERLAP SYNDROME

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Systemic sclerosis is an autoimmune connective tissue disease (CTD) characterized by progressive fibrosis of the skin and internal organs, injury of blood vessels and the presence of autoantibodies. The diagnosis of systemic sclerosis may sometimes be challenging, especially in the early stage of the disease. Some patients may also demonstrate features of more than one autoimmune CTD suffering from so called overlap syndromes. Here, we present a case of a 20-year-old man, with digital ulcers and interstitial lung disease (ILD), however, without any skin hardening. The laboratory examination revealed the presence of anti-PM/Scl antibodies. As the patient did not fulfil diagnostic criteria of any specific CTD, an overlap syndrome has been diagnosed. Due to progressing ILD and digital ulcers the treatment with intravenous cyclophosphamide combined with oral sildenafil was administered, which resulted in complete healing of the skin lesions and stabilization of ILD.

CUTANEOUS COLLAGENOUS VASCULOPATHY: A REPORT OF TWO CASES

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Cutaneous collagenous vasculopathy is a rare idiopathic microangiopathy clinically manifesting with acquired cutaneous telangiectasias. Here, we report two cases occurring in a 33-year-old woman and a 66-year-old man who both presented with disseminated telangiectasias and no additional symptoms accompanying the abnormal cutaneous findings. In

both patients, the diagnosis was confirmed by skin biopsy that showed dilated superficial cutaneous vessels with marked collagen deposition within the vessel walls. Cutaneous collagenous vasculopathy is considered a rare yet underrecognized and underreported cause of generalized teleangiectasias. Typically, skin lesions spread progressively from distal parts of the lower limbs towards the trunk and upper extremities. Face is usually spared, as well as mucous membranes. Histological examination of skin biopsy specimen shows the presence of a thick hyaline collagenous wall around the affected capillaries, comprising the accumulation of collagen type IV. Differential diagnosis includes mainly generalized essential telangiectasia which displays identical clinical presentation.

NEONATAL LUPUS ERYTHEMATOSUS — A CASE SERIES OF 3 PATIENTS

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Neonatal lupus erythematosus (NLE) is a rare autoimmune disease associated with maternal anti-Ro/La or anti-U1-RNP antibodies transmission. Spontaneously resolving cutaneous lesions usually appear a few weeks after birth, commonly affecting face and scalp. The most serious NLE manifestation is third-degree heart block.

We present a case series of 3 infants, who developed annular, erythematous plaques with central clearing during 4th to 7th week of life and were diagnosed with NLE. Additionally, patients suffered from thrombocytopenia, transaminase elevation and right bundle branch block. Laboratory findings revealed the presence of antinuclear antibodies in mothers, who were diagnosed with Sjögren's syndrome.

NLE may be the first sign of the connective tissue disease in hitherto asymptomatic mothers, as described in our case series. NLE suspicion should indicate a need of careful diagnostics both in children and mothers, due to possible perinatal complications.

PEMPHIGUS VEGETANS POSSIBLE ASSOCIATION WITH ENALAPRIL

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Pemphigus vegetans is the least common form of pemphigus, clinically manifested by blisters transforming into papillous or pustular eruptions. Treatment involves administration of systemic glucocorticosteroids in monotherapy or combined with immunosuppressants.

A 58-year-old man was admitted with papillous lesions persisting for few weeks in the anogenital area and axillae, receiving hypotensive enalapril for several months, diagnosed with pemphigus vegetans based on clinical manifestation and immunopathologic examination. Enalapril was discontinued and prednisone was introduced at the maximum dose of 2 mg/kg/day, with subsequent improvement of the condition. Considering adverse effects of chronic glucocorticosteroid therapy, azathioprin was also introduced at the dose of 50 mg/day, with gradual reduction of the prednisone dose. The patient in good condition remains under dermatological supervision.

A case report presents a patient with lesions initially suggesting papillary pyroderma, which subsequently underwent rapid progression, significantly hindering the daily functioning of the patient, and which may have been induced by enalapril.

LICHEN PLANUS ATROPHICUS ALONG LINES OF BLASCHKO — CASE REPORT

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Lichen planus is an inflammatory, non-infectious dermatosis characterized by presence of itchy papules in predilections sites as: the inner part of the wrists and the back of the feet. The lesions often occur in mucous membranes. Nail dystrophy and fibrosing alopecia are less common presentations of that disease. There are clinical variants of this dermatosis that have been described so far including lichen planus atrophicus. We present a rare variant of lichen planus atrophicus along the lines of Blaschko and the difficulties associated with its treatment.

INTOXICATION OF METHOTREXAT — CHALLENGING PATIENT

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The poisoning of the MTX is most often caused by patients' overdosing the drug by mistake or physicians' incorrect recommendation. The MTX intoxication leads to the bone marrow suppression and the dysfunction of the liver and kidney as it impairs the process of cells' proliferation.

The aim of this study is to present three cases of patients who developed the symptoms of MTX toxicity. Patients were admitted to the hospital because of extensive erosions developed on the mucous membrane of the mouth and throat.

Levofolinic acid, filgrastim and preparations supporting kidney and liver function were used in the treatment, resulting in the disappearance of skin and mucous lesions and improvement of laboratory parameters. Skin and mucosal lesions may precede other complications associated with MTX intoxication including bone marrow suppression. The prognosis depends on the adopted MTX total dose and the time of the intensive treatment implementation

STORIES OF A RARE BUT SPECTACULAR DISEASE WITH SKIN LESIONS

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TRAPS is a genetically determined syndrome in which relapsing fever episodes are accompanied by skin symptoms.

I. A 9-month-old boy was admitted to the clinic due to the third episode of high fever and non-characteristic skin lesions. The analysis of the interview suggested the auto-inflammatory nature of the disease, which was confirmed by genetic testing.
II. A 23-month-old boy was admitted to the clinic because of relapsing fevers of unknown origin. From early childhood, the child has been repeatedly hospitalized with the diagnosis of erythema multiforme, erythema annular or allergic rashes. The periodic occurrence of fever episodes suggested an auto-inflammatory basis of changes, which was confirmed by the detection of mutations in the TNFRSF1A gene.

The occurrence of periodic episodes of fever with skin changes and laboratory markers of intensified inflammation, should be differentiated with autoinflammatory diseases, which is an indication for genetic testing, including TRAPS.

THE REACTIVATION OF HERPES SIMPLEX VIRUS INFECTION AS A RESULT OF PHOTODYNAMIC THERAPY — CASE REPORT

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Actinic keratosis (AK) is a common disorder, presented with scaly, erythematous lesions. It is associated with chronic exposure to ultraviolet (UV) radiation. AK is capable of transforming into an invasive squamous cell carcinoma.
Photodynamic therapy (PDT) is one of non-invasive methods of treatment AK. PDT can either stimulate or repress immune response. Common early side effects occure directly after PDT and comprise erythema, eodema, desquamation or pustulae.
We report the case of a 61-year-old female patient who developed a reactivation of herpes simplex virus (HSV) infection localized to the nose, where PDT for AK had been performed. The patient received systemic antiviral therapy, and after treatment the lesions had completely disappeared. Considering the broad use of PDT, the reactivation of HSV infection seems to be a very rare but potentially serious complication. It has to be distinguished from common inflammatory reactions after PDT.

REACTIVE GRANULOMATOUS DERMATITIS IN CLINICAL PRACTICE — 5 STUDY OF TWO CASES

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Reactive granulomatous dermatitis (RGD) is a rare dermatological entity of unknown etiology, belonging to a group of non-infectious cutaneous granulomas that may mimic various connective tissue diseases and therefore requires a thorough approach from the dermatologist. Classic clinical manifestation of the disease described in the literature is that of asymptomatic red or violaceous well demarcated plaques with linear, cord-like distribution on the trunk and limbs in patients with arthralgia. However, more recent reports in the literature suggests that clinical picture of the disease is more variable and may include multiple symmetrically distributed plaques and papules, urticarial plaques, erythematous nodules and annular lesions. Because of wide clinical spectrum, a diagnosis requires histological examination. We present two cases of RGD manifested clinically with multiple, hard, subcutaneous nodules distributed symmetrically within the skin overlying joints.

DYSPNEA AND ARTHRALGIA IN A PATIENT TREATED FOR HYPOCOMPLEMENTEMIC URTICARIAL VASCULITIS SYNDROME

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Hypocomplementemic urticarial vasculitis syndrome (HUVS) is a disorder characterized by urticarial lesions on the skin. Laboratory findings include low complement levels and presence of anti-C1q antibodies in the serum. Although HUVS is mainly related with a skin manifestation, it can be also accompanied by extracutaneous manifestations such as laryngeal edema, arthritis, glomerulonephritis, and pulmonary involvment. Corticosteroids and immunosuppressive agents are usually used in the treatment.
This case shows a 52-year-old woman treated for the cutaneous manifestation of hypocomplementemic urticarial vasculitis syndrome from 3 years and reported artralgia and dyspnoea. There was no skin leasions in this patient from 2016 due to treatment with methylprednisolone and dapson. An involvment of lungs and joints in the course of HUVS was suspected. Diagnostics revealed chronic obstructive pulmonary disease more related with nicotinism and osteoarthritis. Finally there was no treatment modification for HUVS. Inhaled corticosteroids and nonsteroidal anti-inflammatory drugs were administered for this patient.

XANTOGRANULOMA NECROBIOTICUM

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Xantogranuloma necrobioticum is an extremely rare disease of unknown etiology, which is almost always accompanied by paraproteinemia. It is more common in older people. Characteristic symptoms of the disease are red-yellow infiltrative plaques located typically in the orbital area, as well asthe rest of the face, neck and chest. Advanced changes can spread to the subcutaneous tissue and cause ulcerations. The histological image shows massive necrobiosis, numerous giant cells and accumulation of lymphocytes. The case of a 51-year-old woman with xantogranuloma necrobioticum diagnosed on the basis of the clinical features and histological examination is presented. Skin changes were accompanied by IgG lambda monoclonal gammopathy. A magnitude of therapies were employed including chlorambucil, intravenous immunoglobulins, systemic and intralesional corticosteroids, cyclophosphamide and thalidomide, however, progression of skin lesions was observed despite treatment.

PUSTULAR RASH WITH UNEXPECTED DEVELOPMENT

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A 44-year-old woman came to a outpatient night shift with pustular rash lasting 1 day and fear of a chickenpox. She suffered from ankylosing spondyloarthritis, but she negated systemic medication. She was reassured that chickenpox is implausible, received topical therapy and was sent home. Four days later she came back because of a worsening. She reported new sore throat, CRP was 30, the condition was assessed as susp. parainfectious exanthema/reaction due to viral pharyngitis. Next week, the skin condition worsened further, with new facial involvement. A biopsy was performed with result "Acute purulent folliculitis and perifolliculitis with large amount of eosinophils". The pathologist suggested a drug rash. At next follow-up, she had completely new scaling leasions and it was found that she had forgotten to mention experimental therapy with certolizumab-pegol for uveitis. Paradoxical psoriasis induced by TNF inhibitor has been suspected, with confirmation by a new biopsy.

DRUG-INDUCED SUBCUTANEOUS LUPUS ERYTHEMATOSUS

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An 81-year-old woman, treated for six months dermatologically, was referred to the Department of Dermatology, Venereology and Allergology in Wroclaw due to the lack of a satisfactory therapeutic effect of previously used topical therapy with potent glucocorticoid. On admission a numerous erythematous lesions with a characteristic ring-like structure were observed. They were localized on the skin exposed to UV radiation. The most severe skin lesions were present on the face, V-neck area and on the upper back. In addition, the patient complained of pruritus accompanying the skin lesions. The pruritus severity according to the 10-point NRS scale (Numerical Rating Scale) was 6 points. The patient emphasized that exposure to UV--radiation causes a significant exacerbation of skin lesions. The patient also complained about the excessive hair loss since 3 months. Because of hypertension the patient has been treated for a year with spironolactone, and for more than two years in the treatment of gastroesophageal reflux disease she was taking a pantoprazole- a proton pump inhibitors (PPI). After cessation of PPI a gradual improvement of the skin lesions was observed. Patient was diagnosed with drug-induced subcutaneous lupus erythematosus.

A LEUKEMIA INFILTRATE OF THE NOSE SKIN

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Multiform, nonspecific skin lesions, often occurring with pruritus, especially in the elderly, should always be differentiated with leukemia or lymphomas.
Here, we present a case of 63-year-old woman, suffering from chronic lymphocytic leukemia, who was admitted to the Dermatology Clinic in Rzeszów because of the swelling and erythema within the nose. The first skin changes appeared about 7 days before hospitalization as a reddening and a gradually growing swelling of the top of the nose and nasal wings. Prior hospitalization treatment with amoxicillin with clavulanic acid was used, however, no improvement was observed. On admission, a swelling and an tender erythema of the top and wings of the nose with erosions was noticed. Lab tests showed leukocytosis with neutropenia and lymphocytosis and slightly increased –reactive protein level. Erysipelas of the nose area was suspected and therapy with clindamycin subsequently combined with cefuroxime, but again, no improvement was achieved. Finally, a skin biopsy was taken, which revealed the presence of an infiltrate of chronic lymphocytic leukemia (immunohistochemistry showed the presence of antigens CD20 (+), CD5 (+), CD23 (+), bcl2 (+), and the Ki-67 proliferative activity equaled 15-20%) and the patient was sent to the Clinic of Hematology for further treatment.
Based on our case we would like to stress, that non-specific skin eruptions in the course of leukemias can cause great diagnostic difficulties due to the large variety.

SQUAMOUS CELL CARCINOMA ARISING ON INGUINAL HIDRADENITIS SUPPURATIVA

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Introduction: Hidradenitis suppurativa is a chronic inflammatory skin disorder characterized by recurrent formation of abscesses and scarring on the skin. Long-standing infection and abscess formation results in ulcers, fistulas and progressive scars. Squamous cell carcinoma is considered the most severe complication of HS.
Case report: A 48-year-old man was referred to our clinic with a 20 year history of HS ocasionally treated with surgical incisions and oral antibiotics. His gluteal fistulas had started 20 years ago, his inguinal fistulas 10 years ago and in the previous 8 months, he had developed a large inguinal mass. Physical examination revealed a 20 × 5 cm irregular, wart-like ulcerative mass on his left groin area. Histopathological examination of skin biopsy showed features of invasive SCC. Radical resection of the tumor was not possible due to local dimensions and organs nearby. 2 cycles of radiotherapy were performed. 6 months later the patient was hospitalized in our clinic with fever and signs of sepsis. CT and PET/CT were performed and revealed metastasis to the pelvic bone with osteomyelitis on the top. The patient refused bone biopsy for confirmation and staging of the disease, he was then transferred to a hospice where he is currently receiving palliative care. Oncologists ended the case with a bad prognosis and no indication for further chemo or radiotherapy.
Key message: Misdiagnosis and inadaquate treatment complicate the progressive course of the disease. SCC in HS is rare, but mortality is high.