MALTESE ASSOCIATION OF DERMATOLOGY & VENEREOLOGY

DERMFEST 2018 – FOCUS ON THE YOUNG AND THE ELDERLY

26-27th October, The Palace Hotel, Sliema

ABSTRACTS

Friday 26th October

TRAINEE PRESENTATIONS

An Edinburgh dermatology elective experience

Jeanclaude Scicluna, Medical Student, University of Malta

Medical students and junior doctors alike are on the constant lookout for experiences and opportunities to boost their medical training. Electives abroad, medical summer schools and workshops are a great way of doing this, but they involve a lot of research, paperwork and asking around. Moreover, limited time and money mean that students often get few chances to have these experiences. This presentation, based on my own Edinburgh medical student elective in dermatology, will discuss key points and tips about how to make the most of such an elective. This includes the necessary preparation, applying for student bursaries and grants and integrating into a new hospital setting. Moreover, certain cultural aspects of working with colleagues, seniors, nursing staff and not least patients from a different area of the world are also tackled.

Dermschool is a medical workshop tailor-made for dermatology, with particular emphasis on junior doctors attending taster sessions or medical students who are enthusiastic about dermatology. Various different techniques commonplace in dermatology practice were introduced, such as cryotherapy administration and post-cryotherapy care. Other techniques included punch biopsy, the primary technique for obtaining diagnostic full-thickness skin specimens. Electrosurgery for the skin was also tackled, including all the major modalities such as electrodessication, fulguration and electrocoagulation. All this teaching came with practical tips as well as plenty of time to get some hands-on work done using the actual instruments, on synthetic full thickness skin, with different materials substituting the epidermis and dermis.

The lesser-known cousin

A Vella Baldacchino, R Corso, MJ Boffa, Department of Dermatology, Sir Paul Boffa Hospital, Malta

Superficial granulomatous pyoderma (SGP) was initially described in 1988 as a rare, localized variant of pyoderma gangrenosum (PG), with superficial ulcerative lesions and a granulomatous histologic appearance. Although considered to be typically benign and more responsive to treatment than classical PG, a growing body of literature suggests otherwise. Several treatments have been used with varying degrees of success for this condition, including corticosteroids and other systemic immunosuppressive therapies. High-dose intravenous immunoglobulins (IVIg) have been used for a number of severe dermatological autoimmune diseases, including PG, but we found only one report on the use of IVIg in SGP. We report a case of aggressive SGP in a 68-year-old lady. Treatment with high-dose IVIg resulted in stabilisation and resolution of disease, allowing tapering of prednisolone without recurrence. This case further suggests that IVIg represent a valid therapeutic option in SGP.

Fifty shades of grey hair in Dermatology

M Cachia, S Aquilina, Department of Dermatology, Sir Paul Boffa Hospital, Malta

Grey hair is known by many to be a sign of maturity however this is not always the case. We present a case of a boy who presented to a paediatrician at 6 months of age with an episode of sepsis associated with hepatosplenomegaly. Examination revealed silvery-grey hair, eyebrows and eyelashes together with features of partial albinism with bronze coloured skin and hypopigmented macules. The patient was diagnosed with Type 2 Griscelli syndrome. He underwent a successful stem cell transplant at 2 years of age and was referred to the Dermatology Department for follow-up in view of an increased risk of skin malignancy.

Griscelli syndrome is an autosomal recessive condition with a mutation in RAB27A causing both immunodeficiency and pigmentary dilution. It is one of the many conditions causing partial albinism due to defects in melanosome biogenesis or transfer. Various other disorders of pigmentation exist and these can present with various shades of grey hair. Grey hair in the paediatric population should therefore always be worked up.

Cutaneous mastocytosis: the skin and beyond

J Sammut, L Mercieca, MJ Boffa, Department of Dermatology, Sir Paul Boffa Hospital, Malta

Cutaneous mastocytosis is the abnormal accumulation of mast cells in the skin and according to the World Health Organization classification (2016) is subdivided into maculopapular cutaneous mastocytosis, previously known as urticaria pigmentosa, diffuse cutaneous mastocytosis and mastocytoma of the skin. This presentation will give an overview of three different cases of cutaneous mastocytosis with their histological features and management. The criteria for the

diagnosis of cutaneous mastocytosis and the differences between childhood-onset and adult-onset cutaneous mastocytosis will also be discussed, highlighting the importance of excluding systemic involvement in adults.

Neither cellulitis nor eczema

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Skin metastases are reported in 0.6-10.4% of cancers and account for around 2% of skin tumours. Excluding melanoma, the commonest sources of cutaneous metastases are lung cancer in males and breast cancer in females. Skin metastasis generally heralds a poor prognosis with mean survival of around 7.5 months.

Three cases of cutaneous metastases from breast carcinoma are presented here: carcinoma erysipeloides presenting with erythema and induration, nodular metastases presenting with firm, skin-coloured nodules and a case mimicking lymphangioma circumscriptum.

Cutaneous metastases from breast cancer can present in various ways, namely nodular metastatic breast carcinoma, inflammatory metastatic breast carcinoma, *carcinoma en cuirasse*, telangiectatic carcinoma, alopecia neoplastica, metastatic mammary carcinoma of the eyelid with histiocytoid histopathology and mammary Paget's disease. With such variable presentation, a high index of suspicion is required to recognise these lesions and expedite their management.

Psoriasis and the microbiome

D Mintoff[1], F Benhado[2], B Schnebert[3], H Bing Thio[4], [1]Department of Medicine, Mater Dei Hospital, Malta, [2]Dermatology Department & [3]Medicine Faculty, Université Libre de Bruxelles, Brussels, Belgium, [4]Dermatology Department, Erasmus Medical Center, Rotterdam, The Netherlands

The Human Microbiome Project* has triggered a big interest in the scientific community for the better understanding of the role played by the microbiome in various aspects of chronic inflammatory disease. Psoriasis is a chronic inflammatory skin disorder that appears to have a microbiota distinct from healthy, unaffected skin. The aim of this presentation is to introduce the microbiome as a potential key player in the pathophysiology and treatment of psoriasis.

*Turnbaugh PJ, Ley RE, Hamady M, Fraser-Liggett CM, Knight R, Gordon JI. The human microbiome project. *Nature* 2007;**449**(7164):804.

Giving a voice to the voiceless: The creation of a dermatology-specific quality of life assessment instrument for infants and toddlers

R Corso[1], MJ Boffa[1], P Chernyshov[2], [1]Department of Dermatology, Sir Paul Boffa Hospital, Malta and [2]Department of Dermatology and Venereology, National Medical University, Kiev, Ukraine.

The use of validated health-related quality of life (HRQoL) instruments is important in the assessment of disease burden in patients. While in adults and children over the age of 4 years there are dermatology-specific HRQoL questionnaires available, regrettably there is as yet no corresponding instrument validated for assessing dermatology-specific HRQoL from birth up till this age.

A multi-centre project involving 10 European dermatology centres, including Sir Paul Boffa Hospital in Malta, is currently underway to create a validated dermatology-specific proxy instrument for the assessment of HRQoL in this neglected paediatric age group in each centre's respective language, including Maltese. The project is divided into various stages, with focus group sessions and pilot testing of the questionnaire in each centre's respective language having been completed. The resultant questionnaire is titled 'Infants and Toddlers Dermatology Quality of Life' (InToDermQoL) and is filled in by the child's parent or guardian. It comes in 3 age-specific versions: for children who are under the age of one year, for those between one and 3 years old, and for those who are 3 years or older, and consists of 10, 12 and 15 questions respectively.

Pilot testing across participating centres confirmed that the InToDermQoL questionnaire is understandable and clear whilst being internally consistent across all 3 age groups and also able to distinguish severity-related variations. Ongoing international field testing will provide further validation of this dermatology-specific HRQoL instrument for use in children up to 4 years of age.

SPECIALIST PRESENTATIONS

SESSION 1

Dry skin: is it a normal part of ageing?

Dawn Caruana, Consultant Dermatologist, St James Hospital, Malta

Dry skin in the elderly is common, and often multifactorial. Whilst some cases are mild and trivial, others may be related to important underlying systemic disease. Associated pruritus may be a feature and results in significant deterioration in quality of life. In this review, we discuss the various causes of dry skin in this population, identify instances where investigations for underlying illnesses would be indicated and provide an overview for the management of such patients.

Bullous pemphigoid and the elderly

Michael J. Camilleri, Associate Professor of Dermatology, Mayo Clinic, USA

Bullous pemphigoid (BP) is the most common autoimmune mucocutaneous blistering disorder, characterised by the production of autoantibodies against the hemidesmosomal basement membrane zone proteins, BP 180 and BP 230. It most commonly affects the elderly, usually above the age of 60 years. The incidence of BP has been increasing and is accompanied by an increase in mortality, usually from sepsis or dementia. It is associated with an increased incidence of neurodegenerative disorders, such as dementia, Parkinson's disease, multiple sclerosis and seizures. It may be induced by several medications, including loop diuretics, spironolactone, neuroleptics, dipeptidyl peptidase 4 inhibitors (or gliptins) used in diabetes mellitus and the PD-1 and PDL-1 checkpoint inhibitors used in cancer therapy.

BP classically presents with tense blisters, accompanied by erythematosus, urticarial plaques, usually starting in the intertriginous areas and spreading to become more generalised. However non-bullous presentations of pemphigoid, including urticarial, eczematous and pruritic variants have been increasingly recognized. Non-inflammatory presentations have also been described in BP, especially associated with the use of gliptins. These atypical non-bullous variants of BP often times result in delay of diagnosis. The diagnosis of any form of BP is confirmed by immunopathological studies on skin biopsies and serum. Direct immunofluorescence studies on skin biopsies will show the characteristic linear basement membrane zone deposition with IgG and complement C3. Indirect immunofluorescence studies on serum will demonstrate a circulating basement membrane zone antibody with an epidermal pattern on salt-split skin substrate. ELISA testing for antibodies against BP 180 and BP 230 in serum will be positive. Treatment of BP is dependent on the severity and the extent of disease and ranges from topical high potency and systemic corticosteroids, doxycycline, dapsone, immunosuppressive agents, intravenous immunoglobulin, omalizumab and rituximab.

Acne treatment in children and adolescents

Sue Aquilina, Consultant Dermatologist, Sir Paul Boffa Hospital, Malta

Acne affects most teenagers, often starting in early adolescence, and can have a profound impact on their self-esteem and quality of life. Treatment should be guided by acne type and disease severity. Topical retinoids are the foundation therapy, acting mainly on comedones and precursor lesions, and are also very useful for maintenance treatment. Oral antibiotics are the standard treatment for moderate to severe inflammatory acne, but tetracyclines are contraindicated in children under 8 years of age due to their effect on teeth development. Oral antibiotics should be limited to the shortest duration possible, with review after 3-4 months. Benzoyl peroxide helps to reduce bacterial resistance to topical and oral antibiotics. Hormonal therapy with a combined oral contraceptive may be useful as second-line therapy in pubertal females with moderate to severe acne. Oral isotretinoin is recommended for severe, scarring,

and/or refractory acne in adolescents and may be used in younger patients. Acne in mid-childhood is very uncommon and should trigger a search for underlying pathology.

Update on hidradenitis suppurativa/acne inversa

Christos C. Zouboulis, Director, Departments of Dermatology, Venereology, Allergology and Immunology, Dessau Medical Center,Brandenburg Medical School Theodor Fontane, Dessau, Germany

Hidradenitis suppurativa/acne inversa (HS) is a chronic, inflammatory, recurrent, debilitating skin disease (of the terminal hair follicle) that usually presents after puberty with painful, deep-seated, inflamed lesions in the apocrine gland-bearing areas of the body, most commonly the axillary, inguinal, and anogenital regions (Dessauer definition). Diagnosis is made according to established clinical criteria. Follicular occlusion due to hyperkeratosis, regardless of disease duration, leading to occlusion of the apocrine gland with subsequent follicular rupture, inflammation and possible secondary infection is the initial pathogenetic course. A global HS prevalence of 1% has been recorded in Europe. The current mean duration between onset of the disease and diagnosis is 7.2 years. Male gender correlates with disease severity, while smoking, obesity and metabolic syndrome are recognized as trigger factors. Bacteria regulate the innate immunity but HS is not an infection. HS ranks on the top among all dermatological diseases regarding stressfulness and reduction of quality of life. The involvement of anatomic regions is statically evaluated by the Hurley grading and the dynamic severity by the new International HS Severity Score System (IHS4). Follicular occlusion disorders, inflammatory bowel diseases, spondylarthropathy, other hyperergic diseases, genetic keratin disorders associated with follicular occlusion and squamous cell carcinoma are the most common HS comorbid diseases.

The European S1 guideline for the treatment of HS suggests that the disease should be treated based on its individual subjective impact and objective severity. Locally recurring lesions can be treated by classical surgery or LASER techniques, whereas medical treatment either as monotherapy or in combination with radical surgery is more appropriate for widely spread lesions. The rapid development of new aspects has led to an ongoing revision: First line medical therapy may include a combination of systemic antibiotics (clindamycin plus rifampicin) or monotherapy, tetracycline or acitretin. The anti-TNF agent adalimumab represents the only second line approved treatment for moderate to severe HS in adults with an inadequate response to conventional systemic HS treatment. Weight loss and tobacco abstinence are adjuvant measurements, proven to improve the severity of HS as independent factors.

SESSION 2

Skin infections in the elderly

Godfrey Baldacchino, Resident Specialist in Dermatology, Sir Paul Boffa Hospital, Malta

With advancing age one is more prone to experience health problems. This includes the risk of developing skin infections. Certain fungal, bacterial and viral infections are encountered more often in the elderly. Intertrigo, onychomycosis, infected ulcers, cellulitis and shingles are a few examples. Multiple factors such as xerosis, other medical conditions, immobility, nutritional status and gradual waning of the immune status may contribute to the increased frequency of such infections in old age. One must obtain an accurate diagnosis for the best management of such infections. To do so, requires clinical acumen with awareness of some caveats in addition to clinical and laboratory investigations. Treatment of these conditions can generally be started immediately and if need be adjusted according to the results of the investigations performed.

Keeping up appearances

Eileen Borg Resident Specialist in Dermatology, Sir Paul Boffa Hospital, Malta

The skin is an important component of outward beauty and health and is considered a principal factor representing overall "well-being", however skin ageing is an inevitable biological phenomenon of human life. It results from age-dependent decline of cell function known as *intrinsic ageing* or it may be accelerated from cumulative exposure of environmental factors known as *extrinsic ageing*. The latter include sun exposure especially UV radiation, smoking and pollution and these may all lead to premature ageing of skin as shown by signs of wrinkling, sagging and laxity. Dermatologists and cosmetic surgeons have various strategies and tools to advise and give their patients means to "keep up appearances". These include preventive measures, cosmetic procedures, topical and systemic therapeutic agents and invasive procedures.

Clues to diagnosis of malignant skin lesions in the young and old

Elaine Agius, Consultant Dermatologist, Frimley NHS, UK & St Anne's Clinic, Malta

Dermoscopy is a useful technique for diagnosing melanocytic naevi, but the clinician should take into consideration additional factors such as change in naevus pattern with patient age to optimise the management of suspicious lesions. Melanocytic naevi can occasionally manifest clinical features resembling melanoma, and the presence of such naevi in children can elicit anxiety. Melanoma in childhood is however rare, and appears more commonly either in association with a congenital nevus, or with Spitzoid features than *de novo*. Congenital melanocytic naevi carry a higher risk of melanoma development as compared with common naevi. The risk of melanoma is proportional to the naevus size; thus, particular attention should be paid to large congenital naevi. Childhood melanoma often lacks the classical features of pigmented melanoma, and it is more often an amelanotic and nodular lesion.

The number of melanocytic naevi decreases after the fourth decade of life, and therefore elderly patients usually present with few, mainly harmless intradermal naevi. Any newly developing, growing, or large melanocytic skin lesion in elderly patients should raise the suspicion of melanoma or nonmelanoma skin cancers. Similarly signs of actinic damage or the

presence of suspicious skin lesions at visible body sites, such as the face or forearms, should be considered important risk factors for additional melanoma or nonmelanoma skin cancer and therefore examination of generally uncovered body sites, such as the torso is crucial.

Nutrition & acne

Christos C. Zouboulis, Director, Departments of Dermatology, Venereology, Allergology and Immunology, Dessau Medical Center, Brandenburg Medical School Theodor Fontane, Dessau, Germany

Nutrition may play a critical role in the manifestation and management of inflammatory pilosebaceous disorders. There is rich potential for insight into the impact of dietary effects on the pathophysiology of inflammatory pilosebaceous disorders, especially in acne vulgaris. Several external and internal factors, including air pollution, aggressive skincare products, medication, mechanical, hormonal and familial factors and, more recently, lifestyle and stress, have been suggested as having an impact on acne. Moreover, for many years nutrition was believed to cause or worsen acne. Over the last decades, however, it has become a dermatological doctrine that there is no direct association between diet and acne. Even if recent research has allowed to identify certain nutritional elements and behaviour that may have an impact on acne, including the excessive intake of dairy products and hyperglycaemic food, modern lifestyle nutrition, obesity and eating disorders, knowledge about the role of nutrition in the physiopathology of acne still remains sparse and hypotheses and myths continue to dominate the debate. Thus, clinical and translational research is necessary to investigate and confirm the association between nutrition and acne. Western diet may influence acne vulgaris by increasing insulin and modulating FOX01/mTOR, resulting in over-expression of cytokeratins, hyperproliferation of keratinocytes, and hypercornification of the follicular wall but current research has shown that the association of nutrition and acne is reasonably complicated and has led to controversial results.

Saturday 27th October

SPECIALIST PRESENTATIONS (contd.)

SESSION 3

Nuances and confusing terminology in skin histopathology reports

Alexandra Betts, Consultant Histopathologist, Mater Dei Hospital, Malta

The majority of histopathology reports are issued with a conclusive, definite diagnosis. Such reports enable clinicians to treat patients with a high degree of confidence that their patient's disease has been accurately and definitely diagnosed. In a substantial number of cases however, there is a varying degree of uncertainty in the proffered diagnosis. This may be due to

a number of causes which include limited biopsy material, artefact, unusual histological features, unexpected or ambiguous special stain and/or immunohistochemical results, insufficient clinical information and lack of diagnostic experience. In dermatopathology uncertainty most often, but not exclusively, occurs in inflammatory dermatoses, where considerable histological overlap is seen between clinically distinct diseases. Histopathologists use a variety of phrases in order to communicate such diagnostic uncertainty in their reports. There is no accepted standardised way of communicating uncertainty to clinicians and different pathologists use different phrases to transmit the level of uncertainty present in their reports. This has led to histopathology reports being interpreted differently than the pathologist intended. Better communication between pathologists and clinicians, and, possibly, use of a limited number of ideally pre-agreed terms to describe the degree of uncertainty in reports may help to reduce, but unfortunately not completely eliminate, ambiguity and misunderstanding.

Tangas & panties – The STIs spectrum

Valeska Padovese, Consultant Dermato-Venereologist & Head of Genito-Urinary Clinic, Mater Dei Hospital, Malta

Adolescents and young people are particularly vulnerable to poor sexual health outcomes of high rates of sexually transmitted infections (STIs) and unwanted pregnancy. Risk factors comprise higher rates of sexual partner change and poor levels of contraception, including condoms. Older adults continue to be sexually active in their later years. A range of STIs and HIV infection have been reported among older adults. Psychosocial changes (e.g., loss of partner or spouse and re-entering the dating scene) and risky sexual behaviours, including no or infrequent use of condoms, are listed as co-factors.

GU clinic data from 2015 to 2018 reveal that 1155 adolescents and young adults (YAs= <21 years) attended the service, the 50.9% were females, 80% heterosexual. The most common STIs diagnosed were ano-genital warts (15.3%), chlamydia (8.4%), gonorrhoea (3%) and mycoplasma genitalium (2.9%). In the same period, 240 patients over the age of 60 attended the service (age range 60-85), the 85% were males, 75% heterosexual. The most common STIs diagnosed were ano-genital warts (12.5 %), syphilis (5.4%), genital herpes (2.9%) and chlamydia (2.5%). Two new HIV diagnoses were recorded.

Sexual education programmes that explicitly target adolescents and YAs are needed. Tailored programmes can help this particularly vulnerable age group to develop healthy sexual behaviours and decrease their HIV/STI risk. Screening of adults for STIs/HIV should occur regardless of age. One way of contributing to breaking down barriers and taboos is undoubtedly to ensure that physicians are willing to discuss their patients' sexual history.

Mycoplasma genitalium: hype or should we worry?

Philip Carabot, Consultant Genito-Urinary Physician, St James Hospital, Malta

Mycoplasma genitalium was only discovered in 1980. In this short period it has emerged as a major STI with serious complications and increasing prevalence. Most importantly it is proving increasingly difficult to treat showing resistance to different antibiotics. Yet it remains the least known amongst medical practitioners. A brief review of the latest guidelines will attempt to redress the balance

The impact of chronic skin disease on child development

Chris Sciberras, Consultant in Neuro-Developmental Paediatrics, Mater Dei Hospital, Malta

Infancy, childhood and adolescence, each have their respective neuropsychological developmental stages that can be uniquely impacted by differences in cutaneous physical appearance. From early infancy until 3 years of age, self-image is shaped by the strength of the attachment between the child and his or her caregivers. The bond between infants and caregivers can be affected by the emotions parents have about having a child with a skin disorder. From 2 to 10 years of age, relationships with peers increase in importance and children may encounter teasing and bullying. During this critical time, children develop their body image and by 7 years of age, children are able to recognise aesthetic differences between themselves and their peers. This recognition of physical differences can influence self-esteem but even so, the early school-age years are marked generally by positive self-perception and optimism. During teenage years, children generally have lower self-esteem and are more pessimistic and self-critical. During the school-age years and beyond, self-esteem manifests outwardly through children's motivation, confidence, and resilience. More research on the impact of dermatological conditions on the growth of children and adolescents is required; stress, sleep disturbance and long-term chronic topical and systemic steroid therapy, being the most common factors involved in the growth discrepancy of these children.

Modern management of infantile haemangiomas

Michael Boffa, Consultant Dermatologist, Sir Paul Boffa Hospital, Malta; President MADV

Infantile haemangiomas (IHs) are the most common vascular tumours of infancy, occurring in 4.5% of babies in a recent large prospective study in the United States. Clinical variants include congenital, segmental and multifocal forms, with or without extracutaneous involvement. Although the natural history of IHs is of spontaneous involution following a proliferative phase, resolution may be incomplete and complications may sometimes occur; these include functional impairment, ulceration and disfigurement, particularly with larger lesions.

Until recently, the available treatment options for IHs including corticosteroids, interferon, vincristine, imiquimod and physical therapies were unsatisfactory. Treatment of IHs with propranolol was first reported in 2008 and has since become the first choice for cases requiring intervention. It is generally effective and well-tolerated. Postulated potential mechanisms of action include pericyte-mediated vasoconstriction, inhibition of vasculogenesis, catecholamine-induced angiogenesis and downregulation of the renin–angiotensin–aldosterone axis. This

presentation will give an overview of the clinical features and diagnosis of IHs and discuss management with reference to the latest guidelines. The use of propranolol will be presented in detail including indications and contraindications for starting treatment, pre-treatment investigations, starting and target dose, monitoring for adverse effects, and how to stop treatment.

SESSION 4

Prescribing in children
Anne-Marie Cassar Flores, Clinical Pharmacist, Neonatal & Paediatric Intensive Care Unit, Mater Dei Hospital, Malta

Prescribing medications for children is often challenging. Although the decision for choosing a drug may be straightforward, determining the dosage can be more difficult. Paediatric patients comprise a wide age range, from preterm infants to adolescents and young adults. Changes in the body, physiology and organ maturation have a significant impact on drug pharmacokinetics and on establishing the appropriate dose for the required dosage form in paediatric patents. Often, children cannot take medication in tablet form, therefore the most appropriate route must be determined. Since most medicinal products are not currently available in formulations suitable for administration to children, healthcare professionals frequently need to resort to the preparation and administration of off-license formulations by manipulation of adult dosage forms.

The need for individual patient dosing and the unavailability of suitable dosage forms for children increase the potential for medication errors. Prescribers face multiple challenges when prescribing for children. Understanding and addressing these challenges may help to reduce medication errors and improve the appropriateness and safety of prescribing in paediatric patients.

The impact of dermatological treatment in childhood and adolescence
Mark Buttigieg, Consultant Paediatrician & Paediatric Endocrinologist, Gozo General Hospital, Malta

Children and adolescents may present with a variety of acute and chronic dermatological conditions. The approach to the management of these conditions in this patient cohort must be age-appropriate as children are not young adults from a physiological and cognitive perspective. The doctor-patient relationship over the years changes from being parent-oriented in childhood to a more direct patient contact in teenage patients resulting in improved patient understanding of their condition and treatment compliance.

Any acute or chronic condition will have an impact on childhood growth if the disease is not controlled. Dermatological treatment particularly the use of glucocorticoids, in itself may

influence childhood growth and well-being and may cause hypothalamic-pituitary-adrenal axis suppression in the short or long-term. Dermatologists must therefore find a balance between disease control, maintenance of growth and drug treatment choices.

Prescribing in older people: When to stop, when to start, should all doctors just lose heart?
Anthony Fiorini, Consultant Geriatrician & Clinical Chairperson, Department of Geriatrics, Malta

Writing out a prescription for an older patient can be viewed as a challenging task. Whilst older people should not be denied a recommended medication just because they are old, on the other hand it is known that this same medication can precipitate an adverse outcome in a frail, vulnerable patient or may even no longer be indicated in a very dependent, institutionalised patient, with limited life expectancy. Therefore, decisions to prescribe or even to de-prescribe medications have to take into consideration the fitness or frailty status of an older patient and the severity of such frailty if present.

Today, tools exist to help resolve challenging clinical scenarios. Aids to gauge frailty are available whilst prescribing guidelines have been published in the form of the STOPP (Screening Tool of Older Persons' Prescriptions), the START (Screening Tool to Alert to Right Treatment) and the more recent STOPPFrail (Screening Tool of Older Persons' Prescriptions in Frail Adults with limited life expectancy) criteria - hence the title of this presentation. These user-friendly tools, easily accessible and regularly updated, certainly help to weigh benefits versus risks, to avoid drug-drug interactions and to cut down on the number of prescriptions. They are even more useful if a clinical pharmacist is present, for example on ward rounds, to assist in the formulation of the right prescription.

In conclusion, prescribing for older people is not so daunting if thought out properly, taking into consideration their fitness/frailty status and using recommended clinical tools and pharmacists for guidance. Doctors should, therefore, not lose heart and should, I hope, with more confidence now depart!

In a Syrian refugee camp - from Deir Az Zawr to Al Zaatari
Joe Pace, Consultant Dermatologist; Past President MADV

Deir az Zawr has important connotations for me since the first work on non-venereal syphilis was carried out there by E H Hudson. This was confirmed in Iraq in 1953 by George Csonka who much later became a much-appreciated adviser and co-worker in my research on endemic syphilis in Saudi Arabia in 1978-83. Little did I know that so many years later, I myself would be meeting and caring for people from a now bombed out Deir az Zawr in Al Zaatari camp.

In August 2017, an international appeal was made by Prof Clare Fuller (Chair IFD) to support a call for volunteers to join a medical mission to the Syrian refugee camps in Jordan with an

emphasis on Dermatology. This was organised by SAMS (Syrian American Medical society) and scheduled for January 2018.

Given my experience in the Middle East (5 years in Saudi Arabia) and a working knowledge of colloquial Arabic, a current part time practice which enables me to up and go in a short time, and a long-standing wish to give a hand in my advancing years, I applied 24 hours later hoping that my age would not be held against me! I was accepted and in January this year proudly joined a multinational team as the sole representative of European dermatology. An Italian colleague also applied and joined a later group.

This presentation will illustrate my experiences (good and not so good) that included working at the Al Zaatari refugee camp that two years ago numbered 100,000 persons and then…they stopped counting. The stress of seeing patients and not having even the most basic investigatory tools, the practical impossibility of doing a skin biopsy, and the severe limitations of available treatment all made for serious reflection on my part. These topics came up strongly in discussion with the patients and their representatives with their reply: *"Whether you cure us or not is not the whole matter! What really matters to us is that you unselfishly came, and doubtlessly gave your best. When we go to bed at night, we know that we have not been forgotten as can very easily happen, but that somebody has thought of us. Thank you and please come back"*. I will. I believe that I personally received much more than I gave from this wonderful moving experience that makes one reflect, again and again.

"One last thing before I go" - dermatology in general practice
Martina Aquilina, Specialist in Family Medicine, Malta

In the UK, GP consultations are mainly 10-minute slotted appointments for a single presenting complaint. On the contrary, here in Malta, our consultations feel more like disorganised shopping lists! Dermatology conditions may occasionally be the primary complaint to our practices, but repeatedly are referred to by the patient as those 'spots' he/she remembers on the way out of the door; the ones too embarrassed to mention upfront. This is usually due to some conditions carrying a "taboo" associated with them, being confronted by a new doctor, or for it being in an awkward place. Occasionally, an obvious severe case of a skin condition goes unmentioned during the consultation, which one feels an obligation to highlight.

This is what it is really like to work in general practice – unpredictable. Together with generally unprepared consultations, overwhelmed with people impatiently waiting outside our door, details related to skin manifestations can often go unmentioned. Our role as general practitioners is to make sure those missing details are carefully filled by our attention, clinical acumen and examination, moreover, correctly managing and highlighting the cases needing specialist care.

Blistering disorders in the paediatric population

Michael J. Camilleri, Associate Professor of Dermatology, Mayo Clinic, USA

Blistering disorders in children are a fairly common presentation of dermatological disease in this age group. These disorders usually will present with fluid-filled blisters, which may contain clear fluid as in linear IgA blister dermatosis, cloudy purulent fluid (pustules) as in a neonatal pustular melanosis or blood as in vulvar lichen sclerosus. However, since the blisters are usually fragile, many times these disorders will present with erosions or ulcerations of the skin, in the location where the blisters were previously present as is seen in staphylococcal scalded skin syndrome, epidermolysis bullosa congenita and toxic epidermal necrolysis. Blistering disorders in children may be common and self-resolving such as neonatal erythema toxicum neonatorum, miliaria crystallina, neonatal pustular melanosis and sucking blisters, common and easily treatable such as herpes simplex infection and bullous impetigo and rare, but serious such as epidermolysis bullosa congenita especially the junctional and the dystrophic varieties, staphylococcal scalded skin syndrome, autoimmune blistering disorders especially linear IgA bullous dermatosis, and Stevens Johnson syndrome/ toxic epidermal necrolysis.

The diagnosis for the cause of blistering disorders in children is based on the age and clinical presentation and specific confirmatory diagnostic tests. Often times the diagnosis is based on the clinical presentation without the need of any specific diagnostic tests as in erythema toxicum neonatorum, neonatal pustular melanosis, miliaria crystallina, and sucking blisters while others require specific diagnostic tests especially a skin biopsy as in linear IgA bullous dermatosis and other autoimmune blistering disorders, Stevens Johnson syndrome/toxic epidermal necrolysis, and staphylococcal scalded skin syndrome, as these are serious disorders that require specific and timely treatment.

PATIENTS' SYMPOSIUM

Quality of life in skin disease

Liam Mercieca, Resident Specialist in Dermatology, Sir Paul Boffa Hospital, Malta

Skin diseases such as psoriasis and eczema are associated with a significant impairment in the patient's quality of life. This presentation targets a wide audience including patients with skin diseases, relatives, medical professionals and the general public. Understanding the way skin diseases affect relationships, jobs, self-confidence and mental well-being is essential. Patients and medical professionals should discuss the disease impact on each individual's quality of life to manage their skin problems in a holistic manner. Nowadays, there are many tools and modalities to help patients cope with chronic skin diseases. This patient symposium will include talks on real patient experiences and provide a platform for patients to share their own thoughts and experiences. Joining local patient-led support groups such as the Psoriasis Association of Malta and the Malta Eczema Society is to be encouraged. Our goal is to create an alliance between patients, relatives and caregivers to support themselves and others with chronic skin diseases and increase awareness amongst the general public.

Advances in treatment of eczema and psoriasis

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The improvement of the treatment of inflammatory skin diseases has been a major target of current dermatotherapy research as counterpart to the impressive therapeutic advances in dermato-oncology. The psoriatic disease (psoriasis vulgaris, psoriatic arthritis and associated comorbid disorders) results in significant disability and socioeconomic burden and has been selected as target of the modern treatment modalities relatively early. The past three decades have witnessed remarkable advances in targeting specific elements of the immune and inflammatory response, fueled by advances in both biotechnology and disease knowledge. Psoriasis treatments range from topical treatments and phototherapy to oral systemic medications and injections. Mild-to-moderate psoriasis treatments include topicals, localized phototherapy, and newer therapies combining two types of topicals, phototherapy with topicals, and easy-to-use foam and spray vehicles. Moderate-to-severe psoriasis therapies include monotherapy or various combinations of generalized phototherapy, oral treatments, and biologic agents. Small molecules (dimethyl fumarate, apremilast) have completed the group of classical first line oral treatments. Targeting biomarkers for therapeutic benefit has become a promising field. Initially, Tumor necrosis factor (TNF)α receptor antagonist (etanercept) and TNFα inhibitors (infliximab, adalimumab) and currently biologic agents targeting the T-helper 17 axis, directed towards interleukin (IL)-17 (secukinumab, ixekizumab, bimekizumab), IL-17 receptor (brodalumab), IL-12/23p40 (ustekinumab, briakinumab) and IL-23p19 (guselkumab, tildrakizumab) as well as Janus kinase inhibitors (tofacitinib, ruxolitinib) are highly effective compounds with a positive safety profile. Lately, atopic dermatitis treatment has also experienced the introduction of new compounds based on emerging knowledge of the pathogenesis of the disease. The topical phosphodiesterase inhibitor crisaborole and the systemic inhibitor of the IL-4 receptor α subunit (IL-4 and IL-13 signaling inhibitor) dupilumab have currently been approved for the treatment of atopic dermatitis.