MALTESE ASSOCIATION OF DERMATOLOGY & VENEREOLOGY

DERMFEST 2019 – UPDATE IN DERMATOLOGY & GENITO-URINARY MEDICINE

THE PALACE HOTEL, SLIEMA

Abstracts

FRIDAY 29th NOVEMBER

PATIENTS' EVENT

Treatment of skin disease - New approaches in 2019

Razvigor Darlenski, Associate Professor in Dermatology & Venereology, *Department of Dermatology & Venereology, Acibadem Cityclinic Tokuda Hospital, Sofia, Bulgaria*

Dermatology is an active field of development of new therapeutic agents. The main reasons for this are the social burden of skin diseases, the advantages of topical therapy and the introduction of novel biologic and non-biologic drugs.

Nowadays about 5% of all diseases are treated by biologic therapies. Psoriasis and atopic dermatitis are a field for investigation and application of these new agents. In addition, there is still space for implementation of novel topical drugs. We review the novel biological agents for inflammatory skin diseases as well a special focus is set on other novel therapeutic options such as JAK and phosphodiesterase inhibitors.

A certain progress has been witnessed in cutaneous oncology in the treatment of metastatic and inoperable skin tumors by biologic agents. We discuss novel therapeutic options in this field.

SATURDAY 30th NOVEMBER

TRAINEE PRESENTATIONS

Blisters in diabetics: An increasingly common encounter

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

We are all aware of the increased risk of skin disease amongst diabetics. Over the past 2 years we have seen a surge in diabetics presenting with pruritus and bullae and having a positive serological and/or histological diagnosis of bullous pemphigoid. Diabetes mellitus is a risk factor for bullous pemphigoid but, in our cohort of 14 patients, dipeptidyl peptidase-4 inhibitors (DPP4Is) were started in the previous months (range: 6-28 months). Moreover, upon cessation of the DPP4I, symptoms almost always improved or resolved completely.

In the literature, DPP4Is have increasingly been identified as causative agents of bullous pemphigoid. Drugs should always be considered as possible aetiological factors for skin disease. Physicians should have a low threshold for investigating diabetics who present with unexplained pruritus, erythema and bullae, especially if these patients are on DPP4Is.

Not as smooth as silk

D Gamoudi, A Schembri, V Padovese, Genito-Urinary Clinic, Mater Dei Hospital, Malta

Genital ulceration is a common presentation to GU physicians and dermatologists alike. Genital ulcers may be caused by infectious or non-infectious aetiologies. The differential diagnosis of these lesions is very broad and the causes can be multifactorial. We present a case of a chronic persistent genital ulcer and review the salient clinical, diagnostic and therapeutic considerations.

Our work within the European Hidradenitis Suppurativa Foundation

D Mintoff, S Aquilina, Department of Dermatology, Sir Paul Boffa Hospital, Malta

Hidradenitis Suppurativa (HS) is a “Cinderella” condition which has recently been adopted by Dermatology. In this talk we discuss findings of a multicenter, cross-sectional study of more than 2000 patients suffering from HS and co-morbid pilonidal sinus disease. We also present work focused on familial HS in which we identify associations between gender, phenotype and disease severity. Finally, we present results from a study aimed at establishing the HS disease severity scoring system with best inter-rater reliability.

Which primary melanomas lead to metastasis in Malta?

K Mercieca, L Mercieca, S Aquilina Department of Dermatology, Sir Paul Boffa Hospital, Malta

Aim: There are currently no studies looking specifically at the characteristics of the primary melanoma in patients who died of metastatic melanoma in Malta. This retrospective study gives an overview of the epidemiology of melanoma mortality in Malta and looks at the demographics and characteristics of the primary melanoma in this population.

Method: Mortality data secondary to metastatic melanoma between 2007 and 2016 was gathered from the Malta National Cancer Registry. All patients whose death certificates had metastatic melanoma as the cause of death were included in this study. Further data on histology and imaging was gathered from the hospital electronic database when available.

Results: There were 87 recorded deaths (45 males and 42 females) in Malta secondary to metastatic melanoma between 2007 and 2016, with an average age at diagnosis of 64.3 years (range 23-92 years), average age at death of 67.9 years (range 28-96 years) and an average duration of survival after diagnosis of 34.7 months (range 1-180 months). The primary melanoma was identified histologically in only 54 cases (62%); the remaining cases had confirmed metastatic melanoma on histology and imaging, but no cutaneous, ocular or mucosal primary melanoma could be identified. The commonest histological subtype of the primary cutaneous melanoma was nodular (39%), followed by superficial spreading (30%) and acral (22%) melanoma. The commonest site for the primary cutaneous melanoma was the back, followed by the legs, hands and feet (acral). The Breslow thickness was available in 49 cases (56%); the mean Breslow thickness was 4.23mm (range 0.3-13mm). Ulceration was noted to be present in 21 cases. A sentinel lymph node biopsy result was available for 30 cases (34%) - 28 of the cases were positive while two were negative. The commonest sites of metastases were distant lymph nodes, followed by the skin, liver and lung.

Conclusion: Mortality secondary to metastatic melanoma is prevalent in the over 60 age group with the back being the commonest site of the primary melanoma. Melanoma screening and prevention campaigns would benefit to help identify higher risk groups and educate patients on mortality risk based on local data.

Nutritional biomarkers in patients with venous leg ulcers: a case-control study

D Micallef[1], C Agius[2], I Brincat[2], M Gruppetta[3], G Buhagiar[2], K Cassar[4], MJ Boffa[1], [1]Department of Dermatology, Sir Paul Boffa Hospital, [2]Department of Pathology, [3]Department of Diabetes & Endocrinology, [4]Department of Vascular Surgery, Mater Dei Hospital, Malta

Venous leg ulcers are very commonly encountered in clinical practice. Vitamin C plays a vital role in wound healing and there have been reports regarding the role of vitamin D in this process.

The principal aim of this study was to investigate for a significant difference in plasma total ascorbic acid and serum 25-hydroxy-vitamin-D status in a cohort of ambulatory non-hospitalised patients with venous leg ulcers as compared to an age and sex-matched control population without venous leg ulcers. Serum C-reactive protein (CRP) and albumin levels, being markers of inflammatory response, were also measured and compared to assess for any difference in background inflammation. Secondary aims were to characterise the different populations with respect to various factors, including age, sex, weight, nutritional problems, smoking, alcohol intake, presence of comorbidities and assess for any significant difference in the measured markers based on such factors.

41 individuals with venous leg ulcers were compared to 42 control subjects. There was no significant difference between the two groups in age, sex, smoking status, alcohol intake or comorbidities except for a past history of deep vein thrombosis which was present in 13 cases with venous leg ulcers. There was no significant difference in vitamin C or D levels between cases and controls even when ulcer size or duration were taken into consideration. Furthermore there were no significant differences between severity of deficiency of the two vitamins across both groups.

While vitamin C or D are both important in wound healing it appears that other factors, namely deep venous insufficiency and obesity are more commonly associated with venous leg ulcers and should be given due attention.

The diagnosis at your fingertips

MM Boffa, N Calleja, MJ Boffa, Department of Dermatology, Sir Paul Boffa Hospital, Malta

Introduction and Aims: The finger-prick sign results from self-monitoring of blood glucose (SMBG) using finger-stick blood sampling and is a useful clinical clue that a patient has diabetes mellitus (DM). This study aimed to define the prevalence and clinical features of the finger-prick sign in DM patients.

Methods: We studied 105 DM patients attending a hospital diabetes clinic (n = 44) or dermatology outpatients (n = 61) who performed SMBG at least once daily, and 105 age- and sex-matched controls, looking for typical prick marks on their fingers.

Results: A positive sign, defined as two or more prick marks, was noted in 88 participants (84%), with strong positive correlation between daily SMBG frequency and number of prick marks observed, $r = 0.723$, $p < 0.0001$. Prick mark numbers were highest for the ring followed by the little, middle and index fingers and lowest for the thumb, with significant variation between the different fingers ($p < 0.0001$). They were commoner on the non-dominant compared to the dominant hand ($p < 0.0001$). Finger-prick marks were not seen in any of the controls.

Conclusion: The finger-prick sign is positive in most persons with DM who perform SMBG, especially in those who test more frequently. It is a clinically useful pointer to DM, particularly in emergency situations when a person's medical history is unobtainable, such as during a hypoglycaemic event or other states of impaired consciousness.

SPECIALIST PRESENTATIONS

SESSION 1

Hair disorders - what's new?

Dawn Caruana, Consultant Dermatologist, St James Hospital, Malta

This presentation will focus on some important advances in the diagnosis and management of various hair disorders, namely alopecia areata and androgenetic alopecia. We will explore systematic reviews published over the past year with a relevance to clinical practice. This will also include a discussion on old treatments and ones that are being developed.

Case histories in Infectious Diseases

Charles Mallia Azzopardi, Consultant in Infectious Diseases, Mater Dei Hospital, Malta

The presentation will consist of a number of short case histories illustrating the overlap between Infectious Diseases and Dermatology.

Systemic drug reactions with skin involvement: Stevens-Johnson syndrome, toxic epidermal necrolysis and DRESS: controversial aspects

Razvigor Darlenski, Associate Professor in Dermatology & Venereology, *Department of Dermatology & Venereology, Acibadem Cityclinic Tokuda Hospital, Sofia, Bulgaria*

The skin is often affected in adverse drug reactions. Although the majority of cutaneous adverse drug reactions are benign and self-limiting, Stevens-Johnson syndrome (SJS), toxic epidermal necrolysis (TEN), and drug rash with eosinophilia and systemic symptoms (DRESS), affecting multiple organs and systems, are potentially fatal. Many organs can be affected, including the mucosal membranes, gastrointestinal tract, liver, lungs, kidneys, and eyes. We discuss the causes, pathophysiologic aspects and main clinical features of SJS, TEN and DRESS as systemic diseases with skin involvement. Controversial remains the question on the adequate

management of these conditions in dermatology. We review the therapeutic options and the treatment algorithm of these severe cutaneous drug reactions.

SESSION 2

Meeting the GODs (Giants of Dermatology)

Joseph Pace, Consultant Dermatologist; Past President MADV

In 48 years of Dermatology I have had the privilege to know personally many eminent dermatologists from the four corners of the globe. As my final curtain draws ever nearer, it is my privilege today to honour a small representative group of these colleagues who by their scientific, clinical, and above all human qualities singled them out as… GIANTS OF DERMATOLOGY. Some I admired as a young dermatology trainee in clinical meetings all over the UK, others I met later in various international congresses especially the annual meetings of EADV and AAD, the World Congresses, and in several national society meetings. The hand of friendship was inevitably extended and help with difficult clinical problems was always on offer. We became good friends, with many visiting our island to participate in one or more of the several academic meetings I have been involved in, be it MaltaDerm or RheumaDerm, the First EADV Spring Meeting, First IACD World Congress, the IUSTI European Congress, and two Dowling Club visits. Some were delighted to be elected honorary members of our fledgling MADV!

Today I shall endeavour to introduce you to my Giants team, men and women who by their scientific rigour, clinical acumen, and continuing devotion to Dermatology were among the many who strove successfully against difficult odds to make our specialty what it is today. Many have since passed away and I reminisce with a few who are still around.

Meet my choices of Giants of Dermatology …

The mind and the skin

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

Links between the psyche and the skin have long been recognised and the skin has been described as ‘the mirror of the mind’. Psychological factors are important in a significant proportion of patients presenting for a dermatological opinion. These include those with conditions that are primarily psychiatric but which often present to a dermatologist (e.g. delusional infestation and body dysmorphic disorder), factitious skin disease (e.g. dermatitis artefacta), dermatoses caused or aggravated by harmful habits and compulsions (e.g. nodular prurigo and trichotillomania), and dermatoses in which there may be emotional precipitating or

perpetuating factors (e.g. alopecia areata and psoriasis). Management of psycho-cutaneous disease is frequently challenging; many patients resist referral to a psychiatrist but may be more amenable to accept help from a psychologist. This presentation will give an overview of the main psycho-cutaneous conditions seen in clinical practice, include clues to making a correct diagnosis and provide some tips on management.

Acute presentations of Genito-Urinary Medicine for the general physician

Colm O'Mahony, Countess of Chester NHS Trust, UK

"By the way Doc I also have a problem down below", may not be the words you want to hear during a medical consultation! However, rather than dispatch this 'red herring' off to a GUM clinic it can be worthwhile to at least have a look. You might be surprised and the patient will appreciate your care.

Opportunities for quality improvement in Dermatology

James Clark, Consultant, Clinical Risk Management Unit, Mater Dei Hospital, Malta

Although predominantly outpatient based, the delivery of Dermatology services must also respond to a changing healthcare environment that puts a strong emphasis on quality, innovation and patient safety. Applying a failure mode analysis to the Donabedian model of quality care delivery can help shed light on potential opportunities for quality improvement in Dermatology practice that may help address the challenges of a rising demand and higher expectations from the people who fund our health services: the patients.

Dermoscopy: Indications other than pigmented lesions/skin cancer

Dimitrios Ioannides, Professor of Dermatology-Venereology, Aristotle University Medical School; Head, 1st Department of Dermatology-Venereology, Hospital of Skin and Venereal Diseases, Thessaloniki, Greece

Although traditionally used for evaluation of skin tumors, dermoscopy continuously gains appreciation in other fields of dermatology. The dermoscopic patterns of several inflammatory and infectious skin diseases have already been described, and the technique has been shown to improve clinical performance in terms of differential diagnosis in the daily practice.

The increasing use of dermoscopy in general dermatology was significantly enhanced by the development of the new generation hand-held dermatoscopes, which can be easily placed in every dermatologist's pocket and do not require use of immersion fluid.

Four main categories of dermoscopic criteria should be considered when applying the technique in inflammatory diseases: 1) vascular features, including purpuric structures (morphology distribution); 2) color variegations; 3) follicular abnormalities and 4) specific features. Nowadays, the dermatoscope should not be regarded a second-level diagnostic equipment, but an irreplaceable diagnostic tool in everyday clinical setting, similar to the stethoscope in general medicine. In this presentation, an up-to-date summary of data on dermoscopy in general dermatology will be provided, attempting to assist attendees to profitably utilise and apply the available knowledge in the everyday practice.

PAEDIATRIC DERMATOLOGY UPDATE

Hair disorders in children

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

Hair loss or thinning in children is responsible for around 3% of Paediatric Dermatology visits. It is bound to cause extreme anxiety and apprehension in both parents and the child. Most cases of paediatric alopecia can be treated successfully after a proper diagnosis. Alopecia in children can be caused by a number of conditions and has patterns that are different from that seen in adults. Although many conditions are self-limiting, early diagnosis and intervention is essential to prevent permanent alopecia in certain cases. Every physician should be able to distinguish scarring from non-scarring alopecias since the former can lead to permanent hair loss.

Alopecias can also uncover underlying psychological issues and these should be considered in any child presenting with hair loss. Many other causes are benign and self-limiting and only need reassurance.

This session will be an interactive case-based discussion focusing on the common conditions but also tackling rarer aetiologies of paediatric hair loss. It should enable you to diagnose and manage paediatric alopecias with more confidence. We look forward to seeing you at Dermfest!

The sick child with a rash

David Pace, Consultant Infectious Disease Paediatrician, Mater Dei Hospital, Malta

Rashes in children are common. Many are a manifestation of a trivial illness but certain exanthems might indicate an underlying serious disease. Diagnosis can be challenging, emphasising the importance of a good history and clinical examination looking for symptoms and signs of serious illness. Meningococcal septicaemia may mimic a viraemia and present as a maculopapular rash with evolution into purpura and multi-organ failure over just a few hours. Bacterial toxins may primarily target the skin resulting in impetigo following local production of

an exfoliating toxin by *Staphylococcus aureus* or cause staphylococcal scalded skin syndrome, even in the absence of cutaneous infection, if the toxin is released into the bloodstream. In toxic shock syndrome the release of other superantigens by *Staphylococcus aureus* or *Streptococcus pyogenes* results in shock and an erythrodermic rash. The polymorphous rash in Kawasaki disease is a reflection of the underlying multisystem vasculitis that may unfortunately affect the coronary arteries if not recognised and treated appropriately. Blistering skin lesions together with involvement of the mucosae would raise the suspicion of Stevens Johnson syndrome and toxic epidermal necrolysis. Formulating a proper differential diagnosis in children presenting with a rash will help identify the ill child who would benefit from timely initiation of the necessary treatment.

Paediatric skin infections

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

Paediatric skin infections are very common. They may be caused by bacteria, viruses, fungi, and parasites. The fact that young children may be unaware of the importance of hygiene, and may be relatively immunologically naïve, predisposes them to certain infections such as impetigo, molluscum contagiosum and dermatophyte infections. Whatever the causative organism, paediatric skin infections can cause some anxiety in older children and often undue and distressing anxiety in parents, school teachers, and childcare staff as well as in the primary caregivers.

In this presentation a few of the more common skin infections in children are outlined with some key points in their diagnosis, differentiation and management. This is intended for a more practical approach in helping to alleviate the effects of these infections.

Paediatric pruritus

Daniel Micallef, Higher Specialist Trainee in Dermatology

Patients present with symptoms not diagnoses and the diagnosis behind pruritus in children can be challenging to identify and even more so to manage. In children, pruritus not only affects the quality of life of the child but also of the whole family.

Itchy skin is often associated with a rash. The morphology of the rash, associated symptoms and history help distinguish between common differential diagnoses including eczema, urticaria, papular urticaria, insect bites, scabies and eczematised inflammatory conditions or infections. Pruritus without a rash is rare in children but should trigger investigation for “internal” conditions.

In most cases, the diagnosis is clinical and treatment is aimed at symptom control with antihistamines and the use of topical and/or systemic agents depending on the diagnosis and the body site(s) involved. Moreover, it is essential to consider the age of the child, ensure prescription of appropriate quantities at the right doses and spend time educating the whole family to ensure adherence to a suitable treatment plan.

Paediatric Dermatology in a private General Practice

Kenneth Vassallo, Family Doctor in General Practice, Malta

Several paediatric medical conditions present with a dermatological sign or signs. Be it a macule, papule, pustule, generalised rash etc, correctly identifying these dermatological signs, is important in making a correct diagnosis and thus issuing effective treatment. I will be going through several common and not so common yet challenging paediatric skin exanthems I encounter in my practice. I will also discuss ways how we can improve collaboration between general practice and dermatology, to increase efficiency and improve patient care.

SKIN CANCER UPDATE

Which skin lesions need urgent referral?

Dillon Mintoff, Higher Specialist Trainee in Dermatology & Sue Aquilina, Consultant Dermatologist, Sir Paul Boffa Hospital, Malta

The identification of malignant skin lesions is not always straightforward. This can sometimes lead to potential diagnostic delay. In this discussion, we present bedside clinical tips on how to make a more confident diagnosis of melanoma and non-melanoma skin cancers which require timely review by a dermatologist.

Dermoscopy of skin cancer: a few tips

Dimitrios Ioannides, Professor of Dermatology-Venereology, Aristotle University Medical School; Head, 1st Department of Dermatology-Venereology, Hospital of Skin and Venereal Diseases, Thessaloniki, Greece

The presentation will feature case histories demonstrating the place of Dermoscopy in the diagnosis of skin cancer.

Skin lesions that can be safely treated in primary care

Alex Magri, Family Doctor in General Practice, Malta

This presentation will provide an overview of skin surgery in the field of family medicine discussing competencies and facilities required to enable its safe practice, together with its diagnostic and therapeutic role. The logistics and difficulties encountered to perform skin surgery in primary care will also be discussed.

The indications for skin surgery in primary care will be presented together with a discussion on types of lesions which can safely be treated in primary care and those which necessitate referral to specialised dermatological care. The presentation will include a brief overview of techniques and materials used together with a presentation of the various types of skin surgery possible in primary care.

The main complications which can arise following skin surgery together with the precautions which need to be taken to minimise the risk of these complications will also be discussed.

The commonest skin lesions around the eyes and how to manage them

Maria de Bono Agius, Consultant Ophthalmologist, Gozo General Hospital, Malta

Eyelid cancers account for 5% to 10% of all cutaneous malignancies. The incidence of eyelid cancer is approximately 15 cases per 100,000 individuals per year. Basal cell carcinoma is by far the most common cutaneous malignancy in the periocular area; other cutaneous malignancies that occur in this area include, in decreasing order of frequency, squamous cell carcinoma, sebaceous carcinoma, melanoma, and Merkel cell carcinoma.

The major predisposing factor for the development of eyelid cancer is chronic sun exposure, particularly in childhood. Other common factors include fair skin, other forms of ionising radiation, immunosuppression, previous skin malignancy and premalignant states, such as multiple actinic keratosis.

The most common treatment for eyelid carcinomas is surgical resection with frozen section examination for margin control, but exenteration may be needed when there is orbital invasion. Adjuvant radiotherapy may be needed in patients at high risk for local recurrence; sentinel lymph node biopsy may be considered in patients at high risk for lymph node metastasis. Primary or residual in situ disease of the conjunctiva can be treated with topical chemotherapy, such as mitomycin C, 5-fluorouracil, or interferon alpha-2b. For patients with metastatic or locally advanced basal cell or squamous cell carcinoma not amenable to surgical excision or radiotherapy, targeted therapy against the hedgehog pathway (for basal cell carcinoma) or epidermal growth factor receptor (for squamous cell carcinoma) has been shown to be effective in preventing disease progression. Patients with eyelid and ocular surface

malignancies need to be monitored with careful clinical examination for at least 5 years after surgical treatment, and additional investigations may be warranted in some cases.

Closing in on melanoma

Melanoma Surgical Update

Simon De Gabriele, Resident Specialist in Plastic, Reconstructive & Aesthetic Surgery, Plastic Surgery & Burns Unit, Mater Dei Hospital, Malta

Melanoma was first described in the 5th Century BC. Improvement and progress in the management of melanoma has been slow through the years. Medical treatment has changed time and time again. Many treatment modalities were introduced but they did not improve survival rates. Surgery has been the mainstay of treatment.

For many years it was common practice to carry out elective lymphadenectomy on melanoma patients. Complications from such an approach were not uncommon. Surgical management started changing as studies in the new millenium showed that lymphadenectomy did not improve survival rates, either. Excision margins for melanoma scars, of thicker malanomas, reduced from 3cm to a maximum of 2cm. Surgical lypmhadenectomy became more selective with the introduction of sentinel node biopsy (SNB). SNB was purely a prognostic indicator until recent changes in medical treatment. Radiological follow-up with CT scans, PET-CT or MRI became more frequent.

BRAF mutation is present in more than 50% of melanoma patients and MEK mutation in a smaller number. The introduction of BRAF & MEK target inhibitors and immunotherapeutic agents have finally brought about an improvement in survival in BRAF-positive melanoma patients. This in turn imposed a further change in the surgical approach. We have moved from an era of protocol lymphadenectomy to a scenario where a simple wider excision and SNB, where indicated, may suffice. The relevance of SNB has now changed from being simply a prognostic indicator to one that determines the treatment pathway. It serves as the patient's ticket into medical treatment. Lymphadenectomy procedures are thus not as common as they once were.

Update on treatment of metastatic melanoma

Nick Refalo, Consultant Oncologist, Sir Anthony Mamo Oncology Centre, Malta

Metastatic melanoma has long been considered an insidious and difficult condition to manage. Despite exhibiting abilities both for rapid growth and widespread dissemination, it proved to be stubbornly chemo-resistant, and very poor response rates and survival rates were obtained with this modality of treatment. This was disappointing, especially in an era when

chemotherapy was making inroads into the management of solid tumours like breast and colon cancer. Modest responses were obtained with interferon, also when used in the adjuvant setting. Despite being late to the party with the use of targeted agents, eventually a host of new drugs was successfully implemented in advanced melanoma and also in the adjuvant setting for stage III disease. These involve BRAF and MEK inhibition as well as immunotherapy with CTLA-4 and more recently PD-L1 inhibition. The results in some cases have been nothing short of spectacular, ensuring that 5-year survivals for this dismal condition have soared from beneath 5% to around 35%, meaning that 1 in 3 patients with metastatic melanoma are now obtaining useful good-quality long-term survival. This talk aims to illustrate the improvement in survival for advanced melanoma over the past two decades, with a highlight on mode of action of the newer drugs and future directions.

GENITO-URINARY MEDICINE UPDATE

A rare outlook on a rear problem

Donia Gamoudi, Higher Specialist Trainee in Genito-Urinary Medicine, Genito-Urinary Clinic, Mater Dei Hospital, Malta

Proctitis, proctocolitis and enteritis are common presentations to various medical and surgical specialties. There are many different infections that can cause proctitis but sexually transmissible pathogens which can be responsible for these syndromes are often forgotten. The clinical presentation of patients presenting with sexually transmitted proctitis may not differ from those with ulcerative or Crohn's proctitis, and patients may undergo unnecessary investigations if appropriate questions on their sexual practices are not asked. Treatment should be prompt and extended to sexual partners who have been exposed to the infection. Effective treatment can alleviate discomfort and avoid potentially serious complications associated with sexually transmitted proctitides. In this interesting case, these causes of proctitis are discussed and the important tests that facilitate diagnosis and speed treatment are discussed.

Stop the Drop: tackling urethral discharge

Alexandra Gauci, General Practitioner with special interest in Genito-Urinary Medicine, Genito-Urinary Clinic, Mater Dei Hospital, Malta

Urethral discharge in males is frequent, is a symptom of urethritis, many times also associated with dysuria and is almost always sexually transmitted. Clinically, the cause of urethral discharge is classified into gonococcal urethritis or non-gonocccal urethritis [NGU] by appearance and consistency of the discharge together with point of care microscopy of a

discharge sample obtained. The presence of Gram-negative diplococci, which confirm gonorrhoea, cannot however exclude a concomitant infection with *Chlamydia trachomatis*, a frequent cause of NGU. Other common causative organisms of NGU include *Mycoplasma genitalium* and *Trichomonas vaginalis*. Specific diagnosis always requires laboratory testing by means of specific NAATS. Empirical treatment recommended includes a course of doxycycline 100mg twice daily for seven days together with a single dose of an antibiotic active against *N. gonorrhoea* when this is detected microscopically. Use of the appropriate antibiotic treatment regimens is very important because of the increasing resistance of *N. gonorrhoea* to antibiotics. Recent sexual partners should always be traced, tested and treated accordingly.

If it barks and wags its tail…

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

Vaginal discharge is one of the most common reasons women seek medical advice. Perhaps because it is so common, the diagnosis may be taken for granted and is based mainly, if not exclusively on history alone resulting in unnecessary treatment and frustrated patients. This short presentation will try to highlight some of the problems involved.

Mistakes

Colm O'Mahony, Countess of Chester NHS Trust, UK

We all make mistakes. It's inevitable. Luckily, they are usually easily resolved and no one comes to harm. A wise man said "Learn from your mistakes, but even better is to learn from someone else's"! A cacophony of errors will be presented with no harm done, other than to the ego of the speaker.

STI or not?

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

The specialties of Dermatology and Venereology are intrinsically tied to each other explaining the various difficulties of differentiating harmless genital inflammations from sexually transmitted diseases. Clinicians who are confronted with genital manifestations need to be familiar with clinical manifestations of STI as well as inflammatory diseases. You are cordially invited to take an active part in this quiz.