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Reports on Scientific Meeting

11th CUHK Dermatology Symposium & Social Hygiene Symposium

Reported by TSH Chan 陳上熙, CY Jeung 蔣頌儀, WYK Lam 林旭強, AWH Leung 梁衛紅, CFY Siu 蕭鳳兒, LP Wong 王麗萍, SM Wong 黃思敏, WF Wu 胡惠福

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Venue: Shaw Auditorium, Postgraduate Education Centre, Prince of Wales Hospital, Hong Kong
Organisers: Dermatology Research Centre, Faculty of Medicine, The Chinese University of Hong Kong and Social Hygiene Service, Centre for Health Protection, Department of Health

Skin manifestations of immunocompromised patients

Speaker: Dr. Lai-ping Wong
Medical & Health Officer, Social Hygiene Service, Centre for Health Protection, Department of Health, Hong Kong

Immunocompromised patients are more prone to the development of various kinds of skin diseases: 1) infections; 2) malignancies and pre-malignant lesions; 3) non-infective, non-malignant drug-related manifestations; and 4) skin manifestations of the underlying disease. Dr. Wong presented eight clinical cases to illustrate the skin manifestations in immunocompromised patients:

Case 1: Ecthyma and perianal streptococcal disease in a homosexual gentleman with multiple sclerosis, who had received rituximab and high-dose intravenous methylprednisolone.

Case 2: Wart and cushingoid features in a renal transplant recipient on prednisolone, mycophenolate mofetil and cyclosporin A.

Case 3: Widespread molluscum contagiosum in a psoriasis patient on methotrexate.

Case 4: Pityriasis versicolor in a renal transplant recipient on prednisolone, azathioprine and tacrolimus.

Case 5: Tinea pedis, tinea unguium and herpes zoster in a renal transplant recipient on prednisolone, azathioprine and cyclosporin A, who had post-transplant diabetes mellitus.

Case 6: Penicillium marneffei infection in a HIV positive gentleman who presented with fever, malaise, shortness of breath and brownish papules over the body.

Case 7: Bowen's disease in a farmer who had renal transplant and received immuno-suppressants for eight years.

Case 8: A gentleman with suspected AIDS infection who developed isoniazid-resistant pulmonary tuberculosis and Kaposi's sarcoma.

Learning points:

Immunocompromised patients are prone to the development of cutaneous infection, malignancy or pre-malignant lesions, drug-related cutaneous manifestations or skin manifestations of the underlying disease. Liaison between physicians and dermatologists is essential in the diagnosis and management of these patients.

The nurse-led warts clinic in National Skin Centre

Speaker: Ms. Kim-lian Tan
Nurse Clinician, National Skin Centre, Singapore

The nurse-led warts clinic in National Skin Centre in Singapore is a clinic managed by registered nurses with specialised training. The aim is to manage the high patient load and decrease the number of doctor consultation. After patient sees the dermatologist with a confirmed diagnosis of wart infection, the doctor will order cryotherapy and patients are referred to nurse-led warts clinic. Nurses will offer assessment, treatment and review for the patients regularly. Moreover, the roles of nurses in the nurse-led warts clinic also include providing information and offering patient education.

A retrospective study on the nurse-led warts clinic in 2012 found that one third of the patients with warts resolved; consultation fee, transportation fee, travelling time and waiting time of patients were saved. As a result of the success, nurse-led clinics on phototherapy, photodynamic therapy, sexually-transmitted infections for male and female were also set up at National Skin Centre, Singapore.

Learning points:

Nurse-led warts clinic in National Skin Centre, Singapore is successful in managing high patient load and reduce unnecessary doctor consultation. With good planning and management, it can offer favourable long-term outcomes for the clinic.

Update on the pathogenesis and management of urticaria

Speaker: Dr. Shang-Ian Tee
Specialist in Dermatology, National Skin Centre, Singapore

The pathogenesis of chronic urticaria is very complex. Mast cell activation and degranulation is the core part for the development of urticaria. Autoimmunity, cellular signal dysfunction, coagulation defects and chronic infection are believed to have a role in the pathogenesis of urticaria.

In the management of chronic urticaria, patients should be advised to avoid the potential triggers. Antihistamines remain the first line treatment. Second generation H1 receptor antagonists have better efficacy and safety profiles than the first generation. Antihistamine updosing is a well accepted approach in unresponsive cases. But in refractory cases, montelukast, cyclosporine, hydroxychloroquine, methotrexate, omalizumab may be required.

Learning points:

Urticaria can be a recalcitrant disease and is distressing to patients. We need to keep updated treatment options to help these patients.

Update on onychomycosis

Speaker: Dr. Sze-man Wong
Medical and Health Officer, Social Hygiene Service, Department of Health, Hong Kong

Onychomycosis is a common fungal infection of the nail plate/bed caused by dermatophytes, non-dermatophyte moulds and yeasts. The prevalence is about 2-13% worldwide. There is significant psychosocial impact on patients' life. The cure rate is relatively low but the relapse rate is high. Poor prognostic factors can be

divided into three categories: host, pathogen and clinical. Host factors include old age, male gender, immunocompromised state and poor peripheral circulation. Pathogen factors include non-responsive pathogen and drug resistance. Poor clinical prognostic factors include: lateral or matrix involvement, dermatophytoma, subungual hyperkeratosis and total nail dystrophy. Sometimes investigations are required to supplement the clinical diagnosis of onychomycosis in order to identify the species and provide more appropriate treatment. At least 2 positive results are required to fulfil three diagnostic criteria: fungal viability, penetrance to the nail plate, species identification.

Treatment target should be individualised. Systemic antifungal agents remain the gold standard of treatment for onychomycosis, especially if the disease fails to respond after 6 months of topical treatment. New advances have been made for the treatment of onychomycosis such as device-related modality: laser and photodynamic therapy but optimal treatment regime is yet to be confirmed. Terbinafine is found to be a better option in terms of higher mycological cure rate and less recurrent rate. Amorolfine nail lacquer has been shown to be less likely to have recurrence if used as maintenance therapy as compared to untreated group after initial successful oral treatment. Combined oral and topical antifungal therapy has been shown to have better efficacy as compared to sole oral regime.

Learning points:

Patients who have positive fungal culture at 24 week post treatment are likely to experience recurrence of onychomycosis and re-treatment with systemic antifungal agents should be considered.

Life style and dermatology

Speaker: Dr. Christina FY Siu
Medical and Health Officer, Centre for Health Protection, Department of Health, Hong Kong

Smoking, obesity and aquatic sports predispose individuals to the development of many dermatology conditions. Smoking not only poses danger to the general health, but also brings adverse impact to the skin. Mucocutaneous lesions, precocious skin ageing, skin cancer, exacerbation of psoriasis and cutaneous lupus erythematosus are known associations.

Obesity is related to a number of dermatoses, which could be explained by the physical effects or the associated metabolic disturbance. Intertrigo, venous stasis, lymphoedema, striae distensae, skin tags, acanthosis nigricans, acne, hirsutism, androgenic alopecia and psoriasis are some of the examples.

Aquatic sports dermatoses and swimmer's dermatoses are not uncommon. Swimming pool granuloma (fish-tank granuloma), swimmer's itch (cercarial dermatitis), swimmer's ear (otitis externa), pseudomonas folliculitis, pseudomonas hot foot syndrome, cutaneous larva migrans, sea bather's eruption and jelly fish stings are discussed.

Learning points:

Prevention is better than cure. Doctors should be aware of the dermatoses associated with smoking, obesity and aquatic activities.

Osmidrosis operation with suction assisted cartilage shavers: my method from local anaesthesia to the bandage

Speaker: Dr. Wei-ming Wu
Assistant Professor and Chief, Department of Dermatology, Kaohsiung Chang Gung Memorial Hospital, Taiwan

Unpleasant odour in axillary osmidrosis causes significant physical and psychosocial impacts on patients. Non-surgical treatments of osmidrosis include applications of deodorants, injection of botulinum toxin, laser and microwave treatment. However, most of these treatments allow only temporary relief of the symptoms. Surgical treatment of osmidrosis including scissoring, curettage or subcutaneous shaver had been used to remove dermal-subcutaneous tissue harbouring the apocrine glands and achieved long-term remission.

The speaker proposed modifications to the traditional operation of osmidrosis for better surgical outcomes by using arthroscopic shaver-based operation. For anaesthetics, a large amount (400 ml) of tumescent solution was infiltrated into each axilla to achieve hydrodissection that reduces intraoperative bleeding and facilitates further dissection. Dissection of subcutaneous space was achieved by a 2 mm skin punch and a 1 mm blunt dissector. Scissor was not recommended as it required a larger hole (1 cm) for dissection. A 4 mm arthroscopic shaver was then inserted into the subcutaneous space. The surgical wound could be minimised up to 6 mm with a better healing process and a barely observable scar. Good postoperative attachment between dermal flap and subcutis is essential for better treatment outcome of osmidrosis. Satisfactory attachment is crucial to provide a good oxygenation and reduce risks of haematoma, seroma, skin necrosis and ulcers. Fixation using running buried quilting sutures allowed early mobilisation of arm after only 24 hours of compressive bandage. This suture technique could avoid complications similar to frozen shoulder associated with the use of drainage tube and tie-over sutures that required prolonged immobilisation.

Learning points:

The proposed modifications can potentially achieve a safer and more effective osmidrosis operation.

Sexually transmitted infections in young people

Speaker: Dr. King-man Ho
Consultant, Social Hygiene Service, Centre for Health Protection, Department of Health, Hong Kong

Adolescence is at a transitional stage from childhood to adulthood. It is an important period for them to explore and gain experience of different life events. Value and behaviour of adolescents can be influenced by extensive information from the media and internet. These teenagers are at risk of acquiring sexually transmitted diseases. Sexually transmitted diseases may cause significant physical and psychological impacts on adolescents.

According to the Sexuality Survey conducted by the Family Planning Association of Hong Kong in 2011, percentages of male and female respondents who had sexual experience were 9.8% (144/1475) and 7.4% (108/1459) respectively. For those who had sexual intercourse in the past 6 months, less than 40% had used condom. The mean age of sexual debut was 14.6 years in male and 15.3 years in female. It is important to note that more than 20% of the Form 3 to 7 students could not identify the statement "condom reduces the chances of getting sexually transmitted diseases" as correct. The percentages of male and female respondents who had the experience of browsing or watching pornographic materials were 53% and 30% respectively.

There is no comprehensive statistics on sexually transmitted diseases of adolescents in Hong Kong. Data from the Social Hygiene Service revealed that teenagers aged 10 to 19 years contributed to about 6% of the total new cases of sexually transmitted diseases in 2013. *Chlamydia trachomatis* infection was the most common sexually transmitted disease.

Learning points:

Adolescents are important targets in the prevention and care of sexually transmitted diseases.

Cutaneous manifestations of connective tissue diseases in children

Speaker: Dr. Kin-fon Leong
Paediatric Dermatologist, Paediatric Institute Kuala Lumpur, Malaysia

Cutaneous lupus erythematosus, morphoea and dermatomyositis are the more common autoimmune connective tissue diseases in childhood. They have unique cutaneous manifestations and potential associated complications.

Dermatomyositis characteristically manifests with heliotrope rash, Gottron's papules and Shawl sign. In contrast with adult onset dermatomyositis, juvenile dermatomyositis is more likely to develop calcinosis and lipodystrophy, but less likely to have underlying malignancy.

Cutaneous lupus erythematosus can be categorised as acute, subacute and chronic cutaneous lupus erythematosus (CLE). CLE is the most common one in the paediatric population. It can be subdivided into discoid lupus erythematosus, lupus erythematosus tumidus and lupus panniculitis, according to the depth of skin involvement.

The onset of neonatal lupus erythematosus (NLE) usually occurs before the age of six months. It should be suspected if a baby presents with annular erythema on bilateral periorbital and photosensitive areas. Babies of mothers with positive Anti-SSa, Anti-SSb, lupus erythematosus or Sjögren syndrome have an increased risk of NLE.

Morphoea can be classified into circumscribed, linear, generalised, pansclerotic and mixed morphoea. It commonly manifests as an atrophic, indurated plaque with a violaceous rim. Its potential complications include contractures, functional limitation and cosmetic disfigurement. Options of treatment include phototherapy, topical and systemic therapies.

Learning points:

Neonatal lupus erythematosus usually occurs before the age of six months. It should be suspected if a baby presents with annular erythema on photosensitive areas.

Medication safety in dermatology

Speaker: Professor Vivian WY Lee
Associate Professor, School of Pharmacy, The Chinese University of Hong Kong, Hong Kong

There have been a lot of challenges in medication safety nowadays. Dermatological reactions represent the most frequently reported form of adverse drug reactions. Adverse drug reactions can be simply classified into allergic drug reaction and pseudo-allergic reactions. Allergic drug reactions are immune mediated while pseudo-allergic reactions are non-immune mediated. Both of them can manifest similarly. The common drugs for adverse drug reactions include beta-lactam antibiotics, sulphonamides, radio-contrast media, aspirin and non-steroidal anti-inflammatory drugs, anticonvulsants and chemotherapy. Busy

workload and human errors among healthcare providers are the major hurdles for the delivery of proper medications to patients. Possible solutions to maximise drug safety include improvement of public awareness of drug safety, effective reporting system for adverse drug reactions and utilisation of technology in drug prescription, etc.

Learning points:

Dermatological reactions are the most frequently reported forms of adverse drug reactions.

Perfect moisturisers for childhood eczema

Speaker: Professor Ellis KL Hon
Department of Paediatrics, Prince of Wales Hospital, Hong Kong

The use of moisturisers remains as a cornerstone in preventing childhood eczema. Classical teaching maintains that frequent application of non-perfumed or non-fragrant moisturisers will offer optimal benefits. While it might hold true for patients with exemplary adherence, the reality is that patients and their parents often fare poorly when it comes to the use of moisturisers for various reasons. Issues with the texture – it being too greasy or uncomfortable to apply, busy school routines are but a few of the commonly quoted reasons. The disparity between parental and physician expectations of the "perfect" moisturiser might contribute to suboptimal control in childhood eczema.

The speaker quoted a survey conducted by his paediatric dermatology clinic which found that the majority of patients/parents with mild eczema were of the view that perfect moisturisers were to be applied twice daily; whereas patients with moderate to severe eczema preferred more frequent use. Most patients preferred creams which were non-fragrant, non-herbal and white. It is highly advisable that patients apply emollients within five minutes after bathing. Doctors remain an important source of recommendation of the perfect moisturiser, which must be suited to the patient's preference.

Learning points:

The perfect moisturiser should cater to both the physician's and the the patient's preferences.

A review of cutaneous T-cell lymphoma

Speaker: Dr. Thomas SH Chan
Dermatologist, Private Practice, Hong Kong

There are many types of cutaneous T-cell lymphoma (CTCL) and mycosis fungoides (MF) is one of them. MF is featured by the malignant proliferation of T helper cells. Classically, it consists of three stages namely patches, plaques and tumours. Patch stage MF is featured by the fine scaly atrophic erythematous patches in the trunk, buttock and limbs. Patients may feel itchiness but are more often asymptomatic. Lesions of plaque stage MF may increase in size gradually and some may show regression at the centre. Occasionally, plaques of MF may develop erosions and ulceration. Tumours of MF often have different sizes. The cause of MF may be related to genetic, infective and environmental factors, the pathogenesis has not been fully defined.

The other type of CTCL is the Sezary syndrome (SS). SS is an erythrodermic leukaemic variant of CTCL. Clinically it is characterised by erythroderma, oedema, pruritus and lymphadenopathy. Very often, SS arises de novo, but can also arise from MF and other non-specific dermatitis.

The staging of MF at diagnosis determines the extent of investigation and the treatment approach. In early stages MF, patients can be treated by skin-directed therapies such as topical steroids, psoralen-UVA and narrow band UVB. However, in late stage MF, patients may require systemic treatment such as alpha-interferon, methotrexate, radiotherapy or chemotherapy.

Learning points:

Classic mycosis fungoides presents with patches and plaques on non-sun exposed areas. Sezary syndrome is an aggressive, leukaemic cutaneous T-cell lymphoma variant. Treatment is directed at clearing cutaneous and extracutaneous disease, minimising disease recurrence, and preventing disease progression. Treatment is palliative and must be balanced against the increased risk of toxicity.

Announcement

Application for Interim/Exit Assessment, June 2015 Specialty Board in Dermatology & Venereology Hong Kong College of Physicians

Please be reminded that the application for the Interim/Exit Assessment, June 2015 is now open to eligible candidates, who should be:

1. Registered trainees in Dermatology & Venereology, Hong Kong College of Physicians
2. Qualified for/will be able to qualify for the Interim/Exit Assessment by 30 June 2015

Those who wish to attend the Assessment should complete the Higher Physician Training (HPT) Interim Assessment Application Form or the Higher Physician (HPT) Exit Assessment Application Form plus Testimonial to the Examination Co-ordinator of the Specialty Board in Dermatology & Venereology on time according to the requirement of HKCP. You may refer to the website of the Hong Kong College of Physicians www.hkcp.org/ for details. Late applicants will not be accepted to sit for the assessment.

Dr. HO Hing-fung
Chairman
Specialty Board (Dermatology & Venereology)
Hong Kong College of Physicians