

22nd Regional Conference of Dermatology (Asian-Australasian)

Reported by LP Wong 王麗萍

Date: 21-24 April 2016
 Venue: Raffles City Convention Centre,
 Singapore
 Organiser: Dermatological Society of
 Singapore

Learning points:

The combination of topical corticosteroids and vitamin D analogues is a safe and effective first-line treatment for mild to moderate plaque psoriasis.

"Optimizing outcome for the psoriasis patient today" round-table-discussion. Topical treatment in the age of biologics

Speaker: Siegfried Segaert
 Department of Dermatology, University Hospitals Leuven,
 Leuven, Belgium

In the era of biologics, topical treatment still plays an important role in the treatment of psoriasis. The combination of topical corticosteroids and vitamin D analogues are safe and effective first-line treatments for mild to moderate plaque psoriasis. Corticosteroids act primarily as immunosuppressors, targeting pro-inflammatory cytokines and chemokines; whereas vitamin D analogues primarily act by counteracting epidermal dysregulation, inhibiting epidermal hyperproliferation and inducing keratinocyte differentiation.

The combination of both drugs has been shown to have a better effect with decreased side-effects compared to monotherapy. Although clinical data supports the improved efficacy and tolerability of the combination of betamethasone dipropionate and calcipotriol, more studies are needed to further investigate the underlying mechanisms.

Cicatricial alopecias: what do I do?

Speaker: Jerry Shapiro
 York University, School of Medicine, Canada

Cicatricial alopecia is considered to be a "trichological emergency" as hair loss may be permanent. Dr. Shapiro emphasised the importance of rapid control of the problem as opposed to an expectant approach.

Cicatricial alopecia is characterised by a loss of follicular ostia with replacement by fibrous tissue. Primary cicatricial alopecia targets the hair follicle and involves the destruction of the follicular epithelium with sparing of interfollicular dermis. In secondary cicatricial alopecia, the hair follicle is destroyed in tinea capitis, infiltrative diseases such as metastasis and sarcoidosis, inflammatory conditions, trauma and burns.

Skin biopsy is crucial in the management of cicatricial alopecia as the treatment decisions are guided by the cell infiltrate. Dr. Shapiro suggested taking a 4 mm punch biopsy and two may be necessary: one for transverse and one for longitudinal sectioning.

For patients suffering from discoid lupus erythematosus, if less than 10% of the scalp is involved, ultrapotent topical corticosteroids with or without corticosteroid injections may be used to prevent deterioration. If more than 10% of the scalp is involved, the use of hydroxychloroquine plus ultrapotent topical steroids, plus steroid injections, plus oral use of prednisolone may be necessary.

Patients with lichen planopilaris present with peripheral hyperkeratosis, or frontal fibrosing alopecia. According to the speaker's experience, intralesional steroid with or without oral tetracycline may prevent or slow down the progression of frontal fibrosing alopecia.

Learning points:

Cicatricial alopecia is considered to be a "trichological emergency" as hair loss may be permanent. Skin biopsy is necessary and crucial in the management of cicatricial alopecia as the treatment decisions are guided by the cell infiltrate.

Varicose veins – surgical vs non-surgical treatments

Speaker: Jason Yang
Chang Gung Memorial Hospital, Taiwan

Varicose veins may be asymptomatic and treatment in such cases is for cosmetic reason. When symptoms are present, e.g. heaviness, lower limb swelling, pain, fatigue, cramp, skin changes and ulcers, treatment is warranted. The treatment options include lifestyle modification, compression stockings, surgical and non-surgical procedures.

In general, weight control, exercise, elevation of the legs and compression stockings are advised. Non-surgical procedures for varicose veins include: sclerotherapy and vein ablation by laser. Endovascular ablation by

radiofrequency or laser can close the large veins with leaky valves. Surgery for varicose veins includes micro-incision phlebectomy and large varicose vein stripping.

Learning points:

Treatment of varicose veins depends on the severity of symptoms, location and cause. Most patients need a combination of surgical or non-surgical treatments to achieve the best results.

Updates in the management of infantile haemangiomas and other vascular anomalies

Speaker: David Luk
Department of Paediatrics and Adolescent Medicine,
United Christian Hospital, Hong Kong

Infantile haemangiomas are benign vascular lesions that typically appear during the first few weeks of life. Superficial haemangiomas are usually raised, bright red lumps over the skin. Deep haemangiomas may appear bluish in colour and usually present as a swelling and may not be noticeable for the first few weeks after birth.

Most infantile haemangiomas have an uncomplicated clinical course but some require special treatment.

Treatment of infantile haemangiomas is individualised according to the location and size, rate of proliferation and involution, the results after involution and the risk of developing complications. In the following situations, treatment is suggested: 1) if the haemangioma is particularly large or affects areas where resolution may be incomplete e.g. around the nose and lips; 2) if the haemangioma is ulcerating; 3) if the haemangioma is interfering with important functions or development.

Treatment options for infantile haemangiomas include: corticosteroids, topical timolol, oral propranolol, laser treatment or surgery. Dressings, pain relief and antibiotics may also be required.

Dr Luk presented several patients with infantile haemangiomas treated with topical timolol gel. Topical timolol gel is a good choice for superficial haemangioma, patients waiting for propranolol or tapering off propranolol. He also demonstrated the importance of dressings, pain control and the use of antibiotics when complications arise.

Learning points:

The treatment of infantile haemangiomas should be individualised. While most haemangiomas will resolve with time, active management e.g. corticosteroid, propranolol, topical timolol, laser or surgery may be required.

Minimising risks of injectables

Speaker: Nancy Garcia-Tan
Department of Dermatology, University of the East-Ramon Magsaysay Memorial Medical Centre, Philippines

Cosmetic injectables are associated with the risk of early and delayed complications. The causes can be classified into three types: 1) related to the injection; 2) related to the product; 3) related to the injection technique.

Early and expected side effects include: erythema, swelling and bruising at the injection site. The chance of side-effects can be minimised by using smaller gauge needles, slower injection and stopping medications like antiplatelet or anticoagulant few days before the injection. Allergic reactions and granuloma formation are uncommon but have been reported.

Technique-associated complications include injecting too superficially, injecting at a wrong plane or injury and paralysis to facial muscles. Complications such as skin necrosis, intravascular injection and infection must be managed as soon as possible.

Before the procedure, it is advised that physicians must provide adequate counselling and patient education on the potential risks and complications from injectables. The risks and complications can be minimised through adequate knowledge of the anatomy and training.

Learning points:

Risk assessment and prevention, good patient communication and education, knowledge on the anatomy and adequate training are vital to minimise the risks of injectables.

The steroid phobic patient

Speaker: Yung Hian Leow
Department of Dermatology, National Skin Centre, Singapore

The use of topical corticosteroids is important in the daily practice of dermatology. Yet, many patients and their care-givers are concerned about the safety of steroid use. Topical corticosteroid phobia is common and the most commonly cited concern is the potential side effect of skin atrophy or skin thinning. There is evidence to support that their fears may affect medication use and thus compromise optimal care and treatment of the patient's skin condition.

There are several management strategies for steroid phobic patients: 1) using a steroid-sparing agent, e.g. calcineurin inhibitor to treat eczema; 2) the use of moisturiser can improve

the skin barrier function and reduce the need of topical steroid; 3) giving detailed instructions on how to apply a corticosteroid, such as the fingertip unit; 4) rephrasing the instructions like "use sparingly" instead of "apply enough on affected areas".

Learning points:

In the management of skin diseases, patients' concerns, like steroid phobia, must be taken into account. Patient education and giving detailed instructions by the physicians will make the difference between a patient who gets better by following the treatment and the one who doesn't.