

16° Corso di Aggiornamento per il Medico di Base

Update: dermatologia

Giubiasco, 26 Settembre 2018



Carlo Mainetti

Dermatologia EOC
Bellinzona – Mendrisio





Dermatological emergencies in a non-university hospital in Southern Switzerland: analysis of the reasons for consultation

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- Simone Cazzaniga ²
- Lorenzo Grizzetti ³
- Elizabeth Gaviña Morales ¹
- Francesca Ghitti ⁴
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Background and goals

The spectrum of dermatologic broad and encompasses diseases such as infectious skin diseases, adverse reactions, erythroderm of chronic inflammatory skin c and angio-oedema [1-2]. Howev about what both patients and ge

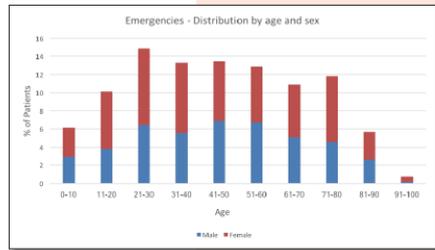


Fig. 1: Distribution by age and sex of patients attended the emergency consultation

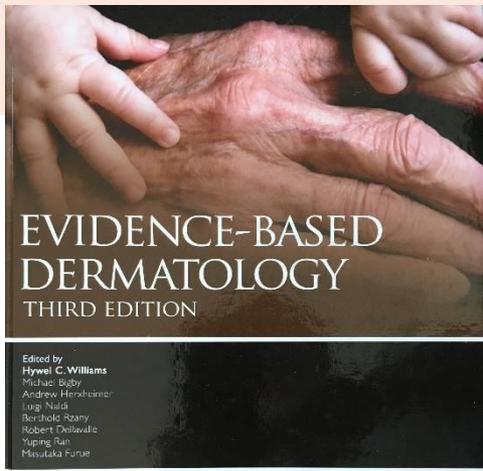
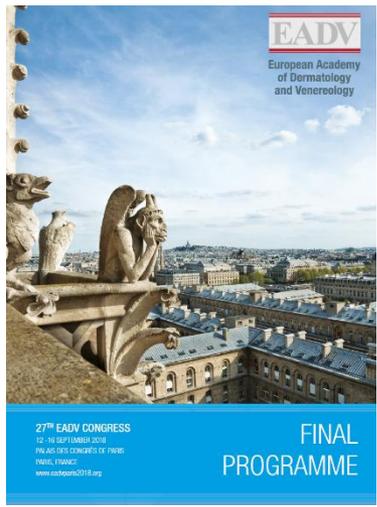
Emergencies, %	Sheduled Appointments, %
1. Flares of atopic dermatitis, 13.3	1. Melanocytic nevus, 17.3
2. Bacterial infections, 12.7	2. Malignant skin lesions, 11.5
3. Viral infections, 11.7	3. Benign non-melanocytic tumors, 9.9
4. Contact dermatitis, 10.1	4. Acne and rosacea, 8.5
5. Parasitic dermatitis, 4.8	5. Viral infections, 7.8
6. Benign non-melanocytic tumors, 4.4	6. Flares of atopic dermatitis, 7.0
7. Insect bites, 4.0	7. Premalignant skin lesions, 6.8
8. Acute urticaria, 3.8	8. Plaque psoriasis, 3.4
9. Fungal infections, 3.7	9. Fungal infections, 3.0
10. Drug-induced reactions, 3.7	10. Contact dermatitis, 2.9

Emergencies, %	Sheduled Appointments, %
1. Flares of atopic dermatitis, 13.3	1. Melanocytic nevus, 17.3

D1T13.4 15:00 - 16:30 Best papers of the year - A look into dermatological editing across the globe

Chairs: Johannes Ring (Munich, Germany)
 Dirk Elston (Charleston, United States)

- D1T13.4A 15:00 Welcome and introduction**
 Johannes Ring (Munich, Germany)
- D1T13.4B 15:05 Best papers of the year from AAD**
 Dirk Elston (Charleston, United States)
- D1T13.4C 15:25 Best papers from BJD**
 Alexander Anstey (Conwy, United Kingdom)
- D1T13.4D 15:45 Best papers of the year from JDS**
 Yoshiki Tokura (Hamamatsu, Japan)
- D1T13.4E 16:05 Best papers of the year from JEADV**
 Johannes Ring (Munich, Germany)
- D1T13.4F 16:25 General discussion**



Sommario

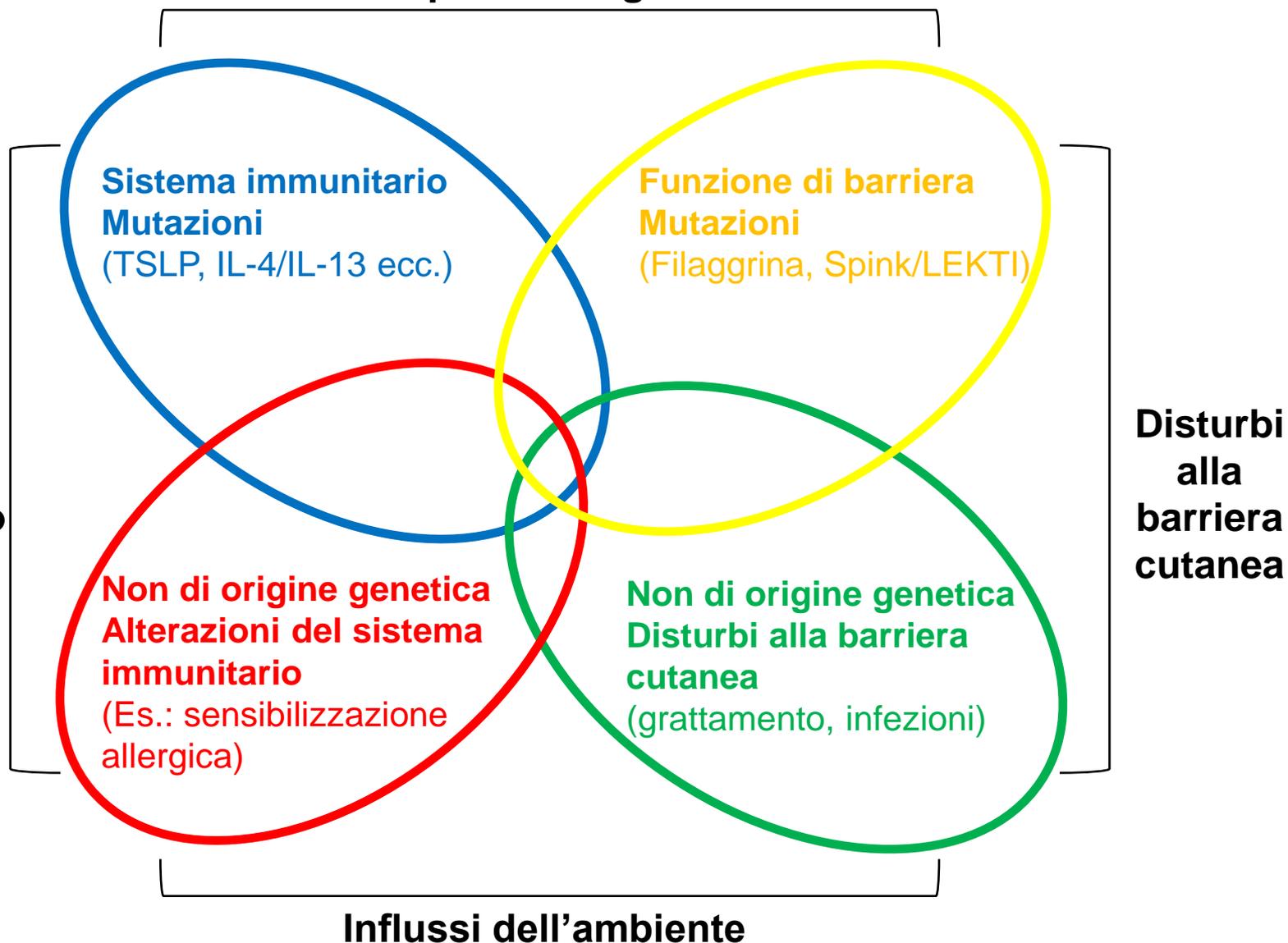
- **Dermatite atopica**
- **Psoriasi**
- **Acne e Rosacea**
- **Orticaria cronica**
- **Novità particolari**
- **6 tipi di risposte immunologiche nelle dermatosi infiammatorie**

Dermatite atopica (AD)

- **Definizione:** malattia infiammatoria cutanea cronica caratterizzata da prurito e eruzioni cutanee rosse col tempo infiltrative, che colpiscono prevalentemente le pieghe
- **Prevalenza** in Europa: **15-20 %** nei soggetti con 7 – 18 anni
- **Eziologia:** genetica – immunologica – ambientale
- **Patogenesi:** difetti barriera strato corneo – predominanza di TH-2 – agenti infettivi
- **Prognosi:** 60% dei casi l'eczema scompare; > 35% intermittente
- **Obiettivi delle cure:** controllo del prurito e normalizzazione della cute

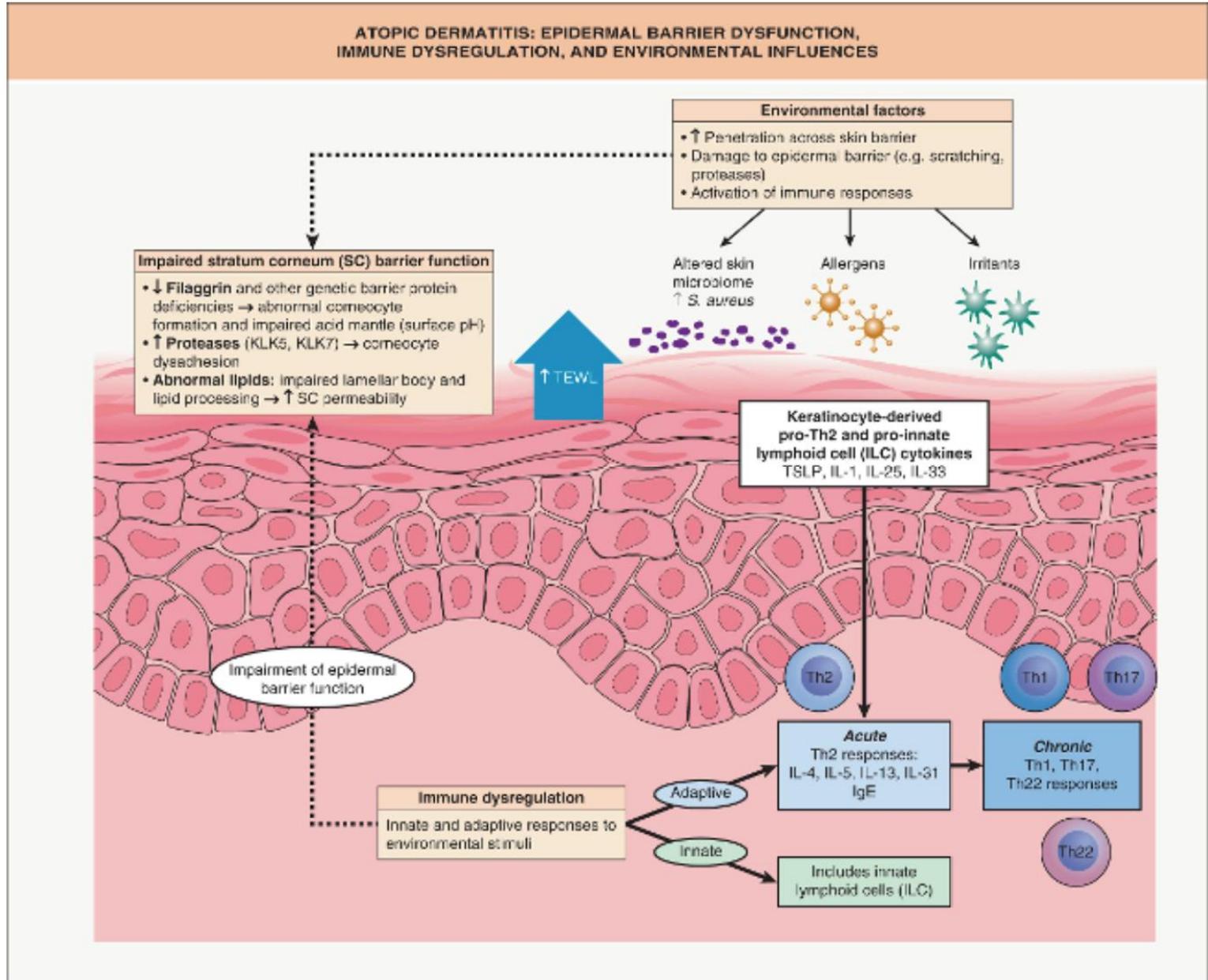
Eziologia multifattoriale della AD

Predisposizione genetica

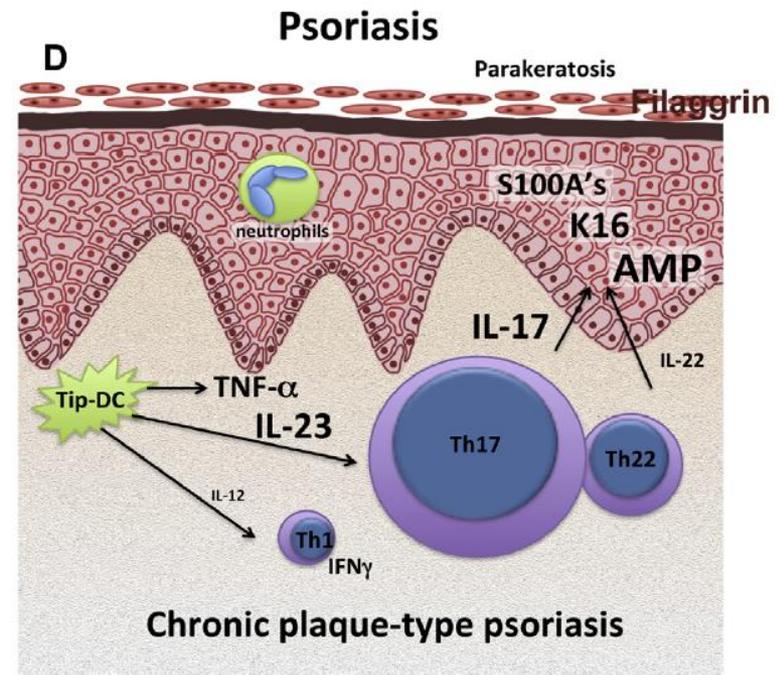
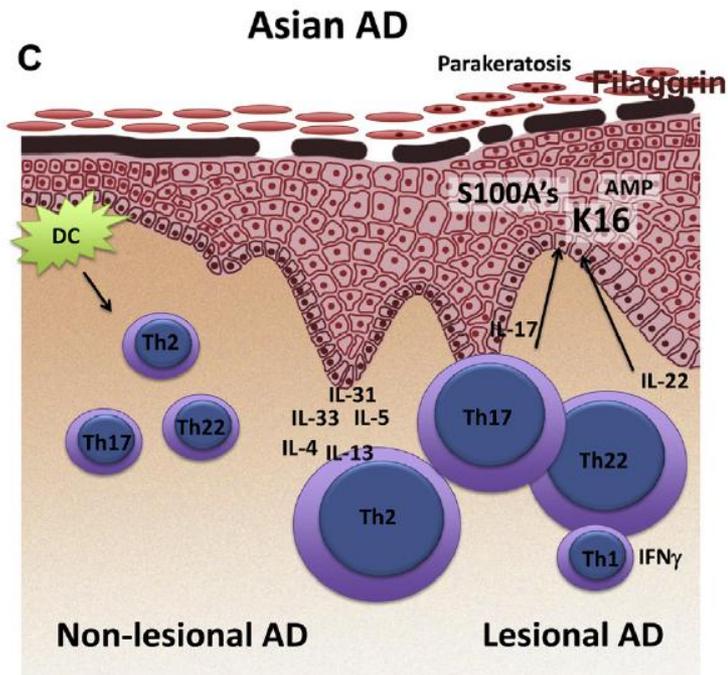
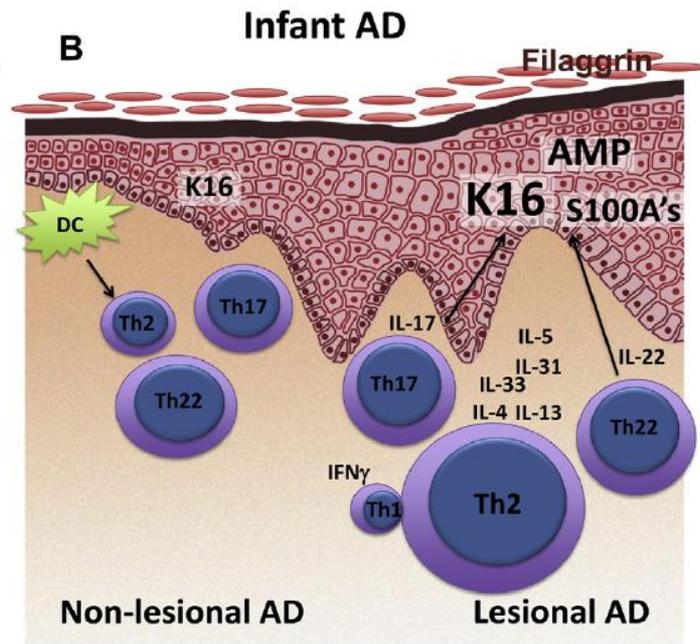
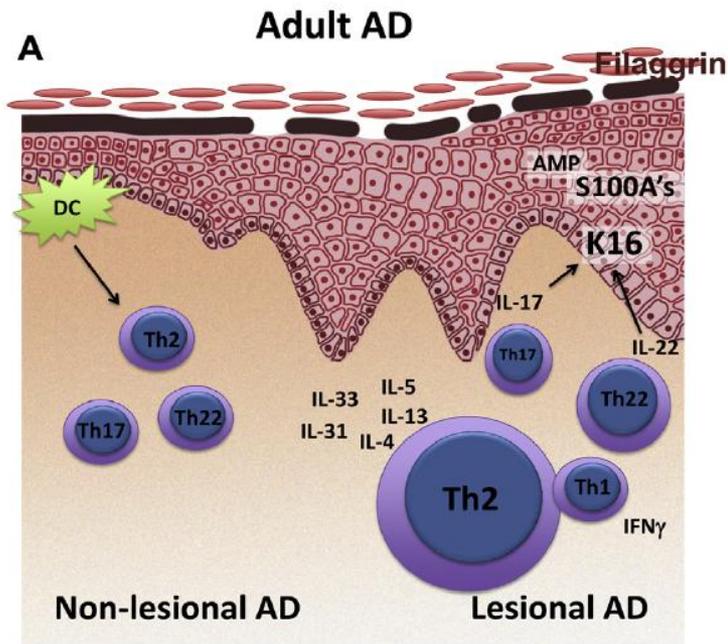


Influssi dell'ambiente

Patogenesi della AD

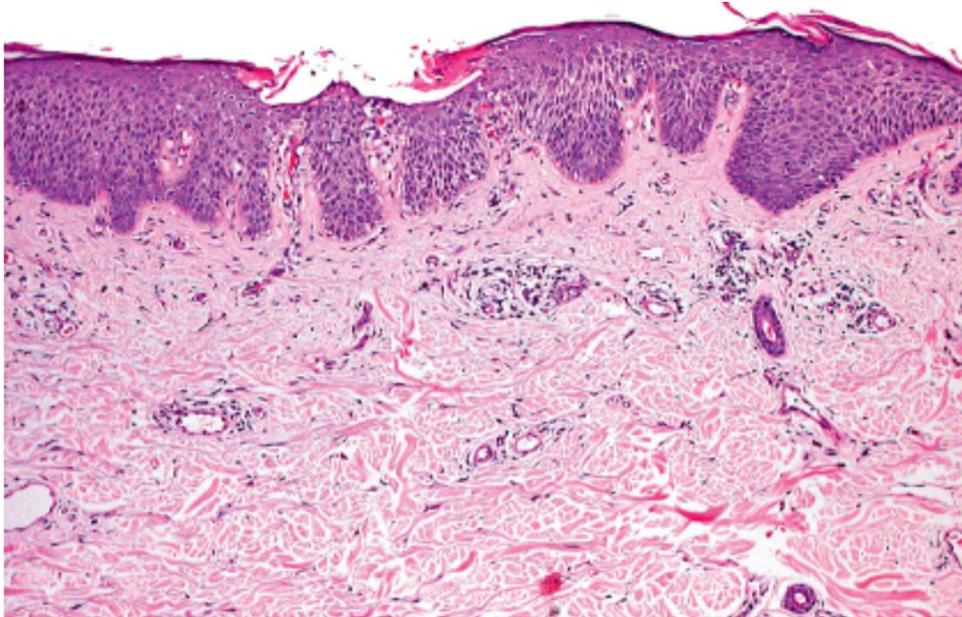


- SC:**
Stratum corneum
- KLK:**
Kallikrein
- TEWL:**
Transepidermal water loss
- TSLP:**
Thymic stromal lymphopietin

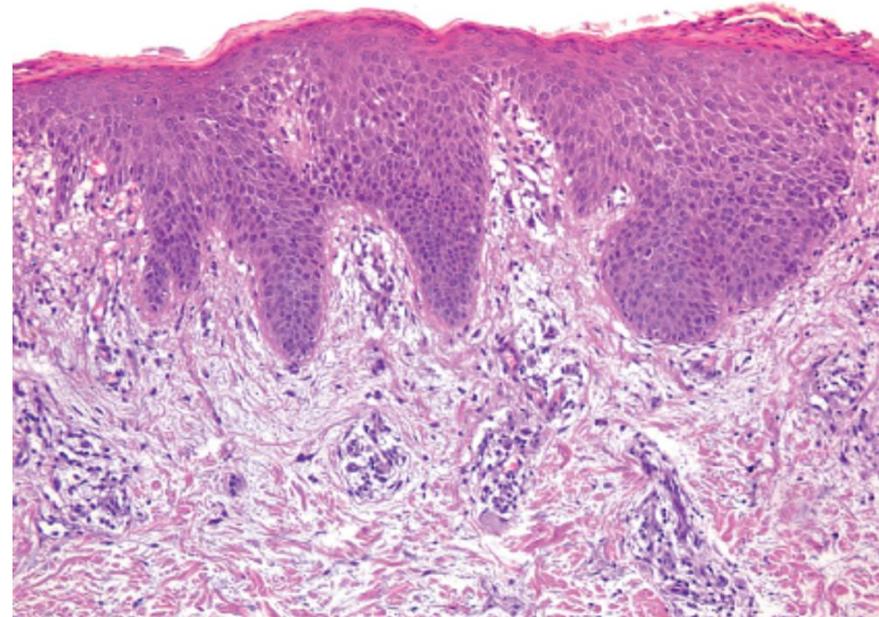


Istologia della AD

acuta

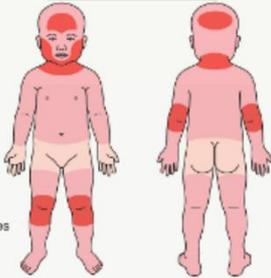


cronica



Manifestazioni e topografia della AD

Infantile atopica dermatitis



■ Most common sites
■ Other frequently involved sites



Childhood and adolescent atopic dermatitis

Head and neck dermatitis:
primarily of face and neck
after puberty;
may be triggered by
Malassezia overgrowth

Ear eczema:
erythema, scaling and fissuring
under earlobe and/or in
retroauricular region, +
bacterial superinfection

Eyelid eczema*:
often has prominent
lichenification

Nipple eczema:
exacerbated by rubbing
of clothing (e.g. in
joggers/athletes)

Dryness (chapping) of
vermillion lips, ± peeling,
fissuring, angular cheilitis

Erythema and scaling
surrounding vermillion
lips, often due to irritation
from licking (lip licker's
eczema)

**Frictional lichenoid
eruption:**
multiple, small, flat-
topped pink to skin-
colored papules on
elbows > knees,
classically in atopic boys
in spring/summer

Dyshidrotic eczema:
deep-seated vesicles
favoring sides of fingers
and palms

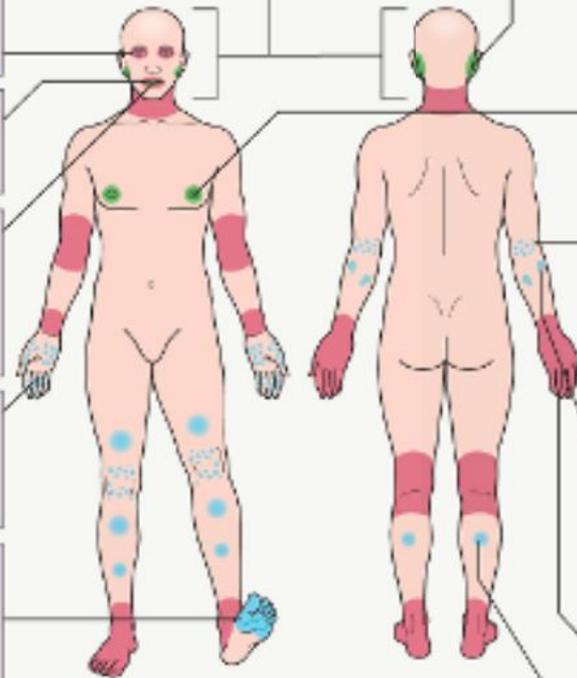
Prurigo-like lesions:
firm, dome-shaped
papulonodules with
central scale-crust,
favoring extensor
extremities

**Juvenile plantar
dermatosis:**
glazed erythema, scaling
and fissuring of plantar
forefeet

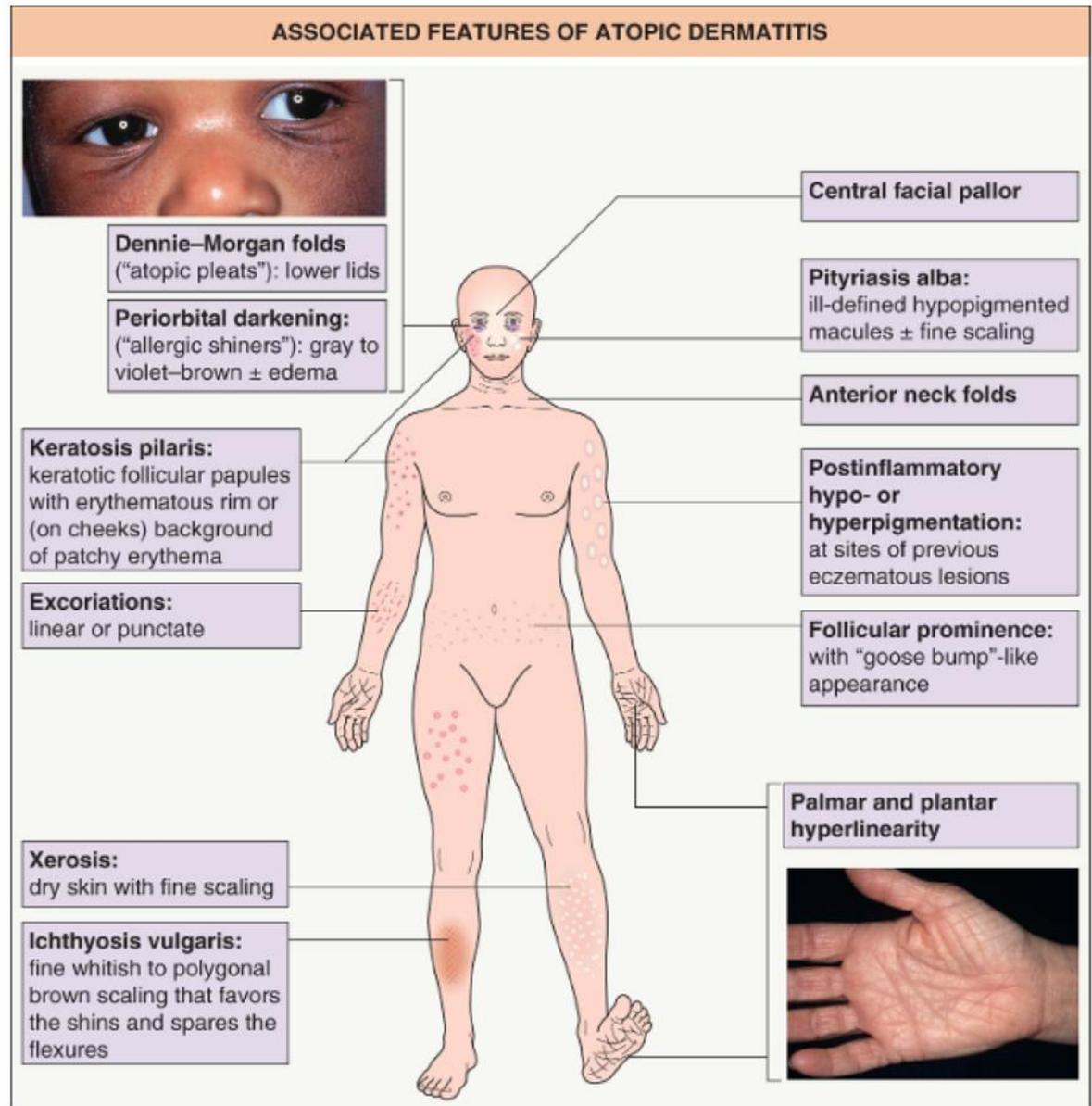
Atopic hand eczema*:
often superimposed
irritant contact dermatitis

■ Most common sites
■ Other sites of predilection
■ Specific variants

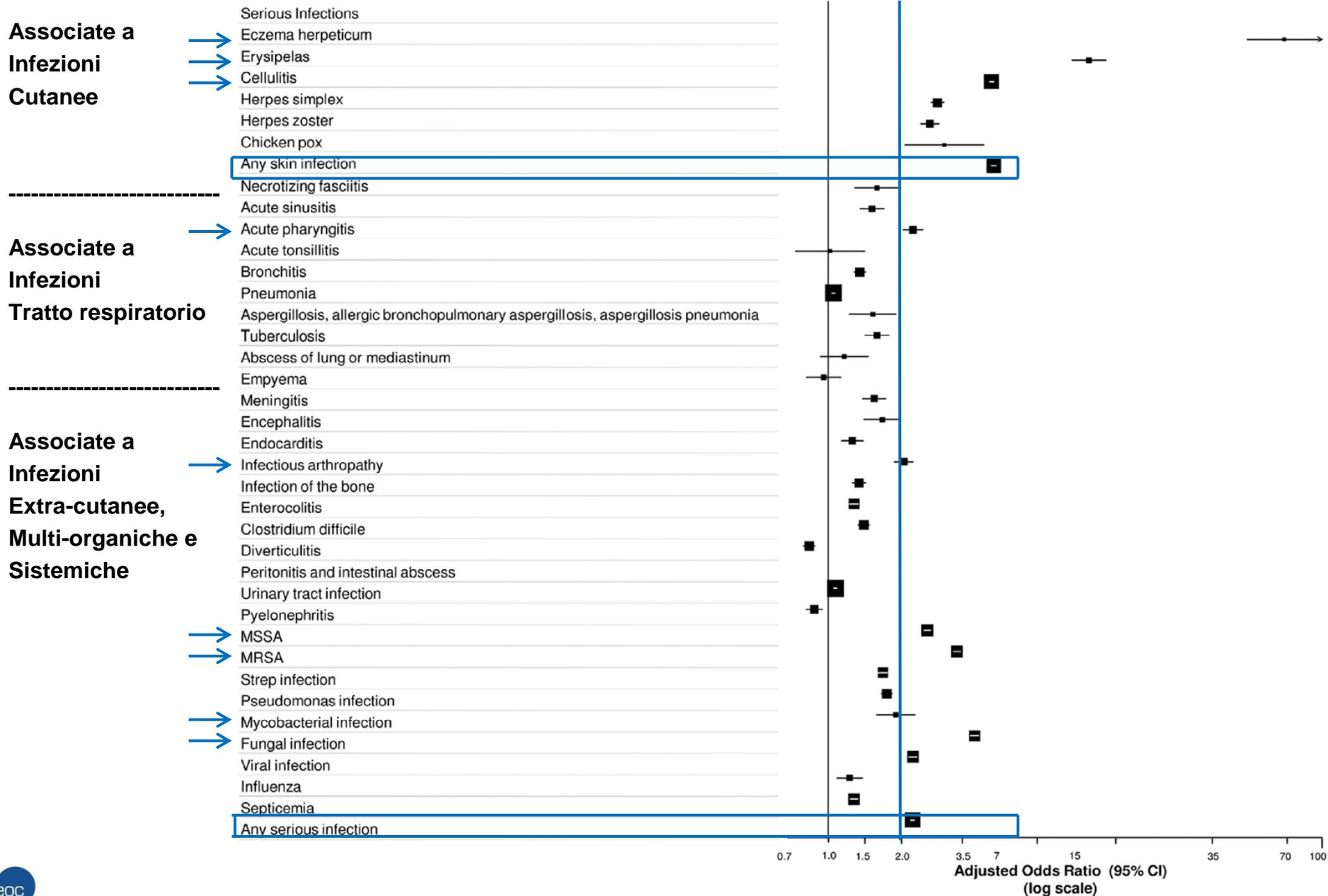
Nummular lesions†:
coin-shaped eczematous
plaques, often with
oozing/crusting, favoring
extremities

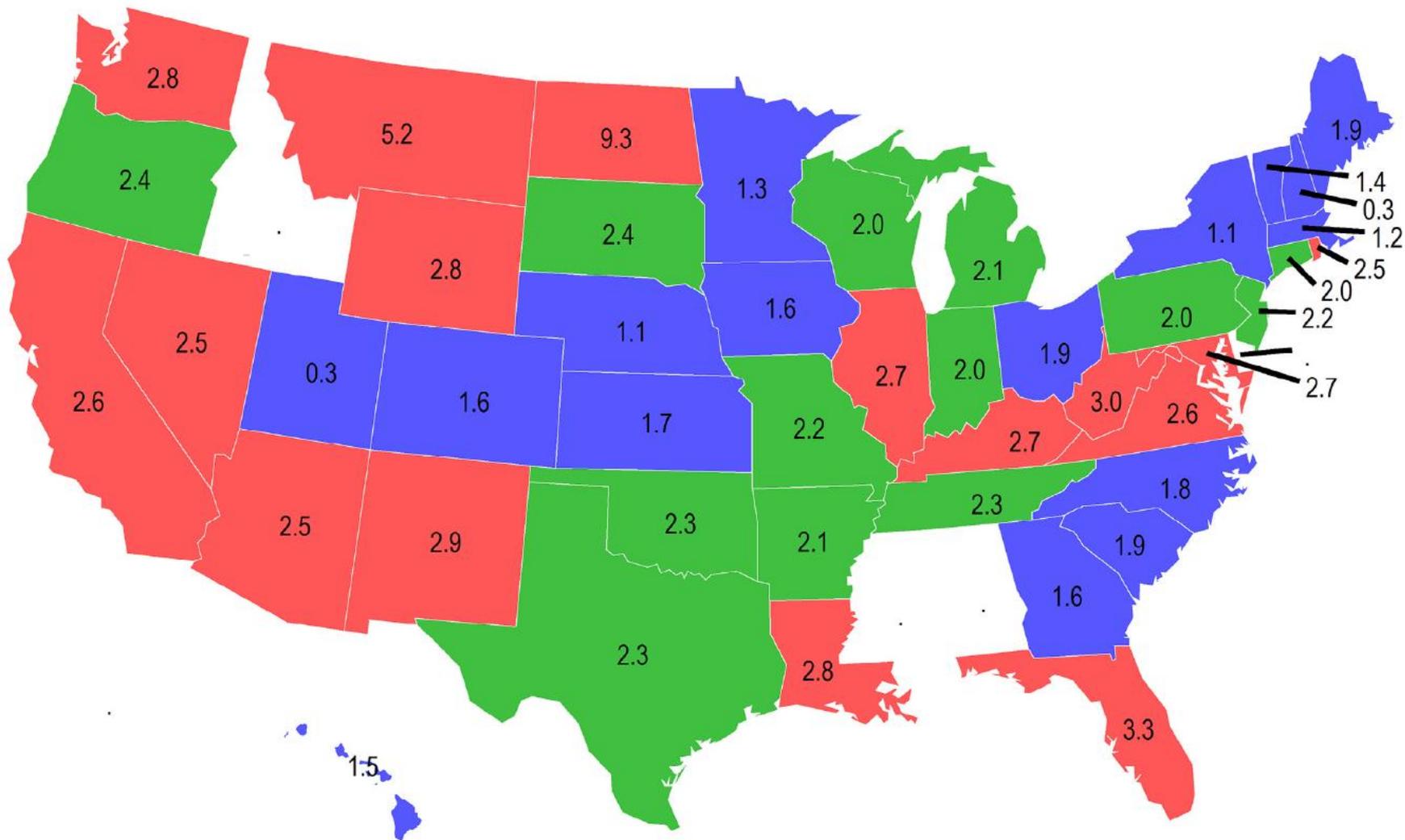


Manifestazioni associate alla AD e loro topografia



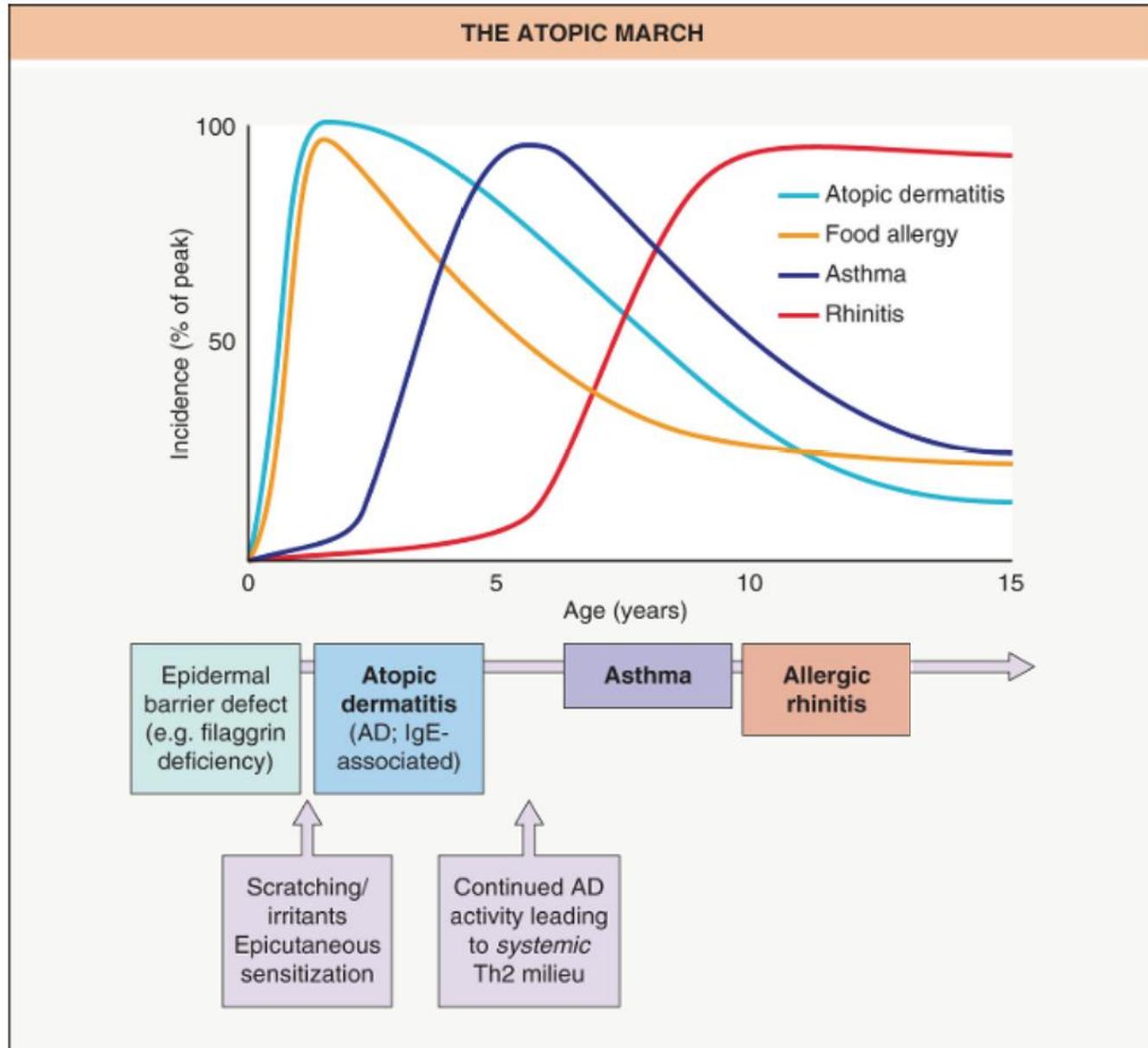
AD ed infezioni





eFigure 1. State-level mean annual prevalence of methicillin-resistant *Staphylococcal aureus* in adults with atopic dermatitis or eczema (blue, lowest tertile; green, middle tertile; red, highest tertile).

AD: malattia sistemica



Increasing Comorbidities Suggest that Atopic Dermatitis Is a Systemic Disorder



JID Open

Patrick M. Brunner¹, Jonathan I. Silverberg², Emma Guttman-Yassky³, Amy S. Paller², Kenji Kabashima⁴, Masayuki Amagai⁵, Thomas A. Luger⁶, Mette Deleuran⁷, Thomas Werfel⁸, Kilian Eyerich⁹ and Georg Stingl¹⁰, Councilors of the International Eczema Council

Atopic dermatitis comorbidities extend well beyond the march to allergic conditions (food allergy, asthma, allergic rhinitis, allergic conjunctivitis, and eosinophilic esophagitis), suggesting both cutaneous and systemic immune activation. In reviewing atopic dermatitis comorbidities, Councilors of the International Eczema Council found a strong pattern of immune activation in peripheral blood and the propensity to both skin and systemic infections. Associations with cardiovascular, neuropsychiatric, and malignant diseases were increasingly reported, but confirmation of their link with atopic dermatitis requires longitudinal studies. Given the possibility of atopic dermatitis-related systemic immune activation, future investigations of new interventions should concurrently examine the impact on these comorbidities.

www.nature.com/scientificreports

Journal of Investigative Dermatology (2017) **137**, 18–25; doi:10.1016/j.jid.2016.08.022

SCIENTIFIC REPORTS

Correction: Author Correction

OPEN The atopic dermatitis blood signature is characterized by increases in inflammatory and cardiovascular risk proteins

Received: 2 May 2017
Accepted: 24 July 2017
Published online: 18 August 2017

Patrick M. Brunner¹, Mayte Suárez-Fariñas^{2,3,4}, Helen He⁵, Kunal Malik⁶, Huel-Chi Wen⁷, Juana Gonzalez¹, Tom Chih-Chieh Chan⁸, Yeri Estrada⁹, Xiuzhong Zheng¹, Saakshi Khattri², Annunziata Dattola¹, James G. Krueger² & Emma Guttman-Yassky^{1,2}

Raccomandazioni terapeutiche nella AD dell'adulto

SEVERE:
SCORAD >50 / or
persistent eczema

Hospitalization; systemic immunosuppression: cyclosporine A², short course of oral glucocorticosteroids², dupilumab^{1,2}, methotrexate³, azathioprin³, mycophenolate mofetil³; PUVA¹; alitretinoin^{1,3}

MODERATE:
SCORAD 25-50 / or
recurrent eczema

Proactive therapy with topical tacrolimus² or class II or class III topical glucocorticosteroids³, wet wrap therapy, UV therapy (UVB 311 nm, medium dose UVA1), psychosomatic counseling, climate therapy

MILD:
SCORAD <25 / or
transient eczema

Reactive therapy with topical glucocorticosteroids class II² or depending on local cofactors: topical calcineurin inhibitors², antiseptics incl. silver², silver coated textiles¹

BASELINE:
Basic therapy

Educational programmes, emollients, bath oils, avoidance of clinically relevant allergens (encasings, if diagnosed by allergy tests)

Raccomandazioni terapeutiche nella AD in età pediatrica

SEVERE:
SCORAD >50 / or
persistent eczema

Hospitalization, systemic immunosuppression: cyclosporine A³, methotrexate³, azathioprin³, mycophenolate mofetil^{1,3}

MODERATE:
SCORAD 25-50 / or
recurrent eczema

Proactive therapy with topical tacrolimus² or class II or III topical glucocorticosteroids³, wet wrap therapy, UV therapy (UVB 311 nm)¹, psychosomatic counseling, climate therapy

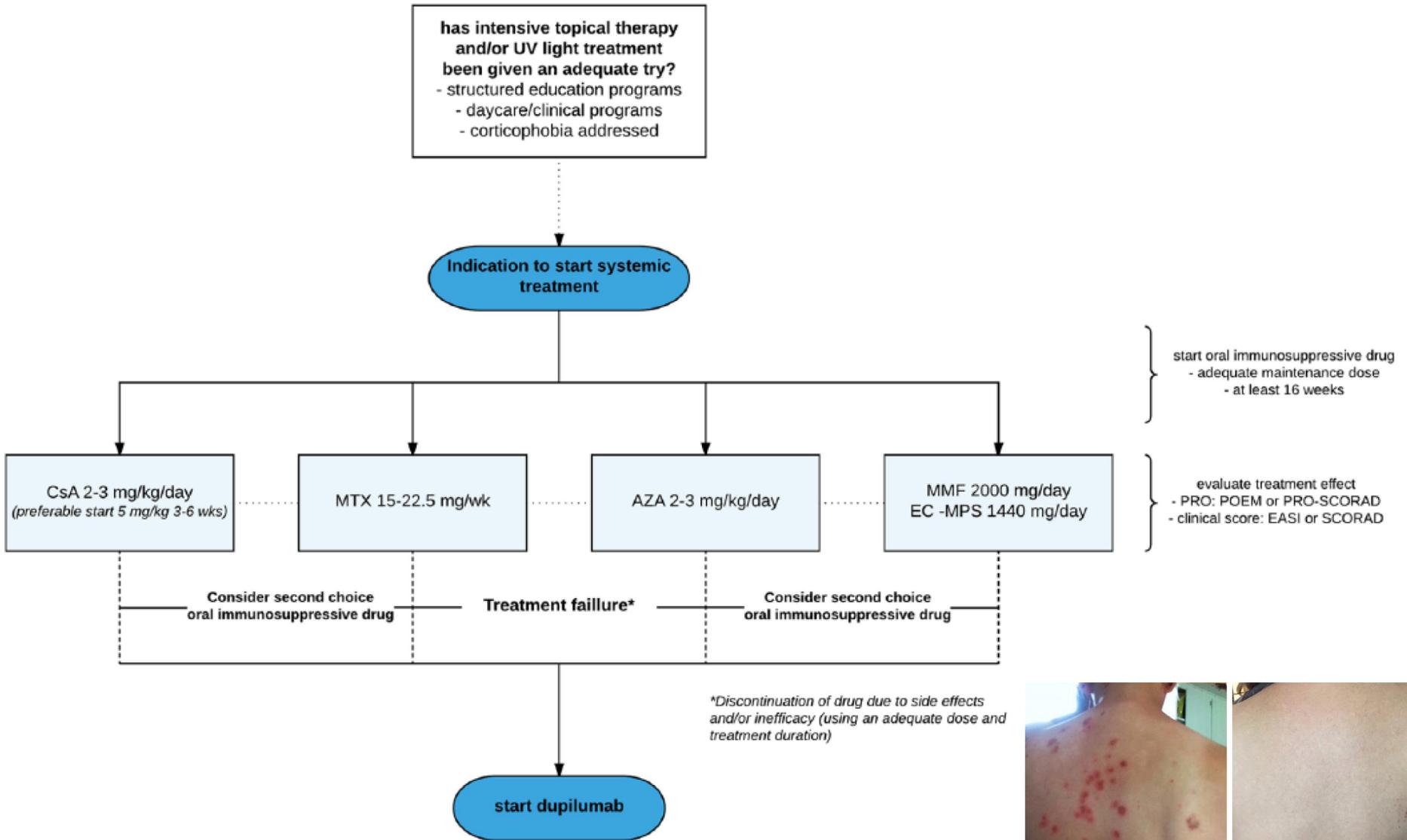
MILD:
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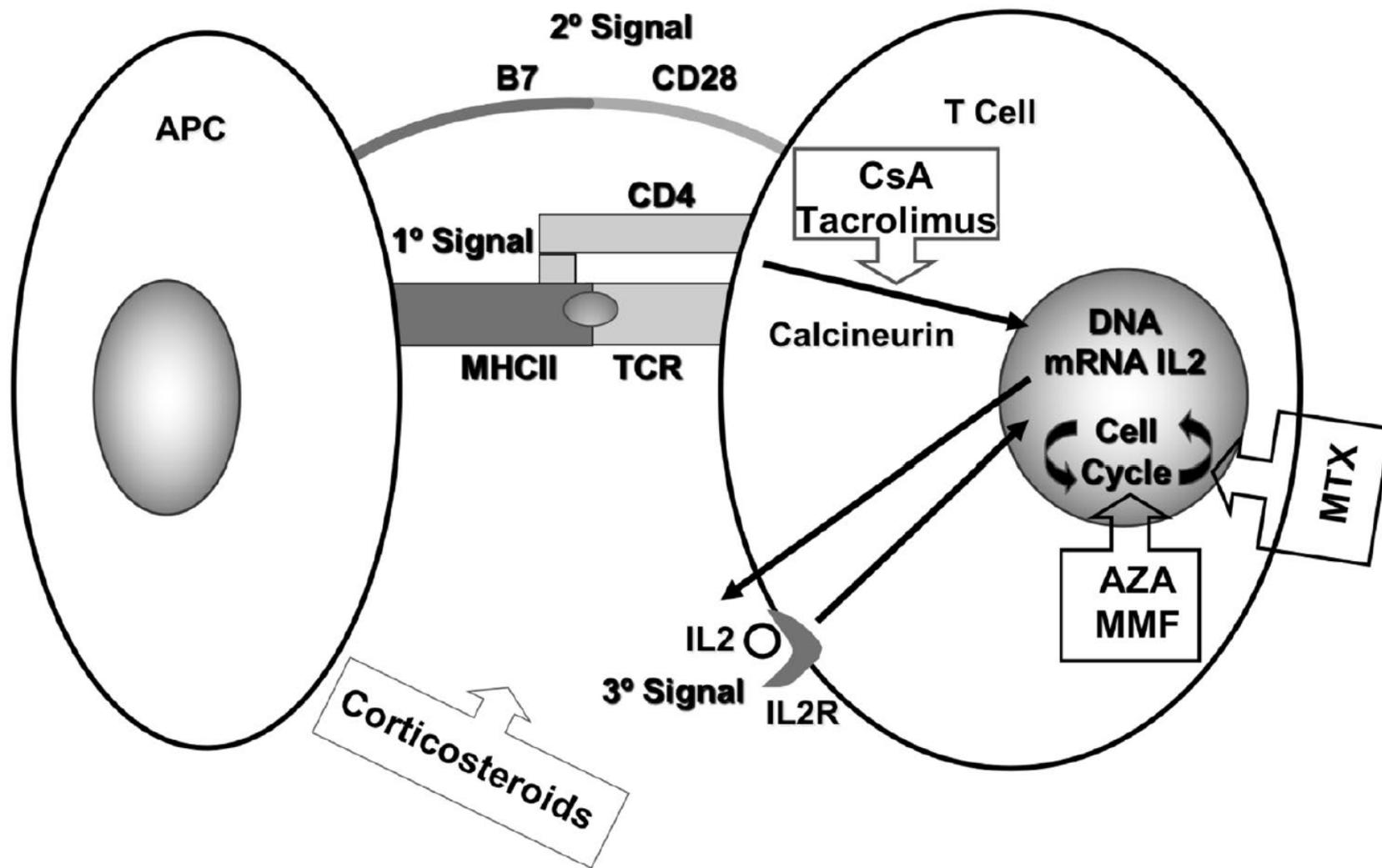
BASELINE:
Basic therapy

Educational programmes, emollients, bath oils, avoidance of clinically relevant allergens (encasings, if diagnosed by allergy tests)

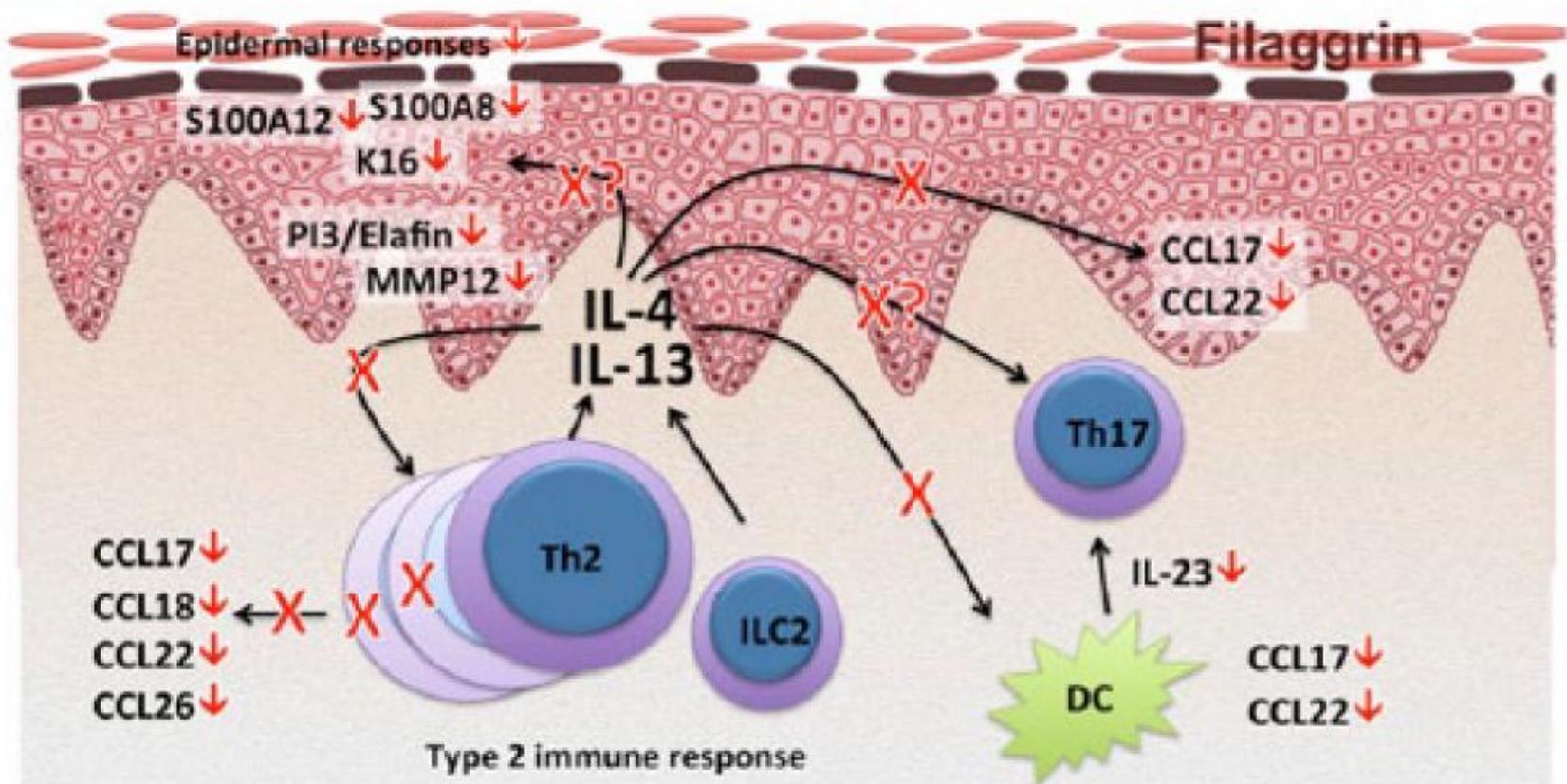
Proposta di algoritmo terapeutico per AD



Meccanismi d'azione nella AD: farmaci immunosoppressori



Meccanismo d'azione di Dupilumab nella AD



Presente e futuro della terapia della AD

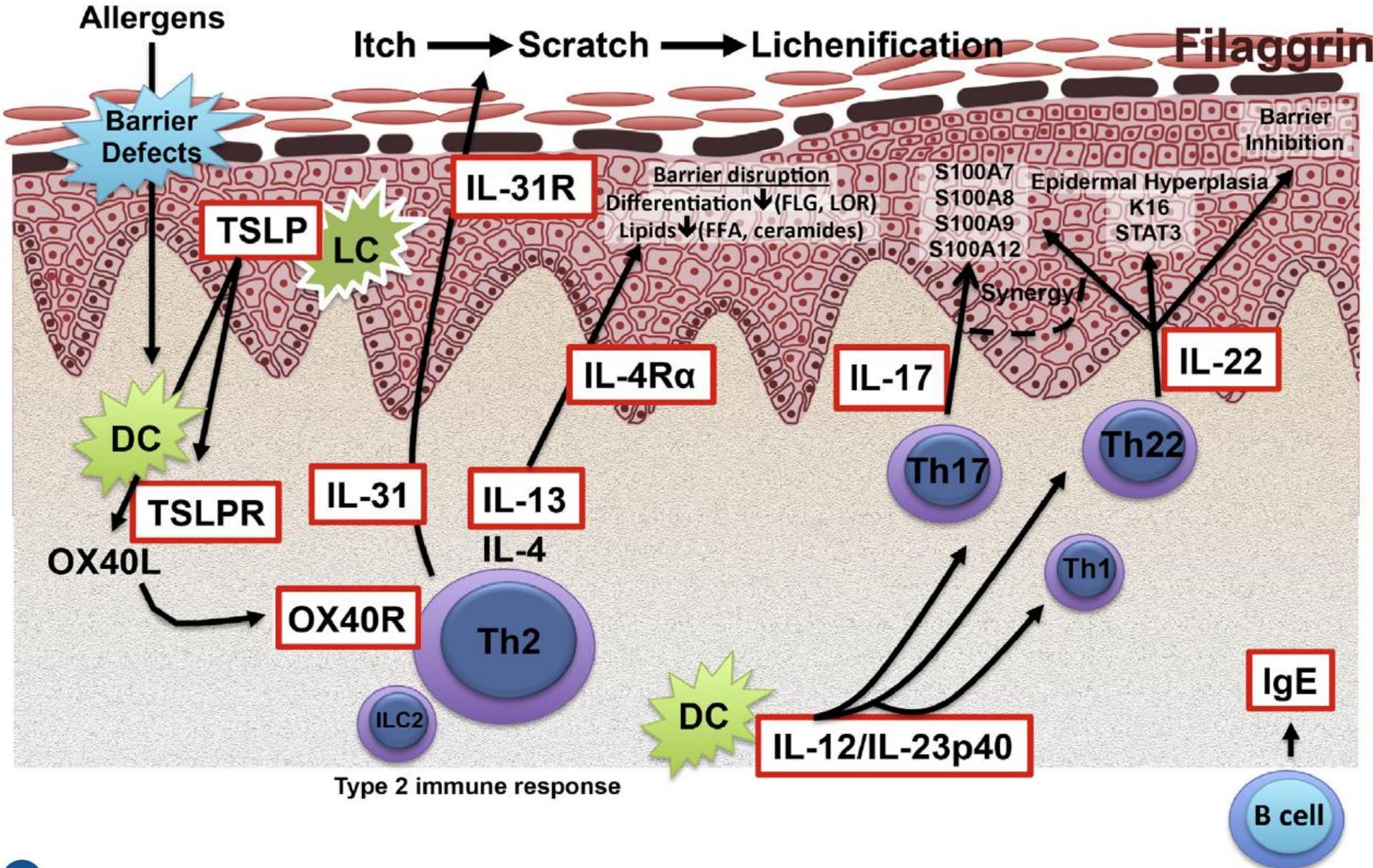
TABLE I. Recent controlled trials in patients with AD

Agent	Trade name	Target	Drug	Phase	Manufacturer	ClinicalTrials.gov
→ Dupilumab		IL-4R α	Anti-IL-4R α mAb	Phase III published	Regeneron, Tarrytown, NY	NCT02277743 NCT02277769
→ Crisaborole		PDE4	Topical PDE4 Inhibitor	Phase III published	Pfizer, New York, NY	NCT02118766 NCT02118792
→ Ustekinumab	Stelara	IL-12/23p40	Anti-p40 mAb	Phase II published	Janssen, Titusville, NJ	NCT01806662
→ Tralokinumab		IL-13	Anti-IL-13 mAb	Phase II completed	MedImmune, Gaithersburg, Md	NCT02347176
→ Tofacitinib		JAK1/3	Topical JAK1/3 Inhibitor	Phase II published	Innovaderm, Montreal, Quebec, Canada	NCT02001181
Lebrikizumab		IL-13	Anti-IL-13 mAb	Phase II completed	Hoffmann-La Roche, Basel, Switzerland	NCT02340234
CIM331/ Nemolizumab		IL-31R	Anti-IL-31R mAb	Phase II completed	Chugai, Tokyo, Japan	NCT01986933
QGE031		IgE	Anti-IgE mAb	Phase II completed	Novartis, Basel, Switzerland	NCT01552629
Apremilast	Otezla	PDE4	PDE4 inhibitor: oral small molecule	Phase II completed	Celgene, Summit, NJ	NCT02087943
QAW039/ Fevipirant		CRTH2	CRTH2 inhibitor: oral small molecule	Phase II completed	Novartis	NCT01785602
ILV-094		IL-22	Anti-IL-22 mAb	In Phase II	Pfizer	NCT01941537
GBR830		OX40	Anti-OX40 mAb	In Phase II	Glenmark, Mumbai, India	NCT02683928
Secukinumab	Cosentyx	IL-17	Anti-IL-17 mAb	In phase II	Novartis	NCT02594098
OC000459		CRTH2	CRTH2 Inhibitor: oral small molecule	In phase II	Atopix, Chiesi, Parma, Italy	NCT02002208
Baricitinib		JAK1/2	Jak1/2 inhibitor: oral small molecule	In phase II	Eli Lilly, Indianapolis, Ind	NCT02576938
PF-04965842		JAK1/2	Jak1/2 inhibitor: oral small molecule	In phase II	Pfizer	NCT02780167
ZPL389		H4R	Histamine H4 receptor inhibitor: oral small molecule	Phase II completed	Ziarco Pharma, Canterbury, United Kingdom	NCT02424253
BMS-981164		IL-31	Anti-IL-31 mAb	Phase I completed	Bristol-Myers Squibb, New York, NY	NCT01614756
AMG157/ Tezepelumab		TSLP	Anti-TSLP mAb	Phase I completed	Amgen, Thousand Oaks, Calif	NCT00757042
MK-8226		TSLPR	Anti-TSLPR mAb	In phase I	Merck, Kenilworth, NJ	NCT01732510

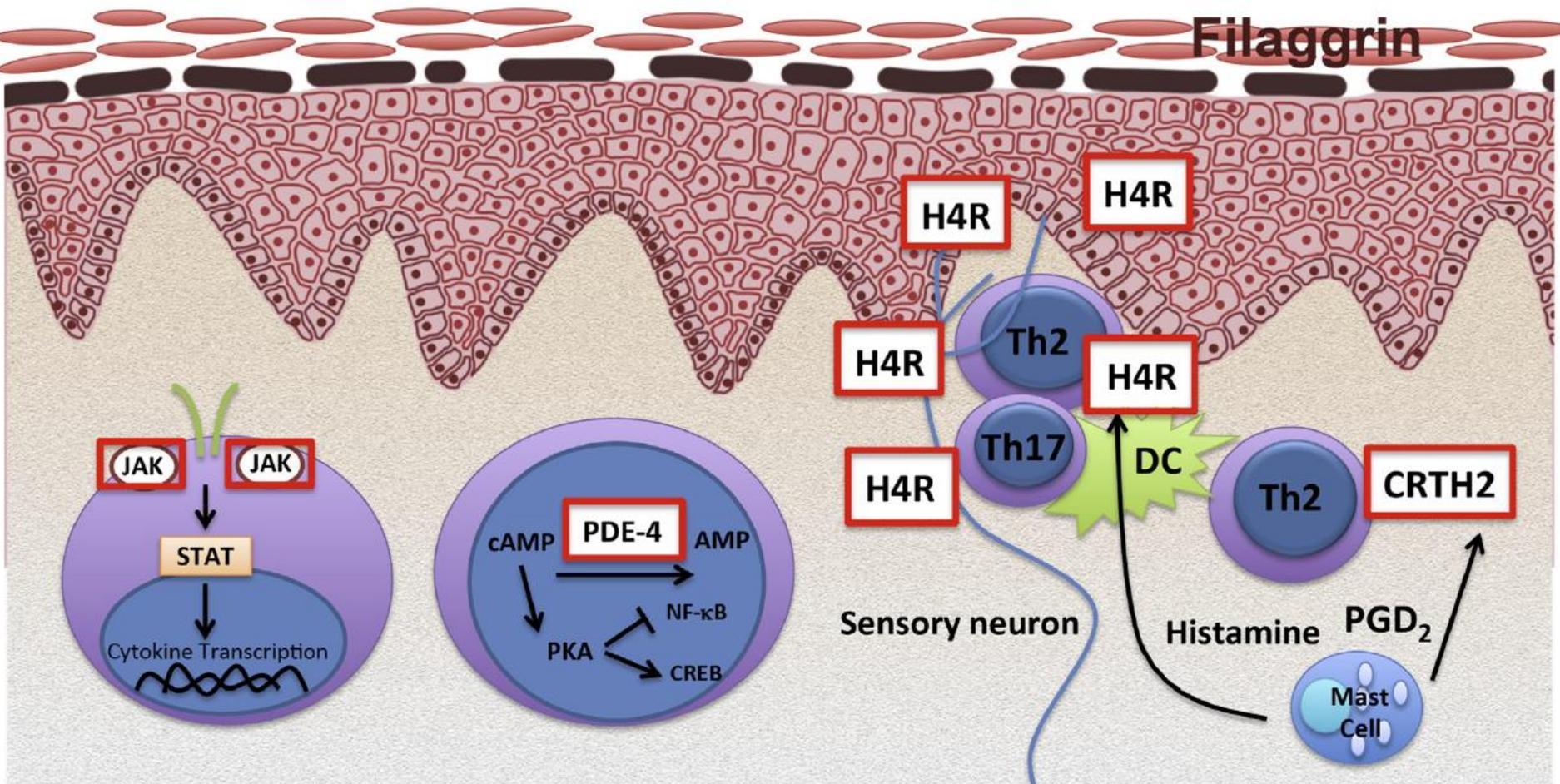
CRTH2, Prostaglandin D₂ receptor 2; H4R, histamine H4 receptor; IL-4R, IL-4 receptor; TSLPR, thymic stromal lymphopoietin receptor.

A

mAbs currently assessed in clinical trials



Small molecules currently assessed in clinical trials



Dermatite atopica: EBM

- **Ruolo degli emollienti?**
- **I corticosteroidi topici aiutano?**
- **Gli anti-istamici orali aiutano?**
- **Ruolo degli inibitori della calcineurina topici**
- **Quando utilizzare un antibiotico o antimicotico?**
- **Ruolo degli UV, immunosoppressori e farmaci biologici**

AD: Ruolo degli emollienti (RCTs)

- Evidenza: **uso degli emollienti**
 - **risparmio utilizzo corticosteroidi topici**
 - **prevenzione recidiva di eczema**
- Per mancanza di buoni RCTs, non possiamo quantificare l'importanza del ruolo terapeutico degli emollienti nella AD

AD: I corticosteroidi (CS) topici aiutano? (RCTs)

- Evidenza: **CS topici vs placebo mostrano un ampio effetto terapeutico**
- Non è possibile paragonare i vari CS topici tra di loro e stabilire quale sia il migliore
- Evidenza: **Efficacia utilizzo: 2 x giorno \approx 1 x giorno**
- Evidenza: **Utilizzo CS topico potente 2 x settimana può ridurre il numero delle recidive sia nel bambino che nell'adulto**
- Nessuna evidenza: **l'uso corretto** dei CS topici **non porta ad una diminuzione dello spessore della pelle** (ma gli studi erano di corta durata)

AD: Gli anti-istamici orali aiutano? (RCTs)

- Evidenza: **Anti-H1 non portano nessun beneficio**
- Nei bambini possono essere usati occasionalmente per le loro proprietà sedative

AD: Ruolo degli inibitori della calcineurina topici (RCTs)

- **Tacrolimus** 0.1% o 0.03% unguento / **Pimecrolimus** 1% crema
- Inibitori della calcineurina topici sono **meno efficaci di un CS topico potente**: Il pimecrolimus è probabilmente meno efficace del tacrolimus
- Evidenza: Efficacia superiore all'acetato di idrocortisone
- Effetti secondari: **Bruciore transitorio** in quasi la metà dei pazienti

AD: Nuovo trattamento topico (RCTs)

- Crisaborole è un composto di benzoxaborolo che ha l'abilità di legare il centro dell'enzima PDE4 (fosfodiesterasi-4), inibendo l'attività del PDE4
- Inibitori della PDE4 sopprimono la produzione di citochine ed inibiscono le reactive oxygen species

	Crisaborole efficacy compared to vehicle control	Crisaborole safety
	Significant improvement in investigator global assessment	Most common adverse event is application-site pain/burning, mild-to-moderate intensity
→	Significant improvement in pruritus	Low systemic absorption
	Well-tolerated in intertriginous skin and facial skin	No black box warning regarding malignancy

AD: Quando utilizzare un antibiotico o antimicotico? (RCTs)

- AD infetta necessita di una cura antiinfettiva, ma non c'è evidenza sul migliore trattamento
- Farmaci anti-stafilococco sono efficaci riducendo la colonizzazione di stafilococco dorato, ma non c'è evidenza sul beneficio clinico in AD non infette
- **Farmaci antifungini:** pochi piccoli studi: nessuna evidenza di beneficio
- Effetti secondari ai farmaci antimicrobici sono relativamente bassi: ma rimane il rischio di sviluppare microorganismi con resistenze, quando le terapie sono prolungate

AD: Ruolo degli UV, immunosoppressori e farmaci biologici (RCTs)

- Evidenza: **Ciclosporina utile per la AD severa**
 - **Limite:** a lungo termine diversi ES (danno renale)
 - Utilizzo: **stabilizzare AD e ripassare alle cure locali**
- Evidenza: **AZA, MTX**, efficacia a corto termine nelle AD severe, mancano studi a lungo termine. **MMF** efficace per AD severa, ma mancano RCTs
- Evidenza Fototerapia:
 - **UVA1:** eczema acuto
 - **UVB TL-01:** eczema cronico
- Evidenza: **Dupilumab e Ustekinumab**

AD: Novità 2018 e ...?

- **Dupilumab** sotto cute
- **Crisaborole** unguento 2% (Eucrisa): inibitore della fosfodiesterasi-4
- AD: **malattia sistemica?**
- Nuovi farmaci sistemici fra poco a disposizione con indicazione AD:
Ustekinumab, ...

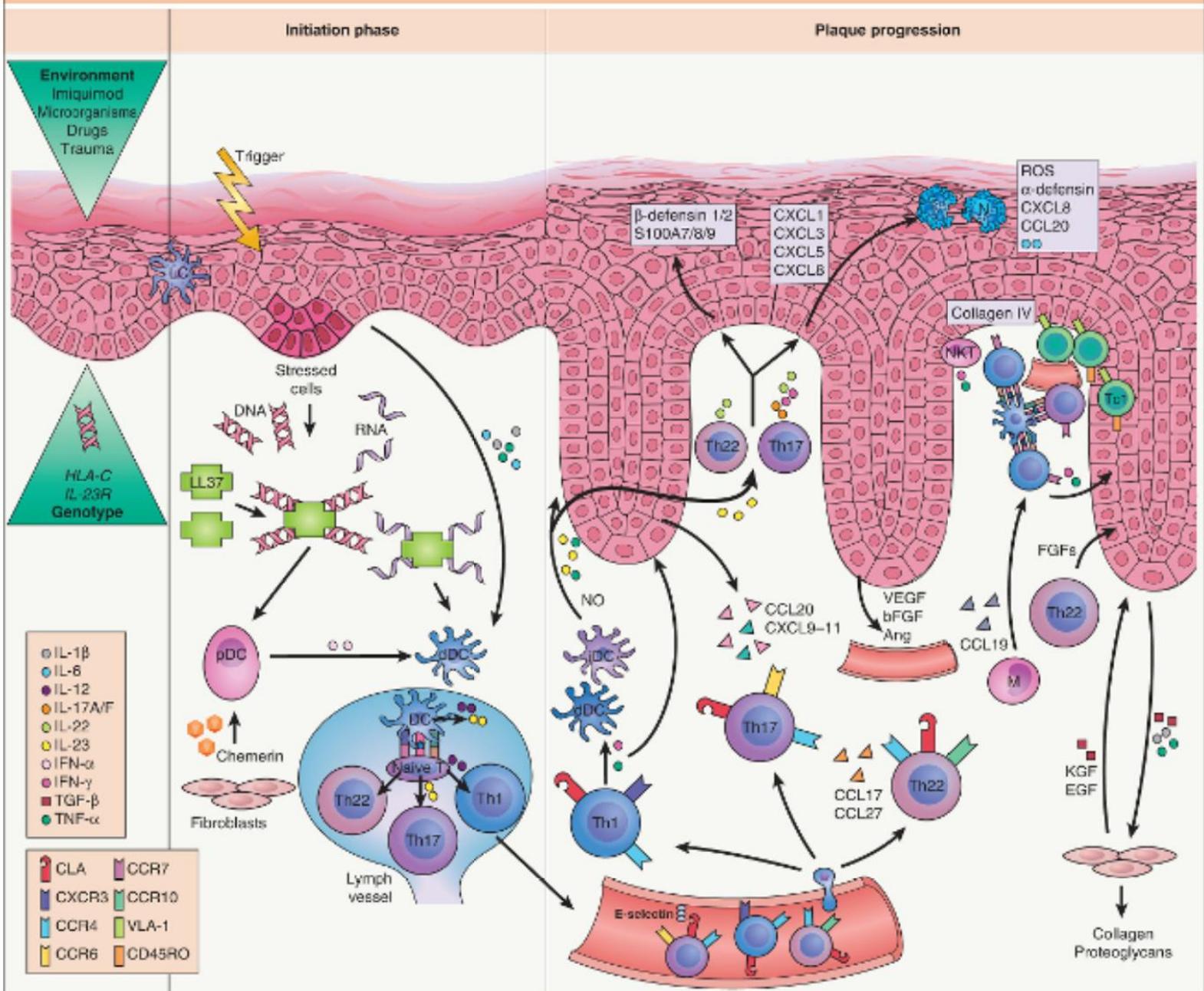
Sommario

- **Dermatite atopica**
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- **Orticaria cronica**
- **Novità particolari**
- **6 tipi di risposte immunologiche nelle dermatosi infiammatorie**

Psoriasi (PSO)

- **Definizione:** malattia infiammatoria cutanea caratterizzata da un turnover epidermico accelerato con iperproliferazione e maturazione difettosa dei cheratinociti
- **Prevalenza** in Europa: **1-3 %** della popolazione
- **Eziologia:** genetica – immunologica – ambientale – abitudini
- **Patogenesi:** «Effetto Köbner» – Alterazione sistema immunitario innato e adattivo
- **Prognosi:** remissioni intermittenti; PSO severa associata a rischio significativo di morbidità cardio-vascolare
- **Obiettivi delle cure:** controllo della malattia e diminuire rischio cardio-vascolare

IMMUNOPATHOGENESIS OF PSORIASIS

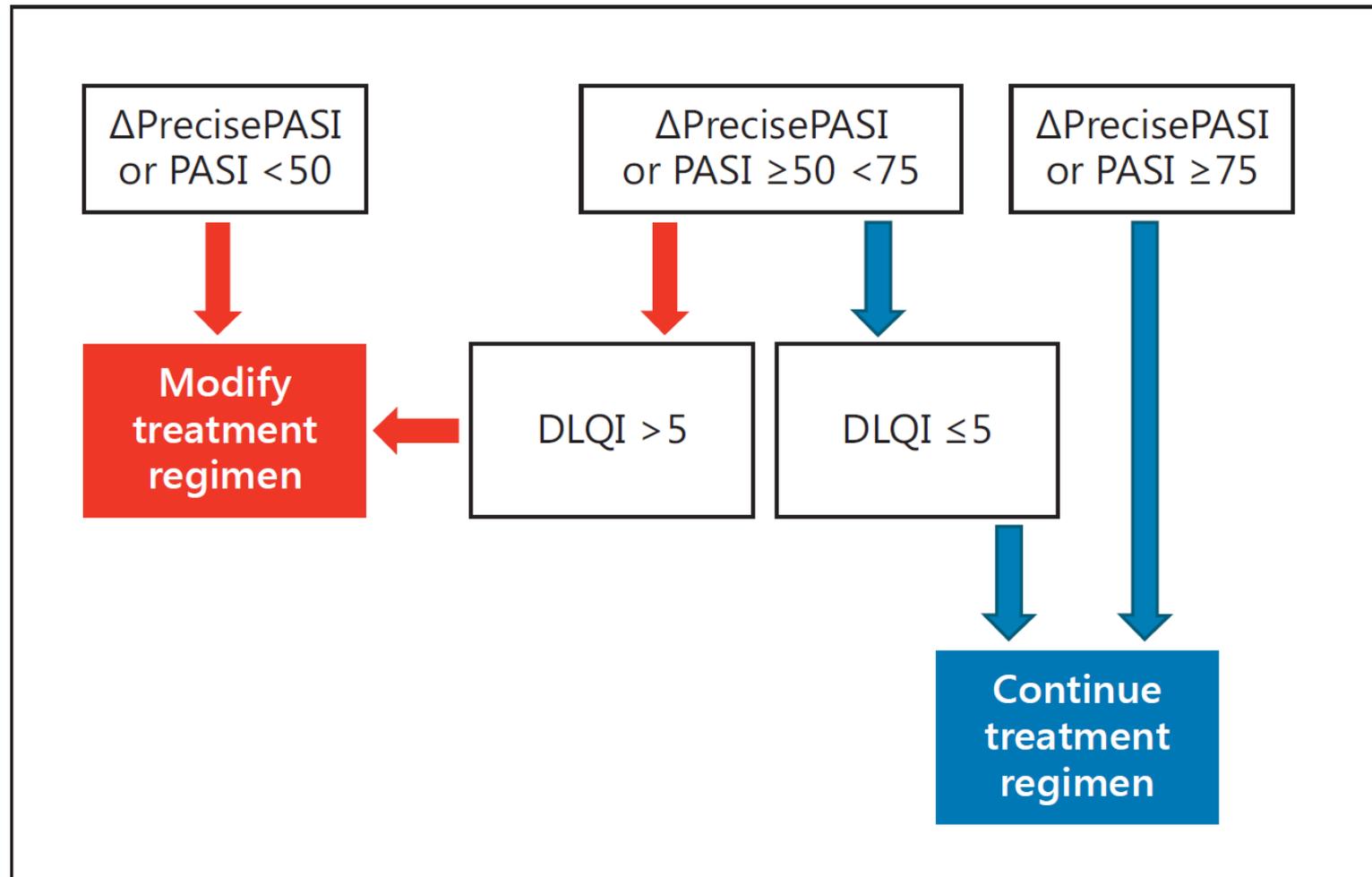


Swiss S1 Guidelines on the Systemic Treatment of Psoriasis Vulgaris

Antonios G.A. Kolios^{a,b} Nikhil Yawalkar^c Mark Anliker^d Wolf-Henning Boehncke^e
Luca Borradori^c Curdin Conrad^f Michel Gilliet^f Peter Häusermann^g Peter Itin^g
Emmanuel Laffitte^o Carlo Mainetti^h Lars E. French^o Alexander A. Navarini^a

Departments of ^aDermatology and ^bImmunology, Zurich University Hospital, Zurich, ^cDepartment of Dermatology, Bern University Hospital, Bern, ^dDepartment of Dermatology and Allergies, St. Gallen Cantonal Hospital, St. Gallen, ^eDivision of Dermatology and Venereology, Geneva University Hospital, Geneva, ^fDepartment of Dermatology and Venereology, Lausanne University Hospital, Lausanne, ^gDepartment of Dermatology, Basel University Hospital, Basel, and ^hDepartment of Dermatology, Regional Hospital of Bellinzona, Bellinzona, Switzerland

Traguardi da raggiungere con la cura sistemica



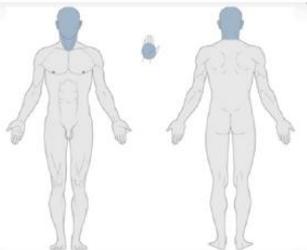
PASI SCORE

Paziente:.....Data:.....

The neck is included as part of the head

Head and Neck = 10% (10 palms)

Patient's palm = 1%
Total BSA = 100% (100 palms)



Superficie	Eritema	Infiltrazione	Desquamazione
0	0	0	0
1 (1-9%)	1	1	1
2 (10-29%)	2	2	2
3 (30-49%)	3	3	3
4 (50-69%)	4	4	4
5 (70-89%)			
6 (90-100%)			

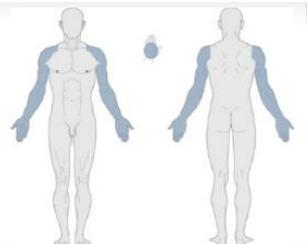
E + I + D =

x S =

x 0,1 =

Upper extremities = 20% (20 palms)

Patient's palm = 1%
Total BSA = 100% (100 palms)



Superficie	Eritema	Infiltrazione	Desquamazione
0	0	0	0
1 (1-9%)	1	1	1
2 (10-29%)	2	2	2
3 (30-49%)	3	3	3
4 (50-69%)	4	4	4
5 (70-89%)			
6 (90-100%)			

E + I + D =

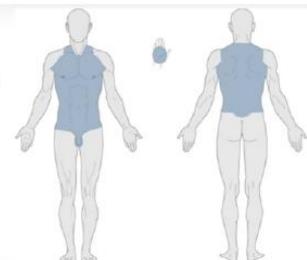
x S =

x 0,2 =

The axillae and genitals are included with the trunk

Trunk (axillae and groin) = 30% (30 palms)

Patient's palm = 1%
Total BSA = 100% (100 palms)



Superficie	Eritema	Infiltrazione	Desquamazione
0	0	0	0
1 (1-9%)	1	1	1
2 (10-29%)	2	2	2
3 (30-49%)	3	3	3
4 (50-69%)	4	4	4
5 (70-89%)			
6 (90-100%)			

E + I + D =

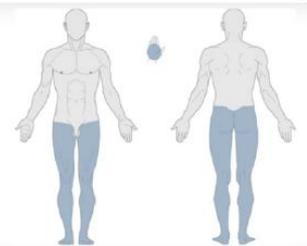
x S =

x 0,3 =

The inguinal canal separates the trunk and legs anteriorly

Lower extremities (buttocks included) = 40% (40 palms)

Patient's palm = 1%
Total BSA = 100% (100 palms)



Superficie	Eritema	Infiltrazione	Desquamazione
0	0	0	0
1 (1-9%)	1	1	1
2 (10-29%)	2	2	2
3 (30-49%)	3	3	3
4 (50-69%)	4	4	4
5 (70-89%)			
6 (90-100%)			

E + I + D =

x S =

x 0,4 =

PASI = TESTA.....+ ARTI SUP.....+ TRONCO.....+ ARTI INF.....=.....

Appendix 1: Dermatology Life Quality Index

Hospital No.:

Name:

Address:

Date:

Diagnosis:

Score:

DLQI

The aim of this questionnaire is to measure how much your skin problem has affected your life OVER THE LAST WEEK. Please tick one box for each question.

- Over the last week, how itchy, sore, painful or stinging has your skin been?

Very much	<input type="checkbox"/>
A lot	<input type="checkbox"/>
A little	<input type="checkbox"/>
Not at all	<input type="checkbox"/>
- Over the last week, how embarrassed or self-conscious have you been because of your skin?

Very much	<input type="checkbox"/>
A lot	<input type="checkbox"/>
A little	<input type="checkbox"/>
Not at all	<input type="checkbox"/>
- Over the last week, how much has your skin interfered with you going shopping or looking after your home or garden?

Very much	<input type="checkbox"/>
A lot	<input type="checkbox"/>
A little	<input type="checkbox"/>
Not at all	<input type="checkbox"/>
Not relevant	<input type="checkbox"/>
- Over the last week, how much has your skin influenced the clothes you wear?

Very much	<input type="checkbox"/>
A lot	<input type="checkbox"/>
A little	<input type="checkbox"/>
Not at all	<input type="checkbox"/>
Not relevant	<input type="checkbox"/>
- Over the last week, how much has your skin affected any social or leisure activities?

Very much	<input type="checkbox"/>
A lot	<input type="checkbox"/>
A little	<input type="checkbox"/>
Not at all	<input type="checkbox"/>
Not relevant	<input type="checkbox"/>
- Over the last week, how much has your skin made it difficult for you to do any sport?

Very much	<input type="checkbox"/>
A lot	<input type="checkbox"/>
A little	<input type="checkbox"/>
Not at all	<input type="checkbox"/>
Not relevant	<input type="checkbox"/>
- Over the last week, has your skin prevented you from working or studying?

Yes	<input type="checkbox"/>
No	<input type="checkbox"/>
Not relevant	<input type="checkbox"/>

If 'No', over the last week how much has your skin been a problem at work or studying?

A lot	<input type="checkbox"/>
A little	<input type="checkbox"/>
Not at all	<input type="checkbox"/>
- Over the last week, how much has your skin created problems with your partner or any of your close friends or relatives?

Very much	<input type="checkbox"/>
A lot	<input type="checkbox"/>
A little	<input type="checkbox"/>
Not at all	<input type="checkbox"/>
Not relevant	<input type="checkbox"/>
- Over the last week, how much has your skin caused any sexual difficulties?

Very much	<input type="checkbox"/>
A lot	<input type="checkbox"/>
A little	<input type="checkbox"/>
Not at all	<input type="checkbox"/>
Not relevant	<input type="checkbox"/>
- Over the last week, how much of a problem has the treatment for your skin been, for example by making your home messy, or by taking up time?

Very much	<input type="checkbox"/>
A lot	<input type="checkbox"/>
A little	<input type="checkbox"/>
Not at all	<input type="checkbox"/>
Not relevant	<input type="checkbox"/>

Please check you have answered EVERY question. Thank you.

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Table 16. Small molecules

	Methotrexate	Acitretin	Fumaric acid esters	Cyclosporine A	Apremilast
Mode of action	Folate analog acts as immunosuppressive by inhibiting the dihydrofolate reductase and leading to inhibition of DNA synthesis	Antiproliferative effect on keratinocytes by binding to nuclear RAR and RXR receptor	Anti-inflammatory and cytoprotective via e.g. Nrf2 induction, NF- κ B inhibition, action on immune/glial and endothelial cells and keratinocytes	Immunosuppressive via inhibition of calcineurin/NFAT pathway and JNK signaling, esp. in T cells	Phosphodiesterase-4 inhibition results in cAMP increase in immune and nonimmune cells, leading to decreased expression of inducible NOS, TNF- α , IL-23 and increased IL-10
Registration in dermatology [30]	Severe psoriasis unresponsive to phototherapy or acitretin	Severe pustular and plaque psoriasis	Moderate-to-severe plaque psoriasis unresponsive to topicals [71] (Germany only)	Severe psoriasis unresponsive to other therapies	Moderate-to-severe plaque psoriasis which failed MTX, CsA, acitretin or PUVA
Prior treatment initiation [5, 72]	Full blood count, transaminases, creatinine, urine analysis, β -HCG, CRP, HBs-Ag, HBs-Ab, HBe-Ab, HCV screening, HIV, chest X-ray	Blood count, transaminases, creatinine, fasting blood lipids, fasting glucose, β -HCG (once monthly up to 2–3 years after stop of therapy)	Blood count, transaminases, creatinine, β -HCG, urine analysis	Blood count, transaminases, creatinine, electrolytes incl. Mg, K, urine analysis, lipids, uric acid, HBs-Ag, HBs-Ab, HBe-Ab, HCV screening, HIV, blood pressure at two different time points, β -HCG	Screening for HBs-Ag, HBs-Ab, HBe-Ab, HCV and HIV; creatinine, β -HCG Optional: blood count, transaminases, CRP, IFN- γ release test (tuberculosis)
Laboratory values, control intervals [5]	Differential blood count, creatinine, liver values, CRP after 1, 2, 3, 4, 5, and 12 weeks, then every 3 months; fibroscan every 1.5 g of cumulative dose of MTX [64]	Blood count every 8 weeks, liver values after 4, 8, then every 8 weeks, pregnancy test 1 \times monthly, lipids after 4, then every 12 weeks	Blood count, liver/kidney values, urine analysis monthly until month 4, then every 8 weeks	Blood count, transaminases, electrolytes (Mg, K), creatinine, urine at weeks 2, 4, then every 4 weeks; uric acid every 4 weeks, lipids every 4 weeks; blood pressure after 2, 4, 6, 8, 10, and 12 weeks, then every month	Optional: blood count, CRP, AST/ALT, creatinine
Administration	p.o. and s.c.	p.o.	p.o.	p.o.	p.o.
Dosage [5]	Induction with 7.5–15 mg/week, maintenance up to 25 mg/week as needed; 24–48 h after application 5 mg folic acid orally, in case of ongoing gastrointestinal complaints also 24 h before MTX	Induction with 0.3–0.5 mg/kg/day for 4 weeks, then 0.5–0.8 mg/kg/day	Induction with 1 tablet Fumaderm [®] initial (30 mg) daily and increase weekly with 1 tablet until 1–1–1 for 1 week, switch to 1 tablet Fumaderm [®] (120 mg) daily and increase weekly with 1 tablet up to 2–2–2 (see table 7)	Induction with 2.5–3 mg/kg/day, in case of inefficiency increase dosage with 0.5–1 mg/kg/day up to a maximum of 5 mg/kg/day; interval therapy (8–16 weeks) with a dosage reduction at the end of induction therapy (e.g. 0.5 mg/kg body weight every 14 days) or continuous long-term therapy with dosage reduction, e.g. 50 mg every 4 weeks after week 12	Induction over 5 days Day 1: 10–0–0 mg Day 2: 10–0–10 mg Day 3: 10–0–20 mg Day 4: 20–0–20 mg Day 5: 20–0–30 mg Day 6 and ongoing/maintenance: 30 mg twice daily
Median onset of effect [5]	4–6 weeks	4–8 weeks	6 weeks	4 weeks	10 weeks
PASI75 [5]	Week 16: 35–75% [73–75]	Week 12: 25–41% (monotherapy) [76, 77], 94% (re-PUVA) [78]	Week 16: 50–70% [31]	Weeks 8–16: 50–70%, dose-dependent, 3 mg/kg [79, 80]	Week 16: 32–41% [81]
PASI90	Week 10: 19% Week 22: 39% [82]	Up to 40% [83] (time point unclear)	Week 16: 9% [84]	Week 4: at least 40% [85, 86]	Week 16: 9.8% [81]
Contra-indications [5]	Absolute: severe infections, severe liver disease, renal failure, conception (men and women)/breast-feeding, alcohol abuse, bone marrow dysfunction/hematological changes, immunodeficiency, acute peptic ulcer, significantly reduced lung function, hypersensitivity to MTX Relative: kidney or liver disorders, ulcerative colitis, history of hepatitis, lack of compliance, active desire to have a child for women of childbearing age and men, gastritis, diabetes mellitus, previous malignancies, congestive heart failure Caution in case of: lung diseases, live vaccination, multiple drug consumption	Absolute: severe renal or hepatic dysfunction, hepatitis, women of childbearing age (see chapter acitretin), excessive alcohol consumption, incompatible medication, unwillingness to cease blood donation during and until 1 year after treatment, hypersensitivity to acitretin Relative: alcohol abuse, diabetes mellitus, contact lenses, childhood, history of pancreatitis, hyperlipidemia (particularly hypertriglyceridemia) and drug-controlled hyperlipidemia, atherosclerosis Caution in case of: tetracyclines because of the risk of pseudotumor cerebri; relative contraindication for MTX	Severe general disease, chronic gastrointestinal diseases, severe liver and kidney diseases, chronic diseases accompanied by disturbances in leukocyte counts and functions, malignancies, pregnant or lactating women, hypersensitivity to FAEs Caution in case of: concomitant use of MTX, retinoids, CsA, psoralen, nephrotoxic medication	Absolute: kidney dysfunction, uncontrolled arterial hypertension, uncontrolled infection, current or past malignancy (exception nonmelanoma skin cancer), hypersensitivity to CsA; relative: liver dysfunction, pregnancy and lactation, concomitant use of substances that interact with CsA, simultaneous phototherapy or PUVA pretherapy with a cumulative dose >1,000 J/cm ² , concomitant use of other immunosuppressants, retinoids, or long-term pretherapy with MTX, uncontrolled chronic hepatitis B (positive HbsAg)	Absolute: rare hereditary problems of galactose intolerance, lapp lactase deficiency or glucose-galactose malabsorption, pregnancy/breast-feeding, hypersensitivity to apremilast, live vaccines Relative: severe renal impairment (creatinine clearance <30 ml/min estimated by the Cockcroft-Gault equation), dose should be reduced to 30 mg once daily, caution in case of depression, underweight at the start of treatment

PSO: terapia sistemica con piccole molecole

- **MTX**
- **Acitretina**
- **Esteri dell'acido fumarico**
- **Ciclosporina A**
- **Apremilast**

Table 17. Biological therapies

	Anti-TNF- α			Anti-p40 (IL-12/23)	Anti-IL-17A
	Enbrel [®]	Remicade [®]	Humira [®]	Stelara [®]	Cosentyx [®]
Generic name	Etanercept ETA	Infliximab IFX	Adalimumab ADA	Ustekinumab UST	Secukinumab SEC
Producer	Pfizer	Centocor/MSD	AbbVie AG	Janssen	Novartis
Mode of action	Human TNF receptor Fc fusion protein which binds soluble/membrane-bound TNF- α and lymphotoxin- β	Chimeric monoclonal IgG1, binds soluble and membrane-bound TNF- α	Human monoclonal IgG1 antibody, binds soluble and membrane-bound TNF- α	Human monoclonal IgG1 antibody, binds and blocks p40 of IL-12 und IL-23 [90]	Fully human monoclonal IgG1 antibody, binds and blocks IL-17A
Registration in dermatology [30]	Plaque-type psoriasis in adults, in case of ETA, IFX, ADA, and UST also psoriatic arthritis, in case of ETA indicated from the age of 6 years				
Swiss health insurance coverage	Yes (IFX: in case of failure of previous TNF inhibitor treatment)				
Limitation for reimbursement [17]	PASI >10 or BSA >10% and/or DLQI >10 and unsatisfactory response to phototherapy or 1 prior systemic treatment (like CsA, MTX, acitretin); in case of IFX also failure to one other TNF blocker in label for psoriasis; see each medication for detailed information				
Galenic form	Prefilled syringe, pen	Lyophilisate	Prefilled syringe, pen	Prefilled syringe	Prefilled syringe, pen
Prior treatment initiation	Full blood count, liver enzymes, creatinine, urine analysis, urine pregnancy test, CRP/ESR; optional: ANA; screening for HBV, HCV, HIV, and tuberculosis, incl. chest X-ray				
Laboratory values [81]	Full blood count, CRP, liver transaminases, creatinine, urine analysis, β -HCG				
Control intervals	Months 1, 3, then every 3 months	Before every infusion	Months 1, 3, then every 3 months	Before each injection	Months 1, 3, then every 3 months
Administration	s.c.	i.v.	s.c.	s.c.	s.c.
Dosage	1 \times 50 mg/week or 2 \times 25 mg/week [91]; alternative 2 \times 50 mg/week for 12 weeks; 0.8 mg/kg/week in children	5 mg/kg in weeks 0, 2, 6, then every 8 weeks; combination with MTX can prolong drug survival [41]	80 mg in week 0, 40 mg in week 1, then every 2 weeks 40 mg	Weeks 0 and 4, followed every 12 weeks: 45 mg s.c. <100 kg, 90 mg s.c. \geq 100 kg	300 mg in weeks 0, 1, 2, 3, followed every 4 weeks, starting in week 4

Psoriasi (PSO)

- **Efficacia della terapia topica?**
- **Efficacia della fototerapia?**

PSO a chiazze: Efficacia della terapia topica? (RCTs)

- Evidenza: **CS: trattamento prima scelta**
- **Derivati Vitamina D:** in combinazione con CS efficacia nettamente superiore, che in monoterapia
 - Possono irritare
 - **Mai > 100 g / settimana:** alterazioni metabolismo fosfo-calcico
- **Ditranolo?**
- **Inibitori della calcineurina:** non è un trattamento di prima scelta. Indicazioni particolari: viso, pieghe, anogenitale,...

PSO a chiazze: Efficacia della fototerapia? (RCTs)

- **UVB a banda stretta (TL-01):**

- ideale per una psoriasi moderata-severa che non è più controllata con le terapie locali
- 2-3 x settimana; «safe» durante la gravidanza
- Controindicata: pazienti con **NMSC** e **Fotosensibilità**

- **PUVA (psoralene + UVA):**

- ideale per una psoriasi moderata-severa che non è più controllata con le terapie locali
- 2-3 x settimana; «proibita» durante la gravidanza ed allattamento
- Proteggere gli occhi con occhiali e il corpo con indumenti
- Controindicata: pazienti con **NMSC** e **Fotosensibilità**

PSO: Novità 2018 e ...?

- **Anti-IL-17:** Secukinumab / Ixekizumab / Brodalumab

- **Anti-IL-23:**

Guselkumab

Risankizumab

Tildrakizumab

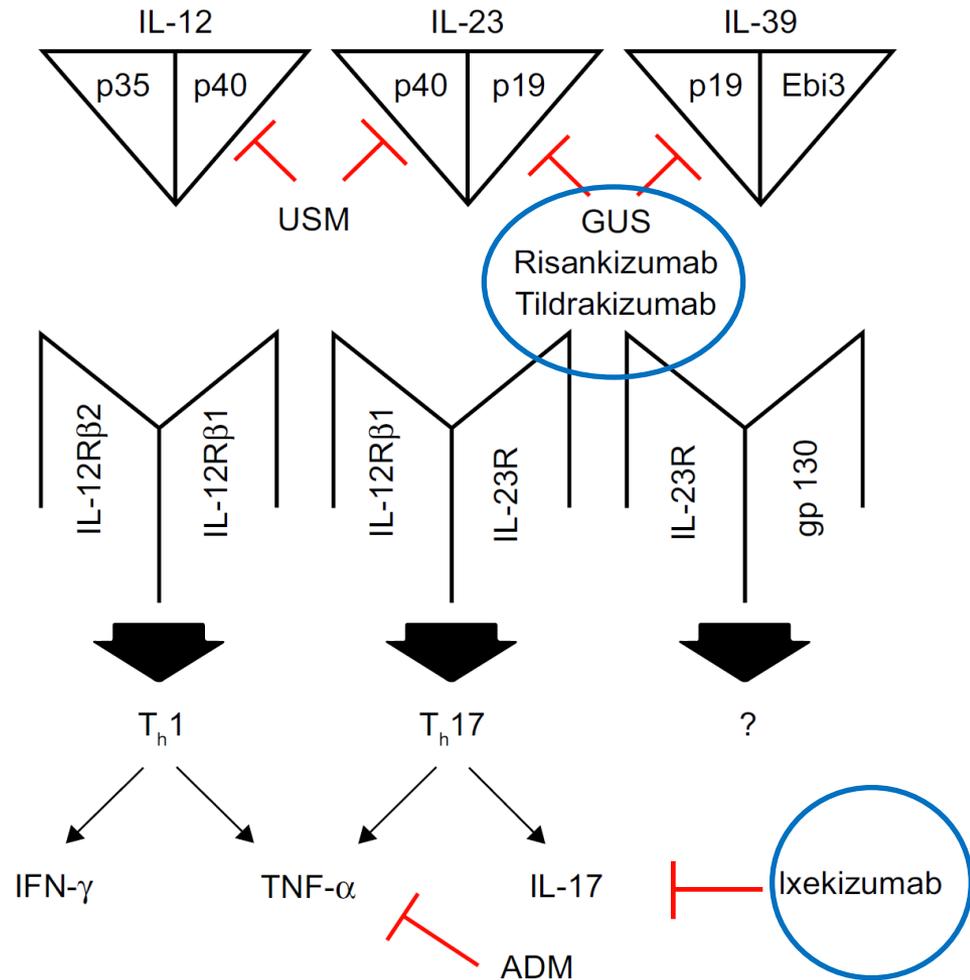
IL-23 appartiene ad una famiglia eterodimerica di citochine, che includono IL-12, IL-27, IL-35 e IL-39

Nella PSO:

IL-12, IL-23 citochine pro-infiammatorie

IL-27, IL-35 citochine inibitrici

IL39 ?



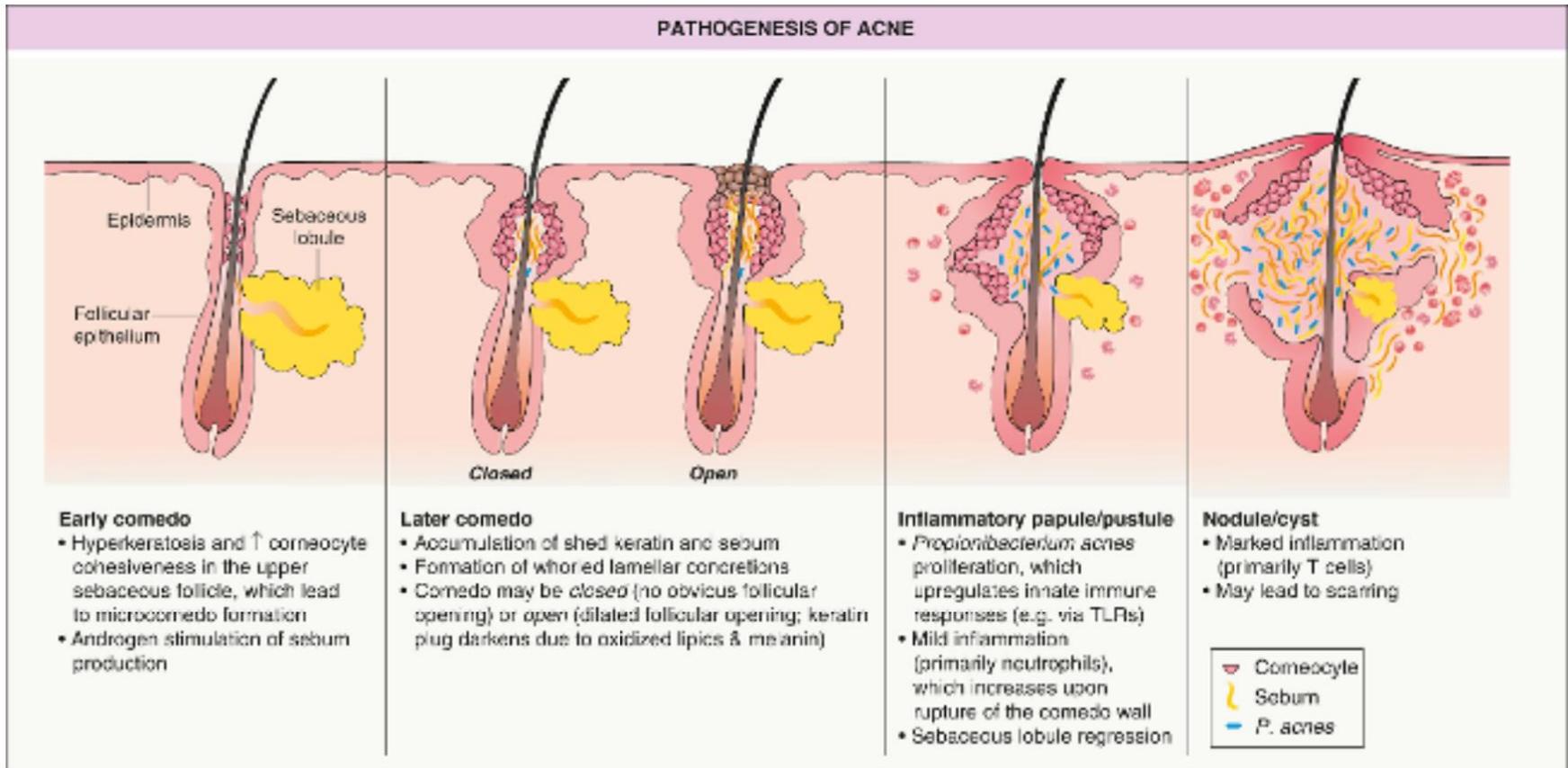
Sommario

- **Dermatite atopica**
- **Psoriasi**
- **Acne e Rosacea**
- **Orticaria cronica**
- **Novità particolari**
- **6 tipi di risposte immunologiche nelle dermatosi infiammatorie**

Acne

- **Definizione:** malattia dell'unità pilosebacea con diversi tipi di lesioni: acne comedonica, papulo-pustolosa e nodulo-cistica
- **Prevalenza:** > 25 anni: **22%** ♂ e **40%** ♀
- **Eziologia:** genetica – ormonale – immunologica
- **Patogenesi:** ipercheratosi dell'ostio del follicolo pilifero: occlusione – iperseborrea – risposta immunologica individuale al commensale *Propionibacterium acnes*
- **Prognosi:** remissione spontanea – ♀ > 25 anni: accertamenti ormonali
- **Obiettivi delle cure:** accelerare la remissione ed evitare le cicatrici soprattutto al viso

Patogenesi dell'acne



Terapia dell'acne

Leggera

Moderata

Severa

	Comedonal	Papular/pustular	Papular/pustular	Nodular	Conglobata/fulminans
1° scelta	Topical retinoid	BPO ± topical antibiotic Topical retinoid + topical antimicrobial(s)*	Oral antibiotic [†] + topical retinoid ± BPO Topical retinoid + BPO ± topical antibiotic	Oral antibiotic [†] + topical retinoid ± BPO	Oral isotretinoin (may require concurrent oral corticosteroid, esp. for acne fulminans)
2° scelta	Alternative topical retinoid Azelaic acid Salicylic acid	Alternative topical retinoid and/or topical antimicrobial Azelaic acid Salicylic acid Topical dapsone	Alternative oral antibiotic [‡] + alt. topical retinoid ± BPO/azelaic acid	Oral isotretinoin Alternative oral antibiotic [‡] + alt. topical retinoid ± BPO/azelaic acid	Oral antibiotic (± high dose)+ topical retinoid + BPO Oral dapsone
Opzione per ♀			Oral contraceptive/antiandrogen	Oral contraceptive/antiandrogen	Oral contraceptive/antiandrogen
Manuale	Comedo extraction		Comedo extraction	Comedo extraction Intralesional corticosteroid	Intralesional corticosteroid
Acne resistente		Exclude Gram-negative folliculitis	Exclude Gram-negative folliculitis		
			Female patient: exclude adrenal or ovarian dysfunction Exclude use of anabolic steroid or other acne-exacerbating medications		
Mantenimento			Topical retinoid ± BPO	Topical retinoid ± BPO	Topical retinoid ± BPO

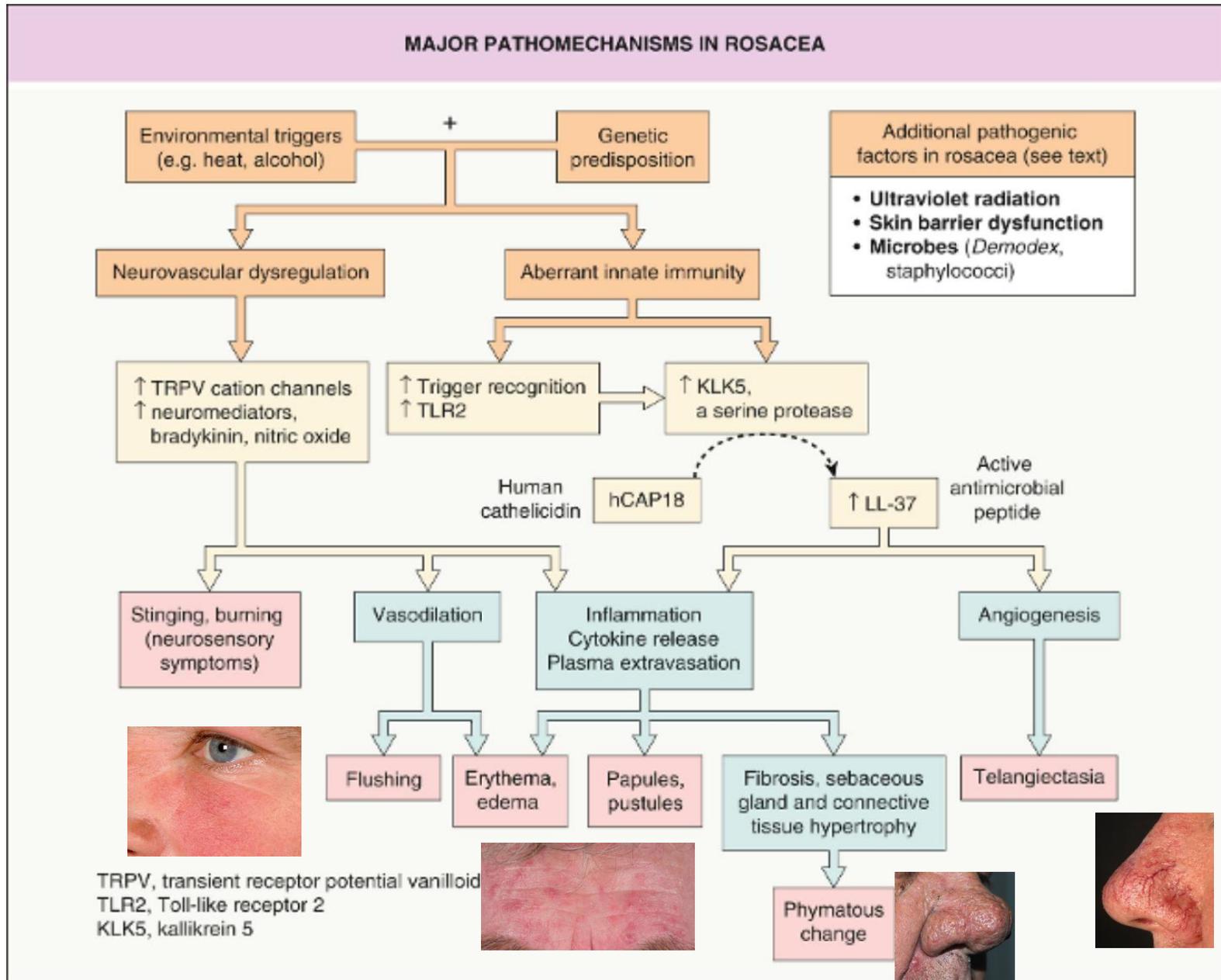
Acne: Novità 2018 e ...?

- Nessun nuovo farmaco
- Antibiotici locali meno utilizzati: evitare sviluppo di germi resistenti!

Rosacea

- **Definizione:** malattia a più stadi: flush, eritrosi, telangiectasie, papulo-pustolosa, granulomatosa, linfedematosa e rinofima. Localizzata prevalentemente al viso, senza dimenticare la componente oculare (blefaro-congiuntiviti e calazio)
- **Prevalenza** in Europa: \approx **10%** della popolazione
- **Eziologia:** genetica – ambientale – vascolare – immunologica
- **Patogenesi:** disregolazione neurovascolare – risposta aberrante del sistema immunitario innato
- **Prognosi:** ? (nessun studio EBM)
- **Obiettivi delle cure:** remissione – migliorare la qualità di vita

Patogenesi della rosacea



Norme comportamentali: «Skin care»

- Wash with lukewarm water and use soap-free cleansers that are pH balanced
- Cleansers are applied gently with fingertips
- Use sunscreens with both UVA and UVB protection and an SPF ≥ 30
- Sunscreens containing the inorganic filters titanium dioxide and/or zinc oxide are usually well tolerated
- Use cosmetics and sunscreens that contain protective silicones
- Water-soluble facial powder containing inert green pigment helps to neutralize the perception of erythema
- Moisturizers containing humectants (e.g. glycerin) and occlusives (e.g. petrolatum) help to repair the epidermal barrier
- Avoid astringents, toners, and abrasive exfoliators
- Avoid cosmetics that contain alcohol, menthols, camphor, witch hazel, fragrance, peppermint, and eucalyptus oil
- Avoid waterproof cosmetics and heavy foundations that are difficult to remove without irritating solvents or physical scrubbing
- Avoid procedures such as glycolic peels or dermabrasion

Istruire il paziente

- Reassure the patient about the benign nature of the disorder and the rarity of rhinophyma, particularly in women
- Emphasize the chronicity of the disease and the likelihood of exacerbations
- Direct patients to information websites such as those of the National Rosacea Society (www.rosacea.org) or the American Academy of Dermatology (www.aad.org)
- Advise to avoid recognized triggers
- Explain the importance of compliance with topical regimens
- Educate on the importance of sun avoidance



Terapia: Rosacea eritemato-telangiectatica

Facial skin care recommendations (see Table 37.4 )	Particularly useful as this subtype is prone to skin irritation and “sensitivity”
Photoprotection	UVR may potentiate dermal matrix damage
Topical agents, e.g. azelaic acid, metronidazole	May reduce erythema, but their use is often limited by their irritant effects
Topical brimonidine tartrate (0.33% gel)*, [†]	Selective α_2 -adrenergic agonist that improves erythema
Topical oxymetazoline HCl (1% cream)*	Selective α_{1A} -adrenergic agonist that improves erythema
Laser therapy [†]	Use of vascular lasers (e.g. pulsed dye, potassium titanyl phosphate) as well as intense pulsed light may improve grades 2 and 3

Terapia topica: Rosacea papulo-pustulosa

→ Metronidazole (0.75% gel or cream; 1% cream)*, † once or twice daily	Can be used as initial treatment to clear inflammatory lesions or as indefinite maintenance therapy
→ Ivermectin (1% cream)*, † once daily	More effective than placebo and slightly more effective than topical metronidazole in randomized controlled trials
→ Azeleic acid (15% gel)*, † twice daily	Appears to be more effective than topical metronidazole but with more side effects, e.g. irritation Azeleic acid (20% cream twice daily) is a non-FDA-approved alternative dose
Sodium sulfacetamide (10%) and sulphur (5%) in a cream or lotion* once or twice daily	May include 10% urea
Erythromycin (2% solution) twice daily	Alcohol in solution may reduce tolerance
Clindamycin (1% lotion) daily	
Permethrin (5% cream) daily –weekly	Shown to be as effective as topical metronidazole for the treatment of papules and erythema May have future role in combination with antibiotics, but further studies needed
Pimecrolimus (1% cream) or tacrolimus (0.03%, 0.1% ointment) twice daily	Some studies have shown improvement in erythema, but there have been case reports of exacerbations, so further studies needed

Terapia sistemica: Rosacea papulo-pustulosa

→ Doxycycline ^{*,†}	40 mg daily (30 mg immediate release and 10 mg delayed release) for 4–8 weeks As effective as the 100 mg dose but with fewer adverse effects
→ Doxycycline	50–100 mg once or twice daily for 4–8 weeks
Minocycline	50–100 mg twice daily or sustained action formula (1 mg/kg) daily for 4–8 weeks ^{**}
Tetracycline [†]	250–500 mg twice daily for 4–8 weeks
Erythromycin	250–500 mg once or twice daily for 4–8 weeks
Azithromycin	250–500 mg (5–10 mg/kg) thrice weekly for 4–8 weeks
Metronidazole	200 mg once or twice daily for 4–8 weeks
→ Isotretinoin [†]	0.3 mg/kg/day

Terapia: Rosacea «Phyma»



Isotretinoin	May reduce nasal volume and halt the progression of rhinophyma
Surgical excision	Can effectively debulk and resculpt the nose
Electrosurgery	
CO ₂ laser	



Terapia: Rosacea oculare

→ Eyelid hygiene and artificial tears	Frequently used to treat mild disease Useful for maintaining remission following treatment of grades 2 and 3 disease with systemic antibiotics
→ Fusidic acid	
Metronidazole gel	
Cyclosporine 0.5% ophthalmic emulsion [†]	More effective than artificial tears in treatment of ocular rosacea
→ Systemic antibiotics (see above section)	For grade 2–3 disease



Rosacea: Novità 2018 e ...?

- **Ivermectina topica: efficace**

DOI: 10.1111/jdv.14349

JEADV

GUIDELINES

Swiss S1 guideline for the treatment of rosacea

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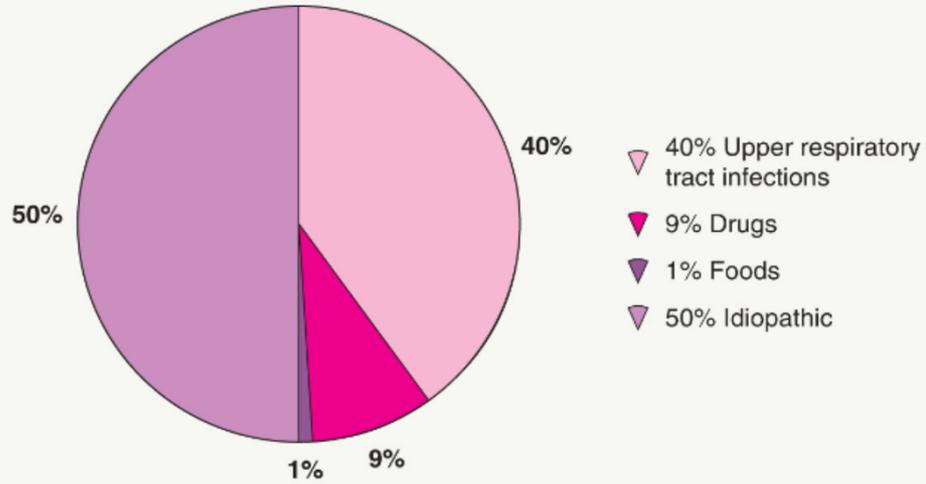
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Orticaria cronica

- **Definizione:** un'orticaria che dura > 6 settimane con pomfi o angioedema o entrambi. Un prurito è solitamente associato
- **Prevalenza** in Europa: **0.1-0.8%** della popolazione. ♀ : ♂ = 2 : 1
- **Eziologia:** immunologica – ambientale
- **Patogenesi:** Attivazione e degranulazione dei mastociti – liberazione di istamina, proteasi e citochine – vasodilatazione
- **Prognosi:** in 10% dei casi orticaria ancora presente dopo 5 anni
- **Obiettivi delle cure:** controllo del prurito e raccorciare il corso della malattia

CAUSES OF ACUTE URTICARIA



CAUSES OF CHRONIC URTICARIA

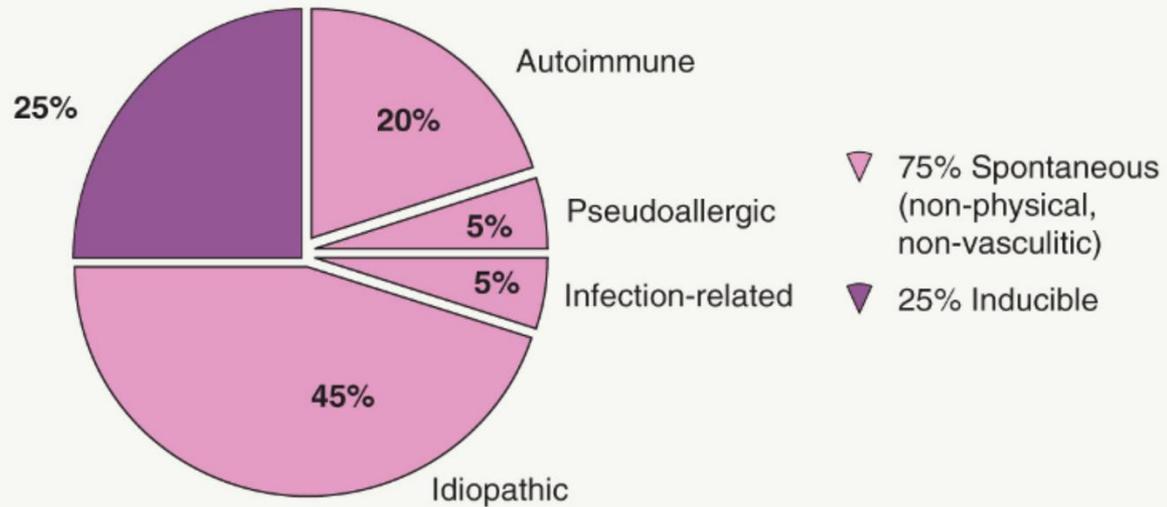
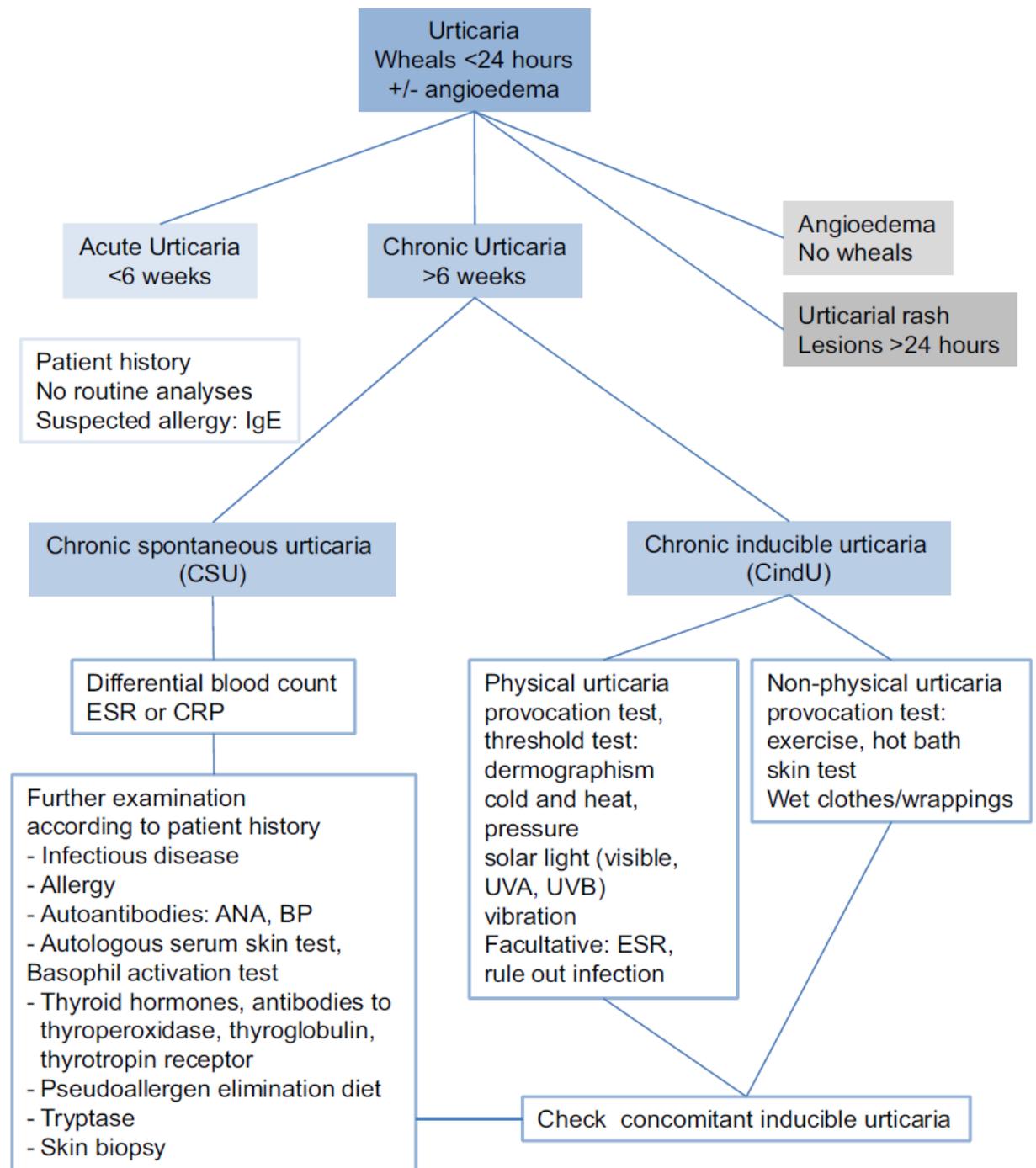


Fig. 2 Diagnostic work-up of urticaria with/without angioedema

Radonjic-Hoesli S et al.
 Urticaria and Angioedema: an Update on
 Classification and Pathogenesis.
 Clin Rev Allergy Immunol.
 2018;54:88-101.



ANTIHISTAMINES FOR URTICARIA			
Class	Examples	Plasma half-life (hours)	Daily adult dose*
Classic (sedating) H ₁ antihistamines	Chlorpheniramine (1)	12–15	4 mg three times daily (up to 12 mg at night)
	Hydroxyzine (1)	20	10–25 mg three times daily (up to 75 mg at night)
	Diphenhydramine (2)	4	10–25 mg at night
	Doxepin [†] (1)	17	10–50 mg at night
Second-generation H ₁ antihistamines	Acrivastine [‡] (1)	2–4	8 mg three times daily
	Cetirizine [§] (1)	7–11	10 mg once daily
	Loratadine (1)	8–11	10 mg once daily
	Mizolastine (1)	13	10 mg once daily
Newer second-generation H ₁ antihistamines	Desloratadine (1)	19–35	5 mg once daily
	Fexofenadine (1)	17	180 mg once daily
	Levocetirizine (1)	7–10	5 mg once daily
	Rupatadine (1)	6	10 mg once daily
H ₂ antagonists [¶]	Cimetidine (1)	2	400 mg twice daily
	Ranitidine (2)	2–3	150 mg twice daily

MANAGEMENT OF SPONTANEOUS AND INDUCIBLE URTICARIAS

Remove identifiable cause, avoid physical triggers, and minimize aggravating factors

Pharmacologic therapy

First line **All patients**

Non- or low-sedating H1 antihistamines

If little or no response

Increase up to four-fold product license (e.g. cetirizine)

If little or no response

Add H2 antagonist

Second line

Combination therapies
(e.g. including doxepin)

Systemic corticosteroids
(for short-term use in acute urticaria and emergencies; avoid in chronic urticaria if possible)

Epinephrine (for severe throat angioedema or anaphylaxis only)

Others (as determined by history and investigations)

Third line **Specialist use only**

Immunomodulatory therapies, e.g. omalizumab, systemic immunosuppressives (severe refractory chronic urticaria)

SECOND-LINE MEDICATIONS FOR CHRONIC OR PHYSICAL URTICARIA

Generic name	Drug class	Route	Dose	Special indication/associated diseases
Prednisone (2)	Corticosteroid	Oral	0.5 mg/kg daily	Severe exacerbations (days only) – “rescue” treatment
Epinephrine (2)	Sympathomimetic	Subcutaneous, IM (self-administered)	300–500 mcg	Idiopathic or allergic angioedema of throat/anaphylaxis
Montelukast (3)	Leukotriene receptor antagonist	Oral	10 mg daily	Aspirin-sensitive urticaria, ? delayed pressure urticaria
Colchicine (3)	Neutrophil inhibitor	Oral	0.5/0.6–1.5/1.8 mg* daily	Neutrophilic infiltrates in lesional biopsy specimens or urticarial vasculitis
Sulfasalazine (3)	Aminosalicylates	Oral	2–4 g daily	Delayed pressure urticaria

Presente e futuro della terapia dell'orticaria cronica

Target	Drug name	Mechanism	Phase	ClinicalTrials.gov
IgE	Ligelizumab	Humanized monoclonal antibody targeting Cε3 domain of IgE [124]	Phase 2b	NCT02477332
	Quilizumab	Humanized monoclonal antibody targeting M1-prime segment of membrane bound IgE on IgE-switched B cells, IgE memory B cells and plasmablasts [125]	Phase 2	NCT01987947
Syk	GSK2646264	Potent and selective topical Syk inhibitor [123]	Phase 1	NCT02424799
CRTh2	AZD1981	CRTh2 antagonist [123]	Phase 2a	NCT02031679
IL-1β	Canakinumab	Human monoclonal anti-IL 1β antibody [126]	Phase 2	NCT01635127
	Rilonacept	Dimeric fusion protein composed of ligand binding domain of IL-1 receptor and IL-1R accessory protein bound to IgG1 [126]	Phase 2	NCT02171416
Vitamin D3		Supplementation because of reduced vitamin D levels in CU patients [127]	Phase 3	NCT02873364

Orticaria cronica: Novità 2018 e ...?

- **Omalizumab**: efficace e «safe»

Sommario

- **Dermatite atopica**
- **Psoriasi**
- **Acne e Rosacea**
- **Orticaria cronica**
- **Novità particolari**
- **6 tipi di risposte immunologiche nelle dermatosi infiammatorie**

Medicina: costi-efficacia

JAAD 2018;78:1232-5.

- **Laboratorio mensile** per pazienti in cura con **isotretinoina**:
 - Se dopo 6-8 settimane, nessun rialzo dei parametri
 - Improbabile che ciò avvenga
- **TSH di routine** per pazienti con **vitiligine**?
 - Test in pazienti con sintomi o reperti clinici
 - Istruire i pazienti sui sintomi o reperti clinici
- **Anticorpi anti-nucleari**:
 - Testarli prima di iniziare una cura con farmaco biologico

Pemfigoide bolloso: Non-Bollosa: review sistematica

JAAD 2018;78:989-995.

- Considerati 39/133 articoli con 132 casi:
 - **Placche orticariose ed eritematose (52.3%)**
 - **Papule – Noduli (20.5%)**
 - Solo una **minoranza** sviluppano in seguito bolle (9.8%)
- **Età media della manifestazione 74.9 anni**
 - **Diagnosi posta in ritardo** in media di **22.6 mesi**
- **Diagnosi:**
 - IFD positiva in 93.2% dei casi
 - IFI positiva in 90.2% dei casi

Pemfigo volgare (PV): Fumare fa bene? review sistematica

J Eur Acad Dermatol Venereol 2018 Feb 25.

- Considerati 13 articoli:
 - Pazienti con PV fumano meno rispetto ai casi controllo
 - **Papule – Noduli** (20.5%)
 - Solo una **minoranza** sviluppano in seguito bolle (9.8%)
- Uno studio dimostra che per le **lesioni alla mucosa dei non fumatori** sono nettamente **più gravi rispetto ai fumatori**
- **Conclusione:**
 - **Fumare** può avere un **ruolo protettivo** per le lesioni della mucosa in pazienti con PV
 - Saranno necessari studi con migliore metodologia

Biotina: è necessario un supplemento dietetico?

JAAD 2018;78:1236-8.

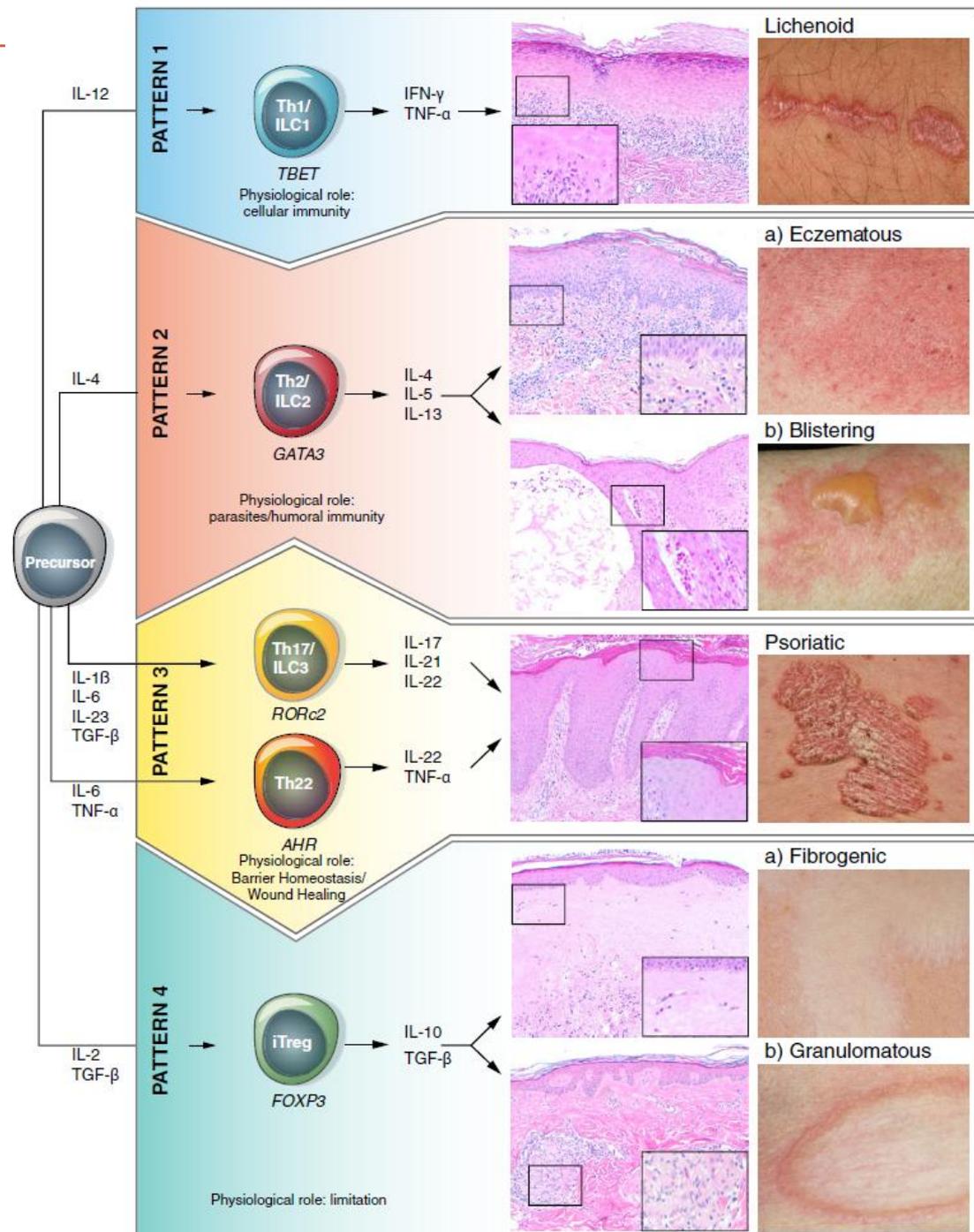
- **Deficit** in biotina può causare:
 - **Disfunzioni neuro-muscolari**
 - **Alopecia**
 - **Dermatite**
- Biotina (Vitamina H): tuorlo dell'uovo, latte, noci, grani, ...
 - Dieta occidentale: 35-70 microg / die
- **Quando utilizzarla:**
 - 2.5 – 5 mg / die: migliora onicopatie (trachonichia, fragilità) e perdita capelli
 - 5 mg / die: migliora la dermatite atopica

Sommario

- **Dermatite atopica**
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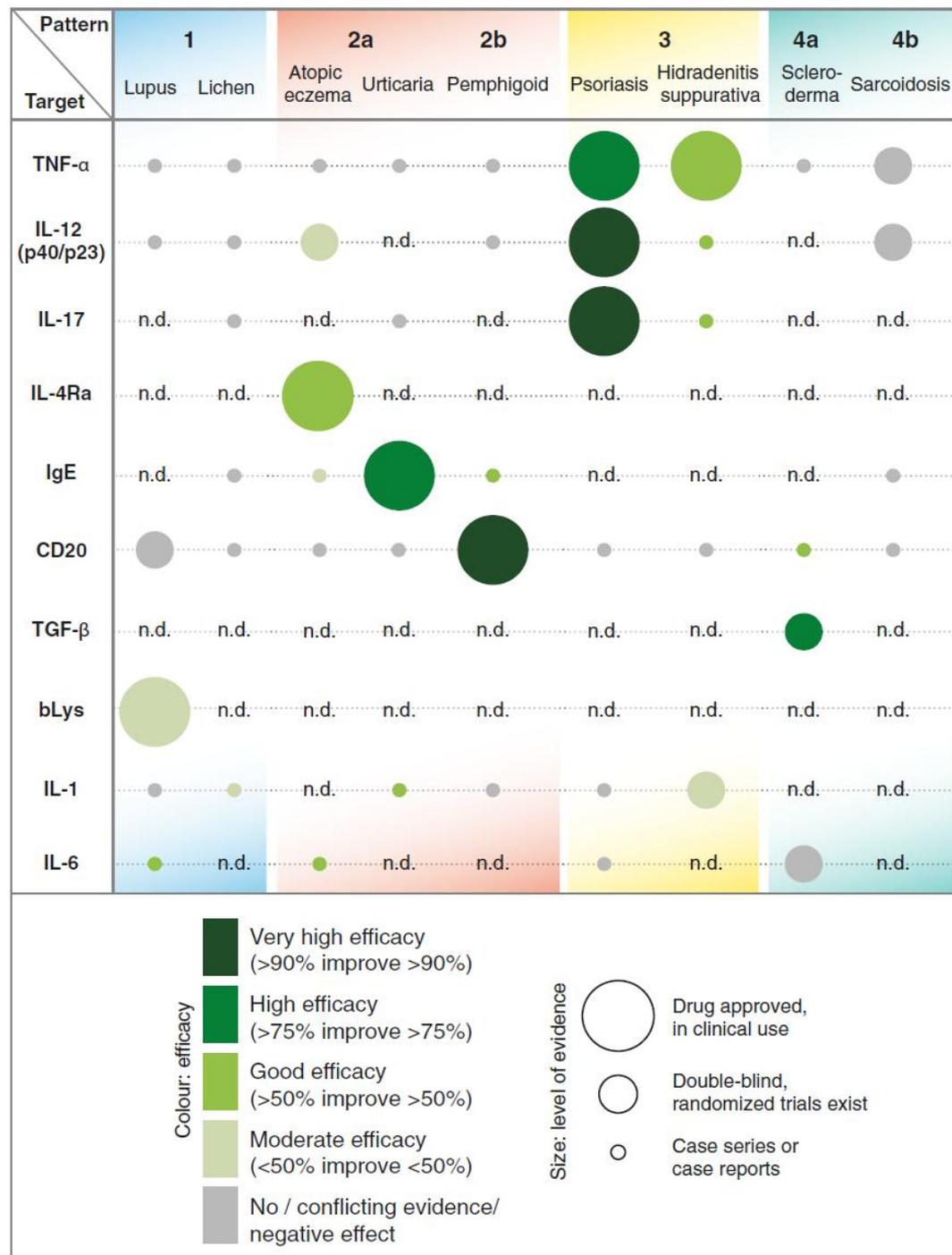
REVIEW ARTICLE

Immune response patterns in non-communicable inflammatory skin diseases

K. Eyerich,^{1*} S. Eyerich²

Eyerich K & S. Immune response patterns in non-communicable inflammatory skin diseases.

J Eur Acad Dermatol Venereol 2018;32:692-703.



Eyerich K & S.

Immune response patterns in non-communicable inflammatory skin diseases. J Eur Acad Dermatol Venereol 2018;32:692-703.



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Grazie
per l'attenzione