

# Post-Congress in Tokyo

10th Meeting of the German-Japanese Society of Dermatology



**Date: November 18 (Sun) – 19 (Mon), 2012**

**Venue: Hyatt Regency Tokyo, Shinjuku Tokyo  
2-7-2 Nishi-Shinjuku, Shinjuku-Ku, Tokyo, Japan 160-0023**

**Tel: +81 3 3348 1234 Fax: +81 3 3344 5575**

**Chair :Y. Mitsuhashi**

**Department of Dermatology, Tokyo Medical University  
6-7-1 Nishi-shinjuku, Shinjuku-ku, Tokyo, 160-0023, Japan**

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## Welcome note Chairman

Dear German and Japanese friends and colleagues,

First, we would like to express our sincerest thanks to the German people and government for their kind friendship and support following the great earthquake and tsunami which occurred in the Tohoku area of east Japan on March 11, 2011.

It is our pleasure to welcome you to the post-congress programme, to be held on November 18-19, 2012 in Tokyo, after the 10th Meeting of the German-Japanese Society of Dermatology (GJSD), which will be held on November 14-17, 2012 in Tokushima, Japan.

We have no doubt that you will find the post-congress events of the GJSD in Tokyo worthwhile, not only for the academic interaction you will have with your colleagues, but also for the many thrilling forms of entertainment you can find in Tokyo. As your hosts, we are prepared to regale you in Tokyo with academic lectures, a sightseeing trip in the city, and a Japanese-style banquet. We are thankful for the participation of so many distinguished guests from Germany and Japan.

If you have any questions or requests, please do not hesitate to contact us by E-mail.

We look forward to seeing you in November, 2012 in Tokyo as well as in Tokushima.

A handwritten signature in blue ink, which appears to read 'Y. Mitsuhashi'.

Prof. Dr. Y. Mitsuhashi

Post-Congress Chair

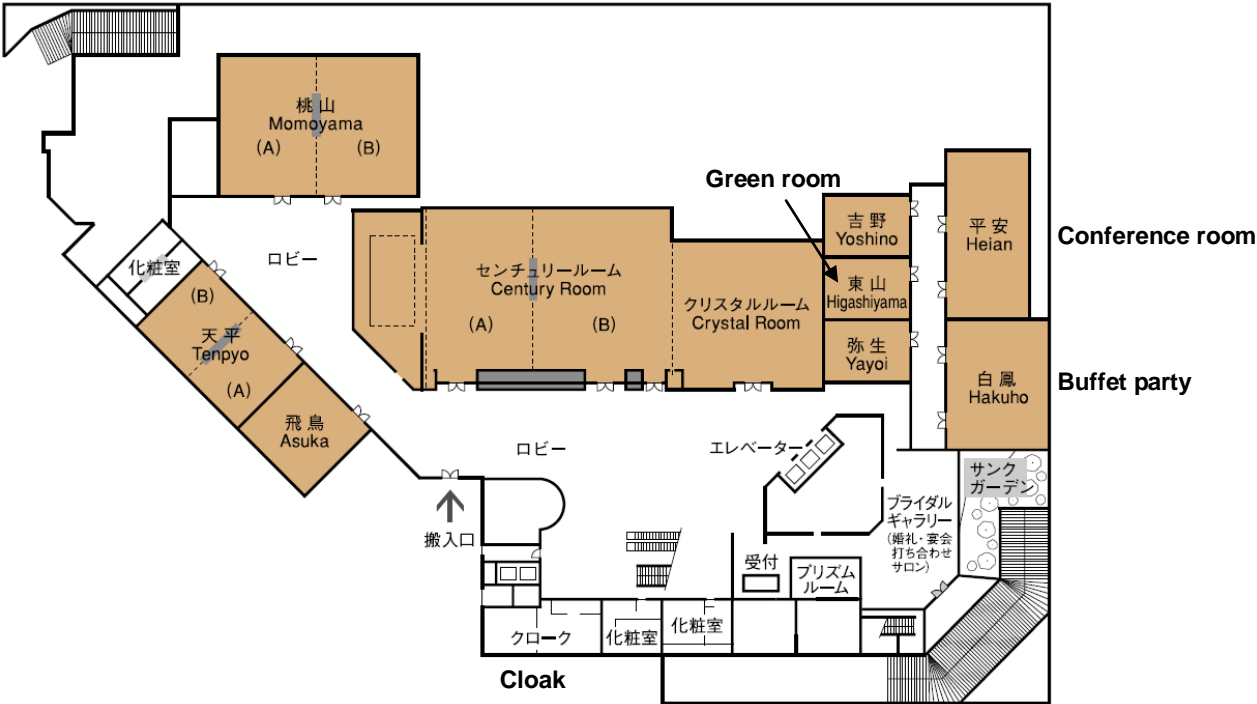
Department of Dermatology, Tokyo Medical University, Shinjuku, Tokyo

Map & Directions



Conference room

Hyatt Regency Tokyo B1F “Heian”



## Programme Schedule

### **Sunday, November 18, 2012 (at Hyatt Regency Tokyo)**

PM 3:30-PM 5:10 Scientific Programme

PM 5:30-PM 6:30 Evening Seminar

PM 6:30-PM 8:30 Social Gathering (Buffet party) at Hyatt Regency Tokyo

PM ?? Tokyo night-tours (Aquarium, Newhalf show, Karaoke)

Leave the party depending on each tour-schedule.

### **Monday, November 19, 2012 (at Hyatt Regency Tokyo)**

AM 10:00-AM 11:40 Scientific Programme

AM 12:00-PM 1:00 Luncheon Seminar

PM 2:00-PM 9:00 A sightseeing bus tour in Tokyo and Farewell dinner

(Japanese-style Restaurant, Hisago-an,

<http://www.kaiseki-hisagoan.com/access/index.htm>)

## General Information

### #Conference Information

Date: November 18 (Sun)-19 (Mon), 2012

Venue: Hyatt Regency Tokyo, Shinjuku Tokyo

2-7-2 Nishi-Shinjuku, Shinjuku-Ku, Tokyo, Japan 160-0023, Tel: +81 3 3348 1234

### #Registration

Door opens at 30 minutes before the start time.

You pay registration fee at the reception desk and receive your name tag.

### Registration Fees

German and Japanese Participants

Active Participant (member) 10,000JPY

Active Participant (non-member) 10,000JPY

Accompanying Persons Free

All participants are invited to all social programme (except optional Tokyo night-tours at Nov. 18), but are requested first to register for preparing the tables for the Banquet and Party.

\*Credit card is not available. Payment will accept only by cash.

### #Oral presentation

#### 1. Presentation time

7 minutes with 3 minutes of discussion. Special presentations are 15 minutes with 5 minutes discussion. Special presentations are indicated by \* at the head of the title of the presentation.

#### 2. Presentation format

A computer (Windows) containing Windows PowerPoint 2002-2010 and a LCD projector will be provided. Presenters are requested to operate the devices on their own when presenting.

#### 3. Presentation data

Please bring your presentation data in an USB or CD-R to the PC counter at least 30 minutes before your presentation. Basically, your own PC is unavailable.

### #Conference language

The official language is English. There will be no simultaneous translations.

### #Secretary General

Tomonobu Ito: Department of Dermatology, Tokyo Medical University

e-mail : tomonobu@tokyo-med.ac.jp

**Post-Congress in Tokyo**  
**10th Meeting of the German-Japanese Society of Dermatology**  
**Programme**

**#Sunday, November 18, 2012**

**Welcome and Opening**

3:25PM-3:30PM    Yoshihiko Mitsuhashi    Post-congress Chair

**Scientific Programme 1**

**3:30PM-4:00PM    Chair: Tetsuo Shiohara (Tokyo, Japan)**

1. Folliculosebaceous cystic hamartoma arising on the thigh.  
Mutsumi Moriki (Hamamatsu, Japan)
2. \*PAPA and PASH Syndromes. New, Rare or not so Rare?  
Gerd Plewig (Munich, Germany)
3. Impression mold techniques (IMT): A useful method for the analysis of sweating responses.  
Yohei Sato (Tokyo, Japan)

**Scientific Programme 2**

**4:00PM-4:40PM    Chair: Alexander Kapp (Hannover, Germany)**

4. Sweating disturbance as a trigger for lichen planus.  
Yoshiko Mizukawa (Tokyo, Japan)
5. \*How ingrown nails develop and how to treat them?  
Hiroko ARAI (Tokyo, Japan)

**Scientific Programme 3**

**4:40PM-5:10PM    Chair: Yoshiki Tokura (Hamamatsu, Japan)**

6. Secondary extramammary Paget's disease underlying advanced bladder cancer.  
Yuta Kurashige (Hachioji, Japan)
7. \*Stevens-Johnson syndrome and toxic epidermal necrolysis: clinical pattern, etiology and pathogenetic approaches.  
Erwin Schöpf (Freiburg, Germany)

**Evening Seminar**

**5:30PM-6:30PM    Chair: Kensei Katsuoka (Kanagawa, Japan)**

1. Efficacy and histological response due to adalimumab for treatment of psoriasis patients.  
Yukari Okubo (Tokyo, Japan)
2. The great east Japan earthquake: a report from Fukushima.  
Toshiyuki Yamamoto (Fukushima, Japan)

**Social Gathering (Buffet party) at Hyatt Regency Tokyo**

6:30PM-8:30PM    Hakuho-no-Ma

**Tokyo Night-Tours (Karaoke, Newhalf show, Aquarium) Optional**

**#Monday, November 19, 2012**

**Scientific Programme 4**

**10:00AM- 10:30AM Chair: Yukari Okubo (Tokyo, Japan)**

8. Relapsing polychondritis (RP) associated with psoriasis vulgaris.

Yuichiro Kato (Tokyo, Japan)

- 9.\*DRESS (Drug reaction with eosinophilia and systemic symptoms) is mainly caused by carbamazepin and allopurinol.

Uwe-Frithjof Haustein (Leipzig, Germany)

**Scientific Programme 5**

**10:30AM- 11:10AM Chair: Kiyoshi Nishioka (Osaka, Japan)**

10. Granuloma anulare giganteum – a case report.

Ulrike Proske (Dresden, Germany)

11. Generalised lichen myxedematosus treated with high dose intravenous immunoglobulins.

Christiane Pfeiffe (Ulm, Germany)

- 12.\*Treatment of atopic dermatitis – Novel approaches.

Alexander Kapp (Hannover Germany)

**Scientific Programme 6**

**11:10AM- 11:40AM Chair: Uwe-Frithjof Haustein (Germany)**

13. A case of epidermal nevus type of epidermolytic hyperkeratosis.

Rie Yatsu (Tokyo, Japan)

- 14.\*Twin spotting in human skin: new aspects.

Rudolf Happle (Freiburg, Germany)

**\*at the head of the title indicates the Special Presentation.**

**Luncheon Seminar**

**12:00PM- 1:00PM Chair: Ryoji Tsuboi (Tokyo, Japan)**

Three musketeers of skin barrier and atopic diseases

Masayuki Amagai (Tokyo, Japan)

**A sightseeing bus tour in Tokyo and Farewell dinner**

1:30PM- 6:00PM Bus Tour (from Hyatt Regency Hotel)

6:00PM- 9:00PM Japanese-style Restaurant, Hisago-an

<http://www.kaiseki-hisagoan.com/access/index.htm>



# **Post-Congress in Tokyo**

**10th Meeting of the German-Japanese Society of Dermatology**

## **Abstract**

## Evening Seminar (1)

### **Efficacy and histological response due to adalimumab for treatment of psoriasis patients.**

Yukari Okubo

Department of dermatology, Tokyo Medical University, Tokyo, JAPAN

Psoriasis treatments by biologics, such as TNF- $\alpha$ inhibitors ( Adalimumab, Infliximab ) and anti-IL-12/23 p40 antibody ( Ustekinumab ), have resulted in significant clinical benefits for patients.

Clinical evaluation on Adalimumab were performed for 20 patients with moderate to severe psoriasis in Tokyo Medical University Hospital.

The clinical types were 14 patients of psoriasis vulgaris (PV) , 3 patients of psoriasis arthritis (PsA) and 3 patients of generalized pustular psoriasis (GPP) . After 24 weeks of treatment, 58% of adalimumab-treated patients achieved a PASI 75 response, and 42% of adalimumab-treated patients achieved a PASI 90 response

Skin biopsy specimen were analyzed before and after treatment from 3 Japanese psoriasis patients by hematoxylin and eosin (H&E) stain, immunohistochemistry and electron microscopy.

Biologics for psoriasis rapidly decreased dermal immunocytes, IL-17A+cells and epidermis was restored to normal differentiation.

## **Evening Seminar (2)**

### **The Great East Japan Earthquake: a report from Fukushima.**

Toshiyuki Yamamoto

Department of Dermatology, Fukushima Medical University, Fukushima, JAPAN

Since March 11th in 2011, we had been suffering from uncomfortable situations caused by the disasters. Because of the anxiety for nuclear power plant troubles, several of the staffs in our department had gone. However, nowadays we are offering ordinal dermatology clinics. At the time of emergency, several cutaneous diseases got worse because of a number of causes, such as shortness of drugs, stress, increased smoking opportunity, loss of taking a bath, and so on. In particular, venous insufficiency of the lower limbs, psoriasis, palmoplantar pustulosis, urticaria, herpes zoster, and autoimmune bullous diseases are representative exacerbated conditions. In this talk, I would introduce our troubles during last year, and also present current status of dermatology in Fukushima.

## **Luncheon Seminar**

### **Three musketeers of skin barrier and atopic diseases.**

Masayuki Amagai

Department of Dermatology, Keio University School of Medicine, Tokyo, Japan

Classic atopic dermatitis is complicated by asthma, while in the "atopic march," allergic rhinitis, conjunctivitis, and food allergies are subsequently acquired, all together referred to as atopic diseases. Recent discoveries of mutations in the filaggrin gene as predisposing factors for atopic diseases have refocused investigators' attention on epidermal barrier dysfunction. The skin's barrier has three musketeers : the stratum corneum (air-liquid barrier), tight junctions (liquid-liquid barrier), and the Langerhans cell network (immunological barrier). Clarification of the molecular events underpinning epidermal barrier function/dysfunction should lead to a better understanding of the pathophysiological mechanisms of atopic diseases. The recent advances in skin barrier and cutaneous sensitization will be discussed for better understanding of pathophysiological mechanisms of atopic diseases.

## **1. Folliculosebaceous cystic hamartoma arising on the thigh.**

Mutsumi Moriki, Taisuke Ito, Takatoshi Shimauchi, Satoshi Hirakawa, Yoshiki Tokura

Department of Dermatology, Hamamatsu University School of Medicine

Folliculosebaceous cystic hamartoma (FSCH) is a rare cutaneous hamartoma comprised of follicular, sebaceous and mesenchymal elements. The head and neck area is its predilection site. A 30-year-old woman had a solitary, oval, non-tender, subcutaneous nodule, 5 mm in diameter, on the inner aspect of the left thigh. Histopathologically, the excised tumor was an infundibular cyst-like structure surrounded by collagen bundles and containing horny materials, but not hair shafts. Multiple hypertrophic sebaceous lobules were radially connected to the cyst wall and consisted of matured sebaceous cells. Individual sebaceous glands were opened to the cyst. Immunohistochemically, sebaceous ducts, and sebaceous lobules, the suprabasal cells were positive for K1 and K10, and the basal cells were positive for K14 and K15. In contrast, no K19 expression was seen. There were CD34-positive spindle cells in the stroma surrounding the cyst. The D2-40 staining exhibited the presence of not only lymphatic vessel endothelial cells but also germinative cells in the most outer layer of the sebaceous lobules. No expression of nestin was found. We thus diagnosed the tumor as FSCH. Only two cases of FSCH on the extremities have been previously reported. In addition, our case is characterized by its presence in the subcutaneous fat.

## **[Special Presentation]**

### **2. PAPA and PASH Syndromes. New, Rare or not so Rare?**

Gerd Plewig

University of Munich, Germany

PAPA stand or pyogenic arthritis, pyoderma gangrenosum, and acne. It was first described by Lindor et al (A new autosomal disorder of pyogenic sterile arthritis, pyoderma gangrenosum, and acne. Mayo Clin Proc 72: 611-615,1997) and was subsequently seen in several centers around the world. For good reasons it is seen by various specialties, like rheumatology, radiology, pediatrics, dermatology and laboratory/genetic medicine. Associated findings are mentioned with new case reports, such as hypogammaglobulinemia, elevated serum tumor necrosis factor alpha levels, periodic fever and others.

We have seen several patients with PAPA syndrome, in whom the pyrin/PSTPIP1 protein is affected. Targeted therapy with a recombinant human interleukin-1 receptor antagonist (Anakinra) immediately improved the devastating lesions of pyoderma gangrenosum.

PASH stands for pyoderma gangrenosum, acne, and suppurative hidradenitis. It was recently described by Braun-Falco M, Kovnerysty O, Lohse P, and Ruzicka T (Pyoderma gangrenosum, acne, and suppurative hidradenitis (PASH) – a new autoinflammatory syndrome distinct from PAPA syndrome. J Am Acad Dermatol 66: 409-415, 2012) from the working group in our Munich department. Both reported patients lacked episodes of pyogenic arthritis, but instead they featured hidradenitis suppurativa (also known as acne inversa). Mutations in the PSTPIP1 exons 1 to 15 were excluded. IL1beta may be of pathogenic importance. Case histories and clinical illustrations of patients with PAPA and PASH syndrom will be presented.

### **3. Impression mold techniques (IMT): A useful method for the analysis of sweating responses.**

Yohei Sato, Yurie Komatsu, Yukiko Ushigome, Takaaki Doi, Yoshiko Mizukawa, and Tetsuo Shiohara

Department of Dermatology, Kyorin University School of Medicine, Tokyo, JAPAN

Various patterns of sweating disturbance are increasingly recognized as having a strong impact on the rise in inflammatory skin disease such as atopic dermatitis (AD). Several methods are currently in use to identify the distribution and the number of actively secreting sweat glands. Although starch-iodine reaction is a rapid standard indicator that can be used to detect sweat droplets, this method has obvious disadvantages, such as inadequate sensitivity and consistency, and spotty definition of separate sweat gland openings. We have established a quantitative method, the impression mold techniques (IMT), which allows an accurate quantification of each sweat gland actively delivering sweat and the volume of sweat it produces. In this method, sweat droplets are visualized as small holes corresponding to the sweat pores: an evaluation of individual sweat droplet size and number can be obtained. The IMT enables us to more quantitatively analyse sweating responses after thermal stress or injecting acetylcholine than starch-iodine reaction. The IMT is a useful technique for the quantitative assessment of sweating responses of individual sweat glands.

#### **4. Sweating disturbance as a trigger for lichen planus.**

Yoshiko Mizukawa, Yohei Sato, Takaaki, Doi, Yurie Komatsu, Yukiko Ushigome, Tetsuo Shiohara

Department of Dermatology, Kyorin University School of Medicine, Tokyo, JAPAN

Despite recent advances in understanding the immunopathogenesis of lichen planus (LP), the initial triggers of T cell infiltrates and the essential pathogenic pathways are poorly understood. Sweating disturbance in inflammatory skin diseases has received considerable attention in recent years. To investigate whether sweating disturbance could represent the initial trigger, we analyzed the sweating responses to thermal stress in the patients with LP using the silicone impression mold technique (IMT). A remarkable absence of active sweat glands was found in the LP lesions. An area of pin-point loss of sweat droplets was detected in clinically normal skin around the LP lesion which becomes a lesion. Such a pin-point loss was hardly detected around psoriasis vulgaris lesions. Immunohistochemically, eccrine glands/ducts were filled with sweat characterized by strong expression of dermcidin (DCD). DCD was also detected in sweat retained in the lumen of sweat ducts even in the clinically normal perilesional skin, indicating an inability to deliver sweat to the skin surface. Thus, leakage of sweat into the dermo-epidermal junction subsequent to blockage of the duct is likely represent an earliest event of the cascade leading to the recruitment of T cells into the site.



## [Special Presentation]

### 5. How ingrown nails develop and how to treat them.

Hiroko ARAI<sup>1,2</sup>, Takeo ARAI<sup>2,3</sup>, Eckart HANEKE<sup>4,5</sup>

<sup>1</sup>Department of Dermatology, Arai Dermatology Clinic, Tokyo, Japan, <sup>2</sup>Department of Dermatology, Yokohama City University, Japan, <sup>3</sup>Department of Dermatology, You Dermatology Clinic, Yokohama, Japan, <sup>4</sup>Department of Dermatology, Inselspital, University Berne, Switzerland, <sup>5</sup>Dermatol Clinic Dermaticum, Freiburg, Germany

An ingrown nail is a simple mechanical disorder due to a foreign body reaction against offending, penetrating nail edges which are mainly caused by improper nail cutting or nail breakage, while compounded by improper footwear, other bad habits, foot deformities, etc. The offending nail edges, such as spicules, always exist underneath granulation tissue or inflamed nail folds.

Destructive surgeries of the nail matrix such as phenolization are commonly performed even for small children, although ingrown nails do not originate in the nail matrix. These surgeries are unnecessary and rather harmful, since they may inadvertently cause permanent complications decades afterwards. Therefore, they should not be performed. Patients may suffer from disfigurement, chronic pain, difficulties in walking, feelings of loss, psychological problems and restricted social activities.

Based on the correct understanding of the pathophysiology, ingrown nails can be easily and reliably treated using tape and plastic tubes, namely anchor and window taping and acrylic affixed gutter splint (singularly or in combination). To date, 4000 patients have been treated over the past 30 years using these conservative methods. It is our goal to spread these non-invasive modalities worldwide as the standard treatment of ingrown nails.

Workshop on Origami paper-craft and taping is provided.

## **6. Secondary extramammary Paget's disease underlying advanced bladder cancer**

Yuta Kurashige and Tetsuo Nagatani

Department of Dermatology, Hachioji Medical Center of Tokyo Medical University, Tokyo, Japan

A 64 year-old Japanese woman visited our hospital complaining of a painful vulval eruption that persisted for seven months. She had been diagnosed with advanced bladder cancer, histopathologically classified as urothelial carcinoma, which had metastasized to the lung, vagina, and some distal lymph nodes. The eruption presented an erythematous, partially erosive, relatively well-demarcated plaque accompanied by multiple nodules with a diameter of 5 to 15 mm. This lesion was clinically seen as reaching the vaginal opening and external urethral orifice. The two largest nodules were resected. Histopathological examination revealed large atypical cells with clear eosinophilic cytoplasm proliferating within the epidermis. Mitotic figures were found. Immunohistochemical examination showed that the tumor cells were generally positive for CK7, but were restrictedly positive for CK20, in one of the two specimens. Given the above data, we made a diagnosis of secondary extramammary Paget's disease. This lesion appeared to have formed as a result of intraepidermal invasion by the bladder cancer.

## **[Special Presentation]**

### **7. Stevens-Johnson syndrome and toxic epidermal necrolysis: clinical pattern, etiology and pathogenetic approaches.**

E. Schöpf und M. Mockenhaupt

Dokumentationszentrum schwerer Hautreaktionen (dZh), Dept. of Dermatology, University Medical Center, Freiburg, Germany;

Stevens-Johnson syndrome (SJS) and toxic epidermal necrolysis (TEN) are severe cutaneous adverse reactions mainly caused by drugs. They are characterized by erythematous lesions with blisters and mucosal erosions.

Diagnostic procedures should always include a skin biopsy. In terms of etiology, allopurinol, antibacterial sulfonamides, several antiepileptic agents, oxicam-NSAIDs and nevirapine have a high risk to induce SJS/TEN. While risk estimation of drugs in SJS/TEN has been done by case-control studies, an algorithm called ALDEN has been created for causality assessment in the individual case. In-vivo- and in-vitro-tests have not been successful to detect the inducing agent in SJS/TEN,

In a genome-wide association study the HLA-region on chromosome 6 was identified to be of major importance for SJS/TEN and certain HLA-alleles have been found to be related, e.g. HLA-B\*1502 and carbamazepine-induced SJS/TEN in Han-Chinese or HLA-B\*5801 in allopurinol-induced SJS/TEN in Chinese and partly in Europeans. Currently, the link between drugs inducing SJS/TEN and immunologic mechanisms is investigated based on the assumption of an immunogenetic pathway. In this respect, the cytolytic protein granulysin, which has been shown to be elevated in the blister fluid of SJS/TEN, is highly important and may act as a future therapeutic target.

## **8. Relapsing polychondritis (RP) associated with psoriasis vulgaris.**

Yuichiro Kato, Junko Wakamatsu, Ryoji Tsuboi, Yoshihiko Mitsuhashi

Department of Dermatology, Tokyo Medical University Hospital, Tokyo

RP is a rare disease manifesting as a recurrent inflammation of the cartilaginous tissues. We report a case of RP associated with psoriasis vulgaris. An 83-year-old man presented with a history of swelling, tenderness, and erythema on both sides of the earlobes. He had suffered from a drug eruption. He displayed erythema on the forehead and left earlobe even after the drug eruption had subsided. Tests for antibody to type II collagen were positive. A skin biopsy specimen from the auricle showed an inflammatory infiltration composed of lymphocytes, plasma cells, and eosinophils in the perichondrium. Oral prednisone was prescribed, resulting in a gradual regression of the auricular inflammation. After the treatment, erythematous plaques with scales appeared on the extremities. A skin biopsy confirmed the diagnosis of psoriasis vulgaris. RP is believed to be an autoimmune disease, and auto antibodies to type II collagen are pathognomonic. The significance of the association of psoriasis with autoimmune diseases like RP is unclear. The different courses of the two diseases suggest a common underlying immune defect could be responsible for the manifestations of the different immunological diseases.

## [Special Presentation]

### **9. DRESS (Drug reaction with eosinophilia and systemic symptoms) is mainly caused by carbamazepin and allopurinol.**

U.-F. Haustein<sup>1,2</sup>, M. Mockenhaupt<sup>2</sup>, P. Sekula<sup>3</sup>, J.-C. Roujeau<sup>4</sup>, S. Kardaun<sup>5</sup>

<sup>1</sup>Klinik und Poliklinik f. Dermatologie, Venerologie u. Allergologie, Universitaet Leipzig; <sup>2</sup> Dokumentationszentrum schwerer Hautreaktionen (dZh), Dept. of Dermatology, University Medical Center, Freiburg, Germany; <sup>3</sup>Institute of Med Biometry and Med Informatics, University Medical Center, Freiburg, Germany; <sup>4</sup>Dept. of Dermatology, Hopital Henri Mondor, Université Paris XII, Créteil, France; <sup>5</sup>Dept. of Dermatology, Reference center for cutaneous adverse drug reactions, University Medical Center, Groningen, Netherlands

Drug reaction with eosinophilia and systemic symptoms (DRESS) or Drug-induced hypersensitivity syndrome (DIHS) is a severe reaction mostly caused by drugs and characterized by an extensive cutaneous eruption, hematologic changes and organ involvement.

The RegiSCAR-study group enrolled 201 potential DRESS-cases, reviewing them with a standardized scoring system. The reviewers were blinded for risk factors including drug use. Finally, 117 cases were validated as probable or definite DRESS-cases. Drug causality determination based on timing of drug exposure, prior use without reaction and notoriety.

In the month before onset of DRESS these 117 patients used at least one drug, (115 (98%) a median of 5 different drugs) (interquartile range 2-8) / patient. 37 cases had a very probable causality, 56 a probable, others were possible, undetermined or unlikely. Antiepileptic drugs, especially carbamazepine, were blamed responsible in 36% of cases followed by allopurinol in 18%.

Summary: carbamazepine and allopurinol were considered responsible in 38% of the cases. Although these drugs also have a high risk to induce Stevens-Johnson syndrome (SJS) and Toxic epidermal necrolysis (TEN), the time latency between beginning of drug use and onset of the adverse reaction is substantially longer for DRESS ( $26.2 \pm 19$  days) than for SJS/TEN.

## **10. Granuloma anulare giganteum – a case report.**

Ulrike Proske, Gottfried Wozel

Department of Dermatology, University Hospital Carl Gustav Carus at the Technical University Dresden, Germany

Granuloma anulare is a skin disease characterized by granulomatous inflammation. The skin lesions are mainly annular patched with elevated margin. The typical manifestation are at the extremities, backside of hands and foots and in the face.

We report on a case of granuloma giganteum in the skin of the neck.

A 44-year-old man was seen the first time in October 2005 complaining about a ringlike lesion in the neck. During the following year the granuloma was getting larger with central ulceration. Two similar lesions had developed on the lower arm left and on the right hand. During one year the size of the lesions in the neck has doubled. Topical steroids and steroid injections were given for 10 month, hydroxychloroquin 400mg per day was given for four month without any effect. Then we decided to treat with Dimethylfumarat and Ethylhydrogenfumarat (Fumaderm®) up to 600 mg per day. Under this therapy the granulomata flatten out and the size decreased. The lesion at the neck healed with a scar. We finished treatment because patient developed a hyperthyreosis.

We want to demonstrate the success of the treatment of granuloma anulare with an anti-psoriatic drug.

## **11. Generalised lichen myxedematosus treated with high dose intravenous immunoglobulins.**

Christiane Pfeiffer, Karin Kunzi-Rapp, Karin Scharffetter-Kochanek

Department of Dermatology and Allergology, University Hospital, Ulm University, Germany

A 59-year old male engineer presented with symmetrically distributed firm, flesh-coloured or waxy, partially disseminated, predominantly coalescing lichenoid papules of 2-3mm each, affecting the dorsa of fingers and hands, the wrists, the lower arms, glabella, cheeks, and knees, impairing finger and wrist movement. Histology revealed mucin deposition and fibroblast proliferation, consistent with lichen myxedematosus. Serum analysis demonstrated a monoclonal paraproteinemia (IgG kappa).

Under treatment with 40 cycles Re-PUVA, 3 cycles melphalan (Alexian scheme), 4 cycles bortezomib disease progressed further to nearly generalized erythema of the extremities, body and central face, thickly infiltrated, yellowish skin folds overlying fingers, wrist, elbows and knees, and waxy papules in linear distribution on the proximal extremities. Thalidomide and mycophenolate mofetil, 3 months each, did not halt disease progression. The following year, 3 cycles plasmapheresis, followed by 14 cycles immunoadsorption were applied. Erythema decreased, no new infiltrates appeared, but the established infiltrates persisted. Only by starting high dose intravenous immunoglobulins, a continuous resolution of infiltrates was observed. The patient is in near to complete remission for one year, with a continuing therapy of 0,4g immunoglobulin/kg body weight/day for 5 consecutive days every six weeks.

## [Special Presentation]

### 12. Treatment of atopic dermatitis – Novel approaches.

Alexander Kapp, MD, PhD and Thomas Werfel, MD, PhD

Department of Dermatology and Allergy, Hannover Medical School

Atopic dermatitis (AD) is one of the most frequent chronic inflammatory skin diseases. Most patients show an enhanced susceptibility to cutaneous colonisation with *Staph.aureus* or with *Malassezia sympodialis*. We and others showed (i) that AD may be worsened by secreted toxins working as superantigens and by constitutional proteins. Autoimmunity may be triggered in AD due to crossreactions of T-cells or specific IgE with microbial and human proteins. Therefore, antimicrobial treatment may be justified in many patients with AD. Management of AD must consider the individual variability of the disease. Basic therapy is focused on hydrating topical treatment, and avoidance of unspecific and specific provocation factors. Late eczema reactions may be caused by inhalant and food allergens. However, dietary recommendations should be given only for patients with proven food allergens. Allergen-specific immunotherapy may be useful in selected cases only. Anti-inflammatory treatment is used for exacerbation management and more recently for proactive therapy. Adjuvant therapy may include UV irradiation with UVA1 or with UVB 311nm. Systemic immune-suppressive treatment is an option for severe refractory cases. Recent reports described beneficial effects of anti-IL12p40, anti-CD20 or anti-IL6R antibodies on AD. New drugs such as inhibitors of the H4R or of the itch-inducing cytokine IL-31 are already under clinical investigation.



### **13. A case of epidermal nevus type of epidermolytic hyperkeratosis.**

Rie Yatsu, Hiroshi Kawakami, Masaki Uchiyama, Yasuharu Horie, Yoshihiko Mitsuhashi,

Department of Dermatology, Tokyo Medical University, Tokyo, Japan

We report the case of a 3-year-old girl who has presented multiple linear hyperkeratosis on her left axilla since three months old. The keratotic lesion formed closely aggregated plaques along Blaschko's lines. A skin biopsy revealed irregular acanthosis and granular degeneration of the upper layers of the epidermis. Mild perivascular infiltration of lymphocytes in the upper dermis was also observed. We diagnosed this case as epidermolytic hyperkeratosis type - epidermal nevus. Due to shared clinical features, inflammatory linear verrucous epidermal nevus (ILVEN) poses a problem in the differential diagnosis of those cases of linear hyperkeratosis, especially on the juvenile cases.

The lesion of the presented case responded slightly to a topical treatment with calcipotriol (VD<sub>3</sub>) ointment. Although topical VD<sub>3</sub> has rarely been effective in these cases of epidermal nevus, ILVEN, on the other hand, has been reported to be successfully treated with topical VD<sub>3</sub>.

In this report discussed are the differences between epidermolytic hyperkeratosis-type epidermal nevus and ILVEN in terms of their clinical and histopathological features, including their response to VD<sub>3</sub> treatment.

## [Special Presentation]

### 14. Twin spotting in human skin: new aspects.

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Twin spots are paired mutant patches that differ from each other and from the surrounding tissue. In humans, molecular proof of this principle is so far lacking. An example of allelic didymosis is nevus flammeus paired with nevus anemicus. Another example is ‘mixed vascular nevus’ consisting of an admixture of small lesions of nevus anemicus and a light-red telangiectatic nevus. Extracutaneous anomalies involve the cerebral vessels (‘mixed vascular nevus syndrome’). Cutis tricolor is heterogeneous. Large hyper- and hypopigmented macules that do not respect the midline and form in part a peculiar sash-like arrangement, being associated with cerebral defects, are a characteristic syndrome. Cutis tricolor parvimaclata is likewise associated with brain defects. Another type is arranged along Blaschko’s lines. In Darier disease, allelic didymosis in the form of excessive or absent involvement has been documented. By contrast, proposed examples of non-allelic didymosis should today be regarded with caution. For example, phacomatosis pigmentokeratotica can no longer be regarded as a didymosis because the associated nevus sebaceus was found to be caused by heterozygous *HRAS* or *KRAS* mutations. Future molecular research may show whether phacomatosis cesioflammea, phacomatosis spilorosea, phacomatosis cesiomarmorata, and phacomatosis melanorosea fulfill the criteria of non-allelic didymosis.