Treatment tricks in dermatology
round table

Prof. Miklós Sárdy, MD, PhD

Dept. of Dermatology, Venerology and Dermatooncology
Faculty of Medicine, Semmelweis University, Budapest, Hungary

Dept. of Dermatology and Allergology
Ludwig Maximilian University, Munich, Germany

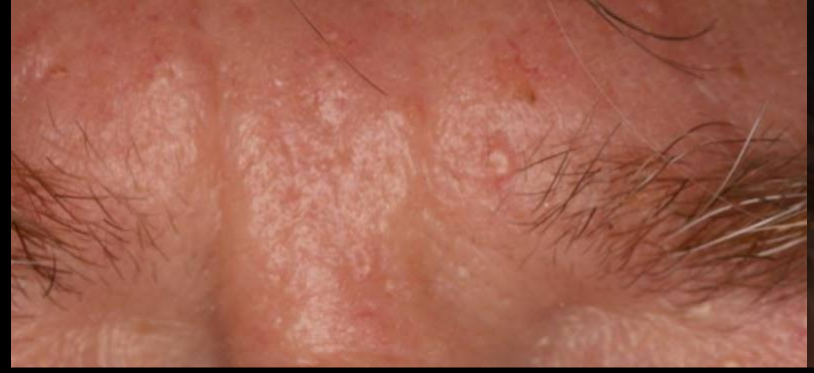
Faculty

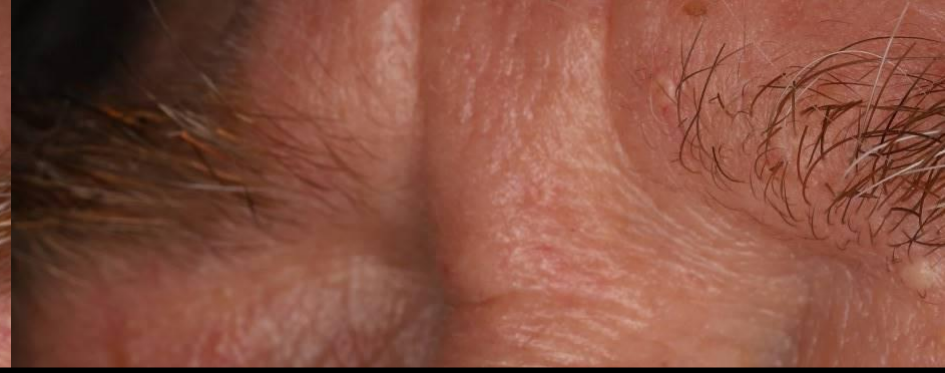
- Prof. Thomas Dirschka (Wuppertal, Germany)
- Assoc. Prof. Dr. Dániel Törőcsik (Debrecen, Hungary)
- Prof. Miklós Sárdy (Budapest/Munich, Hungary/Germany)

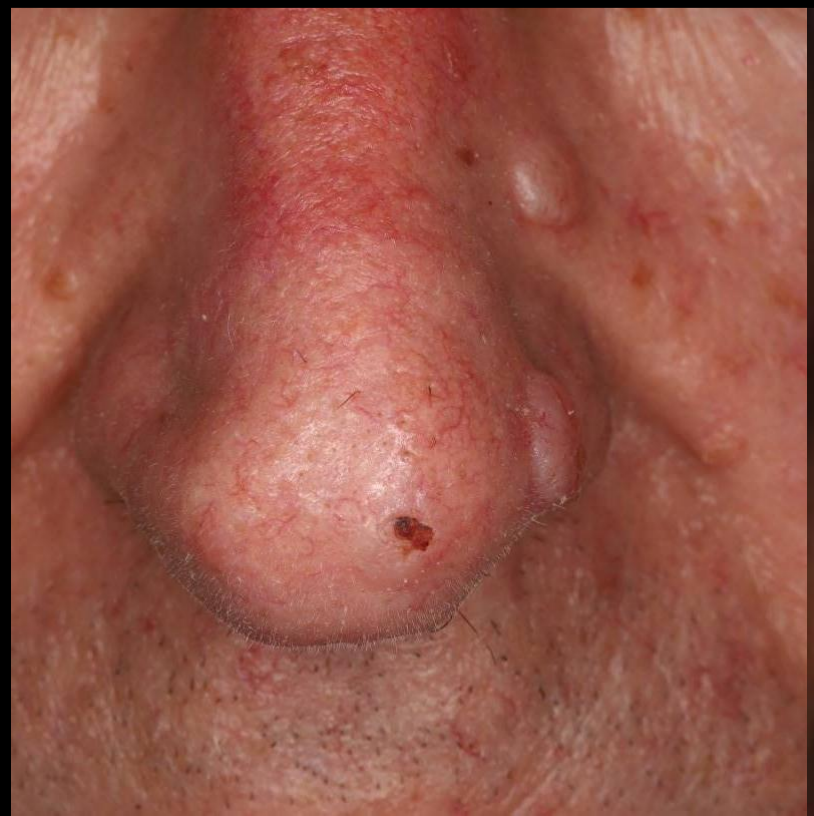
Round table

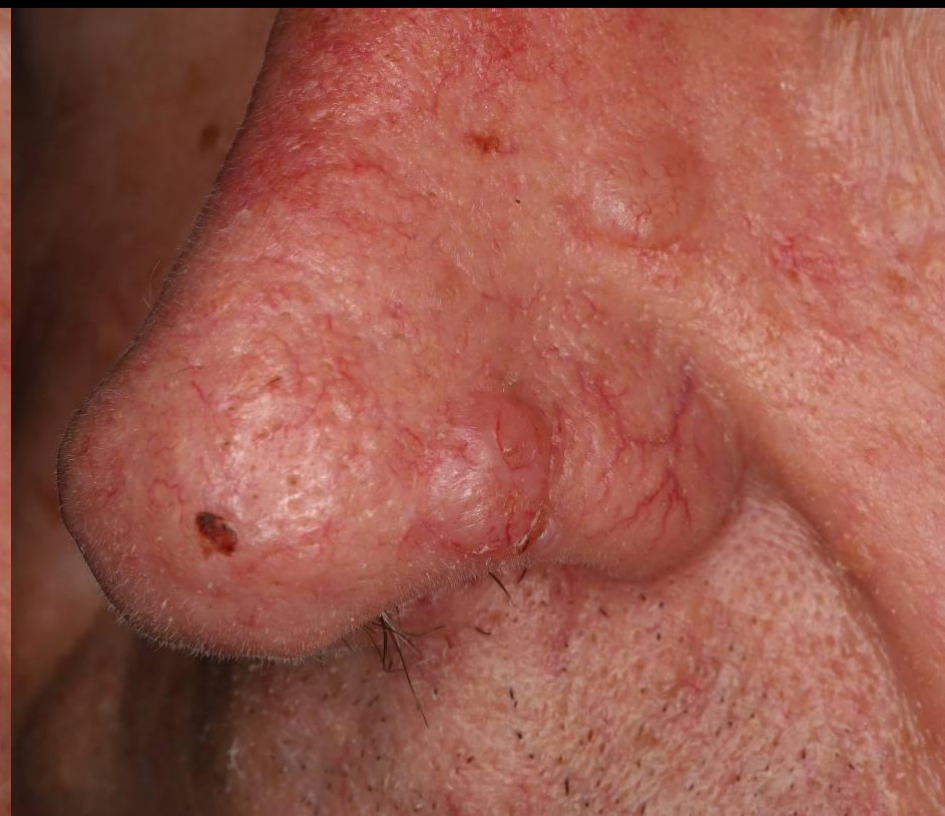
- Some real cases from my patient pool are presented
- The other faculty members have not been previously informed about these patients
- Faculty members are asked to share their opinions on each patient's management
- Residents are encouraged to participate actively in the discussion by asking questions and sharing their views

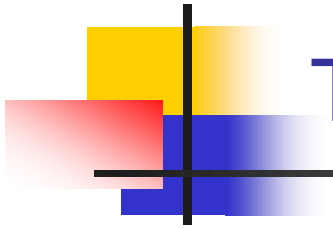
- 70-years-old male
- Presents with 3 skin lesions on the nose
- You diagnose BCCs with your dermoscope











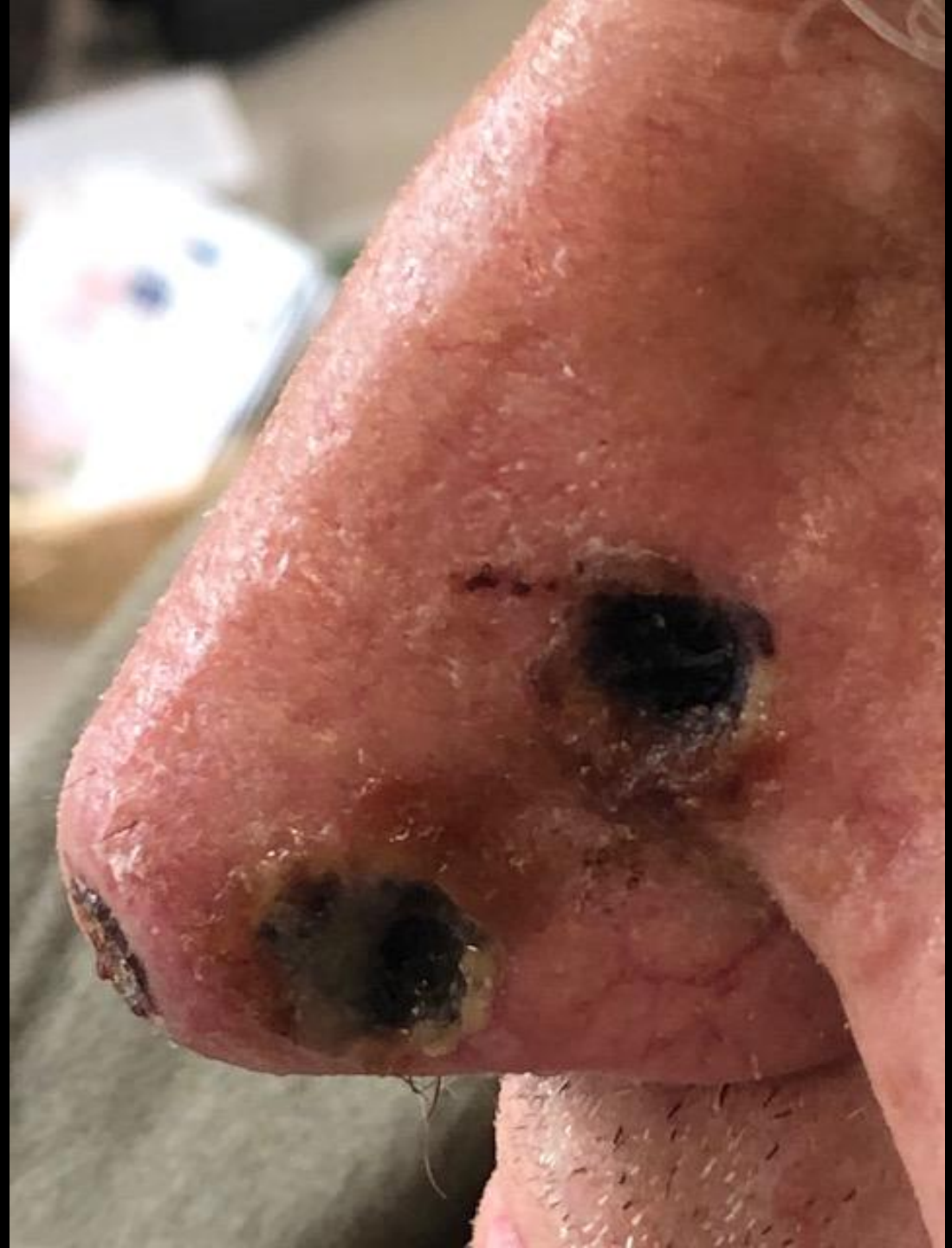
Treatment options?

- There are quite a few in the textbooks, but which one would be the best?

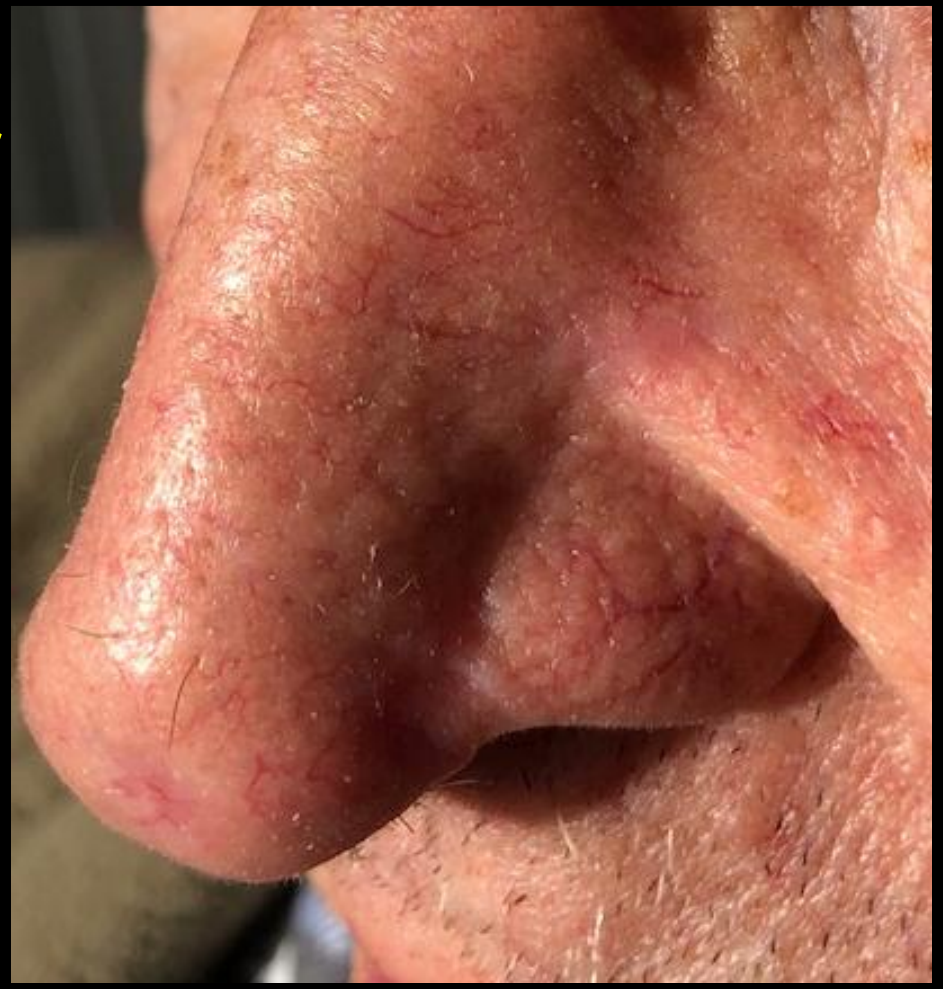
My choice was chemosurgery

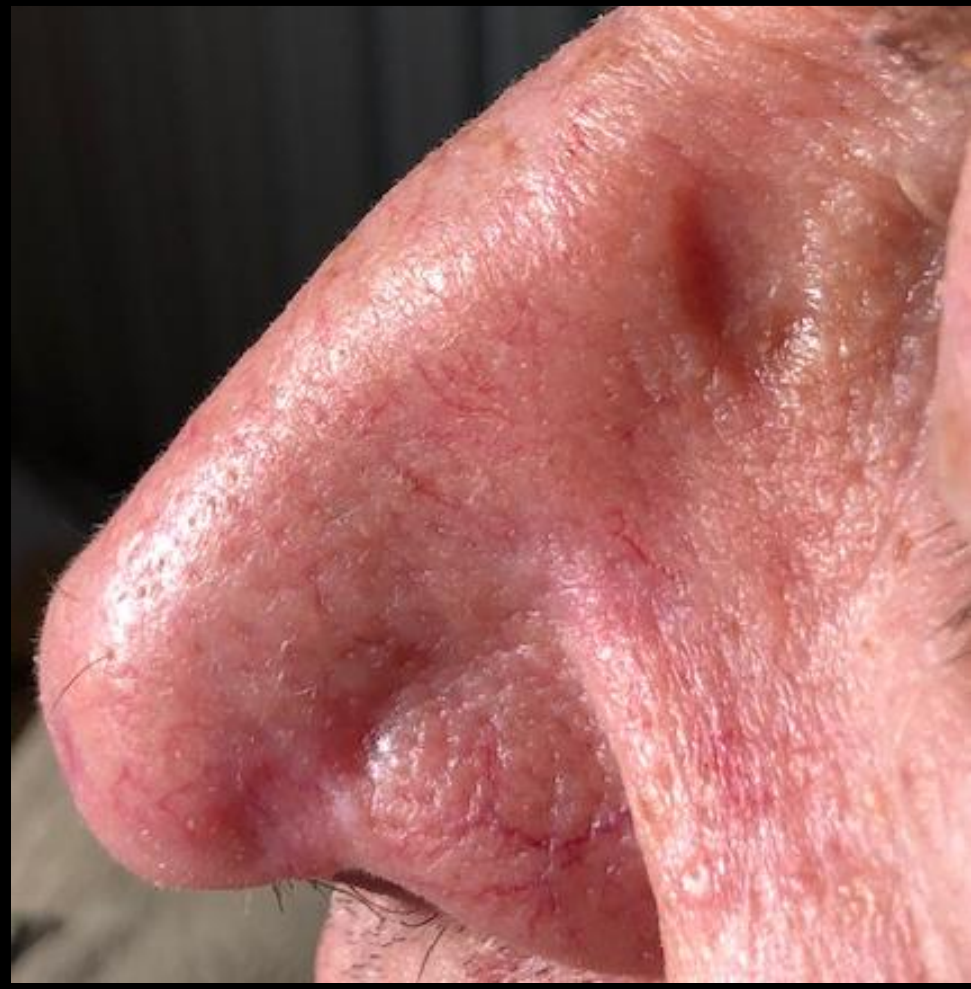
- Optimal therapy for the nose

- 8 days after chemosurgery

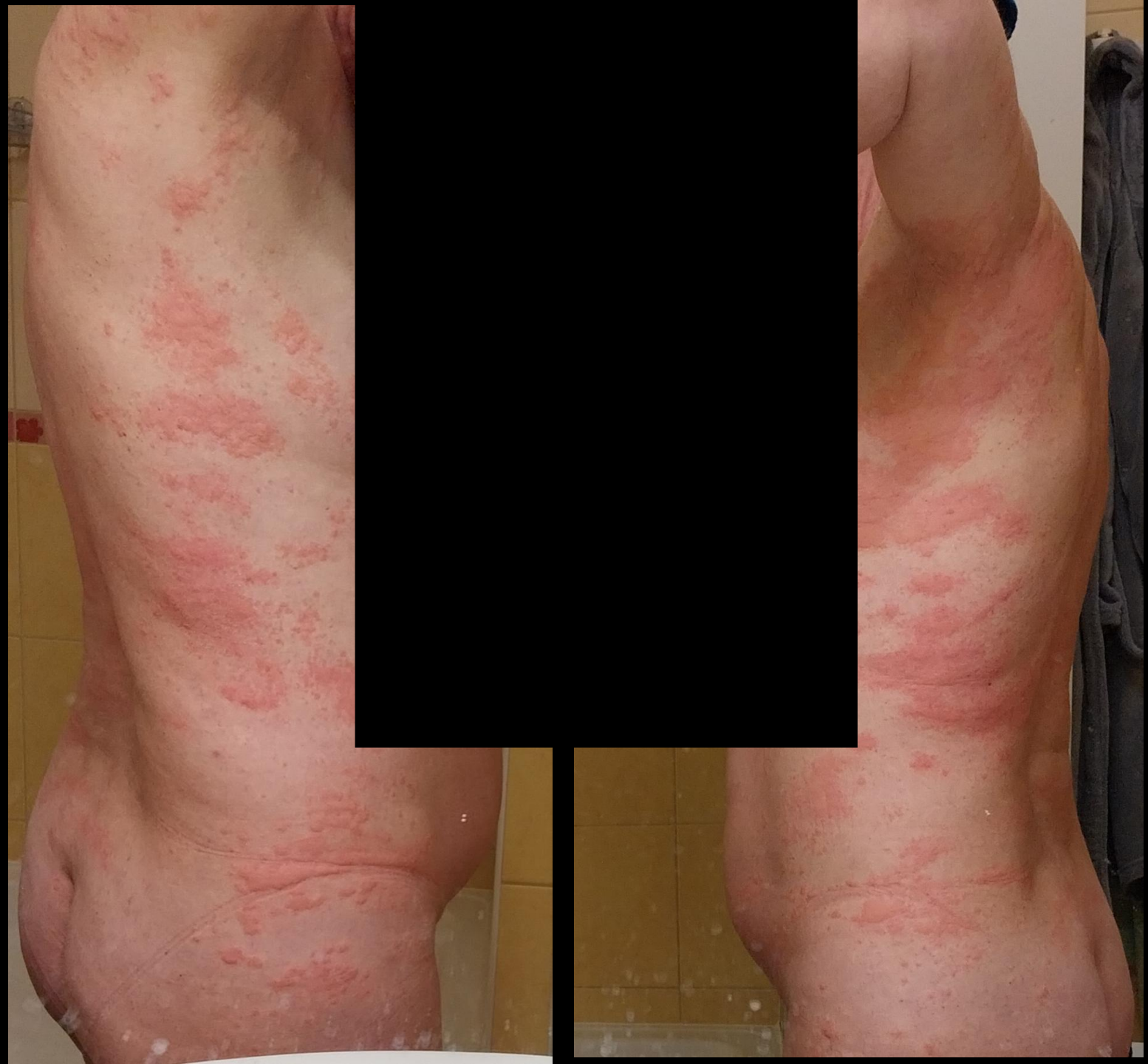


- 6 months after chemosurgery



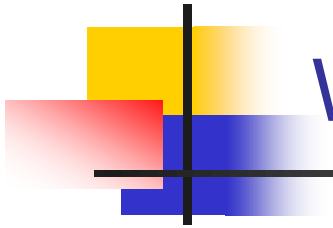


- Itchy skin lesions for a year, with relapses nearly every day
- Lesions typically appear at night, which is why she has brought photos to show them
- Diagnosis: chronic spontaneous urticaria



Medical history

- Current treatment: desloratadine tabl. 2-3x5 mg twice a day, omalizumab injection 300 mg every 4 weeks s.c. (for 4 months already)



What would you do?

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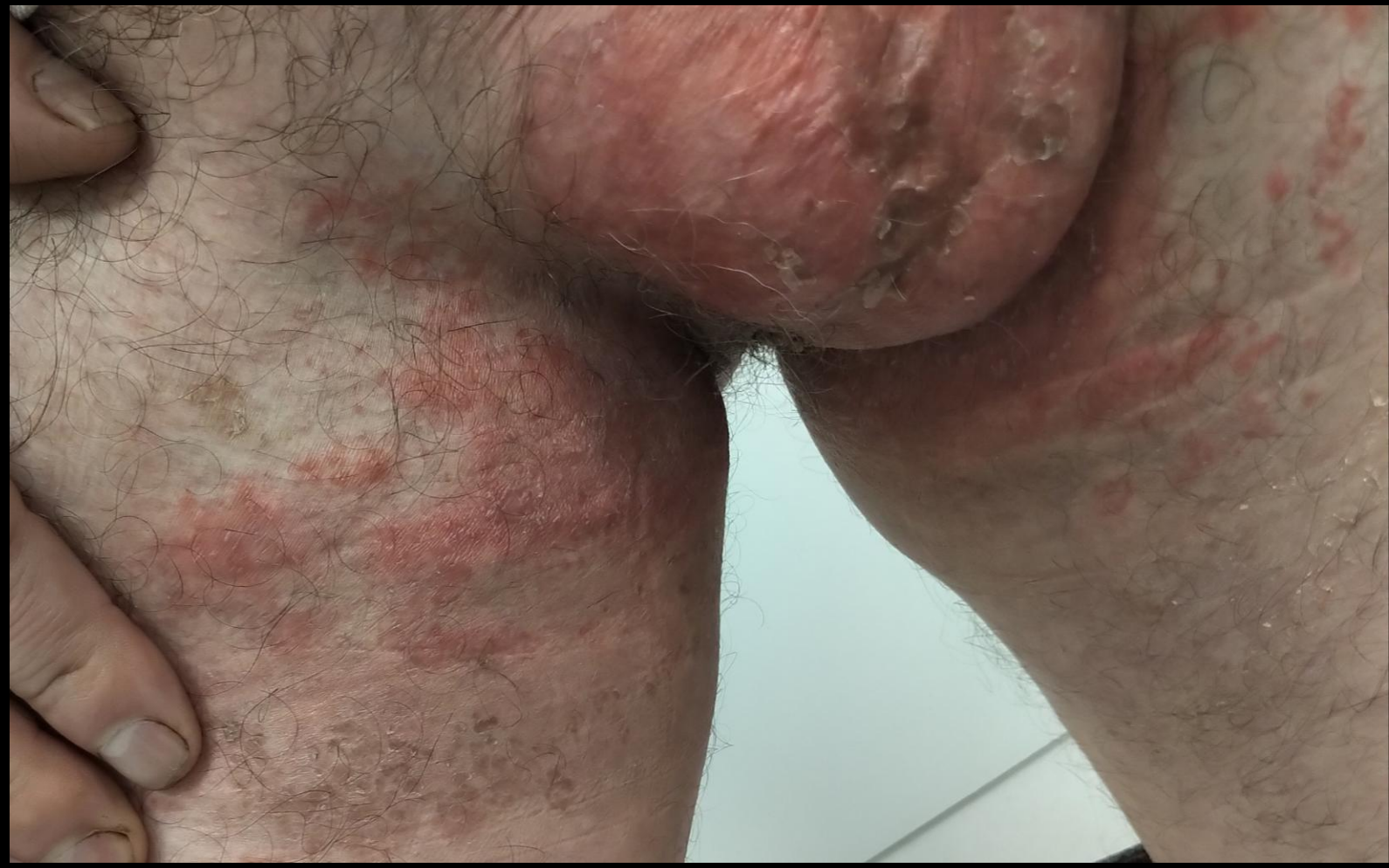
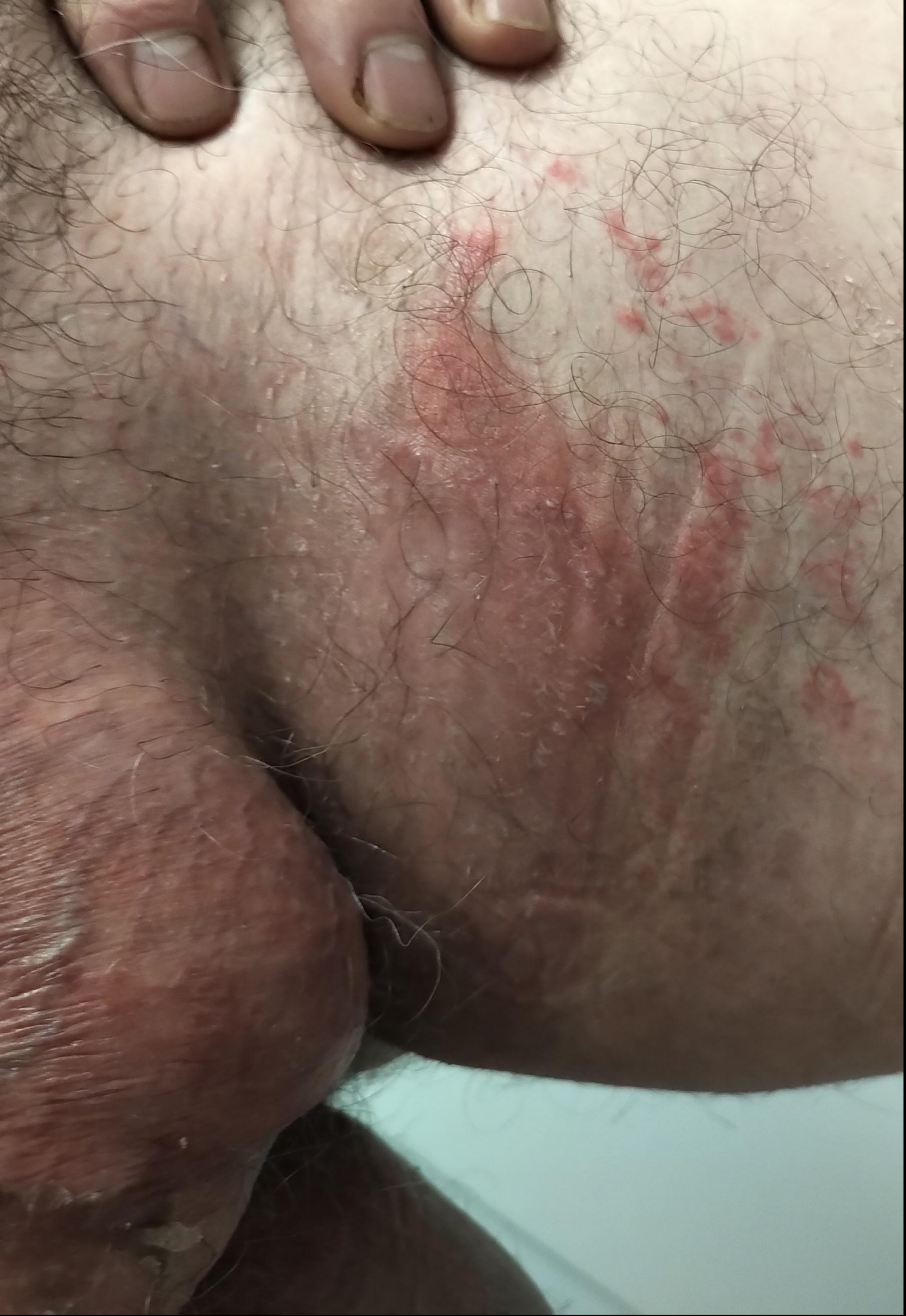
What would you do?

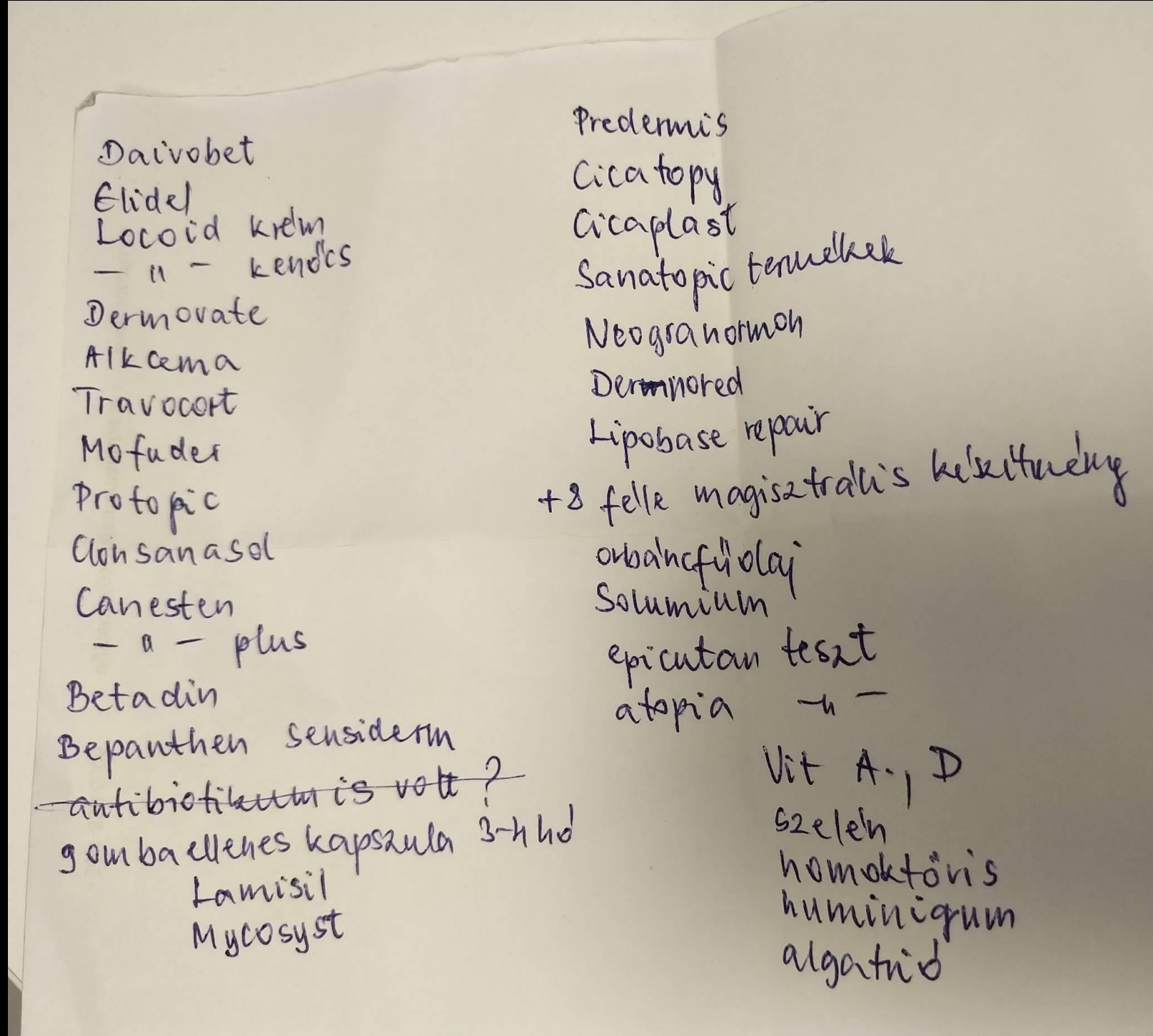
- My choice was 10 mg prednisolone once daily in addition
- Permanent full remission achieved within one week
- Then reduced to 5 mg daily for two months, subsequently stopped
- Tapering of the other drugs slowly

- Itching, persisting skin lesions for a year
- Topical corticosteroids were consistently effective, but lesions typically relapsed within 2-3 days after discontinuation



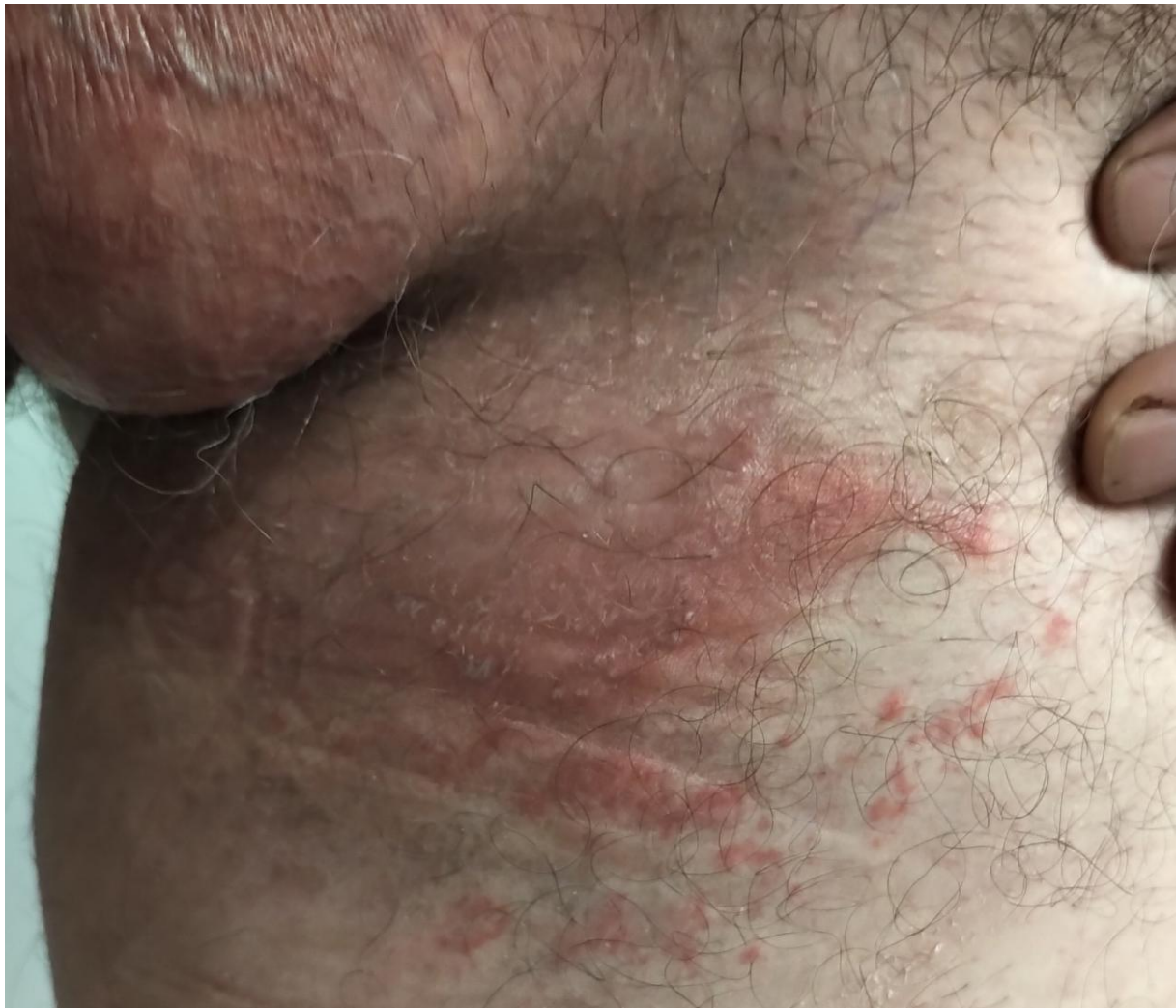


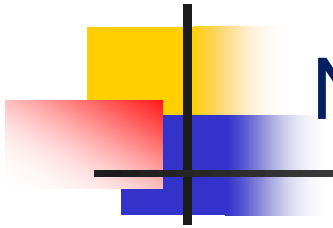
- When asked about previous therapies, the patient showed me an extensive list
  - Glucocorticoids
  - Antimycotic topical and systemic preparations
  - Antiseptics
  - Emollients



Diagnosis

- Contact dermatitis
  - Intertriginous areas uninvolved (= no fungal intertrigo or erythrasma)
  - Intensely red, small, follicular papules (suggestive of follicular diffusion of the triggering factor)
  - Small subcorneal pustules on the larger plaques (=> immunological disease, not an infection)
  - Asymmetric distribution, irregular shape
- What could be the allergen?





Next step?

Next step?

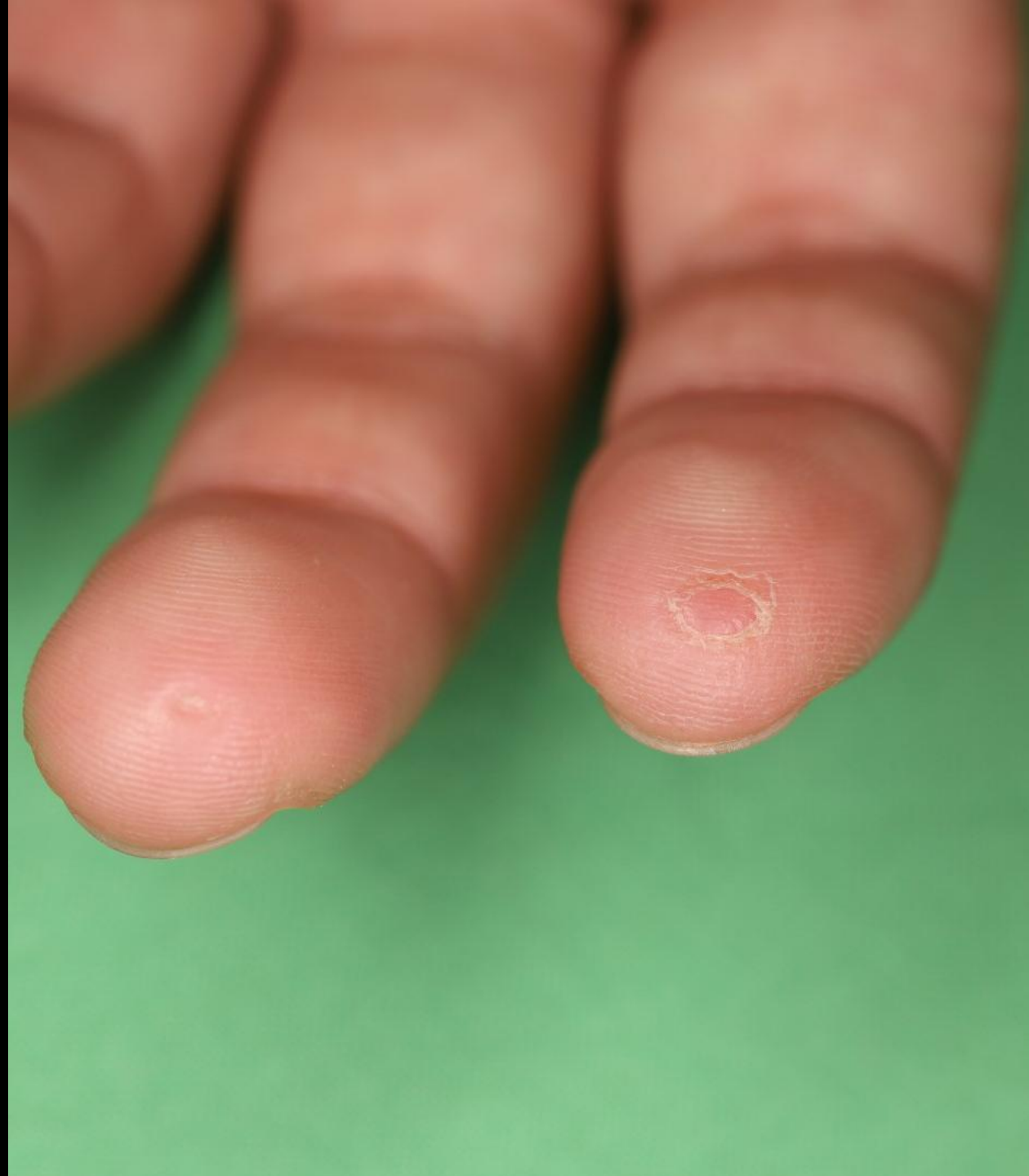
- Epicutaneous patch test has proven delayed-type hypersensitivity against
  - Nickel
  - Cobalt
  - **Lanolin**

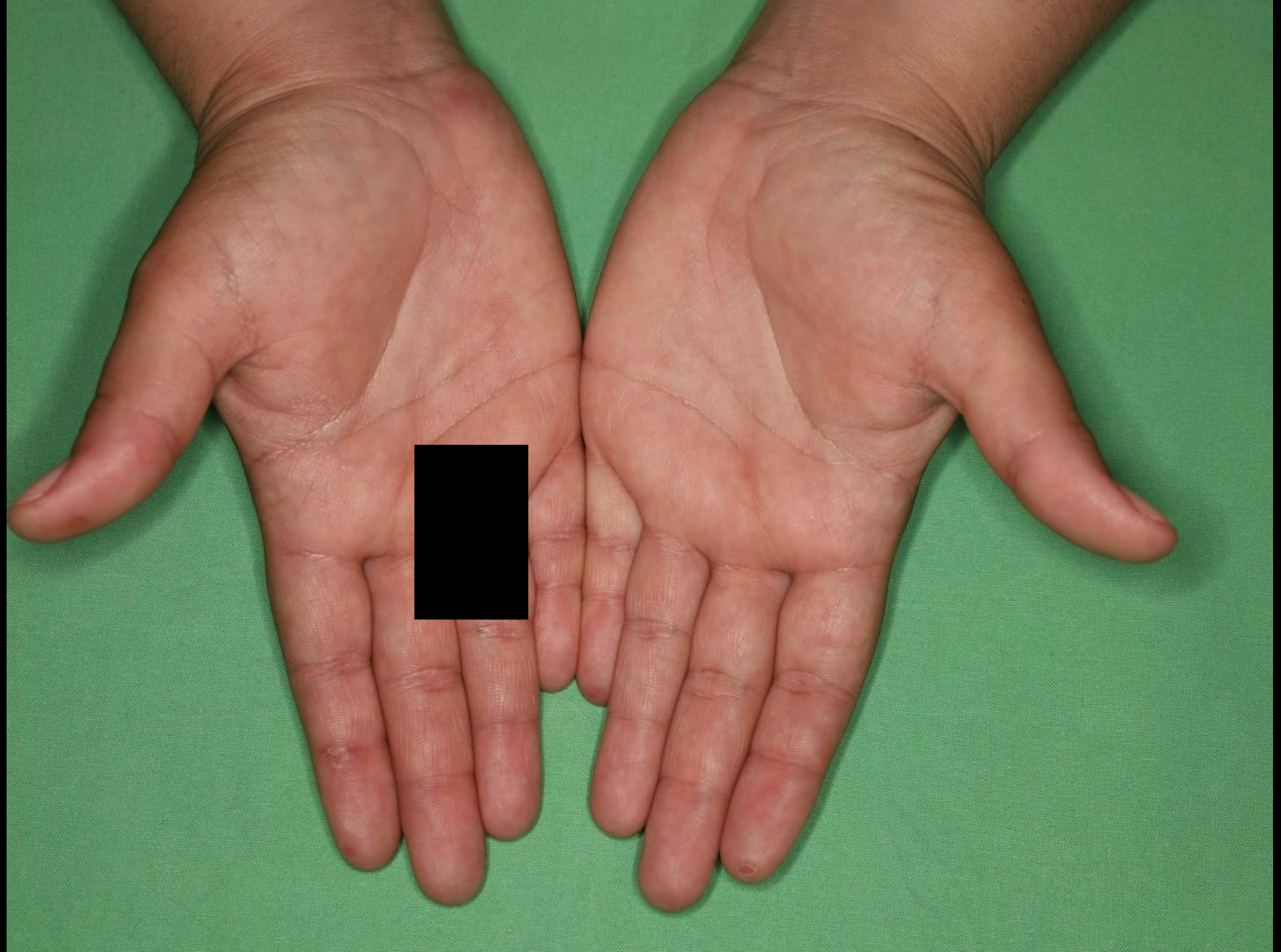
Therapy?

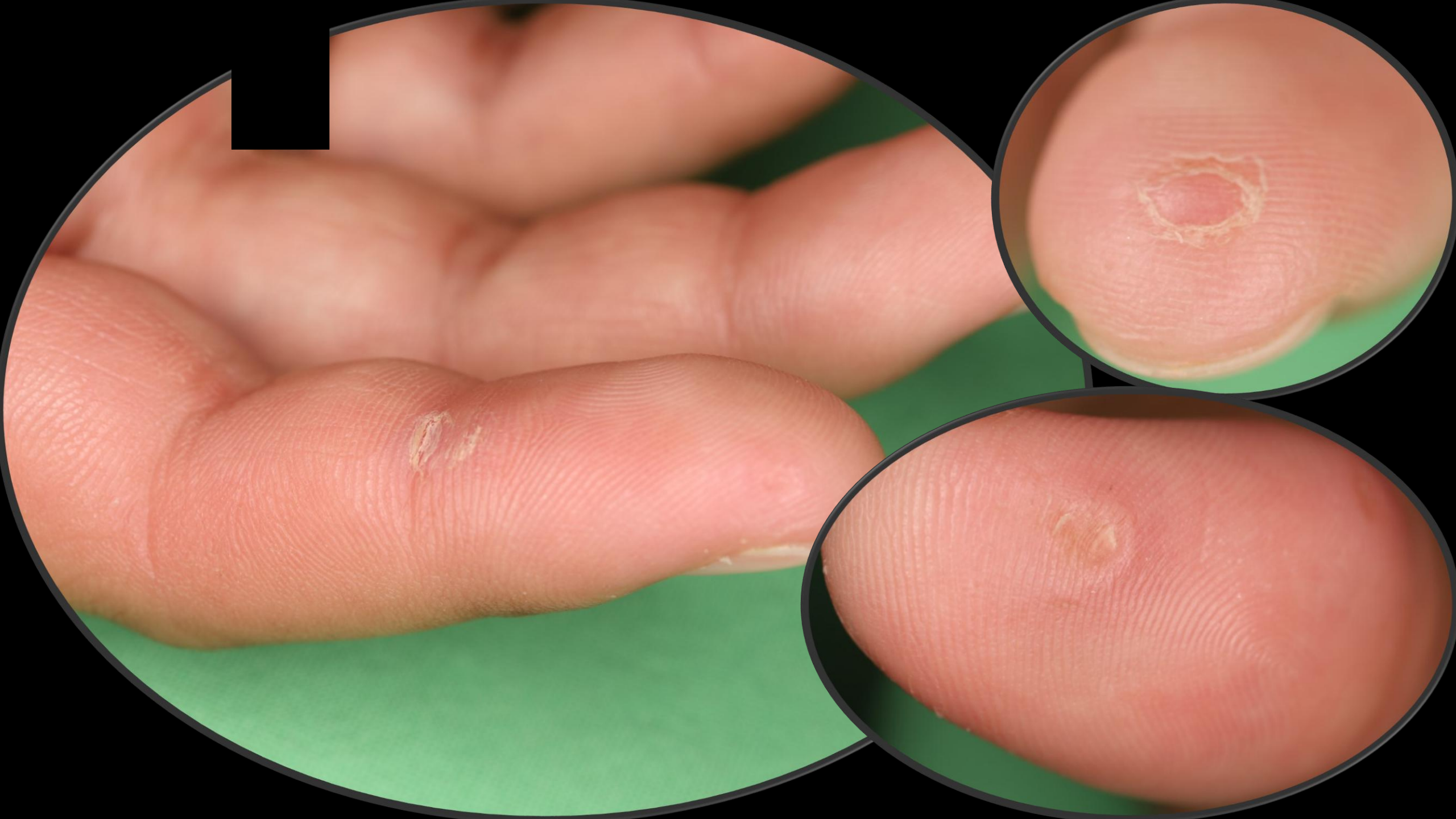
Therapy

- If possible, avoidance of all topical treatments.
- Only lanolin-free topical preparations (e.g., Elocom® ointment)
- Use of hypoallergenic soaps, such as additive-free olive oil soap
- Avoidance of liquid detergents

- 30-years-old female
- Persisting skin lesions for a few months
- No itching or pain
- Consulted already 5 dermatologists
- Topical steroids, antimycotic creams have not been efficient







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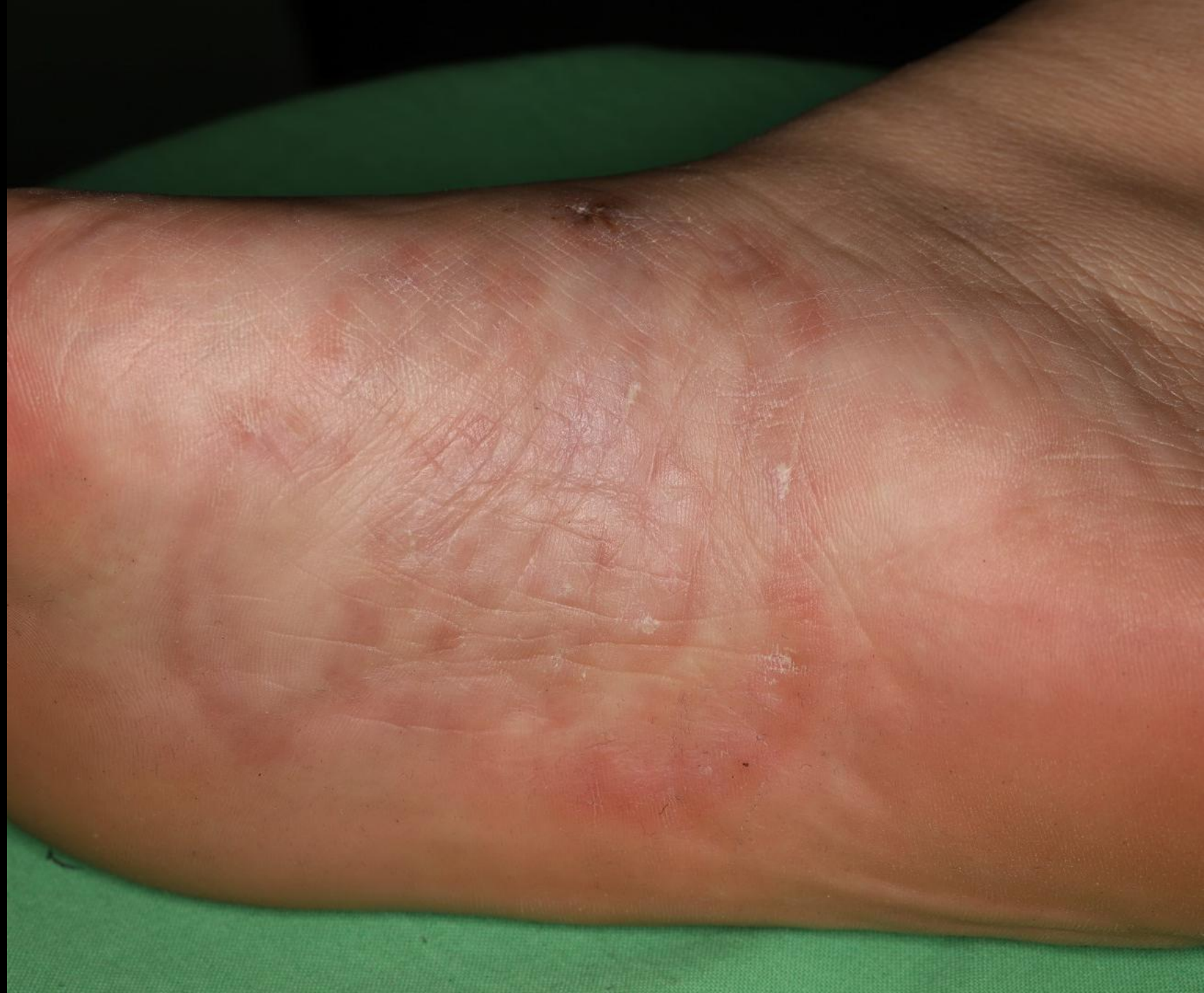
- Do you already know the diagnosis?

- No other colleague has looked at the soles so far…
- But I wanted her to show me the plantar regions anyway



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- Do you already know the diagnosis?
- Differentials?

Diagnostics

What would you do first?

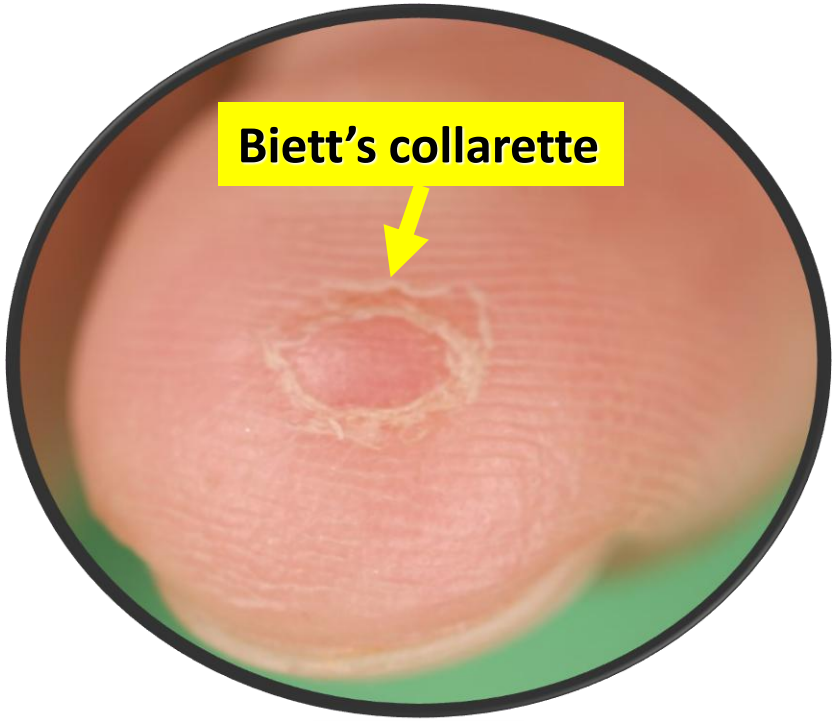
- Biopsy from the plantar lesion
- Biopsy from the digital lesions
- KOH test for detection of fungi
- Fungal culture from the palmoplantar areas
- Syphilis serology
- Complete STI screening (HIV, syphilis, HBV, HCV serologies, and cervicovaginal PCR for N. gonorrh., C. trachomatis, M. genitalium, U. urealyticum)
- Epicutaneous patch test
- Measurement of serum glucose and glucagon + oral glucose tolerance test

Results

- Histological evaluation of biopsy from the plantar lesion: nonspecific dermatitis

Results

- Syphilis serology: positive (both RPR 1:32 and TPPA 1:64)
- Every other examination: negative or within normal limits



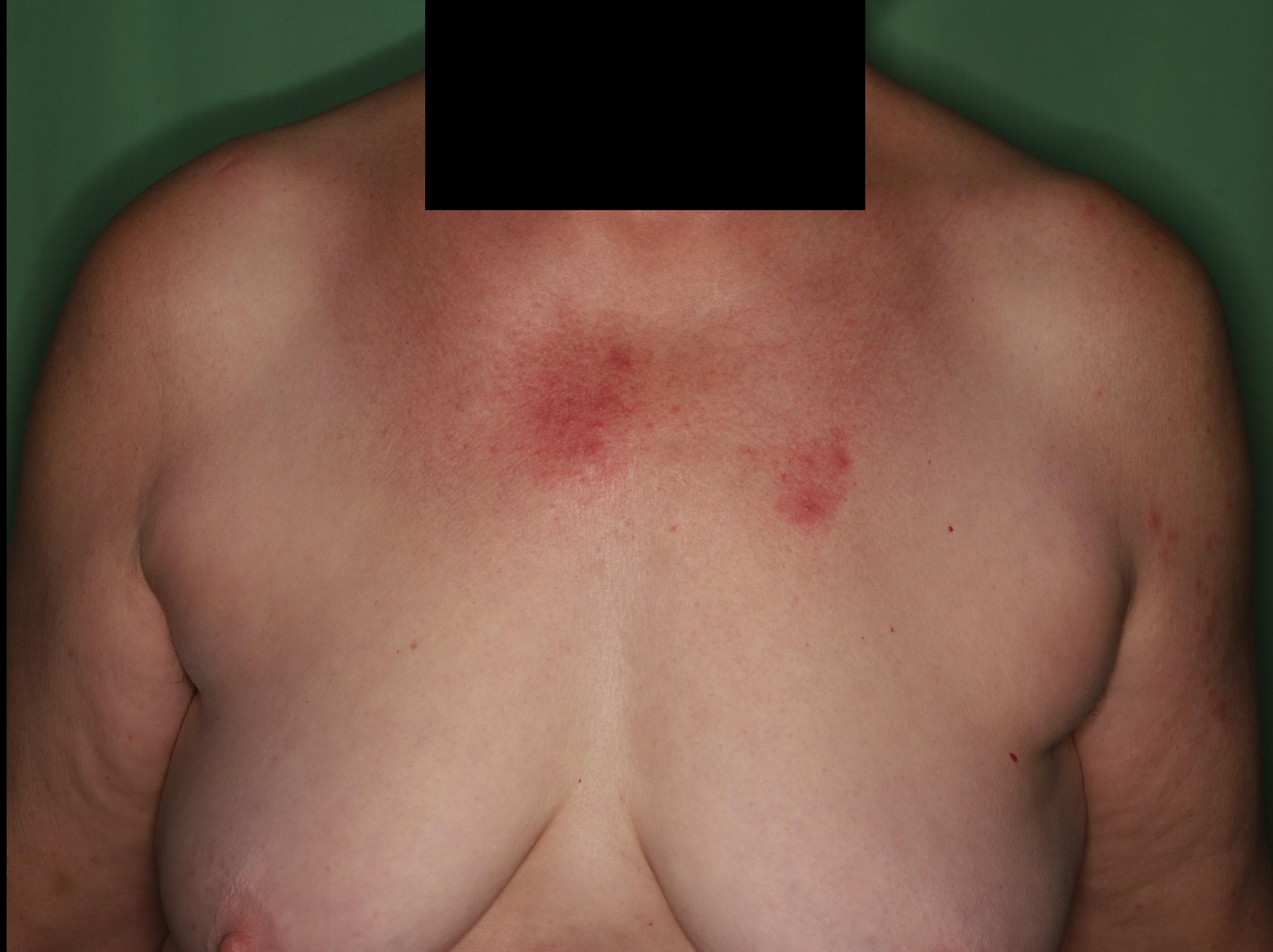
Further results

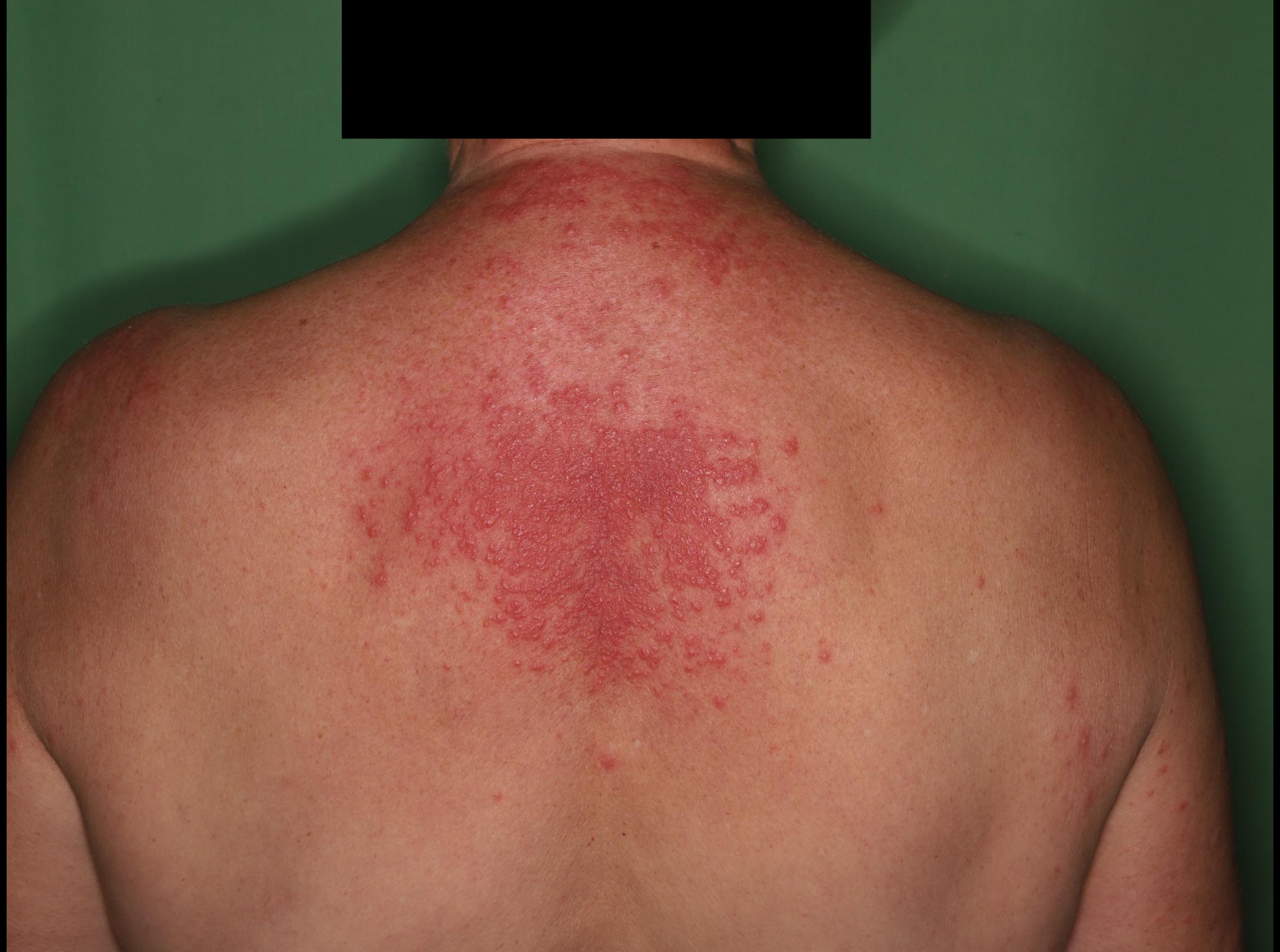
- Syphilis serology of the husband was also positive (both RPR and TPPA)

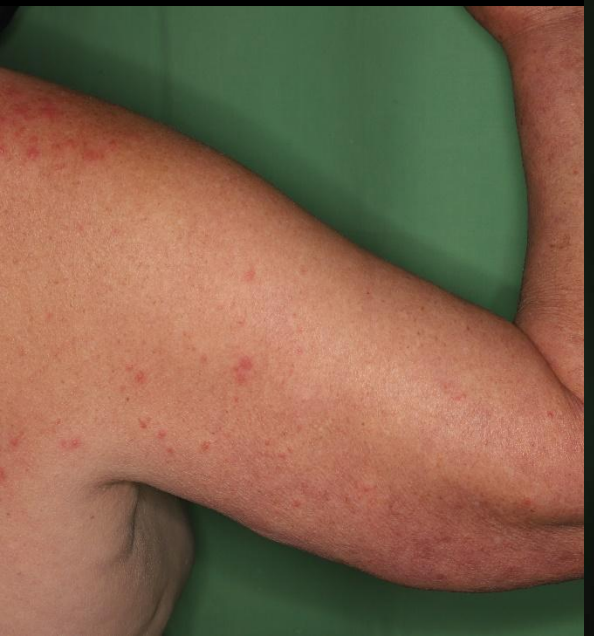
Therapy

What would be your preferred treatment?

- 70-year-old female
- Burning skin lesions for a few days in April

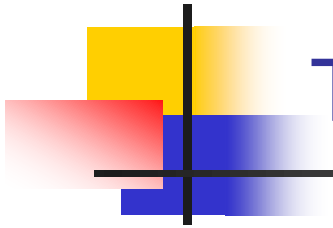






Diagnosis

- Histological analysis: polymorphic light eruption



Therapy?

- Several options…

Therapy?

- Several options…
- The combination of
  - Sun protection
  - Hardening
  - Potent topical corticosteroid
  - Hydroxychloroquine

And what would you recommend if the patient wants vacation on a tropical island?

- ?

And what would you recommend if the patient wants vacation on a tropical island?

- Systemic glucocorticoid prophylaxis

Summary

- Please think in terms of protocols and guidelines, but act individually, customize the therapy to meet the patients' specific needs.
- If a skin condition does not heal within 3 months, it may be worth changing the treatment approach or seeking help – dermatology is a consultative profession! Be creative!
- It's advisable to recall patients for follow-up visits, study the literature, ask ChatGPT. Without feedback from other colleagues and ChatGPT, without reading literature, we don't improve, we don't learn from our mistakes, we don't get the capability of solving complex cases, and we won't have new ideas.

Thank you very much for your kind attention