Evening Medical Update: Dermatology and Allergy - April 2023

Managing allergic rhino conjunctivitis – Professor Syed Hasan Arshad

For patients with chronic symptoms, would you recommend inhaled corticosteroids for an ongoing basis or limit to a set amount of time?

I presume you mean "topical nasal steroids" (as the term "inhaled steroids" is often used for asthma inhalers). The treatment with nasal steroids needs to be long term and there is usually no end date to it. However, it is reasonable to monitor response to therapy and step up or step down treatment based on their symptoms.

Do you advise to start treatment with corticosteroids?

Yes, as first line therapy. They are safe to use for long term and treat nasal inflammation (rather than just suppressing symptoms), therefore long-term complications of untreated allergic rhinitis such as nasal polyps or hypertrophy of the turbinate are avoided.

If immunotherapy is so effective in managing symptoms, why are these not first line?

Because of the expense, resources required and a treatment course that lasts for 3 years. Almost 25% of the population suffer from seasonal allergic rhinitis (grass and/or tree pollen allergy) and additionally many have perennial rhinitis due to dust mites, mould or animal allergies. Providing allergen immunotherapy as a first line treatment will soak a lot of NHS resources. Also, topical nasal steroids and/or antihistamines are safe and effective treatments.

Can high IGE affect your decision on treating rhinitis?

Yes, as it will steer me towards allergen immunotherapy. However, the treatment algorithm remains the same (with high or low IgE) i.e., if the patient has mild to moderate disease and respond adequately to pharmacotherapy, then allergen immunotherapy is not indicated.

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Skin manifestations of systemic disease – Dr Binita Guha – Niyogi

Can histaglobulin injections be used in Allergic Rhinitis?

The evidence for the use of histaglobulin for allergic rhinitis is minimal and it is not approved for allergic rhinitis or other allergic conditions in this country. Its mechanisms of action is also unclear. I have never used this for allergic rhinitis.

Am I understanding correctly, if purpuric rash is noted and vasculitis suspected, one can just watch and wait?

We often diagnosis skin features of vasculitis clinically and if you have a very mild asymptomatic petechial rash with no systemic symptoms you might be thinking of a capillaritis or a mild localised cutaneous vasculitis, which you could watch as this will likely resolve on its own. However, if the rash is prominent/extensive (as the case I showed), you should exclude systemic vasculitis. If you're unsure you should always discuss with your local dermatologist who will be able to advise on a case by case basis and advise on the tests to do to exclude a systemic vasculitis.

In erythema nodosum, how long should patient continue steroids?

Depending on the patients age, extent and symptoms I usually start on 30mg prednisolone and wean by 5mg every week and then stop.

How to treat lichenification after chronic eczema?

This is chronic thickening of the skin due to longstanding eczema. Essentially regular emollients and if the skin is itchy/inflamed topical steroids which can be escalated in strength if needed, will help manage this.

What cutaneous lesion in face can present in periodic intermittent relapsing coarses every 2/3 months in form vesicles and skin discoloration?

It's difficult to comment without seeing the patient or more history, however, if it is a recurrent vesicular rash localised to the same site you should exclude herpetic infection with a viral swab. You would want to determine if these are actually vesicles or pustules, there are a number of underlying causes for a pustular facial rash. The skin discoloration could be postinflammatory.

What is the commonest skin sign in dermatomyositis?

A facial rash is said to be the most common initial sign, but these changes can be very subtle, which is why a good history is so important

Why do you check ESR & CRP? I understood that this was not good practice to do both, and have a paper somewhere to show that CRP is more reliable

You don't have to check both, I've mentioned them as they are both markers of inflammation.

Should nifedipine be used in winter only or year round?

It would depend on the patient's symptoms and the severity. If the patient's symptoms are usually controlled in the summer months you can trial them off it, but some may suffer all year round and need something continuous

What's the name for the rash on the shins for scleroderma again please?

This lady has scleroderma

What's your take on Chronic Hyperpigmented Cellulitis with bilateral oedema of the lower limbs?

This sounds as though you're talking about chronic venous insufficiency and venous eczema if involving both legs. You do not get bilateral cellulitis. The pigmentation tends to be postinflammatory and due to the chronic changes. The patient would require ABPIs to assess appropriateness for compression given the oedema and topical management with regular emollients and if the skin becomes inflamed managing with topical steroids.

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Immunosuppression and dermatology – Dr Lorna Mackintosh

Since ever increasing use of immunosuppressant's puts a strain on resources for monitoring for skin cancers, is there evidence for use of AI/machine learning to increase capacity of surveillance services?

Mole mapping machines are available in the private sector (not in NHS in my local area) – potential use to aide monitoring of moles but I'm not aware of any similar machines that could be used for non melanoma skin cancer which is the main clinical problem in this population.

Can patients with immunodeficiency syndromes (e.g. Dock-8 deficiency "(respond to immunotherapy (e.g. for warts)?

I'm not sure if that has been trialled – I would expect that the risks associated with immunotherapy would be too great

The side effects of cyclosporine you have mentioned are they reversible?

Yes – with early cessation of the drug, gum hypertrophy and hypertrichosis are reversible.

What be the best mode of treatment in a paediatric patient with 5 year history recurrent URTI & bronchial asthma, strong paternal history of asthma & eczema - presented with Chronic Urticaria complicated by Knee inflammation?

Chronic urticaria is normally managed with antihistamines. "knee inflammation" – would require investigations to determine the aetiology.

Does reduction in long term immunosuppression help reduce frequency of skin cancers in patients > 10 years post-transplant?

Yes, even 10 years post transplantation, overall reduction in immunosuppression burden is beneficial. Risk/benefit discussion required between Dermatology and transplant team. Can also consider the use of agents such as Acitretin to reduce frequency of further skin cancers in patients who have already developed SCC.