Abstract N°: 80

A Systematic Review of Isotretinoin and its Contraindications in Peanut, Soybean, and Cashew Nut Allergies

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Introduction & Objectives:

Should oral isotretinoin be considered contraindicated in patients with peanut, soybean, and cashew allergies? A systematic literature search of PubMed, EMBASE and The Cochrane Library up to July 2023 was conducted to identify randomised control trials (RCTs), cohort studies, case reports, and cross-sectional studies investigating if isotretinoin should be contraindicated in patients with various allergies including peanut, soybean, and cashew allergies.

Materials & Methods:

Primary outcomes explored included relapse, adverse effects, and safety profiles of oral isotretinoin at varying doses. Secondary outcomes included efficacy as well as economic considerations. The quality of studies, including risk of bias, was assessed using GRADE (Grading of Recommendations, Assessment, Development and Evaluations). A total of 8 studies were included.

Results:

The majority of studies suggested that isotretinoin should not be considered inadvisable. In cases with peanut allergies, minimal adverse effects were noted with various dosages of isotretinoin and prolonged treatment duration. In cases with soybean allergies, similar results and conclusions were obtained to the cases with peanut allergies, however the number of studies were not of similar value to those of peanut allergies.

Conclusion:

Comparison between studies was challenging due to differing methods of assessment, subjective interpretation of severity and duration of follow-up. This review highlights the need for an adequately powered RCT, to decipher whether isotretinoin should not be given to patients with peanut, soybean or cashew allergies.

Abstract N°: 300

Efficacy and Safety of Omalizumab Intended-Copy Biosimilar vs. Biologic in Urticaria: A prospective, observational, real-world unicentric cohort study

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Introduction & Objectives:

Chronic spontaneous urticaria (CSU) is a challenging condition that severely impacts patients' quality of life. Omalizumab, a monoclonal anti-IgE antibody, has revolutionised its management, but high costs limit accessibility, particularly in resource-limited settings like India. Biosimilars offer a cost-effective alternative, though their efficacy and safety in CU remain underexplored. We aimed to compare the efficacy of omalizumab intended copy biosimilars (Available in India) to the reference biologic in patients with chronic urticaria (CU) based on Urticaria Activity Score (UAS) and Urticaria Control Test (UCT) outcomes and providing insights into their potential role in expanding affordable care.

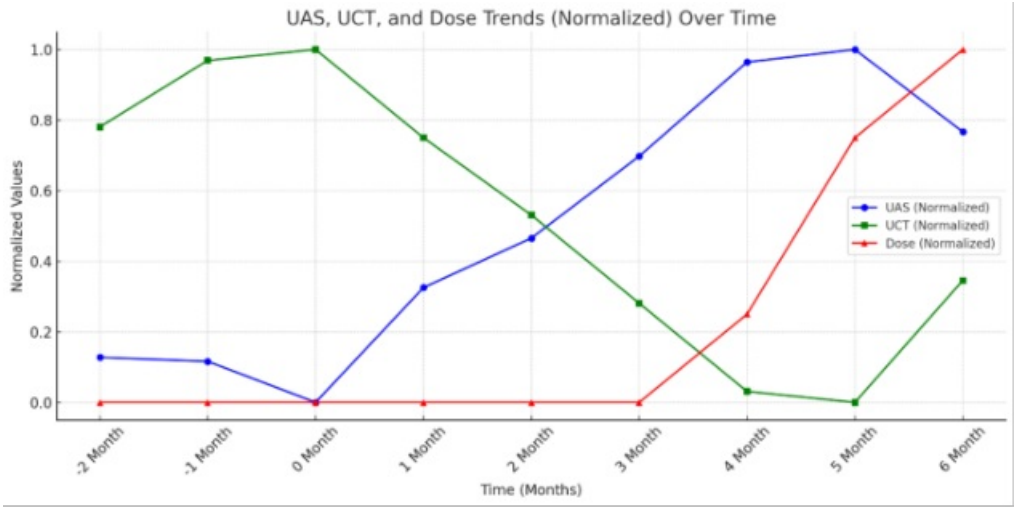
Materials & Methods:

It was a prospective, observational, real-world unicentric cohort study. The patients in this study were previously on omalizumab biologics for varying durations and had achieved good disease control. Due to the unavailability of the biologics, they were transitioned to omalizumab-intended copy biosimilars, with the transition period marked as 0 months. Disease control was evaluated using the Urticaria Activity Score (UAS) and Urticaria Control Test (UCT) at baseline and monthly for six months. Initial dosing matched prior biologic regimens (mean 266.67 mg/month) but was escalated up to 600 mg/month based on clinical response. Changes in UAS and UCT scores, along with safety and tolerability, were analyzed to compare biosimilars' effectiveness against the reference biologic.

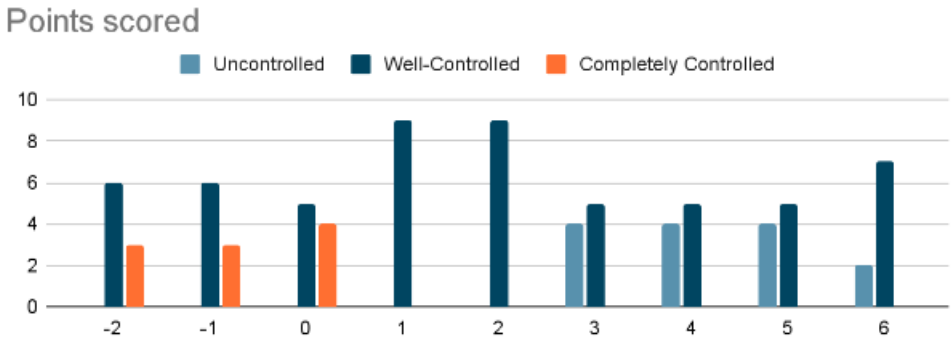
Results:

At baseline (0 months), patients transitioned to omalizumab biosimilars had well-controlled chronic urticaria, with a mean UAS of 2.55±2.12 and a mean UCT of 15.33±0.71 while on the reference biologic (mean dose: 266.67 mg/month). However, after switching to biosimilars, disease control worsened progressively, peaking at month 5 with a mean UAS of 12.11±6.62 and a mean UCT of 11.77±3.19, despite dose escalation. The dose was increased to 450 mg/month for four patients at month 5 to address the worsening disease control. Despite this, two patients showed minimal improvement, leading to further escalation to 600 mg/month. Following these adjustments, some improvement was noted by month 6, with the mean UAS decreasing to 9.88±3.1 and the mean UCT improving to 13±1.73. Disease control under intended copy biosimilars remained inferior compared to the original biologics, even with a significantly higher mean dose.

Conclusion: Our study highlights significant differences in the efficacy of omalizumab intended copy biosimilars compared to the reference biologic in managing chronic urticaria. Despite dose escalation, disease control deteriorated after transitioning to biosimilars, with higher UAS and lower UCT scores observed over six months. Although some improvement was achieved with increased dosing, intended copy biosimilars remained inferior to the biologic in maintaining symptom control. These findings emphasize the need for rigorous clinical evaluation of omalizumab intended copy biosimilars before widespread adoption, particularly in resource-limited settings where accessibility and affordability remain key concerns.



 # Figure 1: Graphical representation of UAS, UCT, and Dose of the drug and their relation (Data normalized)



 # Figure 2: Number of patients with Completely controlled, Well-controlled and Uncontrolled Urticatia as per UCT

Abstract N°: 388

Photoallergy to Diclofenac

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Introduction & Objectives:

Diclofenac, a widely prescribed nonsteroidal anti-inflammatory drug (NSAID) belonging to the phenylacetic acid derivatives of arylcarboxylic acids, possesses analgesic, anti-inflammatory, and antipyretic properties. It is commonly used to manage acute and chronic pain conditions as well as inflammatory disorders. Here, we report a case of a photoallergic reaction to Diclofenac.

Materials & Methods:

A 28-year-old male patient with a history of polytrauma following a road traffic accident presented with left-sided lower back pain. His trauma specialist prescribed topical Diclofenac gel (1%) for symptomatic relief.

One week after initiating treatment, the patient developed a well-demarcated, pruritic erythematous plaque with vesicles at the site of gel application on the left flank. Clinical examination confirmed the diagnosis of a localized photoallergic reaction.

Patch testing was conducted one month later, with Diclofenac gel applied under occlusion for 48 hours. The test produced a strongly positive (++ reaction) result, characterized by an erythematous plaque with vesicles, confirming Diclofenac as the causative agent.

The patient was treated with topical corticosteroids, which resulted in significant improvement and complete resolution of lesions within seven days. He was advised to avoid both topical and systemic Diclofenac and educated on the importance of photoprotection.

Results:

Diclofenac, a potent cyclooxygenase-2 inhibitor, is widely used for its anti-inflammatory effects. Nonsteroidal anti-inflammatory drugs, including Diclofenac and Ketoprofen, are recognized as potential causes of photoallergic reactions.

Photoallergic dermatitis typically presents as pruritic, vesiculobullous eczema at the site of topical application following ultraviolet (UV) exposure. Secondary extension to other areas, such as urticarial reactions or erythema multiforme, may occur due to systemic immune responses, manual transfer, or contamination of clothing.

Although Ketoprofen is more commonly implicated, Diclofenac can induce photoallergic reactions through similar mechanisms. Patch testing remains the most reliable diagnostic tool, aiding in identifying and eliminating the responsible agent.

Conclusion:

Photoallergy to Diclofenac typically presents as localized vesiculobullous eruptions in areas exposed to sunlight and treated with topical Diclofenac. Management includes discontinuation of the causative agent, the use of topical corticosteroids, photoprotection, and avoidance of cross-reactive agents.

As photoallergic reactions may have a delayed onset, a thorough patient history is essential for accurate diagnosis and effective management.

Abstract N°: 956

Palmoplantar dyshidrosis and nickel allergy: the price to pay for a smile

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Introduction & Objectives:

Palmoplantar dyshidrosis is a skin condition characterized by itchy, tense vesicles and bullae on the palms, soles, and fingers, followed by peeling. While often idiopathic, factors like atopy, allergic or irritant contact dermatitis, dermatophytosis, hyperhidrosis, stress and smoking can predispose individuals. This report describes an unusual case of palmoplantar dyshidrosis triggered by an allergy to orthodontic materials.

Materials & Methods:

Results:

A 23-year-old female student with a personal and family history of atopy presented with a very pruritic vesiculobullous eruption on her palms and soles, followed by extensive desquamation, leading to a functional impairment affecting her studies. She had been treated with topical corticosteroids and barrier creams without improvement. Clinical examination showed erythema on the palms and soles with scarlatiniform scales. No other somatic abnormalities were noted, including no mucosal lesions. Additionally, she was wearing orthodontic braces, which coincided with the onset of the eruption. Patch tests were positive for nickel (+) and methacrylates (+), confirming an allergy to orthodontic materials. The treatment plan involved replacing the dental materials, leading to the complete resolution of the lesions.

Conclusion:

This case illustrates an atypical trigger for palmoplantar dyshidrosis (an allergy to materials used in orthodontics), highlighting how systemic reactions to dental materials can manifest as skin conditions, which is called systemic contact dermatitis.

It underscores the growing importance of considering dental history in dermatological diagnoses,

offering an opportunity for more targeted treatments, such as removing the suspected materials and using nickel-free orthodontic materials which was essential for effective management in our case.

Abstract N°: 1104

Generalized Lichen Planus Pigmentosus Induced by 2-Hydroxyethyl Methacrylate in Dental Crowns

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Introduction & Objectives:

Lichen planus pigmentosus (LPP), is a rare variant of lichen planus (LP), with etiology remains uncertain. Immune-mediated mechanisms and contact hypersensitivity have been implicated. In this case, we discuss a potential link between allergens contained in dental crowns, particularly 2-hydroxyethyl methacrylate (HEMA), and the onset of LPP.

Materials & Methods:

A 35-year-old woman presented with pruritic, hyperpigmented macules that had been evolving for over a year. Clinical examination revealed dark brown and gray-blue macules clustered on the face, neck, and the limbs. A thorough examination of the oral cavity showed white reticular lesions and erosions in direct contact with dental crowns that had been put in place one year and half earlier. Thus, the diagnosis of LPP was suspected and confirmed by histopathology. Patch testing revealed a sensitization to HEMA (++/++). Consequently, a diagnosis of methacrylate-induced LPP due to dental crowns was established, and treatment with topical corticosteroids was initiated. The removal of the dental crowns was discussed but ultimately refused by the dentist because of the absence of alternatives without acrylates. The follow-up showed moderate symptomatic relief, with persistent pigmented lesions.

Results:

While the etiology of LPP remains unclear, contact hypersensitivity to dental materials has been increasingly recognized as a potential trigger. Contact allergens such as HEMA, nickel, and mercury have been implicated in oral lichenoid reactions, but their role in LPP is rarely reported. Pathogenesis likely involves a delayed-type hypersensitivity reaction, leading to chronic inflammation and melanocyte activation, resulting in hyperpigmentation. While topical corticosteroids provide symptomatic relief, the persistence of hyperpigmentation highlights the challenge of managing LPP in cases where the allergen remains in place.

Conclusion:

This case highlights the role of allergens in dental crowns in the pathogenesis not only of oral lichenoid lesions but also distant lesions as cutaneous LPP. Through this case, we emphasize the need for collaboration between dermatologists and dentists in evaluating patients with unexplained hyperpigmentation following dental restorations and discussing treatment options.

EADV SYMPOSIUM PRAGUE 22-24 MAY 2025

Abstract N°: 1304

Contact Sensitization to Fragrances in Patients with Lichen Planus: A Series of six Cases

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Introduction & Objectives:

Lichen planus is a chronic condition, with poorly understood pathophysiology. While the association between contact allergy to metals in dental materials and oral lichen has been well established, it remains controversial for other allergens, particularly in cases of cutaneous or genital lichen. Recent literature has reported contact sensitization to fragrances in patients with lichen planus.

The aim of our study was to evaluate the association between lichen planus and contact sensitization to fragrances.

Materials & Methods:

Six patients presented the association of lichen planus with contact sensitization to Fragrances (Five womens and one man). The mean age was 56.66 years (from 35 to 70 years). The duration of the disease varied from 2 months to 8 years. No patient had personal or family atopy, associated autoimmune disease, or infection with hepatitis B or C viruses. The female patients presented with pruritic, polygonal, violaceous papules, which were scaly and located on the face, limbs and trunk. The male patient had cheilitis and a lichenoid network on the buccal mucosa. In all cases, the evolution was chronic and poorly improved by topical corticosteroid therapy. Histology revealed orthokeratotic hyperkeratosis, a band-like lymphohistiocytic infiltrate, and spongiosis in all cases. Patch testing with the European Standard Series was performed. All patients showed positive reactions to Peru balsam. This reaction was considered pertinent in all cases (Peru balsam was present in hygiene products used by the female patients and in the toothpaste used by the male patient with oral lesions. For all patients, avoidance was indicated. There was a marked partial improvement for all patients after three months follow-up.

Conclusion: ** We report an original case series of patients presenting an association of lichen planus and contact sensitization to fragrances. Through this series, we emphasize the need for larger studies to establish the correlation between contact sensitization to fragrances and cutaneous and mucosal lichen planus.

Abstract N°: 1323

Beauty with a bitter cost: Allergic cheilitis from lip gloss in a young girl

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Introduction & Objectives:

** Allergic cheilitis (AC) to cosmetics, characterized by inflammation of the lips and surrounding areas, is rarely reported in adults and has not previously been documented in children due to phenoxyethanol (PE), a common cosmetic preservative. We present the youngest known case of AC triggered by PE in lip gloss.

Materials & Methods:

NA

Results:

A 4-year-old girl experienced recurrent cheilitis over nine months. Her medical history showed no signs of atopy or tics. Upon examination, her lips and perioral skin displayed swollen, reddened, and fissured plaques with mild crusting, but no other skin issues were present. Her symptoms began shortly after she started using her mother's Miss Betty® lip gloss. Following the guidelines from the International Contact Dermatitis Research Group, patch testing was conducted using the European Baseline Series and Cosmetics Series with IQ Ultra Chambers®. Results on days 2 and 3 showed a positive reaction (++/++) to phenoxyethanol (1% pet.), correlating with its presence in the lip gloss. A confirmatory repeat open application test (ROAT) with the lip gloss also yielded a positive reaction after five days. The patient's symptoms improved significantly within three weeks of avoiding the lip gloss, with only mild xerosis remaining.

Conclusion:

This report identifies a case of AC triggered by PE in a child, confirmed through positive patch testing and symptom resolution upon allergen avoidance. While PE is generally considered safe, allergic reactions can occur, emphasizing the need for caution in pediatric use. Previous cases have reported PE-induced reactions in adults, including dermatitis and urticaria. This case underscores the importance of patch testing in diagnosing AC in children and suggests that if flare-ups recur, further testing may be needed to identify other allergens in personal care products. Healthcare providers should remain vigilant regarding potential allergic reactions to PE in cosmetics.

EADV SYMPOSIUM PRAGUE 22-24 MAY 2025

Abstract N°: 1385

Generalized lichenoid eruption due to Nickel and Chromium allergy in orthopedic implant initially misdiagnosed as toxidermia

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Introduction & Objectives:

The presence of metals, such as Nickel, Cobalt and Chromium, in orthopedic implants has been increasingly recognized as a potential cause of allergic reactions in susceptible individuals. Metal-based prostheses are widely used in orthopedic surgery due to their durability and mechanical properties. Allergic symptoms range from localized allergic contact dermatitis next to the implantation site to widespread lichenoid eruptions.

Observation:

We report the case of a 51-year-old female who developed a generalized cutaneous eruption that has been evolving for four months. The eruption was characterized by diffuse pruriginous purple erythematous papules and plaques. The diagnosis of toxiderma was initially suspected, due to recent antibiotic use following a tibial fracture treated with osteosynthesis. Histopathological examination was suggestive of lichenoid toxiderma. The pharmacovigilance investigation ruled out the drug origin given the persistence of the rash after stopping the antibiotic tratement. Patch testing revealed positive reactions to Nickel sulfate (++/++) and Potassium dichromate (+/+). The results were considered pertinent given the fact that these metals are commonly found in orthopedic implants. The patient was referred to orthopedic departement for eventual removal of the osteosynthesis implant and treated with topical corticosteroids.

Discussion:

Systemic contact dermatitis due to metals, such as Nickel and Chromium is uncommon. Besides the usual erythematous pruritic lesions, it can manifest with extensive cutaneous eruptions, mimicking other dermatological conditions such as drug-induced toxidermia, causing a delay in diagnosis. Metal hypersensitivity is an often-overlooked cause of postoperative dermatological reactions, particularly in individuals receiving orthopedic implants.

Conclusion:

This case highlights the importance of considering metal allergies in patients with generalized lichenoid eruptions mainly if the patient reports the onset of the lesions after the placement of the metallic implant. We emphasize the need of collaboration between dermatologists and orthopedists in discussing treatment options.

Abstract N°: 1570

Periorbital Dermatitis as a Side Effect of Timolol: A Clinical Dilemma

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Introduction & Objectives:

Eyelid and periorbital dermatitis (PD) are frequently caused by allergic contact dermatitis from topical ophthalmic medications. We present a case of PD induced by timolol in ophthalmic eye drops, emphasizing the importance of identifying causative allergens in such conditions.

Materials & Methods:

NA

Results:

A 60-year-old dental prosthetist presented with four months of intermittent erythematous, pruritic eyelid lesions, stinging, and ocular redness. Her medical history included a conjunctival injury, allergic conjunctivitis (2015), and mixed glaucoma (2022), initially managed with Timolol/dorzolamide and Latanoprost, later transitioning to Latanoprost monotherapy. She primarily used preservative-free Timolol/dorzolamide but occasionally substituted it with a benzalkonium chloride (BAk)-preserved formulation. Dermatological examination revealed erythematous squamous plaques at the inner canthi and conjunctival hyperemia, suggesting medication-induced eczema and conjunctivitis. Patch testing using demonstrated positive reactions to Timolol/dorzolamide in both preservative-free and BAK-containing formulations, indicating an allergy to the active ingredients. Further tests, including separate patch and Repeated Open Application Tests (ROAT) for dorzolamide and timolol, confirmed a positive reaction to timolol, identifying it as the causative allergen. Discontinuation of timolol-containing medications led to significant improvement in PD.

Conclusion:

Eyelid skin, being the thinnest and most delicate, is highly susceptible to contact dermatitis from irritants and allergens. PD can be exacerbated by ocular surgery, harmful products, and ophthalmic medications like timolol/dorzolamide eye drops containing BAK. While some studies attribute PD to preservatives like BAK, others implicate active ingredients such as timolol. In this case, timolol was identified as the primary allergen, supported by patch and ROAT results.

This case underscores the necessity of comprehensive allergological evaluation in patients with PD linked to ophthalmic treatments. Identifying the specific allergen—whether a preservative or active ingredient—is critical for effective management and prevention. Timely discontinuation of the offending agent, as demonstrated here, can lead to significant clinical improvement.

Abstract N°: 2334

Generalised Bullous Pemphigoid in a Young Man After Exposure to Haemodialysis Membrane: A Case Report

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Introduction & Objectives:

Bullous pemphigoid (BP) is the most common subepidermal immunobullous disorder, usually affecting older individuals. Established triggers include certain medications (such as furosemide and D-penicillamine), ultraviolet light, infections, vascular grafts, and autoimmune conditions. However, BP in younger patients is unusual. This report describes a 23-year-old male with end-stage renal disease (ESRD) who developed BP after exposure to a polysulfone membrane dialyser, a synthetic filter used in hemodialysis (HD) to remove waste products from the blood.

Materials & Methods:

A 23-year-old male with chronic kidney disease progressing to ESRD was admitted for HD initiation via an internal jugular vein catheter. Hemodialysis was performed three times per week using a polysulfone membrane dialyser (Fresenius, Germany). Six hours after the first session, the patient reported a burning sensation on the skin and developed fluid-filled blisters on the trunk, extremities, and oral mucosa. Dermatological examination noted a negative Nikolsky's sign (skin layers do not dislodge with slight pressure) and a positive bulla spread sign (gentle pressure on an intact blister spreads fluid within it). Some erosions had healed with atrophy and hypopigmentation. A Tzanck smear (a rapid microscopic test on blister fluid) showed no acantholytic cells. Histopathological examination of a biopsy from an intact bulla demonstrated a subepidermal cleft containing eosinophils and neutrophils, while direct immunofluorescence revealed linear IgG and C3 deposits along the basement membrane zone, confirming BP.

Hemodialysis was suspended, and the patient was managed with oral prednisolone at 1 mg/kg/day. Clinical improvement was evident within one week. When HD was resumed using the same polysulfone dialyser under identical parameters, blistering recurred within four hours, despite ongoing corticosteroid therapy. The prednisolone dose was increased to 1.5 mg/kg/day, but the patient was lost to follow-up thereafter.

Results:

A pronounced temporal correlation was observed between exposure to the polysulfone dialyser and the onset or exacerbation of BP, suggesting an immunologic trigger. Literature indicates that dialyser membranes or vascular access interventions may expose hemidesmosomal antigens—such as BP180 and BP230—leading to autoimmune reactions. Younger individuals rarely manifest these events, but ESRD may predispose to immune dysregulation that contributes to BP development.

Conclusion:

This case illustrates that polysulfone membrane dialysers can precipitate bullous pemphigoid in younger patients with ESRD. Early recognition of potential dialysis-related triggers is essential when patients present with new vesiculobullous lesions after initiating hemodialysis. Prompt dermatological assessment, biopsy, and immunofluorescence studies are vital for confirming the diagnosis. Avoiding re-exposure to the implicated dialyser and optimising immunosuppressive therapy may significantly improve outcomes. Awareness of dialyzer-related triggers is crucial for delivering comprehensive care to patients undergoing hemodialysis.