Caribbean Dermatology Association

30th Caribbean Dermatology Conference

November 5 - 6

A VIRTUAL EXPERIENCE

Virtual Caribbean Dermatology Conference

November 5 - 6 | 2021

PROGRAMME

abbvie

Skyrizi™
(risankizumab)

NOTHING* IS EVERYTHING[1]

Your patients can live with a better quality of life**[2] without the limits of psoriasis

Only 4 maintenance doses per year
150 mg/ml[3]

AB-RISN-210015 – Material aimed at healthcare professionals

*Nothing on the skin is defined as 75% achievement of PASI 90 at Week 16 and 56% achievement of PASI 100 at Week 52 in UltIMMa-1 and UltIMMa-2.

1. Blome C, Gosau R, Radtke MA, et al. Patient-relevant treatment goals in psoriasis. Arch Dermatol Res.2016;308(2):69-78

**is defined as 75% achievement of PASI 90 at Week 16 and 56% achievement of PASI 100 at Week 52 in UltIMMa-1 and UltIMMa-2.

2. Gordon KB, Strober B, Lebwohl M, et al. Efficacy and safety of risankizumab in moderate-to-severe plaque psoriasis (UltIMMa-1 and UltIMMa-2): results from two double-blind, randomised, placebo-controlled and ustekinumab-controlled phase 3 trials. Lancet. 2018;392 (10148):650-661.
3. Skyrizi® Product Monograph Date of Revision: April 17, 2019, and Control No. 215753

Dear Doctor, please note that Skyrizi is only approved for Aruba, Curacao & Sint Maarten

Aruba

Skyrizi® (Risankizumab) 75 mg solution for injection in pre-filled syringe. Each pre-filled syringe contains 75 mg risankizumab in 0.83 ml solution (90mg/ml). Therapeutic indications: SKYRIZI (risankizumab injection) is indicated for the treatment of adult patients with moderate to severe plaque psoriasis who are candidates for systemic therapy or phototherapy. Posology: The recommended dose of SKYRIZI is 150 mg (two 75 mg injections) administered by subcutaneous injection at Week 0, Week 4, and every 12 weeks thereafter. If a dose is missed, administer the dose as soon as possible. Thereafter, resume dosing at the regular scheduled time. Contraindications: SKYRIZI is contraindicated in patients who are hypersensitive to risankizumab or to any ingredient in the formulation or component of the container. Warnings and precautions: SKYRIZI (risankizumab injection) may increase the risk of infections. SKYRIZI should not be given to patients with any clinically important active infection until the infection resolves or is adequately treated. In patients with a chronic infection or a history of recurrent infection, the risks and benefits should be considered prior to prescribing SKYRIZI. SKYRIZI must not be given to patients with active tuberculosis (TB). Patients receiving SKYRIZI should be monitored for signs and symptoms of active TB during and after the treatment. Prior to initiating therapy with SKYRIZI, completion of all appropriate immunizations should be considered according to current immunization guidelines. SKYRIZI should not be used with live vaccines. As with all therapeutic proteins including SKYRIZI, there is potential for anaphylaxis. If an anaphylactic or other serious allergic reaction occurs, immediately discontinue the administration of SKYRIZI and initiate appropriate medical treatment. Consult complete product monograph to consult adverse reactions. The use of SKYRIZI in pregnant women has not been studied. SKYRIZI is not indicated in the pediatric population, as the efficacy and safety of SKYRIZI have not been evaluated in patients less than 18 years of age. Please refer to instruction for use. Content: Each pre-filled syringe contains 75 mg Skyrizi® (Risankizumab) in 0.83 ml. Skyrizi® (Risankizumab) is available in packs containing 2 pre-filled syringes and 2 alcohol pads. Store in a refrigerator (2°C - 8°C). Do not freeze. Marketing authorization number: Aruba: 24.09.18.088. SKYRIZI® Product Monograph. Date of Revision: March 11, 2020.

Curacao & Sint Maarten

Skyrizi® (Risankizumab) 75 mg solution for injection in pre-filled syringe. Each pre-filled syringe contains 75 mg risankizumab in 0.83 ml solution (90mg/ml). **Therapeutic indications:** SKYRIZI (risankizumab injection) is indicated for the treatment of adult patients with moderate to severe plaque psoriasis who are candidates for systemic therapy or phototherapy. **Posology:** The recommended dose of SKYRIZI is 150 mg (two 75 mg injections) administered by subcutaneous injection at Week 0, Week 4, and every 12 weeks thereafter. If a dose is missed, administer the dose as soon as possible. Thereafter, resume dosing at the regular scheduled time. **Contraindications:** SKYRIZI is contraindicated in patients who are hypersensitive to risankizumab or to any ingredient in the formulation or component of the container. **Warnings and precautions:** SKYRIZI (risankizumab injection) may increase the risk of infections. SKYRIZI should not be given to patients with any clinically important active infection until the infection resolves or is adequately treated. In patients with a chronic infection or a history of recurrent infection, the risks and benefits should be considered prior to prescribing SKYRIZI. SKYRIZI must not be given to patients with active tuberculosis (TB). Patients receiving SKYRIZI should be monitored for signs and symptoms of active TB during and after the treatment. Prior to initiating therapy with SKYRIZI, completion of all appropriate immunizations should be considered according to current immunization guidelines. SKYRIZI should not be used with live vaccines. As with all therapeutic proteins including SKYRIZI, there is potential for anaphylaxis. If an anaphylactic or other serious allergic reaction occurs, immediately discontinue the administration of SKYRIZI and initiate appropriate medical treatment. The use of SKYRIZI in pregnant women has not been studied. SKYRIZI is not indicated in the pediatric population, as the efficacy and safety of SKYRIZI have not been evaluated in patients less than 18 years of age. **Content:** Each pre-filled syringe contains 75 mg Skyrizi® (Risankizumab) in 0.83 ml. Skyrizi® (Risankizumab) is available in packs containing 2 pre-filled syringes and 2 alcohol pads. Store in a refrigerator (2°C - 8°C). Do not freeze. **Marketing authorization number:** Curacao: 1910155; St. Marteen: 1900011SXM. SKYRIZI™ Product Monograph. Date of Revision: April 17, 2019.

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Message from the President

Dear Colleagues and Friends,

On behalf of the Executive Committee and members of the 2021 Conference Planning Committee, please let me welcome you to the 30th Annual Meeting of the Caribbean Dermatology Association (CDA) and our second Virtual Meeting due to the coronavirus pandemic.

We would like to extend a special welcome to our Guest Speakers, Professor Hywel Williams, Order of the British Empire (OBE), from the University of Nottingham who will deliver the keynote address and the Lois LaGrenade Distinguished Lecture on "*The Philosophy of Disease Diagnosis in Dermatology*"; Dr Joanne Latkowski, Chief of Dermatology at New York University who will speak on "*Cutaneous Lymphomas*"; and Dr. Stephanie Smith-Matthews of Jamaica who will speak on "*Cutaneous Oncology*".

Special thanks to members of the CDA Planning Committee and the CDA Executive Team for doing most of the planning to ensure that we have a successful meeting. The CDA would like to extend our sincere gratitude to members of the pharmaceutical and cosmeceutical industries who gave their support by way of virtual exhibits, sponsorship and sponsored speakers and to Mr. Hanif Smith and his team from the CDA Secretariat who were responsible for the planning and logistics of the meeting.

I would like to thank everyone who took time out from their busy schedules to attend the virtual conference where participants would cultivate and maintain vibrant collegial relationships, experience the camaraderie and charm of the CDA and participate in the scientific activities. We hope you and your families try to be safe during these challenging times of the coronavirus pandemic.

Dr. Jeffrey Edwards

President
Caribbean Dermatology Association

Tremfya® (guselkumab)

IN PATIENTS WITH PLAQUE PSORIASIS[1]

TREMFYA® REACHES SUPERIOR AND SUSTAINED SKIN CLEARANCE OVER TIME[†1-3]

Demonstrated superiority in skin clearance vs anti-TNFα and interleukin IL-17 and IL-12/23 inhibitors.[1-4]

Sustained efficacy over time with 8 out of 10 patients reaching PASI 90 and more than half of the patients reaching and maintaining total clearance at 5 years.[2]

Safety profile established with 5 years of follow-up and a mechanism of action that helps to avoid important adverse events such as inflammatory bowel disease.[2,5]

IN PATIENTS WITH PLAQUE PSORIASIS[1]

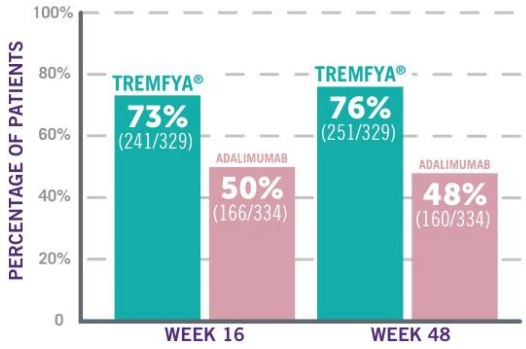
TREMFYA® REACHES A SUPERIOR PASI 90 RESPONSE VS ADALIMUMAB AND SECUKINUMAB[1,3]

PASI 90

PRIMARY ENDPOINT - PASI 90 AT WEEKS 16 AND 48 FOR VOYAGE 1 STUDY AND WEEK 48 FOR ECLIPSE STUDY[1,3]

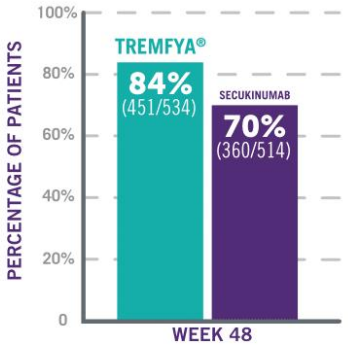
PASI: Psoriasis Area and Severity Index
* Adapted from Blauvelt *et al.* J Am Acad Dermatol 2017
† Adapted from Reich, K; *et al.* The Lancet. 2019

VOYAGE 1 STUDY*



P<0.001 vs ADALIMUMAB

ECLIPSE STUDY†



P<0.001 vs SECUKINUMAB

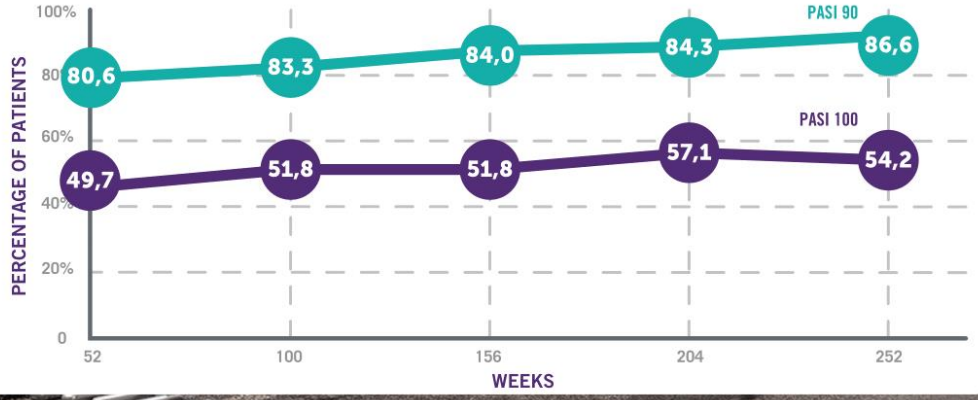
IN PATIENTS WITH PLAQUE PSORIASIS[1]

TREMFYA® DEMONSTRATES THERAPEUTIC LONGEVITY WITH HIGH EFFICACY RATES AFTER 5 YEARS[2]

PASI 90-100

VOYAGE 1: PRE-SPECIFIED SECONDARY ANALYSIS - 5 YEAR RESULTS (OBSERVED DATA - GLOBAL ANALYSIS)[2]

Adapted from Griffiths. C.E.M, *et al.* VOYAGE 1: 5- year follow up. Presented at Coastal Derm 2020

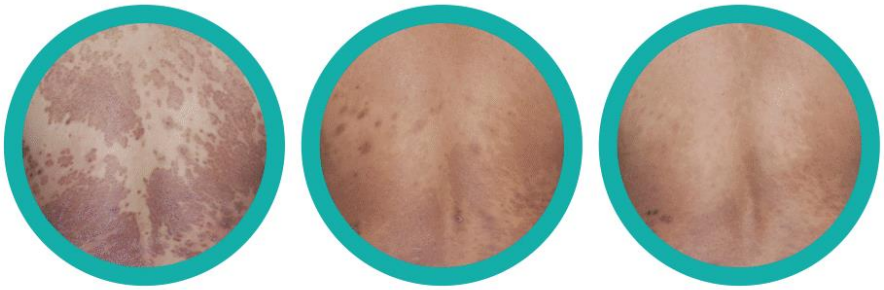


COMPLETE SKIN CLEARANCE IN A PATIENT TREATED WITH TREMFYA®[6]

TREMFYA® DEMONSTRATES THERAPEUTIC LONGEVITY WITH HIGH EFFICACY RATES AFTER 5 YEARS[2]

- Age: 36
- IMC: 31.1 kg/m2
- BSA affected: 54%
- Duration of psoriasis: 12 years
- Previous therapies: topical and biological agents

The individual results can change. Photos are from an actual VOYAGE 2 patient (North America) who received TREMFYA® 100mg at weeks 0, 4, and every 8 thereafter through week 48. Other affected areas (not shown) gave results similar to the ones shown here. Images for illustrative purposes only, used with permission from Janssen Biotech, Inc.



WEEK 0 WEEK 16 WEEK 48

Janssen Immunology
PHARMACEUTICAL COMPANIES OF Johnson & Johnson

ABOUT THE CONFERENCE

The Virtual Caribbean Dermatology Conference is the premier opportunity for the Caribbean's Dermatologists to be informed, educated and updated on the latest scientific, surgical and clinical developments in the diagnosis, treatment and management of the dermatology patient in the Caribbean. Various treatments, management approaches and diagnostic tools will be assessed for their applicability and accessibility within the Caribbean.

The Virtual Caribbean Dermatology Conference will serve to cultivate and maintain vibrant collegial relationships between the Caribbean's Dermatologists, while remaining physically distanced. The Annual CDA Conference is attended by doctors from the Caribbean, the United Kingdom, Canada, the United States of America, and the US Virgin Islands.

Educational Objectives

At the completion of this Conference, participants should:

1. Be able to identify developments that can positively impact the diagnosis, treatment, and management of dermatological diseases and conditions within the Caribbean region.
2. Have a better understanding of diagnostic and management approaches to challenging cases through the presentation and discussion of live clinical cases.
3. Be prepared to apply the knowledge gained to decisions regarding the diagnosis, management and treatment of dermatological patients in the Caribbean.

Accreditation Statement

The Virtual Annual Caribbean Dermatology Conference has been approved for **Continuing Medical Education Credits** by the **National Committee of Continuing Medical Education** of the **Medical Council of Jamaica** for a maximum of **Eight (8) hours of credit**. Each participant should claim only those CME hours actually spent in the activity.

Evaluations and CME Certificates

Conference, participants will be asked to complete evaluations electronically and CME certificates will be sent by e-mail at the conclusion of the meeting.

Virtual Meeting Platform

The conference will be held using **ZOOM.** Participants will be required to sign-up using their first name, lst name and email address to access the meeting.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roved: Digital, November 2021

Faculty Disclosures

In its efforts to ensure balance, independence, objectivity, and scientific rigour in its continuing medical educational programmes, the Caribbean Dermatology Association requires that all faculty participating in any CDA CME activity disclose to the audience any real or apparent conflict(s) of interest that may have direct bearing on the subject matter of the programme, and any off-label use of products that will be discussed.

The following speakers have indicated that they **DO HAVE** a relationship which poses a potential conflict of interest to disclose.

André Vicente Esteves de Carvalho	**Grant/Research Support:** Abbvie, Boehringer Ingelheim, Lilly Novartis **Consultant:** Abbvie, Boehringer-Ingelheim, Lilly, Novartis, Janssen, Leo Pharma **Speaker's Bureau:** Abbvie, Boehringer-Ingelheim, Lilly, Novartis, Janssen,

The following speakers have indicated that they **DO NOT HAVE** a relationship which poses a potential conflict of interest to disclose.

Alicia McNish
Andrew Burton
Janelle Welch
Arusha Campbell-Chambers
Brian Morrison, M.D.
Ausama Atwan
Renée Mah-Lee Sharpe
Gabriel Magariños
Hywel C Williams
Jason Thomas
Jeffrey Edwards
Jo-Ann Latkowski
Jonathan Ho
Nirmala Hallai
Orchid Dawkins
Rajkiran Takharya
Rodane Ruddock
Soraya Azzawi
Stephanie Smith-Matthews
Sumir Chawla

The following speakers **HAVE** indicated they will be discussing off-label products in their presentations.

Jo-Ann Latkowski

The following speakers **HAVE** indicated they will **NOT BE** discussing off-label products in their presentations.

Alicia McNish
André Vicente Esteves de Carvalho
Andrew Burton
Janelle Welch
Arusha Campbell-Chambers
Brian Morrison
Ausama Atwan
Renée Mah-Lee Sharpe
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Rajkiran Takharya
Rodane Ruddock
Soraya Azzawi
Stephanie Smith-Matthews
Sumir Chawla

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THE "APPLE" AWARD

The Professor Hywel Williams Research Prize, fondly referred to as The "Apple" Award, was given to the **Caribbean Dermatology Association** by our 2000 Guest Speaker Professor Hywel Williams (Nottingham, UK) — who joins us again as our 2021 Lois LaGrenade Distinguished Lecturer. The prize is awarded at the end of the Annual CDA Conference to the presenter of the best original research paper with the greatest relevance to the Caribbean.

Past Awardees

2000	Dr. Michael Fitz-Henley	2006	Dr. Michael Fitz-Henley	2013	Dr. Marilyn Suite
2001	Dr. Michael Fitz-Henley	2007	Dr. Doris Joseph	2014	Dr. Jeffrey Edwards
2002	Dr. Suleman Bhamjee	2008	Dr. Suleman Bhamjee	2015	Dr. Kyjuan H. Brown
2003	Dr. Althea East-Innis	2010	Dr. Sandra McLeod	2016	Dr. Althea East-Innis
2004	Dr. Morgan Basanta	2011	Dr. Neilia-Kay McGill	2017	Dr. Jeffrey Edwards
2005	Dr. Donna Thompson	2012	Dr. Sean Bullen	2018	Dr. Marilyn Suite

2019 Dr. Rebeca de Miguel Madurga

CONFERENCE SCHEDULE Day 1

All Times are Atlantic Standard Time AST (GMT-4) | (8:30am in Trinidad | 7:30am in Jamaica)

TOPIC	SPEAKER	TIME
SCIENTIFIC SESSION I **8.30am – 9.55am**		**Chairperson: Jonathan Ho**
Friday November 5		
Welcome	CDA Organizing Committee	8.30 – 8.35
GSK Sponsored Talk Recent Updates in SRD Management Beyond the Pandemic	Dr. Alexandra Marta *Portugal*	8.35 – 9.05
The Epidemiology of Dermatological Diseases at a Jamaican Paediatric Hospital	Dr. Andrew Burton *Jamaica*	9.05 – 9.15
Cutaneous Toxicities Occurring During Palbociclib (CDK4/6 Inhibitor) and Endocrine Therapy in Patients With Advanced Breast Cancer: A Single-Centre Experience	Dr. Sumir Chawla *United Kingdom*	9.15 – 9.25
Comparison Of Efficacy Of 40% Mandelic Acid With 30% Salicylic Acid Peels In Mild To Moderate Acne Vulgaris	Dr. Rajkiran Takharya *India*	9.25 – 9.35
A Series of Six Patients With Eccrine Syringofibroadenomas	Dr. Orchid Dawkins *Jamaica*	9.35 – 9.45
QUESTIONS AND ANSWERS		9.45 – 9.55
BREAK		9.55 – 10.30

Scapho® secukinumab

For patients with psoriatic disease, **skin is only part of the story**[1]

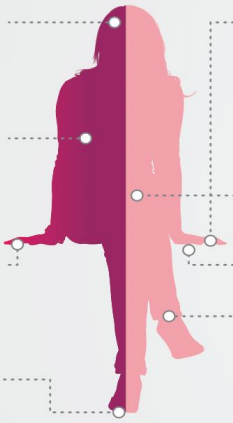
Visible manifestations[1-4]

Scalp psoriasis[2]
40%-90%

Plaque psoriasis[1]
100%

Nail psoriasis[3]
54%-61%

Palmoplantar psoriasis[4]
12%-16%



Invisible progressive manifestations[5-8] and comorbidities[9]

Psoriatic arthritis[5,6]
30%-41%

Spondylitis[7]
5%-25%

Dactylitis[8]
50%

Enthesitis[8]
35%

Arterial hypertension[9]
36%

Obesity[9]
18%

Ischemic heart disease[9]
13%

Diabetes[9]
12%

Infl ammatory bowel disease[9]
1%

Quality of life[6,10-12]

Diminished quality of life[10,11]
79%

Decreased mobility[11]
12%

Depression[11,12]
54%

Psychosocial burden[12]
33%

Decreased work productivity[6,11]
31%

Psoriatic disease is a **progressive, systemic infl ammatory disease** that impacts the body **deeper than skin**[1]

- **~2 out of 3 psoriasis patients*** treated with biologics have more than one manifestation[1]
- An **increasing severity** of manifestations predicts **rapid disease progression**[13,14]
- Patients are potentially at risk of **irreversible structural joint damage**[15]

* Patients with psoriasis who are treated with a biologic therapy.

Psoriatic disease requires **early intervention** with a **complete treatment approach**

The goal for psoriatic disease management is the early and long-lasting complete treatment of all manifestations to alleviate disease impact on patients' lives

Scapho® secukinumab

References: **1.** Duffin KC, et al. 2018 Las Vegas Dermatology Seminar. 1-3 November 2018; Las Vegas, NV, USA. Poster. **2.** Crowley J. J Drugs Dermatol. 2010;9(8):912–918. **3.** Baran R. Dermatology. 2010;221(suppl 1):1-5. **4.** Merola JF, et al. Dermatol Ther. 2018;31(3):e12589. **5.** Reich K, et al. Br J Dermatol. 2009;160(5):1040–1047. **6.** Mease PJ, et al. J Am Acad Dermatol. 2013;69(5):729-735. **7.** Richette P, et al. Ann Rheum Dis. 2013;72(4):566-571. **8.** Bagel J, et al. Am J Clin Dermatol. 2018;19(6):839-852. **9.** Augustin M, et al. Acta Derm Venereol. 2010;90(2):147-151. **10.** McInnes IB, et al. Lancet. 2015;386(9999):1137-1146. **11.** Krueger G, et al. Arch Dermatol. 2001;137:280-284. **12.** Langley RG, et al. Ann Rheum Dis. 2005;64(suppl 2):ii18-ii23. **13.** Rouzaud M, et al. J Eur Acad Dermatol Venereol. 2014;28(suppl 5):17-26. **14.** Ogdie A, et al. Curr Rheumatol Rep. 2015;17(10):64. doi: 10.1007/s11926-015-0540-1. **15.** Tucker LJ, et al. Curr Rheumatol Rep. 2018;20(11):71. doi: 10.1007/s11926-018-0781-x.

SCAPHO® Important note: Before prescribing, consult full prescribing information. Presentation: Secukinumab. Powder for solution for subcutaneous injection, solution for subcutaneous injection in pre-filled syringe or pre-filled pen containing 150 mg of secukinumab. Indications: • Plaque psoriasis: SCAPHO® is indicated for the treatment of moderate to severe plaque psoriasis in adult patients who are candidates for systemic therapy or phototherapy. Alternative: Scapho is indicated for the treatment of moderate to severe plaque psoriasis in adults who failed to respond to, or who have a contraindication to, or are intolerant to other systemic therapies including ciclosporin, methotrexate and PUVA. • Psoriatic arthritis: Scapho is indicated for the treatment of adult patients with active psoriatic arthritis. Scapho can be used alone or in combination with methotrexate. • Ankylosing spondylitis: Scapho is indicated for the treatment of adult patients with active ankylosing spondylitis. Dosage and administration: • Plaque psoriasis: The recommended dose is 300 mg by subcutaneous injection with initial dosing at weeks 0, 1, 2, 3, and 4 followed by monthly maintenance dosing. Each 300 mg dose is given as two subcutaneous injections of 150 mg. • Psoriatic arthritis: The recommended dose is 150 mg by subcutaneous injection with initial dosing at Weeks 0, 1, 2, 3, and 4 followed by monthly maintenance dosing. Based on clinical response, the dose can be increased to 300 mg. For patients who are anti-TNF-alpha inadequate responders or patients with concomitant moderate to severe plaque psoriasis, the recommended dose is 300 mg by subcutaneous injection with initial dosing at Weeks 0, 1, 2, 3, and 4 followed by monthly maintenance dosing. Each 300 mg dose is given as two subcutaneous injections of 150 mg. For other psoriatic arthritis patients, the recommended dose is 150 mg or 300 mg by subcutaneous injection with initial dosing at weeks 0, 1, 2, 3, and 4 followed by monthly maintenance dosing. • Ankylosing spondylitis: The recommended dose is 150 mg by subcutaneous injection with initial dosing at Weeks 0, 1, 2, 3, and 4 followed by monthly maintenance dosing. Contraindications: • Scapho is contraindicated in patients who have/had severe hypersensitivity reactions reaction to the active substance or to any of the excipients. Warnings and precautions: • Infections: Caution in patients with chronic or history of recurrent infection. If a patient develops a serious infection, the patient should be closely monitored and Scapho should not be administered until the infection resolves. Anti-tuberculosis therapy should be considered prior to initiation of Scapho in patients with latent tuberculosis. Scapho should not be given to patients with active tuberculosis. • Crohn's disease: Patients with active Crohn's disease treated with Scapho should be followed closely. • Hypersensitivity reactions: Rare cases of anaphylactic reactions have been observed during clinical trials. Administration of Scapho should be discontinued immediately and appropriate therapy initiated if an anaphylactic or other serious allergic reaction occurs. • Vaccinations: Scaphoshould not be given concurrently with live vaccines. Pregnancy, lactation, females and males of reproductive potential Pregnancy: Scapho should be used during pregnancy only if the benefits clearly outweigh the potential risks. Lactation: Caution should be exercised when Scapho is administered to a woman who is breast-feeding. Adverse drug reactions: Very common (≥10%): Upper respiratory tract infections (nasopharyngitis, upper respiratory tract infection, rhinitis, pharyngitis, sinusitis, tonsillitis). Common (≥1 to <10%): Oral herpes, diarrhoea, urticaria, rhinorrhoea. Uncommon (≥0.1 to <1%): Oral candidiasis, neutropenia, tinea pedis, conjunctivitis. Frequency not known: Mucosal and cutaneous candidiasis Interactions: Live vaccines should not be given concurrently with Scapho. In a study in subjects with plaque psoriasis, no interaction was observed between secukinumab and midazolam (CYP 3A4 substrate).

For further information, please contact: Dirección Médica Novartis Farmacéutica, SA (AC), Anillo periférico 30-31, Zona 11, 01011, Guatemala City, Guatemala, Central America, PO Box 1115. PBX (502) 2422-8400. Fax (502) 2422-8606.
E-mail: medical.info_service@novartis.com
C62007843913 — Start date: July, 2020

NOVARTIS

TOPIC	SPEAKER	TIME
SCIENTIFIC SESSION II **10.30am – 12.00pm**	**Chairperson: Dr. Donna Thompson**	
Spectrum of Skin Manifestations Following COVID-19 Vaccine	Dr. Soraya Azzawi *United States*	10.30 – 10.40
Effects of Sanitizers and Masks on the Skin	Dr. Arusha Campbell-Chambers *Jamaica*	10.40 – 10.50
Impact of COVID-19 and PPE Measures on Occupational Skin Disease in Healthcare Workers	Dr. Sumir Chawla *United Kingdom*	10.50 – 11.00
Lois La Grenade Distinguished Lecture On the Philosophy of Disease Diagnosis in Dermatology	Professor Hywel Williams *United Kingdom*	11.00 – 11.40
QUESTIONS AND ANSWERS		11.40 – 12.00
LUNCH BREAK		12.00 – 1.00

TOPIC	SPEAKER	TIME
SCIENTIFIC SESSION III **1.00pm – 2.50pm**	**Chairperson: Dr. Carol Burrell**	
Novartis Sponsored Talk Psoriasis: Achieving Complete Control, it is possible!	Dr. Merlinda Gooderham *Canada*	1.00 – 1.30
Guest Speaker Cutaneous Lymphomas	Dr. Jo-Ann Latkowski *United States*	1.30 – 2.00
Nail Unit Tumors: A Practical Approach to Diagnosis	Dr. Brian Morrison *United States*	2.00 – 2.10
Guest Speaker Cutaneous Oncology	Dr. Stephanie Smith-Matthews *Jamaica*	2.10 – 2.30
What Are We Looking For?	Dr. Nirmala Hallai A. Lalla V. Mahase K. Singh *Trinidad and Tobago*	2.30 – 2.40
QUESTIONS AND ANSWERS		2.40 – 2.50

TOPIC	SPEAKER
WORKSHOPS	
Dermoscopy	Dr. Ausama Atwan *United Kingdom*
Patch Testing	Dr. Donna Thompson *United Kingdom*
Dermatopathology 101: Practical Aspects	Dr. Naomi Dolly *Trinidad and Tobago* Dr. Jonathan Ho *Jamaica*

CONFERENCE SCHEDULE Day 2

Saturday November 6

TOPIC	SPEAKER	TIME
SCIENTIFIC SESSION IV **9.00am – 10.45am**		**Chairperson: Dr. Richard Desnoes**
Ecthyma Gangrenosum: An Unusual Manifestation of Methicillin Resistant Staphylococcus Aureus (MRSA) Septicaemia	Dr. Jason Thomas *Jamaica*	9.00 – 9.10
A Rare Case: One-sided Reticulate Acral Pigmentation of Kitamura	Dr. Rajkiran Takharya *India*	9.10 – 9.20
Painful Sensations, Heat Intolerance, Wheals and Acute Anhidrosis in an 18-Year-Old Male	Dr. Anastasia Douglas *Jamaica*	9.20 – 9.30
Plexiform Neurofibroma Is Pathognomonic of Neurofibromatosis. Or Is It?	Dr. Rodane Ruddock *Jamaica*	9.30 – 9.40
Janssen Sponsored Talk Inhibiting IL-23 in Psoriasis: An Approach to Treat Psoriatic Disease	Dr. Gabriel Magariños *Argentina*	9.40 – 10.10
QUESTIONS AND ANSWERS		10.10 – 10.30
BREAK		10.45 – 11.15

TOPIC	SPEAKER	TIME
SCIENTIFIC SESSION V **11.15am – 12.30pm**		**Chairperson: Dr. Marilyn Suite**
Sanfer Sponsored Speaker SOS a Simple Solution to Wound Care and Disinfection	Dr. Llorenia Muir-Green *Jamaica*	11.15 – 11.45
Abbvie Sponsored Talk PASI 90 - 100, the New Normal!	Dr. André Carvalho *Brazil*	11.45 – 12.15
QUESTIONS AND ANSWERS		12.15 – 12.30

TOPIC	SPEAKER	TIME
Clinical Cases **12.30pm – 2.00pm**		**Chairperson: Dr. Marilyn Suite**
Multifocal Lupus Vulgaris Co-Existing with Cutaneous Myiasis	Dr. Rajkiran Takharya *India*	12.30 – 12.40
An Ulcerating Lesion Around the Eye	Dr. Jeffrey Edwards Dr. Naomi Dolly Dr. Gregory Boyce *Trinidad and Tobago*	12.40 – 12.50
Herpes Zoster in a 4-Year-Old Male with a History of Maternal Varicella Zoster Virus Infection During Pregnancy	Dr. Renee Mah-Lee Sharpe *Jamaica*	12.50 – 1.00
Multiple, Rare, Cutaneous Infections in a Patient with Iatrogenic Immunosuppression and Neuromyelitis Optica	Dr. Alicia McNish *Jamaica*	1.00 – 1.10
Diffuse Papules and Thickening of the Skin: A Case Series of 3 Patients with Scleromyxedema	Dr. Janelle Welch *Jamaica*	1.10 – 1.20
QUESTIONS AND ANSWERS		1.20 – 1.40
WORKSHOP QUESTIONS AND ANSWERS		1.40 – 2.00
CLOSING REMARKS		2.00 – 2.05

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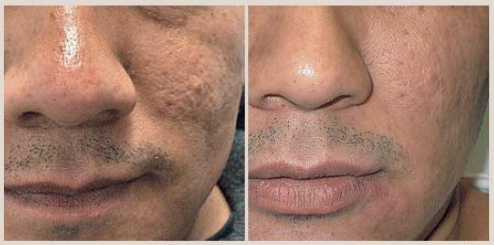

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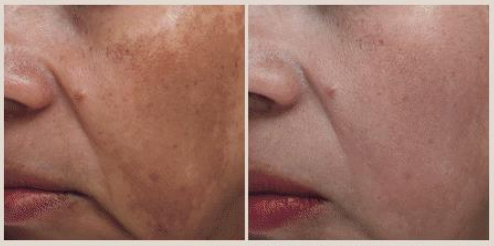

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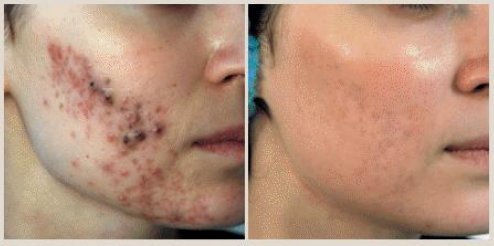

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ABSTRACTS

TITLE: Spectrum of Skin Manifestations following COVID19 vaccine
AUTHOR (S): Soraya Azzawi; Dr. Brian Morrisson
Submitted for: Medical Dermatology

ABSTRACT BODY:
INTRODUCTION: With new variants of COVID heralding incipient outbreaks, many health regulatory agencies are considering booster vaccines. During a global pandemic, dermatologists can play a key role in public health custodianship by advocating current vaccination and social distancing guidelines; however, the presentation of dermatologic vaccine reactions can be dramatic and alarming to patients and physicians in other specialties. Therefore, dermatologists should be cognizant of cutaneous adverse events related to vaccine administration, prevention and management.

METHODS: A literature search was performed on PUBMED, the Vaccine Adverse Event Reporting System and the American Academy of Dermatology COVID19 Registry. Articles published in the English language were focused on.

RESULTS: Diverse cutaneous adverse events have been reported with Pfizer, Moderna and Johnson & Johnson COVID19 vaccines. This spectrum ranges from mild local injection site reactions to urticaria, zoster or herpes simplex flares or pityriasis rosea like reactions. The Moderna vaccine also triggered dermal filler reactions; to our knowledge, this reaction has not yet been reported with the Pfizer vaccine. Patients predominantly developed these reactions after the first dose of vaccination in a series.

DISCUSSION: As more of the global population receives COVID19 vaccination, it is anticipated that the incidence of cutaneous adverse reactions to the vaccines may rise, making pre-vaccine counseling by dermatologists particularly relevant. In patients with a history of allergies or urticaria, preventative management with antihistamines or topical corticosteroids may be beneficial. Patients considering fillers should also receive counseling about immunologic dermal filler reactions. Ultimately, the risks of a cutaneous adverse event related to the vaccine pale in comparison to the benefit of preventing a possibly fatal communicable disease.

TITLE: The Epidemiology of Dermatological Diseases at a Jamaican Paediatric Hospital
AUTHOR (S): Andrew Burton; Prof. R. B. Pierre, Dr. A. Clare Lyn-Shue, Dr. M. Richards-Dawson
Submitted for: Pediatric Dermatology, Research

ABSTRACT BODY:
Given the dearth of published data regarding paediatric dermatological conditions Jamaica and the English-speaking Caribbean, we aimed to characterize the spectrum of conditions presenting to the outpatient paediatric dermatology clinics at Bustamante Hospital for Children (BHC), Kingston, Jamaica. The BHC is a specialized institution, the only of its kind in Jamaica and the region, and the major referral centre for paediatrics diseases.

A retrospective, descriptive study was conducted including out-patients of the Accident & Emergency (A&E) Dermatology service between January 1, 2012 to December 31, 2012 and clients attending the Dermatology clinic in the Outpatient Department (OPD) between January 1, 2012 to December 31, 2016. Data included demographics and specialist-determined diagnoses. Prevalence of dermatological conditions was summarized and patterns of occurrence explored using univariate analyses. Between January 1, 2012 to December 31, 2012, 2,312 records were identified (221 OPD; 2,091 A&E clinic log). Male to female ratio was 1:1, median (range) age 2 (0 to 12) years and majority were infants, less than 12 months (29.5%, n=682). Skin infections and infestation (42.5%, n=1,222), eczema (27.7%, n=799) and the urticarias and erythemas (12.4%, n=356) were the most prevalent diagnoses. Fungal infections were commonest subcategory among infections (23.3%, n=671), and tinea capitis (16.5%), atopic eczema (12.2%) and papular urticaria (10.6%) the most prevalent individual diagnoses overall.

Infection and infestations (p< 0.05), eczema (p< 0.01) and disorders of skin appendages (p< 0.001) were more frequent among males during 2012. Infections and infestations (p< 0.001) and papulosquamous disorders (p< 0.01) were most prevalent among referrals from the Kingston Metropolitan Area. Among clients presenting to OPD over the 5 years, eczema accounted for 33%

(n=425) of total diagnoses.These findings should inform continued professional education agenda for healthcare professionals and could assist public health professionals to devise appropriate interventions to mitigate risk factors in the communities.

TITLE: Effects of Sanitizers and Masks on the Skin
AUTHOR (S)*:* Arusha Campbell-Chambers;
Submitted for: Medical Dermatology

ABSTRACT BODY:
Although necessary to help prevent COVID-19 spread, sanitizers and masks can cause unwanted cutaneous effects. Hand sanitizer use can cause or exacerbate contact dermatitis, atopic dermatitis and alcohol poisoning can also occur if ingested. Sanitizers containing triclosan may also have negative effects on hormones and cause an increased risk of bacterial resistance to antibiotics. In an unpublished survey of twenty-three physicians (Dermatologists and Dermatology Residents) in Jamaica in October 2020, 83% saw increased skin reactions in their patients related to increased hand sanitizer use. 87% of the physicians used a lot of hand sanitizers.

Among the physicians' symptoms and signs, skin dryness (96%), itching (61%) and redness (48%) were the most common. Face masks can cause acne vulgaris, rosacea, contact dermatitis, seborrhoeic dermatitis, folliculitis and pressure urticaria. Appropriate skin care measures, medical treatment and procedures like the 650 microsecond Nd:YAG laser treatments can help to prevent and treat some of these unwanted effects on the skin.

TITLE: Cutaneous toxicities occurring during palbociclib (CDK4/6 inhibitor) and endocrine therapy in patients with advanced breast cancer: a single-centre experience
AUTHOR (S)*:* Sumir Chawla;
Submitted for: Medical Dermatology

ABSTRACT BODY:
Purpose: Treatment with Palbociclib, a cyclin-dependent kinase 4/6 inhibitor, has demonstrated significantly improved progression-free survival in patients with hormone receptor-positive, HER2-negative, advanced breast cancer, when used in combination with letrozole or fulvestrant endocrine therapies. However, limited information exists on its cutaneous adverse effects (AE). Hence, we conducted a retrospective cohort study to investigate the prevalence and management of cutaneous AE during palbociclib and endocrine therapy.

Method: We included 324 adult patients with advanced breast cancer who received palbociclib between March 2016 and August 2020 within a tertiary comprehensive cancer centre. Patient demographics, details of previous and concurrent treatments, as well as treatment-related cutaneous AE were recorded from electronic records.

Results: The incidence of treatment-related cutaneous AE was 14.2% (46 from a total of 324 patients). The most frequent cutaneous reactions included maculopapular rash (41%), asteatosis (37%), pruritus and urticaria (20%), and bullous dermatitis reactions (9%). We identified two patients with treatment-induced subacute cutaneous lupus erythematosus, one case of bullous pemphigoid, and a single erythema multiforme. Patients received an average of 9 cycles of treatment, completing an average of 6 cycles before developing cutaneous AE, which persisted for a median of 43 days. Only 15% (n = 7) of affected patients required temporary suspension, and 4% (n = 2) required discontinuation. The majority were managed with potent topical steroids, with oral corticosteroids being required in 3 patients, and one patient required hydroxychloroquine.

Conclusion: Our study describes both the spectrum of cutaneous AE of palbociclib and endocrine therapy, and approaches to management. Prompt management may limit the negative impact on patients, facilitating beneficial continuation of palbociclib and endocrine therapy.

TITLE: Impact of COVID-19 and PPE measures on occupational skin disease in healthcare workers
AUTHOR (S)*:* Sumir Chawla; Magnus Fugger, Mehar Chawla, Claudia Moore-Gillon, Richard Watchorn
Submitted for: Medical Dermatology, Research

ABSTRACT BODY:
Introduction: The crucial role of infection prevention and control (IPC) measures has been emphasised in controlling the spread of Severe Acute Respiratory Syndrome Coronavirus-2 (SARS-CoV-2). More rigorous hand hygiene practices and wearing of face masks have lead to increased reports of skin problems of the hand and face. A retrospective survey was conducted to investigate the incidence and severity of occupational skin disease in healthcare workers (HCWs).

Methods: An electronic survey was circulated to HCWs working in two London hospital sites between January 2021 to May 2021. Demographics, details on hand washing, alcohol gel, emollient and face mask use was recorded along with details of skin disease. Results:75 responses were recorded from doctors (57%), nurses (20%), healthcare students (12%), therapists (7%) and students (4%). 19 people (25%) washed their hands more than 30 times a day, 37 (49%) people 10-30 times, and 12 people (16%) washed between 5-10. Similar results were found for alcohol gel use. 34 (47%) did not apply moisturiser or emollient once during a shift. Common hand symptoms included dryness (89%, n=67), erythema (65%, n= 49) and cracked skin (57%, n=43). 73 (97%) HCWs wore face masks more than 4 hours a day, with common facial symptoms being acneiform lesions (71%, n=43) and erythema (62%, n=37). 61 participants were unsure who to contact regarding occupational skin disease.

Discussion and conclusion: Our results illustrate high levels of occupational skin disease in HCWs, including symptoms of xerosis and dermatitis. A large minority do not apply emollient, indicating either poor knowledge of or adherence to strategies to prevent or minimise occupational skin disease. With the COVID19 pandemic likely to continue for the foreseeable future, strategies are required to minimise IPC-related dermatological morbidity among HCWs. Campaigns to improve knowledge and adherence regarding emollient application may help to substantially minimise the prevalence of occupational skin disease among HCWs.

TITLE: A series of six patients with eccrine syringofibroadenomas
AUTHOR (S)*:* Orchid Dawkins; Jonathan Ho MBBS, D.Sc, Dip.Dermpath
Submitted for: Dermatopathology, Medical Dermatology

ABSTRACT BODY:
Eccrine syringofibroadenoma is a rare benign neoplasm/hyperplasia arising from the epithelium of the eccrine apparatus. Five categories of eccrine syringofibroadenoma have been described. We report the clinical and histopathologic features of six cases including both solitary and reactive subtypes.

TITLE: Painful sensations, heat intolerance, wheals and acute anhidrosis in an 18-year-old male
AUTHOR (S)*:* Anastasia Douglas; Jonathan Ho MBBS, D.Sc, Dip.Dermpath
Submitted for: Dermatopathology, Medical Dermatology

ABSTRACT BODY:
Acquired idiopathic generalized anhidrosis (AIGA) is a heterogeneous syndrome including idiopathic pure sudomotor failure, sudomotor neuropathy and sweat gland failure. We present a case of a young male with painful sweating, heat intolerance, wheals and acute anhidrosis.

TITLE: An ulcerating lesion around the eye
AUTHOR (S)*:* Jeffrey Edwards; Naomi Dolly, Gregory Boyce
Submitted for: Medical Dermatology

ABSTRACT BODY:
A 30 year old female was diagnosed with HIV infection in 2008, baseline CD4 and HIV VL were 696 cells/mm3 and 327 copies/ml respectively. The patient defaulted from clinic and in November 2020 was hospitalized with fever, diarrhoea and weight loss and was noted to have an ulcerated lesion medial to the right eye extending to the upper and lower eyelids with raised, rolled edges. At that time the CD4<50 cells/mm3, VL 408,855 copies/ml. On November 23, 2020, a punch biopsy was performed and the specimen sent for histopathology.. The clinical differential diagnosis included a basal cell carcinoma, squamous cell carcinoma, lymphoma or a tumour-like herpes simplex ulcer

TITLE: What are we looking for?
AUTHOR (S)*:* Nirmala Hallai; Arianne Lalla, Varune Mahase and Karina Singh
Submitted for: Medical Dermatology

ABSTRACT BODY:
We present a case series with a range of clinical diagnoses where laboratory investigations have and have not been useful. Case 1. An infant with bloody stool, cowâ€™s milk protein intolerance, eczema and thrombocytopenia, found to have immunodeficiency. Case 2. Paediatric Ulcerative Colitis controlled with infliximab, developed bilateral parotitis , alopecia and a widespread papulopustular eruption. Immunodeficiency undetected. Case 3. Early onset mucous membrane pemphigoid in adult, with oral, ocular and nasal involvement. Failure to respond to immunosuppressants. Case 4. A middle aged female with generalized pruritus, predating autoimmune disease. Case 5. A middle aged female with thirteen year history prurigo, several skin biopsies and variable responses to treatment. Differential diagnoses and therapeutic options will be discussed.

TITLE: Herpes zoster in a 4-year-old male with a history of maternal varicella zoster virus infection during pregnancy
AUTHOR (S)*:* Renee Mah-Lee Sharpe; Michael Fitz-Henley MBBS, DM, Dip.Derm; Jonathan Ho MBBS, D.Sc, Dip.Dermpath
Submitted for: Pediatric Dermatology

ABSTRACT BODY:
Herpes zoster is typically seen in adults with a history of previous varicella zoster virus infection. We present a case of a 4-year-old Jamaican male with right sided facial herpes zoster and a history of maternal varicella zoster infection during pregnancy

TITLE: Multiple, rare, cutaneous infections in a patient with iatrogenic immunosuppression and neuromyelitis optica
AUTHOR (S)*:* Alicia McNish; Jonathan Ho MBBS, D.Sc, Dip.Dermpath
Submitted for: Dermatopathology, Medical Dermatology

ABSTRACT BODY:
Unusual organisms may cause skin and soft-tissue infections in the immunocompromised. We present a 40-year-old female with neuromyelitis optica on long-term systemic corticosteroids and concurrent deep fungal, algal and atypical mycobacterial infections.

TITLE: Nail Unit Tumors: A Practical Approach to Diagnosis
AUTHOR (S)*:* Brian Morrison;
Submitted for: Cutaneous Surgery, Medical Dermatology

ABSTRACT BODY:
A proper understanding of how to perform nail unit biopsies is critical for the diagnosis and management of nail disease, especially tumors of the nail matrix. A recent study found that only 0.28% and 1.01% of general dermatologists and Mohs surgeons, respectively, performed nail biopsies in 19/50 (38.00%) states and 69/929 (7.42%) zip codes in the United States. It is critical that

dermatology trainees and practicing dermatologist learn to identify nail lesions concerning for malignancy, including subungual melanoma, and know how to appropriately perform nail unit biopsies so that we can better detect early lesions and improve patient outcomes.

The first step in evaluating any nail unit tumor is to determine if the lesion involves the nail bed or the nail matrix. Nail bed tumors typically results in onycholysis (lifting of the nail plate from the nail bed) or a visible lesion through the nail plate. Nail matrix tumors, on the other hand, result in longitudinal nail plate changes. The main clinical findings that correspond with tumors of the nail matrix are longitudinal melanonychia, erythronychia and pachyonychia. While subungual melanoma is the chief concern for patient with monodactylous longitudinal melanonychia, the differential diagnosis remains broad and includes melanocyte activation, lentigo, nevus, Bowen's disease, onychomatricoma, fungal melanonychia and erythrasma.

Longitudinal erythronychia, caused by localized loss of nail matrix and subsequent thinning of the nail plate, has a similarly broad differential diagnosis including onychopapilloma, lichenoid inflammation, glomus tumor, verruca, Bowen's disease and amelanotic melanoma. Lastly, longitudinal pachyonychia, which presents as localized longitudinal thickening of the nail plate, usually represents a benign tumor. The most common causes are an onychomatricoma or onychocytic matricoma but malignancy is possible with cases of onychocytic carcinoma and squamous cell carcinoma reported in the literature .My lecture will include an outline of my algorithmic approach to working up nail matrix tumors and videos demonstrating how to properly perform a tangential shave of the nail matrix.

TITLE: Plexiform neurofibroma is pathognomonic of neurofibromatosis. Or is it?
AUTHOR (S)*:* Rodane Ruddock; Jonathan Ho MBBS, D.Sc, Dip.Dermpath
Submitted for: Dermatopathology, Medical Dermatology

ABSTRACT BODY:
The plexiform neurofibroma is often thought of as pathognomonic for neurofibromatosis.We report a case of a middle-aged Jamaican female with a solitary, non-syndromic plexiform neurofibroma of the palm and review the published literature on this uncommon occurrence.

TITLE: A Rare Case : One-sided Reticulate Acral Pigmentation of Kitamura
AUTHOR (S)*:* RAJKIRAN TAKHARYA; DR. JUDE ERNEST DILEEP
Submitted for: Dermatopathology, Pigmented Lesion and Melanoma

ABSTRACT BODY:
INTRODUCTION - Reticulate pigmentary disorders are rare genetic abnormalities generally inherited in an autosomal dominant manner. These disorders include reticulate acropigmentation of Dohi, reticulate-acropigmentation of Kitamura, Haber's syndrome, Dowling-Degos disease, and Galli-Galli disease.

CASE REPORT - An 18 -year-old lady came with asymptomatic, darkish coloured skin lesions on the dorsum of the right hand for two months with no other complaints. The lesions were first less in number then progressed proximally to involve most of the right hand and forearm. The colour of lesions darkened with time from light brown to darkish brown. There was no history of chronic intake of any drugs, trauma or photosensitivity. Dermatological examination revealed hyperpigmented, angulated, atrophic macules in a reticulate pattern involving only the right side of her hand and forearm. The ventral surface of the same hand was not involved. Pits with breaks in dermatoglyphics were absent on both the palms. Other body parts like soles, scalp, hair, nails, teeth, Mucous membranes were normal. Cutaneous biopsy of a hyperpigmented macule over the right dorsum of the hand revealed thinning of the epidermis, elongation of rete ridges with increased number of melanocytes in the basilar keratinocytes. A diagnosis of unilateral reticulate acral pigmentation of Kitamura was made.

DISCUSSION - Kitamura and Akamatsu from Japan originally described reticulate-acropigmentation of Kitamura. Clinically characterized by hyperpigmented, angulated, and slightly atrophic macules over the distal extremities. On histopathology will reveal atrophic epidermis with club-like elongation of the rete ridges and an excess of melanin in the basal layer. Our patient had cutaneous lesions, which are classically observed in RAPK, and the skin biopsy confirmed the diagnosis of reticulate acropigmentation of Kitamura. Notably, our patient had a unilateral distribution of the lesions, which is exceptional in reticulate acropigmentation of Kitamura. This made us come to a conclusion that condition makes our patient become is a case with unilateral acral reticulate pigmentation of Kitamura.

TITLE: Multifocal Lupus Vulgaris Co-existing With Cutaneous Myiasis
AUTHOR (S): RAJKIRAN TAKHARYA; DR. JUDE ERNEST DILEEP
Submitted for: Dermatopathology, Cutaneous Surgery, Medical Dermatology

ABSTRACT BODY:
Lupus vulgaris is the most common variant of cutaneous tuberculosis. It presents as unifocal or multifocal plaques with advancing edges, leaving behind scarring and atrophy. Cutaneous myiasis is infestation of skin caused by fly larvae, commonly called maggots. Herein, we report a case of a 75 year old male who presented with multifocal lupus vulgaris co-existing with cutaneous myiasis.

A 75 year old male presented to us with complaints of itchy and scaly skin lesions over neck, shoulders and back for 3 years. There was history of loss of appetite and weight. He also gave history of an ulcer over the lower back with insect crawling sensation. On examination, multiple atrophic plaques with scarring and advancing infiltrated scaly edges studded with papules and pustules were seen over neck, shoulder, mid-back. Plaques over mid back showed draining sinus infested with maggots. Bilateral axillary lymphadenopathy was present.

Histopathology of skin showed focally ulcerated and thinned out epidermis and dermis showed granulomas with epitheloid cells, histiocytes, lymphocytes and occasional giant cells. FNAC from axillary lymph node showed granulomatous lymphadenitis. He was started on ATT and showed resolutions of plaques on follow-up. Maggots were manually removed and the sinus was cleaned and dressed. Lupus vulgaris requires treatment for several months with antitubercular drugs. Response is clinically seen by resolution of the advancing edge. Myiasis is treated with application of oils like Terpene oil over central punctum, to cut the larvaâ€™s oxygen requirements. These are then manually removed with forceps. multifocal lupus vulgaris co-existing with cutaneous myiasis is rare.

TITLE: Comparison Of Efficacy Of 40% Mandelic Acid With 30% Salicylic Acid Peels In Mild To Moderate Acne Vulgaris
AUTHOR (S): RAJKIRAN TAKHARYA;
Submitted for: Laser and Cosmetic Surgery, Pigmented Lesion and Melanoma

ABSTRACT BODY:
Acne vulgaris is one of the commonest skin disorders mainly affecting adolescent age group. The severity can range from mild -to -severe. Different treatment modalities available now days. Chemical peels is a relatively inexpensive, popular, and safe method for the treatment of acne. Mandelic acid an alpha-hydroxyl-acid which is derived from hydrolysis of an extract of bitter almonds. It is a new emerging peeling agent for acne. As it's a newer peeling hence to compare it with an older established peeling agent, salicylic acid in the treatment of acne vulgaris required.

Comparison of efficacy of 40% mandelic acid with 30% salicylic acid peels in mild-to-moderate facial acne-vulgaris in south Indian patients. A prospective, randomized study of 12â€week duration was done and institute gave ethical clearance to perform this study. Total 30 patients from age 18-30 years, suffering from mild-moderate acne vulgaris were randomly divided into two groups 15 each, group one receiving 40% mandelic acid peels and the other receiving 30% salicylic acid peels with intervals of 2 weeks for six sessions. Total duration of the study was 12 weeks.

Michaelsson acne scores and clinical photographs were used to evaluate the efficacy of therapy objectively. Adverse reactions of both the peeling agents were also noted at each visit. The difference in results between the two groups was found to be significant from 4 weeks onwards till end of the therapy. Overall both the peeling agents showed almost equal efficacy in improving mild-to-moderate acne vulgaris. Salicylic acid was found better in treating non-inflammatory lesions, while mandelic acid in treating inflammatory lesions. Adverse effects were lesser with mandelic acid peels. About 40% mandelic acid peel was found to be equally effective as 30% salicylic acid peel in mild-moderate facial acne-vulgaris. However, safety and tolerability of mandelic acid peel were better than salicyclic acid peel

TITLE: Ecthyma gangrenosum: An unusual manifestation of methicillin resistant Staphylococcus aureus (MRSA) septicemia
AUTHOR (S)*:* Jason Thomas; Jonathan Ho MBBS, D.Sc, Dip.Dermpath
Submitted for: Dermatopathology, Medical Dermatology

ABSTRACT BODY:
Ecthyma gangrenosum is a septic vasculitis most commonly associated with Pseudomonas aeruginosa bacteremia. We report a case of a 60-year-old Jamaican male with ecthyma gangrenosum secondary to methicillin resistant Staphylococcus aureus bacteremia.

TITLE: Diffuse papules and thickening of the skin: A case series of 3 patients with scleromyxedema
AUTHOR (S)*:* Janelle Welch; Jonathan Ho MBBS, D.Sc, Dip.Dermpath
Submitted for: Medical Dermatology

ABSTRACT BODY:
Scleromyxedema is a rare primary cutaneous mucinosis often associated with a monoclonal gammopathy. We present three cases seen at the University Hospital of the West Indies and discuss the clinical and histopathological manifestations of this uncommon entity.

TITLE: Could photodistributed Stevens-Johnson syndrome be a cutaneous marker of underling HIV infection?
AUTHOR (S)*:* Janelle Welch; Jonathan Ho MBBS, D.Sc, Dip.Dermpath
Submitted for: Medical Dermatology
Status: Withdrawn

ABSTRACT BODY:
Phototoxic drug eruptions are well described in association with a variety of medications. Photosensitivity may also be been in patients who are HIV positive. We present a case of Stevens-Johnson/Toxic epidermal necrolysis-overlap to cefuroxime with photodistributed lesions in a patient with newly diagnosed HIV infection. Could this pattern be a cutaneous marker for underlying HIV infection?

FACULTY

Dr Ausama Atwan (UK) is a locum consultant dermatologist at the Royal Gwent Hospital in Newport (UK) and an Honorary Senior Lecturer at Cardiff University. Dr Atwan completed his MSc in Clinical Dermatology (2008); the Dermatology Speciality Certificate Examination (SCE) (2013); the European Board in Dermatology and Venereology (EBDV) (2017); and Medical Doctorate (MD) from Cardiff University (2019). He has contributed to several Clinical Trials as a principal and co-investigator, and published in the Cochrane Library and other peer reviewed journals. Dr Atwan has a special interest in dermoscopy. He was the former director of the "Introduction to Dermoscopy" course at Cardiff University (2012-2017) and he is currently a UK Board Member of the International Dermoscopy Society (IDS). He is a Fellow of the Higher Education Academy (FHEA) and the Academy of Medical Educators (FAcadMEd). His contributions to teaching were recognised by winning the Cardiff University Excellence in Teaching award.

Dr Andrew Burton is a faith-centred, fun-loving physician who enjoys his career as a ministry to children and families almost as much as he loves to smile. A proud Jamaican, he obtained both undergraduate and postgraduate medical degrees from the University of the West Indies, Mona, and is a product of the esteemed Campion College. His other passions include music, socialising, travel and volunteerism. Dr Burton has a special love for team dynamics and public service, and is employed full-time at Bustamante Hospital for Children as a Senior Registrar in the Paediatric Out-patient Department. He also may be found privately as a Paediatrician at The Kidz Klinik. He has developed a special interest in Paediatric Dermatology, and attributes this to invaluable time spent in the Dermatology clinic during elective months, and mentorship by Dr. Clare-Lyn Shue. His research submission for the completion of the Doctor of Medicine in Paediatrics, was on the epidemiology of dermatoses at the Bustamante Hospital for Children, the abstract of which he will share with us today.

Dr. Arusha Campbell-Chambers trained at the University of the West-Indies, Mona and the St. John's Institute of Dermatology, King's College London. She founded the Dermatology Solutions Skin Clinics & Medical Spas in Montego Bay, Kingston, St. Vincent and Antigua.

She has received several awards and honours academically, and has extensive additional training in Cosmetic Dermatology. Dr. Campbell-Chambers is an International Fellow of the American Academy of Dermatology, past Vice-President of the Dermatology Association of Jamaica and committee member of the Caribbean Dermatology Association. She has authored scientific publications, newspaper articles and her first best-selling book: LAUGH LOVE GLOW – A guide to choosing joy, loving yourself and caring for your skin.

Dr. Andre Vicente Esteves de Carvalho Graduated in Medicine from Faculdade Federal Foundation of Medical Sciences of Porto Alegre (1998). Specialist in Dermatology by the Brazilian Society of Dermatology (SBD) (2001). Specialization course in Dermatologic Surgery and Mohs micrographic at the Dermatology at Yale School of Medicine (2001). Masters and Ph.D. in pathology from the Universidade Federal de Ciências da Saúde de Porto Alegre.

Has been dermatologist and preceptor at Complexo Hospitalar Santa Casa de Porto Alegre, responsible for the Psoriasis Ambulatory from 2002 to 2018 Currently is a dermatologist of the Moinhos de Vento Hospital and a researcher on the Instituto de Ensino e Pesquisa (Teaching and Research Institute on the same institution. Responsible for the Psoriasis Department of the Brazilian Society of Dermatology (SBD), 2013 -2014 term. Scientific Reviewer for the Brazilian 2nd Edition of Dermatology, by Bolognia, Jorizzo and Rappini. Has experience in the area of medicine, with emphasis in Dermatology, Psoriasis, Dermatologic Surgery and Mohs micrographic surgery. Councilor of the International Psoriasis Council (IPC)

Dr. Sumir Chawla I am a clinical fellow in dermatology based in Charing Cross hospital (Imperial College Healthcare NHS Trust, London), with a keen interest in allergy and cutaneous adverse drug reactions. I have been involved with numerous dermatology research projects, most notably a large retrospective cohort study on cutaneous reactions on palbociclib, a new targeted therapy, on over three hundred breast cancer patients at the Royal Marsden over a period of four years. I am also interested in the role of psychodermatology, and the importance of mental and physical wellbeing in skin conditions, particularly in the context of oncodermatology.

I am currently researching the impact of COVID-19 on occupational skin disease in healthcare workers in Imperial College NHS, particularly looking at irritant contact dermatitis and facial skin disease. I am also passionate about medical education, and am an associate fellow of the higher education academy, having regularly taught and organised a teaching programme within the Royal Marsden. In the future I aim to further contribute to the research and raise awareness of skin conditions in patients of colour.

Dr. Orchid Dawkins is a first year Dermatology resident at the University of the West Indies, Mona campus. She completed the Bachelor of Medicine, Bachelor of Surgery degree from UWI in 2015. She then pursued her internship and senior house officer years at University hospital of the West Indies, where she rotated through Dermatology and Plastic surgery. She is interested in Procedural dermatology and Cutaneous Oncology.

Dr. Naomi Dolly graduated from the Faculty of Medical Sciences at The University of West Indies on a Further Additional Scholarship from the Republic of Trinidad and Tobago. Dr. Dolly completed her dermatology residency at SUNY Downstate Medical Center, Brooklyn, New York. She has also completed fellowships at NYU Medical Center in advanced medical dermatology and dermatopathology at the Akerman Academy of Dermatopathology, New York. Dr. Dolly holds board certifications in dermatology as well as dermatopathology with the American Board of Dermatology

Dr. Anastasia Douglas is a Senior House Officer currently rotating through Dermatology at the University Hospital of the West Indies. Her philosophy of caring for the patient with an introspective, inclusive and professional approach is well noted amongst her peers. In her previous tenure, she completed internship in the Cayman Islands. Moving with empathy, she aims to pursue a career in Dermatology. She has a keen passion for patients who have sustained major cosmetic injury. Her studies in Marine Biology and Medicine from the University of the West Indies have prepared her for a rich and engaging future where she will further provide equitable care for all patients.

Dr. Jeffrey Edwards is a graduate in Medicine of the Faculty of Medical Sciences, University of the West Indies (UWI) and is the holder of a Postgraduate Diploma in Genitourinary Medicine from the University of Liverpool, a Master of Science in Dermatology from the University of Wales, Cardiff and a Doctorate in Public Health from the University of the West Indies. He is the Director/Consultant of the Medical Research Foundation of Trinidad and Tobago (a large HIV Clinic, Coordinator of the Master of Public Health Programme at UWI St Augustine and President of Caribbean Dermatology Association.

Dr. Melinda Gooderham is a Dermatologist and Medical Director at the SKiN Centre for Dermatology and an Investigator with Probity Medical Research. She is an Assistant Professor at Queens University and a Consultant Physician at the Peterborough Regional Health Centre. She is a fellow of the Royal College of Physicians and Surgeons of Canada.

Dr. Gooderham has been the principal investigator for 170 clinical trials and she practices with a focus on inflammatory diseases of the skin. She also contributes to several peer-reviewed dermatology publications as an associate editor, reviewer and has been an author of 150 articles. She enjoys lecturing to global audiences on new therapies for skin diseases.

Dr. Nirmala Hallai graduated from UWI, St Augustine 1997. Postgraduate Dermatology Training South Wales and South Yorkshire, UK. Consultant Dermatologist 2008, Doncaster Royal Infirmary, UK, where she was the lead clinician for Contact Dermatitis and Principal Investigator BADBIR (BAD Biologics and Immunomodulators Register). Consultant Dermatologist at Eric Williams Medical Sciences Complex, and lead clinician for Dermatology, North Central Regional Health Authority, Trinidad and Tobago, since 2014.

Associate Lecturer UWI, St Augustine Campus, Faculty of Medical and Paraclinical Sciences. Member of British Association of Dermatologists (BAD), British Society Cutaneous Allergy, Caribbean Dermatology Association and Trinidad and Tobago Dermatology Society. Special interests are Medical, Paediatric and Occupational Dermatology. Dr Hallai has a keen interest in developing Dermatology services in the region.

Dr. Jonathan Ho is a Consultant Dermatologist and Dermatopathologist and a Lecturer of Dermatology and Pathology at the University of the West Indies, Mona Campus, Jamaica. He is the Co-Director of the Dermatology Residency Program and Director of the Dermatopathology Service at UWI. He is also the director of Dermatopathology Laboratory Services Limited. Dr. Ho is the current President of the Dermatology Association of Jamaica.

Dr. Jo-Ann Latkowski is an Associate Professor of Dermatology in the Ronald O. Perelman Department of Dermatology at New York University Grossman School of Medicine. She is Director of the NYU Dermatology residency program, which most recently was ranked the #3 Dermatology Residency Program in the US by *US News and World Report* and the highest ranked residency program at NYU Langone Medical Center. In her capacity as Program Director, Dr. Latkowski serves on many institutional and departmental committees including the NYU Graduate Medical Education Committee and NYU Accreditation Oversight Committee. She is also the Chief of Dermatology at the New York Harbor Veterans Affair Healthcare System, New York campus. Dr. Latkowski oversees the operations of one of the busiest VA Dermatology clinics nationwide with over 11,000 clinic visits each year, 5 full time faculty, 16 voluntary faculty and 6 residents.

Dr. Gabriel Magariños is Associate Professor of Dermatology at the USAL (Salvador´s University), Director at EPSOR foundation (dedicated to digital medical education about immune-mediated skin diseases), coordinator of the Diploma in Psoriasis at UCES University and the SAD (Argentinian Society of Dermatology), Director of Clinical Research of Psoriahue Medical Center participating as Principal Investigator in more than 20 clinical trials, Consultant in Dermatology at Houssay´s Hospital of Vicente López, Dermatopathologist at the Buenos Aires British Hospital, General Coordinator of the Advanced Course in Dermatology Specialists at Colegio de Médicos in Buenos Aires, Argentina. Doctor Gabriel Magariños published many papers about psoriasis and other immune-mediated skin diseases, and he dictated more than 200 lectures in 28 countries.

Dr. Renee Mah-Lee graduated from the University of Miami with a BSc in Biology and a minor in English Literature — biology because she wanted to pursue a career in medicine, and literature for her love of writing and books. She subsequently returned to Jamaica and studied medicine. It was while rotating through dermatology, in her third year of medical school that she fell in love with the field of the skin. She is a second year resident in the Dermatology DM programme and aspires to be a Paediatric Dermatologist.

She is the proud mother of three wild and beautiful children, and an avid reader — the bible being her all time favourite book. She loves nature, gardening, hiking, jogging, the arts, and music. She is a huge foodie and always enjoys a glass of red wine.

Dr. Alexandra Marta is Global Medical Director at GSK, a Registered dermatologist practicing in Lisbon, Portugal and Member of the Portuguese Society of Dermatology and Venereology (SPDV); Spanish Society of Dermatology and Venereology (AEDV) and European Academy of Dermatology and Venereology (EADV). She has a wide range of clinical experience in dermatology, including acne, atopic dermatitis, skin cancer, bullous diseases and dermatologic surgery

Dr. Alicia McNish is a proud graduate from the prestigious University of the West Indies (Mona) where she was a recipient of the Faculty of Medical Sciences Dean's List Award. She completed her MBBS in 2015 at the University Hospital of the West Indies (Mona). She is now a third year resident in the Doctor of Medicine (DM)-Dermatology at the University of the West Indies (UWI), where she currently is the chief resident. She successfully completed part 1 DM Dermatology at UWI.

In addition to this, Alicia has been the secretary of the Dermatology Association of Jamaica since 2018. Her interests include complex medical dermatology, cutaneous oncology and Mohs surgery. She plans to complete a fellowship and to pursue an academic career in the future focusing on "hospital in-patient dermatology" . Above of all, she is highly interested in growing the field of dermatology in her homeland.

Dr. Brian Morrison is a Board-Certified Dermatologist with broad areas of interest including international medicine, nail disorders and dermatological education.

Dr. Morrison obtained his medical degree at New York University School of Medicine and enthusiastically moved back home to Miami to complete his medical education as a dermatology resident at the University of Miami/Jackson Memorial Hospital. After completing his residency, he joined faculty at the rank of Assistant Professor in the Philip Frost Department of Dermatology and Cutaneous Surgery at the University of Miami Miller School of Medicine where he currently acts as the associate residency director, co-director of resident aesthetic education and director of Jackson Memorial Hospital outpatient dermatology services. Over the past 9 years, he has worked closely with his Haitian dermatology colleagues in Port-au-Prince to educate other physicians and help provide care to patients throughout Haiti.

Dr. Llorenia Muir-Green graduated from the University of the West Indies, (UWI), first obtaining a double major in Chemistry and Biochemistry in 2002. She then went on to pursue a career in Medicine at UWI. Upon graduating in 2007, she went on to pursue postgraduate specialisation in Clinical Dermatology at Cardiff University, for which she got Distinction. She was a recipient of the 2013 Fellowship in Hair and Scalp Disorders at the University of British Columbia.

She is a member of the American Hair Research Society, International Society of Hair Restoration Surgery, and a member of the Caribbean Dermatology Association. She is a Past President of the Dermatology Association of Jamaica and is an Associate Lecturer in Dermatology (UWI). She is the Head of Dermatology at the Cornwall Regional Hospital, Montego Bay, where she conducts a once a month Hair and Scalp Disorder Clinic. She also conducts a Hair Loss clinic at the Dermatology Clinic at National Chest Hospital in Kingston which she first established in 2014.

Dr. Rodane Ruddock is a first year Dermatology Resident at the University of the West Indies Mona Campus. He completed his MBBS degree at UWI mona in 2019, and did his internship at University Hospital of the West Indies. He initially thought he would become a surgeon, until he fell in love with dermatology while rotating on the firm as a senior house officer. He currently expresses an interest in surgical dermatology, particularly Mohs micrographic surgery.

Dr. Stephanie Smith-Matthews received her BSc. in Biology from Bay Path College in Massachusetts. She then started her medical training at the University Hospital of the West Indies (Mona) where she completed her MB BS and internship.

Stephanie's interest for Dermatology began after working for 1 year as a Medical Officer in the Department of Dermatology at UHWI. She then pursued a 2-year Master of Science degree in Dermatology at the Boston University School of Medicine where she had the role of Chief Trainee from 2016-2018.

Her interested peaked in the area of Cutaneous Oncology and she stayed at Boston University to complete a fellowship year in this sub-specialty. At the end of her fellowship year she was the recipient of the Boston University School of Medicine Department of Dermatology 2017-2018 Marie-France Demierre Award for Humanism in Medicine and the Nancy and G. Robert Baler, MD Distinguished Clinical Scholar Award, June 2018.

Dr. Rajkiran Takharya MBBS, FAM, is a Final Year Postgraduate Student (MD DVL) at the Aarupadai Veedu Medical College And Hospital in India. He is a dedicated individual who is committed to providing exceptional care to all patients. A young budding dermatologist with knowledge in variety of areas including clinical care, small/minor surgical and cosmetic procedures, and research. He is interested in working with latest technology in respect with cosmetic dermatology and procedures.

Dr Jason Thomas is a 1st year resident in Dermatology at the University of the West Indies, Mona campus. He awarded the Bachelor of Medicine, Bachelor of Surgery degree in 2017 at the aforementioned institution. Dr Thomas' interest in Dermatology was initially as a result of his personal journey with vitiligo. He worked previously as a medical officer in Dermatology and Accident and Emergency at the University Hospital of the West Indies. Currently his interests lie in Cutaneous Oncology. Personal passion includes learning new languages.

Dr. Donna Thompson is a Consultant Dermatologist and current Specialty lead for Dermatology at the Birmingham Skin Centre, City Hospital, a part of the Sandwell and West Birmingham Hospitals NHS Trust located in Birmingham, UK. Her subspecialty interests include Paediatric Dermatology as well as Cutaneous Allergy, and she is the lead physician for a dedicated Regional Cutaneous Allergy Unit providing patch testing and other investigations required as part of the management of contact dermatitis and other contact, occupational and environmentally induced skin diseases.

Dr. Thompson is a graduate of the University of the West Indies (UWI) where she obtained a Bachelor of Science (BSc.) degree in Chemistry from the faculty of Natural Sciences, as well as a Bachelor of Medicine and Bachelor of Surgery (MBBS) degree from the faculty of Medical Sciences. She is also a graduate of the University of London having obtained a Master of Science (MSc) degree in Clinical Dermatology with distinction from the St. John's Institute of Dermatology. She is a Fellow of the Royal College of Physicians (FRCP) of London.

Dr. Janelle Welch, is a first year Dermatology Resident at the University of the West Indies Mona Campus. She originates from Barbados where she graduated with her Bachelor of Medicine, Bachelor of Surgery degree from the University of the West Indies, Cave Hill Campus in 2014. She then continued her medical training in Antigua, where she completed one year of Internship at Mount St. John Medical Centre and then worked as a Medical Officer in Internal Medicine for 4 years. She currently expresses an interest in Procedural Dermatology & Paediatrics Dermatology.

Prof. Hywel Williams trained in dermatology in King's College, London, where he developed an interest in eczema and how it affected the local Afro-Caribbean population. He then did a PhD at St. Johns developing diagnostic criteria for atopic eczema for use in epidemiological studies. Hywel joined the University of Nottingham in 1994 where he now co-directs the Centre of Evidence-Based Dermatology and serves as a consultant paediatric dermatologist at Nottingham University Hospitals NHS Trust.

His research interests include independent randomised clinical trials and systematic reviews of interventions to prevent and treat skin diseases such as atopic eczema. He is one of the most cited clinical dermatologists in the world with over 137,000 citations. Outside of dermatology, he directed the funding of clinical trials for medicine and surgery in the UK (the NIHR HTA Programme) from 2016 to 2020 and then continued to act as a senior advisor to the Department of Health participating in ongoing COVID-19 research oversight. Hywel cares passionately about research that is directly relevant to the UK National Health Service and is a champion of patient and public involvement in research. Hywel is a proud holder of the British Association of Dermatologists Sir Archibald Gray medal, fellow of the RCP, an NIHR senior investigator and fellow of the Academy of Medical Sciences. He was awarded an OBE in 2021 for his services to higher education and medical research.