JEADV

VOLUME 33, SUPPLEMENT 3, APRIL 2019

6th Congress of the Skin Inflammation and Psoriasis International Network
25-27 April, 2019
Paris, France

WILEY

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Volume 33, Supplement 3, **April 2019**

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Central obesity in juvenile psoriasis

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Background: Psoriasis is not just a skin disease. It's associated with insulin resistance and metabolic comorbidities in adults [1]. In children, the central obesity (WHr) is a valid tool to evaluate and cardiometabolic risk [2]. In some studies, psoriasis severity was associated with a higher WHr [3]. In others, WHr is significantly associated with psoriasis but regardless of severity [4].
Objectives: Thus, we aim to study the association between WHr and the severity of juvenile psoriasis.
Methods: Through a study performed in the department of dermatology of the main military training hospital in Tunis from January 2014 to December 2015, we included all psoriasis patients under 18 years old. Central obesity is defined as a waist circumference to height ratio (WHr) ≥ 0.5 [2].
Results: We enrolled 71 patients. Central obesity was noted in 35% of cases. There were 11 girls and 14 boys. We compared psoriasis children with and without WHr. In the central obesity group, children were older (13 vs 9.8 years, $P = 0.02$) and familiar psoriasis less frequent (32% vs 24%, $P = 0.02$). Mean PASI is higher in psoriatic children with central obesity (4.2 vs 2.8, $P = 0.11$), but the difference was not significant. Palmoplantar psoriasis was significantly associated with central obesity (6 vs 2, $P = 0.019$). No difference was found in other psoriasis subtypes.
Disclosure of Interest: None Declared.
Keywords: Central obesity, Comorbidity, Juvenile psoriasis
References:

1. Armstrong AW, Harskamp CT, Armstrong EJ. Psoriasis and metabolic syndrome: A systematic review and meta-analysis of observational studies. J Am Acad Dermatol. 13;68(4):654-62.
2. Graves L, Garnett SP, Cowell CT, Baur LA, Ness A, Sattar N, et al. Waist-to-height ratio and cardiometabolic risk factors in adolescence: findings from a prospective birth cohort. Pediatr Obes. 2014;9(5):327-38.
3. Lee A, Smith SD, Hong E, Garnett S, Fischer G. Association Between Pediatric Psoriasis and Waist-to-Height Ratio in the Absence of Obesity: A Multicenter Australian Study. JAMA Dermatol. 2016;152(12):1314.
4. Paller AS, Mercy K, Kwasny MJ, Choon SE, Cordoro KM, Girolomoni G, et al. Association of Pediatric Psoriasis Severity With Excess and Central Adiposity: An International Cross-Sectional Study. JAMA Dermatol. 2013;149(2):166.

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Overweight in childhood psoriasis: a case-control study

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Background: Psoriasis is the most common chronic inflammatory skin disease. In adults, the link between psoriasis and overweight is established [1]. In children, few studies are available and their results are different [2–4]. We aim to study the association between overweight and childhood psoriasis and to evaluate the severity of psoriasis in this group.
Objectives: We aim to study the association between overweight and childhood psoriasis and to evaluate the severity of psoriasis in this group.
Methods: Through a case-control study performed in the department of dermatology of the military hospital in Tunis from January 2014 to December 2015, we collected all cases of psoriasis patients under 18 years old. The body mass index (BMI) was compared with a control group.
Results: In total, 71 psoriatic children were enrolled. Male to female ratio was 1.15. The mean age was 11 years. The control group included 278 children. Overweight was associated with psoriasis. It noted in 34% of cases versus 19% of controls ($P = 0.007$). The comparison by age and sex showed that overweight was significantly more common among boys over 7 years old ($P = 0.003$). The prevalence of obesity was not significantly different between the groups ($P = 0.33$). However, it was significantly more prevalent in male than in female psoriasis patients (5 cases vs 0 cases, $P = 0.039$). Mean psoriasis area and severity index (PASI) was 3.3. It was higher in overweight children (4.07) compared to children with normal BMI (2.98). It was also higher in obese boys (6.72) compared to boys with normal BMI (3.1). But the difference was not statistically significant. Efficiency of topical and systemic treatments did not depend on BMI.
Disclosure of Interest: None Declared.
Keywords: Childhood psoriasis, Comorbidity, Overweight
References:

1. Armstrong AW, Harskamp CT, Armstrong EJ. The association between psoriasis and obesity: a systematic review and meta-analysis of observational studies. Nutr Diabetes. 2012;2(12):e54.
2. Bryld L, Sørensen T, Andersen K, Jemec G, Baker J. High Body Mass Index in Adolescent Girls Precedes Psoriasis Hospitalization. Acta Derm Venereol. 2010;90(5):488-93.
3. Boccardi D, Menni S, La Vecchia C, Nobile M, Decarli A, Volpi G, et al. Overweight and childhood psoriasis. Br J Dermatol. 2009;161(2):484-6.
4. Paller AS, Mercy K, Kwasny MJ, Choon SE, Cordoro KM, Girolomoni G, et al. Association of Pediatric Psoriasis Severity With Excess and Central Adiposity: An International Cross-Sectional Study. JAMA Dermatol. 2013;149(2):166.

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Clinical and histopathological characteristics of HIV-psoriasis cases

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Background: Psoriasis affects the individual, their social and family environment (1,2), comorbidity with human immunodeficiency virus (HIV) could worsen its clinical presentation, an underlying cause of this shame are dysregulation and immunosuppression (3). It has been postulated that gp120 HIV glycoprotein acts as superantigen that activate $CD4^+$ cells, B-cells, and basophils, even it could stimulate expression HLA-DR in keratinocyte, a feasible mechanism for HIV to cause psoriasis in previously non-psoriatic individuals (3).
The prevalence of psoriasis-HIV is between 2.5% to 5%. Psoriasis can be the initial cutaneous manifestation of an HIV infection, and it is present during all phases of disease including AIDS. Vulgar, guttate and erythrodermic psoriasis are most frequently associated with HIV (3).
Objectives: To describe the clinical and histopathological characteristics of HIV-psoriasis cases.
Methods: A retrospective survey was carried out at Laboratorio de Dermatopatología, Universidad de Antioquia, Medellín, Colombia, to describe HIV-psoriasis cases presented between 1976 to 2016. Ethical management of information.
Results: 1473 cases of psoriasis were diagnosed, four of them, were HIV/AIDS-associated. All patients were adult men, average age 35.25 years old SD 8.99. In three of them, the period of disease evolution was less than three months. Less than a year passed between the diagnosis of HIV and the appearance of skin lesions.
All patients presented psoriasis vulgaris, three had moderate to severe psoriasis and had nail psoriasis. Three had AIDS-associated comorbidities as candidiasis, Kaposi's sarcoma and tuberculosis. It is noteworthy that Kaposi's

sarcoma was suspected in three patients; the neoplasia was confirmed only in one of them; lesions in the other two individuals corresponded to psoriasis. Three patients presented refractoriness to skin lesions treatment. Only one patient received antiretroviral therapy before the onset of skin lesions. Skin biopsies of all patients showed hyaline thickening of the small vessels' walls, prominent endothelium, hypertrophic nervous fillets, perivascular and perineural edema, and increased chronic lymphocytic inflammatory infiltrate. These findings were not observed in psoriasis without HIV infection. The distinctive vascular changes must be alert to suspect HIV infection in psoriasis patients.

Disclosure of Interest: None Declared.

Keywords: Histology, HIV, Psoriasis

References:

1. Ramírez LC, Velásquez MM. Aspectos de la IL-17 en la inmunopatogénesis de la psoriasis: un nuevo blanco terapéutico. Rev Asol Colomb Dermatol 2015;23(1):61-8
2. Ortega-Hernández A, Restrepo-López N, Rosero YS, Úsuga-Úsuga F, y col. Características epidemiológicas, clínicas e histopatológicas de pacientes con psoriasis y factores asociados con las formas vulgar y pustulosa. Dermatol Rev Mex 2018;62(3):193-205
3. Morar N, Willis-Owen SA, Maurer T, Bunker CB. HIV-associated psoriasis: pathogenesis, clinical features, and management. Lancet Infect Dis 2010;10(7):470-8

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Determining surgical versus nonsurgical options for an unknown inflammatory disorder in a charcot foot patient

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Background: When a patient presents with an inflammatory disorder in the lower extremity it is critical to determine whether the condition is stable, and if a mass is involved whether it is benign or malignant. The nature of the abnormal growth is determined by patient history, physical, and if necessary special imaging or a biopsy. If the mass is malignant in nature or even suspicious it should be surgically removed. Another reason for excision would be for pain or compromised gait due to the mass.

Objectives: Risk verses benefits considered when dealing with chronic inflammatory conditions while balancing a patient with multiple comorbidities.

Methods: Case study following a 48 year old male with past medical history of Diabetes Mellitus type 2, hypertension, blindness, end stage renal disease on hemodialysis, and bilateral Charcot foot. Followed patient for 2 years through wound care and podiatry clinics for chronic and recurring conditions to determine best course of action for soft tissue mass and inflammatory disorders. Consulted several other services including general surgery to determine best course of action.

Results: A biopsy was performed on the foot which revealed an ulcerated, acutely inflamed, keratin and bacteria-encrusted partly infarcted multinodular mass of inverted presumably pseudoepitheliomatous squamous epithelium that did not appear dysplastic. Groups of stromal vessels were found filled with fibrin microthrombi. The patient states that his mass had become so large, and in combination with his Charcot foot, it had become almost impossible to ambulate. Due to the patient's unstable chronic conditions of uncontrolled diabetes and end stage renal disease, and in combination with the patient's history of noncompliance it is believed that the best option is to continue to treat the soft tissue mass with outpatient debridement and dressings.

Disclosure of Interest: None Declared.

Keywords: Charcot, Inflammation, Treatment

References:

1. Downey, Michael. "Evaluation and treatment of suspicious soft tissue tumors of the foot and ankle." McGlamry's Comprehensive Textbook of Foot and Ankle Surgery, vol. 1, 2013, pp. 215–226.
2. Berlin S. Statistical Analysis of 307,601 Tumors and Other Lesions of the Foot. Journal of the American Podiatric Medical Association, Nov 1995; 85(11): 699-703.
3. Maretty-Kongstad, Katja et al. "A Validated Prognostic Biomarker Score for Adult Patients with Nonmetastatic Soft Tissue Sarcomas of the Trunk and Extremities." Translational Oncology 10.6 (2017): 942–948. PMC.
4. Frykberg RG and Belczyk R. Epidemiology of the Charcot foot. Clin Pod Med Surg, 2008; 25: 17-28.
5. Herbst SA, Jones KB, Saltzman CL. Pattern of diabetic neuropathic arthropathy associated with the peripheral bone mineral density. JBJS-B, 2004; 86: 378-383.

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Upadacitinib improved patient-reported sleep in moderate-to-severe atopic dermatitis: results from a phase 2b randomized, placebo-controlled trial

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Background: Atopic dermatitis (AD) is a chronic, inflammatory skin disease that imposes a substantial burden on patients, including sleep. Upadacitinib (UPA) is a selective JAK-1 inhibitor being investigated for treatment of moderate-to-severe AD and other inflammatory diseases.

Objectives: Evaluate patient-reported sleep from different measures, following UPA treatment, from the initial 16-week, double-blind portion of an 88-week trial.

Methods: Adults ($N = 167$) with moderate-to-severe AD (EASI $\geq$ 16, BSA $\geq$ 10%, IGA $\geq$ 3) were randomized to once-daily UPA 7.5, 15, or 30 mg ($N = 42/42/42$), or placebo (pbo; $N = 41$). Sleep was assessed by the Scoring Atopic Dermatitis (SCORAD) Visual Analog Scale (VAS) sleep item (sleep loss during previous 3 days; range 0–10), Patient Oriented Eczema Measure (POEM) sleep item (frequency of disturbed sleep; range 0–4), and

Table P131: Baseline Scores & Improvement at Week 16

	pbo			UPA 7.5 mg			UPA 15 mg			UPA 30 mg		
	N	Baseline	Δ	N	Baseline	Δ	N	Baseline	Δ	N	Baseline	Δ
SCORAD-sleep	38	5.0	0	42	5.5	−2.4***	41	6.3	−2.5***	42	4.6	−3.1***
POEM-sleep	37	2.9	−0.5	42	2.9	−1.3**	40	3.1	−1.5**	42	2.7	−2.0***
Difficulty falling asleep†	15	6.0	−1.9	14	5.9	−4.2*	6	4.5	−4.8*	9	5.2	−4.8*
Degree of AD impact during sleep†	15	6.0	−2.0	14	6.0	−4.3*	6	4.4	−4.7*	9	5.0	−4.9*
Bothered by waking during sleep†	15	6.3	−2.2	14	5.6	−4.0	6	4.3	−4.7	9	4.9	−4.8*

*$P < .05$; **$P < .01$; ***$P < .001$; pbo vs UPA. †ADerm endpoints were implemented mid-study, thus, data is only available for a subset of all enrolled patients. Δ=mean change from baseline; this was obtained from ANCOVA with region, baseline value and treatment in the model. Negative change values indicate improvement.