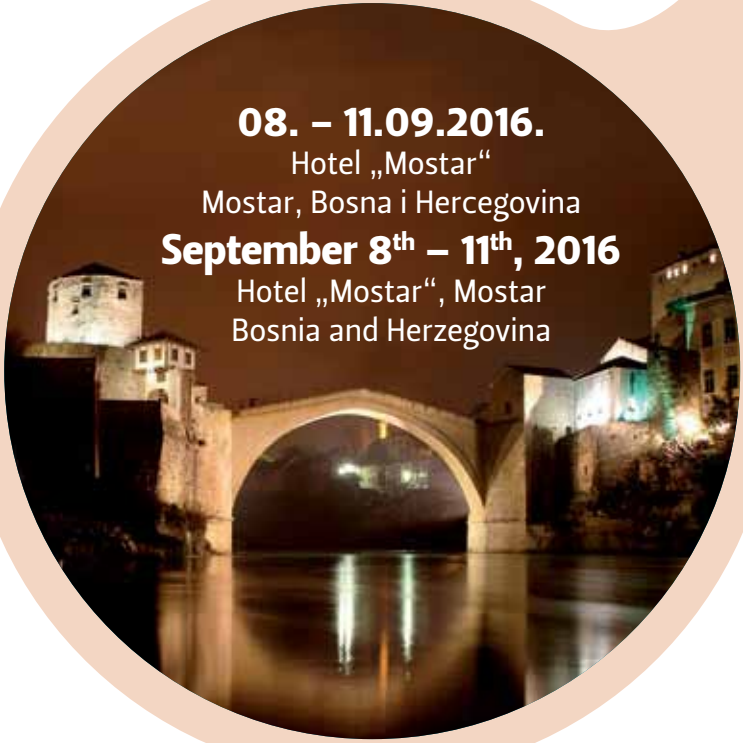
# 3. Regionalni dermatovenerološki kongres

# 3rd Regional Congress of Dermatology & Venereology



**08. – 11.09.2016.**
Hotel „Mostar“
Mostar, Bosna i Hercegovina

**September 8th – 11th, 2016**
Hotel „Mostar“, Mostar
Bosnia and Herzegovina

www.derma-regional2016.org

**PROGRAM**
**KNJIGA SAŽETAKA**
/
FINAL PROGRAMME
ABSTRACT BOOK

Udruženje Dermatovenerologa Crne Gore
Montenegrin Association of Dermatovenerology

**Pod pokroviteljstvom / Under the auspices of:** Sveučilišta u Mostaru / University of Mostar
**U organizaciji / Organized by:** Hercegovačkog dermatovenerološkog društva / Herzegovinian Dermatovenereological Society
**U suradnji s / In cooperation with:** Medicinskim fakultetom Sveučilišta u Mostaru / School of Medicine University of Mostar
i / and Sveučilišnom kliničkom bolnicom Mostar / University Clinical Hospital Mostar

# Sona® bez **acne** zona!

ADAPALEN

krema

gel

JEDINI REGISTRIRANI ADAPALEN

**Terapijske indikacije** Acne vulgaris (komedoni, papule i pustule) **Kontraindikacije** Primjena je kontraindicirana u bolesnika preosjetljivih na djelatnu tvar ili neki od pomoćnih sastojaka ovog lijeka. **Posebna upozorenja i mjere opreza** Ako pri primjeni Sona gela ili kreme dođe do reakcije preosjetljivosti ili teškog oblika iritacije kože, primjenu lijeka treba odmah prekinuti. Ovisno o stupnju lokalne iritacije, bolesniku se može savjetovati da smanji učestalost primjene gela ili kreme ili da privremeno prekine liječenje. Sona gel ili krema ne smiju doći u kontakt s očima, ustima, rubovima nosa ili sluznicama. Ako gel ili krema dođu u kontakt s očima, potrebno ih je odmah isprati toplom vodom. Gel ili krema se ne smiju primijeniti na oštećenu (posjekotine i abrazije) ili ekcematoznu kožu, u bolesnika s teškim oblikom akni ili aknama koje zahvaćaju veliku površinu tijela, tijekom trudnoće te u žena u reproduktivnoj dobi ako ne poduzimaju odgovarajuće kontracepcijske mjere. Propilenglikol (E 1520) može izazvati iritaciju kože, a metilparahidroksibenzoat (E 218) može izazvati alergijske reakcije koje mogu biti i odgođene. **Nuspojave** Pri primjeni adapalena zabilježene su sljedeće nuspojave: iritacija kože (eritem, suhoća, ljuštenje, osjećaj pečenja, fragilnost) i bockanje na mjestu primjene, koje nestaju ako se smanji učestalost primjene ili potpuno prekine primjena lijeka. Rjeđe se javljaju edem vjeđa, kao i iritacija očiju ako lijek dođe u kontakt s očima. **Doziranje i način uporabe** Sona gel ili krema se primjenjuje na područja zahvaćena aknama jedanput na dan, navečer prije spavanja, na čistu i suhu kožu. Gel ili krema se nanosi vrhovima prstiju u tankom sloju, izbjegavajući područja oko očiju i usta. S obzirom da je u liječenju akni uobičajeno izmjenjivati terapiju, preporučuje se da liječnik procijeni poboljšanje promjena na koži nakon tri mjeseca liječenja Sona gelom ili kremom. U bolesnika kod kojih je potrebno smanjiti učestalost primjene ili privremeno prekinuti terapiju, ona se može ponovno nastaviti prema procjeni liječnika. Ako bolesnici koriste kozmetičke proizvode, oni ne smiju imati komedogeno i adstringentno djelovanje. Neškodljivost i učinkovitost adapalena nisu utvrđene u novorođenčadi i male djece. **Ime i adresa proizvođača:** BELUPO lijekovi i kozmetika, d.d., Ulica Danica 5, 48000 Koprivnica, Hrvatska **Ime i adresa nositelja odobrenja:** FARMAVITA d.o.o. Sarajevo, Igmanska 5a 71320 Vogošća, Bosna i Hercegovina. **Broj i datum rješenja o dozvoli za stavljanje gotovog lijeka u promet SONA® krema:** 04-07.1-2611/12 od 23.04.2013; **SONA® gel:** 04-07.1-1640/12 od 23.04.2013. **Način izdavanja** Lijek se izdaje uz liječnički recept.

SAMO ZA ZDRAVSTVENE RADNIKE. Ovaj promotivni materijal sadrži bitne podatke o lijeku koji su istovjetni cjelokupnom odobrenom sažetku svojstava lijeka te cjelokupnoj odobrenoj uputi.

Zdravo budi!

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## SADRŽAJ / CONTENTS



## Knjiga sažetaka / Abstract Book

Poštovane kolegice i kolege, dragi prijatelji,

ugodna mi je dužnost pozvati Vas u Mostar, grad domaćin 3. regionalnog dermatovenerološkog kongresa, koji će se održati od 8. do 11. 9. 2016.g.
Nakon Crne Gore i Slovenije, treće zajedničko okupljanje dermatovenerologa regije je u Bosni i Hercegovini, u organizaciji Hercegovačkog dermatovenerološkog društva, uz potporu ostalih dermatoveneroloških bosanskohercegovačkih udruženja.
Stoga nam se pridružite i svojim odzivom potvrdite naše zajedništvo, a sudjelovanjem, odabirom tema, razmjenom iskustava i novim spoznajama, učinite da ovaj skup ostane priznati i poznati znanstveni skup. Ciljevi kongresa nisu se promijenili. Oni i dalje ostaju u službi promicanja dermatovenerologije i prijateljstva među sudionicima kongresa.
Svim sudionicima želim dobrodošlicu i nadam se da ćemo zajednički ostvariti još jedan dobar kongres i time postati bolji dermatovenerolozi i prijatelji.

Dobro došli!

Prof. dr. sc. **Dubravka Šimić**
Predsjednica Kongresa

Dear colleagues, dear friends,

It is an honor to invite you in Mostar, the host city of the 3rd Regional Dermatovenereological Congress, during the period from September 8th 2016 until September 11th 2016.
After Montenegro and Slovenia, the third collective gathering of the regional dermatovenereologists is now in Bosnia and Herzegovina, organized by the Herzegovinian Dermatovenereological Society, with the support of other Bosnian and Herzegovinian dermatovenereological associations.
You are welcome to join us and to confirm our communion by your participation. The choice of subjects, exchange of experience and new knowledge will make this congress a recognized and well-known scientific meeting.
The objectives of the Congress have not changed. They remain in the service of promoting dermatovenereology and friendship among the participants of the Congress.
We welcome all the participants and we hope that together we will achieve another good Congress and thus become better dermatovenereologists and friends.

Kind regards,

Professor **Dubravka Šimić**, M.D., Ph.D.
Congress President

**Predsjednica kongresa / Congress President**
Dubravka Šimić

**Predsjednica znanstvenog odbora / Scientific Board President**
Mirna Šitum

**Znanstveni odbor / Scientific Board**
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**Organizacijski odbor / Organization Board**
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**Predsjednica lokalnog organizacijskog odbora / Local Organization Board President**
Jasna Zeljko Penavić

**Lokalni organizacijski odbor / Local Organization Board**
Suzana Jelčić Arapović, Branka Galić, Anita Gunarić, Kristina Jurišić, Ana-Marija Krtalić, Kata Lovrić, Mile Pilatić, Marina Prlić, Branka Sivrić, Ivana Topić, Dubravka Šimić

**Pozvani predavači** *(abecednim redom)*
Prof.dr.sc. Ivana Binić (Srbija)
Dr.med. Željana Bolanča (Hrvatska)
Prof.dr.sc. Zrinka Bukvić Mokos (Hrvatska)
Dr.med. Aleksandra Dugonik (Slovenija)
Prim.dr.med. Djordji Gocev (Makedonija)
Prof.dr.sc. Nermina Hadžigrahić (Bosna i Hercegovina)
Prof.dr.sc. Lidija Kandolf Sekulović (Srbija)
Dr.sc. Sanja Kezić (Nizozemska)
Prof.dr.sc. Branka Marinović (Hrvatska)
Prof.dr.sc. Željko Mijušković (Srbija)
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Prof.dr.sc. Asja Prohić (Bosna i Hercegovina)
Mr.sc.dr.med. Alma Prtina (Bosna i Hercegovina)
Prof.dr.sc. Andrija Stanimirović (Hrvatska)
Dr.med. Dragana Starović (Bosna i Hercegovina)
Prof.dr.sc. Mirna Šitum (Hrvatska)
Prim.dr.med. Predrag Štilet (Crna Gora)
Doc.dr.sc. Jasna Zeljko Penavić (Bosna i Hercegovina)

**Invited Speakers** *(in alphabetical order)*
Professor Ivana Binić, M.D., Ph.D.(Serbia)
Željana Bolanča, M.D., Ph.D. (Croatia)
Professor Zrinka Bukvić Mokos, M.D., Ph.D. (Croatia)
Aleksandra Dugonik, M.D., Ph.D. (Slovenia)
Djordji Gocev, M.D., Ph.D. (Macedonia)
Professor Nermina Hadžigrahić, M.D., Ph.D. (Bosnia and Herzegovina)
Professor Lidija Kandolf Sekulović, M.D., Ph.D. (Serbia)
Sanja Kezić, M.D., Ph.D. (Netherlands)
Professor Branka Marinović, M.D., Ph.D. (Croatia)
Professor Željko Mijušković, M.D., Ph.D. (Serbia)
Professor Suzana Nikolovska, M.D., Ph.D. (Macedonia)
Professor Miloš Pavlović, M.D., Ph.D. (Slovenia)
Tanja Planinšek Ručigaj, M.D., Ph.D. (Slovenia)
Professor Asja Prohić, M.D., Ph.D. (Bosnia and Herzegovina)
Alma Prtina, M.D., Ph.D. (Bosnia and Herzegovina)
Professor Andrija Stanimirović, M.D., Ph.D. (Croatia)
Dragana Starović, M.D., Ph.D. (Bosnia and Herzegovina)
Professor Mirna Šitum , M.D., Ph.D. (Croatia)
Predrag Štilet, M.D., Ph.D. (Montenegro)
Assistant Professor Jasna Zeljko Penavić, M.D., Ph.D. (Bosnia and Herzegovina)

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## ČETVRTAK 08.09.2016. / THURSDAY, SEPTEMBER 8, 2016

17,00 – 19,00 **Registracija sudionika** / Registration

20,00 – 22,30 **Otvaranje kongresa i svečana večera u Ljetnikovcu Radobolja (polazak sudionika organiziranim prijevozom ispred hotela „Mostar" u 19,30h)** / Opening ceremony and gala dinner at the summerhouse „Radobolja" (organized transport in front of the Hotel „Mostar" at 19,30)

## PETAK 09.09.2016. / FRIDAY, SEPTEMBER 9, 2016

**Korektivna dermatologija (1)** / Corrective dermatology (1)
*Predsjedavajući / Chairpersons: Ivana Binić, Branka Marinović, Neira Puizina-Ivić*

09,00 – 09,15 *Branka Marinović*
Autoimune bolesti i lice / Autoimmune diseases and the face

09,15 – 09,30 *Suzana Nikolovska*
Venska jezerca. Da li znamo kako ih tretiramo? / Venous lakes. Do we know how to treat them?

09,30 – 09,45 *Ivana Binić*
Ožiljci na koži – terapijske mogućnosti / Cutaneous scars – therapeutic options

09,45 – 09,55 *Ines Sjerobabski Masnec*
Perifolliculitis capitis abscedens et suffodiens i hidradenitis suppurativa – terapijski izazov / Perifolliculitis capitis abscedens et suffodiens and hydradenitis suppurativa – therapeutic challenge

09,55 – 10,05 *Neira Puizina Ivić, Deny Anđelinović, Antoanela Čarija, Olga Kosor, Ranka Ivanišević, Dubravka Vuković, Lina Mirić Kovačević, Ana Sanader*
O kemijskim pilinzima / About chemical peels

10,05 – 10,20 Rasprava / Discussion

10,20 – 10,50 **Stanka za kavu** / Coffee break

10,50 – 11,20 **Satelitski simpozij** / Satellite symposium: **BELUPO**

## Korektivna dermatologija (2) / Corrective dermatology (2)

*Predsjedavajući / Chairpersons: Predrag Štilet, Zrinka Bukvić Mokos, Miloš Pavlović*

11,20 – 11,35 *Alma Prtina*
Neželjene reakcije upotrebe hijaluronskih filera / Adverse reactions hyaluronic fillers uses

11,35 – 11,50 *Željana Bolanča*
Microneedling u rejuvenaciji kože / Microneedling in the rejuvenation of the skin

11,50 – 12,05 *Miloš Pavlović, Metka Adamič*
Indikacije, tehnika i naši rezultati primjene ablativnog CO2 lasera u liječenju fotoostarjele kože / Indications, techniques and results of our application ablative CO2 laser in the treatment of photoaging skin

12,05 – 12,15 *Edin Suljagić*
Primjena lasera u dermatologiji i ginekologiji / The use of lasers in dermatology and gynecology

12,15 – 12,30 *Predrag Štilet*
Long pulse cooled Nd:Yag 1064 nm laser i proprietary Dye PL tehnologija kao rješenje za koagulaciju kapilara i liječenje vaskularnih lezija / Long pulse cooled Nd:Yag 1064 nm laser and proprietary Dye PL technology on for total solution for coagulation of the capillaries and treatment of vascular leasions

12,30 – 12,45 Rasprava / Discussion

12,45 – 13,30 **Satelitski simpozij** / Satellite symposium: **PIERRE FABRE**

13,30 – 14,30 **Stanka za ručak** / Lunch

## Slobodne teme (1) / Free topics (1)

*Predsjedavajući / Chairpersons: Nermina Hadžigrahić,Tanja Planinšek Ručigaj, Jurica Arapović*

14,30 – 14,45 *Djordji Gocev*
Neke rijetke bolesti sa karakterističnom lokalizacijom na koži lica / A rare disease with characteristic localisation of the facial skin

14,45 – 14,55 *Mirjana Bakić*
Zašto koža stari? / Why skin ages?

14,55 – 15,05 *Ana-Marija Sulić, Jasna Zeljko Penavić, Dubravka Šimić, Branka Sivrić*
Korektivna dermatologija u dismorfičnim poremećajima / Corrective dermatology and body dysmorphic disorder

15,05 – 15,15 *Neira Puizina Ivić, Deny Anđelinović, Antoanela Čarija, Olga Kosor, Ranka Ivanišević, Dubravka Vuković, Lina Mirić Kovačević, Ana Sanader*
Sve o gnojnom hidradenitisu / All about hidradenitis suppurativa

15,15 – 15,25 *Zlatica Jukić, Melita Vukšić Polić, Renata Vukadin, Nela Šustić*
Jači od HS-a! - kampanja podizanja svijesti javnosti o teškoj bolesti Hidradenitis suppurativa u RH / Stronger than HS! – Public awareness campaign of a serious disease hidradenitis suppurativa in Republic Croatia

15,25 – 15,40 *Nermina Hadžigrahić, Munevera Bećarević, Midheta Bijedić*
Atopijske bolesti i migracija / Atopic disease and migration

15,40 – 15,55 *Tanja Planinšek Ručigaj, Mojca Vreček*
Limfedem: ne samo zdravstvena nego i estetska smetnja / Lymphoedema: not only health but also an aesthetic disorder

15,55 – 16,10 Rasprava / Discussion

16,10 – 16,40 **Stanka za kavu** / Coffee break

## Slobodne teme (2) / Free topics (2)

*Predsjedavajući / Chairpersons: Djordji Gocev, Aleksandra Dugonik, Željana Bolanča*

16,40 – 16,50 *Jurica Arapović*
Preporuke u liječenju infekcije varicela zoster virusom (VZV) / Recommendations for treatment of varicella-zoster virus (VZV) infection

16,50 – 17,00 *Andrea Kordić*
Endovenska laserska ablacija (EVLA) - kada i što poslije? - naše iskustvo / Endovenous laser ablation (EVLA) - when and what after? - our experience

17,00 – 17,10 *Andrea Kordić, Davor Zubac*
Naše iskustvo sa „SOURCING", - identificiranje površnog refluksa u venskih ulkusa nogu / Our experience with „SOURCING"- identifying the source of superficial reflux in venous leg ulcers

17,10 – 17,20 *Karmela Husar, L.Tambić-Bukovac, M.Skerlev, S.Murat-Sušić, I.Martinac, B.Marinović*
Liječenje sklerodermije sistemskom terapijom u djece / The treatment of scleroderma in childern with systemic therapy

17,20 – 17,30 *Liborija Lugović Mihić, Iva Japundžić, Dario Novak*
Zašto su profesionalne dermatoze učestalije u stomatoloških djelatnika? / Why are professional skin disorders more common in dental professionals?

17,30 – 17,40 *Hrvoje Cvitanović, Ilko Kuljanac*
Incidencija kondiloma akuminata u području Karlovca od 1998 do 2015.g. / Incidence of condyloma acuminata in Karlovac area 1998-2015

17,40 – 17,55 Rasprava / Discussion

18,00 **Izlet u Međugorje u pratnji vodiča** *(izlet nije uključen u cijenu kotizacije)* / **A trip to Medjugorje accompanied by a guide** *(excursion is not included in the registration fee)*

## **SUBOTA 10.09.2016./** SATURDAY, SEPTEMBER 10, 2016

**Tumor kože kao profesionalna bolest /** Skin cancer as an occupational disease – StanDerm Session
*Predsjedavajući / Chairpersons:* *Sanja Kezić, Sanja Poduje, Fabrizio Guarneri*

09,00 – 09,15 *Sanja Kezić*
Biomarkeri izloženosti UV zrakama i UV-inducirani učinci / The biomarkers of UV exposure and UV-induced effects

09,15 –09,30 *Fabrizio Guarneri, Rosella Gallo*
Tumor kože kao profesionalna bolest, podržano od EU Horizon 2020 cost td 1206 Action – StanDerm / Occupational skin cancer, held by the EU Horizon 2020 cost td 1206 Action – StanDerm

09,30 – 09,45 *Dubravka Šimić, Ivana Topić, Ana-Marija Sulić, Anita Gunarić, Kristina Jurišić, Marina Prlić*
Što znamo o bazocelularnom karcinomu kao profesionalnoj bolesti / What is familiar about carcinoma basocellulare as a professional disease

09,45 – 09,55 *Sanja Poduje*
Aktiničke keratoze i planocelularni karcinom kože kao profesionalna bolest / Actinic keratosis and squamous cell carcinoma as occupational disease

09,55 – 10,05 *Sanja Špoljar*
Syndroma Huriez u jedne obitelji iz Hrvatske i razvoj planocelularnog karcinoma / Huriez syndrome in one Croatian family and development of squamous cell carcinoma

10,05 – 10,20 Rasprava / Discussion

10,20 – 10,50 **Stanka za kavu /** Coffee break

**Melanom /** Melanoma
*Predsjedavajući / Chairpersons:* *Mirna Šitum, Deny Anđelinović, Dragana Starović*

10,50 – 11,05 *Mirna Šitum*
Najnovije smjernice u dijagnostici i praćenju oboljelih od melanoma / The latest guidelines for the diagnosis and monitoring of patients with melanoma

11,05 – 11,20 *Lidija Kandolf Sekulović*
Melanom i trudnoća / Melanoma and pregnancy

11,20 – 11,35 *Aleksandra Dugonik, Denis Špelič, Denis Horvat, Bogdan Dugonik*
Korisna tehnološka poboljšanja u digitalnoj dermoskopiji / Useful technological improvements in digital dermoscopy

11,35 – 11,45 *Deny Anđelinović, Neira Puizina Ivić, Olga Kosor*
Prognostička uloga BRAF testiranja i nm23 tumor supresor gena u melanomu / Prognostic role of BRAF testing and nm23 tumor supressor gene in melanoma

11,45 – 12,00 *Dragana Starović*
Kvaliteta života bolesnika s melanomom / Quality of life in melanoma patients

12,00 – 12,15 Rasprava / Discussion

12,15 – 12,45 **Satelitski simpozij / Satellite symposium: ROCHE**

12,45 – 13,45 **Stanka za ručak / Lunch**

## Psorijaza / Psoriasis

*Predsjedavajući / Chairpersons: Željko Mijušković, Asja Prohić, Andrija Stanimirović*

13,45 – 14,00 *Asja Prohić*
Nove spoznaje u liječenju psorijaze u djece / An update on management of psoriasis in children

14,00 – 14,15 *Željko Mijušković*
Savremeno liječenje psorijaze / Current treatment of psoriasis

14,15 – 14,30 *Andrija Stanimirović*
Topičko liječenje plak psorijaze / Local treatment of plaque psoriasis

14,30 – 14,45 *Jasna Zeljko Penavić*
Psihopatološki aspekti i liječenje bolesnika s psorijazom / Psychopathological aspects and treatment in psoriatic patients

14,45 – 14,55 *Svetlana Popadić, Ljiljana Medenica, Dušan Popadić*
Polimorfizmi pojedinačnih nukleotida kod pacijenata sa vulgarnom psorijazom / Single nucleotide polymorphisms in patients with psoriasis vulgaris

14,55 – 15,05 *Larisa Prpić Massari, Sandra Peternel, Marijana Vičić, Marija Kaštelan*
Nove imunološke spoznaje o nastanku psorijaze / New immunological understanding in the development of psoriasis

15,05 – 15,15 *Ivana Topić, Dubravka Šimić, Jasna Zeljko Penavić*
Metabolički sindrom i njegove sastavnice u bolesnika s psorijazom / Metabolic syndrome and its components in patients with psoriasis

15,15 – 15,25 *Eldina Malkić Salihbegović, Nermina Hadžigrahić, Nermina Kurtalić, Midheta Bijedić, Merisa Imamović Kuluglić, Senija Mahmutbegović*
Psorijaza i gojaznost / Psoriasis and obesity

15,25 – 15,35 *Zoran Vručinić*
Specifičnosti u liječenju hipertenzije pacijenata oboljelih od psorijaze / Specific in the treatment of hypertension in patients with psoriasis

15,35 – 15,50 Rasprava / Discussion

15,50 – 16,20 **Stanka za kavu** / Coffee break

16,20 – 16,50 **Satelitski simpozij** / Satellite symposium: **LA ROCHE POSAY**

20,00 – 22,00 **Posjet vinariji Romanca s večerom (polazak autobusa u 19,30)** / Visiting the Winery Romance with a dinner (bus departure at 19,30)

## NEDJELJA 11.09.2016. / SUNDAY, SEPTEMBER 11, 2016

**Sekcija za specijalizante** / Section for young residents – **Prikaz slučaja** / A case report
*Predsjedavajući / Chairpersons: Dubravka Šimić, Liborija Lugović Mihić, Jasna Zeljko Penavić*

09,00 – 09,10 *Jagoda Balaban, Dragana Popović*
Ekstremni kožni oblik neurofibromatoze tip 1 / Extreme cutaneous form of neurofibromatosis type 1

09,10 – 09,20 *Milena Ristanović, Jelena Bojković*
Akralni lentiginozni melanom / Acral lentiginous melanoma

09,20 – 09,30 *Kristina Jurišić, Anita Gunarić*
Maligni melanom i bazocelularni karcinom u bolesnika koji je više puta liječen zbog bazocelularnog karcinoma: prikaz slučaja / Coexistence of malignant melanoma and basal cell carcinoma in a patient with previous treatment of multiple basal cell carcinomas: a case report

09,30 – 09,40 *Emilija Šijaković*
Angiosarkom – prikaz slučaja / Angiosarcoma – a case report

09,40 – 09,50 *Tamara Nikše, Vladimir Jegdić*
Liječenje hemangioma u djece propranololom / Propranolol treatment for hemangiomas in infants

09,50 – 10,00 *Anita Gunarić, Kristina Jurišić*
Kliničke značajke svraba nakon posjeta tropskoj zemlji – prikaz slučaja / Clinical manifestations of scabies after visiting a tropical country: A case report

10,00 – 10,10 *Teo Tomić, Iva Tomić*
Atopijski dermatitis u općoj promjenjivoj imunodeficijenciji / Dermatitis atopica in Common variable immunodeficiency (CVID)

10,10 – 10,20 *Mateja Jelača, Edita Simonić, Marija Kaštelan*
Koegzistencija psorijaze, vitiliga i buloznog pemfigoida u bolesnika starije životne dobi / Coexistence of psoriasis, vitiligo and bullous pemphigoid in elderly patients

10,20 – 10,30 *Ana Ivekić Jambrošić, Sandra Peternel, Srđan Novak, Irena Krznarić-Zrnić, Ines Brajac, Marija Kaštelan, Larisa Prpić Massari*
Koegzistencija psorijaze, psorijatičnog artritisa i Crohnove bolesti uspješno liječena adalimumabom / Coexistence od psoriasis, psoriatic arthritis and Crohn's disease successfully treated with adalimumab

10,30 – 10,40 *Mirjana Bakić*
Sarkoidoza kože – prikaz slučaja / Sarcoidosis of the skin – a case report

10,40 – 10,50 *Tea Rosović, Sandra Peternel, Ines Brajac, Edita Simonić, Valentina Saint-Georges, Marija Kaštelan*
Istovremena pojavnost vulgarne psorijaze, buloznog pemfigoida i lipoidne nekrobioze - prikaz slučaja / Coexistence of psoriasis vulgaris, bullous pemphigoid and necrobiosis lipoidica – a case report

10,50 – 11,05 Rasprava / Discussion

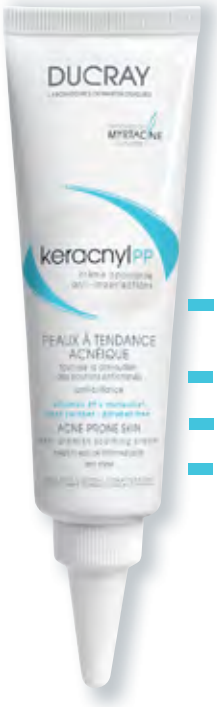
11,05 – 11,35 **PREZENTACIJA POSTERA – POSTER PRESENTATION – Rasprava / Discussion**
*Moderatori / Moderators: Dubravka Šimić, Jasna Zeljko Penavić, Suzana Jelčić – Arapović*

1. *Bojana Jovanović*
   Prikaz slučaja bolesnika s kondilomima na terapiji aldarom / A case report of genital warts treated by aldara
2. *Hana Helppikangas*
   Kožne nuspojave povezane s BRAF inhibitorom vemurafenibom / Cutaneous side effects associated with the BRAF inhibitor vemurafenib
3. *Jasmina Sekulić, Ljuba Vujanović, Dunja Jakovljević, Jovan Sekulić, Sanja Jakovljević*
   Exanthema fixum izazvan ibuprofenom / Exanthema fixum caused by ibuprofen
4. *Sanja Jurišić, Mladen Ćubela*
   Produljenje kliničke krune zuba laserom – prikaz slučaja / Extending clinical tooth crown with laser – a case report
5. *Craig Leonardi, Richard Langley, Andrew Blauvelt, Kenneth Gordon, David Stanley Shrom, Lisa Nichole Farmer Kerr, Ivaylo Stoykov, Clement Ojeh, Kristian Reich, Vladimir Malobabic*
   Brzi početak učinkovitosti u bolesnika s psorijazom liječenih s ixekizumab: skupna analiza podataka obrasca dvije faze triju randomiziranih kliničkih ispitivanja (uncover-2 and uncover-3) / Rapid onset of efficacy in patients with psoriasis treated with ixekizumab: a pooled analysis of data form two phase 3 randomized clinical trials (uncover-2 and uncover-3)
6. *Marija Nedeva, Bajić Lazar, Mirjana Paravina*
   Neželjena dejstva preparata za kozmetiku i održavanje higijene / Side effects of cosmetic and hygiene products
7. *Ivanka Muršić, Nela Šustić, Marina Vinaj, Igor Kuric, Marina Vekić Mužević, Marija Šola*
   Liječenje trajnog gubitka kose i vječna želja za kosom / Treating baldness and eternal longing for hair
8. *Selma Poparić, Hana Helppikangas, Dinara Tashbulatova*
   5% imiquimod u liječenju hipertrofičnih i hiperkeratotičnih aktiničkih keratoza / 5% imiquimod in therapy of hypertrophic and hyperkeratotic actinic keratosis
9. *Ivanka Muršić, Ksenija Marjanović, Nela Šustić, Igor Kuric, Vera Plužarić, Maja Tolušić – Levak*
   Dermatofibrosarcoma protuberans – prikaz slučaja / Dermatofibrosarcoma protuberans – a case report

11,35 **ZATVARANJE KONGRESA UZ DRUŽENJE I KAVU / CLOSING CEREMONY WITH A COFFEE BREAK**

# KOŽA SKLONA NASTANKU AKNE

# keracnyl PP




- Djeluje na upalne promjene nakon 7 dana primjene [1]
- Smanjuje vidljivost trajnih ožiljaka [1]
- Osigurava umirujući učinak [2]
- Olakšava podnošenje lokalne anti-akne terapije [2]

**UČINKOVITOST DOKAZANA POD DERMATOLOŠKOM KONTROLOM**

## REVOLUCIONARNO ANTI-BIOFILM DJELOVANJE

Ducray Dermatološki Laboratoriji razvili su inovativni djelatni sastojak **Myrtacine** s ciljem djelovanja na *P.acnes* biofilm

patentirana MYRTACINE inovacija

1. Dvostruko djelovanje na *P.acnes* biofilm [3]

- Destrukcija postojećeg *P.acnes* biofilma
- Inhibicija formiranja novog *P.acnes* biofilma

2. Optimizira djelovanje lokalne anti-akne terapije antibioticima [3]

- Onemogućava rezistentnost *P.acnes* organizirane u biofilm [3]

*(1) Pomaže ukloniti upalne promjene. Klinička i i biometrička studija pod dermatološkom kontrolom. 20 ispitanika s kožom sklonom nastanku akne. Primjena dva puta dnevno, tijekom 28 dana.*

*(2) Studija podnošljivosti u kombinaciji s lokalnom anti-akne terapijom ljekovima - 45 ispitanika s kožom sklonom nastanku akne – dvije primjene dnevno tijekom 28 dana. Trenutno umirujući učinak iskazan kod 96% ispitanika.*

*(3) In vitro test proveden s Myrtacine ® djelatnim sastojkom radi procjene njegovog djelovanja na P.acnes.*

DUCRAY
LABORATOIRES DERMATOLOGIQUES

OKTAL PHARMA
*Vaš najbolji izbor*

## ČETVRTAK 08.09.2016. / THURSDAY, SEPTEMBER 8, 2016

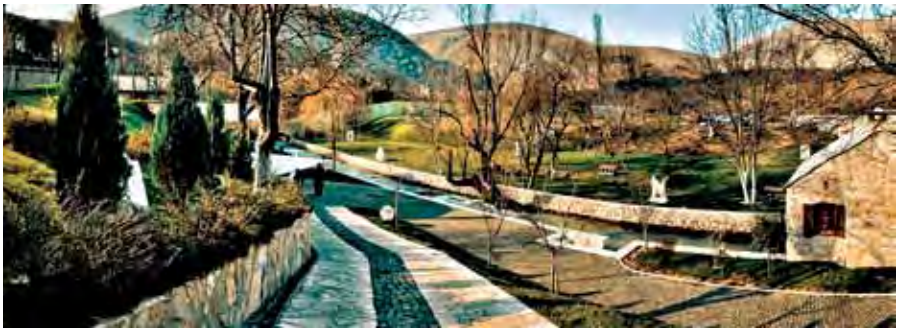
20,00 – 22,30 **Otvaranje kongresa i svečana večera u Ljetnikovcu Radobolja** *(polazak sudionika organiziranim prijevozom ispred hotela „Mostar" u 19,30h)* / Opening ceremony and gala dinner at the summerhouse „Radobolja" *(organized transport in front of the Hotel „Mostar" at 19,30)*

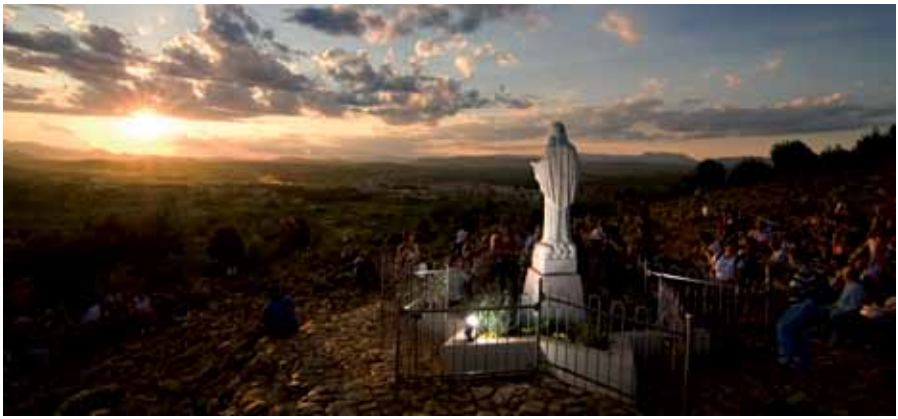
## PETAK 09.09.2016. / FRIDAY, SEPTEMBER 9, 2016

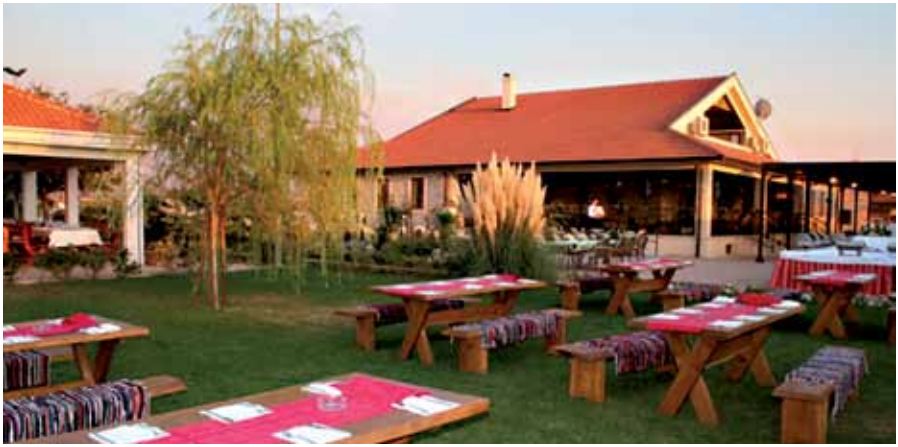
18,00 **Izlet u Međugorje u pratnji vodiča** / A trip to Medjugorje accompanied by a guide
CIJENA / PRICE: 7,00 eur (po osobi / per person)
*(Informacije i booking na registracijskom i info desku / Information and booking at registration and info desk)*

## SUBOTA 10.09.2016. / SATURDAY, SEPTEMBER 10, 2016

20,00 – 22,00 **Posjet vinariji Romanca s večerom** *(polazak autobusa u 19,30)* / Visiting the Winery Romance with a dinner *(bus departure at 19,30)*







**Mjesto i vrijeme održavanja kongresa / Place and Time of the Congress**
Mostar, hotel Mostar, 08.-11.09.2016.
Mostar, hotel Mostar, September 8-11, 2016

**Tehnički organizator / PCO professional congress organizer**
SPEKTAR PUTOVANJA
Ulica Andrije Hebranga 34, Zagreb, Croatia
Tel.: +385 1 4862 600
Fax: +385 1 4862 622
E-mail: congress@spektar-holidays.hr

**Službeni jezik / Official language**
Službeni jezici kongresa su jezici država u regiji i engleski, simultanog prevođenja neće biti.
The official languages of the Congress are languages of the countries in the region and English. No simultaneous translation will be provided.

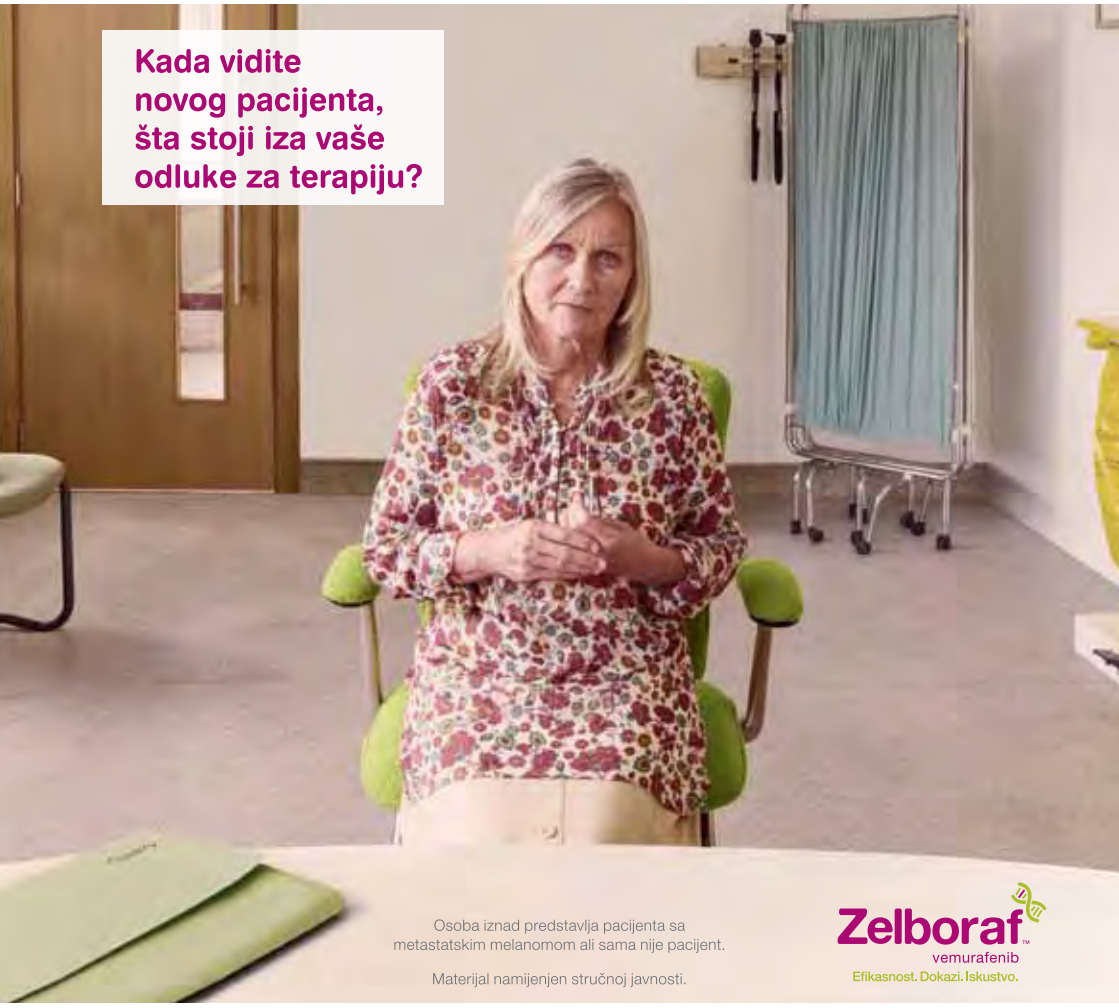
**Kotizacija/ Registration fees**

| Kotizacija / Registration fee | ON SITE |
|---|---|
| Specijalist / Regular | 150,00 EUR |
| Specijalizant / Resident | 100,00 EUR |
| Osoba u pratnji / Accompanying person | 50,00 EUR |
| Izlagač (izložbeni prostor), Sponzor / Exhibitor, sponsor | 50,00 EUR |

**Vrijeme registracije / Registration and info desk**

| | | |
|---|---|---|
| Četvrtak / Thursday | 08.09.2016. | 17,00-19,00 |
| Petak / Friday | 09.09.2016. | 08,00-18,00 |
| Subota / Saturday | 10.09.2016. | 08,00-17,00 |
| Nedjelja / Sunday | 11.09.2016. | 08,00-11,30 |

**Prostor za izložbu / Exhibiton Area**
Vrijeme postavljanja izložbe/ Set up time
Četvrtak, 08.09.2016. od 09,00-15,00
Thursday , September 9, 2016 - 09,00-15,00
Vrijeme raspremanja izložbe/ Dismantling time
Nedjelja, 11.09.2016. od 12,00
Sunday, September 11, 2016, from 12,00 p.m.




**Naziv gotovog lijeka i aktivne supstance** Zelboraf 240 mg, film tableta Vemurafenib, ATC oznaka: L01XE15 ▼ *Ovaj lijek podliježe dodatnom nadzoru. To će omogućiti brzu identifikaciju novih informacija koje se tiču sigurnosti primjene lijeka. Od zdravstvenih radnika se traži da prijave svaku suspektnu nuspojavu.* **Terapijske indikacije** Vemurafenib je namijenjen kao monoterapija u liječenju odraslih bolesnika s neoperabilnim ili metastatskim melanomom s pozitivnom mutacijom V600 gena BRAF. **Kontraindikacije** Preosjetljivost na aktivnu tvar ili neku od pomoćnih tvari. **Doziranje i način primjene** Liječenje vemurafenibom mora započeti i nadzirati ljekar s iskustvom u primjeni lijekova protiv karcinoma. Prije primjene vemurafeniba u bolesnika se validiranim testom mora potvrditi da je tumor pozitivan na BRAF mutaciju V600. *Doziranje* Preporučena doza vemurafeniba je 960 mg (4 tablete po 240 mg) dvaput na dan (što odgovara ukupnoj dnevnoj dozi od 1920 mg). Prva se doza mora uzeti ujutro, a druga se doza mora uzeti približno 12 sati kasnije, naveče. Svaka jutarnja i večernja doza se uvijek mora uzeti na isti način, tj. ili uz obrok ili bez obroka. *Trajanje liječenja* Liječenje vemurafenibom treba nastaviti do progresije bolesti ili dok se ne razvije neprihvatljiva razina toksičnosti. *Propuštene doze* Ako se propusti doza, može se uzeti do 4 sata prije vremena predviđenog za sljedeću dozu kako bi se održao raspored uzimanja dvaput na dan. Ne smiju se uzeti obje doze u isto vrijeme. *Način primjene* Vemurafenib tablete moraju se progutati cijele, s vodom. Vemurafenib tablete ne smiju se žvakati niti drobiti. **Posebna upozorenja i mjere opreza pri upotrebi** Prije primjene vemurafeniba u bolesnika se validiranim testom mora potvrditi da je tumor pozitivan na BRAF mutaciju V600. Djelotvornost i sigurnost primjene vemurafeniba nisu s dovoljnom sigurnošću utvrđene u bolesnika koji imaju tumor s BRAF mutacijom V600 koja nije V600E. Vemurafenib se ne smije primjenjivati u bolesnika koji imaju maligni melanom s divljim tipom gena BRAF. Takode, potrebno je obratiti pažnju na sljedeće: reakcije preosjetljivosti, dermatološke reakcije, produljenje QTintervala, oftalmološke reakcije, planocelularni karcinom kože, planocelularni karcinom koji nije na koži, novi primarni melanom, poremećaj jetrene funkcije, oštećenje jetre, oštećenje bubrega, fotoosjetljivost, učinci vemurafeniba na druge lijekove, učinci drugih lijekova na vemurafenib. **Neželjena djelovanja** Kao i svi drugi lijekovi, Zelboraf može uzrokovati nuspojave iako se neće javiti kod svakoga. Zabilježene su teške alergijske reakcije: oticanje lica, usana ili jezika, otežano disanje, osip, osjećaj moguće nesvjestice. Što prije se obratiti svom ljekaru ako se primijete bilo kakve promjene na koži. Vrlo česte nuspojave: javljaju se u više od 1 na 10 osoba: osip, svrbež, suha ili ljuskava koža, kožni problemi uključujući bradavice, jedna vrsta karcinoma kože (planocelularni karcinom kože), sunčane opekline, povećana osjetljivost na sunce, gubitak apetita, glavobolja, promjene osjeta okusa, proljev, zatvor, mučnina, povraćanje, opadanje kose, bol u zglobovima ili mišićima, mišićno-koštana bol, bol u udovima, bol u ledima, umor, vrućica, oticanje, obično nogu (periferni edem), promjene rezultata testova jetrene funkcije (povišen GGT), kašalj.

*Za detalje pogledati posljednji odobreni sažetak glavnih karakteristika lijeka i uputstvo o lijeku*

**Ime i adresa nosioca odobrenja za stavljanje u promet gotovog lijeka u BiH**
Broj i datum odobrenja za stavljanje u promet gotovog lijeka u BiH

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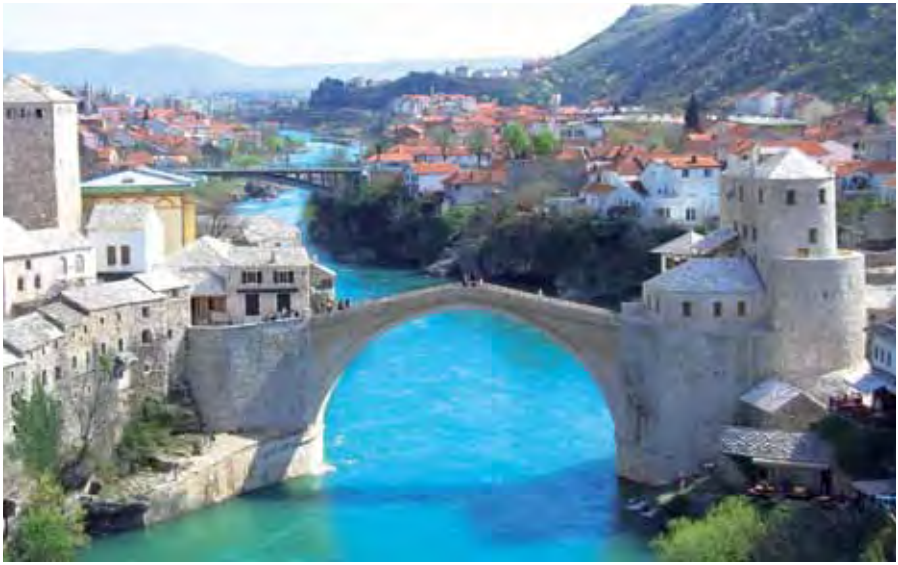
Juli, 2016. 055-07/2016

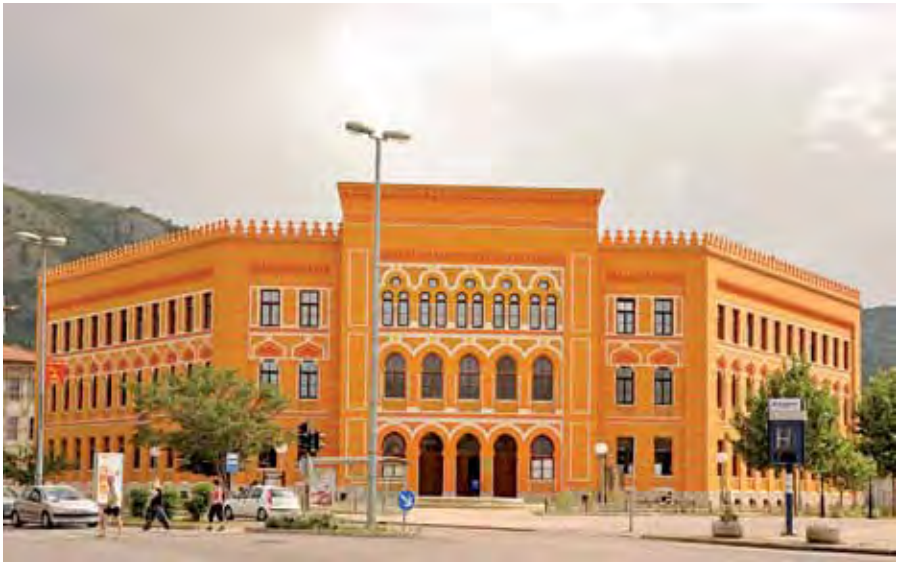
**Mostar** je grad u Bosni i Hercegovini, kulturno je i gospodarsko središte Hercegovine, ujedno najveći i tradicionalno najvažniji grad Hercegovine.Ubraja se u jedan od najljepših gradova u Bosni i Hercegovini. Grad je dobio ime po čuvarima mostova (mostarima) na obalama rijeke Neretve. Osim Starog mosta (1566.) u urbanoj zoni grada nalaze se još: Most Musala (1882.), Lučki Most (1913.) i Carinski most (1917.), svi izgrađeni u austro-ugarsko doba. Osim Starog mosta, u starom dijelu grada se nalaze i druge važne znamenitosti: Kriva ćuprija, kule oko Starog mosta, Tabhana, ulica Kujundžiluk, samo su neke od poznatijih znamenitosti. Crkva svetog Petra i Pavla – franjevačka crkva, s najvišim zvonikom u Bosni i Hercegovini i vrijednom zbirkom starih knjiga, katedralna crkva s krovištem u obliku križa uz Biskupski dvor, Saborna crkva u Mostaru slovila je za jedan od najljepših pravoslavnih hramova na ovom dijelu Balkana, Karađozbegova džamija – najstarija i najljepša džamija u Hercegovini. U okolici je posebno razvijeno vinogradarstvo. Stari most preko Neretve iz XVI. stoljeća je simbol grada i zajedno sa starim dijelom grada od 2005.g. nalazi na popisu zaštićene kulturne baštine UNESCO-a. Mostar ima umjerenu sredozemnu klimu s blažim, ali hladnim zimama, a vrućim ljetima i najtopliji je grad u Bosni i Hercegovini (uz Atenu najtopliji grad u Europi). Mostar je grad s najviše sunčanih dana u godini.

U Bosni i Hercegovini je valuta konvertibilna marka (BAM). 1BAM=1,955EURA

Cijene taksi usluga su povoljne i vožnja u bilo koji dio grada iznosi od 2-3 BAM.



**Mostar** is a city in Bosnia and Herzegovina, cultural and economic center, is also the largest and traditionally most important city in Herzegovina. Belongs to one of the most beautiful cities in Bosnia and Herzegovina. The city is named after the bridge keepers (bridgers) on the banks of the Neretva River. In addition to the Old Bridge (1566) in the urban area of the city are still:Musala Bridge (1882), Harbour Bridge (1913) and the Customs Bridge (1917), all built in the Austro-Hungarian period. In addition to the Old Bridge, in the old part of the town there are other important attractions: Crooked Bridge, the tower around the Old Bridge, Tabhana, street Kujundžiluk, are just some of the famous sights. Church of St. Peter and Paul – Franciscan church with the highest bell tower in Bosnia and Herzegovina and valuable collection of old books, the Cathedral church of the roof in the shape of a cross with the Bishop's Palace, the Orthodox Church in Mostar is famous for one of the most beautiful Orthodox churches in this part of the Balkans, Karadjozbeg's mosque – the oldest and most beautiful mosques in Herzegovina. Nearby is a specially developed grape. The Old bridge over the Neretva from the XVI.century is the symbol of the city and together with the old part of the city since 2005 listed World Heritage by UNESCO. Mostar has a moderate mediterranean climate with mild, but cold winters and hot summers, and the warmest city in Bosnia and Herzegovina (with Athens hottest city in Europe). Mostar is the city with the most sunny days a year.
In Bosnia and Herzegovina is valut konvertibil mark (BAM). 1BAM = 1,955EURA
Prices of taxi services are reasonable and driving in any part of the city is from 2-3 BAM.



# Knjiga sažetaka / Abstract Book

# KOREKTIVNA DERMATOLOGIJA / CORRECTIVE DERMATOLOGY

## O – 1
## AUTOIMMUNE SKIN DISEASES AND THE FACE

*Branka Marinović[1], [1]University Hospital Center Zagreb, Department of Dermatology and Venereology, School of Medicine University of Zagreb, Zagreb, Croatia*

Autoimmune dermatoses are group of diseases which encompass many clinically different diseases including autoimmune blistering diseases, scleroderma, lupus erythematous, dermatomyositis, vasculitides, vitligo, alopecia areata, but also psoriasis vulgaris and arthropathica, chronic urticaria, lichen planus and graft-versus-host disease. It is obvious that with further research and investigations number of diseases that will be included in this group will increase in the future. Most of these diseases can manifest, beside other localizations, also on the face. As the face is the most visible part of our body it is very important to learn about different clinical pictures but also about differential diagnoses of these diseases to diagnose them as early as possible. And that give us possibility to start therapy or send patient to specialist of other specialty as early as possible, what usually gives better prognosis to our patients.

## O – 2
## VENOUS LAKES. DO WE KNOW HOW TO TREAT THEM?

*Suzana Nikolovska[1], [1]University Clinic of Dermatology, Skopje, Republic of Macedonia*

Although venous lakes (VLs) are described as common lesions, there is scarce evidence in the literature about their epidemiology, classification and pathogenesis eigther because they represent a minor dermatological and aesthetic problem or due to confusion and/or lack of agreement about the definition of VLs. First mentioned under this name by Bean & Walsh in 1956, VLs were described as dark-blue soft, compressible papules 2–10 mm or more in diameter, most often localized on the ears, face, lips and neck in elderly men. Histologically these benign vascular malformations lie in the superficial layer of the papillary dermis and consist of dilated venulas with monolayer endothelial cells and no muscular layer, on background of disintegrated connective tissue. Ultra-structural studies confirmed the presence of vascular spaces lined with normal endothelial cells, with open junctions and no fenestration. It is hypothesized that VLs form as a result of solar damage to the vascular adventitia and dermal elastic tissue. Due to their color and nodularity, VLs may appear clinically similar to melanoma or pigmented basal cell carcinoma. However, dermoscopy demonstrating lacunas is valuable and noninvasive diagnostic tool in diferentiating this vascular lesions from tumors. Although various types of therapeutic modalities are available for VLs, including surgical excision, cryosurgery, sclerotherapy, electrocoagulation, and various types of lasers and lights, there remains a lack of general consensus as to which one is superior treatment modality. The following laser and laser-based devices have been used for VLs: neodymium –doped yttrium

aluminium garnet (Nd:YAG), diode, argon, pulsed-dye laser (PDL), CO2, infrared coagulation and IPL. Lasers offer a more practical alternative for the treatment of VLs comparing to other classical treatments due to their ease of use and fewer side effects. Taking into account the superfitial and/or deeper location of the lesions, one can consider combined and more inventive treatments such as combination of sclerotherapy and Nd:YAG laser, PDL and alexandrite, PDL and Nd:YAG, low-powered, high-frequency electrical current delivered through needle into the lesion. However, further studies that establish standardized protocols are warranted.

## O – 3

## CUTANEOUS SCARS – THERAPEUTIC OPTIONS

*Ivana Binić[1],[1]School of Medicine Niš, Department of Dermatology and Venereology, Clinical Hospital Centre Niš, Niš, Serbia*

A scar is a growth of collagen beneath the skin that is formed as the result of the complex processes of wound healing; therefore, every cut or injury to the skin heals to form a scar. Well-healed mature scars are the optimal result of wound healing. Optimization of scar formation begins before surgery and is affected by cytokines, growth factors, immunoglobulins, tissue tension, secondary infection, and any insult during the healing process. Low tensile strength, texture irregularities, pigment alterations, and sensation abnormalities may result from abnormal wound healing, as well as pathologic scar formation Normal wound healing results in a flat and flexible scar. Although there are no standard definitions for the classification of scars, keloids, hypertrophic, and atrophic scars are the primary types of pathologic scars. Multiple factors such as patient age, race, anatomic location, and type of trauma or injury may lead to the development of a pathologic scar. Pathologic scars are a common problem.Despite advancements in knowledge of different mechanisms of wound healing and scar formation, both normal and hypertrophic scars remain difficult to treat and to prevent. Therapeutic approaches fall into three broad categories: alteration of the inflammatory response, modification of collagen metabolism, and surgical and physical manipulation of the shape of the scar. Current management of normal and hypertrophic scars encompasses a wide range of techniques, from traditional invasive methods such as gross excision and radiation to intralesional and topical application of agents designed to take effect on a cellular level. Preclinical studies of emerging treatment strategies cover the transforming growth factor (TGF)- superfamily, NSAIDs, gene therapy, and several other novel modalities. Current clinical studies of scar reduction and prevention include topical and intralesional corticosteroids, 5-fluorouracil, bleomycin, pressure therapy, silicone gel sheeting, laser therapy, surgical treatment, radiation, and combinations of techniques. There is no universal consensus in the literature about optimal treatment. After initial injury, a robust inflammatory cascade is incited, during which much of the downstream outcome of scar development is mandated. Inhibition of the inflammatory process is the main factor that can decrease scar formation.Numerous methods can inhibit the inflammatory cascade at different levels of the pathway. There is a need to strategically block the inflammatory pathway and other pathways to scar formation with a polytherapeutic protocol. Such an ap-

proach includes inhibiting inflammation at upstream and downstream targets and addressing other mechanisms of scarring such as infection, cell signaling, collagen metabolism, and fibroblast migration and proliferation. There remains a great need for additional clinical studies of scar-reducing agents using well-designed, double-blind, placebo-controlled, multicenter randomized trials with objective and standardized evaluative measures. A polytherapeutic approach to scar reduction have the greatest potential for successful amelioration of both normal and pathologic scars, and future studies should focus on evaluating the efficacy of such an approach in addition to exploring the potential role of emerging and novel agents of scar reduction.

## O – 4

## PERIFOLLICULITIS CAPITIS ABSCEDENS ET SUFFODIENS AND HIDRADENITIS SUPPURATIVA – THERAPY CHALLENGE

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Perifolliculitis capitis abscedens et suffodiens or dissecting cellulitis, is a rare chronic disease of the scalp, characterized by painful pus-filled nodules, fistulas, purulent and hemorrhagic secretion and keloids. The cause of the disease is still unknown. The disease can be associated with hidradenitis suppurativa, sinus pilonidalis and acne. It can be treated with antibiotics, corticosteroids, retinoids, radiation therapy, laser ablation or surgical excision with transplantation of the skin. Sporadically, patients can be treated with biologial medications adalimumab and infliximab. We report a case based on our experience in the treatment of a 25 years old patient with facial papulopustular acne in puberty, developing perifollitulitis capitis abcedens et suffodiens and suppurating hidradenitis in axillar, inguinal and pubic region. After unsatisfactory long-term treatment with isotretinoin and antibiotics, the treatment with adalimumab was started with satisfactory control of the disease. Our experience has confirmed sporadic allegations of literature that TNF-α antagonist is efficacious in the treatment of perifollitulitis capitis abcedens et suffodiens in patients who do not respond to conventional therapy.

## O – 5

## ABOUT CHEMICAL PEELS

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According to the diagnosis as well as degree of photoaging, it can be utilized several various agents to obtain superficial, medium depth and deep peeling of the skin. It is quite reasonable choice for acne, rosacea, melasma, post-inflammatory hyperpigmentation and photoaging. Acne can be treated according to phase and degree of inflammation, as well as rosacea

for which only salicylic acid is recommended. Treatment of epidermal melasma obtain better results than dermal forms. Mild to moderate photodamaged skin can be treated with serial superficial peeling agents such as alpha hydroxy acids (AHA) in concentration of 50 – 70%, and 30 – 50% trichloracetic acid (TCT). Salicylic acid 20 – 30% and pyruvic acid 40 – 70% also showed beneficial results in treatment of advanced photodamage of the neck and chest. TCT and phenol are used in treatemnt of advanced photodamage. Combination of various agents are recommended due to enhancement efficacy of each other. So, AHA 70% or Jessner solution prior TCT 35% damages epidermal layer and enhance penetration of TCT in deeper part of the skin.

## O – 6

## ADVERSE REACTIONS HYALURONIC FILLERS USES

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Filler injections, if done correctly, are very safe procedures, there however a very small risk of complications. Most common, although still infrequent, complications of the filler injections are infection and filler irregularity migration. Red and painful inflammatory nodules that occur 3-15 day after injection, should be treated as an infection, and may be single or multiple nodules with pustular collection and inflammation. Biofilms are an irreversible assemblage of micro-organisms enclosed in a polysaccharide matrix Presents as a delayed-onset skin reaction, with fluctuant abscess-like swelling or non-fluctuant inflammation. More often after injections with long-lasting fillers and deep injection pose a higher risk Superficial injection can cause lumps under the skin, but deep injected HA, can cause inflammatory or non-inflammatory nodules. Small grannulomas (nodules) is a rare (<1%) immune reaction, develop an average 4-6 months following injection and often combine with bacterial infection (biofilm). Probably the most serious complication is tissue necrosis which results from occlusion of the small blood vessels feeding the area by the filler.

## O – 7

### MICRONEEDLING IN SKIN REJUVENATION

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Today, the rejuvenation market offers many tretments with different outcomes. The sosciety and estethic industry have set the expectetation bar of each rejuvenation treatment very high and therfore it is difficult to to choose the optimal treatment. The knowledge about skin anantomy and physiology is mandatory. If we look at children's skin as the gold standard, we can say that healthy skin is smooth, firm, evenly pigmented, hydrated, and with functional skin barrier. In order to keep good looking skin, it is necessary to provide the nutrients, exercise daily to boost circulation and lymphatic drainage and to encourage and stimulate the secretion of growth factors (primarily TGF beta 3 and EGF) and cytokines. The only esthetic procedure that allows maximum penetration of active ingredients and allows maximum secretion of growth factors is microneedling (CIT -colageninduction therapy). Collagen induction therapy is the only treatment that does not damage the melanocytes and therefore is ideal for all skin types and with almost no risk of hyperpigmentation. The treatment does not cause damage to the uppermost layer of skin that protects us from UV radiation, and therefore it can be performed throughout the year.

## O – 8

### INDICATIONS, TECHNIQUE AND OUR RESULTS OF THE APPLICATION OF THE CO2 LASER ABLATIVE RESURFACING IN THE TREATMENT OF THE PHOTOAGED FACIAL SKIN

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Twenty years ago a new era in the treatment of aged facial skin has started: reduction of elastosis and rhytides by controlled ablation by ultrapulsed CO2 lasers. The effects of the procedure were excellent. Changes which could not have been corrected by face-lifting and other excisional/tightening approaches were now amenable. However, the efficacy was at the expense of a higher incidence of side-effects. With years the use of CO2 laser has been steadily declining and newer fractional varieties aggressively promoted to avoid prolonged healing times and side effects. Yet the effects of the newer methods are inferior to those of the ablative CO2 ultrapulse laser. Here we shall discuss the advantages and disadvantages of partial and full face resurfacing by the use of ultrapulse CO2 laser in a series of our patients and describe our method of use of the laser inlcuding various modes of anesthesia. Apart from a bit longer healing time (7-10 days) and dyspigmentation, other side effects have not been recorded. It is possible to obtain optimal results without major side effects and complications. A proper selection of the patients and their compliance are the most important determinants of treatment safety and success.

## O – 9

### THE USE OF LASERS IN DERMATOLOGY AND GYNECOLOGY

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Thirty years ago, the lasers have been used for numerous indications in corrective dermatology. Starting with the ruby lasers for permanent hair removal, through diode lasers, alexandrite, the technology progress has occured. Today, we can say that the use of Nd YAG lasers, Erbium Yag lasers, allows us treatment of a wide variety of benign skin changes, vascular disorders, pigmented lesions and similar. Along with the development of laser technology, the use of lasers in the field of gynecology, in order to address a stress incontinence, and similar disorders, is enabled through the changing attachments (handpiece) of the certain laser systems. Lasers treatments of HPV infection in women are already becoming standard care. Laser treatments of snoring, as well as intraoral rejuvenation, are opening up a completely new therapeutic horizons.

## O – 10

### LONG PULSE COOLED ND:YAG 1064 NM LASER AND PROPRIETARY DYE PL TECHNOLOGY ON FOR TOTAL SOLUTION FOR COAGULATION OF THE CAPILLARIES AND TREATMENT OF VASCULAR LESIONS

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The Effect of Nd:Yag 1064 nm for treating the capillaries, spider veins and telangiectasia is well known for decades due to its fair absorption in water and oxy hemoglobin. Many patients looks for aesthetic non–invasive treatment for unwanted capillaries up to 3 mm in diameter. Effective veins coagulation with minimum side effects and recovery time described. Feeder veins most of the time located in the grey zone and cannot be observed with neither with the naked eye nor with diagnostic US. Infrared light diagnostic methods of capillaries blood supply could be beneficial for the practitioners. Complex ClaCS methods for using Nd:Yag 1064 nm together with Zimmer Cryo device and sclera– therapy investigated and found very effective. Long Pulsed cooled Nd:YAg 1064 nm In combination with proprietary Dye Pl technology on Harmony XL offers a total solution for capillaries and vascular lesion treatment either for face and for the legs.

## O – 11
### SOME RARE DISEASES WITH CHARACTERISTIC LOCALISATION ON FACIAL SKIN

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On facial skin, as disclosed part of the body, there are various changes often caused by various factors of the foreign environment, but also changes with infectious, allergic, genetic, autoimmune or another etiology. The changes that occur on the face, even those benign and asymptomatic, which generally represent only an aesthetic problem, very often are the reason that patients contact a dermatologist. Most of the changes / dermatoses, especially those more frequently, do not have a greater diagnostic problem, not for the young and less experienced dermatologists. But not a few dermatoses are rare and those diagnosis is still a privilege of experienced dermatologist with many years of clinical practice, who had a chance to at least once see it. Not recognizing these dermatoses, which are often part of multisystem disease, leading to long wandering patients through the medical maze, subjected to numerous and inadequate testing, and random use of ineffective and often harmful terapije. In this presentation will be displayed characteristic changes that can be seen on the skin of the face in some rare diseases (such as: necrobiotic xanthogranuloma, mucinosis follicularis, granuloma faciale, dermatosis neglecta and others), which were diagnosed during the many years of personal clinical practice.

## O – 12
### WHY SKIN AGES?

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Introduction: Physiological or chronological skin aging is irreversible, multifactorial process, which involves a progressive degenerative changes. The structural and physiological changes in the skin that occur in this process, are certainly result of the synergistic activity of endogenous and cumulative effect of exogenous factors. Aim: Changes in the epidermis include changes of the number, as well as the volume and surface of corneocytes, melanocytes and Langerhans cells. Obvious changes occur in the level of dermo-epidermal layer, which manifests as its reduced adhesivity. During the aging process, the biggest changes are affecting the dermis. In fact, it leads to the reduction of dermis, disorganization of the matrix, reduce of vascularization and hypocellularity, with significant reduction of fibroblasts and mast cells. The main issues in this segment of the skin are related to the loss of the integrity of collagen and elastic fibers, as a result of an imbalance, that is, their increased degradation and reduced synthesis. The redistribution of body fat occurs in the hypodermis, as well as decreased production of sebaceous glands. The amount of fat tissue in certain regions is a factor which gives

a youthful skin. During the aging process the redistribution, accumulation and atrophy of fat tissue occurs.The functional changes occur as a result of structural changes in the skin during the aging process. Therefore, the aim of this study is to point to most significant changes in the structure of all skin layers, leading to physiological aging. Discussion: These structural and functional changes of the aged skin are causing skin atrophy, decreased muscle tone, which results in creating fine wrinkles and development of benign growths. Conclusion: It is important to define the natural aging of the skin as well as the mechanisms that lead to it. Possibilities of preventing and correcting skin changes incurred in the process of physiological aging are now numerous and are the focus of aesthetic dermatology.

## O – 13

## CORRECTIVE DERMATOLOGY AND BODY DYSMORPHIC DISORDER

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Corrective dermatology is a rapidly growing specialty and cosmetic dermatologists are frequently consulted to evaluate and treat various cosmetic defects. While many such problems are easily treated and have a good treatment outcome, practitioners need to be alert to patients with body dysmorphic disorder (BDD), relatively common in cosmetic practise, but mostly remains under-recognized. Body dysmorphic disorder (BDD), also known as dysmorphophobia, are preoccupied with an imagined or slight defect in appearance; if a slight physical anomaly is present, the appearance concerns are excessive. In other words, these patients consider themselves ugly or deformed despite an objectively normal appearance. People suffering from BDD are concerned with minimal or non-existent defects, develop social avoidance and may become depressed or even suicidal. The prevalence of BDD varies in different studies, but all have found that a high percentage of patients with the disorder presented in aesthetic practices. Patients can present signs of this disorder at any age, but most patients have noted that symptoms started to develop in adolescence and even childhood. Patients who screened positive for BDD received a variety of dermatologic diagnoses. The most common diagnoses were problems such as acne, rosacea, scarring, benign vascular lesions such as haemangiomas and telangiectasias. The dermatology literature, on the basis of clinical observations, notes that these patients can be difficult to treat and are often dissatisfied with and have a poor response to dermatologic treatment. BDD is primarily a psychiatric health problem and patients usually consult dermatologists, plastic surgeons, other specialists or general practitioners, but not mental health specialists, as patients firmly believe that their disease is a physical problem. Conclusion: However, once diagnosed BDD, a holistic psychodermatological approach, focusing not only on the disease, but also on his/her psychological, emotional, physical, and social needs has to be taken into account and be treated.

## O – 14
## ALL ABOUT HIDRADENITIS SUPPURATIVA

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Hidradenitissuppurativa (HS) is a chronic relapsing disease that manifestsin the form of painful nodus with occasional secretion and the consequent creation of fistulas, sinus and scars. It occurs after puberty and takes an average of about 18 years. The disease is mainly seen in the armpits, around the breast, groin, perineum and perianal. Three to five times more likely to occur among women. Perianal region and perineum are more often affected in men, while in women armpits and groin are more often affected. The etiology of HS is unknown, but it seems that the underlying disorder increased acrotrichium cornification. In one third of patients there is a positive family history. The disease can manifest varying degrees of difficulty (classification by Hurley in three stages). There are various modalities of treatment using antibiotics (doxycycline, rimfapicine in combination with clindamycine), acitretin and in case of resistant and severe forms it can be used TNF-alpha blockers and surgical treatment. In addition, the patient is required recommend smoking cessation and weight-loss. Early diagnosis and proper treatment can reduce symptoms and significantly improve quality of life and reduce the incidence of comorbidity.

## O – 15
## STRONGER THAN HS! – PUBLIC AWARENESS CAMPAIGN OF A SERIOUS DISEASE HIDRADENITIS SUPPURATIVA IN CROATIA

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Hidradenitis suppurativa (HS) is an immune-mediated, inflammatory and extremely painful disease of the skin. The prevalence of disease in the population is about 1%. From the onset and diagnosis passes around 8-12 years.It is often unrecognized by general practitioners, patients and doctors of different specialties. Given the chronic nature, pain and odor, HS has an extremely negative impact on quality of life, resulting in mental disorders. Very big problem are the patients who are unwilling to talk about their illness. Considering all the above, the Coalition of associations in Health Care, under the sponsorship of Croatian dermatovenereological Society, Croatian Medical Association, the Coordination of Croatian Family Medicine and Croatian Association of Primary Health Care, launched the campaign "We are stronger than HS "which was aimed to show the importance of early detection and diagnosis of the disease. The campaign events were held in Osijek, Split, Rijeka and Zagreb. An internet web site www.hsonline.com.hr was designed, intended for patients and contains all the essential information about the causes, symptoms, treatment and the importance of timely diagnosis.The prepara-

tion of the Guidelines of Croatian Dermatovenereological Society of how to treat HS-a is in the process. In Osijek, the action led to results. Patients are coming in much greater numbers. In the treatment next to dermatovenerologists, there are also included surgeons, gynecologists, and psychodermatologist, and in a female patient in whom all other treatment optionsup to now were exhausted, we started the treatment with biological drug adalimumab. The goal which was implemented by public health action was achieved.It is necessary to continue with work, whose foundations were given by this public health care action.Severely ill patients of HS are requiering very comprehensive care.

## O – 16

## ATOPIC DISEASES AND MIGRATION

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The development and phenotypic expression of atopic diseases depends on complex interaction between genetic factors and enviromental exposure to allergens. Europe has become the destination of a considerable number of immigrants. Migration to allergy-prevalent countries involves exposure to a new allergens and changes in housing conditions, diet and accessibility to medical services, all of wich are likely to affect migrant's health. Epidemiological and laboratory studies have implied that atopic diseases, such as asthma, atopic dermatitis or rhinoconjuctivitis, are more prevalent in immigrants compared with the prevalence of atopy in their countries of origin. The effect of migration is time- and age- dependent. Allergy symptoms usually start to apper a several years after migration and increase with time. Early age increase the likelihood of developing allergenic symptoms. Compared to the local population, recent immigrants have higher levels of IgE, which gradually decrease to the levels of the general population. Migrants should be aware of the potential of developing atopic diseaeses and prevention guidelines should be developed for immigrants to atopic-prevalent developed countries.

## O – 17

### LYMPHOEDEMA: NOT ONLY HEALTH BUT ALSO AN AESTHETIC DISORDER

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The incidence rate of lymphoedema is increasing in western countries, due to the increasing incidence rate of malignant diseases and their treatments. It represents not only a large health problem, but also an aesthetic problem due to the disfiguration of the body, especially for the patients with stage III lymphoedema. Patients with lymphoedema feel anger, frustration, sadness and shame due to the clinical manifestations of lymphoedema. Their quality of life depends on a stage of lymphoedema and possibilities to find the shoes and clothes among a lot of other things. We present the solutions for patients with stage III lymphoedema: a possibilities for treatment in the acute and maintance phase, in order to improve their quality of life.

## O – 18

### RECOMMENDATIONS FOR TREATMENT OF VARICELLA ZOSTER VIRUS (VZV) INFECTION

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Primary varicella-zoster virus (VZV) infection is manifested by varicella (chickenpox), usually during childhood, while reactivation of latent virus is manifested as herpes zoster (HZ). In the vast majority of cases, primary VZV infection does not cause serious disease in immunocompetent patients, but it can be related to the higher morbidity and mortality in adults and in immunocompromised individuals. In accordance, HZ is also associated with much higher morbidity in immunocompromised patients, especially in those patients with impaired cell-mediated immune responses, but also in elderly patients. The objective of this talk is to provide evidence-based recommendations for rational treatment of patients with HZ. The only rational choice of therapy for HZ is acyclovir, since other antivirals are not available in Bosnia and Herzegovina. Specific recommendations for the use of corticosteroids are still controversial, but if chosen, they should be recommended in combination with specific antivirals.

## O – 19

### ENDOVENOUS LASER ABLATION (EVLA) – WHEN AND WHAT AFTER? – OUR EXPERIENCE

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Endovenous laser ablation (EVLA) is a percutaneous technique that uses laser energy to ablate incompetent superficial veins. The axial veins are the primary target for this therapy and

include the great saphenous vein (GSV), small saphenous vein (SSV), accessory saphenous veins (ASVs), perforating veins (PV) and Ulcus cruris(UC). They can be various in size, lenght, location, form and can be performed on multiple vein segments. The use of the 1470 nm laser wavelength allows us to reach greater depths with less scattering and much better control of the laser energy applied ( "laser crossectomy"). The EVLA procedure is performed on an outpatient basis under ultrasound guidance and Tumescent Local Anesthesia (TLA) and can be performed in combination with ultrasound guided foam sclerotherapy (UGFS) and mini phlebectomy procedure. Both legs can be performed int he same act. Preoperativeexamination of the patient in the supine and standing position with individual and mapping approach and proposal of one or more of treatment , depending on the findings – the most common procedures are multiprocedural. For the correct diagnosis is very important expertise , experience, a good knowledge of anatomy, anatomical variations, veins pathology, surgical procedures on veins and post operative findings. Postoperatively we recommend heparin therapy based on Caprini DVT Risk Score and compression stockings II.CC with follow up after 24hours, 7 days 1, 3 and 6months and 1year.Up to 3months after procedure leads to fibrotic changes in the treated veins laser which is not different from the surrounding tissue. In 5 years ( from 2011 to 2016.y ) we had 822 patients with interventional vein treatments– EVLA with or without MF and UGFS.– cca 165/y without complication recidives, and DVT.

## O –20

## OUR EXPERIENCE WITH „SOURCING" – IDENTIFYING THE SOURCE OF SUPERFICIAL REFLUX IN VENOUS LEG ULCERS

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Objective: The aim of the study was to show source of origin medially or laterally located venous leg ulcers associated with mapping of venous reflux routes.
Materials and Methods: From May 2015 to May 2016, 92 patients (44 male and 48 female) were investigated by duplex ultrasound preforming in consecutive leg ulcer patients, all with venous reflux. A total of 92 patients (at 20 patients both legs; at 72 patients one leg– total 112 legs ), with chronic venous leg ulcers (CEAP: C6) were examined venous function was assessed with duplex ultrasound and cases were described using CEAP classification. Additionally, a „sourcing" technique was performed with duplex ultrasound investigation of ulcer bed and the venous reflux from the ulcer area to its proximal origin. The detected reflux routes were classified as „axial" or „crossover" type.
Results: All ulcer patients showed clinically visible varicose veins. 104 legs (88%) had medial ulcers, 14 (12%) lateral ulcers, 92 (78%) of medially located ulcers had reflux in the great saphenous vein (GSV), 6 (5%) showed reflux in the medial perforating veins – axial types, 4 (3%) small saphenous vein (SSV) incompetence –crossover type and 2 (2%) showed reflux in perforating veins – crossover type. 8 (7%) lateraly located ulcers had reflux in the great saphenous vein (GSV)– crossover type, 2 (2%) small saphenous vein (SSV) incompetence –crossover type

and 4 (3%) showed reflux in the lateral perforating veins – crossover type. 22 patients (24%) were successfuly treated with EVLA and healed venous ulcers.
Conclusion: In venous ulcer patients, an extended examination (CEAP classification) and a special duplex technique- „sourcing" are recommended to identify the specific route responsible for the venous reflux. This seems essential for planning a rational and successeful treatment of venous reflux ulcers.

## O – 21

### THE TREATMENT OF SCLERODERMIA IN CHILDREN WITH SYSTEMIC THERAPY

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Scleroderma is a rare connective tissue disease that is manifested by cutaneous sclerosis and variable systemic involvement. Two categories of scleroderma are known: systemic sclerosis, characterized by cutaneous sclerosis and visceral involvement, and localized scleroderma or morphea which classically presents benign and self-limited evolution and is confined to the skin and/or underlying tissues. Localized scleroderma is a rare disease of unknown etiology. In children, the most common subtype is linear scleroderma (50-60%), which has the potential for the most disability secondary to its effect on joints and resultant contractures from deep tissue involvement. Treatment should be started very early, before complications occur due to the high morbidity of localized scleroderma.

## O – 22

### WHY ARE PROFESSIONAL SKIN DISORDERS MORE COMMON IN DENTAL PROFESSIONALS?

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The high frequency of occupational dermatoses in dental professionals, especially skin reactions to latex gloves, is already featured in some of the earlier international studies, but there is no previous Croatian data. Dental professionals can often develop unwanted skin reactions, most frequently on the hands, that can be associated with the use of latex gloves during their work. There are different possible allergic and non-allergic pathomechanisms with the emergence of different clinical pictures (contact urticaria, contact dermatitis and other). This study was conducted to investigate the prevalence of adverse skin reactions in Croatia in professional dental staff and student population of School of Dental Medicine in the University of Zagreb. A survey was conducted with 444 persons, 200 of them were tested with prick test. The survey examined a number of factors (the number of changed gloves and hand washing per day, the presence of allergic diseases in history, long-term contact of hands with liquids

out of the work hours). The results were statistically analyzed. Our results have proven positive prick test in 7% of patients, but skin changes were more often noticed in dental professionals (56.1%). Skin changes were mostly related to frequent glove changes, persons with work experience longer than 30 years and those who wash their hands frequently. Skin changes were also significantly associated with history of previous allergies in which the appearance of skin lesions is 2.2 times higher.

## O – 23

## INCIDENCE OF CONDYLOMA ACUMINATA IN KARLOVAC AREA 1998–2015

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Most common clinical manifestation of human papilloma virus infection in genital localisation are condyloma acuminata. Clinically small papules that can gradually increase in number and size, become papilomatous and grow into cauliflower-like structures. Differential diagnosis include: condyloma lata (lues), spinocellular carcinoma, pemphigus vegetans. Therapeutic options are: cryosurgery, electrosurgery, laser, local application of 20% Podophylin tincturae, topical use of immunomodulatory agents (imiquimod, interferon). During 1998–2015 in our Department of dermatovenereology 534 patients were admitted with Condyloma acuminata. It was 0.36% of all patients examined in our Department. Number of patients with Condyloma acuminata increased during 1998–2015 from 7 patients to 34 patients per year. Average age of patients was 33,5 years. Men was 98% and women 2%.The highest frequency of patients was during summer months. Average number of treatment was four times. The most common therapy was in 80% of patients cryotherapy followed with application of imiquimod in 15% patinets and Podophylin in 5% of patients. In conclusion frequency of Condyloma acuminata rised more then five times in past ten years. This increase is explained with a trend of increasing number of sexual partners, but also there are influence of public health campaign agianst HPV and better education of young population.

PROFESIONALNE BOLESTI KOŽE / OCCUPATIONAL SKIN CANCER
HELD BY THE EU HORIZON 2020 COST TD 1206 ACTION – STANDERM

## O – 24

### THE BIOMARKERS OF UV EXPOSURE AND UV-INDUCED EFFECTS

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Skin exposure to ultraviolet radiation (UVR) can induce DNA and cell damage, which can give rise to various biological effects including cell death, photoaging and cancer.Non-melanoma cancer is the most common malignancy in Caucasian populations worldwide, UVR being the main risk factor. There is a growing need for reliable biomarkers of UVR-induced damage which might help to understand better the mechanisms which underlay development of adverse effects. Furthermore, in epidemiological studies and clinical settings the biomarkers can aid in estimating internal UVR dose, detection of early effects, diagnostics, therapy and development of preventive strategies.
Traditionally, search for an appropriate biomarker and response was hypothesis-driven and focused on a candidate approach evaluating various endpoints based on known biological mechanisms. As DNA was considered the main target of UVR, several molecular biomarkers of DNA damage and repair were proposed. However, as UVR initiates a complex series of cellular and molecular responses, which are not necessarily dependent on DNA damage there is a demand for novel biomarkers which would cover all of the key molecular events related to UVR-induced effects. Development of the high-throughput technologies oromics technologies have opened a new way to identify novel markers, although the translation of findings to applicable biomarkers has proved complex.
This presentation will address various biomarkers used to evaluate the effects of UVR with emphasis on their applicability in the intervention studies and diagnostics.

## O – 25

### COST ACTION STANDERM AND THE PREVENTION OF OCCUPATIONAL SKIN CANCER

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Occupational skin diseases (OSD) account for up to 30% of occupational diseases and a social cost of over 5 billions euro/year. The authors present an overview of the COST action "StanDerm", born to coordinate local initiatives for OSD prevention in Europe, and the preliminary results of an Italian multi-center observational study. Primary objectives of this study are:

a) assessment of occupational/recreational UV exposure-associated risk for non-melanoma skin cancer (NMSC) and b) evaluation of perceived UV-related risk, also in correlation to individual and environmental factors (occupational or not). Secondary objective is information on risks of improper sun exposure and on prevention.The target sample size is 2700 NMSC patients. For each patient, two controls without NMSC, matched for sex and of similar age (within a range of 5 years), are enrolled. All participants must fill a questionnaire on potential individual, environmental and occupational risk factors in their personal history, and receive written information on UV-related risks and prevention methods. For patients, clinical history, type and treatment of NMSC(s) are recorded. As of July 2016, 171 patients and 204 controls have been enrolled. NMSC is more frequent in outdoor workers, with phototype I-III and history of 2 or more sunburns/year in childhood. Despite similar perception of UV-related risk, patients and controls have different behaviors. At workplace, patients use protective clothing much less frequently; use of sunscreens is low in both groups. Sunbathing is equally frequent, but patients more often sunbathe for >60 days/year; less than 5% of subjects declare use of sunbeds. Photoexposure due to hobbies is more frequent and prolonged among patients. Sunscreens and protective clothing are used much more than at work, equally by patients and controls. Potential benefit of improved prevention at workplace appears interesting, and prompts for further extension of the study.

## O – 26

## WHAT IS FAMILIAR ABOUT CARCINOMA BASOCELLULARE AS A PROFESSIONAL DISEASE

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Introduction: Basal Cell Carcinoma (BCC) is the most common malignant skin tumour, usually develops on chronically photo-exposed areas of the skin. The risk factors associated with this tumour areultraviolet, ionizing radiations and chemical agents. Long term exposure to UV radiation can cause a mistake in the reparation processes that, as a consequence, results with irreversible growth of malignant cells. It is reasonable to assume that outdoor workers with a long history of work-related UV exposure are at increased risk of developing BCC. We analyse the epidemiological evidence of an association between occupational UV exposure and BCC risk in outdoor workers. Patients and Methods: The study was conducted at the Department of Dermatology and Venereology of the University Clinical Hospital Mostar. Weanalyzed: age, gender, occupation, and skin type. Results: The occurrence of BCC was more frequent in male patients, and greatest number of patients with BCC was found in persons older than 60 years. With regards to occupation relative frequency in outdoor workers is higher in comparison to relative frequency in indoor. The results of the research showed that most of patients with BCC had the skin types 1 and 2. Discussion: BCC is the most frequent malignant skin tumor. Its frequency depends on endogenous and exogenous factors and therefore the percentage

of patients diagnosed with BCC varies significantly. Therefore, it is more frequent in countries with high insolation. This indicates that timely protection from UV rays may reduce the risk of occurrence of malignant skin tumors. On the basis of the data on the patient's medical history, our study shows that most of patients with BCC stated they had been frequently over exposed to UV rays for the reason of their occupation, i.e. agricultural works. Conclusion:This research indicates that outdoor workers are at significantly increased risk for BCCand confirms previous reports on the increased risk of BCC in outdoor workers compared to indoor workers.

## O – 27

## ACTINIC KERATOSES AND SQUAMOUS CELL CARCINOMA AS OCCUPATIONAL DISEASE

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Natural UV radiation have been classified as carcinogen for humans since 1992 by the International Agency for Research on Cancer (IARC), while artificial UV light has been recognised as carcinogen in 2007. UV radiation induce non melanoma skin cancer (actinic keratoses, squamous-cell carcinoma and basall cell carcinoma) as well as melanoma. It is estimated that 90% od NMSC are caused by excessive exposure to ultraviolent radiation during leisure activities and holidays but also during long time outdoor work. Squamous cell carcinoma (SCC) and actinic keratoses (AK) are strongly associated with chronic, cumulative UV exposure and can be prevented by long-term use of sunscreens, while BCC is more associated with intermitent, intense UV exposure and are not prevented by use of sunscreens.
The incidence of NMSC as the most common cancer in the world is constantly increasing with 2-3 million people affected each year. The risk of AK and SCC increase with age with the higher prevalence in men that can be partially explained by greater exposure to sun during their worktime. Outdoor workers such as construction workers, farmers, mariners, fishermans, gardners, ski instructors, ect., have increase risk of skin cancers, but dispite this, long-term occupational exposure is still not officially recognised as occupational disease in most countries. The global action is needed to recognise AK and NMSC as occupational disease wich can force employers to implement better preventive measures (limit the UV exposure, using sunscreens and protective clothes) and perform regular screening among outdoor workers.

## O – 28

## HURIEZ SYNDROME AND THE DEVELOPMENT OF SQUAMOUS CELL CARCINOMA IN ONE CROATIAN FAMILY

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We describe a case of a 31-year-old woman who developed a hyperkeratosis on the fingertip of the third finger of the right hand. Three months later, fissure appeared on the same place and gradually increased to ulceration, accompanied with an itchiness, redness and swelling of the finger. For the period of two years the patient applied antiseptic, antibiotic, bioclusive cover bandages and neutral preparations locally and systemic antibiotics. Conducted therapy did not lead to epithelialization. Since birth the patient had thin and pointed fingers and toes with hypoplastic and longitudinally ridged nail plates. The skin on the palms was thin, and thickened on the feet. The feeling of oral dryness was presented. The patient is the mother of two daughters. The patients 2-year-old daughter, the mother, the grandfather and the grandfathers sister have identical changes on the hands and feet since birth. The grandfather had died from metastatic skin cancer which had arisen on the hand. The biopsy from the patients ulcer margin was performed and histopathological analysis revealed squamous cell carcinoma (SSC). X-ray examination of the both hands was performed and it hasen't showed any signs of bone destruction. Ultrasound of the axillary lymph node and abdomen, X-ray examination of the lung were normal. Afterwards the excision of the SCC was performed and the histopathological analysis revealed carcinoma cells at the base of excised lesion. Five days later the reexcision was performed, and the histopatological analysis revealed clear re-section marigins. Based on the history and clinical findings, the diagnosis of Huriez syndrome was made, and six days later the amputation of the distal part of the medial phalange of the third finger of the right hand was made. Histopathological analysis of the amputated part of the finger after the decalcification of the bone revealed carcinoma cells infiltrating underlying bone. Computed tomography of the chest and oncologist examination was made. The diag-nosis of familiar palmoplantar keratoderma with sclerodactily (Huriez sy), a rare autosomal dominant genodermatoses was made. The development of squamouse cell carcinoma of the affected skin is a distinctive feature of the syndrome. It is characterized by early onset (30-40 years of age) and by early metastasis formation.

KEY WORDS: genodermatoses, autosomal dominant, palmoplantar keratoderma with sclero-dactily, squamous cell carcinoma.

## O – 29
### THE LATEST GUIDELINES IN DIAGNOSIS AND MONITORING OF PATIENTS WITH MELANOMA

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Every person with the melanoma diagnosis belongs into a category of patients who need lifelong screening. The extent of screening depends on the stage of the disease as well as the possible existence of DisplasticNevus Syndrome. When the melanoma is more than 1 mm thick, it is possible to detect the stage of the illness only after the completion of the full surgical treatment and diagnosis (scar reexcision, Sentinel lymph node biopsy, laboratory and radiologic tests coordinated in relation to the primary tumour and the status of regional lymph nodes).
There are three main arguments that are essential for screening melanoma patients. The first argument is early detection of relapse – timely treatment ensures better prognosis. The second one is early detection and eventual appearance of the next primary melanoma. Numerous studies have shown that 2–8 % of patients with diagnosed melanoma have increased risk of developing another melanoma or multiple primary melanomas. Screening of patients with multiple primary melanomas is conducted with regularity and extent of tests in order for it to be adequate in treating patients diagnosed with the thickest melanoma stage.
The third argument is informing, educating and supporting patients by doing regular screenings and appropriate diagnostic procedures. Melanoma has a significant effect on the patient's quality of life so psychosocial support is justified and needed.
The complete guidelines will be presented at the Congress.

## O – 30
### MELANOMA AND PREGNANCY

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The link between melanoma and pregnancy, hormonal replacement therapy and oral contraceptive use was investigated in small number of studies with conflicting results. The incidence of melanoma in premenopausal females is higher than in males, suggesting an influence of hormonal factors. Also, in pregnancy, changes in melanocytic nevi do occur, but there is no evidence that there is an increased risk for malignant transformation. However, any changing lesion fulfilling criteria for excision must lead to biopsy and histopathological diagnosis, since there is a possibility of melanoma development, with the estimated incidence from 2.8 to 5.0 per 100 000 pregnancies. Management of melanoma in pregnancy is challenging since there are no guidelines for the treatment established in these cases. Regarding prognosis, in

some studies increased risk for lymphovascular spread and mortality was described, but in other studies it was found that outcomes do not appear to be poorer in comparison to non-pregnancy melanoma, if stratified by the same stage at diagnosis. It is found that melanoma in pregnancy is diagnosed in later stages, with higher tumor thickness, that lead to poorer outcomes and points out to the better early diagnosis in this group of patients. In a recent systematic review and meta-analysis of risk of death from, or recurrence of, pregnancy-associated melanomas compared with other melanomas in women of reproductiveage, it was found again that there is an increased risk of melanoma death after adjustment for patient age and stage of melanoma for pregnancy-associated melanoma compared with other melanomas. More data are needed for a definite conclusion, and development of guidelines for treatment in melanoma in pregnancy is highly needed. The latest data and current recommendations based on available studies will be presented.

## O – 31

## USEFUL TECHNOLOGY IMPROVEMENTS IN DIGITAL DERMATOSCOPY

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Objectives: Cutaneous melanoma (CM) is a malignant tumour, with a consistent increase in incidence among the white population over the past four decades. CM has a high tendency to metastasize, unless it is discovered in the early stages of the disease.Dermatoscopy is a diagnostic method intended to maximize early detection of CM performed by the dermatoscope. Digital dermatoscopy is an upgraded method of the manual dermatoscopy, where the lens on the handle are replaced by a digital camera with the possibility of recording an enlarging image and storing it on a computer. Performing digital dermatoscopy in everyday practice is, on account of the technical limitations of the digital dermatoscope, often a time-consuming procedure for the therapist. To address the limitations of existing systems a novel, digital dermatoscopy system e-Derma is developed. It integrates a high-resolution camera that provides a wireless image transfer on a computer for a review and storage. Methods and materials: We perform the working process of evaluation on available state of the art dermatoscopy systems the most commonly used in everyday dermatology practice. Some findings like operability, image quality (resolution, color reproduction, sharpness, illumination), user-friendliness, and safety are used for the development motivation of an e-Derma dermatoscopy system. Results: a novel dermatoscopy system eliminates the limitations of existing systems. Test shows that the presented system improves overall macro and micro image quality (resolution, sharpness, illumination, reproduction) and, due integrated wireless system enhances the handling.Conclusions: To address the limitations of existing systems we presented a novel e-Derma dermoscopy system for use in the dermatological practice. Due a high-resolution imaging camera that transfers image files to a computer system wirelessly the user experience is improved and it shortened the time of the examination. Although a e-Derma system reached the final stage

of the development phase (not ready for production) the test shows some important improvements (image quality, usability, safety and mobility) compared to other, on market available digital dermatoscopy system.

## O – 32

## PROGNOSTIC ROLE OF BRAF TESTING AND NM23 TUMOR SUPRESSOR GENE IN MELANOMA

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Cutaneous melanoma is a tumor derived from activated or genetically altered epidermal melanocytes, the result of complex interactions between genetic, constitutional and environmental factors. Melanoma is not genetically homogenous, and the existing differences between the pathologic categories particularly in areas such as type of growth phase (radial and vertical growth), ulceration of primary tumor, Clark level of invasion, thickness of tumor tissue and metastatic process, have profound prognostic and therapeutic implications. 124 primary melanomas including 29 metastatic melanomas were subjected to immunohistochemistry in order to detect Nm23 protein expression. There was strong inverse correlation between low level of Nm23 protein expression (1 and 2) and tumor thickness (more than 1 mm), Clark level of invasion (4 and 5), ulceration, vertical growth phase and metastases. The Nm23 protein expression is correlated closely with reduced metastatic behavior and may serve as a prognostic indicator of malignancy and survival in patients with melanomas. Nm23-H1 protein inactivates kinase growth suppressor and stops Ras signaling pathway which further activates cascade of proteins Raf, KSR, MEK i ERK/MAPK which acts on citoplasmatic substrates in nucleus. This mechanism shows tumor suppressor activity Nm23-H1 protein. His histidin kinase activity reduces proliferation malignant cells and acts by suppressing metastasing.

Fine regulation and interaction between oncogenes and tumor suppressing genes under control cell processes allowing cells to enter proliferation and cell division (Ras activation) or stay in quiescent state (Nm23-H1 activity). When this balance is disrupted by mutations which results in inactivation of Nm23-H1 or activation of Ras protein, the mechanisms of cell controls are lost and cell proliferates without control leading to malignant transformation and consecutive metastasing.

The BRAF gene is a protooncogene located on chromosome 7q34. This gene is member of the raf family which consists of ARAF, BRAF i CRAF (RAF1) that encode serine/treonine kinase of the RAS / RAF MEK/ERK/MAP signal pathway. Mutations in the BRAF gene have been associated with the development of cancer. The most common alteration in the BRAF gene is a mutation called V600E, which alters the valine at position 600 in the protein to a glutamic acid. The V600E mutation causes the BRAF protein to be permanently activated even in the absence of growth factors. Aberrant BRAF signaling due to the V600E mutation can result in excessive cell proliferation and an adverse resistance to apoptosis.

O – 33

## QUALITY OF LIFE IN MELANOMA PATIENTS

*Dragana Starović*

## O – 34

### AN UPDATE ON MANAGEMENT OF PSORIASIS IN CHILDREN

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Psoriasis is a relatively common immune-mediated disorder, that accounts for 4% of all dermatoses seen in children under 16 years of age. It is important for clinicians to appreciate the impact of psoriasis on children and teenagers. Even mild forms of psoriasis can affect childhood psychosocial functioning and quality of life. The therapeutic approach should be simplified and tailored to the individual patient to optimize compliance, because therapy is time consuming. There are currently no international standardized guidelines for medical treatment of pediatric psoriasis. The majority of children with psoriasis have mild disease that can be managed with topical agents. Systemic treatments such as phototherapy, acitretin, methotrexate and cyclosporine have been used to manage severe pediatric psoriasis for decades. Newer biologic agents have demonstrated their effectiveness in adult psoriasis and are accumulating promising data in children. Psychosocial support is another important component of therapy for children with psoriasis. Educating the patient and family on the chronicity of psoriasis, triggering factors, and treatment modalities is important, in addition to prescribing treatment.

## O – 35

### CURRENT TREATMENT OF PSORIASIS

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Psoriasis is a chronic, recurrent, inflammatory, systemic, immune-mediated inflammatory skin disorder associated with genetic and immunological characteristics. The largest number of patients have a mild form of the disease and about 30% of the total number of patients have moderate to severe form of psoriasis, with or without psoriatic arthritis. Treatment should be tailored to meet individual patient's needs. It is important to determine the goals and desires of each patient, and then develop a treatment strategy that will meet the expectations and be practical and easily applicable at the same time. There are numerous topical treatments used for psoriasis vulgaris (emollients, keratolytics, tar derivatives, dithranol, retinoids, corticosteroids, vitamin D analogs, inhibitors of calcineurin). Application of a particular substance in a different formulation may alter drug penetration, and therefore it's efficiency. Occlusive treatment enhances efficacy of the topical medications. Individual therapeutic approach should be taken when selecting one of these treatment options. Systemic treatment of psoriasis is mandatory when the surface of the skin affected by psoriasis (BSA) is greater than 10% or when PASI score is greater than 10, when the psoriatic arthritis is present or a localized form of a

disease that does not respond to topical treatment (BSA <10, PASI <10 with a significant impact on quality of life, psoriasis of palms and soles, scalp psoriasis). Biological treatments are used in patients who require systemic treatment of psoriasis, therefore severe forms of psoriasis, psoriatic arthritis and localized forms resistant to local therapy, including psoriasis of palms and soles and scalp psoriasis. Due to the cost of biological medications these drugs are used as a second line treatment for patients resistant to phototherapy and conventional systemic therapy in Europe, but are also used as a first line treatment if phototherapy is unavailable and if there are contraindications for classical systemic therapy use or it's side effects are presented.

## O – 36

## TOPICAL THERAPY FOR THE TREATMENT OF PLAQUE PSORIASIS

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Psoriasis is a chronic inflammatory skin disease affecting 2–3% of worldwide population. Although the exact etiopathogenesis of the disorder is not completely understood, many studies point out that the dysfunction of the immune system has a crurial role in the development of this disease. According to the quite broad clinical presentation of psoriasis we divide existing treatment options not only due to the method of administration, but also due to the degree of severity of the disease. Therapy available for the treatment of psoriasis can be divided into several groups: topical therapy, systemic therapy (conventional and biological), phototherapy and climatotherapy. When applying a topical medication, it is extremely important to choose the correct form of the applying medication, because the application of a particular substance in a different formulation may alter drug penetration, and therefore its efficiency. It is also important to control the amount of applied medication and the duration of therapy due to side effects of topical medication that can occur mainly because of their prolonged and uncontrolled use. The group of topical psoriasis treatments include: keratolytics, corticosteroids, vitamin D analogues, retinoids, immunomodulators, anthralin and tars. Use of keratolytic agents is essential due to their ability to remove the scales and hyperkeratosis of the psoriatic plaques and therefore can improve the activity of other topical medication. Due to their anti-inflammatory, immunosuppressive and anti-proliferative characteristics, topical corticosteroids present the basis of topical treatment of psoriasis. Vitamin D analogues, calcipotriol, calcitriol, tacalcitol are often used in a combination with topical corticosteroids or UVB phototherapy. Topical tazarotene can also be applied in a combination with a topical corticosteroid, and besides the local irritation of the skin it also has a potential teratogenic effect. Due to their poor penetration through the thickened horny layer, topical immunomodulators, tacrolimus and pimecrolimus, are applied to the areas with a thin horny layer such as face, intertriginous areas and the genital region. Anthralin and tars are the oldest form of medication used for the treatment of psoriasis whose application has recently significantly been reduced due to the occurrence of aesthetically more acceptable alternative therapeutic options.

## O – 37

## PSYCHOPATHOLOGICAL ASPECTS AND TREATMENT IN PSORIATIC PATIENTS

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Considering how patients with psoriasis vulgaris are stigmatized by visible skin changes, which they share with their surroundings, sometimes this makes it harder to face the stigma and results in a greater problem than the disorder itself. Changes on the skin, nails and scalp result in changes in appearance and distort the body image, which makes psoriasis treatment extremely demanding and longterm with the final goal of not only diminishing the disorder but the complete recovery of the person in question. Previous research point out the significant role of psychological stress on the development of psoriasis. Clinical research show how patients affected with psoriasis have a significantly lower quality of life, tendency towards depression, anxiety and other psychiatric disorders. Psychotherapy in treatment of psoriasis can be seen as complement to standard treatment methods as it is justified and useful. With frequent limitations, dermatologists carrying out psychosocial therapy have to carefully sensitize the patient on the biopsychosocial dimension of psoriasis. The therapy should be conducted interdisciplinary, with opportunities of education, selfhelp groups, psychotherapy, relaxation techniques and working alongside with the patients family. The patients themselves should at all times be informed of the opportunities of interdisciplinary treatments of psoriasis. Furthermore, the impact of psoriasis be considered individually when it comes to the patients' emotional, social and psychological aspects of life.

## O – 38

## SINGLE NUCLEOTIDE POLYMORPHISMS IN PATIENTS WITH PSORIASIS VULGARIS

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Psoriasis is a common chronic inflammatory skin disease affecting approximately 2–4% of individuals in general population. The prevalence and incidence of this disease is showing significant ethnic and geographic variations. Previous studies have shown that psoriasis belongs to the so-called complex genetic diseases, in which the risk of inheriting the disease appears to be determined through the interaction of multiple genes. Exposure to environmental factors leads to development of the disease in genetically susceptible individuals. In 30% of patients, psoriasis is associated with psoriatic arthritis. Due to the tendency of individual approach to the diagnosis and treatment of complex diseases such as psoriasis, it is useful to define biomarkers such as single nucleotide polymorphisms (SNP). SNP may help the process of diagnosis, disease classification, prognosis and monitoring of treatment response. We will discuss significance of SNP in psoriasis patients and present our results obtained on 130 psoriasis patients and 306 healthy controls.

## O – 39

### NEW IMMUNOLOGICAL UNDERSTANDING IN THE DEVELOPMENT OF PSORIASIS

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Psoriasis is a common chronic, inflammatory skin disorder, typically characterized by erythematous papules and plaques with a silver scale, localized predominantly on the extensor sufraces of the extremities and lumbosacral region. In most cases, the changes affectscalp and nails. Estimates of the prevalence of psoriatic arthritis among patients with psoriasis have ranged from 10 to 20 percent. Severe forms of psoriasis are linked with a higher incidence of associated comorbidities such as diabetes, cardiovascular diseases and depression. Psoriatic plaque is characterized by an increased proliferation and rapid maturation of keratinocytes, and accumulation of inflammatory cells in the dermis. The cause of these changes lies in the genetic predisposition and external stimulating factors, of which the most are referred to trauma, stress, infections and certain medications. In the initial phase of an immune response, the dendritic cells have a central role in antigen recognition and activation of T lymphocytes. By a secretion of type 1 and type 17 cytokines and other pro-inflammatory mediators, activated T cells keep create and utilize psoriatic plaques. However, an important role in this process have other inflammatory cells, such as NK and NKT cells and macrophages, which by the secretion of cytokines and chemokines help substantial migration of cells into an area of inflammation and epidermal proliferation. In the last decade the continuous research and work on clearing up complex immunopathogenesis factors, have lead to the discovery of targeted biological drugs and their introduction in the treatment of psoriasis. This has greatly improved the treatment of emotionally burdensome and physically devastating disease.

## O – 40

### METABOLIC SYNDROME AND ITS COMPONENTS IN PATIENTS WITH PSORIASIS

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Introduction: Development of imunnology and molecular biology have led to new concepts of the pathogenesis of psoriasis and of the disease entity itself. Similarities in the inflammatory process, and the spectrum of associated diseases, as well as in the response to certain types of treatment, have enabled psoriasis to be classified as one of the „immune-mediated inflammatory diseases" (IMID). Metabolic syndrome is composed of obesity, hyperglycemia, hypertension and dyslipidemia. Previous reports have shown higher prevalence of metabolic syndrome in patients with psoriasis. It is believed that similar inflammatory changes lie in the pathophysiological background of psoriasis and metabolic syndrome. Objective: The main objective of this study was to assess the prevalence of metabolic syndrome and its components

in patients with psoriasis, as well as to investigate association of metabolic syndrome with disease severity of psoriasis. Methods: This case control study was conducted at the Department of Dermatology and Venereology Clinical Hospital Mostar. Study included 60 patients with psoriasis and the same number of control persons (patients with fibroma, seborrheic keratoses, moles, viral warts, stretch marks...). We measured antropometric parameters (body height, body mass, waist circumference, body mass index) and laboratory parameters (fastig glucose, triglicerides and HDL colesterol), and the metabolic syndrome was defined according to National Cholesterol Education Program–Adult Treatment Panel III criteria (NCEP–ATP III) and Psoriasis Area and Severity Indeks (PASI) score was determined to all patients with psoriasis. Results: This study showed a statistically significant presence of obesity (48.3%) and hyperglycemia (23.3%) in patients with psoriasis, while the prevalence of metabolic syndrome was 46.7%. There was no statistically significant difference in the prevalence of dyslipidemia and hypertension between groups. Conclusion: Finding of significantly frequent components of the metabolic syndrome, obesity and hyperglycemia in patients with psoriasis practitioners are encourage to screen psoriasis patients, especially when disease is severe, for metabolic disorders and cardiovascular risk factors and institute appropriate prevention strategies.

## O – 41

## PSORIASIS AND OBESITY

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Introduction: Psoriasis is a chronic skin ailment which can be connected with the onset of other diseases, including obesity. Aim:The purpose of the research is to confirm the frequency of obesity in those affected by psoriasis, just as the correlation between the severity of psoriasis and obesity. Examinees and methods:This prospective research has been conducted which gathered 70 examinees affected by psoriasis of an average age of 47,14 (SD =± 15,41), average duration of psoriasis on them was 15,52 (SD=±12,54), 51,43% were men and 48,57% were women. Average value of BMI in the examinees was 29,03 (SD=±4,94). Results:Frequency of the obesity was 47,14%, average age of obese was 55,42 (SD=±11,51), and average duration of the basis of the disease was 18,54 (SD=±12,69). PASI positively correlated with obseity (r=0,35, p=0,001). Conclusion:Psoriasis is a chronic skin ailment connected with the often appearance of obesity and weight is correlated with the incidence of obesity.

## O – 42

## SPECIFIC IN THE TREATMENT OF HYPERTENSION IN PATIENTS WITH PSORIASIS

*Zoran Vručinić*

## SEKCIJA ZA SPECIJALIZANTE – PRIKAZ SLUČAJA / SECTION FOR YOUNG RESIDENTS – A CASE REPORT

### O – 43

### EXTREME CUTANEOUS FORM OF NEUROFIBROMATOSIS TYPE 1

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Neurofibromatosis type 1 is one of the most common hereditary multi systemic diseases.This disease has different clinical manifestations such as hyperpigmentation skin lesions (café au lait spots, axilar and inguinal freckles), multiple benign tumors of nerve sheath (neurofibromas), and iris hamartomas (Lisch nodules).There can be changes in the CNS, bone, endocrine, digestive and cardiovascular system.Type 1 neurofibromatosis is inherited autosomal-dominant and it is associated with mutations in NF1 gene on chromosome 17 that produces a protein neurofibromin. Until today there are identefied more than 500 different mutations in the NF1 gene, and 50% of the cases result from a ("de novo") mutation.There was no difference in the severity of clinical symptoms between inherited and "de novo" mutations. We present a 78-years-old female patient with extreme cutaneous form of neurofibromatosis type l. No one in the immediate family has the same disease, from which we can conclude that in this case there is a "de novo" mutation.

### O – 44

### ACRAL LENTIGINOUS MELANOMA

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Acrallentiginous melanoma (ALM) is a clinical form of melanoma, which represents 1-3% of all melanomas. Changes occur on palms, soles, fingers and toes, as well as subungval region. Although initiallyALM may resemble tolentigomaligna, this form of melanoma early and quickly invades deep tissue and therefore has a worse prognosis. Late diagnosis contributes also the thickness of the corneal layer of the predilection places. In our department, during the last two years, we have diagnosed three cases of ALM. The first patient is a 56-year-old woman, who came to the examination due to wounds on the left foot. Clinical findings: on the left foot to the heel, from the outside, the palpable nodulus,about 3 cm in diameter were noticed, with hyperkeratotic surface, ulceration and eclipse crust. Histopathology: Melanoma. The histological type of cells: spindle cells; Mc Govern grade 3; Breslow: 3mm; Clark: III.Clinical and pathological type: acrallentiginous melanoma. Signs of regression: ++, lymphocytic infiltrate: + -. The presence of pigment: discreetly; ulceration + (up to 2mm). The lesion was entirely surgically removed, the free edge of the distant 9-15 mm from the tumor. The second patient was a 69-year-old male patient, with black and brown stained IV finger of the left hand. Clinical findings: on the

distal phalanx ofthe IV finger of the left hand, the brown pigmented change in the level of the skin was notices, with a missing nail plate. Histopathology: Melanoma, Clark III; Breslow: 2 mm; no surface erosion; with satelit; nevoid type cells; pigment grade II; lymphocytic infiltration grade I; no vascular invasion; edge resection free. The third patient was a 57-year-old female patient, with changes on the thumb of the left foot in the form of dark discoloration around the nail plate, for about 5 months before the first inspection. We have performed a biopsy, and then finger amputation. Histopathological findings: ALM, Breslow 3,7mm, Clark IV, mitosis with ulceration, without microsatelit. All patients performed dermoscopy in the first review, and after surgery and histopathological verification, clinical, radiological and laboratory processed are still under the supervision of an oncologist using the protocol for melanomas, and with supervision of a dermatologist as well.

## O – 45

### COEXISTENCE OF MALIGNANT MELANOMA AND BASAL CELL CARCINOMA IN A PATIENT WITH PREVIOUS TREATMENT OF MULTIPLE BASAL CELL CARCINOMAS: A CASE REPORT

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Basal cell carcinoma (BCC) is the most common skin cancer in humans. It usually occurs predominantly in body areas exposed to the sun and it is most common on the head and neck, followed by trunk, arms and legs. Patients who are diagnosed with BCC have a higher risk of developing another BCC and have a substantial increased risk for developing malignant melanoma (MM). We report a case of a 79-year-old male patient, deminer by trade, with a history of multiple basal cell carcinomas and gastric cancer that was presented to our Department for evaluation of a two newly developed but fast growing lesions. One lesion was located on the left frontotemporal region and the other on the tragus of the left auriculae. After detailed clinical and dermatoscopy examination we indicated excisional biopsy of two described changes. Histopatological examination of the lesions revealed malignant melanoma (MM) and basal cell carcinoma (BCC).

## O – 46

### ANGIOSARCOMA – A CASE REPORT

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Angiosarcoma is a rare malignant tumor of vascular origin. Mainly localized in the upper half of the face and skin of the scalp. Clinical appearance in the initial stage is varied. Method of treatment is radical surgical excision. Case report: A 60-years-old female patient came for a check up because of the lesion on the face. Six months before the inspection she noticed a

lump above her right eyebrow. She reported symptomes like itching and pain. The patient is otherwise healthy person and except this present disease she has no other diseases in medical history. Objective findings: Clinical examination of the face: in the right supraorbicular area there were erythematous papules, 6 mm in diameter, covered with a crust. On the follow up after the application of antibiotic ointments crust was removed, an erosion was present. Dermoscopy reveald pink field, with blood vessels on the periphery. The patient was referred for surgical treatment. Treatment and outcome of the disease: Plastic surgeon: extirpation of the tumor was performed. Patohistological findings: High grade sarcoma? In order to establish a definitive diagnosis requires a consultative examination of the histological preparation and IHC staining. Definitive HP finding from the Institute of Pathology, School of Medicine in Belgrade revealed: on the basis of morphological and immunohistochemical characteristics we believe that the tumor is most likely to be high-graded, primary malignant mesenchymal tumor type epithelioid angiosarcoma. The lesion is present on the line of resection. IORS Belgrade Consilium for soft tissue - sarcoma: reexcision of operative scarring. Plastic surgeon: widely excised scar. PH findings: Non-specific granulomatous inflammation. Laboratory analyzes were within the normal limits. Chest X-ray and abdominal ultrasound were clean. The patient must be clinically examined every 3 months to detect possible relapse. The patient must be under the supervision of oncologist. Comment: Sarcoma is an aggressive tumor with a poor prognosis due to the high potential for metastasis to the other organs. Treatment and prognosis of patients with sarcoma depend on: type and size, location and stage of the tumor.Good cooperation between dermatologists, plastic surgeons, pathologists and oncologists is particularly important for treatment of sarcoma. The biggest problem with diagnosis is that the symptoms seem harmless, which unfortunately leads to a delay in the detection and treatment.Sarcoma is difficult to diagnose clinically and with dermoscopy, definitive diagnosis is histological. The patient is presented here because of the rare clinical picture and an advanced stage of the disease.

## O – 48

## PROPRANOLOL TREATMENT FOR HEMANGIOMAS IN INFANTS

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Hemangioma is a vascular tumor, the most common benign tumor in infancy. It is well-known for its rapid growth during the first weeks to months of a child's life followed by a spontaneous and slow involution. They present more than 60% on the face, head and neck. Many studies have shown that 80% of final size is reached by 3 months of life. The early proliferative phase is followed by a period of slower growth until age 6–9 months, the late proliferative phase, and finally period of involution that takes place over years. Most hemangiomas do not require treatment because they regress spontaneously and do not leave significant sequel. Indications for intervention can be divided into three main groups: ulceration, disfigurement and impairment of function of vital structures. In 2008, propranolol, a non-selective β-adrenoceptor blocker,

was discovered for the treatment of hemangiomas. Although its specific mechanism of action on hemangiomas remains mostly unknown, it induce vasoconstriction and apoptosis and decrease expression of pro-angiogenic factors. Children are monitored in hospital for 2 days at the start of the treatment to detect possible side effects of this drug. The dosage of propranolol that should be given is 1 mg/kg/day on the first day and 2 mg/kg/day from the second day. Treatment is usually stopped at 12–14 months of age but can be given longer. Gradual dose reduction should be given over 2–4 weeks. The patients are monitoring 4–6 weeks after starting treatment, then 3–4 monthly. We present 2 month old female baby (weight 4320 g.) who was born prematurely at 32 weeks, born from twin pregnancy. She has hemangioma located on her nose, 2.5 cm x 1.5cm in size. She has also one located on the right side of the abdomen. Before initiating therapy with propranolol, several exams were done (ultrasound of the brain, ECHO). Oral propranolol therapy was given in dose of 1 mg/kg/day for 3 days, then 2 mg/kg/day continuously. She was tolerating therapy very well, so we continue treatment. A excellent clinical response was noticed one month after the beginning of the treatment. We still follow her up because she is still on the therapy. Propranolol is highly effective as a treatment for hemangiomas, it is well-tolerated, having mild adverse effects and it should be used as a first line of therapy for hemangiomas when intervention is required.

## O – 49

## CLINICAL MANIFESTATIONS OF SCABIES AFTER VISITING A TROPICAL COUNTRY: A CASE REPORT

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Scabies is an infestation of the skin by the mite Sarcoptes scabiei var. hominis that results in an intensely pruritic eruption with a characteristic distribution pattern. The estimated prevalence ranges from 0,2 to 71 percent, with as many as 100 million people affected worldwide. Transmission of scabies is usually from person to person by direct contact, by wearing or handling heavily contaminated clothing, or by sleeping in an unchanged bed recently occupied by an infested individual. The essential lesion is a small, erythematous, nondescript papule, often excoriated and tipped with hemorrhagic crusts. The diagnosis of scabies is generally made from the history and the distribution of lesions, as well as the skin scraping, dermoscopy, and the adhesive tape test. Topical permethrin 5% cream and oral ivermectin are the first-line therapies. We report a case of a 56-year-old male patient presented with a one week history of an extensive pruritic rush on the trunk and limbs accompanied with a purpuric dermatitis. Skin changes have started to occure two days after arriving in India on a bussines trip and have worsened in the following days. Microscopic examination of material scraped from few nodules demonstrated numerous living mites and eggs leading to the diagnosis of scabies. Histological examination of a nodular purpuric lesion revealed hyperkeratosis, focal parakeratosis, acantosis, spongiosis and a dense infiltrate of lymphocytes, histiocytes and eosinophils

through the epidermis and dermis. Infiltrating cells were arranged around small dermal vessels that showed signs of a lymphocytic vasculitis. Scabies - associated leucocytoclastic vasculitis was diagnosed. The patient refused any further diagnostic approach including a laboratory examination. Treatment consisted of two applications of topical 5% permethrin cream followed by a topical steroid therapy which resulted in a complete recovery.

## O – 50

## DERMATITIS ATOPICA IN COMMON VARIABLE IMMUNODEFICIENCY (CVID)

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Common variable imunodeficiency (CVID) is the most common clinical manifested primary imunodeficincy with incidence 1:10000-1: 50000. Disorder is usually manifested in second or third decade of life. Clinal manifestions of CVID are reccurent infections of respiratory and gastroenterology system, autoimmune, inflamatory and lymphoprolifatory disorders. Ethiopathogenacly, it is differentation disorder of lymphocyte B to plasma cells, which results decreased production of antibodies. Diagnostic criteries are: 1. Low level of two classes of serum imunoglobulins (IgG, IgA, IgM least 2 sd under the age); low/absent titer isohemaglutenin and/or no reaction on vaccination; 3. Symptoms show after the age of two; 4. Excluding other cause of hypogammaglobulinemia. Our patient is 14-year old boy who was diagnozed celiac disease when he was 5. Gluten free diet was not strictly regulated. He has had atopic dermatitis since he was infant. Since last two years he has had common respiratory infections, and diarrhea in last two months. When he was incharged, he was malnourished, body weight 27 kilos (<5.centile), body height 136.4 centimetars (<5.centile), ashen dry skin which sporadic desquameted, crackles on his lungs, splenomegaly.It is low level of all three classes of immunoglobulin (IgG, IgM, IgA), decreased titer isohemaglutinin. He has sever sideropenic anemia (E 3.94x1012/L, Hb 65g/L, Htc 0.258L/L, MCH 16.5pg, MCV 65.5fL, MCHC 252.0g/L, Fe 1.4µmol/L, UIBC 68.4µmol/L, feritin 2.9ng/mL). Small intestine biopsy has showed celiac disease, colon biopsy has showed inflamatory bowel disease. He was treated prednison 1mg/kg, sulphasalasin 15mg/kilos, human immunoglobulin 0,8mg/kilos. Skin has been treated with corticosteroid ointment. One month later patient is in better condition,with good appetite, getting on weight, without clinical manifestations of gastroenterology disorders, with better skin condition. He gets human immunoglobulin thearapy every 4 weeks. Aim of our case is giving attention to connection of atopic dermatitis and primary imunodeficiency. CVID is not common in pediatric population but also it is often unrecognized in adults. There is no a lot experiance with CVID and it is important to give attention in different medical proffesions to improve treatment and patiens health.

## O – 51

## COEXISTENCE OF PSORIASIS, VITILIGO AND BULLOUS PEMPHIGOID IN ELDERLY PATIENTS

*Mateja Jelača [1], Edita Simonić[1], Marija Kaštelan[1], [1]Clinical Hospital Centre Rijeka, Rijeka, Croatia*

We report a case of an older patient suffering from psoriasis, vitiligo and bullous pemphigoid. The occurrence of multiple chronic autoimmune diseases and their treatment, especially in elderly patients, requires interdisciplinary access to the treatment, frequent monitoring and encouragement of patients to actively participate in the treatment.Due to the use of systemic corticosteroid and immunosuppressive therapy in the treatment of bullous pemphigoid, and the possibility of developing a number of side effects, condition of our patient requires close monitoring and hospitalization in the case of worsening. Elderly individuals suffering from several chronic autoimmune diseases, require a thorough evaluation of comorbidities prior to starting the treatment. It is crucial to determine all the medication that is taken, with the assessment of psychological status and the circumstances in which the patient lives. The treatment of patients with multiple autoimmune diseases requires an individual approach and treatment of those diseases that threaten the acute physical and mental health.

## O – 52

## COEXISTENCE OF PSORIASIS, PSORIATIC ARTHRITIS AND CROHN'S DISEASE SUCCESSFULLY TREATED WITH ADALIMUMAB

*Ana Ivekić Jambrošić[1], Sandra Peternel[2], Srđan Novak[3], Irena Krznarić-Zrnić[3], Ines Brajac[2], Marija Kaštelan[2], Larisa Prpić Massari[2]: Koegzistencija psorijaze, psorijatičnog artritisa i Crohnove bolesti uspješno liječena adalimumabom, [1]Sanatorium Veli Lošinj, Veli Lošinj,[2]Clinical Hospital Centre Rijeka, Department of Dermatovenereology, Rijeka,[3]Clinical Hospital Centre Rijeka, Clinic of Internal Medicine, Department of Rheumatology and Clinical Immunology, Rijeka, Croatia*

Psoriasis is a common chronic, inflammatory disease affecting skin, scalp, nails and joints. Estimates of the prevalence of psoriatic arthritis among patients with psoriasis have ranged from 10 to 20 percent. We report a case of a 40-year old male patient with a history of psoriasis since he was 11 years old, and a psoriatic arthritis since he was 18. At the beginning, the disease was treated topically, but since it has been worsened over the years, various forms of systemic therapy, such as phototherapy and photochemotherapy and then retinoids and methotrexate were performed. Since no therapy has achived a long-term satisfying remission, in 2008 the treatment with infliximab in combination with 7,5 mg of methotrexate was initiated and the remission of both diseases during a period of 5 years was accomplished. However, in summer 2013, he was admitted to the Department of Dermatology, Clinical Hospital Centre Rijeka, due to generalized staphylodermia, which wasdue to diagnostic procedures and expertiseconnected to the immunosuppression, and the next dose of infliximab was delayed. An infection

was cured with antibiotics.During this period a worsening of psoriasis and psoriatic arthritis have occured, which persisted for three weeks despite the increasement of methotrexate and infliximab dosage.In the following week the patient became febrile,with a convulsive pain in the abdomen anddiarrhea. Bacteriological and mycological stool examination showed negative results, as well as the x-rays and ultrasound examination. Computed tomography of the abdomen and pelvis, as well as the colonoscopy with biopsy and histopathological analysis, confirmed the diagnosis of Crohn's disease. After the diagnosis of Crohn's disease was confirmed, our patient was transferred to the Department of Gastroenterology, where the therapy with aminosalicylates and antibiotics was initiated, which leaded to the normalization of the stool, the patient became afebrile witha normal physical examination of the abdomen.Psoriasis, psoriatic arthritis and Crohn's disease are immune-mediated inflammatory diseases, associated with increased expression of proinflammatory cytokines, particularly TNF - alpha. Since our patient was confronted with three diseases, there has been a question regarding a further treatment options. A multidisciplinary approach of the dermatologists, rheumatologists and gastroenterologists resultet with an initiation of treatment with adalimumab. There has been a very good response to adalimumab therapy. After 4 years of therapy with adalimumab associated with 10 mg methotrexate, the patient is still in remission, without any psoriatic skin lesions and without symptoms of psoriatic arthritis and Crohn's disease.

## O – 53

## COEXISTENCE OF VULGAR PSORIASIS, BULLOUS PEMPHIGOID AND LIPOID NECROBIOSIS – A CASE REPORT

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53-year-old woman washospitalized for additional treatment and psoriatic skin changes accompanied by itching and erythematous - brown infiltration on the lower extremities. From 1996 to 2016, clinical, histopathological and laboratory analysis indicated several different diagnoses, with high values of IgE and eosinophilic infiltrates in the histological findings. The patient was previously treated with cyclosporine, methotrexate and azathioprine, which were set a side, due to the pronounced side effects and further therapy. Also there were several PUVA therapycycles, but without significant effect. A significant, but short-term clinical improvement occurred after applying medium dose of methylprednisolone. In clinical examination, the skin was dry, like eczema, scaly focus, mainly on the trunk and upper limbs and clearly limited red-brown plaques with a few minor erosion on the lower limbs. On the both hands and lower legs, numerous of prurigo papules and nodules were observed. On the palms and soles the mild erythema and flaking along with a few sores were present. Nails on the feet werehyperkeratotic.During the hospitalization, an appropriate processing off parasitological infections and paraneoplastic syndrome was conducted. In laboratory findings the elevatedtiter of BP180 IgG 148 RU / ml, BP230 IgG> 200 RU / ml, ANA 1: 640 with IgE 7561 kIU/L were observed, while other findings were within normal values. Histopathological analysis of indurate plaques confirmed

the diagnosis of lipoid necrobiosis, and other multiple biopsy indicated a probable diagnosis of psoriasis vulgaris with a simultaneous remarkable finding intraepidermal eosinophils, which is however indicative of prebulosus phase of bullosus pemphigoid. Direct and indirect immunofluorescence showed IgG deposits along the basement membrane and to a lesser extent, the keratinocytes, and the "salt – split skin" sample were found deposits of IgG on the epidermal side. Negative immunofluorescence findings on urothela and ELISA tests on envoplakin, excluded the diagnosis of paraneoplastic pemphigus. In addition to topical corticosteroid therapy during the summer months performances expressed clinical improvement, hence the introduction of systemic therapy plans with performance deterioration of the disease.

## O – 54

## SARCOIDOSIS OF THE SKIN – A CASE REPORT

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Aim: Sarcoidosis of the skin may have an extremely heterogeneous clinical presentation, so that the definitions of 'great imitator' and 'clinical chameleon' have long been used. The purpose of this report is to present a case of skin sarcoidosis on the face,previously treated as initial changes of other inflammatory dermatoses. Diagnosis is based on histological findings and clinical symptoms. Material and methods: We report a case, of a 43-year-old patient, with changes on the facial skin, initially manifested as papules and papulopustules, localized on periorbital skin and beard, and later in the form of papular and subcutaneous nodules, localized on the skin and the dorsum of the nose, as well as the frontal region. Patient was treated with systemic antibiotics, corticosteroids, and as local therapy highly potent dermosteroids, antifungal, antibiotic preparations, with a discreet improvement, and was followed by the emergence of persistent papules and nodules as livid erythema, diameter of several mm to 1 cm on the face, resistant to topical preparations, as well as the presence of persistent palpebral edema. The report about pathohistological findings- in the connective tissue of the dermis the epithelioid granuloma cell, lymphocytic infiltrate and a few giant cells, Langerhans type, were noticed. There were no signs of necrosis. Conclusion – due to the findings of correspond chronic granulomatous inflammation, the diagnosis of sarcoidosis came at the first place. After histopathological verification, the oral Pronison in dose of 40 mg was inducted in the therapy. Results: After histopathological findings pointing to the skin sarcoidosis, systemic therapy included oral prednisone. After two weeks, the slight regression of the skin changes was noticed, and after a month, there was complete regression of the face skin changes, after which the dose of prednisone was reduced. Conclusion: Cutaneous lesions appear to be the first manifestation and, therefore, may guide to an appropriate diagnosis. The role of the dermatologist is large in an identification and timely diagnosis.

# POSTERI / POSTER PRESENTATION

## P – 1
## CASE REPORT OF GENITAL WARTS TREATED BY ALDARA

*Bojana Jovanović*[1], *[1]Health Institution Niš, Niš, Serbia*

We report a case of a 52-year-old male patient, a civil engineer and an outdoor worker. The first noticed changeappeared a year prior to the clinical examination, in the form of hard bumps on the head of the penis. Shortly thereafter, within one month, the new warts appeared.After trauma, the wart on the right groinwas growingrapidly. The personal and familiarhistory was negative. He had sex only with his wife. At the first examination, there were numerous of pointy wartson the sulcus coronarius and on the right groin one giant wart was noticed. The therapy was started with Aldara cream three times weekly, and the control examination was-scheduled in 10 days. He came to the control examination with general signs and symptoms, that resembled flu and with local erythema reaction. The following photos of the patient were made in that period. At the fourth control, 14 days after the first examination,there wasen't any general symptoms presented, and the warts have beenwithdrawned. The livid scar was presented on the right groin. That was the last control examination. The patient was satisfied with outcome. The total amount of his treatment time was 40 days.

## P – 2
## CUTANEOUS SIDE-EFFECTS ASSOCIATED WITH THE BRAF INHIBITOR VEMURAFENIB

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Introduction:In 2012, the first specific BRAF mutation inhibitor, vemurafenib, was licensed for the monotherapy of adults with BRAF V600 mutation-positive unresectable or metastatic melanoma. It have significant impact on progression-free and overall survival in advanced melanoma, so cutaneous side effects are frequent. Like other targeted therapies, vemurafenib is associated with a predictable pattern of adverse events, including skin toxicities. Patients and methods: Case reports based on 2 patients. A 47-year-old Caucasian man with metastatic melanoma presented with a pigmented nodular lesion above the left eyebrow. He underwent a treatment with vemurafenib within local ethic committees approved clinical trials. Research and clinical observations have revealed that melanomas and nevi that harbor the BRAF V600E mutation involute when the patient is given vemurafenib. All skin reactions were collected and documented prospectively. Second patient was also treated with vemurafenib and during the therapy , we found second primary melanoma in situ on the right scapular region. Results: Vemurafenib was well tolerated, but it had some side effects, with the dose of 960 mg. Of cutaneous side effects they experienced photosensitivity, maculopapular exanthema pruritus, folliculitis, hair thinning (mild alopecia) and nail changes. Keratosis pilaris and acanthopapillo-

ma were common skin reactions, as well as plantar hyperkeratosis. Also they reported us that they had tachycardia and their general health was not good time to time. Conclusions: Those cutaneous side-effects are cause of concern due to their intrinsic potential for malignancy or because of their impact on patients' quality of life. Management of those skin toxicity relies on symptomatic measures and sun photo protection. Regular skin examination and management by experienced dermatologists as well as continuous prophylactic photo protection including an UVA optimized sun screen is mandatory. Despite these side effects, vemurafenib is a new hope and a chance for patients to cure or prolong their life.

## P – 3

## EXANTHEMA FIXUM CAUSED BY IBUPROFEN

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Introduction: Fixed exanthema is asymmetric allergic exanthema, which can be caused by drugs from different groups, among which the most common are antibiotics (tetracyclines and sulphonamides) and salicils. Pathogenesis of the disease is unknown. Skin changes appear as a result of disorders in the levels of cellular immune response, and do not exclude the cytotoxic mechanisms. At an early, inflammatory, stage of the disease, damaged keratinocytes lose theirphagocytic ability for melanosoma, so pigment goes into the dermis, and after the withdrawal of acute symptoms pigment persists chronically, an asymptomatic phase of the disease. Relaps of the skin changes, on the same place, after repeated use of the same drug may be explained by the binding of antibodies to the previously affected surface. We report a case of a 52-year-old patient with a single, erythematous, macular change on the palms and dorsal side of the ring finger of the left foot. The appearance of skin lesions was accompanied by subjective feeling of itching and burning. Seven to ten days before the appearance of skin lesions, the patient took oral ibuprofen therapy. Afterwards we have received an information, that during the last three years on several occasions, he had the same skin changes localized on the same place, and he is occasionally taking ibuprofen. An antihistamine therapy, low doses of corticosteroids and topical corticosteroid tjerapy for several days were performed, after which the incidence of symptoms subsided, withe the residual hyperpigmented maculous changes. Two months after allergy treatment was performed the patch test "in loco morbi" established the existence of hypersensitivity to ibuprofen coated. Conclusion: allergy treatment is determined by the cause of the fixed exanthema (ibuprofen) and the prohibition of the usement of ibuprofen resulted in no longer appearance of skin lesions. The patient is presented as ibuprofen rarely causes adverse reactions to the skin in a type of fixed exanthema. Key words: exanthema fixum, ibuprofen.

## P – 4

## EXTENDING CLINICAL TOOTH CROWN WITH LASER – CASE REPORT

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Extending the clinical crown of the tooth is a therapeutic procedure in the domain of mucogingival surgery. For gingival corrections are used surgical techniques gingivectomy and gingivoplasty. Gingivectomy is used to remove excessive gingiva, then gingivoplastyis used to shape and recontour the edges. In cases of asymmetry regarding the length of the teeth in the frontal area, this technique improves the aesthetics of a smile. Knowledge of anatomy and relationships between hard and soft tissues, as well as the concepts of biological width of the dental and gingival complex is necessary to achieve the desired aesthetic effect and the maintenance of periodontal health. Laser surgery in the orofacial region is becoming more prevalent. Diode lasers have an affinity for hemoglobin and water - chromophores in the gums, are effective for vascular lesions resulting in excellent coagulation and hemostasis. Laser ensures sterility in the operating area, reduces post-operative pain, accelerate healing and epithelialization of the tissue. The aim of this study was to present that the process of extending the clinical crown with laser has an excellent therapeutic effect with minimal invasiveness. Material and Methods: This case report presents a case of 37-year-old female patient who was unhappy with her smile because of uneven color and unequal lengths of the upper front teeth. The central incisors were asymmetrical lengths. The patient was submitted to prosthetic therapy with prior surgical procedure with laser to extend the clinical crown of the left central incisor. The patient was advised to do a prosthetic therapy with prior surgical procedure with laser to extend the clinical crown of the left central incisor. After creating and cementing temporary crowns with paradontological soda, the distance between the edge of the alveolar bone and gingival margin was determined. In compliance with the protocol for handling diode laser (Picasso Lite, AMD lasers, Indianapolis, USA) gingivectomy and gingivoplasty were performed, acting in continuous mode power of 2 W. With good hemostasis there was no post-operative pain, or other subjective or objective symptoms. Results: The successful outcome of surgical treatment with the use of lasers is evident on the follow up after 2 and 3 weeks from the procedure. Conclusion: Based on the displayed case it is evident that the application of this technique used in the extension of the clinical crown of the tooth shows significant benefits such as good hemostasis and optimum precision with an excellent aesthetic effect.

## P – 5

## RAPID ONSET OF EFFICACY IN PATIENTS WITH PSORIASIS TREATED WITH IXEKIZUMAB: A POOLED ANALYSIS OF DATA FROM TWO PHASE 3 RANDOMIZED CLINICAL TRIALS (UNCOVER–2 AND UNCOVER–3)

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Background & Aims: For patients with psoriasis, rapid onset of clinical improvement is an important attribute of treatment success[1]. It has been demonstrated that clinical improvement observed early during treatment has predictive value for subsequent clinical response at later time points[2]. In this analysis, we evaluated the speed of onset of clinical improvement in psoriasis patients treated with ixekizumab (anti–IL–17A IgG4 monoclonal antibody with high binding affinity; IXE) compared with placebo and the active comparator, etanercept (ETN).
Methods: Combining data from the 12–week (wk) Induction Phase of UNCOVER–2 and UNCOVER–3, 2,570 patients with moderate–to–severe plaque psoriasis were randomized to receive placebo (PBO, n=361), high–dose ETN (50 mg bi–weekly; n=740), or a single 80–mg subcutaneous injection of IXE once every 2 wks (IXE Q2W; n=736) or every 4 wks (IXE Q4W; n=733) after receiving a 160–mg initial dose at Wk 0. Mean percentage improvement was analyzed by MMRM and response rates by Cochran–Mantel–Haenszel test, where missing data were imputed using nonresponse. Time to PASI 75 was estimated using the Kaplan–Meier product limit methodology.
Results: Significant differences in mean % change from baseline (improvement) in the PASI were observed between the IXE treatment groups compared with PBO and ETN as early as Wk 1 ($p<0.001$) with mean (SE) % improvements of 32.7 (0.76) in IXE Q2W, 33.6 (0.76) in IXE Q4W, 5.31 (1.08) in PBO, and 10.3 (0.76) in ETN. At Wk 2, the mean % improvement was 53.7 (0.86) in IXE Q2W, 53.3 (0.86) in IXE Q4W, 9.25 (1.23) in PBO, and 23.3 (0.86) in ETN. At Wk 1, the PASI 50 response rate was 22.8% in the IXE Q2W and 26.6% in IXE Q4W compared with 1.4% in PBO ($p<0.001$) and 3.9% in ETN ($p<0.001$), and at Wk 2, the PASI 50 response rate was 58.8% in the IXE Q2W and 57.6% in IXE Q4W compared to 4.2% in PBO ($p<0.001$), and 14.6% in ETN ($p<0.001$). Median time (95% CI) to PASI 75 was 30 (29,43) days in the IXE Q2W group, 31 (30,55) days in the IXE Q4W group, and 85 (85,87) days with ETN.
Conclusions: IXE treatment resulted in clinically meaningful improvements (PASI 50) observed from Wk 1, which were statistically significant compared with ETN and PBO. At least 50% of patients had PASI 75 after about 4 wks of IXE treatment.
1. Seston et al. Arch Dermatol. 2007;143:1175–9
2. Zhu et al. BJD 2013;169:1337–41

## P – 6

### SIDE EFFECTS OF COSMETIC AND HYGIENE PRODUCTS

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Cosmetic and hygiene products are widely used. Although the companies producing new products required to monitor the quality and safety of the products before being placed on the market, these funds can still cause adverse effects on the skin. It can cause many different reactions such as: allergic contact dermatitis, irritant dermatitis, contact urticaria, hyperpigmentation, hypopigmentation, acne, pigmented cosmetic dermatitis, sensitive skin, adverse reaction to nail cosmetics, photocontact dermatitis, etc. Cosmetic products have complex structure and very different substances can cause adverse reactions. In order of treatment and prevention it is necessary to search for the cause and to observe each patient with a special care and access. The cooperation between the patient and dermatologist ,and a dermatologist with manufacturers of these product is very important and necessary.

## P – 7

### TREATING BALDNESS AND ETERNAL LONGING FOR HAIR

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Throughout the history of mankind hair was a symbol of manliness for men and beauty for women. Androgen alopesis was never considered as a symbol of machoism despite the significant role that testosterone has in its development. Remedies for hair loss and for stimulating hair growth are some of the first cosmetic treatments to appear in human history and have remained equally popular today. Wigs and hairpieces are mostly created out of vain attempts to cover one's bald scalp. Women regularly used some form of headscarf to cover their heads. This practice may have caused some frustration in young age, but in the older age it proved to be very useful for women who suffered from physiological hair loss during menopause. In modern times hair loss remedies are in significant commercial products in all cultures. Their consumers do not ask questions about the ingredients, side-effects or price. They do not doubt the product's efficiency, because they want to believe it works. Old recipes and advices are gaining popularity among people, and are being used again without any critical consideration or rational thinking, by strongly believing that they "might help". This work introduces traditional advices from old Croatian and Bosnian manuscripts of folk recipes, herbalist books and various publications for the masses.

## P – 8

## 5% IMIQUIMOD IN THERAPY OF HYPERTROPHIC AND HYPERKERATOTIC ACTINIC KERATOSIS

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Abstract: Actinic keratoses (AKs) are common, pre-malignat, intraepidermal tumours, which result from the proliferation of transformed neoplastic keratinocytes. They are typically induced by chronic exposure to ultraviolet radiation, and can often develop into squamous cell carcinoma (SCC). Usually affect large areas of skin and patients typically present with multiple clinically visible lesions. Number of 23 patients were treated with the immune response modifier, imiquimod, as a 5% cream, 3 times per week, for up to 8 weeks. Topical application of imiquimod for 8 weeks resulted in complete clearance. No new or recurrent lesions were observed during a 6–8 month follow-up period. They have experienced mild to moderate side-effects, consisting of erythema, itching,bleading and burning. We report a case of a 73-year-old female patient, with dermoscopy confirmed diagnosis of multiple hypertrophic,hyperceratotic actinic keratosis of the face. Lesions were treated with 5% imiquimod per scheme 3x a week for a total period of 8 weeks, with breaks due to the appearance of complications (redness, swelling, bleeding and pain). After conducted therapythe complete regression of the skin changes occured, with a dermoscopy verification.Imiquimod is the first of a new class of immune response modifiers (IRMs). Unlike the majority of other currently available IRMs, which act to inhibit immune responses, imiquimod stimulates the immune system. Imiquimod induces cytokine production in the skin, which was considered to trigger the patient's immune system to recognise that a tumour is present. The patient's immune response is then able to go on to clear the lesion. Among drugs, imiquimod is unique in being a topically active cytokine inducer and stimulant for the innate and cell-mediated adaptive immune responses. Imiquimod is a reasonable treatment option in patients with multiple AKs. Health Canada has approved the treatment course at twice weekly for 16 weeks. Other treatment regimens can also be considered after the above treatment schedule. We conclude that the individual approach is necessary because the response to imiquimod and its tolerability by the patient is very variable. The appearance of the skin after treatment is very acceptable and unlike other treatments do not leave the hyper and hypopigmentation or scars on facial skin.

## P – 9

## DERMATOFIBROSARCOMA PROTUBERANS

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Dermatofibrosarcoma protuberans (DFSP) is a low-grade soft tissue sarcoma that originates from the dermis layer and invades deeper tissues. It usually presents in early or middle adult life between ages 20 and 59 with a slight male predominance and no racial predilection. The annual incidence of DFSP in Europe has been estimated to be 3-4 cases per million population. DFSP is a slow progressing tumor that starts as small asymptomatic papule gradually evolving into a large, indurated plaque several centimeters in diameter with irregular reddish brown or skin colored nodules. The trunk is the most common site of involvement.These tumors are locally aggressive with a high rate of recurrence following surgery, but with an excellent prognoses when effectively treated. Complete surgical resection is the prefered treatment method with optional adjuvant radiotherapy. Imatinib chemotherapy may be beneficial in cases with inoperable, recurrent, or metastatic disease. We present a case of a 57 year old male who reported a tumorous growth on his abdomen that was slowly enlarging for 20 years with a slight burning sensation present in the past few weeks. His medical records and family history were unnotable.He was inspected by his family medicine specialist and was referred to our department with a diagnosis of Fibroma molle for electrosurgery. Upon the examination we described a brownish tumorous lesion roughly 3 cm in diameter with several skin colored nodules of varying size. We opted to forgo the suggested electrosurgery and performed a skin biopsy instead.Histologic findings showed regular epidermis. In dermis there was a tumorous cluster of mainly spindle cells with elongated hyperchromatic cores and moderately pronounced pleomorphism. The serial cuts showed 0-4 mitosis on 10 HPF. Tumor cells were CD34 positive. The diagnosis was dermatofibrosarcoma protuberans.The tumor was surgically treated with a wide local excision. The following pathology processing showing clear borders. Follow up examination was conducted after 6 month showing no recurrence with further semi-annual examinations planned. We are presenting our case in order to remind of this rare tumor as a diagnostic consideration when dealing with uncommon looking acrochordons, always remembering the old surgeon's law of "when in doubt, cut it out."

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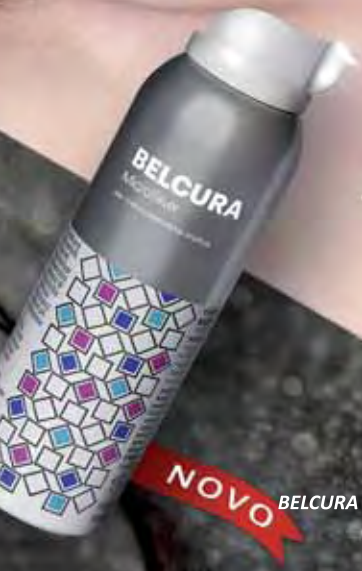


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