BIODERMA CONGRESS REPORTS

RADLA 2025

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THE SMALL MOLECULE REVOLUTION

WHAT ARE SMALL MOLECULES?

Speaker: Dr Valenzuela Fernando (Chile)

They are low-weight compounds usually containing between 20 and 100 atoms, and are chemically synthesised, which makes them stable and easier to manufacture. This would enable easy, typically oral administration. These are drugs that we have been dealing with for a long time in some cases. Aspirin is an example of a small molecule and insulin of a large molecule. JAK inhibitors (JAKi) are small molecules, of less than 500 kD which undergo intestinal absorption and skin permeation, and are minimally lipophilic. As final drugs, they do not depend on metabolisation for their pharmacological effect; they are rapidly absorbed and have an early clinical effect. Their plasma peaks and elimination half-lives are brief. They have immunomodulatory, anti-proliferative and anti-inflammatory effects, providing a steroid-sparing approach. The less selective ones are tofacitinib and peficitinib and the selective ones, upadacitinib (JAK1i), abrocitinib (JAK1i) and deucravacitinib (TYK2). Side effects: HSV and HZV-associated infections, nasopharyngitis, upper respiratory tract and urinary tract infections, acne and gastrointestinal symptoms. Initial screening is essential, with subsequent follow-up visits at 1 and 3 months and then every 3–6 months.

SMALL MOLECULES IN PSORIASIS

Speaker: Dr Cristina Echeverria (Argentina)

(Oral) apremilast is a phosphodiesterase-4 (PDE-4) inhibitor. It is approved for adults and was recently approved for children over 6 years of age and weighing over 20 kg. It is effective in psoriatic arthritis, with nail, scalp, palmoplantar and genital involvement. Adverse effects include: diarrhoea, nausea, headache and weight loss; and to a lesser extent: fatigue, depression, abdominal pain, vomiting and upper respiratory infections. It has advantages over other systemic treatments in arterial hypertension, dyslipidaemia, metabolic syndrome, liver disease, chronic infections (HIV, HBV, HCV, TB and a history of cancer of less than 5 years). It also has advantages over biological treatments in patients with congestive HF, demyelinating diseases, chronic infections and a history of cancer of less than 5 years. (Oral) roflumilast was approved by the FDA and EMA for COPD and is used off-label in dermatology (also in topical form). Adverse effects include diarrhoea, weight loss, nausea, headache and insomnia. Deucravacitinib is an allosteric TYK2 inhibitor with an excellent safety profile and is the first in its class approved for the oral treatment of adults with moderate-to-severe psoriasis. The next generation of small molecules (DC-806, icotrokinra, SAR441566) promise to further expand the therapeutic arsenal, taking personalised medicine to another level.

SMALL MOLECULES IN ATOPIC DERMATITIS (AD)

Speaker: Dr Angela Londono (Colombia)

She spoke about baricitinib, abrocitinib and upadacitinib, all of which are very effective with a significant decrease in pruritus in the first 2 weeks. Adverse effects with an acceptable safety profile include nasopharyngitis, headache, upper respiratory tract infections and, to a lesser extent, HZV/HSV, acne/folliculitis, and lipid and haematological disorders. Its EASI90 results are superior to those of dupilumab.

SMALL MOLECULES IN OTHER DERMATOSES

Speaker: Dr Valeria Aoki (Brazil)

In blistering diseases such as pemphigus herpetiformis, bullous pemphigoid and pemphigus vulgaris: tofacitinib, baricitinib, upadacitinib and abrocitinib. Other dermatoses: Vitiligo, alopecia areata and chronic urticaria.

TRICHOLOGY: FROM DIAGNOSIS TO TREATMENT

MALE PATTERN ALOPECIA (AGA)

Speaker: Dr Marianne Gosch Caroca (Chile)

After some generalisations, she talked about the pathophysiology of the condition, mentioning the microinflammatory factor due to the dysregulation of cytokine expression in particular. As associated factors, she mentioned microbial flora, oxidative stress, ageing, smoking, UV radiation and pollutants. She also highlighted the need to rule out metabolic syndrome, especially in treatment-refractory patients. In terms of routine lab tests, she suggested adding PSA testing in men over 45 years of age. Perifollicular brownish pigmentation and yellow dots are found on dermoscopy. In terms of treatment, minoxidil and finasteride are approved, with dutasteride being used off-label. The latter has proven to be more effective in use 3 times/week than finasteride daily. Hair transplantation should be evaluated, although not everyone is a candidate and never in individuals under 25 years of age.

FEMALE PATTERN ALOPECIA (FAGA)

Speaker: Dr Gisela D'Atri (Argentina)

She pointed out the importance of early diagnosis assisted by trichoscopy (anisotrichosis greater than 20%, 10% increase of vellus hairs in frontal area, hairs finer than in the occipital area, parietal hair less dense and, as an early sign, increase of FU of a single hair). She suggested screening for metabolic syndrome in both pre- and post-menopausal women. Part of the treatment involves recommending weight loss and watching for signs of hyperandrogenism. Among associated pathologies: PCOS 90%, hyperprolactinaemia 2–3%, congenital adrenal hyperplasia 1–2% and ovarian/adrenal tumours less than 1%. The use of testosterone pellets should be questioned since

it can raise testosterone levels to supra-physiological values. Most patients do not require hormonal studies so only ask for lab tests if there are signs of hyperandrogenism, severe alopecia, sudden onset/rapid progression or male pattern/virilisation.

LYMPHOCYTIC CICATRICIAL ALOPECIAS

Speaker: Dr Jorge Larrondo (Chile)

General characteristics include perifollicular erythema and mild follicular fusion and hyperkeratosis, affecting the stem cells and causing fibrosis. These include follicular lichen planus, discoid lupus erythematosus and centrifugal cicatricial alopecia. Regarding treatment, in the anti-inflammatory phase, high potency corticosteroids, intralesional steroids (risk of atrophy), antibiotics, immunosuppressants and retinoids are used. In the regrowth phase: Topical or oral low-dose minoxidil, 5 alpha-reductase inhibitors, PRP, LLLT (low level laser therapy) or surgical restoration. Tofacitinib in lichen planus pilaris and/or frontal fibrosing alopecia, starting with 5 mg twice daily and then 10 mg twice daily.

NEUTROPHILIC CICATRICIAL ALOPECIAS

Speaker: Dr Jeyce Reynoso (Dominican Republic)

Its aetiology has been described to include immunosuppression, the role of *Staphylococcus aureus* (even in the presence of negative cultures), DM and nephropathy. Trichological findings include follicular hyperkeratosis, perifollicular erythema, tufted hairs (not pathognomonic), diversity of diameters, white cicatricial patches and yellow dots. Dissecting cellulitis may be reversible in its early stages. Among associated condition are: acne conglobata, pilonidal cyst, HS, seronegative arthritis, KID syndrome, musculoskeletal disorders and pyoderma vegetans. Trichoscopy shows black dots or cadaver hairs, vellus hairs, broken hairs, white dots and exclamation mark hairs (sign of severity). Regarding treatment, there is no cure, there are no clear guidelines and relapses are frequent.

SELF-INDUCED ALOPECIAS

Speaker: Dr Hugo Martinez (Mexico)

He included trichotillomania, alopecia artefacta and traction alopecia in this group. Impulsive and compulsive disorders were described. In trichotillomania, psychotropic treatments only mask the response temporarily, and can even worsen the cases, so he suggested the use of 600–1200 mg/day of N-acetyl cysteine, for an average of 3 months, in addition to topical or oral minoxidil. Psychological support is essential. Traction alopecia is becoming increasingly common, with marginal, bitemporal, banded and geometric forms being described.

SECRET THERAPEUTIC TIPS FROM THE MAYO CLINIC

Speaker: Dr Mark Davis (United States)

Dr Davis presented interesting case reports, including a severe case of HS in which, despite general measures (weight loss and smoking cessation) and medical treatments (ATB/Biologicals), surgical treatment was imposed. He also described a recalcitrant dermatitis of the thumb and hand refractory to topical and systemic treatments, which turned out to be MF that was treated with proton beam therapy (PBT) with excellent results as the lymphocytes are exquisitely sensitive to radiotherapy. The next case was a patient with severe leonine facies due to MF who also responded to PBT, with the condition resolving in 3 sessions. He then showed a patient referred for a diagnosis of "ulcerative psoriasis" which turned out to be a cytotoxic lymphoma, and the patient decided to stop treatment altogether. The next case was a patient with ulcerative MF who improved after 45 days of electron beam therapy (EBT). For a patient with recalcitrant palmoplantar pustulosis, he recommended radiotherapy and, in a patient with erythromelalgia, he recommended ruling out any associated myeloproliferative disease (5%). As a therapeutic tip for localised areas of skin pain, he recommended patches with lidocaine or amitriptyline/ketamine cream/gel 50 mg twice a day, which act by blocking sodium channels. Systemically, he was highly enthusiastic about the recent approval of suzetrigine for surgical or injury pain without the effects of opioids because it blocks pain at the peripheral nerve level and investigators hope it will be the first of a new generation of powerful, non-addictive drugs. He then demonstrated dressings for atopic dermatitis patients with rapid symptomatic relief of pruritus.

MYTHS AND REALITIES OF THE EXPOSOME

Speaker: Dr Susana Puig Sarda (Spain)

She spoke about the relative importance of the ozone layer on the skin as it is more complex, and influenced by natural climate changes and human activity, thereby generating gases that retain heat and increase temperatures. Global warming with shorter winters and higher UVR (UV radiation) intensity increases exposure and exacerbates the incidence of skin cancer. With regard to Vitamin D, she mentioned that, although the main source of this vitamin is

the sun, it also comes from food. The absorbance curve is the same as that which causes DNA damage and skin cancer, so the time needed is less than that needed to burn. As it is fat-soluble, it can accumulate and is toxic. She suggested little time daily and not overdoing exposure at weekends. The use of photoprotection and vitamin D synthesis capacity is controversial. Studies in children have shown that those who used photoprotection had higher vitamin D levels. Regarding questions about whether the use of sunscreen has an impact on skin cancer, its usefulness is well documented. When asked whether it is possible to repair UVR damage with topical treatment, she showed studies with Eryfotona and Anthelios in which improvements have been found in

field cancerisation when monitoring with confocal OCT microscopy which combines confocal optical tomography and confocal microscopy. She then also discussed whether there was a relationship between diet, microbiota and skin cancer as a controversial topic. She said that the Mediterranean diet could lower the incidence of BCC and MM, citrus fruits could increase the risk of MM/BCC/SCC and ultra-processed foods could increase the risk of MM. Coffee (2 cups a day) could reduce the risk of non-melanoma cancer by 3–8% and MM by 25%. Alcohol increases the risk of BCC/SCC and MM. As for vitamins, only nicotinamide is presumably protective. Rice irrigated with arsenic-contaminated drinking water increases the risk of BCC/SCC. As for the microbiota, the role of the microbiota as a predictor of immunotherapy evolution in metastatic MM still needs to be investigated, as different profiles have been observed in different countries. Transplantation of faecal microbiota could make them responders according to a study.

HIDRADENITIS (HS): PHARMACEUTICALS AND BEYOND

Speaker: Dr Alina Patricia Hernandez Santos (Dominican Republic)

She spoke about the coexistence of HS and psoriasis which share comorbidities due to the same physiopathogenic mechanisms as well as triggers (smoking/obesity). She mentioned concurrent pilonidal cyst in 23% of cases with HS, with some authors considering it to be a localised form of the same pathology. Other comorbidities include: RA, ankylosing spondylitis and spondyloarthritis, metabolic diseases, cardiovascular diseases, non-alcoholic fatty liver disease, IBD, psychiatric

pathology, and dermatological conditions such as SCC, acne, PG, dissecting cellulitis of the scalp and pilonidal cyst. Screening should be performed annually. She explained its physiopathogenesis and, with regard to approach, she mentioned the usefulness of ultrasonography carried out by someone familiar with the pathology for correct reporting as a support in therapeutic decision-making. She mentioned that CRP is an important marker of progression and that it is important to work on earlier diagnosis as it takes an average of 8 years for the correct diagnosis to be made and to access dermatological treatment. It reaches moderate-to-severe stages in 73% of cases ("therapeutic window of opportunity concept"). Apart from the general algorithms and measures already known, she concluded that there are no standardised treatments. There should be a focus on holistic treatment and a combination of innovative therapies should be used such as small molecules (JAK inhibitors), liraglutide in patients who do not respond to biologics (the skin has GLP-1 receptors in psoriasis lesions and in HS, although it is not known whether this is due to a direct anti-inflammatory effect or weight reduction).

PATHOLOGY OF THE FEMALE GENITAL MUCOSA. LEARNING THROUGH CASE REPORTS

THE NUMEROUS ASPECTS OF UNUSUAL VULVAR LESIONS

Speaker: Dr Martin Sangueza (Bolivia)

He showed cases of vulvitis facticia, emphysematous vaginitis due to gas-forming bacteria in immunocompromised patients, Lipschutz ulcers (rare pathology caused by non-bleeding and typically "mirror-like" EBV), Jacquet's erosive dermatitis (volcano lesions on a papillomatous cobblestone secondary to erosive diaper dermatitis), papular acantholytic dyskeratosis (HPV must be ruled out and patients may develop pemphigus), lichen sclerosus with naevus pigmented lesion (histopathological differential diagnosis impossible but screening for fibrosis should be performed: "pseudomelanoma") and, finally, vulvar melanoma (very aggressive behaviour).

VULVAR LICHEN SCLEROSUS (LS): WHAT EVERY DERMATOLOGIST SHOULD KNOW

Speaker: Dr Cristian Vera Kellet (Chile)

It is generally asymptomatic at onset until infectious complications, atrophy or introitus narrowing occur, usually 4–6 years from onset to diagnosis. After a general review of the pathology, he focused on the importance of high- and very high-potency topical corticosteroids as the only treatment that in randomised studies and meta-analyses has been shown to reduce the risk of malignant progression and recurrence, but must be used for life: 1 to 2 times per day for 3 months and then 2 to 3 times per week for very high-potency or every other day for moderate-potency topical corticosteroids. Other treatments are used for symptomatic relief: calcineurin inhibitors, topical retinoids, topical JAK inhibitors, and topical PDE-4 inhibitors provide unconvincing data, only reports or are under active research. Topical hormonal treatments, oral or intralesional corticosteroids, immunosuppressants, IL-17 and IL-4 inhibitors also show limited evidence and should not be used as monotherapy or as a replacement for topical corticosteroids. The same applies to procedures such as PRP, radiofrequency and photodynamic therapy. Lasers can only be complementary treatments by enhancing topical steroid absorption and delaying/preventing hyperkeratosis. There is a 4–5% risk that LS can progress to vulvar intraepithelial neoplasia and then to SCC 10 years after LS diagnosis. However, when the diagnosis is histological, it increases to 28–76%. Furthermore, 61% of SCC have histological alterations of LS and should ALWAYS be biopsied.

VULVAR GENITAL ULCER; NOT EVERYTHING IS SYPHILIS

Speaker: Dr Viviana Leiro (Argentina)

They can be acute (without systemic involvement: trauma, contact, infections or with systemic involvement: Lipschutz ulcers) or chronic (with

and without oral involvement). She showed case reports of primary syphilis, multiple chancres, persistent chancres and secondary syphilis. She also showed HSV, soft chancres, Rollet's mixed chancre (syphilis associated with soft chancre), donovanosis, trichomoniasis, and Mpox. She then continued with PG. She highlighted the diagnostic and therapeutic challenges posed by these pathologies.

IF ALL WOMEN HAVE HPV, WHY DOES IT SCARE US SO MUCH?

Speaker: Dr Mariana Jimena Martinez (Argentina)

A total of 80% of women will be infected with HPV at some point in their lives. This particularly generates a lot of anxiety and stress. Studies have been conducted on the impact chronic stress has on the manifestations of HPV infection and carcinogenesis through the hypothalamic-pituitary-adrenal (HPA) axis and sympathetic nervous system (SNS) by suppressing cellular immunity with HPV reactivation, promoting the expression of viral oncogenes, shifting the immune response from Th1 to Th2, which reduces the body's ability to eliminate the virus, thereby increasing the likelihood of pre-cancerous lesions and associated cancer. Therefore, in addition to the usual therapy adapted to each case, she suggested an interventional strategy aimed at stress management (mindfulness, cognitive behavioural therapy), support and clear information (most HPVs are low-oncogenic-risk HPVs), promotion of healthy living and follow-up/monitoring.

PSORIASIS TREATMENT TIPS

Speaker: Dr Steven Feldman (United States)

Dr Feldman suggested tailoring screening to patient age as the risk of AMI is higher in severe psoriasis, thus requiring lipid and BP monitoring. He emphatically stressed trying to simplify treatments to improve patient adherence. In patients with lesions resembling a "coral reef", there is a tendency to think that topical treatments would be ineffective due to thickened skin. However, clobetasol spray has very good results. With regard to topical non-steroidal anti-inflammatory drugs, he suggested reserving them for steroid-sensitive areas, but not complicating things for the patient with combination treatments as this will not improve adherence and consequently will not improve psoriasis. Regarding scalp psoriasis, he said it is very frustrating. The right vehicle must be chosen and the patient must be informed that if it is strong or itchy, it will get better faster. There are many treatment options for severe psoriasis. One of them is home phototherapy, which makes it easier for the patient to comply with treatment. Acitretin is very easy to use and increases the efficacy of UVB, with simple monitoring and adequate side effect reporting. It is also very useful in palmoplantar psoriasis. Regarding associated joint pain, if the skin needs systemic

treatment, he recommended using it; if the joints require a biologic, he recommended using it. However, if the skin requires only UV and the joints only need NSAIDs, he recommended not using biologics. Dr Feldman advised providing MTX side effects in writing. Finally, he said that there is probably no one biologic that is better than another, but there is more or less patient compliance depending on how calmly we inform them of potential risks. These are revolutionary drugs for those who really need them!

NAIL MELANOMA. DIAGNOSIS, TREATMENT AND PROGNOSIS

Speaker: Dr Eckart Haneke (Germany)

The developer of the functional, non-amputative, conservative technique for nail MMs was able to demonstrate that survival with this technique was greater than with amputation. He demonstrated the tangential biopsy technique, several case reports and the functional and cosmetic repairs it promotes. As a tip, always keep MM in mind, especially in individuals over 25 years of age.

EVERYTHING CHANGES IN A HURRY. WHAT WILL DERMATOLOGY BE LIKE IN 2030?

Speaker: Dr Josep Malvehy (Spain)

With the advent of the industrial revolution, we have reached the current era of the Internet and renewable energies, but we are already facing the 5.0 revolution (AI) and the next one, 6.0 (nanotechnology, robotics, synthetic biology, biotechnology, neuroscience, neurotechnology and, finally, communication and information technologies). We face an ageing population (>80 years) that will triple by 2050, a population over 65 that will outnumber 24–35 year olds globally, chronic diseases by 1:3 and an even more severe healthcare workforce deficit in addition to financial constraints and inequality in access to health. In dermatology, AI and big data help us create predictive models and machine learning, identify complex phenotypes and optimise

therapeutics. An Expert Consensus on AI competency items for healthcare professionals was conducted and comprises 6 items: 1) understanding the value, limitations and use of AI solutions; 2) understanding basic data science concepts; 3) choosing the best AI tool for each medical indication; 4) integration into patient workflow; 5) legal and ethical standards; 6) communication to patients. It should be stressed that AI must go hand in hand with human intelligence. Work is also underway on DIGITAL TWIN, a kind of patient avatar by digital phenotype that enables a personalised simulation. Synthetic biology enables targeted manipulation of the microbiota, cellular reprogramming and skin regeneration. This could become a possible therapeutic strategy for the treatment and study of diseases. Skin organoid cultures are laboratory-grown cultures of human cells where drugs are screened by genetic characterisation to predict toxicity and efficacy for precision medication. Continuing medical education, as well as patient education and empowerment are fundamental in all of this. Regarding the use of social media, he described the known benefits, but emphasised the lack of publications by dermatological doctors. This leads patients to quickly access poor quality educational information from influencers with no scientific knowledge. His conclusion was optimistic: the dermatology of the future will include disruptive technologies, a better understanding of skin biology and a new patient relationship model. A strategic vision, investment in digital infrastructures and continuous updating of professionals are needed. However, regulation that guarantees the ethical, safe, sustainable and equitable use of the new tools is imperative.

ADDRESSING DIFFERENT PERSONALITIES IN THE DOCTOR'S OFFICE

PERSONALITY TRAITS AND DISORDERS

Speaker: Dr Rolando Hernandez Perez (Venezuela)

He spoke of PERSONALITY TRAITS as inherent to human beings; they are flexible, allow people to adapt to different situations and are not necessarily harmful. Then he spoke of PERSONALITY DISORDERS, which constitute a lasting pattern of inner experience and behaviour that deviates markedly from the expectations of the individual's culture and manifests itself in two or more areas: cognitive, affective, interpersonal functioning or impulse control. He classified them into GROUP A: paranoid/schizoid/schizopathic.

GROUP B: antisocial/borderline/histrionic/narcissistic. GROUP C: avoidant/dependent/obsessive-compulsive. PERSONALITY is the individual's unique way of relating to themselves and others, which may determine how they develop their illness, their relationship with their doctor and their response to treatment. Personality traits are often accentuated during the illness, with the illness requiring adjustment and hospitalisation being a stress test for the personality.

ADDRESSING PERSONALITIES IN PATIENTS WITH ATOPIC DERMATITIS (AD)

Speaker: Dr Lourdes Bolla (Paraguay)

When considering the skin as a communication channel and anxiety modeller (common ectodermal origin), if modulation is deficient, there is a predisposition to somatisation. She emphasised early tactile skin experience (before the development of speech) for emotional and physical development. Skin perception organises the body image and the individual can resort to artefactual diseases to affirm their existence and define boundaries. AD is associated with high levels of stigma, anxiety, depression, isolation and low self-esteem, resulting in impaired quality of life and disruption of family dynamics. A holistic, multidisciplinary approach is essential,

with the participation of psychologists and psychiatrists when the patient shows signs of not showing emotions and feelings. DLQI-type indices should be used.

ADDRESSING PERSONALITY IN ACNE PATIENTS

Speaker: Dr Karina Malvido (Argentina)

At a time when appearance is more relevant than ever, skin diseases have a significant psychological and social emotional impact, and should never be dismissed. This impact can include depression, low self-esteem, anxiety, shame, suicidal ideation and suicide attempts. These diseases are often accompanied by social isolation, fear, anger attacks, drug and alcohol use and abuse leading to compulsive behaviours such as picking and self-harm. Patients may have an uncontrollable urge to harm themselves as a way of coping with difficult emotions. Associated disorders include anger, depression, anxiety, borderline personality disorder, narcissistic personality disorder, OCD, delusions and BDD (body dysmorphic disorder). Empathic

listening and a good doctor-patient relationship will help early diagnosis and multidisciplinary treatment.

ADDRESSING THE PERSONALITY OF PSORIASIS PATIENTS

Speaker: Dr Lianet Silverio Carrasco (Dominican Republic)

Chronic stress acts as a trigger for flare-ups. Up to 30% of patients develop depressive symptoms, depression or anxiety. Personality traits include perfectionism and difficulty expressing emotions, sensitivity to rejection and high neuroticism. While there is no such thing as a "psoriatic personality", some traits may influence patient adjustment to the disease and impact its clinical course. In addition to the approaches mentioned above, referral to support groups and in some cases to a rheumatologist is of utmost importance.

ADDRESSING THE PERSONALITY OF PATIENTS SEEKING AESTHETIC TREATMENT

Speaker: Dr Susana Misticone (Venezuela)

In some cases, these patients represent a real psychological challenge that affects our clinical practice since we are often able to recognise that they have a psychopathological problem, but we do not know how to identify the correct clinical diagnosis. Social media often lead to unrealistic body images, increasing body image dissatisfaction and BDD comorbidities, such as depression and eating disorders. She spoke of Zoom dysmorphia in the wake of the COVID pandemic, the Instagram face, the "fan" patient, the demanding, the cautious, the fickle, the status-dependent and the intolerant. In the aesthetic practice there is a higher number of patients with personality disorders: up to 15% present with BDD and borderline personality disorder. The most frequent are borderline, narcissistic, histrionic and obsessive-compulsive. They should be carefully referred to a

psychiatrist. It is unlikely that a BDD patient will be satisfied, and they usually become aggressive, escalating into serious situations and/or initiating legal action. If they are satisfied, they move their concern to another area. Not treating them and only in some cases correcting minimal defects after psychiatric assessment are recommended.

ADDRESSING PERSONALITY IN PATIENTS WITH ONCOLOGICAL PROBLEMS

Speaker: Dr Maria Vasquez (Argentina)

A total of 10% of patients will require psychological treatment within the first year of diagnosis and 73% of patients with depression do not receive adequate treatment. The most common disorders are: depression, anxiety, adjustment disorder and PTSD (post-traumatic stress disorder), especially in more aggressive cancers or in more advanced stages. Comorbidities related to body image and suicidal ideation are also common. In addition to all the tools mentioned, there is also social support.

UPDATE ON DERMATOMYOSITIS (DM), SCLERODERMA AND LUPUS

Speaker: Dr Julio Sartori Valinotti (United States)

New emerging therapies target the individual phenotype of each patient.

- SLE: He mentioned the following:
  1) LITIFILIMAB: BDCA2 target/phase 2 trial; fairly well-tolerated in trials, but not yet available. Adverse effects: hypersensitivity, oral HSV and HZV.
  2) ANIFROLUMAB: IFN-1 receptor subunit 1 target/phase 3 study; minimal adverse effects in SLE, HZV and bronchitis. Rapid response in CLE.
  3) LENALIDOMIDE: Thalidomide analogue/minor side effects: mild leukopenia/DVT. It should not be forgotten that proton pump inhibitors are the drugs that most frequently cause drug-induced SLE and are very easily accessible to patients.

- DM: always rule out occult cancer, screening according to risk (IMACS guidelines). ANTI-TIF1 would be a predictive marker of cancer associated with myositis. ANIFROLUMAB in recalcitrant DM.

- SCLERODERMA: NINTEDANIB, TYK inhibitor/TOCILIZUMAB, IL-6 receptor antagonist/RITUXIMAB, anti-CD20/ABATACEPT, T-cell

inhibitor/LENABASUM, cannabinoid receptor 2 agonist/ROMILKIMAB, anti IL-4, IL-13/INEBILIZUMAB, anti-CD19. Moreover, botulinum toxin was recommended for use in digital ulcers for pain reduction, disappearance of haemorrhages and is much more inexpensive than other therapies. Never apply it on the thumb; the dilution is 50 U/1.25 ml of saline solution, every 4 weeks, 10 U per finger (5 on each side at the base of each finger), i.e. 40 U per hand.