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Reports by Albertine Lynch (Dermatology Intern, Lyon)

Atypical drug-induced hypersensitivity

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Speakers: L. Guenard-Bibault and C. Bernier

Atypical organ hypersensitivity

Speaker: L. Guenard-Bibault

Drug-induced hypersensitivity with an immunological-allergic mechanism should be distinguished from toxicity due to overdose and from a side effect specific to the inducing drug. The speaker chose an organ-by-organ approach.

Antibiotics, cancer treatments and cardiotropic drugs are the main causes of **respiratory** involvement; drugs are thought to be responsible for 2-10% of cases of lung disease in patients hospitalised for acute respiratory failure, and up to 17% of cases of diffuse interstitial lung disease.

The radiological-clinical presentations are extremely varied – more than 41 pictures have been described – and the same drug can cause different phenotypes.

Bronchoalveolar lavage can reveal eosinophilic alveolitis, which is more suggestive than lymphocytic or neutrophilic alveolitis, while lung biopsy is of limited diagnostic value because it is non-specific and invasive. Diagnosis should be based on a rigorous causality analysis, using tools such as Pneumotox.

Drug-induced **renal** impairment is involved in 40-60% of cases of acute interstitial nephritis and up to 20% of cases of acute renal failure, of which 1-5% are due to an immunological-allergic mechanism involving humoral or cellular immunity. The absence of a dose-response relationship, extra-renal manifestations – particularly cutaneous manifestations – blood eosinophilia and eosinophiluria above 5% – specific but inconstant – point to such a mechanism. Renal biopsy has good diagnostic value but can be avoided if renal function recovers by more than 50% within seven days of avoidance of the suspect drug, in which case the entire therapeutic class should be contraindicated.

In terms of **haematology**, beta-lactam antibiotics, particularly ceftriaxone and piperacillin, can cause severe neutropenia that regresses within a few days to six weeks, and autoimmune cytopenias have also been reported.

Guillain-Barré syndrome is the most common acute drug-induced **polyradiculoneuritis**, with a recent review attributing 45% of cases to anti-SARS-CoV-2 vaccines. It can also be caused by olanzapine and allopurinol. Acute disseminated encephalomyelitis, which is most often post-viral, has been described in association with several vaccines. **Encephalopathies** take a variety of forms: convulsive with beta-lactams, psychotic with ofloxacin or metronidazole, and cerebellar with MRI abnormalities with metronidazole.
Drugs are responsible for 18% of cases of autoimmune **hepatitis**, with autoantibodies frequently being positive (up to 83% with nitrofurantoin).

The immunological-allergic phenotype is often accompanied by extra-hepatic symptoms (exanthema, fever, adenopathy, eosinophilia). TNF inhibitors, statins and herbal medicines are frequently implicated.
Drug-induced enterocolitis syndrome (DIES) is a manifestation of non-IgE-mediated hypersensitivity characterised by vomiting occurring one to four hours after ingestion of the drug, with no associated extra-digestive signs. It is associated with diarrhoea in the first 10 hours after taking it; this is sometimes profuse and can lead to severe dehydration or even hypothermia and hypotension. Twelve cases have been published, with amoxicillin-clavulanic acid being the drug most often implicated. Tryptase is always normal.

Lastly, the concept of "compartmental allergy" has been introduced to account for delayed hypersensitivity to LMWHs, proven by skin tests and subcutaneous challenge tests, in patients who are otherwise tolerant of intravenous heparins. Compartmental lymphocyte homing is suspected.

Atypical cutaneous hypersensitivity

Speaker: C. Bernier

DRESS can present with a number of atypical features: it can be pustular or bullous, and there are forms without skin involvement. The time to onset can be short – 24 to 48 hours – particularly for iodinated contrast media (ICM) and certain antibiotics. In the acute phase, co-sensitisation and neo-sensitisation are frequent, so care should be taken to avoid ICM injections and the introduction of new drugs.

In patients treated with checkpoint inhibitors, symptoms similar to toxic epidermal necrolysis (TEN) are observed, with no ophthalmological or respiratory involvement, but with constant oral lesions.

General condition is better preserved than with TEN. The time to onset varies widely (from one to 38 weeks), and is often longer than in TEN. Other autoimmune disorders are frequently observed. General corticosteroid therapy, which is contraindicated in TEN, is effective in this form of bullous lichenoid drug eruption induced by PD1, PDL1 or CTLA4 inhibitors. Resumption of immunotherapy may be discussed at a multidisciplinary team (MDT) meeting, provided that the patient returns to a grade ≤ 2.

Fixed pigmented erythema (FPE) can present with exclusive mucosal or genital involvement. There are peri-labial, HSV-like vesicular forms. Doxycycline, when prescribed as post-exposure prophylaxis or for repeated occasional use for STIs, is frequently implicated. In a series of 15 cases in men treated for STIs, nine presented exclusively with genital symptoms. Repeated occasional use of the responsible drug has been identified as a specific triggering factor. Investigation of FPE is based on *in situ* patch tests, supplemented if negative by an *in situ* ROAT (in a previously damaged area) before discussing a rechallenge if this is negative.

Erythema scarlatiniforme desquamativum recidivans (ESDR) – formerly Féréol-Besnier disease – presents bilaterally and symmetrically on the palms of the hands and sometimes the soles of the feet, with or without generalised exanthema. This clinical entity has been described in association with viruses, staphylococcal and streptococcal infections, as well as diuretics, quinolones and NSAIDs. A French series of 30 cases showed symmetrical palmar involvement in 100% of cases, plantar involvement in 50% of cases, a median time to onset of 2.75 days and a median total duration of 18 days. Beta-lactams were responsible in two-thirds of cases and ICM in almost one-third of patients. As skin tests are of low diagnostic value, an oral challenge test is necessary. Systematic recurrence after a rechallenge argues for an immunological-allergic mechanism possibly involving palmoplantar memory resident T cells.

On the other hand, the non-extension of the lesions after re-exposure distinguishes this entity from a true progressing drug eruption.

Severe cutaneous reaction with hypotension (SCoRCH) is a new entity described in an American series of seven patients who were treated with cotrimoxazole (O'Brian, *JAMA Dermatology* 2023) and experienced: hypotension, hyperthermia, tachycardia, "sunburn" erythema, conjunctivitis, oedema and lymphopenia. Symptoms appeared four to 11 days after the start of cotrimoxazole treatment, but this time was reduced to less than 24 hours in the event of re-exposure. Symptoms regressed rapidly, within 72 hours. Skin tests were negative. The pathophysiology remains unknown, and may be similar to the cytokine release observed with chemotherapy, which could justify measuring IL-6. Reintroduction is likely to cause very severe symptoms.

Oral communications

Reports by Albertine Lynch (Dermatology Intern, Lyon)
Speakers: L. Muchembled, A. Fievez, L. de Chaisemartin, B. Brunie, C. Tacquard and S. Le

L. Muchembled presented data on the epidemiology of perioperative hypersensitivity in paediatrics in France, taken from the GERAP surveys (1997-2012) and a national database set up in 2017.

The incidence in children is between 1/10,000 and 1/36,000 depending on the cohort, compared with 1/10,000 in adults. Among 461 children enrolled (median age 14 years, the largest paediatric cohort to date), half the reactions were grade I, a quarter grade II or III, and 1% grade IV.

A causal agent was identified in 44% of cases, primarily curare (30% of cases, 38% of which involved first-time exposure, suggesting environmental sensitisation to quaternary ammoniums) and latex (29%), with the latter disappearing after 2017 thanks to specific prevention measures. Reactions were significantly more severe in the group with an identified causal agent. The main limitations of the study were that baseline tryptase levels were not available and the data spread out over a period of 25 years were heterogeneous.

A. Fievez presented a retrospective analysis of the diagnostic value of patch tests in lamotrigine-induced drug eruptions (monocentric cohort of 30 patients; lamotrigine was mainly indicated for a thymic disorder). Patch tests, carried out with the active ingredient at 10% in petroleum jelly or with the commercial form diluted 1:3 in water, saline solution or petroleum jelly, were positive in 33% of patients, with dilution in petroleum jelly yielding the highest positivity rate (7/10 positive versus six in water and zero in saline solution). No correlation was found between the clinical phenotype (type of drug eruption) and test sensitivity. With a positivity rate of around one-third, patch tests appear to be of good diagnostic value in this indication, with the best sensitivity achieved with the commercial form diluted in petroleum jelly.

L. de Chaisemartin described a new entity, transfusion-related alpha-gal syndrome, characterised by a severe transfusion allergy to group B/AB blood products in group O recipients sensitised to alpha-gal. Severe transfusion reactions occur in less than 1% of transfusions, and anaphylaxis in 1/30,000 (mainly with platelets).
Three cases of severe anaphylaxis following exposure to group B products in patients with alpha-gal IgE antibodies have been reported. As the B antigen shares structural similarity with alpha-gal, groups B and AB are protective against alpha-gal syndrome. A retrospective study (2022-2024) of 1.5 million transfusions identified alpha-gal IgE antibodies in the sera of group O patients who had reacted to B or AB products.

It is now recommended that alpha-gal IgE antibodies should be routinely measured in all group O patients who have suffered a transfusion accident, and that group B products should be avoided in group O patients outside life-threatening emergency situations. Interestingly, these patients did not react to meat.

B. Brunie assessed the frequency of cross-sensitisation between amoxicillin and piperacillin-tazobactam in a two-centre study (2024-2025) of 58 patients (44 cases of immediate hypersensitivity (HS), 14 of delayed). An allergy to amoxicillin alone was confirmed in 71% of the sample, to piperacillin-tazobactam alone in 3%, and to both drugs in 26%. The negative predictive value of piperacillin-tazobactam tests was 86% for delayed HS and 100% for immediate HS. The risk of cross-reaction is therefore not negligible. The maximum non-irritating concentration of piperacillin-tazobactam remains to be validated.

C. Tacquard studied mast cell activation profiles in cases of immediate hypersensitivity affecting 939 GERAP patients (2017-2024) for whom acute-phase and baseline tryptase levels were available. Mast cell activation was defined as a peak greater than 1.2 times the baseline value + 2. Four profiles were identified based on the presence of a significant change in tryptase levels and the baseline tryptase concentration. Whatever the amplitude of the change, as soon as it was significant, the clinical profile was severe, with haemodynamic signs and co-release of histamine. Patients without a significant change in tryptase levels had less severe reactions, but skin tests could be positive. In this cohort, the majority of severe reactions were therefore accompanied by mast cell activation, compatible with an IgE- or MRGPRX2-mediated mechanism.

S. Le presented a feasibility study on the reintroduction of beta-lactam antibiotics in outpatient settings in children. Ten percent of children are labelled allergic to penicillin. This retrospective multicentre study included 265 children who had received an oral challenge test initiated in an allergology practice with brief monitoring for one hour; then, reintroduction was continued at home over a period of five days with systematic follow-up via teleconsultation. The median age at the time of the index reaction was two years. The median investigation period was less than six months. Of the entire cohort, only 14 tests were positive in the form of exclusively cutaneous reactions, with no anaphylaxis. This approach allows allergy labels to be removed, thereby limiting exposure to broad-spectrum antibiotics. Its extension to adults and to other practitioners (paediatricians, GPs) remains to be evaluated.

Recent developments in drug-induced HS

Reports by Albertine Lynch (Dermatology Intern, Lyon)

Speakers: F. Tetard, S. Oro and A. Barbaud

Recommendations for the management of severe drug eruptions: DRESS, AGEP

Speaker: F. Tetard

Acute generalised exanthematous pustulosis (AGEP) is a rare drug eruption (1 to 5 cases per million per year), predominantly affecting adult women, with a mortality rate of less than 5%.

A French national diagnostic and care protocol (PNDS) is currently being drawn up, and European recommendations (ToxiTEN group) have recently been published in the form of expert opinions. The picture is one of sudden erythema of the skin folds, superficial pinhead-sized pustules and high fever.

Facial oedema, purpura, atypical target lesions, vesicles and pseudo-Nikolsky's sign (non-specific) are sometimes seen. Mucosal involvement occurs in less than 20% of patients. Haemodynamic instability may occur. Biological inflammatory syndrome is pronounced, with neutrophilic hyperleukocytosis. Moderate eosinophilia is observed in 30% of cases. Visceral involvement (liver, kidneys, bone marrow, lungs) is found in one in five patients. Overlapping syndromes with DRESS or TEN are possible.

Ninety percent of cases are drug-induced – mainly by antibiotics, hydroxychloroquine and ICM – with a characteristically short time to onset – sometimes less than 24 hours (pristinamycin) and always less than 12 days. Cases associated with vaccines and spider bites have been reported in children. The immunological mechanism involves specific cutaneous CD4 and CD8 T cells producing IL-8, as well as Th17 cells producing IL-17 and IL-22 and monocyte-derived IL-36, constituting a therapeutic target. Differential diagnoses include generalised pustular psoriasis, pustular DRESS and Sneddon-Wilkinson syndrome. No therapeutic trials are available for this condition. A single-centre French study showed that, as systemic corticosteroid therapy was replaced by topical treatments, hospital stays were gradually shortened. Cases of efficacy with ciclosporin and IL-17 and IL-36 inhibitors have been described. Management involves hospitalisation, skin biopsy, bed rest, emollients and strong to very strong topical corticosteroids. Systemic corticosteroids (0.5 mg/kg) should be reserved for severe forms and can be discontinued without tapering off – unlike what is recommended for DRESS. The EuroSCAR score is a retrospective diagnostic validation tool. In children, an infectious cause should always be suspected.

DRESS, with an incidence of 10 cases per million population per year and up to 1/10,000 in patients who have recently started anti-epileptic therapy, carries a risk of multiorgan involvement. Mortality is between 7% and 20%. It may have a time to onset of up to eight weeks, but there is no lower limit. Symptoms can occur the first time the person is exposed to the drug.

The risk of polysensitisation is specific to this drug eruption. A PNDS is available online. The immunopathology involves IL-5-producing type 2 T cells, recruitment of eosinophils by CD8 and CD4 T cells, probable hyperactivation of the JAK-STAT pathway and an increase in regulatory T cells in the acute phase, explaining the delayed autoimmune complications. The cases of herpes group viral reactivation observed reflect an immune environment favourable to replication. A recent proteomic analysis of 26 patients confirmed the involvement of type 2 inflammation (IL-4, IL-5, eosinophils). Paradoxically, severe forms are accompanied by fewer circulating eosinophils, as they are recruited in tissues.

Clinically, DRESS combines high fever, flu-like syndrome and morbilliform exanthema of the face, trunk and extremities, with pronounced oedema and skin infiltration. A pustular presentation is observed in 20% of cases. It is the drug eruption that is most often accompanied by visceral involvement: hepatic cytolysis (75%), renal involvement (10-30%), and pulmonary (5-25%) and sometimes digestive, haematological (macrophage activation syndrome), pancreatic or neurological involvement. The recommended work-up includes: CBC, electrolytes, proteinuria, liver function tests, troponin, blood cultures and viral PCR (respiratory viruses, HHV6, CMV, EBV). Eosinophilia is absent in 20% of cases, and the presence of activated lymphocytes is highly suggestive. Biopsy is mainly used to rule out differential diagnoses. The RegiSCAR score remains retrospective.
Severity is classified as minor (serum creatinine < 1.9 ULN or cytolysis < 4 ULN), moderate or immediately severe when visceral involvement other than renal or hepatic involvement is present. Anticonvulsants, anti-tuberculosis drugs, antibiotics and sulphonamides are the main responsible medications, with predisposing HLA types documented for several drugs.

Treatment depends on severity: very strong topical corticosteroids in minor forms, tapering off over six weeks to three months, general corticosteroid therapy at 0.5 mg/kg for at least one month in moderate forms, and general corticosteroid therapy at 1 mg/kg without bolus (risk of viral reactivation) in severe forms. Anti-IL-5 and anti-IL-5Rα therapies (mepolizumab 300 mg every four weeks or as a single dose, benralizumab 30 mg) are promising options for corticosteroid-resistant forms. Prolonged follow-up for at least one year is necessary because of the risk of relapse and delayed autoimmune complications (thyroiditis, type 1 diabetes, lupus, vitiligo), which is particularly high in children.

Recommendations for the management of severe drug eruptions: SJS/Lyell and focus on anti-epileptic drugs

Speaker: S. Oro

Toxic epidermal necrolysis (TEN) is an emergency due to its mortality rate (10 to 40% in the acute phase) and the risk of sequelae (90%). The prognosis depends on the percentage of surface area detached, with SJS (<10% detachment) being less likely to result in death but more likely to result in ocular sequelae. Mortality is higher in overlap syndrome (10-29% detachment) and Lyell's syndrome (>30%). Acute skin failure is life-threatening due to haemodynamic repercussions, electrolyte-fluid, caloric and protein losses, or sepsis due to multiple entry sites and cytopenia. Age and co-morbidities have a decisive influence on the prognosis. Mucosal failure carries a risk of respiratory failure, digestive perforation and serious eye damage. The presence of painful purpuric macules should be recognised as an early warning sign of progression to TEN.

The PNDS, which was updated in 2023, gives details concerning supportive care, which is the pillar of the management strategy. No curative treatments have shown to be effective (TNF inhibitors, IV immunoglobulins, immunomodulators), due to a lack of robust trials in this rare drug eruption. JAK inhibitors could be the way forward. This was suggested in a recent publication in *Nature* on seven cases of AGEP. However, some patients may instead have developed bullous lichenoid drug eruptions in association with checkpoint inhibitors. Transferring the patient to an expert centre and alerting the intensive care unit are essential as soon as detachment exceeds 10% of the skin surface. Acute ocular involvement requires preservative-free artificial tears, application of vitamin A ointment and, in severe forms, amniotic membrane transplantation. Monitoring of ophthalmological sequelae is based on a standardised data collection form attached to the PNDS. A multidisciplinary assessment of the sequelae is essential. The speaker stressed the need to include a wide range of patients, including the most severe cases, in prospective studies.

Anti-epileptic drugs carry a particularly high risk of drug eruption: a relative risk of 72 for carbamazepine and its derivatives, 17 for phenytoin, 16 for phenobarbital and 14 for lamotrigine, which is too often prescribed as a first-line treatment for mood disorders. The HLA-B15:02 allele is associated with an increased risk of DRESS and TEN during treatment with carbamazepine or lamotrigine. In some Asian countries, systematic screening for this allele before prescribing these drugs has helped reduce the incidence rate. Although desirable, this practice is not yet applied in France. Compliance with the recommendation to gradually increase lamotrigine doses on initiation is currently poor (50%). Cross-allergies between anti-epileptic drugs are common.

In the event of a carbamazepine- or lamotrigine-induced drug eruption, the patient should be tested for the HLA-B15:02 allele and, if the result is positive, all associated drugs should be contraindicated (phenobarbital can be authorised).

In the event of an even mild drug eruption associated with lamotrigine, skin tests should be carried out without reintroducing the drug. If a benzodiazepine is the only suspect drug, the whole class should be contraindicated, but if other drugs are more likely to be responsible, another benzodiazepine may be reintroduced. Alternatives should be discussed with neurologists and psychiatrists.

Exploratory algorithm for drug eruptions

Speaker: A. Barbaud

An update on skin testing methods for drug eruptions, drawn up by the EAACI task force, is currently being published. Delayed-reading prick tests can now replace IDTs if the latter are not feasible. IDTs should be performed using a controlled volume of 0.02 ml and should be read after 24-48 hours for delayed hypersensitivity. For patch testing, the tablets are ground into a powder in 30% petroleum jelly. Commercial forms can be used, specifying the final concentration of the active ingredient. ICM should be tested undiluted, as should heparins and certain beta-lactams.
Heparins cause injection site reactions, which may become generalised in the form of maculopapular rash. In this case, patch tests are unnecessary. The IDT should be carried out immediately and read on D1-D3 or even D7 (late positivity is possible). Tests are formally contraindicated in the event of a necrotic reaction at the injection site. Photosensitisation should be investigated by photo-patch tests irradiated with 5J UVA at 24 hours, with a non-irradiated control. There is no room for prick tests or IDTs.

Fixed pigmented erythema should be tested by patch tests and repeated open application tests (ROATs) in the previously damaged area *(in situ).* The diagnosis is made in 30% of cases by an *in situ* patch test, in 30% by a ROAT and in 30% by an oral challenge test, although the latter is prohibited for generalised bullous FPE.

For maculopapular rash with no signs of severity, an IDT can be carried out straight away without any prior patch testing.

In DRESS, patch tests are of good diagnostic value, with an overall positivity rate of 57% in meta-analyses, higher than that observed in simple maculopapular rash, but remain negative for certain drugs such as allopurinol. They are well tolerated, although there is a potential risk of viral reactivation in HIV patients treated with anti-tuberculosis drugs. Unlike with simple maculopapular rash, IDT should only be carried out if patch testing is negative. However, IDTs are well tolerated. Rechallenge with DRESS should be reserved for experienced teams, after negative skin tests, and should not be performed for drugs that are highly suspect. Allopurinol, for example, should not be reintroduced. If a drug is reintroduced, this should be done more than six months after the acute phase, using a very gradual dosing regimen starting at one hundredth of the target dose. In a French series of 65 cases, 20% of patients had a recurrence of maculopapular rash on rechallenge, but half were able to continue treatment without seeing the rash worsen. In AGEP, IDTs are of good diagnostic value when patch tests are negative. In TEN, on the other hand, the diagnostic value of tests is low (less than 20% of patch tests are positive, and prick tests and IDTs are of little value). Any rechallenge with suspect drugs is contraindicated in TEN, although it may be considered for less strongly suspected drugs introduced concomitantly; in a series of 32 patients, these reintroductions were well tolerated, with the exception of one apparently incidental immediate hypersensitivity reaction.

Chronic urticaria in all its forms

Reports by Albertine Lynch (Dermatology Intern, Lyon)

Speakers: A. Badaoui and P. Mathelier-Fusade

New recommendations for the management of chronic urticaria

Speaker: A. Badaoui

The previous international recommendations for the management of chronic urticaria dated back to 2022 and already included second-generation H1 antihistamines, initially at standard doses, increasing up to four times the standard dose if needed and, in the event of treatment failure, omalizumab starting at 300 mg every four weeks, with possible dose escalation up to 600 mg every two weeks. Ciclosporin appeared as a third-line treatment in these recommendations.

The recommendations were updated in 2024, at a meeting of 213 experts from 59 countries, and published in *Allergy*. With regard to the investigations required, for acute urticaria (<6 weeks), no tests are recommended by the experts unless there is evidence of allergy. The minimum recommended work-up for chronic spontaneous urticaria (CSU) includes a complete blood count and CRP testing. TPO antibodies may be tested for on a non-routine basis, particularly in expert centres. Inducible urticaria should be investigated using appropriate challenge tests. In cold urticaria, testing for cold agglutinins or cryoglobulinemia is not recommended unless there are suggestive clinical findings. Skin biopsy is recommended to investigate differential diagnoses, particularly urticarial vasculitis, if the lesions are of a fixed nature (>24 hours). Associated systemic signs in favour of a differential should be investigated on questioning.

The current therapeutic objective in chronic urticaria is to achieve complete remission (UCT score = 16) before considering a reduction in treatment. Our attention was drawn to a large American cohort study with over 200,000 CSU patients, which showed a higher risk of all-cause mortality at three months to one year. Complete control of the disease is both a crucial challenge and a realistic objective.

The new recommendations maintain H2 antihistamines as first-line treatment for CSU, up to four times the standard dose. In the event of failure, three second-line systemic treatments are available: omalizumab, dupilumab and remibrutinib (with the latter awaiting marketing authorisation in Europe).

The experts suggest that long-term corticosteroid therapy should not be used, although short courses of corticosteroids could be used to get through an acute episode.

In children, the treatment algorithm based on expert consensus is identical, with omalizumab tailored to weight and age. The algorithm is the same for pregnant and breastfeeding women, for whom antihistamines such as omalizumab can be authorised in complete safety (Vidal, CRAT).

Concerning recent therapeutic developments, the omalizumab biosimilar has been on the market since 2024, with similar efficacy. The efficacy of dupilumab in CSU was demonstrated in omalizumab-naive patients in two phase III studies (CUPID A and B, with 138 and 108 patients respectively). In this indication, dupilumab is approved for children aged two and over (not yet reimbursed).

Remibrutinib, a Bruton's tyrosine kinase inhibitor, demonstrated efficacy in adult CSU in two phase III randomised controlled trials, based on the UAS7 activity score at 12 weeks, with efficacy maintained at 52 weeks.

Petechiae were reported in the first few months of treatment, without any associated thrombocytopenia. There was no increased risk of infection.

Few data are currently available comparing the different second-line drugs. A meta-analysis of 93 studies on 11,398 patients identified omalizumab and remibrutinib as the best-performing drugs in terms of efficacy and safety (Chu AWL, *J Allergy Clin Immunol*. 2025).

No second-line systemic treatments currently have MA for use in chronic inducible urticaria, but a trial is currently in progress for remibrutinib.

New therapeutic approaches targeting Bruton's tyrosine kinase and c-KIT inhibition (barzolvolimab) are currently being evaluated.

Urticaria and social media

Speaker: P. Mathelier-Fusade

Twenty percent of the world's population experiences at least one episode of urticaria during their lifetime, as do up to 80% of atopic individuals. Despite recent therapeutic advances and efforts to update the recommendations for the management of this disease, there are still many misconceptions about it. Social media is a powerful source of information for 5.2 billion users worldwide, with social media time averaging 20 hours a week. In France, 78% of the population uses social media, at a rate of 1 hour 48 minutes a day, with Facebook, YouTube and Instagram in the lead.
The 2020 pandemic led to an increase in the amount of time spent on social media, but also to a proliferation of information – both true and false – making it more difficult to access reliable sources. Half of French Internet users searched for information about their health in 2023. Health misinformation existed long before the pandemic, and the subject most prone to misinformation was vaccination.

A French study in 2023 explored French people's beliefs about medical information: it showed that vaccine refusal and avoidance of medical care were associated with a lower level of health knowledge, more frequent use of social media with a high level of confidence in the content available, susceptibility to conspiracy theories and 'alternative' therapies, an intuitive rather than analytical way of thinking, distrust of science and medicine, and poor personal medical experiences.

When it comes to chronic urticaria, the main themes identified in online discourse are allergy as a suggested cause, the idea that there are supposedly no available or effective treatments, and the promotion of diets and food supplements and so-called alternative or 'natural' treatments. The link between vaccines and outbreaks of urticaria is also a recurring topic of discussion. The following are also put forward as possible causes of the condition: digestive parasites and fungal infections. On Instagram and TikTok in particular, users film and describe their outbreaks, sometimes on a daily basis, and the measures taken to control them. Various methods are suggested: anti-parasite treatments, corticosteroid therapy, "low histamine" diets and other avoidance diets (gluten-free, lactose-free, low-salt) including fasting, homeopathy, acupuncture, Chinese herbs, magnetism, etc.

In international studies where questionnaires were administered to urticaria patients, the people concerned expressed a desire to have access to reliable online resources for information about their disease, but the interpretation, understanding, uptake and use of the information are issues at least as crucial as the availability of the information itself.

Health literacy refers to an individual's ability to find, understand, evaluate and use information with the aim of developing their autonomy within the healthcare system. In a French study in 2021, 44% of adults found it difficult to use information independently.

These difficulties were associated with an unfavourable social status, financial difficulties, chronic health problems and the lack of a GP. Seventy-two percent of people doubted their ability to adequately assess the information to which they were exposed, and 30% of respondents reported forgetting the information they were given.

Free and now virtually continuous access to profuse and unregulated content on health issues via social media could therefore increase the risk of misinformation. Particularly in the age of algorithms that generate homophily (the tendency to be exposed to similar content based on the user's preferences), regulations seem necessary to curb an expected increase in misinformation. It is the responsibility of healthcare professionals to provide patients with access to high-quality medical information – online if possible (fact sheets, websites of learned societies and patient associations) – but also to combat medical wandering, which may gradually lead them to less reliable sources. We still need to think about ways in which healthcare professionals and influencers, whose core business is the production of online content, can work together.

Comparative views: Contact allergy to artisanal cosmetics in the French-speaking world: six clinical cases

Reports by Albertine Lynch (Dermatology Intern, Lyon)
Speakers: N. Ouedraogo (Burkina Faso), R. Karkar (Algeria), O. Bauvin (France), G. Chidiac (Lebanon), F. El Fatoiki (Morocco) and F. Zeglaoui (Tunisia)

This session brought together six clinical cases in dermatology-allergology presented by speakers from six countries, illustrating the diversity of exposure patterns depending on the cultural context and the growing role of so-called natural preparations in contact dermatitis.

N. Ouedraogo (Burkina Faso) reported the case of a 45-year-old woman presenting with both fleeting papular lesions on the trunk and limbs and generalised vesicular plaques – an unusual combination of urticaria and contact eczema. Patch tests with the European baseline series were positive for fragrance mix I, fragrance mix II and Lyral. Further questioning revealed regular use of incense smoke – a blend of roots soaked in fragrance – above which the patient would position herself. A positive prick test result for incense supported the diagnosis of contact urticaria, but the patch test was also strongly positive at 48 hours, and the biopsy revealed spongiosis and exocytosis; all these findings were very much in favour of allergic contact eczema. Avoidance led to the disappearance of both components within three weeks, but the patient experienced a recurrence after resuming incense smoke.

R. Karkar (Algeria) presented the case of a 29-year-old woman suffering from pruritic and painful plantar dermatitis that made walking difficult and was progressing to sheet-like desquamation, following the use of an artisanal antiperspirant cream of unknown composition.

ROAT on healthy skin, with twice-daily application for seven days, triggered marked erythema on D4 that extended beyond the area of application, confirming the allergy; ROATs with pharmaceutical-grade musk and zinc oxide remained negative. The essential oils contained in the cream, or a fabric softener, were suspected but could not be identified. This case illustrates the deceptive nature of artisanal cosmetics, which are wrongly perceived as harmless.

O. Bauvin (France) reported on a media incident in 2015 involving "home-made" cinnamon masks, which caused burns and possibly allergies. Cinnamon, via cinnamaldehyde, is both caustic and allergenic, and can cause highly erosive irritant dermatitis, as well as allergic cheilitis and stomatitis. The problem with online DIY tutorials is that home-made cosmetics are not regulated.

G. Chidiac (Lebanon) reported the case of a young woman who developed erosive dermatitis with targetoid lesions after applying black seed oil. A positive patch test confirmed the diagnosis. Black seed oil has anti-inflammatory, antioxidant and antineoplastic properties and is widely used in traditional medicine, particularly for acne and eczema. Its sensitising potential has been documented since 1997, when a series of seven cases published in *JAMA Dermatology* described target lesions, vesicles or bullae, and Nikolsky's sign. Other essential oils, such as tea tree and bay laurel oils, can cause pseudo-erythema multiforme presentations. Thymoquinone, the main component of black seed oil, is thought to be responsible for the reactions, and tert-butylhydroquinone, an antioxidant with a similar structure, can be used as an indirect marker. The speaker described a case of indirect exposure, occurring when the person came into contact with their partner's beard coated with black seed oil. More severe cases have been reported following oral absorption.

F. El Fatoiki (Morocco) described bullous eyebrow lesions associated with palpebral oedema and cutaneous and ocular burns in a 57-year-old female patient after an initial application of *Euphorbia characias*. The outcome was favourable following treatment with topical corticosteroids. This Mediterranean plant, whose caustic properties are used in traditional medicine to treat warts, is also responsible for skin and eye accidents, which are well known in horticulture.

This case is a reminder of the central role played by medicinal plants in traditional Moroccan medicine, where the profession of herbalist is regulated but there is no academic training, and where the artisanal and unregulated manufacture of preparations entails a risk of accidents.

Lastly, **F. Zeglaoui (Tunisia)** reported the onset of pruritic bullous lesions in a young woman 48 hours after application of a temporary tattoo. Artisanal tattoo preparations, which take a long time to make, have gradually been replaced by ready-to-use products sold online, which are often enriched with paraphenylenediamine (PPD) to intensify the colour, which was the case here. PPD, which is found in hair dyes, textiles, paints and some henna products, can have cumulative effects, even when used at low concentrations. It can cause systemic toxicity secondary to topical application. Temporary tattoos are popular because they are painless and inexpensive, but they carry a real risk of allergic reactions that remains too frequently overlooked.

Hypersensitivity to iodinated contrast media (ICM)

Reports by Albertine Lynch (Dermatology Intern, Lyon)
Speakers: M. Lefevre and M. Tauber

Immediate HS

Several learned societies have issued recommendations on immediate HS to ICM: EAACI (European allergology), ESUR (European radiology), and the ACR/AAAAI (international radiology and allergology). While allergists focus on testing, which ends with the reintroduction of an alternative, radiologists propose a more pragmatic approach consisting of switching drugs in the event of any history of urticaria occurring within an hour of injection.

Immediate reactions to ICM remain rare (around 1.4%). Most are mild, with severe forms not exceeding 0.04%. The main challenge is to distinguish between the expected physiological and physical-chemical effects of the media – diffuse heat, metallic taste, nausea, vagal discomfort – that do not warrant any allergy investigation, and genuine systemic immediate HS phenotypes (bronchospasm, laryngeal oedema, shock), which require a full work-up. Between the two, there remains a grey area made up of isolated immediate cutaneous manifestations (urticaria, pruritus, flushing, angioedema) in the hour following injection which, according to the 2021 European recommendations, should be investigated by skin tests and possible reintroduction.

The process begins with precise documentation of the index episode: nature of the ICM, time to occurrence, phenotype, treatments undertaken, differential diagnoses and, in the event of severe anaphylaxis, the search for other suspects, including latex. Prick testing, which is of low diagnostic value, is nevertheless still included in the recommendations; IDT is recommended at a 10^{-1} dilution, or even pure when the clinical history is very suggestive. Testing can be carried out four to six weeks after the episode, and no blood tests can replace skin tests. The reintroduction of an alternative that tests negative is still routinely indicated, although there is no agreed protocol. In the event of urgent reintroduction without the possibility of prior testing, a switch with premedication should be chosen in grade I reactions, and the same approach with reinforced monitoring in a safe environment is advised in the event of anaphylaxis. In non-emergency situations, the sequence of skin tests followed by reintroduction can distinguish between genuine allergic immediate HS and non-allergic forms.

Delayed HS

ICM are frequently overlooked as suspects in delayed HS, particularly as they are administered as a single injection. Drug eruptions caused by ICM occur within a short period of time, ranging from a few hours to eight days after a single injection. The seven elimination half-lives do not need to be taken into account. In the event of a mild drug eruption, we wait six weeks before carrying out a patch test as is, followed by a pure IDT, and more than six months in an expert centre for severe forms, with a patch test with the solution as is as first-line assessment, followed by a pure IDT if the patch test is negative. Three ICM should be tested from the outset: the suspect if known, as well as one representative of group A and one of group B (classification based on the chemical structure of ICM, in particular the position of the side chains on the triiodobenzene ring). In 2025, a study by the drug eruption group (FISARD) focusing on 300 patients investigated for maculopapular rash caused by an ICM, with a positive result for at least one product, showed that IDTs were more sensitive than patch tests. However, patch tests still identified some patients with negative IDTs, justifying their continued use.

Fixed pigmented erythema should be investigated by patch testing on previously affected skin. In acute generalised exanthematous pustulosis, patch tests and IDTs can be performed simultaneously if the index episode was not particularly severe. Erythema scarlatiniforme desquamativum recidivans (ESDR)-type eruptions are observed within three days. ICM have been described as responsible agents. Skin tests should also be carried out *in situ* for this entity.

Lastly, a FISARD study in 2024 documented 43 cases of drug eruptions with positive patch tests or IDTs for all seven ICM tested, illustrating the frequency of co-sensitisation, whose mechanisms remain poorly understood but which justify widespread use of the full test panel for delayed HS to ICM.

Chronic hand eczema

Reports by Albertine Lynch (Dermatology Intern, Lyon)

Speakers: C. Leuleu, F. Castelain and P. Pralong

Latest developments in the treatment of chronic hand eczema

Speaker: C. Leuleu

Chronic hand eczema (CHE) should be investigated for a contact factor. Daily emollients remain the cornerstone of treatment. First-line treatment with topical corticosteroids or topical calcineurin inhibitors is recommended after looking for signs of local secondary infection. The correct use of topical treatments should be monitored and patient education repeated. Alitretinoin has MA as a second-line treatment for CHE after failure of topical therapy.

In recent news, delgocitinib (MA in 2024, 65% reimbursement) has been made available for moderate to severe CHE in adults. This is a topical pan-JAK inhibitor that can only be prescribed by dermatologists and allergists. A thin layer should be applied twice a day. In the 2:1 randomised Delta 1 trial, 638 patients were treated with delgocitinib and compared with 320 patients who received a placebo. At week 16, delgocitinib showed significant superiority over the placebo in achieving an IGA-CHE score of 0 or 1. A clinical response was observed after just four weeks of treatment, in terms of overall disease activity as well as pruritus and pain, with continued improvement in outcomes up to week 16. A 75% improvement in the Hand Eczema Severity Index (HECSI) score was achieved by half the patients treated with delgocitinib.

The safety data were satisfactory in this trial. In the extension study of this trial (Delta 3), the initial responders maintained their response at week 36, and the results suggested a persistence effect, with efficacy maintained even several weeks after application was discontinued.

The randomised Delta Dorce trial compared alitretinoin with delgocitinib in over 500 adult patients with severe CHE, for whom topical corticosteroids had not been effective. At week 24, delgocitinib was superior to alitretinoin in achieving HECSI90 and improving pruritus and pain. The safety data were also in favour of delgocitinib, as adverse events were more common – and more frequently severe – in patients treated with alitretinoin (10% of adverse events led to treatment discontinuation in the alitretinoin group).

Also in the news was a meta-analysis published in January 2026 that included 374 patients treated with dupilumab for CHE; it estimated the response rate to be 80% between weeks 4 and 16 of treatment, with an improved response with continued treatment. Efficacy appeared to be lower in hyperkeratotic forms, and better in atopic patients.

In a 1:1 randomised placebo-controlled trial involving 133 patients over the age of 12 with severe topical corticosteroid-resistant CHE, dupilumab was more effective than the placebo in terms of disease activity scores and pruritus.

With regard to tralokinumab, data from clinical trials in which six patients with CHE were included suggest a rather slow improvement in the HECSI score with this treatment.

Retrospective data are also available for 16 patients with CHE resistant to topical treatments, who were treated with tralokinumab and monitored for a period of 52 weeks with permission to continue topical therapies during follow-up: a decrease in the HECSI was observed from the fourth week of treatment, and 100% of patients achieved a 75% decrease in the HECSI at week 52. Sixty percent of these patients were able to space out injections to every four weeks over the period.

Lastly, with regard to the possible role of Janus kinase inhibitors in the treatment of CHE, in the randomised Measure Up 1 and 2 trials evaluating the efficacy of upadacitinib versus a placebo in atopic dermatitis, in the patients included who had CHE, significant efficacy was achieved from the first week of treatment compared with the placebo.

When work is the culprit

Speaker: F. Castelain

The presentation was organised in the form of clinical vignettes.
The first case presented was that of a young 18-year-old hairdresser, consulting for hyperkeratotic hand eczema, with a clear occupational pattern (improvement during periods off work). This type of presentation requires a distinction to be made between three different scenarios, corresponding to the different aetiologies of occupational eczema. Firstly, irritant dermatitis occurs rapidly after exposure to irritating products. It does not involve an immunological-allergic mechanism or a period of sensitisation. It typically presents as a papular, hyperkeratotic and scaly eruption on the backs of the hands with relatively well-defined borders, progressing to fissuring. Healing is rapid once the irritants have been removed.
Atopic dermatitis, which often affects the hands, is aggravated in humid environments, as in the hairdressing sector (shampoos), so this is a differential diagnosis.

Lastly, **allergic contact dermatitis**, which is a delayed hypersensitivity reaction following a period of sensitisation, never occurs on first exposure to the allergen, but rather 48-72 days after re-exposure. Less common than irritant contact dermatitis, it can complicate it (an impaired skin barrier promotes sensitisation). Allergy testing diagnoses the condition by proving sensitisation. If contact allergy is strongly suspected, investigations can begin with an open test without covering the test area with a patch, which may be sufficient to confirm the diagnosis while avoiding a severe reaction to patch tests. The treatment of allergic contact dermatitis involves not only avoiding the allergen, but also avoiding irritants wherever possible.

These three diagnoses are not mutually exclusive. They all share the same preventive measures. In primary prevention, the risk of sensitisation should be reduced by wearing suitable gloves, caring for hands (emollients, drying with a dry cloth) and washing instruments, using nickel-free tools and less irritating shampoos, dividing tasks involving contact with moisture (e.g. shampooing) between several members of staff, and checking the water temperature.

The speaker then presented the case of a patient – an industrial grinder – with a clinical picture of pulpitis showing an occupational pattern. It is worth noting that when it comes to detecting an occupational pattern, which is the strongest argument for suspecting an occupational origin for a dermatosis, improvement during holiday periods is often a more sensitive indicator than the workweek/weekend pattern, as weekends are too short to observe any real improvement in symptoms. The occupational pattern of contact dermatitis can also be seasonal (particularly for florists).
Because of the precision required for the actions performed, this patient handled small metal objects without gloves, so an allergy to metals was initially strongly suspected. However, sensitisation was ultimately attributed to the cutting fluid.

The allergy could only be documented thanks to particularly meticulous questioning that retraced each of the actions carried out daily by the patient as part of his job. This case also demonstrates the importance of **testing products brought in directly** by the patient, after scrupulously checking the safety data sheets and pH levels of professional products.

The third clinical situation was that of a 25-year-old computer scientist complaining of eczema initially limited to the medial aspect of the right thumb, then extending to the peri-labial region and then the palpebral region. Questioning helped retrace the exact progression of the lesions, suggestive of hand-borne transfer to the face, and above all identify the object responsible for the initial eczema on the right thumb. At work, the patient used an ergonomic computer mouse with a special rubber-lined thumb slot. Allergy investigations revealed a positive patch test for IPPD (N-isopropyl-N-phenyl-paraphenylenediamine); this antioxidant used to protect rubber against oxidation and cracking was present in the composition of the patient's mouse. The dermatosis healed completely after the tool was replaced.

The fourth patient, an ophthalmologist, presented with cuff-pattern hand eczema. He suspected several of the products used in his practice. A repeated open application test (ROAT) carried out with the patient's own products revealed sensitisation to the alcohol-based hand sanitizer gel used in his practice.
Avoidance of this product only led to partial improvement in the hand eczema, which was finally explained by further allergy investigations, as there was also sensitisation to tetracaine (anaesthetic eye drops) and to the gloves used by the patient, which were therefore also avoided.

Avoidance of the alcohol-based hand sanitizer gel could pose a problem, given the nature of his professional activity, but an analysis of the ingredients in this gel helped specify the nature of the allergy: the patient was sensitised to a carbomer contained in the product. He was able to continue using the same brand of alcohol-based hand sanitizer solution, without any tolerance problems.

A fifth case again illustrated the importance of questioning in the field of allergy, as well as the importance of details that are sometimes discovered by chance. A 25-year-old woman with atopy presented with pulpitis with an occupational pattern. She worked making windows and handled metal parts on a daily basis, so she brought them in for testing. On the day of her visit, the rubber band used to hold the parts in place during transport caught the attention of the allergists. As part of her work, the patient explained that she removed the rubber bands around the metal parts several times a day before handling them. It was decided to include a sample of this rubber band brought in by chance in the investigations, and it was these tests that proved positive.

The last patient, a baker, had consulted for chronic eczema, which was frequently exacerbated during periods of work. He reported no symptoms of rhinitis or asthma at the workplace.
The patient underwent patch testing with the European baseline series as a routine measure; however, the professional context (food industry) and the rapid onset of flare-ups during exposure were suggestive of protein contact dermatitis (PCD), a diagnosis confirmed by prick testing and specific IgE antibodies to wheat flour proteins.
PCD is an allergy, often occupational, in which impairment of the skin barrier promotes the passage of high-molecular-weight compounds, leading to IgE-mediated sensitisation (type 1, immediate hypersensitivity).

On re-exposure, patients rapidly (within a few minutes) develop pruritus, contact urticaria, and sometimes rhinitis, conjunctivitis or asthma (especially for airborne allergens). These are combined with oedematous eczema lesions, which appear more rapidly than in classic allergic contact dermatitis. PCD should be considered in professionals exposed to animal or plant proteins.

Therapeutic patient education in hand eczema

Speaker: P. Pralong

Therapeutic patient education (TPE) can be likened to a "driving licence" – a necessary step if you want to be able to move your vehicle (your body) through a chronic disease. CHE is a very specific form of eczema, as the hands play a central role in everyday life, both personally and professionally. They are a tool for expression, communication and work. Managing this disease involves not only knowing how to recognise it as such and prescribing appropriate treatments, but also giving patients the tools they need to use these treatments optimally.

TPE should not be confined to dedicated training sessions, which are very useful but are organised on an ad hoc basis and only in certain centres. It also relies on an educational approach that can be adopted in consultations and is based on active listening, tailoring communication to the patient, using simple, illustrative explanations and checking that the information given is understood.

Showing patients images of eczema lesions directly enables them to identify with the condition, better understand what a flare-up represents and identify the specific targets of the treatments they are prescribed.

Patients should also be informed of the mechanism(s) at work in their disease: atopy, irritation or allergy. These different phenomena do not imply the same prognosis or the same treatment measures, although they are often interlinked. Suspicion of an allergic mechanism warrants allergy testing, the principles and benefits of which should be explained to the patient.
Patients should be aware of the irritating factors that can aggravate their dermatosis: dampness, cold, unsuitable cleansing or cleaning products, and friction. They can be given advice sheets detailing hand washing and care techniques (warm water, oil or syndet, pat-drying, barrier cream, reduced washing frequency, etc.).

It is essential to explain to patients that emollients are not the “first-line” treatment for a flare-up, enabling them to avoid or defer application of topical corticosteroids.

It is important to stress the urgency of treating an eczema flare-up as soon as it appears, and explain that local anti-inflammatory agents cannot be avoided.
Similarly, the patient should understand the importance of treating the flare-up “to the end”, i.e. until the skin looks and feels normal. We can use the image of embers reigniting a fire, with the aim being to extinguish even the last remaining ember. The same fire analogy can help the patient understand why it is advisable to treat a slightly larger area than the one affected by the flare-up itself.

As for the amount to be used, the fingertip unit can be a useful reference for some patients, and we should not hesitate to note it on prescriptions and demonstrate it during consultations – seeing the doctor touch the topical corticosteroid can convey a positive message about the harmlessness of these products and downplay their use. Patients should be told that there is no risk of dependence when using topical corticosteroids.

TPE necessarily involves a skilful effort to counter the misinformation and inappropriate treatments to which patients often turn. There is also a need for guidance when faced with the vast range of dermocosmetics on the market, particularly when it comes to choosing emollients, which are a key pillar of treatment. The message should be that the "best" cream is the one the patient likes enough to apply it every day without exception. The aim of all the advice given during consultations should be to encourage patients to be as independent as possible.

What's new in atopic dermatitis?

Reports by Albertine Lynch (Dermatology Intern, Lyon)
Speakers: D. Staumont-Sallé, A Nosbaum and M. Viguier

New French recommendations for the management of atopic dermatitis (AD)

Speaker: D. Staumont-Sallé

Drawn up between 2022 and 2025, these recommendations updated those of 2004 and are in line with the European recommendations published in 2022.
The full algorithm and text are available in **Annales de Dermatologie**. The aim of the presentation was to highlight the key messages.
From a paraclinical point of view, a **skin biopsy** should be carried out – and repeated if necessary – in the presence of any atypical lesions. However, no routine allergy testing is recommended.

Topical treatments continue to play a central role: they control the majority of mild to moderate AD cases and remain an essential complement to systemic treatments in more severe forms.

An important new development is that **in cases of impetiginized AD**, topical corticosteroids and tacrolimus can be continued as long as appropriate antibiotic therapy (local or systemic, depending on the extent) is initiated. On the other hand, if there is a suspicion of herpetic secondary infection, local anti-inflammatory agents should be suspended, then resumed after 48 hours of antiviral treatment. This should be started without waiting for the PCR result.
The eligibility criteria for systemic treatment were clarified: poorly controlled AD (activity scores or impact on quality of life) despite appropriate and well-administered local treatment, or inability of the patient to administer local treatment.

In adults, the need for at least four tubes of strong topical corticosteroids per month over the long term is also an indication for systemic treatment.
The recommendations do not establish any hierarchy between the systemic therapies available: ciclosporin, JAK inhibitors and biotherapies. However, the French reimbursement system still requires ciclosporin to be used before other systemic treatments. Ciclosporin is still appropriate in adults when rapid control is required (4-5 mg/kg/day for up to one year).

JAK inhibitors should be avoided for patients over 65, smokers, patients with risk factors for cardiovascular or venous thromboembolic disease, and patients with a history of cancer. A dose reduced by half may be proposed.

Topical corticosteroids, calcineurin inhibitors and phototherapy are authorised during pregnancy and breastfeeding. The use of ciclosporin and biotherapies (very few data are available) needs to be discussed on a case-by-case basis. JAK inhibitors must not be used.

Concerning local care

Speaker: A. Nosbaum

The therapeutic foundation represented by the emollient-topical corticosteroid combination remains solid. Rebuilding the skin barrier is essential. Emollients have been shown to prolong flare up-free periods. As far as cleansing is concerned, showers and baths should be short and warm, using products with a pH of 5-6. On the other hand, the frequency of washing should be left open, as it has no impact on the disease.
For the treatment of flare-ups, topical corticosteroids remain the best option: strong activity on the body and moderate activity on the face, including in children. No tapering is recommended. They should be applied from the first signs of a flare-up, until the skin returns to normal. The fingertip unit remains the reference and no maximum amount applies in the acute phase.
Topical calcineurin inhibitors (TCIs) are suitable for areas at risk of cortisone-induced atrophy, or as follow-up treatment after topical corticosteroids. They can be used in children. There is no associated risk of cutaneous lymphoma.
Proactive treatment with topical corticosteroids or TCIs – two applications per week – increases the time between flare-ups by a factor of 8 in the event of frequent recurrences. It was recently shown that in mice, these topical agents inhibit the resident memory T cells involved in flare-ups. This effect is suspensive, and complete cessation will result in a resumption of inflammatory cell activity.

In terms of innovations, more than 40 drugs are under development and three new classes have been approved by the FDA for AD since 2016. Firstly, topical **JAK inhibitors** have been developed. **Delgocitinib** is a pan-JAK inhibitor recommended for the treatment of moderate to severe chronic hand eczema in adults following failure of topical corticosteroids. It achieved 30% clearance at week 16 compared with 10% for the placebo.

It has a rapid effect on pruritus. Its safety profile is good. It is already used as a first-line treatment for AD in children aged ≥ 2 years in Japan. **Ruxolitinib** (a JAK1-2 inhibitor) has been approved in the USA since 2021 for patients over 12 years of age whose AD is not controlled by topical corticosteroids, when the disease affects less than < 20% of the body surface area. It achieves 70% clearance after eight weeks, with an effect on pruritus within the first few minutes. In the USA? The drug is used as a first-line treatment, including in children aged two and over.

Secondly, three **PDE4 inhibitors** have been approved by the FDA: **crisaborole** for mild to moderate AD from the age of three months; **roflumilast,** also used for seborrhoeic dermatitis and psoriasis, with a good safety profile but efficacy inferior to that of topical corticosteroids and topical JAK inhibitors; **difamilast** (Japan 2021, USA 2026), which can be used from the age of two, with modest efficacy (40% success rate after four weeks) and a good safety profile.
Lastly, tapinarof is an aryl hydrocarbon receptor agonist approved in the USA in 2024 for AD and previously in 2022 for psoriasis. It is indicated for mild to moderate AD from the age of two. It achieves a 46% response rate after eight weeks. The main adverse effects to be feared are folliculitis and headaches.
A network meta-analysis (*Zhang* et al*., JAMA Dermatol 2026*) compared the efficacy and safety of these different topical agents. It showed that not all drugs are equal: topical corticosteroids have a better efficacy/safety ratio than tacrolimus, for example, and are far superior to PDE4 inhibitors. As for JAK inhibitors, their efficacy is excellent, but little information is available on their safety. What's more, the cost of these treatments has to be factored into the choice of treatment, and in the case of JAK inhibitors, it is very high.

All in all, the combination of emollients and topical corticosteroids remains unbeatable. The new topical agents on the market are innovations, but their economic sustainability raises questions.

Focus on GREAT clinical trials

Speaker: M. Viguier

Cutaneous lymphoma, atopic dermatitis and dupilumab

Cases of cutaneous T-cell lymphoma (CTCL) have been reported with dupilumab in AD, raising the question of true induction of lymphoma by dupilumab versus unmasking of CTCL with effective treatment of AD or initial diagnostic confusion between AD and CTCL. There is a biological rationale for the potential induction of lymphoma by dupilumab based on the increased bioavailability of IL-13, which may promote tumour proliferation via the IL-13Rα2 receptor.

The joint GREAT-GFELC study included 547 patients managed for AD who had developed CTCL during treatment with dupilumab; the mean age was 58 years.

The dermatosis labelled "AD" had begun after the age of 40 in 41% of them. At the time of diagnosis of CTCL, 75% of patients had worsening of pre-existing lesions rather than *de novo* lesions (25%).

A modified Delphi method was used to reach expert consensus.

The experts recommended carrying out skin histology with T-cell clonality assessment and lymphocyte immunophenotyping in the presence of certain atypical historical features – patients aged over 40, with no history of atopy – and clinical signs: erythroderma, alopecia, follicular involvement, palmoplantar keratoderma.

If the appearance of the lesions changes during treatment, or if they worsen, a histological examination with a clonality assessment should be carried out or repeated. In the event of confirmed or strongly suspected CTCL, dupilumab should be discontinued. Specific treatment of CTCL may be deferred for three months (wait-and-see approach) in non-aggressive forms.

If the diagnosis is uncertain, it is suggested that sampling be repeated if the lesions persist for three months – and sooner if they have worsened. If CTCL is suspected, a therapeutic switch to methotrexate may be considered.

Blepharoconjunctivitis during biotherapy: DUPI-OEIL and TRALO-OEIL studies

Blepharoconjunctivitis (BC) during biotherapy for AD is relatively frequent: in therapeutic trials, its frequency is estimated at 25% on dupilumab, 7 to 10% on tralokinumab, and less than 5% on lebrikizumab. A meta-analysis in 2023 found no significant difference in risk between the three biotherapies.

The DUPI-OEIL study included 181 patients taking dupilumab. In this cohort, 18.7% of the patients developed BC, with all cases occurring *de novo,* without any worsening of pre-existing BC.
BC developing during treatment was moderate in 80% of cases. The risk of BC was not associated with prior ophthalmological involvement. The risk factors identified were: head and neck involvement, erythroderma and dry eyes.

The TRALO-OEIL study included 96 patients taking tralokinumab. The available interim analysis revealed 11 cases of *de novo* BC (14.6% of patients), most often of moderate severity. In the 23 patients who had BC before starting biotherapy, the disease was stable or resolved after four months without worsening.

These data suggest that the introduction of dupilumab or tralokinumab should not be contraindicated in patients with blepharoconjunctivitis.

Therapeutic de-escalation of dupilumab

Therapeutic de-escalation is motivated both by medical-economic considerations (expensive products) and by patients themselves, who may request it after prolonged efficacy. A study conducted by GREAT (2022) had described a late step-down strategy (beyond 12 months after eight months of disease control) in 88 patients. The MADULO study currently in progress is a prospective non-inferiority study comparing a very gradual step-down strategy with a standard regimen in good responders. The inclusions are complete. The step-down regimen has yet to be validated.

When taking care of yourself hurts you

Reports by Albertine Lynch (Dermatology Intern, Lyon)
Speakers: A. Herman and N. Raison-Peyron

Do-it-yourself (DIY) cosmetics: what are the risks?

Speaker: A. Herman

Growing distrust of industrial cosmetics is prompting many patients to make their own products. There are many reasons for this: a desire to consume better, the fun aspect of preparing cosmetics, ecological concerns and financial considerations. This is sometimes compounded by a lack of access to certain products, which makes home-made cosmetics unavoidable.

It is estimated that 9% of French people make DIY cosmetics. In the United States, the prevalence of allergic contact eczema (ACE) linked to cosmetic products increased by a factor of 2.7 between 1996 and 2026. And yet, contrary to popular belief, a home-made product is not necessarily more “natural”.

The lay literature devoted to this topic is abundant and often conflicting, and numerous paid training courses are available. Only 6% of DIY blogs are written by people with cosmetology training.

Paradoxically, few cases of ACE related to DIY products have been reported in the literature. This may be because patients spontaneously discontinue the suspected products without consulting, or because the responsible products are not suspected and therefore not bought in to the consultation.

Various risks are associated with these preparations: they often contain common allergens, particularly food allergens (cinnamon, lemon), as well as essential oils (used in 30% of DIY preparations), plant and animal proteins and plants. There is a risk of percutaneous sensitisation to food proteins and of immediate reactions (e.g. egg in hair masks). Irritant dermatitis is a dose-dependent risk. Saponification processes entail a caustic risk in the absence of mechanical protection. The use of plants is associated with risks of phytophotodermatitis and direct toxicity from certain plants. Preservative-free DIY products can promote fungal and bacterial infections. Lastly, a non-negligible risk is the lack of efficacy of the products, which is particularly problematic for sunscreens: out of 15 recipes, three contained no filters and 12 had an SPF < 6.

Wellness professions: risks and allergies

Speaker: A. Herman

Beauticians, nail technicians and hairdressers are the professionals most exposed to skin irritants and allergens. Atopy and extra-occupational co-exposure exacerbate this risk, which is particularly high in occupations exposed to humidity.

Irritant contact dermatitis, which has a non-immunological mechanism, results in well-defined scaly patches on the backs of the hands. Its onset is promoted by the concentration of irritants, but also by the contact surface, friction, the duration and frequency of exposure, occlusion under gloves, atopy and the winter season. Prevention is based on reducing exposure, wearing appropriate gloves, limiting humidity and ensuring good ventilation. Allergic contact dermatitis takes the form of vesicular lesions on the backs of the hands that are sometimes oedematous; it is mainly caused by acrylates, fragrances and essential oils, preservatives, rubber additives and metals. Acrylates, which are ubiquitous in gel nails and false nail glues, frequently cause fissuring pulpitis, periungual eczema, onycholysis, subungual hyperkeratosis and sometimes palpebral eczema. Up to 60% of professionals sensitised to HEMA – now included in the European baseline series – are hairdressers or beauticians. It is sometimes necessary to read patch tests on D7 for these compounds, and it should be emphasised that the HEMA regulatory restriction applies to consumers but not professionals. Only multi-layer laminated gloves offer truly effective protection, but their high cost limits their use, such that a change of professions is sometimes necessary.

Massage therapists and aromatherapists are particularly exposed to fragrances and essential oils, with the most sensitising oils being ylang-ylang, citronella, jasmine, sandalwood, clove and neroli. Nickel and cobalt, which are widely present in the tools used by beauticians, barbers and hairdressers, should be systematically tested, as should methylisothiazolinone, a preservative used in hair products. Paraphenylenediamine, a major hair colour allergen, requires the use of single-use nitrile gloves. Me-PPD is an alternative tolerated by 70% of patients allergic to PPD. Lastly, rubber components cause damage to the backs of the hands, with a tendency to extend in a cuff-like distribution; this can easily be investigated using the glove repeated application test (GRAT).

Occupational contact urticaria, which has an incidence of six cases per 100,000 and occurs within a few minutes of exposure, particularly among hairdressers and beauticians, is most frequently associated with latex.

These professions combine exceptional exposure to irritants and allergens. Prevention and avoidance are the cornerstones of management, with cessation of activity sometimes being the only option.

Retrospective review of allergens over the past 10 years

Speaker: N. Raison Peyron

Linalool and limonene occupy the first two places on this "top 10" list. These aromatic terpenes are pre-haptens whose hydroperoxides are the real sensitisers, often making patch test interpretation tricky. Although mandatory labelling is required for these substances in cosmetics in Europe, they occur naturally in dozens of essential oils.
Black seed oil is a vegetable oil that can cause severe Lyell-like or DRESS-like skin reactions. Its allergen, thymoquinone, is not commercially available for patch testing, but tert-butylhydroquinone from the cosmetics series can be used. Acrylates – in particular HEMA – which were responsible for a recent European epidemic linked to nail care, were added to the baseline series in 2019; co-sensitisation between acrylates, in particular with ethyl cyanoacrylate, is frequent, and the clinical picture combines fissuring pulpitis, periungual eczema and onycholysis. The consequences are serious for very young allergic patients, who will be forced to avoid certain professions such as dentistry and remain vigilant with regard to medical devices containing these compounds.

Paraphenylenediamine, a major allergen in hair dyes, causes severe eczema with palpebral oedema and involvement of the edge of the scalp. Tests often produce strong reactions, warranting the use of lower concentrations (0.1% instead of 1%) and a shorter application time (2-12 hours). It should also be considered when faced with reactions to fake black henna tattoos. The majority of sensitised patients are also sensitised to para-toluenediamine, which should therefore be routinely tested. When tests are strongly positive, co-sensitisation should be investigated, particularly co-sensitisation to local anaesthetics. Pure plant-based dyes such as henna, or temporary dyes, are alternatives.

Methylchloroisothiazolinone and methylisothiazolinone, which are cosmetic preservatives with a broad biocidal spectrum, are found in particular in wipes and lotions; their concentration is regulated in rinse-off products and their use is prohibited in leave-on products.
Vitamin C derivatives, particularly 3-O-ethyl ascorbic acid, are used in anti-ageing and brightening products.

Glucosides, which are gentle, biodegradable emulsifiers and surfactants, are a new addition to the baseline series, with decyl glucoside having been included in 2023, due to frequent sensitisation in atopic subjects.

Tin fluoride, found in toothpastes, is responsible for cheilitis, stomatitis and perioral dermatitis; the toothpaste should be tested as is and tin oxalate at 1% in petroleum jelly.

Lastly, alkaline persulphates are hair bleaching agents that are also used to clean dental appliances and in the textile, chemical and pharmaceutical industries. They are represented in the hairdressing series by ammonium persulphate. They often give rise to immediate reactions without any specific IgE being identified, and it is important to be aware of them when nummular eczema occurs in the context of frequenting spas or jacuzzis.

This top 10 list illustrates the growing diversity of cosmetic allergens and the need to tailor test series to the actual exposure of each patient, whether cosmetic, occupational, hair-related or dental; successive regulatory changes also reflect the speed at which this landscape is evolving.