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SUBMISSION

ISID0501 - Comparison of the effectiveness of optically guided high-frequency ultrasound and multispectral imaging for the in vivo measurement of melanoma tumor thickness

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Treatment patterns in Japanese patients with generalized pustular psoriasis (GPP) with/without concomitant psoriasis vulgaris (PsV) and in elderly patients

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Introduction: Patients with GPP require long-term treatment plans and our previous study showed the treatment patterns over several lines of therapy. As GPP can be preceded by PsV, and little is known about biologics use among the elderly, we conducted subgroup analyses to identify any treatment pattern changes in these groups. **Aims:** To describe treatment patterns in Japanese patients with newly diagnosed GPP with or without concomitant PsV at baseline and in elderly patients. **Methods:** Retrospective cohort study using claims data from a large database (Medical Data Vision Co., Ltd). Eligible patients had a confirmed GPP diagnosis (≥ 2 ICD-10 code L40.1; January 1, 2016 to August 31, 2021), and were followed for ≥ 1 year after the index date. **Results:** Overall, 434 patients with GPP were included; 159 with PsV (ICD-10 code L40.0) and 275 without. First-line (1L) therapies differed between cohorts; apremilast (6.3% vs 0.8%) and cyclosporin-based (17.6% vs 12.2%) regimens were used more frequently in patients with PsV vs without. However, use of TNF- α inhibitor-based regimen was lower in those with (4.4%) vs without (10.3%) PsV. Biologics use increased in later lines, particularly in patients with PsV. In the elderly cohorts, aged ≥ 65 (n=185) and ≥ 75 years (n=87), fewer patients received 1L biologic-based regimens (14.0% and 10.7%, respectively) vs the overall population (24.7%). TNF- α inhibitor-based regimens were not used as 1L treatment in the ≥ 75 years cohort. Use of biologic-based regimens increased in elderly cohorts at 3L (22.9% and 25.6%, respectively) but remained lower than in the overall population (38.0%). **Conclusions:** Treatment patterns differed between GPP patients with/without PsV and between elderly patients and the overall cohort, suggesting that concomitant PsV and age at GPP diagnosis affect treatment selection.

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Comparison of the effectiveness of optically guided high-frequency ultrasound and multispectral imaging for the *in vivo* measurement of melanoma tumor thickness

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Breslow thickness (BT) is the most important predictor of melanoma behavior. Several *in vivo* imaging techniques offer melanoma diagnosis, but most cannot assess tumor thickness. We and others have shown that multispectral imaging (MSI) and high-frequency ultrasound (HFUS) are uniquely suited to predict BT. However, the performance of HFUS and MSI has to date not been compared. Here we aimed to compare the effectiveness of optically guided high-frequency ultrasound (HFUS) and multispectral imaging (MSI) for the estimation of melanoma BT. 79 patients with primary melanoma (average BT: 1.631 ± 1.745) were included. Imaging was performed with an optically guided 33 MHz HFUS device and an MSI prototype, and results were compared to BT established by histology. Three clinically significant categories of tumor thickness (≤ 1 mm, 1-2mm, >2 mm) were investigated. MSI images were classified into these three categories based on our previously developed algorithm, while the greatest tumor thickness was directly measured in the HFUS images. HFUS-measured tumor thickness correlated better with the histological BT than MSI (MSI: $r: -0.6788$, $p < 0.0001$, HFUS: $r: 0.9706$, $p < 0.0001$). Compared to MSI (sensitivity: 58.44%, specificity: 79.22%), HFUS differentiated tumor thickness groups with higher sensitivity (93.42%) and specificity (96.71%). Our results show that optically guided HFUS is superior to MSI for the noninvasive prediction of BT. Moreover, our data indicate that HFUS may aid in surgical margin selection for curative surgery even before the histological assessment of melanomas.

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Comorbidities in 630 male patients with lichen sclerosis: A case-control study

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We studied the comorbidities in 630 male patients with lichen sclerosis (LS). The patients were diagnosed between 2004 and 2020 in Turku University Hospital, and identified either by the ICD-10 diagnosis code for lichen sclerosis (L90.0), or leukoplakia of the penis/balanitis xerotica obliterans (N48.0), or from the pathology information system. Ten age- and sex-matched controls with no diagnosis of LS were randomly selected from the hospital's electronic health records for each identified patient. The incidence of lichen sclerosis increased during the study period from 0.05 per 1,000 people to 0.275 per 1,000 people. The mean age of the patients was 39.2 years, and the median age was 35.0 years. They were most often diagnosed at 20–24 years. The association of LS with other diseases was analyzed using Fisher's exact test. The results are presented as odds ratios (ORs). The Benjamini and Hochberg method was used to adjust the P-values for multiple comparisons. Only results with $p < 0.05$ are presented here. Atopic dermatitis (OR 2.4) and other atopic diseases, as well as psoriasis (OR 3.5) and lichen planus (OR 16.8) were found to be more common in patients with LS. Risks for penile carcinoma (OR 81.0) and carcinoma *in situ* of the penis (OR 60.5) were increased. Angina pectoris (OR 1.8) and diseases related to metabolic syndrome including obesity (OR 2.6), type 2 diabetes (OR 2.3), hypercholesterolemia (OR 2.0), and essential hypertension (OR 1.9), as well as sleep apnea (OR 2.0) were about twice as common in male patients with LS compared with the control group. Many of the previous studies on comorbidities have been small and without a control group, and the results have not always been consistent. To our knowledge, this is the largest study on diseases associated with LS in male patients, and it also includes a control group. The variety of comorbidities should be taken into account when treating these patients.

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Worldwide epidemiologic factors in pemphigus vulgaris and bullous pemphigoid

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Autoimmune blistering diseases such as Bullous Pemphigoid (BP) and Pemphigus Vulgaris (PV) are complex, multifactorial, and polygenic diseases, whose exact pathogenesis are difficult to pinpoint. Research aimed at elucidating the associated epidemiologic risk factors of these two diseases has been hampered by their rare disease status. Further, a lack of centralization and standardization of available data makes the practical application of this information challenging. In order to collate and clarify the available literature we comprehensively reviewed 61 PV articles from 37 different countries and 35 BP articles from 16 different countries addressing a range of disease relevant clinical parameters including age of onset, sex, incidence, prevalence, and HLA allele association. The reported incidence of PV ranged from 0.035 to 5 patients per 100,000 people, while BP ranged from 0.21 to 7.63 patients per 100,000. Prevalence of PV ranged from 0.38 to 30 per 100,000 people and BP ranged from 1.46 to 47.99 per 100,000. The mean age of onset in patients ranged from 36.5 to 71 years for PV and 64 to 82.6 years for BP. Female-to-male ratios ranged from 0.46 to 4.4 in PV and 1.01 to 5.1 in BP. Our analysis provides support for the reported linkage disequilibrium of HLA DRB1*0402 (an allele previously shown to be associated with PV) and DQB1*0302 alleles in Europe, North America, and South America. Our data also highlights that HLA DQB1*0503 (also known to be associated with PV) appears in linkage disequilibrium with DRB1*1404 and DRB1*1401, mainly in Europe, the Middle East, and Asian countries. The HLA DRB1*0804 allele was only associated with PV in patients of Brazilian and Egyptian descent. Only two HLA alleles were reported as associated with BP more than twice in our review, DQB1*0301 and DQA1*0505. Collectively, our findings provide detailed insights into the variation of disease parameters of PV and BP that can be expected to inform future work aimed at unraveling the complex pathogenesis of these conditions across the globe.