Schedule of Events

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American Contact Dermatitis Society
17th Annual Meeting
San Francisco Marriott
San Francisco, CA
March 2, 2006

The ACDS Annual Meeting is a full day focused on current issues in contact dermatitis and occupational skin diseases. Presentations include abstract and poster presentations on state-of-the-art research in the basic, applied and clinical science of contact dermatitis.

Ticketed Events

There is no additional charge for these tickets, however, space is limited and reservations required. If you do not have tickets for any of these events, please check availability with the registration desk.

Breakfast Symposium
Roundtable Luncheon
Cocktail Reception

Fisher Resident Awards

Residents are eligible for the Fisher Resident Awards for the best oral abstract presentations. Eligible presenters are denoted with an asterisk following their presentation.

Verification of Attendance/Evaluation

You will receive evaluation forms for the meeting in your registration packet. Please complete the form and deposit them in the collection box at the registration desk following the meeting.

Appropriate credit for attendance should be ascertained and reported by individual physicians to the particular state or medical society to which he or she belongs. A certificate of attendance will be provided to all registrants.

CME Credits

The American Contact Dermatitis Society's Annual Meeting certifies that this educational activity has been recognized for a maximum of 6 credit hours in Category I and may be applied towards the American Academy of Dermatology Continuing Medical Education Award.
Program: 532-100

ACDS Membership

Membership in ACDS is open to dermatologists, physicians, researchers and medical professionals with an interest in dermatitis and occupational dermatology. Membership information can be found at www.contactderm.org.

Dermatitis

Dermatitis the official journal of the American Society of Contact Dermatitis. This quarterly, peer-reviewed journal, under the direction of Editor-in-Chief Ponciano D. Cruz, MD, provides clinically focused articles on diagnosis and treatment of dermatologic conditions caused by irritants and allergic reactions. Available online, Dermatitis, is searchable and accessible anywhere there is an internet connection. The journal is free with an ACDS membership or to order a subscription please, call 1-800-568-7281 or visit www.bcdecker.com.

Disclosure Statement

The American Contact Dermatitis Society requires balance, independence, objectivity and scientific rigor in all of its educational activities. The Board of Directors requires that all presenters and audience members comply with all applicable laws and regulations governing disclosure.

ACDS Address

138 Palm Coast Parkway NE #333
Palm Coast FL 32137 USA
Tel (386) 437-4405 Fax (386) 437-4427
Email: info@contactderm.org Web Site: www.contactderm.org

2006 Sponsors

The American Contact Dermatitis Society wishes to thank those organizations listed below for their support of the society's educational programs in 2006

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- Dormer/Chemotechniques
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- Pharmaceutical Specialties

Patrons

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September 28 – 30, 2006
Marriott Waterfront Hotel
Baltimore, Maryland

Contact Dermatitis 2006

Blending Science *with* Best Practice

- Meeting of the Experimental Contact Dermatitis Research Group (ECDRG) and the American Contact Dermatitis Society (ACDS).
- Organized by ECDRG, ACDS, the National Institute for Occupational Safety and Health (NIOSH), the National Occupational Research Agenda (NORA) Allergic and Irritant Dermatitis Team and the University of Maryland School of Medicine.
- Thursday, Friday, Saturday, September 28-30, 2006 in Baltimore, Maryland

The only meeting that brings together researchers and practitioners in the field of contact dermatitis.

Schedule of Events

17th Annual Meeting of the ACDS
Schedule of Events

Location: San Francisco Marriott Hotel
55 Fourth Street
San Francisco, CA 94105

Time	Session	Room
7:00 AM	**Registration opens**	**Golden Gate B**
7:30 AM	**ACDS Breakfast Symposium** **David Cohen, MD** Facial Dermatitis Breakfast sponsored by CollaGenex	**Yerba Buena 4/5**
8:30 AM	**Welcome to the 17th ACDS Annual Meeting** **Kathryn Zug, MD,** ACDS President **Denis Sasseville, MD,** ACDS Annual Meeting Committee Chair	**Golden Gate B**
8:35 AM	**General Session**	**Golden Gate B**
8:35 AM	**Victoria Garnemark, MD**.** Simultaneous Contact Allergies in Patients with Photocontact Allergy to Ketoprofen*	
8:45 AM	**Josephine Okwechime, MD**. Retrospective Analysis of Patients Exposed to Rubber Allergens at the Ottawa Civic Hospital over a Ten Year Period*	
8:55 AM	**Panta Rouhani, MPH**. Surgical-Related Allergic Contact Dermatitis: Questionnaire*	
9:05 AM	**Tace Steele, BA**. Patch Testing in the Pediatric Population: Does Atopy Predispose to Detergent Allergy?*	
9:15 AM	**Lael Desmond, MD**. Transitional Cell Carcinoma Presenting as Contact Dermatitis*	
9:25 AM	**Jeffrey Donovan, MD, PhD**. Cross-Reactions to Desoximetasone and Mometasone Furoate in a Patient with Multiple Topical Corticosteroid Allergies*	
9:35 AM	**Ghanima Alomer, MD**. Contact Urticaria from Carboxymethylcellulose in Chalk*	
9:45 AM	**Allison Hoffman, MD**. Localized Type 1 Allergy to Insulin*	
9:55 AM	**Margaret Lee-Bellantoni, MD, PhD**. Defibrillator Dermatitis*	
10:05 AM	**Kristina Paley, MD**. Cutaneous B-Cell Pseudolymphoma Due to Paraphenylenediamine*	
10:15 AM	**Ellen Roh, MD**. Patch Testing Patients on Etanercept*	
10:25 AM	**Horatio F. Wildman, MD**. Bullous Allergic Contact Dermatitis to Nickel-Plated Knitting Needles	

10:35 AM **Peter C. Schalock, MD**. Tricks and Tips from 10 Years of Patch Testing and Teaching*

10:45 AM **Break/Exhibits/Posters** **Golden Gate C3**

11:15 AM **Occupational Dermatology Symposium** **Golden Gate B**
Chaired by **Boris Lushniak, MD**

11:15 AM **Andrea Costanza, DO**. Oil Acne in an Assembly Line Worker*

11:25 AM **Jeffrey Donovan, MD, PhD**. Detection of Allergic Contact Dermatitis in the Automechanic: Need for a New Tray?*

11:35 AM **Patricia Malerich, MD**. A Retrospective Look at the Effect of Removing Powdered Latex Gloves on Occupational Latex-Related Illness*

11:45 AM **Haydee Ramirez de Knott, MD**. Post-traumatic eczema.

11:55 AM **Anthony Gaspari, MD.** Announcement of the combined ECRDG/ACDS Meeting, Baltimore, Sept 28-30, 2006.

12:00 AM **ACDS Roundtable Lunch** **Golden Gate A2/A3**
Sponsored by Dormer/Chemotechnique

1:30 PM **General Session** **Golden Gate B**

1:30 PM **James S. Taylor, MD**. Remembering Robert M. Adams.

1:40 PM **Alexander A. Fisher Lecture.**
Pr. Magnus Bruze, MD. Occupational Dermatoses in Southern Sweden

2:30 PM **ACDS Awards**

2:45 PM **Donna Richardson, RN**. Contact Derm Nursing Alliance.

2:55 PM **David Basketter, MD**. Do We Understand the Factors Controlling the Induction of Skin Sensitization?

3:05 PM **Eunyoung Lee, MD**. Comparison and Correlation Between Stinging Responses with Lactic Acid Stinging Test and Bioengineering Parameters.

3:15 PM **Leigh Ann Scalf, MD**. Patient Survey Results From Patch Testing at the Mayo Clinic.

3:25 PM **Joseph Genebriera, MD**.** What Patients Remember After Patch Testing.

3:35 PM **Break/Exhibits/Posters** **Golden Gate C3**

4:00 PM **Maria Antonieta Rios Scherrer, MD**. Contact Dermatitis to Snuff.

4:10 PM **Gimenez Arnau, MD,** Granulomatous Lesions Secondary to Polylactic Acid Contained in Leuprolin Acetate Depot Injections.

4:20 PM **Mark D. P. Davis, MD**. Results of Patch Testing to a Corticosteroid Series: Experience with 1000 patients at Mayo Clinic.

4:30 PM **Susan Nedorost, MD**. Retention of Allergens in Clothing.

4:40 PM **Justin Woodhouse, MD**. Contact Allergy to Thioureas.

4:50 PM **Closing Remarks and Business Meeting**

5:15 PM **Cocktail Reception** **Golden Gate C1**
Sponsored by Ferndale Laboratories

* CANDIDATES FOR THE ALEXANDER A. FISHER RESIDENT AWARD.

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Exhibitors

ACDS invites attendees to visit the following exhibitors behind the general session. Breakfast and morning and afternoon breaks will be served in the exhibit area.

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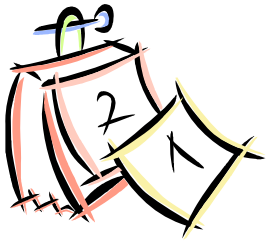
ACDS 2006 Calendar



Important Dates in 2006

April 15	**Mentoring Award** applications due.
October 15	**Mentoring Award** applications due.
September 1	**Nominations** for ACDS Board of Directors and President-Elect due.
December 1	**Abstract Submissions due for 2007 ACDS Annual Meeting**
December 1	**Maibach Travel Award** applications due.
December 1	**Alexander A. Fisher Resident Award** applications due.
December 1	**Clinical Research Fellowship** applications due.

Upcoming Meetings

March 2, 2006	**17th Annual Meeting of ACDS,** San Francisco, CA
Sept 28-30, 2006	**Blending Science with Best Practice:** Combined Meeting of the Experimental Contact Dermatitis Research Group and the American Contact Dermatitis Society
Feb. 1, 2007	**18th Annual Meeting of ACDS,** Washington, DC

Abstract Summary

ORAL PRESENTATIONS

SIMULTANEOUS CONTACT ALLERGIES IN PATIENTS WITH PHOTOCONTACT ALLERGY TO KETOPROFEN

M. Hindsèn, E. Zimerson, **V. Garnemark,** M. Bruze,
Department of Occupational and Environmental Dermatology, Malmö University Hospital, Malmö, Sweden

Background: In Sweden ketoprofen has been used for topical application sinse 1995, and its use is increasing. Photoallergic contact dermatitis from ketoprofen-containing topical treatment has been reported since many years and usually includes severe eczematous reactions. This study includes 35 patients that have been photopatch tested with ketoprofen with very strong photopatch test reactions as the result.

Methods: Photopatch testing with our photopatch series and patch testing with our standard series and fragrance mix compounds. Patch testing and photopatch testing with ketoprofen containing gel, its ingredients and other benzophenones.

Results: 13 of 19 patients (68.4%) had positive patch test reactions to myroxilon pereirae when tested with the standard series; 18 of 35 patients (51.4%) were positive on the non-irradiated side when photopatch tested. Corresponding figures for fragrance mix were 8 of 19 patients (42.1%) and 15 of 35 patients (42.9%) respectively. 7 of 8 fragrance mix positive patients tested with different components in the mixture were positive for cinnamic alcohol. Photoallergic patients showed an overrepresentation of contact allergy to PTBP-resin as 5 of 18 (27.8%) tested positively.

Conclusion: Contact allergy to fragrance mix, myroxilon pereirae, PTBP- resin are common in individuals photoallergic to ketoprofen. Are these allergies predisposing to photoallergy to ketoprofen?

RETROSPECTIVE ANALYSIS OF PATIENTS EXPOSED TO RUBBER ALLERGENS AT THE OTTAWA CIVIC HOSPITAL OVER A TEN YEAR PERIOD

Josephine Okwechime, Melanie Pratt
Division of Dermatology, University of Ottawa, Ottawa, Canada

BACKGROUND

Rubber is a versatile substance used in various products such as gloves, condoms, shoes, sports equipment, orthopedic appliances, cosmetic products, etc. Accelerators added during the manufacturing of rubber to hasten its production have been associated with contact dermatitis. We review 10 years of patients seen in the Ottawa patch-test clinic with rubber accelerator contact allergy from 1995-2005.

OBJECTIVE

1. Examine the various sources and sites of rubber exposure and correlate with the patient's specific positive rubber accelerators.

2. Determine the frequency of sensitivity to these different rubber allergens.

3. Report the occupations/hobbies associated with rubber-related dermatitis

4. Evaluate the relevance of the positive patch test results

METHODS

Approximately 4400 patients were patch-tested in the Ottawa Clinic over the past decade, 1995-2005. A total of approximately 300 subjects were identified for review. Full details on 2/3 were available; therefore the study only examined 210 cases.

RESULTS (PRELIMINARY)

128 Females and 82 Males were evaluated for the study. 93 subjects reacted to gloves, 13 reacted to athletic equipment and 17 to shoes. 19 possibly had the bleached rubber syndrome while 7 reacted to their medical appliances. Make-up sponges were culprit in 12 patients. 4 patients possibly reacted to glue, while 15 were from rubber accessories.

SURGICAL-RELATED ALLERGIC CONTACT DERMATITIS: QUESTIONNAIRE

Panta Rouhani, MPH*, Antoine Amado, MD^, Keyvan Nouri, MD*, Sharon E. Jacob, MD*
*Department of Dermatology and Cutaneous Surgery, University of Miami, Miami, FL, USA.
Department of Dermatology, Cleveland Clinic Foundation, Cleveland, Ohio, USA

BACKGROUND: The AAD Burden of Skin Disease Study estimates 72.4 million Americans have contact dermatitis. With the growing number of dermatologic surgeons, there is greater risk for exposure and sensitization to surgically related antigens. The specific exposures to potential contact allergens in the surgical setting, however, are not well established.
OBJECTIVES: Assess practices and knowledge base of contact dermatitis among dermatologic surgeons.
METHODS: Anonymous questionnaires were sent to Florida Society of Dermatologic Surgery members (221). [IRB 2005-0243]
RESULTS: 45 surveys were returned (20.4% response rate).
CONCLUSIONS: 75% of respondents patch tested. Respondents primarily used the T.RU.E. test to screen for adhesives (73.3%) and nickel (63.3%) allergy. 26.7% reported T.R.U.E. test screening for suture allergy. One-fifth of patch testers did not suspect ACD to the top T.R.U.E. test allergens. This pilot data suggests that while the T.R.U.E. test is being utilized by dermatologic surgeons, its efficacy can be optimized.

PATCH TESTING IN THE PEDIATRIC POPULATION: DOES ATOPY PREDISPOSE TO DETERGENT ALLERGY?

Tace Steele, B.A., Elizabeth A. Connelly, M.D. & Sharon E. Jacob, M.D.
Department of Dermatology and Cutaneous Surgery,
University of Miami, Miami, FL, USA

Allergic contact dermatitis affects 72 million persons per year in the United States. While ACD in children may be underreported, incident cases are on the rise. Bruckner *et al*. demonstrated that the prevalence of ACD in children was 24.5% when testing asymptomatic children between the ages of 6 months-65.5 months in Denver.

We report comprehensive patch testing of 18 children (ages 3 to 17 years old) diagnosed with allergic contact dermatitis from the referring pediatric dermatologist, in the last 6 months. The demographics of this pilot population were 44% Caucasian, 33% Hispanic, 17% African-American, and 6% Asian. 33% of the children were atopic. The most common allergens were Thimerosal, Neomycin and Cocamidopropyl Betaine (CAPB). Notably, CAPB prevalence was higher in the atopic group.

TRANSITIONAL CELL CARCINOMA PRESENTING AS CONTACT DERMATITIS

Lael Desmond, M. D., University of South Florida, Tampa, FL, Debra Fett, M. D., NOVA Southeastern University, Largo, FL

We present a 61-year-old woman with referral diagnoses of dermatitis and delusions of parasitosis. She reported a 2 year history of pruritic patches on skin, the passage of long worms in her urine and the sensation that these were crawling under her skin. She had been seen by multiple specialists without definitive diagnosis and was refractory to treatment. She was using a topical medication containing grapefruit extract. Her exam revealed impetiginized plaques. Laboratories were normal except for mild eosinophilia and elevated alkaline phosphatase. Skin biopsy was notable for epidermal necrosis with superficial dermal edema and eosinophilia. A “worm” specimen she collected from her urine was negative for parasites and was subsequently sent for histopathology, yielding the diagnosis of red cell cast. Abdominal and pelvic CT scan revealed an obstructing mass at the right renal pelvis, ultimately leading to the diagnosis of transitional cell carcinoma. Following right nephrectomy, her symptoms improved significantly.

We present this case for interest and for discussion of unusual outcome with the diagnosis of contact dermatitis.

CROSS-REACTIONS TO DESOXIMETASONE AND MOMETASONE FUROATE IN A PATIENT WITH MULTIPLE TOPICAL CORTICOSTEROID ALLERGIES

Jeffrey C.H. Donovan and Joel G. DeKoven
Division of Dermatology, University of Toronto, Canada

Patients with topical corticosteroid allergy frequently present with unresponsiveness to treatment or exacerbation of their eczema. We present a case of a 60 year-old man with a lower leg dermatitis that failed to respond to multiple group B and D topical corticosteroids. Subsequent patch testing showed cross-reactions to multiple group B and D corticosteroids as well the uncommon cross-reaction to group C desoximetasone and group D1 mometasone furoate. His patch testing was negative to the group A hydrocortisone and tixocortol pivalate. The patient's dermatitis ultimately resolved following avoidance of topical corticosteroids.

Group C corticosteroids are infrequently involved in corticosteroid cross-reactions; the patient presented represents one of the few patients reported in the literature to have cross-reactions to both desoximetasone and mometasone furoate. Patients in the literature that demonstrate cross-reactions to the C_6-halogenated desoximetasone are frequently patch test negative to the non-halogenated group A corticosteroids. Further study is needed to better understand the sensitizing potential of steroidal preparations and to better define the molecular basis for cross-reaction patterns.

CONTACT URTICARIA FROM CARBOXYMETHYLCELLULOSE IN CHALK

Linda Moreau[1], **Mowza Al-Sowaidi1,** Normand Dubé[2], Denis Sasseville[1]
[1]Division of Dermatology, McGill University Health Centre, Royal Victoria Hospital, Montréal, QC and [2]Greenfield Park, QC, Canada

Background: Carboxymethylcellulose (CMC) is an anionic cellulose polymer with wide industrial applications as binder in resins, inks, paints, and textiles. It is used in consumer goods, foods and medicaments as a suspender and viscosity enhancer. It can cause immediate and delayed allergic reactions.
Objective: We present an unusual case of contact urticaria due to CMC in chalk with possible cross-reaction to methylhydroxyethylcellulose (MHEC).
Method: A 15-year –old student complained of immediate urticaria after handling sticks of white chalk, after being touched by the fingers of someone who had handled chalk. The NACDG standard series was used for patch tests with readings at 48 and 96 hours. Open and prick tests with readings after 30 minutes were done using 2 brands of chalk (one containing CMC and the other MHEC) and various pet. and aq. dilutions of CMC and MHEC. Additional ingredients of both brands of chalk were tested as well.
Results: Our patient developed frank urticarial reactions during open tests with both powdered chalks, and milder reactions to the open test with CMC 10% aq. and to prick test with CMC 0.1% aq. There was no reaction to MHEC or to other ingredients of the chalks. No relevant late reaction was seen.
Conclusion: Already known to cause anaphylaxis after parenteral or oral exposure, CMC can cause contact urticaria as well. It remains unclear why our patient reacted more strongly to the chalk than to pure CMC. We speculate that the abrasive nature of the chalk enhances cutaneous penetration of CMC, or that calcium carbonate, the main ingredient of the chalk acts as an adjuvant. Although we could not demonstrate cross-reactions between CMC and MHEC, it is possible that such reactions can occur, and that our negative results to MHEC were due to improper testing technique or concentrations.
References:
1. Hamada T, Horiguchi S. Allergic contact Dermatitis due to sodium carboxy-methyl cellulose. Contact Dermatitis 1978: 4: 244.
2. Bigliardi PL, Izakovic J, Weber JM, Bircher AJ. Anaphylaxis to the carbohydrate carboxymethylcellulose in parenteral corticosteroid preparations. Dermatology 2003; 207: 100-103.
3. Johnsson M, Fiskerstrand EJ. Contact urticaria syndrome due to carboxymethylcellulose in a hydrocolloid dressing. Contact Dermatitis 1999: 41:344-345.

LOCALIZED TYPE I ALLERGY TO INSULIN

Allison Hoffman, M.D., Department of Dermatology, University of Minnesota, Minneapolis, MN, USA; Erin Warshaw, M.D., M.S., University of Minnesota, Minneapolis, MN, USA

Systemic and localized reactions to insulin itself or additives have been reported. Although most cases present with dermatological findings, most articles are published in allergy or endocrinology journals.

We present a 74 year old male with type 2 diabetes mellitus who was referred for evaluation of lesions at the site of insulin injections. These reactions began minutes after injections and lasted several days without generalized urticaria, angioedema, or systemic symptoms. On examination, the patient had indurated erythematous wheals at injection sites on the abdomen. Patch testing to 12 different insulin types and common additives was negative. Intradermal tests to 13 insulins and a histamine control were positive. Saline control was negative. Localized type I allergy to insulin was diagnosed.

Evaluation of a suspected insulin allergy and desensitization protocols will be discussed.

DEFIBRILLATOR DERMATITIS

Margaret Lee-Bellantoni, MD, PhD (Tufts-New England Medical Center; Boston University, Boston, MA), Juliet Gunkel, MD (University of Wisconsin Hospital, Madison, WI), Pamela Scheinman, M.D. (Tufts-NEMC, Boston, MA)

Objective: We present a 57-year-old man with a history of ventricular tachycardia who developed expanding macular erythema overlying the site of an implantable cardioverter defibrillator (ICD) on his abdomen. He had 3 prior ICDs implanted without incident over the years. Results: After antibiotic treatment and hospitalization for presumptive infection, patch testing provided evidence of contact hypersensitivity to polyurethane 75D and peroxide cured silicone rubber, present in his ICD. Identification of his allergens helped his cardiologist choose a new ICD that successfully replaced the preceding device. Conclusions: Although defibrillator dermatitis is uncommon, the implantation rate has increased dramatically over the past several years, especially in the United States. Given the presence of potential sensitizers in ICDs and the need for repeated replacement surgeries due to battery depletion, we may start observing increases in contact allergy to ICD components. Prompt recognition of this entity can help prevent unnecessary morbidity and expense associated with antibiotic treatment and hospitalization. Patch testing is a cost-effective and noninvasive way to evaluate patients with eruptions overlying ICDs.

CUTANEOUS B-CELL PSEUDOLYMPHOMA DUE TO ARAPHENYLENEDIAMINE

Kristina Paley, M.D., Larisa J. Geskin, M.D., Matthew J. Zirwas, M.D.
University of Pittsburgh, Department of Dermatology

Lymphomatoid contact dermatitis is a form of T-cell pseudolymphoma that was first described in 1976 by Orbaneja et al. Since that initial report a number of allergens have been reported to cause this type of pseudolymphoma.

We describe a case of cutaneous B-cell pseudolymphoma due to paraphenylenediamine (PPD). Our patient presented with violaceous tumors on the right temple and left post-auricular area in close proximity to the hairline. Due to the location of the lesions, history of exposure and pathology the diagnosis of pseudolymphoma secondary to hair cosmetic allergy was suspected. Patch testing confirmed allergy to PPD which was present in patient's hair dye. All lesions resolved with in 2 months after discontinuation of the PPD.

This report underscores the importance of thorough history and observation when assessing patients with suspected lymphoproliferative processes. Most cases of lymphomatoid contact dermatitis are T-cell predominant, and B-cell pseudolymphoma due to contact allergy is extremely rare. This is, to our knowledge, the first report of paraphenylenediamine induced B-cell pseudolymphoma.

PATCH TESTING PATIENTS ON ETANERCEPT

Ellen Roh, Matthew Zirwas
University of Pittsburgh, Pittsburgh, PA

Background: Studies have shown that immunosuppressants can cause false-negative patch test results. Thus, one might assume that patients on TNF-α inhibitors are not good patch testing candidates. However, we present two patients on etanercept therapy who were patch tested with positive, relevant results.
Objective: To investigate the accuracy of patch testing in patients receiving etanercept.
Methods: We conducted patch testing in two patients, both on etanercept, who were referred to our contact dermatitis clinic.
Results: Our first patient presented with a scalp and feet dermatitis. On patch testing, he had 3+ reactions to neomycin, bacitracin, balsam of peru, and nickel; a 2+ reaction to p-tert-butylphenol formaldehyde resin; and 1+ reactions to narcissus and dandelion. Our second patient was referred for a painful palmoplantar dermatitis. She exhibited 3+ reactions to fragrances and methyldibromoglutaronitrile/phenoxyethanol and 2+ reactions to bacitracin, ethyl cyanoacrylate, other acrylates and sorbitan sesquioleate. Both patients improved with avoidance.
Conclusion: Patch testing can be successfully performed on patients taking etanercept. Prospective studies with patch testing performed both while taking and not taking etanercept are required to determine if it has any effect on patch testing results.

BULLOUS ALLERGIC CONTACT DERMATITIS TO NICKEL-PLATED KNITTING NEEDLES

Horatio Wildman, MD; William S. Sawchuk, MD; Alison Ehrlich, MD, MHS
Department of Dermatology, George Washington University

Nickel is the most common contact allergen screened by patch-testing. Most cases present as ear-lobe dermatitis induced by nickel-containing costume jewelry. However, the presence of nickel containing products in our environment is ubiquitous, including metal fasteners on articles of clothing, coins, cosmetic applicators, eyeglass frames, parts of musical instruments, and orthodontic hardware.

We present the case of a 58-year-old female with a 2-month history of a vesicular eruption involving the face, chest, and fingers. She also gives a history of intermittent eczematous dermatitis involving the arms and legs for 10 years. The patient's hobbies included knitting for approximately 3-4 hours each night. Patch testing to the NACDG standard, cosmetic, hairdressing, and textile series showed positive reactions to nickel sulfate and nickel sulfate hexahydrate. At a follow-up visit, the patient brought in her sewing needles, which were nickel-plated.

Strict avoidance of nickel containing products, inlcuding use of nickel-free knitting needles has cleared the eruption. This case demonstrates a unique environmental exposure of nickel resulting in allergic contact dermatitis.

TRICKS AND TIPS FROM 10 YEARS OF PATCH TESTING AND TEACHING

Peter C. Schalock, MD, Kathryn A. Zug, MD
Dartmouth-Hitchcock Medical Center, Lebanon, NH USA

Testing patients for delayed-type cutaneous allergy through patch testing does not have to be static or arduous for practitioner or patient. Our goal is to reveal our prejudices, tricks and tips accumulated over 10 years from an established patient and resident education focused patch testing clinic. Some include:

- using a printed handout, “Lo-Cal” (Low Contact allergen likelihood) skin diet prior to testing
- most useful “workhorse” handouts
- letter/phone call prior to patch testing
- virtue of a template history via computer
- preparing/consenting the patient using visual aids
- patching to personal care products
- organization of digital clinical photography
- follow-up

OIL ACNE IN AN ASSEMBLY LINE WORKER

Andrea Costanza, D.O., Debra Fett, M.D. Sun Coast Hospital, NOVA Southeastern University, Largo, FL

We present a 41-year old assembly line worker with oil acne induced by cutting oil. She was involved in the production of rubber seals, which included exposure to cutting oil, rubber, silicone, and heat, while working within a small, poorly ventilated 3-sided cubicle. She wore gloves but no goggles or face shield. On examination, she had multiple open and closed comedones as well as numerous inflammatory papules on the face and neck. The diagnosis was consistent with oil acne, induced by her exposure to cutting oil.

Cutting oils are widely used throughout industry for cooling and lubrication. They are a frequent cause of occupational dermatoses, with nearly two million workers in the United States exposed annually. Cutting oils are divided into insoluble (neat) oils and water-based fluids, each causing various skin diseases. Although neat oils are not used as often today as in the past, oil acne remains a common occupational skin disease. We present this case for interest, and for review of oil acne as an occupational-induced dermatosis.

DETECTION OF ALLERGIC CONTACT DERMATITIS IN THE AUTOMECHANIC: NEED FOR A NEW TRAY?

Jeffrey C.H. Donovan, Irena Kudla and D. Linn Holness
James R. Nethercott Occupational Health Clinic
St. Michael's Hospital, University of Toronto, Canada

Contact dermatitis is common in automechanics. Patch testing with the North American Screening Series coupled with the Oils and Coolants Tray likely underestimates the true frequency of allergic contact dermatitis. There is a need to evaluate additional allergens that may contribute to the development of allergic contact dermatitis in automechanics. We reviewed over 500 potential exposures of mechanics and have identified a list of potential allergens that could be incorporated into a new 'Mechanic Tray.' We report the results of patch testing with the standard tray, the Oil and Coolants Tray and a panel of 19 allergens which comprise our current 'Mechanic Tray'.

A RETROSPECTIVE LOOK AT THE EFFECT OF REMOVING POWDERED LATEX GLOVES ON OCCUPATIONAL LATEX RELATED ILLNESS

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Background: Natural rubber latex represents a major allergen in health care. Latex related illness can present as irritant or allergic contact dermatitis, and anaphylaxis. The latter two reactions require sensitization. Powdered latex gloves enhance sensitization through environmental exposure to latex proteins. Powder binds to latex proteins and the coupled compounds spread widely upon removal of the gloves. This exposure can increase sensitization and eventual latex reaction. In order to protect patients and caregivers from increased risk of latex reactions, Geisinger Medical Center switched to powderless latex gloves.

Methods: Retrospective chart review of occupational latex related illness claims before and after the switch to powderless latex gloves.

Results: Since the implementation of powderless latex gloves, latex related occupational illness has fallen.

Conclusion: Natural rubber latex illness can be decreased in the workplace by eliminating sensitizing products. Geisinger Medical Center has noted a reduction in employee latex related illness as a result of removing powdered latex gloves. The expense of changing gloves is offset by corresponding decease in employee work days lost and workmen's compensation claims.

POST-TRAUMATIC ECZEMA

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Dermatitis occurring at sites of chemical, physical, mechanical or surgical trauma has been variously described and defined. The eczema usually begins within weeks to months following **acute** injury at the site of the trauma or medical procedure, such as an excision or graft and may persist or recur for long periods of time.

We have seen a number of cases and report a 48 year old woman who developed a severe flare of eczema several months post-operatively at the site of a transverse rectus abdominus myocutaneous flap for intraductal carcinoma of the breast. She had received no radiation and had intermittent childhood and flexural eczema. Patch testing was noncontributory. Her dermatitis persisted requiring intermittent topical and systemic corticosteroids.

Differential diagnosis includes infection or cellulitis, superimposed allergic contact dermatitis from topical medications, trauma induced psoriasis and foreign body reactions. Two types have been proposed by Mathias; the isomorphic reaction may be primary or secondary depending if the trauma preceded or followed the endogenous eczema and the idiopathic reaction, in which endogenous eczema is absent.

Post-trauma eczema presents important medico-legal implications, especially in occupational cases.

CONTACT DERM NURSING ALLIANCE

Donna Richardson, RN, Mayo Clinic, Rochester, MN. Mary Smith, RN, MSN, University Hospitals of Cleveland, Westlake, OH

Background: The contact dermatitis nurse is essential to the flow of the practice, management of the patch test clinic and care of the contact dermatitis patient. Their role has not been well recognized by peers or the contact dermatitis community. The need to develop an alliance that will serve as a forum for collaboration of these nurses is essential.

Objective: Through collaboration provide the highest quality of nursing care for the contact dermatitis patient.

Methods:

- Introduction of the Contact Dermatitis Nursing Alliance to the American Contact Dermatitis Society and Dermatology Nurses Association
- annual meetings at ACDS
- support outcome based nursing research in the area of contact dermatitis
- education of contact dermatitis nurse
- pool resources
- chat room to discuss contact dermatitis & patch testing topics

Results: Nurses with the common interest of contact dermatitis have recognized the need to organization of the Contact Dermatitis Nursing Alliance.

Conclusion: The Contact Dermatitis Nursing Alliance request the recognition & support of the American Contact Dermatitis Society & the Dermatology Nurses Association.

DO WE UNDERSTAND THE FACTORS CONTROLLING THE INDUCTION OF SKIN SENSITIZATION?

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Studies have demonstrated that increasing dose impacts the induction of skin sensitization and in an experimental setting, a number of other variables received attention some decades ago. However, in the work reported here, the relative importance of the number of exposures is highlighted, together with the impact of duration. In a human repeated insult patch test, reduction of exposure duration from 9 x 48h to 9 x 5 min per application decreased the sensitisation rate to 1% p-phenylene- diamine (PPD) from 54% to 3%. However, in a clinical study, infrequent longer duration and higher concentration exposure to PPD was significantly less likely to induce sensitisation compared to more frequent, short duration, lower concentration exposure. Detailed statistical analysis of the results indicated that the most important factor driving the induction of skin sensitisation was the number of exposures. An appreciation of such factors is vital for risk assessments where exposure is likely to be above the skin sensitization induction threshold.

COMPARISON AND CORRELATION BETWEEN STINGING RESPONSES WITH LACTIC ACID STINGING TEST AND BIOENGINEERING PARAMETERS

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In evaluating the safety of a novel cosmetic product or a new chemical, it is important to assess susceptible population. One group of subjects are known to stingers who are more likely to experience sensory effects such as stinging and burning after contacting with cosmetics.
The purpose of the study is to measure skin biophysical parameters non-invasively in stingers and non-stingers, and to see their correlations with stinging responses. Two hundred and ninety eight women were evaluated by modified lactic acid stinging test with 5% lactic acid solution rather than classic 10% solution because of strong irritant reaction in Asians. Transepidermal water loss (TEWL), skin hydration, sebum content and pH were measured using the bioengeering instruments in an environment-controlled room. Correlations between stinging responses and biophysical parameters were statistically analyzed.
There was a positive correlation between stinging and TEWL measurement. However, no correlations were observed between stinging responses and other parameters such as skin hydration, sebum content and pH.
Our data indicate that there is a relationship between the degree of stinging and skin barrier function. However, we think variable additional studies are necessary to characterize skin of stingers and their pathogenesis.

PATIENT SURVEY RESULTS FROM PATCH TESTING AT THE MAYO CLINIC

Leigh Ann Scalf, MD[1]; Sara A. Farmer[2]; Mark D.P. Davis, MD[1]; 1. Department of Dermatology; 2. Division of Biostatistics, Mayo Clinic, Rochester, Minnesota

Background: Patch testing is the gold standard for identifying contact allergens in patients with suspected allergic contact dermatitis. This is not a simple process and it requires significant patient education in the avoidance of identified allergens.

Objective: We sought to identify the level of patient satisfaction with the patch testing process and to determine if patients felt that the testing was beneficial.

Methods: 1458 surveys were mailed to patients that had been most recently patch tested at the Mayo Clinic, Rochester to the standard series as of December 31, 2004. We received 757 completed surveys.

Results: Greater than 75% (578) of the respondents were at least "somewhat satisfied" with the overall process, with 51% (388) reporting that they were "very satisfied." 58.3% (430) of the patients reported an improvement in their skin condition since patch testing.

Conclusion: Overall, patients reported both satisfaction with the patch testing process and an improvement in their skin conditions. This data supports the continued use of patch testing to identify contact allergens.

WHAT PATIENTS REMEMBER AFTER PATCH TESTING

Joseph Genebriera, MD;* Leigh Ann Scalf, MD;* Sara A. Farmer;** Mark D.P. Davis, MD;* Departments of Dermatology* and Biostatistics;** Mayo Clinic, Rochester, Minnesota.

Background: Patients at our institution receive verbal and written information detailing the allergens identified during patch testing.

Objective: To query patients on whether the allergens identified are recalled and identify which population os more likely to recall this information.

Methods: A write-in question regarding allergens recalled was included with 1458 surveys mailed after patch testing (mean 13.4 months from time of survey completion, SD 6.5 months) at the Mayo Clinic group practices. 757 were returned (response rate 51.9%)

Results: Of 757 patients, 45.7% (n=346) remembered all allergens correctly. Of the 2724 reactions to allergens, 50.6% (n=1377) were remembered correctly. Among all the patients, the average percentage of allergens remembered correctly was 58.6%. Patients in the 50-59 year age group and females were more likely to remember the allergens correctly.

Conclusion: This study shows that only 50.6% of patch test-positive allergens are recalled by patients. This data supports the need for on-going educational reinforcement in allergen avoidance and the use of adjunctive tools to assist patients in remembering allergens.

CONTACT DERMATITIS TO SNUFF

Maria Antonieta Scherrer, Marilda Brandão – UFMG, Brazil

Snuff is a mixture of cured tobacco, mentol, fragrances, etc. It has a heterogeneous composition, varying from region to region. Dipping snuff and using smokeless tobacco are common among some groups of people. There are few references to snuff contact dermatitis in literature.Hypersensitivity to tobacco itself is extremely rare, although there are a few references to tobacco dermatitis due to infection, injuries and irritant contact.

A 66-year-old-retired man has presented itchy and lichenified lesions on his face for 8 years.He used nasal drops with nafazoline and snuff.The lesions appeared when he started dipping snuff. At that time he was working in the countryside, exposed to the sun.He was patch-tested to standard and cosmetic series, some fragrances, nasal drops and snuff. The repeated open application test was performed with snuff on the forearm and on the face, close to the lesions. The results were negative. The lesions were reduced after he decreased the snuff consume and was treated with topical corticosteroids. We believe that the lesions were caused by irritants present in the snuff
mixture and aggravated by sun exposure.

GRANULOMATOUS LESIONS SECONDARY TO POLYLACTIC ACID CONTAINED IN LEUPRORELIN ACETATE DEPOT INJECTIONS

Ana Giménez-Arnau M.D., Marta Ferran M.D., Agustí Toll M.D., Mireia Yébenes M.D., Verónica Baena M.D.*, Josep Lloreta M.D.*, Ramon M. Pujol, M.D.
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Introduction: Leuprorelin acetate is a synthetic agonist analogue of gonadotropin-releasing hormone used in the treatment of advanced prostate cancer. New depot formulations, with leuprorelin entrapped in lipophilic synthetic polymer microspheres, allow sustained release of the drug. Several cases of local reactions at the injection sites have been reported with depot formulations.

Case Report: A 78-year-old man presented with sterile abscesses at different injection sites of 3-month depot leuprorelin formulation. Histopathological studies disclosed foreign body reaction with translucid round microspheres. After negative patch and prick tests, intradermal test with the entire depot formulation (leuprorelin and acid polylactic) resulted in the development of an inflammatory papule 30 minutes after injection, persisting for more than 4 months. Conversely, intradermic injection of non-depot formulation yielded negative results.

Discussion: Both leuprorelin acetate itself and lipophilic synthetic polymer have been incriminated as responsible for granulomatous reactions. Intradermal tests have demonstrated that lipophilic synthetic polymer causes such local reactions in our patient.

RESULTS OF PATCH TESTING TO A CORTICOSTEROID SERIES: EXPERIENCE WITH 1000 PATIENTS AT MAYO CLINIC

Mark DP Davis MD,* Sara Farmer,** Departments of Dermatology* and Biostatistics**, Mayo Clinic Rochester, MN

Background: Topical corticosteroids have increasingly been recognized to cause allergic contact dermatitis.
Methods: Retrospective study of our institutional experience with patch testing to corticosteroid series over a 5-year period (1/1/2000-3/31/2005).
Results: 1053 patients with suspected allergy to topical corticosteroids were patch tested to the corticosteroid series. Of 17,188 allergens tested, the allergic reaction rate overall was 1.6%; relevance 94.8%. Allergic reaction rates varied from 0.48% (Halcinonide 1%) to 5.24% (Tixocortol 21 pivalate 1%). Reaction rates to the corticosteroid groups varied from 5.98% (Group A), 5.22% (Group D), 5.13% (Group B) and 1.25% (Group C). Significant cross-reactions between groups were noted (50% between Groups B and D). Markers did not always identify potential allergens across the whole group (3.1% were only "picked up" by a non-marker).
Conclusion: Allergic patch test reactions to corticosteroids are relatively common, and depend on the corticosteroid used. Crossover occurs between groups, and group markers fail to 'pick up' some reactions to the groups. Patch testing to individual corticosteroid allergens may be better than depending on groups.

RETENTION OF ALLERGENS IN CLOTHING

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Background: Retention of allergens in shoes and socks has been previously reported.
Methods: Case reports of patients with incompletely resolved dermatitis at one-month visit after patch testing in the UHHS contact dermatitis clinic.
Results: Patients with dermatitis at sites other than the feet may react to allergens retained in clothing even after the clothing is washed. These allergens were often mistakenly regarded at time of patch test interpretation as being of only past relevance. In another scenario, the patient may fail to improve despite complete avoidance of application of the known allergen after patch testing. Discarding the contaminated clothing leads to cure.
Summary: Allergens retained in clothing are usually medicaments and of large molecular weight. Examples include bacitracin, corticosteroids, and clioquinol. Sites of dermatitis are in close contact to areas of clothing such as cuffs, hems, bras, and gloves.

CONTACT ALLERGY TO THIOUREAS

Justin G. Woodhouse, James S. Taylor
Cleveland Clinic Foundation, Cleveland, Ohio

Introduction: Thioureas are an uncommon but important cause of allergic and rarely photoallergic contact dermatitis.
Methods / Objective: We retrospectively reviewed our patch test data base registry to identify patients with reactions to thioureas between 1982-2004. Individual records were reviewed to identify the relevance of test results and the source of thiourea exposure.
Results: Thirty-seven patients were identified with positive patch tests to thioureas. Fifty percent of patients had definite or probable relevance to their current dermatitis. Of those patients, 90% were related to exposure to neoprene, all of which were related sporting goods or medical devices.
Conclusion: In our series positive patch tests to thioureas were frequently relevant. Directed questioning about contact with neoprene products may be helpful for identification of relevant exposures. If clinical history reveals neoprene as a likely source of the patient's dermatitis, T.R.U.E. and European Standard Series testing will not identify the allergen. Wider use of personal electronic products with neoprene cases may lead to more contact allergy to thioureas. Less common sources of thiourea exposure include adhesives, paper, and film toners.

POSTER PRESENTATIONS

CONTACT ALLERGY TO LIDOCAINE

Antoine Amado, MD, Apra Sood, MD, James S. Taylor, MD,
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Lidocaine is widely used as an injectable local anesthetic in health care and dermatology, as an intravenous treatment for cardiac arrhythmias, and as a topical anesthetic. Reports of allergic contact dermatitis (ACD) and delayed hypersensitivity reactions to this "amide" anesthetic are limited. Lidocaine 15% was added to the NACDG Standard Tray in 2001 after an Australian study reported 29 cases of ACD from lignocaine.

We report six cases of lidocaine contact allergy over two years. Three of three patients were patch test positive to lidocaine dilutions (15%, 10%, 5% and 1%). Intradermal tests with lidocaine, mepivacaine and bupivacaine were performed in 5 cases, with positive reactions to lidocaine in 3 and negative in 2; mepivacaine was positive in 1 case. Relevance was overt to topical and injectable use in 1 case each and covert in 4 cases.

Delayed hypersensitivity to lidocaine may present as "suture allergy", treatment failure, typical contact allergy, or other local skin or dental reactions. Allergen substitution is based on further patch and intradermal testing, the results of which may be discordant.

LANDMARKS, LEGENDS AND THE LEGACY OF CONTACT DERMATITIS

Sadegh Amini, MD, Tace Steele, and Sharon E. Jacob, MD
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Starting in the days of Jadassohn, patch test education has been deeply rooted in tutorials with mentors imparting their knowledge and experiences to the new generation of apprentices. This poster highlights landmark achievements and the legendary master mentors in contact dermatitis. From Jadassohn (*dermatitis medicamentosa*), Sulzberger (*Father of American Patch Testing*), Baer (*Langerhan immunology*), Fisher (*Guru on the Third Floor*), Storrs (*Patterns of hand dermatitis*), Belsito (*Pathophysiology, cytokines and adhesion molecules*), Adams (*Founder ACDS*), Maibach (*TRUE test*), and many more.

FIXED DRUG ERUPTION DUE TO METAMIZOLE (NOLOTIL®): THE USEFULNESS OF PATCH TEST

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Dermatology Department. Hospital de la Santa creu i Sant Pau. Barcelona.
Keywords: Fixed drug eruption, metamizole, patch test.

Fixed drug eruption(FDE) is an adverse cutaneous drug reaction. It is characterised by itching, erythematous macules repeatedly appearing in the same areas, after to be exposed to an oral medication, leaving residual hyperpigmented lesions once the drug has been withdrawn.

We present a 39-year-old woman with a FDE secondary to metamizole.Patch tests with the standard and NSAID batteries were negative. Liquid Nolotil® (metamizole) was applied occlusively on the back, in the area where the FDE presented initially, with a positive skin reaction (++).Nolotil® applied on the arm -an area free of FDE lesions when the patient came to the clinic- was negative. One month later, occlusive 1% metamizol in petrolatum was applied to the back area where the FDE first appeared, and gave a positive skin reaction (++) again.

The FDE diagnosis is based on clinical evaluation and the oral provocation test. To make the etiologic diagnosis, topic provocation test has been used instead of the oral provocation in the areas where the lesions appeared for the first time. In some cases of FDE due to metamizole the topical provocation test with this drug has been reported to be positive in the area where the lesion first appeared. We recommend the patch test with occlusive application of 1% metamizole in petrolatum, as the first diagnostic step in FDE cases due to metamizole, especially when the patient rejects the oral provocation test or when the test can reproduce unwanted side effects.

A CASE OF COMPOSTIAE AIRBORNE DERMATITIS EXACERBATED BY MOISTURIZER CONTAINING FEVERFEW.

Christina Killoran MD, Anita Pedvis-Leftick MD. Roger Williams Department of Dermatology and Skin Surgery, Providence, RI.

A 45 year old woman presented in October with a history of an eruption involving her scalp and face including behind her ears and eyelids. The eruption began at the end of August. It flared after she used Aveeno Calming moisturizer which contains feverfew. The patient was advised to stop all skin care products and was switched to Vani products. She was treated with a course of mid-potency topical steroids with almost complete resolution of the eruption. She was patch tested to the North American Contact Dermatitis Series. She had a 1+ reaction to sesquiterpene lactone mix, 1+ reaction to Compositae mix, 1+ reaction to parthenolide, 1+ reaction to tanacetum vulgare and a 1+ reaction to Aveeno Calming Moisturizer. It is felt that her dermatitis is a result of airborne contact dermatitis to pollens of the Compositae family. The eruption was exacerbated by her use of the Aveeno Calming moisturizer which contains feverfew.

PERIPHERAL BLOOD GRANULOCYTE ACTIVITY IN THE ELICITATION PHASE OF CONTACT HYPERSENSITIVITY

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The intensity of inflammation in contact hypersensitivity reaction (CHS) could be quantitated by ear swelling which is the classical manifestation of contact hypersensitivity. It was shown that in CHS not only antigenspecific but also proinflammatory effects of haptens contribute to the elicitation of CHS, highlighting the importance of mechanisms of innate immunity.
The experiments were performed on inbred male Albino Oxford rats. Groups of 6 to 8 rats received 100 μl of DNCB or an equal volume of vehicle solely. Ear swelling assay and dermal infiltrate density were employed for quantification of CHS reaction.
Changes in peripheral blood granulocyte function were demonstrated following a challenge with 0.66% DNCB. Increased MTT index was noted in cultures of granulocytes from sensitized animals. Both spontaneous and PMA-stimulated NBT reduction was increased following challenge with 0.66% DNCB. A stronger PMA-stimulated adhesion of granulocytes was noted in DNCB-treated group.
Significantly higher responses provoked with suboptimal PMA (50 ng/ml) in granulocytes from challenged animals compared to those seen in controls, suggest a primed state of the granulocytes. The increased functional status of peripheral blood granulocytes following challenge with DNCB was accompanied by the increased survival of these cells.

HAIR DYE ALLERGY

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Gazi University Medical Faculty Department of Dermatology-
ANKARA-TURKEY

Contact allergy to hair dye ingredients is a well-known entity, seen both in consumers using hair dyes and among hairdressers with occupational contact dermatitis .Coloring of hair can cause severe allergic contact dermatitis. The most frequently reported hair dye allergen is p- phenylenediamine (PPD).
39 positive reaction to PPD were analyzed in contact dermatitis unit according to ICDRG criteria between 2003-2005.These cases were evaluated in relation to age, sex, site of rush, occupation , history of atopic eczema and suspicion of sensitization through “black henna tattoo”.
Paraphenylene diamine (PPD) may be added to black henna to accelerate, darken and to increase the longevity of henna tattoos. This has led to increased reporting of cutaneous reactions after hair dying. There is significant increase of PPD allergic patients sensitization through black henna.

PATCH TEST UTILITY IN SKIN REACTION TO ORAL HYDROXYZINE.

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Key words: Hydroxyzine, patch test.

Several cases of drug eruptions related to oral antihistaminic treatment have been described but it's not always easy to demonstrate the cause relationship.

We present a case of a 36-year-old-man that coinciding with an episode of psoriasis began treatment with calcipotriol with betamethasone dipropionate (Daivobet®) and oral hydroxyzine (Atarax®). Forty-eight hours later, he presented a generalised desquamative erythematous maculo-papular rash with pruritus. The patient reported he had previously taken oral hydroxyzine without any complications and also he had used Daivobet® several times. He denied taking any other oral medication.

The results of the European standard series and the Trolab series of vehicles, the 0.12% betamethasone valerate, the Daivonex® and the Daivobet® were negative. However, the 2.5% hydroxyzine in petrolatum was positive (++) at 48 and 96 hours, so the patient was oriented as a drug eruption due to hydroxyzine. The patient rejected the oral provocation test. Patch test with 2,5% hydroxyzine in 10 control subjects were all negative.

Hydroxyzine is an ethylenediamine dihydrochloride[1]. Five maculo-papular eruptions case due to hydroxyzine have been reported.

It is important to study every patient whose skin condition worsens after the reintroduction of antihistaminics. We recommend the patch test with 2.5% hydroxizine in vaseline as the first diagnostic step to be made in these cases, especially in patients who do not wish to perform the oral provocation test or in whom the test could induce severe side effects.

American Contact Dermatitis Society Cocktail Reception

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