14952

**Surgical management of extramammary Paget disease of the genitalia and perineum: A single-center case series**

Judy Hamad, BS, School of Medicine, University of North Carolina, Chapel Hill; Brad Figler, MD FACS, Sagar Patel, BS, University of North Carolina, Chapel Hill; Mark Fowler, University of North Carolina Hospital; Paul Googe, Bradley G. Merritt, University of North Carolina, Chapel Hill

Background: Extramammary Paget disease (EMPD) is an uncommon intraepithelial malignancy with sparse guidelines for management. Although surgical excision remains the mainstay of treatment, disease recurrence and reoperation are challenges. This is one of the largest series to describe the multidisciplinary management of genital and perineal EMPD to better understand disease progression following surgery.

Methods: Biopsy-proven EMPD patients were identified from 2012 to 2019. Medical charts were evaluated for demographic, clinicopathologic, and surgical treatment variables. Kaplan-Meier method was used to generate reoperation (defined as time from first to second surgery) and disease recurrence (time from first surgery to positive rebiopsy) models.

Results: Nineteen patients were identified, 18 of whom had primary EMPD (94.7%). Anatomic distribution of disease included vulvar/labial (52.6%), anal/perineal (21.1%), and scrotal/penile (26.3%). Four patients received Mohs micrographic surgery (21.1%), 8 received wide local excision (42.1%), and seven received vulvectomies with varying margin widths (36.8%). Thirteen (68.4%) patients had positive margins on final surgical pathology. Patients required an average of 4 operations over their treatment course, including reoperation and reconstruction. Recurrence and reoperation rates were both 78.9% (n = 15) with median (95% CI) times to recurrence and reintervention of 18 (12-36) and 19 (4-37) months, respectively. 10- and 30-month disease-free rates were 78.9% and 42.1%.

Conclusions: Cutaneous genital and perineal disease offers unique challenges for resection and reconstruction given anatomic location. These patients have difficulty achieving negative-margins with subsequently high disease recurrence requiring multiple operations. More investigation is warranted to develop methodologies to successfully treat genital and perineal EMPD.

*Commercial disclosure: None identified.*

14974

**Cutaneous syphilitic gumma in an immunocompetent male**

Esio Souza, MD, Aline Erthal, University of São Paulo; Walter Belda Junior, MD, PhD, Department of Dermatology, Medical College, University Of São Paulo

A 69-year-old married man from Rio Grande do Sul, Brazil, presented with a 10-year history of hardened nodules in his left elbow. Dermatologic examination revealed infiltrated erythematous nodular lesions in the left elbow, with ulcerated center and fibrin-purulent fundus. Serology for syphilis by chemiluminescence immunoassay was made, with a positive result. VDRL and FTA-ABS were nonreactive. Left upper limb nuclear magnetic resonance described multiple confluent nodular formations in subcutaneous tissue, with peripheral contrast enhancement. Anatomopathologic examination revealed chronic granulomatous dermatitis. Dermis with extensive areas of caseous/gummy necrosis surrounded by palisade composed of epithelioid cells, gigantocytes, lymphocytes and rare plasma cells. Grocott stains for fungal research and Faraco stains for acid-resistant bacilli were negative. Culture for aerobic, anaerobic, fungi and mycobacteria haven't identified infectious agents. Patient underwent intravenous treatment with crystalline penicillin. He presented significant clinical improvement, with progressive closure of the ulcer borders and reduction of the volume of the nodules. Syphilis is a sexually transmitted disease caused by Treponema pallidum. Only a third of patients with untreated syphilis will evolve to the tertiary form. It can present with cutaneous, bone, neurological and cardiovascular manifestations. The syphilitic gumma is a necrotizing granulomatous inflammatory response to a small number of spirochetes. Tertiary syphilis is now an uncommon disease. Clinical diagnosis can be difficult and although VDRL titers are often included in routine blood tests, it is consistently negative in 25% of patients. The recommended treatment is intravenous crystalline penicillin or intramuscular benzathine penicillin, depending on the reference guideline.

*Commercial disclosure: None identified.*

14980

**Safety and clinical outcomes of the 1064-nm neodymium-doped yttrium aluminum garnet laser combined with topical antifungal agents for onychomycosis in patients with diabetes mellitus**

Jong-Kil Seo, MD, Seoul, Korea, Dong Hye Suh, Hyun-Joo Kim, Ye-Jin, Hyo-Eun Kwon, Hye-Jin Ahn, Ki-Heon Jeong, Mu-Hyoung Lee, MD, PhD, Min Kyung Shin, MD, PhD, Department of Dermatology, School of Medicine, Kyung Hee University, Seoul, Korea

Background: Onychomycosis affects approximately one third of patients with diabetes. But, treatment failure risk of oral antifungal agents in diabetic patients is high due to poor patient compliance, drug interactions and decreased immune status. The neodymium-doped yttrium aluminum garnet (Nd:YAG) laser has recently been widely used as one of therapeutic options for onychomycosis. However, there have been few studies on clinical outcome of 1064-nm Nd:YAG laser treatment in diabetic patients.

Objective: The aim of our study was to evaluate the safety and clinical outcome of 106four nm Nd:YAG laser treatment for onychomycosis with diabetes mellitus (DM).

Methods: We performed a retrospective chart review to collect data such as sex, age, hemoglobin A1c, clinical photo and adverse effects. Nails with onychomycosis were treated by topical antifungal agent and 1064-nm Nd:YAG laser with 4-6 sessions at 4-week intervals. We assessed onychomycosis severity index (OSI) score and compared outcomes and safety in classified three groups; controlled DM, uncontrolled DM, and healthy control.

Results: There was no adverse effect after the treatment in three groups. The average response rate (posttreatment OSI/pretreatment OSI) were ~30% in all 3 groups. The response rate was not significantly different between three groups ($P = .985$).

Conclusions: The 1064-nm Nd:YAG laser may be a safe and alternative treatment option for onychomycosis in diabetic patients.

*Commercial disclosure: None identified.*

14998

**Reductions in absolute PASI over 144 weeks of treatment with certolizumab pegol in patients with plaque psoriasis: Pooled analysis from two phase 3 trials (CIMPASI-1 and CIMPASI-2)**

Alice Gottlieb, MD, PhD, Department of Dermatology, Icahn School of Medicine at Mount Sinai; Andrew Blauvelt, MD, MBA, Oregon Medical Research Center; Diamant Thaci, MD, Institute and Comprehensive Center Inflammation Medicine; Yves Poulin, MD, FRCPC, Hôpital Hôtel-Dieu; Fiona Brock, MSc, Catherine Arendt, MD, PharmD, Marion Boehnlein, PhD, UCB Pharma; Kristian Reich, MD, PhD, Center for Translational Research in Inflammatory Skin Diseases, Institute for Health Services Research in Dermatology and Nursing, University Medical Center Hamburg-Eppendorf, and Skinflammation Center Hamburg, Germany

Background: Certolizumab pegol (CZP) is an Fc-free, PEGylated anti−tumor necrosis factor. Here, we report the proportions of patients with moderate to severe plaque psoriasis (PSO) achieving clinically relevant absolute PASI thresholds over 144 weeks' CZP treatment.

Methods: Data were pooled from the CIMPASI-1 (NCT02326298) and CIMPASI-2 (NCT02326272) phase 3 trials in adults with PSO≥ 6 months (PASI ≥12%/≥10%, BSA-affected/PGA ≥3); study designs have been reported. Patients were randomized 2:2:1 to CZP 400 mg every two weeks (q2w), CZP 200 mg q2w (400 mg wks 0/2/4), placebo. At wk 48, PASI50 responders entered open-label treatment; all received CZP 200 mg q2w at wk 48, with subsequent dosing adjustment permitted (mandatory or at Investigator discretion). We present the proportions achieving PASI <5, <3, and <2 through wks 48-144. Responder rates reflect the simple average response. Patients not achieving PASI50 from wk 16 were subsequently treated as non-responders; other missing data were imputed using Markov Chain Monte Carlo methodology.

Results: 175/186 patients were randomized to CZP 400 mg q2w/CZP 200 mg q2w; baseline mean PASI 19.6/19.2. Of the CZP 200 mg q2w-randomized patients, 74.9%/63.1%/53.3% achieved PASI <5/3/2 at wk 48. Responder rates were maintained to wk 144: 72.4%/59.9%/49.7%. Of the CZP 400 mg q2w-randomized patients, a high proportion achieved PASI <5/3/2 at wk 48: 82.2%/73.8%/63.6%. After dose reduction, wk 144 responder rates were 71.0%/59.6%/44.9%.

Conclusions: Sustained reductions in absolute PASI were observed in CZP 200 mg q2w-randomized patients. Responder rates within CZP 400 mg q2w-randomized patients decreased following wk 48 dose reduction.

*Commercial disclosure: Sponsored by Dermira and UCB Pharma. Medical writing support was provided by Costello Medical, funded by UCB Pharma.*