

Correspondence

Dermatological management in special population affected by psoriasis: A case report of an amputated transgender with psoriasis treated with apremilast

Psoriatic disease (PsO) is currently regarded as a systemic inflammatory chronic disease capable to trigger several metabolic and cardiovascular comorbidities that impair the microcirculation.^[1,2] PsO patients who are unresponsive or partially responsive end up to have a progressive vascular damage, limiting microcirculation functionality and wound healing, and potentially impoverishing surgical outcomes (i.e., amputation).

Amputation exposes psoriatic patients to a continuous mechanic trauma in the prosthesis area that may trigger new psoriatic plaques in nonlesional skin areas (true Koebner phenomenon).^[2] In order to prevent the Koebner phenomenon, anti-psoriatic treatment should be optimized, and a precision medicine-based approach may improve the overall clinical response.

A 64-year-old transgender female (biological male sex) with a body mass index of 29.1 kg/m² and metabolic syndrome underwent a sex reassignment surgery and developing plaque psoriasis 5 months after starting feminizing hormone therapy with valerate oestradiol. After a car crash, she/he had to undergo a transfemoral amputation of the left leg and started to experience several infectious complications (i.e., recurrent erysipelas), together with a loss of cutaneous response with both adalimumab and ixekizumab [Figure 1]. Then, she/he experienced a venous thrombosis linked to the hormonal therapy that she/he refused to stop. Thus, dermatologists switched from biologics to apremilast, achieving and at 52 weeks maintaining PASI 90 (PASI_{baseline}: 14, PASI_{16 weeks}: 6, PASI_{24 weeks}: 1, PASI_{52 weeks}: 1) Apremilast was administered to an in label-dose for PsO with the five-days titration from 10 mg to 50 mg/day and the maintenance dose at 60 mg/day.

Due to the significant decrease of pruritus (itch visual analogue scale from 8 to 1) and to the scalp and genital clearance, her/his quality of life drastically improved (The Dermatology Life Quality Index). No apremilast-related side effects were registered, but in the amputated leg, the Koebner phenomenon was still present due to the daily traumatism of the prosthesis.



Figure 1: Transgender patient with psoriasis and a transfemoral amputation of the left leg.

Therapeutic suggestions for psoriatic patients experiencing amputations or gender reassignment are not present in literature, and their real-life management remains challenging in terms of drug-related side effects and synergic treatments.

Mutilated patients may experience stump infections, especially in the case of both local and systemic immunosuppression, but at the same time, the frequent narrow-band ultraviolet B visits are both practically and logistically difficult to perform.^[3] Body mass index (BMI) is even more challenging since no corrections are validated for mutilated patients, seriously underestimating their BMI, as in our case. Thus, in light of the previous considerations and to the beneficial cardiometabolic effect,^[4] apremilast was prescribed.

Likewise, the clinical evaluation of transgender patients for metabolic syndrome is really challenging for practical motivations such as waistline gender-related referral parameters.^[5] Furthermore, hormonal therapies may modulate psoriasis inflammation and emphasize the procoagulative effect of psoriasis inflammation exposing transgender patients to an incremented cardiovascular risk. For these motivations, the

full control of psoriasis inflammation should be achieved also by minimizing complications occurrence.

In conclusion, amputated and transgender patients deserve more frequent follow-up to strictly evaluate the therapeutic outcomes.

Declaration of patient consent

The authors certify that they have obtained appropriate patient consent form. In the form, the patient has given the consent for the images and other clinical information to be reported in the journal. The patient understands that name and initial will not be published and due efforts will be made to conceal identity, but anonymity cannot be guaranteed.

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Conflicts of interest

Dr. Giovanni Damiani has received honoraria from Novartis, Amgen, Galderma for participation on advisory boards, and grants from Almirall and Rocchetta for participation as an investigator, and speaker honoraria from Novartis, Almirall, Sanofi.

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