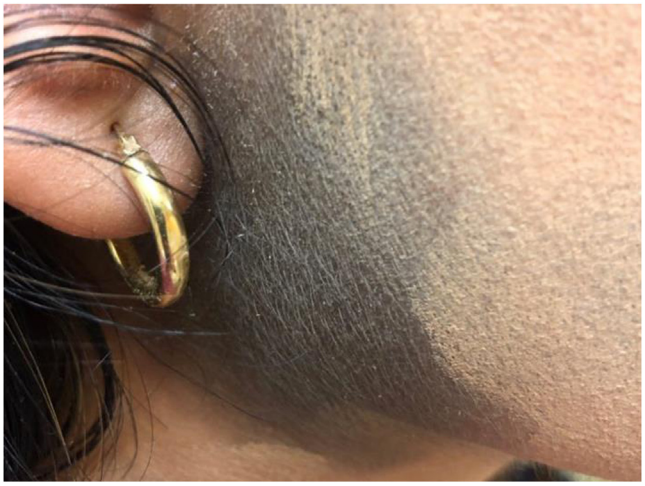
testing to progesterone was positive(0.005mg/ml). Upon collaboration with her parents, pediatrician, and gynecologist, she was started on an oral contraceptive and topical tacrolimus. With continued consistent treatment, her rashes have remained dormant.

Discussion: Catamenial Dermatosis is a rare disorder that is difficult to diagnose and is likely underdiagnosed. This case demonstrates the importance of a detailed history and multidisciplinary approach for successful patient outcomes.

With each menstrual cycle, this area becomes erythematous, pruritic and then heels with melanotic appearing hyperpigmentation. The lesions to the face continue to spread and are disfiguring.



M557

SUCCESSFUL TREATMENT AND COMPLETE STEROID SPARING USING OMALIZUMAB IN BULLOUS PEMPHIGOID MASQUERADING AS REFRACTORY URTICARIA

H. Pham*[1], D. Lanoue[2], J. Valois[2], W. Yang[2], *1. Montreal, QC, Canada; 2. Ottawa, ON, Canada.*

Introduction: The classic form of bullous pemphigoid (BP) presents with widespread tense bullae; however, early presentations of BP can be non-specific: pruritus alone, eczema, or urticaria. Prednisone is the typical first-line treatment for extensive disease. Traditionally, IgG autoantibodies against hemidesmosome components were the focus of this condition, but more recently, the pathogenicity of IgE autoantibodies has emerged and its blockade as a therapeutic target using omalizumab has been successfully described.

Case Description: A 78-year-old male was seen clinic in for severe chronic hives located on his arms and trunk. Chronic spontaneous urticaria was the working diagnosis, but he did not respond to maximally tolerated doses of antihistamines and thus, an application for omalizumab was made. In the interim, a skin biopsy described findings consistent with BP. As such, in addition to omalizumab, he was started on prednisone 15 mg and methotrexate 2.5 mg/day as well July 2018. As of March 2019, he was weaned completely off of prednisone, and by April 2020, he stopped methotrexate and achieved remission with omalizumab and bilastine PRN.

Discussion: Since obvious bullous lesions may be absent in early BP, diagnosis can be challenging and requires a high degree of clinical suspicion, especially in patients older than 60 years old presenting with new-onset refractory urticaria. Even in the setting of biopsy-proven BP, omalizumab was effective in controlling urticaria for this patient. This case lends support to the existing literature on omalizumab as a possible treatment modality in BP. Controlled studies are needed to rigorously establish omalizumab's efficacy in BP.

M558

STEROID SPARING BENEFIT OF OMALIZUMAB IN A PATIENT WITH BULLOUS PEMPHIGOID AND METASTATIC SALIVARY CANCER

D. Lanoue*[1], H. Pham[2], J. Valois[1], W. Yang[1], *1. Ottawa, ON, Canada; 2. Montreal, Canada.*

Introduction: Prednisone and conventional immunosuppressants such as mycophenolate mofetil are commonly employed in treatment of extensive bullous pemphigoid (BP). However, broad immunosuppression is undesirable in the setting of malignancy. Traditionally, IgG autoantibodies were the focus of this condition, but more recently, the pathogenicity of IgE autoantibodies has emerged and its blockade as a therapeutic target using omalizumab has been successfully described.

Case Description: A 75-year-old male with BP was urgently seen in allergy clinic for consideration of omalizumab in the context of newly diagnosed metastatic acinic salivary carcinoma, whereby his dermatologist and otolaryngologist highly desired to taper prednisone and avoid broad immunosuppressants. He had an inadequate response to antihistamines and potent topical steroids; also, a trial of tetracycline caused a delayed maculopapular rash, which was reproduced when patient re-challenged himself. Although mycophenolate mofetil and IVIG were proposed as alternatives, otolaryngology cautiously advised against these agents given his widespread active malignancy. After 2 doses of omalizumab, he had a >90% improvement in pruritus and was able to taper prednisone from 30 to 5 mg.

Discussion: Given significant side effects and broad immunosuppression associated with prednisone and conventional immunosuppressants, alternative treatments with a narrower spectrum of activity should be considered, such as targeted anti-IgE blockade with omalizumab. This case lends support to the existing literature on omalizumab as a possible treatment modality in BP, especially when corticosteroids alone fail to control the disease or in the presence comorbidities limiting the use of immunosuppressants. Controlled studies are needed to rigorously establish omalizumab's efficacy in bullous pemphigoid.

M559

SUCCESSFUL TREATMENT AND STEROID SPARING USING OMALIZUMAB FOR BULLOUS PEMPHIGOID REQUIRING PREDNISONE AND INTRAVENOUS IMMUNOGLOBULIN

J. Valois*[1], H. Pham[2], D. Lanoue[1], W. Yang[1], *1. Ottawa, ON, Canada; 2. Montreal, Canada.*

Introduction: Prednisone is often used first-line for extensive bullous pemphigoid (BP), but limited by comorbidities and adverse effects. Concomitant liver disease further limits steroid sparing options. In these circumstances, alternatives are few, such as tetracyclines, IVIG, and biologics. More recently, the pathogenicity of IgE autoantibodies has emerged and its blockade as a therapeutic target using omalizumab has been successfully described.

Case Description: A 63-year old female with prednisone-dependent bullous pemphigoid was seen in allergy clinic February 2018 for consideration of omalizumab due to significant cardiometabolic comorbidities and fatty liver, after failing steroid sparing with tetracycline and IVIG. Omalizumab 300 mg SC q4weeks was started May 2018 alongside prednisone 10 mg and IVIG 80 mg x 2 days per month. By October 2018, she was weaned to prednisone 5 mg/day as a maintenance due to adrenal insufficiency. By Nov 2018, she was off of IVIG and decreased to tetracycline to 500 mg/day. Since her BP was well-controlled since December 2018, she was able to stop omalizumab in March 2019 and has remained in remission.

Discussion: Given adverse effects associated with prednisone and resource-intensive requirements of administering intravenous immunoglobulin therapy, alternative treatments with a better safety profile and less invasive route of administration should be