EADV
European Academy of Dermatology and Venerology

Info Sheet

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Old wives' tales don't work

The truth about acne

Why is that people still cling to Old Wives' Tales when we live in a world rich with medical expertise? The accusations that fatty foods or 'soap dodging' can somehow cause acne are just a couple of examples. Thankfully, leading acne expert Professor Andreas Katsambas, from the 'A. Syngros Hospital' in Athens is at hand to separate the facts from the fiction.

"It is often believed that unhealthy eating habits or inadequate personal hygiene are responsible for acne, despite the fact that no scientific link has ever been established to support this," explains Professor Katsambas. "Another old wives tale", he continues ''is that acne is infectious. Acne is simply not transmitted from one person to another".

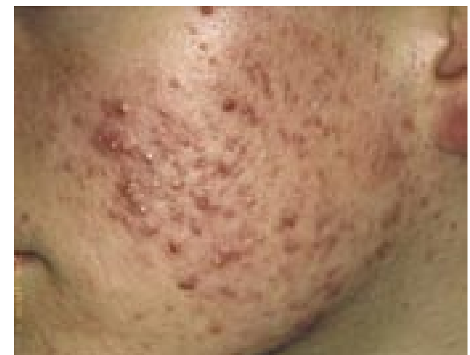
Acne is a common skin condition characterised by spots or blackheads on the face, chest, and back. It occurs when the pores of the skin become clogged with oil, dead skin cells and bacteria. Our skin is covered with tiny holes called pores. The pores contain an oil called sebum that moistens the skin. The glands usually produce the correct amount of sebum but sometimes a pore becomes blocked due to an excess of sebum. This can result in acne.

According to Professor Katsambas "acne is an almost universal skin disease, which affects 79 to 95% of the adolescent population." Acne, however, doesn't just affect teenagers as is often widely perceived. "In men and women older than 25, 40-54% will experience some degree of facial acne" adds Professor Katsambas.

A white head is an everyday name for a pore that has become blocked, closed, and protrudes from the skin. If a pore clogs up but remains open, the surface becomes dark and this is commonly known as a 'blackhead'. Sometimes the walls of the pore are broken, allowing sebum, bacteria, and dead skin cells to get under the skin. This causes a small, red infection called a pimple. Blocked pores that open up deep in the skin can lead to nastier infections known as cysts.

The Cure

According to Professor Katsambas "the basic rule in treating acne is to stop using facial care & cleaning products that increase sebum production. A dermatologist will advise as to a more appropriate course of treatment that best suits the patient". "A typical course of acne treatment", he adds "will usually consist of a combination of topical (applied directly on to the skin) and systemic treatments (administered orally)."



Typical papulo-pustular acne on facial skin, showing in addition to the inflammatory lesions also comedones and closed comedones. Photo: © Raimo Suhonen

The topical agents used include retinoids (vitamin A based medicine), antibiotic lotions, benzoyl peroxide and azelaic acid (a cream derived from wheat, rye and barley.) Systemic treatments include antibiotics, hormonal therapy – most-

ly oral contraceptives – and the powerful isotretinoin (dries up oily secretions but is only used in severe forms of acne that have proved resistant to other treatments.")

Why use a dermatologist?

Professor Katsambas advises that treating acne should not be taken lightly. "Acne is a skin disease which causes disfigurement to the face/ body and has the potential to lead to permanent scarring. To prevent significant psychological and social impairment in acne patients and; most of all, to diminish the risk of scarring, healthcare providers must prescribe topical and/or systemic forms of treatment. Needless to say that such treatment can only be prescribed by dermatologists - a purely cosmetic approach can neither manage the more severe cases of the disease nor decrease the risk of scarring."

Acne scars – The cure

Acne scars can be improved by a dermatologist by using Collagen injection (the removal or improvement of acne scars by injecting collagen beneath the skin to replace the body's own natural collagen.) Autologous fat transfer (Fat from one part of the patient's body is injected into the skin to elevate depressed scars.) Dermabrasion (The top layers of skin are rubbed away by an electrical machine. The skin will subsequently appear smoother and fresher.) Chemical peels (The top layer of skin is removed with a chemical application allowing the skin to regenerates, thus improving its appearance.)
New promising treatments for acne include Topical anti-androgens (used to combat male hormones.) Phototherapy (A light-based method, which penetrates the skin and destroys acne bacteria.) Anti-inflammatory agents (Lipoxygenase inhibitors' for example reduce sebum & inflammation.) ♦

Expert Advice

The Do's & Don'ts of Acne

- Do not pick or squeeze spots! The inflammation will get worse, scarring may also occur.
- Only a dermatologist or a medically qualified cosmetic specialist should open blocked pores.
- Avoid washing too much! Strong soaps, excessive washing and hard scrubbing irritate the skin.
- Gently use non-perfumed cleansing lotions with a neutral ph value.
- Avoid greasy salves and creams.
- If you use makeup, always ensure that it is 'oil-free.'
- Be careful when using moisturisers! Moisturisers can induce a lumpy infected outbreak in the skin (Perioral Dermatitis.)
- Sunbathing may disguise acne but a sun tan should be seen as skin damage. Too much sun will irritate the skin, thus aggravating acne.
- Don't expect miracles! Be patient! Irregular treatment or the incompletion of a course of treatment may well lead to failure. ♦

Tom Sayer's cure for warts

... but there are real treatments!

Once they've read Mark Twain's 'Tom Sawyer', every child knows how to get rid of warts: Under a full moon at midnight you bury a dead black cat and say out loud "Cat! Take the wart! Devil! Take the cat!" and before you know it they've vanished. It may seem difficult to believe, but one-third of warts actually do just vanish at some point. For the other two-thirds it's best not to rely on 'dead cats and snails' but a dermatologist!

Warts are caused by the Human Papilloma virus infection, which exploits a weakness in our immune system. They occur in people of all ages - but most commonly in children and young adults - and spread from one person to another. There's actually no clear explanation as to why one person has warts and another does not. Some people, it seems, are simply more vulnerable to warts than others.
The Common wart is usually found on both the hands and feet. It has a thick and rough appearance and often spreads over the skin of the person affected. Verrucas are found on the soles of the feet, and can often grow painfully deep. They are often contracted in swimming-pools, fitness centres or saunas.
Flat warts are frequently found on the face or hands and resemble flat, smooth skin-coloured bumps. Plantar warts are found on the bottom of the foot and Palmar warts on the palm of the hand. And Filiforme warts are characterised by the brisles that grow out of the affected area.

The cure

Dermatologists will treat most warts with a plaster containing medicine on the sticky side. This serves to soften the wart, which is then removed with a scalpel or electrosurgical cautery. Excision and cautery are usually both carried out under a local anaesthetic or a general anaesthetic if there are numerous warts. Encouragingly, a new pain-free cure is now available that stimulates the local immune system by using water-filtered infra-red radiation. "The patient benefits

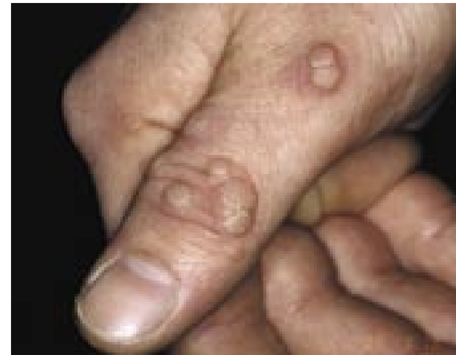
from this new treatment because of the absence of pain and scarring," informs German skin physician Dr. Steffen Lindner. "Therefore, the procedure is especially recommended for children." When it comes to treating warts Dr. Linder advises a two-pronged attack. "A combination of these treatments will significantly reduce the risk of the wart reappearing."

Genital warts – A case apart

Genital warts are highly contagious and can lead to serious health problems if left untreated. Being spread by sexual intercourse, they are far more infectious than the Common wart. Genital warts differ from warts elsewhere on the body due to their particularly contagious nature. "It would be uncommon for Palmar warts on the hands to be transferred to the genital region," explains Dr. George Kinghorn, consultant in genitourinary medicine at the Royal Hallamshire Hospital in Sheffield, UK.
"Genital warts are highly infectious and the lifetime risk of acquiring such an infection may be as high as 75% or more" estimates our expert Dr. Kinghorn. "Sub clinical infections without the appearance of warts are common. When lesions occur, they appear in areas where maximum friction occurs during sexual intercourse. Transfer to the perianal area is common in women and may also occur in men who have not engaged in anal intercourse."

Genital warts – The cure

Genital warts can be treated with so called 'destructive methods', such as laser ablation, surgical excision and the application of chemical agents, such as Podophyllotoxin, which is applied as a solution/cream to lesions. Another treatment is Cryotherapy, which is the application of extreme cold to destroy diseased tissue. This will only cause minor discomfort and usually requires no anaesthetic.
A further form of treatment is Immunomodulation, which involves using Imiquimod or Interferon. Immunomodulators stimulate the body's own immunity to combat lesions caused by the wart virus. Imiquimod is applied as a cream and Interferon has to be injected directly into the warts. Both treatments cause some local inflammation and associated mild discomfort.



Common viral warts on the dorsal surface of thumb, typical location and typical size of the lesions. Photo: © Raimo Suhonen

"It is recommended that those being screened for genital warts should also be screened for other Sexually Transmitted Diseases," advises Dr Kinghorn. "In addition to this, I would recommend that the sexual partners of those affected also undergo an examination."

Warts - Post Treatment

It should be noted that scarring as a result of the above treatments is very uncommon. It is also difficult to predict the number of treatments required as it depends on the number and size of the warts. Finally, recurrence of warts after apparently successful treatment occurs in at least 25% of cases - irrespective of the type of treatment used. ♦

"The goal is to restore the function of the skin"

Inerview with Vitiligo-expert Prof. Jean-Marie Naeyaert

An interview with leading Vitiligo expert, Professor Jean-Marie Naeyaert from the University of Ghent in Belgium.

What is Vitiligo and who suffers from it?

Prof. Naeyaert: Vitiligo is a commonly acquired and unpredictable skin disease, which causes milky-white patches to appear on the skin. Vitiligo affects all races, ethnicities, both sexes and can occur at any age - although appearance of Vitiligo in new born children is very rare. Vitiligo will most likely strike between 10 and 30 years of age. Vitiligo sufferers often also attribute the onset of the disease to pregnancy, illness, and sunburn, physical or emotional stress.
What are the causes and risks of Vitiligo?

Prof. Naeyaert: The precise cause of Vitiligo is unknown. A variety of different factors - genetic, immunologic and neurogenic - do however play an important role. Doctors and researchers have several different theories as to the cause of Vitiligo:

Self-destruction of Melanocytes - Melanocytes are the cells that produce hair and skin colour pigments in skin. One theory is that the Melanocytes destroy themselves.
Neurochemical factors - According to this theory the damage to Melanocyte cells in Vitiligo sufferers is a consequence of an increased production of toxic substances by abnormally functioning nerve cells.
Autoimmunity - Another theory is that people develop antibodies that destroy the Melanocytes in their own bodies. This hypothesis is supported by the fact that Vitiligo patients have a greater

Prof. Jean-Marie Naeyaert from the University of Ghent in Belgium is one of the leading Vitiligo-Experts in Europe

risk of having other auto-immune diseases such as 'alopecia areata' (patches of baldness).

Are there other factors which can trigger Vitiligo?

Prof. Naeyaert: Emotional stress, physical stress during illness, chronic pressure/friction, sunburn and exposure to several chemicals all seem to trigger depigmentation (loss of color in the skin) in some predisposed Vitiligo patients.

Is Vitiligo hereditary?

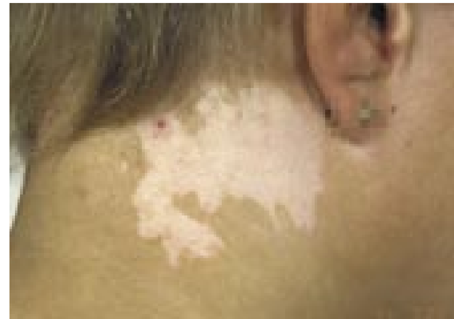
Prof. Naeyaert: Familial cases of Vitiligo are common, varying from 6 to 38%. Up to 21 % of first-generation family members may also become affected by Vitiligo.

What should the patient be aware of when beginning treatment?

Prof. Naeyaert: The goal of Vitiligo treatment is to restore the function of the skin and to improve appearance. Treating Vitiligo takes a long time – perhaps several months or years.

Could you explain how Vitiligo is treated?

Prof. Naeyaert: The treatment of Vitiligo can be broadly divided into two categories: medical and surgical therapies.
Medical therapies aim to stabilize the disease and induce repigmentation. They include treatment with creams containing corticosteroids or calcipotriol (a vitamin D derivative), or treatment with ultraviolet irradiation - either ultraviolet B or psolaren with ultraviolet A (PUVA).
Surgical therapies aim to restore pigment to limited areas of Vitiligo. The techniques involve either the transfer from one part of the body of normal pigmented skin (autologous skin graft) or pigmented cells (autologous cellular grafting) to areas of depigmentation. These techniques are only used if Vitiligo is stable in a patient and if all other medical treatments have failed.
Important 'adjunctive therapies' - therapies, which can be used alongside either surgical or medical treatments - include the use of sunscreens to protect Vitiligo from sunburn and the use of cosmetics to camouflage depigmented areas.



Characteristic patch of vitiligo on the neck area of a patient. Vitiligo may appear on any skin area, also on the face. The aesthetic burden is the main reason for therapy. Photo: © Raimo Suhonen

With patients who have extensive Vitiligo on more than 50 percent of their bodies, total depigmentation may be more appropriate. This involves fading the rest of the skin on the body to match the affected white areas. A cream containing monobenzylether or hydroquinone is used in this procedure.

Are there any new innovative forms of treatment for Vitiligo?

Prof. Naeyaert: Immunosuppressants such as such as pimecrolimus and tacrolimus are new creams that induce repigmentation in Vitiligo. They work by modulating the immune function of the skin so that the immune destruction of pigment cells is prevented. Their effects are enhanced when they are combined with an excimer laser. This particular form of laser treatment, however, is only suitable for localized Vitiligo as the small size of the laser makes treating large surface areas extremely time-consuming and costly. ♦

A challenge for Europe

14th EADV congress in London to focus on "Skin and sexual health"

The title of the 14th congress of the European Academy for Dermatology and Venereology (EADV) is also the programme for the conference – „Skin and sexual health: a challenge for Europe". The challenge will take place in the former Docklands of London from the 12th to the 16th of October, approximately 50 years after the first congress of skin physicians was held on the river Thames.

The prestigious four-day meeting sets a clear emphasis on prevention, diagnostics and therapy of sexually transmitted diseases. „Europe is facing increasing pressure on dermatological services, as well as an unprecedented rise in sexually transmitted diseases including HIV," underlines congress president Professor Martin Black. In addition to the congress's main theme, participants will also have the opportunity to attend seminars and scientific presentations on a whole range of issues including: wound healing, allergology, immunology, photodermatology, the handling of chronically inflammatory skin diseases, skin tumours and anti-ageing.
The possibilities for the dermatologist in Innovative Diagnostics and Therapy will play an important part in the 6 plenary sessions, 11 courses, 16 midday seminars, 28 workshops and 44 sym-

posia as well as the latest results from the UK's highly developed health care research. The supervisors of the congress - under the leadership of the British Association of Dermatologists (BAD) - expect approximately 8000 attendees from across Europe, North America, The Middle East and Asia. Participants will therefore have an excellent opportunity to exchange scientific and medical ideas with colleagues from all across the globe. But it is the legally required medical training on offer, which for many of the European attendees is the main reason to attend the congress.

The EADV congress will be held in the new London congress centre in the Docklands area of the east end of London. Once an area of decline following the collapse of the shipbuilding industry, Docklands is now considered to be a model example of urban renewal.

The count down to the 14th EADV Congress has, however, been regrettably overshadowed by the July 7th terrorist attack in London. Nevertheless, Congress president Professor Martin Black would like to reassure all participants that an intense security effort has been put in place to make London once again safe. „Our visitors will be in safe hands in London as in any other European city," he states.

EADV was founded as a non-profit association in 1987. It provides continuing medical education in the fields of Dermatology and Venereology helping to maintain high professional standards within the specialities, related professions and health services. More information on the programme and exhibition is available at www.eadv2005.com ♦

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