WHO initiatives supporting dermatology

International collaboration between dermatology and the World Health Organisation (WHO) is thriving and many EADV members have been prominent in this work.

Links with WHO have largely depended on a growing cooperation between the International League of Dermatology Societies (ILDs) or its developing country arm, the International Foundation for Dermatology (IFD), but the enthusiastic input and support of individual dermatovenereologists is critical for its success.

Essential Medicines Programme

The initial links between ILDS and WHO were brought about through the Essential Medicines Programme where dermatological advice on the value and usage of medicines for the care of skin disease was provided. This has led to continuing participation (by Antoine Mahe, Olivier Chosidow, Luigi Naldi, Rod Hay and Jean-Hilaire Saurat) in successive revisions of these guidelines for the treatment of both children and adults that reflect current evidence-based treatments for common skin diseases. While primarily targeted on the needs of developing countries the list of drugs is comprehensive and provides a balanced view of essentials to effective care.

The Regional Dermatology Training Centre (RDTC) in Moshi, Tanzania - an initiative of the IFD - has continued to grow as a valued resource in sub-Saharan Africa and it has been designated a WHO collaborating centre for skin disease, leprosy and sexually-transmitted infection. While it focuses on education and training, the RDTC has an increasing interest in health services research and the WHO representative is a strong supporter on the RDTC advisory Board.

continued on page 2 ▶▶

In this issue

- 19th EADV Congress, Gothenburg ............ 3
- President’s Perspective ...................... 4
- Psorot Campaign Report .................. 5
- Patients’ Information: Vulval Pain Society .. 6
- Update from the Ethics Committee .......... 7
- Dermatology in Portugal .................... 8
- Update from the Vitiligo Task Force .......... 9
- Skin ageing and hormones .................. 10
- Notice of AGM ........................................ 11
- Update from the Venereology Task Force .. 13
- President-elect candidates’ statements .... 14
- Update from the CME-CPD Committee ... 16
- Sister Society News: ESMS ................. 17
- EADV Election Notices and Nomination Forms ......................... 18
- Update from the Fostering Training Education Committee ..................... 23
- Spotlight on young researchers .............. 24
- Treasurer’s Report .............................. 25
- Update from the Secretary General ......... 26
- Calendar of Events ......................... 27
- Picture Gallery: photos from Cavtat ........ 27
A major new initiative has been the invitation to the ILDS to provide the lead for skin disease in the complex task of revising the WHO international classification of disease in its latest form, ICD11. Dermatology is one of only a few specialties to be granted the status of a Task Advisory Group (TAG) which is a recognised operational division of this WHO project (group co-chairs: Robert Chalmers and Michael Weichenthal). A group of dermatologists, including many EADV members, are currently working on the revised scheme and setting about the difficult task of trying to link a classification which is based on aetiology to the practically relevant problems of a clinically-based specialty where different disease pathologies present in a single organ, in this case the skin.

New strategy

A small working group of the IFD (Rod Hay, Olivier Chosidow, Luigi Naldi and Antoine Mahe) is currently developing a strategy together with the children’s medicines group of WHO and representatives from paediatrics and pharmacy to devise ways of reducing the incidence of scabies and secondary bacterial infection in regions where these are major problems in child health. Recent evidence has demonstrated a clear link between infectious complications such as nephritis and rheumatic fever, along with childhood septicaemia and scabies. The group is developing formal guidelines for the control of scabies and will act as a focus for research and evaluation of new control measures.

This list is not exhaustive. For instance there is dermatological involvement in the Alliance for Wound and Lymphoedema Care, the Global Alliance for the Elimination of Lymphatic Filariasis, the Global Burden of Disease project and the African Organisation for Onchocerciasis Control, all examples of initiatives that are strongly supported and partnered by WHO.

Roderick Hay
Chairman
International Foundation for Dermatology

Jean-Hilaire Saurat
President
International League of Dermatology Societies

Freedom from work or to work?

Sea, sun, sand and hammocks are upon us. The Chinese concept of ying and yang becomes very explicit every summer, and here I am not thinking of the contrasts of red and white skin. It is rather the contrast between the complexities of a life integrated with that of collaborators, administrators and staff in a larger organisation compared to the simplicity of holiday life away from it all.

The balancing of our lives between the many requirements of modern society, of our own expectations and our needs rests precariously upon the transition from one state to another. Spending all your time in an active producing mode is usually rewarding, but in spite of encouragement and success along the way, may lead to loss of productivity if it is not balanced. Similarly, vegetating in the land of the lotus eaters is pleasant and can put perspectives on everything, but unrealised perspectives plans can so easily lead to the unhappy loss of motivation if not balanced by active production. So, ideally the ‘up’ is balanced by the ‘down’ just as ‘ying’ is balanced by the ‘yang’ which together form a wheel symbolising life rolling on to better times.

For some people the wheel is very large, rotating slowly over long periods; for others the wheel is small and rotates very fast. For some the prospect of three weeks of vacation is better, while other prefer many shorter holidays spread out over the year. And then there are those who work over summer. The skeleton crews that manage our organisations over summer are usually highly productive. It may be speculated that it is the season’s positive influence, but there is another and perhaps better explanation: absence of interference. When large numbers of collaborators, administrators and staff all disappear to sea, sun, sand and hammocks elsewhere, it becomes possible to concentrate on the real work – and that is a kind of vacation as well.
The 19th EADV Congress will bring together dermatologists from Europe and all over the world to share their expertise and discuss together the most recent developments in dermatology and venereology.

The Scientific Programme will cover the full spectrum of dermatological diseases as well as novel trends in rapidly moving fields such as cutaneous oncology, venereology and allergy, as well as autoimmune, inflammatory and other infectious disorders of the skin.

New research

Emphasis will also be placed on new research which has shed light on the aetiology, pathology, diagnosis and therapy of dermatologic diseases. In addition to the diversity of symposia, workshops, courses and other sessions we believe that the plenary lectures will be of special interest. Highlights here include the lectures by:

- Brian Diffey on “Sun, Vitamin D and the Skin”
- Yann Barrandon on “An Overview of Stem Cells in Dermatology”
- Uta Jappe on “Multi-resistant Bacteria: Are They Important in Dermatology?”

Following the style of previously successful EADV meetings, we will also again offer so-called “What’s new?” sessions dedicated to the most recent developments in dermatological research, dermatology therapy and dermatopathology.

International perspectives

The rapid development of global dermatology will be reflected in the 19th EADV Congress by two scientific sessions dedicated to dermatological practice outside Europe. Accordingly, dermatology in India and Africa will be addressed in special symposia.

In addition to the scientific events at the Congress itself, EADV will continue its successful partnership with specialised dermatological sub-specialty societies who will hold satellite meetings at the Congress Centre on the Wednesday prior to the Congress opening. For detailed information please consult our website at www.EADVGothenburg2010.org

EADV and the Local Organising Committee are pleased to welcome you to Gothenburg and every effort will be made to offer a scientific and practice-orientated meeting to make this Congress a most memorable scientific, social and cultural experience.

We are very much looking forward to seeing you there.

Olle Larkö
2010 Congress President
On behalf of the Local Scientific Committee
President's Perspective

EADV continues its international outlook

Dear friends,

Well, it has not been all that long since the 7th EADV Spring Symposium in Cavtat, Croatia, came to an end. Those who were able to attend the symposium would have experienced a wonderful event set in a beautiful coastal area not far from unique and historic Dubrovnik, but equally picturesque and tranquil. It was an enjoyable and fruitful meeting with a warm and friendly atmosphere.

Prof Jasna Lipozencic and her local team of organisers are to be congratulated for their efforts to produce a successful meeting that contained a mixture of academic topics and practical presentations leaving the participants deeply interested in the scientific programme and thus filling out the lecture halls throughout the day.

New EADV HQ

I am happy to report that the Academy is now officially registered at a new address in Lugano, Switzerland. The EADV has rented office space at Via delle Scuole 12, CH-6900 Lugano, Switzerland to accommodate the newly recruited staff which includes an accountant, assistant accountant and PCO expert; the office began its function at the end of May 2010.

At the annual American Academy of Dermatology meeting in Miami in March 2010 the forthcoming AAD/Review Course was discussed among the officers of both Academies and it has been agreed that the next Joint Meeting will now take place in 2011 under the responsibility of our American colleagues who will provide more details in due course.

India and China

After the completion of the recent meeting in four cities of India in March 2010, which proved very successful for all parties concerned, the next event is currently being organised and it is hoped that at the end of August three invited EADV members will be on their way to India for another adventurous journey and series of lectures.

The International Exchange Initiative with China has begun with a new series of teleconferences. The first took place at the end of May 2010 and more will follow approximately every two months throughout the remainder of the year.

One last thing I would like to mention is that in mid-May 2010, the number of memberships was reported to be the same as that in December 2009; therefore, I am pleased to say that we are looking at reaching a record number of members which is foreseen to increase throughout the year.

As the days become warmer and the summer months begin I am sure we are all slowly winding down in preparation for our summer break and time of relaxation.

Upon our return our focus will turn towards the imminent EADV Congress in Gothenburg, Sweden, which promises to be another spectacular EADV event and one I hope you will not miss.

Until then I wish everyone a pleasant and relaxing summer.

Kind regards,

Andreas Katsambas
EADV President (2008-2010)
What is Psonet?

Psonet is an investigator-initiated, international network of population-based registries of psoriasis in Europe. It was supported at its establishment by a grant from the Italian Drug Agency (AIFA). The armamentarium of new agents for the treatment of psoriasis is fast growing and there is an increasing need to take a long-term view on psoriasis outcome. The main aim of the Psonet collaboration is to share experience and to perform coordinated post-marketing surveillance studies aimed at monitoring the long-term effectiveness and safety of systemic agents in the treatment of psoriasis. Nine European registries at different stages of development are associated in Psonet to date (see table below). Psonet is a registered organisation within the European Network of Centres for Pharmaco-epidemiology and Pharmacovigilance (ENCePP) promoted by the European Medicines Agency (EMEA).

Why link Psonet to EADV?

As Psonet is a European collaborative project in a key area of interest to dermatology, a link with the European Academy of Dermatology and Venereology (EADV), the leading professional organisation for European dermatologists, appeared an obvious and welcome step which may enable further development of the system and dissemination of the collaboration to additional European countries. The link has been recently accomplished. An EADV representative will be appointed to the Psonet co-ordinating group and EADV will be recognised in Psonet documents and publications. Among its key aims, the Psonet collaboration sets out to deliver:

1. regular reports on the effectiveness and safety data for systemic treatments of psoriasis
2. rapid alerts on newly recognised unexpected events
3. analyses of factors associated with treatment response as a preliminary step to identifying relevant biomarkers.

Presentations of Psonet data will be arranged at the annual EADV meetings.

EADV sponsorship

The maintenance of national registries is assured by local funding. Sponsorship from EADV - €50,000 per year for the next two years - is being used to organise investigator meetings, to help extract data for pooled analyses and to maintain central coordination. A report concerning these activities is expected to be submitted to EADV by July 2010. The link with EADV is an exciting development for Psonet and it could represent the starting of a long-lasting collaboration.

Registries participating in the Psonet collaboration

<table>
<thead>
<tr>
<th>COUNTRY</th>
<th>REGISTRY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Australia</td>
<td>Australian Psoriasis Registry</td>
</tr>
<tr>
<td>Denmark</td>
<td>DermBio</td>
</tr>
<tr>
<td>France</td>
<td>PsoBioTec</td>
</tr>
<tr>
<td>Germany</td>
<td>PsoBest</td>
</tr>
<tr>
<td>Israel</td>
<td>Clalit Health Service</td>
</tr>
<tr>
<td>Italy</td>
<td>Psocare</td>
</tr>
<tr>
<td>Spain</td>
<td>Biobadaderm</td>
</tr>
<tr>
<td>Sweden</td>
<td>PsoReg</td>
</tr>
<tr>
<td>Switzerland</td>
<td>SDNB</td>
</tr>
<tr>
<td>The Netherlands</td>
<td>PRESTON</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>BADBIR</td>
</tr>
</tbody>
</table>

Contact registries expressing interest

Portugal: Not yet defined

Tunisia: Not yet defined
Main activities
The Vulval Pain Society (VPS) gives out information on all aspects of vulvodynia, including diagnosis, treatment options and sexual dysfunction. Anecdotally, women diagnosed with vulvodynia find the information extremely useful and it often helps them deal with their symptoms in a more positive way. Many effective treatments for vulvodynia are not necessarily prescription-based and once a patient has a correct diagnosis we encourage her to work with her GP looking at different treatments.

Patients with vulvodynia have either unprovoked pain where the treatment approach is akin to a chronic pain management strategy eg tricyclic drugs such as nortriptyline, acupuncture and anaesthetic gels, or provoked pain ie pain on sexual intercourse. These patients are more likely to benefit from desensitisation of the vulva/pelvic floor as vaginismus can develop and phobias can exist about touching the area. Desensitisation can be performed with vaginal trainers, simple vibrators or vulval massage. Self-directed treatment can work but some patients need more formal input from a women’s health physiotherapist. Creams should generally be avoided as they can cause irritancy, a common secondary problem, yet they are still often used by patients as they are often prescribed. Anti-fungal creams are a common culprit in causing irritancy.

Meetings
Informal support is important and we run three workshops a year around the UK for women and partners. During the day we give out information on vulval care, discuss treatment options and give advice on how to take treatments. We hear women’s frustrations and the difficulties they have in accessing good medical care. We also encourage sufferers to think about setting up local support groups as these can be very beneficial. Several themes are raised at each meeting with regard to the care of vulval pain; how disjointed the medical care can be, the absence of a treatment plan and so little general information as well as the feelings of isolation experienced.

Publications
The VPS website is an award-winning resource for patients and doctors and copies of the VPS handbook can also be accessed at: www.vulvalpainsociety.org

Main goals
Advocacy is a key goal to raise awareness of women with vulval problems among the wider public. We will also continue to inform and educate through educational events and to provide support for those who have and do not have a diagnosis of vulval pain.

Contact
Vulval Pain Society
PO Box 7804
Nottingham NG3 5ZQ, UK
Website: www.vulvalpainsociety.org
A good general precept is, “Do unto others what you would have done unto yourself”.

All human societies have ground rules to prevent chaos. The practice of medicine has at all times and in all societies had rules for the conduct of its medical practitioners. These are to protect the patient, society and the doctor. Therefore it is important for dermato-venereologists within EADV to understand what drives the Ethics Committee in the maintenance of these high standards of professional behaviour.

Like all EADV committees, the members of this committee are elected by the Board of Directors through nomination and approval procedures to ensure transparency. At present there are 5 members of the Ethics Committee: myself as Chair, Dr Anne Kobza Black (UK) our Honorary Secretary, Prof Antonio Picoto (Portugal), Prof Lucio Andreassi (Italy) and Dr Päivikki Susitaival (Finland). Between us we have the equivalent of 200 years' experience of clinical, research, teaching, administration and communications. We know what does and can go wrong but mostly goes right.

The committee has been looking at three issues in particular:

1 Professional Relationships with one another

We are professional colleagues and must behave as such to one another. We must not denigrate one another. We should ask permission and make sure that it is given before using others’ materials such as photographs, clinical investigations and results, especially if they are to be used for presentation at conferences or published. Much research is the taking up of thoughts and findings of others but we must not plagiarise. This is especially true for poster presentations where up to date photographic devices and mobile phones make it so easy to steal others’ hard work.

2 EADV Elections

I took advice from the independent Electoral Reform Society (ERS) in England about this. It has been accepted by the Board of EADV. Our elections are now well run and ERS counts the votes and reports. There is no reason why any candidate should not canvass for votes. The candidate however must not offer any material or professional inducement. The candidate must not denigrate any other candidate.

3 EADV Congresses or Spring Symposia

i) It is imperative that all presenters speaking and all poster presenters declare all conflicts of interest. They must declare if this work has been done for a commercial organisation or has been paid for by a commercial organisation. They should declare if they have been sponsored in any material way by commercial organisations for travel, hospitality, or accommodation. They should declare if they hold shares in such commercial organisations.

ii) Privacy and confidentiality of clinical material shown at Congresses or Spring Meetings: permission must be obtained from the patient for photographs used for teaching and possible publication. Most hospitals and universities demand this for doctors employed by them. Photographs should have the eyes blacked out. References to the patient’s identity should not be able to be seen in any clinical photographs or results illustrated about that patient. This also means that the audience must not take photographs of presenters’ slides or illustrations without permission (this is so easily done with contemporary technical devices and more or less impossible to police). There has been publicity recently about misuse in copying intimate photographs of children, or the unauthorised copying of intimate photographs of adults. Conference organisers are required to make sure all clinical material is deleted after use by the technical staff.

iii) It goes without saying that there is nothing more annoying than mobile phones going off in a presentation. It is a discourtesy to the speaker. “Manners maketh man.” Enjoy and learn at our congresses and symposia but always remember society demands respect for its obligations to one another from those who are privileged to be members of this wonderful, now mature organisation, EADV.

Michael Waugh
Chairman
EADV Ethics Committee
mike@mawpud.fsnet.co.uk

AGM Notice

EADV
NOTICE OF ANNUAL GENERAL MEETING 2010
Notice is hereby given that the 2010 Annual General Meeting (AGM) of the EADV will be held on

Thursday, 7 October 2010 - in room H2
At the Swedish Exhibition and Congress Centre (Hotel Gothia Towers) Gothenburg, Sweden - at 11.15

The Agenda will appear on the EADV Website and the Autumn edition of EADV News
Dermatology in Portugal

History

Dermatology in Portugal gained importance at the beginning of the 19th century as a result of the influence of Bernardino António Gomes (1768-1823), the author of the first Portuguese book on cutaneous pathology *Ensaio Dermosográfico – Succinta e Systemática descrição das Doenças Cutâneas* (1820, 1822) (*Dermosographic Essay – succinct and systematic description of cutaneous diseases*), following the orientation of Willan and Bateman. Bernardino Gomes was a navy doctor. He lived in Brazil for four years where he studied the yaws differentiating it from syphilis (1815), elephantiasis and leprosy (1820), and also various local plants such as Cinchona and Quina (1812). At the same time he fought for the creation of hospitals and nursing wards for the treatment and teaching about skin diseases. He is the patron of the Portuguese Society of Dermatology and Venereology.

However, other Portuguese doctors graduating from the universities of Coimbra (founded in March 1290), Salamanca (Spain) and other European universities (France, Italy, Holland), living either in their country or having emigrated elsewhere in Europe (fleeing from the Inquisition because of their Jewish origin) had written about skin diseases, leprosy and syphilis. Amatus Lusitano (1511-1561), Zacuto Lusitano (1575-1642), Duarte Madeira Arraes (?-1652), António Ribeiro Sanches (1669-1783). The latter was the author of a chapter about “Maladies venériennes” in the *Enciclopédie* (1751) of Diderot and d’Alembert (Paris).

The first hospital built according to the criteria and with a well defined organisation was the Hospital Real de Todos os Santos, built in Lisbon, in 1492 by King João II, the driving force behind the sea voyages of discovery. This hospital had a ward reserved for syphilis patients called Casa das Boubas (House of the yaws).

It was only towards the end of the 19th century, however, that the first hospitals with differentiated care for cutaneous diseases began to emerge.

In 1911, with the establishment of the republican regime the university education was subjected to a major reform, changing the Medical Schools of Lisbon and Porto into Faculties of Medicine and introducing new curriculum programmes. Dermatology and Syphiligraphy became a subject and an autonomous hospital centre.

Growth of dermatology

This specialisation increasingly gained prestige through the actions of four outstanding figures: Thomas de Mello Breyner (1866-1933) and Sá Penella (1889-1955) in Lisbon, Luis Viegas (1889-1928) in Porto and Rocha Brito (1885-1961) in Coimbra. At the time the medical activity of the specialty was conditioned by the care and social problems related to leprosy (then still endemic in Portugal), together with venereal diseases and tinea capitis. As a result, various centres for diagnosing and the treatment of syphilis, were created. A national centre to combat leprosy was created and the leprosy colony-hospital for about 1500 patients was built. Sanitary campaigns were carried out throughout the whole country diagnosing and treating tineas. The results were remarkable: in a very few years, due to their actions and treatment and social progress, the endemic diseases of leprosy and tineas became extinct and the incidence of venereal diseases dropped radically and came under control. At the same time the first big university hospitals were built in Lisbon (Hospital de Santa Maria, 1956), in Porto (Hospital de S. João, 1959) and in Coimbra (Coimbra University Hospital, 1987).

Modern times

In the 1960s, the creation on a national level of hospital medical careers and the enforcing of compulsory internships to
Vitiligo European Task Force (VETF)

Fostering collaboration

The VETF was officially created at the Ghent ESPCR (European Society for Pigment Cell Research) meeting in 2003 with the objective to foster collaboration within teams with an interest in vitiligo clinical and basic research.

The work on SCORAD done earlier by ETFAD (European Task force on AD which celebrates its 20th anniversary in Gothenburg) was used as a template. The initial close interaction between research groups in Bordeaux and Rome was instrumental in developing VETF. The link to EADV was needed to obtain a larger interface with clinical dermatologists, in view also of the international growth of EADV and attractiveness for African, Middle East and Asian dermatologists for whom pigment cell disorders are a priority.

The 2007 VETF consensus paper on the definition and assessment of vitiligo has been well received in the vitiligo community and its criteria are now used more and more commonly for the initial assessment of patients. Further validation steps are in progress especially to improve assessment of disease progression during trials. The newly released Vitiligo book (Picardo & Taïeb, eds, Springer) is expanding the work done initially by VETF members and witnesses the enlargement of contacts established at the international level, especially at meetings of regional and international pigment cell societies.

Next steps

Current priorities are to establish vitiligo consensus recommendations at the international level taking account of worldwide constitutive pigmentation differences, as well as the agenda of the next International Pigment Cell conference to be held in Bordeaux in 2011.

On behalf of the VETF
Dr Mauro Picardo and Prof Alain Taïeb
E-mail: picardo@ifo.it

Dermatology today

Presently there are about 330 dermatologists, nearly all of whom are members of the Portuguese Society of Dermatology and Venereology (SPDV). This was founded on the 14 November 1942, by a group of 42 doctors led by Sá Perenella. Its activity has been very regular and important from the start: it has implemented and developed the specialisation. The Society has 2 regular meetings per year and a biennial National Congress; which publishes 4 issues of the specialist magazine Trabalhos da Sociedade Portuguesa de Dermatologia e Venereologia was also started in 1942; promotes regular training courses and postgraduate courses in dermopathy, contact dermatitis, surgery, paediatrics etc. It also promotes various seminars and meetings with societies in Spain and Brazil and has maintained regular exchanges with a great number of European colleagues.

The active participation of Portuguese dermatologists is also evident in their cooperation in international textbooks and their close relationship with the main European centres. In addition to work of the SPDV the support of the College of Dermatology and Venereology of the Medical Council is also important.

A Poiares Baptista
E-mail: apoibaptista2@gmail.com

continued from page 8
Skin ageing and hormones

Signs of ageing become evident over time and skin constitutes the first obvious battle field of this process. One of the major factors which have been proposed to play an exquisite role in the initiation of skin ageing is the physiological decline of hormones.

Currently, in the western world, women live one-third of their life and men at least 20 years of their life in a state of hormonal deficiency. Serum levels of circulating hormones decline with age \[14\] due to a reduced secretion of the pituitary, adrenal glands and the gonads or due to an intercurrent disease in female and male individuals. In females, serum levels of 17β-estradiol, dehydroepiandrosterone (DHEA) and its sulphated form DHEA-S, progesterone, growth hormone (GH) and its downstream hormone insulin-like growth factor I (IGF-I) are significantly decreased with time.

Skin being a target for a plethora of hormones and also a peripheral endocrine organ by itself \[10\] can be affected to a big extent by the decline of hormones. The importance of the GH/IGF-I axis for the skin ageing process has been illustrated by several studies. Patients with isolated GH deficiency (IGHD), multiple pituitary hormone deficiency (MPHD) including GH, or primary IGF-I deficiency (GH resistance, Laron syndrome) present signs of early skin ageing such as dry, thin and wrinkled skin \[11-14\].

Post-menopausal factors

After menopause in females, which is marked by the sudden decline of oestrogens, dermal cellular metabolism is influenced leading to changes in the skin thickness, collagen content, alterations in the concentration of glycosaminoglycans \[21-25\] and most importantly the water content \[26\] and the cutaneous vascular reactivity. Moreover, one of the most important consequences is delay in cutaneous wound healing, as reduced levels of oestrogen have been associated with impaired cytokine signal transduction, unchecked inflammation and altered protein balance \[24\]. Administration of oestrogen given both topically and systemically may reverse the observed alterations and retard the skin ageing process \[27,28\].

DHEA has been also related to the process of skin ageing through the regulation of production and degradation of extracellular matrix by increasing procollagen synthesis and inhibiting collagen degradation through decrease of matrix metalloproteinases (MMP)-1 and collagenase synthesis, and increase of tissue inhibitor of matrix metalloprotease (TIMP-1) and stromelysin-1 production in cultured dermal fibroblasts \[24,32\]. Improvement of skin quality has been observed after treatment with DHEA, particularly in women in terms of hydration, epidermal thickness, sebum production, and pigmentation \[29\]. Consequently, researchers have suggested the possibility of using DHEA as an anti-skin ageing agent \[19,37\].

Impact of testosterone

Testosterone has been shown to enhance the keratinisation of epidermal cells \[38\] and increase angiogenesis in human foreskin \[39\]. In addition, high levels of testosterone in vivo have been implicated with enhanced sebaceous gland activity in humans \[40,41\]. This is postulated to be the result of the generated production of the potent androgen 5α-DHT. Testosterone supplementation therapy in hypogonadal healthy men can lead to positive effects on sexual function, lean body mass and vertebral bone mass, however no amelioration of skin ageing signs has been described \[41\].

Progesterone is known to enhance the keratinization of epidermal cells \[38\], increase keratinocyte proliferation \[41\], block action of 5α-reductase in genital fibroblasts, a key enzyme in normal male sexual differentiation \[42\] and inhibit growth of fibroblasts in vitro \[51\]. Topical application of progesterone seems to have positive effects on aged skin through increase of skin elasticity and firmness in peri- and postmenopausal women \[54\].
New developments

In the past decade, the rapid development of genomics, proteomics, metabolomics and bioinformatics has enabled a comprehensive assessment of skin ageing at the fundamental levels of gene and protein expression as well as their downstream metabolic procedures and has helped us to identify important biomarkers of hormone-induced skin ageing. The most significantly altered signalling pathway has been shown to be that of transforming growth factor β (TGFβ). These data demonstrate that hormones interact in a complex fashion, and skin cells may be affected to a large extent by the changes in their circulating blood levels with age.

Measurement of skin parameters and the influence of the endocrine environment on them has become a great tool for researchers to reveal the significance of hormones in human and develop new strategies for reversing age-associated effects.

Eugenia Makrantonaki MD PhD
Departments of Dermatology, Venereology, Allergology and Immunology
Dessau Medical Center
Auenweg 38
D-06847 Dessau, Germany

and

Laboratory for Biogerontology, Dermatoendocrinology and Dermatopharmacology
Institute of Clinical Pharmacology and Toxicology
Charité Universitätsmedizin Berlin
Gra pystrasse 5
D-14195 Berlin, Germany

This is an abridged version of the full article which can be downloaded, with the full list of references, from the EADV website: www.eadv.org

References
STIs – venereology 2010

The lecture hall promises of a decade ago have now come to full fruition. We have an armamentarium of highly sensitive and specific Nucleic Acid Amplification Tests (NAATs) to diagnose conditions that are clinically silent and elusive to investigation.

The sensitivity of our diagnostic ability for *Chlamydia trachomatis* has increased by 40-50% and the test systems are robust, more amenable to automation and allow multiple sample sites, including self-sampling. The same applies to herpes simplex virus detection. This methodology has allowed recognition of *Mycoplasma genitalium* as a significant sexually-transmitted infection (STI), with a clinical spectrum similar to *Chlamydia trachomatis* although not as yet commercially available in many European countries.

What has been the result of this step forward? Have we seen a reduction in the epidemic of chlamydia and other STIs? Have we seen increased awareness of infections, and an enhanced response to combat them? Have our own practices changed: have they changed for the better?

**Improving consultation**

We will address the last question first. There has been a move towards screening asymptomatic patients with NAATs tests only, triaging them away from a more time-consuming assessment with examination. This ‘pee in a pot’ is certainly reliable for the diagnosis of chlamydia and gonorrhoea, although the sensitivity of some NAATs has caused concern about false positives in low prevalence populations. But does it amount to a clinical consultation? Symptomatology in STI is notoriously unreliable, so triaging on that basis is hardly robust. Is a patient asymptomatic when two weeks ago there was urethral irritation? There is no clinical examination to identify recognised warts, ulcers or molluscum. And what about the doctor-patient relationship which is so valuable in reassurance, support, giving information about conditions that are not identified by this screening and directing behavioural change towards safer sex practices.

**Better prevention strategies**

On a public health approach, we have not seen any worthwhile effect from the introduction of these tests. We have not seen any European-wide screening programmes, although there are case finding and limited screening approaches for chlamydia in a few countries. We are aware of only a few targeted public information campaigns to encourage those at risk to be tested. We sense a numbing silence in the face of a continuing increase in these infections and the emergence of previously quiescent infections, such as lympho-granuloma venereum, syphilis and gonorrhoea. These occur especially in men who have sex with men, often those who are HIV Ab positive. Rather than a piecemeal approach to testing, is it not time to consider a co-ordinated prevention strategy? This should be based on good public information, access to services, and with referral to more specialised services, which work to the same standards and are linked up. There should be a focus on partner notification and prevention as an integral part of clinical management.

Thirty years on in the HIV epidemic there is progress to be reported. Where available, effective anti-retroviral treatment (ART) has transformed the prognosis of this infection. We now see people with HIV survive to face the problems of old age and for many their major problem maybe failure to provide for a pension. ART has also reduced the fear of infection in the younger generations, who have grown up in the era of HIV/AIDS, have not been exposed to the media hyperbole of the eighties and nineties, and are less afraid of early death from catching HIV. Risk-taking has returned, especially in the large cosmopolitan ‘fun’ cities, as well as in economically deprived areas where prostitution and drug use are prevalent. At long last, the question of transmission is starting to be addressed. In 2006, the CDC guidelines were changed to encourage widespread HIV testing with an ‘opt out’, rather than an ‘opt in’ policy. Testing is encouraged at every point of medical intervention, irrespective of ascertained risk history, not dissimilar to the guidelines for testing for syphilis introduced in the 1930s in the US, and which were also so successful in containing syphilis in the former USSR until its break-up.

Essentially, if someone knows they are HIV positive, they are less likely to pass it on. Other measures include the recognition of male acquisition reduction by 60% by circumcision in men who have sex with women and a possible secondary benefit to their partners on a population basis. Anti-retroviral therapy contributes to substantially reduced transmission in those patients who maintain a sustained viral suppression. Early identification of those infected must now be the focus of attention. All physicians have their part to play. Performing limited STI testing in non-specialist sites may do nothing to raise awareness of HIV risks and ensure testing to identify those who have been infected. However not raising HIV testing with a patient, when a condition could be attributable to HIV, and failing to take an HIV test is also poor medicine.

continued on page 17
ECZEMA IS ALWAYS WAITING TO ATTACK

FOR LONG-TERM ECZEMA CONTROL
YOU NEED TO MANAGE THE UNDERLYING INFLAMMATION ACTIVELY.

Atopic eczema flares can be managed in the short-term, but the threat of another flare is always lurking under the surface. Twice-weekly PROTOPIC™ offers an effective way to control eczema in the long-term by treating the sub-clinical inflammation between flares. It prevents flares and prolongs flare-free intervals in adults and children with moderate and severe eczema.

SO DON’T WAIT FOR THE FLARE, USE TWICE-WEEKLY PROTOPIC TO CONTROL ECZEMA IN THE LONG-TERM.

With intermittent use. Patients should have had an initial response to an acute exacerbation with PROTOPIC twice daily (max. 6-weeks) treatment.

REFERENCES: 1. Wolfenbeng & Beer T Allergy 2009; 64: 276-279. 2. Bittan S & Abbiga J J Dermatol. Treatment 2009; 29: 34-44. PRESCRIBING INFORMATION: PROTOPIC™ 0.03% ointment (tacrolimus monohydrate) PROTOPIC™ 0.1% ointment (tacrolimus monohydrate). ACTIVE INGREDIENTS: PROTOPIC™ 0.03% ointment (1g) contains 0.5mg of tacrolimus as tacrolimus monohydrate (0.002%). PROTOPIC™ 0.1% ointment (1g) contains 1.5mg of tacrolimus as tacrolimus monohydrate (0.001%). THERAPEUTIC INDICATIONS: PROTOPIC™ 0.03% – treatment of moderate to severe atopic dermatitis in children (2 years of age and above) who failed to respond adequately to conventional therapies such as topical corticosteroids – treatment of moderate to severe atopic dermatitis in adults who are not adequately responsive or to an intolerant of conventional therapies such as topical corticosteroids. PROTOPIC™ 0.1% – treatment of moderate to severe atopic dermatitis in adults who are not adequately responsive or to an intolerant of conventional therapies such as topical corticosteroids. PROTOPIC™ 0.3% - maintenance treatment of moderate to severe atopic dermatitis for prevention of flares and prolongation of flare-free intervals in patients experiencing a high frequency of disease exacerbations (i.e. occurring 4 or more times per year) who have had a full response to a maximum of 6 weeks treatment of twice daily tacrolimus ointment. Lesions cleared, almost cleared or mildly affected. DOSAGE AND METHOD OF USE: PROTOPIC™ should be initiated by physicians with experience in the diagnosis and treatment of atopic dermatitis. PROTOPIC™ can be used for short-term and intermittent long-term treatment. Treatment should not be continuous. PROTOPIC™ should be applied as a thin layer to affected or commonly affected areas of the skin and may be used on any part of the body, including face, neck and flexure areas (except eyes and mucous membranes). PROTOPIC™ should not be applied under occlusion. PROTOPIC™ is not recommended for use in children below the age of 2 years until further data are available. Specific studies have not been conducted in elderly patients. However clinical experience has not shown the necessity for dosage adjustment. Treatment of flares: PROTOPIC™ treatment should begin at the first appearance of signs and symptoms. Each affected region of the skin should be treated with PROTOPIC™ until lesions are cleared, almost cleared or mildly affected. Therefore, patients are considered suitable for maintenance treatment (see below). At the first signs of recurrence (flares) of the disease symptoms, treatment should be re-initiated. General considerations for treatment of flares: Use in children (2 years of age and above) PROTOPIC™ 0.1% is not indicated for use in children. Treatment with PROTOPIC™ 0.03% should be started twice a day for up to three weeks. After the interval of application should be reduced to once a day until clearance of the lesion. In use in adults (16 years of age and above) Treatment should be started with PROTOPIC™ 0.1% twice a day and continued until clearance of the lesion. If symptoms recur, twice daily treatment with PROTOPIC™ 0.1% should be restarted. An attempt should be made to reduce the frequency of application or use the lower strength if the clinical condition allows. Generally, improvement is seen within one week of starting treatment. If no improvement is seen after two week of treatment, further treatment options should be considered. Maintenance of flare-free intervals: PROTOPIC™ should be applied once-every-weekly (i.e. Monday and Thursday) to commonly affected areas to prevent progression to flares. Between applications there should be 2-3 days without PROTOPIC™ treatment. Adult patients (16 years of age and above) should use PROTOPIC™ 0.1% (children 2 years of age and above) should use the lower strength: PROTOPIC™ 0.03%. If signs of a flare recur, twice daily treatment should be re-initiated. After 12 months, a review of the patient’s condition should be conducted by the physician and a decision taken whether to continue maintenance treatment. In children, this review should include suspension of treatment to assess the need to continue this regimen and to evaluate the course of the disease. UNDESIRABLE EFFECTS Very common: Burning sensation (which tends to resolve within one week of starting treatment), pruritus. Common: Sensation of warmth, erythema, pain, irritation, paresthesia and rash at site of application; Alcohol odour (facial flushing or skin irritation after consumption of an alcoholic beverage); Patients may be at an increased risk of herpes viral infections (Herpes simplex (cold sores), Herpes zoster (shingles) and Varicella zoster (chickenpox) eruption) and folliculitis. Uncommon: acne. During post-marketing experience: Rash. Also, cases of malignancies, including cutaneous and other types of lymphoma, and skin cancers, have been reported in patients using tacrolimus ointment. Application site impetigo and application site infections occurred more frequently in a study of maintenance treatment in adults and children. Prescribers should consult the summary of product characteristics in relation to other side effects. PRECAUTIONS FOR USE: PROTOPIC™ should not be used in patients with congenital or acquired immunodeficiencies or in patients on therapy that causes immunosuppression.

The effect of treatment with PROTOPIC™ on the developing immune system of children, especially the young, has not yet been established and this should not be taken into account when prescribing to this age group. Exposure of the skin to sunlight should be minimized and the use of ultraviolet (UV) light from a solarium, therapy with UVB or UVA in combination with psoralens (PUVA) should be avoided during use of PROTOPIC™. Patients should be advised on appropriate sun protection methods, such as minimization of the time in the sun, use of a sunscreen product and covering of the skin with appropriate clothing. PROTOPIC™ ointment should not be applied to lesions that are considered to be potentially malignant or pre-malignant. Emollients should not be applied to the same area within 2 hours of applying PROTOPIC™. Concomitant use of other topical preparations has not been assessed. There is no experience with concomitant use of systemic steroids or immunosuppressive agents. Before commencing treatment with PROTOPIC™, clinical infections at treatment sites should be cleared. The potential for local immunosuppression (possibly resulting in infections or cutaneous malignancies) in the long term (i.e. over a period of years) is unknown. PROTOPIC™ contains the active substance tacrolimus, a calcineurin inhibitor. In transplant patients, prolonged systemic exposure to intense immunosuppression following systemic administration of calcineurin inhibitors has been associated with an increased risk of developing lymphomas and skin malignancies. In patients using tacrolimus ointment, cases of malignancies, including cutaneous and other types of lymphoma, and skin cancers have been reported. Patients with atopic dermatitis treated with PROTOPIC™ have not been found to have significant systemic tacrolimus levels. Lymphadenopathy was uncommonly (6%) reported in clinical trials. The majority of these cases related to infections (skin, respiratory tract, tooth) and resolved with appropriate antibiotic therapy. Patients who receive PROTOPIC™ and who develop lymphadenopathy should be monitored to ensure that the lymphadenopathy resolves. Lymphadenopathy present at initiation of therapy should be investigated and kept under review. In case of persistent lymphadenopathy, the antibody to the lymphadenopathy should be investigated. In the absence of a clear antibody to the lymphadenopathy or in the presence of acute infections mononucleosis, discontinuation of PROTOPIC™ should be considered. PROTOPIC™ should be used with caution in patients with hepatic failure. PROTOPIC™ should not be used in patients with Netherton syndrome. Care should be exercised if applying PROTOPIC™ to patients with extensive skin involvement over an extended period of time, especially in children. The development of any new change different from previous eczema within a treated area should be reviewed by the physician. PROTOPIC™ should not be used during pregnancy unless clearly necessary and is not recommended when breast-feeding. The safety of PROTOPIC™ has not been established in patients with generalised erythroderma. PROTOPIC™ is unlikely to have an effect on the ability to drive or use machines. CONTRAINDICATIONS Hypersensitivity to macrolides in general, to tacrolimus or to any of the excipients. INTERACTIONS Because of the potential risk of vaccination failure, vaccination should be administered prior to commencement of treatment, or during a treatment free interval with a period of 14 days between the last application of PROTOPIC™ and the vaccination. In case of live attenuated vaccination, this period should extend to 30 days. Antiviral prophylaxis should be given to patients with a history of varicella or herpes zoster infection, or who are at risk of developing herpes zoster infection. The prophylactic use of the antiviral agent may be required longer than the standard duration. ANTIBIOTIC Prophylaxis may be required for at least 14 days after the completion of therapy. If an infection occurs at the treatment site, use of an appropriate antibiotic therapy is recommended. The common side effects of tacrolimus are summarized in the summary of product characteristics for the product. It is important to consider the possibility of other side effects, which may be more frequent in long-term treatment with the product. Patients should be advised to report any adverse events to their healthcare professional. Further information is available from: Astellas Pharma Europe Ltd, Lovett House, Lovett Road, Staines, TW18 3AZ, UK, DATE OF REVISION: April 2009, FOR FULL PRESCRIBING INFORMATION REFER TO THE SUMMARY OF PRODUCT CHARACTERISTICS. As prescribing information may vary from country to country, see local Prescribing information for full details. APELS2005

Advice events should be reported. Reporting forms and information for the UK can be found at www.yellowcard.co.uk. For other countries please check local requirements. Advice events should also be reported to your local Astellas office. © June 2009 Astellas Pharma Europe Ltd. Unless otherwise stated, all trade marks are owned by Astellas Pharma Inc. and/or its related entities.
Election of EADV President-elect

Meet the candidates

**Jana Hercogová**  
(Czech Republic)

EADV was born 23 years ago in 1987. She (Academy is feminine in Latin) reached adulthood after some childhood diseases and puberty problems. Now, the Academy has reached the age of a proud, young, and mature lady who is building her future based on the foundation of the marvellous ideas of her great founders and past and present and supporters. EADV was able to stage a number of successful congresses, has created an impact factor journal and is presently developing a number of new exciting activities for all European dermato-venereologists.

Let me become the visionary who can see the European dermatological community as a unique, multicultural society of colleagues, who will nurture our discipline to become a leading specialty in medicine. Dermato-venereology is already now a prestigious branch of medicine and surgery and it has changed profoundly during the last two decades. Changes bring turbulences and create opportunities. How can we, together, profit from this? I believe we should work together, we should meet and exchange ideas, problems, successes and failures. Together, we should work with political leaders and administrators and seek the co-operation with and the support of patient organisations. To be a leader in our Academy means to be able to attract the attention of the EU and be devoted to service, to listen to people - patients and colleagues - all over Europe and beyond. A leader in EADV should be a good dermatologist, teacher, researcher and friend. To me, to be a European leader, would mean to serve each and every European dermato-venereologist to give him/her:

1. Feelings of togetherness, friendship, and fruitful co-operation;
2. Equal chances to be listened to, to share knowledge, to lecture, to publish personal observations, scientific results;
3. Fair support to those who have not been privileged in the past and now need help in education, skills, exchange programmes and research co-operations;
4. Proper direction to grow professionally, ethically and personally in our European dermatology community.

And how can we achieve these goals? Our Academy has enlarged by National Societies members. It should be now promoted as the society where all members would get a common voice. Intensive exchange programmes, educational events held at each country and more money devoted to scholarships should be planned and realised.

I am ready to mature with all of you to reach these goals. In Prague, after the communist system collapsed, I served our Academy for five years on the Board and on the Executive Committee. In 2002 I served the Academy as Congress President in Prague. The expectations were for a maximum 3,000 participants and profit for the EADV up to €200,000. Together with my colleagues of the local organising committee and the leadership of the EADV we were able to double the expectations. We attracted more than 6,000 participants to Prague (6 weeks after a disastrous flood), we made a profit of more than €400,000, and, last but not least, it was the first congress in the history of European dermatology where 1,200 colleagues from previous communist Eastern countries attended. This opened a new era for EADV. The vast majority - you - put me to the first position during the EADV Presidency Election two years ago. I was asked by most of you to be a candidate again. So, I am ready to serve the Academy. If the Academy is now a proud, young and robust lady, it is time that a devoted lady from a now vibrant European country forgotten for 40 years, comes to harmonise, develop and unify European dermatology.

**Thomas Luger**  
(Germany)

Dermato-venereologists in Europe have been very successful in resolving the underlying cause of many skin diseases and subsequently developing novel effective therapeutic strategies. Despite these significant achievements, which already improved the health and quality of life of many patients, our specialty throughout Europe is currently facing serious problems from health authorities and insurances. However, facing these challenges we must not forget that this also may represent a tremendous chance to strengthen and improve dermato-venereology.

*My experience as clinician, researcher and chairman of a large department of dermatology has given me the opportunity to recognise the dangers and problems facing our profession. These experiences were further enhanced by being the President of the German Society of Dermatology. Working in EADV as a Board member, as chairman of the scientific committee and as organiser of the 18th EADV Congress in Berlin has provided me with the experience and knowledge required to further support and serve EADV if the members of our society should give me the opportunity to be allowed to be President.*

In the future EADV should focus on:

- Professionalisation of lobbying to promote dermato-venereology both at the national as well as European level
- Increasing public awareness of skin...
diseases at the European level by high profile media campaigns
• Standardisation and improvement of education and training in close collaboration with UEMS and EDF
• Further supporting training and exchange programmes for residents and postdoctoral fellows
• Supporting dermatological research in collaboration with the ESDR and ESRF
• Strengthening the international cooperation between European and other dermatology societies
• Making EADV even more attractive to increase the number of European and international members

If I am elected I will do my best to achieve these goals in order to promote dermatovenereology and our EADV. I will also ensure that operations within the Academy are handled in a democratic, fair and transparent manner. I will try hard to strengthen EADV for the benefit of our specialty and the best care of our patients.

Fenella Wojnarowska (UK)

I would define EADV thus: the EADV ensures excellent and equitable clinical care for every European patient with skin or sexual health problems. In addition EADV should promote community, collaboration, exchange, and friendship between dermato-venereologists from all European countries.

My main objectives for the EADV would be to:
• ensure that the EADV is a truly democratic and representative institution
• promote education in its widest sense
• become inclusive with increasing participation of nurses and patients
• become a political force

A democratic and representative EADV: The majority of the members are private practitioners and many are women, but these groups are under-represented in policy, decision-making and administration in EADV, as are the countries that have recently joined from Eastern and Southern Europe. Positive action needs to be taken to ensure that all these groups are engaged and are present within the administration.

Education: This would apply to specialists and trainees, to nurses engaged in dermato-venereology practice and also to patients.

Dermato-venereologists: Providing education for dermato-venereologists in the broadest sense, encompassing clinical skills and knowledge of therapeutic and cosmetic dermatology, developments in medical ethics, the practicalities of managing their practice, and achieving a work-life balance. This would be done by the EADV Professional Development Programme by way of interactive tools, visits to other centres or practices, online education and the innovation of brief one-page summary guidelines for common and important conditions.

Nurses: Education for nurses is essential because of their expanding role in dermato-venereology. EADV can lead on developing their clinical skills and knowledge, awareness of patient education, role as patient advocate, and medical ethics. Their skills complement those of doctors enabling the services offered to patients to be improved and extended.

Patients: Dermato-venereology exists to serve patients. EADV can be first in developing, screening and collating online informative and accurate patient information in all European languages, that can then be used to enhance patient understanding and to empower them to participate in their treatment.

An inclusive EADV: Altruism plays a large part in the decision to study medicine and we all wish to do the best for our patients. Good practice involves collaboration with nurses and EADV should recognise this by including nurses in EADV activities and supporting them in their professional development.

EADV must facilitate our interactions with patients. We should be partners with patients, informing them about their diseases, responding to their concerns and including them in decision-making concerning their treatment. We must collaborate with and encourage Patient Support Groups, involving them in our congresses and activities, and the provision of patient information and resources. An overarching EADV Patient Support Group is essential as our greatest spokespersons are our patients who, by engaging the interest of the media, can recruit support for us from the public and politicians.

EADV as a political force: EADV must champion our specialty with the public and politicians, the links with EU politicians must be strengthened with the help of dermatology nurses and our patients. The expansion of EADV by inclusion of national dermato-venereology societies has given it a larger voice in Europe. However, to increase its influence with politicians and the public it should consider similar arrangements with nursing societies as supporting members to give EADV a large and representative base with which to influence politicians and the public. An overarching EADV Patient Support Group would be our most powerful ally in campaigning with the public and politicians.

EADV must continue to forge links with allied societies in the world as a whole, discovering common ground and learning from each other. I witnessed the effectiveness of such collaboration recently as part of the Knowledge Exchange Initiative in India.

In conclusion, I am passionate about EADV, as demonstrated by my contribution to congresses, committees and EADV's international role. I feel that I could lead EADV because I have a clear vision of the role of EADV and an inclusive management style that delegates and empowers all individuals to be stakeholders in the success of EADV, with their contribution valued and recognised.

An inclusive and democratic EADV will raise the status and standard of dermatovenereology in Europe to the benefit of patients and doctors.
By our personal professional commitment but now also bound by national laws in some countries we are obliged to offer “lifelong learning” or “Continuing Professional Development”.

Whether continuing medical education is compulsory or optional depends on the country you live in; you have to prove that you are continuously updating your knowledge and skills. You have to prove it to your patients (who are paying for optimal care), to your colleagues and also, last but not least, to the insurance companies which reimburse you, directly or indirectly.

It isn’t enough to pretend that we are the specialists and experts of healthy and sick skin. We also have to do our homework to keep up to the standards of our discipline!

Besides visiting our Congresses and Symposia, why don’t you also try to enhance your knowledge and skills by testing yourself online?

EADV has been offering you this opportunity since 2009. Try it! Visit our website: www.eadv.org > education > gain cme online. You will be able to print a certificate immediately after having passed the test.

Going to Gothenburg in October? For the first time there we shall offer you the opportunity to get familiar with our CME online and to practise it.

Whether you are already an EADV member or not, we want to show you how our CME online works. The CME-CPD Committee, together with our colleagues in Gothenburg, will install a platform for CME online. There will be several PCs to practise on on-site and people to assist you. After having passed the test, you will get a certificate printed out at once – and one credit point!

We hope we have aroused your interest.

See you in Gothenburg!

On behalf of the CME-CPD Committee
Jean-Paul A Gabbud
Chairman
jgabbud@bluewin.ch

---

Be an artist of the new era.

**SP Dynamis** The Next Generation in Multi-Application

The all-in-one anti-aging laser platform incorporates three laser modalities, including a QCW Nd:YAG for surgical treatments, such as laser lipolysis. Runner scanners and fractional handpiece options make its top performing Er:YAG laser a true all-rounder in treating aging skin. TURBO Technology for high-definition fractional treatments and V-Smooth Technology further enhance the Er:YAG. The SP Dynamis is S-11 Nd:YAG scanner compatible for large area and novel treatments such as FRAC3R rejuvenation.

Become an artist of the new era!
Visit www.fotona.com today.
Vaccination as a prevention strategy is beginning to show promise. Hepatitis A and B vaccination has been with us for several decades. Their efficacy is well proven. We now have an effective vaccine for HPV, which has the potential to eliminate carcinoma of the cervix in countries where types 16 and 18 are the most prevalent, if it was available at an economic cost and effectively deployed. Recent data from Australia has shown the ability of the quadrivalent vaccine to significantly reduce the prevalence of genital warts in the population vaccinated. But vaccines for herpes, HIV, and Chlamydia remain elusive.

Which brings us full circle: control of HIV and STIs, reduction of incidence and eventually of prevalence, comes back to a co-ordinated approach which must include widespread access to provision of full clinical care with a clinical examination, screening for all infections, treatment where possible, partner notification and good advice by those who are properly trained and with the empathy to address personal and intimate problems. This can be supplemented by other approaches, but these should be seen as part of an STI/HIV control strategy. As dermatovenereologists and venerologists, we are in the unique position to provide the full clinical service and use our expertise to ensure standards and governance in other clinical and non-clinical sites. Where is the European response?

On behalf of the EADV Task Force on Venereology

Derek Freedman MD FRCP
GUIDE Clinic
St James’s Hospital, Dublin, Ireland
E-mail: freedman@iol.ie

Angela Robinson MBBS FRCP
Dept of Genito-urinary Medicine
Mortimer Market Centre, London, UK
E-mail: Angela.Robinson@Camdenpct.nhs.uk

European Society for Micrographic Surgery

Membership
ESMS has over 150 members from 20 different countries, including current EADV Board Members Martino Neumann (Netherlands) and Antonio Picoto (Portugal). The members are registered dermatologists-dermatosurgeons trained in (Mohs) micrographic surgery.

Application for full membership requires registration in dermatology, a training by a full member of our Society in a (Mohs) micrographic surgery (100 documented micrographic procedures: oncological excision, preparation of the excised tissue for complete margin control, histopathological examination and reconstruction of the defect in a training centre for micrographic surgery; a letter of recommendation by a full Member of the Society; and at least 50 procedures on an annual basis.

A new member has to apply for membership and present her/himself at the annual Membership meeting of the Sister Society meetings during the EADV Annual Congress. We closely cooperate with the EADV and plan our meetings at the EADV Annual Congress. This year we have a symposium on Mohs microsurgery in Gothenburg.

Main activities
Skin cancer, and Basal cell Carcinoma (BCC), in particular, is becoming the most common diagnosis in dermatology. Although some BCCs can by treated by non-surgical procedures, most of them need to be treated by surgery. And a growing number of recurrent, morpheic or infiltrative BCCs require (Mohs) micrographic surgery.

Therefore the European demand for dermatosurgeons and (Mohs) micrographic surgeons will continue to rise in the next decades. Our main activities consist of building a platform for dermatologist-dermatosurgeons to improve and expand dermatological micrographic surgery procedures for skin cancer by dermatologists. Micrographic Surgery consists of surgery with complete margin control techniques followed by immediate reconstructive techniques. We recently (January 2009) organised, together with the Dutch Society for Dermatology and Venereology a European Course on Dermato-surgery in the Catharina Hospital, Eindhoven, The Netherlands. The course included live demos in Mohs micrographic surgery and workshops in 3D histopathology, dermato-oncology and reconstructive techniques.

Contact
Dr Judith Ostertag
ESMS Secretary
Catharina Hospital
Michelangeloalaan 2
NL-5623 EJ Eindhoven
Tel: +31 40 239 7265
E-mail: Judith.ostertag@cze.nl
Website: www.esms-mohs.eu
**EADV**

**ELECTION OF BOARD DIRECTORS**

**ICELAND, NORWAY, RUSSIAN FEDERATION, SWITZERLAND, TURKEY and UNITED KINGDOM**

2010-2013

June 2010

Notice is hereby given that in terms of the Statutes (Articles 14, 15, 16 & 17) nominations for Board Directors representing Iceland, Norway, Russian Federation, Switzerland, Turkey and United Kingdom will be received by the Secretary General not later than **MONDAY, 16 AUGUST 2010**.

The relevant nomination form* is on page 20 and should be sent to:

**EADV (succursale belge), Avenue General de Gaulle 38, B-1050 Brussels, Belgium, by post or by fax to: + (32) 2650 0098.**

*the form can be photocopied before completing and sending back to EADV

Further information can be obtained at http://www.eadv.org

If more than two valid nominations are received the single transferable voting system will be used.

Only Specialist Members are entitled to stand for election. Voting members from **Iceland, Norway, Russian Federation, Switzerland, Turkey and United Kingdom** shall elect their national Board Member. Each candidate **must be a national of and resident in the country they are representing** and be nominated by two voting members resident in their country.

Successful candidates’ term of office will commence at the Board meeting in Gothenburg in October for a period of three years. They may be re-elected once for a further three year period.

Joseph L Pace MD
Secretary-General
MEMORANDUM

From
THE SECRETARY GENERAL
Re
RE-ELECTION OF STANDING BOARD DIRECTORS
To
EADV members from countries below
Date
June 2010

AUSTRIA – HONIGSMANN Herbert
NETHERLANDS – NEUMANN Martino
BELGIUM – ANDRE Josette
PORTUGAL – FIGUEIREDO Americo
BELGIUM – LAMBERT Julien
SERBIA – MEDENICA Ljiljana
FINLAND- RANTANEN Tapio
SLOVAKIA – PEC Juraj
FRANCE – PAUL Carle
SPAIN – ALOMAR Agustin
IRELAND – ROGERS Sarah
UNITED KINGDOM – ROBINSON Angela
ITALY – MONFRECOLA Giuseppe

Dear friends,

The above Board members’ current term expires in October. I am pleased to inform you that their attendance record at meetings has been excellent and they have participated most satisfactorily in the proceedings of the Board of Directors. These Board members have offered themselves for re-election for a further three-year term of office with the exception of the Board Directors from Ireland, and the United Kingdom who may be re-elected for one year only, having already served for five years on the Board.

According to EADV’s electoral regulations, the standing Board Director will still need to be proposed and seconded by two voting members from his/her country. Members also have the right, if they so wish, to nominate other eligible specialist members to contest this position, in which case a formal election will be carried out in September.

Please find the relevant nomination form* on page 20 which can be sent to:

ATTENTION SECRETARY-GENERAL
By post to:
EADV (succursale belge), Avenue General de Gaulle 38, B-1050 Brussels, Belgium

or by fax to: + (32) 2650 0098.
not later than MONDAY, 16 AUGUST 2010
*the form can be photocopied before completing and sending back to EADV

Further information can be obtained at http://www.eadv.org. Any required clarification can be requested from the Office of the Secretary-General at eadvsecgen@keyworld.net

If more than two validly made nominations are received, the single transferable voting system will be used.

Joseph L Pace MD
Secretary General

Avenue General de Gaulle 38, B-1050 Brussels, Belgium
Tel: +32 2 650 00 90, Fax: +32 2 650 00 98, E-mail: office@eadv.org
EADV
NOMINATION FORM*
BOARD DIRECTOR

I, the undersigned, nominate

Dr / Prof

a specialist member of EADV, to represent ________________________________ on the Board of Directors.

Proposer’s Name: ............................................................................. EADV Membership Number: .................

E-mail: ...........................................................................................................

Fax: ..................................................................... Telephone: ..............................................................

Proposer’s signature:

Seconder’s Name: ...................................................................... EADV Membership Number: .................

E-mail: ...........................................................................................................

Fax: ..................................................................... Telephone: ..............................................................

Seconder’s signature:

(Both Proposer and Seconder should be fully paid up members with voting rights and resident in nominee’s country)

*this form can be photocopied before completing and sending back to EADV

Acceptance of nomination

I, Dr/Prof .................................................................................................................................

a national of and resident in ________________________________ hereby accept the nomination for the position of Board Director representing this country.

EADV Membership Number: ..................................................................................................

Address: .............................................................................................................................

E-mail: .............................................................................................................................

Fax: ..................................................................... Telephone: ..............................................................

Signature: Date: ...........................................................................................................

(Both Proposer and Seconder should be fully paid up members with voting rights and resident in nominee’s country)

For office use:
RECEIVED EADV OFFICE Date................................... Signature

SENT TO: SECRETARY-GENERAL Date................................... Signature

CHAIR NOMINATIONS COMMITTEE Date................................... Signature
CALL FOR NOMINATIONS TO FILL VACANCIES ON
BOARD COMMITTEES - 2010
CHAIRPERSONS

June 2010

Notice is hereby given that elections will be held shortly to fill current vacancies on Board Committees.

Candidates for election to CHAIRPERSON must be proposed and seconded by two BOARD members. Only Specialist members are entitled to stand for election.

Chairpersons are elected by the Board of Directors at a Board meeting or electronically and the single transferable vote system will be used if necessary.

Nominations (please see form* on page 22) will be received by the Secretary General not later than MONDAY, 16 AUGUST 2010

by post to: EADV (succursale belge), Avenue General de Gaulle 38, B-1050 Brussels, Belgium, or by fax: +32 2650 0098.

*this form can be photocopied before completing and sending back to EADV

Current Vacancies:

CHAIRPERSONS:
CME-CPD Committee
Membership Committee

Updated information and the Internal Rules regarding EADV Committees are available at www.eadv.org

Joseph L Pace MD
Secretary General
EADV
NOMINATION FORM*
BOARD COMMITTEES - CHAIRPERSON

I, the undersigned, nominate
Dr / Prof

For the position of Chairperson of the _____________________________ Committee.

Proposer’s Name: ........................................................................... EADV Membership Number: ....................
E-mail: ............................................................................................................................
Fax: ................................................................................................................................. Telephone: ...............................................................
Proposer’s signature: Date: .............................................

Seconder’s Name: ........................................................................... EADV Membership Number: ....................
E-mail: ............................................................................................................................
Fax: ................................................................................................................................. Telephone: ...............................................................
Seconder’s signature: Date: .............................................

Candidates for election to Chairperson must be proposed and seconded by two Board Members)

*this form can be photocopied before completing and sending back to EADV

Acceptance of nomination

I, Dr/Prof ..............................................................................................................................

Hereby accept the nomination for the Chairmanship of the

_________________________________________ Committee

E-mail:................................................................. Fax: ................................................................. Telephone: ...............................................................

Signature: Date: .................................................................

For office use only:
RECEIVED: EADV OFFICE Date................................. Signature
SENT TO: SECRETARY-GENERAL Date................................. Signature
CHAIR NOMINATIONS COMMITTEE Date................................. Signature
In 2005, EADV started a Fostering Excellence in Education Programme with the aim:

• To raise standards of dermatology throughout Europe by offering trainee dermatologists high quality theoretical and practical training and an emphasis on best practice to benefit patients and dermatologists

• To promote community, collaboration and exchanges among European dermatologists

Fostering Trainee Education Committee

The Fostering Trainee Education Committee is currently composed of Josette André (Belgium), David Gawkrodger (UK), Anna Gorkiewicz-Petkow (Poland), Eggert Stockfleth (Germany) and Bertrand Richert (Belgium). Jean-Paul Gabbud (Switzerland) is a co-opted member.

The main activity of this committee is to select the courses that are to be offered to trainees. These courses should be interactive and provide some hands-on added value that cannot be offered at regular congresses. The number of participants is restricted to a maximum of 30, to allow the organisation of practical sessions, interactivity during the courses and social and professional networking.

The trainee selection is assumed by the course organiser and one of the committee members. Priority is given to trainees who are already EADV members, but a geographical balance between the different European countries is also taken into account. The selected trainees receive free registration, lodging, breakfasts, coffee breaks, luncheons and are invited to a social event. Junior EADV members also receive an educational grant.

Past programme

The Fostering Excellence in Education Programme is a success with 18 courses having been concluded since 2005, for 316 residents from 43 different countries. All the courses were oversubscribed and the evaluation by the participants were excellent with 100% replying that the choices of course topics were relevant to their training, the sessions were a useful way of sharing findings, the course was relevant to their educational needs and that the course sessions would influence their clinical practice.

2010 Programme

In 2010, a Training Course Genodermatoses was organised in January, led by Prof Johann Bauer, in Salzburg, Austria; the Summer School Dermatopathology (part 2) will take place in July, led by Dr Sofie De Schepper in Ghent, Belgium; and a Training Course Hair & Scalp will be held in November, led by Dr Bianca Maria Piraccini, in Bologna, Italy.

An ESDR/EADV Summer School will also take place in July, led by Prof Nick Reynolds and Prof Erwin Tschachler, in Vienna, Austria. This Course is the first joint project between the European Society of Dermatological Research and EADV. Announcements for these courses can be found on the EADV website.

2011 Programme

For 2011, several courses are in the pipeline: a Training Course Contact Dermatitis organised by Prof David Gawkrodger, in London, UK; a Training Course Interventional Cosmetics organised by Dr Christopher Rowland Payne, in London, UK; an Introduction to Virtual Dermatopathology organised by Dr Eileen Mooney, in Reykjavik, Iceland; a Summer School Dermatopathology (part I) organised by Prof Lorenzo Cerroni, in Graz, Austria; and a Training Course Psychodermatology organised by Dr Françoise Poot, in Brussels, Belgium.

I would like to take this opportunity to sincerely thank Prof Fenella Wojnarowska who initiated the programme, as well as all the course organisers, the members of the Committees, especially Bertrand Richert and Ildiko Papp, our EADV administrative officer, for their invaluable help. I hope that the trainees all keep good memories of these courses and make international dermatological friends forever.

Josette André
Chair
Fostering Trainee Education Committee

If you wish to organise an EADV fostering course for trainees, you can find a user-friendly document entitled “Have you ever considered organising a fostering course for trainees? This is what you need to know” on the EADV website: www.eadv.org.

You can also contact Ildiko Papp at Ildiko@eadv.org

If you wish to apply for a course, the application form can also be found on the website.
Spotlight on young researchers

Andor Pivarcsi (Hungary)

“I was born in 1974 in Hungary. I am a molecular biologist and my main interests are the molecular and immunological mechanisms underlying skin diseases. During my PhD training, conducted in the lab of Prof Lajos Kemeny at the Department of Dermatology, University of Szeged, Hungary, I studied pattern-recognition receptors on keratinocytes, the major cell type of the epidermis. In these studies, we identified that functional Toll-like receptor 2 and 4 are present in keratinocytes. This finding contributed to the better understanding of skin innate immune functions. The skin is a highly accessible organ which gives unique opportunities to understand the molecular background of human diseases and so I continued my research in the field of skin biology after receiving my PhD in 2001.

In 2004, I became involved in the 5th Framework of the European Community’s grant to study “The Role of Chemokines in the Pathogenesis of Atopic Eczema” together with researchers from Germany, Finland, France and Hungary. This provided me with an excellent opportunity to extend my knowledge of chemokine biology, learn new methods and experience a foreign culture while continuing my work on skin diseases (inflammation and cancer) in the laboratory, led by Prof Bernhard Homey at the Department of Dermatology, Heinrich-Heine-University Düsseldorf, Germany and Prof Thomas Ruzicka. During this period I was involved in the work investigating the function of chemokines in chronic inflammatory skin diseases and identified CCL18/DC-CK1/PARC to be specifically associated with atopic eczema. In parallel, I performed the analysis of chemokine expression in human skin cancers and identified a chemokine, CCL27/CTACK (Cutaneous T-cell-attracting chemokine), to be lost in non-melanoma skin cancers suggesting a novel mechanism of tumour immune escape by the loss of homeostatic chemokine expression.

In 2007, after receiving my Marie-Curie postdoctoral fellowship, I initiated an investigation which aimed to explore the role of a new type of genes, microRNAs, in skin diseases, in the laboratory of Prof Mona Ståhle, Department of Dermatology, Karolinska Institute, Stockholm, Sweden. Our results implicate microRNAs in human skin inflammatory diseases such as psoriasis and atopic eczema. In 2009, I received the prestigious European Skin Research Foundation New Investigator Award (funded by EADV), which will support my continued research in the field of microRNAs and human skin diseases.”

Claus Johansen (Denmark)

“My name is Claus Johansen. I am 36 years old and live in a city called Skanderborg in Denmark. In 1994 I started as a student in molecular biology and graduated from the Faculty of Science, Aarhus University in 1999. The last year of my studies I spent in the research laboratory at the Department of Dermatology, Aarhus University Hospital, where I also undertook my Master’s thesis.

Inspired by the great colleagues working at the Department of Dermatology, I soon started as a PhD student in the research laboratory and received a PhD scholarship from the Faculty of Health Sciences, Aarhus University. During my PhD study, I examined the effect of vitamin D3 on intracellular signalling cascades and transcription factors in human keratinocytes and skin biopsies from psoriatic patients treated with or without vitamin D3 analogues. My PhD study was performed in close collaboration with my supervisors Prof Knud Kragballe and Prof Lars Iversen.

In 2003 I finished my PhD and started as a postdoctoral fellow in the research laboratory at the Department of Dermatology, Aarhus University Hospital. At first I was funded by private foundations. However, in 2004 I received a three-year postdoctoral grant from the Danish Council for Independent Research in Medical Sciences. During these years the main focus of my work was to characterise the role of the MAPK signalling pathway in the pathogenesis of psoriasis but also in inflammatory processes in general.

Within the past few years, our lab has also been interested in skin carcinogenesis and the role of intracellular signalling pathways in skin tumour development. In 2009 I received the European Skin Research Foundation (ESRF) New Investigator Award for a project examining the role of the MAPK signaling pathway and inflammation in the development of non-melanoma skin cancer. The ESRF is a foundation kindly supported by EADV, ESDR, European Dermatology Forum and Fondation René Touraine, aiming to promote research and development in dermatology and venereology in Europe through research grants.

I am now working as an associate professor in the research laboratory at the Department of Dermatology, Aarhus University Hospital, where I am a supervisor for several PhD students and undergraduate students.”
Dear EADV members,

It has been a while since I have communicated with you through EADV News. The financial status of EADV is presently quite good and I imagine that many similar organisations would consider themselves lucky to be in our shoes.

In real life, however, things are rarely perfect. The EADV congresses have all been very successful and on top of that the last 10 meetings have left EADV with a healthy surplus. No-one knows if this will continue. If two large meetings in a row were not to be successful, a serious dent will be made to our reserves. Our Academy needs to have substantial funds to be able to honour all the commitments that have been made. To name a few, EADV sponsors educational projects for dermatology residents and specialists in Europe as well as in Africa and India. In addition it supports research projects, the JEADV, humanitarian aid, our employees who have served the Academy exceptionally well and, last but not least, EADV members.

There are, however, other things to consider. EADV has some possible liabilities, the largest one being the possibility of taxation of the surplus of some of the past congresses. The Belgian tax authorities have recently made a routine tax inspection of the EADV office in Brussels. In the reports to the board, the possibility of such an inspection has been pointed out. A rough calculation of the worst case scenario for the above mentioned liabilities shows that a large part of EADV’s funds would vanish. Furthermore, most of the projects would have to be postponed or cancelled, in order to protect the future of EADV and to retain the necessary staff for that purpose. We do certainly not expect this to happen but who could have predicted that an ash cloud from a volcano in my country would have disrupted air traffic as profoundly as it did? My opinion is that it is imperative to “Be Prepared”, to quote the international Scout motto.

The moving of EADV’s headquarters from Luxembourg to canton Ticino in Switzerland was not made to secure the financial status of the Academy but rather to be able to streamline our statutes and to allow electronic voting. EADV did also gain tax-free status in canton Ticino. The tax-free status is, however, subject to conditions. The main condition is that EADV should not accumulate more funds and assets than were present soon after the transfer of its headquarters to canton Ticino. This means that the annual surplus that the Academy has up to now been fortunate to have must be spent within a reasonable period. This condition is normal for a non-profit association in Switzerland but it can make the Academy financially vulnerable if it continues to grow as it has done for the last 10 years. The larger the Academy becomes the more funds it needs to have in reserve in order to be safe. This is something that needs to be addressed in the near future.

Voluntary work

The work of the EADV officers (president, secretary general and treasurer), the “elected officers”, editors, committee chairmen, board members as well as all other members who work for EADV like the members of committees and task forces, is carried out voluntarily without salary. I have really enjoyed working for EADV. The benefits are many, such as gaining new friends all around Europe and getting to know many distinguished colleagues from all countries. As an officer it is necessary to attend EADV’s congresses and symposiums so the airfare, hotel and registration are refunded by EADV. Indeed this is a benefit, which also applies to our board members and invited guests. However, there are many tasks to be carried out during these meetings and the daily workload of the officers, as well as some of the chairmen, has become quite considerable over the last few years. The time has probably come to open up a discussion of whether EADV officers should receive a small monetary remuneration to compensate the loss of working time for private practitioners or clinical time.

Give us ideas!

If you, as an EADV member, have some ideas concerning EADV’s finances, or a project that you feel that the EADV should be a part of, please feel free to contact me. They will be looked at carefully and discussed in the Finance Committee, before going to the Executive Committee and, if gaining positive assent, then incorporated in the budget.

I hope to see you in beautiful Gothenburg in October where our next congress will take place.

Jón H Olafsson
EADV Treasurer
E-mail: jonh@landspitali.is
Dear friends,

As my period of office as Secretary General draws to an end, I will be organising the last run of elections and what a marathon this will turn out to be. We will elect a new President for 2012-2014, two new Board members to sit on the EC, a number of Board Committee members including two important Committee Chairs, as well as a number of Board members. Russia, Turkey and the UK will all elect their second Board members having surpassed the statutory membership requirement.

The fundamental change is, however, a result of the amendments to the Statutes passed overwhelmingly in Cavtat. As a result:

- All members paid up by 31 May (and not 31 August as previously) will be eligible to vote irrespective of nationality or country of residence
- New members approved by the Board after the date of amendment of the Statutes will only have voting rights after 12 months of membership.

These changes go a long way to make our Academy more democratic, more transparent, and less open to manipulative applications for membership. These changes may be seen to close a circle on the radical changes adopted in Istanbul which opened the doors of EADV to all those interested in our specialty. From a small closed society where decisions were taken only by a single category of members, and where membership was restricted, despite our claim to represent Dermatology and Venereology in Europe, we have come to the current situation where voting rights have been gradually extended to trainees, retired and honorary members, and eventually to all bona fide members who have joined because of an interest in our specialty.

Truly representative

In addition, the national societies membership scheme has added much to the legitimacy to being the sole representatives of Dermatology and Venereology throughout geographical Europe from the Atlantic to the Urals. Fortunately, the extreme fears of a flood of applications from persons who would detract from the stature of our Academy did not materialise; we are happy to welcome scientists, physicians from other specialties and dermatology nurses into our midst with full membership rights. Patient groups will surely follow!

This new look EADV bodes well for the future and far from being looked down upon by Sister Societies in other parts of the world, the opposite is the case with innovative scientific exchanges being ongoing with both China and India and a new generation of members that will surely work on the premise of a health alliance between scientist-physician-nurse-patient with all stakeholders having their appropriate say in decision-making processes that can only lead to better healthcare in all its aspects - research, prevention and curative.

Joseph L Pace MD
Secretary General
Calendar of Events

> 2010

25th IUSTI-Europe Conference
Tbilisi, Georgia
23-25 September 2010

Interacademic Course of Onychology
Brussels, Belgium
24-25 September 2010

19th EADV Congress
Gothenburg, Sweden
6-10 October 2010

1st World Congress on Controversies in Plastic Surgery and Dermatology (CoPLASDy)
Barcelona, Spain
4-7 November 2010

2nd World Congress on Genodermatology
Maastricht, The Netherlands
17-20 November 2010

COSMODERM XVI – The International Aesthetic Dermatology Congress
Dresden, Germany
9-12 December 2010

> 2011

3rd Annual Meeting of the Multidisciplinary Interventional Cosmetics Group of the RSM
London, United Kingdom
28 February 2011

8th EADV Spring Symposium
Carlsbad, Czech Republic
14-17 April 2011

22nd World Congress of Dermatology
Seoul, South Korea
24-29 May 2011

2nd 5 Continent Congress
Lasers and Aesthetic Medicine
15-17 September 2011
Cannes, France

Interacademic Course of Onychology
Brussels, Belgium
23-24 September 2011

20th EADV Congress
Lisbon, Portugal
20-24 October 2011

7th EADV Spring Symposium

The 7th EADV Spring Symposium took place in Cavtat, Croatia from 13-16 May 2010. There were all together 1,793 participants from all over the world. Here is a selection of photos from the event.
19TH CONGRESS OF THE EUROPEAN ACADEMY OF DERMATOLOGY AND VENEREOLOGY

EADV
Gothenburg 2010
6–10 October | The Swedish Exhibition Centre

For information and questions please contact:
MCI – Berlin Office
Markgrafstrasse 56
10117 Berlin, Germany
Phone +49 (0)30 20 45 90
Fax +49 (0)30 20 45 959
E-mail info@EADVGothenburg2010.org

www.EADVGothenburg2010.org