Following the launch by EADV of the pan-European “Healthy skin@work” campaign in November 2009 (see EADV News N° 33), the European Parliament is currently considering a motion on the urgent need to support the prevention of occupational skin disease (OSD). A majority of the Parliament has to support it, so dermatologists throughout Europe are urged to approach their MEPs on the issue now. This will help to create a favourable climate for improving efficient dermatological patient management and disease prevention. The campaign seeks to raise public and political awareness about the issue of OSD and what dermatologists can do for their prevention, proper diagnosis and treatment.

OSDs are the leading cause of occupational illnesses. OSD costs exceed €5bn each year in the EU due to loss of productivity and causes extensive suffering for the affected workers. Additionally, prolonged sick leave due to OSD jeopardises competitiveness, particularly of small and medium-sized companies. Dermatology could help, but insurance systems in many countries do not support early dermatological intervention and effective prevention.

“Safe Hair”
As a happy omen for 2010, the European Commission has granted funding for an unprecedented research project - “Safe Hair”. It aims at OSD prevention by defining common standards of safety and health in the Nº 1 OSD high risk profession of hairdressing. It includes implementing teaching curricula for apprentices’ and masters’ courses, in order to make adequate skin protection and skin care a habit in the trade. This is the first European Commission initiative in the field of OSD prevention in risk professions and we hope that other branches at risk will follow. In a series of meetings the basis for a scientifically-guided consensus on prevention amongst all stakeholders, including the European hairdressers’ employers associations and trade unions, as well as suppliers and safety engineers, has been established, most recently on 17-18 June 2010 in Copenhagen. It is remarkable that this EU project was initiated by the hairdressers’ associations and trade unions. This underlines that trades affected by OSD are increasingly getting aware (a) of the disease burden and (b) that dermatology can offer a solution. “Safe Hair”, which is carried out with other partners in the European Initiative for the Prevention of Occupational Skin Diseases (EPOS) and run by the University of Osnabrück, comes under the umbrella of the EADV campaign and underlines its significance.

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Only Toctino treats chronic hand eczema from the inside—so patients can do more on the outside.

Severe chronic hand eczema (CHE) is hard on the hands. But it can be even harder on patients’ lives.1,2 Toctino restores clear/almost-clear hands for nearly half of patients in just 24 weeks with a convenient, once-daily oral dose.3,4

*Toctrino is licensed in adults to treat severe chronic hand eczema unresponsive to treatment with potent topical corticosteroids.

Prescribing Information: TOCTINO® 10 mg or 30 mg soft capsules. Active substance: altretinoin 10 mg/30 mg. Excipients: Capsule contents: Refined soybean oil, partially hydrogenated soybean oil, medium chain triglycerides, yellow beeswax, alginic acid-sodium alginate. Capsule shell: gelatin, glycerol, liquid sorbitol, purified water, iron oxide (E 172). Indications: TOCTINO® is indicated for use in adults who have severe chronic hand eczema that is unresponsive to treatment with potent topical corticosteroids. Dosage: The recommended start dose: 30 mg once daily. The capsules should be taken with a meal. Dose reduction to 10 mg once daily is in patients with unacceptable adverse reactions. Contraindications: TOCTINO® is THERATOGENIC. Pregnancy is an absolute contraindication. If pregnancy does occur in spite of the pregnancy prevention precautions during treatment or in the month following discontinuation of therapy, there is a great risk of very severe and serious malformations of the fetus. TOCTINO® is contraindicated in women of childbearing potential unless all of the conditions of the Pregnancy Prevention Program (PPP) are followed. The PPP consists of patient education and contraceptive counselling, pregnancy testing (before, during and 3 weeks after the end of treatment) and effective contraception without interruption one month prior, during and one month after treatment. Patients should not donate blood during therapy and for 1 month following discontinuation. Prescriptions of TOCTINO® for women of childbearing potential should be limited to 30 days of treatment and continuation of treatment requires a new prescription. Discontinuation of altretinoin should be completed within a maximum of 7 days of the prescription. For further details of the PPP please refer to the Summary of Product Characteristics. TOCTINO® is contraindicated in nursing mothers and in patients with hepatic insufficiency; severe renal insufficiency; uncontrolled hypercholesterolemia; uncontrolled hypertriglyceridemia; uncontrolled hyperglycaemia; uncontrolled hypothyroidism; hyperkalaemia A; hypersensitivity to altretinoin, other retinoids or any of the excipients in particular in case of allergies to peanut or soy; receiving concurrent treatment with tetracyclines. Precautions: Psychiatric disorders (depression), enhancement of UV light effect, bone changes, myalgia and arthralgia and increased serum creatinine phosphokinase values, dry eyes and decreased night vision, benign intracranial hypertension (pseudotumor cerebri), decrease in thyroid stimulating hormone (TSH) levels and free thyroxin (FT4), increase in liver transaminases, inflammatory bowel disease, increase in cholesterol and triglyceride levels, values should be monitored more frequently in high-risk patients with diabetes, obesity, cardiovascular risk factors or a lipid metabolism disorder (these patients should be started with 10 mg once daily and titrated up to a maximum dose of 30 mg, if necessary); allergic reactions. Undesirable effects: very common: headache, hypertriglyceridemia, high-density lipoprotein decreased, hypercholesterolemia; common: anaemia, increased iron binding capacity, monocytes decreased; thrombocytes increased; TSH and free T4 decreased; conjunctivitis, dry eyes, eye irritation, flushing, transaminase increased, dry skin, dry lips, chills, eczema, dermatitis, erythema, pruritus, asthenia, myalgia, blood creatinine phosphokinase increased; uncommon: blurred vision, anorexia, epistaxis, pruritus, rash, skin exfoliation, asthenia, exfoliation, only among patients with severe chronic hand eczema and a population-based study, Br J Dermatol. 2007 Jan; 159 (1): 116-24. 2. Molberg C, et al. Incidence and quality of life: a population-based study, Br J Dermatol. 2009 Nov; 161 (5): 898-900. 3. Ruzicka T et al. Efficacy and safety of oral altretinoin (9-cis retinoic acid) in patients with severe chronic hand eczema refractory to topical corticosteroids: results of a randomized, double-blind, placebo-controlled, multicentre trial. Br J Dermatol. 2008; 158:808-817. 4. Prescribing Information available in this journal. Date of preparation: July 2009. 5. Toctino is a trademark of Basilea Pharmaceutica Ltd.
Helping patients help themselves

When skin cancer patients come for their follow-up visits after the summer, you generally do not want to see them too tanned. UV radiation was classified as a Group 1 carcinogen by the World Health Organisation in 2009 and is as unhealthy as it sounds. A tanned skin cancer patient is therefore a failure. A failure for you and a failure for themselves, and the analytical dermatological mind must, by its very inquisitive nature, seek an explanation for this. Did you explain it well enough? Did you provide enough information? Was it understandable? Did you make sure that the patient understood it? And many other questions like that, which I am sure that we can all answer in the affirmative. Yes, dermatologists do take time and effort to explain the risks of UV-irradiation to patients at risk. Yet it is one of the fastest conclusions we draw to say, that if the message given was right, then the full guilt of non-adherence must fall on the patient.

We know from other studies that patients generally take a lax view of dermatologists’ prescriptions. More than 50% of topical treatments are never used and one can therefore question how much of the well-intended advice is followed – if any. Paternalistic anger may justifiably ensue.

Patients do however also agonise over UV-irradiation. They feel guilt, they feel uneasy, they suffer from the admonitions of their nearest and dearest and many regulate their behaviour. Yet still they tan. There are many aspects of tanning behaviour that remain a challenge, but then again why should it be easier to modify tanning behaviour than it is to modify the intake of calories or tobacco?

Anger is rarely a positive element in communication. It makes us blind to possibilities, it hides solutions and it reduces the humane interaction that is crucial for the development of mutual understanding between people. In contrast, acceptance is positive for communication. So we all have a task ahead of us this autumn. When the tanned skin cancer patients start coming into your office for their check-up, talk to them. Find out where they are in their understanding, which resources they command, and then help them help themselves better next time. And when they have left, take a deep breath and congratulate yourself on being so professional.

The EADV campaign is scientifically guided by EPOS which is a network of – so far – 70 experts from more than 50 dermatological centres in 23 European countries under the large umbrella of EADV (www.eadv.org/press-corner/campaigns/). The campaign aims to create a dermatological prevention service system that interlocks and builds upon each other for the benefit of exposed individuals in high risk environments throughout the EU. As structured prevention programmes are unevenly available throughout European countries, mutual transfer of knowledge and best practice sharing is necessary. If you’re interested in becoming a regional partner, please let us know (www.epos2010.eu). The next EPOS meeting will be held on the occasion of the 19th EADV Congress, in the Swedish Exhibition Congress Centre, Gothenburg, Sweden on Wednesday, 6 October 2010, at 12.30-15.30.

EADV strongly supports national sub-campaigns in Europe. Bulgaria started one in 2009 (EADV News N° 34) and more countries will follow. In Germany, all dermatological societies have now initiated an unprecedented concerted action with the Ministry of Labour, the Federal labour authorities, the German statutory accident insurance industry and occupational physicians to conduct a national “OSD Week” from 20-24 September. During this week, free consultations, including diagnosis, will be offered to patients assumed to have OSD, in dermatological practices and clinics throughout the country. Costs will be covered by the statutory insurances. Further activities by the partners in selected branches will contribute to the event. A joint press conference of all partners, including EADV board members, will be held in Berlin on 8 September 2010 to announce this first “OSD Week”. Donations by the partners have made this initiative possible, which is gratefully acknowledged.

Our recent experience is that politicians and authorities are very open to our suggestions. Again, this underlines the current awareness of OSD by decision-makers. Moreover, in Germany, this fact has recently precipitated a substantial increase in the reimbursement of dermatological diagnostic and therapeutic measures for OSD patients. Hopefully this encourages colleagues in other countries to address politicians, insurance companies, trade associations and other stakeholders. It’s definitively an effective way to do something for our patients and our small specialty. Let’s gain momentum. Do consider activities in the framework of the EADV campaign in your country. Let’s do it together – now! ⬇️

To find out how to support the campaign, please contact:

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Dear friends,

It has been a quiet time during the summer months and I hope everyone enjoyed their break. Having returned from our holidays refreshed and relaxed, we begin to get back into gear for the remainder of the year.

Although some time has passed since the meeting in Cavtat, I still receive some positive comments from enthusiastic participants and such reviews further confirm the success of the meeting. Congratulations again to all involved.

As previously mentioned, the EADV has rented office space in Lugano Switzerland, where it officially opened its doors in mid-June and is ready to take on new tasks such as the EADV in-house PCO. This latest direction we have undertaken will prove an adventurous but promising future for the Academy which is clearly spreading its wings each year with bigger and more challenging roles.

Supporting prevention and education

Also in June, a meeting was organised between EDF/EADV and the European Health & Consumer Policy Commissioner John Dalli. It was an interesting meeting where many ideas were exchanged and discussed and our friends and colleagues representing EDF, EADV and UEMS reported that the meeting went very well. They also informed that Mr Dalli encouraged such meetings to be planned in the future with experts in Brussels. This is indeed a vital step towards the developing need for prevention and education in many areas of dermatology in Europe and I sincerely thank our friends and colleagues for their time in attending this meeting and for their contribution and support of this worthwhile initiative.

New President-elect to be chosen

On the horizon, and in fact at the next annual EADV Congress in Gothenburg, we are to vote for a new President-elect. Three candidates have expressed their interest to undertake this role and they are, in alphabetical order, Jana Hercogova, Thomas Luger and Fenella Wojnarowska. All three candidates are renowned colleagues and long-standing members of EADV. All three are strong candidates with proven records of support and contribution to the Academy who undoubtedly would do a splendid job in a presiding role. I wish them all the very best of luck.

We are soon to meet in Gothenburg, Sweden, in October and presumably the pace has picked up on the organisational front with last-minute preparations. I am looking forward to this congress, admittedly however, with a slightly poignant feeling - as this will be my last as EADV President. Nevertheless, I am sure it will be a successful meeting and we will enjoy an interesting scientific event full of new information and ideas.

That’s all for now until we next meet in Gothenburg. I look forward to seeing you there for an enjoyable meeting along with your extra support as I exit my EADV Presidency on a high note!

Kind regards,

Andreas Katsambas
EADV President (2008-2010)
Prognosis of stage IV melanoma has remained unchanged during more than 30 years with a median survival of between 6 and 9 months. A new form of immunotherapy finally brings a durable benefit to patients and represents a major advance in patient management. Cytotoxic T lymphocyte antigen-4 (CTLA-4) is a downregulator of T-cell mediated immune responses. It is expressed on the surface of activated T lymphocytes, interacts with B7 on the surface of the dendritic cells and transduces a negative signal to T lymphocytes. Ipilimumab is a fully human, antagonistic monoclonal antibody directed against CTLA-4.

Ipilimumab, as a monotherapy, has already been shown in phase I and phase II trials to induce 20–30% durable disease control and 2-year survival in patients with advanced melanoma. The interest of combination with vaccines has been suggested from preclinical studies. Under Ipilimumab, different clinical activity patterns have been described: conventional responses in baseline lesions after the induction dosing, slow steady decline in tumour burden, response after progression and finally response in the presence of new lesions. The appearance of new lesions may reflect pre-existing, radiologically occult, micrometastasis that could be increased in size due to Ipilimumab mediated inflammation. Side-effects are mostly immune-related, generally manageable and reversible with specific algorithms.

The results obtained in the two arms containing Ipilimumab were significantly superior to those obtained with the vaccine alone for overall survival (p=0.0026) and for the secondary endpoints, progression-free survival and overall response rate. Ipilimumab increased overall survival of patients by more than 30% (increase in the absolute median survival of 3.7 months). Moreover, lasting responses were observed with 24% survivor rates after 2-years’ follow up maintained after 4-years’ follow-up. Severe immune-related side effects were seen in about 15% of patients but they were generally manageable. One point to be discussed in this study is the validity of the vaccination-alone control arm, since it is probably the least effective. However, Dacarbazine, which is the first-line standard of treatment, could not be used here since patients were second-line or more. The potential deleterious role of the vaccine (PFS and overall response rate in the combination arm are inferior to Ipilimumab alone) is an open debate. However, although some vaccines have been shown to be noxious, this is not the case for gp100 which was even shown to potentiate high dose IL2 in melanoma patients (ASCO 2009).

In conclusion, Ipilimumab is a major breakthrough in advanced melanoma treatment and should be approved for the treatment of these patients. The results of another phase III (Ipilimumab 10mg/kg combined with DTIC) are awaited within a few months. Combination of Ipilimumab with the very promising BRAF and MEK inhibitors will soon be evaluated.

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References
Patients' Information

One voice for cancer patients

Background
Established in 2003, ECPC is the voice of the European cancer patient community, uniquely representing the interests of all cancer patient groups from the major to the rarer cancers. The Coalition is committed to improving cancer prevention, screening, early diagnosis and best treatment, reducing disparity and inequity across the EU.

Membership
ECPC derives its mandate to speak with "one voice" for all cancer patients from its membership and democratic structure. With its motto - "Nothing about us without us!" - ECPC is an umbrella organisation of more than 300 patient organisations from 42 countries, mainly from the 27 EU Member States, representing organisations supporting hundreds of thousands of cancer patients in Europe day by day.

Organisation and Governance
ECPC is an independent, non-profit umbrella organisation registered under Dutch charity law. ECPC is a truly patient-led organisation because it is run and governed by cancer patients, having a volunteer Board of 9 cancer survivors from 9 different countries. This is a unique composition and the strongest legitimacy an initiative can have to address issues of concern in cancer.

ECPC holds quarterly Board meetings and informs its membership through the Annual General Assembly, the ECPC website, regular newsletters and ECPC Summits and Masterclasses. ECPC has a Brussels office close to the European institutions and its head office is based in Munich.

Main achievements
ECPC maintains close links with the EU institutions: Commission, Parliament, Council and European Medicines Agency (EMA). ECPC monitors political development at EU level, identifies those which could impact on cancer patients, informs its member societies and contributes the cancer patient perspective to European health issues. ECPC is invited to many (scientific) conferences to speak with a united voice for all cancer patients, with cancer affecting one third of the EU population. ECPC continuously influences the European health policy agenda by working closely with, for example, Members of the European Parliament through the recently launched Forum Against Cancer Europe – FACE (see www.forumagainstcancer.eu), the European Commission ("European Partnership on Action against Cancer", DG Sanco, DG Research, DG Internal Market, DG Enterprise), the Health Policy Forum (HPF), EMA and the EU Committee of Experts on Rare Diseases or EU research projects such as “European Guidelines for Colorectal Cancer Screening” or “RARECARE”.

Furthermore, ECPC provides a forum for European cancer patient groups to share best practice and skills. ECPC capacity building efforts include annual Masterclasses on patient advocacy for the ECPC member organisations as well as the setting-up of an “Advocacy Toolbox” to provide helpful resources for cancer patient advocates and organisations, such as the ECPC Conference Toolbox, ECPC Patients Rights Charter, Guide on Building Good Patient Group Websites and the EU Policy Handbook.

Join ECPC
We welcome all European cancer patient organisations as members of ECPC and hope you will join us in the fight against cancer. Membership is currently free and the application form can be downloaded from the ECPC website at http://www.ecpc-online.org/members

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Six strategic goals
- Making cancer a priority for action on the European health policy agenda
- Effecting change in legislative or regulatory policies to help optimise cancer prevention, detection, treatment and care throughout Europe
- Ensuring that all cancer patients in the EU have access to timely and appropriate information about prevention, screening, early intervention, ongoing clinical trials and best quality treatment and care
- Ensuring that best cancer practice is shared across the EU and gaps within and between Member States are eradicated
- Empowering cancer patients to take an active role in shaping European and national policy that impacts on cancer prevention, screening, early intervention
- Fostering co-operation between the cancer patients’ organisations within Europe and to develop a common policy

Priority Areas (2009 - 2013)
- Influence EU policy that has an impact on the prevention, detection and treatment of cancer
- Reach out to national level to support ECPC members in their capacity-building efforts on the national level
- Build strategic partnerships with key cancer stakeholders to create mutual benefit
- Build ECPC’s capacity through an effective and growing organisation
Welcome to Gothenburg!

European dermatologists and colleagues from all over the world will be joining us at the 19th EADV Congress in Gothenburg to share their knowledge and discuss together the most recent developments in dermatology and venereology.

The Scientific Programme presented will cover important developments and exciting new trends regarding the full spectrum of dermatological diseases. Whether your interests are in the fields of cutaneous oncology, allergy, autoimmunity, inflammation, infection, pathology, research or cosmetics, we are positive that all participants will find plenty of interesting news and practical information among the plethora of symposia, workshops, courses, forums and other sessions.

Considering the rapid development of global dermatology, the most important and exciting issues of dermatology in Africa and India will be addressed in special symposia at the Congress. In addition, EADV also continues its successful partnership with specialised dermatological societies which will hold meetings at the Congress venue on the Wednesday prior to the Congress opening. For detailed information please consult our website at www.EADVGothenburg2010.org.

So, join us in Gothenburg and participate in an outstanding scientific programme as well as enjoying our city in the heart of Scandinavia. We believe that Gothenburg will provide a most stimulating environment to let you thoroughly enjoy the 19th EADV Congress. Gothenburg, the city by the sea, is a vital part of Swedish industry, education and culture, business and shipping. Besides car manufacturers Volvo and SAAB and the SKF bearing factory, the city is also well-known for its important pharmaceutical and biotech companies like Astra Zeneca and Nobel Biocare. Gothenburg has a fascinating maritime history which you can discover in its bustling port, its canals and the magnificent archipelago on the coast. The city also offers inspiring museums and excellent entertainment. And for those who enjoy freshly caught seafood, any one of the city’s five Michelin-starred restaurants can certainly provide excellent culinary experiences.

Swedish dermato-venereology has an almost 110-year history and a good reputation both for unconventional patient settings such as outpatient psoriasis treatment and for focus on research. EADV and the Local Organising Committee are pleased to welcome you to Gothenburg. We will make every effort to offer you a scientific and practice-oriented meeting to make this Congress a most memorable scientific, social and cultural experience.

Olle Larkö
Congress President 2010
On behalf of the Local Scientific Committee
Photopatch Testing

A multi-centre European study

Photopatch Testing

Photoallergy is an uncommon occurrence which today tends to arise with sunscreens and topical non-steroidal anti-inflammatory agents. Clinicians are only too familiar with the facial dermatitis patient in whom a contact factor is suspected and yet negative contact patch testing results are obtained. Where a photo exposed site is involved, we should remember the possibility of photoallergy and consider an extension of patch testing, ie photopatch testing as the next investigation. Historically, photopatch test series have contained a number of obsolete chemicals, for when a chemical is discovered to be potent photoallergen, it often vanishes from the marketplace.

Better diagnosis

In the past, photopatch testing has had a “Cinderella” reputation, falling between the two sub-specialist areas of the contact dermatitis and photodermatologist groups. One less than familiar with optical physics, in particular dosimetry and the other usually relatively inexperienced in the patch test technique.

New methodology

Under the umbrella of EADV affiliated groups, the European Society of Photodermatology (ESPD) and European Society of Contact Dermatitis (ESCD), a consensus photopatch testing methodology for Europe was established in 2004 (see JEADV 2004 Vol 18, pages 679-682, Photopatch Testing Consensus Methodology for Europe). The reason that this came about was simply that historically the investigation of photoallergy had varied greatly between member states. This had the effect of not allowing comparison of the results from various published series. In addition, there was the problem with testing too many obsolete photoallergens and a relative lack of consistent interpretation of results particularly in the area of clinical relevance.

More information

There is a lack of information across Europe regarding the frequency of contact and photo contact allergy to sunscreens and non-steroidal anti-inflammatory agents particularly the newer sunscreens which, as with all sunlight screening agents, may be present in a surprising range of cosmetic products.

As a group, it was decided to conduct a multi-centre European study to assess the relative rates of sunscreen and non steroidal anti-inflammatory drugs contact and photo contact allergy across Europe. This was anticipated to have the value of informing clinicians and industry regarding the newer agents by performing what is considered to be an under used investigation technique. The study which commenced in July 2008 is co-ordinated at the University of Dundee in Scotland and run by Alastair Kerr, Lecturer in the Department of Dermatology as part of his MD thesis.

We encourage those centres which are participating to continue recruitment. We are pleased to report that the study is now approaching completion and will hopefully be at the study end by early 2011.

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Main activities
ESSCA is a working group of the European Society of Contact Dermatitis (ESCD). Its main activities are the standardisation and collection of patch test data from several European countries (see list of members below), as well as regular comparative and pooled analyses to provide up-to-date figures on the prevalence of contact allergy (to allergens of the European Baseline Series) across Europe.

Main achievements
ESSCA is a catalyst for European cooperation in the field of contact allergy research, including beyond “routine” analyses and publications. Moreover, ESSCA enables between-centre and international comparisons which allow for mutual benchmarking (quality control) which would otherwise be impossible.

Main goals in the next five years
The goals include:
- institutional support by the EU
- extension of the scope of allergens monitored (eg fragrances, biocides)
- further expansion of the network, such as presently happening in Spain.

Interaction with EADV
Members of ESSCA participate in EADV congresses and provide both current data and tutorial sessions regarding patch testing and contact allergy, thus promoting standardisation and dissemination of knowledge beyond highly specialised groups. ESSCA participates in the EADV congresses as a sister society for meetings and scientific sessions, as many ESSCA members regularly attend the EADV meetings.

Board of Directors
- Barry N Statham (see box above)
- Axel Schnuch (Information Network of Departments of Dermatology [IVDK], University of Göttingen, Germany)
- Wolfgang Uter (Dept of Medical Informatics, Biometry & Epidemiology, University of Erlangen-Nürnberg, Germany), Convener (chairman) of ESSCA

Information
Please visit www.essca-dc.org. For publications check PubMed for “ESSCA”. Most publications appear in the journal Contact Dermatitis, which is the official organ of the ESCD.

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Call for Applications

EADV Scholarships: 8\textsuperscript{th} EADV Spring Symposium 2011

1. Michael Hornstein Memorial Scholarship
   Named after the late friend and distinguished colleague Dr Michael Hornstein, EADV will offer the Michael Hornstein Memorial Scholarship to one selected applicant of each Central, Eastern & Northern European country.

   Eligible countries - geographic Central, Eastern & Northern Europe: Austria, Armenia, Azerbaijan, Belgium, Belarus, Bosnia & Herzegovina, Bulgaria, Czech Republic, Estonia, Finland, France, Former Yugoslav Republic of Macedonia, Germany, Georgia, Hungary, Iceland, Ireland, Kazakhstan, Kyrgyzstan, Latvia, Lithuana, Luxembourg, Norway, Poland, Republic of Moldova, Romania, Russian Federation, Serbia, Slovakia, Slovenia, Sweden, Switzerland, The Netherlands, Turkmenistan, Ukraine, United Kingdom, Uzbekistan

2. John Stratigos Memorial Scholarship
   Named after the late dear friend and distinguished colleague Prof John Stratigos, EADV will offer the John Stratigos Memorial Scholarship to one selected applicant of each Southern European & Mediterranean country.

   Eligible countries - geographic Southern Europe & Mediterranean countries: Albania, Andorra, Algeria, Croatia, Cyprus, Egypt, Greece, Israel, Italy, Lebanon, Libyan Arab Jamahiriya, Liechtenstein, Malta, Monaco, Morocco, Palestine, Portugal, Montenegro, Spain, Syria AR, Tunisia, Turkey

3. Imrich Sarkany Non-European Memorial Scholarship
   Named after the late friend and distinguished colleague Dr Imrich Sarkany, EADV will offer the Imrich Sarkany Non-European Memorial Scholarship to a maximum of eight (8) young dermatologists of non-European countries.

   Eligible regions - Rest of the world (except Eastern European and Mediterranean countries already listed before) eg Africa, Arab countries, Asia, Latin America, North America (incl. Alaska, Canada), Oceania (Australia, New Zealand etc...)

Every EADV scholarship award consists of €1000 less the fee for a one-year EADV membership*, according to the status of each recipient. Free registration to the symposium is also provided for each winner.

* The membership year and status will be activated for the upcoming calendar year 2012.

Required documentation for application to be submitted in English only for any of the scholarships listed above:

- The completed Scholarship Application Form
- A CV and a list of publications (not more than 3 pages)
- A letter of support written either by the training director/head of department, hospital or clinic endorsing the application
- A letter of support written by a “specialist” EADV member endorsing the application
  - A current copy of the applicant’s training or specialist certificate
  - A copy of an ID (ie identity card, passport) with a passport-size photo

Application deadline for all scholarships: 29 October 2010

Further information & the application form(s) available at:
http://www.eadv.org/scholarships/
or upon request by e-mail to:
Prof N Tsankov, Honours & Awards Committee Chairman, at scholarship@eadv.org

Note: Applicants will be notified about receipt of application by e-mail.
This information will be available on the EADV website from the beginning of September 2010. Applicants will be informed about the status of their application around mid-January 2011.
Dear friends and colleagues,

It is my pleasure and honour to invite you, on behalf of the Local Organising Committee and Local Scientific Committee, to attend the 8th EADV Spring Symposium which will be held in Karlovy Vary (Carlsbad in English or Karlsbad in German), Czech Republic, from 14-17 April 2011.

Why Carlsbad?

The Czech Republic is usually connected with its capital Prague. We understand that it is one of the most beautiful cities of the world and we certainly did not omit it from our social programme. On the other hand, the Czech Republic is rich in many other picturesque and famous areas and the biggest Czech spa city of Carlsbad is one of them. It is located approximately 1 hour’s drive from Prague Airport or 1 hour’s drive from the German motorway network. Carlsbad was founded 640 years ago by the well known Charles IV who was both the Czech king and at the same time the Holy Roman Emperor. On 14 August 1370, he gave city privileges to the place that was subsequently named after him and where, according to legend, he had acclaimed the healing power of the hot springs.

During the 14th century, his empire represented a significant part of Europe and the organisation of our Symposium in this city has, therefore, a historical and symbolic European unifying value. It is emphasised by another unique fact for EADV, namely that this is the first time that an EADV symposium or congress has been organised by 2 countries - the Czech and Slovak Republics. This idea was naturally born from the long-term experience of both Czech and Slovak Dermatological Societies which organise very successful dermatological congresses every year.

"I owe this town my completely new life!"

J W Goethe on Carlsbad

The eventful history of the city has imbued the atmosphere and historical sights of Carlsbad up to the present day and this is today combined with modernity and its achievements without disturbing the unique character of the place. The curative springs have been restoring people’s health since time immemorial where great names of science, politics and art have had their rendez-vous for seven centuries. You could hardly find somebody who would not like to walk on streets where Casanova admired the natural beauty of Czech ladies, where the Russian Tsar Peter the Great relaxed after overseeing the building of Russian cities, where Paganini tested his new violin, where Beethoven, Chopin or Mozart composed, where Mucha found inspiration for his ethereal artworks, where Goethe, Gogol or Kafka sharpened their pencils, where Freud meditated on his theories, where... Oh, stop here! Can you imagine that your children will read about Carlsbad’s history and will learn that also Katsambas, Powell or even YOU were on site!

Actually, your children will envy you much sooner. The city is also known for the Karlovy Vary International Film Festival. In its already 45-year history it has hosted many excellent celebrities like Renée Zellweger, Leonardo Di Caprio, Gregory Peck, Danny De Vito, Antonio Banderas, John Malkovich, Robert de Niro, Cybill Shepherd, Andy Garcia, Sharon Stone, Robert Redford, Franco Nero, Jacqueline Bisset, Roman Polanski, Eliah Wood, Scarlet Johansson, Ben Kingsley, Nastassia Kinski, Michael Douglas, Ornella Muti, Milos Forman, Salma Hayek, Nikita Mikhalkov, Alan Alda, Gregory Peck, Pierre Richard, Gina Lollobrigida, Philippe Noiret, Shirley Temple Black, Peter Fonda, Carlo Ponti, Richard Attenborough, Claudia Cardinali, Henry Fonda, Andrzej Wajda, Laurence Olivier, Luis Buñuel and many others.
The city has been used as the luxurious location for a number of movie shoots, including the 2006 movie ‘Last Holiday’ and the recent James Bond box-office hit ‘Casino Royale’, both of which used the city’s Grandhotel Pupp in different guises.

Carlsbad became famous for its hot (73°C) springs: 13 main springs, about 300 smaller springs, and the warm-water Teplá River and offers a unique combination of balneology and relaxation stays with a range of possibilities for different events from corporate meetings up to congresses of world importance. The unique atmosphere goes hand-in-hand with the highly developed infrastructure and first-rate services which makes it almost inevitable that it will fulfill and surpass all visitors’ expectations.

The 8th EADV Spring Symposium will run under the logo “Caring for Skin and Well-being” because it will bring together a rich scientific programme emphasising the profound and complex influence of skin health on all the aspects of human life.

The local organisers
The Czech Dermato-venereology Society which belongs to the Czech Medical Association group of official medical national societies accommodates and represents all Czech dermato-venereologists in the country. It was founded in 1922. During its almost 90-year history it has been executing all the functions of a national society, including specialty representation on domestic and international levels, publication of dermatological journals: Cesko-slovenska dermatologie (founded 85 years ago), Referátový výběr z dermatovenerologie (founded 50 years ago), national or international meeting organisation, including the successful 2002 EADV Congress in Prague or annual congresses together with the official national Slovak Dermato-venereology Society etc. The Slovak Dermato-venereology Society has a similar history and national function and their board members are, together with board members of the national Czech Dermato-venereology Society, co-organisers of the 8th EADV Spring Symposium in Carlsbad.

Interested?

But remember - nothing can replace your own experience. Therefore, simply register for the 8th EADV Spring Symposium at www.eadv.org and enjoy both the carefully selected scientific programme and rich options of social activities, including extended spa relaxing, massages, balneotherapy, swimming, thermal bathing, golf, tennis, horse riding and of course sightseeing walks and tours.

Don’t forget to mark 14-17 April 2011 on your calendar. See you in Carlsbad!

Petr Arenberger
Chairman
8th EADV 2011 Spring Symposium
President
Czech Dermato-venereology Society
of the Czech Medical Association
Chairman
Dept of Dermato-venereology,
Charles University, Prague

Key dates to remember
- Abstract submission deadline
  15 October 2010
- Abstract evaluation deadline
  17 January 2011
- Early bird registration
  14 January 2011
- Hotel reservation deadline
  28 February 2011
- Opening of the Symposium
  14 April 2011
Ethnicity and skin diseases

Western societies are becoming increasingly multiracial and multicultural. Patients who consult dermatologists originate from different parts of the world. They may suffer from “exotic” diseases such as leprosy, deep mycosis or worm infections, but they will certainly have different skin types and different cultural backgrounds. Many living in the “West” visit tropical countries and may carry home infectious diseases, ranging from infestations to protozoan diseases like leishmaniasis or just a simple STI.

In dermatology the presentation of a skin condition is decidedly different in darker skin than in lighter skin. For instance erythema, redness, a sign of inflammation - the hallmark of the European-American dermatology - is difficult to appreciate in a pigmented skin. Instead, pigment changes dominate the picture.

Moreover, the cohesion between the keratinocytes in black African skin is stronger than that of lighter Caucasian skin and its stratum corneum, despite having the same thickness, contains more layers. As a result, dark skin is not easily damaged by scratching. Vesicles may, due to the overlying pigment, present as papules. As a result, eczema in black skin is often monomorphic papular and not polymorphic as described in Western textbooks.

Climate and culture

Since there is no agreement concerning the delineation of mankind into races, photo skin type is used to describe 6 skin types, from pale, easily burning skin to black skin. Races, however, are different due to genetic differences that manifest themselves in body build, form of head and face, length and shape of muscles and bones, the colour and texture of the skin and the colour and shape of the hair.

Until recently, most publications on “racial” differences in dermatology were not well researched and did not make allowances for different climatic, cultural or socio-economic circumstances. It has become clear that these differences are important; they influence or may even cause skin diseases. It may therefore be better to talk about “ethnic” differences. For example, people coming from the tropics are, in general, used to frequent washing and showering and often use aggressive soaps, which in centrally-heated housing and air-conditioned workplaces results in dry itchy skin and astheatotic eczema.

The colour of the skin is largely determined by the pigment melanin produced by epidermal melanocytes and transferred to the epidermal keratinocytes. In darker skin, melanocytes are larger and more dendritic, and produce larger melanosomes, which are transferred in larger amounts to the epidermal keratinocytes. (See table on page 15 for the major differences between dark and light skin.)

It is important to realise that although the clinical presentation of the individual lesions may be different, the localisation on the skin and the configuration of the lesions are independent of skin colour (see photos). This will assist in the diagnosis.

An influence that must not be underestimated is a cultural one, in which a lighter skin is often preferred by darker-skinned people, with extensive bleaching as result, while the ‘healthy tan’ is preferred by lighter-skinned people resulting in excessive exposure to solar radiation. Both attitudes may result in skin changes and disease.

People with darker (non-white) skin may seek medical attention for pigmentary problems that sometimes are physiological for a particular skin type. Pigment problems can be very disturbing to patients with dark skin, particularly when greater contrast with the normal skin colour emerges, such as can be seen in patients with vitiligo.

Even objectively mild pigment problems can have important culturally determined psychosocial connotations in dark-skinned patients. Therefore, these problems should always be taken seriously. In some cultures pigment changes are easily associated with leprosy, leading to social isolation of the persons involved. On the other hand a missed diagnosis of leprosy may result in severe disabilities. All these aspects present challenges to the modern-day dermatologist.

References

• Naafs B. Coloured versus white skin
  Grotendiekszorg, Maarsen The Netherlands 2006: 35-45
Research Update

Spotlight on a young researcher

Carrie Ambler (United States)

My name is Carrie Ambler and I am a proud recipient of the 2009 European Skin Research Foundation (ESRF) New Investigator Award. I joined Durham University (UK) in 2007 where I started my own research laboratory to study epidermal skin cells during skin development, wounding and disease. This includes our current focus on human scarring hair loss diseases.

New surgical model

My research training has taken me on a journey in terms of both physical location and the wide variety of research I have done in plant and animal sciences. I completed my undergraduate degree in Plant Sciences from Kansas State University, USA. This initial experience sparked my interest in pursuing a research career. However, I wanted to continue my training in an area of biomedical research. I obtained my PhD training (1997-2002) with Victoria Bautch at the University of North Carolina at Chapel Hill, USA, studying blood vessel development and patterning. In order to track the origin of blood vessel stem cells (angioblasts) and to understand how these angioblasts use signals to regulate vascular patterning, I used mouse-quail surgical chimeric embryos. Setting up this new surgical model system was a wonderful experience and challenge. Also, my initial studies using mouse-avian chimeric embryos opened up a new avenue of research for Prof Bautch that is still ongoing in her laboratory.

Notch signalling

After my PhD, I moved to the United Kingdom to join Fiona Watt’s lab at Cancer Research UK (2003-2007). In Prof Watt’s lab I started working on the role of Notch signalling in skin development and regeneration. I generated a unique transgenic mouse model where the Notch pathways can be selectively activated in epidermal stem and progenitor cells. In generating these mice I discovered one unexpected and interesting consequence. Mice with forced Notch activity develop a scarring alopecia-like disease. In my own research lab we are now working with Dr Andrew Messenger, Consultant Dermatologist (Sheffield, UK) to understand if the Notch pathway is dysregulated in human patients with scarring hair loss diseases. I am grateful for the funds from ESRF’s New Investigator Award that enabled me to begin this research project. Based on our initial work, future funding has been secured from the British Skin Foundation to continue this study.

Differences between dark and light pigmented skin

Differences manifest in:

- the clinical expression of erythema
- the de-, hypo- and hyperpigmentation of the darker skins
- the larger cohesion between the keratinocytes in the darker skin, with a stratum corneum that consists of more layers, but has the same thickness
- the greater tendency of the non-Caucasian skins to lichenification
- the greater tendency of the non-Caucasian skin to keloid formation
- the greater risk of epidermal skin cancers in “white” skins
- greater traction alopecia due to hair “care” in dark-skinned patients with curly hair.

References

Dr Jean-Paul Gabbud

To create the scientific programmes of our congresses and symposia, it is essential that the whole of dermato-venereology is covered: the “core” topics which constitute our daily routine, as well as all the sub-specialties of our discipline. Besides, it is our concern to take into account the wishes and needs of our members. That's why it is so important to get your evaluation and your opinion after every scientific event.

We have again put your ratings and rankings into statistics of the Cavtat Spring Symposium 2010 which has been a great success thanks to Prof Jasna Lipozenčič and her wonderful team.

**The 10 top ranked events (with more than 20 participants)**
1. Test Yourself in Dermoscopy (FS03)
2. Managing Adult-onset Acne (FS06)
3. STIs in Adolescence (FS05)
4. The Skin and Internal Malignancy (FS07)
5. Practical Considerations in Cutaneous Lymphomas (F01)
6. Paediatric Dermatology (W09)
7. Hair and Nail Diseases (F02)
8. Sexually-transmitted Infections (W08)
9. Dermatomycoses (S12)
10. Skin Clues of Systemic and Connective Tissue Diseases (S07)

**The 10 best attended topics**
1. Plenary 2: Novel Imaging Techniques - Exogenous Acne Revisited - STIs (PL02)
2. Plenary 1: Allergy, Environment & the Skin – Brain-Skin Axis – Immunotherapy for Skin Diseases (PL01)
4. Update on Melanoma Management (S01)
5. Acne & Rosacea (S06)
6. Skin Conditions and Endocrinology (S02)
7. Managing Adult-onset Acne (FS06)
8. Botulinum Toxin: Use and Misuse (FS01)
9. Photodermatology (S08)
10. Psoriasis (S03)

NOTE: For reasons of confidentiality, we do not publish individual speaker ratings. Speakers may ask for their personal data at cme-cpd@eadv.org.

Thank you very much for your collaboration!

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

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**Fostering Dermatology & Venereology - Excellence in Education - Training Programme**

- Training Course Contact Dermatitis
  - 23-25 February, 2011 in London, UK
  - Course chairs: Prof. David Gawkrodger Dr. Jonathan White, Dr. John McFadden
  - Application deadline: 17 October, 2010
  - Number of places: 30

- Training Course Interventional Cosmetics
  - 26-27 February, 2011 in London, UK
  - Course chair: Dr. Christopher Rowland-Payne
  - Application deadline: 22 October, 2010
  - Number of places: 30

For the program & online application form, please consult: [http://www.eadv.org/nc/fostering-courses/apply-for-a-fostering-course/](http://www.eadv.org/nc/fostering-courses/apply-for-a-fostering-course/)

For further information and questions, please contact: EADV Success Sales at Tel: +32 2 650 00 90
Fostering@eadv.org

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**Selected participants receive:**
- A hands-on, practical & interactive course
- Educational Material, Certificate of Attendance
- 1 dinner (social event), free accommodation and catering during the course
- EADV members: Educational grant
- Course language: English

www.eadv.org
8th EADV Spring Symposium

Carlsbad Czech Republic
14–17 April 2011

„Caring for Skin and Well Being“

EADV

www.eadvcarlsbad2011.org
The steady growth of EADV has allowed us to give scholarships and grants to young trainees in dermatology and young dermatologists (under the age of 35) from Europe and all over the world. Scholarships are named after leading European dermatologists: the Prof John Stratigos Award – targeted at fellows from geographic Southern Europe and from each Mediterranean country; the Dr Michael Hornstein Award - one selected applicant from each geographic Central, Eastern & Northern European country; and the Dr Imrich Sarkany Award – giving the opportunity to non-European candidates to participate in the EADV meetings.

Other grants, such as the EADV-American Academy of Dermatology (AAD) Scholarship offers three scholarships to dermatologists from the United States of America or Canada who are selected by the AAD. The AAD Grant is given to three young dermatologists in Europe to facilitate their attendance at its Annual Meeting in the USA. Once a year, the Scottish Dermatology Society (SDS) invites one young EADV member from Eastern Europe to attend its Annual General Meeting in the UK.

The evaluation system was discussed during the EADV congresses in Paris (2008) and Berlin (2009). The committee members decided that the evaluation of the applicants could not be on the basis of country of origin and specialisation, participation in congresses without presentations, or the international authority of the head of the department who recommended the applicant, because that would be non-objective and discriminatory. The evaluation scale is based on the number of participations with communications or posters in national and international congresses and on papers published in national and international journals.

The committee members take into consideration that in some countries national dermatological journals do not exist and dermatology is still in active development. The committee strives for objectivity and selects only one candidate from each country to keep a principle of wider geographic balance.

For the last EADV Spring Symposium in Cavtat, Croatia (2010) a total of 64 people applied and 31 (48.4%) were awarded: Michael Hornstein Memorial Scholarship – 13; John Stratigos Memorial Scholarship – 9; Imrich Sarkany Non-European Memorial Scholarship – 5; AAD – 3; Scottish dermatological society grant – 1.

The number of applicants has increased considerably. For the next EADV Congress in Gothenburg we have 123 applicants and 48 of them (39%) will be awarded.

As ever, following the accepted tradition, the scholarship ceremony is attended by Prof Andreas Katsambas, EADV President, and Prof Joe Pace, Secretary General, which is highly appreciated by the participants.

One of the challenges facing our committee is to encourage young fellows from each country in geographical Europe and all over the world to apply. This raises the authority of EADV because participation in EADV congresses remains an unforgettable memory and the opportunity to broaden scientific horizons in the field of dermatology.

Nikolai Tsankov
Chairman
EADV Honours and Awards Committee

Scholarship winners at the 18th EADV Congress in Berlin
**Board Member Profiles**

**Magnus Bruze (Sweden)**

Magnus Bruze studied medicine at the University of Lund, Sweden. He specialised in dermatology and venereology at the Department of Dermatology, University Hospital, Malmö. In 1981 he started to work at the Department of Occupational Dermatology in Lund. For one year (1987-1988) he was a visiting associate professor at the division of Occupational Medicine, School of Hygiene and Public Health, Johns Hopkins University in Baltimore, USA. Since 1991 he has worked at the Department of Occupational and Environmental Dermatology in Malmö, becoming Chairman of the department in 1995. He was appointed Professor in 2000 and is the current Chairman of the Swedish Society of Dermatology and Venereology.

His research activities are focused on improved diagnostics and prevention of skin diseases related to work and the environment. He is the current Chairman of the European Environmental and Contact Dermatitis Research Group and the Vice-Chairman of the International Contact Dermatitis Research Group.

Within Europe there are great national differences in the possibility to diagnose contact allergy and allergic contact dermatitis. Without the diagnostic tools, thousands of European patients will suffer from allergic contact dermatitis. Furthermore, correct diagnosis of contact allergy and allergic contact dermatitis are also the basis for preventive measures. As an EADV board member he will, among other things, work to promote training in occupational dermatology with particular focus on diagnostics and prevention of allergic contact dermatitis.

**Nikolay Potekaev (Russia)**

“Let me thank all the Russian dermatologists who elected me to the Board of Directors of EADV and all the European colleagues and friends for their support and warm acceptance. This is a great honour for me to hold this senior position in this competent and influential organisation. Each EADV member has the opportunity to communicate with international colleagues from different parts of Europe and exchange experiences - this explains the great success of EADV.

I hope that the involvement of Russian dermatologists in the work of the EADV Board will consolidate the collaboration between Russian and European scientific schools and will be useful for the development of our relationships, resulting in an increase in professionalism and the quality of medical service. As President of Russian National Alliance of Dermatologists and Cosmetologists, Professor of Dermatology at the Sechenov Moscow Medical Academy and Head expert-dermatologist of the Federal Agency for Inspection of Public Health Establishments, I will do my utmost to support these aims.

EADV is a very progressive organisation, which continuously develops. That is why I would like to consider the main issues which in my opinion will be interesting for Academy and thus may be used as a separate scientific tendency within our specialisation. First is aesthetic and cosmetic dermatology. This is one of the main developing parts of science, based on close connection of classic dermatology and the latest scientific achievements. Nowadays modern high-tech methods are used for treatment of different skin lesions.

Being an adherent of classical dermatology, particularly of the classical Russian dermatological school, I still support the separation of cosmetology as a medical discipline in Russia.”

**Caius Solovan (Romania)**

Caius Solovan graduated in 1983 from the University of Medicine and Pharmacy “Victor Babes” in Timisoara, a multicultural city on the western border of Romania. He then went on to specialise there in dermatology and venereology. Since 1991 he has taught dermatology at the same university where he is currently a professor in the University Clinic of Dermatology and Venereology and also maintains a private practice.

Over time, he has developed an affinity for dermatopathology by attending intensive courses (Leipzig, 2006; Graz 2008; San Francisco 2009) and by organising a Laboratory of Dermatopathology in the “Laboratories Bioniclinca”. In 2009 he organised the Romanian Society of Dermatopathology and the First National Symposium of Dermatopathology with international participation. He proposed a curriculum of dermatopathology to the Romanian authorities to develop a national programme, a complementary study, in order to pursue more accurate diagnoses. This mandate has given him the chance to receive support and assistance from EADV in implementing the sub-specialisation in Romania.

Commenting on his appointment to the EADV Board, Prof Solovan said, “Thanks, colleagues, for electing me as their representative on the EADV Board and I reaffirm my commitment to present their problems and desires at the Academy. I present this way my total availability and interest to work with EADV fellow Board Members. I believe that increased cooperation among EADV and its sister societies, the development of many programmes that involve as many members of EADV and others, represents a challenge for the future”. 
Zafer Türköglu (Turkey)

Greetings from Istanbul! Living in Istanbul is considered to be exciting. Sharing a day with the population of a cultural cocktail has many components, such as hearing adhan (call to prayer) and church bells in the same street but it is calming to see as well sympathy and harmony between them: something from the old Eastern Roman Empire, something from the Ottoman Empire and something from modern Europe and the new world.

Being a doctor in this crowded city can never be boring. Here, knowledge in medical books doesn’t remain in the pages. In the clinic with its very different patient population, evaluation is inevitable. I love my profession; I have always admired the reflection of whole body health on the intelligent structure of the skin. To me, it is kind inspection with a magnifying glass to look under the skin defect to get to the pathological, microbiological, physiological and immunological clues. All this makes me feel satisfied about my work in dermatology. Especially allergy which always gets my attention because to me immunology is a real puzzle. In our clinic I am especially focused on allergic patients and I have made some clinical studies, including one about skin autoreactivity and its probable relation with other systemic diseases like thyroiditis where EADV has been used as a guideline to emphasise key points. I hope I will become a member of an international scientific team making laboratory researches.

I would just say to my collegues from Europe, If you ever get too tired and exhausted you should really drink a cup of Turkish coffee on the banks of the Bosphorous under the lights of the whole city. Nothing can be more than refreshing.”

3rd Edition of the White Book


At its inception in 1998 the European Dermatology Forum (EDF) produced a position paper entitled: ‘The Future of Dermatology in Europe’. This paper mapped out the goals of EDF against the challenges of the ‘new’ Europe and changing climate of delivering appropriate health care to EU citizens. By 2001 this white paper had expanded into the first edition of the EDF White Book, edited by Peter Fritsch, which defined the competencies of dermatology professionals, highlighted the scientific gains in our knowledge of skin physiology and pathology and provided a platform for the promotion of the highest standards of clinical practice.

The completely revised second edition of the EDF White Book was published in 2005, edited by Peter Fritsch and Walter Burgdorf, with the specific aim of presenting a survey of important dermatological diseases, highlighting those of specific significance in Europe and championing the role of the dermatologist in treating them to the highest possible level. With publication of this book it became clear that the audience for it should not be within dermatology but needed to engage other physicians, the pharmaceutical and medical device companies, as well as healthcare providers, policy-makers, hospital administrators and politicians. To this end the EDF commissioned a third edition of the White Book, edited by Jonathan Barker and Walter Burgdorf, to further support the delivery of optimal dermatological care in Europe.

€20 (including VAT and shipping costs within Europe)
Order form and further details can be found on the EDF website: www.euroderm.org

For further information please contact:
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▷ Professor Giampiero Girolomoni, Chair of Dermatology, University of Verona (Italy) and Secretary-General of EDF:
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▷ Professor Lars French, Chair of Dermatology, University of Zurich (Switzerland) and Treasurer of EDF:
lars.french@usz.ch
▷ Professor Jonathan Barker, Chair of Dermatology, St John’s Institute of Dermatology, London (UK) and Editor of the White Book: jonathan.barker@kcl.ac.uk
Some 7 years ago, I participated in the election of the Secretary General with mixed feelings: I had sat on the Board for 6 years and really thought that it was time to go. It was, however, put to me that I had something to offer to EADV at that particular time and out of a sense of duty I sent in my nomination. The Board saw fit to elect me to this high position where, with hindsight, I can say that besides the obvious organisational ability, the holder is expected to combine diplomacy with tight rope walking ability, wisdom with crystal ball expertise, priesthood with legal acumen, firm application of the laws of EADV to all equally without fear or favour - and remain good friends with all and sundry.

This remarkable person does not exist and it is for our Board Directors and EADV members to decide how close to or far from that job description I have come.

When I took over as Secretary General 6 years ago, our Academy was in a difficult position trying to recover from a number of strife-filled years that almost tore our organisation apart. With plenty of goodwill and a massive amount of hard work we moved in the right direction. Peace was negotiated with the opposing parties agreeing to bury the hatchet conclusively. Concurrently EADV finally managed to achieve the goal of moving the domicile of EADV out of Luxembourg to Switzerland, enabling proper governance of EADV apart. With plenty of goodwill and a massive amount of hard work we moved in the right direction. Peace was negotiated with the opposing parties agreeing to bury the hatchet conclusively. Concurrently EADV finally managed to achieve the goal of moving the domicile of EADV out of Luxembourg to Switzerland, enabling proper governance of EADV apart. With plenty of goodwill and a massive amount of hard work we moved in the right direction. Peace was negotiated with the opposing parties agreeing to bury the hatchet conclusively. Concurrently EADV finally managed to achieve the goal of moving the domicile of EADV out of Luxembourg to Switzerland, enabling proper governance of EADV apart. With plenty of goodwill and a massive amount of hard work we moved in the right direction. Peace was negotiated with the opposing parties agreeing to bury the hatchet conclusively. Concurrently EADV finally managed to achieve the goal of moving the domicile of EADV out of Luxembourg to Switzerland, enabling proper governance of EADV apart.

As a result several crucial changes took place:

First - and perhaps most important of all - matters such as the election of a President or changes to the Statutes would henceforth be decided by ALL the voting members, not just those few who managed to attend the general meeting. These would give their decision electronically with the result becoming available shortly after closure of the ballot. The much abused proxy system was abolished.

Secondly, the much awaited expansion of the EADV Board to many countries primarily but not exclusively from Eastern Europe took place within the timeframe promised to them. Now we could really speak of a EUROPEAN Academy “from the Atlantic to the Urals”. In addition, the election of each Board member became a matter of democratic choice of the members of that country alone rather than, as previously, the choice of any EADV member who happened to be present at the General Meeting!

Thirdly, we were later to be given non-taxpaying status by the tax authorities in Lugano with the condition that the lion’s share of any surplus goes to medical educational projects and that the Academy opens its doors to non-dermatologists at all levels. The first is our raison d’être but the second raised a number of eyebrows and visions of invasion by legions of non-dermatologists of dubious intent that were happily not fulfilled. Indeed, today we are proud to offer full membership to all those active in the fields of dermatology and venereology and it would be a brave man to say that we stand to learn nothing from our fellow healthcare professionals, researchers in cutaneous biology and indeed from our patients!

Along with the soaring membership level combined with the highly successful national society membership, I am especially pleased with the ever successful education programmes being offered through different fora, the very active Board Committees and, perhaps among the most important of all, the electoral process that has evolved and significantly reduced the potential for electoral abuse or manipulation both before and during the voting process, while simultaneously giving each and every member a voice in decision-making processes. The publication of an electoral register prior to the election has contributed to the increased transparency and enhanced the perception of EADV in international circles.

I leave EADV a strong organisation that has received due recognition of the mission it carries out. EADV is a family that has wisely opened its doors to those who embrace its philosophy and now treats them as family members and not as observers. We must continue to be the advocate of our patients and involve them more in decisions that will affect their daily lives with our fellow healthcare professionals in nursing and other fields.

I am thankful for a superb working relationship with each of the three Presidents I have had the privilege to work with: Johannes Ring, Alberto Giannetti, and Andreas Katsambas. To their credit, none sought to impose but to discuss, debate and eventually decide - and always in the interest of EADV. I am indebted to Jon Olafsson who has carried out a superb job as Treasurer for some years and to our legal adviser Valter Cassola whose wisdom, commonsense, and sheer ability has helped the EADV ship to survive. I will just say that without Valter EADV as we know it today would not exist.

Final thanks go to the backroom EADV staff in Brussels and Malta. Unseen, and led by Nancy Induni, the Brussels personnel are the backbone of the EADV office engaged in membership matters, dues reminders and collection, committee reports, and a million other tasks which amount to a huge workload for which their praises are rarely sung. Of course Monica Cauchi deserves a special accolade in her own right. Poached from the EU desk at the University of Malta and in an earlier life a magistrate in the North of England (with power to imprison for up to 3 months!), Monica was the perfect Personal Assistant without whom I could not have functioned. Besides providing minutes of the highest quality and an efficient organiser of the highest calibre, she was also on occasion an invaluable adviser, and her no-nonsense but warm approach combined with utmost efficiency contributed immensely to her success. To my successor Erwin Tschachler I wish every success in his monumental task.

Thank you all!
**Photo Competition**

**EADV News** is launching a photo competition open to all EADV members to showcase the most interesting photos from your clinical practice (e.g., presentation of symptoms in any aspect of dermatology or venereology, dermatology-related historical artefacts, people or practices from member countries etc.). The editors will review all the entries and the most interesting will be published in *EADV News* starting with the Winter Issue (No 37).

To take part, please e-mail your photos to Alexandre Dewaide at alexandre@eadv.org. Members whose photos are published will receive a copy of a specially-chosen work of dermatology.

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**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 6 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

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**EADV News**

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➤ Please send your suggestions, feedback and contributions to Alexandre Dewaide at alexandre@eadv.org
EVEN WHEN SKIN IS FLARE-FREE ON THE SURFACE

ECZEMA IS ALWAYS WAITING TO ATTACK

FOR LONG-TERM ECZEMA CONTROL
YOU NEED TO MANAGE THE UNDERLYING INFLAMMATION ACTIVELY.¹

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.² It prevents flares and prolongs flare-free intervals in adults and children and moderate and severe eczema.³

SO DON’T WAIT FOR THE FLARE, USE TWICE-WEEKLY PROTOPIC TO CONTROL ECZEMA IN THE LONG TERM.⁴

With intermittent use, Patients should have had an initial response to an acute exacerbation with PROTOPIC, twice daily (6x, 6 week) treatment.

REFERENCES:
1. Wollenberg A & Bieber T Allergy 2009: 64: 276-278, 2. Jeftovic S & Allergy R J Dermatol Treatment 2010: 31: 34-44. PRESCRIBING INFORMATION: PROTOPIC™ 0.03% ointment (tacrolimus monohydrate) PROTOPIC™ 0.1% ointment (tacrolimus monohydrate). ACTIVE INGREDIENT PROTOPIC™ 0.03% ointment (1g) contains 0.3mg of tacrolimus as tacrolimus monohydrate (0.03%). PROTOPIC™ 0.1% ointment (1g) contains 1.0mg of tacrolimus as tacrolimus monohydrate (0.1%). 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 for prevention of flares and prolongation of flare-free intervals in patients experiencing high frequency of disease exacerbations (i.e. occurring 4-6 times per year) who have had an initial response to a maximum treatment of twice-weekly tacrolimus cream or ointment, treatment of moderate to severe atopic dermatitis in children 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 any 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. Afterwards the frequency of application should be reduced to once a day until clearance of the lesion. 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 resumed. 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 signs of improvement are seen after two weeks of treatment, further treatment options should be considered. Maintenance of flare-free intervals; PROTOPIC™ should be applied once a day twice weekly (e.g. 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™ 0.3% children (2 years of age and above) should use the lower strength PROTOPIC™ 0.03%. If a sign of flare recurs, 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 sensations which tend to resolve within one week of starting treatment, pruritus, Common: Sensation of warmth, erythema, pain, irritation, pruritus and rash at site of application. Alcohol intolerance (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], eczema herpetiformis, Kaposi’s varicelliform eruption) and folliculitis. Uncommon: acne. During post-market experience, rosacea. Also, cases of malignancies, including cutaneous and other types of lymphomas, 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 be taken into account when prescribing to this age group. Exposure of the skin to sunlight should be minimized and the use of sunblock (SPF 30) light from a solarium, therapy with UVB or UVA in combination with psoralen (PUVA) should be avoided during use of PROTOPIC™. Patients should be advised on appropriate sun protection methods, such as minimisation 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. Emetics 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 lymphomas, 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 uncommon (0.03%) 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 aetiology of the lymphadenopathy should be investigated. In the absence of a clear aetiology for the lymphadenopathy or in the presence of acute infectious 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's syndrome. Care should be exercised in patients undergoing dialysis. PROTOPIC™ is likely to have an effect on the ability to drive or use machines. CONTRAINDICATIONS Hypersensitivity to tacrolimus, in tacrolimus or to any of the excipients. INTERACTIONS Because of the potential risk of vaccination failure, vaccination should be avoided 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 the attempted vaccination, this period should be extended to 28 days or the use of alternative vaccines should be considered. Systemically available tacrolimus is metabolized via the hepatic CYP3A4/5 and the possibility of interactions cannot be ruled out and the coadministration of any other CYP3A4 inhibitors in patients with widespread and/or erythematous disease should be done with caution. PACKAGE SIZES Prices exclude VAT: PROTOPIC™ 0.03% ointment (30 g) £36.54 (30 g) tube, £36.04 (60 g tube) PROTOPIC™ 0.1% ointment £31.60 (30 g tube), £41.04 (60 g tube). Prices from the UK are provided as an example. LEGAL CATEGORY: POM. MARKETING AUTHORISATION OTHERS FURTHER INFORMATION AVAILABLE FROM: Astellas Pharma Espana Ltd, Lovett House, Lovett Road, Solihull, B91 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. APIL3595 Adverse 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. Adverse 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.
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