Forum for Nordic Dermato-Venereology
Official journal of the Nordic Dermatological Association

31st Nordic Congress of Dermato-Venereology
May 31 – June 3, 2008 in Reykjavik, Iceland

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May 31–June 3, 2008 in Reykjavik, Iceland

Programme and Abstracts
Protopic® provides effective control of atopic eczema

- Fast relief of itch\(^1\)
- Effective control of atopic eczema\(^2\)
- For short-term and intermittent long-term treatment in adults and children (>2 years)\(^3\)

REFERENCES:
Use in children (2 years of age and above): Protopic should be initiated by physicians with experience in the diagnosis and treatment of atopic dermatitis. Protopic ointment should be applied as a thin layer to affected areas of the skin. Protopic may be used for short term and intermittent long term treatment. At the first signs of recurrence (flares) of the disease symptoms, treatment should be re-initiated. Protopic is not recommended for use in children below age 2 years until further data are available.

If no signs of improvement are seen after two weeks of treatment, further treatment options should be considered. 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.

Contraindications:
- Hypersensitivity to macrolides in general, to tacrolimus or to any of the excipients.
- Exposure of the skin to sunlight and solarium should be minimised.
- There are no adequate data from the use of tacrolimus ointment in pregnant women.
- Studies in animals have shown reproductive toxicity following systemic administration. The potential risk for humans is unknown. Protopic ointment should not be used during pregnancy unless clearly necessary. Human data demonstrate that, after systemic administration, tacrolimus is excreted into breast milk. Although clinical data have shown that systemic exposure from application of tacrolimus ointment is low, breast-feeding during treatment with Protopic ointment is not recommended.


*Indications:* Treatment of moderate to severe atopic dermatitis in adults who are not adequately responsive to or are intolerant of conventional therapies such as topical corticosteroids. Protopic 0.03% is also indicated for the 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.

*Posology:* Protopic should be initiated by physicians with experience in the diagnosis and treatment of atopic dermatitis. Protopic ointment should be applied as a thin layer to affected areas of the skin. Treatment should be started with Protopic 0.03% 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. Treatment should be continued until clearance of the lesion. If symptoms recur, twice daily treatment with Protopic 0.01% should be restarted. An attempt should be made to reduce the frequency of application or to use the lower strength Protopic 0.01% ointment if the clinical condition allows.

*Warnings and precautions:* Exposure of the skin to sunlight and solarium should be minimised should be avoided during use of Protopic ointment. Emollients should not be applied to the same area within 2 hours of applying Protopic ointment. Before commencing treatment with Protopic ointment, clinical infections at treatment sites should be cleared. Care should be taken to avoid contact with eyes and mucous membranes. Occlusive dressings are not recommended.

*Interactions:* Formal topical drug interaction studies with tacrolimus ointment have not been conducted. Tacrolimus is not metabolised in human skin, indicating that there is no potential for percutaneous interactions that could affect the metabolism of tacrolimus. A potential interaction between vaccination and application of Protopic ointment has not been investigated. 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 be extended to 28 days or the use of alternative vaccines should be considered.

*Undesirable effects:* Burning, pruritus, warmth, erythema, pain, irritation, paraesthesia, dysaesthesias, alcohol intolerance (facial flushing or skin irritation after consumption of an alcoholic beverage), rosacea.

Reimbursement status: Reimbursed only after individual approval.

Marketing authorisation holder: Astellas Pharma GmbH, Neumarkter Straße 61, D-81673 Munich, Germany.

Icelandic representative: Vistor hf, Horgatunni 2, 210 Garðabær.

* The section has been altered/shortened.
ETTAMOUSSE
IOPSY
UNCH
REVOXYL
ERIDAL
LARELUX
LINDOXYL
UAC
5OTREX
3ANOXYL
3TIOXYL
HYSGEL
EBIPROX
7ARTEC

We hope to see you at our stand

Stiefel Laboratories (Nordic) ApS • Havnegade 39 • DK -1058 Copenhagen K
WELCOME TO REYKJAVIK

At the time these words are written it is clear that the Nordic Congress in Reykjavik has all the known parameters necessary to be a success. It is hoped that the one random parameter, the weather, will be favourable. We are proud to be able to present a varied scientific programme, with speakers bringing together a wealth of experience from all over the western hemisphere. Experience is precisely what the organizing committee would like speakers to share with their colleagues in the audience; we encourage all speakers to endeavour to provide participants with a “take home” message. It is hoped that most of you will read the programme and find that you want to be at many symposiums at the same time; in that case the scientific committee will have succeeded.

This is the second occasion on which nurses have been invited to the Nordic congress and this seems to be a trend worth continuing. A special course in basic dermatology has been provided for dermatological nurses.

Socializing with our colleagues and enjoying Iceland are two other very good reasons for attending the Congress. We have put together a social programme that includes the most popular tourist activities. In addition, there is a wealth of different tours and excursions presented by the Congress Bureau. We have done our best to arrange enjoyable conditions for networking; the rest is up to you!

On behalf of the Congress committee and Bolli Bjarnason, chairman of the Icelandic Dermatological Association, I welcome you to Iceland for a combination of education and fun that can only be found here and now.

Baldur Baldursson  
Congress President

Torbjörn Egilrud  
Secretary General, Nordic Dermatology Association

Dear congress participants,

Just a few words to express my sincere thanks to Baldur Baldursson and his colleagues on the congress committee for endless work and enthusiasm on the congress. The Nordic congress is our precious little diamond. It travels between our countries bringing unity and education to us all strengthening Nordic dermatology and venereology.

Bolli Bjarnason  
Chairman, Icelandic Dermatological Association
CONGRESS INFORMATION

Organizing Committee
Baldur Baldursson, President
Gísli Ingvarsson
Ellen Mooney

Conference Venue
The congress will be held at the Hilton Reykjavik Nordica Hotel, Sudurlandsbraut 2, Reykjavik.

Registration Desk
The Congress Secretariat (Iceland Incentives Inc.) will have their registration desk on the ground floor at Hilton Nordica.

At the registration desk you will receive your badge, congress bag and other congress material.

All unpaid invoices, including final payment for hotel and tours, must be settled with the Congress Secretariat before receiving the registration material.

Phone numbers at registration desk:
(+354) 892 7073 / 696 1402 / 696 1403

Opening hours at the registration desk:
Saturday May 31st 15.00–18.00
Sunday June 1st 07.30–18.00
Monday June 2nd 07.30–17.00
Tuesday June 3rd 08.30–12.30

Registration Fees
The registration fee includes admission to lectures, congress material, welcome reception at Háskólatorg (University Forum) May 31st, coffee and lunches on June 1st and 2nd and the Blue lagoon tour/dinner on Monday June 2nd.

The registration fee for accompanying persons includes the welcome reception at University Square and the Blue lagoon tour/dinner on June 2nd.

Badges/Tickets
The congress badge must be worn at all scientific sessions and as admission to the Blue Lagoon.

Lunches and Coffee Breaks
Coffee and lunches will be served in the exhibition area on June 1st and 2nd.

Exhibition and Posters
An industrial exhibition is held in connection with the congress. The exhibition area is on the ground floor at Hilton Nordica, in front of the main lecture halls A and B.

Posters will be on display on the 2nd floor of Hilton Nordica.

Social Programme
Saturday May 31st:
09.00–17.00: Golden Circle congress tour (optional, not included in the registration fee).
18.00–19.30: Welcome reception in Háskólatorg (University Forum). Included in the registration fee.

Sunday June 1st:
18.00–21.00 Horse riding and Grill Party (optional)

Monday June 2nd:
17.00/17.30–22.30/23.00: Blue lagoon tour/congress dinner with entertainment. Incl. in the registration fee.

Conference Transportation
Saturday May 31st:
17.30 and 17.45: Bus from Hilton Nordica Hotel to Háskólatorg (University Forum) for the welcome reception.
19.15–19.30: Buses to City Centre/Hilton Nordica Hotel.

Sunday June 1st:
Buses from/to Hilton Nordica Hotel in connection with the Horse riding-Grill Party tour.

Monday June 2nd:
Buses from/to Hilton Nordica hotel in connection with the Blue lagoon tour and dinner.

Language
English – no simultaneous translation available.

Information for Speakers
The lecture rooms are equipped with computers and projectors. Access to computers is also available at the Congress Center on the 2nd floor of the Hilton Nordica Hotel.

Special Dietary Requests
Please contact Iceland Incentives Inc at the Registration desk in Nordica for special dietary needs.
Food allergies, vegetarian requests and diseases are taken into consideration.

**Keflavík International Airport transportation**

**Arrivals**
A FLYBUS operates all day from Keflavík Airport to Reykjavík in connection with all incoming international flights. The Flybus brings passengers to the Flybus terminal at the Central Bus Station in Reykjavík (BSÍ) near the center of town. From there passengers are taken to most of the major hotels and guesthouses in Reykjavík.

Kindly note that not all hotels and guesthouses are provided with shuttle service from the Central Bus station, but taxis are available outside the terminal.

**Departures**
The Flybus operates all day in connection with all outgoing flights. A free pick-up service is available from most of the major hotels and guesthouses in Reykjavík. The day before departure, passengers need to inform the reception desk staff of their hotel/guesthouse that they want the Flybus to pick them up the following day.

The Flybus has a special schedule based on departures from the BSÍ terminal, picking up passengers approximately ½ an hour prior at the hotels.

Flybus fare: ISK 1.300 pr. person one way.

Children 0–11 yrs. are free of charge. Children 12–15 yrs. pay half price.

Taxi service between Keflavík and Reykjavík is also available.

**Public transportation**
Reykjavik has an extensive city bus system called “Strætó”. Routes, timings and maps for all city buses can be found on http://www.bus.is/english/routes. Please also consult with your hotel/guesthouse reception staff. One way fare with a city bus is ISK 280 and you must have the exact change ready, the bus driver can not change money.

**Climate**
June is usually sunny, but can be cold with temperatures around 10°C (50 Fahrenheit). As the weather in Iceland is very changeable, one should be prepared for both wind and rain and umbrellas are usually of no use! For the countryside, layered clothing which may be peeled off in tune with the weather changes, is the best idea. Don’t forget to bring your swimsuit, as a visit to one of the many geothermally heated swimming pools in Reykjavík or in the countryside should not be missed.

**Banks and Money**
Official banking hours in Reykjavik are 09.15–16.00 Monday to Friday. All banks can exchange foreign currency, and some shops (especially those catering to tourists) will accept payment in US dollars or Euros.

Most shops and businesses accept the major credit cards (Visa, Euro/Mastercard and American Express), so it is generally not necessary to carry much cash. Cards are commonly used in Iceland even for quite small transactions. ATMs are to be found in many places.

The currency used in Iceland is the Icelandic “krona” or “crown,” abbreviated ISK. The approximate exchange rate 10 April 2008 was: USD 1.00 = ISK 73 and EUR 1.00 = ISK 115.

It is best to exchange your money into ISK in Iceland, and re-exchange any surplus before you leave, as foreign banks may not deal in ISK. You can exchange your money at the bank at the airport on arrival and departure. Kaupthing Bank is in the same building as Hilton Nordica as well as an ATM machine.

**Telephones**
Direct calls can be made to all parts of Iceland. The code into Iceland from overseas is +354 ...

Mobile phones in Iceland use the European GSM system.

**Shopping hours in Reykjavik**
Downtown opening hours may vary but stores are generally open from 10-18:00 on weekdays and 10-14:00 on Saturdays. Some stores stay open longer on Saturdays and most downtown stores are open until 18:00 on the first Saturday of each month.

There are two shopping malls in Reykjavik, Kringlan (Sat: 10–19, Sun 13–18) and Smaralind and they are both open on weekends. Kringlan which is a 8-10 minutes walk from Hilton Nordica is open Saturdays 10.00–18.00 and Sundays 13.00–18.00.
Programme

Sunday June 1st, 2008.

08.30–10.00 **Parallel Session: Wound Healing. Chairs: Uwe Wollina and Tonny Karlsmark**

- Leg Ulcers in Practice – Diagnostic and Treatment, Uwe Wollina
- Conservative Treatment of Chronic Wounds, Tonny Karlsmark

**Parallel Session: Drug Reactions and Interactions. Chairs: Neil Shear and Gunilla Sjölin-Forsberg**

- ADRs and the Skin From a Regulatory Perspective, Gunilla Sjölin-Forsberg
- Franz Diffusion Cells Experiments for *In vitro* Transdermal Permeations Studies, Bergthóra S. Snorradóttir and Már Másson
- What You Need to Know about Skin Reactions, the Old & New, Neil H Shear

**Course: Dermatological Problems in Women. Chairs: Fenella Wojnarowska, Dr Elisabet Nylander and Dr Monika Gniadecka**

- How Women Perceive Skin Disease, Elisabeth A Holm
- Overview of Lichen Sclerosus and Lichen Planus, Elisabet Nylander
- Overview of Lupus in Women, Filippa Nyberg
- Overview of Swollen Legs in Women, Monika Gniadecka
- Contact Dermatitis – How do Women Cope with the Disease? Tove Agner
- Autoimmune Disease in Pregnancy, Fenella Wojnarowska
- Overview of Pregnancy Dermatoses, Ellen Mooney

10.30–12.00 **Parallel Session: Atopic Dermatitis Update. Chairs: Baldur Baldursson**

- Treatment of Anaphylactic Reactions, Johannes Ring
- Management of the Atopic Dermatitis Patient, Thomas L. Diepgen
- Climate Change, Pollen and Allergy, Heidrun Behrendt

**Parallel Session: Oral Dermatology. Chairs: Ginat W. Mirowski and Mats Jontell**

- Oral Manifestations of Systemic Diseases, Mats Jontell
- White Lesions of The Oral Cavity, Ginat Mirowski

**Course: Dermatological Problems in Women, contd.**

12.00–13.10 **Sponsored Lunch Symposia.** Galderma (Room H) and Schering Plough (Room I)

13.10–14.00 **Plenary Lecture on Atopy**

Atopic Eczema – What is New? Johannes Ring

14.30–16.00 **Corporate Sponsored Symposium: Sponsored by Astellas**

**Parallel Session: Hidradenitis Suppurativa. Chairs: Gregor Jemec and Gíslí Ingvarsson**

- Current Understanding of Aetiology and Pathogenesis of Hidradenitis Suppurativa, Gregor B Jemec
- Clinical Presentation and Disease Severity, Karin Sartorius
- Medical Treatment of Hidradenitis Suppurativa, Gíslí Ingvarsson
- Surgical Treatment of Hidradenitis Suppurativa, Nathalie Dufour

**Parallel Session: Biologics – Anything Unsaid? Chairs: Mona Ståhle, Peter Berg and Marcus Schmitt-Egenolf**

- Systematic Treatment for Psoriasis – a New Biologic Era, Mona Ståhle
- Systematic Follow-up of Conventional and Biologic Psoriasis Treatment: The Swedish Registry PsoReg, Marcus Schmitt-Egenolf
- Biologic therapy of psoriasis in clinical practice, Peter Berg

**Course: Dermatological Theories in Practice. Chair: Theis Huldt-Nyström**

- Basic skin physiology with special attention to skin barrier function and the application of emollients, Theis Huldt-Nyström
- UV Treatment – Challenges and Pitfalls, Eli J. Nordal
- UV Treatment of vitiligo – A Sport for Risk Seekers? Eli J. Nordal
- The DLQI Questionnaire and Other Questionnaires to Measure the Effects of Dermatological Therapy in Atopic Dermatitis, Hand Eczema, and Itch, Theis Huldt-Nyström
- How to Use the PASI score, Morten Dalaker
16.30–18.00 Corporate Sponsored Symposium: Sponsored by Basilea
Course: Dermatological Theories in Practice, contd.

Monday June 2nd 2008

08.00–09.30 Parallel Session: Psoriasis Update. Chairs: Steingrímur Davíðsson and Olle Larkö
Effect of Tonsillectomy on Patients with Chronic Plaque Psoriasis, Ragna Hlín Porleifsdóttir, et al. PS07.1
Science Meets Nature: Why do Psoriasis Patients Benefit from Bathing in the Blue Lagoon? Jean Krutmann PS07.2
Economic Burden of Psoriasis, Olle Larkö PS07.3
The Use of PDI in Measuring Quality of Life in Patients at the Blue Lagoon Clinic, Steingrímur Davíðsson PS07.4

Parallel Session: Dermatology and Policies of Administration. Chairs: Evan Farmer, Fenella Wojnarowska and Olle Larkö
Current Issues in American Academic Dermatology, Evan Farmer PS08.1
Skin Cancer in the UK – Can UK Government Driven Models of Working have Application Elsewhere? Fenella Wojnarowska PS08.2
Dermatology and Policies of Administration, Olle Larkö PS08.3

Workshop: Self-assessment in Dermatopathology. Chair: Philip LeBoit
Course: Dermatopathology. Chair: Ellen Mooney. Co-chairs: Mari-Anne Hedblad and Ole Clemmensen
From The Clinic to the Microscope, Dr Ellen Mooney
Cutaneous Lymphoma - Clinicopathologic Correlation and Diagnostic Pitfalls, Dr Werner Kempf
Lupus Erythematosus – Clinicopathologic Correlation, Dr Ole Clemmensen
New Inflammatory Dermatoses – Microscopic Clues to Clinical Diagnoses, Antoinette Hood
The Tumour Through Technology and Treatment
Lentigo Maligna – Diagnosis and Soft X-Ray Treatment, Dr Mari-Anne Hedblad C03.1
Spitz Nevi – Tough to Diagnose, Easy to Treat? Professor Phil Leboit
Nevoid Melanoma – The Dreaded Tumour That Defies Us, Dr Ellen Mooney

10.00–11.30 Parallel Session: Skin and Malignancies. Chair: Werner Kempf
Parapsoriasis – Inflammatory Disorder or Cutaneous T-cell Lymphoma? Werner Kempf PS09.1
Squamous Cell Carcinoma in Venous Leg Ulcers. Baldur Baldursson PS09.2
Genital Precancerous Lesions and Treatment Modalities, Olle Larkö PS09.3
The Epidemiology of Skin Cancer in Organ Transplant Recipients, Bernt Lindelöf PS09.4

Parallel Session: Contact Dermatitis. Chairs: Bolli Bjarnason and Marlene Iskasson
Detection of Contact Allergy by Interleukins in Patch Test Blisters, Margret S Sigurdardottir, et al. PS10.1
Characteristics of Disease in Patients with Multiple Contact Allergies, Berit C Carlsen, et al. PS10.2
Screening for Acrylate/Methacrylate Allergy in the Baseline Series, Marlene Isaksson, et al. PS10.3
Low Test Volume for Patch Test Standardization, Bolli Bjarnason, et al. PS10.4
Contact Allergy to Aluminium, Magnus Bruze PS10.5
Comparison Between Two Different Fragrance Mix Test Systems, F Andersen and KE Andersen PS10.6
Adverse Reactions to Dental Materials: Reporting and Cases, Lars Björkman PS10.7
Allergic Contact Dermatitis to Topically Applied Metronidazole in Two Nurses, Jakob Torp Madsen, et al. PS10.8

Workshop: Self-assessment in Dermatopathology, contd.
Course: Dermatopathology, contd.

11.30–12.40 Sponsored Lunch Symposia. Photocure
12.40–13.30 Plenary Lecture
Certification and Maintenance of Certification in Dermatology, Antoinette Hood PL02

Infectious Causes of Human Cancer, Harald zur Hausen PS11.1
**Parallel Session: Melanoma Update. Chair: Jon Hjaltalin Olafsson**

- Mycoplasma Genitalium – 15 Years Experience, **Carin Anagrius**
- Syphilis in Baltic: Epidemiology, Clinic, Therapy and Prevention – an Update, **Andris Rubins, et al.**

**Genome-wide SNP Association Studies of Pigmentation Traits and Melanoma Risk, Simon N. Stacey et al.**

**Melanoma and Dysplastic Nevi in Icelandic Air Crew Members. The Importance of Screening, Sigurdardottir G et al.**

**Sunbed Usage in Iceland, Borgeir Sigurðsson**

**Removal of Nevi as Prophylaxis for Melanoma. A Cost-benefit Analysis, Bernt Lindelöf et al.**

**Is Sunlight Beneficial and are Dermatologists too Narrow-sighted? Olle Larkö**

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**Tuesday June 3rd, 2008**

**Parallel Session: Photodermatology and Photoprotection. Chairs: Vigfús Sigurðsson and Hans Christian Wulf**

- Photoprotection is More Than Just Sunscreen, **Elisabeth Thieden**
- Variables in UVB Treatment of Skin Diseases, **Hans Christian Wulf**
- Home UVB Phototherapy is Effective, Safe and Greatly Appreciated. A Randomized Comparison of Home and Outpatient UBV Treatment for Psoriasis: The PLUTO study, **MBG Koek, et al.**

**Parallel Session: Infotech, Telemedicine, Dermatological Websites. Chairs: Lars Erik Bryld and Thor Bleeker**

- Teledermatology on the Faroe Islands, **Gregor Jemec**
- An Internet-based Case-file System for Systematic Follow-up of Non Melanoma Skin Cancer, **Lars Erik Bryld**
- Exciting Website for Dermatologists: www.pdf.nu and www.ssdv.se, **Thor Bleeker**


**Parallel Session: Free Papers Session. Chair: Bernt Lindelöf**

- Ichthyosis, the Role of Conservative Eyelid Surgery!? **Haraldur Sigurðsson**
- Hundreds of Children in the Gothenburg greater area with Vaccine Related Contact Allergy to Aluminium, **Annica Inerot**
- Our Experience in Treatment of Atopic Dermatitis in Latvia, **Andris Rubins**
- Treatment with a Moisturizing Cream Delays Recurrence of Atopic Eczema, **Karín Wirén**
- Long-term Treatment with Moisturizers Affects Gene Expression of Epidermal Enzymes, **Izabela Buraczewska**
- “Fractional” Lasers for Treatment of Rhytides, Scars, Pigment and Overall Skin Rejuvenation, **Martin Kassir**
- Eczema Counselling via the Internet – Telemedicine as a Tool in Home Care Eczema Counselling, **Thomas Schopf**
- A New High-powered Radiofrequency Device used for Non-invasive Lipoplasty of the Abdominal Region, **Martin Kassir**

**Parallel Session: Nail Disorders. Chair: Robert Baran**

- Classification of Onychomycosis Revisited, **Robert Baran**
- Differential Diagnosis of Nail Psoriasis and Onychomycosis, **Eckart Haneke**
- Nail Malignancies, **Robert Baran**

**Workshop: Tutorials for Self-assessment in Dermatopathology, contd.**

**Parallel Session: Free Papers Session, contd.**

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**Closing Remarks**
The scientific committee acknowledges a generous travel grant from Glaxo Smith Kline that enables us to invite overseas and European speakers to the congress.
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<th>Time</th>
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<td>18:00-19:30</td>
<td>Opening Ceremony followed by Welcome Reception at Icelandic University Forum</td>
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<td>Wound Healing (Room A)&lt;br&gt;Chairs: Ole Wolff and Tommy Karlsmark</td>
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<td>16:30-18:00</td>
<td>CSS02 – Room A&lt;br&gt;SP07 – Room A&lt;br&gt;Pсорiasis Update&lt;br&gt;Chairs: Sigurður Davíðsson and Olafur Jónsson</td>
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<td>08:00-09:30</td>
<td>PS08 – Room B&lt;br&gt;Dermatology and Policies of Administration&lt;br&gt;Chairs: Evan Farmer, Fenella Wojnarowska and Olafur Jónsson</td>
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<td>09:30-10:00</td>
<td>Exhibition and Coffee</td>
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<td>10:30-10:30</td>
<td>PS02 – Room B&lt;br&gt;Drug Reactions and Interactions&lt;br&gt;Chairs: Neil Shear and Gunnilla Sjölin-Forsberg</td>
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<td>11:00-12:30</td>
<td>PS03 – Room A&lt;br&gt;Atopic Dermatitis Update&lt;br&gt;Chairs: Baldur Baldursson</td>
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<td>12:00-13:10</td>
<td>Exhibition and Sponsored Lunch Symposia, Galderma (Room H) and Schering Plough (Room I)</td>
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<td>13:10-14:00</td>
<td>PL01 – Room AB&lt;br&gt;Atopic Eczema – News on Pathophysiology and Treatment&lt;br&gt;Chairs: Johannes Ring</td>
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<td>14:00-14:30</td>
<td>Exhibition and Coffee</td>
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<td>14:30-16:00</td>
<td>CSS02 – Room A&lt;br&gt;SP05 – Room A&lt;br&gt;Self-assessment in Dermatopathology&lt;br&gt;Chairs: Philip LeBoit and Mari-Anne Hedblad</td>
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<td>16:00-16:30</td>
<td>Exhibition and Coffee</td>
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<td>16:30-18:00</td>
<td>CSS02 – Room A&lt;br&gt;SP07 – Room A&lt;br&gt;Pсорiasis Update&lt;br&gt;Chairs: Sigurður Davíðsson and Olafur Jónsson</td>
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| 10.00–11.30  | **PS09 – Room A**  
Skin and Malignancies  
Chair: Werner Kempf |
|              | **PS10 – Room B**  
Contact Dermatitis  
Chairs: Bolli Bjarnason and Marlene Isaksson |
|              | **W01 – Room D**  
Self-assessment in Dermatopathology, contd. |
|              | **C03 – Room FG**  
Dermatopathology, contd. |
| 11.30–12.40  | **Exhibition and Sponsored lunch**  
Symposium, Photocure – Room HI |
| 12.40–13.30  | **PL02 – Room AB**  
Certification and Maintenance of Certification in Dermatology  
*Antoinette Hood*, Executive Director, American Board of Dermatology |
| 13.40–15.10  | **PS11 – Room A**  
Venereology in Scandinavia  
Chair: Harald Moi |
|              | **PS12 – Room B**  
Melanoma Update  
Chair: Jon Hjaltaín Ólafsson |
|              | **W01 – Room D**  
Self-assessment in Dermatopathology, contd. |
| 15.10–15.30  | **Exhibition and Coffee** |
| 15.30–17.00  | **Nordic Dermatology Association, General Assembly – Room A** |
| 17.30–18.30  | **Buses to Congress Event at the Blue Lagoon (bathing, food and fun)** |
| **Tuesday June 3rd, 2008** | |
| 09.00–10.30  | **PS13 – Room A**  
Photodermatology and Photoprotection  
Chairs: Vigfús Sigurðsson and Hans Christian Wulf |
|              | **PS14 – Room B**  
Infotech, Telemedicine, Dermatological Websites  
Chairs: Lars Erik Bryld and Thor Bleeker |
|              | **W02 – Room FG**  
Tutorials for Self-assessment in Dermatopathology  
Chair: Philip LeBoit, Antoinette Hood and Mari-Anne Hedblad |
|              | **PS15 – Room I**  
Free Papers Session  
Chair: Bernt Lindlöf |
| 10.30–11.00  | **Exhibition and Coffee** |
| 11.00–12.30  | **PS16 – Room A**  
Nail Disorders  
Chair: Robert Baran |
|              | **W02 – Room FG**  
Tutorials for Self-assessment in Dermatopathology, contd. |
|              | **PS15 – Room I**  
Free Papers Session, contd. |
| 12.30        | **Closing Remarks** |

PL: Plenary Lecture; PS: Parallel Session; C: Course; CSS; Corporate Sponsored Symposium; W: Workshop
PLENARY SESSIONS

Sunday June 1st, 13.10–14.00

PL01

Atopic Eczema – What is New?

Johannes Ring

Department of Dermatology and Allergy Biederstein, Technische Universität München, München, Bavaria, Germany

Atopic eczema (AE) is one of the most common inflammatory skin diseases with a chronic or relapsing course and strong itching. The prevalence of AE has increased over the last decades tremendously in most countries of the world. In Germany we have prevalence rates between 5–20% in various areas. AE, allergic bronchial asthma and allergic rhinoconjunctivitis are closely linked, as we know from classical genetics.

Surprisingly, with modern molecular genetic technology, associations overlap more between AE and psoriasis than with asthma.

For many gene loci with high association no clear-cut function has been described. Recent data describe a genetic polymorphism on chromosome 1 in the area of the epidermal differentiation complex, namely in the profilaggrin molecule; this polymorphism is highly associated with ichthyosis vulgaris and also with AE. Other associations have been described for proteases and protease inhibitors. The importance of the barrier function and its disturbance in this disease is underlined by these studies.

Few diseases are characterized by similarly elevated IgE values as AE. For a long time this was regarded as an epiphenomenon. By the discovery of IgE and the high affinity IgE receptor on epidermal Langerhans’ cells, especially in AE, together with the introduction and standardization of the atopy patch test (APT) it has become clear that IgE inducing allergens also play a role in eliciting or aggravating eczematous skin lesions in this disease.

New data also arise from studies regarding the pathophysiology of itch. Recently, the itch sensation has been visualized with positron emission tomography (PET). Atopic itch has been shown to differ in specially validated questionnaires qualitatively from itch in other pruritic skin diseases. Autonomic nervous system dysregulation may influence both itch and inflammatory reactions.

The basis of therapy in AE is the restoration of the disturbed barrier function which is often described clinically as “dry skin”. This dermatologic basic therapy is especially important during phases of remission. The individual selection of emollients (different for different body areas and different individuals) is crucial. Progress has been made with new emollients containing special lipids in various galenic forms.

New anti-inflammatory treatments with topical calcineurin inhibitors (tacrolimus and pimecrolimus) have enriched the therapeutic arsenal. Various UV wave lengths have been successfully tried as adjuvant strategies. Climate therapy (at the North Sea level or high altitude in alpine regions) can help ameliorate the situation. The role of allergen-specific immunotherapy (ASIT) is still controversial; however, a recent double-blind placebo-controlled study has shown efficacy also in AE. It remains to be seen whether the new biologics will find their way in routine treatment of AE. Preliminary studies have shown limited to moderate effects with anti-IgE (omalizumab) or anti IL-5 (mepolizumab).

The individual variability of the clinical expression and course of AE requires the active cooperation of the informed patient over months and years. This can be achieved by “eczema school” programs which have been successfully evaluated in a national multicenter trial in Germany. The essence of these eczema school programs is the interdisciplinary character in a close cooperation between medical doctors (pediatricians and dermatologists), psychologists and nutrition experts.


Monday June 2nd, 12.40–13.30

PL02

Certification and Maintenance of Certification in Dermatology

Antoinette Hood

Executive Director of the American board of Dermatology

Dermatology has evolved from internal medicine into a fully mature subspecialty of cutaneous medicine. In the 21st century, assuring quality healthcare requires a new paradigm of post-graduate education, self-assessment and practice evaluation. The road to quality is not easy; it is necessary.
PARALLEL SESSIONS

Wound Healing

PS01.1
Leg Ulcers in Practice – Diagnostic and Treatment

Uwe Wollina

Department of Dermatology and Allergology, Hospital Dresden-Friedrichstadt, Academic Teaching Hospital of the Technical University of Dresden, Dresden, Germany

Correspondence should be sent to: Prof. Dr. Uwe Wollina, MD, Department of Dermatology, Hospital Dresden-Friedrichstadt, Academic Teaching Hospital of the Technical University of Dresden, Friedrichstrasse 41, 01067 Dresden, Germany; E-mail: wollina-uw@khdf.de.

Leg ulcers are the most common conditions presenting with chronic and in many cases disabling wounds. The spectrum of underlying disease causing leg ulcers is remarkably broad although the most common cause in Europe and other Western countries is venous insufficiency. In Africa, Asia and South America infectious diseases count for a significant number of cases. In a globalizing world the usual pattern of disease is becoming mixed.

Leg ulcers are by no means a diagnosis, just a symptom. In any case search for the underlying cause is necessary to provide the appropriate treatment for the patient. Therefore, standardization of treatment is not the final target but a tool to offer optimal treatment in individual situations. The target of leg ulcer therapy is the individual patient. To be treated in a rational and successful way, exact diagnosis of the underlying cause(s) and associated diseases is necessary. This can be done in the most effective way by an interdisciplinary approach. The collection of cases demonstrates the need for careful clinical investigation substantiated and supported by vascular, histopathologic and microbiologic techniques wherever needed. Although not every ulcer can be cured, improvement of the medical situation and of quality of life of the patient is possible in most cases.

PS01.2
Conservative Treatment of Chronic Wounds

Tommy Karlsmark

Department of Dermato-Venereology, Bispebjerg Hospital, Kopenhagen, Denmark

Chronic wounds represent a major but unfortunately neglective health care problem resulting in distress and disability for the patients, potentially loss of working capability, reduced quality of life and an increasing burden to health care providers. It is estimated that approximate 1% of the population in the industrialised world suffers from wounds that need professional treatment. The aim of this lecture is to give an overview of the conservative treatment of chronic wounds – including new kind of dressings, compression therapy and hypothesis about bacteria influence in non-healing ulcers.

Drug Reactions and Interactions

PS02.1
ADRs and the Skin From a Regulatory Perspective

Gunilla Sjölin-Forsberg

Medical Products Agency, Sweden

Background: Adverse drug reactions (ADRs) are frequent causes of morbidity and also mortality in patients worldwide. They are often classified into type A, B, C, D and E reactions. Most skin reactions have been considered to be type B, i.e. idiosyncratic or hypersensitivity reactions. The hypersensitivity reactions are in principal further grouped into four different types depending on underlying immunological mechanisms.

Objective: To describe the reporting patterns of ADRs in the skin: Most commonly reported type of reactions, most commonly reported medicinal products in relation to skin reactions and recent regulatory actions. Regulatory announcements on websites of authorities (EMEA and FDA).

Results: New products and skin reactions, new warnings and recent findings will be addressed.

Conclusion: Any new lesson learnt? Can we prevent ADRs in the skin?

PS02.2
Franz Diffusion Cells Experiments for in Vitro Transdermal Permeations Studies

Bergþóra S. Snorradóttir and Már Másson

Faculty of Pharmacy, University of Iceland, Reykjavik, Iceland

In principle there are three possible routes for the penetration of topically applied substances through the stratum corneum; the transcellular, intercellular and follicular route. Adhesive tape stripping measurement and confogal microscopy have been used to determine which is the dominant of penetration route. The purpose of in vitro studies to determine transdermal permeation, penetration and absorption can vary and thus different approaches and models are used for such studies. Franz diffusion cell are often chosen as tools for in vitro experiments. The practice of Franz diffusion cells experiments will be discussed and some typical results will be shown.
PS02.3

What You Need to Know about Skin Reactions, the Old & New

Neil H Shear
University of Toronto Medical School

Cutaneous reactions are common but can be markers of systemic disease and be challenging to manage. An organized approach to diagnosis (focusing on morphology and presence of fever), and visually mapping drug exposure can lead to thoughtful causality assessment. Patch testing may also help in special circumstances. Our understanding of both simple exanthems and the drug hypersensitivity syndrome have been helped by important research. Treatment is not evidence-based but experience has helped create some guidelines. Case examples and simple algorithms will be used to illustrate the most clinically useful approach to all drug reactions in the skin.

Atopic Dermatitis Update

PS03.1

Treatment of Anaphylactic Reactions

Johannes Ring
Department of Dermatology and Allergology, Klinikum rechts der Isar, Technische Universität München, Germany

Anaphylaxis is the maximum variant of an acute generalized hypersensitivity reaction which can rapidly progress and involve several organ systems. 90% of cases show skin manifestations. Therapeutic interventions depend on the history (e.g. eliciting substances, kinetics) and the clinical presentation regarding symptoms; a severity grading from I to IV has been proven valuable in the past (Ring, Messmer, Lancet 1977).

General measures in management of anaphylaxis comprise the appropriate positioning and an intravenous catheter for an infusion line. Drug of choice is epinephrine (first i.m., in manifest shock i.v.) as well as histamine H1 antagonists (especially in grade I and II reaction). Glucocorticosteroids (i.v. bolus) have proven to be helpful in prevention of late type or dual reactions. In grade IV (cardiac and/or respiratory arrest) classical cardio-pulmonary resuscitation has to be initiated. When airway symptoms are predominant, inhalative 2 agonists can be used. Volume substitution (electrolytes, plasma expanders) is crucial starting from grade III. For self-medication, patients should receive an emergency kit containing an epinephrine autoinjector as well as an antihistamine and a glucocorticosteroid. Epinephrine autoinjectors are available both for adults and children. The German Academy for Allergy and Environmental Medicine has started an educational program for patients and relatives. Patients should be informed about the disease, the relevant elicitors as well as possible avoidance strategies together with adequate training in the use of emergency drugs.

Reference:

PS03.2

Management of the Atopic Dermatitis Patient

Thomas L. Diepgen
University Hospital Heidelberg, Dept. of Social Medicine, Occupational and Environmental Dermatology, Germany

Atopic eczema (AE) is a well known but difficult to treat common, chronically relapsing, inflammatory skin disease with a high economic burden and high impact on the quality of life. In recent years epidemiological findings have challenged the prevailing concepts in understanding AE and this might have a major impact on how we manage AE from a clinical point of view. First, although atopy is associated with AE in some degree, its importance is not likely to be a simple cause and effect relationship, especially at a population level. This has a major impact on the prevention of AE. Perhaps there are more types of “atopic” eczema, the defining pattern of which will become clearer as we learn more about the genetic and environmental causes of what is currently recognized as the common phenotype of AE. Second, the inverse relationship (if this link is present) between infections and AE risk is likely to be more complex, depending critically on the timing and type of infectious exposure. Third, although eczema, asthma and allergic rhinitis tend to cluster in the same individuals and families, the exact relationship between early eczema and subsequent asthma (the atopic march) over time is far from clear. However, knowledge about the course of a chronic disease is important for patients, physicians and health authorities. In a prospective cohort study we could identify by statistical modeling three subgroups of AE. Fourth, patient education programs are part of patient empowerment to solve problems with chronic diseases but there efficacy has not yet been proven for AE. In a recent multicentre study (randomised prospective controlled trial) the efficacy of an educational program for the self management of AE in children and adolescents was evaluated. The results demonstrate that this educational group intervention program is effective in the long term disease management of AE. This educational program should be considered a part of the routine care of children and adolescents with AE.

In conclusion, these observations underline the importance of epidemiological studies conducted at a population level to gain a more balanced understanding of the endigma of atopic...
eczema, and the importance of large randomised controlled clinical trials to get new insights for the management of these patients in our daily routine.

**PS03.3**

**Climate Change – Impact on Pollen and Allergy**

Heidrun Behrendt

ZAUM - Zentrum Allergie und Umwelt - Center for Allergy and Environment, Technische Universität München, Munich, Bavaria, Germany

Allergy represents a major health problem in most countries of the world with increasing prevalence rates of atopic diseases (rhinoconjunctivitis, asthma and eczema). Among hypothetical concepts trying to explain this increasing prevalence both loss of protective factors (early immune stimulation by infectious disease, vaccination or exposure to Th1 stimulating agents) and effects of allergy enhancing factors (environmental tobacco smoke in the indoor and traffic exhaust exposure in the outdoor environment) have been identified. On the example of pollen allergy, a few thoughts concentrating on allergen exposure – both in a quantitative and qualitative way – may add a third hypothesis (“allergen exposure hypothesis”).

In the past decades, there have been 3 major changes with regard to pollen exposure which will be shortly discussed:

1. More pollen: Phenological observations over the last 30 years have yielded significantly prolonged flowering times of many anemophilous plants with earlier start of pollination and later dying of leaves leading to a prolonged pollination period by more than 10–15 days in the average in Central Europe (WHO report, 2005). This implies that more pollen are in the atmosphere over longer periods of time.

2. New pollen: Due to climate change and/or globalisation many countries of the world experience new plants (neophytes) appearing in the traditional habitat, the most remarkable example being ragweed (ambrosia artemisiifolia) spreading from Southern France and Eastern Europe to large parts of Central Europe.

3. Altered pollen: By atmospheric pollution pollen grains are altered and show morphological changes of surface structures with increased extrusion of allergenic material. Among factors contributing to these effect volatile compounds (VOCs) in the indoor and fine and ultrafine particles from traffic exhaust in the outdoor are the most prominent.

Furthermore, we have recently found that pollen not only act as allergen carriers but also secrete highly bioactive proinflammatory lipids, the so-called pollen associated lipid mediators (PALMs) which contribute to the recruitment of immune cells in the early phase of the initiation of an allergic reaction. A subgroup of PALMs (phytoprostanes) has been shown to enhance the shift towards Th2 in dendritic cells after allergen contact, thus facilitating an allergic immune response.

Since global warming with consecutive climate change seems to be no fiction but rather a scientifically proven reality, allergists should be aware of these phenomena of possible new and prolonged pollen exposure in the environment of their patients. Rational prevention programs should not only focus on patients and indoor avoidance recommendations, but also imply action plans in reducing outdoor allergen exposure.

References:


**Oral Dermatology**

**PS04.1**

**Oral Manifestations of Systemic Diseases**

Mats Jontell

Oral Medicine, Institute of Odontology, Sahlgrenska Academy, University of Gothenburg, Gothenburg, Sweden.

The oral cavity is sited at the mucocutaneous interface between the skin and the gastrointestinal tract. Diseases in the two latter body compartments reflect the pathological conditions observed in the oral mucosal lining. The oral mucosa, as the skin, has the advantage of being easily accessible for ocular examination although the reaction pattern may appear to be different from what is seen in a dermatologic practice. Even though there is a limited spectrum of reactions patterns, their recognition is critical for a correct diagnosis. This presentation will focus on diagnosis and management of some of the most common reaction patterns signalling systemic dermatological and gastrointestinal diseases including vesiculobullous diseases, food allergies and inflammatory bowel disease. These will be presented as examples of disease that are expressed in the oral cavity.
White Lesions of The Oral Cavity

Ginat Mirowski

Department of Dermatology, Feinberg School of Medicine, Northwestern, University, Chicago, Illinois, USA

White lesions are extremely common findings in the oral cavity. Benign and physiologic entities may present as white lesions; systemic conditions and infections as well as malignancies may also present as white oral lesions. An appreciation of the clinical entities that white lesions may represent is necessary if a differential diagnosis is to be elucidated. The appreciation of subtle clinical findings associated with white lesions of the oral cavity will permit clinicians to better care for their patients. A clinical approach, the differential diagnosis and, diagnostic studies as well as treatment options will be discussed.

Hidradenitis Suppurativa

Current Understanding of Aetiology and Pathogenesis of Hidradenitis Suppurativa

Gregor B. Jemec
Roskilde, Denmark

Traditional understanding of Hidradenitis suppurativa (HS) suggests that it is a disease of the hair follicle. There is considerable understanding of the disease mechanism, which involves lesions of the deep portions of the follicle epithelium. The aetiology however remains unknown. Current trends in aetiological reserach of HS will be presented in the perspective of the disease mechanism as we understand it today.

Hidradenitis Suppurativa – Clinical Presentation and Disease Severity

Karin Sartorius

Department of Dermatology, Karolinska University Hospital

Hidradenitis suppurativa (HS) is a chronic recurrent disease causing inflammation, suppuration and scarring of inverse areas. In the classic Hurley clinical grading system, stage I consists of one or more abscesses with no sinus tract or cicatriztion, stage II consists of one or more widely separated recurrent abscesses with a tract or scarring. The most severe cases, stage III, have multiple interconnected tracts and abscesses throughout the entire affected area.

Among HS patients seeking help from dermatologists for their disease, cases graded as Hurley II form the majority, and within this common disease stage group there is a wide variation of clinical findings and symptoms. Milder cases with comparatively small problems exist in this group, while the more severe cases may have debilitating symptoms. It is therefore important to develop a more dynamic and precise scoring system for HS by adding clinical details to the staging process. It is proposed that the following outcome variables are explicitly mentioned in future reports:
1. Anatomical region involved.
2. Number and scores of lesions.
3. The longest distance between two relevant lesions.
4. Are all lesions clearly separated by normal skin?

By assigning numerical scores to these variables, disease intensity can be quantified in a more clinically meaningful way on an open-ended scale. Furthermore, as pain is an important feature of HS a subjective evaluation should be included, preferably a visual analogue scale score of pain from the worst lesion as chosen by the patient.

Medical Treatment of Hidradenitis Suppurativa

Gisli Ingvarsson
Lágmúla 5, IS-108 Reykjavík, Iceland

This lecture is based on medical literature and personal experience in everyday management of this orphan disease. The main themes of medical treatment are mentioned and specific medical options evaluated. Guidelines for medical treatment will be suggested.

Surgical Treatment of Hidradenitis Suppurativa

Nathalie Dufour
Brinkvegen 24, N-9012 Tromsø, Norway

The lecture will be based on information from medical literature and personal experience in everyday management of this disease. The main strategies of surgical treatment will be mentioned but the focus will be on surgical CO₂ laser treatment of hidradenitis suppurativa. The procedures and guidelines for CO₂ laser treatment in a Norwegian department of dermatology will be presented.
Biologics – Anything Unsaid

PS06.1
Systemic Treatment for Psoriasis – a New Biologic Era

Mona Ståhle
Department of Medicine, Karolinska Institutet, Stockholm, Sweden

Psoriasis is the most prevalent inflammatory skin disease in our part of the world. Despite considerable advances in our knowledge about disease pathology, the ultimate cause of psoriasis remains elusive. Current understanding recognizes the significant clinical heterogeneity of the disease, which may result from differences in pathomechanisms and variations in the genetic background. How such differences translate into therapeutic response in the individual patient is an emerging challenge, which has become more obvious with the introduction of the novel biologic drugs. In fact, these drugs constitute powerful in vivo models for disease mechanisms and may give important clues to pathogenesis. Even within the class of drugs antagonizing TNF-α there are differences in response among psoriatic patients and interestingly, insufficient response to one drug does not preclude an excellent response to another. In the Nordic countries we currently have access to four different biologics for treatment of psoriasis: Infliximab, Etanercept, Efalizumab and Adalimumab and additional drugs are already in clinical trials. This is indeed a fortunate situation for patients with psoriasis and gives us new possibilities to control even the most severe disease manifestations.

PS06.2
Systematic Follow-up of Conventional and Biologic Psoriasis Treatment: The Swedish Registry PsoReg

Marcus Schmitt-Egenolf
Department of Public Health and Clinical Medicine, Dermatology and Venereology, Umeå University, Sweden

The selection of the best and safest treatment for each individual patient out of numerous options from today’s pharmacopeia requires substantial knowledge. With the introduction of new systemic drugs for the management of psoriasis we felt an obligation in Sweden to establish a trusted tool to monitor their use. We formed PsoReg to create a solid, long-term database in order to analyze the safety and effectiveness of different systemic psoriasis treatment regimes. In contrast to randomized clinical trials and spontaneous reporting of adverse effects, registries for collecting observational data can provide a systematic but real-life picture of the diseased population in actual practice. PsoReg will provide information to help clinicians individualize therapy on a rational basis through evaluation of effectiveness and adverse effects in specific patient subgroups. Designed and managed by specialized healthcare professionals, PsoReg enrolls all psoriasis patients on systemic treatment to allow a fair comparison of old versus new generation psoriasis treatments. PsoReg even creates benchmark data for quality assurance of the medical service. A web-based design allows real-time pharmacovigilance and will enable the registry to assist clinicians in their day-to-day management of psoriasis patients. In this way PsoReg can become an integrated part of tomorrow’s dermatology.

PS06.3
Biologic Therapy of Psoriasis in Clinical Practice

Peter Berg
Department of Dermatovenereology, Karolinska University Hospital, Solna, Sweden

Nearly one million patients are treated worldwide with biologics due to chronic inflammation, mainly with the diagnosis rheumatoid arthritis, Crohn’s disease, and psoriasis with or without arthritis. We will present some severe cases with psoriasis, where it has been difficult to direct which biologics you should choose as treatment. There will be a focus on side effects and why we had to change to some other biologicals for best clinical effect in the patient. In the presentation of some ten cases we will find all the four different biologicals represented in Sweden, Infliximab, Etanercept, Efalizumab and Adalimumab. At the time being these patients have benefited out of the given treatment with biologics compared with traditional systemic treatment for psoriasis.

Psoriasis Update

PS07.1
Effect of Tonsillectomy on Patients with Chronic Plaque Psoriasis

Ragna Hlín Porleifsdóttir1,2, Andrew Johnston1, Jón Hjaltalín Ólafsson2, Bárður Sigurgeirsson2, Hannes Petersen1, Sigrún Laufey Sigurðardóttir2 and Helgi Valdimarsson1

1Department of Immunology, 2Department of Dermatology, Landspitali University Hospital, Reykjavik, Iceland, 3Department of Dermatology, University of Michigan, USA, 4Department of ENT, Landspitali University Hospital, Reykjavik, Iceland

Background: Streptococcal throat infections are associated with the onset and exacerbation of psoriasis. A number of uncontrolled studies have shown the benefit of tonsillectomy in patients with psoriasis. The aim of this study is to determine whether tonsillectomy could be an effective treatment option...
for patients with chronic plaque psoriasis and to investigate the potential role of tonsillar T cells in psoriasis.

Methods: 40 patients will be recruited into an observer blinded randomized controlled study and half of the patients will undergo tonsillectomy. They will be examined every 2 months for 2 years and their skin disease monitored clinically by PASI score. In addition, a number of immunologic tests will be performed on blood and tonsillar T cells using flowcytometry and luminex techniques.

Results: At this stage 21 patients have been participating in the trial for at least 2 months. Preliminary results indicate an average decrease of 42% in PASI score for the tonsillectomized patients (n=13) compared to an average decrease of 1% in the control group (n=8). Additionally there seem to be tonsillectomy associated changes in the responses of blood T cells to streptococcal M-protein and keratin peptides that share amino acid sequences.

Conclusion: These preliminary results suggest that tonsillectomy may have beneficial effect on moderate to severe chronic plaque psoriasis, and that this effect may be associated with changes in T-cell responses to peptides postulated to be autoantigens in psoriasis.

PS07.2
Science Meets Nature: Why do Psoriasis Patients Benefit from Bathing in the Blue Lagoon?
Jean Krutmann
Institut für Umweltmedizinische Forschung an der Heinrich-Heine-Universität Düsseldorf GmbH, Düsseldorf, Germany

Bathing in the Blue Lagoon, a specific geothermal biotope in Iceland, has been known for many years to be beneficial for human skin in general and for patients with psoriasis and atopic dermatitis in particular. The scientific rational for this empirical observation, however, has remained elusive. We now report that extracts prepared from silica mud and two different microalgal species derived from the Blue Lagoon are capable of inducing involucrin, loricrin, transglutaminase-1 and filaggrin gene expression in primary human epidermal keratinocytes. The same extracts also affected primary human dermal fibroblasts, because extracts from silica mud and one type of algae inhibited UVA radiation-induced upregulation of matrix metalloproteinase-1 expression, and both algae, as well as silica mud extracts induced collagen 1A1 and 1A2 gene expression in this cell type. These effects were not restricted to the in vitro situation because topical treatment of healthy human skin (n=20) with a galenic formulation containing all three extracts induced identical gene regulatory effects in vivo, which were associated with a significant reduction of transepidermal water loss. In aggregate these results suggest that the Blue Lagoon contains biological activities which have the capacity to improve skin barrier function and to prevent premature skin aging. These observations explain at least some of the beneficial effects of bathing in the Blue Lagoon and provide a scientific basis for the use of Blue Lagoon extracts in cosmetic and/or medical products.

PS07.3
Economic Burden of Psoriasis
Olle Larkö
Department of Dermatology and Venereology, Sahlgrenska Academy, University of Gothenburg, Gothenburg, Sweden

Psoriasis is a chronic disease often starting before the age of 25. Patients may undergo different types of treatment for decades. The economic burden to society can be substantial. It has been shown that patients with arthritis are the costliest as sick leave is often necessary. Drug treatment constitutes for a minor part of the total cost to society. Methotrexate is probably the cheapest treatment for moderate to severe psoriasis. UVB is also a cheap alternative, although travel distances may be limiting. Home solarium therapy was described decades ago but has not become very popular. Education of patients to deal with their own disease is very important. Newer biologic therapeutic modalities seem extremely expensive but still constitutes a minor part of the total cost.

PS07.4
The Use of PDI in Measuring Quality of Life in Patients at the Blue Lagoon Clinic
Steingrimur Davidsson
Department of Dermatology, University Hospital Reykjavík, IS-105 Reykjavík, Iceland

This lecture will report the use of PDI (Psoriasis Disability Index) in measuring the quality of life in psoriasis patients attending the Blue Lagoon clinic. Eighty-three patients were asked to answer the questions before the treatment, 4 weeks after the start and finally 12 weeks after starting therapy. Forty-two patients answered all 3 forms, 16 who answered the first 2 forms and 25 patients only answered the first questionnaire. The results will be presented in the lecture.

Dermatology and Policies of Administration

The subject of the meeting

At keynote lectures on dermatological conferences the good quality and importance of the dermatological speciality are emphasised and colleagues are encouraged to further its repu-
Parallel Sessions

PS08.1
Current Issues in American Academic Dermatology
Evan Farmer

The issues and trends facing American academic dermatology in the context of American healthcare delivery will be presented and discussed at this symposium.

PS08.2
Skin Cancer in the UK – Can UK Government Driven Models of Working have Application Elsewhere?
Fenella Wojnarowska

The UK has for 10 years had an evolving model of cancer networks. A skin cancer network will serve an area of 1–5 million people and will include a University and local (district general) hospitals. There is a network cancer lead, and the members consist of dermatologists, plastic surgeons, radiotherapists, oncologists, other surgical specialties that do skin cancer work, histopathologists, nurses, a user (skin cancer patient) and network representatives. The local network agrees treatment protocols and patient information, and shares working practices. The UK government has had a programme to improve cancer outcomes in the UK, and has produced an Improving Outcomes Guidance for Skin Cancers. This lays down standards of care that must be met. A major change has been very clearly defined levels of care between GPs, who can treat only BCCs, and local and specialist hospitals. In addition all complex BCCs, all SCCS and melanomas must be reviewed at regular (1 or 2 weekly) Multidisciplinary Team meetings of dermatologists, plastic surgeons, radiotherapists, oncologists, histopathologists, and specialist skin cancer nurses for review, there is usually only one per network. The Cancer networks are responsible for initiating these procedures and documenting and overseeing them. They are subject to peer review at intervals of 5 years, and failure to meet standards in theory means they cannot treat cancer.

PS08.3
Dermatology and Policies of Administration
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Dermato-venereology has undergone big changes in recent years. The number of beds has been reduced dramatically, in some instances to 10% of the former level. In certain parts of, at least Sweden, a dermatologist is no longer in charge of the unit. This poses special problems of running and administrating clinics and research. Also, the academic staff has lost influence in running dermatology departments. Consequently, we may have trouble in the future to defend some areas of the specialty. The very basis for dermato-venereology relies on research and academic work. If this is obliterated we may run into difficulties in the future. In my opinion, at least university clinics should be reasonably EU-compatible, handling both training and patient care for the entire spectrum of dermato-venereological problems. Unfortunately, patient care and training of young colleagues has quality problems in certain areas of the Nordic countries. This refers specially to skin cancer care, histopathology and advanced venereology. The financial system differs somewhat between countries but also within a country. Overall, it gives us a reasonable freedom to act.

Skin and Malignancies

PS09.1
Parapsoriasis – Inflammatory Disorder or Cutaneous T-cell Lymphoma?
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Although described more than 100 years ago, there is a considerable debate on the terminology and nosologic relation of parapsoriasis (PPS) to MF. Based on clinical features, two main forms of parapsoriasis can be distinguished. Small-plaque parapsoriasis (SPP) (synonyms: digitate dermatosis, chronic superficial dermatitis) is characterized by oval or digitate patches, 2 to 6 cm in diameter, preferentially located on the lateral parts of the trunk and showing a reddish or yellowish surface with...
pseudoatrophic wrinkling and slight pityriasisiform scaling. In large-plaque parapsoriasis (LPP) (synonym: parapsoriasis en grandes plaques), relatively few large (>10 cm in diameter), irregularly shaped, reddish and fairly well demarcated lesions with pityriasisiform scaling are located on the trunk and/or extremities. Histologically, the epidermis shows slight acanthosis with patchy parakeratosis. Scant perivascular infiltrates of small lymphocytes may be seen in the upper dermis, with or without subtle single-cell epidermotropism. In general a few eosinophils are present, but plasma cells are not observed. Phenotypically, the infiltrate in SPP and LPP is mainly composed of CD4+, CD8-, and CD45RO+ T cells intermingled with a few CD8+ cells. Clonal rearrangement of T-cell receptor genes is found occasionally in SPP and LPP. The major differential diagnosis of SPP and LPP includes early-stage MF and chronic eczema, which on histologic grounds alone usually cannot be distinguished. Additional information including clinical presentation and course of the disease are needed for the diagnosis. However, in some cases only the stable course of the condition without progression allows one to differentiate SPP from MF retrospectively. The prognosis of SPP is exceptionally good without any influence on survival. Fatal outcome of SPP has so far not been reported. A subset of patients with LPP, however, shows progression of LPP to overt MF. Thus some authors including ourselves consider LPP as variant of MF with usually very slowly progressive course potential for progression to MF. In contrast to LPP, in our experience SPP behaves biologically like a chronic benign inflammatory disorder. To our opinion, SPP does not represent a precursor of MF.

References:

PS09.2
Squamous Cell Carcinoma in Venous Leg Ulcers
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A cohort from the Swedish In-patient Registry with 10,913 patients with the diagnosis venous ulcer was matched with the Swedish Cancer registry. This search resulted in 23 cases of squamous cell carcinoma (SCC), of which 17 were considered certainly secondary to venous ulcers. This gave a significantly increased relative risk (RR= 5.8; 95% CI 3.1–9.3), of getting SCC in a venous ulcer. The conclusion is that SCC is indeed a complication of venous leg ulcers and the risk is approximately fivefold compared to the general population of Sweden.

A study of the case histories and histological slides of 25 patients with SCC in venous ulcers gave the following results: Twenty-three of the patients were dead. The mean age at cancer diagnosis was 78.5 years, and the median duration of the ulcer before diagnosis of SCC was 25 years. All patients who had a poorly differentiated SCC died within a year from diagnosis. Survival was significantly shorter (p = 0.008) than in the control group with squamous cell carcinoma on the lower limb. Thus, this complication is lethal in many cases, and there should be no hesitation to biopsy unusual or prolonged cases of venous ulcers. Studies on histopathological blocks for the presence of human papillomavirus (HPV) as well as on control samples from chronic venous ulcers without cancer revealed no HPV whereas 10 of the ulcer samples were positive. Indeed the difference in positivity between the ulcers and the SCCs was statistically significant (p = 0.01). Immunohistochemistry studies for expression of p21WAF1/CIP1 (p21), p53, bcl-2 and Ki-67 showed no expression of p21, p53 or bcl-2 in the venous ulcer samples and no expression of bcl-2 in any of the samples. 22 SCC samples were positive for p21 and 15 for p53. The absence of p53 expression in the ulcers and adjacent to the SCCs probably reflects the non-UV carcinogenic mechanism of these cancers which places them in a somewhat unique position amongst SCCs, most of which are p53 positive.

PS09.3
Genital Precancerous Lesions and Treatment Modalities
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The term VIN and PIN correspond to a histological anglo-saxon definition. They represent intra-epithelial neoplasia which can progress to squamous cell carcinoma. Penile intraepithelial neoplasia (PIN) is a precancerous lesion of the penile epithelium. In younger men Bowenoid papulosis often has a generally benign course. Middle-aged and elderly patients often present solitary PIN lesions with an increased risk of progression to SCC. The management of PIN lesions has proven to be difficult and recurrences are frequent. There are many different treatment modalities such as; local excision, Mohs micrographic surgery, topical 5-fluorouracil, cryo surgery, CO2 laser, electrocoagulation, interferon and imiquimod. The cure rates vary. Photodynamic therapy has evolved as a new therapy for PIN.
PS09.4
The Epidemiology of Skin Cancer in Organ Transplant Recipients

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Organ transplant recipients (OTR) are at increased risk of having both cutaneous and systemic cancer develop. Since 1971, many papers concerning cancer in OTR, most of them including skin cancers, have been published but very few of them have been population-based and the figures on incidence and risks must be interpreted with caution. The overall increased risk for any type of cancer in OTR has been estimated to be four-fold greater than that in the general population. The most common post-transplantation cancers in a Western population include non-melanoma skin cancer, lip cancer, non-Hodgkin’s lymphoma, the vulva, vagina, oral cavity and anal cancer. The standardized incidence ratios (SIRs) of skin cancer are greatly increased in different studies. The most frequently encountered skin cancers in OTR are squamous cell carcinoma (SCC) (SIRs: 18–253). They are also believed to be more aggressive with a higher risk of metastasis than in the general population. Other unusual features are the young age of the patients and the high incidence of multiple tumors. Approximately 30–50% of the OTR with SCC also have basal cell carcinoma (BCC) (SIR: 10). Existing studies are not in full agreement over whether OTR have an increased risk of malignant melanoma, (SIRs: 18–253). They are also believed to be more aggressive with a higher risk of metastasis than in the general population. Other unusual features are the young age of the patients and the high incidence of multiple tumors. Approximately 30–50% of the OTR with SCC also have basal cell carcinoma (BCC) (SIR: 10). Existing studies are not in full agreement over whether OTR have an increased risk of malignant melanoma, while the incidence is affected by allograft type, geographic location, and duration after the transplant. Few studies have reported figures on mortality but it has been reported that the risk of death caused by SCC in OTR is much increased (standardized mortality ratio SMR: 52).

Contact Dermatitis

PS10.1
Detection of Contact Allergy by Interleukins in Patch Test Blisters

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Objective: To investigate whether interleukins in blisters formed at patch-test sites can be used as markers of the grade of contact allergy.

Methods: Recently patch-tested volunteers with and without allergy to nickel sulfate were retested with 5 nickel sulfate patch tests and 5 control tests. 48 h later, the tests were removed and the perfusion of the test sites was assessed with a laser Doppler perfusion imaging (LDPI) technique. Then, suction blisters were made at the test sites. Blister fluids were collected separately from the allergen test sites and the control test sites.

Results: The patch test results prior to the study and in current study, and the results with the LDPI helped to distinguish between subjects with and without allergy to nickel sulfate. The concentration of one of the interleukins was high in the blister fluid from the nickel-test sites in all of the allergic subjects while the concentration was not detectable or low in fluid from the control sites and in fluid both from the nickel and the control sites in subjects without nickel allergy.

Conclusion: Immunological factors in fluid from blisters at patch test sites may be important for the detection of contact allergy.

Acknowledgement: Icelandic Research Council.

PS10.2
Characteristics of Disease in Patients with Multiple Contact Allergies

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Background: It is generally believed that multiple-allergic individuals (multiple contact allergies = 3 or more contact allergies) have widespread, long-lasting and hard-to-treat eczema but has never been the objective of any study.

Objective: To describe characteristics of disease in multiple-allergic individuals.

Patients/Methods: Questionnaire case-control study. 562 multiple-allergic individuals patch-tested at a hospital dermatology department between 1985 and 2005 were matched 1:2 on age, sex and time of patch test with mono/double-allergic individuals. In total, 1686 individuals were included.

Results: Collection of questionnaires is in the final stage and keying is currently done. The results presented are preliminary and based on the first 500 replies (36.2% had multiple contact allergies) keyed in at time of abstract submission. 91.7% multiple-allergic and 83.6% mono/double-allergic individuals had eczema ($\chi^2$, p = 0.03). A larger part of the multiple-allergic versus the mono/double-allergic group had atopic dermatitis ($\chi^2$, p = 0.008), had received UV treatment ($\chi^2$, p = 0.012) and...
had been treated with oral prednisolone ($\chi^2$, $p=0.008$). No difference was found between the two groups regarding immunosuppressive drug treatment. No overrepresentation of leg ulcer patients was found in the multiple-allergic group. More multiple-allergic than mono/double-allergic individuals reported hand eczema ($\chi^2$, $p<0.01$) and eczema on the arms excluding armpits and elbow flexure ($\chi^2$, $p=0.033$) at eczema debut. The frequency of eczema on any other body location at eczema debut did not differ between the two groups.

Conclusions: Unique data on characteristic features of disease in multiple-allergic patients are presented.

**PS10.3**

Screening for Acrylate/Methacrylate Allergy in the Baseline Series

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Background: No studies to specifically determine the prevalence of contact allergy to acrylate/methacrylate in patch-tested populations have been published.

Objectives: To determine the prevalence of acrylate/meth acrylate allergy in all patients tested to the baseline series.

Methods: 5 acrylate/methacrylate allergens [2-hydroxyethyl methacrylate (2-HEMA), methyl methacrylate (MMA), ethyl-eneglycol dimethacrylate (EGDMA), triethyleneglycol diacrylate (TREGDA) and 2-hydroxypropyl acrylate (2-HPA)] were included in the baseline series for at least 2 years in Malmö and Singapore.

Results: 38 patients in total had reacted to acrylate/methyl acrylate allergens in the baseline series during the study period in both populations. The overall ranking in number of positive reactions was: 2-HEMA, TREGDA, EGDMA, 2-HPA, MMA. In Malmö, there were 26 (1.4%) patients with positive patch tests to acrylate/methacrylate allergens. The positive reactions in the baseline series, in order of frequency, were: 2-HEMA, TREGDA, 2-HPA, EGDMA, MMA. In Singapore, there were 12 (1.0%) patients with positive patch tests to acrylate/methyl acrylate allergens. The positive reactions in the baseline series, in order of frequency, were: TREGDA, EGDMA, 2-HEMA.

Conclusions: The prevalence of acrylate/methacrylate allergy in our patch-tested dermatitis populations is 1.4% in Malmö and 1.0% in Singapore.

**PS10.4**

Low Test Volume for Patch Test Standardization

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Objectives: Patch tests have not been optimized. We introduce low test volume for patch test standardization avoiding irritant false positive tests. We investigate whether the laser Doppler perfusion imaging technique (LDPIT) can be used to assess test substance coverage of patch test sites by experiments with a specific test technique using low test volume and 8 mm Finn Chambers®.

Patients/Methods: Tests with methylene blue in petrolatum were applied for 48 h on subjects. The test substance coverage at the test sites was investigated with the LDPIT.

Results: The LDPIT allowed assessment of the test substance coverage. A 4 µl volume with the specific test technique yielded 86% median coverage. Earlier investigations with subjective visual assessments suggest 24 µl to be required but 12 µl to be insufficient and spread the test substance outside the test sites that may affect test results.

Conclusions: The LDPIT allows assessment of test sites’ coverage by a test substance. The low volume of 4 µl should be used to standardise tests with the specific test technique. Optimal concentration of each test allergen should then be adjusted for optimal test sensitivity and specificity.

**PS10.5**

Contact Allergy to Aluminium

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Aluminium and aluminium compounds are ubiquitous. Until recently, few cases of contact allergy to aluminium and allergic contact dermatitis from aluminium have been reported. Aluminium is considered a weak contact allergen. Occupational contact dermatitis due to aluminium exposure has been reported in aluminium production and in air craft manufacture. Water-soluble aluminium salts in antiperspirants may cause axillary dermatitis and systemic aluminium contact dermatitis from tooth paste has been reported. The last years hundreds of children and adolescents with contact allergy to aluminium have been reported from the Gothenburg area in Sweden. All these individuals have been vaccinated with aluminium-
absorbed pertussis vaccines. Aluminium hydroxide is used as an adjuvant in injection preparations for hyposensitization therapy. Similarly to the mentioned pertussis vaccination this administration of aluminium seems to constitute a significant risk of sensitization to aluminium. To trace contact allergy to aluminium, an empty Finn Chamber and aluminium chloride hexahydrate at 2% in petrolatum have been recommended.

PS10.6
Comparison Between Two Different Fragrance Mix Test Systems
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A paired comparison of patch tests using Fragrance Mix True Test and Fragrance Mix Hermal was conducted from January 2002 to January 2008 at the dept. of dermatology, Odense University Hospital. Both systems contain the same allergens, at different concentrations and different vehicles: True Test contains 0.43 mg/cm² fragrance mix in hydroxypropyl cellulose and β-cyclodextrin whereas Hermal contains 8% fragrance mix in petrolatum and sorbitan sesquioleate as an emulsifier. True Test is a completely standardized ready to use system, where as the Hermal system requires manual application of the allergen in question on Finn Chambers on Scanpor. A total of 2755 patients were patch-tested with both allergen systems over a 6-year period. According to our preliminary data 123/2755 (4.5%) reactions were positive and 259/2755 (9.4%) were questionable using the True Test mixture. When using the Hermal mixture 250/2755 (9.1%) reactions were positive and 773/2755 (28%) were questionable. The two different fragrance mixes apparently differ so much in allergen concentration that they can be used as endpoints in a dilution series, True Test Fragrance Mix being the weaker of the two. It can be speculated that one test system is too weak whereas the other is too potent. Data analysis is still ongoing.

PS10.7
Adverse Reactions to Dental Materials: Reporting and Cases
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The Norwegian Dental Biomaterials Adverse Reaction Unit has three main objectives: Recording of adverse reaction reports from dentists and physicians, clinical examination of referred patients, and to provide information about adverse reactions to dental materials. The Unit consists of four part-time clinical positions (three dentists and one physician), an executive officer and a leader. From the start in 1993 to the end of 2005, a total of 1479 reports regarding adverse reactions in patients were received. Of these, 630 were also referred to the Unit and examined. The most common reason for referral was health complaints or clinical signs allegedly related to amalgam (72% of the referrals). Amalgam was also the most frequent material involved in the adverse reaction reports. After the clinical examination and additional allergy test to dental materials (e.g. “Dental Screening” series) when needed, it was found that 211 of 398 tested patients (53%) were positive to at least one substance in the test series. The most frequent substances with positive patch test reaction were nickel sulfate (32%), goldsodiumthiosulphate (28%), cobalt chloride (18%) and palladium chloride (14%). A majority of the patients with positive allergy test were given recommendations related to this finding – either removal of restorations (if the allergy test was found to be of clinical relevance) or avoiding the substance in the future. Three cases are presented and discussed: Cases with clinical relevant allergy to (i) gold, (ii) mercury, and (iii) two dental acrylates (EGDMA, 2-HEMA). In addition the advantage of an adverse reaction registry will be discussed in the light of possible associations between exposure to dental materials and prevalence of disease. Additional information is found at the web-pages of the Dental Biomaterials Adverse Reaction Unit (http://www.uib.no/bivirkningsgrupperen).

PS10.8
Allergic Contact Dermatitis to Topically Applied Metronidazole in Two Nurses
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Contact dermatitis to topically applied metronidazole is a rare side effect, especially considering the large number of patients using it on a daily basis. Only 5 cases are published so far.

Two female patients with rosacea developed facial dermatitis after a few days use of topical metronidazole. They had never used topical metronidazole before. The rapid onset of contact dermatitis to topically applied metronidazole made us consider if sensitization developed prior to the roacea treatment. Both were nurses and one of them had previously been frequently exposed to metronidazole professionally by administering metronidazole intravenously to patients at a time when protective gloves were not used routinely.
Venereology in Scandinavia

PS11.1 Infectious Causes of Human Cancer

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During the past two decades a number of infectious agents have been linked to human carcinogenesis. They include various members of different virus families, but also bacterial and parasitic infections. The global incidence of cancers resulting from these infections is presently estimated within a range of 20–21%. The percentage varies widely between developed and developing parts of the world, reaching close to 40% in specific regions, like sub-saharan Africa. The available knowledge of infectious events linked to human cancer development should provide us with novel approaches to prevent specific cancers by vaccination. Vaccines against Hepatitis B virus have been shown to prevent persisting Hepatitis B virus infections, and thus remove one of the prime risk factors for hepato-cellular carcinomas. They emerge as the first successful vaccine against an important human cancer. Presently a larger number of clinical trials against ‘high-risk’ human papillomavirus (HPV)-types (mainly against HPV16 and 18) provide promising results. The present state of these vaccines in the prevention of cervical pre-malignant lesions and cervical cancer will be reviewed. Various approaches and vaccination protocols will be summarized. Successful vaccination against these papillomavirus infections has the potential to drastically reduce the risk for cervical cancer which is still in several parts of the world the most common cancer of women. Global vaccination programs against Hepatitis B and high-risk HPV infections, if applied to all populations world-wide, could theoretically reduce the cancer risk for women by 15%, for males by approximately 7%.

PS11.2 Mycoplasma Genitalium – 15 Years Experience

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Today Mycoplasma genitalium (Mg) is a well established pathogen in NCNGU (non chlamydial non gonococcal urethritis). Mg as a cause of salpingitis and infertility is almost proven, less information is available about it’s role in arthritis, epididymitis and prostatitis. Commercial nucleic acid amplification tests are still not available. Azitromycin is the drug of choice for treatment although adequate dosage is essential to prevent development of resistance.

PS11.3 Syphilis in Baltic: Epidemiology, Clinic, Therapy and Prevention – an Update

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Syphilis diagnostics, therapy and prevention are still the problems in many countries of the world. Therapy after the discovery of penicillin has been under control, yet, the incidence of the disease in separate periods of time in different regions of the world and countries has been unsteady. Thus, in the middle of the 90s, the morbidity of the disease in the Eastern and Central European countries (Baltic, Russia, Ukraine, etc.) was very high, 100–250 cases per 100,000 population, while in the Western European countries (Germany, France, England, Holland, etc.) and the USA, the incidence ranged from 2–10 cases per 100,000 population.

Syphilis incidence in Europe has decreased the last years, and it is 1–3 (W-Europe) till 30 cases per 100,000 population, respectively (East and Central Europe). In Latvia 33.1, 20.7 and 12.9 in 2003, 2006 and 2007, respectively. Syphilis in the Western world is more confined to males who have sex with males, while in the Eastern world, it is heterosexual and high in pregnant women in the developing countries. However, a new problem arises, since in many countries, especially (Latvia, Ukraine, etc.), in about 50% cases (in Latvia 58% in 2007), a latent syphilis is seen to appear without any clinical signs, which can be diagnosed only by means of serological methods, which is an evidence for insufficient early diagnostics and prevention, etc.

In many countries CDC or IUSTI/WHO European Syphilis Guidelines are used, which in some countries are slightly modified. The main therapy is still being the penicillin group medications (Benzathine penicillin, procaine penicillin) of various treatment doses for respective syphilis clinical forms and stages, as well as special doses for pregnant women and children. Laboratory confirmed zyphilis reporting is playing a central role in modern syphilis surveillance. Questions will deal with the possibilities to use different methods of treatment in cases of penicillin intolerance cases.

Conclusion: Syphilis morbidity remains to be on a relatively high level in Baltic, especially in Latvia. In order to make syphilis diagnostics, therapy, disease prevention and the decrease of morbidity, it is important to introduce and use a unified IUSTI/WHO Guidelines for syphilis, which would regulate a unified diagnostics of this disease, its therapy and prevention, as well as widely applying serodiagnostics in all the necessary, suspicious or unclear cases.
Melanoma Update

**PS12.1**

**Genome-wide SNP Association Studies of Pigmentation Traits and Melanoma Risk**

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New, massively parallel SNP genotyping technologies make possible the simultaneous analysis of representative SNPs covering the entire human genome in a single DNA sample. This permits high resolution, whole genome case-control association analyses to be conducted without a requirement for preconceived notions of possible candidate regions. Using Illumina Human Hap300 and CNV-duo 370 microarrays, each capable of genotyping over 300,000 SNPs, we carried out a genome-wide association scan for SNPs associated with natural variation in pigmentation traits such as eye colour, hair colour, propensity to freckle and tanning responses. We identified numerous variants that are associated with these traits, some previously known and others novel, including variants near MC1R, OCA2, KITLG, TYR and SLC24A2 genes. Because certain pigmentation traits are known risk factors for skin cancer, we are testing a number of pigmentation trait-associated variants for potential involvement in predisposition to melanoma and basal cell carcinoma. Recent progress will be presented.

**PS12.2**

**Melanoma and Dysplastic Nevi in Icelandic Air Crew Members. The Importance of Screening**

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Introduction: Incidence of melanoma is higher in pilots and other air crew members than the general population according to recent studies. Ionizing radiation of cosmic origin is a possible explanation. Sun exposure has not been shown to be more common in this group. Organized screening of aircrew members could be of value in detecting skin cancers in this group. In this study we present the results of screening for skin tumours in Icelandic pilots over the years 2001–2005.

Materials and methods: From the year 2001 The Icelandic AirLine Pilots Association has offered their members annual screening for skin tumours. Each pilot was screened clinically by a dermatologist. Computerized dermatoscopy was performed if significant pigmented lesions were found. We are presenting the data collected from this screening.

Results: 376 out of 503 pilots in this group were screened. The screening visits were 497. There were 368 lesions removed from 141 pilots. Dysplastic changes were found in 64 lesions from 42 pilots. Seven cases of malignancy in 6 pilots were detected. One case of superficial spreading melanoma, one case of lentigo maligna, two cases of basal cell carcinoma and three cases of squamous cell carcinoma in situ.

Conclusions: 1) Incidence of dysplasia needs to be assessed by comparison to the general population or another cohort. 2) In order to evaluate the efficacy of screening pilots for skin cancer it is important to continue to follow this group with dermatological examination.

**PS12.3**

**Sunbed Usage in Iceland**

Porgeir Sigurdsson

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The incidence of melanoma has increased rapidly in Iceland, especially among young women. Sunbed usage is by many considered a risk factor for melanoma and this increase could possibly be linked together. Reliable quantitative information on Icelandic sunbed usage is incomplete but in this paper the available data is presented and discussed. The data comes primarily from two unpublished sunbed surveys done in 1988 and 2005 both showing a large number of sunbeds per capita with a new survey planned in 2008. In 1988 more than 1.5 sunbeds were found per 1000 inhabitants in the Reykjavik area. About half of these were in dedicated tanning salons, most of the remaining were in gyms and fitness centers. In the survey from 2005 more than one sunbed per 1000 inhabitants were listed outside the Reykjavik area. The findings of the two surveys are compared to information obtained in yearly telephone polls on sunbed usage that have been conducted since 2004. Each survey included more than 1350 persons randomly selected from the national registry. The average number of tanning sessions per person, per year is estimated during the last 20
years to be at least 2–3. The conclusion is drawn that sunbed usage in Iceland has probably been greater than in Sweden and the UK and that a link to the observed increase in melanoma is indeed possible. The data have been collected by the Icelandic Radiation Protection Institute in co-operation with the Environment and Food Agency, Capacent Gallup in Iceland, Icelandic dermatologists and the Cancer society.

PS12.4
Removal of Nevi as Prophylaxis for Melanoma. A Cost-benefit Analysis
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Large amounts of nevi are removed yearly in Sweden as prophylaxis or because they resemble malignant melanoma. We attempted to estimate the annual cost and if this measure has had any effect on the incidence of malignant melanoma. We received computerized data on diagnosed nevi, dysplastic nevi and malignant melanomas from all pathological laboratories in the Stockholm area (1.8 million inhabitants). The figures were then extrapolated to the whole Swedish population.

In Sweden approx. 154 900 nevi were removed in 2000 and approx. 133 000 in 2005. The cost in 2005 was estimated to be 287–318 million Swedish crowns (30.4–33.7 million Euros). During the studied 6 year period, the number of excised nevi decreased with 14% and the number of malignant melanomas increased with 33%. Therefore, the increase of malignant melanomas can be partly explained by the decreased nevi removal. Furthermore the number of removed nevi per removed malignant melanoma was much lower for dermatologists than for general practitioners. Dermatologists were also much more efficient in removing dysplastic nevi.

PS12.5
Exposure to Artificial UV Radiation and Skin Cancer
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Most artificial tanning devices carry a cancer risk comparable to Mediterranean sunlight. Experiments in human volunteers conducted during the last decade have shown that commercial tanning lamps produce the types of DNA damage associated with exposure to the solar spectrum.

In 2005, the IARC convened a Working Group of international experts on skin cancer and UV radiation in order to perform a systematic review of the potential association between sunbed use and skin cancer. The Working Group undertook a series of actions including a meta-analysis of the available twenty-three published studies (22 case-control, one cohort) in light-skinned populations which investigated the association between indoor tanning use and melanoma risk. The summary relative risk for ever versus never use of indoor tanning facilities from 19 informative studies was 1.14 (95% Confidence Interval (CI): 1.00–1.31). When the analysis was restricted to the nine population-based case-control studies and the cohort study, the summary relative risk was 1.17 (95% CI: 0.96–1.42). The Working Group identified 7 epidemiological studies that assessed the melanoma risk associated with sunbed use according to age. All these studies found melanoma risks ranging from 1.4 to 3.8 with sunbed use starting during adolescence or during young adulthood. The meta-analysis performed by the IARC Working Group using published results of these seven studies found an overall increase in the risk of melanoma of 75% (summary relative risk: 1.75, 95% CI: 1.35–2.26) when sunbed use started before 35 years of age. Studies on exposure to indoor tanning appliances and squamous cell carcinoma found some evidence for an increased risk for squamous cell carcinoma, especially when age at first use was below 20 years.

Long latency periods may be expected between sunbed exposure and skin cancer, and therefore the real magnitude of the association may not yet be detectable. A considerable body of experimental and epidemiological knowledge support the hypothesis that exposure during childhood and adolescence are the most crucial periods of life for the initiation of biological phenomenon involved in the genesis of melanoma that will usually be diagnosed during adulthood.

In conclusion, it would be logical to recommend avoidance of sunbed use before 30 years old.

PS12.6
Is Sunlight Beneficial and are Dermatologists too Narrow-sighted?
Olle Larkö
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Sunlight is the most common cause of skin cancer. The association is strongest for squamous cell carcinoma but basal cell carcinomas and malignant melanoma are also considered to be sun-related. The current recommendations for protection include clothes, staying out of the sun during noontime, seeking shade and the use of sunscreens.
Photodermatology and Photoprotection

PS13.1

Photoprotection is More Than Just Sunscreen

Elisabeth Thieden
Bispebjerg Hospital, Copenhagen, Denmark.

We have investigated the sun exposure behaviour among subgroups of the Danish population: children, adolescents, indoor workers, sun worshippers, golfers and gardeners (age range, 4–68 years). The subjects recorded sun exposure behaviour including sunscreen use and sunburn in diaries and carried personal, electronic UV dosimeters, measuring timestamped UV doses continuously in median 119 days covering total 39068 days and 346 sun-years (one subject participating in one summer-half-year). There were great variations in sunscreen use, which was highly correlated to risk behaviour (sunbathing/exposing upper body) \( r = 0.39; p < 0.01 \). Sunscreens were used in median 5 days per sun-year and 10% females and 41% males never used sunscreens. Females used sunscreens more but had also more unprotected risk behaviour than males (8 days vs. 4 days, \( p < 0.001 \)). Sunscreen use was not correlated to age and children had as much unprotected risk behaviour as adults. Sunscreens were used 86% of the days with risk behaviour in Southern Europe vs. 20% in Northern Europe (\( p < 0.001 \)). The UV doses were significantly higher on days with sunscreen (\( p < 0.03 \)) and on sunburn days (\( p < 0.001 \)). Since sunscreens are used so irregularly, reducing the UV dose to below the erythema level could be a better sun protection. UV dose = UV-intensity \( \times \) exposure duration. Therefore sun exposure should be avoided when the UV intensity is high such as between 12–15, at midsummer or in Southern countries. Or the exposure time reduced by having breaks indoor or in the shade of a tree or parasols which corresponds to sun protection factor, SPF 8–10. If sunbathing or having long-term outdoor activities at risk hours, sunscreen is recommended.

PS13.2

Variables in UVB Treatment of Skin Diseases

Hans Christian Wulf
Bispebjerg Hospital, Copenhagen.

Phototherapy is very commonly used in the treatment of skin diseases like eczema, psoriasis and vitiligo. UV treatment is very commonly dosed according to a fixed scheme and frequently without any measurement of light intensity or consideration about skin type. The most important variables are long-term variation in the intensity emitted by the light source, which can change by a factor 3 from the tubes are new to the intensity after 5–600 accumulated burning hours. To control this regular measurement of light intensity is needed. Another variable factor is the type of UV source. The most common UVB cabins for full body treatment are equipped with narrowband UVB tubes (Philips TL01), broadband UVB tubes (Philips TL12), or broadband UV6 tubes (Waldmann). When the same physical dose is given by these three sources, the biological effect (erythema) will vary with a factor of 4–5, and therefore the dose or time must be regulated accordingly to avoid burning of the skin. This is often done by gut-feeling, but measurement of the intensity in biological units should be performed. The third important variable is skin type. The most sensitive persons can tolerate 1 SED (standard erythema dose) before showing erythema of the skin and the most UV robust Caucasian may tolerate about 10 SED before eliciting erythema. It is therefore important to take skin type into consideration. Fitzpatrick’s skin type is most commonly used but also very unreliable. It would be preferable to make a MED test before treatment or to measure skin type by remittance spectroscopy, which can be performed in a few seconds. Because of these variables it is not recommendable to use time or Joule as dosing units. It is recommendable to use biological units, MED or even better MED, as the limit for the maximal exposure dose is erythema of the skin.

PS13.3

Home UVB Phototherapy is Effective, Safe and Greatly Appreciated. A Randomized Comparison of Home and Outpatient UVB Treatment for Psoriasis: The PLUTO study

MBG Koek, E Buskens, H van Weelden, PHA Steegmans, CAFM Bruinzeel-Koomen and Vigfus Sigurdsson

UMC Utrecht, The Netherlands

Context: No randomized studies comparing home and outpatient ultraviolet B (UVB) phototherapy for psoriasis have
Previously been conducted. Despite ongoing debate regarding treatment results and safety, home UVB treatment is being increasingly prescribed. The scarce literature and guidelines suggest being prudent, but both patients and clinicians claim that home UVB phototherapy is associated with a lower burden of treatment and better quality of life.

**Objective:** To compare effectiveness, side effects, Quality of Life (QoL), Burden of Treatment (BoT) and patient satisfaction of home and outpatient UVB phototherapy.

**Design, setting, and patients:** A pragmatic multicenter single-blind randomized clinical trial (the PLUTO-study) was conducted. From 2002 through 2005 we enrolled 196 patients with psoriasis who were clinically eligible for narrowband (TL-01) UVB phototherapy.

**Intervention:** Patients were randomly allocated to undergo either home UVB phototherapy or outpatient UVB phototherapy.

**Main outcome measures:** Improvement in the Psoriasis Area and Severity Index (PASI) and the Self-Administered PASI (SAPASI), QoL (36 item Short Form Health Survey, Psoriasis Disability Index), BoT (questionnaire), patient preferences and satisfaction (questionnaire), dosimetry and short-term side effects (diary).

**Results:** SAPASI and PASI scores decreased by 82% and 74%, respectively for patients treated at home versus 79% and 70% for patients treated in an outpatient setting, showing a significant treatment effect (\(p<0.000\)) similar across groups (\(p>0.52\)). Total cumulative doses of UVB and the occurrence of short-term side effects did not differ. The burden of undergoing UVB treatment was significantly lower for patients treated at home (\(p<0.001\)). QoL increased equally during therapy regardless of treatment group, but patients treated at home more often rated their experience with therapy as “excellent” than did patients treated in hospital (\(p=0.001\)).

**Conclusions:** Home UVB phototherapy compared to outpatient phototherapy is equally safe and effective, both clinically and in terms of quality of life. Furthermore, UVB treatment at home results in a lower burden of treatment and leads to greater patient satisfaction.

### Infotech, Telemedicine, Dermatological Websites

#### PS14.1

**Teledermatology on the Faroe Islands**

Gregor B. Jemec

Roskilde, Denmark

Many different teledermatological projects have been tested in the Nordic region. The department of Dermatology, Roskilde Hospital services the Faroe islands (pop. 45000) with dermatological expertise running a store-and-forward system integrated with a nurse led clinic. The experience from the first 5 years of routine treatment of 4000+ patients will be described.

#### PS14.2

**Teledermatological Videoconferences in Northern Norway, the Kirkenes Experience**

Dagfinn Moseng

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Teledermatological videoconferences were established between the university hospital in Tromsø and Kirkenes in Northern Norway, 900 km away, in the early nineties. This was thought of as a way of giving dermatological service to people living in the area, instead of having to use airborn travel to see a dermatologist. From 1993 we have done weekly consultation with patient and GP on one side and the specialist on the other, communicating by picture and sound. This should count for around 7000 patient visits, mainly routine, everyday dermatology. The clinic gives UV treatment for chronic diseases like psoriasis and eczemas. Trained nurses are giving dermatological treatments, baths, bandaging and testing. Quality of videoconferencing has gradually increased. In case of diagnostic doubts, we use ordinary visits (maybe 1 or 2 in 10). Comparisons Videoconference/Store-and-forward and Videoconference/Face-to-face has shown 90% identical or near identical diagnosis. About 20% of patients are considered unfit for this form: hearing problems, communication difficulties, disease localized to head/genitals, naevi. About 20% of patients are considered unfit for this form: hearing problems, communication difficulties, disease localized to head/genitals, naevi. Well suited for follow-up patients with established diagnosis undergoing treatment, on different medication. Patients mention nearness and availability as two key factors. They experience less waiting, earlier diagnosis, reduced stress, less use of time, cost and less sick-leave. For the specialist, this is a demanding form with a different role communicating both with the GP and the patient and also with the patient through the GP, who represents our prolonged arm.

Law: The Specialist is responsible, the GP also for his actions.

#### PS14.3

**A Critical Analysis of the Role of Telemedicine in Improving the Quality of Health Care Access in Alaska**

John H. Bocachica

Chief, Dermatology and Teledermatology, Asst Prof of Dermatology, Alaska Native Medical Center, Anchorage, Alaska U.S.A.
Alaska and other circumpolar communities face unique challenges in obtaining access to quality special health services including dermatology. The lack of connecting road systems in Alaska results in 75% of all of our communities and 25% of all our residents be unconnected by road to a hospital. These communities must depend on other modes of transport, such as playing, boats, and snow machine to access basic medical services. Alaska’s weather conditions are notoriously severe, making travel to medical facilities difficult or in many cases impossible. Travel costs engendered in transporting rural patients to urban medical centers can be prohibitive. Physicians and mid-level providers are scarce in Alaska and Canada’s rural and remote locations. In a recent poll, Alaska ranked 48th among the 50 states in the ratio of doctors to patients. To make matters worse, the vast majority of physicians in Alaska are concentrated in the state’s three urban areas with few providers located in the most rural areas of the state.

The rural native population of Alaska is most affected by the obstacles to specialty health care access, including dermatology, in their regions.

The advent of Teledermatology has proven to be a viable alternative to specialty health care access among these rural populations. Teledermatology has assured access to quality health care services via interactive and store and forward technologies.

**PS14.4**

An Internet-based Case-file System for Systematic Follow-up of Non Melanoma Skin Cancer

Lars Erik Bryld

Department of Dermatology, Roskilde Hospital Denmark

A systematic evaluation of the benefits claimed for new NMSC-treatments requires valid registration on treatment outcomes and comparable outcome data on existing treatments. Treatments must be compared with regards to efficacy, cosmetic result, and cost. The challenge is in a systematic and dependable way to keep track of a huge number of individual skin cancers in a number of patients who may be referred to and from a number of different health providers.

To that end, our department has been testing and developing an Internet-based case-file system aimed specifically at easing the task of doing systematic follow-up of treated NMSC. We have required a system, that should be used by ourselves as well as dermatologists in private practice, which was visually mappable, easy to use, safe in regards to privacy and the like, and – most importantly – quick.

Our current experience is encouraging, but newly evolved issues are now considered for correction. We need e.g. a way to correct entry errors without compromising accountability. The entry of multiple lesions, especially the simultaneous treatment of these is still a major annoyance, and the follow-up of multiple lesions, who did not show signs of recurring are other issues. Privacy safeguards and access controls are in full accordance with Danish legislative requirements and seems to us to be one of the minor issues, but our systems security standards might be considered too lenient for other jurisdictions. One of our main challenges is to maintain this system alongside our existing, and legally binding case file system. At present we have no working solutions to integrate the two systems, thereby forcing us to do parallel data entry.

Our current prototype will be demonstrated – life, if possible.

**PS14.5**

Exciting Website for Dermatologists: www.pdf.nu and www.ssdv.se

Thor Bleeker

Department of Dermatology, Lidköping, Sweden

The website for dermatologists in Sweden has existed for six years. To develop it was my idea, and I made a suggestion about it to the Swedish Association of Dermatologists in Private Practice (Privatpraktiserande Dermatologers Förening, PDF). In order to avoid economic hazards for the association, the decision was made to invite all members to contribute with capital in order to constitute a joint stock company.

More and more features have been added to the website in order to cover as much as possible on the subject of dermatology and make the site attractive to its members. The latest “blue doors” have been “Academy”, where we supply – and also plan to cover as much as possible on the subject of dermatology and make the site attractive to its members. The latest “blue doors” have been “Academy”, where we supply – and also plan for additional – web-based medical education. Another “blue door” is “What’s new?”, where Dr Håkan Mobacken frequently has presented summaries of news in the recent literature, which has been much esteemed among our members. Further features are waiting to be implemented.

About three years ago we could – free of charge – arrange a similar website for our dermatology colleagues in Finland (where Dr Jukka Juhela is responsible for the content) and in the autumn of 2007 a Norwegian website could also be launched (where dr Jon Langeland is responsible). The purpose is to link these sites together in order to finally be able to connect all dermatologists in the Nordic countries. Thus, in the future we hope to develop Danish and Icelandic sites as well.
Free Presentations

PS15.1
Ichthyosis, the Role of Conservative Eyelid Surgery!?  
Haraldur Sigurdsson, Gudleif Helgadottir and Baldur Tumi Baldursson  
Department of Ophthalmology and Department of Dermatology, Landspitalinn, University of Iceland, Iceland  

There are five types of ichthyosiform dermatoses. The most common one is lamellar ichthyosis (ichthyosis congenital), which is an autosomal recessive disease. The medical treatment is usually lubrication, exfoliations treatment, oral retinoid and artificial tear ointment around the eyes. The conventional surgical treatment has been skin grafting if there is a severe ectropion. We describe and show photos of 3 cases of congenital ichthyosis where a lid shortening and inverting sutures were used to correct the lower eyelids. In two of the cases a good anatomical correction was achieved but in one the ectropion persisted but improved. The role of joint medical and conservative surgical treatment is discussed.

PS15.2
Hundreds of Children in the Gothenburg Greater Area with Vaccine Related Contact Allergy to Aluminium  
Annika Inerot, E. Bergfors and B. Trollfors  
Hudkliniken, Sahlgrenska sjukhuset, Göteborg, Sweden  

During trials of aluminium adsorbed diphtheria–tetanus/acellular pertussis vaccines from a single producer, persistent intensely itching nodules at the vaccination site were observed in an unexpectedly high frequency (about 1 %) in the study area around Gothenburg, Sweden. All afflicted children were offered patch-testing with aluminium.

Objectives: To analyse the frequency and strength of positive patch-test reactions in relation to the age of the children.

Materials and Methods: All children with clinical symptoms of localised pruritus at the site of vaccination were offered patch test with aluminiumchloridehexahydrate 2% in petrolatum (Chemotechnique Diagnostics, Sweden) in plastic chambers, and also with an empty Finn Chamber (Epitest, Finland). Siblings vaccinated with the same vaccine but without symptoms were also offered the same patch test. The tests were read on day 3 using the ICDRG’s criteria.

Results: Among the group of children (n = 438) with itching nodules at the vaccination site 77% had a positive patch test reaction to aluminium. Among the siblings (n = 270) without itching 7% were positive for aluminium in patch test. The age of the children with positive reactions were from 2 to 15 years of age, with an average around 6 years. The strongest test reaction was seen in the very small children.

Conclusions: Sensitisation to aluminium was demonstrated in a high frequency (77%) in children with persistent itching nodules after vaccination with aluminium adsorbed vaccines. In this population of vaccinated children we saw the strongest reaction in the very small children.

PS15.3
Our Experience in Treatment of Atopic Dermatitis in Latvia  
Andris Rubins, K. Cirule, S. Rubins, L. Chigorevska and S. Zigue  
Latvian Institute of Dermatology, Chair of Dermatovenereology, Riga Stradins University, Latvia  

Atopic dermatitis (AD) is the most common and inflammatory skin disease that typically has chronically repalsing cause. AD has affected more than 15% of children in many countries, 70% of the cases, starting in children younger than 5 years of age. During the last decade there have been elaborated 2 effective drugs, calcineurin inhibitors (CNI) – Pimecrolimus cream 1% and Tacrolimus 0.03% and 0.1% ointment which are successfully used in the therapy of atopic dermatitis (AD) for both the children and adults, and which is a good alternative for the topical corticosteroids which is used for a long period may cause various side effects including skin atrophy. By applying the Calcineurin inhibitor ointment there appeared a real possibility to help children who have AD. In Latvia more than 500 atopic dermatitis children patient with local calcineurin inhibitor ointment 0.03% have been treated.

Methods: Calcineurin inhibitor ointment 0.03% was applied twice a day for mild and moderate AD patients. Patients with severe AD at first were treated with mometasone furoate once a day for 3 days, to prevent burning sensation, and then follow with calcineurin inhibitor ointment 0.03% twice a day.

Patients were grouped according to percentage of affected body surface area (BSA). Group I: 5–20%, group II: >20–40 %, group III: >40%. Tacrolimus ointment was rubbed in all damaged skin areas twice a day till remission, and 2 weeks more. 1% pimecrolimus cream was approved for children with mild and moderate AD from 2 years and up.

Results: Score of skin process damage has decreased for all patients by 4–5 times. At the same time the remissions have become longer and slight AD exacerbations have been observed only 1–2 times a year. In children of the young group the improvement of the damaged skin was noticed to occur
on 4–6 days after first application of calcineurin inhibitors decreased skin inflammation, infiltration and itch, but within two weeks a radical improvement was achieved the score of the damaged skin decreased on average by 50%, as well as itch. No patient was seen to have the worsening of the skin process; most satisfied were children’s parents.

Conclusion: The clinical efficiency and safety of Tacrolimus ointment were proven during the study. These days we have very good medicine calcineurin inhibitors for treatment patients with atopic dermatitis including small children.

PS15.4

Treatment with a Moisturizing Cream Delays Recurrence of Atopic Eczema

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Background and objective: Health care professionals emphasize the use of moisturizers in treating eczema, also when the eczema is cleared. However, the influence of moisturizers on the recurrence of eczema is not fully elucidated; and to our knowledge no data are available where this has been studied clinically. The objective of this study was to investigate the possible prevention of atopic eczema by treatment with a moisturizing cream with 5% urea. The moisturizer was previously shown not only to diminish the signs of dryness, but also to improve skin barrier function in dry atopic skin.

Methods: Patients with atopic eczema were treated with topical corticosteroids for three weeks. Patients with cleared eczema (n=44) were randomized to either treatment with the urea-cream or to no treatment. The treatment period lasted up to 180 days or until the first sign of eczema relapse. The time to a possible recurrence of eczema was recorded.

Results: After 180 days, 15 of 22 (68%) of the intention-to-treat population treated with the moisturizer had no recurrences compared to seven of 22 (32%) of the untreated patients. The number of eczema free days differed significantly between the two groups (p<0.05).

Conclusions: Treatment with the moisturizer delayed the time to recurrence of eczema and accordingly proved to be a useful treatment adjunct in atopic patients.

PS15.5

Long-term Treatment with Moisturizers Affects Gene Expression of Epidermal Enzymes

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Moisturizers are often used as supplements to topical and/or systemic anti-inflammatory drugs in various types of skin conditions and disorders, such as contact dermatitis, atopic dermatitis, psoriasis, and ichthyosis, in order to break a dry skin cycle. However, there is still a lack of knowledge about the effects of moisturizers on the skin after long-term treatment, especially regarding the impact on the molecular level. Therefore, in a randomized and controlled study, we evaluated the effect of a 7-week treatment with two moisturizers on epidermal mRNA expression, in healthy human volunteers. The moisturizers differentially altered expression of several genes believed to be important for skin barrier function, i.e. genes involved in keratinocyte differentiation, proliferation, and desquamation as well as genes involved in lipid synthesis or processing. Alterations in gene expression were also accompanied by changes in the skin barrier function, measured as transepidermal water loss (TEWL). In conclusion, moisturizers are able to influence the skin at a molecular level and may also change the function of the skin. Therefore, they should not be perceived simply as inert topical preparations. Since the type of influence depended on the composition of the moisturizer, it is possible that different types of skin conditions should be treated with different types of moisturizers. This hypothesis merits further investigations.

PS15.6

“Fractional” Lasers for Treatment of Rhytides, Scars, Pigment and Overall Skin Rejuvenation

Martin Kassir

Mona Lisa Dermatology, Dallas, Texas, USA

“Fractional” lasers are the latest popular technology utilizing light energy for skin rejuvenation. Since the introduction of the first device 2 years ago, several manufacturers now offer “Fractional” technology. Which wavelength is best? What is the optimal depth of penetration into the dermis? What is the ideal diameter-to-depth ratio of the beam? Number of passes?
Do we need anesthesia for all the technologies? How do we compare the technologies? Is a microthermal zone just like a microbeam? Which handpiece is better? In this lecture, Dr. Martin Kassir will be speaking about the various technologies and wavelengths, handpieces, and discussing the treatment of rhytides.

At the conclusion of this presentation attendees should have a much more clear idea of how each technology works and how each may be best utilized. They should also be able to more objectively compare and contrast the top technologies and decide in a much more objective manner which would best fit into their practice.

**PS15.7**

Eczema Counselling via the Internet – Telemedicine as a Tool in Home Care Eczema Counselling

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**Background:** Atopic eczema (AE) is a chronic inflammatory non-contagious skin disease characterized by intensive itching and erythematosus skin lesions with a typical distribution on the skin surface. It is related to other atopic diseases like bronchial asthma and hay fever. In Norway it is one of the most common chronic diseases with prevalence in children of 20–25%. AE often starts during the first years of life. Due to its chronic and relapsing course with itching, scratching and impaired sleep AE imposes a great burden on affected families. Management of moderate-severe AE is a therapeutic challenge.

**Objective:** We want to investigate how individual home-based counselling affects families with children with AE.

**Design:** Prospective randomised controlled trial.

**Setting:** Outpatient clinics at the University hospital of North Norway and at Hammerfest County hospital

**Interventions:** Between 2005 and 2007 98 children with AE participated in the trial. Parents of enrolled children in the intervention group used a secure Internet connection to send electronic requests about eczema to the Departments of Dermatology or Paediatrics at the University hospital of North-Norway. This system enabled the patients to send pictures and text to their provider using an ordinary web-browser. To fulfil the security requirements for sending sensitive information over the Internet, the patients had to log in with a user name and a password over an encrypted connection using a public key infrastructure (PKI). This required a two-phased authentication that was solved by sending a one-time password valid for only 10 min, to the patient’s mobile phone during the login process. In addition to “free writing” parents were asked to use a form showing extent and severity of the eczema. Photographs of affected skin areas were sent as attachments. There were no limitations concerning the length or frequency of requests provided they were dealing with AE. Internet communication was available immediately after the patient was randomised. An experienced resident in dermatology answered requests within the next working day. Notification about an answer was sent by text message to the patients’ mobile phone. Two nurses trained in treating children with AE answered messages when the doctor was on leave or holiday. Medical guidance was available all the time for the nurses. When advice on medication was requested (local or systemic), a doctor was always consulted.

**Main outcome measures:** Objective-SCORAD index at start-up and at follow-up after 1 year. The frequency of visits to general practitioners or specialists and hospital admissions. The frequency of UV therapy or systemic treatment (i.e. antibiotics and immunosuppressants, excluding antihistamines). Health behaviour and self-efficacy. Medical cost, travel cost and patient cost. Cost-effectiveness and willingness-to-pay values.

Content analysis of requests sent.

**Results:** 158 requests were received during the study period. Data of the study are currently being analysed. We present first results.

**PS15.8**

A New High-powered Radiofrequency Device used for Non-invasive Lipoplasty of the Abdominal Region

Martin Kassir

Mona Lisa Dermatology, Dallas, Texas, USA

Many efficacious techniques exist for elimination of unwanted fat and skin tightening. Traditional liposuction, ultrasonic liposuction, and laser-assisted liposuction have all been used with excellent results for fat reduction in various body areas. All are associated with varying degrees of patient sedation and downtime. Dr. Kassir will discuss a new high-powered radiofrequency (RF) device used for non-invasive lipolysis of the abdominal region. 5 patients with abdominal fat with BMI < 40, no pre-existing medical conditions, and no metal implants (IUDs, pacemakers, metal clips, artificial joints or valves) were treated. These patients had no prior liposuction or abdominal surgery. Height, weight, and various measurements were taken. Pre- and post-study abdominal CT scans and bloodwork were performed. Patients were treated for 5 sessions, 3–4 days apart (M-Th, M-Th, M) High-powered RF with
a large handpiece was used; the abdomen was slowly heated to maintain a temperature of 41°C for 30 min. Post-study CT scans and measurements revealed a decrease in abdominal fat and circumference. RFAL (Radiofrequency Assisted Lipoplasty) is an efficacious non-invasive method for fat reduction.

Nail Disorders

PS16.1
Classification of Onychomycosis Revisited

Robert Baran
Nail Disease Center, Cannes, France

In 1998 we expanded Zaïas’ classification of the clinical appearances of onychomycosis devised a quarter of century earlier. However new clinical and histological data which have accumulated over the past 10 years prompted us to propose an updated classification of onychomycosis.

Scheme for the classification of onychomycosis

1. Distal and lateral subungual onychomycosis (DLSO). This may be associated with four major clinical features whose contribution may vary with individual cases.
   1.1 Subungual hyperkeratosis
   1.2 Onycholysis
   1.3 Paronychia
   1.4 Chromonychia particularly melanonychia

2. Proximal subungual onychomycosis
   2.1 With paronychia
      2.1.1. So called candida paronychia. Either as commensal or from colonization of a previous paronychia
      2.1.2. True candida paronychia (very rare), usually observed in CMCC or HIV positive subjects.
      2.1.3. Non-dermatophyte mould paronychia, sometimes associated with leukonychia (e.g. Fusarium)
      2.1.4. Dermatophyte infection (exceptional)

   2.2 Without paronychia
      2.2.1. Classical PWSO consists of white subungual patches appearing beneath the PNF.
      2.2.2. PWTSO presents as a PWSO with atypical patterns: striate leukonychia as isolated or multiple. Transverse subungual white strips, separated by areas of nail which are both clinically and histologically normal, affecting the same digit. Proximal to distal longitudinal leukonychia affecting a single digit is exceptional.
      2.2.3. Acute PWSO: a rapidly developing form of PWSO recorded in patients with human immunodeficiency virus, who usually have a CDY+ cell count of less than 450 cell/mm³. This acute type of nail invasion involves several digits simultaneously.

   2.2.4. Candida PWSO has been reported in CMCC.
   2.2.5. Another combination pattern is seen in AIDS patients where PSWO and SVO may develop at the same time and spread rapidly to involve the nail plate.

3. Superficial onychomycosis
   3.1. Classical SVO type restricted to the visible NP (There is a black variant)
   3.2. SVO from under PNF
      3.2.1. Acute SVO
      3.2.2. Superficial white transverse onychomycosis (SWTO)
      3.2.3. SVO with deep invasion
      3.2.4. Mixed forms with 2 variants:
         3.2.4.1. SVO associated with PWSO
         3.2.4.2. SVO associated with histologically restricted involvement of the ventral aspect of the NP (Bipolar type)
      3.2.5. Mixed form SVO associated with DLSO

4. Endonyx onychomycosis (Typical of T. soudanense but this fungus also causes other forms of onychomycosis)

5. Total dystrophic onychomycosis
   5.1. Secondary TDO to other forms
   5.2. Primary TDO (CMCC)

PS16.2
Differential Diagnosis of Nail Psoriasis and Onychomycosis

Eckart Haneke
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Psoriasis is the dermatosis that most frequently affects the nail organ. Onychomycosis makes up for 30 to 40% of all nail diseases. Though having a different aetiology it may resemble each other and sometimes pose huge problems in distinguishing them. Not making the correct diagnosis will lead to inadequate and expensive treatment. The diagnosis of nail psoriasis is usually made on clinical grounds: more than 20 pits, salmon or oil spots, onycholysis with a reddish proximal border, yellowish nail discoloration, splinter haemorrhages as an eequivalent of Auspitz’s sign, psoriatic leukonychia, nail destruction, psoriatic arthropathy and periungual psoriasis lesions as well as psoriasis elsewhere and in the family commonly allow the diagnosis of psoriasis to be made. Fungi are usually not demonstrable. Onychomycosis is subdivided into different forms the most common of which is distal-lateral subungual onychomycosis. It is mainly this type of onychomycosis that may look like ungual psoriasis. Onycholysis with nail discoloration, loss of transparency and nail shine, subungual hyperkeratosis and an occasional pit-like depression on the
nail surface are the most common symptoms. Demonstration of invasive fungal elements is a prerequisite for the diagnosis. Development to total dystrophic onychomycosis with complete nail destruction is not rare.

Histopathologically, psoriasis shows a typical pattern with parakeratosis in the saucer-shaped pits and a mainly lymphocytic infiltrate in the depth of the nail pocket when a biopsy is taken from this location. Salmon spots and psoriatic onycholysis reveal moderate epithelial thickening of the nail bed with lymphocytic epitheliotrophic infiltrate in the superficial dermis as well as lymphocytic and neutrophilic exocytosis into the mildly spongiotic nail bed epithelium. Sometimes, the formation of typical Munro’s microabscesses is seen whereas Kogoj’s pustules are rare in the non-pustular psoriasis variants. The subungual keratosis contains large portions of parakeratosis that are sometimes arranged in obliquely oriented columns. In onychomycosis, the subungual hyperkeratosis as well as the overlying nail plate’s undersurface contain fungal hyphae and/or spores. Dermatophyte hyphae are arranged longitudinally and in a parallel manner as long as the nail grows consistently, but in total dystrophic onychomycosis, their arrangement has lost this order. The nail bed responds with an inflammation to the fungal infection. There is a mononuclear inflammatory cell infiltrate with epitheliotropism and often a considerable spongiosis. Neutrophils concentrate in the superficial epithelial layers and often form collections like Munro’s abscesses. Both in the subungual hyperkeratosis, which is mainly orthokeratotic with occasional parakeratotic material, and the nail plate serum inclusion may be seen that are PAS positive and may be mistaken for fungal elements when they are small and longitudinal. Thus, histopathology reveals several overlapping factors in both nail psoriasis and onychomycosis.

A problem arises when a seemingly psoriatic subject grows fungi in culture or shows fungi histologically. This raises the question of 1) a misdiagnosis or 2) a double pathology. In fact, many studies have shown a relatively high prevalence of onychomycosis in psoriatic subjects, thus it is not rare to have both psoriasis and onychomycosis. We have seen patients that had psoriasis on certain nails, onychomycosis on other nails, and both psoriasis plus onychomycosis on further nails. The difficulty then is to find out what is the most important pathology as fungi may act as a Köbner phenomenon in psoriasis, may simply colonise or really infect a psoriatic nail. In any case, the onychomycosis should be treated first to abolish the isomorphic effect of the infection before the therapy of onychomycosis.

**PS16.3**

**Nail Malignancies**

*Robert Baran*

Nail Disease Center, Cannes, France

On the basis of 121 cases of Acral lentiginous melanoma, Luc Thomas’ team has considered that mitotic activity appears to be of particular importance in predicting the outcome of ALM. The same team has performed a clinicopathological study of 35 cases of squamous cell carcinoma. The spectrum of the clinical features encountered was extremely large, including leuconychia, subungual hyperkeratosis, trachyonychia, subungual tumoral syndrome, longitudinal erythronychia, and melanonychia.

Austrian authors have observed HPV type 26 infection causing multiple invasive squamous cell carcinomas of the fingernails in an AIDS patient under highly active antiviral therapy.

Remarkably, almost all reported digital SCCs that have been attributed to HPV were caused by HPV 16, sometimes 9, or 11 alpha papilloma virus. Interestingly, the first case of SCC arising from lichen planus of nail matrix and nail bed has been published by Japanese authors.

Pigmented Bowen’s disease may clinically mimic melanoma of the nail. A 65-year-old African-American man presented with a 1-year history of a finger nail turning black. Physical examination of the 3rd digit of the right hand revealed a longitudinal melanonychia on the ulnar aspect of the nail plate and two deeply pigmented lesions, namely a verrucous papule of the proximal nail fold and a brown macule on the ulnar aspect of the digit that revealed a pigmented SCC in situ of Bowen’s type.

Melanoma and squamous cell carcinoma were found on different nails of the same hand, each featuring an unusual clinical presentation: amelanotic melanoma presenting as longitudinal melanonychia on the ulnar aspect of the nail plate and two deeply pigmented lesions, namely a verrucous papule of the proximal nail fold and a brown macule on the ulnar aspect of the digit that revealed a pigmented SCC in situ of Bowen’s type.

Simultaneous subungual melanoma does exist. A recent case has been detected on both thumbs of a 38-year-old Caucasian man. This case resembles that published by B. Leppard several years ago, involving both big toenails.

Basal cell carcinoma is not exceptional probably because of the length of life time has increased : the disease involved : one 90-year-old patient’s thumb and two 83-year-old patients’ thumb and index.

Three main features were observed:
- Deforman of the nail with ulceration pigmented on the cubital border.
- Erythematous and ulcerated lesion on the proximal and cubital nail fold.
- Superficial multicentric BCC with jagged borders – a histopathological hallmark for nail unit BCC.
COURSES

Dermatological Problems in Women

Sunday, 1st June, 2008. 8.30–12.00

Programme

Chairs: Professor Fenella Wojnarowska, Dr Elisabet Nylander and Dr Monika Gniadecka

8.30–8.40  Welcome and opening remarks
Professor Fenella Wojnarowska

Overview of Skin Diseases in Adult Women

8.40–9.00  How women perceive skin disease
Dr Elisabeth A Holm

9.00–9.20  Overview of lichen sclerosus and lichen planus
Dr Elisabet Nylander

9.20–9.40  Overview of Lupus in women
Dr Filippa Nyberg

9.40–10.00 Overview of swollen legs in women
Dr Monika Gniadecka

10.00–10.30  Coffee break

10.00–10.30  Contact dermatitis - how do women cope with the disease?
Dr Tove Agner

Overview of Skin Disease in Pregnant Women

11.00–11.30  Autoimmune Disease in Pregnancy
Professor Fenella Wojnarowska

11.30–12.00  Overview of Pregnancy dermatoses
Dr Ellen Mooney

Abstract

C01.1

Autoimmune Disease in Pregnancy

Fenella Wojnarowska

Department of Dermatology, Oxford Radcliffe Hospital, Oxford, UK.

Pregnancy is a physiological event that is accompanied by alterations in the immune system state to ensure the mother does not reject the foetus (a semi-allogeneic graft). This means that to some extent the mother is immunosuppressed. There is a shift from cell mediated (T helper 1) responses towards antibody mediated (T helper 2) responses. Levels of circulating antibodies may rise.

Transplacental transfer of autoantibodies from autoimmune disease in the mother may have dramatic effects on the foetus. The most spectacular example in medicine is myasthenia gravis, where a proportion of infants have transient disease, and very rarely arthrogryposis multiplex congenital (non-progressive congenital contractures) absence of foetal movement. In dermatology we have 3 examples of transplacental transmission of antibody mediated disease. Neonatal pemphigus vulgaris and pemphigoid gestationis occur in a minority of neonates from affected mothers, and resolve within a few weeks. Neonatal lupus is more grave in its results.

Pemphigus may cause difficulties with conceiving and may worsen or present during pregnancy. There is significant associated foetal mortality and morbidity. Pemphigoid gestationis arises only in the setting of pregnancy or placental derived tissue, and remits after delivery. It is usually recurrent with each pregnancy, <10% skipped pregnancies. In subsequent pregnancies it can be the first indicator of conception. Linear IgA disease may remit during pregnancy, and recur at 3 months postpartum. Bullous pemphigoid rarely affects women of childbearing age, but may worsen or improve.

Lupus usually worsens during pregnancy, and adversely affects spontaneous abortion, foetal death, prematurity and foetal growth. Renal disease is particularly adverse. Mothers, some of whom are asymptomatic, with anti Ro and La antibodies that may induce neonatal lupus in about 5% of these children, this may persist for several years. Permanent congenital heart block results from these antibodies in about 2% of such offspring.

The effect of maternal autoimmune disease on the foetus may be profound and long reaching.
Dermatological Theories in Practise. A Seminar for Nurses Working in Dermatology

Sunday, 1st June, 2008. 14.30–18.00

Programme

14.30 Opening of session.
14.40–15.10 Basic skin physiology with special attention to skin barrier function and the application of emollients.
  *Theis Huldt-Nystrøm Hudlege Levanger*
15.10–15.40 UV treatment - challenges and pitfalls.
  *Eli J. Nordal, overlege, Hudavdelingen, Rikshospitalet, Oslo*
15.40–16.10 UV treatment of vitiligo - a sport for risk seekers?
  *Eli J. Nordal, overlege Hudavdelingen, Rikshospitalet, Oslo*
16.10–16.30 Coffee Brake
16.30–16.50 The DLQI questionnaire and other questionnaires to measure the effects of dermatological therapy in atopic dermatitis, handeczema, and itch.
  *Theis Huldt-Nystrøm, Hudlege, Levanger*
16.50–18.00 How to use the PASI score.
  *Morten Dalaker, Hudlege, Trondheim*

Abstracts

C02.1

Basic Skin Physiology with Special Attention to Skin Barrier Function and the Application of Emollients

*Theis Huldt-Nystrøm*

Levanger

The nurses are very important in informing the patients about treatment with emollients and different topical medications. Patients respond very differently to the different sorts of emollients. It is of utmost importance that the nurses have learned about the various contents in emollients and the barrier function of the skin. This session will focus on basic skin physiology and skin barrier function. A brief review of effects of emollients in atopic dermatitis and dry skin will be presented.

C02.2

UV Treatment – Challenges and Pitfalls

*Eli J. Nordal*

Hudavdelingen, Rikshospitalet, Oslo

Often quite independent, the nurses perform the practical part of UV treatment, with varying support, skills and interest in photodermatology from the cooperating dermatologist. This presupposes the nurses to be sufficiently experienced to take this responsibility. The challenge is to provide the patient with the correct UV dose increment at any time, regarding skin type, diagnosis, form of UV treatment and additional treatment given. Overdosage should be avoided, but underdosage may be a larger problem.

C02.3

UV Treatment of Vitiligo – A Sport for Risk Seekers?

*Eli J. Nordal*

Hudavdelingen, Rikshospitalet, Oslo

Patients may experience vitiligo to be a most disfiguring condition. UV treatment may have at least some effect, and NB-UVB (TL01) is considered to be the treatment of choice. In addition to the possible repigmentation, UV treatment induces increased skin thickness and thereby increased sun tolerance in the affected skin. Most often long treatment series are necessary. Protopic ointment may enhance the effect of the UV beams. The risk of malignancies in vitiliginous skin seems so far to be of less importance than expected.
C02.4
The DLQI Questionnaire and Other Questionnaires to Measure the Effects of Dermatological Therapy in Atopic Dermatitis, Hand Eczema and Itch
Theis Huldt-Nystrøm
Levanger
The widespread use of systemic therapies and expensive biological therapies in dermatology has revealed a need of better documentation of effect and follow up results when treating different dermatological conditions. Nurses are important in this respect, and it is important that nurses and doctors are familiar with different questionnaires which deals with this kind of information.
This session is an introduction to the use of questionnaires to measure effect of therapy in atopic dermatitis, hand eczema and itch. We will also look at the DLQI questionnaire.

C02.5
How to Use the PASI Score.
Morten Dalaker
Trondheim
This session is a practical approach to how to use the PASI score the correct way. The participants will receive theoretical information about the PASI score and participate in an interactive “test yourself system” as a part of the practical demonstrations.

Dermatopathology
Monday June 2nd, 2008 8:00-11:30
Chairman: Ellen Mooney, Iceland
Co-Chairs: Mari-Anne Hedblad, Sweden and Ole Clemmensen, Denmark
8.00 Welcome
Dr Ellen Mooney
8.00–10.00 From The Clinic to the Microscope
8.00–8.30 Cutaneous Lymphoma - Clinicopathologic Correlation and Diagnostic Pitfalls
Dr Werner Kempf
8.30–9.00 Lupus Erythematosus – Clinicopathologic Correlation
Dr Ole Clemmensen
9.00–9:30 New Inflammatory Dermatoses – Microscopic Clues to Clinical Diagnoses
Antoinette Hood
9.30–10.00 Coffee break
10.00–11.30 The Tumour Through Technology and Treatment
10:00–10:30 Lentigo Maligna – Diagnosis and Soft X-Ray Treatment
Dr Mari-Anne Hedblad
10.30–11.00 Spitz Nevi – Tough to Diagnose, Easy to Treat?
Professor Phil Leboit
11.00–11.30 Nevroid Melanoma – The Dreaded Tumour That Defies Us
Dr Ellen Mooney
Abstract

C03.1

Lentigo Maligna – Diagnosis and Ultra Soft X (Grenz)-ray Treatment

Mari-Anne Hedblad and Lotus Malbris

Department of Dermatology, Karolinska Hospital, Stockholm, Sweden

Clinical, dermoscopical and histopathological findings in Lentigo Maligna (LM) and our expirences of Grenz-ray treatment, outcome, recommendations and pitfalls will be presented.

**Background:** LM is the in situ phase of LMM. A wide variety of modalities has been used to manage LM, including conventional surgery, staged excision, Moh’s micrographic surgery, cryotherapy, radiotherapy, laser therapy and lately imiquimod.

**Objectives:** LM has been successfully treated by Soft X-rays by Panazzoni et al. The aim of this study was to evaluate the efficacy of Ultra soft X-rays treatment in our practise in LM and early LMM.

**Methods:** 350 patients has been treated 2 times a week during 3 weeks in doses of 100-160 Gy according to the stage of LM and depth of atypical melanocytic periadnexal extensions. 149 patients have been followed up to 5 years, 243 patients for at least 2 years.

**Results:** 301/350 (86%) showed complete clearance after one fractioned treatment. Of 49 that did not respond completely 10 of those showed residual lesions after one treatment, and 39 relapsed, of those 26 within 24 months.

**Conclusion:** Grenz-rays is an efficient and safe treatment in lentigo maligna with very good cosmetic results.

The number of treated patients has been extended since gathering this data and will be presented at the meeting.

WORKSHOP

Self-Assessment Exam in Dermatopathology

*Monday June 2nd, 2008, 8:30-16:00*

Programme

Chairman: Dr. Philip LeBoit, USA

Co-Chairs: Dr. Mari-Anne Hedblad, Sweden and Dr. Antoinette Hood, USA

Other speakers/contributors of cases: Dr. Ole Clemmensen, Denmark and Dr. Werner Kempf, Switzerland

**Monday June 2, 2008**

8.30–16.00 Viewing of Cases

**Tuesday June 3, 2008**

900-12:00 Review of Cases
POSTERS

Atopy, Allergy and Eczema

P01.1
Nanotechnology and Contact Allergy

Jakob Torp Madsen1, Stefan Vogel2, Jeanne Duus Johansen1 and Klaus Ejner Andersen1

1National Allergy Research Centre, Department of Dermatology, Odense University Hospital, and 2Department of Physics and Chemistry, University of Southern Denmark

Nanotechnology is an emerging technique used in the cosmetic and pharmaceutical industry. The benefits of using nanotechnology in skin products include increased delivery of active ingredients to skin, protecting product from degradation, and giving improved cosmetic performance. One case report suggests that retinyl palmitate formulated in polycaprolactone (nanopolymer) in an anti wrinkle crème caused allergic contact dermatitis due to the retinoid in nanoparticles. Patch tests showed increased reactivity to retinyl palmitate formulated in the nanopolymer compared to petrolatum. Studies have shown that a fluorophore (nile red) incorporated in polycaprolactone penetrates deeper in the skin compared to conventional vehicles. Chemicals incorporated in polycaprolactone could theoretically have increased sensitization and elicitation potential. The ongoing project aims to investigate in mice and human volunteers the allergenic effect of selected allergens in nanoparticles. Two different types of nanoparticles used in cosmetics (polycaprolactone and liposomes) are manufactured and loaded with 2 different contact allergens (potassium dichromate (hydrophilic) and isoeugenol (slightly hydrophilic)). Sensitization animal experiments using the local lymph node assay are ongoing and data will be presented.

P01.2
A Multicenter, Randomised Double-blind, Placebo-controlled Study of Efficacy, Safety and Tolerability of Two Topical K301 Formulations in Adults with Seborrhoeic Dermatitis (SD) of the Scalp

Lennart Emtestam1, Sören Gullstrand2, Pawel Berens3 and Birgitta Wilson-Claréus4

1Department of Dermatology, Karolinska University Hospital, Stockholm, 2Möllevångens Huslåkargrupp, Malmö, 3Hälsocentrum, Uppsala, 4Hudmottagningen, Farsta, Sweden

Methods: Of 98 patients, 51 were randomly evenly allocated to one of the two K301 formulations and 47 to a matching placebo. Treatment was to be applied once daily for 4 weeks and three times per week during the following 4 week mainte-

nance phase. Follow-up was after 2, 4 and 8 weeks. Primary end point was the sum of erythema and desquamation scores after 4 weeks treatment which was analyzed using a proportional odds model. Baseline sum score was included in the model.

Results: K301 was superior to placebo in terms of the sum of erythema and desquamation scores after 4 weeks of treatment ($p=0.0253$). The difference was significant also after 2 weeks, but not after 8 weeks of treatment, i.e. after the 4-week maintenance phase. In addition, there was a significant difference between the proportions of responders after 4 weeks ($p=0.0075$), with 67% of patients treated with K301 meeting the predefined responder criteria versus 40% for placebo. Several other secondary efficacy measures also showed results consistent with the primary analysis. No safety concerns were raised.

Conclusion: The results indicate that K301 is safe and efficacious for topical treatment of scalp SD and warrant further investigation.

P01.3
Nail Mycosis at Department of Dermatology, Odense University Hospital

Lisbeth Jensen

Department of Dermatology, Odense University Hospital, Odense, Denmark

Many people consult dermatological wards, clinics and general practitioners with suspicion of mycosis in one or more nails, especially toe nails.

In 2007 a total of 1,885 nail specimens were examined and 319 were positive. The low frequency of positive nail samples may be due to poor sampling technique in combination with frequent non-infectious nail disorders.

P01.4
Managing the Family with Atopic Dermatitis (AD), a Case.

Helle Wulff Ovesen

Department of Dermatology, Odense University Hospital, Denmark

A four-year-old boy, no. 2 of 5 children, followed at the department of Dermatology, Odense University Hospital, under the diagnosis atopic dermatitis (AD), was admitted to the department, due to severe exacerbation, with concomitant staph-infection. After only 2 days intensive local treatment with potent steroids in combination with Fusidic acid vast improvement was noted, improvement continued during the admission. During the admission nursing staff focused on teaching the
family to cope with AD, learning them to use topicals correctly and how to handle exacerbations. The case has since been chosen as learning example for the nursing staff.

**P01.5**

**Methylaminolevulinate as a Cause of Allergic and Irritant Contact Dermatitis; Results from a Randomised Double-blind Study.**

*Ana Soler and Trond Warloe*

The Norwegian Radium Hospital, Oslo, Norway

*Introduction:* More than 300,000 patients have been treated with methylaminolevulinate (MAL) in Metvix® cream in photodynamic therapy (PDT) worldwide, with few serious adverse effects. Some of the ingredients of the Metvix® cream may cause local skin and allergic reactions.

*Objective:* Investigate the potential of MAL-PDT to cause allergic and irritant contact dermatitis.

*Methods:* The study was performed as a double-blind, within-subject, vehicle controlled, randomised single centre study in 21 patients previously treated at least four times with MAL-PDT. Each patient received a single application of 160 mg/g MAL (Metvix®) and placebo cream of each test agent to the left and the right side of the spinal column. Adhesive tape covered the chambers for 48 h, and were then removed. Skin reactions were assessed after 48, 72 and 96 h. Patients with positive patch tests were retested.

*Results:* All enrolled patients completed the study. In Test 1, positive patch tests were observed at three (14%) sites treated with MAL cream. 18 patients (86%) had negative patch tests. In Test 2, the three patients with positive patch tests from Test 1 were retested with three patches of MAL cream with an application-time of 3 hours with and without illumination after removing the patches (two patches) and 48 h (one patch). Patient 1 had a positive patch test on all test sites. Patient 2 had a sharply demarcated erytematous plaque without blistering and spreading outside the test area on the 48 h test site (indicating an irritant contact dermatitis) and the two other test sites were negative. Patient 3 were negative on all three test sites.

*Conclusion:* The results of this Phase IV study support former clinical findings and indicate a low potential for allergic contact sensitisation with MAL cream.

**P01.6**

**A Randomized Double-blind, Placebo Controlled, Study to Evaluate the Efficacy of Liquid Soap Containing 12% Ammonium Lactate + 20% Urea (Axera™) in Atopic Dermatitis**

*Boaz Amichai and Marcelo H. Grunwald*

Department of Dermatology, Sheba Medical Center and Soroka Medical Center, Israel

*Background:* Atopic dermatitis is a common chronic skin disease which affects mostly children. Xerosis is one of the most troublesome signs of the disease.

*Aim:* To evaluate the efficacy of liquid soap containing 12% ammonium lactate + 20% urea (Axera, Perrigo, Israel) in atopic dermatitis patients.

*Methods:* In a randomized, double-blind study, 36 patients both male and female aged 3–40 years suffering from mild to moderate atopic dermatitis were enrolled. Patients were divided randomly into two groups, in a ratio of 2:1 (active: placebo). Soap was used on daily based during shower for 3 weeks. All patients continued all other systemic or topical medication but avoided any other soap or emollients. After three weeks of treatment, the efficacy was assessed both by clinician and patient.

*Results:* Axera liquid soap was found to be statistically better regarding the improvement of objective parameters evaluated by the investigator; scaling ($p<0.0001$), skin dryness ($p<0.0001$) and redness ($p=0.03$), and subjective patients assessment of itch ($p<0.001$).

*Conclusion:* Axera liquid soap was found to be effective in patients with atopic dermatitis. The use of this soap in patients without mild to moderate atopic dermatitis improve skin findings and quality of life of the patients.

**P01.7**

**Do Genetic Polymorphisms in Transglutaminases Contribute to Skin Barrier Dysfunction in Eczema Patients?**

*Maria Bradley, Agne Lieden, Annika Sääf, Carl-Fredrik Wahlgren and Magnus Nordenskjöld*

Karolinska University Hospital, Stockholm, Sweden

Atopic eczema (AE) is a common skin disorder currently affecting up to 20% of children in some countries (1). AE usually begins in infancy or early childhood with a significant proportion of children having continued problems into adult life. Patients with AE suffer from itchy, dry and inflamed skin, often in combination with other atopic manifestations such as allergic asthma and allergic rhinoconjunctivitis (hay
fever). Twin studies indicate a strong genetic contribution in the development of AE (2, 3) and genetic linkage analyses have identified several chromosomal regions linked to AE (4–7). However, very little is known about specific genes involved in this complex skin disease and the underlying molecular mechanism is not yet identified. We used human cDNA microarrays to identify a molecular picture of the programmed responses of the human genome to the pathological condition of AE. Among the genes consistently over-expressed in AE skin as compared to skin from healthy control individuals were members of the transglutaminase family (TGM1 and TGM3) and cornodesmosin (CDSN) that play a central role in forming the outermost layer of the skin, the cornified envelope. These genes are localized to known susceptibility chromosomal regions for eczema (TGM1; 14q11, TGM3; 20p13, CDSN; 6p21.3). It is not known, however, if genetic polymorphisms in these genes contribute to skin barrier dysfunction in eczema patients. To answer this question, we investigated the role of genetic variation at these loci in the development of eczema. In summary, we here present a global gene signature of eczema skin, and furthermore genetic polymorphisms are described in candidate AE susceptibility genes identified by the microarrays. In conclusion, our data supports the hypothesis that barrier dysfunction is an important factor in eczema pathogenesis.

Psoriasis

P02.1

Itraconazole Treatment in Onychomycosis in Psoriatic Patients
Boaz Amichai1, Avner Shemer1, Henri Trau1, Batya Davidovici2 and Marcelo H. Granwald1
1Department of Dermatology, Sheba Medical Center, Tel-Hashomer, 2Dermatology Unit, Kaplan Medical Center, Rehovot, 3Soroka University Medical Center, Ben-Gurion University, Beer-Sheva, Israel

Background: Nail changes in patients with psoriasis have been reported with varying prevalence. Onychomycosis was reported in up to 25% of psoriasis patients.

Objective: The purpose of this study was to determine the prevalence of nail abnormalities, onychomycosis in psoriasis, and response to itraconazole treatment.

Methods: We evaluated 312 patients suffering from psoriasis for nail changes and onychomycosis. Patients having laboratory confirmation of onychomycosis were treated with itraconazole courses (400 mg/day for one week): in fingernails 2 courses and in toenails 3 courses.

Results: Of 312 patients with psoriasis, 67 (21.5%) patients had nail changes, 23 (34%) of them suffered from onychomycosis. Complete cure (clinical and mycological) was achieved in 30% of the patients with onychomycosis.

Conclusion: The response to treatment of onychomycosis in psoriasis patients was found to be lower than in the general population.

P02.2

Early Onset of Psoriasis Vulgaris and Polymorphisms of VDR Gene
Ivana Rucevic, Vladimir Drusko, Melita Vuksic, Ljubica Glavas-Obrovac and Dujomir Marasovic
Department of Dermatology, Laboratory of molecular pathophysiology, Clinical hospital Osijek, and Department of Dermatology, Clinical hospital Split, Croatia

Aim: The aim of this investigation were to establish an association between Apal, BsmI and TaqI restriction fragment length polymorphism (RFLP) at the VDR gene in psoriatics with early onset of disease and healthy controls.

Patients and Methods: 70 psoriatics (35 F:35 M) were randomly recruited and 157 healthy controls (86 F:71 M) with no clinical evidence or family history of psoriasis.Genomic DNA was extracted from peripheral blood leukocytes and the VDR gene was amplified using a polymerase chain reaction (PCR). The RFLP were coded as Aa (ApaI), Tt (TaqI) or Bb (BsmI), where a uppercase letter signifies presence of the restriction site and a lowercase letter signifies presence of the site. Gained results were processed by statistical analysis.

Results: results of this study show that the four more frequent genotypes in healthy controls were: BbAaTt (29.3%), BBaatt (14.7%), BBAatt (14%) and bbAATT (12.7%), and in psoriasis patients were: BbAaTt (33.6%), BBaatt (22.9%), BBAatt (16.4%), and BbAATt (10%). Analysis (Westfall-Young) of genotype effects have not shown significant difference in distribution of BsmI (p<0.206), Apal (p<0.826) or TaqI (p<0.939) genotype frequencies between healthy controls and psoriasis patients.

Conclusion: The results of the present study showed no relationship between psoriasis and the Apal, BsmI, TaqI RFLP VDR genotypes, but BT haplotype showed protective effect on PV with early onset. This obtained data suggests that the VDR gene could be one of some candidate genes implicated in the pathogenesis of psoriasis vulgaris.
P02.3

A DESIRE* for DAIVOBET® – The Results of the DESIRE study

(*Daivobet® Experience Study In Regions of Europe)

Birgitta Wilson-Claréus¹, Ronald Houwing², Jens Hein Sindrup¹ and Suzanne Wigchert³

¹Läkarhuset Farsta Centrum, Hudmottagningen, Karlandaplan 6, 123 47 FARSTA, Sweden ²Department of Dermatology, Deventer Hospital, P.O. Box 5001, 7400GC Deventer, The Netherlands ³Amagerbrogade 18, 3., 2300 Copenhagen S, Denmark, and ⁴LEO Pharma Benelux, Hoge Mosten 16, NL-4822 NH Breda, The Netherlands

To investigate treatment experiences amongst patients in daily clinical practice treated with Daivobet®, a fixed combination of calcipotriol and betamethasone dipropionate for the treatment of psoriasis vulgaris, the DESIRE study was designed. In this non-interventional study 1224 patients with psoriasis vulgaris were followed for a period of 6 months. The primary response criterion was patients’ satisfaction after 4 weeks of Daivobet® treatment. Additional study objectives were to describe the severity of the psoriasis at the time of enrolment into the study and to assess the number of Daivobet® treatment courses during a six months period.

The main results are:

• ~75% of the patients are satisfied to very satisfied after a Daivobet® treatment course
• Patients’ satisfaction is high, regardless of initial psoriasis severity (mild-severe)
• Repeated treatment courses of Daivobet® were prescribed in 20% of the patient population. Patients’ satisfaction remained equally high (~80%)
• Patients’ satisfaction results in this non-interventional study are similar to the results obtained in a well-controlled clinical trial (1)

Reference:

Drug Reactions

P03.1

Full Dapsone Dose made Possible by Control of Anemia with Darbepoetin-alpha and the Effect of Cimetidine on Dapsone-induced Methemoglobinemia

Bolli Bjarnason¹² and Ellen Flosadottir³

¹Utilitslaekning Ehf, Kopavogur, Iceland, ²Karolinska University Hospital, Stockholm, Sweden and ³Faculty of Odontology, University of Iceland, Reykjavik, Iceland

Dapsone is an important immunosuppressive agent but is sometimes not well tolerated because of adverse hematologi-
Facial Dermatitis

P06.1

Treatment of Moderate to Severe Facial Seborrheic Dermatitis with Itraconazole: An Open, Noncomparative Study

Marcelo H. Grunwald1, Avner Shemer2, K. Kaplan2, Henri Trau2, N. Nathansohn2 and Boaz Amichai2

1Department of Dermatology, Soroka Medical Center and 2Sheba Medical Center, Israel

Background: Seborrheic dermatitis (SD) is a common disease. The role of malassezia yeasts, in the pathogenesis of seborrheic dermatitis, as been implicated. Anti-fungal agents are known as effective agent in the treatment malassezia yeasts infection.

Objectives: To evaluate the efficacy of itraconazole in the treatment of mild to severe facial seborrheic dermatitis.

Methods: 60 patients with moderate to severe seborrec dermatitis were evaluated in an open, noncomparative study. Patients were treated with oral itraconazole, initially 200 mg/day for a week, and by a maintenance therapy of a single dose of 200 mg every two weeks.

Results: At the end of the initial treatment significant improvement was reported in three clinical parameters; erythema, scaling and itching. Maintenance therapy leads only a slight further improvement.

Conclusions: In this study we showed that treatment with itraconazole may be of beneficial in patients with moderate to severe facial SD.
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Stadgar för Nordisk Dermatologisk Förening


§1 Föreningens syfte är att befrämja samarbete i vetenskap, undervisning och praktisk läkekonst mellan dermatovenereologer i de 5 nordiska länderna (Danmark, Finland, Island, Norge och Sverige).

§2 Som nya medlemmar kan antas personer i de 5 länderna vilka är verksamma inom dermatologi och venereologi. För inträdde fordras, att den som söker om medlemskap föreslås av dermatologisk förening av samma nation; beslut om inval fattas på allmänt möte vid varje kongress med enkel röstövervikt.

§3 Till hedersledamot kan föreningens allmänna möte kalla den som gjort osedvanligt stora insatser för föreningen eller för nordisk dermatologi och/eller venereologi. För kallelse krävs 2/3 majoritet. Förslag till hedersledamot skall inges skriftligen till generalsekreteraren minst tre månader före allmänna mötet. Förslagen skall godkännas av föreningens styrelser för att kunna presenteras för allmänna mötet.

§4 Årsavgiften bestämmas vid varje kongress. Medlem som uppnått 65 levnadsår är befriad från avgift.

§5 Föreningen håller ett möte i regel varv tredje år i ett av de nordiska länderna. Tid och plats för nästa möte bestämmas på varje möte.

§6 Vid mötet hålls ett sammanträde för föreningsangelägenheter varvid följande ärenden skall förekomma:
   1. Kassa förvaltarens berättelse.
   2. Revisorernas berättelse jämt frågan om ansvarsfrihet.
   3. Årsavgift för kommande 3-årsperiod.
   4. Val av styrelse samt 2 revisorer för kommande 3-årsperiod.
   5. Val av forskningskommitté
   6. Tid och plats för nästa möte fastställes.
   7. Antagning av nya medlemmar.
   8. Övriga ärenden


§8 Det dermatologiska sällskapet i det land där mötet skall äga rum, lägger tillrätta kongressens vetenskapliga och övriga program och ombesörjer tryckningen av förhandlingarna i samråd med styrelsen. Varje föredragshållare och diskussionsdeltagare skall sända in ett referat till sekreteraren vid anmälan till kongressen. Föredraget hålls på danska, norska, svenska eller engelska.

§9 För en förändring av dessa stadgar krävs 2/3 majoritet. Dylika ändringsförslag skall vara insända senast 3 månader före ett mötes avhållande.
Meetings in Nordic Dermatology Association 1910–2008

<table>
<thead>
<tr>
<th>Year</th>
<th>Location</th>
<th>President</th>
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<td>Köpenhamn</td>
<td>C Rasch</td>
<td>K Marcus</td>
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<td>Stockholm</td>
<td>E Sederholm</td>
<td>K Grön</td>
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<td>1916</td>
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<td>C Boeck</td>
<td>A Kissmeyer</td>
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<td>C Rasch</td>
<td>J Strandberg</td>
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<td>S Emanuel</td>
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<td>A Cedercreutz</td>
<td>T E Olin</td>
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<td>M Tottie</td>
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<td>L R Braathen</td>
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<td>1986</td>
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<td>L Juhlin</td>
<td>S Öhman</td>
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<td>1995</td>
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<td>2004</td>
<td>Odense</td>
<td>K E Andersen</td>
<td>F Brandrup, C Bindslev-Jensen</td>
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<td>2008</td>
<td>Reykjavik</td>
<td>B Baldursson</td>
<td>G Ingvarsson</td>
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</table>
1. Agenda
The proposed agenda was accepted.

2. Chairman of the meeting
The Congress President Klaus E Andersen was appointed as chairman and commissioned to check the minutes.

3. Treasurers report
A financial summary for the period 2001–2003 had been published in the Abstract book of the congress and was discussed together with a report from the Secretary General. It was pointed out that the financial surplus exceeds the minimum level decided in Bergen.

4. Auditor’s report
The auditors read their report. The meeting decided to accept discharge of liability for the Secretary General and the Board

5. Annual fee 2004 to year of next congress
The annual member fee was decided to be the same as during the past period, i.e. SEK 30 per year and member.

In accordance with suggestions from the national associations board members were elected as follows:

**Denmark:**
Klaus E Andersen, Knud Kragballe.
Deputies: Susanne Ullman and Jørgen Serup.

**Finland:**
Kristiina Turjanmaa, Anna-Mari Ranki.
Deputies: Aarne Oikarinen, Ilkka Harvima.

**Iceland:**
Jon Olafsson.
Deputy: Gisli Ingvarsson.

**Norway:**
Dag Sollenes Holsen, Per Helsing.
Deputies: Svein Helland, Eli Nordal.

**Sweden:**
Mona Ståhle, Olle Larkö.
Deputies: Birgitta Stymne, Mats Berg

**Auditors:**
Tapio Rantanen, Kristian Thstrup-Pedersen

7. New members
It was decided to accept all persons who since the previous meeting in Gothenburg had become members of national associations for dermatology and venereology in the Nordic countries as new members of the NDA.

8. Next meeting
According to the three-year schedule next meeting should be held in Iceland in 2007. Preliminary information from the Icelandic association said they declined hosting the next congress. Next in turn would be Finland. The year 2007 may not be an optimal time for next congress due to several other large events in 2006 (EADV Spring Symposium hosted by Finland) and 2007 (World Congress in Buenos Aires and hence EADV meeting in spring).
It was stated that the congress in Reykjavik in 1993 was a success and of very high quality, and that efforts should be made to encourage the organisation of a new meeting on Iceland.

It was decided not to make a final decision on next congress, but to instruct the secretary general and the board to investigate alternative possibilities, preferably to have next meeting in 2008, and to open new discussions with Iceland or, if the Icelandic association stays with its decision, with Finland. For the next organiser the guarantee sum should not be less than SEK 250 000. It was decided that reasonable travel expenses for the secretary general and others involved in making preparations for the next congress shall be paid from assets of the NDA.

9. Activities

It was decided not to give further support for the project for international venerology, which was launched at the Gothenburg meeting.

It was decided not to give continued support in its present form of free subscriptions of Acta Dermato-Venereologica to the Baltic countries. Instead residents of dermatology and venereology in the Baltic countries will be given opportunities to apply for free subscriptions for three-year periods. The maximum number of subscriptions will be the same, i.e. 18.

It was decided to follow a proposal from Finland to investigate possibilities for the NDA to arrange focussed educational courses for members.

10. Nordic Forum for Dermatology and Venereology and the NDA

It was decided that the organisers of the next meeting will be recommended to have the Abstract book printed in the Forum, as did the organizers of the present Congress. If the organizers decide to do as recommended, the NDA will support the extra costs for printing and distribution.

11. The future of the NDA

There was general consensus that the present congress had a very high quality and educational value, as had the previous meetings. Similar meetings should therefore be held also in the future. Possibilities to arrange educational events also between congresses should be investigated.

It was agreed that more efforts should be made in order to increase the interest for the NDA among younger Nordic dermato-venereologists. The board was instructed to be more active between meetings.

12. Closing of the meeting

The meeting was closed.

Torbjörn Egelrud
Secretary General

Klaus E Andersen
Congress President

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</table>

¹) Bet 2007

²) Inkl räntefond SEK 500 000
OBITUARIES

Denmark


Æret være deres minde.

DDS

Finland

Huuro Laura 30.10.1961–19.09.2004
Rouhunkoski Sirkka 07.02.1909–19.10.2004
Rostila Timo 09.05.1944–23.11.2004
Helle Juha Pekka 10.11.1920–05.12.2004
Laonis Juhanii 29.01.1935–10.01.2005
Antti Jouko 27.01.1929–01.03.2005
Lassus Allan 31.08.1938–07.06.2005
Leinonen Marijatta 11.03.1940–26.01.2007

Timo Rostila was born on 9.5.1944 and died on 23.11.2004. He studied medicine in the University of Helsinki and graduated in 1970. He was then resident in Dermatology and Venereology in the Helsinki University Hospital, and got his specialty in 1978. During his residency he became interested in contagious diseases and venereology, and after graduation he started working as the venereologist of the City of Helsinki, and since 1983 until his death he was the epidemiologist of the City of Helsinki. In this work he was responsible for the epidemiology of all contagious diseases.

Norway


Tobias Gedde-Dahl jr. (1934–2006). Tobias Gedde-Dahl jr. was educated at the faculty of medicine, Oslo, and became specialist in medical genetics in 1971. In 1970 he defended his academic thesis “Epidermolysis Bullosa: a clinical, genetic and epidemiological study”. From 1970–1986 he was senior researcher in the Department of Genetics at the Norwegian
Radium Hospital, followed by position as professor and head of the Department of Medical Genetics at the University of Tromsø/University Hospital of Tromsø until 1990. In 1992 he became senior researcher and chief of the Dermatological DNA Laboratory at the National Hospital in Oslo, a position he held until 2004. However, he was connected to the DNA Laboratory also after his retirement, until short time before he passed away.

Tobias was closely connected to dermatology throughout his entire career, with emphasis on the genodermatoses. His efforts in dermatological research led to descriptions of variations and mutations in epidermolysis bullosa and ichthyoses, and his work laid foundation to further molecular investigations elucidating the genetics and pathogenesis of the disorders. He had a most extensive international network, and showed a considerable productivity of scientific works including papers in scientific journals, meeting abstracts and book chapters. His work with genetic science was rewarded with the royal medal of honour, and in 2002 he was elected as member of honour in the Norwegian Society of Dermatology.

On March 2 in 2006 he died, after a short period of illness. With his death, the International Dermatological society lost a highly respected colleague, and his patients lost a deeply cherished and dedicated doctor and friend.

Terje Kristensen (1943–2007). Terje had his education from the faculty of medicine in Basel, Switzerland. Later, he worked at the hospital in Örebro, Sweden, where he became specialist in dermatology. He was married to Helén in 1980. They had a very harmonic and happy marriage, and got two children. From 1982, he worked as dermatologist at Lundegata medical Center in Skien, Norway, where his wife worked together with him as his health secretary. Terje was respected among his colleagues, and his patients had a competent and thorough doctor.

Unfortunately, he suffered an acute illness, and deceased abruptly 3rd of June, 2007 – leaving an enormous vacuum for patients and colleagues.

Brynjulf Østensjø (1912–2007). Brynjulf Østensjø was born in Haugesund, 1912. He finished his medical education in 1941, and became a specialist in dermatology in 1951. He settled in his home town where he worked as a dermatologist, a general practitioner and a school doctor until 1984. As a doctor he was thorough, watchful and always in service. He had many interests in addition to work, including wildlife and travelling. He was leader of Rogaland Medical Association for a period of time, and was also a member of Lions Club. In his home town, he was active in developing hiking trails, and received Haugesunds sign of honour ”De fykende måker” (”The Flying Seagulls”). He had many friends and colleagues, who will keep a dear memory of him.

Sweden

Kerstin Wennberg 1939.06.22–2004.12.15
Kristian Fast 1912.11.06–2004.12.27
Erik Skog 1923.11.08–2005.01.30
Kjell Wikström 1927.12.28–2005.03.12
Jan Eric Wahlberg 1932.07.05–2005.08.10
Lennart Juhlin 1926.08.27–2005.10.17
Anne-Marie Hornmark 1948.04.02–2005.11.26
Hjördis Lidman 1909.05.21–2006.10.04
Ove Groth 1922.06.11–2008.01.30
MEMBERS IN THE NATIONAL SOCIETIES

Denmark

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Borgm. Jørgensens vej 6
DK-2930 Klampenborg

Ackerman A. Bernard
Ackerman Academy of Dermatology
14 SE 32 st 10th Floor
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Afzelius Hanse-Wilhelm
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DK-6720 Fansø

Agdell Jan
Regementsgatan 50
SE-217 48 Malmö, Sverige

Agner Tove
Ibstrupvej 57
DK-2820 Gentofte

Ahm Petersen Anette Marie
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Albrechts Birgit
Gentoftegade 28B
DK-2820 Gentofte

Andersen Bo
Læsundsgade 45
Strandgården
DK-5700 Svendborg

Andersen Klaus Ejner
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Solbyen 51
DK-9000 Aalborg
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<td>Rossen Kristian</td>
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<td>Sand Carsten</td>
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Fisman Silje
Anton Iversensveg 6
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N-3237 Sandefjord
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