Summary of Impressions From the EADV Conference in Barcelona in October 2003

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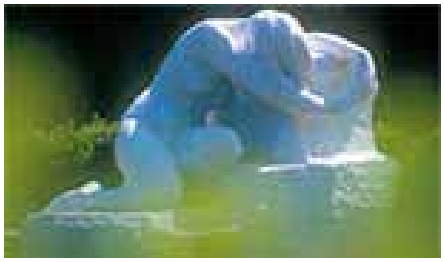
The number of delegates in EADV in Barcelona was higher than ever before, 6.200 participated. Below is a report from selected activities.

European Dermatology Forum

This is a sister association to the EADV, whose purpose is mainly to stimulate the interest in academic dermatology. It is quite obvious that the resources for academic dermatology in Europe are diminishing. It is important to stimulate academic dermatology and maintain the skill to treat the most severely affected patients within our speciality.

Pimecrolimus symposium

The use of the new topical immunosuppressants increases in dermatology. Pimecrolimus is regarded as slightly less effective than tacrolimus, but possibly also connected with fewer side effects. Animal experiments have revealed a small tumour promoting effect from tacrolimus, which had not been seen so far for pimecrolimus. Also, tacrolimus affects both the afferent and efferent parts of the immune response, while pimecrolimus seems to affect only the efferent part. It will be interesting to follow the future oral use of pimecrolimus.



Photodermatology

Herbert Hönigsmann from Vienna discussed PUVA and broad-band UVB. The use of broad-band UVB in dermatology has decreased dramatically. On the other hand, the old equipment can be used for vitamin D induction. This type of treatment can be interesting for patients with bowel disease and poor absorption of vitamin D.

PUVA and narrow-band UVB have largely the same efficacy, possibly with a certain advantage for PUVA. The data we have today suggests that bath-PUVA should be preferred over oral PUVA for safety reasons.

Jean Krutmann from Germany nowadays works within a research institute. One of his ideas is to develop new light sources in dermatology. Krutmann was a pioneer in the development of UVA-1 treatment. Recently, blue visible light has been introduced in the treatment of atopic dermatitis (Dermodyne). Dermodyne emits light mainly in the 400–450 nm wavelength spectrum. Only 2% of the emission is within UVA-1. The first results of Dermodyne on patients with atopic dermatitis seem promising. The mechanism of action is as yet unclear.

Roelands discussed the use of 308 mm excimer laser for the treatment of psoriasis and vitiligo. Possibly there is a niche for this type of treatment for palmar and plantar psoriasis but also localized vitiligo. It seems as if the number of treatments before clearance is lower than with conventional UVB therapy.

John Hawk from London gave a lecture concerning polymorphous light eruption and chronic actinic dermatitis. In these cases, treatment with prednisolone 25–30 mg daily is initiated. However, most of these patients experience a hardening phenomenon and improve when given TL01-UVB twice weekly for approximately 4 weeks. The treatment protocols are highly individual-ised. If TL01 fails, PUVA can be tried according to approximately the same protocol. Sunscreens are often useless for polymorphous light eruption as the protection in the UVA range is relatively poor.

Mario Lecha from Barcelona discussed the treatment of porphyrias. He discus-sed the treatments used today but also that the patients can be hardened with TL01-UVB treat-

ment, as the absorption spectrum of porphyrins in the UVB region is relatively low.

Sally Ibbotson held a lecture concerning the indications for photopatch testing. It is mainly suspicion of a photo allergy against sunscreens and NSAID that warrants testing. Concerning NSAID there is not enough evidence whether or not this is a phototoxic or photoallergic reaction. The most common photoallergic agent in sunscreens is benzophenone. However, other agents can also induce photoallergy from sunscreens. It is well known that some ingredients in sunscreens degrade after exposure to sunlight, and that the photoproducts are possibly allergenic.

Dan Yarosh from New York discussed different methods of increasing DNA repair. Treatment with endonuclease has recently been introduced. Endo-nuclease is capable of decreasing the risk of skin tumours in patients with xeroderma pigmentosum. Also, immunosuppressants can decrease DNA repair apart from other aspects of immunosuppression. There is some concern regarding the long-term risk for skin cancer development from topical immunosuppresants.

Concerning sunscreens the role of re-application was emphasised. Also, the role of antioxidants (vitamin C, vitamin E) was discussed. There is no real evidence today that betacarotene has a cancer-preventing effect. Dihydroxyacetone (DHA) was discussed as a bronzing agent. DHA has a slight photoprotective effect. DNA dimers may be interesting in the future as these agents seem to stimulate the induction of pigment production.

Management of precancerous skin lesions

There has been some discussion recently whether or not actinic keratoses should be treated at all. The overall risk of development of a squamous cell skin cancer from an actinic keratosis is low, but on the other hand treatment is very easy to perform. Clinically it is not always obvious which lesions are actinic keratoses and which are early invasive squamous cell carcinomas. Also, actinic keratoses often itch and are disturbing to the patient. It was argued that more than 50% of patients treated by dermatologists have these kinds of symptoms, for example rosacea, tinea, acne, etc. The conclusion was that patients with multiple actinic keratoses are at a relatively high risk of developing a squamous cell carcinoma.

The treatment of actinic keratoses was discussed. The basis is prevention using UV protection and wise behaviour. New treatments are emerging, such as imiquimod, which seems to have an 80% cure rate. Various treatment protocols are being discussed.

Adapalene may also have a certain effect of actinic keratoses as has diclophenac. However, the results are debatable as the treatment periods are long and patient compliance can be discussed. It has been argued that there is a risk of incompletely treated actinic kerato-ses. Nowadays, photodynamic therapy (PDT) is regarded as the therapy of choice for widespread actinic keratoses. Patients are treated in one or two sessions only. Hence, patient compliance is probably much better than when treatment is extended over several weeks with topical treatment. Also, PDT seems to be superior to cryotherapy, especially on the lower legs. However, pre-treatment with imiquimod before Mohs' surgery seems to be effective. Also, imiquimod may be advantageous when treating HPV-induced cancer.

New indications for PDT

Non-oncologic indications include lichen sclerosus, localized scleroderma, eczema, lichen planus and cutaneous leichmaniasis. Recently, the possible advantage of the new methylester (Metvix®) has been discussed. A recently published report indicates that the pain after Metvix PDT is less than after ordinary ALA-PDT.

In summary, it was a very interesting meeting and the scientific quality is approximately the same (or even superior to) other big international meetings.