Newsletter N° 21

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Letter from the Treasurer of the International League of Dermatological Societies, Mary E. Maloney

Dear Friends and Colleagues

The ILDS has the opportunity to affect health care policy, health care delivery, medical education, individual patient care and health the world over. Some projects may require only volunteer efforts of supervision by members of our societies, but many require funding with both large and small amounts of money. This requires us to set priorities through our revenue streams. It is my job as treasurer to be sure we have the funds to meet our priorities. I would like to outline our sources of revenue for you.

Our funding comes from a wide variety of sources. First there are our membership dues paid by the member organizations. Each National Member Society pays an annual set fee per member of their organization and the International (Affiliate) Societies pay a set fee, per organisation, per year. In some cases, our Societies prefer to pay for the four-year period in advance. Therefore in the case of the larger Member Societies, these pay more than the smaller societies. The second source of funding is our share of the revenue from the World Congress. This includes a *per capita* fee that is part of the registration fee and a 50% share of the net proceeds of the entire Congress. This has been a substantial portion of our budgeted income. These two sources of income are used to maintain the League, paying our overheads, as well as financially supporting many of our special and ongoing projects.

The ILDS also receives support directed specifically to our many projects, both those of the ILDS proper and those of the IFD. Member societies support trainees and/or the staff at the RDTC in Tanzania, the Albino project, the educational conference in Tanzania, our Mexico project and the work with the World Health Organization, most recently helping to develop the ICD 11. These funds are usually donated to a specific project and are dispersed only as directed by the donor. We also have individuals who make significant contributions to specific projects.

Professor Rod Hay, chair of the IFD, works tirelessly to obtain grant funding from foundations and corporations to support the many projects of the IFD.

As you have read, some funding comes once every four years (dues and the Congress revenue), while donations are solicited annually. This requires our budget to be partially fixed to a four year cycle and relatively secure, and partially more fluid, at the mercy of yearly donations. This fluidity can be challenging in a lean economy and requires careful balancing by the Board of Directors.

It has been my pleasure to work as Treasurer, working closely with our other officers, board and administrators to set the priorities and implement them. I am hopeful that each member society can become involved, in some way, with our many projects and continue to support them with dues, special donation and volunteerism.

Mary E. Maloney, Treasurer ILDS

Letter from Kristian Threstrup-Pedersen on his personal view of the 22nd World Congress of Dermatology

22nd World Congress of Dermatology – 2011

The Korean Dermatology Association hosted the World Congress of Dermatology, May 22–29, 2011, in the COEX Center, Seoul, Korea (fig. 1–2).

Fig. 1. A magnificent and very large congress center – with hotels all around

Fig. 2. A look towards COEX from the temple

They did so in a magnificent way. Korean precision – Korean hospitality. They could not have done a better job. Any complaints? Only that one could walk for long distances in the huge congress center; but this was solved using golf car services.

COEX is the height of technology; wi-fi and a full range of facilities were available. And, just across the street, the Bongeunsa temple, which is still a living and working temple where people come to worship (fig. 3). So, you could walk between *genes and diseases* and *moments of mind*. I chose to do both.

First question: Any news? Yes, plenty of news. A World Congress of Dermatology is a 4-year summary of what has been achieved since the previous Congress. I cannot give a full summary as I was one of 11,000+ attending. But, let me give you a few of my impressions:

Certain areas in our specialty are standing still: Contact dermatitis, atopic dermatitis – nothing really new, rather depressing as these areas are clinically so prominent for us. Acne? Hair? Psoriasis? Well, kinase inhibitors are now being tested in psoriasis and there is optimism regarding this.

What impressed me was the following:

Arthur Sober from Harvard gave an excellent review on melanoma in a What's New session, and presented data on a new device called MelaFind, a handheld machine the size of a hair-dryer. Using this device you have a specificity on 98.3% of melanoma compared with 71% from dermatologist. FDA is considering its approval, which means that any beauty parlour can buy one. Forget the derm doctor. The European Medical Agency has approved MelaFind, the FDA not with a vote 8 : 7 for a nay.

Arthur Sober and Stephen Wagner gave interesting news on better treatment options of melanoma; an antibody treatment (ipilimumab) against CTLA4 which in-patients with metastatic melanoma can prolong life with, on average, 3½ months. It carries many side effects and costs approx. 100.000 US dollars per patient. There are also studies on two JAK kinase inhibitors. These show that there are significant achievements in metastatic melanoma. Kinase inhibitors could likely be at the center of future treatment modalities. It is all about secondary signalling mechanisms. These are also intensely studied in psoriasis according to Lars Iversen from Aarhus.

Another highlight of the conference was listening to Magnus Nordborg from Lund, Sweden, now divided between La Jolla and Vienna, where he heads a section at the Gregor Mendel Institute. Magnus is a typical Swede; tall, thin and with waving arms in his body language in presenting his thoughts. And, here comes the news: His wish is to study how *genotype* influences *phenotype*. It was a philosophical lecture. He has chosen a plant, Arabidopsis thaliana, which he can grow by the thousands. They have a rather limited size of gene (of course fully analysed) and then he can change its environment and look at the gene expression in the plants. So, what happens when sodium concentration is increased, what happens if temp is increased – and so on. But environmental influence can change gene expression and thus phenotype.

Pityriasis rubra pilaris is a disease, which we all know about, but seldom see. Please refer to (fig. 4) (I have the permission from the patient). He was previously completely healthy, no psoriasis in his family. Suddenly, he started to shed his skin (Fig. 4). It means some genetic changes must have happened in the epidermis. Shedding skin is related to ichthyosis. I attended workshop 76 on ichthyosis, where investigators from all over the world presented most interesting results. Genes are involved and well described. So, how come PRP suddenly arises? Many years ago I was told that if you place one certain strain of candida albicans cell in the middle of a Sabouraud agar, then it will – after 20 to 30 cell doublings suddenly express an *adhesion molecule* (likely a sugar) so the cell makes a ring on the plate – and then this event is switched off. This is something for Magnus Nordborg (or colleagues) to study. Is there a time – course in gene regulation, which could explain why PRP is a sudden *ichthyosis*?

I attended the exhibition hall where many companies had impressive exhibitions. Cosmetics are becoming more and more prominent. But one of the few companies still on *dermatology* is LEO Pharma and congratulations to them. They have a new plant compound, Ingenol mebutate, which has shown interesting results on actinic keratosis.

During a World Congress The International League of Dermatological Societies holds Assembly of Delegates Meeting(s) to discuss events of the past and plans for the future. Here, the Board of the ILDS has been active in promoting world skin health. Roderick Hay is Chairman of the International Foundation for Dermatology and steers programmes in the developing world.

The most exciting part of the Assembly of Delegates meetings was the bid for the 23nd World Congress of Dermatology and the election of new Board members for ILDS. There were four cities bidding: Bangalore, Rome, Vancouver and Vienna. Vancouver won in the first election with 54% of the votes, followed by Rome (27%), Vienna (13%) and Bangalore (6%). The Canadian Dermatology Association (President Jerry Shapiro and Secretary-General Harvey Lui) were very excited. Wolfram Sterry from Berlin is now President of ILDS the next four years. This is a wise choice and I congratulate him on that.

As an ILDS Board Member, I had the pleasure of being invited to the President's dinner. In his invitation Congress President Hee Chul Eun encouraged guests to dress in their national costumes. After some persuasion my wife, Grethe, came in a dress from 1800 from a small area in Lolland, Denmark (Fig. 5). So, Korea (Mrs Eun) and Lolland (Mrs Thestrup-Pedersen) represented their countries with beautiful designs.

Fig. 3. Worshippers of Buddha at the Bonguensa temple

Fig. 4. Pityriasis rubra pilaris – in a man previously completely healthy. Suddenly he develops this dreadful disease and has suffered from it for almost 2 years.

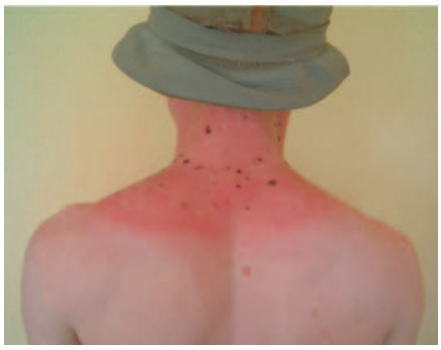
Fig. 5. Professor Hee Chul Eun – his wife (on the left) and Mrs Grethe Thestrup on the right – presenting beautiful dresses from their own culture.
I admire both ladies for presenting the epitome of women's art.

I have been a Board Member of the ILDS for 14 years. I have worked to support developments of skin health in the world. A very impressive and pleasant part of being a Board member is meeting interesting colleagues from all over the world with their strong wish to develop global skin health.

As Elvis Presley sang: *It's Now or Never*. And that is certainly true of a World Congress of Dermatology.

Kristian Threstrup-Pedersen

Hats On For Skin Health



We would like your support for *Hats On For Skin Health*, a global collaboration between the International League of Dermatological Societies (ILDS) and Stiefel, a GSK company, to reduce the devastating effects of skin cancer among people with albinism living in sub Saharan Africa. Research shows that 100% of albinos in this region will present with some form of skin damage by the age of 10 years old, leading if unchecked to advanced, a usually inoperable, skin cancer before the age of 20 or 30. Many albinos are not educated about the importance of sun protection and the consequences of sun damage. Even if they are aware, many can't afford sun-protective items like hats, or long-sleeved clothing.

Hats On For Skin Health is raising funds that will be used by the ILDS to buy hats and other sun-protective items for albinos, initially in Tanzania. Hats are produced locally at a factory in Moshi, Tanzania, which offers indoor employment to some people with albinism in the region. The ILDS' Regional Dermatology Training Center in Moshi will ensure that these hats are put into the hands of those in need. To learn more about Hats On For Skin Health, visit the campaign website at www.hatsonforskinhealth.org.

You can help the *Hats On For Skin Health* campaign by

- Circulating this letter to your members by way of your newsletter, bulletin or other publication
- Recognising the Hats On For Skin Health campaign by issuing a statement from your organization or posting a link to the campaign website on your website
- Asking your members to make a donation at www.hatsonforskinhealth.org (Donations are currently being accepted in 20 currencies, with more to be added)

Thank you for supporting ILDS and Stiefel in our initiative to help albinos in sub-Saharan Africa. Please contact us if you have additional questions, or would like more details on Hats On For Skin Health.

Sincerely,
Wolfram Sterry, President, ILDS
Roderick J. Hay, Chairman, IFD

ICD11 Update

Dermatology and the International Classification of Diseases Revision Project: news on ICD-10 update and ICD-11

Since my report published in Newsletter No 19 (July 2011), there have been a number of developments at WHO relating to the ICD Revision Project. This continues to be a demanding and somewhat formidable task. The change from a world in which paper and books were the norm to one which is rapidly becoming almost exclusively electronic brings with it many opportunities but also many potential dangers.

It was recognised in the summer that the sheer size of the ICD Revision Steering Group impeded its ability to take executive decisions promptly and effectively. As a result, a so-called Small Executive Group has been formed with just eight members to help direct policy. To my surprise I was invited to be one of those members. As such I am the only practising clinician on the Group. We hold twice-monthly teleconferences hosted by WHO in Geneva. At these we have the opportunity to address some of the crucial issues which have resulted from the expansion of ICD from its current form to a much more comprehensive classification of diseases residing on a sophisticated electronic platform.

One of the major issues on which the Small Executive Group is currently focusing attention is the tension between the desire to keep the classification to a manageable size and the requirements of all the anticipated users, including specialty groups such as dermatology. There is thus a virtual battle taking place between *pre-coordinators* and *post-coordinators*. Pre-coordination is the expression used to denote disease concepts in which two or more elements are explicitly combined (e.g. Tuberculous meningitis). In this example Tuberculous meningitis could be represented in a classification by a single pre-coordinated concept or by decomposing the term into two or more component parts which together fully specify the concept (thus Tuberculosis of nervous system and Meningitis in bacterial diseases classified elsewhere). The latter is referred to as post-coordination.

If the post-coordinators were to be unchecked, there is a real danger that the opportunity to represent hundreds of meaningful disease concepts in ICD-11 is lost. If on the other hand the pre-coordinators have the upper hand there is real danger of an explosion of the classification into an unmanageable monster. I have spent a significant amount of time in recent days formulating ways in which these tensions might be reconciled. The sophistication which an electronic platform can provide would allow for both parties' wishes to be accommodated and I feel that I have been able to demonstrate this in a position paper submitted a few days ago to the Small Executive Group. I am now lobbying for support.

Another issue which has been taking up my time in recent weeks is the forthcoming update of ICD-10. As I wrote in my last report, WHO invited me earlier this year to submit proposals for the 2013 update of ICD-10. This should be published some six months before the mandatory switch from ICD-9 to ICD-10 in the U.S. In a short window of opportunity in the spring I worked with members of the American Academy of Dermatology to try to address some of the most glaring defects in ICD-10 from the point of view of its representation of skin disease. The next phase of this process has just finished. This required gathering support for the proposed changes to persuade the members of the Update Revision Committee that they should be accepted. It appears that a number of the more minor proposals probably will be accepted but the more significant ones are proving harder to sell to the Committee. A meeting in South Africa in the near future will be deciding on these. I am grateful to those dermatologists who took the effort to register their support.

I have also been charged with supervising the development of a standardised anatomy classification for ICD where the needs of dermatologists are particularly poorly served. This will draw on existing terms used in the ICD Oncology classification supplemented where possible by terms from the international health care terminology, Snomed CT.

Progress with the skin disease chapter for ICD-11 has necessarily been affected by these other important and time-consuming preoccupations. Nevertheless progress is being made and I am particularly grateful to those colleagues from our Topic Advisory Group and from elsewhere who have contributed their time and expertise to its development. The current state of the ICD alpha draft can be viewed by going to http://www.who.int/classifications/icd/revision/en/. Examples of recent work include the cutaneous lymphomas and immunobullous diseases. Any comments can be directed to me at icd11@ilds.org.

The International Classification of Diseases 11th Revision is due by 2015

ICD is the **international standard** to measure health & health services

- Mortality statistics
- Morbidity statistics
- Health care costs
- Progress towards the **Millenium Development Goals**
- Research

The alpha-draft can be viewed online at: ICD-11 alpha browser

– Alpha draft is updated **daily** as the work progresses
– It is intended to show the **new features** to stakeholders early
– Commenting will be available in July 2011

I continue to find this job immensely stimulating. Combining it, as I now am, with a full-time post as consultant dermatologist in the UK National Health Services is challenging. Nevertheless I do feel that steady progress is being made.

Robert Chalmers
Co-Chair and Managing Editor
Dermatology Topic Advisory Group
Member of Small Executive Group
WHO ICD Revision Project

22nd September 2011

Members' Corner

From Rossitza Lazova, MD, Chair, ISDP Travel Grant Award Committee, and the Officers and Executive Committee Members of the ISDP

The International Society of Dermatopathology (ISDP) was founded in 1979. The ISDP has had a tremendous impact on the development of Dermatopathology, a relatively small, but important sub-specialty of dermatology and pathology. The aims and objectives of the ISDP are to increase knowledge of the structure and function of the skin and of skin diseases by microscopy. The ISDP sponsors international and regional meetings as well as other educational events. The ISDP serves its members by stimulating their curiosity and desire for learning, while simultaneously promoting friendship and scientific exchange among its members from different countries, different scientific schools of thought, and varied socioeconomic backgrounds. To become a member of the ISDP please visit www.intsocdermpath.org. The membership also includes a subscription to The American Journal of Dermatopathology.

The ISDP has established a Travel Grant program that provides funding for physicians from developing countries to attend a meeting of the ISDP. Two grants in the amount of $1,500.00 USD each are awarded annually to qualified applicants. These grants are intended to cover part or all of the costs for attendance to an ISDP meeting held during the award year. An oral or poster presentation at the meeting is highly encouraged. Through this award the ISDP reinforces its global presence; fosters, promotes, and supports Dermatopathology in developing countries; provides a forum for the exchange of ideas and research in Dermatopathology; and facilitates establishing relationships between dermatopathologists throughout the world. To download an application and apply for the Travel Grant award please visit the ISDP website.

2010 Travel Grant Award recipients
From left to right: *Dr. Mohamed El-Khalawany* from Egypt (awardee); *Dr. Rossitza Lazova*, Chair, Travel Grant Award Committee; *Dr. Azita Nikoo* from Iran (awardee); *Dr. María-Teresa Fernandez-Figueras*, President of the XXXI Symposium of the ISDP, October 2010; Barcelona, Spain

2011 Travel Grant Award recipients
From left to right: *Dr. Rossitza Lazova*, Chair, Travel Grant Award Committee; *Dr. Pankaj S Salphale* from India (awardee); *Dr. Rajalakshmi,* Tirumalae from India (awardee); *Dr. Heinz Kutzner*, ISDP President; *Dr. Werner Kempf*, ISDP Vice-President;
XXXII Symposium of the ISDP, September 2011; Geneva, Switzerland

Indian Association of Dermatologists Venereologists and Leprologists (IADVL)

IADVL Ancillary meeting during WCD Seoul
IADVL had a successful Ancillary meeting during WCD Seoul. More than 500 Indian delegates actively participated in the WCD. Dr Hemangi Jerajani was elected to the post of Regional Director of ILDS and Dr S Premalatha, our nominee, was selected for the ILDS Certificate ofAppreciation. Many of our members were invited as guest speakers, chairpersons and many presented papers and posters. Dr Tarun Narang won the Gold medal for posters.

Vitiligo Day was observed all over India on May 19th, 2011. A documentary was screened all over India. Many free camps, educational awareness programmes, Jatha and CMEs were conducted . Kerala branch observed CUTICON, the annual conference on May 7th and 8th.

IADVL conducted CC MIDERMAMEET at Bangalore on Aug 27–28th at Bengaluru. This business meeting was attended by more than 110 executive members from various parts of India. IADVL L'oreal jury meet also took place on Aug 26th at Bangalore to select projects on pigmentation.

The annual conference of IADVL-DERMACON 2012 will be organized at Jaipur, Rajastan on Feb 8–12, 2012. Those who are interested can log on to www.dermacon2012.com

VITILIGO DAY Jatha

IADVL LOREAL PIGMENTATION RESEARCH GRANT JURY MEET

IADVL CC MIDERMAMEET

Annual Congress of the Tunisian Society of Dermatology and Venereology

Hammamet : March 16–17; 2012

Topics:
- Photo DynamicTherapy
- Quality of Life in Dermatology
- Internal Medecine & Dermatology
- Dermoscopy
- Clinical Cases
- Fillers

with the participation of *Andrew Finley* (UK), *Shyam Verma* (India), *Camille Frances* (France)

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