Canadian Skin

The Official Publication of the Canadian Skin Patient Alliance

Volume 11 Issue 2

Pyoderma gangrenosum

Peer-to-peer support

Are biologic treatments the "new kids on the block" for psoriasis?

Complimentary
Summer 2020

Contact Dermatitis: The common culprits

Introduction to phototherapy

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Suggestions and tips for skin patients and their families...

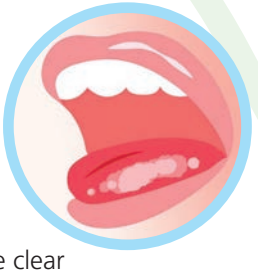
Barbies with **vitiligo and alopecia**

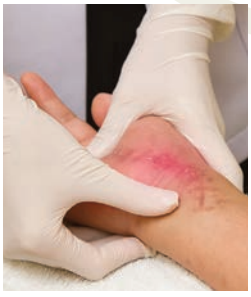
Image: Mattel

Mattel has released new designs to broaden the diversity of its dolls range, including a doll with hair loss (alopecia) and one with a skin condition called vitiligo, which causes patches of skin to lose their pigment. Mattel's prototype, which debuted on Barbie's Instagram page last year, became its most "liked" post ever.

Places to watch for skin cancer

- Soles and Palms: It's typically a flat dark or reddish patch.
- Eyelid: Too much sun is often the cause.
- Tongue: You might notice flat, hard, white patches (leukoplakia) that you can't scrape off.
- Lip: Non-melanoma cancers are the ones that typically affect your lips.
- Iris: You might see "uveal" or "intraocular" melanoma as a dark spot in the colored iris around your pupil.
- White of your eye: Conjunctival melanoma is a cancerous growth on the clear membrane that covers the surface of the eye and inner eyelid. It often appears as a dark or red spot in the white of your eye.





Worried about making **scars less visible?**

There are a number of options that your dermatologist may recommend:

- Silicone gel keeps skin hydrated and lets it breathe so scars can soften.
- Zinc supplements help reduce inflammation and generate cell growth.
- Scar massages break up the collagen building in the tissue underneath.
- Collagen injections may even out bumps or indents.
- Chemical peels and dermabrasion remove surface scars from the top layer of skin.
- Laser therapy targets blood vessels to remove severe scars.
- Microneedling spurs your skin to make collagen, which plumps skin and improves texture.

Waxing before exercise

The gist: To avoid post-wax irritation, schedule your waxing on a rest day.

The expert insight: Waxing pulls hairs from their follicles, which creates micro-wounds in the skin. If you exercise in the hours after your appointment, sweat can transfer bacteria into the follicles, so you're at risk of developing pimples, folliculitis or ingrown hairs.

The bottom line: Stick to low-intensity workouts afterwards. Leave at least 24 hours (enough time for your skin to heal) between your wax and your next big workout.

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Features of Darier-White Disorder and how hormones affect hidradenitis suppurativa

By Dr. Isabelle Delorme

Learn more, live better.
A Canadian health care professional answers your questions.

Q What is Darier-White Disorder. Have there been any treatment advances?

A Darier disease (also known as Darier-White disorder) is an inherited skin condition characterized by wart-like blemishes on the body. They usually first appear in late childhood or early adulthood and often occur on the scalp, face and upper trunk. Other features of Darier disease may include nail abnormalities, such as red and white streaks in the nails with an irregular texture; and small pits in the palms of the hands and soles of the feet. It is not an infection and is not contagious.

Darier-White disorder is a rare disease, affecting one person in 30,000 to 100,000. Men and women are equally affected. It is caused by mutations in a gene called ATPA2.

Blemishes are usually itchy, yellowish in color, hard to the touch, mildly greasy, and can emit a strong odor. The severity of the disease varies over time and people living with Darier disease experience flare-ups. The appearance of the blemishes is influenced by environmental factors, which can cause more blemishes during the summertime because of heat and humidity.

Darier disease is usually diagnosed by the appearance of the skin and family history, but may require a skin biopsy.

Managing Darier disease may include using sunscreen, wearing cotton loose-fitting clothing, and avoiding hot environments. Moisturizers with urea can reduce scaling. The affected skin may smell unpleasant, which may be due to bacteria growing in the rash, which can be suppressed by using an antiseptic cleanser.

Prescription treatments include topical medications such as antibiotic, corticosteroid and retinoid creams. Oral retinoids (isotretinoin, acitretin) have been the most effective medical treatment for Darier disease, leading to reduction of symptoms in 90% of affected people. However, retinoids may cause adverse effects and cannot be used in women who wish to become pregnant. Oral antibiotics are also prescribed to address any secondary infections.

Other treatments include surgery and different types of laser. Studies are underway on the use of diode laser and botulism toxin injections.

Q I have hidradenitis suppurativa (HS) – what role do hormones play in managing this disease?

A Hormones are occasionally used to treat HS. Currently, the evidence for the association between HS and hormonal activity is contradictory. It is well documented that many women experience painful disease flares around menses, and HS is associated with polycystic ovary syndrome, a disease caused by an imbalance of reproductive hormones. Nonetheless, a recent systematic review did not identify a consistent hormonal abnormality in HS patients.

Despite this lack of evidence, a clinical benefit is seen in some HS patients with antiandrogen therapy and oral contraceptives. It is believed that the clinical benefit seen in HS patients with antiandrogen therapy might be secondary to an anti-inflammatory effect of these medications. CS

Dr. Isabelle Delorme *is a certified dermatologist working in Drummondville, Quebec. She was the CSPA Dermatologist of the Year in 2017.*

Ask the Expert

Got a question? Send to **info@canadianskin.ca.** If your question is published you will receive a **$25 gift card. Good luck!**

Contact dermatitis:

The common culprits

By Matthew Ladda and Dr. Patrick Fleming

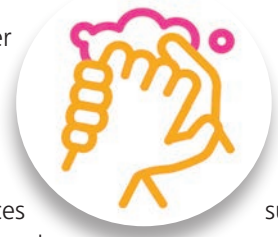
What is contact dermatitis?

Contact dermatitis is a preventable and treatable condition that develops when your skin is exposed to a substance that is irritating or to which you are allergic. After exposure to the triggering material, the skin becomes red, itchy and sometimes painful. Contact dermatitis is classified into two types: irritant and allergic.

Irritant contact dermatitis

Irritant contact dermatitis is caused by exposure to a substance that is irritating and damages the protective layers of the skin. It is not a true allergy and can happen to anyone. Irritant contact dermatitis typically occurs after multiple exposures to an irritant, although very harsh chemicals (e.g., a strong acid) can trigger it immediately. With irritant contact dermatitis the skin is often dry, cracked and sore. In severe cases, blisters or painful ulcers may form.

In infants and children, the most common cause of irritant contact dermatitis is diaper rash. Diaper rash is caused by prolonged contact of moisture, urine or stool with the skin. The best way to prevent diaper rash is to change your child's diaper often and avoid harsh soaps and wipes.



In adults, irritant contact dermatitis is typically caused by substances used at home or at work. People working in certain occupations—such as aestheticians, janitors, mechanics, plumbers, chefs, bartenders and health-care providers—are at increased risk of the condition as they are frequently exposed to chemicals and other materials.

Common culprits responsible for causing irritant contact dermatitis are:

- Harsh detergents and soaps
- Cleaning products
- Adhesives
- Acids and solvents
- Excessive water exposure

Allergic contact dermatitis

Allergic contact dermatitis is caused by an immune reaction to a substance and is considered a true allergy; it occurs when a person is allergic to a particular chemical or natural substance. Food does not cause contact dermatitis.

The rash from allergic contact dermatitis generally develops on the area of the skin that has been in direct contact with the substance. The affected skin may appear red, itchy, cracked, swollen or blistered.

Skin allergies can develop over time, and you can develop an allergy at any point in your life—even to products you have happily used before. For example, some people will develop allergic contact

dermatitis to a skin cream they have used for many years. Allergic contact dermatitis generally resolves a few days or weeks after the initial exposure (as long as the skin is no longer in contact with whatever caused the rash). Sometimes, however, it will last longer because of scratching or if there is trace exposure to the trigger.

Common culprits responsible for causing allergic contact dermatitis are:

- Poison ivy
- Nickel (e.g., in costume jewellery, belt buckles and zippers)
- Preservatives in skin-care products and disposable wipes (e.g., methylisothiazolinone)
- Fragrances and perfumes
- Formaldehyde (e.g., in disinfectants and skin-care products)
- Neomycin (e.g., in some antibiotic creams)
- Black hair dye (e.g., paraphenylenediamine [PPD])
- Rubber by-products (e.g., in shoes and disposable gloves).

How is contact dermatitis treated?

The best way of managing contact dermatitis is to identify and avoid the triggering substance. Identifying the cause of contact dermatitis is sometimes easy, such as after known contact with poison ivy, but can prove challenging if the culprit is less obvious. Your doctor can help you determine the cause of your specific case.

Because the rash from allergic contact dermatitis can be delayed by days or weeks after the exposure, the trigger can be particularly hard to identify. If you have true allergic contact dermatitis then the allergen needs strict lifelong avoidance.

Some people will develop allergic contact dermatitis to a skin cream they have used for many years.

How do you determine the cause of allergic contact dermatitis?

Patch testing is recommended if the cause of allergic contact dermatitis can't be easily identified. It is typically performed by a dermatologist, and involves placing small amounts of common triggers on the back under "patches," which are taped in place. You can't shower or exercise while the patches are in place. Patch testing will often cause you to feel somewhat itchy, but severe reactions are rare.

At a follow-up appointment a few days later, the patches are removed and the different areas of skin are assessed for inflammation. False positives and false negatives are possible, so the results need to be carefully interpreted based on your individual situation. CS

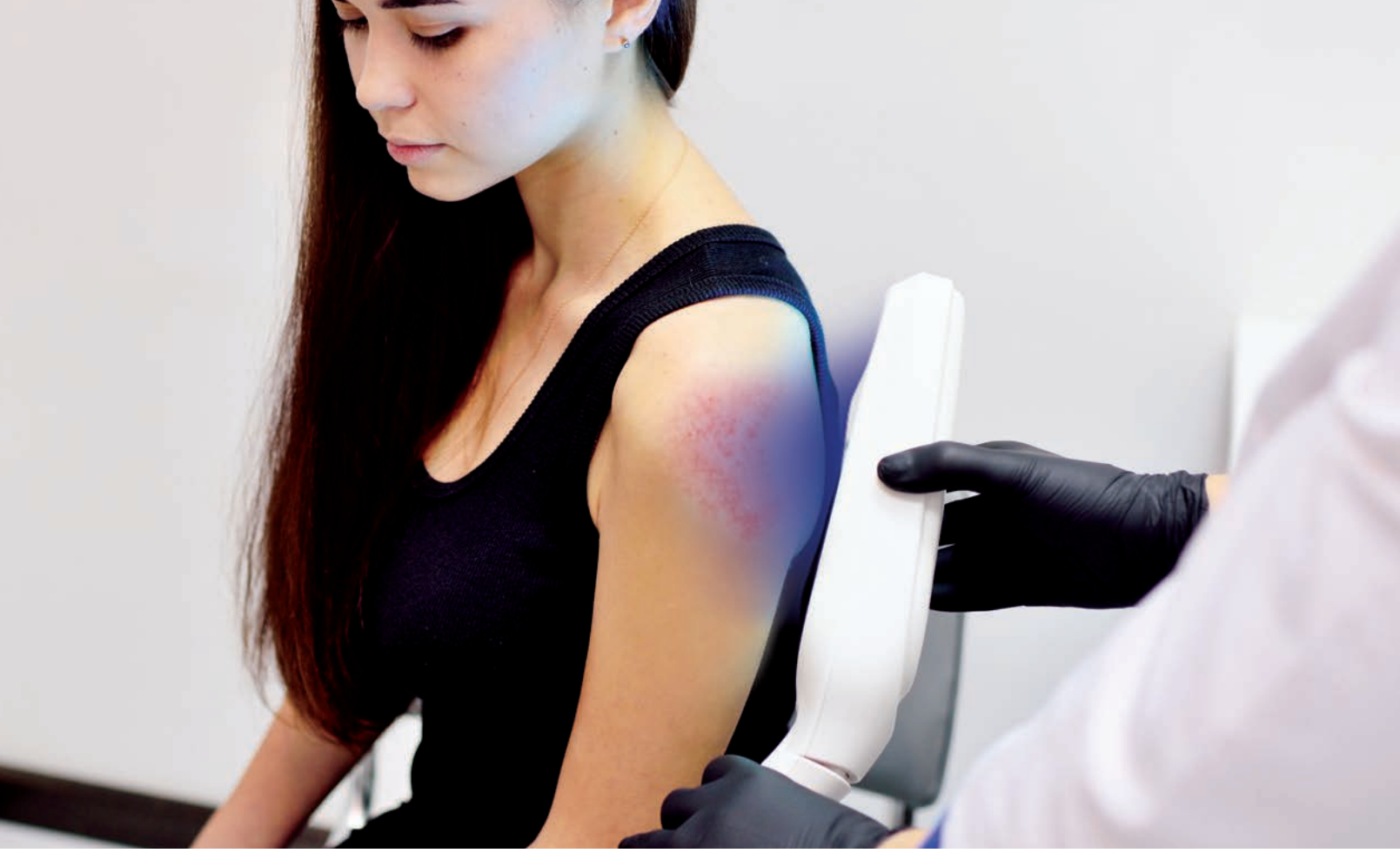
Matthew Ladda, BSc(Pharm), is a pharmacy school graduate and a third-year medical student at the University of Toronto, with an interest in dermatology.

Dr. Patrick Fleming, MD, MSc, FRCPC, FAAD, FCDA, is a Royal College-certified dermatologist and assistant professor of medicine at the University of Toronto. He has clinical and research interests in psoriasis, atopic dermatitis and complex medical dermatology.

How can I prevent contact dermatitis?

- Avoid harsh products and use gentle, non-soap cleansers.
- Because fragrance can cause both irritation and allergies, we recommend using fragrance-free personal-care products.
- Moisturize daily, using gentle products, to maintain the skin's natural barrier and keep allergens out.
- Wear protective gloves and clothing if you are exposed to irritants and allergens at work.

- Many store-bought antibiotic ointments trigger reactions and should, therefore, be avoided. Minor cuts and scrapes without signs of infection can be treated with plain petrolatum jelly ointment from a clean tube, rather than a topical antibiotic.



An introduction to phototherapy

By Dr. Ian Tin Yue Wong and Dr. Gabriele Weichert

For many patients, medicated topical creams, ointments and lotions are familiar treatment options. Further along the treatment spectrum are medications that are taken orally or given by injection, otherwise known as systemic agents. Beyond this are targeted medications that are also given by injection, known as biologics. Topical therapies are often used on localized areas of the skin, while systemic or biologic therapies are typically reserved for treating more extensive areas.

How does phototherapy work?

Phototherapy, commonly referred to as light therapy, is a treatment option that may be less familiar to many patients. Phototherapy allows dermatologists to treat large areas of skin. It might be suggested if topical therapy isn't providing an adequate benefit, or if the patient prefers an external treatment option, rather than taking a medication internally.

You may be aware that the sun emits both visible light and ultraviolet (UV) radiation in varying, uncontrolled amounts. Phototherapy harnesses the power of UV radiation in a filtered, controlled and calculated dose to treat a variety of skin conditions, including psoriasis and eczema. The specifically filtered UV radiation works by decreasing inflammation in the skin. Patients

are generally prescribed treatment sessions two to three times a week, with the aim of tapering off or continuing treatment depending on the patient and their dermatologist.

What does starting treatment look like?

After you have been assessed by a dermatologist and phototherapy has been determined to be appropriate, the dermatologist will formulate a phototherapy prescription plan that takes into account your tendency to burn and tan, and your skin type.

Phototherapy is administered in stand-up, walk-in booths that have encompassing walls lined with a series of UV lights. They are designed to encircle the patient to provide 360 degrees of a specific, calculated dose of light therapy.

The dose of UV radiation prescribed will be low at the start, and will be gradually increased at following visits. This gradual increase lowers the risk of burning—a potential side effect of light therapy. Burns from treatment are often short-term and only occur occasionally. They can be easily addressed by moisturizing the skin and speaking with the phototherapy medical staff to adjust the UV dose.

Phototherapy booth

Phototherapy for atopic dermatitis

Are these phototherapy booths the same as tanning beds?

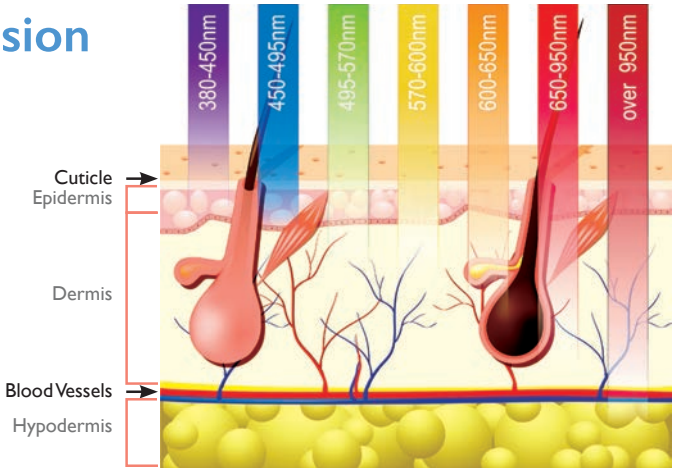
No, phototherapy booths are not tanning beds. Tanning beds produce non-specific and variable light energy that can damage the skin and increase the risk of skin cancer. To date, the most common form of UV used in phototherapy—narrowband UVB—has not been associated with skin cancer. CS

Ian Tin Yue Wong, BSc(Pharmacy), MD, was a practicing pharmacist and is now a dermatology resident at the University of British Columbia, with a special interest in photomedicine.

Gabriele Weichert, MD, PhD, FRCPC, is a practicing dermatologist in Nanaimo, British Columbia, and a clinical instructor at the University of British Columbia.

A typical **phototherapy session**

1. You check in with the phototherapy medical staff, who will answer any questions and address your concerns. They will also track your treatment progress for your dermatologist to review.
2. You undress in a private area, and put on UV eye-protective goggles before entering the phototherapy booth.
3. An appropriate dose of phototherapy is administered for a calculated period of time, typically ranging from seconds to minutes.
4. After each treatment session, you can carry on with your daily activities.



Phototherapy showing different light spectrums that penetrate the skin to different depths.

Pyoderma gangrenosum

By Khalad Maliyar

Pyoderma gangrenosum (PG) is a rare skin disorder that causes painful sores to rapidly develop. PG affects individuals of all ages, with a peak incidence between 20 and 50 years of age, and affects men and women almost equally.

The specific cause of PG has yet to be identified, but is neither infectious nor contagious. Although healthy individuals can develop PG sporadically, it is commonly associated with certain conditions, including:

- Chronic inflammatory diseases of the digestive tract (ulcerative colitis and Crohn's disease)
- Blood disorders (e.g., acute myelogenous leukemia, myelodysplasia, myeloproliferative disorder)
- Rheumatoid arthritis

The development of PG ulcers can also be triggered by minor skin trauma and surgery—most commonly after breast, cardiothoracic or chest surgery. For example, patients who have had a colostomy can develop PG around the opening of the colostomy (the stoma).

How do I know if I have PG?

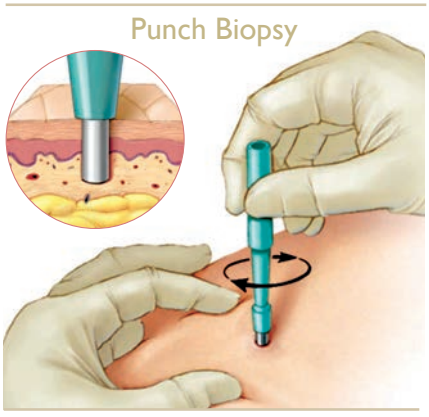
The first sign of PG is typically a small, raised, red–purple bump or blister that may resemble a spider bite. Within several days the bump will rapidly progress to form a large, painful open wound. The edges of the wound are sometimes purple.

The centre of the wound can look fluid or pus filled, or necrotic. The legs are the most common site of involvement for PG, but it can also occur on the head and neck in children, and around the genitals and perianal area in infants.

You should see a doctor or nurse if you develop painful, rapidly growing, open skin wounds that do not heal quickly.

Diagnosis

There is no specific blood test or laboratory investigation to diagnose PG. Various conditions can look like PG, including venous ulcers, infections, injuries, cancers and autoimmune diseases. Diagnosis is typically guided by clinical suspicion via your history and physical examination. Your physician can take a small sample of the skin through a biopsy and examine the sample under a microscope in a laboratory to confirm the diagnosis. They might also take a swab of the wound to rule out infection.



Treating PG

Proper wound care is essential in managing PG, and pain management is another important aspect of care. These wounds are extremely painful, and inadequate pain control can lead to stress, anxiety and a negative impact on quality of life. Topical pain-control agents such as acetaminophen, non-steroidal anti-inflammatory drugs (NSAIDs) and, if the pain is extremely debilitating, opiates can be used. Other aspects of wound management include appropriate cleansing, judicious use of antibacterial agents and removing non-viable tissues (also known as debridement).

Different medications are also required to help heal PG. Your doctor will help you to choose the best agent depending on the cost, disease response and side-effect profile.

Common treatment options:

- An injection of steroids around the area with PG, or topical application of steroid cream
- Oral treatments, including targeted biologics (e.g., infliximab, adalimumab, etanercept) and systemic immunosuppressants (e.g., cyclosporine, sulfasalazine, methotrexate).

There are multiple options for oral therapies, so if one medication does not work then your physician can try something else.

It can take several months or even years for PG to go away completely. If you do have PG, you might, therefore, need treatment for a long period of time. Moreover, when the wound heals it typically leaves a scar. There is also a chance that the wound can come back at a later time. CS

***Khalad Maliyar, BA**, is a third-year medical student in the Faculty of Medicine at the University of Toronto.*

Image: Mayo Clinic

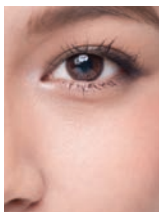
Top Stories in Research

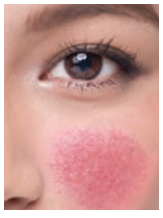
By Irma Shaboian

What's new on the research front? The articles from which these summaries of the latest in skin research are taken are so hot off the press the ink has barely dried.

Brimonidine gel decreases alcohol-induced facial "flushing"

Facial erythema is characterized by facial redness due to increased blood flow to the skin. It typically occurs in 20% to 47% of East Asian individuals after alcohol consumption and is known as alcohol flushing syndrome (AFS). There is currently no approved treatment for this condition. A randomized, placebo-controlled clinical trial of 20 individuals of East Asian descent in the USA found that topical brimonidine decreased observed facial flushing. In particular, researchers examined whether brimonidine gel, 0.33%, decreases facial erythema in patients with AFS after consumption of alcohol. Participants in the study were randomized to apply the gel to either the left or right half of their face, with the placebo being applied to the opposite side. After half an hour, the participants ingested alcohol. Differences in facial redness between the placebo and treated sides of the face were compared 60, 90, and 120 minutes after drug application. The findings indicated that there was a significant difference in facial redness at 60 minutes after the gel was applied, and the effect persisted at 90 and 120 minutes. The participants indicated that they were likely to use the medication again and would recommend its use. The small study's findings suggest that the gel is effective in reducing flushing of the skin in individuals of East Asian descent with AFS and that patients that experience psychosocial distress due to AFS may benefit from its treatment.





Melanoma incidence differs by age group

Melanoma is linked to UV exposure and has been linked to childhood sunburns. Researchers in the USA investigated whether there were any age-specific differences present for melanoma incidence. To do this, researchers looked at almost a million cases of reported invasive melanoma, which can be characterized by penetrating the skin's layer and spreading beyond its original site, over a 14-year timespan. From the database, it was possible to determine annual rates of melanoma in pediatric, adolescent, young adult, and adult age groups. Overall, researchers found that the incidence rate increased as people aged. In adults 40 years and older... or, In adults 40 years and older, melanoma ratesincreased in both men and women. For adolescents and young adults, the opposite observation was seen with incidence rates decreasing. Young women appeared to have twice the risk of melanoma as the young men. The researchers point out that the findings can be possibly attributed to sun protective interventions and that public health efforts influence sun-protective behaviours. The study provides support for ongoing prevention efforts.

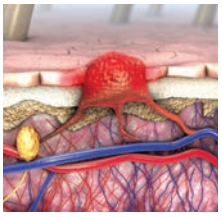
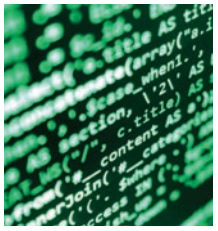


Illustration of a cross-section of diseased skin with melanoma that enters the bloodstream.

Can an algorithm detect keratinocytic skin cancer?

A deep-learning algorithm using region-based convolutional neural network technology was used by Korean researchers between January 2011 and September 2018 to analyze unprocessed photos of patients with possible skin lesions. This technology uses neural networks in order to fulfil its objective of recognizing patterns—specifically patters on the skin. In the past, detecting skin cancer on the face using algorithms was challenging and led to potential false-positive results. The purpose of this research study was to evaluate whether an algorithm can automatically locate suspected areas and predict the probability of a lesion being malignant. Over 920,000 possible lesions were created using over 182,000 clinical photos, which were manually or automatically annotated.



The algorithm was trained with over 1.1 million images to locate and diagnose cancer. The accuracy of predicting skin cancer by the algorithm was comparable to that of dermatologists, and greater when compared to individuals with no medical training. Findings from the study are relevant because they indicate that algorithms can be used to localize and diagnose skin cancer without dermatologists first preselecting suspicious lesions. CS

Irma Shaboian holds a Bachelor's of Science degree and is currently a law student.

Summer Activity Check List

See how many you can do before you head back to school... and don't forget your sunscreen!

- ☐ Have a picnic
- ☐ Play frisbee
- ☐ Eat breakfast for dinner
- ☐ Look for animals in the clouds
- ☐ Make a blanket fort
- ☐ Make a bird feeder
- ☐ Have a water fight (outside of course!)
- ☐ Plant a vegetable and watch it grow
- ☐ Finger paint
- ☐ Dance in the rain

Can you find the matching butterflies?

Match the pair from the left to the ones on the right.

Summer chuckles

1. **When do you go at red and stop at green?**
   (When you are eating a watermelon)
2. **What do cats like to eat on a hot summer day?**
   (Mice Cream cones)
3. **What do you call a dog on the beach in summer?**
   (A Hot Dog)

CAN YOU Find the Differences?

There are 6 differences on the right-side picture? See below for the answers...and no peeking.

1) Turtle Fin. **2)** Orange Fish. **3)** Seaweed. **4)** Bubble. **5)** Coins. **6)** 9 Octopus Arms.

The lasting impact of peer-to-peer support

By Colleen Piekarski

After finding a growing bump on my scalp in February 2014, I was diagnosed with stage III melanoma. I immediately underwent aggressive head and neck surgery at Sunnybrook Hospital, where the surgeon removed a two-inch circle of my scalp and 14 lymph nodes. Two weeks later there was more bad news: melanoma had been found in two of my lymph nodes. The medical team told me that I needed adjuvant therapy, aggressive radiation and experimental drugs right away.

In the midst of despair, I found the Melanoma Network of Canada (MNC). Desperate to talk to someone who would understand my situation, I reached out. Twenty-four hours later, Annette Cyr, MNC founder and Chair of the Board, contacted me directly to connect me to a trained and certified "peer-support partner."

Not long afterwards I received a phone call from a complete stranger who, I'm delighted to say, single-handedly changed my outlook. In our two-hour conversation my peer-support partner, Sue, covered everything—she listened to my story in detail, shared the latest research and even gently "kicked me in the pants." She gave me realistic hope.

In the fall of 2015, Sue and her family even travelled to North Bay to attend my "bell-ringer dance party" following my nivolumab treatment. It's now been more than five years since that first phone call. Since then, I have had one recurrence and have consequently been part of leading-edge research trials. Today, I'm doing extremely well.

In addition to the peer-to-peer support given to me, I appreciate the advocacy work the MNC does for all melanoma patients across Canada. The MNC has helped patients gain access to funding for drugs such as nivolumab, an important part of my treatment. Still, there is more work to do, more people to support, more research to fund and more money to raise—and it's heartwarming to know that the MNC is there to support anyone impacted by melanoma. CS

Colleen Piekarski, a long time North Bayite, has been married to John for 36 years. They have four grown children. Colleen is a nursing teacher at Canadore College.

About the Melanoma Network of Canada

The MNC is a national organization that offers support to individuals whose lives have been changed by melanoma, and is committed to advancing the prevention of melanoma through research, advocacy and education.

One of the services the MNC offers to its patient network is the peer-to-peer support program, which connects patients with a certified peer who has also experienced a melanoma diagnosis. The program offers individuals the opportunity to share their journey with someone who can relate to their concerns and challenges. The program is free, confidential and available by phone or e-mail anywhere in Canada. Patients are matched with a peer based on several demographics, including stage of disease, treatment experience and availability. Peer-to-peer support does not replace professional counselling and medical advice.

If you are a patient or caregiver looking for support services, or if you want to become involved in the peer-to-peer support program, please contact Mary Zawadzki at mzawadzki@melanomanetwork.ca or 1-877-560-8035 ext. 108.

Are biologic treatments the "new kids on the block" for psoriasis?

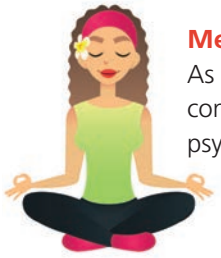
By David Jung and Aryan Riahi

As with other chronic conditions, psoriasis has psychosocial aspects that you should discuss with your health-care provider.

Psoriasis is a common chronic skin condition in which silvery scales and red, raised plaques appear on the body. Less common are other forms of psoriasis, such as nail, pustular, guttate, erythrodermic and inverse psoriasis.

Global estimates of the prevalence of psoriasis range from 0.9% to 8.5% of adults, with Canadian figures resting near 2%. Adults are more affected than children, and individuals aged 30–39 or 50–69 years of age are most vulnerable to the onset of the condition. Common triggers range from prior trauma, certain drugs, infection, sunburns, emotional stress, alcohol, tobacco, and obesity. While there is a range of presentations, mild to severe itching, visible changes to the skin, and painful arthritis in roughly one-third of cases can impair the quality of lives of patients. The diagnosis is generally made clinically with the lesions occurring classically on the scalp, extensor (outside) surfaces of knees and elbows, as well as the buttocks and genital area. Less commonly, the eyebrows, nails, axilla (armpit), perianal, and abdominal regions can be affected. While there is unfortunately no cure for psoriasis, it must be emphasized that it is not contagious and does not result from poor hygiene.

With an increasing incidence of the disease, there is an ever-growing need for prompt, multifaceted treatments that help those with psoriasis maintain a good quality of life. With such a wide array of treatment options available including topical treatments (such as emollients, vitamin D3 analogues, tar, and corticosteroids), phototherapy, and systemic medications (such as methotrexate and cutting-edge biologics), patients may find this vast array of options overwhelming. We discuss common treatment options below.



Mental health

As with other chronic conditions, psoriasis has psychosocial aspects that patients should discuss with their health-care provider. While psoriasis is rarely a life-threatening condition, patients' self-images are affected. It is common for people with psoriasis to experience decreased self-esteem, which can exacerbate any underlying mood disorders such as depression. In addition to self-image, the amount of time it takes to treat lesions all over one's body and maintain proper clothing can also take away from one's quality of life. It is crucial for patients and their health-care provider to keep an eye out for psychiatric symptoms so as to ensure their mental well-being.

Diet

Some wonder if diet can play a role in the management of their psoriasis. According to the Canadian Association of Psoriasis Patients, while no diet can "cure" psoriasis, individuals who are overweight or obese may benefit from a low-calorie diet to maintain a healthy weight. Weight loss is also beneficial for patients who are affected by psoriatic arthritis, a relatively common joint condition that may occur concurrently with psoriasis. Patients should take a common-sense approach to reduce their intake of saturated fats and sugars, while introducing variety to their diet with fruits and vegetables.

Pharmacologic treatments

Pharmacologic treatments for psoriasis include both topical and systemic therapies. The choice depends not only on the severity of the disease, but also on cost and individual responses associated with a particular treatment. Topical treatments have the advantage of minimizing absorption throughout the body, whereas systemic therapies may be needed by those with more severe disease. Choice of therapy depends on patient preferences, as well as the type and severity of psoriasis. Mild plaque psoriasis may benefit from topical treatments. Unfortunately, topical therapies are often insufficient to fully clear the patient's skin if they live with more severe psoriasis. Moderate to severe plaque psoriasis often requires adjuvant phototherapy or systemic medications. In particular, biologics are systemic medications that can provide rapid and efficacious control of the disease. These medications are often used for severe psoriasis, especially presentations that do not readily respond to other treatment options. Most of these drugs function by targeting different components of the immune system, such as chemical messengers.

Following initiation, individuals are monitored for improvements in their skin and how they tolerate the treatment. The National Psoriasis Foundation defines an acceptable

response to biologics as involvement of less than 1% of body surface area with fewer than 25% of symptoms, compared with baseline, after six months of therapy.

Biologic agents are at the cutting edge of treatment for moderate to severe psoriasis. They are remarkably effective and well-tolerated by patients in both short-term and long-term use. Observations using an international registry (PSOLAR) with more than 12,000 participants provide reassurance with respect to the safety of biologics: when compared with non-biologic therapies, biologics were not associated with an increased risk of death, cardiovascular events or cancer. In addition, there are biologic options indicated for pregnant and breastfeeding women living with psoriasis. Considering these factors, biologics may be the "new kids on the block."

For more information, talk to your doctor about the right options for you. CS

David Jung *and* ***Aryan Riahi*** *are third-year medical students at the University of British Columbia. Prior to medicine, their backgrounds were in microbiology and immunology and psychology, respectively.*

CSPA in action: A spotlight on our latest activities, events and other information of importance to skin patients in Canada

Education and awareness

Promoting awareness of the challenges of living with a skin disorder is at the heart of our work. The CSPA launched its successful mental health campaign #ShedTheShame on Bell Let's Talk Day (January 29, 2020) to shine a light on the psychosocial impacts of living with atopic dermatitis. We also shared information on social media about the importance of adhering to topical medications, the challenges of living with truncal acne, and celebrated International Rare Disease Day.

New report-hidradenitis suppurativa

Comparing the experiences of patients in Canada and abroad living with hidradenitis suppurativa (HS), the CSPA published an updated report *Scarred for Life: 2020 Update*. This report found that people living with HS continue to struggle to get an accurate diagnosis and manage their condition effectively.

Advocacy

We have provided patient input to decision-makers to help them recommend whether governments in Canada should cover drugs for atopic dermatitis (Dupixent) and psoriasis (Duobrii & Cimzia). We have also contributed to policy discussions about how the federal government should regulate drug prices to improve patient outcomes, ensured that the Alberta government understood the implications of its Physician Funding Framework on patients receiving phototherapy in the province, and shared our thoughts with the Ontario government about how to improve skin patients' access to care and therapies.

SkIN Canada launch

We are delighted to be part of a grant from the Canadian Institutes of Health Research (CIHR) to help launch the Skin Investigation Network of Canada (SkIN Canada). One of the important pillars of this network is patient engagement and collaboration. The CSPA Executive Director will chair the Patient Advisory Council and help support Patient Research Partners as we work towards better understanding skin disorders and their impacts on patients. If you are interested in becoming a Patient Research Partner, please reach out to us at **info@canadianskin.ca**.

Awareness Days

- Scleroderma Awareness Month – June
- Hidradenitis Suppurativa Awareness Week – June 1-7
- National Sun Awareness Week – June 1-8
- Men's Health Week – June 10-16
- National Cancer Wellness Awareness Day – June 26
- World Scleroderma Day – June 29
- International Self-Care Day – July 24
- Acne Awareness Month – September
- Craniofacial Awareness Month – September CS

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visit **canadianskin.ca/donate**.

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Clinical Trial

Looking for ARCI patients

Scientists in the Department of Dermatology & Skin Science at the University of British Columbia are looking for adult patients with autosomal recessive congenital ichthyosis (ARCI) to participate in a research project. Specifically, the study would require participants to allow the research team to take a small punch biopsy from a hidden part of your skin. The research team will then isolate skin cells from that sample and use them to investigate a new approach which may lead at some point to the development of a new treatment option for ARCI. The research team will reimburse any travel-related costs to attend for the biopsy.

To learn more, please contact Lead Researcher Dr. Sarah Hedtrich, Assistant Professor, Institute for Pharmaceutical Sciences, UBC at **(604)-822-2466** or **sarah.hedtrich@ubc.ca**. CS

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Thank you to the Medical Advisors and Board Members who support the work of the CSPA. For an updated list of names, visit: **canadianskin.ca/about-us.**

Want to WIN a $25 gift card?

Simply answer this question:

Does CSPA's Skin Patient Charter help protect people against discrimination due to the appearance of their skin?

Submit your answer by July 17, 2020 to **info@canadianskin.ca**, along with your name and contact information. **Good luck!**

CSPA AFFILIATES

AboutFace:
aboutface.ca

Acne and Rosacea Society of Canada:
acneaction.ca (acne)
rosaceahelp.ca (rosacea)

Alberta Lymphedema Association:
albertalymphedema.com

Alberta Society of Melanoma:
melanoma.ca

BC Lymphedema Association:
bclymph.org

Canadian Alopecia Areata Foundation (CANAAF):
canaaf.org

Canadian Association for Porphyria:
canadianassociationforporphyria.ca

Canadian Association of Scarring Alopecias:
casafiredup.com

Canadian Burn Survivors Community:
canadianburnsurvivors.ca

Canadian Psoriasis Network:
cpn-rcp.com

Canadian Skin Cancer Foundation:
canadianskincancerfoundation.com

DEBRA Canada (epidermolysis bullosa):
debracanada.org

Eczema Society of Canada:
eczemahelp.ca

Firefighters' Burn Fund:
burnfundmb.ca

HS Aware:
hsaware.com

Melanoma Network of Canada:
melanomanetwork.ca

Myositis Canada:
myositis.ca

Neurofibromatosis Society of Ontario:
nfon.ca

Save Your Skin Foundation:
saveyourskin.ca

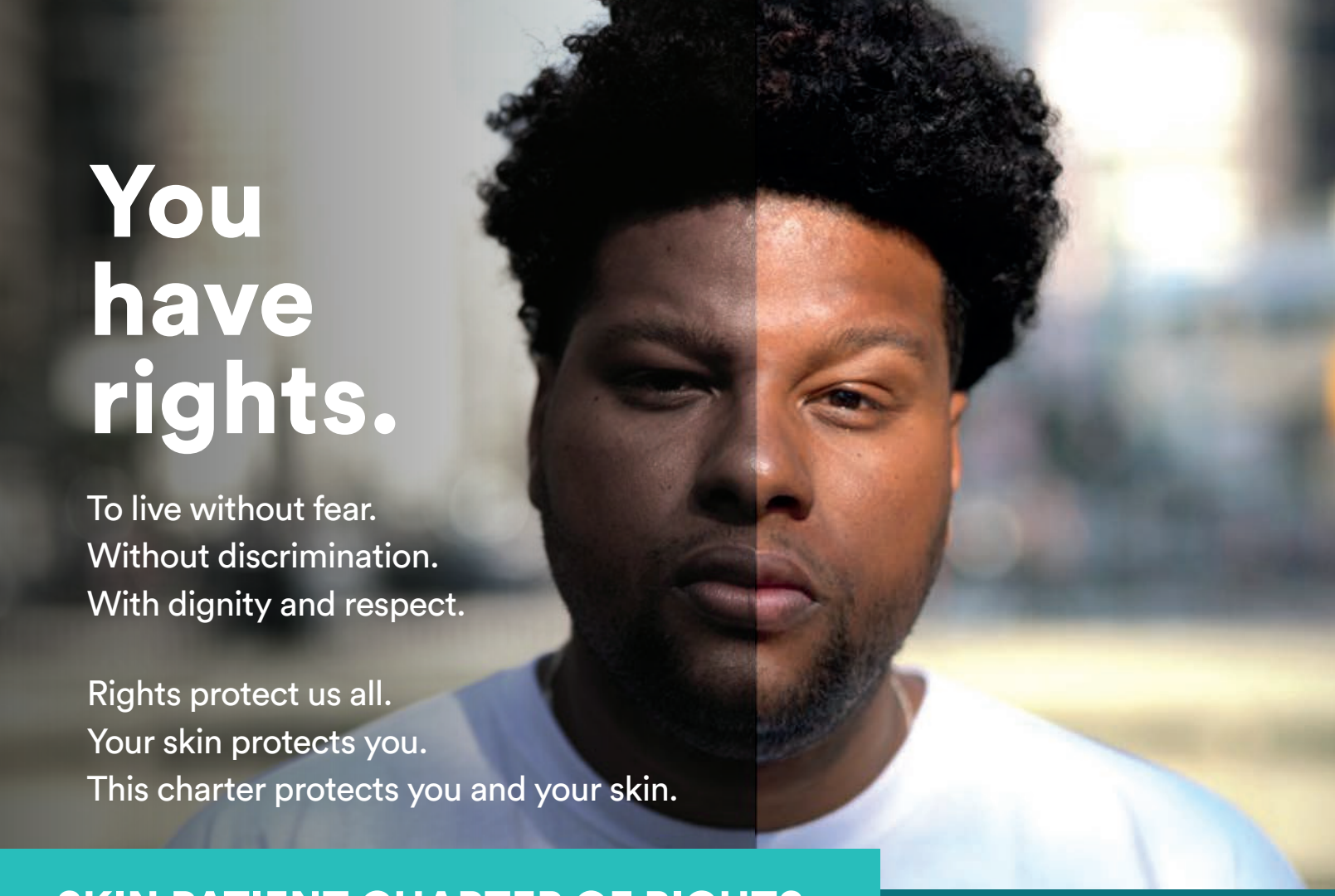
Scleroderma Association of B.C.:
sclerodermabc.ca

Scleroderma Canada:
scleroderma.ca

Scleroderma Manitoba:
sclerodermamanitoba.com

Scleroderma Society of Ontario:
sclerodermaontario.ca

Stevens–Johnson Syndrome Canada:
sjscanada.org



You have rights.

To live without fear.
Without discrimination.
With dignity and respect.

Rights protect us all.
Your skin protects you.
This charter protects you and your skin.

SKIN PATIENT CHARTER OF RIGHTS

canadianskin.ca/charter

1. Live without fear of discrimination due to the appearance of your skin;
2. Be acknowledged that living with a skin condition may have profound effects on overall well-being including physical, emotional, social and financial aspects, which can be just as significant as other diseases are to other patients;
3. Be entitled to societal, employment and government resources should your diagnosis have debilitating effects;
4. Receive comprehensive, evidence-based information about your skin condition, disease, or trauma including the expected impact on your health and available treatment options (including potential side-effects) as well as a prognosis;
5. Maintain your dignity, respect and absolute confidentiality during exams, procedures and treatments;
6. Access to counselling on lifestyle changes and preventive measures known to aid in the management of your disease, including physical activity, diet modification and the avoidance of triggers;
7. Discuss psychosocial concerns resulting from skin disease, and to receive information on coping strategies and referrals to mental health resources as needed; and
8. Be actively engaged in all treatment decisions as you are the ultimate decision-maker including modifications and additions to treatment plans as appropriate.

ACSPA CPD
Canadian Skin Patient Alliance
Alliance canadienne des patients en dermatologie

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