Canadian Skin

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Volume 11 Issue 1

Recognizing truncal acne

Celiac disease of the skin

Living with Scleroderma

Complimentary
Spring 2020

Avoiding lice and scabies: A contagious itch

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Engaging with your pharmacist

skinfacts

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

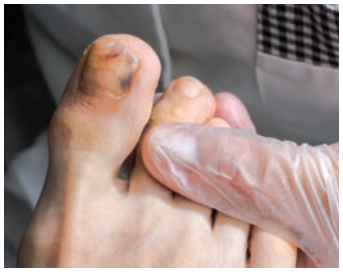


If toenails could talk

Maybe it's time for us to focus on our feet more often (and not just during sandal season). Toenail colour changes can signal health problems. Here's what to watch for and talk to your doctor about.

☐ **Black toenail:** This is commonly caused by a bruise under the nail, technically called a subungual hematoma. Expect your black toenail to grow out in about six to nine months. But it might also be malignant melanoma, a fungal infection, a chronic ingrown nail or other health problem.

☐ **Yellow or white:** When toenails turn yellow or white, a fungus is usually to blame. If left untreated, an infection can worsen or spread.



☐ **Got green:** This might be green-nail syndrome (chloronychia), which is caused by an infection. The culprit is usually bacteria that thrive in damp or wet conditions.

☐ **Shades of blue:** If you get a blue spot for no apparent reason then you might have a mole beneath the nail. In very rare cases, a type of mole called a cellular blue nevus can become cancer.

☐ **Brown streaks:** Called melanonychia, brown usually appears as a line or streak going up and down the nail. Causes range from injury to certain medications, but there's a small chance it could be something serious.

Science of greys

Your hair follicles have pigment cells that make melanin, a chemical that gives your hair its colour. As you age, these cells start to die. Without pigment, new hair strands grow in lighter and take on various shades of grey, silver and eventually white. Once a follicle stops making melanin, it won't make coloured strands again.

What's premature gray?

Some people go grey 10 or more years earlier than average. It's premature if you're grey before:

- 20 years if you're white
- 25 years if you're Asian
- 30 years if you're black

What causes **cellulitis?**

Cellulitis is a life-threatening skin infection that often strikes the arms and legs, but can appear anywhere on the body. Here are the basics on cellulitis and how to protect yourself:

- Cellulitis is not contagious.
- It is caused by common bacteria getting into the skin's deeper layers—usually Streptococcus or Staphylococcus.
- Some people develop cellulitis while others never do.
- Keep your fingernails and toenails clean and trimmed.
- Practice proper wound cleaning—wash cuts and wounds as soon as possible, and apply an antibacterial ointment.
- Keep skin moisturized to prevent tiny cracks in the epidermis.

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Treatment options for palmar psoriasis,

and is it dry skin or athlete's foot?

By Dr. Isabelle Delorme

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

Q I have psoriasis on my hands. My doctor has prescribed topical cortisone cream, but it's not working very well. What other options do I have?

A Hand (or palmar) psoriasis can be more difficult to treat than plaque psoriasis on other parts of the body. It has a big impact on quality of life, as it can interfere with daily activities and work. There are two forms of psoriasis that can be seen on the palms and soles. The plaque form causes dry and scaly plaques and the pustular form causes pustules on the hands and feet.

A few lifestyle changes can ease the discomfort. Avoid friction and wet-work. Protect your hands by using cotton gloves under vinyl gloves. Moisturize regularly, immediately after hand washing and bathing, and anytime inbetween. The treatment depends on the condition's severity. Milder forms may be managed by a family doctor, but if you have moderate or severe psoriasis then you might want to ask for a referral to a dermatologist. Topical treatment is the first-line therapy. Topical medications used to treat palmar psoriasis are topical corticosteroids (more potent ones such as clobetasol propionate are preferred) and calcipotriol.

Treatment options for moderate-to-severe palmar psoriasis include phototherapy and systemic medications. The latter include oral drugs, such as methotrexate, acitretin and ciclosporin, and injected biological agents. These are long-term treatments.

Q The skin between my toes always seems to bubble and peel, especially after a shower or bath. Is this just dry skin or could it be athlete's foot?

A "Bubbling" and "peeling" between the toes are signs of either dyshidrotic eczema or tinea pedis (athlete's foot).

Dyshidrotic eczema is characterized by firm vesicles (bubbles) on the soles and toes and the palms and fingers. They initially contain clear fluid, and resolve after several days by peeling (more technically known as desquamation). The bubbles are usually very itchy. Dyshidrotic eczema usually appears in adults, and people with atopic dermatitis or hay fever are at higher risk of developing it. Blisters normally last for about two to four weeks and may be related to seasonal allergies, changes in humidity or stress. Occasionally, dyshidrotic eczema may be triggered by contact to allergens such as nickel, cobalt or balsam.

Management includes avoidance of triggers. Soaks or cool compresses 2 to 4 times daily can help to dry blisters. Topical corticosteroids are the mainstay of treatment for this condition. For more severe cases, phototherapy is recommended.

Tinea pedis usually presents with redness, scaling, cracks and maceration between the toes, especially the last two web spaces. Vesicles can occur. Itchiness is variable. Tinea pedis is a fungal infection that can also affect the toenails. Treatment is usually with a topical antifungal cream. CS

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

Congratulations Vanessa T. (Calgary), the winner of a $25 gift card. For your chance to win, send us your question for the expert at info@canadianskin.ca.

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!**

A contagious itch
Lice and scabies

By Matthew Ladda and Dr. Patrick Fleming

Learn the difference between these conditions and how to treat them.

Head lice

Head lice are small insects that infest and live on the human scalp. They feed on small amounts of human blood and lay eggs close to hair shafts. After being laid, lice eggs hatch within one to two weeks.

What are the symptoms?

An itchy scalp is the most common symptom of a head lice infestation. Small red bumps can occasionally be seen on the scalp. However, it is possible to have head lice without even noticing these symptoms.

Lice are very small, but they can be seen on the scalp upon careful inspection. Adult lice are no larger than a sesame seed and have a grey-coloured body that may appear redder after feeding. Their eggs are small, brown and difficult to see. However, after hatching, the empty egg case (known as a "nit"), is white and remains attached to a person's hair shaft, making it easier to detect.

How are head lice spread?

It's important to recognize that head lice are highly contagious and spread easily among people, especially children. Group settings such as classrooms, playgroups and camps are particularly susceptible to the spread of lice. However, head lice can only survive for one or two days when not on a human.

How do you treat head lice?

People only need to be treated for head lice if live lice are found in their hair. Because head lice are easily spread from one person to another, it is necessary to check the hair of all family members and anyone else who has been in close contact.

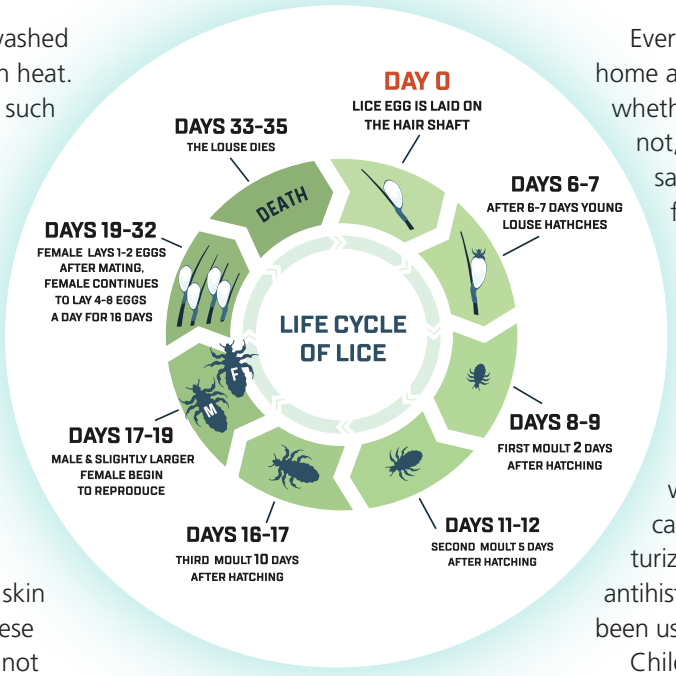
There are several treatments for head lice, and your doctor or pharmacist can recommend a particular product and provide you with instructions on how to use it. They include insecticide treatments such as permethrin, and non-insecticide treatments such as silicone oil dimethicone, isopropyl myristate/cyclomethicone and benzyl alcohol lotion. People with head lice should repeat the same treatment one week later to ensure any newly hatched lice are also killed.

Home remedies such as applying heat to the scalp or covering the scalp with oil or petroleum jelly are not at all recommended. Tea tree oil is also not effective and can often cause unnecessary irritation.

To ensure all lice have been eliminated and to prevent reinfestation, all bed linens, towels,

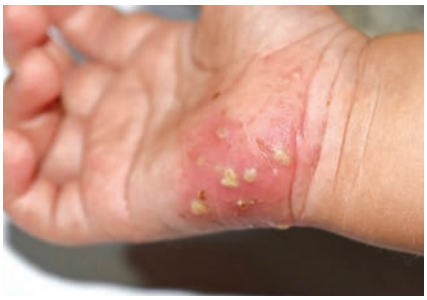
hats and clothing should be washed in hot water and dried on high heat. Items that cannot be washed, such as pillows and jackets, should be sealed in a plastic bag for at least two weeks. Combs, brushes, headbands and other hair-care items should be soaked in rubbing alcohol or thrown away.

Children with head lice can return to school or daycare as soon as they have been treated once.



Scabies

What is scabies? Scabies is a skin condition caused by mites. These mites are microscopic and cannot be seen with the naked eye. Mites that cause scabies burrow into the top layer of skin to live, feed and lay eggs.



What are the symptoms?

An intense itch that is worse at night is one of the characteristics to watch for. Scabies can cause a rash of small red bumps that can occur anywhere on the body. It is especially common on the web spaces of the hands and feet, and on the breasts and genitals.

How is scabies spread?

Also highly contagious, scabies can spread from an infected person to an uninfected person by skin-to-skin contact. The mites can survive for three to four days when not on a human. Anyone can get scabies, regardless of age, cleanliness or personal hygiene. Places with a higher density of people are particularly susceptible to outbreaks and it often spreads within a household.

How do you treat scabies?

Scabies must be treated with medication as it will not resolve on its own. A treatment called permethrin at 5% concentration may be recommended by your doctor. It must be evenly applied to the entire body from the neck down and be left on for eight to 14 hours overnight. This should be repeated one week after the initial treatment to ensure any newly hatched mites are also killed. Rarely, a pill may be prescribed.

Everybody who lives in the same home as a person with scabies, whether they have symptoms or not, should be treated at the same time to prevent the mites from being passed back and forth. Similar to head lice, all linens and clothing in the home should be washed in hot water and unwashable items sealed for two weeks.

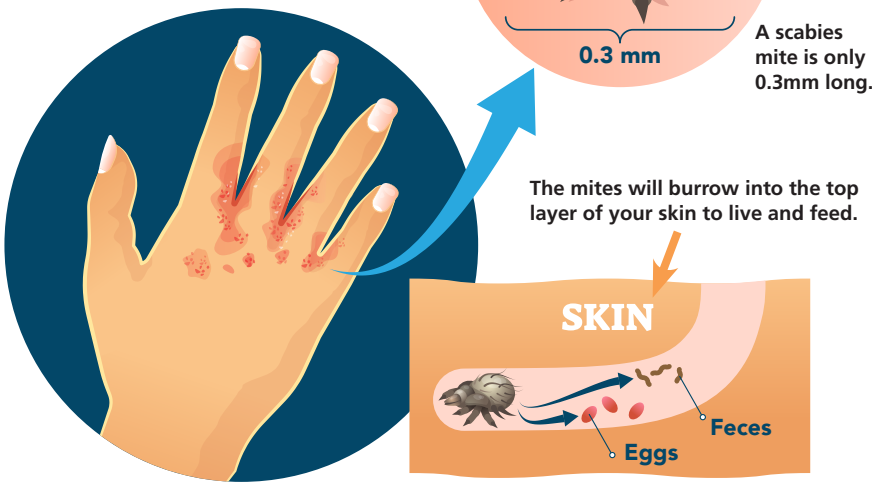
The itching from scabies can remain for four to eight weeks after treatment. Itching can be treated with daily moisturizing, topical cortisones and/or antihistamines after permethrin has been used.

Children with scabies can return to school after a single treatment. 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, is a Royal College-certified dermatologist and Assistant Professor of Medicine at the University of Toronto. He has clinical and research interests in psoriasis and complex medical dermatology.

Scabies is caused by a mite known as the Sarcoptes scabiei. Untreated, these microscopic mites can live in your skin for months.



Truncal acne

Often hidden or unrecognized

By Muskaan Sachdeva and Dr. Jerry Tan

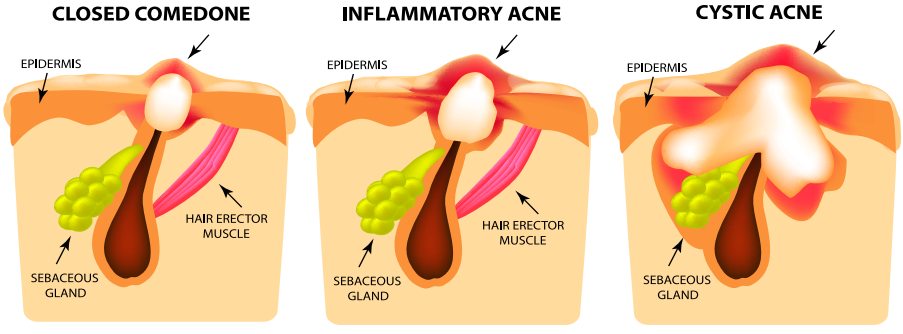
Truncal acne occurs in more than half of individuals who present with acne. It most frequently affects the back, then the chest—hence its name. Truncal acne is characterized and divided into three levels, based on severity.

1. **Comedonal acne:** Small white papules (known as "closed comedones") that result from complete or partial blockage of the sebaceous ducts, or grey–white papules ("open comedones") caused by an increase in sebum (the natural oils produced by the skin for moisturization).
2. **Mild-to-moderate papulopustular acne:** Superficial inflammatory lesions.
3. **Severe acne:** Deep pustules and/or nodules, which can cover large areas and be painful.

Pathways to acne development include:

- an increase in hormones, leading to higher and more inflammatory levels of sebum production
- pore blockage because of overproduction of keratin
- an increased number of bacteria called *Cutibacterium acnes*, which break down oils to free fatty acids that trigger inflammation.

As you can see, several factors can lead to inflammation within the oil glands, including modified sebum, bacteria and free fatty acids. These create the visible features of acne: comedones (white or grey but with



no redness), papules and pustules (otherwise known as zits), and deeper, larger lumps called nodules and cysts.

Other causes of truncal acne include certain medications, environmental exposures, hormonal imbalances (such as polycystic ovarian disease) and pore blockage from the use of hair products or wearing damp clothing.

People with acne can be embarrassed by facial or truncal involvement. And while facial acne is readily visible, truncal acne is often hidden or undetected. Those with truncal acne might use clothing to hide it and avoid situations where they must expose their torso to others (such as swimming or changing in a locker room). Others may not be aware of its presence, particularly if it's on their back.

If you have facial acne, it's important that your doctor also checks your torso. If inadequately treated, the consequences of acne are similar whether facial or truncal—including psychological impacts such as embarrassment, anxiety and depression, and physical outcomes such as scarring or stains. The risk of thickened scars called keloids or hypertrophic scars from acne is often greater with acne on the torso.

Treatment

The treatment of truncal acne varies from person to person, depending on its severity and extent. Those with more severe and extensive acne are typically treated with systemic medications such as antibiotic pills, hormonal medications called antiandrogens or oral isotretinoin. However, there is increasing recognition of the value of topical medications in treating less extensive forms of truncal acne.

Regardless of the therapy, **people affected by acne** should be monitored frequently to **ensure adherence to treatment** and positive therapeutic outcomes.

For reasons of practicality, it's important that the affected individual or a caregiver can reach the affected truncal regions to apply any prescribed therapy. There are other considerations too, such as recognizing that products containing benzoyl peroxide may bleach clothing or bedding. Furthermore, topical agents containing benzoyl peroxide and topical retinoids can increase skin dryness and irritation. Various measures can reduce the risk of these side effects, however, such as using moisturizers and applying the agents less frequently.

Regardless of the therapy, people affected by acne should be monitored frequently to ensure adherence to treatment and positive therapeutic outcomes, as this will mitigate the risk of psychosocial and physical consequences. The most important aspect of therapy is to ensure a timely reduction in inflammation in order to reduce risks.

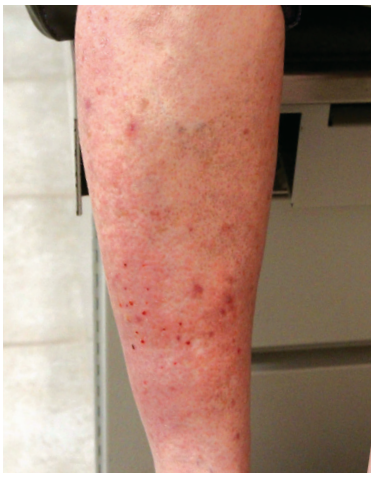
If you have acne and over-the-counter products are ineffective after two or three months of use then it's important to seek further health care advice and management. There are now many treatments that can help, including nutritional management (e.g. a low glycemic index diet), avoiding dairy and medications. New treatment options are also being developed specifically for truncal acne, some of which are available in Canada. Talk to your doctor about the options that are best for you. CS

Muskaan Sachdeva is an MD candidate in the Faculty of Medicine at the University of Toronto. She has a special interest in understanding skin pathologies and raising awareness about skin conditions.

Dr. Jerry Tan is a certified dermatologist who works in Windsor, Ontario. Dr. Tan focuses his research on acne, rosacea and psoriasis. He was the CSPA Dermatologist of the Year for 2018.

For more information

Visit the website of our Affiliate Member, the Acne and Rosacea Society of Canada: **www.acneaction.ca**. The organization offers hope and help to those with acne by providing independent, reputable and current information on the conditions and raising awareness.



Dermatitis herpetiformis: Celiac disease of the skin

By Priya Dhir

Dermatitis herpetiformis (DH) is a skin condition that is caused by a reaction to eating gluten. The vast majority of people with DH also have celiac disease, which is a sensitivity to a protein called gluten that is found in wheat and other grains.

When a person has celiac disease and eats gluten, their intestines make an antibody called immunoglobulin A (IgA). This antibody targets epidermal transglutaminase in the small intestine. However, IgA can also travel under the skin and target the transglutaminase protein located there. This causes what's known as the DH rash.

Signs and symptoms

The classic findings of DH are itchy blisters and red skin lesions that occur in groups. These skin lesions usually appear on both sides of the body, elbows, knees, the lower back region (the sacrum), buttocks and scalp. Given the intensity of the itching, the lesions can sometimes rupture. Individuals with this condition can also have gastrointestinal symptoms such as abdominal bloating, cramping, pain, diarrhea or constipation.

Causes

Most people with DH also have celiac disease, which can be confirmed by a small intestine biopsy. However, some may have a normal duodenal biopsy but nevertheless have their DH triggered by dietary gluten, which is why DH is sometimes referred to as "celiac disease of the skin." DH affects approximately 10–15% of people with celiac disease. First-degree relatives of those with celiac disease and DH have an increased risk for both conditions. DH can affect people of all ages, but most often first appears between the ages of 30 and 40 years.

Diagnosis and treatment

A diagnosis of DH can be made by performing a specific type of skin biopsy called a "punch biopsy." This involves injecting a local anesthetic and using a small, cookie-cutter-like punch to remove a small sample of the skin adjacent to a lesion. The incision is then closed with one stitch. Skin biopsies from people with DH are positive for IgA deposits in a specific pattern.

Blood tests for antibodies that are common in people with celiac disease (e.g., anti-tissue glutaminase) also supplement the diagnosis of DH. If blood antibody tests are positive and the skin punch biopsy has the typical findings of DH then it isn't necessary to conduct an intestinal biopsy to confirm the diagnosis of celiac disease.

Following a strict, life-long gluten-free diet is important for controlling DH. A gluten-free diet can be complex, so those with this condition should be referred to a registered dietitian with expertise in celiac disease for a nutrition assessment, education and follow-up. Unfortunately, even with adherence to a strictly gluten-free diet, it can take a couple of years for the skin rash to totally resolve.

A family of antibiotics known as sulfones can also be prescribed to reduce the swelling and the discomfort caused by the rash. diaminodiphenyl sulfone is a common antibacterial within this family that is used to treat DH, and typically brings relief within 48–72 hours. However, this medication does not replace the importance of maintaining a gluten-free diet.

Coping and support

All diseases that are visible on the skin can cause people discomfort and unease in public. If you think you or a family member may be living with DH then you may also have celiac disease. Speak to your doctor about any signs or symptoms that you're experiencing.

Strict adherence to a gluten-free diet can cause vitamin deficiencies, anemia and even gastrointestinal cancer. If you have been diagnosed with DH then it's very important that you do not take food, drink or medications containing wheat, rye, barley or oats

It can be difficult for some people to maintain a gluten-free diet. Make sure to discuss with your doctor or dietitian, and try to learn more about any specific dietary considerations and options. The Canadian Celiac Association has many local chapters with support groups to help share ideas and coping strategies: **www.celiac.ca**. CS

***Priya Dhir** is a third-year medical student at the University of Toronto. She graduated from the University of Waterloo's honours biology program.*

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.

Increased risk of squamous cell carcinoma with indoor tanning among women

A prospective cohort study of women in Norway found that the association between cumulative exposure to indoor tanning and the risk of squamous cell carcinoma (SCC) was the same regardless of duration of use and age at initiation.

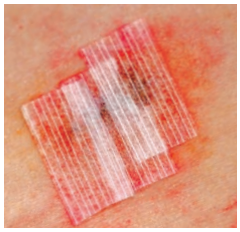
The purpose of the study was to investigate a dose–response relationship between lifetime indoor tanning and SCC risk; the association between duration of use and age at initiation; and the association between age at initiation and age at diagnosis. This study is among the first to investigate a dose–response association between lifetime indoor tanning and risk of SCC.

The cohort study included data from almost 160,000 women born from 1927 to 1963, and baseline questionnaires were issued to participants from 1991 to 2007. Follow-up questionnaires were completed every five to seven years, and the data were analyzed in 2018–2019. The participants reported information such as pigmentation factors, sunburns, sunbathing vacations and indoor tanning. The researchers also collected information on all cancer diagnoses and dates of emigration or death.

The researchers found a significant dose–response association between indoor tanning and SCC—and the association between cumulative exposure to indoor tanning and risk of SCC remained regardless of duration of use and age at initiation. These findings also provide supporting evidence that the risk of SCC is greater among women with a higher cumulative number of indoor tanning sessions. The findings will support policy development regarding indoor tanning.

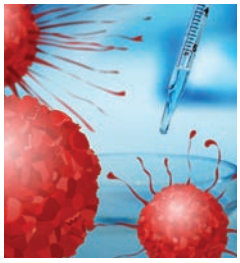
Tape strips are a minimally invasive method for evaluating atopic dermatitis

Researchers have found that tape strips provide a minimally invasive option for evaluating atopic dermatitis (AD) in children. Currently, skin biopsies are the standard for evaluating AD; however, this is not always feasible for children. The objective of the study was to assess whether the tape-strip approach could be used to identify skin biomarkers in place of the traditional approach.



A total of 51 children younger than five years were recruited, including children with both moderate to severe AD and those without. Sixteen tape strips were collected from both lesional and non-lesional skin of children over a period of two years. Gene and protein expressions were evaluated as main outcomes. The researchers concluded that this method may prove useful for tracking pediatric AD therapeutic responses and to assess biomarkers for AD via skin sampling, in place of the traditional biopsy method.

B cells linked to immunotherapy for melanoma



Researchers in Europe have found evidence that B cells may play an important role in immunotherapy for melanoma. B cells are a type of white blood cell that originate in the bones and secrete antibodies. Typically, T cells—another type of white blood cell—have been the focus of immunotherapy research because of their ability to kill cancer cells. But these findings now show that B cells also play a critical role in triggering melanoma-associated inflammation. It was observed that, in the case of melanoma, B cells directed T cells to the tumour when particular messenger molecules were secreted.

Although further research is needed, such as to determine the mechanism B cells use to support the activation of T cells, this research has found that B cells play an important part in the cancer-fighting process and help T cells to find the tumour. CS

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

Can you find all 15 objects hidden in the picture?

Family walk scavenger hunt

It's been a long winter, and hopefully the weather is starting to warm up a little where you are.

Why not get your family together with a smartphone and head out into your neighbourhood for a scavenger hunt? Find the items on the list below and take a picture of each one you find. Go together or divide into teams for some friendly competition—the team with the most found items wins!

- ☐ Number 8
- ☐ Stop sign
- ☐ Playing field
- ☐ Swing set
- ☐ Squirrel
- ☐ White fence
- ☐ Mailbox
- ☐ Colourful front door
- ☐ Red car
- ☐ Baby Stroller/carriage
- ☐ A family
- ☐ Lawn decoration
- ☐ Taxi
- ☐ Fire truck

Living with Scleroderma

By Marion Pacy, President of Scleroderma Manitoba

My personal story of scleroderma began on a cold winter's night in 1989, when I thought I had gotten frostbite on my hands.

At the time, I was working as a Winnipeg Transit bus driver and being in the cold was something I did every day. I did not think it was that cold, but my hands were blue after a night of work. I saw a doctor, who told me I had Raynaud's phenomenon and to try to keep my hands warm.

At the age of 40, in 1992, I noticed that I was going through a roll of antacids a day and I was later diagnosed with acid reflux. That same year, I underwent knee surgery and, as I was waking up, the anesthesiologist told me he thought I had scleroderma in my esophagus and suggested that I see a rheumatologist. Nine months later I got to see a specialist and was officially diagnosed with scleroderma.

Then other symptoms started. My hands curved inwards and the skin on them became very tight and shiny, making it difficult to grip things. In November 1992, my Raynaud's got much worse and, after discussing it with my family, I decided to take some time off from work.

Within the next eight months, my condition declined further and I couldn't return to driving a bus—a job I had really enjoyed. Instead, I was asked to work indoors answering information phones for transit.

During this time my rheumatologist put me on penicillamine, which I seemed to improve on. I was on penicillamine for 9 years. Meanwhile, I was enjoying my job answering information phones. I continued that job on a part-time basis for six years, until my acid reflux started to affect my voice. It often caused me to lose my voice in the middle of a conversation.

Scleroderma now affects my face, hands, upper arms, lower legs and esophagus. It is often called the disease that "mummifies a person alive."

In 1992 I met a lovely lady by the name of Harriet Carter, who was brave enough to invite scleroderma patients into her home and start the first support group, which has continued to this day. In 200I I was contacted by a wonderful group of people in Calgary and was invited to attend a meeting that would be the first meeting of the Scleroderma Society of Canada. We had people from B.C., Saskatchewan, Manitoba, Ontario and Alberta.

Scleroderma Manitoba promotes public awareness of scleroderma, supports those affected by the disease and helps raise funds for research, with the hope of finding a cure. Each June during Scleroderma Awareness Month, the organization holds a walk in St. Vital Park to raise both money and awareness.

In 2019 the organization received a grant, which allowed it to revamp its website (www.sclerodermamanitoba.com) and to publish a magazine, *Scleroderma Manitoba: The Bulletin*. The magazine provides up-to-date information on the progress of scleroderma research and other useful topics to help people cope with the challenges they face in their daily lives. To receive a copy, visit **sclerodermamanitoba.com/the-magazine-le-bulletin**. CS

***Marion Pacy** has been involved with Scleroderma Manitoba since 1993 and became the organization's President in 1995. She has lived with scleroderma for 27 years.*

Engaging with your dermatologist and pharmacist

Why and how?

By Dr. Ian Tin Yue Wong and Dr. Kerri Purdy

In addition to their primary health care provider, there are two key members in a skin patient's health care team: the dermatologist and the pharmacist.

Dermatologists are recognized medical specialists who have received their medical degree and completed a focused and comprehensive, five-year postgraduate residency training program in the field of dermatology. During this time they concentrate on the health of skin, hair and nails. Dermatologists are experts who you can call on for diagnosis, treatment and prevention of a wide variety of diseases. They provide skilled medical and surgical interventions, and non-pharmacologic measures. As such, the dermatologist's clinical examination best positions them to oversee the care of "skin patients" from head to toe.

Pharmacists are medication experts who ensure that medical interventions prescribed for patients are safe, help to promote medication adherence and reinforce the patient's knowledge about their medications and possible side effects. Pharmacists earn their bachelor or doctor of pharmacy degree after completing extensive training in pharmaceutical care. Pharmacists are readily accessible at local pharmacies and are trained to share information in a patient-friendly manner. The checks and balances related to having both a dermatologist and pharmacist oversee medication

Tips for being a proactive patient

- **Be aware of follow-up appointments and prescription refills:** Patients or their primary caregiver should ask if they are to follow-up with their specialist or primary health care provider, or if no follow-up is planned. If no follow-up is arranged or required, ask your health care provider when and how you should seek medical attention. You can also ask your pharmacist how many refills your prescription has when it is being filled. In this way, you can plan ahead and set reminders for a follow-up or refills.
- **Medication adherence is crucial:** Taking treatments as prescribed is often the key to successful treatment. However, there are a variety of reasons why this doesn't always happen, including the cost of medications, hesitancy to use medications because of safety concerns and therapeutic fatigue. Identifying barriers early on and working with your health care team to address them is key.
- **Be curious, ask questions:** Medical information can be found from a variety of sources, including the internet. However, asking specific questions of an expert health care provider, such a dermatologist, can be helpful in obtaining accurate, up-to-date answers based on the academic literature.
- **Medications:** Ask your local pharmacist for a list of your currently prescribed and previous medications to keep on-hand to show other health care providers. This list can be helpful for health care providers to get an understanding of the exact medications you have tried or are currently using.
- **Medication counselling:** Pharmacists often provide medication counselling to patients when new medications are being prescribed. This means outlining the purpose of a medication, describing how to take it and advising on possible side effects. Do not hesitate to talk to your local pharmacist and get further counselling.
- **Be aware of contrary advice:** There may be times when the information provided by pharmacists, dermatologists and other health care providers differs. For example, one health care provider may recommend liberal use of topical corticosteroids, whereas another might say to use them sparingly. This can be confusing and getting clarification is key. Encouraging dialogue between health care providers will help to ensure that everyone is clear on your optimal therapeutic plan.

management provide the best assurance of safety and effectiveness of treatment for patients.

Patients should be an active participant in their medical care, meaning they have a basic understanding of what their medical condition is, what treatment options are available and why these treatments are used in their condition, and knowing when to seek a follow-up or further medical attention. By being an active participant, you will be able to recognize and better manage your medical conditions before your disease progresses. You can also minimize complications that might arise from medication misuse or lack of treatment.

Being proactive may not be possible for everyone. However, keeping in regular communication with your dermatologist, primary health care provider and pharmacist will reinforce your care, help you to address potential knowledge gaps and promote continuity of care. CS

Ian Tin Yue Wong, BSc(Pharm), MD, *was a practicing pharmacist and is now a dermatology resident at the University of British Columbia. He has a special interest in patient-centred care and interdisciplinary medicine.*

Kerri Purdy, MD, FRCPC, *is a dermatologist, an assistant professor at Dalhousie University's Division of Clinical Dermatology & Cutaneous Science, and President of the Canadian Dermatology Association.*

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

Change in leadership at the CSPA

Rachael Manion is now Executive Director of both the CSPA and the Canadian Association of Psoriasis Patients (CAPP), replacing Kathryn Andrews-Clay who has left to start her semi-retirement.

Rachael previously worked as a consultant with a public affairs firm, where she supported national patient organizations and other clients in the health and life sciences sectors to navigate the ever-changing policy, political and regulatory landscapes. A lawyer by background, Rachael has advised Health Canada on regulating health technologies, novel therapies and science policy. She has consistently supported the not-for-profit sector throughout her career, both professionally and as a volunteer board member. Rachael has also worked on the frontlines of health care in a community health centre for the street-entrenched population and in a pharmacy. She has a law degree from the University of British Columbia and an honours degree in mathematics from Dalhousie University.

Welcome, Rachael!

Dates to note

Canadian Drugs and Technologies in Health 2020 Symposium—April 19–21

The Canadian Drugs and Technologies in Health (CADTH) annual symposium will be held in Toronto in April, with the theme of "Decision-Making in an Age of Uncertainty." Join Canadian and international delegates from health research, governments, universities and patient groups. For more information, visit symposium.cadth.ca.

National Volunteer Week—April 19–25

National Volunteer Week 2020 is also in April. We'd like to take this opportunity to say thank you to the many volunteers who contribute to this magazine and to our organization.

Other upcoming awareness days, weeks and months

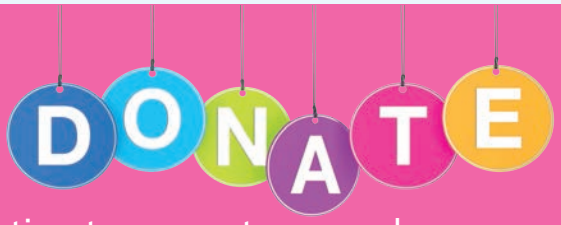
Follow us on Twitter (@CanadianSkin), Facebook (www.facebook.com/CanadianSkin) and Instagram (instagram@canadianskin) for information on upcoming events.

Rare Disease Day—February 29
Rosacea Awareness Month—April
World Health Day—April 7
Ichthyosis Awareness Month—May
Melanoma Monday—May 11. CS

We appreciate our volunteers

Our sincere appreciation to **Dr. Gordon Searles** and **Dr. Marc Bourcier**, Canadian certified dermatologists who review the content of our magazine prior to publication. **Thank you!**

Donate now



Like this magazine?
Like the work of the CSPA?
Please consider making a donation to support our work:
visit **canadianskin.ca/donate**.

Clinical trial:

Research study on lamellar ichthyosis

The Reflect Study is testing the safety and effectiveness of a topical cream for adults and adolescents living with lamellar ichthyosis (LI). This investigational cream is applied to the surface of the skin in an effort to reduce LI symptoms such as dry and cracked skin. The Reflect Study aims to help improve symptoms of LI for current and future generations. There will be two study sites in Canada.

For more information, visit **www.ichthyosisstudy.com**.

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CSPA CORPORATE SPONSORS

CANADIAN SKIN MEDICAL ADVISORS + BOARD MEMBERS

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?

To have a chance of winning a $25 gift card, simply visit our website to find the answer to this question:

Who represents Alberta on the CSPA Board of Directors?

Submit your answer by May 1, 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

What's new with the Canadian Association of Psoriasis Patients?

1. Phase two of "My Skin and Bones" is now complete. The focus was to raise awareness of the connection between psoriasis and psoriatic arthritis. You may have seen ads on television, billboards and social media. Visit myskinandbones.ca for more information.

2. We continue to raise awareness of the challenges faced by individuals with psoriasis in accessing care and treatment. Visit psoserious.ca to get involved.

3. We have new resources on our website for children with psoriasis. This interactive section will be updated regularly, so visit Kids Corner on our website.

4. Sign up for our free quarterly newsletter at canadianpsoriasis.ca.

5. Follow us on social media—like, share and comment on our posts:
   facebook.com/canadapsoriasis
   twitter.com/Psoriasis_CAPP

CAPP ACPP

Canadian Association of Psoriasis Patients
Association canadienne des patients atteints de psoriasis