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Janssen-Sponsored Satellite Symposium at the 30th EADV Virtual Congress 2021

The art of joint forces: crafting psoriatic arthritis care for dermatologists

This virtual satellite symposium will focus on the necessity for practicing dermatologists to understand the burden of psoriatic arthritis in patients with psoriasis. It will emphasize how important it is that dermatologists detect early signals of psoriatic arthritis in patients with psoriasis and also understand why targeting IL-23 directly can be effective in treating and potentially also preventing the development of psoriatic arthritis for their psoriasis patients

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CP-255722

interactions. Participants described a relentless battle with rosacea, trying to conceal the visibility of their skin changes in order to be 'normal' and 'fit in with everyone else'. All participants described the financial impact of their perceived need to use different treatments and skincare products continuously, so as to try and 'stay on top of' their rosacea. On days when they felt they were losing 'the battle' and skin changes were visible, five participants described a sense of 'vulnerability', feeling 'like a second class of people', 'like a shell' and 'disgusting'. The accounts of participants reflected the importance of masking their difficulties from others as a way to defend against pain and emotional distress. When rosacea could not be concealed, five participants described being rejected by others, causing pain and emotional distress within some of their relationships.

Uncertainty towards the cause of rosacea was reflected within all participants' transcripts. 'Something I'd done', 'my fault', 'parasites', 'the immune system', 'hormones', 'pregnancy', 'genetics', 'old age' and 'God' were all indicated as factors thought to be associated with rosacea onset. While one participant described feeling 'scared' following her diagnosis, other accounts described how it helped the patients to make sense of their experiences, reducing feelings of 'embarrassment', 'blame' and 'shame' about their rosacea. The emotional, financial and social toll of living with rosacea was reflected in five participants' experiences and highlighted the importance of personal strength and resilience.

In conclusion, this study has enriched our understanding of the lived experience of rosacea. We acknowledge the lack of representation of skin of colour, and would encourage further work of this type to explore the impact of rosacea in different ethnic groups. Participants in this study reflected feelings of low mood, anxiety, shame, rejection and embarrassment. Therefore, clinicians must be mindful of the psychosocial dimension, administering validated outcome measures to aid in the early detection of patient distress. When providing a diagnosis, clinicians may wish to offer a space where patients' initial thoughts, feelings and coping strategies can be explored. Realistic conversations about prognosis and the limited effectiveness of treatments may be helpful. Training and consultation may be beneficial to support the exploration of psychological distress and signposting to appropriate services.

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Funding sources: none.

Conflicts of interest: the authors declare they have no conflicts of interest.

Data availability: the data that support the findings of this study are available from the corresponding author upon reasonable request.

A summary of the updated report on the incidence and epidemiological trends of keratinocyte cancers in the UK 2013–2018

DOI: 10.1111/bjd.20764

Dear Editor, Skin cancer is the most common cancer in the UK. Skin cancer referrals via the 2-week wait (urgent suspected cancer) pathway outnumber any other suspected malignancy.[1,2] The most common skin cancers are keratinocyte cancers (KCs), which represents basal cell carcinomas (BCCs) and cutaneous squamous cell carcinomas (cSCCs). Accurate KC incidence reporting is crucial for healthcare planning.[3]

Registration of KC is challenging owing to high numbers, multiplicity of cancers per person and various treatment modalities (not all surgical). The incidence of KC routinely reported in the UK is underestimated owing to the current United Kingdom and Ireland Association of Cancer Registries' rule recommending that only the first BCC and cSCC per person be registered; however, metachronous tumours are uniquely common to KC.[4] Previously, we validated the first per patient per annum (PPPA) technique where one tumour per patient per calendar year is counted to provide a better estimate of true tumour count, identifying 50% more tumours and estimating within 10% of the true tumour incidence without additional workload.[5]

We provide a summary of the updated report on epidemiological trends for KC in the UK from 2013 to 2018 with

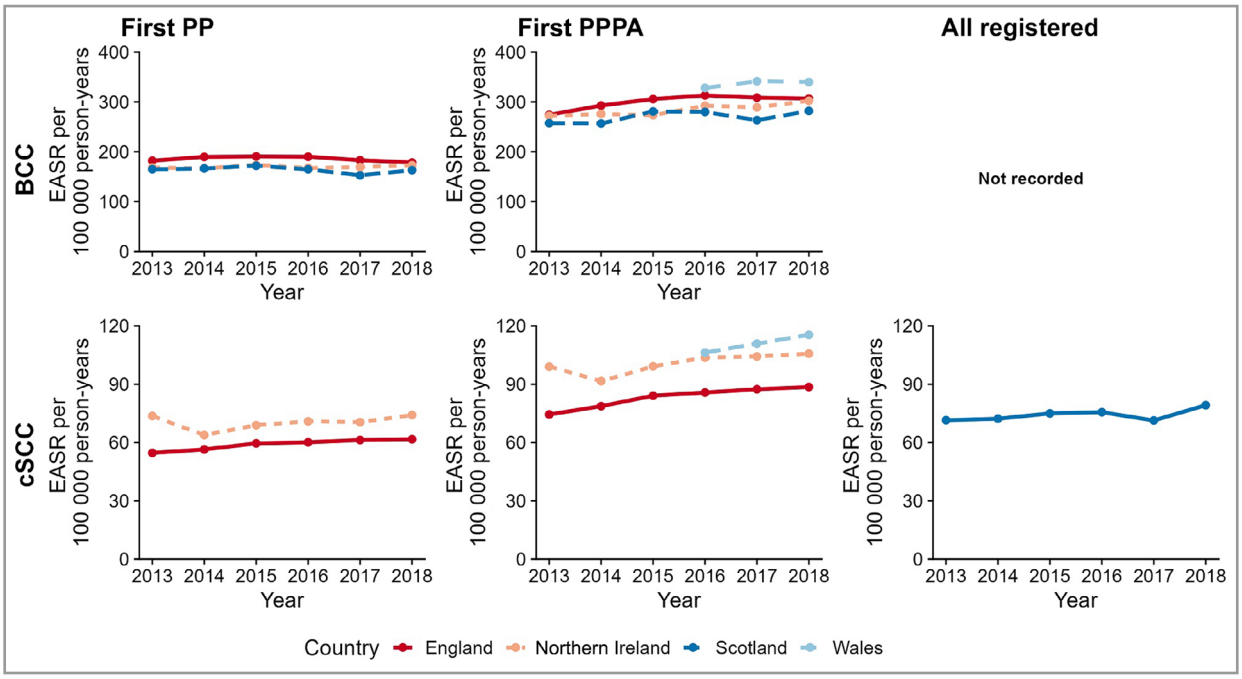

Figure 1 National incidence rate of basal cell carcinomas (BCCs) and cutaneous squamous cell carcinomas (cSCCs) based on three counting techniques. Column 1. National European age-standardized rate (EASR) of BCC (top) and cSCC (bottom) 2013–2018, using first per patient all-time (PP) technique. Column 2. National EASR of BCC and cSCC 2013–2018, using first per patient per annum (PPPA) technique. Welsh data cover the years 2016–2018. Column 3. National EASR of BCC and cSCC 2013–2018, using all registered tumours (all registered) technique. Dotted lines indicate 95% confidence intervals.

three additional years of data, improved Welsh data and lifetime incidence reporting (the full version is available online).[6] Data from the National Cancer Registration and Analysis Service (NCRAS) in England were combined with data from national cancer registries in Scotland, Northern Ireland and Wales from 2013 to 2018 to calculate counts and incidence rates.[7] Further analysis was performed with NCRAS data only, using robust and Poisson regression. Lifetime incidence of nonmelanoma skin cancer (NMSC) was calculated via the Cancer Research UK current probability lifetime risk calculator, using the first all-time NMSC tumour registered.[8,9] Lifetime incidence analysis is limited to NMSC by mortality data and therefore includes rare NMSCs (e.g. Merkel cell carcinoma).

In England, from 2013 to 2018, the average annual count of first PPPA tumours was 146 852 BCCs and 39 017 cSCCs. BCC European age-standardized rates (EASRs) increased by an average of 6·2 cancers per 100 000 person-years (PYs) [95% confidence interval (CI) −0·1 to 12.5], with a decline observed in first all-time BCCs of 1·2 cancers per 100 000 PYs (95% CI −4·6 to 2·3) (Figure 1), both of which were nonsignificant. The EASR of first PPPA cSCC increased on average by 2·8 cancers per 100 000 PYs (95% CI 1·7–4·0), with first all-time cSCC increasing by 1·4 cancers per 100 000 PYs (95% CI 0·7–2·2).

In Scotland, from 2013 to 2018, the average counts for first PPPA BCC and all cSCCs (all cSCCs are manually registered in Scotland) were 13 300 and 3344, respectively. BCC EASR increased on average by 4·1 cancers per 100 000 PYs, although this was nonsignificant (95% CI −2·9–11·0). On average, cSCC EASR increased by 1·4 cancers per 100 000 PYs (95% CI 0·6–2·2). In Northern Ireland, from 2013 to 2018, first PPPA BCC and cSCC average counts were 4423 and 1506, respectively. BCC EASR increased by an average of 5·9 cancers per 100 000 PYs (95% CI 1·4–10·5) and cSCC EASR increased by an average of 1·8 cancers per 100 000 PYs (95% CI 0·1–3·5). In Wales, from 2016 to 2018, first PPPA BCC and cSCC average counts were 10 516 and 3358, respectively. Welsh data for previous years were not available.

One in five (19·7%) people develop at least one BCC, cSCC or other NMSC in their lifetime in England, which equates to one in four (22·3%) men and one in six (17·5%) women. For those under the age of 50 years, we saw a reversal of the male : female ratio, with BCC significantly more common in women than in men (incidence rate ratio 1·37, 95% CI 1·34–1·41), as opposed to the trend seen in older patient groups and the whole population.

Incidence rates of first all-time and first PPPA BCC appear to plateau, whereas cSCC continues to increase significantly; however, more years of data are required to assess the trend. Similar findings showing a plateau in KC incidence rates have been predicted by Garbe *et al.* based on data from registries in Germany and Scotland.[10] This could be due to natural

variation or changes in clinical practice and patient choice; greater awareness of end of life planning and prolonged waiting lists may encourage conservative management of these tumours, where appropriate, or perhaps there is greater skin cancer awareness and prevention in these populations.

The reversal of the male : female ratio in younger age groups is a matter of concern and may be due to lifestyle factors such as increased sunbathing among young women. With one in five persons developing NMSC in their lifetime, optimization of skin cancer research, prevention and clinical management is essential.

Acknowledgments: we are thankful for the support and comments provided by David S. Morrison. A full list of acknowledgments is available in File S1 (see Supporting Information).

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Funding sources: this research was funded in part by the Wellcome Trust [205039/Z/16/Z]. For the purpose of Open Access, the author has applied a CC BY public copyright licence to any Author Accepted Manuscript (AAM) version arising from this submission

Conflicts of interest: S.A. and M.K. are employees of the British Association of Dermatologists (BAD). G.W.M.M. is current Academic Vice President of the BAD and Editor-in-Chief of *Skin Health and Disease*. T.O.B. is BAD president. M.R.A.-J. is chair of the BAD research subcommittee.

Data availability: data used in this study are openly available in a public repository that issues datasets with digital object identifiers.

Supporting Information

Additional Supporting Information may be found in the online version of this article at the publisher's website:

File S1 Full list of affiliations and acknowledgments.

The effect of surgical-site infections on patient-reported cosmetic outcomes of scars in dermatological surgery

DOI: 10.1111/bjd.20773

Dear Editor, Surgical-site infections (SSIs) are highly unsought complications that add unnecessary costs to patients and healthcare systems.[1–4] SSIs are also believed to contribute to poor wound cosmesis,[5] but studies supporting this idea are scarce. We aimed to examine whether differences were found in patient-reported scar outcomes between patients who had an SSI after dermatological surgery and patients with normal wound healing. This comparison was made using SCAR-Q, a validated, patient-reported outcome instrument.

Following ethical approval and registration at ClinicalTrials.gov (NCT04744961), a case–control telephone interview study was conducted at the Department of Dermatology, Skåne University Hospital, Sweden, from March to April 2021. Randomly selected patients over 18 years old diagnosed with SSIs who had undergone skin cancer surgery between March 2017 and March 2020 were compared with a matched control group with no registered SSIs. SSIs were retrieved from an electronic database containing all cases assessed by a dermatologist as infected. All surgical excisions were repaired by either direct closure or skin grafting.