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Forum for Nordic Dermato-Venereology

Official journal of the Nordic Dermatological Association

31st Nordic Congress of Dermato-Venereology

May 31 – June 3, 2008 in Reykjavik, Iceland

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31st Nordic Congress of Dermato-Venereology

May 31–June 3, 2008 in Reykjavik, Iceland

Programme and Abstracts

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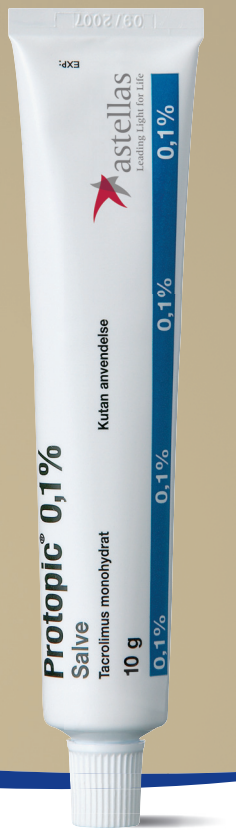

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REFERENCES: 1. Reitamo S., et al. J Allergy Clin Immunol 2002;109: 539-546.
2. Reitamo S. Br. J. dermatol 2005:152:1282-89.
3. Summary of product characteristics Nov. 2006.

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WELCOME TO REYKJAVIK

At the time these words are written it is clear that the Nordic Congress in Reykjavik has all the known parameters necessary to be a success. It is hoped that the one random parameter, the weather, will be favourable. We are proud to be able to present a varied scientific programme, with speakers bringing together a wealth of experience from all over the western hemisphere. Experience is precisely what the organizing committee would like speakers to share with their colleagues in the audience; we encourage all speakers to endeavour to provide participants with a "take home" message. It is hoped that most of you will read the programme and find that you want to be at many symposiums at the same time; in that case the scientific committee will have succeeded.

This is the second occasion on which nurses have been invited to the Nordic congress and this seems to be a trend worth continuing. A special course in basic dermatology has been provided for dermatological nurses.

Socializing with our colleagues and enjoying Iceland are two other very good reasons for attending the Congress. We have put together a social programme that includes the most popular tourist activities. In addition, there is a wealth of different tours and excursions presented by the Congress Bureau. We have done our best to arrange enjoyable conditions for networking; the rest is up to you!

On behalf of the Congress committee and Bolli Bjarnason, chairman of the Icelandic Dermatological Association, I welcome you to Iceland for a combination of education and fun that can only be found here and now.

Baldur Baldursson
Congress President

Torbjörn Egelrud
Secretary General, Nordic Dermatology Association

Dear congress participants,

Just a few words to express my sincere thanks to Baldur Baldursson and his colleagues on the congress committee for endless work and enthusiasm on the congress. The Nordic congress is our precious little diamond. It travels between our countries bringing unity and education to us all strengthening Nordic dermatology and venereology.

Bolli Bjarnason
Chairman, Icelandic Dermatological Association

CONGRESS INFORMATION

Organizing Committee

Baldur Baldursson, President

Gisli Ingvarsson

Ellen Mooney

Conference Venue

The congress will be held at the Hilton Reykjavik Nordica Hotel, Sudurlandsbraut 2, Reykjavik.

Registration Desk

The Congress Secretariat (Iceland Incentives Inc.) will have their registration desk on the ground floor at Hilton Nordica.

At the registration desk you will receive your badge, congress bag and other congress material.

All unpaid invoices, including final payment for hotel and tours, must be settled with the Congress Secretariat before receiving the registration material.

Phone numbers at registration desk:
(+354) 892 7073 / 696 1402 / 696 1403

Opening hours at the registration desk:

Saturday	May 31st	15.00–18.00
Sunday	June 1st	07.30–18.00
Monday	June 2nd	07.30–17.00
Tuesday	June 3rd	08.30–12.30

Registration Fees

The registration fee includes admission to lectures, congress material, welcome reception at Háskólatorg (University Forum) May 31st, coffee and lunches on June 1st and 2nd and the Blue lagoon tour/dinner on Monday June 2nd.

The registration fee for accompanying persons includes the welcome reception at University Square and the Blue lagoon tour/dinner on June 2nd.

Badges/Tickets

The congress badge must be worn at all scientific sessions and as admission to the Blue Lagoon.

Lunches and Coffee Breaks

Coffee and lunches will be served in the exhibition area on June 1st and 2nd.

Exhibition and Posters

An industrial exhibition is held in connection with the congress. The exhibition area is on the ground floor at Hilton Nordica, in front of the main lecture halls A and B.

Posters will be on display on the 2nd floor of Hilton Nordica.

Social Programme

Saturday May 31st:

09.00–17.00: Golden Circle congress tour (optional, not included in the registration fee).

18.00–19.30: Welcome reception in Háskólatorg (University Forum). Included in the registration fee.

Sunday June 1st:

18.00–21.00 Horse riding and Grill Party (optional)

Monday June 2nd:

17.00/17.30–22.30/23.00: Blue lagoon tour/congress dinner with entertainment. Incl. in the registration fee.

Conference Transportation

Saturday May 31st:

17.30 and 17.45: Bus from Hilton Nordica Hotel to Háskólatorg (University Forum) for the welcome reception.

19.15–19.30: Buses to City Centre/Hilton Nordica Hotel.

Sunday June 1st:

Buses from/to Hilton Nordica Hotel in connection with the Horse riding-Grill Party tour.

Monday June 2nd:

Buses from/to Hilton Nordica hotel in connection with the Blue lagoon tour and dinner.

Language

English – no simultaneous translation available.

Information for Speakers

The lecture rooms are equipped with computers and projectors. Access to computers is also available at the Congress Center on the 2nd floor of the Hilton Nordica Hotel.

Special Dietary Requests

Please contact Iceland Incentives Inc.at the Registration desk in Nordica for special dietary needs.

Food allergies, vegetarian requests and diseases are taken into consideration.

Keflavík International Airport transportation

Arrivals
A FLYBUS operates all day from Keflavik Airport to Reykjavik in connection with all incoming international flights. The Flybus brings passengers to the Flybus terminal at the Central Bus Station in Reykjavik (BSI) near the center of town. From there passengers are taken to most of the major hotels and guesthouses in Reykjavík.

Kindly note that not all hotels and guesthouses are provided with shuttle service from the Central Bus station, but taxis are available outside the terminal.

Departures
The Flybus operates all day in connection with all outgoing flights. A free pick-up service is available from most of the major hotels and guesthouses in Reykjavík. The day before departure, passengers need to inform the reception desk staff of their hotel/guesthouse that they want the Flybus to pick them up the following day.

The Flybus has a special schedule based on departures from the BSÍ terminal, picking up passengers approximately ½ an hour prior at the hotels.

Flybus fare: ISK 1.300 pr. person one way.

Children 0–11 yrs. are free of charge. Children 12–15 yrs. pay half price.

Taxi service between Keflavik and Reykjavík is also available.

Public transportation

Reykjavik has an extensive city bus system called "Strætó". Routes, timings and maps for all city buses can be found on http://www.bus.is/english/routes. Please also consult with your hotel/guesthouse reception staff. One way fare with a city bus is ISK 280 and you must have the exact change ready, the bus driver can not change money.

Climate

June is usually sunny, but can be cold with temperatures around 10°C (50 Fahrenheit). As the weather in Iceland is very changeable, one should be prepared for both wind and rain and umbrellas are usually of no use! For the countryside, layered clothing which may be pealed off in tune with the weather changes, is the best idea. Don't forget to bring your swimsuit, as a visit to one of the many geothermally heated swimming pools in Reykjavik or in the countryside should not be missed.

Banks and Money

Official banking hours in Reykjavik are 09.15–16.00 Monday to Friday. All banks can exchange foreign currency, and some shops (especially those catering to tourists) will accept payment in US dollars or Euros.

Most shops and businesses accept the major credit cards (Visa, Euro/Mastercard and American Express), so it is generally not necessary to carry much cash. Cards are commonly used in Iceland even for quite small transactions. ATMs are to be found in many places.

The currency used in Iceland is the Icelandic "krona" or "crown," abbreviated ISK. The approximate exchange rate 10 April 2008 was: USD 1.00 = ISK 73 and EUR 1.00 = ISK 115.

It is best to exchange your money into ISK in Iceland, and re-exchange any surplus before you leave, as foreign banks may not deal in ISK. You can exchange your money at the bank at the airport on arrival and departure. Kaupthing Bank is in the same building as Hilton Nordica as well as an ATM machine.

Telephones

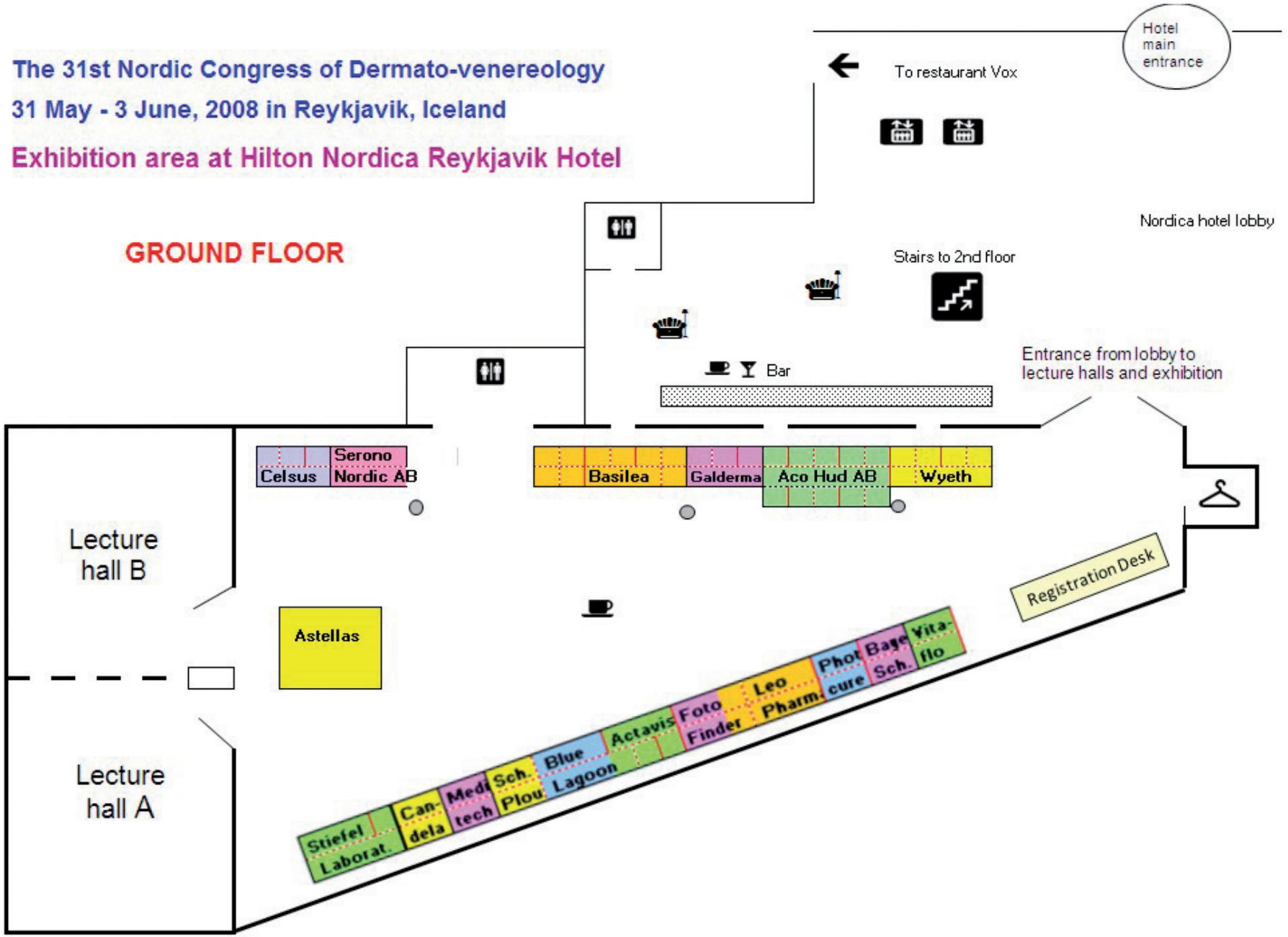
Direct calls can be made to all parts of Iceland. The code into Iceland from overseas is +354 ...

Mobile phones in Iceland use the European GSM system.

Shopping hours in Reykjavik

Downtown opening hours may vary but stores are generally open from 10-18:00 on weekdays and 10-14:00 on Saturdays. Some stores stay open longer on Saturdays and most downtown stores are open until 18:00 on the first Saturday of each month.

There are two shopping malls in Reykjavik, Kringlan (Sat: 10–19, Sun 13–18) and Smaralind and they are both open on weekends. Kringlan which is a 8-10 minutes walk from Hilton Nordica is open Saturdays 10.00–18.00 and Sundays 13.00–18.00.


The 31st Nordic Congress of Dermato-venereology
31 May - 3 June, 2008 in Reykjavik, Iceland
Exhibition area at Hilton Nordica Reykjavik Hotel
GROUND FLOOR
Hotel main entrance
To restaurant Vox
Nordica hotel lobby
Stairs to 2nd floor
Bar
Entrance from lobby to lecture halls and exhibition
Lecture hall B
Lecture hall A
Registration Desk
Astellas
Celsus
Serono Nordic AB
Basilea
Galderma
Aco Hud AB
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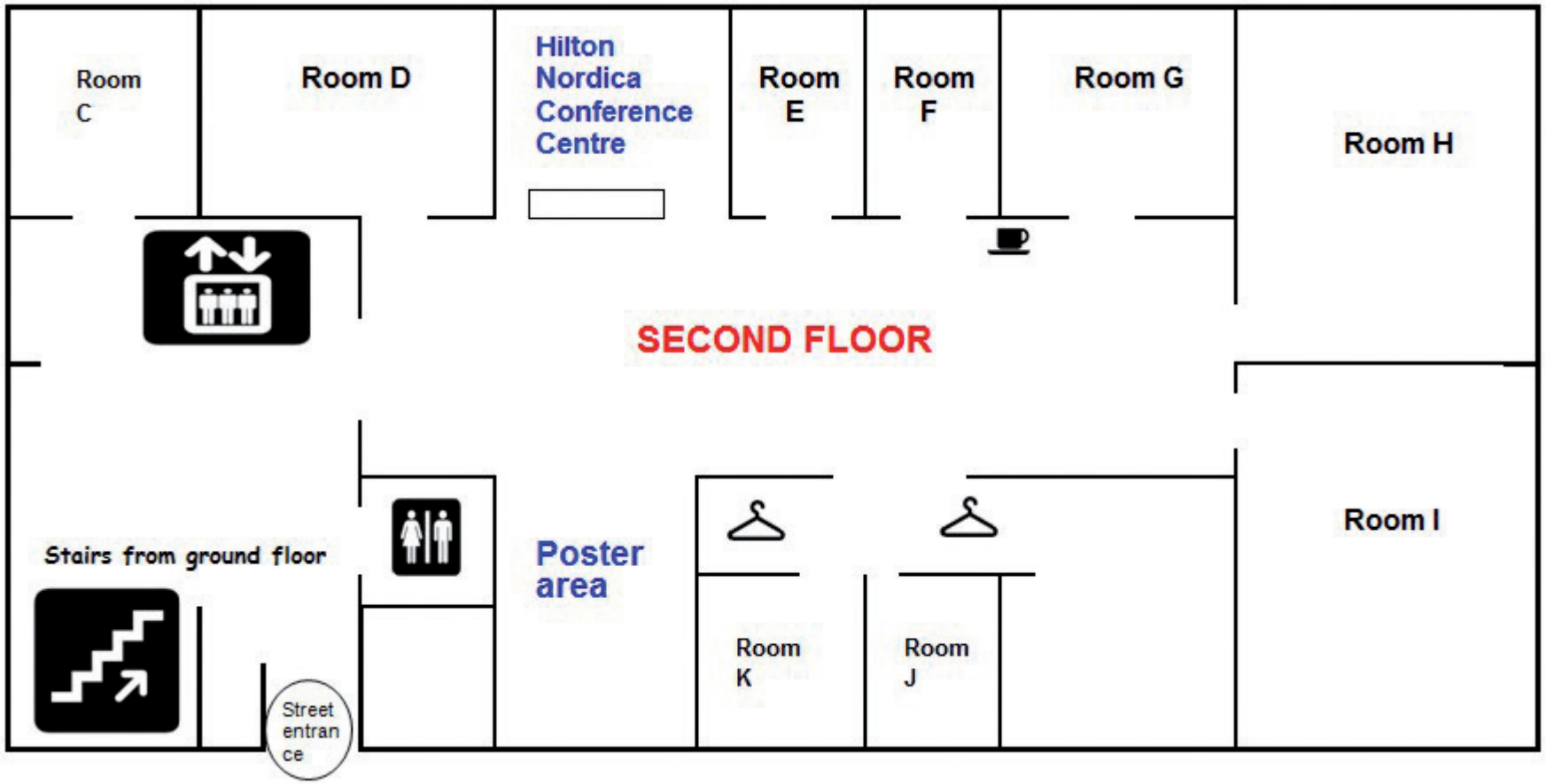
Room C
Room D
Hilton Nordica Conference Centre
Room E
Room F
Room G
Room H
SECOND FLOOR
Stairs from ground floor
Poster area
Room I
Room K
Room J
Street entrance

Programme

Sunday June 1st, 2008.

		Abstract No.	Room
08.30–10.00	**Parallel Session: Wound Healing.** *Chairs: Uwe Wollina and Tonny Karlsmark*		**A**
	Leg Ulcers in Practice – Diagnostic and Treatment, *Uwe Wollina*	PS01.1	
	Conservative Treatment of Chronic Wounds, *Tonny Karlsmark*	PS01.2	
	Parallel Session: Drug Reactions and Interactions. *Chairs: Neil Shear and Gunilla Sjölin-Forsberg*		**B**
	ADRs and the Skin From a Regulatory Perspective, *Gunilla Sjölin-Forsberg*	PS02.1	
	Franz Diffusion Cells Experiments for *In vitro* Transdermal Permeations Studies, *Bergthóra S. Snorradóttir and Már Másson*	PS02.2	
	What You Need to Know about Skin Reactions, the Old & New, *Neil H Shear*	PS02.3	
	Course: Dermatological Problems in Women. *Chairs: Fenella Wojnarowska, Dr Elisabet Nylander and Dr Monika Gniadecka*		**FG**
	How Women Perceive Skin Disease, *Elisabeth A Holm*		
	Overview of Lichen Sclerosus and Lichen Planus, *Elisabet Nylander*		
	Overview of Lupus in Women, *Filippa Nyberg*		
	Overview of Swollen Legs in Women, *Monika Gniadecka*		
	Contact Dermatitis – How do Women Cope with the Disease? *Tove Agner*		
	Autoimmune Disease in Pregnancy, *Fenella Wojnarowska*	C01.1	
	Overview of Pregnancy Dermatoses, *Ellen Mooney*		
10.30–12.00	**Parallel Session: Atopic Dermatitis Update.** *Chairs: Baldur Baldursson*		**A**
	Treatment of Anaphylactic Reactions, *Johannes Ring*	PS03.1	
	Management of the Atopic Dermatitis Patient, *Thomas L. Diepgen*	PS03.2	
	Climate Change, Pollen and Allergy, *Heidrun Behrendt*	PS03.3	
	Parallel Session: Oral Dermatology. *Chairs: Ginat W. Mirowski and Mats Jontell*		**B**
	Oral Manifestations of Systemic Diseases, *Mats Jontell*	PS04.1	
	White Lesions of The Oral Cavity, *Ginat Mirowski*	PS04.2	
	Course: Dermatological Problems in Women, contd.		**FG**
12.00–13.10	**Sponsored Lunch Symposia.** Galderma (Room H) and Schering Plough (Room I)		**H,I**
13.10–14.00	**Plenary Lecture on Atopy**		**AB**
	Atopic Eczema – What is New? *Johannes Ring*	PL01	
14.30–16.00	**Corporate Sponsored Symposium: Sponsored by Astellas**		**HI**
	Parallel Session: Hidradenitis Suppurativa. *Chairs: Gregor Jemec and Gísli Ingvarsson*		**A**
	Current Understanding of Aetiology and Pathogenesis of Hidradenitis Suppurativa, *Gregor B Jemec*	PS05.1	
	Clinical Presentation and Disease Severity, *Karin Sartorius*	PS05.2	
	Medical Treatment of Hidradenitis Suppurativa, *Gísli Ingvarsson*	PS05.3	
	Surgical Treatment of Hidradenitis Suppurativa, *Nathalie Dufour*	PS05.4	
	Parallel Session: Biologics – Anything Unsaid? *Chairs: Mona Ståhle, Peter Berg and Marcus Schmitt-Egenolf*		**B**
	Systemic Treatment for Psoriasis – a New Biologic Era, *Mona Ståhle*	PS06.1	
	Systematic Follow-up of Conventional and Biologic Psoriasis Treatment: The Swedish Registry PsoReg, *Marcus Schmitt-Egenolf*	PS06.2	
	Biologic therapy of psoriasis in clinical practice, *Peter Berg*	PS06.3	
	Course: Dermatological Theories in Practice. *Chair: Theis Huldt-Nyström*		**FG**
	Basic skin physiology with special attention to skin barrier function and the application of emollients, *Theis Huldt-Nystrøm*	C02.1	
	UV Treatment – Challenges and Pitfalls, *Eli J. Nordal*	C02.2	
	UV Treatment of vitiligo – A Sport for Risk Seekers? *Eli J. Nordal*	C02.3	
	The DLQI Questionnaire and Other Questionnaires to Measure the Effects of Dermatological Therapy in Atopic Dermatitis, Hand Eczema, and Itch, *Theis Huldt-Nystrøm*	C02.4	
	How to Use the PASI score, *Morten Dalaker*	C02.5	

16.30–18.00	**Corporate Sponsored Symposium: Sponsored by Basilea**		**A**
	Course: Dermatological Theories in Practice, contd.		**FG**

Monday June 2nd 2008

08.00–09.30	**Parallel Session: Psoriasis Update.** *Chairs: Steingrímur Davíðsson and Olle Larkö*		**A**
	Effect of Tonsillectomy on Patients with Chronic Plaque Psoriasis, *Ragna Hlín Þorleifsdóttir, et al.*	PS07.1	
	Science Meets Nature: Why do Psoriasis Patients Benefit from Bathing in the Blue Lagoon? *Jean Krutmann*	PS07.2	
	Economic Burden of Psoriasis, *Olle Larkö*	PS07.3	
	The Use of PDI in Measuring Quality of Life in Patients at the Blue Lagoon Clinic, *Steingrimur Davíðsson*	PS07.4	
	Parallel Session: Dermatology and Policies of Administration. *Chairs: Evan Farmer, Fenella Wojnarowska and Olle Larkö*		**B**
	Current Issues in American Academic Dermatology, *Evan Farmer*	PS08.1	
	Skin Cancer in the UK – Can UK Government Driven Models of Working have Application Elsewhere? *Fenella Wojnarowska*	PS08.2	
	Dermatology and Policies of Administration, *Olle Larkö*	PS08.3	
	Workshop: Self-assessment in Dermatopathology. *Chair: Philip LeBoit Co-chairs: Antoinette Hood, Mari-Anne Hedblad*		**D**
	Course: Dermatopathology. *Chair: Ellen Mooney. Co-chairs: Mari-Anne Hedblad and Ole Clemmensen*		**FG**
	From The Clinic to the Microscope, *Dr Ellen Mooney*		
	Cutaneous Lymphoma - Clinicopathologic Correlation and Diagnostic Pitfalls, *Dr Werner Kempf*		
	Lupus Erythematosus – Clinicopathologic Correlation, *Dr Ole Clemmensen*		
	New Inflammatory Dermatoses – Microscopic Clues to Clinical Diagnoses, *Antoinette Hood*		
	The Tumour Through Technology and Treatment		
	Lentigo Maligna – Diagnosis and Soft X-Ray Treatment, *Dr Mari-Anne Hedblad*	C03.1	
	Spitz Nevi – Tough to Diagnose, Easy to Treat? *Professor Phil Leboit*		
	Nevoid Melanoma – The Dreaded Tumour That Defies Us, *Dr Ellen Mooney*		
10.00–11.30	**Parallel Session: Skin and Malignancies.** *Chair: Werner Kempf*		**A**
	Parapsoriasis – Inflammatory Disorder or Cutaneous T-cell Lymphoma? *Werner Kempf*	PS09.1	
	Squamous Cell Carcinoma in Venous Leg Ulcers. *Baldur Baldursson*	PS09.2	
	Genital Precancerous Lesions and Treatment Modalities, *Olle Larkö*	PS09.3	
	The Epidemiology of Skin Cancer in Organ Transplant Recipients, *Bernt Lindelöf*	PS09.4	
	Parallel Session: Contact Dermatitis. *Chairs: Bolli Bjarnason and Marlene Iskasson*		**B**
	Detection of Contact Allergy by Interleukins in Patch Test Blisters, *Margret S Sigurdardottir, et al.*	PS10.1	
	Characteristics of Disease in Patients with Multiple Contact Allergies, *Berit C Carlsen, et al.*	PS10.2	
	Screening for Acrylate/Methacrylate Allergy in the Baseline Series, *Marlene Isaksson, et al.*	PS10.3	
	Low Test Volume for Patch Test Standardization, *Bolli Bjarnason, et al.*	PS10.4	
	Contact Allergy to Aluminium, *Magnus Bruze*	PS10.5	
	Comparison Between Two Different Fragrance Mix Test Systems, *F Andersen and KE Andersen*	PS10.6	
	Adverse Reactions to Dental Materials: Reporting and Cases, *Lars Björkman*	PS10.7	
	Allergic Contact Dermatitis to Topically Applied Metronidazole in Two Nurses, *Jakob Torp Madsen, et al.*	PS10.8	
	Workshop: Self-assessment in Dermatopathology, contd.		**D**
	Course: Dermatopathology, contd.		**FG**
11.30–12.40	**Sponsored Lunch Symposia.** Photocure		**HI**
12.40–13.30	**Plenary Lecture**		**AB**
	Certification and Maintenance of Certification in Dermatology, *Antoinette Hood*	PL02	
13.40–15.10	**Parallel Session: Venereology in Scandinavia.** *Chair: Harald Moi*		**A**
	Infectious Causes of Human Cancer, *Harald zur Hausen*	PS11.1	

	Mycoplasma Genitalium – 15 Years Experience, *Carin Anagrius*	PS11.2	
	Syphilis in Baltic: Epidemiology, Clinic, Therapy and Prevention – an Update, *Andris Rubins, et al.*	PS11.3	
	Parallel Session: Melanoma Update. *Chair: Jon Hjaltalin Ólafsson*		**B**
	Genome-wide SNP Association Studies of Pigmentation Traits and Melanoma Risk, *Simon N. Stacey et al.*	PS12.1	
	Melanoma and Dysplastic Nevi in Icelandic Air Crew Members. The Importance of Screening, *Sigurdardottir G et al.*	PS12.2	
	Sunbed Usage in Iceland, *Þorgeir Sigurðsson*	PS12.3	
	Removal of Nevi as Prophylaxis for Melanoma. A Cost-benefit Analysis, *Bernt Lindelöf et al.*	PS12.4	
	Exposure to Artificial UV Radiation and Skin Cancer, *Jean-François Doré, on behalf of the IARC Working Group on exposure to artificial UV radiation and skin cancer*	PS12.5	
	Is Sunlight Beneficial and are Dermatologists too Narrow-sighted? *Olle Larkö*	PS12.6	
	Workshop: Self-assessment in Dermatopathology, contd.		**D**
15.30–17.00	**Nordic Dermatology Association, General Assembly**		**A**

Tuesday June 3rd, 2008

09.00–10.30	**Parallel Session: Photodermatology and Photoprotection.** *Chairs: Vigfús Sigurðsson and Hans Christian Wulf*		**A**
	Photoprotection is More Than Just Sunscreen, *Elisabeth Thieden*	PS13.1	
	Variables in UVB Treatment of Skin Diseases, *Hans Christian Wulf*	PS13.2	
	Home UVB Phototherapy is Effective, Safe and Greatly Appreciated. A Randomized Comparison of Home and Outpatient UVB Treatment for Psoriasis: The PLUTO study, *MBG Koek, et al.*	PS13.3	
	Parallel Session: Infotech, Telemedicine, Dermatological Websites. *Chairs: Lars Erik Bryld and Thor Bleeker*		**B**
	Teledermatology on the Faroe Islands, *Gregor Jemec*	PS14.1	
	Teledermatological Videoconferences in Northern Norway, the Kirkenes Experience", *Dagfinn Moseng*	PS14.2	
	A Critical Analysis of the Role of Telemedicine in Improving the Quality of Health Care Access in Alaska, *John H. Bocachica*	PS14.3	
	An Internet-based Case-file System for Systematic Follow-up of Non Melanoma Skin Cancer, *Lars Erik Bryld*	PS14.4	
	Exciting Website for Dermatologists: www.pdf.nu and www.ssdv.se, *Thor Bleeker*	PS14.5	
	Workshop: Tutorials for Self-assessment in Dermatopathology. *Chair: Philip LeBoit*		**FG**
	Co-chairs: Antoinette Hood, Mari-Anne Hedblad		
	Parallel Session: Free Papers Session. *Chair: Bernt Lindelöf*		**I**
	Icthyosis, the Role of Conservative Eyelid Surgery!? *Haraldur Sigurdsson*	PS15.1	
	Hundreds of Children in the Gothenburg greater area with Vaccine Related Contact Allergy to Aluminium, *Annica Inerot*	PS15.2	
	Our Experience in Treatment of Atopic Dermatitis in Latvia, *Andris Rubins*	PS15.3	
	Treatment with a Moisturizing Cream Delays Recurrence of Atopic Eczema, *Karin Wirén*	PS15.4	
	Long-term Treatment with Moisturizers Affects Gene Expression of Epidermal Enzymes, *Izabela Buraczewska*	PS15.5	
	"Fractional" Lasers for Treatment of Rhytides, Scars, Pigment and Overall Skin Rejuvenation, *Martin Kassir*	PS15.6	
	Eczema Counselling via the Internet – Telemedicine as a Tool in Home Care Eczema Counselling, *Thomas Schopf*	PS15.7	
	A New High-powered Radiofrequency Device used for Non-invasive Lipoplasty of the Abdominal Region, *Martin Kassir*	PS15.8	
11.00–12.30	**Parallel Session: Nail Disorders. *Chair:*** *Robert Baran*		**A**
	Classification of Onychomycosis Revisited, *Robert Baran*	PS16.1	
	Differential Diagnosis of Nail Psoriasis and Onychomycosis, *Eckart Haneke*	PS16.2	
	Nail Malignancies, *Robert Baran*	PS16.3	
	Workshop: Tutorials for Self-assessment in Dermatopathology, contd.		**FG**
	Parallel Session: Free Papers Session, contd.		**I**
12.30	**Closing Remarks**		

SPONSORS

The scientific committee acknowledges a generous travel grant from Glaxo Smith Kline that enables us to invite overseas and European speakers to the congress.

Saturday, May 31st, 2008				
18.00–19.30	Opening Ceremony followed by Welcome Reception at Icelandic University Forum			
Sunday, June 1st, 2008				
08.30–10.00	**PS01 – Room A** **Wound Healing** *Chairs: Uwe Wollina and Tonny Karlsmark*		**PS02 – Room B** **Drug Reactions and Interactions** *Chairs: Neil Shear and Gunilla Sjölin-Forsberg*	**C01 – Room FG** **Dermatological Problems in Women** *Chairs: Fenella Wojnarowska, Elisabet Nylander and Monika Gniadecka*
10.00–10.30	**Exhibition and Coffee**			
10.30–12.00	**PS03 – Room A** **Atopic Dermatitis Update** *Chairs: Baldur Baldursson*		**PS04 – Room B** **Oral Dermatology** *Chairs: Ginat W. Mirowski and Mats Jontell*	**C01 – Room FG** **Dermatological Problems in Women, contd.**
12.00–13.10	**Exhibition and Sponsored lunch Symposia, Galderma (Room H) and Schering Plough (Room I)**			
13.10–14.00	**PL01 – Room AB** **Atopic Eczema – News on Pathophysiology and Treatment** *Johannes Ring*			
14.00–14.30	**Exhibition and Coffee**			
14.30–16.00	**CSS01 – Room HI** Sponsored by Astellas	**PS05 – Room A** **Hidradenitis Suppurativa** *Chairs: Gregor Jemec and Gísli Ingvarsson*	**PS06 – Room B** **Biologics – Anything Unsaid?** *Chairs: Mona Ståhle, Peter Berg and Marcus Schmitt-Egenolf*	**C02 – Room FG** **Dermatological Theories in Practice** *Chair: Theis Huldt-Nyström*
16.00–16.30	**Exhibition and Coffee**			
16.30– 18.00	**CSS02 – Room A** Sponsored by Basilea			**C02 – Room FG** **Dermatological Theories in Practice, contd.**
Monday June 2nd, 2008				
08.00–09.30	**PS07 – Room A** **Psoriasis Update** *Chairs: Steingrímur Davíðsson and Olle Larkö*	**PS08 – Room B** **Dermatology and Policies of Administration** *Chairs: Evan Farmer, Fenella Wojnarowska and Olle Larkö*	**W01 – Room D** **Self-assessment in Dermato-pathology** *Chair: Philip LeBoit* *Co-chairs: Antoinette Hood and Mari-Anne Hedblad*	**C03 – Room FG** **Dermatopathology** *Chair: Ellen Mooney* *Co-chairs: Mari-Anne Hedblad and Ole Clemmensen*
9.30–10.00	**Exhibition and Coffee**			

10.00–11.30	**PS09 – Room A** **Skin and Malignancies** *Chair: Werner Kempf*	**PS10 – Room B** **Contact Dermatitis** *Chairs: Bolli Bjarnason and Marlene Isaksson*	**W01 – Room D** **Self-assessment in Dermato-pathology, contd.**	**C03 – Room FG** **Dermatopathology, contd.**
11.30–12.40	**Exhibition and Sponsored lunch Symposium, Photocure – Room HI**			
12.40–13.30	**PL02 – Room AB** **Certification and Maintenance of Certification in Dermatology** *Antoinette Hood,* Executive Director, American Board of Dermatology			
13.40–15.10		**PS11 – Room A** **Venereology in Scandinavia** *Chair: Harald Moi*	**PS12 – Room B** **Melanoma Update** *Chair: Jon Hjaltalin Ólafsson*	**W01 – Room D** **Self-assessment in Dermato-pathology, contd.**
15.10–15.30	**Exhibition and Coffee**			
15.30–17.00	**Nordic Dermatology Association, General Assembly – Room A**			
17.30–18.30	Buses to Congress Event at the Blue Lagoon (**bathing, food and fun**)			
Tuesday June 3rd, 2008				
09.00–10.30	**PS13 – Room A** **Photodermatology and Photo-protection** *Chairs: Vigfús Sigurðsson and Hans Christian Wulf*	**PS14 – Room B** **Infotech, Telemedicine, Dermatological Websites** *Chairs: Lars Erik Bryld and Thor Bleeker*	**W02 – Room FG** **Tutorials for Self-assessment in Dermatopathology** *Chair: Philip LeBoit, Antoinette Hood and Mari-Anne Hedblad*	**PS15 – Room I** **Free Papers Session** *Chair: Bernt Lindelöf*
10.30–11.00	**Exhibition and Coffee**			
11.00–12.30	**PS16 – Room A** **Nail Disorders** *Chair: Robert Baran*		**W02 – Room FG** **Tutorials for Self-assessment in Dermatopathology, contd.**	**PS15 – Room I** **Free Papers Session, contd.**
12.30	Closing Remarks			
PL: Plenary Lecture; PS: Parallel Session; C: Course; CSS; Corporate Sponsored Symposium; W: Workshop				

PLENARY SESSIONS

Sunday June 1st, 13.10–14.00

PL01

Atopic Eczema – What is New?

Johannes Ring

Department of Dermatology and Allergy Biederstein, Technische Universität München, München, Bavaria, Germany

Atopic eczema (AE) is one of the most common inflammatory skin diseases with a chronic or relapsing course and strong itching. The prevalence of AE has increased over the last decades tremendously in most countries of the world. In Germany we have prevalence rates between 5–20% in various areas. AE, allergic bronchial asthma and allergic rhinoconjunctivitis are closely linked, as we know from classical genetics.

Surprisingly, with modern molecular genetic technology, associations overlap more between AE and psoriasis than with asthma.

For many gene loci with high association no clear-cut function has been described. Recent data describe a genetic polymorphism on chromosome 1 in the area of the epidermal differentiation complex, namely in the profilaggrin molecule; this polymorphism is highly associated with ichthyosis vulgaris and also with AE. Other associations have been described for proteases and protease inhibitors. The importance of the barrier function and its disturbance in this disease is underlined by these studies.

Few diseases are characterized by similarly elevated IgE values as AE. For a long time this was regarded as an epiphenomenon. By the discovery of IgE and the high affinity IgE receptor on epidermal Langerhans' cells, especially in AE, together with the introduction and standardization of the atopy patch test (APT) it has become clear that IgE inducing allergens also play a role in eliciting or aggravating eczematous skin lesions in this disease.

New data also arise from studies regarding the pathophysiology of itch. Recently, the itch sensation has been visualized with positrone emission tomography (PET). Atopic itch has been shown to differ in specially validated questionnaires qualitatively from itch in other pruritic skin diseases. Autonomic nervous system dysregulation may influence both itch and inflammatory reactions.

The basis of therapy in AE is the restoration of the disturbed barrier function which is often described clinically as "dry skin". This dermatologic basic therapy is especially important during phases of remission. The individual selection of emollients (different for different body areas and different individuals) is crucial. Progress has been made with new emollients containing special lipids in various galenic forms.

New anti-inflammatory treatments with topical calcineurin inhibitors (tacrolimus and pimecrolimus) have enriched the therapeutic arsenal. Various UV wave lengths have been successfully tried as adjuvant strategies. Climate therapy) (at the North Sea level or high altitude in alpine regions) can help ameliorate the situation. The role of allergen-specific immunotherapy (ASIT) is still controversial; however, a recent double-blind placebo-controlled study has shown efficacy also in AE. It remains to be seen whether the new biologics will find their way in routine treatment of AE. Preliminary studies have shown limited to moderate effects with anti-IgE (omalizumab) or anti IL-5 (mepolizumab).

The individual variability of the clinical expression and course of AE requires the active cooperation of the informed patient over months and years. This can be achieved by "eczema school" programs which have been successfully evaluated in a national mulitcenter trial in Germany. The essence of these eczema school programs is the interdisciplinary character in a close cooperation between medical doctors (pediatricians and dermatologists), psychologists and nutrition experts.

Reference: Ring J, Allergy in practice. Springer, Berlin, Heidelberg, New York, 2005.

Monday June 2nd, 12.40–13.30

PL02

Certification and Maintenance of Certification in Dermatology

Antoinette Hood

Exectutive Director of the American board of Dermatology

Dermatology has evolved from internal medicine into a fully mature subspecialty of cutaneous medicine. In the 21st century, assuring quality healthcare requires a new paradigm of post-graduate education, self-assessment and practice evaluation. The road to quality is not easy; it is necessary.

PARALLEL SESSIONS

Wound Healing

PS01.1

Leg Ulcers in Practice – Diagnostic and Treatment

Uwe Wollina

Department of Dermatology and Allergology, Hospital Dresden-Friedrichstadt, Academic Teaching Hospital of the Technical University of Dresden, Dresden, Germany

Correspondence should be sent to: Prof. Dr. Uwe Wollina, MD, Department of Dermatology, Hospital Dresden-Friedrichstadt, Academic Teaching Hospital of the Technical University of Dresden, Friedrichstrasse 41, 01067 Dresden, Germany; E-mail: wollina-uw@khdf.de.

Leg ulcers are the most common conditions presenting with chronic and in many cases disabilitating wounds. The spectrum of underlying disease causing leg ulcers is remarkably broad although the most common cause in Europe and other Western countries is venous insufficiency. In Africa, Asia and South America infectious diseases count for a significant number of cases. In a globalizing world the usual pattern of disease is becoming mixed.

Leg ulcers are by no means a diagnosis, just a symptom. In any case search for the underlying cause is necessary to provide the appropriate treatment for the patient. Therefore, standardization of treatment is not the final target but a tool to offer optimal treatment in individual situations. The target of leg ulcer therapy is the individual patient. To be treated in a rational and successful way, exact diagnosis of the underlying cause(s) and associated diseases is necessary. This can be done in the most effective way by an interdisciplinary approach. The collection of cases demonstrates the need for careful clinical investigation substantiated and supported by vascular, histopathologic and microbiologic techniques wherever needed. Although not every ulcer can be cured, improvement of the medical situation and of quality of life of the patient is possible in most cases.

PS01.2

Conservative Treatment of Chronic Wounds

Tonny Karlsmark

Department of Dermato-Venereology, Bispebjerg Hospital, Kopenhagen, Denmark

Chronic wounds represent a major but unfortunately neglectic health care problem resulting in distress and disability for the patients, potentially loss of working capability, reduced quality of life and an increasing burden to health care providers.

It is estimated that approximate 1% of the population in the industrialised world suffers from wounds that need professional treatment. The aim of this lecture is to give an overview of the conservative treatment of chronic wounds – including new kind of dressings, compression therapy and hypothesis about bacteria influence in non-healing ulcers.

Drug Reactions and Interactions

PS02.1

ADRs and the Skin From a Regulatory Perspective

Gunilla Sjölin-Forsberg

Medical Products Agency, Sweden

Background: Adverse drug reactions (ADRs) are frequent causes of morbidity and also mortality in patients worldwide. They are often classified into type A, B, C, D and E reactions. Most skin reactions have been considered to be type B, i.e. idiosyncratic or hypersensitivity reactions. The hypersensitivity reactions are in principal further grouped into four different types depending on underlying immunological mechanisms.

Objective: To describe the reporting patterns of ADRs in the skin: Most commonly reported type of reactions, most commonly reported medicinal products in relation to skin reactions and recent regulatory actions. Regulatory announcements on websites of authorities (EMEA and FDA).

Results: New products and skin reactions, new warnings and recent findings will be addressed.

Conclusion: Any new lesson learnt? Can we prevent ADRs in the skin?

PS02.2

Franz Diffusion Cells Experiments for *in Vitro* Transdermal Permeations Studies

Bergthóra S. Snorradóttir and Már Másson

Faculty of Pharmacy, University of Iceland, Reykjavik, Iceland

In principle there are three possible routes for the penetration of topically applied substances through the stratum corneum; the transcellular, intercellular and follicular route. Adhesive tape stripping measurement and confogal microscopy have been used to determine which is the dominant of penetration route. The purpose of *in vitro* studies to determine transdermal permeation, penetration and absorption can vary and thus different approaches and models are used for such studies. Franz diffusion cell are often chosen as tools for in vitro experiments. The practice of Franz diffusion cells experiments will be discussed and some typical results will be shown.

PS02.3

What You Need to Know about Skin Reactions, the Old & New

Neil H Shear

University of Toronto Medical School

Cutaneous reactions are common but can be markers of systemic disease and be challenging to manage. An organized approach to diagnosis (focusing on morphology and presence of fever), and visually mapping drug exposure can lead thoughtful causality assessment. Patch testing may also help in special circumstances. Our understanding of both simple exanthems and the drug hypersensitivity syndrome have been helped by important research. Treatment is not evidence-based but experience has helped create some guidelines. Case examples and simple algorithms will be used to illustrate the most clinically useful approach to all drug reactions in the skin.

Atopic Dermatitis Update

PS03.1

Treatment of Anaphylactic Reactions

Johannes Ring

Department of Dermatology and Allergology, Klinikum rechts der Isar, Technische Universität München, Germany

Anaphylaxis is the maximum variant of an acute generalized hypersensitivity reaction which can rapidly progress and involve several organ systems. 90% of cases show skin manifestations. Therapeutic interventions depend on the history (e.g. eliciting substances, kinetics) and the clinical presentation regarding symptoms; a severity grading from I to IV has been proven valuable in the past (Ring, Messmer, Lancet 1977).

General measures in management of anaphylaxis comprise the appropriate positioning and an intravenous catheter for an infusion line. Drug of choice is epinephrine (first i.m., in manifest shock i.v.) as well as histamine HI antagonists (especially in grade I and II reaction). Glucocorticosteroids (i.v. bolus) have proven to be helpful in prevention of late type or dual reactions. In grade IV (cardiac and/or respiratory arrest) classical cardio-pulmonary resuscitation has to be initiated. When airway symptoms are predominant, inhalative 2 agonists can be used. Volume substitution (electrolytes, plasma expanders) is crucial starting from grade III. For self-medication, patients should receive an emergency kit containing an epinephrine autoinjector as well as an antihistamine and a glucocorticosteroid. Epinephrine autoinjectors are available both for adults and children. The German Academy for Allergy and Environmental Medicine has started an educational program for patients and relatives. Patients should be informed about the disease, the relevant elicitors as well as possible avoidance strategies together with adequate training in the use of emergency drugs.

Reference:

Ring, J: Allergy in practice; Springer, Berlin, Heidelberg, New York 2005.

PS03.2

Management of the Atopic Dermatitis Patient

Thomas L. Diepgen

University Hospital Heidelberg, Dept. of Social Medicine, Occupational and Environmental Dermatology, Germany

Atopic eczema (AE) is a well known but difficult to treat common, chronically relapsing, inflammatory skin disease with a high economic burden and high impact on the quality of life. In recent years epidemiological findings have challenged the prevailing concepts in understanding AE and this might have a major impact how we manage AE from a clinical point of view. First, although atopy is associated with AE in some degree, its importance is not likely to be a simple cause and effect relationship, especially at a population level. This has a major impact on the prevention of AE. Perhaps there are more types of "atopic" eczema, the defining pattern of which will become clearer as we learn more about the genetic and environmental causes of what is currently recognized as the common phenotype of AE. Second, the inverse relationship (if this link is present) between infections and AE risk is likely to be more complex, depending critically on the timing and type of infectious exposure. Third, although eczema, asthma and allergic rhinitis tend to cluster in the same individuals and families, the exact relationship between early eczema and subsequent asthma (the atopic march) over time is far from clear. However, knowledge about the course of a chronic disease is important for patients, physicians and health authorities. In a prospective cohort study we could identified by statistical modeling three subgroups of AE. Fourth, patient education programs are part of patient empowerment to solve problems with chronic diseases but there efficacy has not yet been proven for AE. In a recent multicentre study (randomised prospective controlled trial) the efficacy of an educational program for the self management of AE in children and adolescents was evaluated. The results demonstrate that this educational group intervention program is effective in the long term disease management of AE. This educational program should be considered a part of the routine care of children and adolescents with AE.

In conclusion, these observations underline the importance of epidemiological studies conducted at a population level to gain a more balanced understanding of the endigma of atopic

eczema, and the importance of large randomised controlled clinical trials to get new insights for the management of these patients in our daily routine.

PS03.3

Climate Change – Impact on Pollen and Allergy

Heidrun Behrendt

ZAUM - Zentrum Allergie und Umwelt - Center for Allergy and Environment, Technische Universität München, Munich, Bavaria, Germany

Allergy represents a major health problem in most countries of the world with increasing prevalence rates of atopic diseases (rhinoconjunctivitis, asthma and eczema). Among hypothetical concepts trying to explain this increasing prevalence both loss of protective factors (early immune stimulation by infectious disease, vaccination or exposure to Th1 stimulating agents) and effects of allergy enhancing factors (environmental tobacco smoke in the indoor and traffic exhaust exposure in the outdoor environment) have been identified. On the example of pollen allergy, a few thoughts concentrating on allergen exposure – both in a quantitative and qualitative way – may add a third hypothesis ("allergen exposure hypothesis").

In the past decades, there have been 3 major changes with regard to pollen exposure which will be shortly discussed:

1. More pollen: phenological observations over the last 30 years have yielded significantly prolongued flowering times of many anemophilous plants with earlier start of pollination and later dying of leaves leading to a prolongued pollination period by more than 10–15 days in the average in Central Europe (WHO report, 2005). This implies that more pollen are in the atmosphere over longer periods of time.
2. New pollen: Due to climate change and/or globalisation many countries of the world experience new plants (neophytes) appearing in the traditional habitat, the most remarkable example being ragweed (ambrosia artemisiifolia) spreading from Southern France and Eastern Europe to large parts of Central Europe.
3. Altered pollen: By atmospheric pollution pollen grains are altered and show morphological changes of surface structures with increased extrusion of allergenic material. Among factors contributing to these effect volatile compounds (VOCs) in the indoor and fine and ultrafine particles from traffic exhaust in the outdoor are the most prominent.

Furthermore, we have recently found that pollen not only act as allergen carriers but also secrete highly bioactive proinflammatory lipids, the so-called pollen associated lipid mediators (PALMs) which contribute to the recruitment of immune cells in the early phase of the initiation of an allergic reaction. A subgroup of PALMs (phytoprostanes) has been shown to enhance the shift towards Th2 in dendritic cells after allergen contact, thus facilitating an allergic immune response.

Since global warming with consecutive climate change seems to be no fiction but rather a scientifically proven reality, allergists should be aware of these phenomena of possible new and prolongued pollen exposure in the environment of their patients. Rational prevention programs should not only focus on patients and indoor avoidance recommendations, but also imply action plans in reducing outdoor allergen exposure.

References:

Behrendt H, Krämer U, Schäfer T, Kasche A, Eberlein-König B, Darsow U, Ring J. Allergotoxicology – A research concept to study the role of environmental pollutants in allergy. ACI International 2001;13:122–128.

Behrendt H, Becker WM. Localisation, release and bioavailbaility of pollen allergens. The influence of environmental factors. Curr Opin Immunol 2001; 13: 709–715.

Traidl-Hoffmann C, Mariani V, Hochrein H, Karg K, Wagner H, Ring J, et al. Pollen-associated phytoprostanes inhibit dendritic cell interleukin-12 production and augment T helper type 2 cell polarization. J Exp Med 2005; 201: 627–636.

Oral Dermatology

PS04.1

Oral Manifestations of Systemic Diseases

Mats Jontell

Oral Medicine, Institute of Odontology, Sahlgrenska Academy, University of Gothenburg, Gothenburg, Sweden.

The oral cavity is sited at the mucocutaneous interface between the skin and the gastrointestinal tract. Diseases in the two latter body compartments reflect the pathological conditions observed in the oral mucosal lining. The oral mucosa, as the skin, has the advantage of being easily accessible for ocular examination although the reaction pattern may appear to be different from what is seen in a dermatologic practice. Even though there is a limited spectrum of reactions patterns, their recognition is critical for a correct diagnosis. This presentation will focus on diagnosis and management of some of the most common reaction patterns signalling systemic dermatological and gastrointestinal diseases inclusing vesiculobullous diseases, food allergies and inflammatory bowel disease. These will be presented as examples of disease that are expressed in the oral cavity.

PS04.2

White Lesions of The Oral Cavity

Ginat Mirowski

Department of Dermatology, Feinberg School of Medicine, Northwestern, University, Chicago, Illinois, USA

White lesions are extremely common findings in the oral cavity. Benign and physiologic entities may present as white lesions; systemic conditions and infections as well as malignancies may also present as white oral lesions. An appreciation of the clinical entities that white lesions may represent is necessary if a differential diagnosis is to be elucidated. The appreciation of subtle clinical findings associated with white lesions of the oral cavity will permit clinicians to better care for their patients. A clinical approach, the differential diagnosis and, diagnostic studies as well as treatment options will be discussed.

Hidradenitis Suppurativa

PS05.1

Current Understanding of Aetiology and Pathogenesis of Hidradenitis Suppurativa

Gregor B. Jemec

Roskilde, Denmark

Traditional understanding of Hidradenitis suppurativa (HS) suggests that it is a disease of the hair follicle. There is considerable understanding of the disease mechanism, which involves lesions of the deep portions of the follicle epithelium. The aetiology however remains unknown. Current trends in aetiological reserach of HS will be presented in the perspective of the disease mechanism as we understand it today.

PS05.2

Hidradenitis Suppurativa – Clinical Presentation and Disease Severity

Karin Sartorius

Department of Dermatology, Karolinska University Hospital

Hidradenitis suppurativa (HS) is a chronic recurrent disease causing inflammation, suppuration and scarring of inverse areas. In the classic Hurley clinical grading system, stage I consists of one or more abscesses with no sinus tract or cicatrization, stage II consists of one or more widely separated recurrent abscesses with a tract or scarring. The most severe cases, stage III, have multiple interconnected tracts and abscesses throughout the entire affected area.

Among HS patients seeking help from dermatologists for their disease, cases graded as Hurley II form the majority, and within this common disease stage group there is a wide variation of clinical findings and symptoms. Milder cases with comparatively small problems exist in this group, while the more severe cases may have debilitating symptoms. It is therefore important to develop a more dynamic and precise scoring system for HS by adding clinical details to the staging process. It is proposed that the following outcome variables are explicitly mentioned in future reports:

1. Anatomical region involved.
2. Number and scores of lesions.
3. The longest distance between two relevant lesions.
4. Are all lesions clearly separated by normal skin?

By assigning numerical scores to these variables, disease intensity can be quantified in a more clinically meaningful way on an open-ended scale. Furthermore, as pain is an important feature of HS a subjective evaluation should be included, preferably a visual analogue scale score of pain from the worst lesion as chosen by the patient.

PS05.3

Medical Treatment of Hidradenitis Suppurativa

Gisli Ingvarsson

Lágmúla 5, IS-108 Reykjavík, Iceland

This lecture is based on medical literature and personal experience in everyday management of this orphan disease. The main themes of medical treatment are mentioned and specific medical options evaluated. Guidelines for medical treatment will be suggested.

PS05.4

Surgical Treatment of Hidradenitis Suppurativa

Nathalie Dufour

Brinkvegen 24, N-9012 Tromsø, Norway

The lecture will be based on information from medical literature and personal experience in everyday management of this disease. The main strategies of surgical treatment will be mentioned but the focus will be on surgical CO_2 laser treatment of hidradenitis suppurativa. The procedures and guidelines for CO_2 laser treatment in a Norwegian department of dermatology will be presented.

Biologics – Anything Unsaid

PS06.1

Systemic Treatment for Psoriasis – a New Biologic Era

Mona Ståhle

Department of Medicine, Karolinska Institutet, Stockholm, Sweden

Psoriasis is the most prevalent inflammatory skin disease in our part of the world. Despite considerable advances in our knowledge about disease pathology, the ultimate cause of psoriasis remains elusive. Current understanding recognizes the significant clinical heterogeneity of the disease, which may result from differences in pathomechansims and variations in the genetic background. How such differences translate into therapeutic response in the individual patient is an emerging challenge, which has become more obvious with the introduction of the novel biologic drugs. In fact, these drugs constitute powerful in vivo models for disease mechansims and may give important clues to pathogenesis. Even within the class of drugs antagonizing TNF-α there are differences in response among psoriatic patients and interestingly, insufficient response to one drug does not preclude an excellent response to another. In the Nordic countries we currently have access to four different biologicals for treatment of psoriasis: Infliximab, Etanercept, Efalizumab and Adalimumab and additional drugs are already in clinical trials. This is indeed a fortunate situation for patients with psoriasis and gives us new possibilities to control even the most severe disease manifestations.

PS06.2

Systematic Follow-up of Conventional and Biologic Psoriasis Treatment: The Swedish Registry PsoReg

Marcus Schmitt-Egenolf

Department of Public Health and Clinical Medicine, Dermatology and Venereology, Umeå University, Sweden

The selection of the best and safest treatment for each individual patient out of numerous options from today's pharmacopeia requires substantial knowledge. With the introduction of new systemic drugs for the management of psoriasis we felt an obligation in Sweden to establish a trusted tool to monitor their use. We formed PsoReg to create a solid, long-term database in order to analyze the safety and effectiveness of different systemic psoriasis treatment regimes. In contrast to randomized clinical trials and spontaneous reporting of adverse effects, registries for collecting observational data can provide a systematic but real-life picture of the diseased population in actual practice. PsoReg will provide information to help clinicians individualize therapy on a rational basis through evaluation of effectiveness and adverse effects in specific patient subgroups. Designed and managed by specialized healthcare professionals, PsoReg enrolls all psoriasis patients on systemic treatment to allow a fair comparison of old versus new generation psoriasis treatments. PsoReg even creates benchmark data for quality assurance of the medical service. A web-based design allows real-time pharmacovigilance and will enable the registry to assist clinicians in their day-to-day management of psoriasis patients. In this way PsoReg can become an integrated part of tomorrow's dermatology.

PS06.3

Biologic Therapy of Psoriasis in Clinical Practice

Peter Berg

Department of Dermatovenereology, Karolinska University Hospital, Solna, Sweden

Nearly one million patients are treated worldwide with biologicals due to chronic inflammation, mainly with the diagnosis rheumatoid arthritis, Crohn´s disease, and psoriasis with or without arthritis. We will present some severe cases with psoriasis, where it has been difficult to direct which biologicals you should choose as treatment. There will be a focus on side effects and why we had to change to some other biologicals for best clinical effect in the patient. In the presentation of some ten cases we will find all the four different biologicals represented in Sweden, Infliximab, Etarnecept, Efalizumab and Adalimumab. At the time being these patients have benefited out of the given treatment with biologicals compared with traditional systemic treatment for psoriasis.

Psoriasis Update

PS07.1

Effect of Tonsillectomy on Patients with Chronic Plaque Psoriasis

Ragna Hlín Þorleifsdóttir[1,2], Andrew Johnston[3], Jón Hjaltalín Ólafsson[2], Bárður Sigurgeirsson[2], Hannes Petersen[4], Sigrún Laufey Sigurðardóttir[1] and Helgi Valdimarsson[1]

[1]Department of Immunology, [2]Department of Dermatology, Landspitali University Hospital, Reykjavik, Iceland, [3]Department of Dermatology, University of Michigan, USA, [4]Department of ENT, Landspitali University Hospital, Reykjavik, Iceland

Background: Streptococcal throat infections are associated with the onset and exacerbation of psoriasis. A number of uncontrolled studies have shown the benefit of tonsillectomy in patients with psoriasis. The aim of this study is to determine whether tonsillectomy could be an effective treatment option

for patients with chronic plaque psoriasis and to investigate the potential role of tonsillar T cells in psoriasis.

Methods: 40 patients will be recruited into an observer blinded randomized controlled study and half of the patients will undergo tonsillectomy. They will be examined every 2 months for 2 years and their skin disease monitored clinically by PASI score. In addition, a number of immunologic tests will be performed on blood and tonsillar T cells using flowcytometry and luminex techniques.

Results: At this stage 21 patients have been participating in the trial for at least 2 months. Preliminary results indicate an average decrease of 42% in PASI score for the tonsillectomized patients (n=13) compared to an average decrease of 1% in the control group (n=8). Additionally there seem to be tonsillectomy associated changes in the responses of blood T cells to streptococcal M-protein and keratin peptides that share amino acid sequences.

Conclusion: These preliminary results suggest that tonsillectomy may have beneficial effect on moderate to severe chronic plaque psoriasis, and that this effect may be associated with changes in T-cell responses to peptides postulated to be autoantigens in psoriasis.

PS07.2

Science Meets Nature: Why do Psoriasis Patients Benefit from Bathing in the Blue Lagoon?

Jean Krutmann

Institut für Umweltmedizinische Forschung an der Heinrich-Heine-Universität Düsseldorf GmbH, Düsseldorf, Germany

Bathing in the Blue Lagoon, a specific geothermal biotope in Iceland, has been known for many years to be beneficial for human skin in general and for patients with psoriasis and atopic dermatitis in particular. The scientific rational for this empirical observation, however, has remained elusive. We now report that extracts prepared from silica mud and two different microalgae species derived from the Blue Lagoon are capable of inducing involucrin, loricrin, transglutaminase-1 and filaggrin gene expression in primary human epidermal keratinocytes. The same extracts also affected primary human dermal fibroblasts, because extracts from silica mud and one type of algae inhibited UVA radiation-induced upregulation of matrix metalloproteinase-1 expression, and both algae, as well as silica mud extracts induced collagen 1A1 and 1A2 gene expression in this cell type. These effects were not restricted to the in vitro situation because topical treatment of healthy human skin (n=20) with a galenic formulation containing all three extracts induced identical gene regulatory effects in vivo, which were associated with a significant reduction of transepidermal water loss. In aggregate these results suggest that the Blue Lagoon contains biological activities which have the capacity to improve skin barrier function and to prevent premature skin aging. These observations explain at least some of the beneficial effects of bathing in the Blue Lagoon and provide a scientific basis for the use of Blue Lagoon extracts in cosmetic and/or medical products.

PS07.3

Economic Burden of Psoriasis

Olle Larkö

Department of Dermatology and Venereology, Sahlgrenska Academy, University of Gothenburg, Gothenburg, Sweden

Psoriasis is a chronic disease often starting before the age of 25. Patients may undergo different types of treatment for decades. The economic burden to society can be substantial. It has been shown that patients with arthitis are the costliest as sick leave is often necessary. Drug treatment constitutes for a minor part of the total cost to society. Methotrexate is probably the cheapest treatment for moderate to severe psoriasis. UVB is also a ceap alternative, although travel distances may be limiting. Home solarium therapy was described decades ago but has not become very popular. Education of patients to deal with their own disease is very important. Newer biologic therapeutic modalities seem extremely expensive but still constitutes a minor part of the total cost.

PS07.4

The Use of PDI in Measuring Quality of Life in Patients at the Blue Lagoon Clinic

Steingrimur Davidsson

Department of Dermatology, University Hospital Reykjavik, IS-105 Reykjavik, Iceland

This lecture will report the use of PDI (Psoriasis Disability Index) in measuring the quality of life in psoriasis patients attending the Blue Lagoon clinic. Eighty-three patients were asked to answer the questions before the treatment, 4 weeks after the start and finally 12 weeks after starting therapy. Forty-two patients answered all 3 forms, 16 who answered the first 2 forms and 25 patients only answered the first questionnaire. The results will be presented in the lecture.

Dermatology and Policies of Administration

The subject of the meeting

At keynote lectures on dermatological conferences the good quality and importance of the dermatological speciality are emphasised and colleagues are encouraged to further its repu-

tation and power. The fact is, however, that the speciality is losing ground in many areas in the Nordic countries especially as it is set under the administration of an infectious diseases unit or general medicine unit, at the medium sized and small hospitals. The lecturers at the symposium have, however, a vast exeperience of communicating with the administrative powers, be they political, hospital administrative, from the industry etc. The lecturers will from their experience, by practical examples or through overview, identify the players of the arena, describe the "soft spots" and give a "take home message".

PS08.1

Current Issues in American Academic Dermatology

Evan Farmer

The issues and trends facing American academic dermatology in the context of American healthcare delivery will be presented and discussed at this symposium.

PS08.2

Skin Cancer in the UK – Can UK Government Driven Models of Working have Application Elsewhere?

Fenella Wojnarowska

University of Oxford and Department of Dermatology, Oxford Radcliffe Hospital, Oxford, UK

The UK has for 10 years had an evolving model of cancer networks. A skin cancer network will serve an area of 1–5 million people and will include a University and local (district general) hospitals. There is a network cancer lead, and the members consist of dermatologists, plastic surgeons, radiotherapists, oncologists, other surgical specialities that do skin cancer work, histopathologists, nurses, a user (skin cancer patient) and network representatives. The local network agrees treatment protocols and patient information, and shares working practices. The UK government has had a programme to improve cancer outcomes in the UK, and has produced an Improving Outcomes Guidance for Skin Cancers. This lays down standards of care that must be met. A major change has been very clearly defined levels of care between GPs, who can treat only BCCs, and local and specialist hospitals. In addition all complex BCCs, all SCCS and melanomas must be reviewed at regular (1 or 2 weekly) Multidisciplinary Team meetings of dermatologists, plastic surgeons, radiotherapists, oncologists, histopathologists, and specialist skin cancer nurses for discussion and decision making concerning management. Complex and rare skin cancers must be referred to a specialist Multidisciplinary team of dermatologists, plastic surgeons, radiotherapists, oncologists, histopathologists, and specialist skin cancer nurses for review, there is usually only one per network. The Cancer networks are responsible for initiating these procedures and documenting and overseeing them. They are subject to peer review at intervals of 5 years, and failure to meet standards in theory means they cannot treat cancer.

PS08.3

Dermatology and Policies of Administration

Olle Larkö

Department of Dermatology and Venereology, Sahlgrenska Academy, University of Gothenburg, Gothenburg, Sweden

Dermato-venereology has undergone big changes in recent years. The number of beds has been reduced dramatically, in some instances to 10% of the former level. In certain parts of, at least Sweden, a dermatologist is no longer in charge of the unit. This poses special problems of running and administrating clinics and research. Also, the academic staff has lost influence in running dermatology departments. Consequently, we may have trouble in the future to defend some areas of the specialty. The very basis for dermato-vnereology relies on research and academic work. If this is obliterated we may run into difficulties in the future. In my opinion, at least university clinics should be reasonably EU-compatible, handling both training and patient care for the entire spectrum of dermato-venereological problems. Unfortunately, patient care and trainging of young collegues has quality problems in certain areas of the Nordic countries. This refers specially to skin cancer care, histopathology and advanced venereology. The financial system differs somewhat between countries but also within a country. Overall, it gives us a reasonable freedom to act.

Skin and Malignancies

PS09.1

Parapsoriasis – Inflammatory Disorder or Cutaneous T-cell Lymphoma?

Werner Kempf

Zürich, Switzerland

Although described more than 100 years ago, there is a considerable debate on the terminology and nosologic relation of parapsoriasis (PPS) to MF. Based on clinical features, two main forms of parapsoriasis can be distinguished. Small-plaque parapsoriasis (SPP) (synonyms: digitate dermatosis, chronic superficial dermatitis) is characterized by oval or digitate patches, 2 to 6 cm in diameter, preferentially located on the lateral parts of the trunk and showing a reddish or yellowish surface with

pseudoatrophic wrinkling and slight pityriasiform scaling. In large-plaque parapsoriasis (LPP) (synonym: parapsoriasis en grandes plaques), relatively few large (>10 cm in diameter), irregularly shaped, reddish and fairly well demarcated lesions with pityriasiform scaling are located on the trunk and/or extremities. Histologically, the epidermis shows slight acanthosis with patchy parakeratosis. Scant perivascular infiltrates of small lymphocytes may be seen in the upper dermis, with or without subtle single-cell epidermotropism. In general a few eosinophils are present, but plasma cells are not observed. Phenotypically, the infiltrate in SPP and LPP is mainly composed of CD4+ , CD8- , and CD45RO+ T cells intermingled with a few CD8+ cells. Clonal rearrangement of T-cell receptor genes is found occasionally in SPP and LPP. The major differential diagnosis of SPP and LPP includes early-stage MF and chronic eczema, which on histologic grounds alone usually cannot be distinguished. Additional information including clinical presentation and course of the disease are needed for the diagnosis. However, in some cases only the stable course of the condition without progression allows one to differentiate SPP from MF retrospectively. The prognosis of SPP is exceptionally good without any influence on survival. Fatal outcome of SPP has so far not been reported. A subset of patients with LPP, however, shows progression of LPP to overt MF. Thus some authors including ourselves consider LPP as variant of MF with usually very slowly progressive course potential for progression to MF. In contrast to LPP, in our experience SPP behaves biologically like a chronic benign inflammatory disorder. To our opinion, SPP does not represent a precursor of MF.

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PS09.2

Squamous Cell Carcinoma in Venous Leg Ulcers

Baldur Tumi Baldursson

University Hospital Reykjavik/Karolinska Institutet

A cohort from the Swedish In-patient Registry with 10,913 patients with the diagnosis venous ulcer was matched with the Swedish Cancer registry. This search resulted in 23 cases of squamous cell carcinoma (SCC), of which 17 were considered certainly secondary to venous ulcers. This gave a significantly increased relative risk (RR = 5.8; 95% CI 3.1–9.3), of getting SCC in a venous ulcer. The conclusion is that SCC is indeed a complication of venous leg ulcers and the risk is approximately fivefold compared to the general population of Sweden.

A study of the case histories and histological slides of 25 patients with SCC in venous ulcers gave the following results: Twenty-three of the patients were dead. The mean age at cancer diagnosis was 78.5 years, and the median duration of the ulcer before diagnosis of SCC was 25 years. All patients who had a poorly differentiated SCC died within a year from diagnosis. Survival was significantly shorter ($p = 0.008$) than in the control group with squamous cell carcinoma on the lower limb. Thus, this complication is lethal in many cases, and there should be no hesitation to biopsy unusual or prolonged cases of venous ulcers. Studies on histopathological blocks for the presence of human papillomavirus (HPV) as well as on control samples from chronic venous ulces without cancer revealed no HPV whereas 10 of the ulcer samples were positive. Indeed the difference in positivity between the ulcers and the SCCs was statistically significant ($p = 0.01$). Immunohistochemistry studies for expression of p21WAF1/CIP1 (p21), p53, bcl-2 and Ki-67 showed no expression of p21, p53 or bcl-2 in the venous ulcer samples and no expression of bcl-2 in any of the samples. 22 SCC samples were positive for p21 and 15 for p53. The absence of p53 expression in the ulcers and adjacent to the SCCs probably reflects the non-UV carcinogenic mechanism of these cancers which places them in a somewhat unique position amongst SCC's, most of which are P53 positive.

PS09.3

Genital Precancerous Lesions and Treatment Modalities

Olle Larkö

Department of Dermato-Venereology, Sahlgrenska Academy, University of Gothenburg, Gothenburg, Sweden

The term VIN and PIN correspond to a histological anglo-saxon definition. They represent intra-epithelial neoplasia which can progress to squamous cell carcinoma. Penile intraepithelial neoplasia (PIN) is a precancerous lesion of the penile epithelium. In younger men Bowenoid papulosis often has a generally benign course. Middle-aged and elderly patients often present solitary PIN lesions with an increased risk of progression to SCC. The management of PIN lesions has proven to be difficult and recurrences are frequent. There are many different treatment modalities such as; local excision, Mohs micrographic surgery, topical 5-fluorouracil, cryo surgery, CO_2 laser, electrocauterization, interferon and imiquimod. The cure rates vary. Photodynamic therapy has evolved as a new therapy for PIN.

PS09.4

The Epidemiology of Skin Cancer in Organ Transplant Recipients

Bernt Lindelöf

Department of Dermatology, Karolinska University Hospital, Stockholm, Sweden

Organ transplant recipients (OTR) are at increased risk of having both cutaneous and systemic cancer develop. Since 1971, many papers concerning cancer in OTR, most of them including skin cancers, have been published but very few of them have been population-based and the figures on incidence and risks must be interpreted with caution. The overall increased risk for any type of cancer in OTR has been estimated to be four-fold greater than that in the general population. The most common post-transplantation cancers in a Western population include non-melanoma skin cancer, lip cancer, non-Hodgkin's lymphoma, the vulva, vagina, oral cavity and anal cancer. The standardized incidence ratios (SIRs) of skin cancer are greatly increased in different studies. The most frequently encountered skin cancers in OTR are squamous cell carcinoma (SCC) (SIRs: 18–253). They are also believed to be more aggressive with a higher risk of metastasis than in the general population. Other unusual features are the young age of the patients and the high incidence of multiple tumors. Approximately 30–50 % of the OTR with SCC also have basal cell carcinoma (BCC) (SIR: 10). Existing studies are not in fully agreement over whether OTR have an increased risk of malignant melanoma, and compared with SCC the low incidence of MM has made it difficult to study OTR prospectively. Kaposi's sarcoma has been reported in excess among OTR especially from areas which the disease is endemic i.e. South Africa. The incidence of Merkel cell carcinoma in OTR appears also to be increased. Furhermore, the incidence of skin cancer is affected by allograf type, geografic location, and duration after the transplant. Few studies have reported figures on mortality but it has been reported that the risk of death caused by SCC in OTR is much increased (standardized mortality ratio SMR: 52).

Contact Dermatitis

PS10.1

Detection of Contact Allergy by Interleukins in Patch Test Blisters

Margret S Sigurdardottir[1,2], Ellen Flosadottir[1,3] and Bolli Bjarnason[1,2]

[1]Utlitslaekning Ehf, Kopavogur, Iceland, [2]Faculty of Medicine, Department of Dermatology and [3]Faculty of Odontology, University of Iceland, Reykjavik, Iceland

Objective: To investigate whether interleukins in blisters formed at patch-test sites can be used as markers of the grade of contact allergy.

Methods: Recently patch-tested volunteers with and without allergy to nickel sulfate were retested with 5 nickel sulfate patch tests and 5 control tests. 48 h later, the test were removed and the perfusion of the test sites was assessed with a laser Doppler perfusion imaging (LDPI) technique. Then, suction blisters were made at the test sites. Blister fluids were collected separately from the allergen test sites and the control test sites.

Results: The patch test results prior to the study and in current study, and the results with the LDPI helped to distinguish between subjects with and without allergy to nickel sulfate. The concentration of one of the interleukins was high in the blister fluid from the nickel-test sites in all of the allergic subjects while the concentration was not detectable or low in fluid from the control sites and in fluid both from the nickel and the control sites in subjects without nickel allergy.

Conclusion: Immunological factors in fluid from blisters at patch test sites may be important for the detection of contact allergy.

Acknowledgement: Icelandic Research Council.

PS10.2

Characteristics of Disease in Patients with Multiple Contact Allergies

Berit C Carlsen, Torkil Menné and Jeanne Duus Johansen

National Allergy Research Centre, Department of Dermatology, Copenhagen University Hospital Gentofte, Denmark

Background: It is generally believed that multiple-allergic individuals (multiple contact allergies = 3 or more contact allergies) have widespread, long-lasting and hard-to-treat eczema but has never been the objective of any study.

Objective: To describe characteristics of disease in multiple-allergic individuals.

Patients/Methods: Questionnaire case-control study. 562 multiple-allergic individuals patch-tested at a hospital dermatology department between 1985 and 2005 were matched 1:2 on age, sex and time of patch test with mono/double-allergic individuals. In total, 1686 individuals were included.

Results: Collection of questionnaires is in the final stage and keying is currently done. The results presented are preliminary and based on the first 500 replies (36.2% had multiple contact allergies) keyed in at time of abstract submission. 91.7% multiple-allergic and 83.6% mono/double-allergic individuals had eczema (χ^2, $p=0.03$). A larger part of the multiple-allergic versus the mono/double-allergic group had atopic dermatitis (χ^2, $p=0.008$), had received UV treatment (χ^2, $p=0.012$) and

had been treated with oral prednisolone (χ^2, $p=0.008$). No difference was found between the two groups regarding immunosuppressive drug treatment. No overrepresentation of leg ulcer patients was found in the multiple-allergic group. More multiple-allergic than mono/double-allergic individuals reported hand eczema (χ^2, $p<0.01$) and eczema on the arms excluding armpits and elbow flexure (χ^2, $p=0.033$) at eczema debut. The frequency of eczema on any other body location at eczema debut did not differ between the two groups.

Conclusions: Unique data on characteristic features of disease in multiple-allergic patients are presented.

PS10.3

Screening for Acrylate/Methacrylate Allergy in the Baseline Series

Marlene Isaksson[1], ATJ Goon[2], E Zimerson[1], C-L Goh[2], D S-Q Koh[2], Magnus Bruze[1]

[1]Institution of Dermatology, Malmö University Hospital, Malmö, Sweden, [2]Institution of Dermatology, National Skin Centre, Singapore, Singapore

Background: No studies to specifically determine the prevalence of contact allergy to acrylate/methacrylate in patch-tested populations have been published.

Objectives: To determine the prevalence of acrylate/meth acrylate allergy in all patients tested to the baseline series.

Methods: 5 acrylate/methacrylate allergens [2-hydroxyethyl methacrylate (2-HEMA), methyl methacrylate (MMA), ethyleneglycol dimethacrylate (EGDMA), triethyleneglycol diacrylate (TREGDA) and 2-hydroxypropyl acrylate (2-HPA)] were included in the baseline series for at least 2 years in Malmö and Singapore.

Results: 38 patients in total had reacted to acrylate/meth acrylate allergens in the baseline series during the study period in both populations. The overall ranking in number of positive reactions was: 2-HEMA, TREGDA, EGDMA, 2-HPA, MMA. In Malmö, there were 26 (1.4%) patients with positive patch tests to acrylate/methacrylate allergens. The positive reactions in the baseline series, in order of frequency, were: 2-HEMA, TREGDA, 2-HPA, EGDMA, MMA. In Singapore, there were 12 (1.0%) patients with positive patch tests to acrylate/meth acrylate allergens. The positive reactions in the baseline series, in order of frequency, were: TREGDA, EGDMA, 2-HEMA.

Conclusions: The prevalence of acrylate/methacrylate allergy in our patch-tested dermatitis populations is 1.4% in Malmö and 1.0% in Singapore.

PS10.4

Low Test Volume for Patch Test Standardization

Bolli Bjarnason[1,2], Margret S Sigurdardottir[1,2] and Ellen Flosadottir[1,3]

[1]Utlitslaekning Ehf, Kopavogur, Iceland, [2]Faculty of Medicine, Department of Dermatology and [3]Faculty of Odontology, University of Iceland, Reykjavik, Iceland

Objectives: Patch tests have not been optimized. We introduce low test volume for patch test standardization avoiding irritant false positive tests. We investigate whether the laser Doppler perfusion imaging technique (LDPIT) can be used to assess test substance coverage of patch test sites by experiments with a specific test technique using low test volume and 8 mm Finn Chambers®.

Patients/Methods: Tests with methylene blue in petrolatum were applied for 48 h on subjects. The test substance coverage at the test sites was investigated with the LDPIT.

Results: The LDPIT allowed assessment of the test substance coverage. A 4 µl volume with the specific test technique yielded 86% median coverage. Earlier investigations with subjective visual assessments suggest 24 µl to be required but 12 µl to be insufficient and spread the test substance outside the test sites that may affect test results.

Conclusions: The LDPIT allows assessment of test sites' coverage by a test substance. The low volume of 4 µl should be used to standardise tests with the specific test technique. Optimal concentration of each test allergen should then be adjusted for optimal test sensitivity and specificity.

PS10.5

Contact Allergy to Aluminium

Magnus Bruze

Department of Occupational and Environmental Dermatology, Lund University, University Hospital, Malmö, Sweden

Aluminium and aluminium compounds are ubiquitous. Until recently, few cases of contact allergy to aluminium and allergic contact dermatitis from aluminium have been reported. Aluminium is considered a weak contact allergen. Occupational contact dermatitis due to aluminium exposure has been reported in aluminium production and in air craft manufacture. Water-soluble aluminium salts in antiperspirants may cause axillary dermatitis and systemic aluminium contact dermatitis from tooth paste has been reported. The last years hundreds of children and adolescents with contact allergy to aluminium have been reported from the Gothenburg area in Sweden. All these individuals have been vaccinated with aluminium-

absorbed pertussis vaccines. Aluminium hydroxide is used as an adjuvant in injection preparations for hyposensitization therapy. Similarly to the mentioned pertussis vaccination this administration of aluminium seems to constitute a significant risk of sensitization to aluminium. To trace contact allergy to aluminium, an empty Finn Chamber and aluminium chloride hexahydrate at 2% in petrolatum have been recommended.

PS10.6

Comparison Between Two Different Fragrance Mix Test Systems

Flemming Andersen and Klaus Ejner Andersen

Department of Dermatology, Odense University Hospital, Odense, Denmark

A paired comparison of patch tests using Fragrance Mix True Test and Fragrance Mix Hermal was conducted from January 2002 to January 2008 at the dept. of dermatology, Odense University Hospital. Both systems contain the same allergens, at different concentrations and different vehicles: True Test contains 0.43 mg/cm^2 fragrance mix in hydroxypropyl cellulose and β-cyclodextrin whereas Hermal contains 8% fragrance mix in petrolatum and sorbitan sesquioleate as an emulsifier. True Test is a completely standardized ready to use system, where as the Hermal system requires manual application of the allergen in question on Finn Chambers on Scanpor. A total of 2755 patients were patch-tested with both allergen systems over a 6-year period. According to our preliminary data 123/2755 (4.5%) reactions were positive and 259/2755 (9.4%) were questionable using the True Test mixture. When using the Hermal mixture 250/2755 (9.1%) reactions were positive and 773/2755 (28%) were questionable. The two different fragrance mixes apparently differ so much in allergen concentration that they can be used as endpoints in a dilution series, True Test Fragrance Mix being the weaker of the two. It can be speculated that one test system is too weak where as the other is too potent. Data analysis is still ongoing.

PS10.7

Adverse Reactions to Dental Materials: Reporting and Cases

Lars Björkman

Dental Biomaterials Adverse Reaction Unit, Bergen, Norway

The Norwegian Dental Biomaterials Adverse Reaction Unit has three main objectives: Recording of adverse reaction reports from dentists and physicians, clinical examination of referred patients, and to provide information about adverse reactions to dental materials. The Unit consists of four part-time clinical positions (three dentists and one physician), an executive officer and a leader. From the start in 1993 to the end of 2005, a total of 1479 reports regarding adverse reactions in patients were received. Of these, 630 were also referred to the Unit and examined. The most common reason for referral was health complaints or clinical signs allegedly related to amalgam (72% of the referrals). Amalgam was also the most frequent material involved in the adverse reaction reports. After the clinical examination and additional allergy test to dental materials (e.g. "Dental Screening" series) when needed, it was found that 211 of 398 tested patients (53%) were positive to at least one substance in the test series. The most frequent substances with positive patch test reaction were nickel sulfate (32%), goldsodiumthiosulphate (28%), cobalt chloride (18%) and palladium chloride (14%). A majority of the patients with positive allergy test were given recommendations related to this finding – either removal of restorations (if the allergy test was found to be of clinical relevance) or avoiding the substance in the future. Three cases are presented and discussed: Cases with clinical relevant allergy to (*i*) gold, (*ii*) mercury, and (*iii*) two dental acrylates (EGDMA, 2-HEMA). In addition the advantage of an adverse reaction registry will be discussed in the light of possible associations between exposure to dental materials and prevalence of disease. Additional information is found at the web-pages of the Dental Biomaterials Adverse Reaction Unit (http://www.uib.no/bivirkningsgruppen).

PS10.8

Allergic Contact Dermatitis to Topically Applied Metronidazole in Two Nurses

Jakob Torp Madsen, Evy Paulsen and Klaus Ejner Andersen

Department of Dermatology, Odense University Hospital, Denmark

Contact dermatitis to topically applied metronidazole is a rare side effect, especially considering the large number of patients using it on a daily basis. Only 5 cases are published so far.

Two female patients with rosacea developed facial dermatitis after a few days use of topical metronidazole. They had never used topical metronidazole before. The rapid onset of contact dermatitis to topically applied metronidazole made us consider if sensitization developed prior to the rocacea treatment. Both were nurses and one of them had previously been frequently exposed to metronidazole professionally by administering metronidazole intravenously to patients at a time when protective gloves were not used routinely.

Venereology in Scandinavia

PS11.1

Infectious Causes of Human Cancer

Harald zur Hausen

Deutsches Krebsforschungszentrum, Heidelberg, Germany, e-mail: zurhausen@dkfz-heidelberg.de

During the past two decades a number of infectious agents have been linked to human carcinogenesis. They include various members of different virus families, but also bacterial and parasitic infections. The global incidence of cancers resulting from these infections is presently estimated within a range of 20–21%. The percentage varies widely between developed and developing parts of the world, reaching close to 40% in specific regions, like sub-saharan Africa. The available knowledge of infectious events linked to human cancer development should provide us with novel approaches to prevent specific cancers by vaccination. Vaccines against Hepatitis B virus have been shown to prevent persisting Hepatitis B virus infections, and thus remove one of the prime risk factors for hepato-cellular carcinomas. They emerge as the first successful vaccine against an important human cancer. Presently a larger number of clinical trials against 'high-risk' human papillomavirus (HPV)-types (mainly against HPV16 and 18) provide promising results. The present state of these vaccines in the prevention of cervical pre-malignant lesions and cervical cancer will be reviewed. Various approaches and vaccination protocols will be summarized. Successful vaccination against these papillomavirus infections has the potential to drastically reduce the risk for cervical cancer which is still in several parts of the world the most common cancer of women. Global vaccination programs against Hepatitis B and high-risk HPV infections, if applied to all populations world-wide, could theoretically reduce the cancer risk for women by 15%, for males by approximately 7%.

PS11.2

Mycoplasma Genitalium – 15 Years Experience

Carin Anagrius

STD-clinic, Falu hospital, Falun, Sweden

Today Mycoplasma genitalium (Mg) is a well established pathogen in NCNGU (non chlamydial non goncoccal urethritis). Mg as a cause of salpingitis and infertility is almost proven, less information is available about it´s role in arthritis, epididymitis and prostatitis. Commercial nucleic acid amplification tests are still not available. Azitromycin is the drug of choice for treatment although adequate dosage is essential to prevent development of resistence.

PS11.3

Syphilis in Baltic: Epidemiology, Clinic, Therapy and Prevention – an Update

Andris Rubins, S. Rubins and J. Pirsko

Department of Dermatovenerology, Riga Stradins University, Riga, Latvia

Syphilis diagnostics, therapy and prevention are still the problems in many countries of the world. Therapy after the discovery of penicillin has been under control, yet, the incidence of the disease in separate periods of time in different regions of the world and countries has been unsteady. Thus, in the middle of the 90s, the morbidity of the disease in the Eastern and Central European countries (Baltic, Russia, Ukraine, etc.) was very high, 100–250 cases per 100,000 population, while in the Western European countries (Germany, France, England, Holland, etc.) and the USA, the incidence ranged from 2–10 cases per 100,000 population.

Syphilis incidence in Europe has decreased the last years, and it is 1–3 (W-Europe) till 30 cases per 100,000 population, respectively (East and Central Europe). In Latvia 33.1, 20.7 and 12.9 in 2003, 2006 and 2007, respectively. Syphilis in the Western world is more confined to males who have sex with males, while in the Eastern world, it is heterosexual and high in pregnant women in the developing countries. However, a new problem arises, since in many countries, especially (Latvia, Ukraine, etc.), in about 50% cases (in Latvia 58% in 2007), a latent syphilis is seen to appear without any clinical signs, which can be diagnosed only by means of serological methods, which is an evidence for insufficient early diagnostics and prevention, etc.

In many countries CDC or IUSTI/WHO European Syphilis Guidelines are used, which in some countries are slightly modified. The main therapy is still being the penicillin group medications (Benzathine penicillin, procaine penicillin) of various treatment doses for respective syphilis clinical forms and stages, as well as special doses for pregnant women and children. Laboratory confirmed zyphilis reporting is playing a central role in modern syphilis surveillance. Questions will deal with the possibilities to use different methods of treatment in cases of penicillin intolerance cases.

Conclusion: Syphilis morbidity remains to be on a relatively high level in Baltic, especially in Latvia. In order to make syphilis diagnostics, therapy, disease prevention and the decrease of morbidity, it is important to introduce and use a unified IUSTI/WHO Guidelines for syphilis, which would regulate a unified diagnostics of this disease, its therapy and prevention, as well as widely applying serodiagnostics in all the necessary, suspicious or unclear cases.

Melanoma Update

PS12.1

Genome-wide SNP Association Studies of Pigmentation Traits and Melanoma Risk

Simon N. Stacey[1], P. Sulem[1], D.F. Gudbjartsson[1], J.H. Olafsson[2], V. Magnusson[3], J. Hansson[3], A.M. Goldstein[4], B. Sigurgeirsson[2], K.R. Benediktsdottir[2], K. Thorisdottir[2], R. Ragnarsson[2], A. Helgason[1], L.A. Kiemeney[5], J.I. Mayordomo[6], E. Nagore[7], R. Kumar[8], T. Rafnar[1], A. Kong[1], U. Thorsteinsdottir[1], K. Stefansson[1]

[1]deCODE Genetics, [2]Landspitali-University Hospital, Reykjavik, Iceland, [3]Department of Oncology Pathology, Karolinska Institutet, Stockholm, Sweden, [4]Genetic Epidemiology Branch, Division of Cancer Epidemiology and Genetics, National Cancer Institute, Bethesda, Maryland, USA, [5]Departments of Epidemiology and Biostatistics and Department of Urology, Radboud University Nijmegen Medical Center, The Netherlands, [6]Division of Medical Oncology, University Hospital, Zaragoza, Spain, [7]Department of Oncology, Instituto Valenciano de Oncologia, Valencia, Spain, [8]Division of Molecular Genetic Epidemiology, German Cancer Research Center, Heidelberg, Germany

New, massively parallel SNP genotyping technologies make possible the simultaneous analysis of representative SNPs covering the entire human genome in a single DNA sample. This permits high resolution, whole genome case-control association analyses to be conducted without a requirement for preconceived notions of possible candidate regions. Using Illumina Human Hap300 and CNV-duo 370 micoarrays, each capable of genotyping over 300,000 SNPs, we carried out a genome-wide association scan for SNPs associated with natural variation in pigmentation traits such as eye colour, hair colour, propensity to freckle and tanning responses. We identified numerous variants that are associated with these traits, some previously known and others novel, including variants near MC1R, OCA2, KITLG, TYR and SLC24A2 genes. Because certain pigmentation traits are known risk factors for skin cancer, we are testing a number of pigmentation trait-associated variants for potential involvement in predisposition to melanoma and basal cell carcinoma. Recent progress will be presented.

PS12.2

Melanoma and Dysplastic Nevi in Icelandic Air Crew Members. The Importance of Screening

G. Sigurdardottir[1], Bárður Sigurgeirsson[2,3], Jon H. Olafsson[1-3]

[1]Landspitali University Hospital, Department of Dermato-venereology, Reykjavik, [2]Húðlæknastöðin "Dermatology Center", Kopavogur, [3]University of Iceland, Iceland

Introduction: Incidence of melanoma is higher in pilots and other air crew members than the general population according to recent studies. Ionizing radiation of cosmic origin is a possible explanation. Sun exposure has not been shown to be more common in this group. Organized screening of aircrew members could be of value in detecting skin cancers in this group. In this study we present the results of screening for skin tumours in Icelandic pilots over the years 2001–2005.

Materials and methods: From the year 2001 The Icelandic AirLine Pilots Association has offered their members annual screening for skin tumours. Each pilot was screened clinically by a dermatologist. Computerized dermatoscopy was performed if significant pigmented lesions were found. We are presenting the data collected from this screening.

Results: 376 out of 503 pilots in this group were screened. The screening visits were 497. There were 368 lesions removed from 141 pilots. Dysplastic changes were found in 64 lesions from 42 pilots. Seven cases of malignancy in 6 pilots were detected. One case of superficial spreading melanoma, one case of lentigo maligna, two cases of basal cell carcinoma and three cases of squamous cell carcinoma in situ.

Conclusions: 1) Incidence of dysplasia needs to be assessed by comparison to the general population or another cohort. 2) In order to evaluate the efficacy of screening pilots for skin cancer it is important to continue to follow this group with dermatological examination.

PS12.3

Sunbed Usage in Iceland

Þorgeir Sigurðsson

Geislavarnir ríkisins, Icelandic Radiation Protection Institute

The incidence of melanoma has increased rapidly in Iceland, especially among young women. Sunbed usage is by many considered a risk factor for melanoma and this increase could possibly be linked together. Reliable quantitative information on Icelandic sunbed usage is incomplete but in this paper the available data is presented and discussed. The data comes primarily from two unpublished sunbed surveys done in 1988 and 2005 both showing a large number of sunbeds per capita with a new survey planned in 2008. In 1988 more than 1.5 sunbeds were found per 1000 inhabitants in the Reykjavik area. About half of these were in dedicated tanning salons, most of the remaining were in gyms and fitness centers. In the survey from 2005 more than one sunbed per 1000 inhabitants were listed outside the Reykjavik area. The findings of the two surveys are compared to information obtained in yearly telephone polls on sunbed usage that have been conducted since 2004. Each survey included more than 1350 persons randomly selected from the national registry. The average number of tanning sessions per person, per year is estimated during the last 20

years to be at least 2–3.The conclusion is drawn that sunbed usage in Iceland has probably been greater than in Sweden and the UK and that a link to the observed increase in melanoma is indeed possible. The data have been collected by the Icelandic Radiation Protection Institute in co-operation with the Environment and Food Agency, Capacent Gallup in Iceland, Icelandic dermatologists and the Cancer society.

PS12.4

Removal of Nevi as Prophylaxis for Melanoma. A Cost-benefit Analysis

Bernt Lindelöf[1], Mari-Anne Hedblad[1], and Ulrik Ringborg[2]

[1]Department of Dermatology and [2]Cancer Centre Karolinska, Karolinska University Hospital, Stockholm, Sweden

Large amounts of nevi are removed yearly in Sweden as prophylaxis or because they resemble malignant melanoma. We attempted to estimate the annual cost and if this measure has had any effect on the incidence of malignant melanoma. We received computerized data on diagnosed nevi, dysplastic nevi and malignant melanomas from all pathological laboratories in the Stockholm area (1.8 million inhabitants). The figures were then extrapolated to the whole Swedish population.

In Sweden approx. 154 900 nevi were removed in 2000 and approx. 133 000 in 2005. The cost in 2005 was estimated to be 287–318 million Swedish crowns (30.4–33.7 million Euros). During the studied 6 year period, the number of excised nevi decreased with 14% and the number of malignant melanomas increased with 33%. Therefore, the increase of malignant melanomas can be partly explained by the decreased nevi removal. Furthermore the number of removed nevi per removed malignant melanoma was much lower for dermatologists than for general practitioners. Dermatologists were also much more efficient in removing dysplastic nevi.

PS12.5

Exposure to Artificial UV Radiation and Skin Cancer

Jean-François Doré, on behalf of the IARC Working Group on exposure to artificial UV radiation and skin cancer

International Agency for Research on Cancer, 150, cours Albert Thomas, 69372 Lyon Cedex 08, France. E-mail: dorejf@visitors.iarc.fr

Most artificial tanning devices carry a cancer risk comparable to Mediterranean sunlight. Experiments in human volunteers conducted during the last decade have shown that commercial tanning lamps produce the types of DNA damage associated with exposure to the solar spectrum.

In 2005, the IARC convened a Working Group of international experts on skin cancer and UV radiation in order to perform a systematic review of the potential association between sunbed use and skin cancer. The Working Group undertook a series of actions including a meta-analysis of the available twenty-three published studies (22 case-control, one cohort) in light-skinned populations which investigated the association between indoor tanning use and melanoma risk. The summary relative risk for ever versus never use of indoor tanning facilities from 19 informative studies was 1.14 (95% Confidence Interval (CI): 1.00–1.31). When the analysis was restricted to the nine population-based case-control studies and the cohort study, the summary relative risk was 1.17 (95% CI: 0.96–1.42). The Working Group identified 7 epidemiological studies that assessed the melanoma risk associated with sunbed use according to age. All these studies found melanoma risks ranging from 1.4 to 3.8 with sunbed use starting during adolescence or during young adulthood. The meta-analysis performed by the IARC Working Group using published results of these seven studies found an overall increase in the risk of melanoma of 75% (summary relative risk: 1.75, 95% CI: 1.35–2.26) when sunbed use started before 35 years of age. Studies on exposure to indoor tanning appliances and squamous cell carcinoma found some evidence for an increased risk for squamous cell carcinoma, especially when age at first use was below 20 years.

Long latency periods may be expected between sunbed exposure and skin cancer, and therefore the real magnitude of the association may not yet be detectable. A considerable body of experimental and epidemiological knowledge support the hypothesis that exposure during childhood and adolescence are the most crucial periods of life for the initiation of biological phenomenon involved in the genesis of melanoma that will usually be diagnosed during adulthood.

In conclusion, it would be logical to recommend avoidance of sunbed use before 30 years old.

PS12.6

Is Sunlight Beneficial and are Dermatologists too Narrow-sighted?

Olle Larkö

Department of Dermatology and Venereology, Sahlgrenska Academy, University of Gothenburg, Gothenburg, Sweden

Sunlight is the most common cause of skin cancer. The association is strongest for squamous cell carcinoma but basal cell carcinomas and malignant melanoma are also considered to be sun-related. The current recommendations for protection include clothes, staying out of the sun during noontime, seeking shade and the use of suncreens.

However, there is accumulating evidence that vitamin D is associated to several beneficial effects. These include a reduced risk for cancer of the prostate, breast, colon and lung. Also, vitamin D may be associated to a reduced risk of multiple sclerosis. Recently, we have shown a beneficial effect on cystic fibrosis and vitamin D levels after UVB treatment with old broad spectrum UVB lamps. The action spectrum for vitamin D-synthesis lies in the short wave UVB spectrum around 300 nm. All our current advice for reducing skin cancer risk also reduces the possibility for vitamin D synthesis. The net health effect of this remains to be established. It may be that staying out in the sun follows a J-curve similar to consumption of erd wine for atherosclerosis. An important source of vitamin D is food but in some instances, small amont of UVB should actually be recommended.

Photodermatology and Photoprotection

PS13.1

Photoprotection is More Than Just Sunscreen

Elisabeth Thieden

Bispebjerg Hospital, Copenhagen, Denmark.

We have investigated the sun exposure behaviour among subgroups of the Danish population: children, adolescents, indoor workers, sun worshippers, golfers and gardeners (age range, 4–68 years). The subjects recorded sun exposure behaviour including sunscreen use and sunburn in diaries and carried personal, electronic UV dosimeters, measuring timestamped UV doses continuously in median 119 days covering total 39068 days and 346 sun-years (one subject participating in one summer-half-year). There were great variations in sunscreen use, which was highly correlated to risk behaviour (sunbathing/exposing upper body) ($r=0.39$; $p<0.01$). Sunscreens were used in median 5 days per sun-year and 10% females and 41% males never used sunscreens. Females used sunscreens more but had also more unprotected risk behaviour than males (8 days vs. 4 days, $p<0.001$). Sunscreen use was not correlated to age and children had as much unprotected risk behaviour as adults. Sunscreens were used 86% of the days with risk behaviour in Southern Europe vs. 20% in Northern Europe ($p<0.001$). The UV doses were significantly higher on days with sunscreen ($p<0.03$) and on sunburn days ($p<0.001$). Since sunscreens are used so irregularly, reducing the UV dose to below the erythema level could be a better sun protection. UV dose = UV-intensity × exposure duration. Therefore sun exposure should be avoided when the UV intensity is high such as between 12–15, at midsummer or in Southern countries. Or the exposure time reduced by having breaks indoor or in the shade of a tree or parasols which corresponds to sun protection factor, SPF 8–10. If sunbathing or having long-term outdoor activities at risk hours, sunscreen is recommended.

PS13.2

Variables in UVB Treatment of Skin Diseases

Hans Christian Wulf

Bispebjerg Hospital, Copenhagen.

Phototherapy is very commonly used in the treatment of skin diseases like eczema, psoriasis and vitiligo. UV treatment is very commonly dosed according to a fixed scheme and frequently without any measurement of light intensity or consideration about skin type. The most important variables are long-term variation in the intensity emitted by the light source, which can change by a factor 3 from the tubes are new to the intensity after 5–600 accumulated burning hours. To control this regular measurement of light intensity is needed. Another variable factor is the type of UV source. The most common UVB cabins for full body treatment are equipped with narrowband UVB tubes (Philips TL01), broadband UVB tubes (Philips TL12), or broadband UV6 tubes (Waldmann). When the same physical dose is given by these three sources, the biological effect (erythema) will vary with a factor of 4–5, and therefore the dose or time must be regulated accordingly to avoid burning of the skin. This is often done by gut-feeling, but measurement of the intensity in biological units should be performed.The third important variable is skin type. The most sensitive persons can tolerate 1 SED (standard erythema dose) before showing erythema of the skin and the most UV robust Caucasian may tolerate about 10 SED before eliciting erythema. It is therefore important to take skin type into consideration. Fitzpatrick´s skin type is most commonly used but also very unreliable. It would be preferable to make a MED test before treatment or to measure skin type by remittance spectroscopy, which can be performed in a few seconds. Because of these variables it is not recommendable to use time or Joule as dosing units. It is recommendable to use biological units, SED or even better MED, as the limit for the maximal exposure dose is erythema of the skin.

PS13.3

Home UVB Phototherapy is Effective, Safe and Greatly Appreciated. A Randomized Comparison of Home and Outpatient UVB Treatment for Psoriasis: The PLUTO study

MBG Koek, E Buskens, H van Weelden, PHA Steegmans, CAFM Bruijnzeel-Koomen and Vigfús Sigurdsson

UMC Utrecht, The Netherlands

Context: No randomized studies comparing home and outpatient ultraviolet B (UVB) phototherapy for psoriasis have

previously been conducted. Despite ongoing debate regarding treatment results and safety, home UVB treatment is being increasingly prescribed. The scarce literature and guidelines suggest being prudent, but both patients and clinicians claim that home UVB phototherapy is associated with a lower burden of treatment and better quality of life.

Objective: To compare effectiveness, side effects, Quality of Life (QoL), Burden of Treatment (BoT) and patient satisfaction of home and outpatient UVB phototherapy.

Design, setting, and patients: A pragmatic multicenter single-blind randomized clinical trial (the PLUTO-study) was conducted. From 2002 through 2005 we enrolled 196 patients with psoriasis who were clinically eligible for narrowband (TL-01) UVB phototherapy.

Intervention: Patients were randomly allocated to undergo either home UVB phototherapy or outpatient UVB phototherapy.

Main outcome measures: Improvement in the Psoriasis Area and Severity Index (PASI) and the Self-Administered PASI (SAPASI), QoL (36 item Short Form Health Survey, Psoriasis Disability Index), BoT (questionnaire), patient preferences and satisfaction (questionnaire), dosimetry and short-term side effects (diary).

Results: SAPASI and PASI scores decreased by 82% and 74%, respectively for patients treated at home versus 79% and 70% for patients treated in an outpatient setting, showing a significant treatment effect ($p = 0.000$) similar across groups ($p > 0.52$). Total cumulative doses of UVB and the occurrence of short-term side effects did not differ. The burden of undergoing UVB treatment was significantly lower for patients treated at home ($p < 0.001$). QoL increased equally during therapy regardless of treatment group, but patients treated at home more often rated their experience with therapy as "excellent" than did patients treated in hospital ($p = 0.001$).

Conclusions: Home UVB phototherapy compared to outpatient phototherapy is equally safe and effective, both clinically and in terms of quality of life. Furthermore, UVB treatment at home results in a lower burden of treatment and leads to greater patient satisfaction.

Infotech, Telemedicine, Dermatological Websites

PS14.1

Teledermatology on the Faroe Islands

Gregor B. Jemec

Roskilde, Denmark

Many different teledermatological projects have been tested in the Nordic region. The department of Dermatology, Roskilde Hospital services the Faroe islands (pop. 45000) with dermatological expertise running a store-and-forward system integrated with a nurse led clinic. The experience from the first 5 years of routine treatment of 4000+ patients will be described.

PS14.2

Teledermatological Videoconferences in Northern Norway, the Kirkenes Experience"

Dagfinn Moseng

Department of Dermatology, University of Northern Norway, 9038 Tromsø, Norway

Teledermatological videoconferences were established between the university hospital in Tromsø and Kirkenes in Northern Norway, 900 km away, in the early nineties. This was thought of as a way of giving dermatological service to people living in the area, instead of having to use airborn travel to see a dermatologist. From 1993 we have done weekly consultation with patient and GP on one side and the specialist on the other, communicating by picture and sound. This should count for around 7000 patient visits, mainly routine, everyday dermatology. The clinic gives UV treatment for chronic diseases like psoriasis and eczemas. Trained nurses are giving dermatological treatments, baths, bandaging and testing. Quality of videoconferencing has gradually increased. In case of diagnostic doubts, we use ordinary visits (maybe 1 or 2 in 10). Comparisons Videoconference/Store-and-forward and Videconference/Face-to-face has shown 90% identical or near identical diagnosis. About 20% of patients are considered unfit for this form: hearing problems, communication difficulties, disease localized to head/genitals, naevi. Well suited for follow-up patients with established diagnosis undergoing treatment, on different medication. Patients mention nearness and availability as two key factors. They experience less waiting, earlier diagnosis, reduced stress, less use of time, cost and less sick-leave. For the specialist, this is a demanding form with a different role communicating both with the GP and the patient and also with the patient through the GP, who represents our prolonged arm.

Law: The Specialist is responsible, the GP also for his actions.

PS14.3

A Critical Analysis of the Role of Telemedicine in Improving the Quality of Health Care Access in Alaska

John H. Bocachica

Chief, Dermatology and Teledermatology, Asst Prof of Dermatology, Alaska Native Medical Center, Anchorage, Alaska U.S.A.

Alaska and other circumpolar communities face unique challenges in obtaining access to quality special health services including dermatology. The lack of connecting road systems in Alaska results in 75% of all of our communities and 25% of all our residents be unconnected by road to a hospital. These communities must depend on other modes of transport, such as playing, boats, and snow machine to access basic medical services. Alaska's weather conditions are notoriously severe, making travel to medical facilities difficult or in many cases impossible. Travel costs engendered in transporting rural patients to urban medical centers can be prohibitive. Physicians and mid-level providers are scarce in Alaska and Canada's rural and remote locations. In a recent poll, Alaska ranked 48th among the 50 states in the ratio of doctors to patients. To make matters worse, the vast majority of physicians in Alaska are concentrated in the state's three urban areas with few providers located in the most rural areas of the state.

The rural Native population of Alaska is most affected by the obstacles to specialty health care access, including dermatology, in their regions.

The advent of Teledermatology has proven to be a viable alternative to specialty health care access among these rural populations. Teledermatology has assured access to quality health care services via interactive and store and forward technologies.

PS14.4

An Internet-based Case-file System for Systematic Follow-up of Non Melanoma Skin Cancer

Lars Erik Bryld

Department of Dermatology, Roskilde Hospital Denmark

A systematic evaluation of the benefits claimed for new NMSC-treatments requires valid registration on treatment outcomes and comparable outcome data on existing treatments. Treatments must be compared with regards to efficacy, cosmetic result, and cost. The challenge is in a systematic and dependable way to keep track of a huge number of individual skin cancers in a number of patients who may be referred to and from a number of different health providers.

To that end, our department has been testing and developing an Internet-based case-file system aimed specifically at easing the task of doing systematic follow-up of treated NMSC. We have required a system, that should be used by ourselves as well as dermatologists in private practice, which was visually mappable, easy to use, safe in regards to privacy and the like, and – most importantly – quick.

Our current experience is encouraging, but newly evolved issues are now considered for correction. We need e.g. a way to correct entry errors without compromising accountability. The entry of multiple lesions, especially the simultaneous treatment of these is still a major annoyance, and the follow-up of multiple lesions, who did not show signs of recurring are other issues. Privacy safeguards and access controls are in full accordance with Danish legislative requirements and seems to us to be one of the minor issues, but our systems security standards might be considered too lenient for other jurisdictions. One of our main challenges is to maintain this system alongside our existing, and legally binding case file system. At present we have no working solutions to integrate the two systems, thereby forcing us to do parallel data entry.

Our current prototype will be demonstrated – life, if possible.

PS14.5

Exciting Website for Dermatologists: www.pdf.nu and www.ssdv.se

Thor Bleeker

Department of Dermatology, Lidköping, Sweden

The website for dermatologists in Sweden has existed for six years. To develop it was my idea, and I made a suggestion about it to the Swedish Association of Dermatologists in Private Practice (Privatpraktiserande Dermatologers Förening, PDF). In order to avoid economic hazards för the association, the decision was made to invite all members to contribute with capital in order to constitute a joint stock company.

More and more features have been added to the website in order to cover as much as possible on the subject of dermatology and make the site attractive to its members. The latest "blue doors" have been "Academy", where we supply – and also plan for additional – web-based medical education. Another "blue door" is "What's new?", where Dr Håkan Mobacken frequently has presented summaries of news in the recent literature, which has been much esteemed among our members. Futher features are waiting to be implemented.

About three years ago we could – free of charge – arrange a similar website for our dermatology colleagues in Finland (where Dr Jukka Juhela is responsible for the content) and in the autumn of 2007 a Norwegian website could also be launched (where dr Jon Langeland is responsible). The purpose is to link these sites together in order to finally be able to connect all dermalogists in the Nordic countries. Thus, in the future we hope to develop Danish and Icelandic sites as well.

Free Presentations

PS15.1

Ichthyosis, the Role of Conservative Eyelid Surgery!?

Haraldur Sigurdsson, Gudleif Helgadottir and Baldur Tumi Baldursson

Department of Ophthalmology and Department of Dermatology, Landspitalinn, University of Iceland, Iceland

There are five types of ichthtyosiform dematoses. The most common one is Lamellar ichthyosis (ichthtyosis congenital), which is an autosomal recessive disease. The medical treatment is usually lubrication, exfoliations treatment, oral retinoid and artificial tear ointment around the eyes. The conventional surgical treatment has been skin grafting if there is a severe ectropion. We describe and show photos of 3 cases of congenital ichthtyosis where a lid shortening and inverting sutures were used to correct the lower eyelids. In two of the cases a good anatomical correction was achieved but in one the ectropion persisted but improved. The role of joint medical and conservative surgical treatment is discussed.

PS15.2

Hundreds of Children in the Gothenburg Greater Area with Vaccine Related Contact Allergy to Aluminium

Annika Inerot, E. Bergfors and B. Trollfors

Hudkliniken, Sahlgrenska sjukhuset, Göteborg, Sweden

During trials of aluminium adsorbed diphtheria–tetanus/acellular pertussis vaccines from a single producer, persistent intensely itching nodules at the vaccination site were observed in an unexpectedly high frequency (about 1 %) in the study area around Gothenburg, Sweden. All afflicted children were offered patch-testing with aluminium.

Objectives: To analyse the frequency and strength of positive patch-test reactions in relation to the age of the children.

Materials and Methods: All children with clinical symptoms of localised pruritus at the site of vaccination were offered patch test with aluminiumchloridehexahydrate 2% in petrolatum (Chemotechnique Diagnostics, Sweden) in plastic chambers, and also with an empty Finn Chamber (Epitest, Finland). Siblings vaccinated with the same vaccine but without symptoms were also offered the same patch test. The tests were read on day 3 using the ICDRG's criteria.

Results: Among the group of children ($n = 438$) with itching nodules at the vaccination site 77% had a positive patch test reaction to aluminium. Among the siblings ($n = 270$) without itching 7% were positive for aluminium in patch test. The age of the children with positive reactions were from 2 to 15 years of age, with an average around 6 years. The strongest test reaction was seen in the very small children.

Conclusions: Sensitisation to aluminium was demonstrated in a high frequency (77%) in children with persistent itching nodules after vaccination with aluminium adsorbed vaccines. In this population of vaccinated children we saw the strongest reaction in the very small children.

PS15.3

Our Experience in Treatment of Atopic Dermatitis in Latvia

Andris Rubins, K. Cirule, S. Rubins, L. Chigorevska and S. Zigure

Latvian Institute of Dermatology, Chair of Dermatovenerology, Riga Stradins University, Latvia

Atopic dermatitis (AD) is the most common and inflammatory skin disease that typically has chronically repalsing cause. AD has affected more than 15% of children in many countries, 70% of the cases, starting in children younger than 5 years of age. During the last decade there have been elaborated 2 effective drugs, calcineurin inhibitors (CNI) – Pimecrolimus cream 1% and Tacrolimus 0.03% and 0.1% ointment which are successfully used in the therapy of atopic dermatitis (AD) for both the children and adults, and which is a good alternative for the topical corticosteroids which is used for a long period may cause various side effects including skin atrophy. By applying the Calcineurin inhibitor ointment there appeared a real possibility to help children who have AD. In Latvia more than 500 atopic dermatitis children patient with local calcineurin inhibitor ointment 0.03% have been treated.

Methods: Calcineurin inhibitor ointment 0.03% was applied twice a day for mild and moderate AD patients. Patients with severe AD at first were treated with mometasone fuorate once a day for 3 days, to prevent burning sensation, and then follow with calcineurin inhibitor ointment 0.03% twice a day.

Patients were grouped according to percentage of affected body surface area (BSA). Group I; 5–20%, group II; > 20–40 %, group III; > 40%. Tacrolimus ointment was rubbed in all damaged skin areas twice a day till remission, and 2 weeks more. 1% pimecrolimus cream was approved for children with mild and moderate AD from 2 years and up.

Results: Score of skin process damage has decreased for all patients by 4–5 times. At the same time the remissions have become longer and slight AD exacerbations have been observed only 1–2 times a year. In children of the young group the improvement of the damaged skin was noticed to occur

on 4–6 days after first application of calcineurin inhibitors decreased skin inflammation, infiltration and itch, but within two weeks a radical improvement was achieved the score of the damaged skin decreased on average by 50%, as well as itch. No patient was seen to have the worsening of the skin process; most satisfied were children's parents.

Conclusion: The clinical efficiency and safety of Tacrolimus ointment were proven during the study. These days we have very good medicine calcineurin inhibitors for treatment patients with atopic dermatitis including small children.

PS15.4

Treatment with a Moisturizing Cream Delays Recurrence of Atopic Eczema

Karin Wirén[1], Christina Nohlgård[2], Filippa Nyberg[3], L Holm[4], M Svensson[5], Anders Johannesson[6], Peter Wallberg[6], Berit Berne[7], F Edlund[1] and Marie Lodén[1]

[1]ACO Hud Nordic AB, Upplands Väsby, [2]Läkarhuset Fruängen, [3]Danderyd Hospital AB, Stockholm, [4]Sophiahemmet, Stockholm, [5]Nacka närsjukhus, Nacka, [6]Läkarhuset, Vällingby, [7]Department of Medical Sciences, Dermatology and Venereology, University Hospital, Uppsala, Sweden

Background and objective: Health care professionals emphasize the use of moisturizers in treating eczema, also when the eczema is cleared. However, the influence of moisturizers on the recurrence of eczema is not fully elucidated; and to our knowledge no data are available where this has been studied clinically. The objective of this study was to investigate the possible prevention of atopic eczema by treatment with a moisturizing cream with 5% urea. The moisturizer was previously shown not only to diminish the signs of dryness, but also to improve skin barrier function in dry atopic skin.

Methods: Patients with atopic eczema were treated with topical corticosteroids for three weeks. Patients with cleared eczema ($n=44$) were randomized to either treatment with the urea-cream or to no treatment. The treatment period lasted up to 180 days or until the first sign of eczema relapse. The time to a possible recurrence of eczema was recorded.

Results: After 180 days, 15 of 22 (68%) of the intention-to-treat population treated with the moisturizer had no recurrences compared to seven of 22 (32%) of the untreated patients. The number of eczema free days differed significantly between the two groups ($p<0.05$).

Conclusions: Treatment with the moisturizer delayed the time to recurrence of eczema and accordingly proved to be a useful treatment adjunct in atopic patients.

PS15.5

Long-term Treatment with Moisturizers Affects Gene Expression of Epidermal Enzymes

Izabela Buraczewska[1,2], Berit Berne[1], Magnus Lindberg[3,4], Marie Lodén[2], Hans Törmä[1]

[1]Department of Medical Sciences, Dermatology and Venereology, University Hospital, SE-751 85, Uppsala, [2]ACO HUD NORDIC AB, Upplands Väsby, [3]Department of Dermatology, University Hospital Örebro, Örebro, [4]Department of Occupational and Environmental Dermatology, Karolinska Institute, SE-171 76, Stockholm, Sweden

Moisturizers are often used as supplements to topical and/or systemic anti-inflammatory drugs in various types of skin conditions and disorders, such as contact dermatitis, atopic dermatitis, psoriasis, and ichthyosis, in order to break a dry skin cycle. However, there is still a lack of knowledge about the effects of moisturizers on the skin after long-term treatment, especially regarding the impact on the molecular level. Therefore, in a randomized and controlled study, we evaluated the effect of a 7-week treatment with two moisturizers on epidermal mRNA expression, in healthy human volunteers. The moisturizers differently altered expression of several genes believed to be important for skin barrier function, i.e. genes involved in keratinocyte differentiation, proliferation, and desquamation as well as genes involved in lipid synthesis or processing. Alterations in gene expression were also accompanied by changes in the skin barrier function, measured as transepidermal water loss (TEWL).

In conclusion, moisturizers are able to influence the skin at a molecular level and may also change the function of the skin. Therefore, they should not be perceived simply as inert topical preparations. Since the type of influence depended on the composition of the moisturizer, it is possible that different types of skin conditions should be treated with different types of moisturizers. This hypotheis merits further investigations.

PS15.6

"Fractional" Lasers for Treatment of Rhytides, Scars, Pigment and Overall Skin Rejuvenation

Martin Kassir

Mona Lisa Dermatology, Dallas, Texas, USA

"Fractional" lasers are the latest popular technology utilizing light energy for skin rejuvenation. Since the introduction of the first device 2 years ago, several manufacturers now offer "Fractional" technology. Which wavelength is best? What is the optimal depth of penetration into the dermis? What is the ideal diameter-to-depth ratio of the beam? Number of passes?

Do we need anesthesia for all the technologies? How do we compare the technologies? Is a microthermal zone just like a microbeam? Which handpiece is better? In this lecture, Dr. Martin Kassir will be speaking about the various technologies and wavelengths, handpieces, and discussing the treatment of rhytides.

At the conclusion of this presentation attendees should have a much more clear idea of how each technology works and how each may be best utilized. They should also be able to more objectively compare and contrast the top technologies and decide in a much more objective manner which would best fit into their practice.

PS15.7

Eczema Counselling via the Internet – Telemedicine as a Tool in Home Care Eczema Counselling

T Schopf[1], T Bergmo[2], C Wangberg[2] and R Bolle[3]

[1]Department of Dermatology, University hospital of North-Norway, [2]Norwegian Centre for Telemedicine, University hospital of North-Norway, [3]Department of Paediatrics, University hospital of North-Norway, Norway

Background: Atopic eczema (AE) is a chronic inflammatory non-contagious skin disease characterized by intensive itching and erythematous skin lesions with a typical distribution on the skin surface. It is related to other atopic diseases like bronchial asthma and hay fever. In Norway it is one of the most common chronic diseases with prevalence in children of 20–25%. AE often starts during the first years of life. Due to its chronic and relapsing course with itching, scratching and impaired sleep AE imposes a great burden on affected families. Management of moderate-severe AE is a therapeutic challenge.

Objective: We want to investigate how individual home-based counselling affects families with children with AE.

Design: Prospective randomised controlled trial.

Setting: Outpatient clinics at the University hospital of North Norway and at Hammerfest County hospital

Interventions: Between 2005 and 2007 98 children with AE participated in the trial. Parents of enrolled children in the intervention group used a secure Internet connection to send electronic requests about eczema to the Departments of Dermatology or Paediatrics at the University hospital of North-Norway. This system enabled the patients to send pictures and text to their provider using an ordinary web-browser. To fulfil the security requirements for sending sensitive information over the Internet, the patients had to log in with a user name and a password over an encrypted connection using a public key infrastructure (PKI). This required a two-phased authentication that was solved by sending a one-time password valid for only 10 min, to the patient's mobile phone during the login process. In addition to "free writing" parents were asked to use a form showing extent and severity of the eczema. Photographs of affected skin areas were sent as attachments. There were no limitations concerning the length or frequency of requests provided they were dealing with AE. Internet communication was available immediately after the patient was randomised. An experienced resident in dermatology answered requests within the next working day. Notification about an answer was sent by text message to the patients' mobile phone. Two nurses trained in treating children with AE answered messages when the doctor was on leave or holiday. Medical guidance was available all the time for the nurses. When advice on medication was requested (local or systemic), a doctor was always consulted.

Main outcome measures: Objective-SCORAD index at start-up and at follow-up after 1 year. The frequency of visits to general practitioners or specialists and hospital admissions. The frequency of UV therapy or systemic treatment (i.e. antibiotics and immunosuppressants, excluding antihistamines). Health behaviour and self-efficacy. Medical cost, travel cost and patient cost. Cost-effectiveness and willingness-to-pay values. Content analysis of requests sent.

Results: 158 requests were received during the study period. Data of the study are currently being analysed. We present first results.

PS15.8

A New High-powered Radiofrequency Device used for Non-invasive Lipoplasty of the Abdominal Region

Martin Kassir

Mona Lisa Dermatology, Dallas, Texas, USA

Many efficacious techniques exist for elimination of unwanted fat and skin tightening. Traditional liposuction, ultrasonic liposuction, and laser-assisted liposuction have all been used with excellent results for fat reduction in various body areas. All are associated with varying degrees of patient sedation and downtime. Dr. Kassir will discuss a new high-powered radiofrequency (RF) device used for non-invasive lipoplasty of the abdominal region. 5 patients with abdominal fat with BMI < 40, no pre-existing medical conditions, and no metal implants (IUDs, pacemakers, metal clips, artificial joints or valves) were treated. These patients had no prior liposuction or abdominal surgery. Height, weight, and various measurements were taken. Pre- and post-study abdominal CT scans and bloodwork were performed. Patients were treated for 5 sessions, 3–4 days apart (M-Th, M-Th, M) High-powered RF with

a large handpiece was used; the abdomen was slowly heated to maintain a temperature of 41ºC for 30 min. Post-study CT scans and measurements revealed a decrease in abdominal fat and circumference. RFAL (Radiofrequency Assisted Lipoplasty) is an efficacious non-invasive method for fat reduction.

Nail Disorders

PS16.1

Classification of Onychomycosis Revisited

Robert Baran

Nail Disease Center, Cannes, France

In 1998 we expanded Zaias' classification of the clinical appearances of onychomycosis devised a quarter of century earlier. However new clinical and histological data which have accumulated over the past 10 years prompted us to propose an updated classification of onychomycosis.

Scheme for the classification of onychomycosis

1. Distal and lateral subungual onychomycosis (DLSO). This may be associated with four major clinical features whose contribution may vary with individual cases.

1.1 Subungual hyperkeratosis
1.2 Onycholysis
1.3 Paronychia
1.4 Chromonychia particularly melanonychia

2. Proximal subungual onychomycosis

2.1 With paronychia
- 2.1.1. So called candida paronychia. Either as commensal or from colonization of a previous paronychia
- 2.1.2. True candida paronychia (very rare), usually observed in CMCC or HIV positive subjects.
- 2.1.3. Non-dermatophyte mould paronychia, sometimes associated with leukonychia (e.g. Fusarium)
- 2.1.4. Dermatophyte infection (exceptional)

2.2 Without paronychia
- 2.2.1. Classical PWSO consists of white subungual patches appearing from beneath the PNF.
- 2.2.2. PWTSO presents as a PWSO with atypical patterns: striate leukonychia as isolated or multiple. Transverse subungual white strips, separated by areas of nail which are both clinically and histologically normal, affecting the same digit. Proximal to distal longitudinal leukonychia affecting a single digit is exceptional.
- 2.2.3. Acute PWSO: a rapidly developing form of PWSO recorded in patients with human immunodeficiency virus, who usually have a CDY+ cell count of less than 450 cell/mm^3. This acute type of nail invasion involves several digits simultaneously.
- 2.2.4. Candida PWSO has been reported in CMCC.
- 2.2.5. Another combination pattern is seen in AIDS patients where PSWO and SWO may develop at the same time and spread rapidly to involve the nail plate.

3. Superficial onychomycosis

3.1. Classical SWO type restricted to the visible NP (There is a black variant)

3.2. SWO from under PNF
- 3.2.1. Acute SWO
- 3.2.2. Superficial white transverse onychomycosis (SWTO)
- 3.2.3. SWO with deep invasion
- 3.2.4. Mixed forms with 2 variants:
  - 3.2.4.1. SWO associated with PWSO
  - 3.2.4.2. SWO associated with histologically restricted involvement of the ventral aspect of the NP (Bipolar type)
- 3.2.5. Mixed form SWO associated with DLSO

4. Endonyx onychomycosis (Typical of T. soudanense but this fungus also causes other forms of onychomycosis)

5. Total dystrophic onychomycosis

5.1. Secondary TDO to other forms

5.2. Primary TDO (CMCC)

PS16.2

Differential Diagnosis of Nail Psoriasis and Onychomycosis

Eckart Haneke

Dermaticum Freiburg, Germany; Dept Dermatol, Inselspital Bern, Switzerland, Dept Dermatol, Univ Hosp Gent, Belgium

Psoriasis is the dermatosis that most frequently affects the nail organ. Onychomycosis makes up for 30 to 40% of all nail diseases. Though having a different aetiopathogenesis they may resemble each other and sometimes pose huge problems in distinguishing them. Not making the correct diagnosis will lead to inadequate and expensive treatment. The diagnosis of nail psoriasis is usually made on clinical grounds: more than 20 pits, salmon or oil spots, onycholysis with a reddish proximal border, yellowish nail discoloration, splinter haemorrhages as an aequivalent of Auspitz's sign, psoriatic leukonychia, nail destruction, psoriatic arthropathy and periungual psoriasis lesions as well as psoriasis elsewhere and in the family commonly allow the diagnosis of psoriasis to be made. Fungi are usually not demonstrable. Onychomycosis is subdivided into different forms the most common of which is distal-lateral subungual onychomycosis. It is mainly this type of onychomycosis that may look like ungual psoriasis. Onycholysis with nail discoloration, loss of transparency and nail shine, subungual hyperkeratosis and an occasional pit-like depression on the

nail surface are the most common symptoms. Demonstration of invasive fungal elements is a prerequisite for the diagnosis. Development to total dystrophic onychomycosis with complete nail destruction is not rare.

Histopathologically, psoriasis shows a typical pattern with parakeratosis in the saucer-shaped pits and a mainly lymphocytic infiltrate in the depth of the nail pocket when a biopsy is taken from this location. Salmon spots and psoriatic onycholysis reveal moderate epithelial thickening of the nail bed with lymphocytic epitheliotropic infiltrate in the superficial dermis as well as lymphocytic and neutrophilic exocytosis into the mildly spongiotic nail bed epithelium. Sometimes, the formation of typical Munro's microabscesses is seen whereas Kogoj's pustules are rare in the non-pustular psoriasis variants. The subungual keratosis contains large portions of parakeratosis that are sometimes arranged in obliquely oriented columns. In onychomycosis, the subungual hyperkeratosis as well as the overlying nail plate's undersurface contain fungal hyphae and/or spores. Dermatophyte hyphae are arranged longitudinally and in a parallel manner as long as the nail grows consistenly, but in total dystrophic onychomycosis, their arrangement has lost this order. The nail bed responds with an inflammation to the fungal infection. There is a mononuclear inflammatory cell infiltrate with epitheliotropism and often a considerable spongiosis. Neutrophils concentrate in the superficial epithelial layers and often form collections like Munro's abscesses. Both in the subungual hyperkeratosis, which is mainly orthokeratotic with occasional parakeratotic material, and the nail plate serum inclusion may be seen that are PAS positive and may be mistaken for fungal elements when they are small and longitudinal. Thus, histopathology reveals several overlapping factors in both nail psoriasis and onychomycosis.

A problem arises when a seemingly psoriatic subject grows fungi in culture or shows fungi histologically. This raises the question of 1) a misdiagnosis or 2) a double pathology. In fact, many studies have shown a relatively high prevalence of onychomycosis in psoriatic subjects, thus it is not rare to have both psoriasis and onychomycosis. We have seen patients that had psoriasis on certain nails, onchomycosis on other nails, and both psoriasis plus onychomycosis on further nails. The difficulty then is to find out what is the most important pathology as fungi may act as a Köbner phenomenon in psoriatics, may simply colonise or really infect a psoriatic nail. In any case, the onychomycosis should be treated first to abolish the isomorphic effect of the infection before the therapy of onychomycosis.

PS16.3

Nail Malignancies

Robert Baran

Nail Disease Center, Cannes, France

On the basis of 121 cases of Acral lentiginous melanoma, Luc Thomas' team has considered that mitotic activity appears to be of particular importance in predicting the outcome of ALM. The same team has performed a clinicopathological study of 35 cases of squamous cell carcinoma. The spectrum of the clinical features encountered was extremely large, including leuconychia, subungual hyperkeratosis, trachyonychia, subungual tumoral syndrome, longitudinal erythronychia, and melanonychia.

Austrian authors have observed HPV type 26 infection causing multiple invasive squamous cell carcinomas of the fingernails in an AIDS patient under highly active antiviral therapy.

Remarkably, almost all reported digital SCCs that have been attributed to HPV were caused by HPV 16, sometimes 9, or 11 alpha papilloma virus. Interestingly, the first case of SCC arising from lichen planus of nail matrix and nail bed has been published by Japanese authors.

Pigmented Bowen's disease may clinically mimic melanoma of the nail. A 65-year-old African-American man presented with a 1-year history of a finger nail turning black. Physical examination of the 3rd digit of the right hand revealed a longitudinal melanonychia on the ulnar aspect of the nail plate and two deeply pigmented lesions, namely a verrucous papule of the proximal nail fold and a brown macule on the ulnar aspect of the digit that revealed a pigmented SCC in situ of Bowen's type.

Melanoma and squamous cell carcinoma were found on different nails of the same hand, each featuring an unusual clinical presentation: amelanotic melanoma presenting as a longitudinal erythronychia and SCC in situ presenting as longitudinal melanonychia. This underscores the need for a low threshold for biopsy in the presence of nail dyschromia of uncertain etiology.

Simultaneous subungual melanoma does exist. A recent case has been detected on both thumbs of a 38-year-old Caucasian man. This case resembles that published by B. Leppard several years ago, involving both big toenails.

Basal cell carcinoma is not exceptional probably because of the length of life time has increased : the disease involved : one 90-year-old patient's thumb and two 83-year-old patients' thumb and index.

Three main features were observed:
- Deformation of the nail with ulceration pigmented on the cubital border.
- Erythematous and ulcerated lesion on the proximal and cubital nail fold.
- Superficial multicentric BCC with jagged borders – a histopathological hallmark for nail unit BCC

COURSES

Dermatological Problems in Women

Sunday, 1st June, 2008. 8.30–12.00

Programme

Chairs: Professor Fenella Wojnarowska, Dr Elisabet Nylander and Dr Monika Gniadecka

8.30–8.40 Welcome and opening remarks
Professor Fenella Wojnarowska

Overview of Skin Diseases in Adult Women

8.40–9.00 How women perceive skin disease
Dr Elisabeth A Holm

9.00–9.20 Overview of lichen sclerosus and lichen planus
Dr Elisabet Nylander

9.20–9.40 Overview of Lupus in women
Dr Filppa Nyberg

9.40–10.00 Overview of swollen legs in women
Dr Monika Gniadecka

10.00–10.30 Coffee break

10.00–10.30 Contact dermatitis - how do women cope with the disease?
Dr Tove Agner

Overview of Skin Disease in Pregnant Women

11.00–11.30 Autoimmune Disease in Pregnancy
Professor Fenella Wojnarowska

11.30–12.00 Overview of Pregnancy dermatoses
Dr Ellen Mooney

Abstract

C01.1

Autoimmune Disease in Pregnancy

Fenella Wojnarowska

Department of Dermatology, Oxford Radcliffe Hospital, Oxford, UK.

Pregnancy is a physiological event that is accompanied by alterations in the immune system state to ensure the mother does not reject the foetus (a semi-allogeneic graft). This means that to some extent the mother is immunosuppressed. There is a shift from cell mediated (T helper 1) responses towards antibody mediated (T helper 2) responses. Levels of circulating antibodies may rise.

Transplacental transfer of autoantibodies from autoimmune disease in the mother may have dramatic effects on the foetus. The most spectacular example in medicine is myasthenia gravis, where a proportion of infants have transient disease, and very rarely arthrogryposis multiplex congenital (non-progressive congenital contractures) absence of foetal movement. In dermatology we have 3 examples of transplacental transmission of antibody mediated disease. Neonatal pemphigus vulgaris and pemphigoid gestationis occur in a minority of neonates from affected mothers, and resolve within a few weeks. Neonateal lupus is more grave in its results.

Pemphigus may cause difficulties with conceiving and may worsen or present during pregnancy. There is significant associated foetal mortality and morbidity. Pemphigoid gestationis arises only in the setting of pregnancy or placental derived tissue, and remits after delivery. It is usually recurrent with each pregnancy, <10% skipped pregnancies. In subsequent pregnancies it can be the first indicator of conception. Linear IgA disease may remit during pregnancy, and recur at 3 months postpartum. Bullous pemphigoid rarely affects women of childbearing age, but may worsen or improve.

Lupus usually worsens during pregnancy, and adversely affects spontaneous abortion, foetal death, prematurity and foetal growth. Renal disease is particularly adverse. Mothers, some of whom are asymptomatic, with anti Ro and La antibodies that may induce neonatal lupus in about 5% of these children, this may persist for several years. Permanent congenital heart block results from these antibodies in about 2% of such offspring.

The effect of maternal autoimmune disease on the foetus may be profound and long reaching.

Dermatological Theories in Practise. A Seminar for Nurses Working in Dermatology

Sunday, 1st June, 2008. 14.30–18.00

Programme

14.30 Opening of session.

14.40–15.10 Basic skin physiology with special attention to skin barrier function and the application of emollients.
Theis Huldt-Nystrøm Hudlege Levanger

15.10–15.40 UV treatment - challenges and pitfalls.
Eli J. Nordal, overlege, Hudavdelingen, Rikshospitalet, Oslo

15.40–16.10 UV treatment of vitiligo - a sport for risk seekers?
Eli J. Nordal, overlege Hudavdelingen, Rikshospitalet, Oslo

16.10–16.30 Coffee Brake

16.30–16.50 The DLQI questionnaire and other questionnaires to measure the effects of dermatological therapy in atopic dermatitis, handeczema, and itch.
Theis Huldt-Nystrøm, Hudlege, Levanger

16.50–18.00 How to use the PASI score.
Morten Dalaker, Hudlege, Trondheim

Abstracts

C02.1

Basic Skin Physiology with Special Attention to Skin Barrier Function and the Application of Emollients

Theis Huldt-Nystrøm

Levanger

The nurses are very important in informing the patients about treatment with emollients and different topical medications. Patients respond very differently to the different sorts of emollients. It is of utmost importance that the nurses have learned about the various contents in emollients and the barrier function of the skin. This session will focus on basic skin physiology and skin barrier function. A brief review of effects of emollients in atopic dermatitis and dry skin will be presented.

C02.2

UV Treatment – Challenges and Pitfalls

Eli J. Nordal

Hudavdelingen, Rikshospitalet, Oslo

Often quite independent, the nurses perform the practical part of UV treatment, with varying support, skills and interest in photodermatology from the cooperating dermatologist. This presupposes the nurses to be sufficiently experienced to take this responsibility. The challenge is to provide the patient with the correct UV dose increment at any time, regarding skin type, diagnosis, form of UV treatment and additional treatment given. Overdosage should be avoided, but underdosage may be a larger problem.

C02.3

UV Treatment of Vitiligo – A Sport for Risk Seekers?

Eli J. Nordal

Hudavdelingen, Rikshospitalet, Oslo

Patients may experience vitiligo to be a most disfiguring condition. UV treatment may have at least some effect, and NB-UVB (TL01) is considered to be the treatment of choice. In addition to the possible repigmentation, UV treatment induces increased skin thickness and thereby increased sun tolerance in the affected skin. Most often long treatment series are necessary. Protopic ointment may enhance the effect of the UV beams. The risk of malignancies in vitiliginous skin seems so far to be of less importance than expected.

C02.4

The DLQI Questionnaire and Other Questionnaires to Measure the Effects of Dermatological Therapy in Atopic Dermatitis, Hand Eczema and Itch

Theis Huldt-Nystrøm

Levanger

The widespread use of systemic therapies and expensive biological therapies in dermatology has revealed a need of better documentation of effect and follow up results when treating different dermatological conditions. Nurses are important in this respect, and it is important that nurses and doctors are familiar with different questionnaires which deals with this kind of information.

This session is an introduction to the use of questionnaires to measure effect of therapy in atopic dermatitis, hand eczema and itch. We will also look at the DLQI questionnaire.

C02.5

How to Use the PASI Score.

Morten Dalaker

Trondheim

This session is a practical approach to how to use the PASI score the correct way. The participants will receive theoretical information about the PASI score and participate in an interactive "test yourself system" as a part of the practical demonstrations.

Dermatopathology

Monday June 2nd, 2008 8:00-11:30

Chairman: Ellen Mooney, Iceland

Co-Chairs: Mari-Anne Hedblad, Sweden and Ole Clemmensen, Denmark

8.00	Welcome *Dr Ellen Mooney*
8.00–10.00	From The Clinic to the Microscope
8.00–8.30	Cutaneous Lymphoma - Clinicopathologic Correlation and Diagnostic Pitfalls *Dr Werner Kempf*
8.30–9.00	Lupus Erythematosus – Clinicopathologic Correlation *Dr Ole Clemmensen*
9.00–9:30	New Inflammatory Dermatoses – Microscopic Clues to Clinical Diagnoses *Antoinette Hood*
9.30–10.00	Coffee break
10.00–11.30	The Tumour Through Technology and Treatment
10:00–10:30	Lentigo Maligna – Diagnosis and Soft X-Ray Treatment *Dr Mari-Anne Hedblad*
10.30–11.00	Spitz Nevi – Tough to Diagnose, Easy to Treat? *Professor Phil Leboit*
11.00–11.30	Nevoid Melanoma – The Dreaded Tumour That Defies Us *Dr Ellen Mooney*

Abstract

C03.1

Lentigo Maligna – Diagnosis and Ultra Soft X (Grenz)-ray Treatment

Mari-Anne Hedblad and Lotus Malbris

Department of Dermatology, Karolinska Hospital, Stockholm, Sweden

Clinical, dermoscopical and histopathological findings in Lentigo Maligna (LM) and our expirences of Grenz-ray treament, outcome, recommendations and pitfalls will be presented.

Background: LM is the in situ phase of LMM. A wide variety of modalities has been used to manage LM, including conventional surgery, staged excision, Moh´s micrografic surgery, cryotherapy, radiotherapy, laser therapy and lately imiquimod.

Objectives: LM has been successfully treated by Soft X-rays by Panazzoni et al. The aim of this study was to evaluate the efficacy of Ultra soft X-rays treatment in our practise in LM and early LMM.

Methods: 350 patients has been treated 2 times a week during 3 weeks in doses of 100–160 Gy according to the stage of LM and depth of atypical melanocytic periadnexal extensions.

149 patients have been followed up to 5 years, 243 patients for at least 2 years.

Results: 301/350 (86%) showed complete clearence after one fractioned treatment. Of 49 that did not respond completely 10 of those showed residual lesions after one treatment, and 39 relapsed, of those 26 within 24 months.

Conclusion: Grenz-rays is an efficient and safe treatment in lentigo maligna with very good cosmetic results.

The number of treated patients has been extended since gathering this data and will be presented at the meeting.

WORKSHOP

Self-Assessment Exam in Dermatopathology

Monday June 2nd, 2008, 8:30-16:00

Programme

Chairman: Dr. Philip LeBoit, USA

Co-Chairs: Dr. Mari-Anne Hedblad, Sweden and Dr. Antoinette Hood, USA

Other speakers/contributors of cases: Dr. Ole Clemmensen, Denmark and Dr. Werner Kempf, Switzerland

Monday June 2, 2008
8.30–16.00 Viewing of Cases

Tuesday June 3, 2008
900-12:00 Review of Cases

POSTERS

Atopy, Allergy and Eczema

P01.1

Nanotechnology and Contact Allergy

Jakob Torp Madsen[1], Stefan Vogel[2], Jeanne Duus Johansen[1] and Klaus Ejner Andersen[1]

[1]National Allergy Research Centre, Department of Dermatology, Odense University Hospital, and [2]Department of Physics and Chemistry, University of Southern Denmark

Nanotechnology is an emerging technique used in the cosmetic and pharmaceutical industry. The benefits of using nanotechnology in skin products include increased delivery of active ingredients to skin, protecting product from degradation, and giving improved cosmetic performance. One case report suggests that retinyl palmitate formulated in polycaprolactone (nanopolymer) in an anti wrinkle crème caused allergic contact dermatitis due to the retinoid in nanoparticles. Patch tests showed increased reactivity to retinyl palmitate formulated in the nanopolymer compared to petrolatum. Studies have shown that a fluorophore (nile red) incorporated in polycaprolactone penetrates deeper in the skin compared to conventional vehicles. Chemicals incorporated in polycaprolactone could theoretically have increased sensitization and elicitation potential. The ongoing project aims to investigate in mice and human volunteers the allergenic effect of selected allergens in nanoparticles. Two different types of nanoparticles used in cosmetics (polycaprolactone and liposomes) are manufactured and loaded with 2 different contact allergens (potassium dichromate (hydrophilic) and isoeugenol (slightly hydrophilic)). Sensitization animal experiments using the local lymph node assay are ongoing and data will be presented.

P01.2

A Multicenter, Randomised Double-blind, Placebo-controlled Study of Efficacy, Safety and Tolerability of Two Topical K301 Formulations in Adults with Seborrhoeic Dermatitis (SD) of the Scalp

Lennart Emtestam[1], Sören Gullstrand[2], Pawel Berens[3] and Birgitta Wilson-Claréus[4]

[1]Department of Dermatology, Karolinska University Hospital, Stockholm, [2]Möllevångens Husläkargrupp, Malmö, [3]Hälsojouren, Uppsala, [4]Hudmottagningen, Farsta, Sweden

Methods: Of 98 patients, 51 were randomly evenly allocated to one of the two K301 formulations and 47 to a matching placebo. Treatment was to be applied once daily for 4 weeks and three times per week during the following 4 week maintenance phase. Follow-up was after 2, 4 and 8 weeks. Primary end point was the sum of erythema and desquamation scores after 4 weeks treatment which was analyzed using a proportional odds model. Baseline sum score was included in the model.

Results: K301 was superior to placebo in terms of the sum of erythema and desquamation scores after 4 weeks of treatment ($p=0.0253$). The difference was significant also after 2 weeks, but not after 8 weeks of treatment, i.e. after the 4-week maintenance phase. In addition, there was a significant difference between the proportions of responders after 4 weeks ($p=0.0075$), with 67% of patients treated with K301 meeting the predefined responder criteria versus 40% for placebo. Several other secondary efficacy measures also showed results consistent with the primary analysis. No safety concerns were raised.

Conclusion: The results indicate that K301 is safe and efficacious for topical treatment of scalp SD and warrant further investigation.

P01.3

Nail Mycosis at Department of Dermatology, Odense University Hospital

Lisbeth Jensen

Department of Dermatology, Odense University Hospital, Odense, Denmark

Many people consult dermatological wards, clinics and general practitioners with suspicion of mycosis in one or more nails, especially toe nails.

In 2007 a total of 1,885 nail specimens were examined and 319 were positive. The low frequency of positive nail samples may be due to poor sampling technique in combination with frequent non-infectious nail disorders.

P01.4

Managing the Family with Atopic Dermatitis (AD), a Case.

Helle Wølk Ovesen

Department of Dermatology, Odense University Hospital, Denmark

A four-year-old boy, no. 2 of 5 children, followed at the department of Dermatology, Odense University Hospital, under the diagnosis atopic dermatitis (AD), was admitted to the department, due to severe exacerbation, with concomitant staph-infection. After only 2 days intensive local treatment with potent steroids in combination with Fusidic acid vast improvement was noted, improvement continued during the admission. During the admission nursing staff focused on teaching the

family to cope with AD, learning them to use topicals correctly and how to handle exacerbations. The case has since been chosen as learning example for the nursing staff.

P01.5

Methylaminolevulinate as a Cause of Allergic and Irritant Contact Dermatitis; Results from a Randomised Double-blind Study.

Ana Soler and Trond Warloe

The Norwegian Radium Hospital, Oslo, Norway

Introduction: More than 300,000 patients have been treated with methylaminolevulinate (MAL) in Metvix® cream in photodynamic therapy (PDT) worldwide, with few serious adverse effects. Some of the ingredients of the Metvix® cream may cause local skin and allergic reactions.

Objective: Investigate the potential of MAL-PDT to cause allergic and irritant contact dermatitis.

Methods: The study was performed as a double-blind, within-subject, vehicle controlled, randomised single centre study in 21 patients previously treated at least four times with MAL-PDT. Each patient received a single application of 160 mg/g MAL (Metvix®) and placebo cream of each test agent to the left and the right side of the spinal column. Adhesive tape covered the chambers for 48 h, and were then removed. Skin reactions were assessed after 48, 72 and 96 h. Patients with positive patch tests were retested.

Results: All enrolled patients completed the study. In Test 1, positive patch tests were observed at three (14%) sites treated with MAL cream. 18 patients (86%) had negative patch tests. In Test 2, the three patients with positive patch tests from Test 1 were retested with three patches of MAL cream with an application-time of 3 hours with and without illumination after removing the patches (two patches) and 48 h (one patch). Patient 1 had a positive patch test on all test sites. Patient 2 had a sharply demarcated erytematous plaque without blistering and spreading outside the test area on the 48 h test site (indicating an irritant contact dermatitis) and the two other test sites were negative. Patient 3 were negative on all three test sites.

Conclusion: The results of this Phase IV study support former clinical findings and indicate a low potential for allergic contact sensitation with MAL cream.

P01.6

A Randomized Double-blind, Placebo Controlled, Study to Evaluate the Efficacy of Liquid Soap Containing 12% Ammonium Lactate + 20% Urea (Axera™) in Atopic Dermatitis

Boaz Amichai and Marcelo H. Grunwald

Department of Dermatology, Sheba Medical Center and Soroka Medical Center, Israel

Background: Atopic dermatitis is a common chronic skin disease which affects mostly children. Xerosis is one of the most troublesome signs of the disease.

Aim: To evaluate the efficacy of liquid soap containing 12% ammonium lactate + 20% urea (Axera, Perrigo, Israel) in atopic dermatitis patients.

Methods: In a randomized, double-blind study, 36 patients both male and female aged 3–40 years suffering from mild to moderate atopic dermatitis were enrolled. Patients were divided randomly into two groups, in a ratio of 2:1 (active: placebo). Soap was used on daily based during shower for 3 weeks. All patients continued all other systemic or topical medication but avoided any other soap or emollients. After three weeks of treatment, the efficacy was assessed both by clinician and patient.

Results: Axera liquid soap was found to be statistically better regarding the improvement of objective parameters evaluated by the investigator; scaling ($p<0.0001$), skin dryness ($p<0.0001$) and redness ($p=0.03$), and subjective patients assessment of itch ($p<0.001$).

Conclusion: Axera liquid soap was found to be effective in patients with atopic dermatitis. The use of this soap in patients with stable mild to moderate atopic dermatitis improve skin findings and quality of life of the patients.

P01.7

Do Genetic Polymorphisms in Transglutaminases Contribute to Skin Barrier Dysfunction in Eczema Patients?

Maria Bradley, Agne Lieden, Annika Sääf, Carl-Fredrik Wahlgren and Magnus Nordenskjöld

Karolinska University Hospital, Stockholm, Sweden

Atopic eczema (AE) is a common skin disorder currently affecting up to 20% of children in some countries (1). AE usually begins in infancy or early childhood with a significant proportion of children having continued problems into adult life. Patients with AE suffer from itchy, dry and inflamed skin, often in combination with other atopic manifestations such as allergic asthma and allergic rhinoconjunctivitis (hay

fever). Twin studies indicate a strong genetic contribution in the development of AE (2, 3) and genetic linkage analyses have identified several chromosomal regions linked to AE (4–7). However, very little is known about specific genes involved in this complex skin disease and the underlying molecular mechanism is not yet identified. We used human cDNA microarrays to identify a molecular picture of the programmed responses of the human genome to the pathological condition of AE. Among the genes consistently over-expressed in AE skin as compared to skin from healthy control individuals were members of the transglutaminase family (TGM1 and TGM3) and corneodesmosin (CDSN) that play a central role in forming the outermost layer of the skin, the cornified envelope. These genes are localized to known susceptibility chromosomal regions for eczema (TGM1; 14q11, TGM3; 20p13, CDSN; 6p21.3). It is not known, however, if genetic polymorphisms in these genes contribute to skin barrier dysfunction in eczema patients. To answer this question, we investigated the role of genetic variation at these loci in the development of eczema. In summary, we here present a global gene signature of eczema skin, and furthermore genetic polymorphisms are described in candidate AE susceptibility genes identified by the microarrays. In conclusion, our data supports the hypothesis that barrier dysfunction is an important factor in eczema pathogenesis.

Psoriasis

P02.1

Itraconazole Treatment in Onychomycosis in Psoriatic Patients

Boaz Amichai[1], Avner Shemer[1], Henri Trau[1], Batya Davidovici[2] and Marcelo H. Grunwald[3]

[1]Department of Dermatology, Sheba Medical Center, Tel-Hashomer, [2]Dermatology Unit, Kaplan Medical Center, Rehovot, [3]Soroka University Medical Center, Ben-Gurion University, Beer-Sheva, Israel

Background: Nail changes in patients with psoriasis have been reported with varying prevalence. Onychomycosis was reported in up to 25% of psoriasis patients.

Objective: The purpose of this study was to determinate the prevalence of nail abnormalities, onychomycosis in psoriasis, and response to itraconazole treatment.

Methods: We evaluated 312 patients suffering from psoriasis for nail changes and onychomycosis. Patients having laboratory confirmation of onychomycosis were treated with itraconazole courses (400 mg/day for one week): in fingernails 2 courses and in toenails 3 courses.

Results: Of 312 patients with psoriasis, 67 (21.5%) patients had nail changes, 23 (34%) of them suffered from onychomycosis. Complete cure (clinical and mycological) was achieved in 30% of the patients with onychomycosis.

Conclusion: The response to treatment of onychomycosis in psoriasis patients was found to be lower than in the general population.

P02.2

Early Onset of Psoriasis Vulgaris and Polymorphisms of VDR Gene

Ivana Rucevic, Vladimira Drusko, Melita Vuksic, Ljubica Glavas-Obrovac and Dujomir Marasovic

Department of Dermatology, Laboratory of molecular patophysiology, Clinical hospital Osijek, and Department of Dermatology, Clinical hospital Split, Croatia

Aim: The aim of this investigation were to establish an association between ApaI, BsmI and TaqI restriction fragment length polymorphism (RFLP) at the VDR gene in psoriatics with early onset of disease and healthy controls.

Patients and Methods: 70 psoriatics (35 F:35 M) were randomly recruited and 157 healthy controls (86 F:71 M) with no clinical evidence or family history of psoriasis.Genomic DNA was extracted from peripheral blood leukocytes and the VDR gene was amplified using a polymerase chain reaction (PCR). The RFLP were coded as Aa (ApaI), Tt (TaqI) or Bb (BsmI), where a uppercase letter signifies absence of the restriction site and a lowercase letter signifies presence of the site. Gained results were processed by statistical analysis.

Results: results of this study show that the four more frequent genotypes in healthy controls were: BbAaTt (29.3%), BBAatt (14.7%), BBaatt (14%) and bbAATT (12.7%), and in psoriasis patients were: BbAaTt (33.6%), BBAatt (22.9%), BBaatt(16.4%), and BbAATt (10%). Analysis (Westfall-Young) of genotype effects have not shown significant difference in distribution of BsmI ($p<0.206$), ApaI ($p<0.826$) or TaqI ($p<0.939$) genotype frequencies between healthy controls and psoriasis patients.

Conclusion: The results of the present study showed no relationship between psoriasis and the ApaI, BsmI, TaqI RFLP VDR genotypes, but BT haplotype showed protective effect on PV with early onset. This obtained data suggests that the VDR gene could be one of some candidate genes implicated in the pathogenesis of psoriasis vulgaris.

P02.3

A DESIRE* for DAIVOBET® – The Results of the DESIRE study

(*Daivobet® Experience Study In Regions of Europe)

Birgitta Wilson-Claréus[1], Ronald Houwing[2], Jens Hein Sindrup[3] and Suzanne Wigchert[4]

[1]Läkarhuset Farsta Centrum, Hudmottagningen, Karlandaplan 6, 123 47 FARSTA, Sweden [2]Department of Dermatology, Deventer Hospital, P.O. Box 5001, 7400GC Deventer, The Netherlands , [3]Amagerbrogade 18, 3., 2300 Copenhagen S, Denmark, and [4]LEO Pharma Benelux, Hoge Mosten 16, NL-4822 NH Breda, The Netherlands

To investigate treatment experiences amongst patients in daily clinical practice treated with Daivobet®, a fixed combination of calcipotriol and betamethasone dipropionate for the treatment of psoriasis vulgaris, the DESIRE study was designed. In this non-interventional study 1224 patients with psoriasis vulgaris were followed for a period of 6 months. The primary response criterion was patients' satisfaction after 4 weeks of Daivobet® treatment. Additional study objectives were to describe the severity of the psoriasis at the time of enrolment into the study and to assess the number of Daivobet® treatment courses during a six months period.

The main results are:

- ~75% of the patients are satisfied to very satisfied after a Daivobet® treatment course
- Patients' satisfaction is high, regardless of initial psoriasis severity (mild-severe)
- Repeated treatment courses of Daivobet® were prescribed in 20% of the patient population. Patients' satisfaction remained equally high (~80%)
- Patients' satisfaction results in this non-interventional study are similar to the results obtained in a well-controlled clinical trial (1)

Reference:

1. Dermatol 2006; 213: 319–326.

Drug Reactions

P03.1

Full Dapsone Dose made Possible by Control of Anemia with Darbepoetin-alpha and the Effect of Cimetidine on Dapsone-induced Methemoglobinemia

Bolli Bjarnason[1,2] and Ellen Flosadottir[1,3]

[1]Utlitslaekning Ehf, Kopavogur, [2]Faculty of Medicine, Department of Dermatology, and [3]Faculty of Odontology, University of Iceland, Reykjavik, Iceland

Dapsone is an important immunosuppressive agent but is sometimes not well tolerated because of adverse hematological effects. An 84-year-old man developed linear IgA disease. Treatment with dapsone resulted in anemia and mild methemoglobinemia at a low-dose that did not control the disease. The anemia was well controlled with darbepoetin-alpha. We understand this is the first time darbepoetin-alpha is used to control a drug-induced anemia apart from its use in conjunction with chemotherapeutic agents. The methemoglobinemia was reduced by cimetidine that has only once before been described to be effective. We fell that the alternative to treat those dapsone induced adverse effects should be considered before stronger immunosuppressants with more serious adverse effects are considered, especially in older people.

Skin Tumours

P04.1

A Non-epidermolytic Epidermal Naevus of a Soft, Papillomatous type with Transitional Cell Cancer of the Blader: A Case Report and a Review of Non-cutaenous Cancers Associated with the Epideral Naevi

Bolli Bjarnason[1,2] and Ellen Flosadottir[1,3]

[1]Utlitslaekning Ehf, Kopavogur, Iceland, [2]Karolinska University Hospital, Stockholm, Sweden and [3]Faculty of Odontology, University of Iceland, Reykjavik, Iceland

We report a case of an epidermal nevus syndrome with a transitional cell cancer of the bladder at the age of 24. This is the 4th case in the literature of an epidermal nevus associated with transitional cell cancer of the bladder making coincidencal association between the nevus and the cancer unlikely as that type of tumor is very rare at that age. We review extra-cutaneous malignancies associated with epidermal nevi.

Wounds, Connective Tissues

P05.1

Imiquimod – Successful Wound Treatment

Inger Tranberg, Nina Johansen and Hanne Hvidsten

Department of Dermatology, Odense University Hospital, Odense, Denmark

An 87-year-old woman was admitted to the department of Dermatology, Odense University Hospital, Odense, Denmark, following 6-weeks of out-patient treatment with imiquimod against actinic keratoses on the forehead, temples and the nasal bridge. The treatment had resulted in widespread crustrated wounds with eschar-formation. Following two-weeks of intensive wound care only a few crusts remained and the patient was discharged to her home to be cared by a home

visitor. This case has lead to a change in the departmental procedures regarding patients in ambulant imiquimod-treatment, it is now mandatory that the patients are evaluated by a doctor/ wound care team after three weeks of treatment.

Facial Dermatitis

P06.1

Treatment of Moderate to Severe Facial Seborrheic Dermatitis with Itraconazole: An Open, Noncomparative Study

Marcelo H. Grunwald[1], Avner Shemer[2], K. Kaplan[2], Henri Trau[2], N. Nathansohn[2] and Boaz Amichai[2]

[1]Department of Dermatology, Soroka Medical Center and [2]Sheba Medical Center, Israel

Background: Seborrheic dermatitis (SD) is a common disease. The role of malassezia yeasts, in the pathogenesis of seborrheic dermatitis, as been implicated. Anti-fungal agents are known as effective agent in the treatment malassezia yeasts infection.

Objectives: To evaluate the efficacy of itraconazole in the treatment of mild to severe facial seborrheic dermatitis.

Methods: 60 patients with moderate to severe seborrec dermatitis were avaleuated in an open, noncomparative study. Patients were treated with oral itraconazole, intially 200 mg/day for a week, and by a maintenance therapy of a single dose of 200 mg every two weeks.

Results: At the end of the initial treatment significant improvement was reported in three clinical parameters; erythema, scaling and itching. Maintenance therapy leads only a slight further improvement.

Conclusions: In this study we showed that treatment with itraconazole may be of beneficial in patients with moderate to severe facial SD.

AUTHOR INDEX

INFORMATION FROM NORDIC DERMATOLOGY ASSOCIATION

Stadgar för Nordisk Dermatologisk Förening

antagna vid föreningens första möte i Köpenhamn 1910, ändrade i Köpenhamn 1935, i Stockholm 1946, i Århus 1977 och senast vid föreningens 26:e möte i Reykjavik den 14 juni 1993.

§1 Föreningens syfte är att befrämja samarbete i vetenskap, undervisning och praktisk läkekonst mellan dermatovenereologer i de 5 nordiska länderna (Danmark, Finland, Island, Norge och Sverige).

§2 Som nya medlemmar kan antas personer i de 5 länderna vilka är verksamma inom dermatologi och venereologi. För inträde fordras, att den som söker om medlemskap föreslås av dermatologisk förening av samma nation; beslut om inval fattas på allmänt möte vid varje kongress med enkel röstövervikt.

§3 Till hedersledamot kan föreningens allmänna möte kalla den som gjort osedvanligt stora insatser för föreningen eller för nordisk dermatologi och/eller venereologi. För kallelse krävs 2/3 majoritet. Förslag till hedersledamot skall inges skriftligen till generalsekreteraren minst tre månader före allmänna mötet. Förslagen skall godkännas av föreningens styrelser för att kunna presenteras för allmänna mötet.

§4 Årsavgiften bestämmes vid varje kongress. Medlem som uppnått 65 levnadsår är befriad från avgift.

§5 Föreningen håller ett möte i regel vart tredje år i ett av de nordiska länderna. Tid och plats för nästa möte bestämmes på varje möte.

§6 Vid mötet hålls ett sammanträde för föreningsangelägenheter varvid följande ärenden skall förekomma:

1. Kassa förvaltarens berättelse.
2. Revisorernas berättelse jämte frågan om ansvarsfrihet.
3. Årsavgift för kommande 3-årsperiod.
4. Val av styrelse samt 2 revisorer för kommande 3-årsperiod.
5. Val av forskningskommitté
6. Tid och plats för nästa möte fastställes.
7. Antagning av nya medlemmar.
8. Övriga ärenden

§7 Styrelsen består av: generalsekreteraren samt 9 styrelsemedlemmar och 9 suppleanter (1 från Island och 2 från vart och ett av de övriga länderna). Som extraordinarie medlem ingår den vid mötet verksamme presidenten såvitt han ej i förväg är medlem i styrelsen. Styrelsen väljer inom sig ordförande och dessutom generalsekreterare, som samtidigt är föreningens kassaförvaltare. Generalsekreteraren väljes på obestämd tid, men bör ej fungera i mer än 12 år. De övrigas funktion sträcker sig från slutet av ett möte till slutet av nästa. Styrelsemedlemmarna kan återväljas för ytterligare två 3-årsperioder. De nationella föreningarna anmodas att senast 3 månader före mötet inkomma med förslag till sitt lands styrelsemedlemmar.

§8 Det dermatologiska sällskapet i det land där mötet skall äga rum, lägger tillrätta kongressens vetenskapliga och övriga program och ombesörjer tryckningen av förhandlingarna i samråd med styrelsen. Varje föredragshållare och diskussionsdeltagare skall sända in ett referat till sekreteraren vid anmälan till kongressen. Föredraget hålles på danska, norska, svenska eller engelska.

§9 För en förändring av dessa stadgar krävs 2/3 majoritet. Dylika ändringsförslag skall vara insända senast 3 månader före ett mötes avhållande.

Meetings in Nordic Dermatology Association 1910–2008

		President	Sekreterare
1. Köpenhamn	1910	C Rasch	
2. Stockholm	1913	E Sederholm	K Marcus
3. Oslo	1916	C Boeck	K Grön
4. Köpenhamn	1919	C Rasch	A Kissmeyer
5. Stockholm	1922	A Afzelius	J Strandberg
6. Helsingfors	1924	J J Karvonen	B Grönroos
7. Oslo	1928	E Bruusgaard	K Grön
8. Stockholm	1932	A Moberg	J Strandberg
9. Köpenhamn	1935	H Boas	S Emanuel
10. Helsingfors	1938	A Cedercreutz	T E Olin
11. Stockholm	1946	S Hellerström	M Tottie
12. Oslo	1949	N Danbolt	R Björnstad
13. Köpenhamn	1953	H Haxthausen	P-H Nexmand
14. Helsingfors	1956	T Putkonen	V Pirilä
15. Oslo	1959	N Danbolt	M H Foss
16. Göteborg	1962	G Seeberg	B Magnusson
17. Köpenhamn	1965	G Asboe-Hansen	H Schmidt
18. Åbo	1968	C E Sonck	E Lundell
19. Oslo	1971	N Danbolt	K Wereide
20. Stockholm	1974	N Thyresson	Ö Hägermark
21. Århus	1977	H Zachariae	J V Christiansen
22. Helsingfors	1980	K K Mustakallio	L Förström
23. Oslo	1983	G Rajka	L R Braathen
24. Uppsala	1986	L Juhlin	S Öhman
25. Köpenhamn	1989	N Hjorth	J Roed-Petersen, G Lange Vejlsgaard
26. Reykjavik	1993	J H Olafsson	B Sigurgeirsson
27. Åbo	1995	V Havu	I Helander
28. Bergen	1998	S Helland	J Langeland
29. Göteborg	2001	O Larkö	H Mobacken, E Voog
30. Odense	2004	K E Andersen	F Brandrup, C Bindslev-Jensen
31. Reykjavik	**2008**	**B Baldursson**	**G Ingvarsson**

NORDISK DERMATOLOGISK FÖRENING
Nordic Dermatology Association

Minutes, General Assembly, May 7th 2004 in Odense

1. Agenda	The proposed agenda was accepted.
2. Chairman of the meeting	The Congress President Klaus E Andersen was appointed as chairman and commissioned to check the minutes.
3. Treasurers report	A financial summary for the period 2001–2003 had been published in the Abstract book of the congress and was discussed together with a report from the Secretary General. It was pointed out that the financial surplus exceeds the minimum level decided in Bergen.
4. Auditor's report	The auditors read their report. The meeting decided to accept discharge of liability for the Secretary General and the Board
5. Annual fee 2004 to year of next congress	The annual member fee was decided to be the same as during the past period, i.e. SEK 30 per year and member.
6. Board 2004–2007	In accordance with suggestions from the national associations board members were elected as follows: *Denmark:* Klaus E Andersen, Knud Kragballe. Deputies: Susanne Ullman and Jørgen Serup. *Finland:* Kristiina Turjanmaa, Anna-Mari Ranki. Deputies: Aarne Oikarinen, Ilkka Harvima. *Iceland:* Jon Olafsson. Deputy: Gisli Ingvarsson. *Norway:* Dag Sollenes Holsen, Per Helsing. Deputies: Svein Helland, Eli Nordal. *Sweden:* Mona Ståhle, Olle Larkö. Deputies: Birgitta Stymne, Mats Berg *Auditors:* Tapio Rantanen, Kristian Thestrup-Pedersen
7. New members	It was decided to accept all persons who since the previous meeting in Gothenburg had become members of national associations for dermatology and venereology in the Nordic countries as new members of the NDA.
8. Next meeting	According to the three-year schedule next meeting should be held in Iceland in 2007. Preliminary information from the Icelandic association said they declined hosting the next congress. Next in turn would be Finland. The year 2007 may not be an optimal time for next congress due to several other large events in 2006 (EADV Spring Symposium hosted by Finland) and 2007 (World Congress in Buenos Aires and hence EADV meeting in spring).

It was stated that the congress in Reykjavik in 1993 was a success and of very high quality, and that efforts should be made to encourage the organisation of a new meeting on Iceland.

It was decided not to make a final decision on next congress, but to instruct the secretary general and the board to investigate alternative possibilities, preferably to have next meeting in 2008, and to open new discussions with Iceland or, if the Icelandic association stays with its decision, with Finland. For the next organiser the guarantee sum should not be less than SEK 250 000. It was decided that reasonable travel expenses for the secretary general and others involved in making preparations for the next congress shall be paid from assets of the NDA.

9. Activities

It was decided not to give further support for the project for international venereology, which was launched at the Gothenburg meeting.

It was decided not to give continued support in its present form of free subscriptions of Acta Dermato-Venereologica to the Baltic countries. Instead residents of dermatology and venereology in the Baltic countries will be given opportunities to apply for free subscriptions for three-year periods. The maximum number of subscriptions will be the same, i.e. 18.

It was decided to follow a proposal from Finland to investigate possibilities for the NDA to arrange focussed educational courses for members.

10. Nordic Forum for Dermatology and Venereology and the NDA

It was decided that the organisers of the next meeting will be recommended to have the Abstract book printed in the Forum, as did the organizers of the present Congress. If the organizers decide to do as recommended, the NDA will support the extra costs for printing and distribution.

11. The future of the NDA

There was general consensus that the present congress had a very high quality and educational value, as had the previous meetings. Similar meetings should therefore be held also in the future. Possibilities to arrange educational events also between congresses should be investigated.

It was agreed that more efforts should be made in order to increase the interest for the NDA among younger Nordic dermato-venereologists. The board was instructed to be more active between meetings.

12. Closing of the meeting

The meeting was closed.

Torbjörn Egelrud
Secretary General

Klaus E Andersen
Congress President

Economical Report for 2004, 2005, 2006 och 2007

Debet

2004	SEK
Ingående saldo	554770,09
Medlemsavgifter	47070,00
Räntor	6985,30
Övriga inbetalningar	249990,00
	858815,39

Kredit

2004	SEK
Diverse utgifter	195651,69
Utgående saldo	663163,70
	858815,39

Debet

2005	SEK
Ingående saldo	663163,70
Medlemsavgifter	28420,00
Räntor	4886,54
Övriga inbetalningar	274508,00
	970978,24

Kredit

2005	SEK
Diverse utgifter	5530,00
Utgående saldo	965448,24
	970978,24

Debet

2006	SEK
Ingående saldo	965448,24
Medlemsavgifter	[1]
Räntor	6168,23
	971616,47

Kredit

2006	SEK
Diverse utgifter	4488,00
Utgående saldo	967128,47
	971616,47

Debet

2007	SEK
Ingående saldo	967128,47
Medlemsavgifter	54770,00
Övriga inbetalningar	395234,47
Räntor	9408,87
	1426541,81

Kredit

2007	SEK
Diverse utgifter[2]	1170268,15
Utgående saldo	256273,66
	1426541,81

[1] Bet 2007

[2] Inkl räntefond SEK 500 000

OBITUARIES

Denmark

Erik Andreas Knudsen blev født 19. februar 1924 og døde 9.10.2004. Han tog lægevidenskabelig embedseksamen i 1952 og blev speciallæge i dermato-venerologi i 1962. Han var uddannet ved de dermatologiske afdelinger på Finsen Instituttet, Rudolph Bergs Hospital og Rigshospitalet. I 1966 blev han overlæge ved National Medical Center Korea. I 1969 overlæge ved Rudolph Bergs Hospital, senere med tjeneste på Hvidovre Hospital og endelig Bispebjerg Hospital, hvorfra han blev pensioneret i 1994. Han var sideløbende hermed praktiserende speciallæge i dermatologi i Helsingør og senere i København. Han var æresmedlem af Korean Dermatological Society. Han publicerede artikler omhandlende bl.a. dermatofyt-infektioner og fotodermatologi.

Ruth Stolze Laursen blev født 30. august 1923 og døde 19.8.2007. Hun tog lægevidenskabelig embedseksamen i 1949 og blev speciallæge i dermato-venerologi i 1965. Hun var uddannet ved de dermatologiske afdelinger på Rudolph Bergs Hospital, Kommunehospitalet og Finsen Instituttet. Hun var praktiserende speciallæge i dermatologi i København fra 1976 til 1995.

Asger Nørholm blev født 13. oktober 1918 og døde 29.1.2006. Efter uddannelse på flere Københavnske dermatologiske afdelinger og Marselisborg Hospitals hudafdeling nedsatte han sig i 1956 i speciallægepraksis i Herning. I 1959 flyttede han til Aalborg. Samtidig med sin praksis arbejdede han ved de private hospitaler Kamilianerklinikken og Sct. Joseph's Hospital, indtil hudafdelingerne i disse hospitaler blev nedlagt. Nørholm oprettede i 1974 en offentlig klinik for kønssygdomme – og passede samtidig en meget stor praksis. Nørholm var meget flittig, meget belæst og meget afholdt af patienterne og af os kolleger.

Poul Asmus Poulsen blev født 3. juli 1945. Han blev cand. med. S. 75 i Aarhus og speciallæge i dermato-venerologi 1989. Efter uddannelse på dermatologiske afdelinger i København og dermatologisk afdeling i Odense overtog han i 1990 speciallægepraksis i Esbjerg. På grund af sygdom måtte han ophøre med praksis i 2005. Han var meget knyttet til sin slægtsgård, hvor han var bosat med sin famile. Poul Asmus Poulsen døde den 26 september 2006 og vi har mistet en god kollega.

Jørgen Søndergaard blev født 20. august 1937 og døde 6.2.2006. Han blev kandidat i 1965 og speciallæge i 1974 med overlægestilling på Rigshospitalet samme år. Disputatsen fra 1973 hed: Studier over mediatorer ved hudens tidlige betændelsesreaktioner.1975-1995 professor i hud- og kønssygdomme og overlæge v. Hvidovre/Bispebjerg hospital. 1996-2003 chefdermatolog på hospital i Abu Dahbi.

Jytte Tissot blev født 7. juni 1928 og døde 9.5.2007. Hun tog lægevidenskabelig embedseksamen fra Københavns Universitet i 1958 og blev speciallæge i dermatologi i 1968. Uddannet i de dermatologiske afdelinger på Finsen Instituttet og Rigshospitalet. Praktiserende speciallæge i dermatologi i Helsingør fra 1968 til 1995.

Paul Jacob Unna blev født 2. marts 1926 og døde 11.4.2004. Han var født som søn og sønnesøn af to kendte dermatologer fra Hamborg. Han blev kandidat i 1952 og speciallæge i 1962. Han var ansat på Københavns Kommunehospital, Rudolph Bergh Hospital og Finsen Instituttet. Som praktiserende speciallæge fra 1962 til 1991 i Aabenraa, delte han de første år praksis med sin far Georg Wilhelm Unna.

Æret være deres minde.
DDS

Finland

Huurto Laura 30.10.1961–19.09.2004

Rouhunkoski Sirkka 07.02.1909–19.10.2004

Rostila Timo 09.05.1944–23.11.2004

Helle Juha Pekka 10.11.1920–05.12.2004

Launis Juhani 29.01.1935–10.01.2005

Antti Jouko 27.01.1929–01.03.2005

Lassus Allan 31.08.1938–07.06.2005

Leinonen Marjatta 11.03.1940–26.01.2007

Timo Rostila was born on 9.5.1944 and died on 23.11.2004. He studied medicine in the University of Helsinki and graduated in 1970. He was then resident in Dermatology and Venereology in the Helsinki University Hospital, and got his specialty in 1978. During his residency he became interested in contagious diseases and venereology, and after graduation he started working as the venereologist of the City of Helsinki, and since 1983 until his death he was the epidemiologist of the City of Helsinki. In this work he was responsible for the epidemiology of all contagious diseases.

Norway

Madela Foss (1906–2005). No information available.

Tobias Gedde-Dahl jr. (1934–2006). Tobias Gedde-Dahl jr. was educated at the faculty of medicine, Oslo, and became specialist in medical genetics in 1971. In 1970 he defended his academic thesis "Epidermolysis Bullosa: a clinical, genetic and epidemiological study". From 1970–1986 he was senior researcher in the Department of Genetics at the Norwegian

Radium Hospital, followed by position as professor and head of the Department of Medical Genetics at the University of Tromsø/University Hospital of Tromsø until 1990. In 1992 he became senior researcher and chief of the Dermatological DNA Laboratory at the National Hospital in Oslo, a position he held until 2004. However, he was connected to the DNA Laboratory also after his retirement, until short time before he passed away.

Tobias was closely connected to dermatology throughout his entire career, with emphasis on the genodermatoses. His efforts in dermatological research led to descriptions of variations and mutations in epidermolysis bullosa and ichtyoses, and his work laid foundation to further molecular investigations elucidating the genetics and pathogenesis of the disorders. He had a most extensive international network, and showed a considerable productivity of scientific works including papers in scientific journals, meeting abstracts and book chapters. His work with genetic science was rewarded with the royal medal of honour, and in 2002 he was elected as member of honour in the Norwegian Society of Dermatology.

On March 2 in 2006 he died, after a short period of illness. With his death, the International Dermatological society lost a highly respected colleague, and his patients lost a deeply cherished and dedicated doctor and friend.

Terje Kristensen (1943–2007). Terje had his education from the faculty of medicine in Basel, Switzerland. Later, he worked at the hospital in Ørebro, Sweden, where he became specialist in dermatology. He was married to Helén in 1980. They had a very harmonic and happy marriage, and got two children. From 1982, he worked as dermatologist at Lundegata medical Center in Skien, Norway, where his wife worked together with him as his health secretary.

Terje was respected among his colleagues, and his patients had a competent and thorough doctor.

Unfortunately, he suffered an acute illness, and deceased abruptly 3rd of June, 2007 – leaving an enormous vacuum for patients and colleagues.

Brynjulf Østensjø (1912–2007). Brynjulf Østensjø was born in Haugesund, 1912. He finished his medical education in 1941, and became a specialist in dermatology in 1951. He settled in his home town where he worked as a dermatologist, a general practitioner and a school doctor until 1984. As a doctor he was thorough, watchful and always in service. He had many interests in addition to work, including wildlife and travelling. He vas leader of Rogaland Medical Assiciation for a period of time, and was also a member of Lions Club. In his home town, he was active in developing hiking trails, and received Haugesunds sign of honour "De fykende måker" ("The Flying Seagulls"). He had many friends and colleagues, who will keep a dear memory of him.

Sweden

Kerstin Wennberg 1939.06.22–2004.12.15

Kristian Fast 1912.11.06–2004.12.27

Erik Skog 1923.11.08–2005.01.30

Kjell Wikström 1927.12.28–2005.03.12

Jan Eric Wahlberg 1932.07.05–2005.08.10

Lennart Juhlin 1926.08.27–2005.10.17

Anne-Marie Hornmark 1948.04.02–2005.11.26

Hjördis Lidman 1909.05.21–2006.10.04

Ove Groth 1922.06.11–2008.01.30

MEMBERS IN THE NATIONAL SOCIETIES

Denmark

Aastrup Bent
Borgm.Jørgensens vej 6
DK-2930 Klampenborg

Ackerman A. Bernard
Ackerman Academy of Dermapathology
14 SE 32 st 10th Floor
NY 10016 New York, USA

Afzelius Hanse-Wilhelm
Toften 1
DK-6720 Fanø

Agdell Jan
Regementsgatan 50
SE-217 48 Malmö, Sverige

Agner Tove
Ibstrupvej 57
DK-2820 Gentofte

Ahm Petersen Ane Marie
Classensgade 67, 1th
DK-2100 København Ø

Albrectsen Birgit
Gentoftegade 28B
DK-2820 Gentofte

AndersenBo
Lasthein Strandhuse 45
Strandgården
DK-5700 Svendborg

Andersen Klaus Ejner
Hjallesegade 9
DK-5260 Odense S

Andersen Møller Rigmor
Oppesundbyvej 1
Sundbylille
DK-3600 Frederiksund

Avnstorp Christian
Sassvej 2
DK-2820 Gentofte

Avrach Wolf Willy
Banegårdsplatsen 1, 5
DK-1570 København V

Baadsgaard Ole
Tuborg Sundpark 10, 1tv.
DK-2900 Hellerup

Balslev Eva
Sassvej 2
DK-2820 Gentofte

Bang Bo
Hellerupvej 2A, 4th
DK-2900 Hellerup

Bang Karen
Væderbrovej 1 E
DK-8660

Bangsgaard Nannie
Dageløkkevej 13
DK-3050 Humlebaek

Baran Robert
42, Rue des Serbes
F-06400 Canne, France

Baumgartner-Nielsen Jane
Fredensgårdsvej 4
DK-8270 Højbjerg

Bech-Thomsen Niels
Linnésgade 16A, 2
DK-1361 København

Beck Hanse-Iver
Perlegade 16
DK-6400 Sønderborg

Bendsöe Niels
Vardavägen 249 F
SE-224 71 Lund, Sverige

Benfeldt Eva Merete
Marskensgade 2,5.TH
DK-2100 København Ø

Bergman Bente
Åbrinken 74
DK-2830 Virum

Bindslev-Jensen Carsten
Bispeengen 70, Anderup
DK-5270 Odense N

Bjerring Peter
Stationsgade 4
DK-8240 Risskov

Blegvad Jensen Axel
Fasanvej 16 Assentoft
DK-8900 Randers

Blichmann Christa W.
Svanevænget 13A
DK-2100 København Ø

Boje Rasmussen Hanne H
Langelinie 157
DK-5230 Odense M

Braae Olesen Anne Karin
Lille Todbjerg 9A Todbjerg
DK-8530 Hjortshøj

BrandrupFlemming
Vestergade 30
DK-5600 Faaborg

Brandt Traulsen Jette
Torvet 21
DK-4600 Køge

Braun Hansen Helle
Skodborgsvej 205 A
DK-2850 Naerum

Bro-Jørgensen Anne Vibeke
Skodsborgvej 179
DK-2850 Nærum

Broby Johansen Urs
Søllerrød Park BL.9 Lejl 2
DK-2840 Holte

Brocks Kim Mathias
Nørremøllevej 58
DK-8800 Viborg

Brodersen Ingelise
Smedievej 23
DK-3400 Hillerød

Broesby-Olsen Sigurd
Sdr. Boulevard 162, 3
DK-5000 Odense

Bryld Lars Erik
Egebjerg 24 Himmelev
DK-4000 Roskilde

Bundgaard Lise
Kollemosevej 24B
DK-2840 Holte

Buus Sanne K
Tjalfesvej 22
DK-8230 Åbyhøj

Bygum Anette
Fjordvej 115
DK-6000 Kolding

Bygum Knudsen Bodil
Tibberup Allé 11 Hareskov
DK-3500 Værløse

Bøgvad Nielsen Eivind
Vestervænget 13 Hjerting
DK-6710 Esbjerg V

Carlsen Karen Marie
Fasanvænget 286
DK-2980 Kokkedal

Castellani Teresa
Stengårds Allé 31C
DK-2800 Lyngby

Christensen Ole
Villavägen 21
SE-216 11 Limhamn, Sverige

Christophers Enno
Hautklinik Schittenhelmstr 7
D-24105 Kiel, Germany

Christophersen Jette
Ved Højmosen 32
DK-2970 Hørsholm

Clemmensen Ole
Langelinie 78
DK-5230 Odense M

Cramers Marie Kristine
Hårbyvej 58 Vindskovg., Stjær
DK-8660 Skanderborg

da Cunha Bang Flemming
Mothsvej 66
DK-2840 Holte

Dabelsteen Erik
Københavns Tandlægehøjskole, Nørre Alle 20
DK-2200 Köpenhamn

Dahl Jens Christian
Charles Hansens vej 5
DK-2791 Dragør

Danielsen Anne Grete
Hovmarksvej 85
DK-2920 Charlottenlund

Danielsen Lis
Skjoldagervej 22
DK-2820 Gentofte

De Fine Olivarius Frederik
Vejlemosevej 42
DK-2840 Holte

Deleuran Mette
Åbyvej 47
DK-8230 Åbyhøj

Due Eva
Parcelvej 54
DK-2840 Holte

Duus Johansen Jeanne
Løvsangsvej 7, st
DK-2900 Hellerup

Dybdahl Helle
Kasted Byvej 6
DK-8200 Århus N

Egekvist Henrik
Bjerget 5
DK-8382 Hinnerup

Ekkert Knudsen Hans
Godthobsvej 113, St+h
DK-2000 Frederiksberg

Elholm Kieffer Marianne
Frederiksdalsvej 171B
DK-2830 Virum

Eriksen Knud
Svanevænget 2 3tv
DK-2100 København Ø

Esmann Jørgen
Ryvangs Allé, 54, at
DK-2900 Hellerup

Fischer Annelise
Drachmannsvej 17
DK-2930 Klampenborg

Flindt-Hansen Henrik
Jægersborgs Allé 35
DK-2920 Charlottenlund

Fløistrup Vissing Susanne
Hyrebakken 4
DK-3460 Birkerød

Foged Erik Klemens
Nørlundvej 15
DK-7500 Holstebro

Fogh Hanne
Ådalsvej 19A
DK-2720 Vanløse

Fogh Karsten
Søtoften 36
DK-8250 Egå

Frankild Søren
Æblehaven 6
DK-8660 Skanderborg

Fregert Sigfrid
Mellanvångsvägen 5
SE-223 55 Lund, Sverige

From Ellis
Irisvej 18
DK-8260 Viby

Funding Anne
Toftegaard Klokkerbakken 47
DK-8210 Aarhus V

Gade Margrethe
Ordrupvej 30F
DK-2920 Charlottenlund

Gammeltoft Michala
Havnegade 21,5
DK-1058 København K

Garcia Ortiz Patricia E.
Kronprinsensvej 43
DK-2000 Frederiksberg

Gilg Ingrid
Virum Stationsvej 104
DK-2830 Virum

Gjede Uffe
Simons Bakke 66
DK-7700 Thisted

Gniadecka Monica
Christiansvej 19
DK-2920 Charlottenlund

Gniadecki Robert
Christiansvej 19
DK-2920 Charlottenlund

Gowertz Rasmussen Ole
Magnoliavej 15
DK-8260 Viby J

Graudal Bodil Charlotte
Batzkes Bakke 11
DK-3400 Hillerød

Grunnet Eva
Ejgårds Tværvej 14, 4. tv
DK-2920 Charlottenlund

Grønhøj Larsen Christian
Rislundvej 7
DK-8240 Risskov

Grønhøj Larsen Frederik
Mikkelborg Allé 72
DK-2970 Hørsholm

Hædersdal Merete
Sundsvænget 32
DK-2900 Hellerup

Hagdrup Hans Kenneth
Skt. Anne Plads 2, 3.
DK-5000 Odense C

Halkier-Sørensen Lars
Værkemestergade 25,16., lejl 1
DK-8000 Århus

Halkjaer Liselotte
Brydensholt Skovvej 34
DK-2820 Gentofte

Hallinger Lise
Kokildehøjen 24
DK-8800 Viborg

Hammershøy Ole
Hans Baghs Vej 49DK-9990
Skagen

Hansen Ulla
Viggo Barfoeds Allé 2
DK-2750 Ballerup

Hansted Birgitte
Gyvelvej 3
DK-2942 Skodsborg

Hattel Thais
Søndertoft 1, 1.tv
DK-9000 Aalborg

Hauss Martin
Gravene 8
DK-6100 Haderslev

Hedelund Lene
Skådehøjen 48
DK-8270 Höjbjerg

Heidenheim Michael
Gentoftegade 45, 3
DK-2820 Gentofte

Held Elisabeth
Ordrupdalvej 13
DK-2920 Charlottenlund

Hendel Jørn
Stumpedyssevej 30Kettinge
DK-2970 Hørsholm

Hendel Lene
Stumpedyssevej 30Kettinge
DK-2970 Hørsholm

Henningsen Sten Juel
Dronningens Vaenge 5, 2tv
DK-2800 Kgs. Lyngby

Henriksen Lars
Sanatorievej 14C
DK-8680 Ry

Hentzer Bent
Clarasvej 10
DK-8700 Horsens

Heydenreich Gerhard
Solvang 36
DK-6100 Haderslev

Hjorther Anne Birgitte
C.F. Richs Vej 20
DK-2000 Frederiksberg

Hjortshøj Anders
Skovvej 29 Houstrup
DK-6830 Nørre-Nebel

Hohwy Thomas
Alimdingen 13
DK-8210 Århus V

Holm Elisabeth
Joensuuvej 8
DK-4000 Roskilde

Hou-Jensen Klaus
Skodsborg Strandvej 218
DK-2942 Skodsborg

Hundevadt Andersen Peter
Jacob Adelborgsalle 34
DK-8240 Risskov

Høyer Henrik
Boldhusgade 2, 2
DK-1062 Köpenhamn

Iversen Lars
Kirsebærhaven 7
DK-8660 Skanderborg

Iversen Line Vinderslev
Hostrups Have 17, 4 th.
DK-1954 Fredriksberg C

Iversen Normann
HudDoktorn i Örebro
Slottsgatan 8
SE-703 61 Örebro, Sverige

Jacobsen Finn Kjær
Egebjergvej 14
DK-8220 Brabrand

Jansen Elin Riedel
Box 138
SE-260 43 Arild, Sverige

Jemec Gregor Borut Ernst
Prinsesse Alexandrines Allé 18.3
DK-2920 Charlottenlund

Jensen Poul Erik
Kordilgade 36, 2tv
DK-4400 Kalundborg

Juldorf Finn
Svejbæk Søvej 4
DK-8600 Silkeborg

Justesen Ole
Solbyen 51
DK-9000 Aalborg

Jøhnke Hanne
Niels Juels alle 128
DK-5250 Odense SV

Jørgensen Jørgen
Skovvangen 3
DK-2920 Charlottenlund

Jørgensen Hans
Lindeengen 153
DK-2740 Skovlunde

Jørgensen Hans Paulli
Lupinvej 10
DK-2970 Hørsholm

Jörgensen Hans-Petter V
Storgatan 15, 4.etg.
NO-1614 Fredrikstad, Norge

Kaaber Knud
Spinkebjerg 58
GjellerupDK-7400 Herning

Kalsbøll Mogens
Rønne Alle 12,2
DK-2800 Kgs. Lyngby

Kaltoft Ryborg Ane
Skoleparken 130
DK-8330 Beder

Kamp Peter
Tornbyvej 10
DK-4600 Køge

Kamp Sören
Kristiansminde 59
DK-2920 Charlottenlund

Karlsmark Tonny
Ingersvej 22
DK-2920 Charlottenlund

Kiellberg Larsen Gitte
Valbyvej 20A, st. th.
DK 2630 Taastrup

Kiellberg Larsen Helle
Bogensegade 5, 3tv.
DK-2100 Köpenhamn

Kirchheiner Rasmussen Mads
Tage Hansens Gade 19, 1tv
DK-8000 Århus

Kirkegaard Erik
Syrenvænget 4
DK-3520 Farum

Kjeldstrup Kristensen Johannes
Vesterbyvej 8C
DK-2820 Gentofte

Klem Thomsen Henrik
Damgårdsvej 29
DK-2930 Klampenborg

Klemp Per
Helstedsvej 4C
DK-3480 Fredensborg

Knudsen Lone
Alexandervej 1
DK-2920 Charlottenlund

Knudsen Nissen Birge
Hovvejen 11
DK-7800 Skive

Kobayasi Takasi
Hvidkløvervej 1
DK-2400 København NV

Kollander Marianne
Wingesvej 10 Over Hornbæk
DK-8900 Randers

Kopp Heinrich
Skovlodden 28
DK-2840 Holte

Korshøj Signe
Solsikkevej 21
DK-8240 Risskov

Kragballe Knud
Klokkerfaldet 42
DK-8210 Århus V

Kristensen Berit
Højlandsvej 25
DK-4400 Kalundborg

Kristensen Mette Espe
Vestergade 73
DK-6270 Tønder

Kristensen Ove
Højlandsvej 25
DK-4400 Kalundborg

Kromann Niels
Ellekildehavevej 16
DK-3140 Ålsgårde

Kroon Susanne
Sankt Nikolaj vej 13, 5 th
DK-1953 Frederiksberg

Kubicka Wioletta
Ejegodvej 33, 2 tv.
DK-4800 Nykøbing F.

La Cour Andersen Sven
Langs Hegnet 3
DK-2800 Lyngby

Lamberg Anna Lei
Solsikkevej 23
DK-8240 Risskov

Lange Kamma
Østerbrogade 53, 3
DK-2100 Köpenhamn

Lange Skovgaard Gunhild R.
Frederiksborgvej 14
DK-3200 Helsinge

Larsen John Carl
Grantoftevej 18
DK-3500 Værløse

Larsen Tina Holst
Vesterbrogade 39, 3th.
DK-1620 Köpenhamn

Laurberg Grete
Klostermarken 39
DK-9000 Aalborg

Lauritzen Thomas Edgar
Pile Alle 17A, 2th
DK-2000 Frederiksberg

Lei Ulrikke
Örbaekgaards Alle 405
DK-2970 Hörsholm

Lerbæk Sørensen Anne
Mølle Alle 21, 4.th.
DK-2500 Valby

Lindskov Rune
Stockholmsvej 41B
DK-3060 Espergærde

Lings Kristina
Kantorparken 10, st. th
DK-8240 Risskov

Lomholt Hans
Jacob Adelborgs Allé 33
DK-8240 Risskov

Lorentzen Henrik Frank
Chr. Danningsvej 77 Strib
DK-5500 Middelfart

Lybaek Dorte Møller
Fåborggade 9, 2 th
DK-8000 Århus C

Lyngsøe Svejgaard Else
Skovvang 67
DK-3450 Allerød

Løkke Jensen Birgitte
Frøhaven 5
DK-2630 Taastrup

Løvgreen Nielsen Preben
Frederiksborgvej 70
DK-4000 Roskilde

Madsen Karin Søgaard
Skovgaardsgade 23
DK-2100 Köpenhamn

Maier Christin
Rågevaenget 18
DK-8270 Höjbjerg

Menné Torkil
Dronning Olgas Vej 37
DK-2000 Frederiksberg

Mikkelsen Flemming
Les Jardins de Farnese-E2 470,
Route de Cagnes
F-06140 Vence, France

Mikkelsen Henrik Ingemann
Ekenæsvej 34
DK-2850 Nærum

Mrowietz Ulrich
Hautklinik der Univ. Kiel
Schittenhelmstr.7
D-24105 Kiel

Munkvad Jan Mikael
Bregnegårds vej 14
DK-2920 Charlottenlund

Munkvad Steffen
Munkedammen 7B Allerslev
DK-4320 Lejre

Mølenberg David
Hunderupvaenget 6
DK-5230 Odense M

Möller Halvor
Ledungsgt 21
SE-217 74 Malmö, Sverige

Mørck Thomsen Inger Birthe
Dyrehavevej 34
DK-2930 Klampenborg

Mørtz Charlotte Gotthard
Kærsagerhaven 20
DK-5260 Odense

Nielsen Mads Frederik R.
Bylaugsvænget 2
DK-2791 Dragør

Nielsen Torben
Mejdal Søvej 11A
DK-7500 Holstebro

Nielsen Niels Henrik
Rude Vang 59
DK-2840 Holte

Nielsen Regitze
Hostrups Have 20, 6
DK-1954 Frederiksberg

Nielsen Ruth
Hostrups have 42, 4tv
DK-1954 Frederiksberg

Niordson-Grysgaard
Ann-Marie
Folehaveparken 16
DK-2970 Hørsholm

Norman Dam Tomas
Dronning Sofies Vej 34
DK-4000 Roskilde

Nyman Peter
Finnedalsvej 3
DK-2770 Kastrup

Obitz Erik Rene
Strabdvejen 278, Skotterup
DK-3070 Snekkersten

Odd Löland Einar
Brønderslevvej 28
DK-9900 Fredrikshavn

Olsen Wulf Hans Chr.
Gammel Strandvej 199C
DK-3060 Espergærde

Osmundsen Poul Erik
Nordtoftevej 2, 1
DK-3520 Farum

Otkjær Nielsen Aksel
Solbakken 6, Gjellerup
DK-7400 Herning

Ottevanger Vibeke
Langagerbej 9B
DK-2950 Vedbæk

Overgaard Olsen Lene
Ryvej 19
DK-2830 Virum

Oxholm Anne Mette
David Balfours gade 4, 5
DK-1402 Köpehamn

Paulsen Evy
Sdr Boulevard 38A, st. 4
DK-5000 Odense C

Peters Kurt Friedrich
Søndre Allé 30
DK-3700 Rønne

Pind Rasmussen Lars
Buen 3, 1, Postboks 434
DK-6000 Kolding

Pock-Steen Bodil
Skovlybakken 4
DK-2840 Holte

Poulsen Anne-Grethe
Stestrupvej 109, Stestrup
DK-4360 Krk-Eskilstrup

Poulsen Jens
Hellehuse 37
DK-4174 Jystrup Midtsj

Poulsen Johan Milling Holk
Prins Knuds Vej 38
DK-8240 Risskov

Qvitzau Susanne
Kofod Anchers Vej 26
DK-5230 Odense

Reincke Jørgensen Gerda
Ekenæsvej 34
DK-2850 Nærum

Reymann Flemming
Parkovsvej 30B
DK-2820 Gentofte

Reymann Ravnborg Lisbeth
Furesø Parkvej 27
DK-2830 Virum

Ring Johannes
Derm. Klinik der Tech Univ
Biedersteinerstr. 29
DE-80802 München, Germany

Risum Gunver
Furesøvej 5
DK-2830 Virum

Roesdahl Kresten
Betty Nansens Allé 37, 3 tv
DK-2000 Fredriksberg

Rorsman Hans
Pålsjövägen 26
SE-223 63 Lund, Sverige

Rosman Niels
Bukkardalen 5, Gadevang
DK-3400 Hillerød

Rossen Kristian
Nymøllevej 23
DK-2800 Lyngby

Rothenborg Hans Walter
Norgesmindevej 16
DK-2900 Hellerup

Rønnevig Jørgen Rikard
Lersolveien 22
NO-0875 Oslo, Norge

Sanby-Møller Jane
Jacob erlandsens Gade 1, 3th
DK-2100 København Ø

Sand Carsten
Rymarksvej 66
DK-2900 Hellerup

Sander-Wiecker Tine
Storegade 19B
Postboks 47
DK-6200 Aabenraa

Schiersing Thomsen Jens
Nordlundvej 79
DK-7330 Brande

Schou Marie
Notvägen 9
SE-711 00 Lindesberg, Sverige
Schultz Larsen Finn
Dronningensgade 72
DK-7000 Fredericia

Schønning Leif
Piletoften 3
DK-2630 Taastrup

Secher Lena Vibeke
Gångehusvej 204
DK-2950 Vedbæk

Seier Kirsten
Jomfrubakken 5
DK-3500 Værløse

Serup Jørgen
Esperance Allé 6B
DK-2920 Charlottenlund

Sindrup Jens Hein
Hovmarksvej 17
DK-2920 Charlottenlund

Sjølin Knud-Erik
Fortunfortvej 4B
DK-2800 Lyngby

Skov Lone
Frydenlund Park 30
DK-2950 Vedbæk

Skoven Inger Grete
Svenstrupvænget 5F
DK-5260 Odense S

Skødt Vera
Classensgade 57, 3tv
DK-2100 Köpenhamn

Skøt Cvetkovski Rikke
Holmbladsgade 44, 3.th
DK-2300 Köpenhamn

Snitker Gerda Florian
Skovlybakken 25
DK-2840 Holte

Sommer Hansen Erik
Ildervej 36
DK-8270 Højbjerg

Sommerlund Mette
Jørgen Brønlundsvej 14
DK-8200 Århus N

Spaun Eva
Hjortholmvej 41
DK-9541 Suldrup

Staberg Bent
Geelsvej 23
DK-2840 Holte

Stahl Dorrit
Gammel Hovedgade 6 B
DK-2970 Hørsholm

Stahl Skov Per
Otto Mønsteds Gade 1,3
DK-1571 Köpenhamn

Stangerup Maja Pouline
Slettebjerget 83
DK-3400 Hillerød

Stausbøl-Grøn Birgitte
Elsdyrvej 35
DK-8270 Højbjerg

Steiniche Torben
P.S Krøyers vej 27
DK-8270 Højbjerg

Stender Ida-Marie
Jægersborg Allé 57
DK-2920 Charlottenlund

Stenderup Jørgen
Hjortholm Allé 17A
DK-2400 København NV

Storrs Frances
Univ Health, 3181 S.W. Jac
97201 Portland, OR, USA

Strangaard Mette
Larsblørnstræde 3
DK-1454 Köpenhamn

Strauss Gitte Irene
Hjemmevej 43
DK-2870 Dyssegård

Svensson Åke
Norregatan 17
SE-289 00 Knislinge, Sverige

Søderberg Ulla
Teglbakken 17
DK-8270 Højbjerg

Søgaard Helmer
P. Heises vej 4
DK-8000 Århus C

Søltoft Peter
Haldor Laxness Vej 5
DK-9220 Aalborg

Sölvsten Henrik
Haraldsgade 15
DK-8260 Viby J

Sørensen Dennis
Kongens gade 30 A St
DK-4800 Nyköping

Tegner Eva
Markaskälsvägen 8
SE-226 47 Lund, Sverige

Ternowitz Thomas
Nøkkeveien 18
NO-4314 Sandnes, Norge

Thestrup-Pedersen Kristian
Hudklinikken, Nygade 4, 1
DK-4800 Nykøbing

Thieden Elisabeth
Johs. V. Jensens Allé 24
DK-2000 Fredriksberg

Thomsen Kristian
Borgm. Schneiders vej 76
DK-2840 Holte

Thormann Henrik
Kløvervaenget 12 C, lejl. 2
DK-5000 Odense C

Thormann Jens
Solvej 41
DK-7120 Vejleø

Thulin Henning
Skyttevanget 17
DK-6710 Esbjerg

Torzynska Magdalena Grazyna
Skorpionens Kvarter 110
DK6710 Esbjerg V.

Ullman Susanne
Halsskovgade 2,5 Lejl. 504
DK-2100 København Ø

Urup Jette M.
Godthåbsvej 4
DK-8600 Silkeborg

Urup Keld
Godthåbsvej 4
DK-8600 Silkeborg

Wadskov Svend
Chr. Winthers vej 18
DK-4700 Næstved

Waersted
Atle Højbjerggårdsvej 22
DK-2840 Holte

Walsøe Ida Sylvia
Mars Allé 98
DK-2860 Søborg

Walther Kassis Vibeke
Jacob Erlandersens Gade 11 2tv.
DK-2100 København Ø

Wanscher Birgitte
c/o Kobberbøl-Jensen
Kamstrupvej 105B
DK-2610 Rødovre

Wedfeldt Rikke
Brordrup Bygade 3
DK-4621 Gadstrup

Veien Niels Kren
M.A. Schultz vej 17
DK-9000 Aalborg

Weismann Kaare
Gøngehusvej 204
DK-2950 Vedbæk

Wendelboe Peter
Østergade 20,I
DK-8500 Grenaa

Vesterager Lene
Kvædevej 99
DK-2830 Virum

Vestergaard Christian
Ølstedvej 3
DK-8382 Hinnerup

Vestergaard Louise
Højstrupvej 22
DK-7120 Vejle Ø

Vestergaard Tine
Hunderupvej 35, 1.
DK-5000 Odense

Wildfang Inger Louise
Marselisvej 21
DK-8000 Århus C

Villadsen Louise Slivsgaard
Esthersvej 43, 3th
DK-2900 Hellerup

Windeløv Ibsen Hans H
Clausens Allé 45
DK-5250 Odense SV

Winther Karen Vanessa
Rungstedvej 74, 3 og 4.tv
DK-2960 Rungsted Kyst

Witmeur Olaf
Frugtparken 21
DK-2820 Gentofte

Wolff-Snedorff Annette
Nordre Strandvej 186
DK-3140 Ålsgårde

Worm Anne Marie
Torvegade 56 4 tv
DK-1400 København K

Voss Jeppsen Lissi
Hanstedvej 53
DK-8700 Horsens

Zachariae Hugh
Ildervej 40
DK-8270 Højbjerg

Zachariae Claus Otto
Store Kongensgade 71, 2.
DK-1264 København K

Ølholm Larsen Poul
Jacob Adelsborgs Alle 30
DK-8240 Risskov

Østerballe Morten
Fyrrehøjen 12
DK-8800 Viborg

Østerlind Anne Lucja G.W.
Københavnsvej 35
DK-3400 Hillerød

Finland

Aalto-Korte Kristiina
Ulvilantie 11 a D 6
FIN-00350 Helsinki

Aaltonen Tellervo
Särkäntie 11 as 2
FIN-80150 Joensuu

Aarnio Petra
Kyntelitie 1
FIN-28610 Pori

Aarnivuo Teuvo
Paimelantie 385
FIN-17110 Kalliola

Abdulkareem Hasan
Lammaslamminkatu 13C 46
FIN-01710 Vantaa

Ackermann Leena
Ampujanmäki 6B
FIN-02360 Espoo

Ahokallio Arja
Jollaksentie 62B 19
FIN-00850 Helsinki

Ahokas Terttuliisa
Munkinpolku 10
FIN-00330 Helsinki

Airola Kristiina
Iirislahdenranta 6 b 4
FIN-02230 Espoo

Ala-Houhala Meri
Postikatu 7A50
FIN-33100 Tampere

Alakoski Anna
Kossinkatu 35
FIN-33730 Tampere

Alanko Kristiina
Kapteeninkatu 16 A
FIN-00140 Helsinki

Alatalo Elina
Hauhianranta 18
FIN-54915 Saimaanharu

Aulamo Sari
Valto Käkelän katu 8 as 3
FIN-53130 Lappeenranta

Autio Pekka
Kivennavankuja 12 B
FIN-02130 Espoo

Bak Joanna
Kuorikatu 2
FIN-15230 Lahti

Bjørge Ellen Marie
Sildråpevegen 66 E
N-7048 Trondheim, Norge

Blomqvist Kirsti
Hopeasalmenranta 5 B
FIN-00570 Helsinki

Blomqvist Viktoria
Styrmansgatan 2-4 A
FIN-10900 Hangö

Brandt Heikki
Tilkankatu 12A14
FIN-00300 Helsinki

Cajanus Suvi
Sofianlehdonkatu 9 A 7
FIN-00610 Helsinki

Dammert Kai
Säveltäjänkatu 10 B 19
FIN-90150 OULU

Erjala Tuire
Katajasaarenkatu 2 as 14
FIN-53900 Lappeenranta

Erkko Pekka
Vemmelsäärentia 6C12
FIN-02130 Espoo

Eskelinen Aarno
FIN-56440 Pohjalankila

Eskelinen Talvikki
Taitoniekantie 9 G 10
FIN-40740 Jyväskylä

EstlanderTuula
Mäntypaadentie 13 as 5
FIN-00830 Helsinki

Fagerlund Varpu-Liisa
Kauhakuja 6
FIN-04460 Nummenkylä

Forsten Yrsa
Aurakatu 20 A 5
FIN-20100 Turku

Fräki Jorma
Kuntokuja 6 B 8
FIN-70200 Kuopio

Förster Johanna
Louhostie 5G
FIN-0273 Espoo

Förström Lars
Soukanlahdentie 3 B 1
FIN-02360 Espoo

Granlund Håkan
Hiihtäjäntie 6 B 31
FIN-00810 Helsinki

Grönholm Magnus
Isäntämiehentie 9
FIN-48400 Kotka

Grönroos Mari
Tehtaankatu 11B8
FIN-00140 Helsinki

Haahtela Anna
Pihapolku 13I
FIN-02420 Jorvas

Haapasaari Kirsi-Maria
OYKS, Ihotautiklinikka
FIN-90220 Oulu

Hagman Johanna
Via Citta di Castello 27/13
IT-00191 Roma, Italy

Hahtola Sonja
Miekka 2E76
FIN-02600 Espoo

Halme Katariina
Adolf Lindforsintie 2 B 5
FIN-00400 Helsinki

Hannuksela Matti
Paatsamakatu 4A3
FIN-00320 Helsinki

Hannuksela-Svahn Anna
Kaivokatu 19 A 6
FIN-48100 Kotka

Happonen Hannu-Pekka
Luoteisväylä 21 B
FIN-00200 Helsinki

Harvima Ilkka
Lönnrotinkatu 10 C 20
FIN-70500 Kuopio

Harvima Rauno
Onkikuja 1
FIN-70800 Kuopio

Hasan Taina
Sopulinkatu 16
FIN-33530 Tampere

Havu Väinö
Käenpiiankuja 2
FIN-20600 Turku

Heikkilä Elina
Kullervonkatu 25B
FIN-20520 Turku

Heikkilä Hannele
Lepolantie 77 A
FIN-00660 Helsinki

Heino Timo
Puutarhakatu 27 B 29
FIN-48100 Kotka

Helander Inkeri
Soliniuksenkuja 12as13
FIN-21200 Raisio

Helanen-Mikko Sirkka
Unioninkatu 45 A 18
FIN-00170 Helsinki

Hervonen Kaisa
Vallikatu 26 A
FIN-33240 Tampere

Hieta Niina
Kotimäenkatu 29b A 4
FIN-20540 Turku

Hietanen Anita
Bredantie 6 F 31
FIN-02700 Kauniainen

Hiltunen-Back Eija
Takametsäntie 17 B
FIN-00620 Helsinki

Hintsanen Kristiina
Töölönkatu 30 B 5
FIn-00260 Helsinki

Hjerppe Anna
Vanhatie 20
FIN-33960 Prikkala

Hjerppe Mika
Hämeenpuisto 25 D74
FIN-33210 Tampere

Hollmén Antero
Haapaniemenkatu 34 A 1
FIN-70110 Kuopio

Horsmanheimo Maija
Helenankuja 7 A
FIN-02700 Kauniainen

Huikko-Tarvainen Sari
Kotikuja 1
FIN-40800 Vaajakoski

Huilaja Laura
Sillankorvantie 14
FIN-90240 Oulu

Huolman Minna
Kauppatie 10 as 7
FIN-66300 Jurva

Huotari-Orava Riitta
Kaartotie 78 A 1
FIN-60100 Seinäjoki

Huovinen Saara
Nikkarmäenkuja 1
FIN-20380 Turku

Huttunen Maria
Käsälä 4 as 1
FIN-40250 Jyväskylä

Hyry Heli
Mannerheimintie 132 B 44
FIN-00270 Helsinki

Hyvärinen Maija
Vanhatie 30 A 11
FIN-15240 Lahti

Hyödynmaa Ritva
Lokinkuja 4 A 19
FIN-80100 Joensuu

Hägg Päivi
Jyräkuja 7
FIN-90420 Oulu

Hämäläinen Tiina
Setterinkuja 5
FIN-33580 Tampere

Härö Sakari
Kallionlaita 3
FIN-02610 Espoo

Höök-Nikanne Johanna
Lohjantie 54 B
FIN-03100 Nummela

Ilves Tiina
Pihlajatie 3 B 6
FIN-67200 Kokkola

Immonen Aila
Nisulankatu 11
FIN-94100 Kemi

Immonen Kati
Purantie 17 B 7
FIN-90240 Koulu

Ingervo Liisa
Kuhatie 12-18 A 2
FIN-02170 Espoo

Isoherranen Kirsi
Kärrmekuusenpolku 4G27
FIN-02880 Veikkola

Itkonen-Vatjus Raija
Tapaninaho
FIN-90900 Kiiminki

Jackson Päivi
Uuvenperäntie 15
FIN-90810 Kiviniemi

Jansén Christer
Yliopistonkatu 24 D 59
FIN-20100 Turku

Jeskanen Leila
Viherniemenkatu 1 A 7
FIN-00530 Helsinki

Joensuu Adrienn
Tiilisaarentie 5 A 3
FIN-70100 Kuopio

Juhela Jukka
Seponk. 12
FIN-29200 Harjavalta

Juvakoski Timo
Laurinlahdentie 15 D
FIN-02320 Espoo

Järveläinen Reijo
Koivukuja 2 A2
FIN-60100 Seinäjoki

Järvinen Marketta
Joonaksentie 4 C
FIN-00370 Helsinki

Järvinen Timo
Vikiöntie 34
FIN-90650 Oulu

Kainu Kati
Itäranta 1B
FIN-02110 Espoo

Kaitila Kari
Havukallionkatu 7 C 29
FIN-01360 Vantaa

Kalimo Kirsti
Honkatie 37
FIN-20540 Turku

Kallioinen Matti
Ketokatu 24
FIN-90140 Oulu

Kalliomäki Pekka
Hannulankatu 11 A 5
FIN-33580 Tampere

Kaminska Renata
A. Chydeniuksenkatu 7 B
FIN-67100 Kokkola

Kandelberg Pirjo
Hintanmutka 18
FIN-90650 Oulu

Kanervo Marja
Alankotie 54
FIN-04400 Järvenpää

Kaprio Leena
Luoteisväylä 32 A 4
FIN-00200 Helsinki

Karakorpi Hanne
Caloniuksenkatu 5 B 47
FIN-00100 HELSINKI

Karenko Leena
Miilutie 4
FIN-00670 Helsinki

Karesoja Leena
Riitankuja 1-3 H64
FIN-00840 Helsinki

Kariniemi Arja-Leena
Maisterintie 16 B
FIN-02700 Kauniainen

Karonen Tiina
Lamppukuja 9
FIN-02780 Espoo

Karppinen Ari
Höytämöntie 59
FIN-33880 Lempäälä

Karppinen Eija
Lapiosaarenkatu 3 F
FIN-33250 Tampere

Karppinen Liisa
Kanneltie 21
FIN-00420 Helsinki

Kartamaa Matti
Itälahdenkatu 13 A 35
FIN-02210 Helsinki

Karvonen Jaakko
Tiilimäki 32 A 2
FIN-00330 Helsinki

Karvonen Seija-Liisa
Tiilimäki 32 A 2
FIN-00330 Helsinki

Kauppi Sampsa
Laani 8 as 15
FIN-40100 Jyväskylä

Kauppinen Kirsti
Liljasaarentie 3 B 6
FIN-00340 Helsinki

Kause Laura
Munstenpellonkatu 4 A 4
FIN-20740 Turku

Kekki Outi-Maria
Nallekarhuntie 34
FIN-36100 Kangsala

Kero Matti
Aurinkokatu 5B39
FIN-13100 Hämeenlinna

Keski-Oja Jorma
Osuuskunnantie 45
FIN-00660 Helsinki

Kianto Ursula
Pietarinkatu 12 B 36
FIN-00140 Helsinki

Kiistala Raija
Tarkk'ampujankatu 4 A 31
FIN-00140 Helsinki

Kiistala Urpo
Tarkk'ampujankatu 4 A 31
FIN-00140 Helsinki

Kinnunen Erika
Hakakatu 10A6
FIN-90140 Oulu

Kinnunen Tuula
Karinkannantie 51
FIN-90800 Oulu

Kiraly Csaba
Julinintie 6 J
FIN-53200 Lappeenranta

Kivekäs Kristiina
Jaakonkuja 1 F 7
FIN-90230 Oulu

Kivinen Petri
Raviraitti 10
FIN-70840 Kuopio

Kivirikko Sirpa
Tekniikantie 11 C 10
FIN-02150 Espoo

Kivisaari Atte
Lumikatu 2 A
FIN-20780 Kaarina

Klimenko Taras
Nummenharjuntie 1-3C
FIN-04300 Tuusula

Knutar Ida
Karviaiskatu 2 C 16
FIN-20720 Turku

Koistinen Anna-Maija
Kaskilankuja 3 as 1
FIN-20540 Turku

Kokk Ave
Sopulinkatu 19 as 1
FIN-33530 Tampere

Korhonen Laura
Kaskitie 21 B 14
FIN-33540 Tampere

Koskenmies Sari
Munkkiluodonkuja 6B17
FIN-02160 Espoo

Koskivirta Outi
Graanintie 24 A 6
FIN-50190 Mikkeli

Kostiainen Minna
Nuotiokatu 3
FIN-15840 Lahti

Kotovirta Marja-Liisa
Mäensyrjä 10 A
FIN-02160 Espoo

Koulu Leena
Sirkkalankatu 17 C
FIN-20700 Turku

Kousa Merja
Yliopistonkatu 7 A 26
FIN-40100 Jyväskylä

Kuittinen Kaarina
Pitkänkalliontie 15 A 12
FIN-02170 Espoo

Kuivanen Tiina
Martintie 10A
FIN-02200 Espoo

Kuokkanen Kirsti
Papinniityntie 27as2
FIN-13210 Hämeenlinna

Kuoppamäki Leena
Länsipuisto 18 B 31
FIN-28100 Pori

Kähäri Veli-Matti
Karjakuja 48 C 12
FIN-20540 Turku

Lahti Arto
Hanhikaari 12 B
FIN-90240 Oulu

Lahtinen Marjo-Riitta
Pajulahdentie 18
FIN-70260 Kuopio

Laine Arja
Välitalontie 110
FIN-00660 Helsinki

Laine Maria
Nallekarhuntie 48
FIN-36100 Kangasala

Laipio Johanna
Peuramäentie 1J24
FIN-02750 Espoo

Lakkakorpi Anitta
Kaunissaari
Honkasaarententie 6
FIN-70100 Kuopio

Lammintausta Kaija
Meltoistentie
FIN-20900 Turku

Lange Terhikki
Liisankatu 15 A 10
FIN-00170 Helsinki

Langen Marja
Eskolantie 21
FIN-86300 Oulainen

Lappalainen Katriina
Samoilijantie 24 as 2
FIN-70200 Kuopio

Larmi Eva
Jaakonpolku 7 B
FIN-90230 Oulu

Lauerma Antti
Työterveyslaitos,
Topeliuksenkatu
FIN-00250 Helsinki

Lauharanta Jorma
Kallvikintie 35 B
FIN-00980 Helsinki

Laukkanen Arja
Ahkiotie 2 A 27
FIN-70200 Kuopio

Laukkanen Kleta
Friedrichstraße 12
D-06667 Weissenfels
Germany

Laulainen Matti
Eteläranta 65-69 A 4
FIN-96300 Rovaniemi

Laurikainen Leena
Ruskontie 118
FIN-21250 Masku

Lavikainen Reima
Punttelintie 7
FIN-48310 Kotka

Lehmuskallio Eero
Kuusikkotie 18 A
FIN-01380 Vantaa

Lehtinen Katriina
Päivärinteenkatu 12 as 9
FIN-15800 Lahti

Leivo Tomi
Melkonkatu 1 B 51
FIN-00210 Helsinki

Liippo Jussi
Rakuunatie 59 D 40
FIN-20720 Turku

Linnamaa Pia
Jokikaustantie 105
FIN-24800 Halikko

Linnavuori Kimmo
Steniuksentie 25 B 8
FIN-00320 Helsinki

Lintu Päivi
Rantapolku 1
FIN-20900 Turku

Liutu Mervi
TYKS Ihotautiklinikka
Kiinanmyllynkatu 4-8
FIN-20520 Turku

Lund Sirkka
Länsipuisto 25 B 32
FIN-28100 Pori

Lähteenmäki Marja-Terttu
Helsingin Lääkärikeskus
Mannerheimintie 12 B
FIN-00100 Helsinki

Lönnrot Maria
Yli-Huikkaantie 44A
FIN-33560 Tampere

Majamaa Heli
Jukolankatu 11 D 8
FIN-33560 Tampere

Majasuo Susanna
Puuvillakuja 11
FIN-20660 Littoinen

Malanin Ken
Tanhuantie 7 D
FIN-53920 Lappeenranta

Mandelin Johanna
Tehtaankatu 16 B 17
FIN-00140 Helsinki

Mashkilleyson Nikolai
Fredrikinkatu 28 B 24
FIN-00120 Helsinki

Mattila Jaana
Pallaksentie 13 A
FIN-65200 Vaasa

Mattila Leena
Väinöläntie 31
FIN-21100 Naantali

Mattila Rauni
Puolukkatie 11
FIN-70280 Kuopio

Mattila Timo
Kukkukuja 2 D
FIN-90810 Kiviniemi

Mattila Ulla
Hännikönk 57
FIN-20600 Turku

Milán Tiina
Wibeliuksentie 16
FIN-20880 Turku

Molander Gerd
Krokbyvägen 630
FIN-10590 Tenhola

Montonen Outi
Tahkokuja 7 A
FIN-02760 Espoo

Much Ari
Veitikantie 35-37 A 6
FIN-96100 Rovaniemi

Muroma Ali
Huvilakatu 25 A 3
FIN-00150 Helsinki

Mustakallio Kimmo K.
Välikatu 2 B 19
FIN-00170 Helsinki

Mustakari Anu
Hiekkakuja 2B51
FIN-33230 Tampere

Mustonen Marja-Terttu
Kyylintie 4
FIN-07230 Monninkylä

Mynttinen Synnöve
Tarjantie 77A7
FIN-15950 Lahti

Mäkelä Leeni
Bratislavankatu 1 F 72
FIN-20320 Turku

Mäki Airi
Parantolankatu 32 B 24
FIN-05800 Hyvinkää

Mälkönen Tarja
Soukan rntatie 12 B8
FIN-02360 Espoo

Mörtenhumer Minna
Matruusinkatu 11 B
FIN-67100 Kokkola

Neittaanmäki Heikki
Savonlinnan keskussairaala
Ihotautien poliklinikka
FIN-57170 Savonlinna

Niemi Kirsti-Maria
Gresan tie 9A8
FIN-02700 Kauniainen

Niemi Lubov
Pihlajatie 30
FIN-48130 Kotka

Niinimäki Aila
Matosuontie 57
FIN-90230 Oulu

Nissi Tuula
Vahdontie 489
FIN-21290 Rusko

Nuutinen Pauliina
Museokatu 13 A 7
FIN-00100 Helsinki

Ohela Kyllikki
Kimpisenkatu 12
FIN-53100 Lappeenranta

Oikarinen Hanna-Leena
Telkkätie 1 B4
FIN-87250 Kajaani

Oikarinen Aarne
Ihotautiklinikka Oyks
FIN-90200 Oulu

Oksman Risto
Rätiälänkatu 18 as 2
FIN-20810 Turku

Paavilainen Outi
Soitontie 9
FIN-21100 Naantali

Pajarre Reino
Olkitie 14
FIN-28360 Pori

Pajuaho Suvi
Pellavatie 8 as 2
FIN-71800 Siilinjärvi

Pajula Outi
Teiskontie 35 Y D 30
FIN-33520 Tampere

Palatsi Riitta
OYKS, Ihotautiklinikka
FIN-90220 Oulu

Palosuo Kati
Koivuviita 14 E 22
FIN-02130 Espoo

Panelius Jaana
Heikinniementie 6 as. 4
FIN-00250 Helsinki

Pasternack Rafael
Pirkankatu 1 A 9
FIN-33230 Tampere

Paukkonen Kari
Päivärinteentie 14
FIN-70940 Jännevirta

Pekanmäki Kalle
Uudenmaankatu 31 F 25
FIN-00120 Helsinki

Pekkola Anne
Ihaistentie 125
FIN-33400 Tampere

Peltomäki Maria
Kellonsoittajankatu 19 as 6
FIN-20500 Turku

Peltonen Juha
Ohrakatu 20
FIN-20740 Turku

Peltonen Leena
Pertunkatu 1 E 159
FIN-20720 Turku

Peltonen Sirkku
Ohrakatu 20
FIN-20740 Turku

Perko Ritva-Liisa
Ruukinp. 5
FIN-70910 Vuorela

Perttilä Leena
Ylä-Fallin kuja 4
FIN-00690 Helsinki

Pesonen Maria
Jyrkänne 3
FIN-01120 Västerskog

Petäys Tuula
Ruutisarventie 23D
FIN-03100 Nummela

Pitkänen Sari
Kehrääjäntie 18 A
FIN-02660 Espoo

Plosila Mikko
Runeberginkatu 29 B 60
FIN-00100 Helsinki

Poikonen Sanna
Sauvakatu 4-6 D 12
FIN-33580 Tampere

Porki Irmeli
Ilkankatu 7 as 12
FIN-53100 Lappeenranta

Pummi Kati
Männikönkuja 6
FIN-21420 Turku

Puolakka Tuula
Vuorenojantie 70
FIN-37420 Vesilahti-Valkkinen

Puolijoki Tuija
Pohjalaistenraitti 7
FIN-60200 Seinäjoki

Puska Pirkko
Jalavatie 4 B 5
FIN-255 00 Perniö

Raitala-Niemi Riitta
Tanhuankatu 6 A 1
FIN-20540 Turku

Raitio Anina
Jokipellontie 2 B 9
FIN-90650 Oulu

Raitio Hanna
Uudenmaankatu 36 D
FIN-00120 Helsinki

Ranki Annamari
Sibeliuksenkatu 11 B 28
FIN-00250 Helsinki

Rantanen Tapio
Rautatienkatu 6 A 21
FIN-15100 Lahti

Raudasoja Riikka
Lahdentauksentie 112
FIN-44250 Äänekoivisto

Rauma-Pinola Tanja
Auringonkierros 26
FIN-67400 Kokkola

Rechardt Leena
Luoteisväylä 33 G
FIN-00200 Helsinki

Rehn Laura
Koroistentie 6 E 18
FIN-00280 Helsinki

Reitamo Sakari
Pitkänsillanranta 5 B 32
FIN-00530 Helsinki

Remitz-Reitamo Anita
Pitkänsillanranta 5 B 32
FIN-00530 Helsinki

Reunala Timo
Liutuntie 15 B 9
FIN-36240 Kangsala 4

Riekki Riitta
Orsitie 1 A 1
FIN-90240 Oulu

Rinne Eliisa
Veräjänkorva 3
FIN-00650 Helsinki

Räsänen Liisa
Lintumaentie 37
FIN-86800 Pyhasalmi

Rönkä Juha
Uusitie 10
FIN-50600 Mikkeli

Saarelainen Ilkka
Pohjoisranta 6 A 1
FIN-00170 Helsinki

Saari Salli
Santamäentie 7
FIN-90440 Kempele

Saari Seppo
Viitakantie 10
FIN-20320 Turku

Saarialho-Kere Ulpu
Hiidenkiukaantie 4 as 17
FIN-00340 Helsinki

Saarinen Jari
Kalliokatu 31
FIN-70600 Kuopio

Saarinen Kari
Kunnantie 199
FIN-15860 Hollola

Saarni Heikki
Kotimäenkatu 16
FIN-20540 Turku

Saksela Olli
Morbacka
FIN-02430 Masala

Salava Alexander
Kaakkurikuja 3
FIN-00200 Helsinki

Salmi Teea
Puu-Tammelanraitti 10 C6
FIN-33500 Tampere

Salminen Mirja-Liisa
Auvaisberg
FIN-20760 Piispanristi

Salo Heikki
Lapin KS, Ihot. pkl
FIN-96101 Rovaniemi

Sandell-Laaksonen Vappu
Palotie 27
FIN-02760 Espoo

Savolainen Outi
Huvilakatu 10
FIN-20720 Turku

Savolainen Leena
Salminkatu 8
FIN-80200 Joensuu

SazonovaNatalia
Arentitie 8 E 28
FIN-00410 Helsinki

Schreck-Purola Ilona
Hongisto
FIN-08500 Lohja

Siberg Lea
Kristianinkatu 5 A 3
FIN-00170 Helsinki

Sihvonen Tuula
Kalliokuja 6
FIN-40900 Säynätsalo

Sillantaka Irmeli
Lomatie 20
FIN-30600 Pälkäne

Sinikumpu Suvi-Päivikki
Vasaesplanaden 4 B 8
FIN-65100 Vaasa

SnellmanErna
Rautatienk. 6 A 21
FIN-15100 Lahti

Soinim Marja
Tiilimäki 5 C
FIN-00330 Helsinki

SomermaSimo
Villenkatu 4 as 1
FIN-18100 Heinola

Somerola-Kunnari Kirsti
Vastarannankatu 35
FIN-33610 Tampere

Soronen Minna
Tatartie 16
FIN-90580 Oulu

Sten Marja
Malikkakuja 14
FIN-78870 Varkaus

Stenberg Anneli
Relanderinaukio 2 F 44
FIN-00570 Helsinki

Strand Ritva
Meritullinraitti 10 a 13
FIN-90100 Oulu

Stubb Sakari
Poijutie 22 A 1
FIN-00980 Helsinki

Suhonen Raimo
Kalevankatu 22
FIN-50100 Mikkeli

Suomela Sari
Paneliantie 29 B
FIN-00940 Helsinki

Suramo Marja-Liisa
Ylisrinne 1 as 29
FIN-02210 Espoo

Susitaival Päivikki
Mielinkatu 16A PL 93
FIN-80200 Joensuu

Suvinen Sonja
Kettutarhantie 15 D 4
FIN-33960 Pirkkala

Sysilampi Marja-Liisa
Keijukaistenpolku 6 A 17
FIN-00820 Helsinki

Särkkä Sylvi
Kasabergsvägen 12 D 14
FIN-02700 Grankulla

Söderqvist Sirkku
Koskelantie 25 B 18
FIN-00610 Helsinki

Taipale Anja
Iltapäiväntie 12 C 10
FIN-02210 Espoo

Talve Lauri
Kontionk. 3-5 A
FIN-20760 Piispanristi

Tammi Raija
Karhonsalmi
FIN-71130 Kortejoki

Tarkaa Rita
Muotialantie 71 C16
FIN-33800 Tampere

Tarvainen Kyllikki
Kovelipolku 12 B
FIN-00430 Helsinki

Tasanen-Määttä Kaisa
Oulun yliopisto
Ihotautien osasto
FIN-90220 Oulu

Taskila Kati
Hanneksenrinne 5N C 36
FIN-60220 Seinäjoki

Teho Arja
Kadetintie 20A5
FIN-00300 Helsinki

Teiskonlahti Senja
Lana 6
FIN-40520 Jyväskylä

Tilus Johanna
Myllytie 28 as 1
FIN-13500 Hämeenlinna

Timonen Kaisa
Hämeentie 30 E 56
FIN-00530 Helsinki

Tiri Hannu
Erkkolantie 3 A 5
FIN-90230 Oulu

Tuomi Marja-Leena
Laalahdenkatu 6 K
FIN-33560 Tampere

Tuomiranta Mirja
Oikokatu 2-4 as 1
FIN-60100 Seinäjoki

Tuovinen Ulla
Vasamakatu 1 C 27
FIN-04230 Kerava

Turjanmaa Kristiina
Palomäentie 7 B
FIN-33230 Tampere

Tuukkanen Inga
Kristianinkatu 5 A 7
FIN-00170 Helsinki

Työlahti Harri
Omenaraitti 12 A 18
FIN-02430 Masala

Uggeldahl Paul-Erik
Suvikatu 8
FIN-80200 Joensuu

Uibu Marge
Kivimäenkatu 8 E
FIN-33820 Tampere

Unnérus Viveca
Marieberg gård
FIN-10210 Ingå

Uurasmaa Tutta
Soinimäentie 65
FIN-21110 Naantali

Uusimäki Kaija
Tukkipojankatu 13
FIN-60200 Seinäjoki

Vaalamo Maarit
Vuorilinnakkeentie 1 A 5
FIN-00430 Helsinki

Vaalasti Annikki
Huhmarenkatu 13
FIN-33560 Tampere

Vainio Eeva
Jalustinkatu 7 E 42
FIN-20880 Turku

Vaismaa Ulla-Kaija
Palomäentie 32 A 3
FIN-33230 Tampere

Valkiala Seija
Kylynkatu 14
FIN-33730 Tampere

Valle Sirkka-Liisa
Mellstenintie 7A
FIN-02170 Espoo

Valmari-Kankkunen Saara
Museokatu 17 A 4
FIN-00100 Helsinki

Varjonen Elina
Munkinpolku 18 as 2
FIN-00330 Helsinki

Wastimo Satu
Taivaanpankontie 8a18
FIN-70200 Kuopio

Viikari Marjukka
Honkatie 28 as 2
FIN-20540 Turku

Viljanen Pertti
Miniäntie 11
FIN-28330 Pori

Vimpari-Kauppinen Leena
Kirkkokatu 8 A7
FIN-87100 Kajaani

Virolainen Anu
Ruskeisentie 4A7
FIN-70900 Toivala

Virolainen Susanna
Jollaksentie 20 B
FIN-00850 Helsinki

Virrankoski Terttu
Bredantie 10 A 2
FIN-02700 Kauniainen

Virtanen Erkki
Raatihuoneenkatu 20 A 30
FIN-68620 Pietarsaari 2

Virtanen Hannele
Norppatie 4A4
FIN-02260 Espoo

Visa Kirsti
Rantakatu 30
FIN-65100 Vaasa

von Willebrand Maria
Ahjotie 3
FIN-02900 Kirkkonummi

Wuokko Pentti
Lönnrotinkatu 7 B 14
FIN-00120 Helsinki

Vuorela Anna-Maija
Kulosaaren puistotie 38 as 3
FIN-00570 Helsinki

Vuorio Tuula
Seikonkatu 1 as. 22
FIN-20610 Turku

Vähävihu Katja
Kihtersuonkatu 5
FIN-13210 Hämeenlinna

Väkevä Liisa
Rakovalkeantie 15 A 3
FIN-00670 Helsinki

Välimäki Ritva
Pyhäniementie 295
FIN-39820 Kihniö

Väänänen Antti
Kauppaseurantie
FIN-90520 Oulu

Väätäinen Niilo
Ilvolankatu 45
FIN-74120 Iisalmi

Ylitalo Leea
Hirvikatu 18
FIN-33240 Tampere

Övermark Meri
Iirislahdenranta 26 D
FIN-02230 Espoo

Iceland

Baldursson Baldur
Alfabrekka 13
IS-200 Kopavogur

Bjarnason Bolli
Hudlaeknastodin ehf
IS-201 Kopavogur

Davidsson Steingrimur
Hudlaeknastodin
Smaratorg 1
IS-5201 Kopavogur

Gudgeirsson Jon
Laxalind 9
IS-201 Kópavogur

Hrönn Thorhallsdottir Helga
Selbraut 34
IS-170 Seltjamarnes

Ingvarsson Gisli
Jadar 4
IS-800 Arborg

Johannesdottir Hanna
Safamyri 75
IS-108 Reykjavik

Kópavogur Ragna
Thrastarhöfdi 18
IS-270 Mosfellsbaer

Mooney Ellen
Laekning, Lagmula 5
IS-105 Reykjavik

Olafsdottir Elin
Drapuhlid 18
IS-105 Reykjavik

Olafsson Jón Hjaltalin
Hrauntun v. Alftanesveg
IS-210 Gardaber

Pálsdóttir Rannveig
Noatun 31
IS-105 Reykjavik

Sigurgeirsson Bárdur
Háaberg 39
IS-220 Hafnafjödur

Steinsson Jon Trandur
Húdlæknastödin
Smáratorg 1
IS-200 Kópavogur

Sveinsson Birkir
Mithskógar 1
IS-603 Bessastadahreppur

Torsteinsdóttir Hugrún
Húdeild Landspítala
Háskólasjúkrahúss
IS-105 Reykjavik

Norway

Aandahl Dag
Bjarne Skaus Vei 88
N-1362 HOSLE

Aarebrot Steinulv
Spesialistsenteret på Straume
N-5353 Straume

Aarstein Kjetil
Ullernkammen 18,
Leilnr. H0301
N-0380 Oslo

Abrahamsen Jenny M. Foss
Medisinsk avdeling
Haukeland, Helse Bergen HF
Jonas Liesv 65
N-5021 Bergen

Al-Mustafa Neena
Solbergveien 12, leil 7 C
N-4615 Kristiansand S

Alves Vanja
Strandflåtveien 35
N-4018 Stavanger

Andersen Thor Henry
Borgundvegen 449
N-6015 Ålesund

Aulie Line Anette
Aspehaugveien 3 D
N-0376 Oslo

Austad Joar
Krillåsveien 10
N-1392 Vettre

Bachmann Ingeborg
Margrethe
Birkelundsbakken 68
N-5231 Paradis

Balieva Flora Nicolaeva
Cort Adelersgt 12
N-4010 Stavanger

Barlinn Christa
Guldbergsvei 18
N-0375 Oslo

Benestad Bjørg
Bjerkealleen 9
N-1363 Høvik

Bengtsson Helge
Moss hudlegekontor
Postboks 77
N-1501 Moss

Bjerke Jens Roar
Oslo hudklinikk
Hegdehaugsvn. 36 B
N-0352 Oslo

Bjørge Ellen Marie
Sildråpevegen 66 E
N-7048 Trondheim

jørnestad Anabella
Arosemena
Wernersholmsveien 18
N-5232 PARADIS

Bohmann Peter
Røhrts vei 70
N-1181 Oslo

Bondevik Bjørn Eriksen
Dr. Bondeviks hudklinikk
Munkerudtunet 12
N-1164 Oslo

Bonesrønning Jon Helge
Torshaugen 12
N-7020 Trondheim

Borup Mårten
Isdammen 11
N-5538 Haugesund

Braathen Lasse Roger
Dermatologische klinik
Inselspital
Ch-3010 Bern, Switzerland

Braun Rosemarie
Rektor Qvigstadsgt. 50
N-9009 Tromsø

Bremnes Katja Eskeland
Hansmarkveien 56
N-9013 Tromsø

Brodd Astrid Andree
Carl Kjelsens vei 32 B
N-0874 Oslo

Bull-Berg Jacob
Landøystranda 6
N-1394 Nesbru

Bø Kristine
Hudavdelingen
Rikshospitalet
N-0027 Oslo

Christensen Eidi
Merkurv. 11 A
N-7036 Trondheim

Colom Drude Høyersten
2 Rue Huysmans
F-75006 Paris, France

Dahle John Sverre
Dermatologisk poliklinikk
Sandesundvn. 23
N-1724 Sarpsborg

Dalaker Morten
Trondheim Hudlegesenter
Carl Johans gt. 3
N-7010 Trondheim

Dalgard Florence
Fredriksborgveien 17
N-0286 Oslo

Danielsen Helge Erik
Gulfjordungsveien 41
N-5700 Voss

Danielsen Kjersti
Heimdalsveien 8 B
N-9006 Tromsø

Dinparvar Darjosh
Klostergata 37 B
N-7030 Trondheim

Dobloug Gerd Cecilie
Thomas Heftyesgt 45 A
N-0267 Oslo

Dotterud Lars Kåre
Tvethes gate 1
N-2613 Lillehammer

Dufour Deirdre Nathalie
Brinkvegen 24
N-9012 Tromsø

Ek Lorens
Hagalundsvågen 30 D
SE-302 74 Halmstad, Sverige

Eklind Jonas Jan Birger
Hudavdelingen
Universitetssykehuset Nord-
Norge - Tromsø
N-9038 Tromsø

Elset Kjersti
Lyngvn. 24
N-3118 Tønsberg

Falk Edvard S.
Rektor Qvigstadsgt. 44
N-9009 Tromsø

Faye Ragnar Solberg
Grorudvn. 115
N-1053 Oslo

Fevang Sheila Ann Mills
Nymansveien 196
N-4015 Stavanger

Fiskerstrand Eli Janne
Kåre Kongsbrorsv. 9
N-7562 Hundhamaren

Fismen Silje
Anton Iversensveg 6
N-9009 Tromsø

Formoe Torill
Stigerveien 11
N-3237 Sandefjord

Frølich Karin Wold
Bønesberget 13
N-5152 Bønes

Funk Jürgen
Ringveien 32
N-1524 Moss

Fyrand Ole Lennart
Heggelivn. 32 C
N-0375 Oslo

Gasior-Chrzan Barbara
HudavdelingeN-UNN
Universitetet i Tromsø -
Det medisinske fakultet
Univ.sykehuset Nord-Norge
N-9038 Tromsø

Geisner Benedikte Larsen
Roald Amundsens vei 103
N-5067 Bergen

Gislerud Gunhild
Drammensveien 84, 3.etg.
N-0271 Oslo

Gjersvik Petter
Observatorie terrasse 7 C
N-0270 Oslo

Gjertsen Bjørn Tore
Svarthammeren 8
N-6900 Florø

Gjørud Magnar
N-3528 Hedalen

Granholt Astri
Florabakken 3f
N-1162 Oslo

Grimstad Øystein
Magnus den Godes gate 33 A
N-7030 Trondheim

Gujdi Judit
Hud poliklinikk
Kristiansund sykehus
N-6508 Kristiansund N

Guldbakke Kjetil Kristoffer
Skjerdal
Solbakkevn. 22 b
N-0678 Oslo

Guleng Guttorm Edvin
Micheletsvei 23 B
N-1366 Lysaker

Gundersen Thor J.
Grimelundshaugen 3
N-0374 Oslo

Haaland Bjørn Helge
Bondevägen 5 A
SE-227 64 Lund, Sverige

Haavardsholm Bård Wiktorin
Sofiesgt 23
N-0168 Oslo

Haavelsrud Odd Ingolf
N-6895 Feios

Hagen Ole Andreas
Billingstadåsen 3
N-1396 Billingstad

Halsos Arne Martin
Hammerfestg 2 A
N-0565 Oslo

Halvorsen Jon Anders
Ullevålsveien 97C
N-0359 Oslo

Halvorsen Trine Lilly
Rådyrvn 23
N-1413 Tärnåsen

Hansen Even
Fotveita 6
N-7012 Trondheim

Hanssen Helle Kathrine
Bjørkveien 14 C
N-7058Jakobsli

Hanssen Leif I.
Dermatologisk avdeling
Ålesund sjukehus
N-6026 Ålesund

Hanstad Inger
Ankervn. 90 C
N-0765 Oslo

Haug Sidsel
Camilla Collets vei 1
N-0258 Oslo

Haugstvedt Åse
Grorudvn. 115
N-1053 Oslo

Helgesen Anne Lise Ording
Ullernvn 12 C
N-0280 Oslo

Helland Svein
Boks 134
N-5852 Bergen

Hellgren Lars Gustav Inge
Bronsgjutaregt 13
SE-421 63 Vestra Frölunda,
Sverige

Helme Per Håkon
Dr. Helmes spesialistpraksis
Torget 2
N-1767 Halden

Helsing Per
Gullbakkvn. 11 B
N-1363 Høvik

Hestholm Freddy
Brattliveien 2
N-4020 Stavanger

Hilleren Per Karstein
Kolheim 66
N-4313 Sandnes

Hoff Kjell Arne Stene
Møllefaret 46 B
N-0750 Oslo

Hohlbrugger Herbert
Nedre Vågen 15
N-4085 Hundvåg

Holm Jan-Øivind
Lysaker Brygge 3
N-1366 Lysaker

Holsen Dag Sollesnes
Hudavdelingen Haukeland
Jonas Liesv 65
N-5021 Bergen

Holst Tormod
Hudlegekontoret i Tønsberg
Bulls gt. 2 A
N-3110 Tønsberg

Huldt-Nystrøm Theis
Hudpoliklinikken i Levanger
Sykehuset Levanger
Innherred Sykehus
N-7600 Levanger

Husebø Åsa Liljestrand
Vestre Fantoftåsen 13
N-5072 Bergen

Høviskeland Aase
Nils Bergsv. 9
N-1363 Høvik

Ingvarsson Gisli
LækningmLagmuli 5, 107, R.
Island

Jensen Ada
Wesselsgt 51
N-4008 Stavanger

Johansen Arne Gudmund
Bjørnefaret 24
N-1270 Oslo

Johnsen Elin Holthe
Slalåmvn 69
N-1350 Lommedalen

Johnsen James Ragnar
Havsteinlia 16
N-7021 Trondheim

Johnsen Paul Otto
Austrusbakken 7
N-4640 Søgne

Johnsson Margareta K.
Orionveien 16
N-7037 Trondheim

Kalgaard Ole Magne
Øverbergveien 10
N-1397 Nesøya

Kavli Gunnar
Ildervn. 18
N-2406 Elverum

Kjus Trine Kristin
Carl Wollebæksveg 17
N-2615 Lillehammer

Klemeyer Anne Blanca Adele
Gimleveien 21 D
N-1358 Jar

Knutsen Alesya
Veståsvn. 4
N-3142 Vestskogen

Koss-Harnes Dørte
S.H. Lundhs vei 7
N-0287 Oslo

Kramer Mette
Hvalstadåsen 46
N-1395 Hvalstad

Kramer Patrick Kent
Gml. Drammensvei 109 A
N-1363 Høvik

Kristiansen Frode
Holmenv 15
N-4816 Kolbjørnsvik

Kroon Susanne
Cecilie Tvedtsgt. 12, leil 33
N-4016 Stavanger

Kråkenes Anine G
Bergvegen 54
N-5152 Bønes

Kulke Reinhard Franz
Dr. Kulkeas spesialistpraksis
Skolegt. 7
N-3611 Kongsberg

Kummels Marianne
11015 N. Valley Drive
Fountain Hills, AZ 85268
USA

Laastad Olav
Porsgrunn hudlegekontor
- Hovengsenteret
Hovenggaten 35
N-3915 Porsgrunn

Ladstein Rita Grude
Kolstien 30
N-5097 Bergen

Langeland Berit
Ths. Heftyesgt.37
N-0264 Oslo

Langeland Jon
Carl Kjelsensv. 32 B
N-0874 Oslo

Langeland Tor
Dr. T. Langeland
St. Olavs plass 3
N-0165 Oslo

Larsen Maria Jentoft
Boks 161
N-9476 Borkenes

Leite Kari
Mokleiva 11
N-1450 Nesoddtangen

Li Xiaotong
Toftveien 27 B
N-9017 Tromsø

Lier Anders
Fauskerudvn. 26
N-2390 Moelv

Lilleeng Ludmila Zotova
Voksenkollveien 13 F
N-0790 Oslo

Lilleskog Eli Synnøve
Moldbakken 22
N-5042 Bergen

Livden John Karsten
Oppetveiten 11
N-5262 Arnatveit

Lofterød Inger Mathilde
Geitmyrv 68
N-0455 Oslo

Loven Anne Marie
Solkollen 19
N-1410 Kolbotn

Lund-Hanssen Kristin
Postboks 6511, Hatlane
N-6024 Ålesund

Lysebo Asta Meland
Sollien 21
N-5096 Bergen

Løken Per Andreas
Pettersandåsen 20
N-1614 Fredrikstad

Lützow-Holm Claus
Lybekkvn 10 F
N-0772 Oslo

Mantaka Panagiota
Nils Collett Vogtsvei 47 C
N-0766 Oslo

Marcusson Jan Anders
Haukelandsbakken 46/313
N-5009 Bergen

Martin-Odegard Brit
Bekkelivn. 16
N-0375 Oslo

Mc Fadden Noel C.
Morgedalsvn. 26
N-0378 Oslo

Midelfart Kjell Herman
Lokesvei 42
N-7037 Trondheim

Midtgard Irina Petrovna
Greisdalsveien 35
N-8028 Bodø

Moi Harald
Olafiaklinikken
Oslo kommunale legevakt
Grensen 5-7
N-0159 Oslo

Morken Tore
Bergen hudlegeklinikk
Valkendorfsgt. 9
N-5012 Bergen

Moseng Dagfinn
Hudavdelingen
Universitetssykehuset
Nord-Norge
N-9038 Tromsø

Moser Karin Hedwig
Schiøtz vei 5
N-7020 Trondheim

Muslibegovic Leila
Udbyesgt 5, leil 22
N-7030 Trondheim

Mørk Cato
Tennisveien 19
N-0777 Oslo

Mørk Gro Igland
Tennisveien 19
N-0777 Oslo

Mørk Nils-Jørgen
Jomfrubråtvn. 27d
N-1179 Oslo

Nielsen Morten Brekne
Åsesvei 183
N-1336 Sandvika

Nilsen Arvid Emil
Saudalskleivane 82
N-5136 Mjølkeråen

Nordahl John Sverre
Sjøgata 1
N-8006 Bodø

Nordal Eli Johanne
Akersborg Terrasse 17
N-0852 Oslo

Nyrud Morten
Vassbonnveien 11
N-1410 Kolbotn

Ohlsson Ylva Maria
Carl Kjelsesn vei 32 B
N-0874 Oslo

Olsen Anne Olaug
Skjoldveien 24
N-0881 Oslo

Olsen Pål
Medisinsk avdeling
Nordlandssykehuset Bodø
somatikk
N-8092 Bodø

Osnes Rannveig Storaune
Tartargt 23
N-5034 Bergen

Pukstad Brita Solveig
Hudavdelingen
St. Olavs Hospital
N-7006 Trondheim

Rajka Georg
Fredrik Stangsgate 44
N-0264 Oslo

Randjelovic Ivana
Fayegata 13
N-3011 Drammen

Raspotnig Margrethe
Vognstølen 21, 2 etg
N-5096 Bergen

Ree Kristian
Hudlege Kristian Ree A/S
Kallerudvn 7
N-2815 Gjøvik

Ree Sidsel Gisela
Lysaker hudlegekontor A/S
Arnstein Arnebergsvei 30
N-1366 Lysaker

Remaut Kinia
Østre Holmensvingen 20
N-0774 Oslo

Rosa-Carrillo Daniel de la
Jonas Reins gt 6
N-0360 Oslo

Roscher Ingrid Allgauer
Binneveien 12
N-0774 Oslo

Rustad Lisbeth
Fløenbakken 27
N-5009 Bergen

Rustenberg Berit I
Sveins Gt. 15
N-3257 LARVIK

Rutle Oddvar
Rosevegen 18
N-2312 Ottestad

Ryggen Kristin
Odd Sørlisveg 25
N-7059Jakobsli

Rødland Ole
Nyhaugåsen 13
N-5072 Bergen

Røen Svein Aksel
N-5457 Høylandsbygd

Rønnevig Jørgen R.
Lersolvn. 22
N-0876 Oslo

Rørdam Ole Martin
Fjordgata 46
N-7010 Trondheim

Sandberg Morten Andre
Oppsalstubben legekontor
Oppsalstubben 3
N-0685 Oslo

Sander Rita
General Fleichersgate 50 C
N-9405 Harstad

Sandvik Lene Frøyen
Øvre Kolstien 26
N-5097 Bergen

Saunes Marit
Prestekragevegen 9
N-7050 Trondheim

Savland Camilla Elisa
Nordheim
N-6817 Naustdal

Schopf Thomas Griesbeck
Ytre Laksvatn
N-9042 Laksvatn

Selvåg Jon Edgar
Benediktenwandstr. 34
D-81545 München
Germany

Sitek Jan Cezary
Vallergata 8 Oppg. 2
N-0454 Oslo

Sjøborg Odd Steinar
Trädgårdsgatan 10
SE-352 34 Växjø, Sverige

Skalle Per Øivind
Dr. Skalles spesialistpraksis
Prinsensgt. 39
N-7011 Trondheim

Slevolden Ellen Margrethe
Bestumåsen 1 G
N-0281 Oslo

Snekvik Ingrid
Ludvig Musts veg 18
N-7052 Trondheim

Solberg Silje Michelsen
Slettebakksveien 22 A
N-5093 Bergen

Soler Ana-Maria Astrid
Lachmannsv 14 C
N-0495 Oslo

Stang Henning Johan
Ribstonvn 6 A
N-0585 Oslo

Stangeland Katarina Maria Zak
Solheimveien 12
N-4015 Stavanger

Steinkjer Bjarte
Vidarsgate 11
N-4011 Stavanger

Stenersen Merete Ziel
Framveien 27
N-7020 Trondheim

Stenvold Svein Erik
Alfheimveien 9 C
N-9007 Tromsø

Stoll Richard Johannes
Kåre Vangens vei 14
N-8656 Mosjøen

Stray Per Andreas
Songdalsveien 252
N-4645 Nodeland

Strøm Sonja Unn
Rute 1039
N-2480 Koppang

Stærfelt Frode
Havblik spesialistsenter A/S
Kystveien 154
N-4842 Arendal

Søyland Elisabeth
Sognsvannsvn 27 A
N-0372 Oslo

Tambs Kari E. Stærnes
Bruksvn. 29
N-1367 Snarøya

Teigen Nina Birgitta
Ivar Aasensvei 9
N-9007 Tromsø

Telnes Ragnhild
Øystein Møylasvei 43 B
N-7037 Trondheim

Ternowitz Thomas
Nøkkvn. 18
N-4314 Sandnes

Thorvaldsen Johannes
Oscars gate 76 A
N-0256 Oslo

Thune Per Olav
President Harbitzgate 27 B
N-0259 Oslo

Thune Turid Jorunn
Nattlandsfjellet 160
N-5098 Bergen

Tigalonova Maya
Oslo hudklinikk
Hegdehaugsvn. 36 B
N-0352 Oslo

Todal Anders
Vangslivegen 62
N-7670 Inderøy

Tolaas Erlend
Slettevikvegen 24
N-5124 Morvik

Tran Hong Thi Diem
Edvard Munchs vei 15 E
N-1063 Oslo

Tveit Kåre Steinar
Hudavdelingen Haukeland
Helse Bergen HF
Jonas Liesv 65
N-5021 Bergen

Tørud Erik
Bertrand Narvesens vei 33
N-0661 Oslo

Vadla Jan Harald Erik
Hudpoliklinikken i Levanger
Sykehuset Levanger
Innherred Sykehus
N-7600 Levanger

Valnes Hans Petter
Gluppehavna 22
N-1614 Fredrikstad

Vatne Øystein
Gjesdal
N-6847 Vassenden

Vik Ingeborg Lyngstad
Furulund 1
N-3440 Røyken

Vindenes Hilde Kristin
Søråshøgda 142
N-5235 Rådal

Volden Gunnar
Parkvn. 19 B
N-1405 Langhus

Wereide Knut
Elisenbergvn. 35b
N-0265 Oslo

West Piera Niiles
Spesialistlegesenteret-Karasjok
Rådhusgt. 7
N-9730 Karasjok

Wollan Terje Kr.
Dr. Wollans spesialistpraksis
Jernbanealleen 30
N-3210 Sandefjord

Wærsted Nils Atle
Højbjerggårdsvej 22
DK-2840 Holte, Danmark

Sweden

Aase Karl
Blekholmsterassen 11
SE-111 64 Stockholm
Abrahamsson Gudrun
Överbyn 130
SE-834 00 Brunflo

Abusland Therese
Vallmovägen 16
SE-66341 Hammarö

Agdell Jan
Regementsgatan 50
SE-217 48 Malmö

Agrup Gun
Klöverv. 13
SE-227 38 Lund

Ahnlide Ingela
Neptuniv 32
SE-237 35 Bjärred

Al-Sabori Sam
Hjälmsäters väg 4A
SE-139 49 Haninge

Alsterholm Mikael
Styrgången 6, 1tr
SE-417 64 Göteborg

Anagrius Carin
Hans Järtas väg 12
SE-791 32 Falun
Anderson Christopher
Kromstigen 9
SE-587 29 Linköping

Andersson Anna-Carin
Stenbergsv 12
SE-752 41 Uppsala

Andersson Bertil
Börjesons väg 56
SE-161 55 Bromma

Andersson Karin
Hantverksgatan 12A
SE-302 42 Halmstad

Andersson Karin
Åsgränd 19
SE-783 30 Säter

Arenlind Lars
Liljebergsgatan 57
SE-506 39 Borås

Arnamo Anna-Maria
Pilfinksvägen 18
SE-183 51 Täby

Aronsson Annika
Hasselgången 3
SE-241 00 Eslöv

Aspegren Nils
Tyska Skolgränd 4-6
SE-111 31 Stockholm

Augustsson Agneta
Grimmereds Läkargrupp
Lergöksgatan 12
SE-421 50 Västra Frölunda

Aziz Omar
Lövdalsvägen 29
SE-141 73 Huddinge

Bamberg Claudia
Laxgatan 33
SE-593 40 Västervik

Barck Lindgren Lykke
Fridkullagatan 26D
SE-412 62 Göteborg

Bartosik Jacek
Skallgången 11
SE-226 52 Lund

Beebe Bruze K
Box 465
SE-351 06 Växjö

Beitner Harry
Bisittargatan 46
SE-129 44 Hägersten

Bendsöe Niels
Vardavägen 249 F
SE-224 71 Lund

Bengtsson Helge
Moss hudlegekontor
Jeløygt. 8, P.O.Box 77
NO-1501 Moss, Norge

Berg Peter
Norra vägen 31
SE-163 41 Spånga

Berg Jan
Logementsvägen 15
SE-281 35 Hässleholm

Berg Mats
Stackvägen 11
SE-756 47 Uppsala

Bergbrant Ing-Marie
Klarbärsv.21
SE-426 55 Västra Frölunda

Bergdahl Kjell
Fagerövägen 23 B
SE-791 53 Falun

Bergfelt Louise
Norra Vaktmansgatan 37
SE-426 68 Västra Frölunda

Berggren Gudrun
Ektorpsvägen 24
SE-131 47 Nacka

Berggård Karin
Flackarps Lilla väg 22
SE-245 61 Staffanstorp

Berglind Mari
Harvaregatan 9
SE-583 33 Linköping

Berglund-Werngren Lena
Eriksbergsg. 4, 2tr
SE-114 30 Stockholm

Bergman Anita
Strömgatan 27
SE-856 43 Sundsvall

Bergqvist-Karlsson Annika
Furudalsvägen 20 B
SE-752 60 Uppsala

Bergstedt Kristina
Solanderg. 44
SE-941 34 Piteå

Bergström Marianne
Arthur Engbergsv. 8
SE-852 40 Sundsvall

Berne Berit
Döbelnsgatan 28 G
SE-752 37 Uppsala

Bernedes Sköldmark Christina
Kastanjev. 28
SE-554 66 Jönköping

Berntsson Matilda
Citrusvägen 22
SE-426 54 Västra Frölunda

Bihi Mohamed
Söndrumsv.51
SE-302 39 Halmstad

Bjarke Torsten
Hallbäcksgatan 3
SE-252 34 Helsingborg

Bjellerup Mats
Pinnhättevägen 15
SE-246 57 Barsebäck

Björkner Bert
Regementsgatan 52 C
SE-217 48 Malmö

Björnberg Alf
Apgränd 10A
SE-271 42 Ystad

Björnelius Eva
Ivar Hallströms väg 30
SE-129 38 Hägersten

Björntorp Elisabeth
Austv. 11 B
SE-426 76 Västra Frölunda

Bleeker Johan
Linjevägen 11
SE-531 50 Lidköping

Bleeker Thor
Kållandsgatan 38
SE-531 50 Lidköping

Blom Inga
Väståstrand 1, 3tr
SE-702 32 Örebro

Bojs Gunnel
Näsbychaussen 14
SE-291 35 KRistianstad

Boman Anders
Yrkes-och Miljödermatologi
Centrum för Folkhälsa
SE-171 76 Stockholm

Borglund Erik
Ulvögatan 15
SE-162 23 Vällingby

Boström Christina
Furugatan 10
641 34 Katrineholm

Boström Åsa
Statarvägen 16
SE-752 45 Uppsala

Brehmer-Andersson Eva
Värtav.17, 2tr
SE-115 53 Stockholm

Broberg Ann
Kastellgatan 19 3tr
SE-413 07 Göteborg

Brodd Astrid
Bigatan 10
SE-431 39 Mölndal

Brolin Maria
Gustav III:s väg 52
SE-168 37 Bromma

Brundin Göran
Bockhornsvägen 1
SE-587 31 Linköping

Bruze Magnus
Lotsgatan 8
SE-216 42 Limhamn

Brännström Daniel
Ådalsvägen 21
SE-262 65 Ängelholm

Burian Elzabieta
Ryd Smedsgården 3
SE-541 91 Skövde

Byrenius-Mellström Birgitta
Björnögatan 5
SE-761 40 Norrtälje

Båmstedt Halina
Odeng. 69, 6tr
SE-113 22 Stockholm

Bäck Ove
Södra Vägen 15
SE-223 58 Lund

Cadova Vera
Näsby Allé 3, 1 tr
SE-183 55 Täby

Carlberg Hans
Hudkliniken Södersjukhuset
SE-118 83 Stockholm

Carstam Ragnar
Adelgatan 15
SE-223 50 Lund

Cederroth Berg Susanne
Karlaplan 10, 7tr
SE-115 20 Stockholm

Christensen Ole
Villavägen 21
SE-216 11 Limhamn

Christiansen Julie
Hudkliniken Lasarettet
SE-221 85 Lund

Coble Britt-Inger
Kopparstigen 3
SE-582 58 Linköping

Cook Catherine
Rådmansgatan 82
SE-113 60 Stockholm

Dahlberg Erik
Brogränd 23
SE-831 41 Östersund

Dahlbäck Karin
Östanväg 12
SE-217 74 Malmö

Dahlman Ghozlan Kristina
Korsfararvägen 114
SE-181 40 Lidingö

Davidsson Karin
Häggvägen 23
SE-587 31 Linköping

Dobrescu Justin
Skolvägen 27
SE-433 61 Sävedalen

Doghramechi Soraya
Tomtnäsv. 14
SE-806 27 Gävle

Domar Margareta
Slagrutevägen 17
SE-756 47 Uppsala

Dunér Kari
Roparebergsvägen 1A
SE-371 42 Karlskrona

Edegran Magnus
Centigatan 38
SE-507 43 Borås

Edeland-Odd Brita
Älvåkersgatan 23B
SE-653 49 Karlstad

Edgardh Karin
Ormängsg. 67D
SE-165 56 Vällingby

Edmar Birgitta
Strandplatsgt 8
SE-426 76 Västra Frölunda

Egelrud Torbjörn
Generalsg. 11
SE-903 36 Umeå

Ek Lorens
Skärsjödalsvägen 14
SE-285 37 Markaryd

Ekbäck Maria
Sturegatan 11 B
SE-702 14 Örebro

Ekholm Elisabeth
Generalsg. 11
SE-903 36 Umeå

Eklind Jan
Kungsklippan 12, 9tr
SE-112 25 Stockholm

Ekmehag Björn
Svalörtsgatan 7
SE-234 38 Lomma

Elmros Theodor
Silvervägen 62
SE-907 50 Umeå

Emilson Axel
Klockaregatan 17, 2tr
SE-752 20 Uppsala

Emtestam Lennart
Ingemansvägen 4A
SE-141 41 Huddinge

Enerbäck Charlotta
Törvedsgatan 24
SE-416 80 Göteborg

Engman Christina
Mossvägen 11
SE-270 22 Köpingebro

Enhamre Anders
Läkargruppen Mörby, Box 89
SE-182 11 Danderyd

Enström Ylva
Botvidsgatan 16A
SE-753 27 Uppsala

Ericsson Jonas
Starrängsringen 22, 3tr
SE-115 50 Stockholm

Ericsson-Eklund Gunnel
Kungsholms kyrkopl 1
SE-112 24 Stockholm

Eriksson Hanna
Ymsenv 10, 5 tr
SE-120 38 Årsta

Eriksson Tomas
Räfsarstigen 38
SE-954 34 Gammelstad

Faergemann Jan
Apotekarg. 7
Sahlgrenska sjukhuset
SE-413 19 Göteborg

Fagerblom Lena
Lundbovägen 5
SE-857 41 Sundsvall

Falk Lars
Strandgatan 4
SE-582 26 Linköping

Falk Anna Maria
Alnängsgatan 2 A
SE-703 62 Örebro

Fellke Marie
Trappstigen 44
SE-791 37 Falun

Filén Finn
Hudkliniken, Akademiska sjukhuset
SE-751 85 Uppsala

Fischer Torkel
Vattugatan 15
SE-111 52 Stockholm

Fjellner Bo
Box 5701
SE-114 86 Stockholm

Flur Barbara
Genvägen 3B
SE-141 37 Huddinge

Flytström Ingela
Hudkliniken, Sahlgrenska sjukhuset
SE-413 45 Göteborg

Forneus Anders
Wiks gård
SE-755 91 Uppsala

Forsberg Annika
Fortvägen 134
SE-187 68 Täby

Forsberg Sofi
Stjärnsundsgatan 3
SE-124 72 Bandhagen

Forsman Sten
Lilla Risåsgatan 20
SE-413 04 Göteborg

Forssgren Alexandra
Rubinvägen 20
SE-541 42 Skövde

Fransson Jessica
Öregrundsgatan 10 6tr
SE-115 59 Stockholm

Fregert Sigfrid
Mellanvångsvägen 5
SE-223 55 Lund

Friberg Katarina
Carl Malmstens väg 52
SE-170 73 Solna

Friedman Marie
Mjärdgränd 2, 7tr
SE-116 68 Stockholm

Frithz Anders
Börjesons väg 49
SE-161 55 Bromma

Frohm-Nilsson Margareta
Stockbyv.5
SE-182 78 Stocksund

Frödin Thomas
Lästgatan 4
SE-582 66 Linköping

Fåhraeus-Morin Lena
Byggmästareg. 12
SE-803 24 Gävle

Färm Gunilla
Blommenbergsv. 159 1 tr
SE-126 52 Hägersten

Gamborg-Nielsen Poul
Hudkliniken Lasarettet
SE-301 85 Halmstad

Gente Lidholm Anette
Askims Skytteväg 6A
SE-436 51 Hovås

Gerdén Barbro
Torgnygatan 9
SE-752 31 Uppsala

Gezelius-Strausser Birgitta
Karlaplan 11, 1 tr
SE-115 20 Stockholm

Ghafor Nauzad
Höglundagatan 29 vån 3
SE-703 68 Örebro

Gilboa Ruth
617 Ridgeline Place
Solana Beach
CA 92075 California, USA

Gisslén Peter
Brotorpsvägen 36
SE-163 59 Spånga

Gjede Uffe
Simons Bakke 66
DK-7700 Thisted

Gonzalez Helena
Mellangatan 11B
SE-413 01 Göteborg

Gossart Maria
Fatburs Brunnsgata 3
SE-118 28 Stockholm

Granger Katri
Runstens Prästgård 4294
SE-386 94 Färjestaden

Grinnemo Pernilla
Björkhagav. 34
SE-554 38 Jönköping

Grängsjö Anders
Celsiusgatan 9
SE-752 31 Uppsala

Grönhagen Carina Döbelnsgatan16 B
SE-113 58 Stockholm

Guermas Leila
Tunnbindareg. 19 2tr
SE-602 21 Norrköping

Guuled Ali
Kronhjortsgatan 3
SE-722 42 Västerås

Gånemo Agneta
Gånarpsvägen 335
SE-266 92 Munka Ljungby

Gärtner Lena
Brändögatan 1
SE-331 32 Värnamo

Haaland Björn
Nypongt. 15
SE-234 43 Lomma

Hackzell-Bradley Maria
Igelkottsvägen 12
SE-161 37 Bromma

Hagforsen Eva
Berthåga Byväg 8
SE-752 50 Uppsala

Hagströmer Lena
Västmannagatan 3
SE-111 24 Stockholm

Hall Martin
Skånegatan 73, V
SE-116 37 Stockholm

Hallander Anna
Hudkliniken Falu lasarett
SE-791 82 Falun

Hallén Anders
Fyrisgatan 14
SE-753 15 Uppsala

Hamnerius-Olofsson Nils
Tessins väg 19B
SE-217 58 Malmö

Hansson Carita
Borgåsvägen 20
SE-438 32 Landvetter

Hansson Christer
Småviltsg. 13
SE-226 52 Lund

Hashim Firouz
Vårlöksgatan 4A
SE-417 06 Göteborg

Hedblad Mari-Anne
Ulvögatan 15
SE-162 23 Vällingby

Hedstrand Håkan
Hudkliniken Akademiska Sjukhuset
SE-751 85 Uppsala

Heijer Arne
Safirvägen 13
SE-451 62 Uddevalla

Heilborn Johan
Vanadisvägen 22A
SE-113 46 Stockholm

Hellgren Lars
Bronsgjutaregatan 13
SE-421 63 Västra Frölunda

Hellström Clas
Mäster Samuelsgatan 49 4tr.
SE-111 57 Stockholm

Henriksson Christina
Övre Olskroksgatan 8
SE-416 67 Göteborg

Herczka Olga
Götgatan 21, 1tr
SE-116 46 Stockholm

Hersle Kjell
Kedjestigen 3
SE-436 50 Hovås

Hesser Göran
Skandiavägen 26
SE-474 31 Ellös

Hestner Anna
Kardborrevägen 3B
SE-541 48 Skövde

Hillström Lars
Lövens Tä 29
SE-802 57 Gävle

Hindsén Monika
Östervångsvägen 9
SE-224 60 Lund

Hofer Per-Åke
Uddgränd 33
SE-165 73 Hässelby

Holik Robert
Ekåsvägen 1
SE-653 42 Karlstad

Holm Joanna
Hudkliniken Uddevalla sjukhus
SE-451 80 Uddevalla

Holm Lena
Hornsgatan 57 3tr/16
SE-118 49 Stockholm

Holm Pelle
Rörviksv. 16
SE-451 77 Uddevalla

Holmberg Jadwiga
Brushanevägen 35
SE-556 25 Jönköping

Holmdahl Meirav
Hudkliniken Universitetsjukhuset
SE-221 85 Lund

Holmdahl-Källén Katarina
Bisterfeldsvägen 9
SE-392 47 Kalmar

Holmgren Helene Ringe
Sturegatan 2B
SE-553 36 Jönköping

Holst Rolf
Roskildevägen 17 CL
SE-217 46 Malmö

Holt Ingebjörg
Hudkliniken Lasarettet
SE-262 81 Ängelholm

Horova Vera
Västra Kyrkogatan 23
SE-903 27 Umeå

Hosseiny Seiran
Läby Nåsten
SE-755 92 Uppsala

Hovmark Anders
Ruriks väg 13
SE-186 50 Vallentuna

Hradil Eva
Rektorsv. 20
SE-224 67 Lund

Hägermark Östen
Skerikes by 9
SE-725 93 Västerås

Häggarth Ingrid
Jaktstigen 4
SE-169 32 Solna

Hägglund Gun
Kolonigatan 11 B
SE-852 39 Sundsvall

Hällgren Jenny
Köpmannagatan 4, 3tr
SE-111 31 Stockholm

Höchtl Elisabeth
Mo 1782
SE-816 94 Ockelbo

Hörnqvist Rune
Södra Gimonäsvägen 72 A
SE-907 42 Umeå

Inerot Annica
Eklanda Gärde 11
SE-431 59 Mölndal

Irestedt Magnus
Villav. 32 C Centralsjukhuset
SE-296 38 Åhus

Isaksson Marlene
Rösträttsgatan 3
SE-227 60 Lund

Isung Josef
Rutger Fuchsg 3
SE-116 67 Stockholm

Itman Sofia
Avenue Maurice 20, bte 1
BE-1050 Bryssel, Belgien

Iversen Normann
HudDoktorn i Örebro
Slottsgatan 8
SE-703 61 Örebro

Jansson Kerstin
Sunnanvindsvägen 6
SE-582 72 Linköping

Jeansson Irene
Gisslabo 219
SE-388 98 Trekanten

Jekler Jan
Hudmottagningen Utsikten
Fjällgatan 45
SE-116 28 Stockholm

Jerner Björn
Eddag 6
SE-802 54 Gävle

Johannesson Anders
Västerled 11
SE-167 55 Bromma

Johannisson Gunnar
Berzeliig. 5
SE-412 53 Göteborg

Johansson Emma
Timmermansgatan 38A, 2tr
SE-118 55 Stockholm

Johansson Eva
Bökersgatan 6
SE-412 73 Göteborg

Johansson-Lange Margaretha
Ripvägen 13
SE-351 42 Växjö

Johnsen Paul Otto
Skippergt. 21
NO-4611 Kristiansand, Norge

Johnsson Margareta Karin
Hudavd. Sankt Olavs Hospital
NO-7006 Trondheim, Norge

Jonell Ragnar
Hästviksgången 16
SE-426 71 Västra Frölunda

Jonsson Lennart
Däldernav. 8
SE-541 47 Skövde

Jonsson Edfast Marie
Sprigr. 10
SE-973 41 Luleå

Josefson Anna
Hudkliniken, Regionssjukhuset
SE-701 85 Örebro

Jurkas Beatrice
Färjestadsv. 4B
SE-168 51 Bromma

Jörgensen Esben Techau
Tegelviksvägen 9B
SE-392 43 Kalmar

Jörgensen Hans-Petter V
Storgatan 15, 4.etg.
NO-1614 Fredrikstad, Norge

Kaaman Ann-Catrin
Herr Stens väg 35
SE-125 30 Älvsjö

Kaaman Taavi
Herr Stens väg 35
SE-125 30 Älvsjö

Karlberg Ann-Therése
Bågspännarvägen 10
SE-125 30 Älvsjö

Karlqvist Mattias
Lövens Tä 14
SE-802 57 Gävle

Karlsson Maria
Hudkliniken
Karolinska Sjukhuset
SE-171 76 Stockholm

Karnå Eva Karin
Helgonabacken 7
SE-451 32 Uddevalla

Karpe Barbro
Fördelningsgatan 18
SE-633 41 Eskilstuna

Kehler Rosenlind Simone
Juvelvägen 11
SE-541 42 Skövde

Kelfve Birgitta
Didriksgatan 3
SE-722 18 Västerås

Killasli Hassan
Stendalsv 120
SE-146 52 Tulling

Kinnman Kristel
Östbovägen 6A
SE-182 56 Danderyd

Klintberg Per
Törnerosgatan 1
SE- 63343 Eskilstuna

Kogan Michael
Drottninggatan 33 2tr
SE-252 21 Helsingborg

Kristensen Berit
Højlandsvej 25
DK-4400 Kalundborg
Danmark

Kristensen Ove
Højlandsvej 25
DK-4400 Kalundborg

Kristoffersson Per Olof
Fåborgvägen 19
SE-311 45 Falkenberg

Krogh Geo von
Läg 1092 Sjökvarnsbacken 12 9tr
SE-131 71 Nacka

Kronberg Anna
Skälängsgatan 11 B
SE-723 36 Västerås

Krook Klas
Artellerigatan 79 2tr
SE-114 45 Stockholm

Krupicka Pavel
Stenbov. 13
SE-735 35 Surahammar

Krynitz Britta
Björkvägen 22
SE-169 33 Solna

Kuylenstierna Maria-Pia
Trollhättegatan 31
SE-554 48 Jönköping

Kuzima Natalia
Hudkliniken
Huddinge sjukhus
SE-141 86 Huddinge

Küssner Kirsten
Aletorpsvägen 25
SE-461 59 Trollhättan

Laestadius Anette
Hudkliniken
Norrlands Universitetssjukh
SE-901 85 Umeå

Lagerholm Björn
Tors väg 11
SE-182 35 Danderyd

Lagmo Kenneth
Persiljevägen 4
SE-585 91 Linköping

Landegren Johan
Värtavägen 16 5tr
SE-115 24 Stockholm

Landgren Anders
Skogmyragatan 19
SE-749 45 Enköping

Lapins Jan
Yttersta Tvärgränd 10D
SE-118 23 Stockholm

Larkö Olle
Arkivgatan 5, 2tr
SE-411 34 Göteborg

Larsen Allan
Örnäsv 87
SE-302 40 Halmstad

Larsson Per-Åke
Lorichvägen 4
SE-791 37 Falun

Larsson-Stymne Birgitta
Nygatan 73B
SE-702 13 Örebro

Laszlo Csilla
Essingeringen 82/853
SE-112 64 Stockholm

Laurell Hans
Kattsfotsvägen 9
SE-459 32 Ljungskile

Lauritzen Thomas Edgar
Pile Alle 17A, 2th
DK-2000 Frederiksberg
Danmark

Lautwein Anna
Hudkliniken
Västerviks sjukhus
SE-539 81 Västervik

Leifsdottir Ragna
Thrastarhöfdi 18
IS-270 Mosfellsbaer, Island

Lengstam Ingvar
Sandhamnsgatan 25 9tr
SE-115 28 Stockholm

Leppert Anna
Schenströmsgatan 5A
SE-724 62 Västerås

Liander Wendela
Hudmottagningen
Borgmästereg. 15
SE-434 32 Kungsbacka

Lidbrink Peter
Klara tvärgränd 5
SE-111 52 Stockholm

Lidén Carola
Upplandsgatan 59
SE-113 28 Stockholm

Lindberg Bo A.
Majvägen 22
SE-139 54 Värmdö

Lindberg Magnus
Rättarvägen 10F
SE-713 30 Nora

Lindberg Lena
Lilla Brog 39 B 3tr
SE-503 35 Borås

Lindborg Lena
Aspövägen 44
SE-125 40 Älvsjö

Linde Ylva
Banérgatan 81
SE-115 53 Stockhom

Lindelöf Bernt
Fornuddsvägen109
SE-135 52 Tyresö

Lindemalm-Lundstam Barbro
Askims Hovslagarväg 10
SE-436 44 Askim

Linder-Carlsson Gerd
Nydalavägen 18 A
SE-903 39 Umeå

Lindeskog Gerhard
Ekåsvägen 18 B
SE-433 62 Partille
Lindewall Gertrud
Banergt 10 3 tr
SE-115 23 Stockholm

Lindholm Ann-Charlott
Trädgårdsgatan 10
SE-633 55 Eskilstuna

Lindström Börje
Lindallén 75
SE-269 34 Båstad

Linse Ulla-Britta
Kometvägen 21, 6tr
SE-183 48 Täby

Lirwall Margareta
Allégatan 11
SE-247 31 Södra Sandby

Ljungberg Anders
Vintervägen 38
SE-182 74 Stocksund

Ljunggren Bo
Cementgatan 22
SE-216 18 Limhamn

Ljunghall Kerstin
Tallbacksv 49
SE-756 45 Uppsala

Lodén Marie
Bergshammra Allé 9
SE-170 77 Solna

Lonne-Rahm Solbritt
Götgatan 61, 4tr
SE-116 21 Stockholm

Lundeberg Lena
Höjdstigen 7
SE-181 31 Lidingö

Lundh Kerstin
Sperlingsgatan 13 B
SE-302 48 Halmstad

Lundqvist Katarina
PL 2613 Lackagården
SE-244 60 Furulund

Lundström Anita
Klippuddsstigen 6
SE-181 65 Lidingö

Löfberg Helge
Stora Tomegatan 29
SE-223 51 Lund

Löfroth Anna
Bergsvägen 7
SE-831 62 Östersund

Löwhagen Gun-Britt
Ingegärdsvägen 2 B
SE-421 68 Västra Frölunda

Mabergs Nils
Ringvägen 131, 2tr
SE-116 61 Stockholm

Magnusson Britt-Louise
Doktor Forseliusgata 12
SE-413 26 Göteborg

Magnusson Irina
Galoppvägen 2
SE-541 70 Skövde

Magnusson Lotta
Hudkliniken Mälarsjukhuset
SE-631 88 Eskilstuna

Magnusson Louise
Sorlabäcksg. 7
SE-216 20 Malmö

Mahmutagic Ramza
Strömstadsvägen 10C, lägh 4B
SE-451 50 Uddevalla

Mallbris Lotus
Bennebolsg. 30
SE-163 50 Spånga

Malmgren Kristina
Hjortvägen 11
SE-430 63 Hindås

Malmkvist Padoan Sigrid
Kristianstadkliniken
Ö Boulevarden 56
SE-291 31 Kristianstad

Malmros-Enander Ingergärd
Lunds Östra 7
SE-621 48 Visby

Marcusson Jan A.
Herserudsvägen 1
SE-181 34 Lidingö

Marku Gina
Mörbyhöjden 15
SE-182 52 Danderyd

Maroti Marianne
Högabergsgatan 37
SE-554 46 Jönköping

Martin Peter
Värtavägen 1
SE-183 63 Täby

Matura Mihaly
Hudkliniken Karolinska
Universitetssjukhuset
SE-171 76 Stockholm

Meding Birgitta
Ankdammsgatan 40, 1tr
SE-171 67 Solna

Meiling Kerstin
Madame Jeannes V. 15
SE-671 41 Arvika

Michaëlsson Gerd
Skogsmyrsv 9
SE-756 45 Uppsala

Miocic Marinko
Schéelegatan 9
SE-416 60 Göteborg

Mirton Beatrice
Wallérs Plats 4
SE-621 56 Visby

Mjörnberg Per Anders
Vårvägen 31
SE-541 33 Skövde

Mobacken Håkan
Karin Boyes Gata 7, 4tr
SE-411 11 Göteborg

Modée Jan
Ellen Keys g. 37
SE-129 52 Hägersten

Modén Margareta
Snöflingegatan 5
SE-723 50 Västerås

Mohammadi Noushin
Hantverkargatan 50, 3tr
SE-112 31 Stockholm

Molin Lars
Sturegatan 16
SE-702 14 Örebro

Molina Martinez Raquel
Drivhusggatan 5
SE-412 64 Göteborg

Molnar Christina
Hudkliniken Centrallasarettet
SE-721 89 Västerås

Munksgaard Ingrid
Coldinuvägen 6
SE-371 42 Karlskrona

Månesköld Anna
Daltorpsgatan 46
SE-412 73 Göteborg

Månsson Tore
Krusbärsvägen 40
SE-262 57 Ängelhom

Möller Halvor
Ledungsgt 21
SE-217 74 Malmö

Mölne Lena
Hudkliniken Sahlgrenska sjukhuset
SE-413 45 Göteborg

Nagy Veronika
Källsprångsgatan 2
SE-413 20 Göteborg

Nielsen Kari
Viktoriapromenaden 6
SE-260 41 Nyhamnsläge

Niklasson Eva
Skördegatan 7
SE-602 12 Norrköping

Nilsen Tore
Specialistläkargruppen
Trädgårdsgatan 10
SE-352 34 Växjö

Nilsson Christian
Gamla Gatan 11
SE-703 61 Örebro

Nilsson Eskil
Jakobsénsväg 5
SE-856 34 Sundsvall

Niordson-Grysgaard Ann-Marie
Folehaveparken 16
DK-2970 Hørsholm
Danmark

Nohlgård Christina
Bergbacken 1
SE-131 50 Saltsjö-Duvnäs

Norborg-Iversen Lise
Lindö
SE-611 93 Nyköping

Nordin Peter
Brottskärrs Byväg 714
SE-436 58 Hovås

Nordin-Björklund Karin
Rektorsgatan 3B
SE-722 15 Västerås

Nordin Håkan
Diskusgr. 4
SE-243 33 Höör

Nordin Leif
Tråkärrslättsvägen 57
SE-427 50 Billdal

Nordlind Klas
Riddargt 72
SE-114 57 Stockholm

Norén Peter
Edov. 13
SE-741 93 Knivsta

Nourbakht Seyed Ali
Söderleden 23
SE-587 31 Linköping

Nyberg Filippa
Skeppsvägen 2
SE-182 76 Stocksund

Nylander-Lundqvist Elisabeth
Pilgatan 8D
SE-903 31 Umeå

Nyman Gunnar
Sälggatan 2
SE-510 54 Brämhult

Nyrén Miruna
Banérgatan 25
SE-115 22 Stockholm

Nyrud Morten
Trollåsveien 25
NO-1414 Tärnåsen, Norge

Odu Solveig
Oskarsgatan 24
SE-331 41 Värnamo

Ohlsson Erik
Bondans Fårö
SE-620 35 Fårösund

Ohlsson Ylva
Uddevallagatan 35 A
SE-416 70 Göteborg

Olausson Per-Håkan
Märstavägen 5
SE-19340 Sigtuna

Oldberg Wagner Sara
Sjätte Villagatan 5
SE-504 54 Borås

Olivecrona Eva
Tegnérgatan 7
SE-111 40 Stockholm

Olson Kerstin
Kasten-Rönnowsgatan 3G, 5tr
SE-302 36 Halmstad

Olsson Elisabeth
Grytholmsg. 4
SE-572 40 Oskarshamn

Olsson Ingegerd
Vanadisvägen 31A
SE-113 23 Stockholm

Oprica Cristina
Bernströmsvägen 38 A
SE-146 38 Tullinge

Ouchterlony Tim
Skalbergsgatan 4B
SE-45046 Hunnebostrand

Overgaard Petersen Hans
Nils Lövgrens väg 1 lgh 112
SE128 64 Sköndal

Paoli John
Pontus Wiknersg. 3
SE-411 32 Göteborg

Passian Shala
Hudkliniken
Karolinska Sjukhuset
SE-117 76 Stockholm

Pawlik Ewa
Hudkliniken
Regionsjukhuset i Umeå
SE-901 85 Umeå

Persson Bertil
Vagnmakaregränden 29
SE-224 56 Lund

Persson Lill-Marie
Hamngatan 6
SE-542 30 Mariestad
Pettersson Lars
Liegatan 7
SE-802 70 Gävle

Pettersson Arne
Överbyn 130
SE-834 00 Brunflo

Piechowicz Malgorzata
Storkstigen 5
SE-393 59 Kalmar

Pietz-Preisler-Häggqvist Anna
Silvervägen 11
SE-907 50 Umeå

Plá Arlés Ulla-Britt
Urbanización el Mirador Pasaje
San José nr 9
ES-12600 Vall de Uxó Castellon, Spain

Pompe Jarmila
Mikrog 62
SE-502 47 Borås

Pontén Fredrik
Patologen C-lab
Akademiska sjukhsuet
SE-751 85 Uppsala

Popova Irina
Matrosgat. 10
SE-392 36 Kalmar

Popovic Karin
Tegnerbyv. 51
SE-168 55 Bromma

Poulsen Jens
Hellehuse 37
DK-4174 Jystrup Midtsj
Danmark

Probierz-Zak Hanna
Ragnar Jändelsvägen 7
SE-371 63 Lyckeby

Pálsdóttir Rannveig
Noatun 31
IS-105 Reykjavik, Iceland

Qvarner Hans
Grev Turegatan 75
SE-114 38 Stockholm

Radecka Maria
Galleasvägen 3
SE-352 55 Växjö

Ramstedt Gunnar
Siglajvs Rute
SE-620 34 Lärbro

Reidhav Inga
Alnarpsv. 34
SE-232 53 Åkarp

Richtnér Tomas
Döbelnsgatan 83
SE-113 52 Stockholm

Ridderström Eva
Ihres väg
SE-752 63 Uppsala

Rietz Minne Helene
Observationsvägen 10
SE-141 38 Huddinge

Rollman Ola
Islandsgatan 8
SE-753 08 Uppsala

Roosling Anna
Hudkliniken Länssjukhuset
SE-391 85 Kalmar

Rorsman Hans
Pålsjövägen 26
SE-223 63 Lund

Ros Ann-Marie
Mälartorget 13
SE-111 27 Stockholm

Rosdahl Inger
Djurgårdsgatan 58
SE-582 29 Linköping

Rosén Karin
Norra Grinnekärrsvägen 24
SE-436 56 Hovås

Rosenberg-Wickström Inger
Turevägen 14
SE-191 47 Sollentuna

Rossman-Ringdahl Ingrid
Tallboängen 66
SE-436 00 Askim

Roupe Gösta
Apotekarg 6
SE-413 19 Göteborg

Rudén Ann-Kerstin
Ringvägen 124, 3tr
SE-116 64 Stockholm

Ryberg Kristina
Björkvägen 4B
SE-459 31 Ljungkile

Rydinge Inger
Hästholmsvägen 15, 7tr
SE-116 44 Stockholm

Rydqvist Lise-Lotte
Gustaf Vasag. 26
SE-392 47 Kalmar

Rystedt Ingela
Majorsg 4
SE-114 47 Stockholm

Rånby Eva
c/o Anders Westerberg
Södra Kungsgatan 22, 1tr
SE-972 35 Luleå

Rönnerfält Lena
Sturegatan 18, II
SE-114 36 Stockholm

Sabockiene Jolanta
Gryningsvägen 51
SE-461 59 Trollhättan

Saighani Timor
Rosenvägen 1
SE-245 44 Stafanstorp

Salih Jalal
Kaserngården 14
SE-703 65 Örebro

Sandberg Carin
Kungshamnsg. 6
SE-421 66 Västra Frölunda

Sandström Eric
Bataljvägen 27
SE-133 33 Saltsjöbaden

Sandström Falk Mari Helen
Nonnensgatan 5a
SE-412 72 Göteborg

Sanner Karin
Tegnerg. 32 C
SE-752 27 Uppsala

Sartorius Karin
Tantogatan 15
SE-118 67 Stockholm

Schmidtchen Artur
Göingegatan 4
SE-222 41 Lund

Schmitt-Eegenolf Marcus
Hudkliniken
Universitetsjukhuset
SE-901 85 Umeå

Schou Marie
Notvägen 9
SE-711 00 Lindesberg

Schön Jenny
Kolvaktargränd 16
SE-907 42 Umeå

Serup Jørgen
Esperance Allé 6B
DK-2920 Charlottenlund
Danmark

Siemund Ingrid
Kulgränden 8
SE-226 49 Lund

Sjöborg Steinar
Ljungsåkra Barnalyckan
SE-355 94 Vederslöv

Sjölin-Forsberg Gunilla
Tors väg 20 A
SE-754 40 Uppsala

Sjövall Peter
Nordmannagatan 11
SE-217 74 Malmö

Skawski Annette
Hudkliniken Centrallasarettet
SE-721 89 Västerås

Skoglund Curt
Grev Turegatan 75
SE-114 38 Stockholm

Skoog Marja-Leena
Domherrevägen 11
SE-585 95 Linköping

Sköld Gunilla
Kaprifolv. 20
SE-603 66 Norrköping

Sokolski Jan
Ivar Vidfamnes gata 12
SE-126 52 Hägersten

Sommerfeld Beatrice
Danavägen 7 B
SE-181 31 Lidingö

Sonesson Andreas
Talmansgatan 10
SE-224 60 Lund

Sonesson Björn
Bäckarännan 3
SE-227 63 Lund

Sparrings Charlotte
Deragården Hornborga
SE-521 98 Broddetorp

Spirén Anna
Hudkliniken, UMAS
SE-205 02 Malmö

Spångberg Sune
Odengatan 16 B
SE-753 13 Uppsala

Staf Olga
Hällebo Servicehus
SE-830 51 OFFERDAL

Starck-Romanus Vera
Fridkullagatan 18, 4tr
SE-412 62 Göteborg

Stark Hans Ulrik
Grindstugev 4
SE-663 41 Hammarö

Stempa Marian
Högbyv 146
SE-175 46 Järfälla

Stenberg Berndt
Rönnbärsstigen 25 D
SE-903 46 Umeå

Stenberg Åsa
Falsterbovägen 35
SE-857 30 Sundsvall

Stenlund Kajsa
Orrspelsvägen 42
SE-167 66 Bromma

Stenmark-Särhammar Gunnel
Videgatan 1
SE-652 30 Karlstad

Stenquist Bo
Hudkliniken, Sahlgrenska
Universitetssjukhuset
SE-413 45 Göteborg

Strand Anders
Geijersgatan 17C
SE-752 26 Uppsala

Strömberg Carin
Tunnevik
SE-471 73 Hjälteby

Sturesdotter Hoppe Torborg
Malma Ringväg 21
SE-756 45 Uppsala

Ståhle Mona
Karlbergsvägen 67 1tr
SE-113 35 Stockholm

Sund-Böhme Maria
Västmannagatan 27
SE-113 25 Stockholm

Sundberg Karin
Lönnholmsgatan 9G
SE-554 50 Jönköping

Surakka Jouni
Norra vägen 8C
SE-163 41 Spånga

Swartling Carl
Gropgränd 2 A
SE-753 10 Uppsala

Svedberg Ylva
Hudkliniken, Falu Lasarett
SE-791 82 Falun

Svedman Cecilia
Vilebov. 21 F
SE-217 63 Malmö

Svensson Louise
Bagaregatan 13, 2tr
SE-611 31 Nyköping

Svensson Margareta
Leksandsv 4
SE-192 67 Sollentuna

Svensson Åke
Norregatan 17
SE-289 00 Knislinge

Svärdhagen Karolina
Lilltorpsvägen 35
SE-791 61 Falun

Synnerstad Ingrid
Bällsjö
SE-590 98 Edsbruk

Szpak Ewa
Björkängsvägen 15
SE-141 38 Huddinge

Särnhult Tore
Hammarvägen 92
SE-421 65 Västra Förlunda

Söderberg Björn
Södra Jöns Davidsgatan 13
SE-372 36 Ronneby

Taklif Tahereh
14 Knotty Pine Trail
Thornhill
Ontario L3T3W4, Canada

Talme Toomas
Porsvägen 19
SE-146 37 Tullinge

Tammela Monica
Flogstavägen 18
SE-752 73 Uppsala

Tarras-Wahlberg Casper
Wrangelsdal
SE-291 95 Färlöv

Tarstedt Mikael
Färjestadsvägen 37
SE-654 65 Karlstad

Tegner Eva
Markaskälsvägen 8
SE-226 47 Lund

Ternestedt Linda
Gyllenstjärnas väg 14 A
SE-371 40 Karlskrona

Terstappen Karin
Älekärr Sandåsen
SE-540 17 Lerdala

Thelin Ingrid
Astrakansvägen 21
SE-224 56 Lund

Thorgeirsson Arnar
Bellmansgatan 3
SE-254 40 Helsingborg

Thornéus Inga-Britt
Morkullevägen 6F
SE-90151 Umeå

Thorslund Kristoffer
Strindbergsgatan 49, 4tr
SE-115 53 Stockholm

Thurfjell Christina
Trekantsgatan 1
SE-652 20 Karlstad

Thyresson Nils
Norbyvägen 41
SE-752 39 Uppsala

Thörneby-Andersson Kirsten
Svenshögsvägen 3
SE-222 41 Lund

Tillman Cecilia
Hudkliniken UMAS
SE-205 02 Malmö

Tjernlund Ulla
Torphagsvägen 4 2TR
SE-104 05 Stockholm

Tjälve Susanne
Parkgatan 7
SE-652 22 Karlstad

Tollesson Anders
Saltsjövägen 15 A
SE-181 62 Lidingö

Torssander Jan
Thun Ollevägen 7
SE-134 34 Gustavsberg

Troilius Agneta
Sundspromenaden 35
SE-211 16 Malmö

Trokenheim Alina
Sankt Eriksgatan 33, 3 tr
SE-112 39 Stockholm

Trolin Ingrid
Albertsväg 14 A
SE-752 60 Uppsala

Trovallius Cecilia
Hallonbergsvägen 21
SE-172 43 Sundbyberg

Tunbäck Petra
Mossgatan 10-12
SE-413 21 Göteborg

Törmä Hans
Hudkliniken
Akademiska sjukh
SE-751 85 Uppsala

Törngren Mats
Sjövikstorget 7
SE-11758 Stockholm

Waad Ibrahim Majeed
Lars Wivallius väg 1
SE-291 46 Kristianstad

Wahbi Abdelhabi
Grödingeväg 3, 2 tr
SE-147 30 Tumba

Wahlgren Carl-Fredrik
Oviksgatan 83
SE-162 21 Vällingby

Vahlquist Anders
Sankt Olofsgatan 1A
SE-753 10 Uppsala

Vahlquist Carin
Sankt Olofsgatan 1A
SE-753 10 Uppsala

Walhammar Mårten
Olof Skötkonungsgatan 64
SE-412 69 Göteborg

Wallberg Peter
Urban Hjärnes väg 5
SE-168 58 Bromma

Wallengren Joanna
Beleshögsvägen 42
SE-217 74 Malmö

Wallenhammar Lena-Marie
Nackagatan 20
SE-116 47 Stockholm

Vandell Uddströmer
Susanne Tolvfors bruksg. 10B
SE-806 26 Gävle

Wanger Lena
Granestigen 8
SE-182 65 Djursholm

Varnauskas Therese
Hudkliniken
Danderyds sjukhus
SE-182 88 Danderyd

Wenger Helena
Björnebergsvägen 8B
SE-553 12 Jönköping

Wengström Claes
Tynneredsv. 25B
SE-421 59 Västra Frölunda

Wennberg Ann-Marie
Arkivgatan 5, 2tr
SE-411 34 Göteborg

Wennersten Göran
Fjällgatan 45
SE-116 28 Stockholm

Went Maria
Valhallavägen 110, 2tr
SE-114 41 Stockholm

Wictorin Åsa
Borgåslingan 14
SE-224 72 Lund

Widén-Karlsson Veronica
Floravägen 15A
SE-181 32 Lidingö

Wiegleb-Edström Desiree
Älghagsstigen 30
SE-165 76 Hässelby

Wielondek Iwona
Hagagatan 60
SE-571 37 Nässjö

Wiik Barbara
Ölmegatan 14A
SE-652 30 Karlstad

Wikström Arne
Kungstensgatan 28D 4tr
SE-113 57 Stockholm

Wilson-Clareus Birgitta
Louiselundsvägen 137
SE-165 70 Hässelby

Vinnerberg Åsa
Sandbergsgt 4
SE-603 55 Norrköping

Wirestrand Lars-Erik
Torsekevägen 243
SE-291 94 Kristianstad

Virtanen Marie
Hudkliniken
Akademiska sjukhuset
SE-751 85 Uppsala

Wolff Hélène
Apotekaregatan 3
SE-413 19 Göteborg

Wolk Katarina
Hudkliniken
Karolinska sjukhuset
SE-171 76 Stockholm

Voog Eva
Sofiagatan 85
SE-416 72 Göteborg

Wrangsjö Karin
Garvargatan 19 2tr
SE-112 21 Stockholm

Wyon Yvonne
Hudkliniken
Universitetssjukhuset
SE-581 85 Linköping

Zak Richard
Ragnar Jändels v 7
SE-371 63 Lyckeby

Zander Ylva
Klingsbergsgatan 13
SE-603 54 Norrköping

Zazo Virgina
Gamliavägen 4
SE-903 42 Umeå

Zwolinski Danuta
Bågfilsgatan 23
SE-230 42 Tygelsjö

Ågren-Jonsson Siv
PL 1490 Ålabodarna
SE-261 63 Glumslöv

Åsbrink Eva
Ruriks väg 13
SE-186 50 Vallentuna

Öhman Hans
Hjalmar Svenfelts v 15
SE-590 60 Ljungsbro

Öhman Sven
Banergt 12 B
SE-752 37 Uppsala

Örsmark Kerstin
Kullagatan 1, Baskemölla
SE-272 94 Simrishamn