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## Recognition at Last for People with Skin Disease?

The Skin Care Campaign (SCC) has been actively promoting the need for the government and the Department of Health (DH) to recognise the needs of people with skin disease, many of whom have to cope with their condition for life. The absence of any mention of skin disease in either the GP contract or the Government publication 'Improving Chronic Disease Management' as well as the classification by the DH of skin disease as a 'minor ailment' seemed to ignore the large number of us who form the fourth most common group of sufferers with a chronic condition.

In this issue of Campaign News it is most encouraging to see the APPGS report (see page 4) of acknowledgement by the government that the extremely high incidence of skin disease has not been taken seriously enough. The constructive discussion with the Chief Medical Officer (CMO) also indicated that there should be some positive developments in services at a local level for people with chronic skin conditions and that the need to educate primary care clinicians in dermatology is being taken seriously.

The value of the NHS Modernisation Agency's Action on Dermatology (AoD) programme is well recognised and we are pleased that the work will continue through the activities of the Long Term Conditions Workforce Care Group – Dermatology Sub-Group (LTCWG-DG). The importance of the patient groups' contribution to the LTCWG-DG is recognised through the nomination of SCC Chief Executive, Peter Lapsley, as Deputy Chairman. Identification of the numbers of all the clinical professionals needed in both primary and secondary areas to provide care for skin disease patients is essential for service development and planning of appropriate educational programmes.

The APPGS report on the review of training highlighted in the May 2004 issue of Campaign News, is expected to be published shortly. The recommendations in the Report will be useful in identifying the training and education requirements for skin disease clinical practitioners. The service developments for provision of appropriate standards of care for people with long term skin conditions will only occur with the government's recognition of the needs of this large group of sufferers and the requisite education and training of the clinical teams providing the service.

We see the issues reported above as the beginning of developments for the long-awaited healthcare service due to people with skin disease.

*Lynette Stone CBE  
Chairman, SCC*

# Looking Ahead

Peter Lapsley, Chief Executive, Skin Care Campaign

## Plotting Patient Pathways

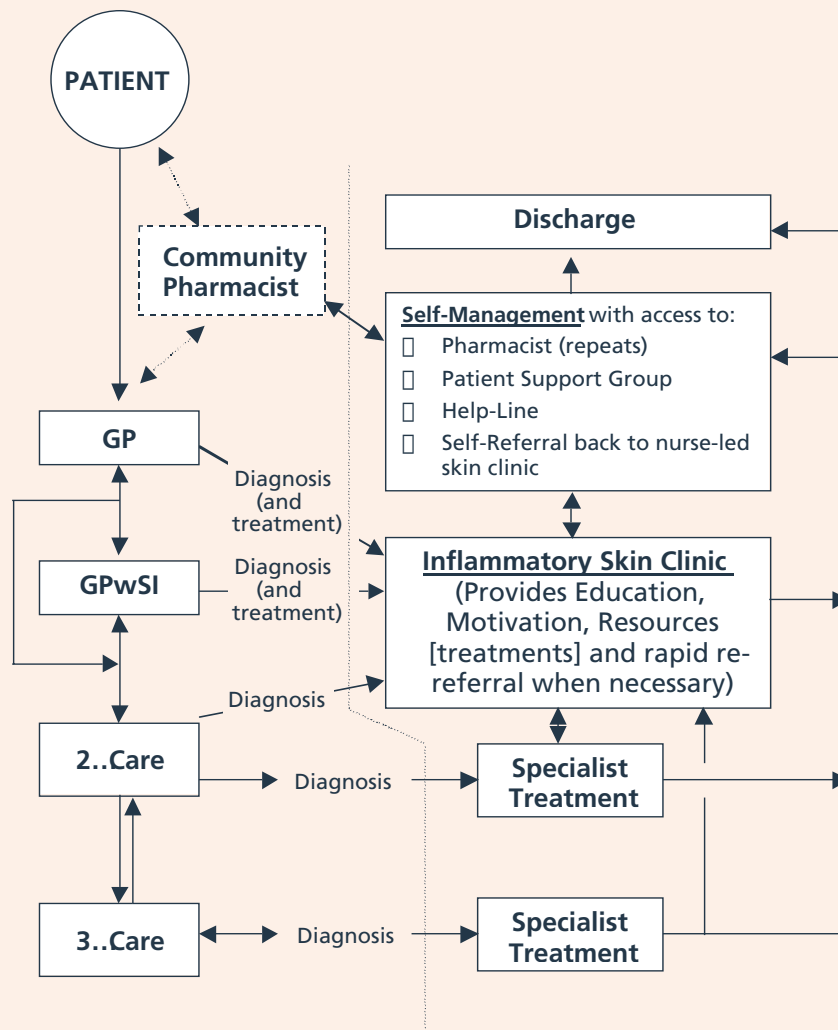
Central to the work of the Long-term Conditions Care Group Workforce Team Dermatology Group (the Dermatology Group) is the opportunity to develop new patient pathways in dermatology. This work is exciting, too, because it provides an opportunity to develop a model that is far better for everyone concerned – a real prospect of that model being widely adopted.

Several of the Action on Dermatology (AOD) pilot studies involved nurse-led clinics in primary care, and the generic patient pathway

that has been developed by the Dermatology Group draws heavily on that work.

The generic pathway (see below) is currently being 'layered' to take account of different disease groups and of patients already within the healthcare system. It has at its core the principal that, while diagnosis of skin diseases can be complex and difficult, and may need to be undertaken by a GPwSI, a consultant dermatologist or even through tertiary referral, a great deal of skin disease, especially inflammatory skin diseases like acne, eczema and psoriasis, can most effectively be managed in primary care –

## Simple Revised Dermatology Patient Pathway



**Potential Benefits:**  
 Meets patients needs, especially in terms of choice and access;  
 Reduces substantially the burden on primary care.

**Requirements:**  
 Quality measures for dermatology in new GP contract;  
 Funding for inflammatory skin disease clinics in primary care, as for asthma and diabetes  
 The tools for the job - i.e. the widest possible range of treatments

often through well-supported self-management at home.

The benefits are obvious. Patients are saved repeated visits to surgeries or clinics. The burden of skin disease, which makes up fifteen to twenty percent of the average GP's workload, is eased considerably. And waiting times for those who need access to secondary care are reduced.

Essential to the success of such systems are proper training for primary care health professionals, which is currently woefully lacking; 'the tools for the job', which is to say access to the treatments patients need in order effectively to self-manage their conditions; and lateral thinking in terms of the provision of proper support to people self-managing their conditions, perhaps through NHS-purchased access to relevant patient support groups.

In her report elsewhere in this edition of *Campaign News* (see 'Is the Government Beginning to Listen to Patients?'), Jessica David mentions the work that has been done recently to impress on the government the need for systems of this sort, and especially for inflammatory skin disease clinics.

Comparable clinics have long been provided for asthma and diabetes and have proved very successful. And we are finding increasing numbers of such clinics springing up around the country – partly in response to the guidance provided in the Action on Dermatology Good Practice Guide, published in January last year, and partly perhaps because they simply seem the obvious thing to do.

Recently, we have become aware of skin clinics being planned or established in Bath, Bicester, Camden, Hounslow, Islington, Norwich, Stockton-on-Tees, and Welwyn Garden City & Hatfield.

We are keen to keep in touch both of the spread of these sorts of clinics, of their progress individually and, particularly, of lessons learnt about potential problems and about ways in which they may be improved.

We would be grateful, therefore, if readers who are aware of primary care skin clinics that were not established as AOD pilot sites and are not listed above could provide Gwen Banford (gbanford@eczema.org) with contact details for those involved.

## Update on Non-Consultant Career Grade Doctors

The British Association of Dermatologists (BAD) now has detailed information on Dermatology Non-Consultant Career Grade Doctors (NCCGs). These grades make up a substantial part of the Dermatology workforce in the UK and contribute significantly to the Specialty.

Some NCCGs work predominantly in Dermatology ie. Associate Specialists, Staff Grades, Trust Grades, Non-GP Clinical Assistants and Non-GP Hospital Practitioners. The term NCCGs includes the GP Clinical Assistants and Hospital Practitioners who work one or two sessions weekly due to their other commitments.

### BAD NCCG sub committee

There is now a BAD NCCG sub-committee. It is raising the profile of NCCGs and representing their interests. It is trying to make sure their educational needs are fulfilled and that they are included in workforce discussions. It is liaising with the Primary Care Dermatology Society so the interests of all NCCGs (GPs and non-GPs) are met.

### NCCG Database

The committee has produced an up-to-date database of these doctors. So far over 650 have been found. Approximately 1550 clinical sessions are done weekly. Over a million patients are being seen in 70,000 clinical sessions annually. Over 300 more Consultants would be needed to cover this work. 58% of these sessions are done by the 180 non-GP grades.

### BAD NCCG Survey

A survey has now been done to find out information on the Non-GP NCCG Dermatology Workforce. 180 questionnaires were sent out, of which 70% were returned. The respondents consisted of 53 Associate Specialists, 33 Staff Grades, 3 Trust Grades, 25 Non-GP Clinical Assistants and 12 Non-GP Hospital Practitioners.

The following information was obtained:

- **Personal / Job Information**

Most were trained in the UK. On average they have worked 13 years in Dermatology. Over half are part time and 79% are female. Most are working totally in Dermatology and have Postgraduate qualifications. 53% were GPs previously. They started as GP Clinical Assistants, preferred Dermatology to General Practice and moved into the Specialty totally.

- **Clinical Work**

Almost all are seeing new patients as well as follow-ups. Most are doing some unsupervised clinics and are seeing complicated cases. The majority have special interests and skills including Minor Surgery and Patch Testing. Most do Ward Consultations.

- **Continuing Professional Development (CPD)**

30% are not achieving their CPD requirements. A few have no access to Dermatology educational sessions. 14% are having problems getting paid study leave and expenses. 91% teach other doctors and health care professionals. They take part in audit, clinical trials, research and are members of committees. 55% have publications.

- **Career Progression / Comments**

Over 50% are having problems getting job plan meetings and being appraised even though this is a Government requirement. Many would like to be regraded to higher NCCG grades. 46% would eventually like to become a Consultant.

The main reasons for becoming an NCCG were listed as – family commitments, need for a part time job, inability to get a Registrar post and preference of Dermatology to General Practice.

The enjoyable job features were – contact with patients and colleagues, wide variety of work and interesting cases, regular hours, no on call and minimum hospital politics.

Features to be improved were – pay, recognition of experience, status, better career structure, reduction in workload, time for audit and research and improved administrative support.

Hopefully some of these issues will be addressed during the Government's planned changes to the NCCG grades.

• **Workforce Discussions**

The survey shows 71% are willing to do more hospital sessions, 67% community clinics and 79% Waiting List Initiatives. Workforce Discussions have concentrated on creating the new post of GP with Special Interest (GPwSI). NCCGs are already working in Dermatology. They are experienced and skilled. It would seem sensible to use them. They could relieve the pressure on Consultants and reduce waiting lists. They have the potential of increasing their sessions, as many are part time. It is hoped Regional Lists of NCCGs, available to do more sessions, will be available in the future.

**Progress**

- The NHS Modernisation Agency's Action on Dermatology has agreed to support a more detailed survey of all NCCGs, which will provide the total picture on availability and numbers.
- The Long Term Conditions Workforce Care Group - Dermatology sub group is aware of the NCCGs contribution to Dermatology.
- The issue of NCCGs was raised at the Improving Dermatology Services Conference.
- The National Action on Steering Group has received the NCCG information very positively, with full agreement that this important staff group needs to be considered in future development of service models.

**Summary**

Dermatology is one of the few Specialties, which has such detailed information on its NCCG Workforce. Hopefully progress will continue to be made in ensuring these grades are used to their full potential.

**Sue Jackson**

*Associate Specialist in Dermatology*

# The All Party Parliamentary Group On Skin

## Is the Government Beginning to Listen to Patients?

To the APPGS's delight, a Government spokesperson in the House of Lords recently acknowledged that 'the incidence of skin disease is extremely high and we may not have taken it seriously enough'. Baroness Andrews, a spokesperson on health matters for the Government, was responding to a question from Baroness Finlay of Llanduff, who had asked what proposals the Government had to improve the provision of treatment for people with chronic skin diseases.

Recently, the APPGS has held a number of meetings with MPs and Peers to discuss the Government's handling of dermatology and these have led to several probing parliamentary questions being tabled. Two of the main issues to which we have sought to draw attention are the GP Contract and the Government's publication 'Improving Chronic Disease Management' - both of which failed to make any reference to skin disease! The Department of Health's (DH) own documentation recently noted that skin conditions are the fourth most common group of chronic conditions and the APPGS feels strongly that it is about time that the Government took some decisive action to reflect this and to improve services.

The APPGS was also very pleased to have the opportunity to meet with the Chief Medical Officer (CMO), Professor Sir Liam Donaldson. This meeting gave us a further indication that the Government appear to be sitting up and taking notice, Sir Liam having agreed to ponder on a number of the APPGS's concerns. Specifically, Sir Liam agreed that a strand on dermatology should

be incorporated into the plans for chronic disease management clinics that are being taken forward by the DH. The APPGS is hopeful that this could lead to the provision of local level disease management clinics for inflammatory conditions such as eczema and psoriasis - offering real benefits to patients and the NHS.

Sir Liam also considered additional matters raised by the APPGS regarding academic research, the downsizing of the Modernisation Agency and the future of Action on Dermatology programme. On the sensitive issue of the GP Contract, the CMO took seriously our concerns about the delivery of dermatology in primary care but pointed out that we needed to make the case for inclusion better than we so far had. Most helpfully, the CMO agreed to meet the same delegation again in two to three months time to discuss progress and to meet with other relevant officials. I look forward to reporting back on positive developments that follow this meeting.

There is a palpable sense that the Government is beginning to listen to what patients and key stakeholders are saying about dermatology services and that significant improvements might be around the corner. Until this objective is realised however, the APPGS will continue to work with interested politicians to highlight deficiencies in the Government's current handling of skin disease and would welcome any input from patient groups to support this.

**Jessica David**

# “Bald by Morning”

## The Alopecia Patients’ Society

The young female voice on the Hairline telephone spoke in an urgent whisper: “I am in a hair clinic and the consultant here says that if I don’t sign his contract for treatment now I could be bald by morning.” She sobbed suddenly, as though aware of the enormity of this prospect. “But I can’t possibly afford it. What shall I do?”

This kind of telephone call is nothing new to us at Hairline International, The Alopecia Patients’ Society. We provide support for both men and women who have lost or are losing their hair. It is a condition which in many cases causes as great an impact in terms of unhappiness and psychological suffering as more recognised skin disease such as severe psoriasis (according to the recent study: “Effect of Hair Loss on the Quality of Life” by the University of Wales, Archives of Dermatology 2000).

The eighteen year old girl on the telephone had strayed into one of the many U.K. commercial establishments offering help for hair loss. The staff give the impression that they are medically qualified, the ‘consultant’ wears a white coat and assures you that help is at hand. He describes your hair loss as extensive and offers you treatment to promote re-growth....at a price.

One of the hardest things about suffering alopecia is that you find out fairly quickly that some help is available – but too often it is the wrong kind of help. The commercial sector offers a miracle treatment for hair loss and because we are feeling low and therefore at our most vulnerable it is all too easy to give in and pay an exorbitant sum for a course of treatments. The very word ‘consultant’ inspires confidence.

You can be forgiven for thinking that this indicates that these are highly qualified medical consultants, doctors who have spent years studying their medical specialty. Sadly, this is usually untrue. In this country, the fact is that **ANYONE CAN CALL HIMSELF A CONSULTANT**. He does not have to admit that he is not a medical consultant.

When your hair suddenly falls out, you are usually so upset that you are grateful to anyone who offers help and are in no mood to ask questions.

When I lost my own hair to Alopecia Areata, I was embarrassed and miserable. Seeing an older man in a white coat, offering reassurance and a treatment for baldness, brought the most wonderful sense of relief. So most patients pay the money, have all kinds of useful concoctions massaged into their scalps, and try to believe that this will make their hair grow again. It won’t, of course. Not a chance.

### The girl on the telephone

This was the kind of establishment which had attracted Tracey, the girl on the telephone. Worried about a small area of thinning ‘see-through’ hair on her scalp, she had been impressed by the colour photographs and lavish advertisements for the High Street commercial clinic. She had been delighted when the receptionist told her that she could see the ‘consultant’ immediately.

Her hair loss had never been in the bald patches of Alopecia Areata or the total loss of all body hair associated with Alopecia Universalis. It was merely a small area of thinning hair which in younger women can be the result of crash ‘yo-yo’ diets, the stress of examinations or even moving house. The condition was not serious and could probably have been corrected by adjusting her diet to include more foods containing red meat such as beef or liver.

But this ‘consultant’ examined Tracey’s scalp very carefully and announced that her hair loss was potentially serious. He advised her to invest in his programme of regular treatments otherwise she ran the risk of much more severe hair loss. “In fact,” he said, “Unless you have this treatment now you could be bald by morning.”

This ‘hard sell’ technique understandably frightened her but luckily she had the commonsense to telephone Hairline before she signed and we were able to rescue her from a situation in which she could easily have lost her money as well as her hair.

This is just one example of the hundreds of hair loss sufferers who are blatantly conned every year by the commercial ‘clinics’ who offer to rescue them from the misery of losing their hair, often at a very high price. When hair is lost suddenly for no obvious reason it is often difficult to know where to turn for help and that is the reason so many patients find themselves at the mercy of unscrupulous ‘cowboys’.

The attitude of the clinic staff may be simply to sell worthless ‘treatments’ which may wreck your bank account but will not actually harm you. Or worse, they may put you on medications which could be seriously harmful to your general health. One clinic in London has been known to sell unopposed oestrogen to younger women in the interest of promoting hair growth. For a young woman with an intact womb unopposed oestrogen can, of course, be dangerous.

### So where do you go for help?

If you have the bald patches of Alopecia Areata you are fortunate in that this is a known medical condition which a GP can at least recognise although he may be of the opinion that very little can be done to help. Ideally he should be willing to refer you to a consultant dermatologist. If you are lucky, this will be one of the very few dermatologists in this country who have a special interest in hair loss conditions and he will be able to prescribe for you.

But if your hair loss is simply the thinning hair of Alopecia Androgenetica the problem is more complex. Strictly speaking, this is not a medical condition but merely the natural balding associated with growing older. However, thinning hair does occur in many younger women as the result of such things as stress, childbirth, surgery, low serum ferritin (iron stores) and crash diets.

Ideally you should be able to consult your GP on this kind of hair loss but too often a doctor may dismiss it as strictly a cosmetic problem. Having eliminated such possibilities as anaemia or thyroid dysfunction, he may make an attempt to be kind by telling you that your hair “looks fine to me” and suggesting that you

should “try not to think about yourself so much.” My own doctor gazed hopefully out of his surgery window and observed: “It might grow back and it might not.” Then added by way of encouragement: “You can get some very pretty hats these days.”

One Hairline member, asked whether her doctor had diagnosed Alopecia Areata, complained, “My doctor would have difficulty in diagnosing it if I had lost my head, let alone my hair!”

Most GPs are horrified when they hear that hair loss patients, out of sheer desperation, have ended up in the dubious hands of the high street practitioners.

Hair loss itself may not be life threatening, but when it breaks up your marriage, wrecks your career and ruins your life in so many other ways, it is hardly surprising that we end up feeling emotionally in pieces and financially devastated. We would do anything really, so long as we are not ‘bald by morning’.

**Elizabeth Steel**  
*Founder*

*Hairline International: The Alopecia Patients’ Society*

## How Good are Other Helplines at Explaining Your Condition?

Like many other charities we run a helpline to inform and reassure patients. Many other organisations also give advice on sexual health. Herpes simplex is quite a complicated condition to explain. A few months ago we were discussing this in the office and we wondered whether other helplines know the answers when they are asked about herpes simplex and whether or not they refer callers to us if they don’t.

We decided to conduct an experiment to find out so we asked ‘mystery callers’ to phone several helplines with various likely scenarios and questions. When we had finished we tabulated the results – which were interesting. We found that some helplines were woefully inadequate. Many of them just refer callers back to their own doctor or GU clinic. In particular, the childbirth helplines were not able to answer our questions about herpes simplex at the time of birth.

The best helpline was unquestionably the Sexual Health Advice Centre at Addenbrooke’s Hospital, Cambridge which came in at 100% and referred people to us as well. NHS Direct showed up

poorly not only because of lack of accurate information, but also because personal details need to be given because the caller is called back – a definite no-no for many. Other helplines were somewhere in between.

Our director Marian Nicholson was discussing the exercise with Dr Raj Patel, of Southampton Hospital’s Sexual Health department and he suggested that we present our findings to a conference of the British Association for Sexual Health and HIV and American Sexually Transmitted Diseases Association at Bath. This was duly done. A poster was prepared and Marian attended the Conference to explain our work.

The lesson is – find out what other organisations are saying about you and your condition. You might be surprised and you might need to do something about it.

**Nigel Scott**  
*Herpes Viruses Association*

## Exciting Developments at the Pemphigus Vulgaris Network

The Pemphigus Vulgaris Network has been having a very busy time recently, largely focused around our new UK website [www.pemphigus.org.uk](http://www.pemphigus.org.uk) which we hope will be particularly useful for people when they’re newly diagnosed.

We’ve increased our Policy and Development Team to six people and are looking at ways to expand our work. In particular we’re hoping to have another national meeting in 2005/06. Of course, all of this is dependent on resources – both financial and people. All of us are volunteers and living with pemphigus ourselves so sometimes ill-health limits our best laid plans.

But it feels as if we’re at a transition point with quite a lot of exciting

projects going on. We’ve been very pleased to be able to help Dr Karen Harman publicise her current research project and initial responses from people on our mailing list has been very enthusiastic.

Of course, the backbone of our work remains supporting people with pemphigus and mucous membrane pemphigoid. Not everyone has computer access and we continue to spend a lot of time talking to people on the phone, or answering letters. We see our website as additional to this work; nothing really replaces dealing with people’s individual questions especially when they’re about a rare disease.

**Siri Lowe**

# Why do People with Vitiligo Consult Alternative Practitioners?

**W**hy do people with skin disease seek alternative and unproven therapies and what is the real cost to them, not only in terms of money but also the effect on their lives?

Speaking from the viewpoint of people with vitiligo the answer to the first question is clear. Vitiligo is a poorly understood condition among many health professionals. It does not itch, or cause any physical symptoms but the psycho-social impact of loss of skin colour is not to be underestimated. The experience of many of the people who contact the Vitiligo Society for help and support confirms the lack of information, treatment and understanding from their GP. Clinicians can be off hand, belittling the impact of vitiligo and trivialising the condition. In recent weeks a number of our callers have clearly been confused by what little information they have been given, and when they have heard phrases such as "auto-immune disease leading to the destruction of melanocytes", "avoid burning at all costs", and "nothing can be done for you", they have come away believing that they have a fatal form of skin cancer.

It is not at all surprising that people regardless of whether they think the disease is life threatening or otherwise, will feel vulnerable and desperate will try to find help from somewhere else, clutching at any straws that offer them hope of a cure.

When the parents of young children encounter unhelpful attitudes from their doctor they are, understandably, anxious and worried, wanting to protect the child from the misery of obtrusive staring, bullying and name calling. They will therefore go to any lengths to find a successful treatment. A recent case of a family who contacted us illustrates this point very well. On the strength of one article in the tabloid press, they have spent £13,000 and many hours of travel time on unproven laser treatment which they hoped would help their child. The result has been minimal, little more than possibly slowing the rate of depigmentation. Had they been encouraged to contact the Vitiligo Society helpline they could have considered a number of options and learned that children can sometimes regain their normal skin colour without any treatment.

The Vitiligo Society is carrying out a survey of all UK dermatology departments regarding the treatments used. The responses have not yet been fully analysed but it is clear that the level and range of treatment offered varies widely. Some dermatology clinics do not offer any treatment for vitiligo at all. Current NHS treatments are not licensed specifically for vitiligo so the offer of treatment depends on the doctor's interest in the condition and understanding of the impact that it will have on

the life of the patient. Any treatment is given entirely at the dermatologist's discretion.

Re-pigmentation is almost always a very slow process and there is a risk that people become impatient with NHS treatments and resort to unproven alternatives. They are then advised that these alternatives will also take a very long time to have an impact. As a result we often hear of sums of £2,000 and upwards being spent, for example, on herbal medicines. Most worryingly some people are tempted to bypass both their GP and the dermatology services to seek treatments from private clinics both in the UK and abroad, some of which may be effective, but clearly many others are not. All will be expensive.

This is happening more and more as access to the Internet becomes the norm. This has brought an explosion of knowledge to many but this medium is not controlled and there is no way of knowing whether this information is reliable or not. The Society has recently received a request for funding for a study to review information on complementary and alternative medicine for vitiligo on the internet which is currently being considered. This study could provide us with much needed evidence of the value of these treatments.

It is not necessarily a question of NHS treatments being 'good' and all alternatives being 'bad' because the evidence base for both is still shaky. However people do respond well to being treated in a holistic manner which is usually the case when they consult an alternative practitioner. The message that the Vitiligo Society would like to convey to health professionals is that telling a patient there is nothing to be done and sending them away is detrimental. Callers to our helpline repeatedly tell us that what they have found most upsetting is the way in which this news is broken to them. Those who are given good information, have all questions answered fully and feel that the distress caused by the condition has been acknowledged, are likely to cope better with their constantly changing appearance.

Doctors and nurses have a duty of care and should realise that patients will seek other treatments if they are desperate. They should at the very least encourage people to contact the relevant patient organisation to discuss alternative therapy and discourage them from responding to unproven claims and bogus cures in the tabloid press and on the Internet.

**Maxine Whitton and Helen Broughton**  
*The Vitiligo Society*

British Association of Skin Camouflage	Chester training course <sup>+</sup>	27–30 August
Skin Care Campaign	Croydon Skin Information Day <sup>o</sup> Fairfield Halls, Croydon	14th August
Changing Faces	Fun Day for families – London venue and date tba <sup>++</sup>	August
British Association of Skin Camouflage	One-day CPD Seminar: MakeUp over Camouflage Master Class <sup>+</sup>	10th September
Psoriatic Arthropathy Alliance	Conference – Woburn Safari Park, Beds <sup>*</sup>	11th September
Changing Faces	Early Years (0-5 year olds) Regional Day, Manchester <sup>++</sup>	11th September
Changing Faces	Working with a Disfigurement Workshop, Birmingham <sup>++</sup>	11th September
British Association of Skin Camouflage	Refresh Your Camouflage Skills Seminar for CPD purposes <sup>+</sup>	24th September <sup>+</sup>
Skin Care Campaign	Bradford Skin Information Day <sup>o</sup> Bradford University	9th October
Changing Faces	Reach Out (Adults) 2-day workshop <sup>++</sup>	October
Changing Faces	Appearance Matters (13-16yr old girls), London <sup>++</sup>	October
Vitiligo Society	Annual Vitiligo Day - London Institute of Child Health, Guilford Street	13th November

<sup>o</sup> For further information please contact Gwen Banford: Tel. 020 7561 8249 or email: gbanford@eczema.org or visit [www.skincarecampaign.org](http://www.skincarecampaign.org)

<sup>+</sup> For further information please contact BASC, PO Box 202, Macclesfield SK11 6SP, tel: 07732 689278, email [basc9@hotmail.com](mailto:basc9@hotmail.com)

<sup>++</sup> For further details on events, venues and dates, as well as booking forms please contact Changing Faces on tel: 0845 4500 275 or email: [info@changingfaces.co.uk](mailto:info@changingfaces.co.uk).

<sup>\*</sup> Entry is FREE via pass available from the PAA office at PO Box 111, St Albans, Herts AL2 3JQ

## Skin Care Campaign Board Members

Lyn Stone CBE	Chairman
Nigel Scott / Marian Nicholson	Herpes Viruses Association (Nigel – Vice-Chairman)
Jane Watts / Rosemary Humphreys	National Eczema Society
Alison Dudley / Dr Nick Varey	Acne Support Group
Jane Freak	The Wessex Cancer Trust's Marc's Line
Maureen Benbow	Tissue Viability Society

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Copy date for the next issue is **Friday 17th September 2004.**

Please send news/articles/details of forthcoming events to

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