

GUEST EDITORIAL

Some Emphasis on Prevention

One of the benefits of having journals published in different countries is the insight they give into the variations in medical facilities between countries. This is typified by the report of Wennberg and colleagues (pp. 370–372) on Moh's Micrographic Surgery (MMS) for aggressive basal cell carcinoma (BCC) in Sweden. Despite the technique being used – and quite widely so – in many countries, Sweden has only one MMS centre, which explains the results. Less than 1% of BCCs in Sweden are treated by MMS compared with 30% in the USA. (I believe that this estimate may be too high.) Over a 5-year follow-up, BCC recurrences constituted 6.5% of primary tumours and 10% of treated recurrent tumours compared with 2% and 7% respectively in the USA. Because of limited resources, Swedish physicians have treated only 265 BCC patients over a period of 16 years, whereas some USA surgeons treat 150 patients every year. The message is quite clear. MMS is an essential part of the management of some patients with BCCs. The procedure is cost effective and governments should ensure adequate funding for MMS in centres where aggressive BCCs are treated.

Eczema was described by the Ancient Greeks, and yet two millennia later how many physicians can adequately assess in the clinic the severity of atopic eczema? I can't, and I guess not many dermatologists can either. How can we adequately follow-up our patients without such systems? The SCORAD (SCORing Atopic Dermatitis) is well proven but is too complex for clinical use. Wolkerstorfer et al. (The Netherlands) (pp. 356–359) report on a new technique – the TIS score (Three Item Severity) based on an evaluation of erythema, oedema/papules and excoriation on a scale of 0–3. They investigated 126 subjects with eczema of varying severity, and showed a very good correlation between TIS and SCORAD. Interphysician correlations were also good. The best correlate was with excoriation. There are sometimes differences among physicians in interpreting the terminology. Personally, I could not fully understand how to assess oedema in the context of eczema. I would simply choose the alternative term – papules. The TIS technique is obviously quick. I have tried it

out in the clinic – it is easy and definitely better than my terminology of 'moderate eczema'. I agree with the authors: TIS is not sensitive enough for clinical trials but it is adequate for use in the clinic. I suggest that you try it in your clinic!

The World Health Organization recently focused its attention on the increasing international problem of bacterial resistance. Of particular concern is MRSA – a problem that we are seeing more frequently in our atopic dermatitis (AD) patients. Our Japanese colleagues (Inoue et al.) (pp. 360–362) have taken a most useful step forward. They have previously reported on the clinical and microbiological (a decrease in *S. aureus*) improvement of AD in patients treated at the Kusatsu Spa (bathing in acidic hot spring water at a high temperature) and have shown that the bactericidal activities are due to manganese and iodide ions in acidic concentrations (pH 2.0–3.0). A considerable amount of pharmacological formulation and clinical work will be necessary before the potential clinical value of their observations is determined. What lends further support to their concept is the fact that the spa water in which AD patients are treated is sterile, despite millions of *S. aureus* bacteria being deposited into it. Perhaps there will be an increase in atopic patients going on package holidays to the Kusatsu Spa.

In editorials we sometimes forget to give a resumé of case reports and letters. On reflecting over the case reports in the present issue of the journal, the feature by Boyvat et al. (Turkey) (pp. 404–405) of a case of 'idiopathic' unilateral localized hyperhidrosis serves to remind the reader of what is usually a functional naevus; in this case, however, onset was at the age of 41 years. The authors present a good discussion on the causes of localized hyperhidrosis and certainly show that in their patient this condition is idiopathic and non-responsive to therapy.

Finally, included in this issue, a letter by Tessari (Italy) (pp. 408–409) serves to remind us of the increased risk of skin cancer in (renal) transplant patients. Their data confirm that the risk is not related to the type of immunosuppression but to sunshine and the duration of therapy. We are all using more immunosuppressants (i.e. cyclosporine) in our severe psoriatic patients – so should there be a time limit for the use of such drugs?

W. J. Cunliffe, The Skin Research Centre, University of Leeds, Leeds, UK