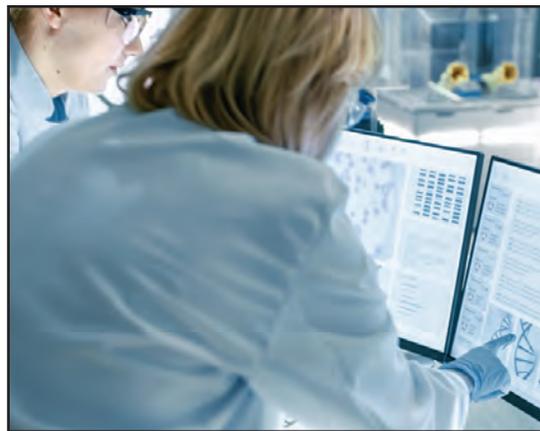




What is the mSWAT?

The mSWAT (Modified Severity-Weighted Assessment Tool) is one of several tools a health care provider uses to monitor active cutaneous T-cell lymphoma (CTCL). CTCL research professionals most commonly use the mSWAT. If you participate in a clinical trial (also known as a research study), chances are your skin will be checked with this tool.

“Tools” sound scary. Fortunately, the mSWAT, and several other assessment tools, only require a provider to look at your skin. A provider may use a tool to complete a visual exam before you even notice.



Before the mSWAT, a dermatology team developed the original SWAT (Severity-Weighted Assessment Tool). The dermatology researchers collected 12 years of data on 323 individual patients over 1186 visits. The SWAT required an additional seven years of analysis before publication in 2002. In total, SWAT development took 20 years.

To perform the SWAT, the provider inspected each individual patch, plaque, and tumor. Multipliers, also known as weighting factors, gave specific “weight” or “value” to each CTCL lesion type. Patches, which are flat, earned a multiplier of one. Plaques, which are raised, earned a multiplier of two. Tumors, which are larger and solid, earned a multiplier of three. Mathematically, a multiplier of three (tumor) contributed to a higher SWAT score than a multiplier of one or two.

The SWAT also utilized a technique known as grid-point counting. The provider used an overlay, or map, to count squares to determine each lesion’s size. Each individual patch size measurement was added with other patch measurements. Plaques and tumors underwent the same process. Next, each patch, plaque, and tumor total was multiplied by the applicable weighting factor. In the last step of the SWAT, the total in each of the three categories of lesions was added to obtain a final score.

The SWAT result was a number that a provider monitored over time. A stable number suggested a stable condition. A lower number suggested less active CTCL and conversely, a higher number suggested more active CTCL.

The “m” in mSWAT means “modified” or changed from the original. Today’s mSWAT increases the tumor weighting factor from a three to a four and eliminates the grid-point counting. Instead, the provider uses body

What is the mSWAT? continued on page 9

2020 Issue 3

From the President and the Chief Executive Officer 3

Living with Cutaneous Lymphoma..... 4

Supporting the Cutaneous Lymphoma Foundation Through Charitable Contributions 5

The Haystack Project 6

Frequently Asked Questions 7

Annual AADA Legislative Conference Update 10

In Memory..... 10

Medical Advisory Council Update 11

What Is Cutaneous Lymphoma?

Cutaneous lymphomas are cancers of lymphocytes (white blood cells) that primarily involve the skin. Classification is based on lymphocyte type: B-lymphocytes (B-cell) or T-lymphocytes (T-cell). Cutaneous T-cell lymphoma (CTCL) is the most common type of cutaneous lymphoma that typically presents with red, scaly patches or thickened plaques of skin that often mimic eczema or chronic dermatitis. Progression from limited skin involvement is variable and may be accompanied by tumor formation, ulceration and exfoliation, complicated by itching and infections. Advanced stages are defined by involvement of lymph nodes, peripheral blood, and internal organs. ❧

FORUM

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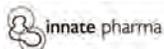
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Disclaimer

The Cutaneous Lymphoma Foundation does not endorse any drugs, treatments or products reported in this newsletter. Information is provided for informational purposes only. Because the symptoms and severity of cutaneous lymphoma vary among individuals, the Cutaneous Lymphoma Foundation recommends that all drugs and treatments be discussed with the reader's physician(s) for proper evaluation, treatment and medical care.

The Cutaneous Lymphoma Foundation's patient educational newsletter, Forum, has been made possible in part thanks to the following generous supporters:



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FROM THE BOARD PRESIDENT

Laurel Carlson



I recently saw a cartoon of an elder speaking to a group of wide-eyed young children, and the caption read, “When I was a kid, we had so much toilet paper we used to throw it into the trees.” That’s a 2020 joke for sure and a reason to laugh at some of this year’s craziness. I think a little bit of humor has been a requirement to help us survive this ordeal.

Another requirement has been flexibility. We have all had to adapt and change our lives in ways that we never could have predicted. Last March, when we had to abruptly stop spending time with our grandchildren, I found a new use for the bedroom that I had created for their sleepovers. I stacked the baby’s crib on top of the toddler’s race car bed, and that allowed enough floor space for me to create a new sewing area. I have been sewing since I was eight years old, but I have never sewn anything that was considered “life-saving” until this year. For the past nine months, I have been making face masks for local medical groups, family members, friends, and anyone else that needed them. It has become more than a pastime. Sewing masks has given me the opportunity to save my sanity while also saving humanity. Although I have not accepted any remuneration, donations to the Cutaneous Lymphoma Foundation were suggested for those wanting to show their appreciation. Consequently,

it has become my very successful making-lemonade-out-of-lemons project.

The Cutaneous Lymphoma Foundation has had to be extremely flexible as well. All of our in-person events had to be cancelled indefinitely and converted to an online format. It has been a challenge, but our staff continues to create virtual events to help meet the needs of our community. Patient networking groups, which we were attempting to expand, are now online and open to everyone, regardless of where they live. I hope that you are able to take advantage of these programs. We welcome your feedback and suggestions to help expand and improve our programming as flexibility is an ongoing process.

Unfortunately, there have been some situations this year where humor and flexibility did not offer the relief that we may have needed. Many of you had treatment regimens interrupted, doctors’ appointments cancelled, coronavirus scares and realities, family separations, and other pandemic-related predicaments. Through it all, I hope that you were able to find a way to save your sanity, and that if you needed any disease-related support, you knew that we were still here, providing the assistance that you needed.

Stay safe and wear your mask,

A handwritten signature in black ink that reads "Laurel". The script is cursive and elegant.

To donate: Text CLFriends1 to 71777 or visit <https://app.mobilecause.com/vf/CLFriends/LaurelCarlson>

FROM THE CHIEF EXECUTIVE OFFICER

Susan Thornton

What a year 2020 has been. I’m guessing you may feel like I do – grateful to see the end of this year and 2021 just around the corner.

Sitting down to write my column for this edition of the Forum, the first thing that came to my mind was THANK YOU!

Thank you for your patience as we moved all of our in-person educational programs to virtual programs.



From the CEO...continued on page 9

Living with Cutaneous Lymphoma

Sarah Gerth



I have been living in Lake Oswego, a small town outside of Portland, Oregon, for over forty years. Originally I am from the East Coast, growing up in Pennsylvania and Maryland, then moving to Portland in my early twenties.

I first had an outbreak of cutaneous lymphoma in 2005, and was diagnosed in 2010 with mycosis fungoides Stage 1 by a local dermatologist. The diagnosis was made after a biopsy was done and sent to a specialty lab. In the past ten years, I have had a variety of treatments. I have had radiation treatments twice on my right forearm and radiation on my right eyelid. The latter was especially difficult to endure, and the radiation both times caused fatigue. The next three years I did phototherapy treatments three times a week, but kept my time in each treatment low because my skin is very sensitive and I burn easily. In 2017, the lesions covered over 15% of my body, so my oncologist started me on chemotherapy with Vorinostat. This was a very difficult chemotherapy, with severe side effects. I experienced fatigue, low blood cell counts, and an inability to eat much due to the strong taste in my mouth. I lost 10 pounds. Most of my hair fell out gradually over a period of four months, then grew back in as curly (my hair is naturally straight.)

In 2017, I found some improvement in the lesions using topical Bexarotene and then topical Nitrogen Mustard. For the next two years I returned to doing phototherapy treatments. My skin is so sensitive I could only do treatments twice a week, and at a low level. Therefore it did not control the outbreaks, which again covered over 15% of my skin. My lymph glands also became enlarged, putting me in Stage 2 of mycosis fungoides. Chemotherapy with Gemcitabine was started in February of 2020. This again had severe side effects, with fatigue, nausea, fevers, thinning hair, and low blood cell counts (neutropenia), so it was discontinued in May 2020.

I am happy to report I am now on an immunological chemotherapy treatment which is working well! It was necessary to have failed two previous chemotherapies to qualify for getting Mogamulizumab as it is so expensive. I understand it has only been available for use in the past two years. I am so grateful to be getting it. I started receiving it in June, and will continue infusions for the next year. There have been five treatments, and I am showing some improvement in my symptoms already.

It has been a long, challenging struggle with MF these past ten years. The treatments have been quite time consuming; applying all the lotions and gels everyday, light treatment two or three times a week, and chemotherapy treatments lasting around four hours each week or two. I am so grateful for my treatments, and for the care I receive from my oncology specialist and from the hospital/clinic. I would recommend others who are getting treatment to find the most knowledgeable doctors, and to get support from family members and friends.

I have found the Cutaneous Lymphoma Foundation to be a great resource and encourage others to participate in it. They have answered my questions and concerns,

continued on page 5

Supporting the Cutaneous Lymphoma Foundation Through Charitable Contributions

As a long time cutaneous lymphoma patient, the newest member of the Board, and a retired estate planning attorney, I'm pleased to offer some suggestions for how you can support the Cutaneous Lymphoma Foundation.

Financial support from individual giving is critical to helping the Cutaneous Lymphoma Foundation fulfill its mission of promoting awareness of cutaneous lymphoma, providing education, advancing patient care and fostering research. These are unprecedented and difficult times; there are so many needs right now. We hope you'll consider making a donation to the Cutaneous Lymphoma Foundation today. Your contribution will help make a difference no matter what the size of your gift.

If you are a patient, talk with your family and friends and let them know the Cutaneous Lymphoma Foundation is important to you. Donations to the Foundation can be made at any time and are wonderful gifts in honor of or as a memorial to someone.

For the remainder of 2020, there are some unique opportunities which can be particularly effective. For people who take the standard deduction and don't itemize (which is many of us these days), you can deduct charitable donations up to \$300, and for those who do itemize, a larger percentage of cash charitable gifts may be deducted. For those taking distributions from IRA's, you probably know that required minimum distributions have been suspended for 2020, but

you can still make qualified charitable distributions directly from your IRA. Depending on your personal situation, there still may be tax benefits in that you are giving away pre-tax assets completely tax free.

Of course, gifts of appreciated assets, such as stock, always present an excellent way to give and can provide a significant tax benefit.

In future editions of the Forum, I will discuss specific estate planning techniques for making charitable gifts. Some are quite simple and can be completed on your own (such as naming the Cutaneous Lymphoma Foundation as a beneficiary in your IRA or life insurance policy), and some will require the assistance of your estate planning attorney (such as naming the Foundation as a beneficiary in your Will or living trust). Be sure to talk with your legal and tax advisors to determine what makes the most sense for you. In the meantime, if you have any questions about making a gift to the Cutaneous Lymphoma Foundation, please contact Holly Priebe at (248) 644-9014, Ext. 2 or holly@clfoundation.org. Your gift will help sustain the critical work of the Foundation in fulfilling its vision of a life free of cutaneous lymphoma.



Living with Cutaneous Lymphoma...continued from page 4

and provided a wealth of information. The Cutaneous Lymphoma Foundation provides a newsletter and online webinars. I have had access to participating in a networking group in which I have met others who are living with this rare disease. Prior to joining the networking group, I had not met anyone else who has this disease. We have shared our stories and supported one another. I was able to attend a conference in Portland presented by the Cutaneous

Lymphoma Foundation a few years ago and to greatly increase my knowledge and awareness. Research into new treatments and advocacy are also provided at the Foundation. I am grateful for all of the support Cutaneous Lymphoma Foundation has provided for me. Knowing I am not alone in the struggle that others are living, learning, coping and thriving with cutaneous lymphoma is heartening. 🌟



The Cutaneous Lymphoma Foundation is an active member of the Haystack Project, a coalition of rare and ultra-rare disease advocacy organizations whose mission is to educate policymakers about – and remove – barriers to patient access to treatments and the reimbursement structures in our healthcare system that systemically discriminates against rare and especially ultra-rare patients. Although much bigger groups like NORD, RDLA and Global Genes have broader policy missions, Haystack singularly focuses on reimbursement, value and patient access – issues that can sometimes seem daunting in their technicality. But their impact is anything but technical – We can get a drug approved as safe and effective after years of research and development, only to be turned away by our insurance plans. That’s NOT technical! And it is why we count on the Haystack Project to unravel technically complex issues for us and help us understand the impact to our patients, now and when new treatments finally

get here. Uniquely, Haystack meets with its participating organizations regularly to both educate about these issues and learn from member organizations’ experiences to inform their work.

The Cutaneous Lymphoma Foundation appreciates the power of working collectively with other ultra-rare disease groups to increase our voice and make a difference. We, and our patients specifically, have shared our patient stories to help get two new Haystack bills introduced that, if enacted, will help our community:

1. The HEART Act contains tangible and practical solutions for involving patients and rare disease experts in the FDA review process to better inform the review of drugs for safety and efficacy.
2. The Access to Rare Indications Act is a game-changing bill that will (a) ensure indications for rare and ultra-rare treatments are covered to the full extent of FDA’s label and (b) requires insurance coverage for off-label uses if listed in compendia or peer-reviewed journals.

Aside from legislation, the Cutaneous Lymphoma Foundation has learned a lot about value assessments and how what patients value is not sufficiently considered. We are working with the Haystack Project to lay the foundation for making sure patients – and not just health plans – are asked what is truly meaningful to them in any new treatment that comes to the market.



Frequently Asked Questions

Can I use light therapy at home?

Dr. Frank Glass: I think it's a great concept, but it has to be done within the context of the way ultraviolet light is given for a number of different reasons. One reason that you might use narrowband at home is because it's difficult to get to a center that has ultraviolet light and another reason might be that the disease is occurring in an area of the body which wouldn't be exposed to conventional narrowband.

It is very effective, for example, somebody might have had ultraviolet light to the point that the disease is only now concentrated let's say to the armpits, because it's a photolabile disease. Well, when you're in a light box getting professional light at the university, it's very hard for you to keep your arms up for the exposure to the

axilla. So you could potentially have a home unit and sort of just hover your armpits over a lamp and treat it that way. So you know there is a lot of benefit to having the home unit, it's usually a narrowband unit, but the only problem is that very few institutions that provide ultraviolet light will help you out because they like to give outpatient narrowband UVB at a center. I do think it's a really valuable asset to be able to do that (at home), but it has to be done properly, so you don't burn, so you don't undertreat, just so many nuances.

.....

If I am being seen by a dermatologist, do I need to get a second opinion from a lymphoma specialist, hematologist, or oncologist? Should they work in conjunction with one another?

Dr. Craig Okada: The role of the different people who are involved in the treatment and the management of mycosis fungoides varies a little bit from

FAQ continued on page 8



FAQ *continued from pg 7*

place to place. It is a rare disease, as I'm sure you are all aware, so many times your local dermatologist, or oncologist, or even radiation oncologist (if you need that kind of treatment), don't see a lot of patients with this disease and don't have the familiarity. In the same way as in the dermatology side of things on the pathology side of things, so when they get the biopsy and say hey, this is suspicious, but I don't see enough of these, it is oftentimes sent to a local expert pathologist who sees a lot of this and can help to determine is this really mycosis fungoides or not?

Whether you see somebody like me, I'm a hematologist, partly depends on the extent of the disease. If the treatment of the disease is going to be what we call skin-based, so light therapy, topical steroids, topical medicines, things like that, I really don't need to be involved very much.

So it isn't always necessary to get a hematologist involved at the initial stages of a person diagnosed with mycosis fungicides. Some institutions have what they call a multi-disciplinary clinic...for example at Stanford University...a dermatologist, a hematologist, and a radiation oncologist, they meet for a clinic there, so a patient who comes there, oftentimes gets opinions from all three different disciplines.

Is there a limit to how much radiation a person can have?

Dr. Christopher Kelsey: The good news is that the skin can tolerate a lot of radiation if it's given over a long time period. So, for example some patients with breast cancer will get six weeks of radiation to the breast and then years later the cancer may come back and we can, in most cases, give an additional four weeks of radiation pretty safely; so that's just to give you an idea of the numbers, that can be about 100 gray, in terms of just the number. Most of my patients that we treat for mycosis fungoides are treated to eight to ten gray or so. So that allows us some flexibility to treat areas more than once if necessary. When we treat with total skin electron beam therapy we either give a low dose or a high dose, but even the high dose is only 36th grade so there is a limit to how much the skin

can tolerate but most patients with mycoses fungoides are getting such low doses that we can repeat it several times over a period of years.

Can tumors in later mycosis fungoides stages be treated with radiation without having tried systemic treatments or is radiation only tried after the tumors have not responded to other treatments?

Dr. Christopher Kelsey: It kind of depends on the circumstances; at Duke we generally will take patients who have larger tumors and try to manage that with a short course of radiation to get those under better control because we know that for example, light therapy is not going to penetrate deep enough. Topical treatments like steroids or nitrogen mustard, they're just not going to penetrate deep enough, and systemic treatments like interferon or Targretin are just often not quite as efficacious when patients have larger tumors.

A very common pattern at our institution is to treat these larger tumors with a short course of radiation, and then we can start some other regimen for everything else, and then re-evaluating at that point. It's not wrong to try other things first, it's just you know, if you have a patient that has a really troublesome tumor that has a bandage on it because it's bleeding or whatever, sometimes it's best just to get it the best treatment for that one and then start with the rest of the things later.

Answers provided by:

Frank Glass, MD
George Washington University School of Medicine and Health Sciences

Craig Okada, MD
Oregon Health and Science University

Questions and responses taken from our Answers from the Experts LIVE video recording from November of 2020. For the full-length video, please visit: https://www.youtube.com/watch?v=TbMAk9F_q48&feature=youtu.be

What is the mSWAT? *continued from pg 1*

surface area (BSA) in 12 body areas to calculate skin involvement. BSA measures the percent of the body with patches, plaques, and tumors. Look at column two in Figure X, titled “% BSA in Body Region”. The 12 body areas are described along with the value assigned to each area. According to the mSWAT, the head represents 7% BSA. The thighs (front and back) represent 19% BSA. Entire body involvement results in 100% BSA. Accordingly, 0% BSA represents clear skin.

Has your provider ever asked to see your hand? Although there are several simple methods available to calculate the BSA, the mSWAT uses the palm plus fingers method. This method equates 1% BSA to the individual patient’s palm plus fingers. The provider needs a good look at the patient’s hand to use this tool. In Figure X, the head size equates to seven of an individual’s palm plus fingers. The neck size equates to two of an individual’s palm plus fingers and so on down the list.

With such a complex tool, it can be helpful to look at an example. Figure X depicts the mSWAT of patient A. Patient A has two CTCL patches, 1% BSA each. According to the 1% definition, each patch is equivalent in size to patient A’s palm plus fingers. One patch is on the upper arm and the other is on the foot. On the stomach, or anterior trunk, there is one plaque, 2% BSA, equivalent to two palms plus fingers. On the forearm, there is a tumor, 0.5% BSA, half patient A’s palm plus fingers. The columns are added

and then multiplied by the assigned weighting factor. In this example, the mSWAT result is 8, the three columns’ summation.

The same provider should perform the mSWAT every time. There are differences in how each provider performs this assessment. If you move from one doctor’s office to another, expect a different mSWAT result, even if your CTCL remains the same.

Some healthcare providers find the mSWAT too difficult to use in routine CTCL care. Instead, many providers choose BSA alone to monitor skin. To get an accurate CTCL picture over months and years, the selected tool and method must remain the same.

Is there an app for that? Yes! A clinical team at St. John’s Institute of Dermatology in London, England, developed the Cutaneous Lymphoma Resource Tools, also known as the CL-App. The CL-App allows a provider to easily input data and quickly calculate a mSWAT result.

Patients often feel overwhelmed when trying to understand medical terminology. Patients diagnosed with a rare disease may find this especially true. Be kind to yourself. It’s a whole new language. Remember that you have partners in this journey. Reach out to your healthcare providers. Reach out to your family and friends. And of course, the Cutaneous Lymphoma Foundation is always here to support you.

Figure X

Modified Severity Weighted Assessment Tool (mSWAT) Example/ Patient A

Body Region	% BSA in Body Region	Assessment of Involvement in Patient’s Skin		
		Patch	Plaque	Tumor
Head	7			
Neck	2			
Anterior Trunk	13		2	
Arms	8	1		
Forearms	6			0.5
Hands	5			
Posterior Trunk	13			
Buttocks	5			
Thighs	19			
Legs	14			
Feet	7	1		
Groin	1			
Subtotal of lesion BSA		2	2	0.5
X Weighting factor		x1	x2	x4
Subtotal lesion BSA x weighting factor		2	+ 4	+ 2 = 8

NOTE: mSWAT score equals summation of each column line. In this example, the mSWAT score = 8
Abbreviations: BSA = body surface area



Don't miss out, make sure to subscribe to the Cutaneous Lymphoma Foundation's YouTube channel (CutaneousLymphomaFnd) and follow us on Facebook and LinkedIn.

For a list of our current virtual programs, please visit our website:

<https://www.clfoundation.org/upcoming-events>

ANNUAL AADA LEGISLATIVE CONFERENCE UPDATE

Every year, the Cutaneous Lymphoma Foundation attends the American Academy of Dermatology Association’s (AADA) legislative conference. The conference includes two days of in-depth learning about issues and legislation that impact the area of dermatology, followed by a day on the Hill meeting with members of Congress to share our mutual concerns. The Academy invites the Coalition of Skin Diseases (CSD) member organizations to participate in the effort to provide the patient voice regarding how the issues impact those living with skin-related diseases.

With COVID-19, this year’s conference and meetings with members of Congress were held virtually. Advocates were prepped on the issues in advance of the virtual Day on the Hill. Perhaps due to the convenience of not needing to travel to participate, this year’s conference attendance exceeded past years with 312

advocates representing 41 states participating in 274 meetings. The issues addressed were largely focused on COVID-19 and its impact on dermatologists’ ability to provide timely and safe care to patients. Additional concerns were the proposed Medicare changes and their potential impact on services like dermatopathology.

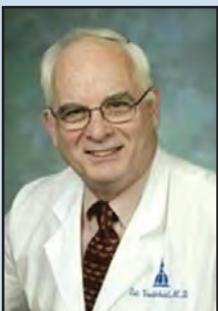
Over the course of the conference, we were excited to cross paths with several dermatologists we consider to be specialists in cutaneous lymphoma. Recognizing the power in combining the medical community and patient advocate “voices” is why the Foundation, as a CSD member, makes participation in the AADA Legislative Conference an annual priority.

If you would like learn more about the Academy’s concerns related to patient access to care and how you can help, visit: <https://fastaction.aad.org/>



In Memory of Dr. Steven Ernest Jones

Steven Ernest Jones, MD, FACC, FSCAI, age 60, passed away peacefully at his home surrounded by his family on September 16, 2020. Dr. Jones was a dedicated physician and interventional cardiologist to thousands of patients spanning his 27 years in practice at CVA. He loved medicine, but he loved his patients even more. He also served on the Cutaneous Lymphoma Research Advisory Council. The Cutaneous Lymphoma Foundation extends our deepest condolences to Dr. Jones’ family and friends.



In Memory of Dr. Eric Carl Vonderheid

Eric Carl Vonderheid, M.D., former Professor of Dermatology and Oncology at Johns Hopkins University between 2002 and 2007, passed away on October 24, 2020. Dr. Vonderheid served in the US Navy for 2 years before starting his dermatology career at the Skin and Cancer Hospital, Temple University and later Hahnemann University in Philadelphia. His research was focused on the study and treatment of lymphomas of the skin. Dr. Vonderheid was a founding member of the International Society for Cutaneous Lymphomas. The Cutaneous Lymphoma Foundation is deeply saddened to hear of Dr. Vonderheid’s passing and we extend our deepest condolences.

MEDICAL ADVISORY COUNCIL UPDATE



Ellen Kim

The Cutaneous Lymphoma Foundation would like to give a heartfelt thank you to Dr. Ellen Kim, who has served for the past three years as the Chair of our Medical Advisory Council (MAC).

The Medical Advisory Council and its members' expertise is invaluable to the Foundation and the people it serves. The Cutaneous Lymphoma Foundation strives to provide the most accurate, up-to-date and credible information to its constituents, and the MAC members' guidance is one way we accomplish this.

Over the past several years, under Dr. Kim's leadership, we have furthered our treatment center program, updated and enhanced our website content as well as printed content, and continued to provide quality programs to our community. We sincerely thank

Dr. Kim for her service and continued dedication to patients.

With Dr. Kim's departure as Chair, she will serve as an Emeritus advisor on the Council and we are pleased to announce that Dr. Michi Shinohara will take over as Chair.

Dr. Shinohara has proven to be an invaluable member of our Council through her tireless efforts to assist with Foundation programs and services. Dr. Shinohara



Michi Shinohara

specializes in the care of complex medical dermatology patients and maintains a multidisciplinary Cutaneous Lymphoma Clinic in addition to holding the title of Director of Inpatient Consultative Dermatology at the University of Washington Medical Center.

From the CEO...continued from pg 3

Thank you for answering our surveys to share your thoughts on providing value to you in an online environment.

Thank you for hanging in there with us as we learned new technology and offered new ways to connect virtually.

Thank you to all the individuals and companies that donated to support our mission.

Thank you to the fantastic Cutaneous Lymphoma Foundation team – Holly, Deb, Hilary and Sue. They worked harder than ever to learn new technology, do more than they thought they could, and gave up many nights and weekends to make the magic happen.

Thank you to our incredibly dedicated volunteer Board of Directors. They helped us navigate these uncertain times with their advice, guidance, and generous support. Thank you to our fabulous clinical volunteers who served on our Medical and Research Advisory Councils. Your knowledge, perspective, and support helped us continue to deliver vetted, valuable clinical information, and programs.

And most of all, thank you to our growing community. It is because of you that the Foundation was created and continues to exist today. We are humbly at your service.

As we open the door to 2021, I see hope for a better year ahead. There will undoubtedly be challenges, and COVID-19 will still have a grip on all of us – and there is light at the end of this long, dark tunnel.

With deep gratitude for your trust and faith in the Foundation, I hope you find this final Forum edition in 2020 filled with informative articles you can use and inspiration for your journey ahead.

Together we will take the leap into the new year. Together we will turn the page and write a new chapter. Together we will weather whatever 2021 has in store for us with hope, community, and a lot of virtual hugs.

Be well,



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TIME SENSITIVE MATERIALS ENCLOSED

Please give what you
can, \$30, \$60, \$120 –
every dollar counts.

We are asking
because we can't do
this without you!



TOGETHER, we are making an impact, but the work is not done. For every connection we've made, there are still many we have not. Every day new people reach out with their unique needs. We need to be here to answer their call.

Your generosity and commitment are helping us build a world free of cutaneous lymphoma one step at a time.

Thank You!

DONATE TODAY; ONLINE, BY PHONE OR BY MAIL

Online: <https://www.clfoundation.org/giving-online>

By Phone: (248) 644-9014 Ext 1

By Mail: PO BOX 374, Birmingham, MI 48012
(a remittance envelope has been enclosed for your convenience)