Guidance for Doctors who Offer Cosmetic specifically with its Council (GMC) generic professional capabilities and transparency is required, aligned with the General Medical Council. Professional behaviour and aspects of our work, we must remain mindful of unconscious bias and conflicted interests, particularly where financial gain is involved. Professional behaviour and transparency is required, aligned with the General Medical Council (GMC) generic professional capabilities and specifically with its Guidance for Doctors who Offer Cosmetic Interventions.

The Director of Education and Quality at Health Education England has observed that ‘social media has changed what is acceptable for professionals to do’: however, it is necessary for us to continually reflect upon and accept constructive feedback in order to develop a culture that champions professionalism.

Regulation of the nonsurgical cosmetic sector is fragmented, owing to the wide range of practitioner background, ranging from GMC-registered specialists such as dermatologists and plastic surgeons, to peripatetic injectors with no qualifications. Complicating matters further is the increasing cohort of so-called ‘DIY injectors’: members of the public who purchase products, often of dubious provenance, online and then self-treat.

The recent breast implant (poly-implant prosthesis) scandal emphasized the consequences of erratic regulation in cosmetic surgery. The subsequent Review of the Regulation of Cosmetic Interventions led by Sir Bruce Keogh in 2013 shone a damning spotlight on the nonsurgical sector, citing an alarming disregard for patient safety. This galvanized pre-existing nascent attempts to increase regulation, led by medical and nursing professional societies.

With multistakeholder involvement and subsequent public consultation, training frameworks for all learner groups in five main techniques used in nonsurgical cosmetic practice (botulinum toxin, dermal filler injection, skin rejuvenation, laser/light therapy and hair restoration) were published in 2015 by HEE. In 2018, at a launch in the House of Lords, the Cosmetic Practice Standards Authority (CPSA) and the Joint Council of Cosmetic Practitioners (JCCP) arose as the winning partnership tasked with raising standards of practice at national level, in the absence of direct regulation.

The CPSA, founded by the British Association of Aesthetic Plastic Surgeons, the British Association of Plastic Reconstructive and Aesthetic Surgeons, the British Association of Dermatologists and the British Cosmetic Dermatology Group is a charitable incorporated organization. Membership includes representation from the founding organizations, the JCCP and patient groups. Multistakeholder workshops and public consultation led to agreed professional standards of practice for all five cosmetic techniques outlined in the HEE frameworks.

The CPSA aims to instil professionalism and champion patient-safety. Supervised practice and development of support networks are instrumental to its ethos, along with the concepts of continuous learning and accountability. In collaboration with the JCCP, further aims include promotion of adverse-event reporting and data collection; including horizon-scanning to raise an early alarm for procedures emerging as outliers in terms of risk.

The JCCP manages the register of practitioners to ensure compliance with CPSA standards. It holds an impressive clutch of supporting bodies across multiprofessional groups, including the GMC, General Dental Council, Nursing and Midwifery Council, and those representing the pharmaceutical and beauty therapy sectors. It also works in recognized partnership with regulators such as the Care Quality Commission, the Medicines and Healthcare products Regulatory Agency, the Advertising Standards Agency, the Office of Qualifications and Examinations Regulation, and environmental/public health institutions. In collaboration with patient support groups and engagement of relevant practitioners, it offers an accepted kite-mark for delivery of high-quality service.

In a sector where a consistent minimum standard of professionalism and lifelong learning is sorely lacking, the CPSA standards and JCCP register have implemented initiatives for the diverse and fragmented practitioner cohort where overarching regulatory bodies may not exist. The
stakes are even higher in the current climate, due to the ‘Zoom boom’ phenomenon and the usual associated procedure-related risks. However, inadvertent dissemination of coronavirus due to nonadherence to government guidance on personal protective equipment and lockdown restrictions by rogue practitioners only adds to the mix. For those who engage in nonsurgical cosmetic practice, enrolment onto a voluntary register not only signals that your individual practice is aligned to agreed professional standards, but is an act of solidarity to support high standards, transparency and professionalism across a sector in dire need of these.

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Conflict of interest: the authors declare that they have no conflicts of interest.
Accepted for publication 15 April 2021

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γδ-T cells as a potential candidate contributing to the development of psoriatic cardiovascular disease

doi: 10.1111/ced.14685

Dear Editor,
Psoriasis is an immune-mediated inflammatory skin disease affecting the cardiovascular system.1 Gamma delta (γδ) T cells are found in the skin lesions of patients with psoriasis and in imiquimod (IMQ)-induced psoriasis mouse models, and are associated with the relapse of psoriatic skin.2 We found that the expression of γδ-T cells in patients with psoriasis is negatively correlated with the neutrophil/lymphocyte ratio (NLR), that is related to risk of cardiovascular event (CVE) (Fig. 1). Therefore, γδ-T cells could possibly play a role in the development of psoriatic CVEs. We present a case of a 63-year-old man who experienced CVE along with a relapse of his psoriasis, closely mimicking our hypothesis.

The patient had a 20-year history of psoriasis, which was managed by topical glucocorticoid application and the lesion area was maintained at < 5% of total body area. He developed contact dermatitis after dyeing his hair and was treated with intravenous dexamethasone 5 mg for 7 days. Two weeks later, he had a relapse of his skin lesions, and his psoriasis type changed to psoriatic erythroderma (Fig. 2a). Meanwhile, without other precipitating factors, the patient also developed squeezing retrosternal chest pain plus dyspnoea, and was admitted to our hospital.

Coronary angiography at admission revealed a 99% narrowing of the left main coronary artery, left anterior descending branch (proximal) and left circumflex branch (proximal) (Fig. 2b). Percutaneous coronary intervention (PCI) was performed and the patient was discharged after 28 days of hospitalization. His cardiovascular system and psoriasis (no new lesions) were both stable. The γδ-T-cell percentage in the patient’s peripheral blood mononuclear cells when measured during the stable phase of psoriasis was 2.1% (7.4% before PCI, 1.0% at 3 weeks after PCI).3 This case indicates that compared with normal levels (3%–5%), the γδ-T-