Progress toward Treatment and Cure of Epidermolysis Bullosa: Summary of the DEBRA International Research Symposium EB2015

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Epidermolysis bullosa (EB), a group of complex heritable blistering diseases, is the topic of triennial research meetings organized by DEBRA International, Vienna, Austria, the network of national EB patient advocacy organizations. The DEBRA 2015 Research Conference, held in May 2015, brought together investigators and clinicians from around the world working at the forefront of EB research. Discussing the state-of-the-art approaches from a wide range of disciplines, there was a palpable excitement at this conference brought about by the optimism about applying new sequencing techniques, genome editing, protein replacement, autologous and allogeneic stem cell therapy, innovations in cancer biology, revertant mosaicism, and induced pluripotent stem cell techniques, all of which are aimed at developing new therapies for EB. Many in the field who have participated in EB research for many years were especially enthusiastic and felt that, possibly for the first time, the field seems uniquely poised to bring these new tools to effectively tackle EB. Multiple complementary approaches are currently in motion toward improved quality of life and eventually a cure for patients suffering from EB, a currently intractable disease.

Journal of Investigative Dermatology (2016) 136, 352–358; doi:10.1016/j.jid.2015.10.050

INTRODUCTION

Epidermolysis bullosa (EB), a group of heritable blistering disorders, consists of four main subtypes primarily distinguished by the level of blistering within the cutaneous basement membrane zone (Table 1). Each of these subtypes can display a spectrum of phenotypic severity reflecting the types and combinations of mutations in different genes, together with modifying environmental factors. The types of mutations also determine the mode of inheritance, either autosomal dominant or autosomal recessive. Currently 18 genes have been shown to be associated with the different subtypes of EB (Table 1). In spite of the tremendous progress made in understanding the molecular basis of different forms of EB, there is no cure for this disease.

DEBRA International, Vienna, Austria, an organization advocating on behalf of the patients with EB and their families, sponsors Triennial Research Conferences. The latest one in this series, organized by DEBRA of America, New York, in Braselton, GA, in May 2015, was attended by more than 100 researchers, physician-scientists, trainees, and patient support group representatives (Figure 1). This meeting report summarizes the presentations and discussions that took place in this conference.

MODEL SYSTEMS FOR EB

Animal models

In addition to many naturally occurring EB forms in animals reviewed previously (Bruckner-Tuderman et al., 2010, 2013; Uitto et al., 2010), a variety of model systems have been generated.

Novel murine models. Some recently developed animal models have revealed unexpected consequences and improved our understanding of phenotypic variability. For example, careful analysis of mouse models for junctional EB (JEB) identified the first major genetic modifier of JEB phenotype due to a laminin-γ2 mutation by collagen XVII, in particular molecular variations in its NC4 domain (Sproule et al., 2014). Also, a recently reported knock-in mouse model for JEB that displays alternative splicing of the Lamb3 gene will aid in defining further genetic modifiers of JEB phenotypes (Hammersen et al., 2015).

Another interesting finding relating to junctional skin blistering was revealed by the deletion of the linker extracellular domain of transmembrane collagen XVII in mice. This led to alternative shedding of the ectodomain, but not to JEB. Instead, induction of autoimmune blistering and itching were observed, and the phenotype of the mice mirrored signs of bullous pemphigoid, including perilesional eosinophilic infiltrations, blood eosinophilia, and elevated serum IgE levels (Hurskainen et al., 2015). Future work will be aimed at discerning mutations and disease mechanisms predisposing to mechanobullous versus inflammatory blistering phenotypes in both humans and mice.

Because of the multiorgan involvement, the severity of the phenotypes, and significant unmet medical need, the

Abbreviations: BM, bone marrow; BMT, bone marrow transplantation; DEB, dystrophic EB; EB, epidermolysis bullosa; HMGB1, high mobility group box 1; iPSCs, inducible pluripotent stem cells; JEB, junctional EB; MSC, mesenchymal stromal/stem cell; RDEB, recessive DEB; SCC, squamous cell carcinoma
Dystrophic forms of EB (DEB) have been the focus of many investigations often using previously developed collagen VII knockout or hypomorphic mice (Fritsch et al., 2008; Heinonen et al., 1999). In addition, a rat model for dominant DEB, which exhibits a gene dosage effect, offers a possibility of evaluating the influence of modifier genes on DEB phenotype (Nyström et al., 2013).

Zebrafish and drosophila. Interesting alternative animal models to study EB have recently been reported, including zebrafish and drosophila. Several of the EB-relevant genes are expressed in zebrafish, and therefore, this model system has been used to generate skin-blistering phenotypes reflecting features of EB, such as morpholino-mediated knockdown of collagen XVII gene expression (Kim et al., 2010; Li and Uitto, 2014). Recent work has used the keratin-free tissue environment in drosophila to investigate the formation of keratin networks and to define mechanisms by which mutated keratins cause cellular pathology (Bohnekamp et al., 2015). Human keratins 5 and 14, when expressed in drosophila epithelia, formed well-organized keratin networks thus validating the fly as a novel genetic model system for keratin physiology and pathology. Inclusion of a mutated keratin 14 in the networks caused semilethality, wing blisters, and perturbed cellular integrity. This drosophila model of EBs will be valuable for further investigation of the effects of different keratin mutations, their cellular consequences, and possibilities for therapeutic interventions.

Organotypic cultures
Yet another model to investigate disease mechanisms and test therapeutic approaches is the 3D skin equivalent organotypic cultures. One study treated grafted human recessive DEB (RDEB) equivalents topically with recombinant human collagen VII and showed that the therapeutic collagen restored

Table 1. Molecular heterogeneity of different forms of EB

| Disease                  | Gene   | Cytogenetic location | Inheritance | Proportion of EB attributed to mutations in this gene |
|--------------------------|--------|----------------------|-------------|-----------------------------------------------------|
| Simplex epidermolysis bullosa (EBS) | KRT5   | 12q13.13            | AD          | 75% of EBS-AD cases;                                |
|                          | KRT14  | 17q21.2             | AR, AD      | 15 cases of EBS-AR have been reported with KRT14 mutations |
|                          | TGM5   | 15q15.2             | AR          | Up to 10% cases of EBS                              |
|                          | DSP    | 6p24.3              | AR          |                                                     |
|                          | PKP1   | 1q32.1              | AR          |                                                     |
|                          | JUP    | 17q21.2             | AR, AD      |                                                     |
|                          | EXPH5  | 11q11.3             | AR          |                                                     |
|                          | PLEC   | 8q24.3              | AR, AD      |                                                     |
|                          | DST    | 6p12.1              | AR          |                                                     |
|                          | ITGB4  | 17q25.1             | AR          |                                                     |
|                          | COL17A1| 10q24.3-q25.1       | AR          |                                                     |
| Junctional epidermolysis bullosa (JEB) | LAMA3  | 18q11.2             | AR          | 9% of all JEB cases; specific mutations in the LOC (Shabir) syndrome |
|                          | LAMB3  | 1q32.2              | AR          | 70% of all JEB cases                                |
|                          | LAMC2  | 1q25.3              | AR          | 9% of all JEB cases                                 |
|                          | COL17A1| 10q24.3-q25.1       | AR          | 10% of all JEB cases                                |
|                          | ITGA6  | 2q31.1              | AR          | A few cases reported                               |
|                          | ITGB4  | 17q25.1             | AR          | Many cases reported                                |
|                          | ITGA3  | 17q21.33            | AR          | A few cases reported                               |
| Dystrophic epidermolysis bullosa (DEB) | COL7A1 | 3p21.3              | AR, AD      | 100% of all DEB cases                              |
| Kindler syndrome (KS)    | FERMT1 | 20p12.3             | AR          | 100% of all KS cases                               |

Abbreviations: AD, autosomal dominant; AR, autosomal recessive; LOC, laryngo-onycho-cutaneous syndrome.
anchoring fibrils and promoted dermal-epidermal adhesion (Wang et al., 2013). Another investigation combined gene corrected epithelial stem cell clones for the epidermal compartment and fibroblasts in the dermal compartment and used the equivalents to test the structure and stability of the corrected skin (Duarte et al., 2014).

**SQUAMOUS CELL CARCINOMA IN RDEB**

**Clinical challenge**

Squamous cell carcinoma (SCC) remains the biggest cause of mortality in patients with RDEB with more than 80% succumbing by age 55 years (Fine et al., 2009). These tumors, while histologically often well differentiated, demonstrate aggressively invasive behavior with development of multifocal lesions and rapid metastasis. Clinically, there is still no consensus on the best way to tackle this formidable clinical problem, and new and effective therapies are in urgent need (Mellerio et al., 2015).

**Therapy development**

It is clear that lack of type VII collagen in RDEB has a significant impact on overall dermal architecture (Küttner et al., 2013; Nyström et al., 2013) that has been shown to promote tumor progression (Ng et al., 2012). One plausible strategy for therapy would be to target this altered, fibrotic microenvironment. For example, targeting the cancer-associated fibroblasts with the Janus Kinase (JAK) inhibitor ruxolitinib has been shown to prevent in vitro invasion of SCC tumors driven by the contractility of activated, surrounding fibroblasts (Albrengues et al., 2014). Given the demonstrable role of fibroblasts in RDEB-associated SCC (Ng et al., 2012), this small molecular inhibitor may well provide a viable SCC treatment option. With respect to targeting the tumor keratinocytes, screening of polo-like kinase inhibitors has identified a lead compound that showed good preclinical data in targeting tumor over normal cells, and this compound is currently in phase II/III trial for other malignancies. As such, there is hope that direct translation of this screen will be possible within a short timeframe.

**SCC genomics**

Genetically, RDEB-associated SCCs remain poorly characterized. Although a high burden of driver mutations has been highlighted in a handful of RDEB tumors as compared with UV-induced SCCs by traditional Sanger sequencing (Arbiser et al., 2004; Pourreyron et al., 2007; Wang et al., 2011), comprehensive analysis of all protein coding genes and overall understanding of tumor burden and spectrum of mutations in these tumors are lacking. In the light of a recent demonstration that non-RDEB UV-exposed skin harbors a huge burden of mutations (Martincorena et al., 2015), one might speculate that the altered microenvironment in RDEB is unable to suppress alterations in proliferation and differentiation as a result of mutations in genes such as TP53 or NOTCH1. Efforts to collect and sequence RDEB-associated SCCs are in progress (Ray Cho, personal communication).

**Roles of infection and inflammation**

Recent work has identified a possible link with microbial infection, inflammation, and tumor development in RDEB (Hoste et al., 2015). Although inflammation has long been suspected to play a major role in tumor development in RDEB, documented evidence is lacking. Recent work using a mouse model has shown that tumors formed after wounding are accelerated by the addition of bacterial flagellin. Antibiotic administration reduced tumor burden, and tumor formation in this model was dependent on leukocytes, Myd88, and TLR5-driven NFkB signaling (Hoste et al., 2015). This evidence raises the possibility that a preventative measure might be to reduce bacterial load in RDEB skin.

**THERAPY DEVELOPMENT**

A number of novel approaches toward the treatment of EB have been recently developed, and in particular, significant progress has been made in cell-based therapies, in gene replacement and repair technologies, and in direct protein replacement therapy (Table 2). Many of these approaches have reached a milestone that allows them to move to early clinical trials; the currently approved clinical trials on EB are listed in Supplementary Table S1 online.

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**Table 2. Molecular and pharmacological approaches for the treatment of EB**

| Approach | Strategies | Current status¹ |
|----------|------------|-----------------|
| Cell-based therapies | Injection of allogeneic fibroblasts | CT |
| | Systemic or perilesional administration of mesenchymal stem cells | CT |
| | Autologous application of revertant mosaic cells | CT |
| | Use of cord blood stem cells | PC |
| Bone marrow transplantation | BMT after complete myeloablation | CT |
| | Nonmyeloablative conditioning | CT |
| | Autologous inducible pluripotent stem cells | PC |
| Gene therapy/mRNA editing | Autologous keratinocyte and/or fibroblast therapy | CT |
| | CRISPR/cas editing | PC |
| | RNA trans-splicing | PC |
| Protein replacement therapy | PTC read-through and NMD antagonists | PC |
| Novel and repurposed drug treatments | Delivery of recombinant type VII collagen in recessive dystrophic epidermolysis bullosa (RDEB) | PC |
| | Anti-itch medications | PS |
| | Antifibrotic molecules (losartan and ruxolitinib) | PC |
| | Anti-inflammatory therapies | PS |
| | Enhanced wound healing (cathelicidin, Zorbila, Kerigel) | PS |

Abbreviations: CT, clinical trials initiated, ongoing or recently completed; PC, these approaches are tested in preclinical studies, often utilizing appropriate mouse models of EB; PS, testing of these drugs is at the planning stages; BMT, bone marrow transplantation; PTC, premature termination codon; NMD, nonsense-mediated mRNA decay.

¹For details on ongoing clinical trials; see Supplementary Table S1.
**Cell therapy**

**Fibroblasts.** Therapeutic application of autologous or allogeneic cells is now being explored in clinical trials in different forms of EB. Two proof-of-concept studies in RDEB subjects demonstrated that a single intradermal injection of allogeneic fibroblasts increased COL7A1 gene expression in most individuals (Nagy et al., 2011; Wong et al., 2008). These trials also demonstrated the low immunogenicity of allogeneic fibroblasts and lack of host response. Two subsequent randomized double-blind studies then assessed the impact of allogeneic fibroblasts on wound healing in RDEB: one found no differences in the extent or rate of re-epithelialization of chronic erosions (Venugopal et al., 2013), whereas the other showed that a single injection could speed up wound healing for up to 28 days compared with vehicle (Petrof et al., 2013).

**Mesenchymal stromal/stem cells.** The use of intradermal mesenchymal stromal cell (MSC) therapy was first reported in two patients with RDEB in 2010, and recently, clinical trials using intravenous BM-derived MSCs from unrelated donors into subjects with RDEB have been performed; clinical improvements in wound healing were observed in most subjects for 4–6 months (Conget et al., 2010; El-Darouti et al., 2015). Furthermore, an early phase clinical trial of intravenously administered allogeneic MSCs in 10 children with RDEB has recently been published (Petrof et al., 2015). In the latter study, although no significant safety concerns were raised, skin biopsies did not reveal an increase in collagen VII or new anchoring fibrils. There were, however, indications of reduced skin inflammation and better wound healing, as well as less skin pain and itching. Thus, although further assessment, including placebo-controlled studies, will be necessary, the anti-inflammatory effects of allogeneic MSCs appear to offer a rationale for their use in clinical care (Petrof et al., 2015). The above observation is in line with preclinical studies showing that a critical number of MSCs has to be reached in skin for significant restoration of collagen VII expression (Kuehl et al., 2015). By virtue of the cells’ low engraftment in peripheral tissues with current treatment regimens this cell number cannot be achieved in skin and oral mucosa by systemic delivery; however, steps are being taken to improve engraftment rates (see below).

A clinical trial of intradermal MSCs to improve wound healing in adults with RDEB is also currently being conducted in Japan (Katsuto Tamai, personal communication, June 2015), with preliminary evidence for improved and sustained wound healing for more than 12 months after a single injection of MSCs into wound margins. Additional studies have demonstrated that preconditioning of MSCs with growth factors or cytokines to augment collagen VII production might have clinical relevance (Perdoni et al., 2014).

**Bone marrow transplantation.** Results of an early clinical trial of whole bone marrow transplantation (BMT) in children with RDEB have been reported (Wagner et al., 2010). In this study, seven patients entered the initial trial and six underwent BMT. All individuals had some clinical improvement and five of the six showed increased collagen VII at the dermal-epidermal junction. No individual has been cured after BMT, but several have shown a marked reduction in blister formation and major improvement in quality of life (Jakub Tolar, personal communication). Nevertheless, toxicity relating to complete myeloablation has been a concern, especially because two of the seven patients enrolled in the initial study died from complications of this procedure. Consequently, BMT protocols have been refined to introduce reduced intensity conditioning with decreasing mortality rates while maintaining clinical improvement. Specifically, to overcome the challenges of complete myeloablation, several studies are underway using nonmyeloablative conditioning to determine the safety and efficacy of this approach using a less toxic conditioning regimen, with early results being reported as having reduced complications and mortality (Geyer et al., 2015; Jakub Tolar, personal communication).

**Mechanisms of BMT.** To explore possible mechanisms of BMT, a mouse model was used to demonstrate that BM-derived keratinocytes represent a specific subpopulation of lineage-negative, platelet-derived growth factor receptor alpha-positive cells, still a somewhat heterogeneous collection of cells (Tamai et al., 2011). The study proposed that skin grafts (and blister roofs in RDEB) act as hypoxic bioreactors, rapidly releasing high mobility group box 1 (HMGB1). After skin grafting, HMGB1 levels in serum increased and HMGB1 was shown to mobilize the lineage-negative, platelet-derived growth factor receptor alpha-positive cells from the BM and recruit these cells along a concentration gradient to the area of hypoxic keratinocytes. Differentiation of these cells into keratinocytes and the capacity to generate new collagen VII in the skin were clearly demonstrated (Tamai et al., 2011). Subsequent work has identified the importance of a stromal derived factor 1-alpha — C-X-C chemokine receptor type 4 signaling pathway in the recruitment of the key regenerative cells (Inumura et al., 2015). These data pave the way for clinical translation, with recombinant HMGB1 peptides to mobilize BM progenitors, and cell therapy approaches using specific subpopulations of MSCs are likely to enter clinical trials in the near future.

**Alternative sources of stem cells.** Cord blood and other compartments of the umbilical cord, such as Wharton's jelly or tissues associated with the placenta, are rich sources of stem cells. In addition to hematopoietic stem cells, cord blood is an important source of other progenitor cells, as well as MSCs, very small embryonic/epiblast I-like stem cells and unrestricted somatic stem cells, which may have individual or collective value in regenerative medicine. Nevertheless, a comparison of umbilical cord cells versus BM stem cells in individuals with RDEB has shown better skin engraftment with a BM-derived population (Tolar et al., 2012), and therefore, the clinical utility of cord cells in EB or other skin disorders remains to be determined in future clinical trials. Other populations, such as human cord blood-derived unrestricted somatic stem cells, are also being explored, in the EB mouse models, in preparation for clinical application (Liao et al., 2014, 2015).

**Revertant mosaicism and inducible pluripotent stem cells**

One striking observation in the skin of patients with EB is that some patches of skin can undergo spontaneous correction of the genetic defect, a phenomenon known as revertant mosaicism or “natural gene therapy” (Jonkman et al., 1997). The predominant mechanisms of gene correction include back mutation, gene conversion, intragenic recombination, and second-site mutation (Kiritsi et al., 2014; Pasmooij et al., 2012). The genetic correction appears to be limited to keratinocytes, but the opportunity to expand keratinocytes derived from a patch of revertant mosaicism in culture,
followed by application of a graft to the affected skin, creates a translational opportunity for personalized revertant cell therapy. The first attempt at revertant cell therapy was reported in an individual with generalized intermediate junctional EB, which yielded inconclusive results because the revertant keratinocyte population dropped from 30% to 3% in culture and no clinical benefits were noted after grafting (Gostynski et al., 2009). An alternative approach using pinch/punch grafting of skin from the revertant patches, however, has been used successfully to heal chronic erosions in a patient with a similar form of EB with mutations in LAMB3 (Gostynski et al., 2014).

One potentially exciting future therapeutic approach may be to combine the natural phenomenon of revertant mosaicism with recent stem cell biology techniques, specifically in creating inducible pluripotent stem cells (iPSCs). Spontaneously corrected cells for iPSC generation that are derived from revertant keratinocytes would avoid the need for further genetic correction or gene editing. With regard to skin, iPSCs have recently been generated from keratinocytes and fibroblasts derived from individuals with EB (Sebastiano et al., 2014; Wenzel et al., 2014) and also from revertant keratinocytes (Tolar et al., 2014; Umegaki-Arao et al., 2014). Although no therapeutic use of iPSCs in dermatology has been achieved yet, it is clearly poised to undergo rapid translation in the future as the entire iPSC field moves into clinical applications.

Gene correction technologies
Over the years, EB investigators’ efforts have revolved around gene replacement, and indeed, several clinical trials are now in progress based mainly on ex-vivo culture of EB keratinocytes, transduction with viral vectors containing genes of interest, and regrafting back onto the patient's skin containing genes of interest, and nocytes, transduction with viral vectors mainly on ex vivo culture of EB keratinocytes population. Trials are now in progress based on ex vivo culture of EB keratinocytes, and indeed, several clinical trials have revolved around gene replacement or gene editing. With regard to skin, iPSCs have recently been generated from keratinocytes and fibroblasts derived from individuals with EB (Sebastiano et al., 2014; Wenzel et al., 2014) and also from revertant keratinocytes (Tolar et al., 2014; Umegaki-Arao et al., 2014). Although no therapeutic use of iPSCs in dermatology has been achieved yet, it is clearly poised to undergo rapid translation in the future as the entire iPSC field moves into clinical applications.

Protein replacement therapy
The consequences of mutations in different genes in EB are varied, but in some cases, such as nonsense and premature termination codon mutations, there is a complete absence of the corresponding protein. The potential for protein replacement by the introduction of recombinant type VII collagen was initially tested in wound healing models in wild-type and Col7a1 knockout mice. Recombinant type VII collagen, when injected intradermally to the mice or applied topically, has been tested in plectin-deficient mice (Winter et al., 2014). Other innovative genome editing techniques are emerging, including antisense-mediated exon skipping to restore the open reading frame of nonsense-bearing mRNA transcripts, spliceosome-mediated RNA trans-splicing, and premature termination codon read-through coupled with antagonists of nonsense-mediated RNA decay (Bidou et al., 2012; Koller et al., 2015; Turczynski et al., 2012). Finally, the advent of CRISPR/cas gene editing techniques is also poised to transform the combined approach of mutation correction with iPSC technologies.

Novel treatments in the pipeline

Treatment of itch. It has become increasingly clear that there is an immediate demand for so-called symptom-relief therapies to ameliorate the disease symptoms with improved quality of life for the patients. Recent surveys of patients with EB have identified intractable itch and pain as one of the main issues for the daily management from the patient’s perspective (Snauwaert et al., 2014). In this regard, investigators with extensive background knowledge of itch have now initiated programs to address itch and its mechanisms in EB, with the hope that it can be effectively counteracted by pharmacological means. Critical for this is understanding the similarities and differences that itch in patients with EB may have in comparison to itch mechanisms as previously delineated in other dermatologic conditions.

Antifibrotic therapies. One of the major complications of EB, particularly the RDEB subtype, is extensive scarring and fibrosis that can result in functional limitations of movement when affecting the joints, and in extensive fusion of the digits in the hands leading to mitten deformities with compromised dexterity. Animal studies using the hypomorphic mouse model have suggested that the fibrosis is driven by transforming growth factor-β, as reflected by transition of dermal fibroblasts to myofibroblasts with capacity for extensive extracellular matrix production. Losartan, an angiotensin II type 1 receptor antagonist that is FDA/EMA approved for hypertension, has been shown to reduce transforming growth factor-β-mediated fibrosis in some connective tissue disorders although its effects are context and disease specific (Nystro¨m et al., 2015). Treatment of hypomorphic DEB mice with Losartan clearly ameliorated disease signs by reducing fibrosis and inflammation, counteracting formation of mitten deformities (Nystro¨m et al., 2015). These observations suggest that clinical trials of Losartan in patients with RDEB are indicated.

One of the major goals in EB is to enhance wound healing processes, and a novel therapeutic approach has been suggested to be the use of antimicrobial peptides that control...
pathogenic infections and activate the adaptive immune system. One of such peptides is cathelicidin that not only has the capability of augmenting host defense but also appears to play a role in tissue repair and wound closure. Preliminary studies have indicated low expression levels of cathelicidin mRNA in RDEB keratinocyte cultures, suggesting that upregulation of cathelicidin could improve wound healing in RDEB. In this regard, vitamin D3 analog calcipotriol was shown to upregulate cathelicidin expression in a dose-dependent manner (Hüttner et al., 2012; Moniaga et al., 2013).

PATIENT PERSPECTIVES AND THE ROLE OF ADVOCACY ORGANIZATIONS

The ultimate beneficiaries of the ongoing research will be people with EB. It is, therefore, critical to involve the patients and their advocacy organizations, such as DEBRA International, to improve quality of life for these patients. To this aim, DEBRA International has initiated the creation of clinical best practice guidelines for major aspects of EB care, including oral health care, wound care, and pain management, which are already freely available to clinicians (www.debra-international.org/med-professionals/clinical-practice-guidelines-cpgs/foreEB.html); other guidelines on cancer management and nutrition are under development. In addition, although DEBRA International provides a route for coordinating information to patients and clinicians about research and clinical trials on EB, it conversely provides information about patients with EB and their priorities to those planning clinical trials. In this meeting, a presentation by DEBRA Ireland noted the importance of investing time in informing patients, and considering patients as participants in the process, and not just as trial subjects. Thus, it is critically important to solicit the patients’ participation with meaningful involvement, and to inform the patient community of clinical trial outcomes.

The participants of the EB2015 included not only researchers but also patients and their family members. In fact, the President of DEBRA International, Rainer Riedl, and the Director of DEBRA of America, New York, Brett Kopelan, are also fathers of children with RDEB. In the closing, they shared the impressions of the patients and the advocacy organizations that EB research is speeding up dramatically and that a striking number of new clinical trials and new medical products can be expected in the very near future. In this regard, this meeting has provided inspiration not only to those working on understanding the disease and developing novel treatments, but also to the patients and the parents whose perspective has been increasingly heard.

CONFLICT OF INTEREST

The authors state no conflict of interest.

ACKNOWLEDGMENTS

The EB2015 symposium was supported in part by the National Institutes of Health Grant R13AR068235 from the National Institute of Arthritis and Musculoskeletal and Skin Diseases (NIAMS) and the National Center for Advancing Translational Sciences (NCATS). Support from the following companies is gratefully acknowledged: Scioderm, Fibrocell Science, Keraplast Technologies, and Shire.

SUPPLEMENTARY MATERIAL

Supplementary material is linked to the online version of the paper at www.jidonline.org, and at http://dx.doi.org/10.1016/j.jid.2015.10.050.

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