

BASIC GUIDANCE & ROLE OF COMMUNITY PHARMACISTS IN SKIN CANCER PREVENTION AND PHOTOPROTECTION COUNSELLING

Charles Ribeyre*, PharmD, Delphine Kerob*#, MD

*La Roche-Posay Laboratoire Dermatologique, Levallois-Perret, France; #Consultant dermatologist Saint Louis, Paris

 This poster is supported by the International Pharmaceutical Federation (FIP)

 Reviewed with the assistance of the International League of Dermatological Societies (ILDS).

LA ROCHE POSAY
LABORATOIRE DERMATOLOGIQUE

FUNDING
This study was supported by La Roche-Posay Laboratoire Dermatologique

ACKNOWLEDGMENTS
The authors acknowledge the writing and editing support of Mariana Carranca, InSkin Consulting, and Neri Monica El (France)



OBJECTIVES

To develop a practical care algorithm and educational guidance for community pharmacists on photoprotection counseling and skin cancer prevention, informed by a literature review, a multinational survey, and input from a global FIP expert panel.

BACKGROUND

Global incidence of skin cancer is rising, though it is among the most preventable cancers, with ultraviolet (UV) exposure as a major risk factor¹ Prevention, primarily through photoprotection, alongside early detection, remains the key strategy to reduce its burden.

Photoprotection is recommended for the entire population, but is particularly important for at-risk individuals, including those with a history of skin cancer, actinic keratosis, or photosensitizing treatments.^{2,3} Despite this, a large-scale survey showed that only 23% of individuals protect themselves from the sun year-round.⁴

Pharmacy-based education campaigns have been shown to improve knowledge, intentions for sun-safe behavior, and sustained preventive practices.⁵ Nonetheless, qualitative studies report knowledge gaps among pharmacy staff regarding sunscreen use, skin type, SPF interpretation, and UV Index application, highlighting the need for targeted education and impartial resources to strengthen counseling globally.⁶⁻⁸

METHODS

A literature review on the pharmacist’s role in dermatological care was conducted in December 2025 using PubMed and AI-assisted research tools. Current dermatology guidelines were also identified.

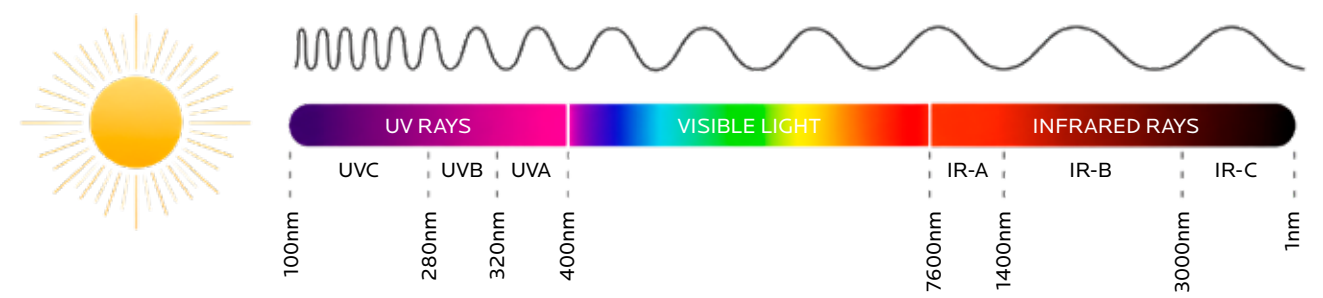
An online survey was conducted among FIP members in March–April 2026 to assess current practices, knowledge, and perceived barriers to greater pharmacist involvement. A structured online questionnaire was distributed by FIP, and 142 completed responses from 51 countries were included in the final analysis.

Based on the review and survey findings, an expert FIP panel of 13 pharmacists from five continents recommended developing practical guidance on skin health to support pharmacy practice.

An algorithm illustrating the pharmacist’s role across the patient journey was developed as basic guidance for skin cancer prevention and photoprotection counseling.

SUN DAMAGE

Understanding the spectrum of sun radiation is critical for effective photoprotection counseling.



UVB: Causes direct DNA damage; responsible for sunburn and immediate pigmentation.⁸

UVA: Causes indirect DNA damage via reactive oxygen species; present year-round and not filtered by clouds or windows; responsible for photoaging and pigmentation disorders.⁸

UVA1: Longer wavelength, penetrates deeper into the skin; inadequately blocked by traditional sunscreens.

VISIBLE LIGHT: Contributes to hyperpigmentation, especially in skin of color.¹⁰

SUNSCREEN RECOMMENDATIONS DERMATOLOGY GUIDELINES

Photoprotection includes behavioral strategies (seeking shade, wearing protective clothing, hats, and sunglasses) and topical measures such as sunscreen to protect the skin from harmful solar radiation. Below, photoprotection strategies depending on:

SKIN PHOTOTYPES:²

Fitzpatrick phototype	Description	Skin color (ITA classification)	UVB protection (SPF)	UVA protection (UVA-PF)	High energy visible light protection (VL-PF)
I	Always burns, never tans	Very light	SPF50+	UVA-PF +++ (> 1/3 labelled SPF)	
II	Burns easily, sometimes tans	Light			
III	Sometimes burns, always tans	Intermediate			
IV	Rarely burns, tans easily	Tan			
V	Rarely burns, tans easily; moderately pigmented	Brown			
VI	Rarely burns, tans promptly and intensely; highly pigmented	Dark	SPF30+	UVA-PF +++ (> 2/3 labelled SPF)	VL-PF+++

Adapted from Passeron 2021 (2)

FOR INDIVIDUALS AT HIGH RISK:^{2,3,11}

- Use of broad-spectrum sunscreen with UVA/UVB (SPF50+) protection on all sun-exposed areas.
- Frequent application (everyday, all year long, reapplication every 2 hours, including indoors near windows).

COMMON SKIN DERMATOSES:²

PIGMENTARY DISORDERS

MELASMA, PIH

- Broad-spectrum sunscreen SPF50+ (UVA/UVB)
- Recommend VL/HEVL protection, especially in phototypes III or higher

SKIN INFLAMMATORY DISORDERS

ROSACEA & ACNE

- Broad spectrum sunscreen, SPF30+ or higher.
- Protection against VL for patients at high risk of PIH (skin phototype →IV or significant sun exposure).

ATOPIC DERMATITIS

- Broad-spectrum sunscreen for preventing photosensitivity; not to be applied before skin lesions and inflammation have resolved.
- Avoid sunscreens that may trigger allergic reactions.
- Prefer inorganic filters, especially for paediatric patients.

PSORIASIS

- Limited exposure to sun can be beneficial.
- Broad-spectrum sunscreens (SPF50+) with high UVA protection for photo-aggravated psoriasis.

HEVL, high energy visible light; PIH, post-inflammatory hyperpigmentation; VL, visible light

RESULTS & DISCUSSION

FIRST LINE HEALTHCARE

Pharmacists play a key role in sun protection education and skin cancer prevention campaigns. Sun protection is also paramount for limiting photoageing effects (sun spots, lentigines, etc.)

- Advise on photoprotection measures, including education on skin phototypes and UV index.
- Teach self-examination using the ABCDE criteria.
- Refer to a healthcare professional if a suspicious lesion is identified.

Sunscreen counseling should be tailored to skin phototype and individual preferences:

- Promote broad-spectrum protection (UVA and UVB protection).
- Educate on correct use: adequate amount (teaspoon rule), application every 2 hours, and 15–20 minutes before exposure.

ADJUNCTIVE THERAPY

Pharmacists should adapt photoprotection education and sunscreen advice to specific skin conditions:

ENHANCED UVA PROTECTION

- Skin cancer
- Polymorphous light eruption
- Drug-induced phototoxicity
- Lupus erythematosus
- Dermatomyositis
- Melasma
- PIH
- Rosacea

ADDITIONAL VL PROTECTION

- Solar urticaria
- Cutaneous porphyria
- Melasma
- PIH
- Rosacea
- Acne

TO GO FURTHER ...

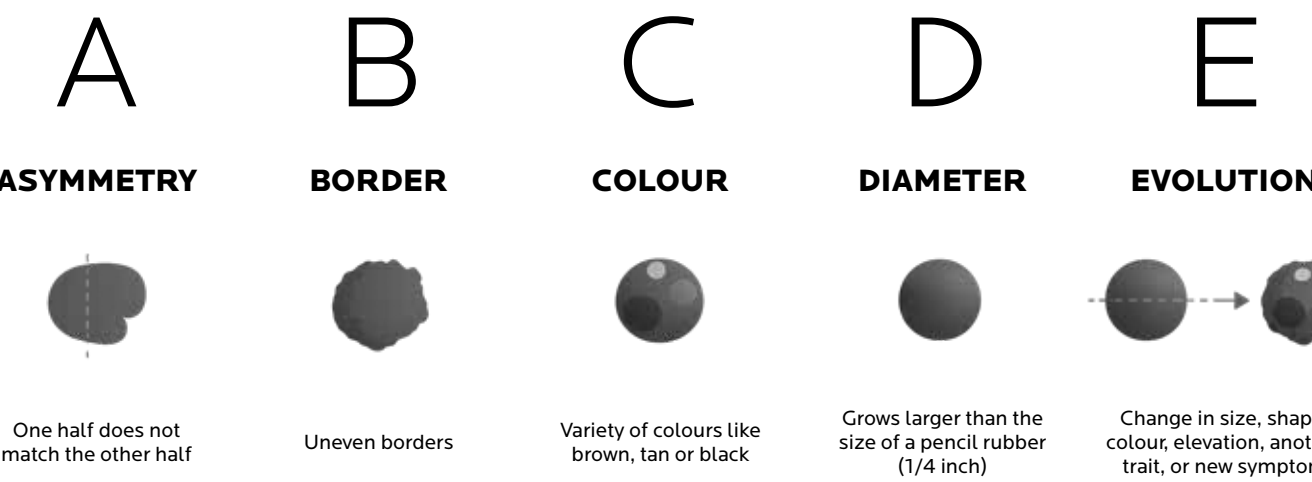
UV INDEX “SUNSCREEN IS NOT ENOUGH”:

Best protection includes clothing + shade + timing

UV INDEX :

- **0-2 (low):** Limited risk (if not photosensitivity)
- **3-5 (moderate):** Broad photoprotection required SPF30, avoid mid-day sun
- **6-11 (High / Very High):** Broad photoprotection required SPF50+, Avoid mid-day sun, clothing

SUSPICIOUS SKIN SPOTS | KNOW YOUR ABCDE’S



CONCLUSION

Community pharmacists play a key role in skin cancer prevention and photoprotection counseling, including patient assessment, education, promotion of sun-safe behaviors and sunscreen use, and evaluation of photosensitizing medications. Their interventions are guided by each patient’s cutaneous phototype, skin conditions, habits, and preferences. Further training is needed to strengthen pharmacists’ guidance.

REFERENCES: 1. Lim HW, Schalka S, Guitera P, Xiang LF. J EADV Clin Practice. 2025;4(S1):S5-S14. | 2. Passeron T, et al. J Eur Acad Dermatol Venereol. 2021 Jul;35(7):1460-1469. | 3. Kandolf L, et al. J Eur Acad Dermatol Venereol. 2024 Jun;38(6):1024-1047. 4. Passeron T et al. J Eur Acad Dermatol Venereol. 2023 Dec;37(12):2481-2489. | 5. McLoone JK, et al. NA. Aust N Z J Public Health. 2014;38(4):321-325. | 6. Diehl K, et al. Healthcare (Switzerland). 2023;11(13). | 7. Diehl K, et al. Journal of Cancer Education. 2021;36(5):1045-1053. 8. Jian Low Q, et al. Med J Malaysia 2021;76(2):212-217. | 9. D’Orazio J, et al., Int J Mol Sci. 2013 Jun 7;14(6):12222-48. | 10. Ezekwe N, et al. Photochem Photobiol 2022 Nov;98(6):1264-1269. | 11. Monteiro AF, et al., Clin Dermatol. 2016 Sep-Oct;34(5):571-81.