SPEAKER 1: In scleroderma, because we have the different subtypes, the treatment will be tailored to the specific issues at hand. And so if it's only affecting the skin, in particular in the limited subtype we may favor not using an aggressive, systemic therapeutic approach. For example, physical therapy plays a major role, and if we're going to use anything on a systemic level, it would be mycophenelate mofetil, because generally, that's the most well tolerated form of immunosuppression.

Now, if the patients then start developing more systemic disease as well as diffuse systemic sclerosis, additional therapies are warranted. So in particular for ray nodes, so calcium channel blockers in particular are useful, such as nifedipine. For the interstitial lung disease, which is the major cause of death, so then we'll mainly consider or an autologous stem cell transplant, as well as mycophenelate mofetil.

In the case of scleroderma renal crisis or renal involvement, the key medication there is going to be an ACE inhibitor. And then in the case of pulmonary arterial hypertension an endothelial antagonist such as bosentan can be used, or also sildenafil as a vasodialating agent. So all these therapies, they target the different aspects of scleroderma, but they don't target actually, at the end of the day, the skin hardening and thickening.

And so that's actually where the data for ECP or extracorporeal photochemotheraepy actually looks good, because it looks as good as the rest if not better. And so somebody who has early disease, so less than two years' duration, in which they're getting progressive fibrosis despite a trial potentially of mycophenelate mofetil, then you would consider adding electric ECP or extracorporeal photopheresis as an adjunctive therapy.