

DermWorld



Friday • March 17, 2023

meeting news A Publication of the American Academy of Dermatology | Association



Late-Breaking Research sessions showcase clinical trial results in recent, unpublished abstracts.

Attendees will get a first-hand account of the latest ground-breaking scientific developments in dermatologic research and be able to evaluate and apply information from recent investigations to their own clinical practices.

Late-Breaking Research lineup includes:

S025 - Late-Breaking Research: Session 1

Saturday, March 18 9 a.m.-12 p.m.

Location: New Orleans Theater B

S042 - Late-Breaking Research: Session 2

Saturday, March 18 1-4 p.m.

Location: New Orleans Theater B



W001 - Hands-On: Innovative **Suture Techniques Update**

Saturday, March 18 9 a.m.-12 p.m.

Location: Room 398



See the online program for ticket information and for more Hands-On sessions happening Monday, March 20.



Old favorites and new programming provide robust experience

elcome to the AAD's Annual Meeting 2023. This is the first time AAD has been in the Big Easy

Each day of the meeting, attendees can access new lectures and presentations and revisit some perennial favorites. Explore more than 50 new titles, including:

- Uo54 Pearls from **Complex Mohs**
- Uo13 Advances in Microneedling Techniques Around the World
- So₅8 Alopecia Areata: **New Therapies**
- F120 Great Debates in Medical Dermatology
- Uo88 When to Put Down the Scalpel: Non-surgical Therapies for Skin Cancer
- Uooo Technology in **Dermatology: Tailoring** Solutions to Your Practice and **Optimizing Joy & Impact**

Today, highlights include two new live demonstration courses, and two new Conquer the Boards sessions have been included, as part of the many offerings for

Don't forget to stop by the AAD Career Networking Event today as well, from 4:30-6:30 p.m. at the Hilton New Orleans Riverside – Grand Ballroom C. There's also a DataDerm™ Registry and Refreshments event today from 5:30 – 6:30 p.m. in the Convention Center Foyer Room 338.

On Saturday, March 18, there are two hands-on courses offered. Saturday is also the day to catch the two Late-Breaking Research sessions. A new So30 - Boards Blitz session is scheduled for Saturday as well.

Sunday, March 19 features the return of the P151 - Plenary with several exciting speakers and guest lecturer Safi Bahcall. On Sunday afternoon, attendees can look

forward to the latest **So48 – Hot** Topics session, a new So44 - Skin of Color session, and a new round of So43 - Resident Jeopardy.

On Monday, March 20, there are four more hands-on courses, and several new and returning sessions. The meeting closes on Tuesday, but not without two favorites, So59 - What's New in Dermatology, and So6o -Therapeutic and Diagnostic Pearls.

That's just the very tip of the iceberg. With more than 300 educational sessions, each day the AAD offers scores of symposiums, focus sessions, courses, and workshops, covering all aspects of your practice from treatment pearls to practice management. Use the AAD mobile app to explore the program and track your favorites.

And when you're not in sessions or exploring New Orleans, be sure to visit the always-vibrant Exhibit Hall and AAD Resource Center in Booth 4039.



C002 - Live Demonstration: The State of the Art of **Aesthetic Dermatology** Friday, March 17

9 a.m.-12 p.m.

Location: Room 393

C004 - Live Demonstration: **Soft Tissue Augmentation And Neuromodulators** - Simultaneous Cadaver

Prosection And Live Patient Injections

Friday, March 17 1-4 p.m.

Location: Room 393



TICKETED EVENT

The live demonstration sessions are restricted, ticketed events that sell out quickly. Check the online program for more information.

Inside

Pediatric Dermatology Through Adult Eyes 3 Board Exam Study Tips 4 Treating Skin Diseases of the Breast 8 Emotional Check-in for Hair, Scalp, and Nail Disorders 19

See More DermWorld **Meeting News!**

Interact with the **AAD's Preferred Providers**

We've aligned with companies who can provide solutions for your life in and out of the office. Stop by their booths in the Exhibit Hall to learn more!



- AAD Member Buying Program, Booth 4543
- Bank of America Practice Solutions, Booth 930
- CareCredit, Booth 3613
- Medjet, Booth 1065
- Medline Industries, LP, Booth 4629
- VisualDx, Booth 2838

For a full list of our providers, visit aad.org/preferredproviders

Don't Miss the **AAD Career Networking Event – Hosted by AAD Career Compass**

Friday, March 17 • 4:30 – 6:30 p.m.

Hilton New Orleans Riverside Hotel, Grand Ballroom C

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We hear it often when practices see our software for the first time. So often that we named it. They're called WOW Moments and it's when you realize you don't have to compromise and live with the limitations of your outdated system any longer.

For Dawn Ricker of Dermatologic Surgery Center of Northeast Ohio, Inc., her WOW Moment was watching system-generated recalls decrease staffing demands:

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The kids are alright, if you know how to treat them

Pediatric dermatology through adult eyes



Valerie Margaret Carlberg, MD, FAAD, assistant professor of dermatology at the Medical College of Wisconsin in Milwaukee and medical director of its Vascular Anomalies Program.

Fr th

F020 – Pediatric Dermatology for the Adult Dermatologist Friday, March 17 | 1–3 p.m. Location: New Orleans Theater A

Kids will be kids. Yet treating their dermatologic conditions can be challenging when the model is designed for adults.

lthough many skin disorders are diagnosed in patients of all ages, some are more common or present differently in children than adults. For example, atopic dermatitis is one of the most common diseases of childhood. In addition to more typical flexural involvement, it can present with follicular prominence, in association with pityriasis alba, or with periorbital distribution in children, according to Valerie Margaret Carlberg, MD, FAAD, assistant professor of dermatology at the Medical College of Wisconsin in Milwaukee and medical director of its Vascular Anomalies Program. Dr. Carlberg is moderating this afternoon's session, "Pediatric Dermatology for the Adult Dermatologist."

Little creatures in a big world

"There is an expression that children are just little adults; however, we know this isn't true," Dr. Carlberg said. "For example, the most common triggers of allergic contact dermatitis in children differ from those in adults due to differences in environmental exposures between these unique patient populations."

Contact dermatitis is one of several dermatologic conditions that speakers will explore during the session. Other concerns include atopic dermatitis, acne fulminans, hidradenitis suppurativa, as well as unique diagnostic and treatment considerations for pediatric patients.

Child-centric approach

To help dermatologists identify and treat skin conditions in children, speakers will guide attendees through a child-centric approach for several of the disorders. The key, Dr. Carlberg said, is understanding the unique differential diagnosis for skin conditions and the challenges of treatment in this age group. Appropriately managing pediatric patients with skin disease requires a special emphasis on knowledge of natural history/ outcomes and optimal treatment strategies for this population.

"There are many nuances between treatment selections in children and adults. Many of the treatments that are FDAapproved for dermatologic conditions in adults are not yet approved for use in pediatric patients," Dr. Carlberg said. "This is primarily due to the lack of inclusion of younger patients in the initial clinical trials evaluating the safety and efficacy of a medication. Thus, treatments are often used off-label until clinical trials in children are completed. Lack of FDA approval can create challenges getting medications approved by insurance. As such, there are fewer treatment options for children."

Dosing and medication considerations

Another challenge dermatologists must consider, according to Dr. Carlberg, is the optimal dosing and route of administration for systemic medications. Pediatric patients require weight-based dosing, necessitating medication adjustments as they grow. "For example, dupilumab is a systemic medication used to treat atopic dermatitis," she said. "Although there is one dosage regimen in adults, the dosing varies based on age and weight in children."

Taking one's medicine

Finally, another factor in managing pediatric patients with skin diseases is the fact that many children are unable to take oral pills, tolerate injected medications, or withstand diagnostic tests such as patch testing or skin biopsies, Dr. Carlberg said.

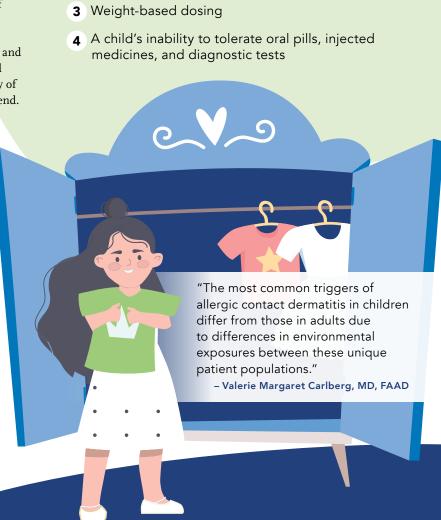
This afternoon's session will prepare for these challenges as well as the importance of partnering with parents.

"Parents are wonderful advocates for their children and are appropriately concerned about the safety and efficacy of the treatments we recommend. Whether discussing topical steroids for atopic dermatitis or FDA-approved oral propranolol for infantile hemangiomas in young infants, both can cause unease," Dr. Carlberg said. "Additionally, many parents consume information from non-dermatologists via social media and other platforms and this can lead to confusion. As the skin experts, dermatologists have an opportunity to partner with parents to become aligned in the same goal of improving the child's

skin." •

Challenges to managing pediatric skin disease:

- 1 Pediatric population often excluded from clinical trials
- 2 Lack of approval by FDA and insurance





What are you looking forward to at the 2023 AAD Annual Meeting?

"I am excited to attend the pre-AAD Society for Pediatric Dermatology (SPD) meeting. While I've attended the SPD for years, this is the first time I will be giving a lecture at the meeting, which is a great honor. I'll be giving a session there and at the main meeting on Pediatric



Dermatology Emergencies, which is a favorite topic of mine. In terms of the meeting in general, I am most excited about reuniting with dermatology friends from residency, fellowship, and beyond at reunions and social events. The meeting is a wonderful way to reconnect with our friends and our specialty in general while enjoying beautiful New Orleans!"

A. Yasmine Kirkorian, MD, FAAD, chief of dermatology, Children's National Hospital, Washington, D.C.

"I am looking very forward to learning about the changing landscape in dermatology practice and what the future holds. Also, I am particularly interested in upcoming therapeutics for immunologic mediated diseases (new JAK/ TYK2 inhibitors; other agents for psoriasis, atopic dermatitis, alopecia areata, and vitiligo)."

Jonathan S. Weiss, MD, FAAD, Georgia Dermatology Partners, Snellville, Loganville, Braselton, and Brookhaven, Georgia

"I look forward to networking and to meeting colleagues from around the world, to building new connections and catching up with old friends. I also look forward to hearing about the cutting-edge advances, emerging therapies in dermatology, and new ideas for research."



Afsaneh Alavi, MD, FAAD, consultant, Mayo Clinic, Rochester, Minnesota

PHOTO GALLERY

Scan the QR code to view the AAD **Annual Meeting**





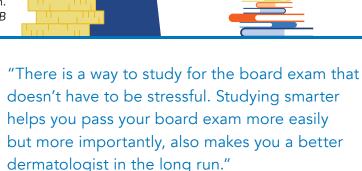


A more effective way to study for your board exam



Sima Jain, MD, FAAD, author of Dermatology: Illustrated Study Guide and Comprehensive Board Review

U023 - Board Review: Work Smarter, Not Harder Friday, March 17 | 4:30-5:30 p.m. Location: New Orleans Theater B



- Sima Jain, MD, FAAD

he dermatology board certification exam by the American Board of Dermatology is the testing pinnacle that challenges every dermatology resident. One of the most daunting challenges may not be the exam itself, however, but rather the stress and fear that accompanies the method by which many dermatology residents study for the exam.

"You don't need to study harder to pass your boards with flying colors, you need to study smarter," said Sima Jain, MD, FAAD, author of *Dermatology*: Illustrated Study Guide and Comprehensive Board Review, one of the most-read board review study guides. "There is a way to study for the board exam that doesn't have to be stressful. Studying smarter helps you pass your board exam more easily but more importantly, also makes you a better dermatologist in the long run."

In this afternoon's session, "Board Review: Work Smarter, Not Harder," Dr. Jain will discuss effective ways to prepare for the dermatology board exam. The key to acing your boards, she said, is not about memorizing details about skin conditions.

Deeper understanding required

The specialists who write board exam questions aren't looking for rote memorization, Dr. Jain explained. They are looking for understanding — the ability to synthesize patient history, visual clues, and clinical elements to guide clinical decisions.

"Learning the buzzwords does not mean you understand

the disease," Dr. Jain said. "Dermatology residents are bright. They are used to being the top of the top students and often do very well on exams. However, this exam is different. Passing the board exam is about understanding information, not memorizing more information. Focusing on effectively understanding the different aspects of skin disease from the start is less stressful than trying to cram more facts into your head. And you will be much more successful when you finally sit for your exam."

The smarter, more effective way to study is to go through multiple question and answer banks and boards study charts to determine your own strengths and weaknesses to guide and focus your study. It is an important way to gauge if you truly understand the material and make sure you are truly translating everything you have learned to help your real-life clinical acumen. Spending more time with skin atlases can also improve understanding and illustrate diagnostic clues that can be difficult to understand in

Picture this

It helps to review as many photographs of skin conditions in as many different skin tones as possible. Some dermatology

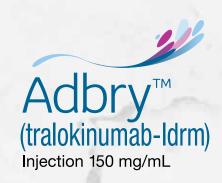
training programs have the benefit of an ethnically diverse patient population. Other programs may not be home to a population that is as diverse, which can leave residents unsure when examining skin of color, as skin conditions look different in different skin tones.

"I trained in Chicago, and our patients were ethnically diverse, but if you haven't had that kind of background during training, you could miss a diagnosis because a rash might not look the same in a patient with skin of color. This is where photos can help supplement your clinical training. It all comes back to being a good dermatologist," Dr. Jain said. "And this way, you're not studying harder, you're studying smarter."

"Studying smarter takes a lot of angst out of the board exam," she said. "That exam is just one day, and we want you to pass with flying colors. We also want you to pass with flying colors every single day while you're practicing. You can meet both of those goals by studying smarter."

The AAD has curated an extensive list of resources for boards study at www.aad.org/education/residents/ **external.** The AAD also has a large archive of Boards Fodder study charts at www.aad.org/ boardsfodder.





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Scan to see where we're at









While in New Orleans, join LEO Pharma for the grand unveiling of

The Museum of Dermatologic ADvancement (MoDA)

A carefully curated interactive experience in moderate-to-severe atopic dermatitis

Explore our special exhibit featured at MoDA Looking Ahead and Giving Back

Leave your mark on the moderate-to-severe atopic dermatitis community with a unique opportunity to benefit Camp Discovery—A life-changing summer camp experience where kids with chronic skin conditions make friends, find acceptance, and are free to be themselves.





During your visit at MoDA...

Immerse yourself in an IL-13 exhibit

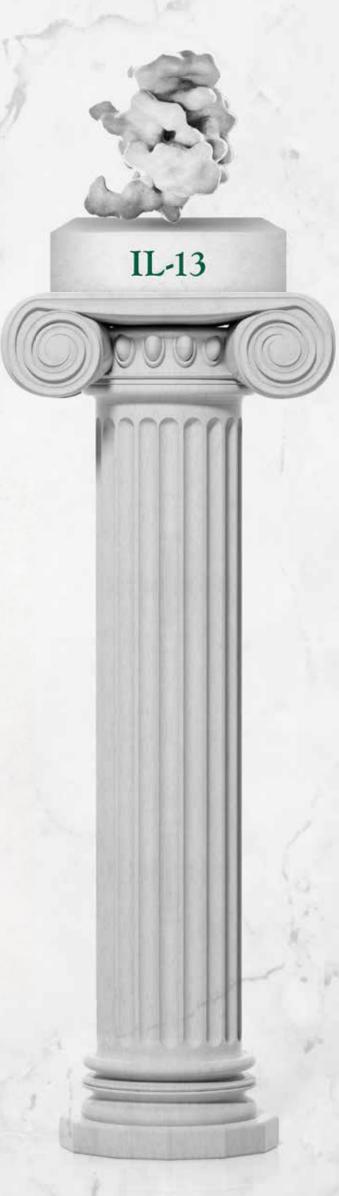
Take an in-depth look at the role of IL-13 in atopic dermatitis





Scan for directions to our booth







The breast is yet to come (to your office)

Dermatologists should be ready to treat skin diseases of the breast.

Miriam K. Pomeranz, MD, FAAD, associate professor of dermatology at New York University Grossman School of Medicine and chief of dermatology at Bellevue Hospital

F022 – Behind the Bra: NEW What Dermatologists **Should Know About** Diseases of the Breast Friday, March 17 | 1–3 p.m. Location: Room 391

hen was the last time you saw a patient with idiopathic granulomatous mastitis? For many dermatologists, the answer is "never," even though this inflammatory disease of breast skin is treated with familiar, anti-inflammatory agents. "There are conditions like idiopathic granulomatous mastitis that breast surgeons see more than we do," said Miriam K. Pomeranz, MD, FAAD, associate professor of dermatology at New York University Grossman School of Medicine and chief of dermatology at Bellevue Hospital. She and a panel of other experts will present the new

session, "Behind the Bra: What Dermatologists Should Know About Diseases of the

"Breast surgeons are the most common clinicians involved, but dermatologists can step in

and be very helpful," Dr. Pomeranz said. "And there are fewer common conditions like diffuse dermal angiomatosis, but pendulous breasts are a common site. It can cause significant discomfort and can look like inflammatory breast cancer, but it's a dermatologic condition, just one of many skin diseases of the breast that are



Inflammatory diseases of the breast as well as infectious and neoplastic

most often seen in patients who are transgender or gender non-binary can have dermatologic sequelae.

"Transgender men sometimes bind their leading experts in minimizing and treating

"There are other complications that we don't often think about, like Raynaud's syndrome," Dr. Pomeranz said. "We tend to think about Raynaud's and fingers or toes, but it can occur in the breast as well, leading to a lot of pain and discoloration. Clinicians aren't always aware that it can happen outside the digits."



Be ready to

answer the call

Dr. Pomeranz said, is that

many patients start their journey with

a breast specialist who refers them

to the dermatologist. Women with

granulomatous mastitis typically go

to a breast surgeon with what looks like an abscess or inflammatory breast

cancer. Once surgeons realize it is not a

malignant or infectious condition, they

"It's important to know your referring

patient with diffuse dermal angiomatosis

Pregnancy, lactation,

Pregnancy and lactation

of dermatitis. Breast size

also increase the likelihood

and other issues

might come to a dermatologist directly,

might refer them to dermatology.

specialists and have good lines of communication," Dr. Pomeranz said. "A

but it doesn't happen often."

irritation, and infection.

One of the complications,

Dermatologists occasionally diagnose breast cancers that present as eczema of the ipple, but they more often see the side effects of chemotherapy or radiation therapy that affect the breast.

Radiation dermatitis can be very uncomfortable, Dr. Pomeranz said, as can postradiation morphea. Morphea often occurs on the breast but can occur elsewhere as well. Dermatologists are frequently called in to help deal with scarring after breast cancer

"Patients, particularly women, may be hesitant to discuss or show the dermatologist diseases on the breast," Dr. Pomeranz said. "They may not initially take their bra off for an exam, so we need to get more comfortable with asking directly if they are having any pain or discomfort. This session will help you get more comfortable with asking about and treating the skin of the breast, including some of the more unusual presentations that may walk into your office." ullet



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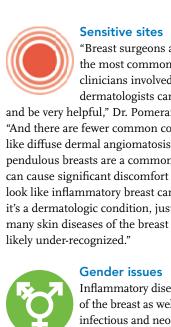


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Breast" today at 1 p.m.

entities affect many

dermatology patients. Procedures

breasts to appear more masculine, which can lead to dermatosis," Dr. Pomeranz noted. "People having top surgery can become very self-conscious about the scarring, and dermatologists are the scars. That's just one set of many areas we are becoming involved in - or should be."

typically increases, which can lead to skin problems, particularly irritant dermatitis. Lactation can also give rise to discomfort,



Take note Where school left off



Keyvan Nouri, MD, MBA, FAAD, professor of dermatology, ophthalmology, otolaryngology, and surgery at the University of Miami Leonard M. Miller School of Medicine

S021 - Business and Leadership in Dermatology and Medicine: What Dermatologists Should Know Friday, March 17 | 1–4 p.m. Location: Room 266

eyond surgery, slides, and Socratic discourse, there are many aspects of dermatology that are not typically part of what is learned in school. It is important to know about the U.S. health care industry, insurance companies, pharmaceutical, physician, patient-physician relationships, as well as how the U.S. health system is funded and the legal aspects of the health care industry.

These will all be discussed in this afternoon's symposium, "Business and Leadership in Dermatology and Medicine: What Dermatologists Should Know," led by Keyvan Nouri, MD, MBA, FAAD, professor of dermatology, ophthalmology, otolaryngology, and surgery at the University of Miami Leonard M. Miller School of Medicine.

Addressing the complexities

"Medicine is one of the largest and most complex industries in the world, and in order to optimize patient care, it is essential for physicians to learn about the business of medicine and dermatology in order to minimize error, optimize operations, and improve quality of care," Dr. Nouri said.

According to Dr. Nouri, the key business aspects in medicine also include other important factors, such as consumer satisfaction and loyalty, repeat purchase, brand, innovation, efficient operations, and legal aspects. Dermatologists must also consider various practice settings as well, including private (solo) practice, group practice, academic practice, and equity practices.

Tapping leadership resources

With all that dermatologists must know and juggle, access to leadership resources can be valuable, Dr. Nouri said, and he encourages dermatologists at every stage of their career to tap those resources. For example, AAD leadership opportunities include the councils, committees, and task forces as well as its Leadership Forum, Academic Dermatology Leadership Program (ADLP), Leadership and Mentoring Reception, as well as leadership courses at the AAD Annual Meeting and AAD Innovation Academy. The American Medical Association (AMA) also has a bank of leadership resources. During this afternoon's session, AMA President Jack Resneck Jr., MD, FAAD, will provide an overview of what the AMA has to offer.

As for today's dermatologists who are interested in curating their own leadership opportunities, Dr. Nouri suggests there are five characteristics of leadership in medicine. They include mentoring others, challenging the status quo, educating

others, creating opportunities for others, and practicing humility.

"The clinical pearls that I can offer include maximizing both intrinsic and extrinsic motivators, the importance of wellness and well-being of physicians and staff, the importance of emphasizing collaboration instead of competition, and that a systembased approach is more beneficial than an individual component," Dr. Nouri said.

Acknowledging the vast expanse of dermatology and health care issues, Dr. Nouri's session will be augmented by many other speakers on a variety of topics, including Daniel D. Bennett, MD, FAAD, Dirk Michael Elston, MD, FAAD, Tammie C. Ferringer, MD, FAAD, Roy G. Geronemus, MD, FAAD, Mark D. Kaufmann, MD, FAAD, Amy J. McMichael, MD, FAAD, Alexander Miller, MD, FAAD, and Robert Sidbury, MD, MPH, FAAD.

In a study of patients with acne, almost 40% of treatment non-adherence was due to side effects¹

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References: 1. Dikicier BS. Topical treatment of acne vulgaris: efficiency, side effects, and adherence rate. *J Int Med Res.* 2019;47(7):2987-2992. **2.** Lain E, Andriessen AE. Choosing the right partner: complementing prescription acne medication with over-the-counter cleansers and moisturizers. *J Drugs Dermatol.* 2020;19(11): 1069-1073. **3.** Dreno B, Araviiskaia E, Kerob Delphine, et al. Nonprescription acne vulgaris treatments: their role in our treatment armamentarium—an international panel discussion. J Cosmet Dermatol. 2020;19:2201-2211. Use products only as directed.

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TODAY'S HIGHLIGHTS

DataDerm™

Using DataDerm[™] to Understand Disparities in Dermatologic Care

3:30-5:30 p.m.

Location: Session F038, Room 345

DataDerm[™] Registry and Refreshments

5:30-6:30 p.m.

Location: Convention Center Foyer, Room 338

U010 – Managing Unique Conditions in Asian Skin 7:30–8:30 a.m.

F001 – Leading by Negotiation

9–11 a.m.

U021 – Practical Practice Enhancements: Applying Evidence-Based Strategies 4:30–5:30 p.m.

Don't miss the AAD Career Networking Event!

The search is on for your future in dermatology.





AAD Career Networking Event
Friday, March 17 | 4:30–6:30 p.m.
Location: Hilton New Orleans Riverside Hotel,
Grand Ballroom C

If you're hunting for a dermatology job or are about to graduate, we recommend you do not miss the AAD Career Networking Event! The AAD Career Networking Event is a great, high-energy opportunity to meet over 50 employers, face-to-face in a dedicated two-hour setting. Drinks will be provided as you meet and mingle with potential employers from all over the country and network with other dermatologists.

Register today to stay in the know!

This event is supported by DermCare Management.



Meet Spot!

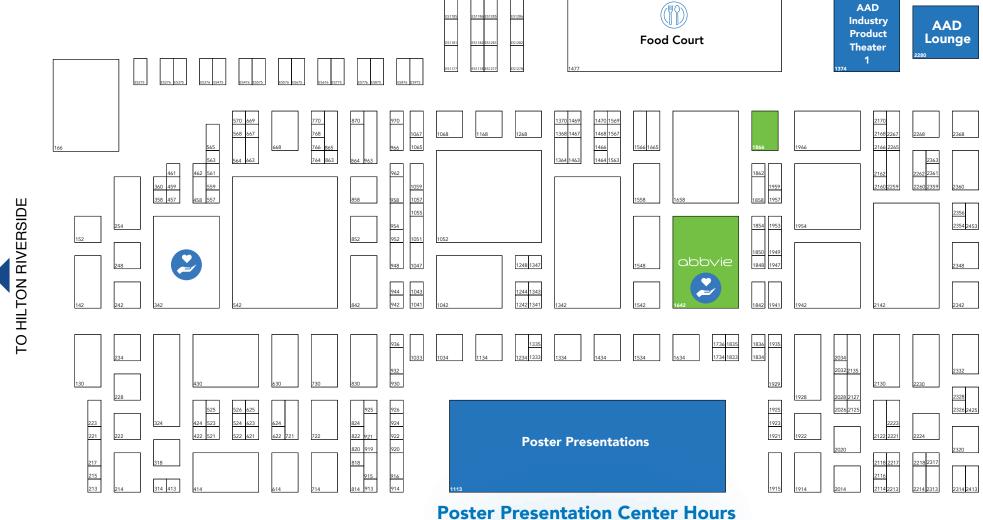
and learn how our AI augmented formulations represent the future of skin care.













Friday – Saturday | 8:30 a.m.–5 p.m.
Sunday | 1-3 pm.



Exhibitor Listing

Data current as of February 21, 2023. Please use the AAD Meeting App aad.org/mobile for the most up-to-date exhibitor list.

3Gen, Inc./DermLite	1928
5CC (5-Continent-Congress)	1248
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Allstate Medical	919
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Avantik Biogroup		1921
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Beiersdorf, Inc		3139
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S&T Development Co., Ltd		
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Benev Company Inc		
Beutner Laboratories		1467
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Biofrontera, Inc.		
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CoNCERT Pharmaceuticals Inc	1534
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Daavlin	
Dartmouth Health942	
DefenAge	
DEKA M.E.L.A. srl	
Delasco	
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Dermadry Laboratories Inc 4633	
Dermaesthetics Beverly Hills 926	
DERMAGNOSTIX	
DermapenWorld	
DermaSensor Inc	
Dermatology Digest, The 2170	
Dermatology Foundation 864	
Dermatology Specialists, The 2162	
Dermatology Times 913	
Dermavant Sciences, Inc	
DermCare Management 1047	
Dermogalenic Experts SA DE CV 564	
Dermosciences Corp 570	
Dermpath Diagnostics 614	
DermTech	
Designs for Vision, Inc	
DiamondTome/Altair Instruments 1055	
DOCS Derm Group 4151	
Doctor Multimedia 3920	
Dow Development Laboratories LLC 559	
eClinicalWorks 1059	

AAD Industry Product Theater 2

Exhibit Hall hours

Friday – Saturday | 10 a.m.-5 p.m. Sunday | 10 a.m.-3 p.m.



Registration

TRANSPORTATION CENTER

2642



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Attend today's QI symposium

S019 - The Quality Improvement and Innovation Symposium Friday, March 17 | 1–4 p.m. Location: Room 391



Brent James, MD, MStat, FACPE, clinical professor at the Clinical Excellence Research Center at Stanford University School of Medicine

e encourage attendance at today's So19 - The Quality Improvement and Innovation
Symposium from 1-4 p.m. in Room 288.
The symposium showcases real-life examples of QI and provides a framework for how quality improvements can be incorporated into dermatologists' daily practice.

The symposium will feature guest speaker, Brent James, MD, MStat, FACPE, clinical professor at the Clinical Excellence Research Center at Stanford University School of Medicine, and renowned for his work in clinical quality improvement, patient safety, and structures underlying successful improvement efforts. He will present "Profession-Based Medicine: The Best Clinical Result at the Lowest Necessary Cost."

The AAD's Resident Quality
Improvement Award recipients and
the AAD's Innovations in Quality
Improvement Award recipients will also
present during the symposium. •



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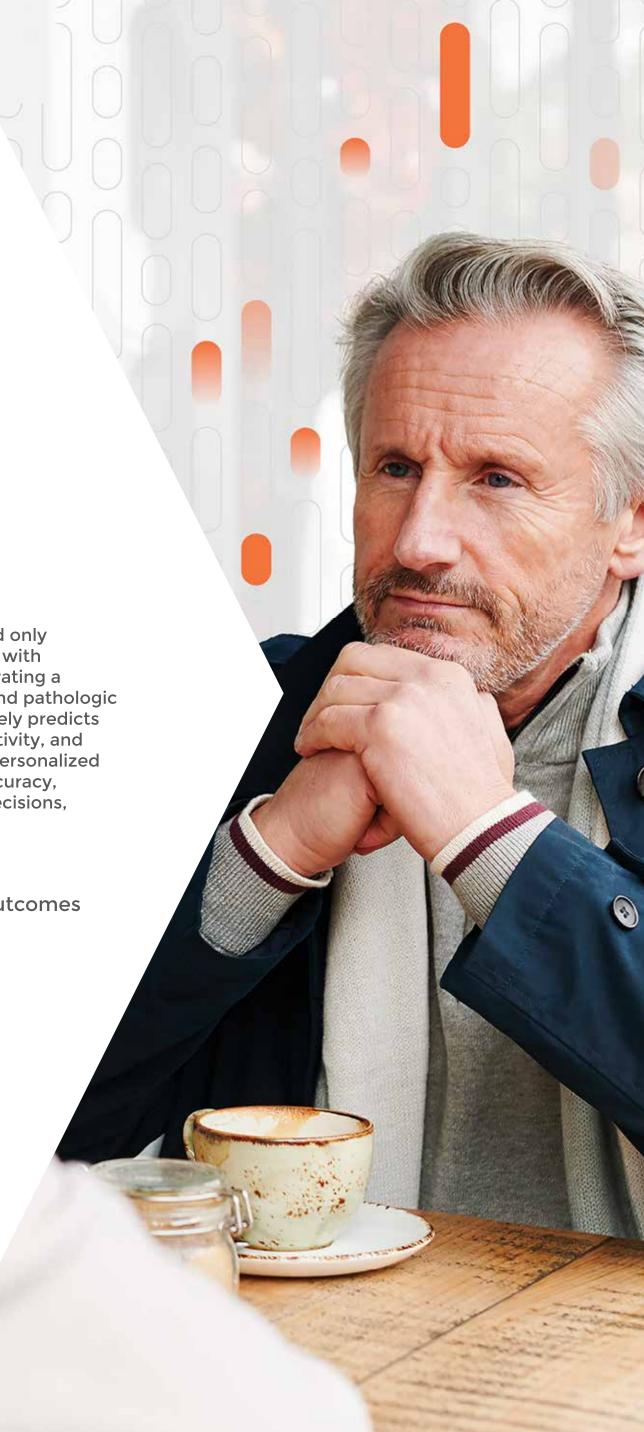
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How are you feeling today?

New session urges emotional check-in treating patients with hair, scalp, and nail disorders.

5

S041 – Up-to-Date Treatment of Hair, Scalp, and Nail Disorders
Saturday, March 18 | 1–4 p.m.
Location: Room 271



Antonella Tosti, MD, professor of dermatology at the University of Miami Miller School of Medicine



Brian William Morrison, MD, MSc, FAAD, professor of dermatology at the University of Miami Miller School of Medicine

Putting a microscope on the diagnoses and treatment of hair, scalp, and nail disorders is a dermatologist's natural inclination. However, a close-up examination of a patient's emotional view of the disorder and the impact it may have on their quality of life should also be one of the first steps in managing patient care.





hat's among the issues to be discussed during Saturday's new session, "So4I-Up-to-Date Treatment of Hair, Scalp, and Nail Disorders." Although the primary focus of the session offers a practical guide for the treatment of hair, scalp, and nail disorders, session codirector Antonella Tosti, MD, said dermatologists must have a thorough understanding of how the disease affects the patient's everyday life. Dr. Tosti is a professor of dermatology at the University of Miami Miller School of Medicine. She is joined by co-director Brian William Morrison, MD, MSc, FAAD, also a professor of dermatology at the University of Miami Miller School of Medicine.



A more comprehensive understanding of patients and their disorders

"Disorders of hair and nails create a big impact on the quality of life of patients as they are very visible and create anxiety and depression," Dr. Tosti said. "Although these diseases are part of dermatology training during residency, it is often not extensive, and many dermatologists are not very familiar with diagnostic procedures and new treatments."

Progressing to the next step and applying new as well as triedand-true treatments can likely change the course of the disease as well as the patient's emotional well-being, she said.



New drugs provide new promise

The latest treatments, including JAK inhibitors, are effective and represent a new option for alopecia areata, Dr. Tosti said, but also show potential for other hair disorders. JAK inhibitors can also be successfully used for some inflammatory nail disorders. Additionally, there are new ways of delivering existing drugs such as minoxidil that can be used as an oral medication or as intralesional administration. Oral minoxidil has recently shown promise in accelerating nail growth rate and can be useful in treating nail disease, she said.

Covering everything from head to toe

Saturday's session will also explore the use of platelet-rich plasma, microneedling, and intra-lesional injections

"These are complements to medical treatment and not an alternative," Dr. Tosti said. "This is important to be clarified to patients who often prefer procedures to treatments they have to do themselves at home. All these procedures improve treatment outcomes and are recommended in association with medical therapy."

Finally, Dr. Tosti said Saturday's panel will address how gender and ethnicity effect treatment of hair, scalp, and nail

disorders. Some hair and nail diseases have a different frequency depending on ethnicity because of genetic factors or exposure to different triggering factors, she said. Recognizing hair type is essential for haircare recommendations. Instance evaluation of nail pigmentation requires greater attention in patients with dark phototypes. For example, melanoma of the nail is more common in this population.

Although designed to educate young physicians, the Saturday session will provide an up-to-date review of hair, scalp, and nails that all dermatologists will find of value.

"Utilize dermoscopy in all patients with hair and nail disorders, not only to evaluate the disease better, but also to take the biopsy in the most active area. Use your dermatoscope in the case of scalp injections to see which areas need to be treated. Always discuss in



Central centrifugal cicatricial alopecia at dermoscopy

depth possible side effects of any treatment to make a decision together with your patient."

– Antonella Tosti, MD



Regardless of the treatment, Dr. Tosti said **teledermatology** can be a good tool to discuss how the patient is compliant with treatment and possible side effects before an in-person follow-up evaluation.



In DERMIS-1 and DERMIS-2, ~40% of patients achieved IGA Success and ~70% of patients achieved I-IGA Success at Week 8.1

DERMIS-1 and DERMIS-2 were identical Phase 3 randomized, parallel, double-blind, vehicle-controlled, multicenter studies that evaluated ZORYVE over 8 weeks as a once-daily, topical treatment for plaque psoriasis. Subjects (N=881) were randomized 2:1 to receive ZORYVE cream 0.3% (n=576) or vehicle (n=305) applied once daily for 8 weeks. Eligibility criteria included a diagnosis of mild, moderate, or severe plaque psoriasis and an affected BSA of 2% to 20%. Primary endpoint was IGA Success at Week 8 and key secondary endpoint was I-IGA Success at Week 8.1

IGA Success was defined as a score of Clear (0) or Almost Clear (1) and a \geq 2-grade improvement from baseline. I-IGA Success was defined as a score of Clear (0) or Almost Clear (1) and \geq 2-grade improvement from baseline.

ZORYVE is not for ophthalmic, oral, or intravaginal use.

BSA = Body Surface Area, IGA = Investigator's Global Assessment, I-IGA = Intertriginous-IGA



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See the results at zoryvehcp.com

Actor portrayal

INDICATION

ZORYVE is indicated for topical treatment of plaque psoriasis, including intertriginous areas, in patients 12 years of age and older.

IMPORTANT SAFETY INFORMATION

The use of ZORYVE is contraindicated in patients with moderate to severe liver impairment (Child-Pugh B or C). The most common adverse reactions (≥1%) include diarrhea (3%), headache (2%), insomnia (1%), nausea (1%), application site pain (1%), upper respiratory tract infection (1%), and urinary tract infection (1%).

Please see brief summary of full Prescribing Information for ZORYVE on the following page.

References: 1. ZORVYE®. Prescribing information. Arcutis Biotherapeutics, Inc; 2022. 2. Data on File. Arcutis Biotherapeutics, Inc.



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Brief Summary of Prescribing Information for ZORYVE™ (roflumilast) cream, for topical use. See package insert for full Prescribing Information.

INDICATIONS AND USAGE

ZORYVE is indicated for topical treatment of plaque psoriasis, including intertriginous areas, in patients 12 years of age and older.

DOSAGE AND ADMINISTRATION

Apply ZORYVE to affected areas once daily and rub in completely. Wash hands after application, unless ZORYVE is for treatment of the hands.

ZORYVE is for topical use only and not for ophthalmic, oral, or intravaginal use.

CONTRAINDICATIONS

The use of ZORYVE is contraindicated in the following condition:

• Moderate to severe liver impairment (Child-Pugh B or C)

ADVERSE REACTIONS

Clinical Trials Experience

Because clinical trials are conducted under widely varying conditions, adverse reaction rates observed in the clinical trials of a drug cannot be directly compared to rates in the clinical trials of another drug and may not reflect the rates observed in practice.

In two multicenter, randomized, double-blind, vehicle-controlled trials (DERMIS-1 and DERMIS-2), 881 subjects 2 years of age or older with plaque psoriasis were treated with ZORYVE or vehicle once daily for 8 weeks.

The median age was 47 years (range 6 to 88). The majority of the subjects were male (64%) and White (82%). The median body surface area (BSA) affected was 5.5% (range 2% to 20%).

The proportion of subjects who discontinued treatment due to adverse reaction was 1.0% for subjects treated with ZORYVE and 1.3% for subjects treated with vehicle. The most common adverse reactions that led to discontinuation of ZORYVE was application site urticaria (0.3%).

Table 1 presents adverse reactions that occurred in at least 1% of subjects treated with ZORYVE, and for which the rate exceeded the rate for vehicle.

Table 1. Adverse Reactions Reported in $\geq \! 1\%$ of Subjects Treated with ZORYVE for 8 Weeks

Adverse Reaction	ZORYVE (N=576) n (%)	Vehicle (N=305) n (%)
Diarrhea	18 (3.1)	0 (0.0)
Headache	14 (2.4)	3 (1.0)
Insomnia	8 (1.4)	2 (0.7)
Nausea	7 (1.2)	1 (0.3)
Application site pain	6 (1.0)	1 (0.3)
Upper respiratory tract infection	6 (1.0)	1 (0.3)
Urinary tract infection	6 (1.0)	2 (0.7)

In 594 subjects who continued treatment with ZORYVE for up to 64 weeks in open-label extension trials, the adverse reaction profile was similar to that observed in vehicle-controlled trials.

USE IN SPECIFIC POPULATIONS

Pregnancy

Risk Summary

There are no randomized clinical trials of oral or topical roflumilast in pregnant women. In animal reproduction studies, roflumilast administered orally to pregnant rats and rabbits during the period of organogenesis produced no fetal structural abnormalities at doses up to 9 and 8 times the maximum recommended human dose (MRHD), respectively. Roflumilast induced post-implantation loss in rats at oral doses greater than or equal to 3 times the MRHD. Roflumilast induced stillbirth and decreased pup viability in mice at oral doses 5 and 15 times the MRHD, respectively. Roflumilast has been shown to adversely affect pup post-natal development when dams were treated with an oral dose 15 times the MRHD during pregnancy and lactation periods in mice.

The background risk of major birth defects and miscarriage for the indicated population is unknown. In the U.S. general population, the estimated background risk of major birth defects and miscarriage in clinically recognized pregnancies is 2% to 4% and 15% to 20%, respectively.

Clinical Considerations

Labor and delivery

ZORYVE should not be used during labor and delivery. There are no human studies that have investigated effects of ZORYVE on preterm labor or labor at term; however, animal studies showed that oral roflumilast disrupted the labor and delivery process in mice.

<u>Data</u>

Animal data

In an embryo-fetal development study, pregnant rats were dosed orally during the period of organogenesis with up to 1.8 mg/kg/day roflumilast (9 times the MRHD on a mg/m² basis). No evidence of structural abnormalities or effects on survival rates were observed. Roflumilast did not affect embryo-fetal development at a maternal oral dose of 0.2 mg/kg/day (equivalent to the MRHD on a mg/m² basis).

In a fertility and embryo-fetal development study, male rats were dosed orally with up to 1.8 mg/kg/day roflumilast for 10 weeks and females for 2 weeks prior to pairing and throughout the organogenesis period. Roflumilast induced pre- and post-implantation loss at maternal oral doses greater than or equal to 0.6 mg/kg/day (3 times the MRHD on a mg/m² basis). Roflumilast did not cause fetal structural abnormalities at maternal oral doses up to 1.8 mg/kg/day (9 times the MRHD on a mg/m² basis).

In an embryo-fetal development study in rabbits, pregnant does were dosed orally with 0.8 mg/kg/day roflumilast during the period of organogenesis. Roflumilast did not cause fetal structural abnormalities at the maternal oral doses of 0.8 mg/kg/day (8 times the MRHD on a mg/ m^2 basis).

In pre- and post-natal developmental studies in mice, dams were dosed orally with up to 12 mg/kg/day roflumilast during the period of organogenesis and lactation. Roflumilast induced stillbirth and decreased pup viability at maternal oral doses greater than 2 mg/kg/day and 6 mg/kg/day, respectively (5 and 15 times the MRHD on a mg/m² basis, respectively). Roflumilast induced delivery retardation in pregnant mice at maternal oral doses greater than 2 mg/kg/day (5 times the MRHD on a mg/m² basis). Roflumilast decreased pup rearing frequencies at a maternal oral dose of 6 mg/kg/day during pregnancy and lactation (15 times the MRHD on a mg/m² basis). Roflumilast also decreased survival and forelimb grip reflex and delayed pinna detachment in mouse pups at a maternal oral dose of 12 mg/kg/day (29 times the MRHD on a mg/m² basis).

Lactation

Risk Summary

There is no information regarding the presence of ZORYVE in human milk, the effects on the breastfed infant, or the effects on milk production.

Roflumilast and/or its metabolites are excreted into the milk of lactating rats. When a drug is present in animal milk, it is likely that the drug will present in human milk. The developmental and health benefits of breastfeeding should be considered along with the mother's clinical need for ZORYVE and any potential adverse effects on the breastfed infant from ZORYVE or from the underlying maternal condition.

Clinical Considerations

To minimize potential exposure to the breastfed infant via breast milk, use ZORYVE on the smallest area of skin and for the shortest duration possible while breastfeeding. Advise breastfeeding women not to apply ZORYVE directly to the nipple and areola to avoid direct infant exposure.

Data

Animal data

Roflumilast and/or its metabolite concentrations measured 8 hours after an oral dose of 1 mg/kg given to lactating rats were 0.32 and 0.02 mcg/g in the milk and pup liver, respectively.

Pediatric Use

The safety and effectiveness of ZORYVE have been established in pediatric patients ages 12 years and older for the treatment of plaque psoriasis. Use of ZORYVE in this age group is supported by data from two 8-week vehicle-controlled safety and efficacy trials which included 14 adolescent patients aged 12 to 17 years, of whom 8 received ZORYVE. Eighteen adolescent patients were treated with ZORYVE in open-label trials of 2- and 24-weeks duration. The adverse reaction profile was similar to that observed in adults.

The safety and effectiveness of ZORYVE in pediatric patients below the age of 12 years have not been established.

Geriatric Use

Of the 881 subjects with psoriasis exposed to ZORYVE or vehicle for up to 8 weeks in 2 controlled clinical trials, 106 were 65 years of age or older. No overall differences in safety or effectiveness were observed between these subjects and younger subjects. Other reported clinical experience has not identified differences in responses between the geriatric and younger patients, but greater sensitivity of some older individuals cannot be ruled out. Based on available data for roflumilast, no adjustment of dosage in geriatric patients is warranted.

Hepatic Impairment

Oral roflumilast 250 mcg once daily for 14 days was studied in subjects with hepatic impairment. The AUC and C_{max} values of roflumilast and roflumilast N-oxide were increased in subjects with moderate (Child-Pugh B) hepatic impairment. ZORYVE is contraindicated in patients with moderate to severe liver impairment (Child-Pugh B or C).

PATIENT COUNSELING INFORMATION

Advise the patient or caregiver to read the FDA-approved patient labeling (Patient Information).

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08/2022

Mirroring society in dermatology practice

Building a workforce that reflects those we serve



F024 - DEI in GME: **Thoughts and Considerations** Friday, March 17 | 1-3 p.m. Location: Room 287

iversity, equity, and inclusion (DEI) is not an academic concept, according to two speakers this afternoon. It is a phrase that describes the reality of dermatology practice, which includes patients, physicians, and staff of all backgrounds, and workplaces of all settings.

"DEI within medical education has, thankfully, become front and center over the past five years," said Jennifer Huang, MD, FAAD, chief of dermatology and director of pediatric oncodermatology at Boston Children's Hospital and associate professor of dermatology at Harvard Medical School. She will co-direct this afternoon's session, "DEI in GME: Thoughts and Considerations," which will focus on DEI in dermatology education.

"DEI issues are important topics for all dermatologists because our trainees graduate and become part of our workforce," Dr. Huang said. "All of us should be welcoming of a more diverse workforce, ensuring an inclusive environment and addressing health disparities in our practices."

One bar for all

"One important strategy in selecting and recruiting residents and faculty from diverse backgrounds is to make it very clear that we are setting the same bar of excellence for everyone," said session co-director Mayra Lorenzo, MD, PhD, FAAD, chair of the Harvard Dermatology Diversity Committee and assistant professor of dermatology at Harvard Medical School. "Nobody should feel like they are receiving an interview or being offered a position solely because of their demographic characteristics. We celebrate diversity and honor excellence."



Jennifer Huang, MD, FAAD, chief of dermatology and director of pediatric oncodermatology at Boston Children's Hospital and associate professor of dermatology at Harvard Medical School



Mayra Lorenzo, MD, PhD, FAAD, chair of the Harvard Dermatology Diversity Committee and assistant professor of dermatology at Harvard Medical School

The reality, she continued, is that the dermatology community does not mirror the diversity of the dermatology patient population. Not yet. A key strategy in the recruitment process is to offer resources and mentorship opportunities that are relevant to both the applicant's identity and their career interests.

Applicants expect more than a simple "yes, you're in," Dr. Lorenzo explained. They want to know how they will be supported both professionally and personally.

Only the beginning

Providing that support begins with changing the way dermatology is taught. Formal training sessions on inclusivity and health care equity are just the beginning.

"It is essential to role model these behaviors and provide hands-on opportunities to practice," Dr. Huang said. "For example, we offer a health policy and advocacy curriculum that includes a didactic portion followed by a group trip to discuss relevant issues with state legislators. An equity committee of faculty and residents discusses issues going on within and outside our community and brainstorms ways to expand our efforts for our patients and our local community."

Residents leading the charge in Boston

Dermatology is also working upstream to expand opportunities for both residents and Boston-area communities. Residents lead multiple service-learning programs, including a high school STEM (science, technology, engineering, and mathematics) pathway program to encourage early interest in science and medicine and a student-run pediatric dermatology clinic.

"We incorporate experiences in caring for underserved populations into our standard clinical curriculum, including skin of color clinics and clinics that serve patients experiencing homelessness, Spanish- and Portuguese-speaking communities, and LGBTQ patients," Dr. Lorenzo said. "Global integration of DEI initiatives within all areas of the program is best, in the classroom and in the clinics at every level," she continued.

"Everyone — faculty, residents, fellows, and support staff — needs to learn more about how to create a diverse and inclusive community. It can be demoralizing for residents to receive this education and feel that nobody else is learning about or respecting the principles of DEI," Dr. Huang said.

"Our work is definitely not done," she said. "We have a lot to learn and hope we can form a closer community of educators who can work together on these important topics." •



See the future of dermatology recognized

The Residents and Fellows Symposium is an opportunity to hear about groundbreaking research performed by dermatology residents and fellows. The top 18 projects are selected from a pool of over 100 applicants to give succinct summaries of their research. Faculty judges selected individuals who presented the most outstanding papers in laboratory and clinical research. The Everett C. Fox Award (formerly the Stelwagon Award) is given to the presenters of the most outstanding clinical and laboratory research.

Don't miss this exciting, inspiring, and instructive event! Winners of the Fox Award will be published in DermWorld Meeting News.



Resident and Fellows Symposium

Saturday, March 18 9 a.m.-12 p.m. Location: Room 291 Led by Cory A. Dunnick, MD, FAAD

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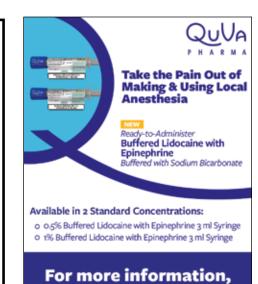
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Transcending burnout

Find the path to joy and a fuller life



F063 - Self Care in **Healthcare: Beyond Burnout** to Finding Fulfillment Saturday, March 18 | 1–3 p.m. Location: Room 276

Kelly M. Cordoro, MD, FAAD, professor of dermatology and pediatrics at the University of California, San Francisco





Dermatologists and other health care workers are at an inflection point, and their health and well-being are on the line, according to Dr. Cordoro. Physicians are incredibly resilient and selfless and will rise to the occasion no matter what is asked of them, she said. "This is great for your patients and teams but can be destructive to you as an individual. There's no better time to afford ourselves time for self-reflection, personal awareness, and professional enrichment that goes beyond medical topics."

"We level up and work harder, do more, and continue to give. But there is a breaking point. If you feel you are near it, or want to avoid it, attend this session. If you want to connect and reconnect with your core values, attend this session," she said.

Burnout versus wellness

This afternoon's session is not a session on burnout, Dr. Cordoro warned. Rather, the session focuses on the "deeply personal and dynamic nature of individual perspectives, values, and the road to joy in work and life."

"Our personal impressions of well-being, our perspectives on work and life satisfaction, and our needs and wants change over time. Our view of well-being is shaped by our perceptions and the lens through which we view the world," she said. "It is important to recognize that, and recognize that even though happiness is related to, and even used in some definitions of wellness, wellness as a concept is so much broader than happiness alone."

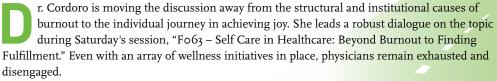
Growth is a universal human value, and this afternoon's session embraces a growth mindset.

"We cannot wait for the 'big fix' to the frustrating systemic issues we face in medicine, we must connect to core values," Dr. Cordoro said. "Although access to outstanding occupational wellness programs to ameliorate 'burnout' abound, and can be helpful, true wellbeing

Today's session will also discuss mental health, an important dialogue, given the prevalence of depression and suicide in medicine, including dermatology, she said.

"I truly think the session will be a change-maker for those who come prepared to take a reflective, deep dive into their own core values and start to align their choices with their self-identified drivers of joy and meaning,"

It's 2023 and physicians are becoming burned out on the topic of professional burnout. The truth is: the structure of the health care system and its impact on physician well-being is unlikely to change. But physicians can change the course of their own, personal journey, according to Kelly M. Cordoro, MD, FAAD, professor of dermatology and pediatrics at the University of California, San Francisco.



"When our values and beliefs are aligned with our work, there is deep meaning and career/ work satisfaction despite structural obstacles and frustrations. In contrast to the many medical professionals who are deeply satisfied and enriched by their work, there are some who are not. We have the power to change that, and it largely comes from within," Dr. Cordoro said.



Self-reflection can be empowering

Dr. Cordoro believes that the same forces that shape us as people shape us as doctors. "Our circle of influence includes our core beliefs, experiences, perspectives, and environment." In medicine, physicians face tremendous pressure to "conform and fall in line as we march along the training and career path largely under the influence of others." Everyone in our professional circle, from colleagues and supervisors to role models and mentors, will influence our decisions and activities.

There is always an opportunity to reshape your career and life by figuring out who you are and what brings you meaning, she said. Of course, it requires a willingness and the time to take a deep personal dive into what brought you to medicine in the first place, the areas that feel energizing, and those that feel stifling.

"Honest self-appraisal is the first step to developing a true understanding of our personal values and beliefs and aligning our choices and actions accordingly. This work is empowering, and can be life- and career-altering, in a good way!" Dr. Cordoro said.

Keep pace with your personal journey

There are big and small ways to create change. It starts with "rethinking your focus and rearranging your plate toward a more favorable balance," Dr. Cordoro said. Session speaker and Batavia, Illinois clinical psychologist Amy MacDonald, PsyD, will present attendees with a selfreflection exercise designed to identify core values and gain perspectives and skills to increase fulfillment and meaning in work and life. The session goals are to:

Determine which of your beliefs and actions are productive and bring joy/satisfaction and which may sustain a destructive or unhealthy pattern.

Develop skills and perspectives that restore meaning in your work by realigning your work with your core values.

Distinguish between environmental and host factors that contribute to joy or dissatisfaction. Environmental factors are the systems, structures, organizations, people, and culture around us that influence us, while host factors are intrinsic to the person.





Are you up for a challenge?

Good news! The ever-popular social media challenges will be returning to the AAD Annual Meeting in New Orleans. This year, there will be two different challenges that attendees can participate in — one on Twitter and one on Instagram. Both will offer the jealousy-inducing grand prize of free registration to the 2024 Annual Meeting in San Diego! Attendees are encouraged to participate in both challenges, and there is no limit to the number of entries submitted on either platform.





Gone are the days of posting selfies and photo carousels video is the new way of sharing your best content on social media. We are asking attendees to share their Annual Meeting experience by creating an Instagram Reel of their time in The Big Easy with the hashtag #AAD2023challenge. Reels can be posted any time between Friday, March 17, and Tuesday, March 21, until 11:59 PM CDT. One grand prize winner will be randomly selected from the total submissions the following week and the reel will be shared from the @AADmember Instagram account.



Twitter is still one of the most popular platforms for dermatologists to share research and discuss specialty topics. Since there is so much to learn about at the Annual Meeting, we are asking attendees to tweet their top pearls or key learnings from their favorite AAD sessions with the hashtag #AAD2023challenge to enter. One randomly chosen winner will be selected the week after the meeting ends.

For more information, see the official rules and regulations online at aadmeetingnews.org/22724379 or direct message @AADmember on Twitter or Instagram.



Headed in the right direction

Novel therapies for alopecia areata are on the rise.



Natasha Atanaskova Mesinkovska, MD, PhD, FAAD, professor of dermatology and vice chair for clinical research at the University of California Irvine School of Medicine

S058 – Alopecia Areata: **New Therapies** Monday, March 20 | 1-4 p.m.

Location: Room 344

landscape for alopecia areata treatments last June with the approval of baricitinib — the first systemic treatment for the condition. The approval helped spur patients' already high interest in new and effective ways to treat hair loss. Natasha Atanaskova

he FDA transformed the

Mesinkovska, MD, PhD, FAAD, professor of dermatology and vice chair for clinical research at the University of California Irvine School of Medicine, will direct this afternoon's new symposium, "So58 - Alopecia **Areata: New Therapies**," which will explore the latest approaches using baricitinib as well as other Janus kinase (JAK) inhibitors in the pipeline, and the latest in procedural and device-based approaches.

Medication for a specific disease

"Alopecia areata is the most common cause of immunemediated alopecia," said Dr. Mesinkovska. "Alopecia areata affects 2% of the U.S. population and is not a cosmetic issue. It is a specific autoimmune disease, and we finally have an approved medication with more on the way."

Alopecia areata does not discriminate by sex or age, Dr. Mesinkovska said, and individuals of African American decent are somewhat more likely to present with this particular form of hair loss compared to those of Caucasian or Asian ethnicities. Women are somewhat more likely to seek treatment than men, maybe because men have the socially acceptable option of shaving their heads to avoid notice.

And unlike many forms of hair loss, alopecia areata can affect children and adolescents as well as adults. The average patient age is in the early 30s.

Finding alternatives

"Healthy hair is important for everyone, so it is vital to be able to identify alopecia areata quickly and correctly because we can treat it effectively with JAK inhibitors," Dr. Mesinkovska said. "We don't typically biopsy children, or even adults, if there is a good alternative, so we will have sessions on how to distinguish alopecia areata from other types of hair loss clinically and using dermoscopy. There are important tips to using dermoscopy as a tool to identify areata in all races and skin types because it can be tricky to

In addition to baricitinib, two other JAK inhibitors, ritlecitinib and deuruxolitinib, are in development. Patients who do not tolerate baricitinib or

have adverse reactions may benefit from off-label use of an alternative agent. JAK inhibitors are relatively expensive and offlabel reimbursement remains problematic.

Non-medical choices

There is also continuing interest in non-medication approaches to alopecia areata. Positive results have been reported for platelet rich plasma, microneedling, light treatments, and laser, although any subsequent hair growth varies by operator and patient factors. There is also the practical consideration of using relatively expensive, time-consuming, and sometimes painful temporary treatments for a chronic autoimmune disease.

Others slated to give presentations on a broad range of alopecia areata topics will be Brittany Gareth Craiglow, MD, FAAD, Chesahna Kindred, MD, MBA, FAAD, Brett Andrew King, MD, PhD, FAAD, Maryanne Makredes Senna, MD, FAAD, Jerry Shapiro, MD, FAAD, Bruna Duque-Estrada, MD, and Ronda S. Farah, MD, FAAD.

"Attendees will leave this session better able to recognize tricky cases of alopecia areata, choose patients suitable for systemic therapy, and feel very comfortable using medications in both adults and children," Dr. Mesinkovska said. "We have the best of the most-experienced alopecia areata speakers at this session to bring us up to date and to help us better treat and understand our patients."

Your Dermatologist Knows: Meet the correspondents!

Your Dermatologist Knows, the AAD's new consumer-positioning strategy, launched in October and is already seeing significant success in educating the public about the expertise of boardcertified dermatologists. You can meet the social media correspondents who are part of the strategy Friday and Saturday; we'll also have an opportunity for you to take videos and photos to share on your own channels, plus refreshments and a gift for attendees. Join us!

AAD Resource Center, Booth 4039

Friday and Saturday, 1-2 p.m.

meeting news

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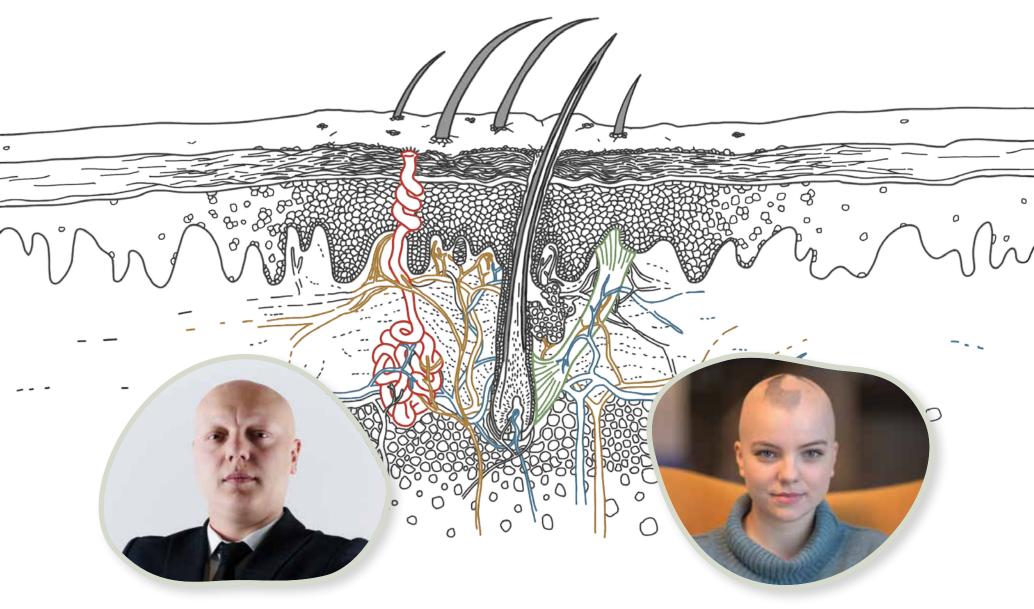
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Re-Examine Alopecia Areata

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Hair loss isn't the whole story.

- Alopecia areata (AA) is an autoimmune disease that can also have effects beyond the scalp.¹
- AA has a complex etiology and is rooted in immune system dysregulation, with many patients having a genetic predisposition.^{2,3}
- Patients often experience autoimmune and psychiatric comorbidities, lifestyle disruptions, and psychosocial distress.^{1,2,4}
- The unpredictable course of AA can make disease management difficult for HCPs and their patients.

To re-examine what you know about alopecia areata, visit <u>education.lillymedical.com/advancesinaa</u>

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DermWorld



Saturday • March 18, 2023

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S025 – Late-Breaking Research: Session 1

Saturday, March 18 9 a.m.-12 p.m.

Location: New Orleans Theater B

S042 – Late-Breaking Research: Session 2

Saturday, March 18 1–4 p.m.

Location: New Orleans Theater B

Finish strong

Don't forget two, important, back-to-back, high-yield symposiums on Tuesday.

S059 – What's New in Dermatology Tuesday, March 21 8–10 a.m.

Location: New Orleans
Theater B
Led by Mark Lebwohl,
MD, FAAD, this session
offers attendees the
chance to discover the
latest developments in
dermatology over the
last 15 months.

S060 – Therapeutic and Diagnostic Pearls Tuesday, March 21 10:15 a.m.–12:15 p.m. Location: New Orleans

Theater B

Uncover practical and valuable insights on a wide range of diseases and disorders. Panel discussion led by Robert T. Brodell, MD, FAAD.

Taking a closer look

Tips for treating skin conditions among Asian population

he advice was simple.
Take extra care when
treating dermatologic
conditions in patients with Asian
skin, said Hye Jin Chung, MD,
FAAD, assistant professor of
dermatology at Harvard Medical
school in Boston. Dr. Chung's
cautious counsel was the
foundation of Friday's session,
"Uo10 – Managing Unique
Conditions in Asian Skin."

A large population with a broad range of conditions

In directing the session, Dr. Chung explained the importance of being attentive to the differences in Asian skin. The Asian population currently constitutes a majority of the global population, comprising nearly 60%. In the U.S., the number of people who identify as Asian is expected to grow to 41 million by the year 2050. In Canada, 25% of the population is expected to be Asian by 2036. Thus, as North America's Asian population increases, the demand



for experienced dermatologic care for Asian skin will increase. Specifically, according to Dr. Chung, dermatologists must become more familiar with the diagnosis and treatment of common medical conditions and cosmetic concerns.

"Asian skin is known to have higher skin irritability to topical agents. Thus, it is important to counsel patients on how to use certain medications which can cause irritation, such as topical retinoids, hydroquinone, etc.," Dr. Chung said. "For example, it is important to start lower concentrations of topical agents and provide patient counseling on using moisturizer and gentle skin care for Asian patients."

Pigmentary and scarring considerations

Certain pigmentary and scarring disorders are common in patients with Asian skin, according to Dr. Chung. For example, melanocytes in Asian skin respond to visible light differently than in the white population. Pigmentation induced by visible light is darker and more sustained. Additionally, there is a strong genetic predisposition for keloid formation. Individuals of skin of color, including Asian ancestry, are particularly prone, she said. Dr. Chung recommended fluorouracil/steroid injections, fractional ablative laser assisted drug delivery, or pulsed dye laser when intralesional steroid

injections fail for keloids or hypertrophic scars. She also discussed a detailed technique of keloidectomy with a fillet flap.

Asian perspective

Dr. Chung also invited three experts from Asia to present at the session. Regarding pigmentary disorders, Woraphong Manuskiatti, MD, from Thailand recommends picosecond laser treatment for melasma, nevus of Ota, and Hori's nevus. Davinder Parsad, MD, IFAAD, from India reviewed recent advances in the management of pigmentary disorders (autologous non-cultured epidermal cell suspension for vitiligo, and medical and laser treatment for acquired dermal macular hyperpigmentation).

When treating patients with Asian skin, Jihee Kim, MD, PhD, from Republic of Korea encourages dermatologists to be aware of anti-aging procedures, which are popular in Asia. Dr. Kim said superficial dermal injection of neuromodulator (with or without hyaluronic acid intradermal injection), and injection of poly-D,L-lactic acid or polynucleotide are popular and effective anti-aging procedures.

Finally, Dr. Chung said, don't forget the importance of sunscreen for people with Asian skin.

"Sunscreen with visible light blocker is very important for Asian skin-typed patients with hyperpigmentation (melasma, post-inflammatory hyperpigmentation, etc.)," she said. •



Inside

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Who will be the future leaders of the Academy?

The Nominating Committee voted to present the following slate of candidates (listed in random order) for the 2023 Academy election of Officers, Directors, and Nominating Committee Member Representatives (West Region).

Visit the AAD Election Connection at aad.org/election to learn about this year's candidates and to interact with them on top issues via the online Ask the Candidates forum.

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View/print an online ballot book at aad.org/election

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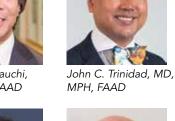
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Arturo P. Saavedra,

MD, PhD, FAAD

Eligible voting members can vote by visiting the personalized voting link sent by email or the AAD Election Connection at aad.org/election. You can also print and fax your online secure election ballot starting March 18 to (877) 235-9052. Ballots received at the AAD office will be considered invalid.

Derm in action

During Friday's interactive session, "C002 - Live Demonstration: The State of the Art of Aesthetic Dermatology," panelists from across the globe shared their techniques and treatment tips with cosmetic procedures. In particular, attendees learned how to

assess the aging face and neck and select the most appropriate aesthetic technique, how to identify the various ambulatory cosmetic procedures and their appropriate uses, and how to recognize and identify facial and neck anatomy as it relates to the use of elective procedures. Examples showcased many FDA-approved fillers, neuromodulators, deoxycholic acid, chemical peels, and microneedling.







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TODAY'S HIGHLIGHTS

U041 – Developing the Next **Generation of Targeted Treatments for Inflammatory Skin Diseases**

7:30-8:30 a.m.

Location: Room 339

S025 - Late-breaking Research: Session 1

9 a.m.-12 p.m.

Location: New Orleans Theater B

S026 - Nail Symposium

9 a.m.-12 p.m. Location: Room 266

S029 - Residents and Fellows **Symposium**

9 a.m.-12 p.m. Location: Room 291

S030 - Boards Blitz

9 a.m.-12 p.m.

Location: New Orleans Theater C

S032 - Diversity, Equity, and Inclusion

9 a.m.-12 p.m.

Location: Room 355

S027 – Gross and Microscopic Symposium

9 a.m.-5 p.m.

Location: Room 270

DataDerm™ Drop-In Hours

10-11 a.m.

Location: AAD Resource Center, Booth 4039

Your Dermatologist Knows/ **Meet the Correspondents** 1-2 p.m.

Location: AAD Resource Center, Booth 4039

F063 – Self Care in Healthcare: **Beyond Burnout to Finding Fulfillment**

1-3 p.m.

Location: Room 276

S041 - Up-to-Date Treatment of Hair, Scalp, and Nail Disorders

1-4 p.m.

Location: Room 271

S042 - Late-Breaking Research: Session 2

1-4 p.m.

Location: New Orleans Theater B

PHOTO GALLERY

Scan the QR code below to view pics from the **Annual Meeting**



Microneedling has global appeal

Technique effective in all skin types.

Across the globe, microneedling has become an increasingly popular dermatologic treatment. Effective for use across all skin types and tones, it's a relatively easy treatment to integrate into a clinical practice across geographical regions.

dermatology instructor at the University of British Columbia in Vancouver

t Friday's new session, "UO13 – Advances in Microneedling Techniques Around the World," experts discussed the benefits of the technique as well as the physician skills necessary to provide patients a safe and effective way to manage various common dermatoses, including scars of various etiologies, striae distensae, androgenetic alopecia, and rhytides.

A technique for each nuance

"Microneedling technique may vary due to specific considerations when treating different skin tones and nuances in presentation of the same medical and cosmetic applications," said session director Monica K. Li, MD, FRCPC, FAAD, a clinical dermatology instructor at the University of British Columbia in Vancouver. "When delivered as a series of treatment

Columbia in Vancouver. "When delivered as a series of treatment sessions with optimal clinical endpoints, microneedling can be an effective, real-world practice option for both facial and body sites."

Dr. Li engaged the expertise of

dermatologists from Brazil, Spain, and Thailand to share their perspectives on microneedling around the globe as well as its use in facilitating transdermal drug delivery. The panel also evaluated evidencebased practices comparing microneedling, radiofrequency microneedling, and microcoring. According to Dr. Li, microneedling is considered generally safe for all skin tones, delivering negligible thermal energy. However, recognizing the appropriate aesthetic and medical conditions is key to optimize outcomes. For example, she said, needle depths should be adjusted to the specific skin location and skin thickness. Consider, too, that deeper needle penetration may be necessary for thick sebaceous skin compared to thin periocular skin.

Pearls on the healing process

"Combining microneedling with the use of topical antioxidants can enhance the regenerative process in the wound healing process resulting from the treatment, specifically with topical vitamin A and C," she said. "However, products not approved for intradermal use during microneedling may cause allergic contact dermatitis or granuloma formation."

Additionally, Dr. Li said patients should be educated about the procedure and be able to commit to the necessary post-procedure care to minimize adverse effects, including the risk of infection. Depending on the skin concern, the benefits of microneedling can be leveraged as part of combination therapies to improve different characteristics seen with scars and striae such as color and texture, she said.

Tuning in to microchannels

Microneedling is also effective in facilitating transdermal drug delivery, Dr. Li said. Specifically, microneedling induces the production of microchannels by way of controlled skin injury with minimal epidermal damage. These microchannels serve as conduit for enhanced penetration of medications that otherwise may not be able to reach the dermis to exert its intended effects.

From a clinical perspective, the difference between microneedling and radiofrequency microneedling is the manually delivered approach with no additional energy to induce collagen remodeling and production, she said.

"Radiofrequency microneedling delivers radiofrequency energy simultaneously as microneedles penetrate the skin, and this is thought to be able to amplify collagen and elastin production," she said. "Because of the added energy, some feel that fewer treatments may be required for radiofrequency microneedling compared to microneedling alone for treatment of the same skin concern. However, this is not conclusive from literature to date."

Microneedling tips



Scars and striae typically require a series of three to five monthly microneedling treatments.



Avoid microneedling on visibly tanned skin or those with recent sun exposure to prevent potential post-procedure dyspigmentation.



Do not perform microneedling over skin that shows signs of active infection or inflammation (active acne).



Apply a crosshatch technique when delivering microneedling passes to prevent skip areas.



Pinpoint bleeding is a useful clinical treatment endpoint.



Microneedling can be performed on discrete cosmetic units without producing lines of demarcation, unlike fully ablative laser resurfacing.



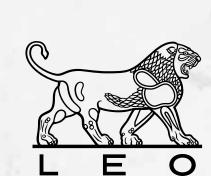
Take extra caution in the application of topical products or medications that are not approved for intradermal use during microneedling, as it may lead to possible allergic contact dermatitis or granuloma formation.

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During your visit at MoDA...

Immerse yourself in an IL-13 exhibit

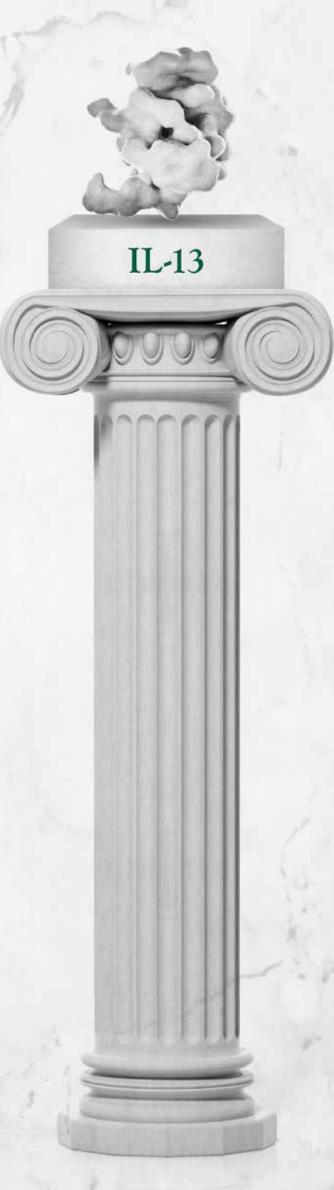
Take an in-depth look at the role of IL-13 in atopic dermatitis





Scan for directions to our booth









Well, what do you know! A highlight of the 2023 AAD Annual Meeting has been attendees showing off our favorite hashtags for photo opps and learning more about **Your Dermatologist Knows**. You can go to the AAD Resource Center, Booth 4039, and take photos, plus you can meet our correspondents from 1–2 p.m. And when you post your photo, don't forget to add #AAD2023!

Don't miss **Poster Presentations**

The Poster Presentation Centers 1 and 2 featuring live presentations and e-Posters are located just inside the Exhibit Hall.

Hours: Saturday 8:30 a.m.-5 p.m.

Sunday 1-3 p.m.









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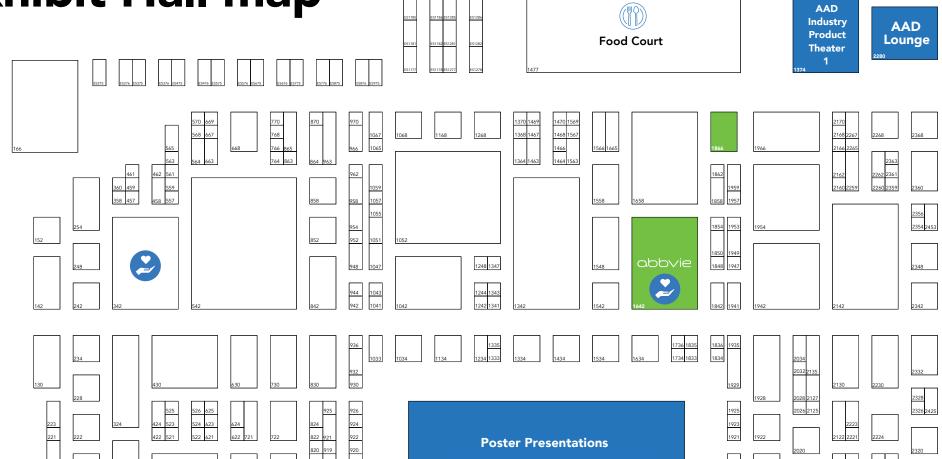
Visit Booth 630





TO HILTON RIVERSIDE







Poster Presentation Center Hours
Friday – Saturday | 8:30 a.m.–5 p.m.
Sunday | 1–3 pm.



Exhibitor Listing

Data current as of February 21, 2023. Please use the AAD Meeting App **aad.org/mobile** for the most up-to-date exhibitor list.

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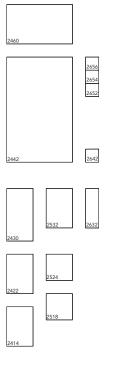
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AAD Industry Product Theater 2

Exhibit Hall hours

Saturday | 10 a.m.-5 p.m. Sunday | 10 a.m.-3 p.m.







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CURRENT AT TIME OF PRODUCTION

Dermatology's history, role in treating STIs

Now, mpox joins the list.

ermatologists are on the front lines in the ongoing battle to prevent and treat sexually transmitted infections.

"Dermatology as a specialty began from a study of syphilology because syphilis causes so many, many skin rashes," said Kieron Leslie, MBBS, professor of dermatology at the University of California, San Francisco (UCSF) School of Medicine. "Similarly, condyloma, mpox, and many other sexually transmitted infections (STIs) are primarily diseases of the skin. When someone comes in with a lesion on the face, the hands, the trunk, they may not share that they also have genital lesions. You need to have

an index of suspicion that this might be

Thinking outside the pox

Dr. Leslie opened Friday's session, "Fo14 – HIV and STIs: Hot Topics" with an update on the latest skin disease to jump from animals to humans, mpox. Since the 1950s, mpox had been considered a zoonotic infection endemic to parts of Africa that can jump from animals to humans, but human-human transmission was rare. That changed in 2022 when mpox suddenly surged to pandemic status. Spread largely, but not exclusively, through sexual contact,

mpox can present as a mild rash to more painful and severe rashes and anogenital lesions.

The good news, according to Dr. Leslie, is that incidence rates in the United States have fallen significantly since the summer of 2022. The drop is likely due to a combination of aggressive vaccination, emphasis on safe sex practices, and widespread infection among the most susceptible populations.

"Dermatologists need to be aware of the morphology of mpox and other STIs because cases continue to present," Dr. Leslie said. "Symptom control is standard of care for mild disease with analgesia for more severe forms. For severe disease, antivirals potentially active against poxvirus are appropriate."

Jump on STOMP

The primary antiviral is tecovirimat, approved under an Emergency Use Authorization (EUA). The agent is also being evaluated in STOMP, the Study of Tecovirimat for Human Mpox.

"For patients who present with mpox, we recommend they get enrolled in STOMP," he said. "Tecovirimat has been evaluated in phase I safety trials and is effective in monkeys, but efficacy in humans has not been evaluated. We hope STOMP will



Kieron Leslie, MBBS, professor of dermatology at the UCSF School of Medicine

answer the question. Mpox remains a longstanding infectious disease that presents in the skin. Dermatologists need to be aware of what the rashes and lesions look like and be able to refer to appropriate treatment."

Making safe sex even safer

Practitioners need to be equally familiar with syphilis, HIV, condyloma, and other STIs and the latest prevention strategies. And while treatments are available, prevention is preferred.

Safe sex practices can make a significant difference, Dr. Leslie said. So can vaccination, which has dramatically reduced the incidence and prevalence of condyloma and other sequelae of human papilloma virus (HPV) infection.

The Advisory Committee on Immunization Practices (ACIP) recommends HPV vaccination for all individuals up to the age of 26 and up to age 45 based on individual factors. HPV

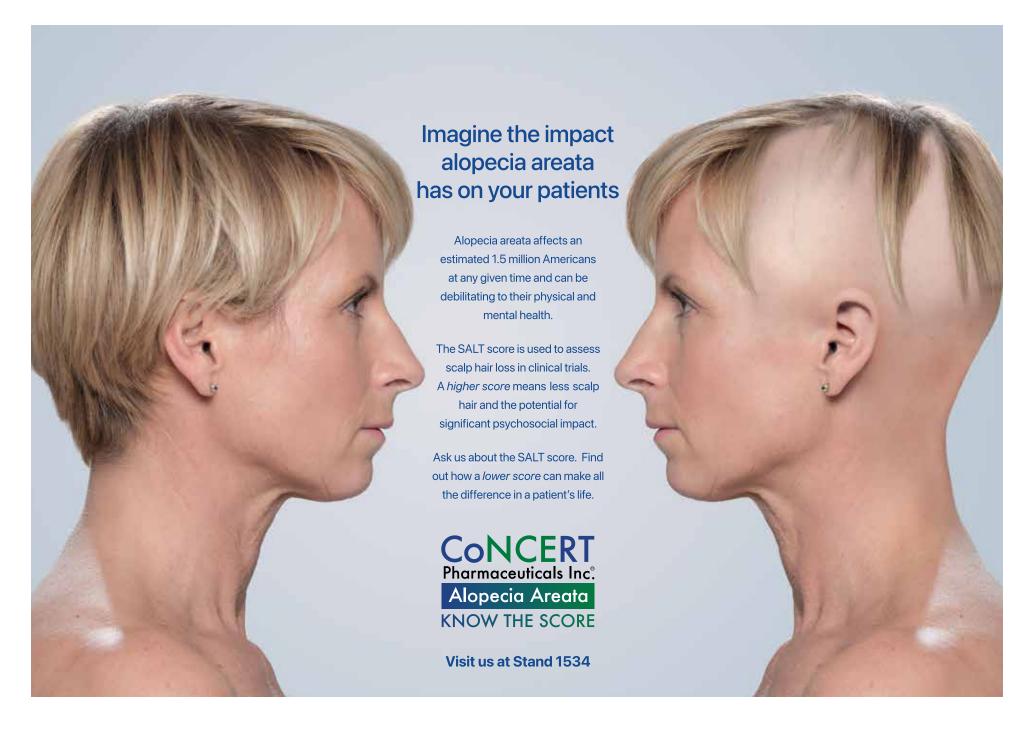


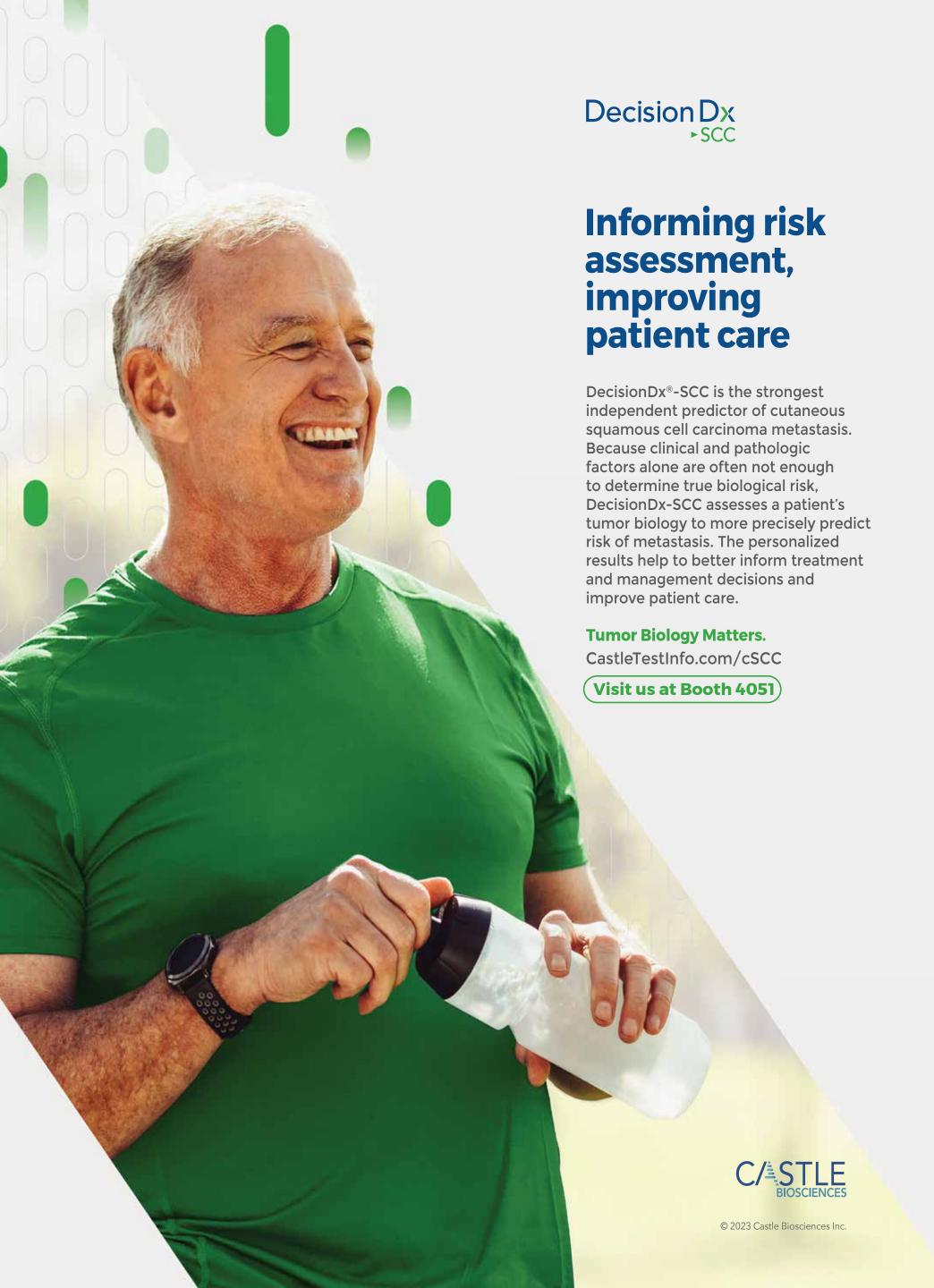
Albert Liu, MD, MPH, assistant clinical professor at the UCSF School of Medicine and director of HIV Prevention, San Francisco Department of Public Health

vaccination is not recommended for older individuals based on both the likelihood of prior HPV infection and the generally lower immune response in older individuals.

PrEP, preexposure prophylaxis, has been used to prevent HIV transmission for a decade, as has PEP (post exposure prophylaxis), according to Albert Liu, MD, MPH, assistant clinical professor at the UCSF School of Medicine and director of HIV Prevention, San Francisco Department of Public Health. The same PrEP-PEP approach has been extended to syphilis using doxycycline, a perennial treatment of choice for acute and secondary syphilis.

"Using doxy as PrEP and PEP is new for syphilis, but the strategies are well established and successful in HIV," Dr. Liu said. "Dermatologists need to understand that there are highly effective prevention strategies for HIV and syphilis and be comfortable talking with patients about their sexual history and activity."







In DERMIS-1 and DERMIS-2, ~40% of patients achieved IGA Success and ~70% of patients achieved I-IGA Success at Week 8.1

DERMIS-1 and DERMIS-2 were identical Phase 3 randomized, parallel, double-blind, vehicle-controlled, multicenter studies that evaluated ZORYVE over 8 weeks as a once-daily, topical treatment for plaque psoriasis. Subjects (N=881) were randomized 2:1 to receive ZORYVE cream 0.3% (n=576) or vehicle (n=305) applied once daily for 8 weeks. Eligibility criteria included a diagnosis of mild, moderate, or severe plaque psoriasis and an affected BSA of 2% to 20%. Primary endpoint was IGA Success at Week 8 and key secondary endpoint was I-IGA Success at Week 8.1

IGA Success was defined as a score of Clear (0) or Almost Clear (1) and a \geq 2-grade improvement from baseline. I-IGA Success was defined as a score of Clear (0) or Almost Clear (1) and \geq 2-grade improvement from baseline.

ZORYVE is not for ophthalmic, oral, or intravaginal use.

BSA = Body Surface Area, IGA = Investigator's Global Assessment, I-IGA = Intertriginous-IGA



Effective. Everywhere. Easy.

A once-daily, steroid-free cream with the power to clear elbows and knees, and the gentleness for face and folds.1.2



See the results at zoryvehcp.com

Actor portrayal

INDICATION

ZORYVE is indicated for topical treatment of plaque psoriasis, including intertriginous areas, in patients 12 years of age and older.

IMPORTANT SAFETY INFORMATION

The use of ZORYVE is contraindicated in patients with moderate to severe liver impairment (Child-Pugh B or C). The most common adverse reactions (≥1%) include diarrhea (3%), headache (2%), insomnia (1%), nausea (1%), application site pain (1%), upper respiratory tract infection (1%), and urinary tract infection (1%).

Please see brief summary of full Prescribing Information for ZORYVE on the following page.

References: 1. ZORVYE®. Prescribing information. Arcutis Biotherapeutics, Inc; 2022. 2. Data on File. Arcutis Biotherapeutics, Inc.



Arcutis Biotherapeutics, Inc. All rights reserved. COM-ARQ-151-2100003 v4.0 02/2023

Brief Summary of Prescribing Information for ZORYVE™ (roflumilast) cream, for topical use. See package insert for full Prescribing Information.

INDICATIONS AND USAGE

ZORYVE is indicated for topical treatment of plaque psoriasis, including intertriginous areas, in patients 12 years of age and older.

DOSAGE AND ADMINISTRATION

Apply ZORYVE to affected areas once daily and rub in completely. Wash hands after application, unless ZORYVE is for treatment of the hands.

ZORYVE is for topical use only and not for ophthalmic, oral, or intravaginal use.

CONTRAINDICATIONS

The use of ZORYVE is contraindicated in the following condition:

• Moderate to severe liver impairment (Child-Pugh B or C)

ADVERSE REACTIONS

Clinical Trials Experience

Because clinical trials are conducted under widely varying conditions, adverse reaction rates observed in the clinical trials of a drug cannot be directly compared to rates in the clinical trials of another drug and may not reflect the rates observed in practice.

In two multicenter, randomized, double-blind, vehicle-controlled trials (DERMIS-1 and DERMIS-2), 881 subjects 2 years of age or older with plaque psoriasis were treated with ZORYVE or vehicle once daily for 8 weeks.

The median age was 47 years (range 6 to 88). The majority of the subjects were male (64%) and White (82%). The median body surface area (BSA) affected was 5.5% (range 2% to 20%).

The proportion of subjects who discontinued treatment due to adverse reaction was 1.0% for subjects treated with ZORYVE and 1.3% for subjects treated with vehicle. The most common adverse reactions that led to discontinuation of ZORYVE was application site urticaria (0.3%).

Table 1 presents adverse reactions that occurred in at least 1% of subjects treated with ZORYVE, and for which the rate exceeded the rate for vehicle.

Table 1. Adverse Reactions Reported in ≥1% of Subjects Treated with ZORYVE for 8 Weeks

Adverse Reaction	ZORYVE (N=576) n (%)	Vehicle (N=305) n (%)
Diarrhea	18 (3.1)	0 (0.0)
Headache	14 (2.4)	3 (1.0)
Insomnia	8 (1.4)	2 (0.7)
Nausea	7 (1.2)	1 (0.3)
Application site pain	6 (1.0)	1 (0.3)
Upper respiratory tract infection	6 (1.0)	1 (0.3)
Urinary tract infection	6 (1.0)	2 (0.7)

In 594 subjects who continued treatment with ZORYVE for up to 64 weeks in open-label extension trials, the adverse reaction profile was similar to that observed in vehicle-controlled trials.

USE IN SPECIFIC POPULATIONS

Pregnancy

Risk Summary

There are no randomized clinical trials of oral or topical roflumilast in pregnant women. In animal reproduction studies, roflumilast administered orally to pregnant rats and rabbits during the period of organogenesis produced no fetal structural abnormalities at doses up to 9 and 8 times the maximum recommended human dose (MRHD), respectively. Roflumilast induced post-implantation loss in rats at oral doses greater than or equal to 3 times the MRHD. Roflumilast induced stillbirth and decreased pup viability in mice at oral doses 5 and 15 times the MRHD, respectively. Roflumilast has been shown to adversely affect pup post-natal development when dams were treated with an oral dose 15 times the MRHD during pregnancy and lactation periods in mice.

The background risk of major birth defects and miscarriage for the indicated population is unknown. In the U.S. general population, the estimated background risk of major birth defects and miscarriage in clinically recognized pregnancies is 2% to 4% and 15% to 20%, respectively.

Clinical Considerations

Labor and delivery

ZORYVE should not be used during labor and delivery. There are no human studies that have investigated effects of ZORYVE on preterm labor or labor at term; however, animal studies showed that oral roflumilast disrupted the labor and delivery process in mice.

<u>Data</u>

Animal data

In an embryo-fetal development study, pregnant rats were dosed orally during the period of organogenesis with up to 1.8 mg/kg/day roflumilast (9 times the MRHD on a mg/m² basis). No evidence of structural abnormalities or effects on survival rates were observed. Roflumilast did not affect embryo-fetal development at a maternal oral dose of 0.2 mg/kg/day (equivalent to the MRHD on a mg/m² basis).

In a fertility and embryo-fetal development study, male rats were dosed orally with up to 1.8 mg/kg/day roflumilast for 10 weeks and females for 2 weeks prior to pairing and throughout the organogenesis period. Roflumilast induced pre- and post-implantation loss at maternal oral doses greater than or equal to 0.6 mg/kg/day (3 times the MRHD on a mg/m² basis). Roflumilast did not cause fetal structural abnormalities at maternal oral doses up to 1.8 mg/kg/day (9 times the MRHD on a mg/m² basis).

In an embryo-fetal development study in rabbits, pregnant does were dosed orally with 0.8 mg/kg/day roflumilast during the period of organogenesis. Roflumilast did not cause fetal structural abnormalities at the maternal oral doses of 0.8 mg/kg/day (8 times the MRHD on a mg/ m^2 basis).

In pre- and post-natal developmental studies in mice, dams were dosed orally with up to 12 mg/kg/day roflumilast during the period of organogenesis and lactation. Roflumilast induced stillbirth and decreased pup viability at maternal oral doses greater than 2 mg/kg/day and 6 mg/kg/day, respectively (5 and 15 times the MRHD on a mg/m² basis, respectively). Roflumilast induced delivery retardation in pregnant mice at maternal oral doses greater than 2 mg/kg/day (5 times the MRHD on a mg/m² basis). Roflumilast decreased pup rearing frequencies at a maternal oral dose of 6 mg/kg/day during pregnancy and lactation (15 times the MRHD on a mg/m² basis). Roflumilast also decreased survival and forelimb grip reflex and delayed pinna detachment in mouse pups at a maternal oral dose of 12 mg/kg/day (29 times the MRHD on a mg/m² basis).

Lactation

Risk Summary

There is no information regarding the presence of ZORYVE in human milk, the effects on the breastfed infant, or the effects on milk production.

Roflumilast and/or its metabolites are excreted into the milk of lactating rats. When a drug is present in animal milk, it is likely that the drug will present in human milk. The developmental and health benefits of breastfeeding should be considered along with the mother's clinical need for ZORYVE and any potential adverse effects on the breastfed infant from ZORYVE or from the underlying maternal condition.

Clinical Considerations

To minimize potential exposure to the breastfed infant via breast milk, use ZORYVE on the smallest area of skin and for the shortest duration possible while breastfeeding. Advise breastfeeding women not to apply ZORYVE directly to the nipple and areola to avoid direct infant exposure.

Data

Animal data

Roflumilast and/or its metabolite concentrations measured 8 hours after an oral dose of 1 mg/kg given to lactating rats were 0.32 and 0.02 mcg/g in the milk and pup liver, respectively.

Pediatric Use

The safety and effectiveness of ZORYVE have been established in pediatric patients ages 12 years and older for the treatment of plaque psoriasis. Use of ZORYVE in this age group is supported by data from two 8-week vehicle-controlled safety and efficacy trials which included 14 adolescent patients aged 12 to 17 years, of whom 8 received ZORYVE. Eighteen adolescent patients were treated with ZORYVE in open-label trials of 2- and 24-weeks duration. The adverse reaction profile was similar to that observed in adults.

The safety and effectiveness of ZORYVE in pediatric patients below the age of 12 years have not been established.

Geriatric Use

Of the 881 subjects with psoriasis exposed to ZORYVE or vehicle for up to 8 weeks in 2 controlled clinical trials, 106 were 65 years of age or older. No overall differences in safety or effectiveness were observed between these subjects and younger subjects. Other reported clinical experience has not identified differences in responses between the geriatric and younger patients, but greater sensitivity of some older individuals cannot be ruled out. Based on available data for roflumilast, no adjustment of dosage in geriatric patients is warranted.

Hepatic Impairment

Oral roflumilast 250 mcg once daily for 14 days was studied in subjects with hepatic impairment. The AUC and C_{max} values of roflumilast and roflumilast N-oxide were increased in subjects with moderate (Child-Pugh B) hepatic impairment. ZORYVE is contraindicated in patients with moderate to severe liver impairment (Child-Pugh B or C).

PATIENT COUNSELING INFORMATION

Advise the patient or caregiver to read the FDA-approved patient labeling (Patient Information).

08/2022

Are you up for a challenge?

Good news! The ever-popular social media challenges will be returning to the AAD Annual Meeting in New Orleans. This year, there will be two different challenges that attendees can participate in — one on Twitter and one on Instagram. Both will offer the jealousy-inducing grand prize of free registration to the 2024 Annual Meeting in San Diego! Attendees are encouraged to participate in both challenges, and there is no limit to the number of entries submitted on either platform.



Instagram Reel Challenge

Gone are the days of posting selfies and photo carousels — video is the new way of sharing your best content on social media. We are asking attendees to share their Annual Meeting experience by creating an Instagram Reel of their time in The Big Easy with the hashtag #AAD2023challenge. Reels can be posted any time between Friday, March 17, and Tuesday, March 21, until 11:59 PM CDT. One grand prize winner will be randomly selected from the total submissions the following week and the reel will be shared from the @AADmember Instagram account.



Twitter is still one of the most popular platforms for dermatologists to share research and discuss specialty topics. Since there is so much to learn about at the Annual Meeting, we are asking attendees to tweet their top pearls or key learnings from their favorite AAD sessions with the hashtag #AAD2023challenge to enter. One randomly chosen winner will be selected the week after the meeting ends.

For more information, see the official rules and regulations online at aadmeetingnews.org/22724379 or direct message @AADmember on Twitter or Instagram.



Pearls from Members Brad P. Glick, DO, MPH, FAAD Member, AAD Board of Directors, residency program director, Larkin Palm Springs Hospital, Miami New

Approvals

"Patients with severe plaque psoriasis and comorbid Crohns disease, who have failed multiple topical, oral systemic, and biologic therapies such as TNF factor inhibitors, should consider the use of risankizuma. It's a highly effective interleukin 23 targeted biologic therapy that now will provide coverage for the skin, the joints, and the gut as it has been recently FDA approved for Crohn's disease."

Dr. Glick is among the panel of judges for today's S029 - Resident and Fellows Symposium in Room 291 from 9 a.m.-12 p.m.

In a study of patients with acne, almost 40% of treatment non-adherence was due to side effects

Strategic use of OTC skincare, including gentle cleansers and moisturizers, can promote adherence by improving tolerability^{2,3}











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References: 1. Dikicier BS. Topical treatment of acne vulgaris: efficiency, side effects, and adherence rate. *J Int Med Res.* 2019;47(7):2987-2992. **2.** Lain E, Andriessen AE. Choosing the right partner: complementing prescription acne medication with over-the-counter cleansers and moisturizers. *J Drugs Dermatol.* 2020;19(11): 1069-1073. **3.** Dreno B, Araviiskaia E, Kerob Delphine, et al. Nonprescription acne vulgaris treatments: their role in our treatment armamentarium—an international panel discussion. *J Cosmet Dermatol.* 2020;19:2201-2211. Use products only as directed.

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The practical side of systemic treatment for adult atopic dermatitis

Late-onset AD is a reality.

dults get atopic dermatitis less frequently than children but are often more difficult to treat than kids. Those easy-to-miss realities leave too many adults with atopic dermatitis undiagnosed and untreated. Even adults who are diagnosed are too often undertreated and suffering needlessly when dermatologists are slow to suggest escalating to systemic treatments. These issues were addressed during Friday's session, "UO12 -Practical Considerations for Systemic Treatment of Atopic Dermatitis in Adults," led by Aaron Mark Drucker, MD, FAAD, and including presentations by Katrina Abuabara, MD, FAAD, as well as Eric Lawrence Simpson, MD, MCR, FAAD.

What's new?

New and different approaches are here. Dermatologists have long used methotrexate, cyclosporin, and azathioprine off label for atopic dermatitis, but clinical trial data are sparse, noted Dr. Drucker, a scientist at Women's College Research Institute and associate professor of medicine at the University of Toronto Institute of Health Policy, Management, and Evaluation in Canada.

"In 2017, we began to get targeted systemic treatments, starting with dupilumab; then tralokinumab was approved. Now we have Janus kinase (JAK) inhibitors approved in the U.S. and Canada. The most important considerations are always how



effective it is and how safe it is, along with cost and accessibility," Dr. Drucker said.

Biologics and JAK inhibitors are both effective, Dr. Drucker said. At higher doses, JAK inhibitors are somewhat more effective than biologics, but also carry greater safety concerns.

"These agents are amazing for patients, and we've got more options that can, hopefully, improve patients' lives with more on the way," he said. "But more effective agents also make conversations with patients and decision making more complex. There are multiple factors to keep in mind, and we must make decisions with patients, not for them."

It's complicated

Dr. Abuabara, an associate professor of dermatology at the University of California, San Francisco, discussed some of the issues surrounding systemic treatment for adults. She asserted that treating adults with atopic dermatitis can be more complicated than treating children because adults have more conflicting considerations and demands on their time.

"Atopic dermatitis is quite common in adults," Dr. Abuabara

Eric Lawrence Simpson, MD, MCR, FAAD said. "The older studies that talked about most atopic dermatitis developing by age two weren't necessarily wrong, but they were limited. If you only follow people to age seven, the majority get it by age two. When you extend the window of observation, you see higher and higher proportions of people with

Topicals are the first-line approach, but it can sometimes be difficult to convince an adult to apply cream or ointment to their skin consistently before work every day. Patients with disease on their face or hands may not be able to go to work, she said, while particularly itchy disease may impact sleep quality, which affects their quality of life.

later and later onset of disease."

"There are logistic factors with adults and topical treatments can be time-consuming and messy, which they won't tolerate. Phototherapy can be effective and is very safe, but it requires going in two or three times a week, which can present work or transportation challenges and sometimes results in high co-pays. And there are patients who have tried topical steroids for years without success and want something new and different."

Lingering questions

The real question is whether the patient thinks their symptoms are under adequate control with the current therapy, said Dr. Simpson, professor of dermatology at Oregon Health and Science University School of Medicine in Portland. If the answer is 'no,' the disease is still bothersome, still has an impact on quality of life. It's time to talk systemic treatment.

Katrina Abuabara, MD, FAAD;

"Your responsibility is to care for your patient," Dr. Simpson said. "And if they're telling you that they are still suffering, despite what you think is an adequate topical or other treatment, they deserve the systemic treatment conversation."

The biggest obstacle to appropriate use of systemics is therapeutic inertia, he said. Clinicians tend to continue using the same approaches they've used in the past.

"There is a real hesitancy to escalate treatment and patients suffer because of it," Dr. Simpson said. "We need to recognize earlier the failure of topical therapy and the continued suffering that brings our patients. We need to offer treatment escalation earlier because, in general, adults with atopic dermatitis are undertreated." •

Exam session provides extra insights into structure, career

Jumpstart your exam prep with this year's new session, F051 - Boards & Beyond. Boardcertified dermatologists will provide residents with an understanding of the structure, format, and process of taking the American Board of Dermatology examination as well as tips on postresidency topics such as disability and life insurance, budgeting, and retirement planning.

The first hour of the session will cover board review. The second hour will focus on financial matters residents can use to prepare for a successful future after residency.

The session is for residents, young physicians, and even practicing dermatologists.

F051 – Boards And Beyond Saturday, March 18 1-3 p.m. Location: Rooms 255-257

DermWorld meeting news

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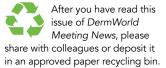
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AAD selects 2023 Gold Medal recipient

uring the AAD/A Annual Business Meeting, Daniel Mark Siegel, MD, MS, FAAD, of New York, will be honored as the 2023 Gold Medal Recipient. Dr. Siegel is a respected physician and leader.

Dr. Siegel founded the division of dermatologic surgery at State University of New York Stony Brook and ran the division for 12 years, establishing a fellowship training program, while actively teaching medical students and dermatology residents. Dr Siegel

was named the American Academy of Dermatology's representative to the AMA practice expense advisory committee, a subcommittee of the congressionally mandated AMA/ Specialty Society RVS Update committee (RUC). Dr. Siegel is currently a clinical professor of the dermatology department at the State University of New York at Downstate Medicine where he teaches residents and medical students.

The Gold Medal is the AAD's highest award and is presented

on a very selective basis to acknowledge outstanding and exceptional service in the field of dermatology. Gold Medal recipients are selected by the president of the Academy and automatically become honorary members.

"I believe my greatest contribution to the specialty is talent spotting and mentoring individuals to reach their full potential to succeed in their careers and provide service to the profession and the community." •



Daniel Mark Siegel, MD, MS, FAAD 2023 Gold Medal Recipient

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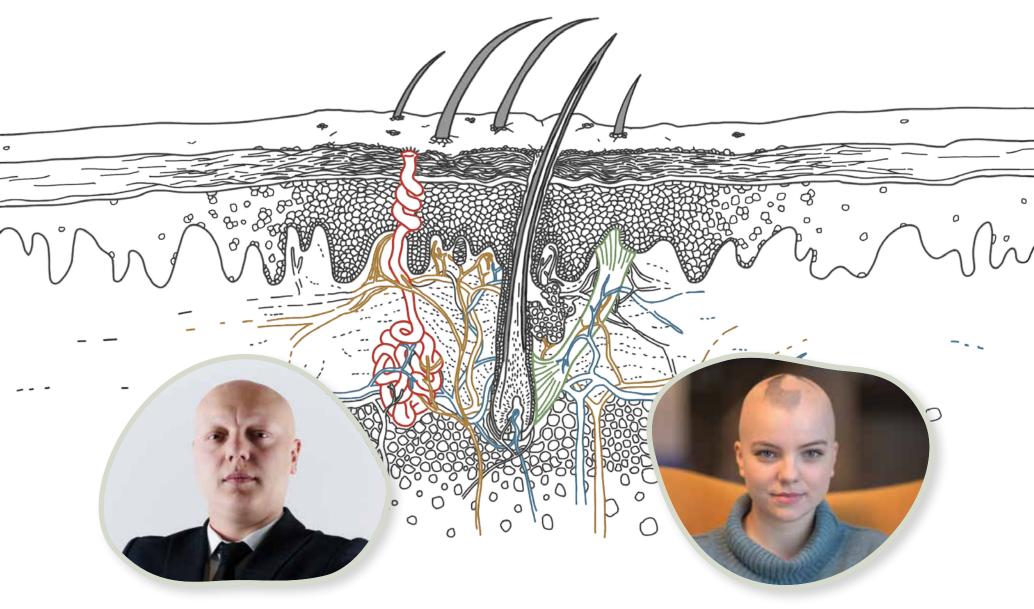
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Re-Examine Alopecia Areata

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Hair loss isn't the whole story.

- Alopecia areata (AA) is an autoimmune disease that can also have effects beyond the scalp.¹
- AA has a complex etiology and is rooted in immune system dysregulation, with many patients having a genetic predisposition.^{2,3}
- Patients often experience autoimmune and psychiatric comorbidities, lifestyle disruptions, and psychosocial distress.^{1,2,4}
- The unpredictable course of AA can make disease management difficult for HCPs and their patients.

To re-examine what you know about alopecia areata, visit <u>education.lillymedical.com/advancesinaa</u>

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DermWorld



Sunday • March 19, 2023

meeting news

A Publication of the American Academy of Dermatology | Association



Plenary Lineup

Sunday, March 19 8:45 a.m.-12 p.m. Location: La Nouvelle Orleans BR

8:45 a.m.

Chair's Welcome

Tammie C. Ferringer, MD, FAAD

8:50 a.m.

Clarence S. Livingood, MD, Memorial Award and **Lectureship: Ethical Dilemmas Hiding in Plain Site** Jane Margaret Grant-Kels, MD, FAAD

9:15 a.m.

President's Address Mark D. Kaufmann, MD. FAAD

9:30 a.m.

Eugene J. Van Scott Award for Innovative Therapy of the Skin and Phillip Frost **Leadership Lecture** Richard L. Gallo, MD, PhD, FAAD

9:55 a.m.

President-Elect's Address Terrence A. Cronin Jr., MD, FAAD

10:10 a.m.

Lila and Murray Gruber **Memorial Cancer Research** Award and Lectureship: The Road to Single Dose **HPV Vaccines**

John T. Schiller, PhD

10:35 a.m.

Marion B. Sulzberger, **MD Memorial Award and** Lectureship: Dermatology, Dermatoepidemiology, and **Antibiotic Use**

David J. Margolis, MD, FAAD

11 a.m.

John Kenney Jr., MD, Lifetime **Achievement Award and Lectureship: Belonging:** A Concept for Dermatology Amy J. McMichael, MD, FAAD

11:25 a.m. **Keynote Speaker** Safi Bahcall

Hair dos and style don'ts

medication on the scalp, and

morning, that's probably not

going to happen," Dr. Barbosa

said. "It is important that we

Sewn-in weaves, wigs, and

be asked to come to their

to ask about the patient's

exam to avoid surprises.

complex hair styles can limit

a scalp exam. Patients should

in a manner that allows a full

appointments with their hairstyles

scalp examination. It is important

hairstyling, including wigs and

Styling also plays a role in

diagnosis. There is a common

has traction alopecia. Tight

in this area.

assumption that a Black woman

with hair loss at the front hairline

braids and cornrows can generate

traction alopecia, but hairstyling

is not the only cause of hair loss

"You also have to think

alopecia?'" Dr. Barbosa said.

'could this be frontal fibrosing

extensions, before starting an

tailor treatments to the patient."

Styling is another key point.

that it should be rinsed out every

Cultural, health, and other factors in Black women's hair examined

lack hair is unique, often dense, and tightly curled. That distinctive hair has contributed to distinctive cultural preferences, styling practices, and hair care products. It puts a similarly distinctive stamp on alopecia and other familiar hair and scalp disorders.

"It is important that we are prepared to care for a diverse patient population," said Victoria Barbosa, MD, MPH, MBA, FAAD, associate professor of dermatology and director of the Hair Loss Program at University of Chicago. "Particularly when you're talking about hair and scalp disorders, there isn't a lot of information about cultural practices that we learn in textbooks. For Black women. in particular, there are different styling practices and grooming habits that play a role in diagnosis and management as well as in their overall health."

Dr. Barbosa directed the March 18 session, "Uo50 – Hair Care, Hair Loss, and Health in Black Women," with a deep dive into the not-always clear connections between cultural practices, scalp and hair health, and overall health.

Hair habits

Differences start with grooming habits. Dense, curly hair doesn't need shampooing every day or even every week, Dr. Barbosa said. Many Black women shampoo every other week, depending on their hairstyle. This can affect dermatologic treatment choices.

"If a dermatologist suggests that a Black woman put a



"Traditionally, FFA was thought to be seen primarily in white women, but experience tells me we were just misdiagnosing some Black women. You also have to think about ophiasis pattern alopecia areata."

Listen to evaluate and treat

A good diagnosis starts with the patient, she continued. For instance, if there is obvious hair loss at the front hair line, but the patient says no, she never wore braids, wigs, or any other style that might induce traction, then you need to broaden your differential.

"Start by listening to the patient and do a thorough exam," Dr. Barbosa said. "A dermatoscope can help you narrow your differential, and you might need to biopsy to confirm a diagnosis."

Mimicry works both ways. Alopecia areata is usually easy to identify from the coin-shaped patches of alopecia. But traction from braids or other hair styles can cause similar patchy hair loss on the scalp.

Alopecia areata at the crown can be mistaken for central centrifugal cicatricial alopecia (CCCA), and vice versa. CCCA is accompanied by follicle loss and scarring and alopecia areata is non-scarring, so dermoscopy can help distinguish the two.

Victoria Barbosa, MD, MPH, MBA, FAAD

Or is it lichen planopilaris? LPP can look very similar to CCCA, Dr. Barbosa said. CCCA is very common in Black women, and LPP much less common, but LPP remains a distinct possibility when examining a scarring alopecia.

"I always encourage people to perform a biopsy when they suspect a scarring alopecia," Dr. Barbosa said. "Sometimes there are clinical clues, but a biopsy can help differentiate between conditions like CCCA and LPP. And that's important because these conditions behave differently, and our treatments differ. It's important to make the right diagnosis."

For more on this story, go to aadmeetingnews.org.



Inside

Meet the Candidates 3 Insects, Spiders, and Ticks, Oh My! 4 Fox Award Winners 8 Warts and All 16 A Healthy Dose of Skepticism 21 Outside the Box 22

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Who will be the future leaders of the Academy?

The Nominating Committee voted to present the following slate of candidates (listed in random order) for the 2023 Academy election of Officers, Directors, and Nominating Committee Member Representatives (East Region).

Visit the AAD Election Connection at aad.org/election to learn about this year's candidates and to interact with them on top issues via the online Ask the Candidates forum.

Nominating Committee Member Representatives



Anthony Rossi, MD,



Louis Kuchnir, MD, PhD. FAAD

View/print an online ballot book at aad.org/election

President-Elect



Andrew H. Weinstein, MD, MPH, FAAD

Susan C. Taylor, MD, FAAD

Vice President-Elect



MD, FAAD



Kevin D. Cooper, MD, FAAD

Board of Directors



Carrie L. Davis, MD, **FAAD**

Arturo P. Saavedra,

MD, PhD, FAAD



Alexander S. Gross, MD, FAAD

John C. Trinidad,

MD, MPH, FAAD



Howard W. Rogers,



Paul S. Yamauchi, MD, PhD, FAAD



M. Laurin Council, MD. MBA. FAAD

Eligible voting members can vote by using the personalized voting link sent by email or the AAD Election Connection at aad.org/election. You can also print and fax your online secure election ballot starting March 18 to (877) 235-9052. Ballots received at the AAD office will be considered invalid.





TODAY'S HIGHLIGHTS

U058 – Preventing Food Allergy In Pediatric Atopic **Dermatitis: Applying the New Guidelines to Your Practice**

Location: Room 255

U068 - Beyond Skin **Deep: Practical Tips on Management of DRESS/DIHS** 7-8 a.m.

Location: Room 344

AAD/A Annual Business Meeting 8-8:45 a.m.

P151 - Plenary

Location: La Nouvelle Orleans BR

8:45 a.m.-12 p.m. Location: La Nouvelle Orleans BR

DataDerm™ Drop-In Hours 10-11 a.m. Location: AAD Resource Center,

Booth 4039 F088 - Itch Tales: Looking **Beyond Atopic Dermatitis**

1-3 p.m. Location: New Orleans Theater C

S043 - Resident Jeopardy 1-4 p.m.

Location: Room 252

S044 - Skin of Color 1-4 p.m. Location: Room 384

S045 - The 2023 Debates: Controversies in Dermatology 1-4 p.m.

Location: Room 388

S048 - Hot Topics 1-4 p.m.

U078 – The Evolving Toolbox for Treating Difficult Warts

Location: New Orleans Theater B

4:30-5:30 p.m. Location: Room 266

PHOTO GALLERY

Scan the QR code below to view pics from the Annual Meeting



Insects, spiders, and ticks, oh my!

What's bugging a patient might be an actual bug.

issecting the dermatologic significance of exposure to arthropods was the focus of Saturday's session, "Fo6o – What's Bugging You? Arthropods of Dermatologic Importance and Their Management: An Up-to-Date Review," directed by Eric



Eric Hossler, MD, FAAD, a Geisinger Health Systems dermatologist and dermatopathologist



Bethany Rohr, MD, FAAD, with University Hospitals in Cleveland, Ohio

Hossler, MD, FAAD, a Geisinger Health Systems dermatologist and dermatopathologist. Bethany Rohr, MD, FAAD, joined Dr. Hossler to answer key, clinical questions about the varied cutaneous reactions to arthropods and provided practical management tips.

"Because of the variety of arthropods that can cause dermatologic manifestations, there is a wide diversity of cutaneous findings," said Dr. Rohr, a dermatologist and dermatopathologist with University Hospitals in Cleveland, Ohio. "In many cases, arthropods cause a nonspecific hypersensitivity reaction. However, there are certain clinical clues that help make an accurate diagnosis. In situations where patients bring in the offending arthropod or show a photo, identification of the insect or spider is very helpful." Dr. Rohr added, "Part of a dermatologist's job is to know when a clinical presentation could signify something more sinister, such as an infestation, or when a bite or sting could lead to secondary complications like an infection or internal organ damage."

Confirm your source

Spider bites are notoriously difficult to diagnose with certainty, given the lack of a widely available confirmatory test, Dr. Hossler said. In fact, most "spider bites" are alternative diagnoses, such as erythema migrans, bacterial furunculosis, pyoderma gangrenosum, and other diagnoses; these need to be thoroughly excluded in presumptive spider bites, he said. Recluse spiders are found in the central and southern U.S. as well as many other parts of the

> world; most bites are minimally symptomatic, but some bites result in necrotic ulcers with a red, white, and blue appearance. Some patients experience loxoscelism, characterized by fever, hemolytic anemia, and renal failure. "Widow spiders, in particular, cause a mild

local reaction, but patients often experience muscle rigidity and other systemic symptoms," Dr. Hossler said. "Tick bites are important because of the potential for disease transmission. Lyme disease

is predominantly a clinical diagnosis in the dermatology office, with one or more spreading red or violaceous patches. Lab testing is of little value in the acute setting, and histology is often nonspecific."

Pyemotes mite bites often cause limited lymphangitis, and cutaneous lesions will show a characteristic comet shape, according to Dr. Hossler.

The distribution of lesions in zoonotic scabies favors the arms, thighs, and other areas that have direct contact with an affected animal

a characteristic

"tram track"

appearance.

Arthropod reactions are often nonspecific in appearance, said Dr. Rohr, but puss moth caterpillar stings have

Red-white-blue ulceration in a patient with hemolytic anemia: THINK recluse spider bite (in an endemic area).



Looks like a spider bite pyoderma gangenosum

Tram-track purpura: THINK puss moth caterpillar envenomation.

The "delta-glider" or jetliner with contrail" are signs in scabies, but you can also see a gray-edged line in truncal burrows. Nodular scabies lesions can also show burrows.



Burrows on the trunk but not on the hands and feet: **THINK** zoonotic scabies.

Debugging: The treatment plan

According to Drs. Hossler and Rohr, most arthropod reactions can be managed with local, supportive care. Bed bug and bird mite infestations need to be managed by professional exterminators. Demodex mites can be treated

> with topical or systemic antiparasitic agents, such as ivermectin, but many cases can be treated with more traditional rosacea treatments such as metronidazole. An antivenom is available for lonomia stings. There is evidence of emerging resistance of both scabies and lice to traditional treatments; for scabies, permethrin in traditional doses may be ineffective, and ivermectin or other alternative treatment is an option. Doxycycline for 10-21 days is the

treatment of choice for erythema migrans; it can also be used as prophylaxis in patients bitten by a tick that can be reliably identified as Ixodes in an area with high rates of Lyme disease. Many patients do not recall a tick bite; the index of suspicion must remain high, Dr. Hossler said. •

Most clinicians recognize the grouped urticarial bites from bed bugs, but similar lesions in areas covered by tight-fitting clothing is a clue to

chigger bites.



Bites in areas of tight-fitting clothing:

Breakfast, lunch, and dinner bites: THINK bed bugs.





dermatologist and dermatopathologist





Arthropods may be spineless, but can be aggressive, nonetheless. Insects and arachnids mean business when mingling with humans, and the bite, sting, or

irritation radiating from your patient's skin may mean

they've made contact with an arthropod.

Furuncles in a returning traveler: THINK

furuncular myiasis

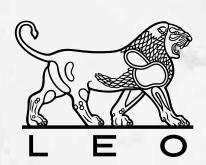


Comet sign: THINK Pyemotes.

Bird mite bites do not have a characteristic morphology, but since the mites bite mostly at night in exposed areas, these can be used as clues to look for an abandoned bird nest around the home.









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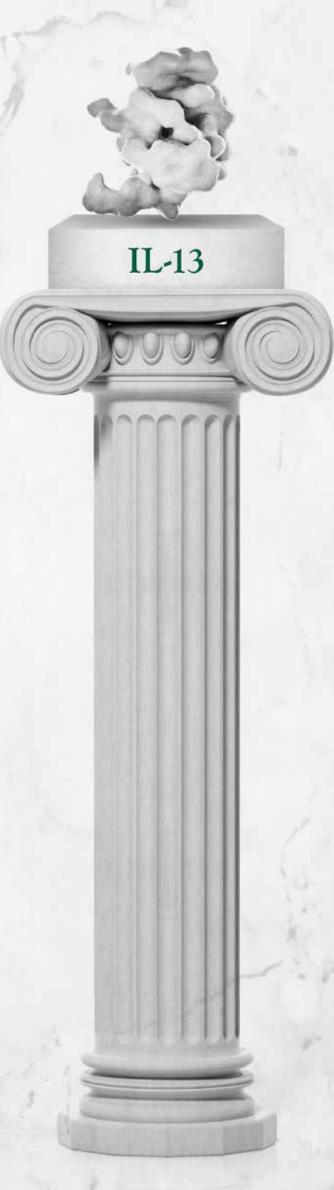
Take an in-depth look at the role of IL-13 in atopic dermatitis





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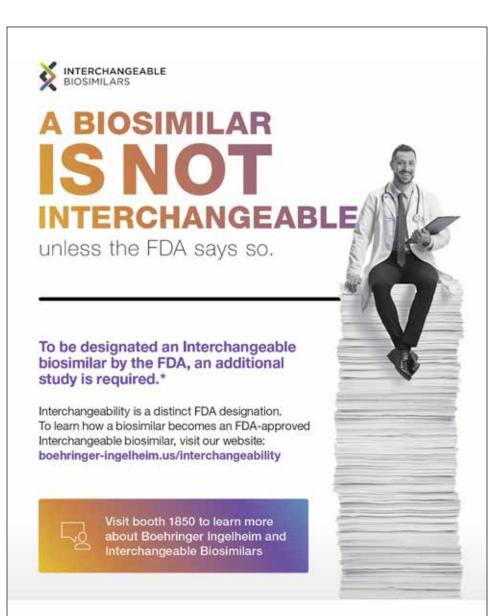




Fox Award: The future of dermatology recognized



Congratulations to all who participated in the 2023 Resident and Fellows Symposium!



*One or more studies may be required by the FDA to

demonstrate Interchangeability

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The Residents and Fellows Symposium was held Saturday, during the 2023 AAD Annual Meeting in New Orleans, led by Cory A. Dunnick, MD, FAAD. Faculty judges selected individuals who presented the most outstanding papers in laboratory and clinical research. The winners of this year's prestigious Everett C. Fox Memorial Award are:

Basic Science Category

Winner Name: Nelson Ugwu, MD

Institution: Department of Dermatology, Yale School of Medicine Title: A gain-of-function somatic mutation in GJA4 underlies venous malformations in the skin and liver, and reveals a novel pathway for therapeutic intervention

Winner Name: Shadi Khalil, MD, PhD **Institution:** University of California, San Diego

Title: Epidermal iron content couples to systemic iron homeostasis

and host defense

Clinical Category

Winner Name: Keegan O'Hern, MD

Institution: Mayo Clinic

Title: Increasing Utilization of Mohs Micrographic Surgery for Melanoma with Improved Survival over Wide Local Excision: A National Cancer Database Analysis

Winner Name: Daniel Joffe, CTCL research fellow

Institution: Department of Dermatology and Cutaneous Biology,

Thomas Jefferson University

Title: Reduced Overall T-cell Receptor Diversity as an Indicator

of Aggressive Cutaneous T-cell Lymphoma

Winner Name: Justin D. Arnold, MD **Institution:** University of California, Irvine

Title: Characteristics and Complications of Anogenital Infantile Hemangiomas

Winner Name: Kun-Lin Lu

Institution: Department of Dermatology, Chang Gung Memorial Hospital,

Linkou branch, Taoyuan, Taiwan

Title: The Role of T helper 17 cells in Paraneoplastic Pemphigus/Paraneoplastic

Autoimmune Multiorgan Syndrome

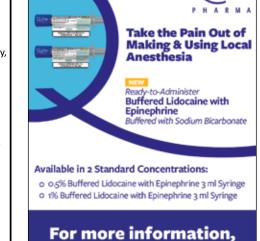
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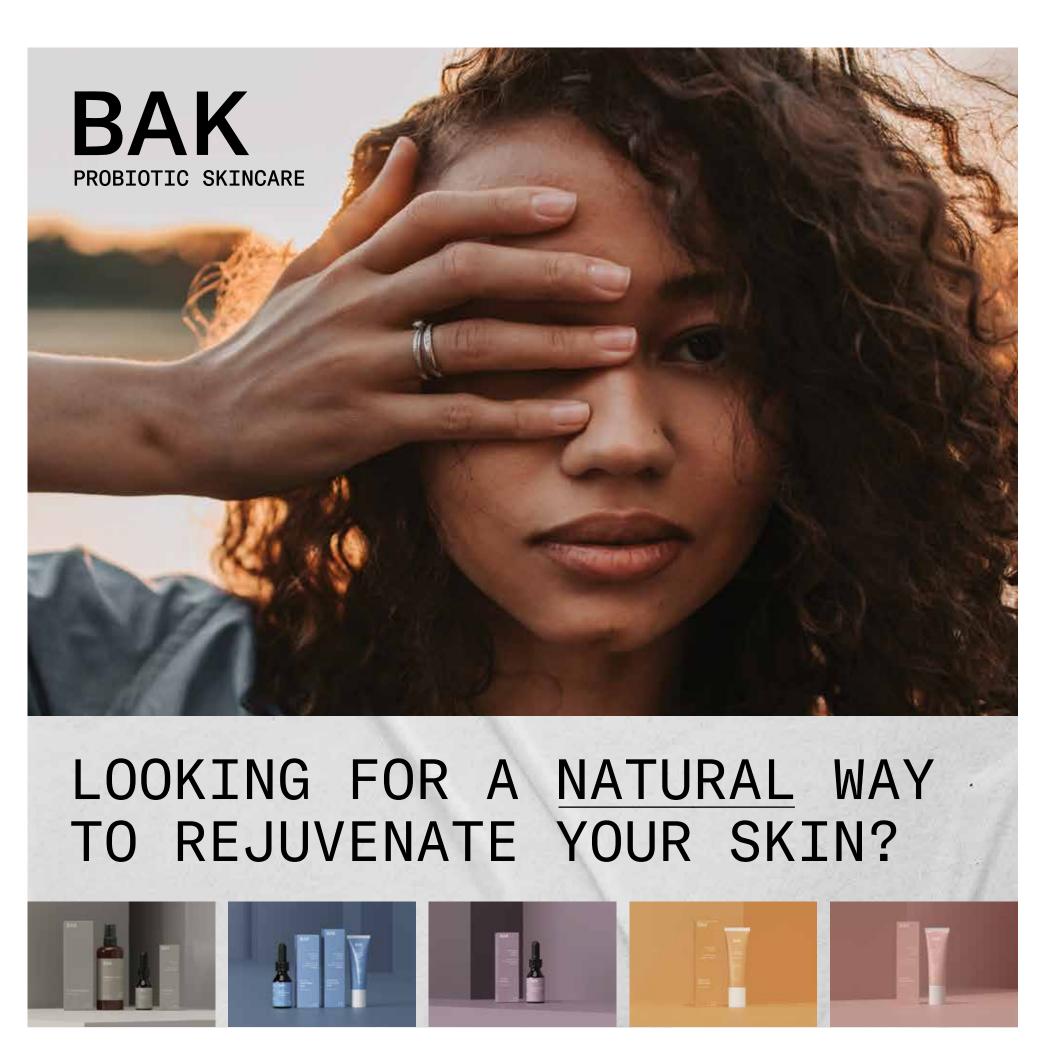
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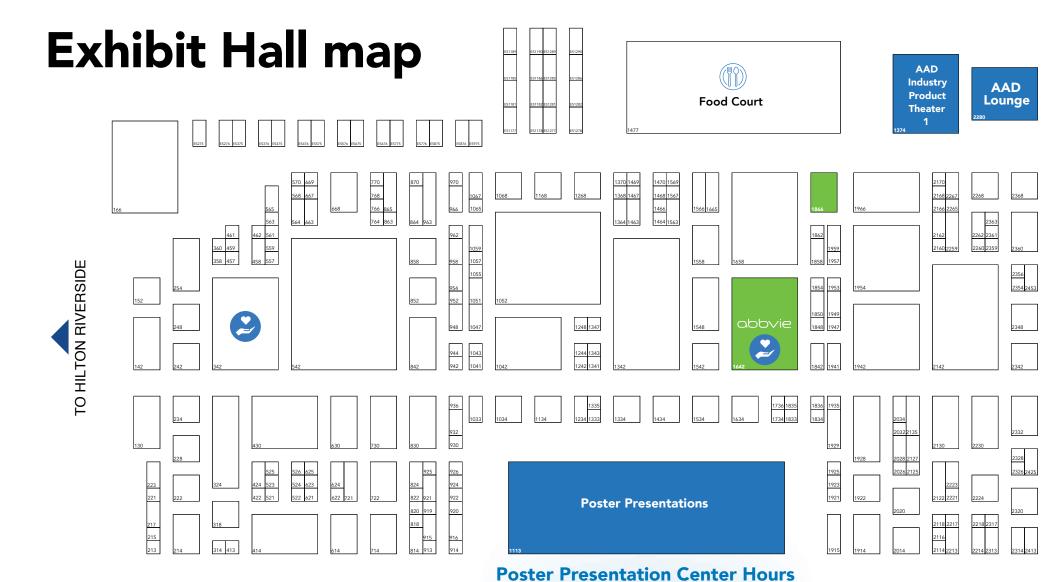
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Visit Booth 630







Exhibitor Listing

Data current as of February 21, 2023. Please use the AAD Meeting App **aad.org/mobile** for the most up-to-date exhibitor list.

ENTRANCE

Friday – Saturday | 8:30 a.m.-5 p.m. Sunday | 1-3 pm.

3Gen, Inc./DermLite	American Society for	Canfield Scientific	Derm Care Billing Consultants 667
5CC (5-Continent-Congress) 1248	Dermatologic Surgery 1736	Cara Therapeutics	Derma Faith, LLC
AAD - Poster Presentations 1113	Amgen, Inc	CareCredit	Dermadry Laboratories Inc 4633
AAD Food Court1477	AMLo Biosciences 4541	Casio America, Inc	Dermaesthetics Beverly Hills 926
AAD Industry Product Theater 1 1374	Anne Arundel Dermatology, P.A 1959	Castle Biosciences 4051	DERMAGNOSTIX
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AAD Lounge	Aqua Dermatology	Chemotechnique Diagnostics/	DermaSensor Inc
AAD Member Buying Program 4543	Aquavit	Dormer Laboratories 1842	Dermatology Digest, The 2170
AAD Preferred Provider 4549, 4551	Arcutis Biotherapeutics, Inc 2460	Clarius Mobile Health 3557	Dermatology Foundation 864
AAD Registration 2757	argenx	CLASSYS	Dermatology Specialists, The 2162
AAD Resource Center 4039	Avante Health Solutions 1041	Clinical Skin LLC	Dermatology Times 913
AAD_Freeman Servicenter 166	Avantik Biogroup 1921	CLN Skin Care (TopMD Skin Care) 2326	Dermavant Sciences, Inc
AbbVie	Baitella AG	Coalition of Skin Diseases 4213	DermCare Management 1047
ABISA 1043	Bank of America Practice Solutions 930	Cobalt Medical Supply, Inc 1563	Dermogalenic Experts SA DE CV 564
Acclaro Medical	Beiersdorf, Inc	COLA Inc	Dermosciences Corp 570
Accurate Manufacturing, Inc 2832	Beijing Sincoheren	Collagen P.I.N	Dermpath Diagnostics 614
AccuTec Inc	S&T Development Co., Ltd 3455	CoNCERT Pharmaceuticals Inc 1534	DermTech
Acuderm	Beijing Syntech Laser Co., Ltd 970	Connect Biopharm 4221	Designs for Vision, Inc
AD Surgical	Belle.ai	Coolibar, Sun Protection You Wear 4231	DiamondTome/Altair Instruments 1055
Advalight	Benev Company Inc 2368	Coous Global Co., Ltd 2314	DOCS Derm Group 4151
Advanced Dermatology	Beutner Laboratories 1467	Coronado Aesthetics LLC 3457	Doctor Multimedia 3920
& Cosmetic Surgery 458	Biodermis	Cortex Technology Aps 1335	Dow Development Laboratories LLC 559
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Aerolase	Biopark Medical	CryoProbe	Ellis Instruments
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AIM Medical Inc	Boehringer Ingelheim	Cutera	Eltraderm Skin Care
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ALMIRALL	Burt's Bees2313	DefenAge	Epiphany Dermatology 865
Alphyn Biologics, Inc	Caliber Imaging & Diagnostics 3531	DEKA M.E.L.A. srl	EunSung Global Corp 722
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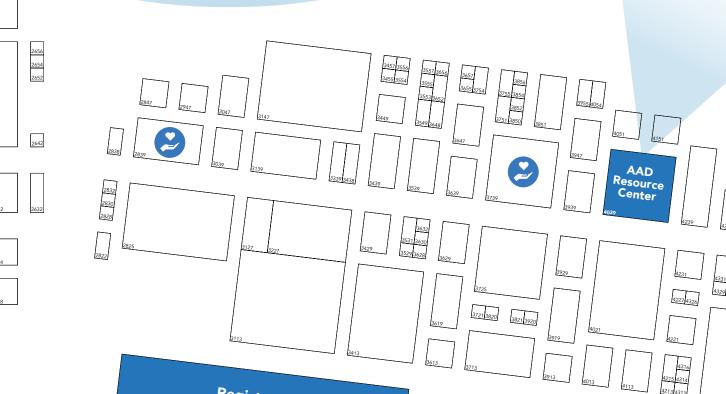
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AAD Industry Product Theater 2

Exhibit Hall hours

Friday – Saturday | 10 a.m.-5 p.m. Sunday | 10 a.m.-3 p.m.





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Forefront Dermatology 858
Fotofinder Systems, Inc 1922
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Frontier Derm Partners
Frontline Medical Communications 221 $$

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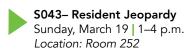
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The question is: What is learning?

Residents put their skills to the test



ontestants representing various residency training programs will face off in a spirited competition based on the iconic, fast-paced game show Jeopardy! Lida Zheng, MD, FAAD, assistant professor of dermatology at Northwestern University's Feinberg School of Medicine in Chicago, will moderate the session at 1 p.m. today.

This fun self-assessment will field queries and image-based inquiries encompassing the breadth of dermatology. Audience members are invited to play along and test their own knowledge. Ultimately, the winning program team of contestants will walk away with the coveted trophy, and the title of 2023 AAD Resident Jeopardy champions!

There is an element of academics involved, of course. Residents will self-assess their core competencies across numerous domains in dermatology, identify gaps in medical knowledge, and interact and network with colleagues at similar career levels from various institutions across the country.

Eligibility requirements: residents had to provide their year of training and email address, register to compete (in-person), create a team of residents, provide an interesting or fun fact about their team or its residents on a wide range of topics from their scariest experience to their most embarrassing moment. In addition to the trophy, each teammate of the winning team will receive a \$15 Amazon gift card and bragging rights for one year.

Dr. Zheng will be joined by Roger Ho, MD, FAAD, Kassandra E. Holzem, MD, FAAD, Kiran Motaparthi, MD, FAAD, Michelle B. Tarbox, MD, FAAD, and Danielle Tartar, MD, PhD, FAAD.

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Bring your completed passport to the AAD Resource Center Booth 4039 by 3 p.m. Sunday, March 19, for your chance to win complimentary registration to the 2024 AAD Annual Meeting Registration in San Diego. PLUS, the first 500 participants will receive a special gift.

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Warts and all

New approaches, existing therapies tackle those stubborn skin disorders.



Peter Friedman, MD, PhD, FAAD, dermatologist at the Skin Center Dermatology Group in New City, New York; instructor in clinical dermatology at Columbia University – New York Presbyterian Hospital

very dermatologist at some point in their career will run into that most pernicious of protrusions — the stubborn wart that just won't go away.

Peter Friedman, MD, PhD, FAAD, a dermatologist at the Skin Center Dermatology Group in New City, New York, and instructor in clinical dermatology at Columbia University – New York Presbyterian Hospital, said hard-to-manage warts are a daily occurrence in his practice, in part because he sees many children. Dr. Friedman said there are several possible explanations for poor outcomes in managing warts.

Speaking at Friday's session, "Uo28 – The Evolving Toolbox for Treating Difficult Warts," Dr. Friedman took on the tough issues.

Where did that wart come from?

"Sometimes there is an explanation, like the lesions are very big or they are in areas where traditional treatments can't be used to the fullest extent," he said. "The side effects or the logistics associated with traditional treatments can also reduce [patient] compliance, and occasionally underlying medical issues, such as immunosuppression, reduce the efficacy of treatments. However, sometimes there is no obvious reason — the wart just doesn't get better."

Two-fold approach

Dr. Friedman takes a twofold approach when it comes to tackling the toughest warts.

"First, I do not do the 'first-line treatment, second-line treatment after failure' approach," he said. "I try to look at every wart patient with all the treatment options in mind and recommend a plan that uniquely suits their individual scenario."

The second prong of his attack involves a combination of treatments.

"I use the traditional methods — I do freeze many warts and I do recommend using over-the-counter salicylic acid products, but almost never as monotherapy and only when that seems more appropriate for the given patient than anything else I can offer," he said. "It has been my experience, which is also supported by a number of studies, that certain combination treatments can work better than monotherapies."

New treatments now and on the horizon

Dr. Friedman discussed several evolving methods that are showing promising results for wart treatment, along with one new one that he said is matching some traditional treatments in terms of efficacy.

"One of the truly novel methods is cold atmospheric plasma, which was developed by a research team I am part of," he said. "This is a very well-tolerated treatment with efficacy on par with the more traditional treatments. The limitation is that it does require a device to administer the treatment, and it is not yet on the market."

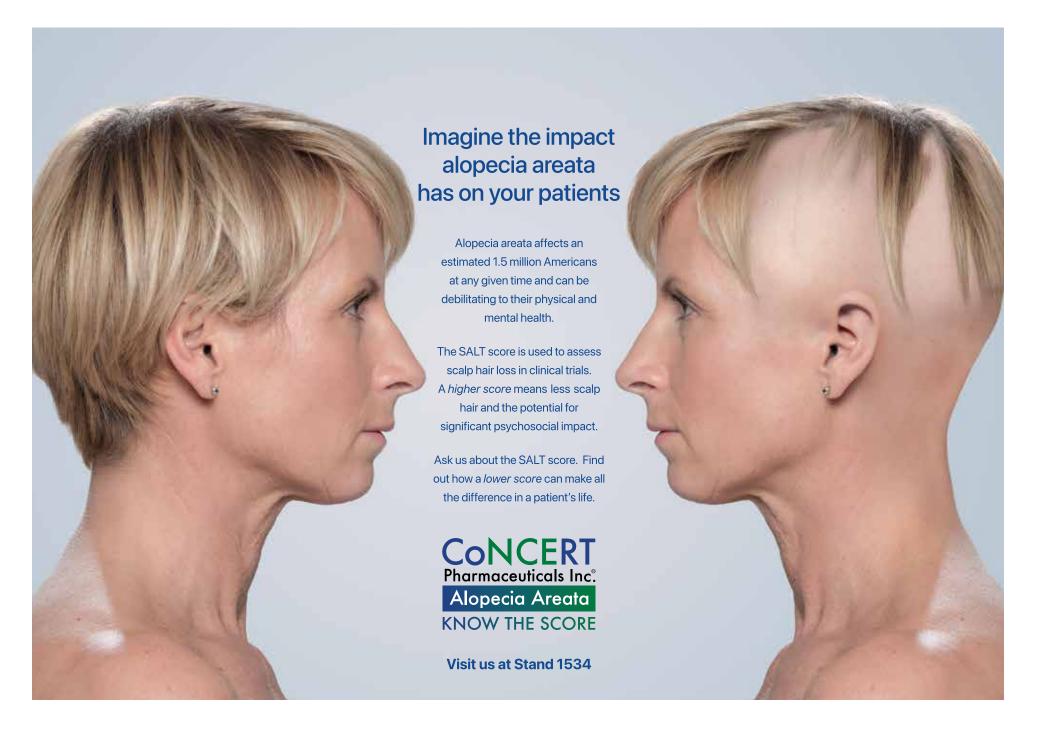
Patient considerations

Ultimately, Dr. Friedman said there are multiple factors to consider when treating stubborn warts, not the least of which is the cost to the patient. "Cost is a very important question and can be a significant barrier," he said. "If we prescribe a medication, the patient may or may not have a co-pay. If they come to the office for treatment, they may or may not have a co-pay or deductible. One part of their benefit package may be more favorable than the other, depending on their insurance. They may live far from the office or work multiple jobs, so it is a big issue to come to see me every three or four weeks for a treatment."

Aside from the cost of the office visit, Dr. Friedman said the cost of just getting to the office and the monetary value of the time patients have to spend on office visits can add up quickly.

"These variables, and not just the purely medical considerations, all factor into the decision process when choosing the best treatment for a patient," he said. "So there really is no one treatment I would recommend above all for all patients.

"We must constantly remind ourselves that our most commonly used first-line wart treatments are far from perfect, as large reviews and analyses have shown time and time again," Dr. Friedman said.





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In DERMIS-1 and DERMIS-2, ~40% of patients achieved IGA Success and ~70% of patients achieved I-IGA Success at Week 8.1

DERMIS-1 and DERMIS-2 were identical Phase 3 randomized, parallel, double-blind, vehicle-controlled, multicenter studies that evaluated ZORYVE over 8 weeks as a once-daily, topical treatment for plaque psoriasis. Subjects (N=881) were randomized 2:1 to receive ZORYVE cream 0.3% (n=576) or vehicle (n=305) applied once daily for 8 weeks. Eligibility criteria included a diagnosis of mild, moderate, or severe plaque psoriasis and an affected BSA of 2% to 20%. Primary endpoint was IGA Success at Week 8 and key secondary endpoint was I-IGA Success at Week 8.1

IGA Success was defined as a score of Clear (0) or Almost Clear (1) and a \geq 2-grade improvement from baseline. I-IGA Success was defined as a score of Clear (0) or Almost Clear (1) and \geq 2-grade improvement from baseline. ZORYVE is not for ophthalmic, oral, or intravaginal use.

BSA = Body Surface Area, IGA = Investigator's Global Assessment, I-IGA = Intertriginous-IGA



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Actor portrayal

INDICATION

ZORYVE is indicated for topical treatment of plaque psoriasis, including intertriginous areas, in patients 12 years of age and older.

IMPORTANT SAFETY INFORMATION

The use of ZORYVE is contraindicated in patients with moderate to severe liver impairment (Child-Pugh B or C). The most common adverse reactions (≥1%) include diarrhea (3%), headache (2%), insomnia (1%), nausea (1%), application site pain (1%), upper respiratory tract infection (1%), and urinary tract infection (1%).

Please see brief summary of full Prescribing Information for ZORYVE on the following page.

References: 1. ZORVYE®. Prescribing information. Arcutis Biotherapeutics, Inc; 2022. 2. Data on File. Arcutis Biotherapeutics, Inc.



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Brief Summary of Prescribing Information for ZORYVE™ (roflumilast) cream, for topical use. See package insert for full Prescribing Information.

INDICATIONS AND USAGE

ZORYVE is indicated for topical treatment of plaque psoriasis, including intertriginous areas, in patients 12 years of age and older.

DOSAGE AND ADMINISTRATION

Apply ZORYVE to affected areas once daily and rub in completely. Wash hands after application, unless ZORYVE is for treatment of the hands.

ZORYVE is for topical use only and not for ophthalmic, oral, or intravaginal use.

CONTRAINDICATIONS

The use of ZORYVE is contraindicated in the following condition:

• Moderate to severe liver impairment (Child-Pugh B or C)

ADVERSE REACTIONS

Clinical Trials Experience

Because clinical trials are conducted under widely varying conditions, adverse reaction rates observed in the clinical trials of a drug cannot be directly compared to rates in the clinical trials of another drug and may not reflect the rates observed in practice.

In two multicenter, randomized, double-blind, vehicle-controlled trials (DERMIS-1 and DERMIS-2), 881 subjects 2 years of age or older with plaque psoriasis were treated with ZORYVE or vehicle once daily for 8 weeks.

The median age was 47 years (range 6 to 88). The majority of the subjects were male (64%) and White (82%). The median body surface area (BSA) affected was 5.5% (range 2% to 20%).

The proportion of subjects who discontinued treatment due to adverse reaction was 1.0% for subjects treated with ZORYVE and 1.3% for subjects treated with vehicle. The most common adverse reactions that led to discontinuation of ZORYVE was application site urticaria (0.3%).

Table 1 presents adverse reactions that occurred in at least 1% of subjects treated with ZORYVE, and for which the rate exceeded the rate for vehicle.

Table 1. Adverse Reactions Reported in $\geq \! 1\%$ of Subjects Treated with ZORYVE for 8 Weeks

Adverse Reaction	ZORYVE (N=576) n (%)	Vehicle (N=305) n (%)
Diarrhea	18 (3.1)	0 (0.0)
Headache	14 (2.4)	3 (1.0)
Insomnia	8 (1.4)	2 (0.7)
Nausea	7 (1.2)	1 (0.3)
Application site pain	6 (1.0)	1 (0.3)
Upper respiratory tract infection	6 (1.0)	1 (0.3)
Urinary tract infection	6 (1.0)	2 (0.7)

In 594 subjects who continued treatment with ZORYVE for up to 64 weeks in open-label extension trials, the adverse reaction profile was similar to that observed in vehicle-controlled trials.

USE IN SPECIFIC POPULATIONS

Pregnancy

Risk Summary

There are no randomized clinical trials of oral or topical roflumilast in pregnant women. In animal reproduction studies, roflumilast administered orally to pregnant rats and rabbits during the period of organogenesis produced no fetal structural abnormalities at doses up to 9 and 8 times the maximum recommended human dose (MRHD), respectively. Roflumilast induced post-implantation loss in rats at oral doses greater than or equal to 3 times the MRHD. Roflumilast induced stillbirth and decreased pup viability in mice at oral doses 5 and 15 times the MRHD, respectively. Roflumilast has been shown to adversely affect pup post-natal development when dams were treated with an oral dose 15 times the MRHD during pregnancy and lactation periods in mice.

The background risk of major birth defects and miscarriage for the indicated population is unknown. In the U.S. general population, the estimated background risk of major birth defects and miscarriage in clinically recognized pregnancies is 2% to 4% and 15% to 20%, respectively.

Clinical Considerations

Labor and delivery

ZORYVE should not be used during labor and delivery. There are no human studies that have investigated effects of ZORYVE on preterm labor or labor at term; however, animal studies showed that oral roflumilast disrupted the labor and delivery process in mice.

<u>Data</u>

Animal data

In an embryo-fetal development study, pregnant rats were dosed orally during the period of organogenesis with up to 1.8 mg/kg/day roflumilast (9 times the MRHD on a mg/m² basis). No evidence of structural abnormalities or effects on survival rates were observed. Roflumilast did not affect embryo-fetal development at a maternal oral dose of 0.2 mg/kg/day (equivalent to the MRHD on a mg/m² basis).

In a fertility and embryo-fetal development study, male rats were dosed orally with up to 1.8 mg/kg/day roflumilast for 10 weeks and females for 2 weeks prior to pairing and throughout the organogenesis period. Roflumilast induced pre- and post-implantation loss at maternal oral doses greater than or equal to 0.6 mg/kg/day (3 times the MRHD on a mg/m² basis). Roflumilast did not cause fetal structural abnormalities at maternal oral doses up to 1.8 mg/kg/day (9 times the MRHD on a mg/m² basis).

In an embryo-fetal development study in rabbits, pregnant does were dosed orally with 0.8 mg/kg/day roflumilast during the period of organogenesis. Roflumilast did not cause fetal structural abnormalities at the maternal oral doses of 0.8 mg/kg/day (8 times the MRHD on a mg/m 2 basis).

In pre- and post-natal developmental studies in mice, dams were dosed orally with up to 12 mg/kg/day roflumilast during the period of organogenesis and lactation. Roflumilast induced stillbirth and decreased pup viability at maternal oral doses greater than 2 mg/kg/day and 6 mg/kg/day, respectively (5 and 15 times the MRHD on a mg/m² basis, respectively). Roflumilast induced delivery retardation in pregnant mice at maternal oral doses greater than 2 mg/kg/day (5 times the MRHD on a mg/m² basis). Roflumilast decreased pup rearing frequencies at a maternal oral dose of 6 mg/kg/day during pregnancy and lactation (15 times the MRHD on a mg/m² basis). Roflumilast also decreased survival and forelimb grip reflex and delayed pinna detachment in mouse pups at a maternal oral dose of 12 mg/kg/day (29 times the MRHD on a mg/m² basis).

Lactation

Risk Summary

There is no information regarding the presence of ZORYVE in human milk, the effects on the breastfed infant, or the effects on milk production.

Roflumilast and/or its metabolites are excreted into the milk of lactating rats. When a drug is present in animal milk, it is likely that the drug will present in human milk. The developmental and health benefits of breastfeeding should be considered along with the mother's clinical need for ZORYVE and any potential adverse effects on the breastfed infant from ZORYVE or from the underlying maternal condition.

Clinical Considerations

To minimize potential exposure to the breastfed infant via breast milk, use ZORYVE on the smallest area of skin and for the shortest duration possible while breastfeeding. Advise breastfeeding women not to apply ZORYVE directly to the nipple and areola to avoid direct infant exposure.

Data

Animal data

Roflumilast and/or its metabolite concentrations measured 8 hours after an oral dose of 1 mg/kg given to lactating rats were 0.32 and 0.02 mcg/g in the milk and pup liver, respectively.

Pediatric Use

The safety and effectiveness of ZORYVE have been established in pediatric patients ages 12 years and older for the treatment of plaque psoriasis. Use of ZORYVE in this age group is supported by data from two 8-week vehicle-controlled safety and efficacy trials which included 14 adolescent patients aged 12 to 17 years, of whom 8 received ZORYVE. Eighteen adolescent patients were treated with ZORYVE in open-label trials of 2- and 24-weeks duration. The adverse reaction profile was similar to that observed in adults.

The safety and effectiveness of ZORYVE in pediatric patients below the age of 12 years have not been established.

Geriatric Use

Of the 881 subjects with psoriasis exposed to ZORYVE or vehicle for up to 8 weeks in 2 controlled clinical trials, 106 were 65 years of age or older. No overall differences in safety or effectiveness were observed between these subjects and younger subjects. Other reported clinical experience has not identified differences in responses between the geriatric and younger patients, but greater sensitivity of some older individuals cannot be ruled out. Based on available data for roflumilast, no adjustment of dosage in geriatric patients is warranted.

Hepatic Impairment

Oral roflumilast 250 mcg once daily for 14 days was studied in subjects with hepatic impairment. The AUC and C_{max} values of roflumilast and roflumilast N-oxide were increased in subjects with moderate (Child-Pugh B) hepatic impairment. ZORYVE is contraindicated in patients with moderate to severe liver impairment (Child-Pugh B or C).

PATIENT COUNSELING INFORMATION

Advise the patient or caregiver to read the FDA-approved patient labeling (Patient Information).

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08/2022

A healthy dose of skepticism

The right tools can help you weigh inherent uncertainty in medical research.

he world is filled with uncertainty
— even when it comes to the most
carefully researched medical study.
Learning to recognize that uncertainty is
key to having a better understanding of
those studies and how they can benefit
your patients.

During Friday's new session, "Uo25 – Uncertainties Masquerading as Certainties: Can You Trust the Study You Just Read?" Stephen Malachowski, MD, MS, dermatology resident at Virginia Commonwealth University's Department of Dermatology in Richmond, said using statistical tools and keeping certain ethical and logical considerations in mind can aid in the correct interpretation of medical literature.

"When the goal is to positively impact patient care, clinicians and researchers alike should strive to step outside of their comfort zone to reason with data, and question statistical assumptions," he said.

Assessing the variables

One common mistake people make when developing studies is dichotomizing — or categorizing — quantitative variables.

"An example would be to take age as it is

measured but deciding to classify people as below some age limit or not," Dr. Malachowski said. "This is problematic in many ways. First, information is lost, which mathematically reduces the statistical power of a study. In the case of a randomized clinical trial, the study must now recruit more patients to the trial to reach the same amount of information. If we create information loss that requires us to recruit more people than necessary, this raises the ethical consideration of exposing more people than needed to the risks of the trial."

Dr. Malachowski said dermatologists should review study statistics such as sensitivity (how often a positive test is rendered to patients who have the disease in question) and specificity (how often a negative test is rendered to a healthy patient) with caution.

"The problem with this is inherent in the interpretation," he said. "For a diagnosis, we don't yet know if a patient has a disease, so something like sensitivity or specificity alone cannot tell us much about diagnosis. In fact, sensitivity and specificity are 'backward' for diagnosis because we don't know who has the disease at the time of



Lee Wheless, MD, PhD, FAAD, assistant professor of dermatology and epidemiology at Vanderbilt University Medical Center in Nashville, Tennessee

completing a test. We only know the test result and try to use the result, along with other information, to make a diagnosis."

Limitations at play

Lee Wheless, MD, PhD, FAAD, assistant professor of dermatology and epidemiology at Vanderbilt University Medical Center in Nashville, Tennessee, said when it comes to reviewing a study, it is important to understand the limitations of its p-value (the likelihood that the study will find a particular set of observations to be associated with the outcome if there is no difference among the groups being studied) and its confidence interval (the range of values that are plausible, based on the data).

"It's important to keep in mind that both of these values are really measures of how well a model explains the data in the study," Dr. Wheless said. "A p-value does not reflect the clinical importance of the finding but rather can speak to how likely or not it is the variables in the model describe the relationship with the outcome. Similarly, a confidence interval does not tell us that 'truth' is found 95% of the time within its bounds. Rather, confidence



Stephen Malachowski, MD, MS, dermatology resident at Virginia Commonwealth University's Department of Dermatology in Richmond

intervals give us a sense of how certain we are about the estimates made by the model. Neither a p-value or a confidence interval tells us about the probability or truth of an error, which is a common misconception."

The ripple effect

Drs. Wheless and Malachowski said it is important to recognize uncertainty in medical research because a clinical mistake based on a dermatologist's uncertainty will affect a single patient, but an uncertain measure in a study that becomes accepted as truth has the potential to impact many patients.

Dr. Malachowski echoed that sentiment with an old adage. "There is an old saying: 'The trouble with people is not that they don't know but that they know so much that ain't so,'" he said. "Recognizing uncertainty in medical research is important because the world we live in is filled with uncertainty, even about things we think we understand. Without recognizing uncertainty, patients may receive treatments that appear to work but don't, or we may dismiss treatments that might work but are written off without proper evidence."

In a study of patients with acne, almost 40% of treatment non-adherence was due to side effects¹

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References: 1. Dikicier BS. Topical treatment of acne vulgaris: efficiency, side effects, and adherence rate. *J Int Med Res.* 2019;47(7):2987-2992. **2.** Lain E, Andriessen AE. Choosing the right partner: complementing prescription acne medication with over-the-counter cleansers and moisturizers. *J Drugs Dermatol.* 2020;19(11): 1069-1073. **3.** Dreno B, Araviiskaia E, Kerob Delphine, et al. Nonprescription acne vulgaris treatments: their role in our treatment armamentarium—an international panel discussion. *J Cosmet Dermatol.* 2020;19:2201-2211. Use products only as directed.

Outside the box

It's the great divide. There has long been a fissure among dermatologists when it comes to weighing the use of cosmetic procedures to treat some dermatologic medical conditions. But it doesn't have to be that way.

itchel P. Goldman, MD, FAAD, medical director at Platinum/West Dermatology and Cosmetic Laser Dermatology in San Diego, said many of the treatments that have been developed for things like wrinkles and aging skin have tremendous possibilities for treating other conditions like acne and rosacea.



"The problem we presently have is that academic dermatologists and dermatology residency programs do not cover and do not embrace the concept of nonmedical dermatology," he said. "That's a polarizing statement because academic dermatologists spend almost all the residents' time on severe dermatology diseases which are extremely important. I don't want to disparage in any way the importance of medical dermatology, but I want to highlight the fact that even though we develop cosmetic treatments for wrinkles and aging skin, those cosmetic treatments can cross over into the medical dermatology field."

Available options

There are two types of lasers that are typically used — fully ablative lasers and non-ablative lasers. Newer lasers have also been developed as recently as last year specifically for treating acne and acne scars.

"These scars affect the quality of life for many, many patients because people become self-conscious of the scarred appearance of their faces," Dr. Goldman said. "And that comes from the lack of effective treatments

Rosacea, while not fatal, can also affect the quality of life for anyone on the





spectrum — from mild, acne-like lesions to more severe forms including rhinophyma, which can lead to redness of the face and a bulbous nose.

"We have a variety of lasers and intense pulse-light devices that were developed for the treatment of benign vascular lesions as well as photodamaged skin and have been shown to also effectively treat the redness and acne-like lesions and enlarged glands found in rosacea," Dr. Goldman said. "That improves the quality of life for our patients."

Getting to know Your Dermatologist Knows

AAD members flocked to the Resource Center Friday and Saturday to chat with the social media correspondents who have been creating content in support of Your Dermatologist Knows, the Academy's new consumer positioning strategy. Ronda Farah, MD, FAAD, Sara Moghaddam, MD, FAAD, and Oyetewa Oyerinde, MD, FAAD, discussed the thinking behind the strategy, which is designed to make sure the public knows that dermatologists are the experts in skin, hair, and nail health and address increased willingness among younger demographics to see a non-physician clinician to address skin, hair, and nail concerns. The upbeat, approachable content created by the correspondents is meeting those demographics where they are — on Instagram, Facebook, and TikTok — to spread the word about the full scope of care patients can expect from a dermatologist.

Members who attended the two events created some fun content for their own social media channels, posing in front of Your Dermatologist Knows backdrop with hashtag signs like #SkinExpert, #HairExpert, #NailExpert, #AAD, and even a six-foot #YourDermatologistKnows.





Learn more about the new consumer positioning strategy at aad.org/yourdermatologistknows.



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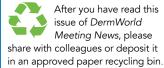
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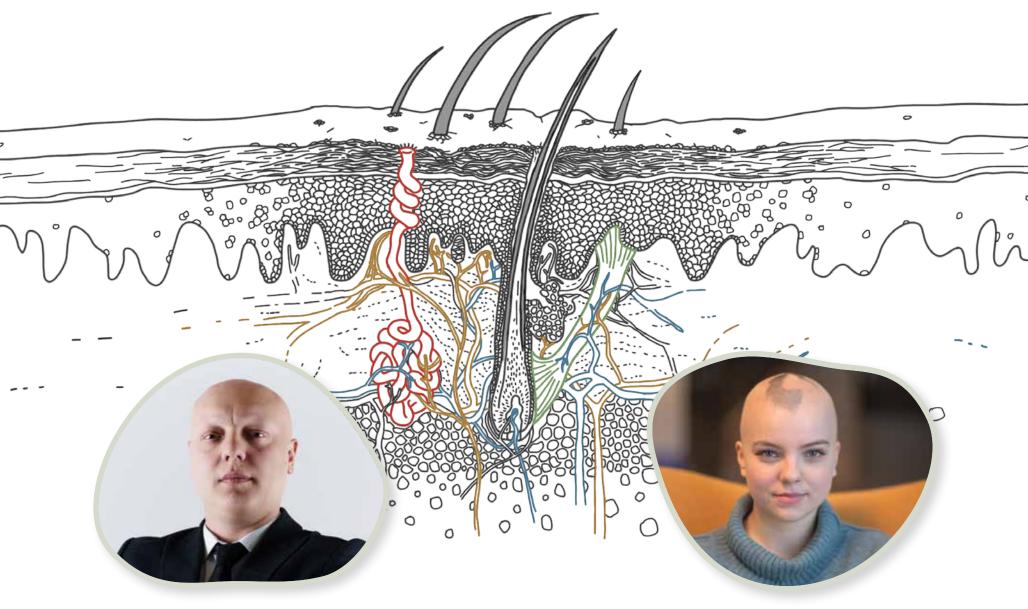
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Hair loss isn't the whole story.

- Alopecia areata (AA) is an autoimmune disease that can also have effects beyond the scalp.¹
- AA has a complex etiology and is rooted in immune system dysregulation, with many patients having a genetic predisposition.^{2,3}
- Patients often experience autoimmune and psychiatric comorbidities, lifestyle disruptions, and psychosocial distress.^{1,2,4}
- The unpredictable course of AA can make disease management difficult for HCPs and their patients.^{5,6}

To re-examine what you know about alopecia areata, visit <u>education.lillymedical.com/advancesinaa</u>



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