AAD
DermWorld meeting news
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Friday • March 7, 2025

See Exhibit Hall floor plan and Exhibitor Listing.
PAGES 10-12

Welcome to the 2025 AAD Annual Meeting

Reach for the sky as you learn, network, and celebrate with us in Orlando!

The world's largest dermatology meeting begins today in Orlando with the start of the 2025 AAD Annual Meeting, March 7-11. The event delivers more education, valuable practice information, and networking opportunities than any other meeting in the specialty.

This year's program features leading experts in dermatology across key topics like cosmetics, surgery, pediatrics, skin cancer, inflammatory dermatoses, and practice management. You can look forward to two Late-Breaking Research sessions, nine Hands-On workshops, and two Live Demonstrations, plus hundreds of sessions, symposiums, and forums to select and attend.

There are more than 50 new sessions, with titles including **F021 – New Drugs, New Rashes: An Update on Cutaneous Drug Eruptions**, **U072 – Social Media and Ethics: A Point-Counterpoint Debate**, **U097 – In Office Surgical Techniques for the Treatment of Moderate to Severe Hidradenitis Suppurativa (HS)**, and **C011 – Advanced Cosmetic Surgery That Dermatologists Can Perform**.

Back by popular demand from previous meetings, don't miss these featured sessions: **S047 – Therapeutic Hotline, F062 – Controversies in Acne and Rosacea**, and **S055 – Hot Topics**.

Session highlights for today include, **U011 – Burn Bright, Not Out! A Toolbox to Rediscover Joy in Derm**, **S006 – Vitiligo**, and **S009 and S012 – Gross and Microscopic Symposium**.

One of the most anticipated events is tonight's **Opening Ceremony** at 5 p.m. in the Chapin Theater. Martha Stewart, the visionary entrepreneur, author, and lifestyle expert, will deliver the keynote address! Hear her presentation tonight during the Opening Ceremony, where AAD President Seemal R. Desai, MD, FAAD, will give a welcome address and then sit down for a fireside chat with Martha.

With a career spanning decades of trailblazing achievements, Martha's unmatched creativity, business acumen, and passion for excellence have made her a household name and an inspiration to millions. Don't miss this opportunity to hear her insights on success, reinvention, and staying ahead of the curve — lessons that resonate across industries.

Saturday's robust lineup includes **F033 – DataDerm 2.0 — A New Era of Leveraging Technology to Add Value to Patients and Practices**, **S027 – Resident and Fellows Symposium**, **F039 – Botulinum Toxins: The Latest Updates**, **S028 and S040 – Late-Breaking Research**, and, of course, **S038 – Resident Jeopardy**.

On Sunday, be sure to attend the **Plenary session** at 9 a.m. in the Chapin Theater, featuring the Annual Business Meeting followed by exciting lectures from industry experts and addresses from AAD leaders.

Round out your schedule with a range of sessions and courses on Sunday and Monday, then stick around for the final two sessions on Tuesday: **S069 – What's New in Dermatology** and **S070 – Therapeutic and Diagnostic Pearls.**

Save some time to visit the 350-plus exhibiting companies in the Exhibit Hall, and make sure to stop by the AAD Resource Center, Booth 3309, to learn more about your member benefits and save on practice management resources, patient handouts, and professional education activities. ●

The Orange County Convention Center is one of the nation's largest meeting spaces, with a surrounding tourism district complete with entertainment, shopping, and world-class dining. Close by are additional areas of attraction, including Disney Springs, Universal Orlando Resort, ICON Park, I-Drive (International Drive), and Pointe Orlando.

Daylight Saving Time (DST) begins Sunday!
Turn your clocks forward an hour on Saturday night and don't miss a session!

Inside

ModMed

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Michael Sherling, MD, MBA,
Cofounder and Chief Medical
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HAPPENING TODAY

Innovation, inspiration in pediatric dermatology

AAD members who treat children cannot miss this new, 'hot' session — happening today.

S005 – Hot Topics in Pediatric Dermatology
9 a.m.-noon | Friday, March 7
Location: W414B

Lawrence F. Eichenfield, MD, FAAD, vice chair of the department of dermatology at the University of California San Diego and chief of Pediatric and Adolescent Dermatology at Rady Children's Hospital

Sheilagh M. Maguiness, MD, FAAD, professor of dermatology at the University of Minnesota and immediate past president of the Society for Pediatric Dermatology

With the rising popularity of the Annual Meeting's general Hot Topics session, the AAD has expanded this year's education offerings to include **S005 – Hot Topics in Pediatric Dermatology**. The new session will provide members with an in-depth look at recent research and emerging trends in the evolving field of pediatric dermatology.

Session co-directors, Lawrence F. Eichenfield, MD, FAAD, and Sheilagh M. Maguiness, MD, FAAD, will introduce this morning's distinguished speakers and moderate questions from the audience.

"We are excited to roll out this new symposium, and the timing could not be better given the incredible changes in disease management in pediatric and adolescent patients and the interesting landscape of dermatology issues we will be discussing," said Dr. Eichenfield, who is vice chair of the department of dermatology at the University of California San Diego and chief of Pediatric and Adolescent Dermatology at Rady Children's Hospital.

A panel of world-renowned leaders are scheduled to present on popular subjects.

- Khaled Ezzedine, MD, PhD, professor of dermatology at Université Paris-Est Créteil Val de Marne, will review recent studies on topical and systemic agents for vitiligo.
- Alan D. Irvine, MD, professor of dermatology at Trinity College Dublin and president of the International Eczema Society, will share his experience and expertise on epithelial genetics and atopic dermatitis.
- Beth Ann Drolet, MD, FAAD, professor and chair of dermatology at University of Wisconsin–Madison, will discuss vascular lesions and provide an update on target therapies for vascular anomalies.
- Dawn Eichenfield, PhD, MD, FAAD, assistant clinical professor of dermatology at University of California San Diego, will evaluate new findings in pediatric acne.
- Elena B. Hawryluk, MD, PhD, FAAD, associate professor of dermatology at Harvard Medical School, will consider renewed guidance on treating melanocytic nevi.
- Brittany G. Craiglow, MD, FAAD, double board-certified dermatologist in Fairfield, Connecticut, and Haley Naik, MD, FAAD, associate professor at University of California San Francisco, will address recent research on two common inflammatory skin diseases — alopecia areata and hidradenitis suppurativa, respectively.

Additionally, Dr. Maguiness, professor of dermatology at the University of Minnesota and immediate past president of the Society for Pediatric Dermatology, will round out the session by examining the overuse of cosmetics and its dermatologic consequences in the tween population — a predominant target for marketers.

"Attendees will come away with clinically important state-of-the-art knowledge of a large set of important pediatric dermatology conditions that will influence their practice now, and in the future," Dr. Eichenfield said. ●

Spring forward into DST:

Don't miss Sunday morning's Plenary and Annual Business Meeting

Get ready for an award-winning lineup of lecturers and speakers.

At this year's AAD Annual Meeting in Orlando, you'll want to attend the Plenary on Sunday morning, March 9, at 9 a.m. (Don't forget to set your clocks forward Saturday night for Daylight Saving Time!)

The Plenary begins with AAD's Annual Business Meeting, led by Daniel D. Bennett, MD, FAAD. Immediately following the Annual Business Meeting, stick around for the 2025 lineup of named lectures and presentations, which promise to be exceptional.

Named lectures:

Clarence S. Livingood, MD, Memorial Award and Lectureship
"Numbers and the Narrative: Leadership and Advocacy With Stories and Data"
Marta J. Van Beek, MD, MPH, FAAD

Lila and Murray Gruber Memorial Cancer Research Award and Lectureship
"From Cell Atlases to Medicines With AI"
Aviv Regev, PhD, MSc

Marion B. Sulzberger, MD, Memorial Award and Lectureship
"Patients Don't Read the Textbooks, They Write Them: Insights From Patient-Driven Investigation"
Rachael Clark, MD, PhD, FAAD

John Kenney Jr., MD, Lifetime Achievement Award and Lectureship
"Vitiligo: A 45-Year Journey of Science and Service"
Pearl E. Grimes, MD, FAAD

Seemal R. Desai, MD, FAAD

Susan C. Taylor, MD, FAAD

During the Plenary, there will also be presentations by AAD President Seemal R. Desai, MD, FAAD, and AAD President-Elect Susan C. Taylor, MD, FAAD.

HAPPENING TODAY

Addressing concerns in DRESS syndrome

New treatments, diagnostic tools can help solve the drug-related mystery.

Abraham Korman, MD, FAAD, clinical assistant professor of dermatology and director of the division of inpatient dermatology at The Ohio State University Wexler Medical Center in Columbus

U024 – High-Yield Updates in DRESS Syndrome
3:30-4:30 p.m. | Friday, March 7
Location: W315A

Drug reaction with eosinophilia and systemic symptoms, or DRESS, is a syndrome that can be accompanied by a variety of symptoms including a rash and fever, but it can also be potentially life-threatening and difficult to track down exactly which drug is responsible.

And while it is rare — the DRESS Syndrome Foundation puts the risk at about one in every 1,000 to 10,000 drug exposures — dermatologists need to be aware of the latest diagnostic clues for rendering a diagnosis of DRESS syndrome.

"This includes new data surrounding the latency period between medicine initiation and syndrome development as well as the use of the earlobe crease sign to identify potential patients with DRESS," said Abraham Korman, MD, FAAD. "And though still in its infancy, there is also the use of augmented intelligence to differentiate DRESS from its main mimicker — a low-risk morbilliform drug eruption."

Dr. Korman, who is a clinical assistant professor of dermatology and director of the division of inpatient dermatology at The Ohio State University Wexler Medical Center in Columbus, will lead a discussion on these and other developments in today's session, **U024 – High-Yield Updates in DRESS Syndrome**. He will be joined by Caroline Nelson, MD, FAAD, and Misha Rosenbach, MD, FAAD.

DRESS syndrome algorithm

One new tool for identifying culprit medicines in DRESS syndrome is the novel drug algorithm of drug causality for DRESS, or ADDRESS. Dr. Korman said ADDRESS is a scoring system that assigns points to the drugs a patient is using based on six different components that will be discussed in this afternoon's session:

- latency
- pharmacokinetics
- prechallenge/rechallenge
- dechallenge
- drug risk level
- alternative causes

The total score for each medicine is determined based on these components, said Dr. Korman, and the medicine is ranked by points to ascertain its relative risk. The higher the score, the more likely the medicine is the cause (and vice versa).

"It is based on a prior, validated drug attribution algorithm called ALDEN, [which is used for] Stevens-Johnson Syndrome, as well as a systematic review that our group performed which was published in the *Journal of the American Academy of Dermatology*," he said.

Dr. Korman cited an example of the ADDRESS system in use: a patient who was taking seven different medications presented with a rash. To determine which medicine caused the rash, doctors applied the algorithm to assign a score to each drug. While most of the medicines had negative scores, two — vancomycin and cefepime — had scores of six and four, respectively, pointing to one or both as the likely cause of the rash.

DRESS syndrome subtypes

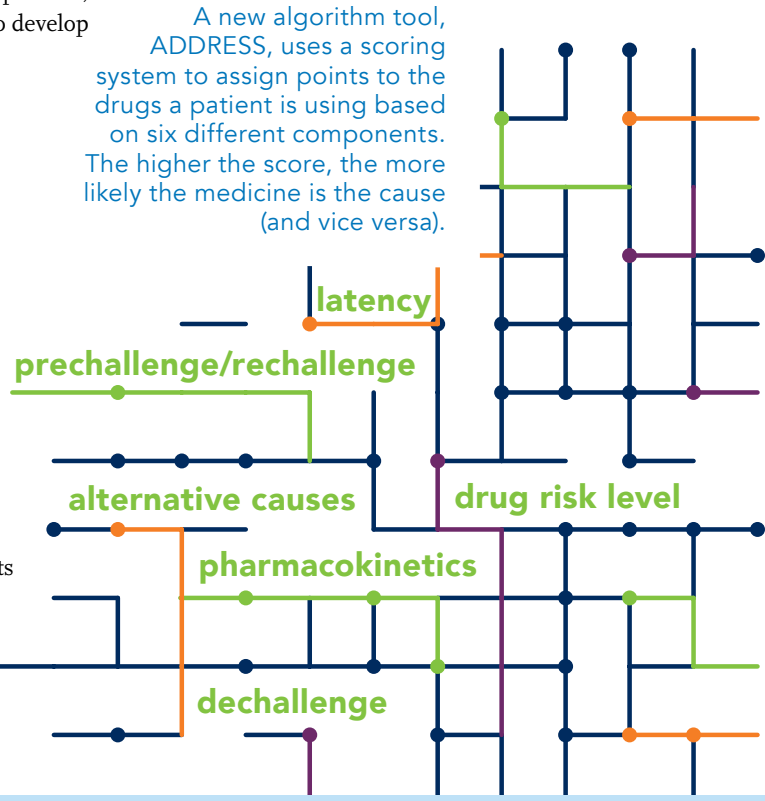
There are a number of subtypes of DRESS syndrome that Dr. Korman said are important for dermatologists to be aware of, including DRESS in African American patients, DRESS in older patients, and patients with DRESS who develop pustules. Each of these groups presents its own unique set of challenges.

"It is important to recognize these because one, African American patients with DRESS have higher mortality than their white counterparts; two, older patients with DRESS have higher rates of cytopenias than their younger counterparts; and three, DRESS patients with pustules have higher rates of flaring and intertriginous involvement than those without pustules," Dr. Korman said.

Despite those challenges, Dr. Korman said there is a lot happening in DRESS research that will shape how the syndrome is treated in the future.

"We are improving diagnostics and the subtyping of DRESS," he said. "It's important to note that it's not all created equal. There are developments happening in the attribution of medicines in DRESS. This is a big issue that has not yet been solved. And in terms of management, there are new drugs being tried with exciting data along with new scoring systems that are helping us track the disease." ●

A new algorithm tool, ADDRESS, uses a scoring system to assign points to the drugs a patient is using based on six different components. The higher the score, the more likely the medicine is the cause (and vice versa).



AAD selects 2025 Gold Medal recipient

Dr. Boni Elewski accepted this prestigious award for her contributions to the profession and its physicians and patients.

Boni E. Elewski, MD, FAAD
2025 Gold Medal Recipient

During the AAD/A Annual Business Meeting on Sunday, Boni E. Elewski, MD, FAAD, of Alabama will be honored as the 2025 Gold Medal Recipient. Dr. Elewski is professor and chair of dermatology at the University of Alabama at Birmingham, and holds the James E. Elder, MD, Endowed Professorship for Graduate Education.

Dr. Elewski is respected as an international leader in fungal and psoriasis research and dermatological clinical trials. Her remarkable research in the field of dermatology has made her world-renowned, and she has delivered hundreds of medical lectures to dermatologists, physicians, residents, and non-physician providers around the world. Her expertise in training and educating dermatology residents is highly regarded across the country. Dr. Elewski has authored more than 400 publications and has served in numerous national societies and professional organizations, including as president of the AAD from 2004-2005, vice president of the AAD, and president of the Women's Dermatologic Society.

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 dermatology has been my work mentoring and teaching both newcomers to the specialty and seasoned physicians. This work has enabled me to impart not only the methodologies and innovations that improve patient lives, but also my love of dermatology and the need to give back to the specialty. I have had the privilege of training scores of dermatology residents, many of whom have gone on to become teachers and leaders. I have also taught countless practicing physicians through CMEs. My dream is this work has set in motion a virtuous cycle of teaching, learning, and healing that benefits patients around the world."

– Dr. Elewski

Enter our daily social giveaways

Follow **@AADmember**

Participate through Monday, March 10, on Instagram!

Did you hear the great news? The **@AADmember Instagram account** will be hosting daily giveaways all weekend long!

Between now and Monday, a new post will be shared each day that attendees can comment on to be entered to win various prizes. **Five winners** will be randomly selected from each post, for a total of 20 winners throughout the meeting!

Find out what today's post will be and see who the lucky winners are tomorrow **@AADmember**.

Best of luck to all!

View more meeting coverage at *DermWorld Meeting News Central*

Scan the QR code for instant access to daily articles, photos, and late-breaking research from the Annual Meeting.

aadmeetingnews.org

AAD annual MEETING
MARCH 7–11, 2025 | ORLANDO, FLORIDA

Discover the latest from Industry at the 2025 AAD Annual Meeting: **Attend Exclusive Non-CME Sessions**

Join our Platinum Sponsors for cutting-edge programs that will enhance your practice with the latest research, live demos, and expert insights. Some sessions include food and beverages!

Platinum INC Programs at the 2025 AAD Annual Meeting:

All sessions are located at the Hyatt Regency Orlando.

THIAMIDOL: A Breakthrough Innovation in Dark Spot Correction
Thursday, March 6, 2025 at 7 p.m. EDT
Location: Regency Ballroom U
Sponsored by: Eucerin

Chronic Hand Eczema: A New Day Is at Hand
Thursday, March 6, 2025 at 7 p.m. EDT
Location: Regency Ballroom T
Sponsored by: Leo Pharma

Understanding Vitiligo: Exploring The Patient Experience
Saturday, March 8, 2025 at 7 p.m. EDT
Location: Regency Ballroom U
Sponsored by: Pfizer

What Went Wrong? How Dysregulated Type 2 Immunity Contributes to AD, PN, CSU, and BP
Saturday, March 8, 2025 at 7 p.m. EDT
Location: Regency Ballroom T
Sponsored by: Sanofi and Regeneron

Atopic Dermatitis Pathway Pursuit: The OX40-Ligand Edition
Sunday, March 9, 2025 at 7 p.m. EDT
Location: Plaza Ballroom H
Sponsored by: Sanofi

Narrowing Nonmelanoma Skin Cancer Gaps With Neoadjuvant Immunotheray: Multidisciplinary Strategies for Success
Sunday, March 9, 2025 at 7 p.m. EDT
Location: Plaza Ballroom G
Sponsored by: Answer in CME

Favorite these programs on the AAD Meeting App!

Scan the QR Code to easily favorite these sessions and add them to your schedule.

Registration begins at 6:30 p.m. on the day of the INC program.

INC Program content is developed and delivered by the sponsor, independent of the official AAD Meeting planned by its Scientific Assembly Committee and does not qualify for AAD continuing medical education (CME) credit.

HAPPENING TODAY

Ask questions, address concerns

Understand the role social determinants of health play in your patients' dermatologic care.

Herbert B. Castillo Valladares, MD, MHS, FAAD, assistant professor of dermatology at University of California San Francisco

U023 – Bridging the Gap: Addressing Social Determinants of Health to Decrease Health Disparities in Dermatology
3:30-4:30 p.m. | Friday, March 7
Location: W208A

Equitable and effective. These are two words driving improved patient care in 2025 and beyond. They also represent a new approach for addressing the role of social determinants — or drivers — of health (SDoH) in dermatology.

SDoH are factors that influence an individual's ability to maximize their health potential. They account for five domains: economic stability, education access and quality, health care access and quality, neighborhood and built environment, and social and community context.

According to Herbert B. Castillo Valladares, MD, MHS, FAAD, an assistant professor of dermatology at University of California San Francisco, there is growing evidence of the impact of health disparities in dermatology. Dr. Castillo Valladares is the director of this afternoon's session, **U023 – Bridging the Gap: Addressing Social Determinants of Health to Decrease Health Disparities in Dermatology.**

"Social determinants of health significantly impact dermatology patients' ability to manage and treat their skin conditions," Dr. Castillo Valladares said. "By assessing social risk factors through thoughtful questions and formulating patient-centered care plans, dermatologists can improve health outcomes and ensure that care is equitable and effective."

In addition to Dr. Castillo Valladares, session speakers Rebecca Vasquez, MD, FAAD, and Olivia Rose Ware, MD, FAAD, will review the impact of SDoH on disease presentation and care delivery for vulnerable populations through a case-based format.

CASE BY CASE

Dr. Castillo Valladares shared several anonymous, illustrative case examples that highlight the impact of SDoH on dermatology patients.

Case 1: "MT" — Low income

Background: MT is a 55-year-old woman who presents with eczema. She has no health insurance and works multiple low-wage jobs to support her family.

Impact of SDoH: Due to her job schedule and financial strain, MT struggles to afford co-pays for medications and dermatology visits. She also lacks reliable transportation to attend appointments.

Consequences: This has resulted in poor control of her eczema, with frequent flare-ups and some inpatient hospitalizations. The stress of balancing her work, financial limitations, and health exacerbates her skin condition.

Case 2: "JC" — Housing instability and poor nutrition

Background: JC is a 30-year-old man with psoriasis who is experiencing homelessness.

Impact of SDoH: JC has irregular access to personal hygiene facilities and difficulty managing his psoriasis due to lack of stable housing. Stress and poor nutrition, both related to homelessness, exacerbate his condition.

Consequences: His psoriasis remains poorly controlled, leading to extensive skin involvement and significant physical discomfort, which impacts his mental and social well-being.

Case 3: "AR" — Limited English proficiency

Background: AR, a 65-year-old man who arrived alone to the U.S. from Syria one year ago, has limited English proficiency and is experiencing pain and increased size of a skin lesion on his nose concerning for basal cell carcinoma (BCC). Although he is eligible for public health insurance, he does not feel comfortable navigating the health care system and is unable to schedule appointments due to language barriers.

Impact of SDoH: Communication and language barriers are leaving AR excluded from timely care. His physicians and non-physician providers may also lack the necessary language skills or resources to communicate effectively with him.

Consequences: Lack of timely dermatology referral delays his care, and the BCC continues to increase in size and cause pain. This may lead to a more complicated procedure in the future.

The importance of screening

Dr. Castillo Valladares encourages dermatologists to implement a routine screening process into the patient intake and the patient encounter to accurately assess SDoH in dermatology. During the session, speakers will review sample, evidence-based questions taken from The Accountable Health Communities Health-Related Social Needs Screening Tool, such as:

Housing/living situation: What is your living situation today?

Food: Within the past 12 months, have you worried that your food would run out before you got money to buy more?

- ○ Often true
- ○ Sometimes true
- ○ Never true

Transportation: In the past 12 months, has lack of reliable transportation kept you from attending medical appointments, meetings, or work or from getting things needed for daily living?

- ○ Yes
- ○ No

Financial strain: How hard is it for you to pay for the very basics, like food, housing, medical care, and heating?

- ○ Very hard
- ○ Somewhat hard
- ○ Not hard at all

How to address your patient's SDoH

Dr. Castillo Valladares said dermatologists should consider the following tips to develop specific treatment plans.

Incorporate social support and resources:
Provide information about community resources (e.g., food banks, transportation options, financial assistance programs, local shelters) that can help patients manage their condition.

Connect patients with patient navigators and social workers/case managers who can help coordinate care and provide support for accessing resources.

Consider medication accessibility:
Prescribe medications that are affordable and accessible, or suggest alternatives if cost is a barrier. Help your patient navigate patient assistance programs, and offer samples or discount cards when possible to help patients manage the cost of prescriptions.

Personalize the treatment plan:
Consider the patient's living conditions, employment, and daily routine when recommending treatments. For example, if a patient has limited access to showers, consider systemic agents over intensive topical regimens if severity warrants this option.

Recognize cultural, language, or literacy differences and provide education in a way that is approachable and understandable (e.g., using plain language or translation services).

Engage in shared decision-making:
Include patients in decisions about their care by discussing their priorities and concerns. This approach helps build trust and ensures that treatment plans are realistic and achievable.

CASTLE BIOSCIENCES

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Delivering personalized insights to guide treatment decisions for patients with skin cancer.

Stop by **booth #1661** for coffee and to learn more about GEP testing for dermatologic cancers

Cocktails with Castle

SATURDAY, MARCH 8 | 3-5 PM
BOOTH #1661

Join Aaron Farberg, MD, Matt Goldberg, MD, Stan Tolkachjov, MD, FAAD, FACMS, and Alexander Witkowski, MD for drinks and discussion

MARCH 7-9
BOOTH # 1661

Skin cancer is not a game. Take a swing at various lesion types and enter to win prizes

Decision Dx ▸Melanoma

Delivers personalized risk-assessment for recurrence and metastasis, including the likelihood of sentinel lymph node positivity, for patients with cutaneous melanoma

Decision Dx ▸SCC

Predicts the risk of metastasis and identifies patients most likely to benefit from adjuvant radiation therapy with high-risk squamous cell carcinoma

MyPath ▸Melanoma

Aids in the diagnosis and management decisions for patients with ambiguous melanocytic lesions, as well as in cases when melanoma cannot be ruled out

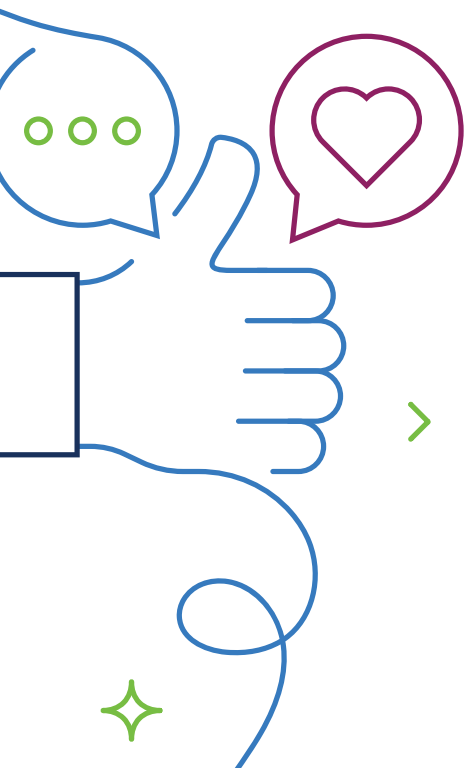
HAPPENING TODAY

Making good ‘impressions’

Engage with experts to make social media work for your practice.

Samantha Karlin, MD, FAAD, a dermatologist with Soine Dermatology & Aesthetics in Covington, Louisiana

F020 – Combatting Misinformation and Positioning the Specialty on Social Media
1-3 p.m. | Friday, March 7
Location: W207A



The most modern marketing tool for your dermatology practice is likely already in your back pocket — or bag. It’s social media, and it’s not just for entertaining youth. Social media is a great professional tool that can be used to educate the public, positively position the specialty, and enhance your dermatology practice.

Admittedly, social media can be a fast-paced and time-consuming marketing effort. But with the right instruction, dermatology practices can use it to develop a solid strategy that leads to a positive long-term outcome. Today’s session, **F020 – Combatting Misinformation and Positioning the Specialty on Social Media**, will provide that instruction to attendees, giving them tips and approaches for building and maintaining a reliable and reputable presence on social media.

Session director Samantha Karlin, MD, FAAD, and a panel of speakers will walk through all the essential steps to set your practice up for success — from developing educational and engaging content to managing negative comments.

Set clear goals for success

“First, you want to set clear goals to hold yourself accountable. Then, you’ll want to determine your key audience and the platforms where they are most active,” said Dr. Karlin, a dermatologist with Soine Dermatology & Aesthetics in Covington, Louisiana, and an AAD social media correspondent. “Next, you’ll want to establish your brand and tone of voice and build a network on social media.”

Still, the million-dollar question remains: How do you create engaging content that educates the public and positively positions the specialty? According to Dr. Karlin, staying organized and having a plan goes a long way toward helping a dermatology practice post consistently on all social media channels. She recommends conducting a content brainstorming session once a month or quarterly. This can be done with the office staff to generate topics, ideas, success stories, etc., that would be of interest to your target audience.

“Think about common questions that you’re hearing in your practice or trends that are popping up in your feed,” Dr. Karlin said. “Position yourself as the expert by identifying yourself as a board-certified dermatologist and sharing evidence-based information on the wide variety of conditions you treat.”

Keep it professional

During the session, speakers will address the importance of recognizing and applying standards of professionalism to social media posts as well as responding appropriately to negative comments. Dr. Karlin cautions that although social media can be more casual than other forms of communication, it is important to always remain professional.

“Avoid sharing controversial opinions or unsubstantiated claims, which can erode the public’s trust in our specialty,” she said. “Never argue with your audience or speak badly about others publicly or privately. And while not all negative comments warrant a response, some situations may benefit from careful engagement.”

Success over time

Measuring the effectiveness of your social media campaign also takes skill and practice. During the session, attendees will learn how to identify key metrics to track and measure the campaign’s success over time. Panelists will discuss how each social media platform has its own algorithm with different features and content types for consideration. The session will also share how dermatologists can get involved in the Academy’s social media efforts to amplify its mission and to positively position the specialty on social media.

“With more and more patients turning to social media for health care and skin care advice, it’s increasingly important for dermatologists to provide a reliable and credible source of information and combat misinformation shared by non-dermatologist ‘influencers,’” Dr. Karlin said. ●

Your Dermatologist Knows
10-11 a.m. | Friday, March 7
AAD Resource Center Exhibit Hall, Booth 3309

One of the AAD’s most successful consumer positioning strategies of late is #YourDermatologistKnows. Stop by the AAD Resource Center this morning to learn about this robust social media campaign that generated **125.2 million impressions** and **20.4 million engagements in 2024**.

Meet the tech-savvy dermatologists who serve as the Academy’s social media correspondents and take a picture with AAD’s fun props to post on your own social media channels to spread dermatology’s message. Show us you’re following the AAD on social media and get a free #YourDermatologistKnows t-shirt, while supplies last.

Be sure to use the official meeting hashtag **#AAD2025** in all your posts and stories, and don’t forget to tag **@AADmember** so we can reshare your content!

Find your way to adventure: Camp Discovery Treasure Hunt

AAD camp discovery

At this year’s AAD Annual Meeting in Orlando, we’re bringing the spirit of summer camp to life with the **Camp Discovery Treasure Hunt!** This interactive activity not only invites you to share the joy kids get from camp, but also gives you a chance to win an exciting, camp-themed prize.

How to participate:

1. **Hunt for camp-themed treasures.** We’ve hidden **four camp-themed signs** around the conference venue, each representing a unique benefit of Camp Discovery and our new digital referral form.
2. **Capture and share the experience.** To complete each “find,” scan the QR code and fill out a brief form.
3. **Return to the Camp Discovery kiosk.** Once you’ve found a treasure (or all four!), return to the Camp Discovery kiosk in the exhibit hall, within the AAD Resource Center (Booth 3309) to get your prize. One “find” gets you a small prize, and all four enters you into a drawing for the grand prize!
4. **Visit the special pop-up event at the Camp Discovery kiosk.** On **Sunday, March 9, noon-1 p.m.**, stop by the Camp Discovery pop-up to learn about this incredible initiative that gives children with chronic skin conditions a chance to enjoy the fun and friendship of summer camp. Find out how you can be a part of it. Sign up to receive a kit and get a special gift. ●

Skyrizi®
risankizumab-rzaa

LET NOTHING STAND IN YOUR WAY

OF BOOTH 1621

abbvie

Exhibit Hall Map and Exhibitor Listing

Data current as of Feb. 24, 2025. Please use the AAD Meeting App **aad.org/mobile** for the most up-to-date exhibitor list.

123 – D

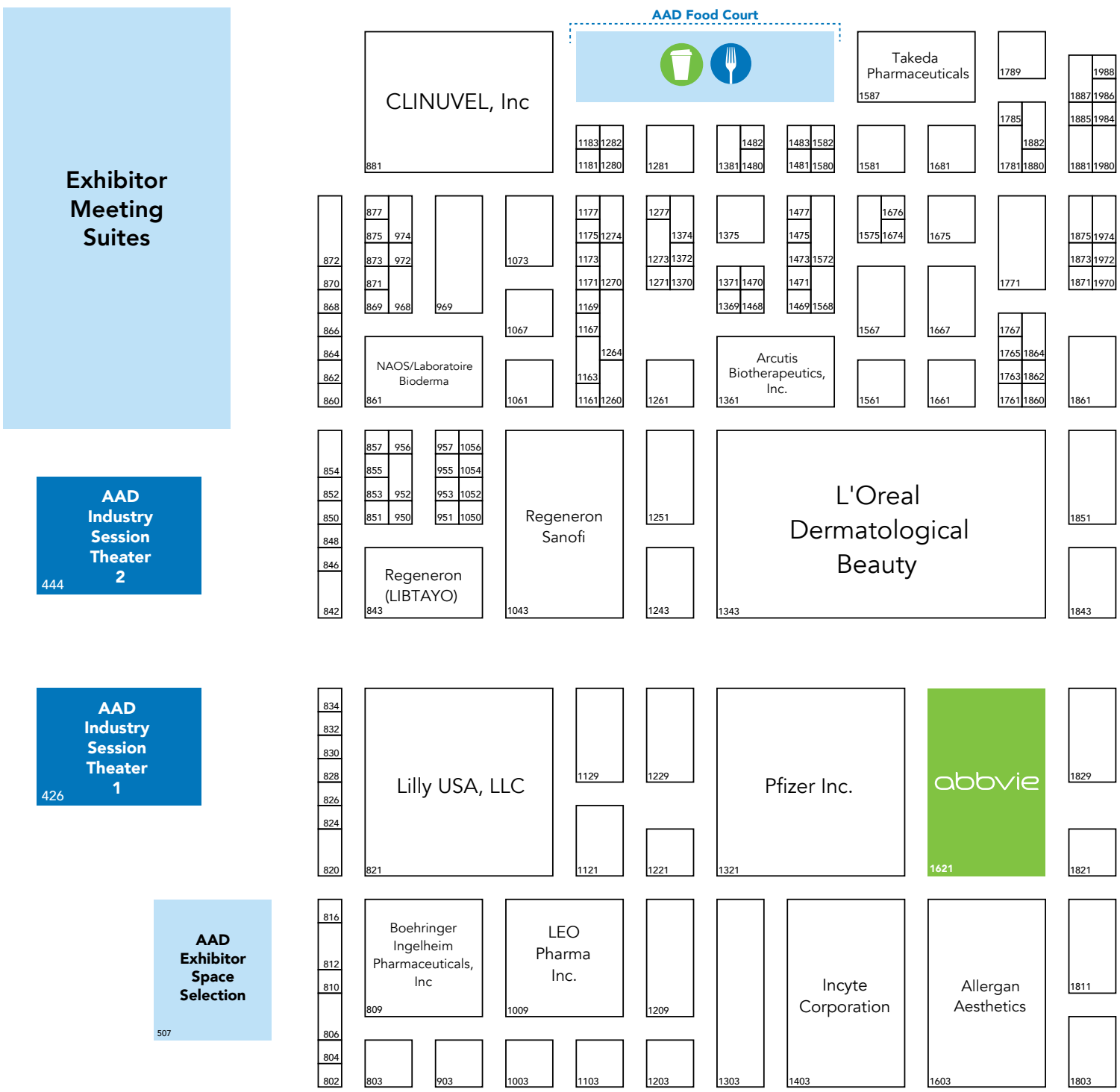


Exhibit Hall hours

10 a.m.-5 p.m. | Friday & Saturday, March 7-8
10 a.m.-3 p.m. | Sunday, March 9

ePosters and Presentations

This special demonstration features separate viewing areas and a hub of computers where you can search and view posters at any time.

7 a.m.-5 p.m.
Friday-Sunday, March 7-9
Located in Exhibit Hall B

Lactation Room

Overflow Area

AAD ePosters and Poster Presentations

see **EXHIBITOR LISTING** page 12

EXHIBITOR LISTING

continued from page 11

J – N

O – S

T – Z

AAD Resource Center, Booth 3309

Where the magic of your AAD Membership comes to life!

Come celebrate the spirit, strength, and unity of the AAD community in the Resource Center.

You'll find a wealth of tools, resources, and support designed to help you successfully practice dermatology and thrive in your career. Whether you're seeking professional development, high quality educational materials, or networking opportunities, we've got everything you need.

We've created a new look and feel for the booth, and we've expanded our list of events and activities. More highlights of the AAD Resource Center include:

- **AAD Career Compass:** Share your CV, search for jobs, or post an open position.
- **AAD Clinical Image Collection:** Learn about this new valuable member resource.
- **Camp Discovery Treasure Hunt:** Discover how you can get involved with the program and send your patients to this one-of-a-kind summer experience and seek your treasure.
- ***Dialogues in Dermatology*:** Tune into this podcast that's newly available to all members.
- **Hydration Station** on Friday
- **Charging station** (all days)
- And, of course, **lots of swag and giveaways!**

While visiting the booth, don't forget to enroll in **DataDerm™**, the world's largest registry for the specialty, and register for the **2025 Innovation Academy in Chicago, July 10-13**.

Members can also get complimentary headshots, learn about new courses or how to claim CME, take a board prep test, or talk with our Practice Management and Coding teams. Did we mention you can also win amazing prizes?

And if you're a resident, come apply for membership in person to receive six months free and a huge discount off regular dues! ●

AAD Resource Center Hours

10 a.m.-5 p.m.
Friday & Saturday,
March 7-8

10 a.m.-3 p.m.
Sunday, March 9

Scan the QR code for a full lineup and additional details.

Vitiligo treatments, myths, and concerns

A recent surge in research has sparked renewed interest in the increasingly common condition.

David Rosmarin, MD, FAAD, chair of the department of dermatology at Indiana University School of Medicine in Indianapolis

F040 – Vitiligo: Evidence-Based Medicine Applied to Cases
1-3 p.m. | Saturday, March 8
Location: W203C

Vitiligo has been known to the dermatologic community for years. According to the Global Vitiligo Foundation, 70 million people across the globe of all races, ethnicities, and genders suffer from vitiligo, which amounts to nearly 1% of the world's population. Despite this prevalence, the foundation said there is very little research funding for vitiligo and many of the currently available treatments are not covered by insurance.

But things may be changing. David Rosmarin, MD, FAAD, chair of the department of dermatology at Indiana University School of Medicine in Indianapolis, said there has been growing recognition in the scientific community of the importance of vitiligo, which has corresponded with increased efforts to study the disease.

"There have been advances, including a mouse model of vitiligo, that have assisted in the understanding of the immunology of the disease," he said. "Additionally, there are assessment tools and a newly established regulatory pathway to allow testing for medications that can help repigment patients."

These latest developments and their impact on vitiligo treatment will be the subject of Saturday's session, **F040 – Vitiligo: Evidence-Based Medicine Applied to Cases.**

Dr. Rosmarin said the most common concern patients with vitiligo have is that their disease will spread. This is why understanding signs of activity in the disease is important.

"Signs include trichrome vitiligo, confetti lesions, Koebner phenomena, and inflammatory vitiligo," he said. "Additionally, it is important to halt progression of the disease urgently as that is significantly easier than subsequently trying to repigment a larger area."

Myths and unknowns

In addition to concerns over spreading, Dr. Rosmarin said there are a number of persistent myths surrounding vitiligo, not the least of which is how it is acquired.

"Unfortunately, some in our community believe vitiligo is contagious. There is also concern that vitiligo can be passed down genetically," he said. "While there is an increased risk of a patient having a child with vitiligo (at close to 4%, which is about six times higher than the baseline rate in the population), it is still more likely than not that a child born to a parent with vitiligo will not develop vitiligo. It is important for dermatologists to compassionately educate our patients and the community to dispel myths and disseminate the latest information we have."

Despite having that information, there is still a good deal that is unknown about vitiligo and those who have it.

"We don't know which patients are more likely to respond to certain treatments based on baseline demographics or disease characteristics," Dr. Rosmarin said. "Additionally, we don't know which patients will maintain repigmentation once achieved and how long it will last once treatment is stopped. Furthermore, we don't understand the optimized way to combine treatments such as phototherapy and immunomodulators."

Even though there are so many unknowns, Dr. Rosmarin said there is still a lot that dermatologists can do to assist people who are suffering from vitiligo.

"We have exciting new therapies in development and some traditional options that still have utility," he said. "Some of our assumptions about vitiligo have been confirmed and some have been refuted by the most recent data. It's an exciting and hopeful time for us in having options to help our patients."

Dr. Rosmarin will lead tomorrow's session, which includes presentations from vitiligo experts and a panel discussion. ●

FOR ADULTS WITH MODERATE TO SEVERE PLAQUE PSORIASIS (PsO)

Everyone deserves the chance to

Emerge **Tremfyant®**

Tremfya® (guselkumab)

VOYAGE 1 and VOYAGE 2 co-primary endpoints at Week 16 (NRI)[1-3]
VOYAGE 1—PASI 90: TREMFYA® 73% (241/329), placebo 3% (5/174) (*P*<0.001). IGA 0/1: TREMFYA® 85% (280/329), placebo 7% (12/174) (*P*<0.001).
VOYAGE 2—PASI 90: TREMFYA® 70% (347/496), placebo 2% (6/248) (*P*<0.001). IGA 0/1: TREMFYA® 84% (417/496), placebo 8% (21/248) (*P*<0.001).

INDICATION

TREMFYA® (guselkumab) is indicated for the treatment of adults with moderate to severe plaque psoriasis who are candidates for systemic therapy or phototherapy.

IMPORTANT SAFETY INFORMATION

CONTRAINDICATIONS

TREMFYA® is contraindicated in patients with a history of serious hypersensitivity reaction to guselkumab or to any of the excipients.

WARNINGS AND PRECAUTIONS

Hypersensitivity Reactions

Serious hypersensitivity reactions, including anaphylaxis, have been reported with postmarket use of TREMFYA®. Some cases required hospitalization. If a serious hypersensitivity reaction occurs, discontinue TREMFYA® and initiate appropriate therapy.

Infections

TREMFYA® may increase the risk of infection. Treatment with TREMFYA® should not be initiated in patients with a clinically important active infection until the infection resolves or is adequately treated.

Consider the risks and benefits of treatment prior to prescribing TREMFYA® in patients with a chronic infection or a history of recurrent infection. Instruct patients receiving TREMFYA® to seek medical help if signs or symptoms of clinically important chronic or acute infection occur. If a patient develops a clinically important or serious infection, or is not responding to standard therapy, closely monitor and discontinue TREMFYA® until the infection resolves.

Pre-Treatment Evaluation for Tuberculosis (TB)

Evaluate patients for TB infection prior to initiating treatment with TREMFYA®. Initiate treatment of latent TB prior to administering TREMFYA®. Monitor patients for signs and symptoms of active TB during and after TREMFYA® treatment. Do not administer TREMFYA® to patients with active TB infection.

Immunizations

Prior to initiating TREMFYA®, complete all age-appropriate vaccinations according to current immunization guidelines. Avoid use of live vaccines in patients treated with TREMFYA®.

ADVERSE REACTIONS

Most common adverse reactions associated with TREMFYA® include: plaque psoriasis and psoriatic arthritis adverse reactions (≥1%): upper respiratory infections, headache, injection site reactions, arthralgia, bronchitis, diarrhea, gastroenteritis, tinea infections, and herpes simplex infections. Ulcerative colitis adverse reactions: induction (≥2%): respiratory tract infections; maintenance (≥3%): injection site reactions, arthralgia, and upper respiratory tract infections.

The overall safety profile observed in patients with psoriatic arthritis is generally consistent with the safety profile in patients with plaque psoriasis, with the addition of bronchitis and neutrophil count decreased.

Please read the full Prescribing Information and Medication Guide for TREMFYA®. Provide the Medication Guide to your patients and encourage discussion.

Dosage Forms and Strengths: TREMFYA® is available in a 100 mg/mL prefilled syringe and One-Press patient-controlled injector for subcutaneous injection, a 200 mg/2 mL prefilled syringe and prefilled pen (TREMFYA® PEN) for subcutaneous injection, and a 200 mg/20 mL (10 mg/mL) single-dose vial for intravenous infusion.

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IGA=Investigator's Global Assessment; **NRI**=nonresponder imputation; **PASI**=Psoriasis Area and Severity Index.

STUDY DESIGNS

VOYAGE 1 (n=837) and **VOYAGE 2** (n=992) were phase 3, multicenter, double-blind, placebo-controlled trials in adult patients with moderate to severe plaque PsO. Patients were randomized to TREMFYA® 100 mg subcutaneous injection at Weeks 0, 4, and 12, then every 8 weeks (q8w); placebo at Weeks 0, 4, and 12, followed by crossover to TREMFYA® at Week 16, Week 20, and q8w; or active comparator through Week 47 (VOYAGE 1) or Week 23 (VOYAGE 2). In VOYAGE 1, patients initially randomized to active comparator entered a washout period after their final dose at Week 47 and entered open-label TREMFYA® from Week 52-252. VOYAGE 2 incorporated a randomized withdrawal and re-treatment from Week 28-72, followed by open-label TREMFYA® from Week 76-252. Safety was assessed through Week 264.[1-3]

References: 1. TREMFYA® (guselkumab) [Prescribing Information]. Horsham, PA: Janssen Biotech, Inc. **2.** Blauvelt A, Papp KA, Griffiths CEM, et al. Efficacy and safety of guselkumab, an anti-interleukin-23 monoclonal antibody, compared with adalimumab for the continuous treatment of patients with moderate to severe psoriasis: results from the phase III, double-blinded, placebo- and active comparator-controlled VOYAGE 1 trial. *J Am Acad Dermatol.* 2017;76(3):405-417. **3.** Reich K, Armstrong AW, Foley P, et al. Efficacy and safety of guselkumab, an anti-interleukin-23 monoclonal antibody, compared with adalimumab for the treatment of patients with moderate to severe psoriasis with randomized withdrawal and retreatment: results from the phase III, double-blind, placebo- and active comparator-controlled VOYAGE 2 trial. *J Am Acad Dermatol.* 2017;76(3):418-431.

Johnson&Johnson

Brief Summary of Prescribing Information for TREMFYA® (guselkumab)
TREMFYA® (guselkumab) injection, for subcutaneous use
TREMFYA® PEN (guselkumab) injection, for subcutaneous use
TREMFYA® (guselkumab) injection, for intravenous use
See package insert for full Prescribing Information.

INDICATIONS AND USAGE: Plaque Psoriasis TREMFYA is indicated for the treatment of adult patients with moderate-to-severe plaque psoriasis who are candidates for systemic therapy or phototherapy. **Psoriatic Arthritis** TREMFYA is indicated for the treatment of adult patients with active psoriatic arthritis. **Ulcerative Colitis** TREMFYA is indicated for the treatment of adult patients with moderately to severely active ulcerative colitis. **CONTRAINDICATIONS:** TREMFYA is contraindicated in patients with a history of serious hypersensitivity reaction to guselkumab or to any of the excipients *[see Warnings and Precautions]*. **WARNINGS AND PRECAUTIONS: Hypersensitivity Reactions** Serious hypersensitivity reactions, including anaphylaxis, have been reported with post market use of TREMFYA. Some cases required hospitalization. If a serious hypersensitivity reaction occurs, discontinue TREMFYA and initiate appropriate therapy. **Infections** TREMFYA may increase the risk of infection. In clinical trials in subjects with plaque psoriasis, infections occurred in 23% of subjects in the TREMFYA group versus 21% of subjects in the placebo group through 16 weeks of treatment. Upper respiratory tract infections, gastroenteritis, tinea infections, and herpes simplex infections occurred more frequently in the TREMFYA group than in the placebo group *[see Adverse Reactions]*. The rate of serious infections for the TREMFYA group and the placebo group was ≤ 0.2%. A similar risk of infection was seen in placebo-controlled trials in subjects with psoriatic arthritis and ulcerative colitis. Treatment with TREMFYA should not be initiated in patients with any clinically important active infection until the infection resolves or is adequately treated. In patients with a chronic infection or a history of recurrent infection, consider the risks and benefits prior to prescribing TREMFYA. Instruct patients to seek medical help if signs or symptoms of clinically important chronic or acute infection occur. If a patient develops a clinically important or serious infection or is not responding to standard therapy, monitor the patient closely and discontinue TREMFYA until the infection resolves. **Pre-treatment Evaluation for Tuberculosis** Evaluate patients for tuberculosis (TB) infection prior to initiating treatment with TREMFYA. Initiate treatment of latent TB prior to administering TREMFYA. In clinical trials, 105 subjects with plaque psoriasis, 71 subjects with psoriatic arthritis, and 31 subjects with ulcerative colitis with latent TB who were concurrently treated with TREMFYA and appropriate TB prophylaxis did not develop active TB. Monitor patients for signs and symptoms of active TB during and after TREMFYA treatment. Consider anti-TB therapy prior to initiating TREMFYA in patients with a past history of latent or active TB in whom an adequate course of treatment cannot be confirmed. Do not administer TREMFYA to patients with active TB infection. **Immunizations** Avoid use of live vaccines in patients treated with TREMFYA. Medications that interact with the immune system may increase the risk of infection following administration of live vaccines. Prior to initiating therapy with TREMFYA, complete all age-appropriate vaccinations according to current immunization guidelines. No data are available on the response to live or inactive vaccines. **ADVERSE REACTIONS:** The following adverse reactions are discussed in greater detail in other sections of labeling: • Hypersensitivity Reactions *[see Contraindications and Warnings and Precautions]* • Infections *[see Warnings and Precautions]* **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. Plaque Psoriasis In clinical trials, a total of 1823 subjects with moderate-to-severe plaque psoriasis received TREMFYA. Of these, 1393 subjects were exposed to TREMFYA for at least 6 months and 728 subjects were exposed for at least 1 year. Data from two placebo- and active-controlled trials (PsO1 and PsO2) in 1441 subjects (mean age 44 years; 70% males; 82% white) were pooled to evaluate the safety of TREMFYA (100 mg administered subcutaneously at Weeks 0 and 4, followed by every 8 weeks). *Weeks 0 to 16* In the 16-week placebo-controlled period of the pooled clinical trials (PsO1 and PsO2), adverse events occurred in 49% of subjects in the TREMFYA group compared to 47% of subjects in the placebo group and 49% of subjects in the U.S. licensed adalimumab group. Serious adverse events occurred in 1.9% of subjects in the TREMFYA group (6.3 events per 100 subject-years of follow-up) compared to 1.4% of subjects in the placebo group (4.7 events per 100 subject-years of follow-up), and in 2.6% of subjects in U.S. licensed adalimumab group (9.9 events per 100 subject-years of follow-up). Table 1 summarizes the adverse reactions that occurred at a rate of at least 1% and at a higher rate in the TREMFYA group than in the placebo group during the 16-week placebo-controlled period.

Table 1: Adverse Reactions Occurring in ≥1% of Subjects through Week 16 in PsO1 and PsO2

	TREMFYA[a] 100 mg N=823 n (%)	Adalimumab[b] N=196 n (%)	Placebo N=422 n (%)
Upper respiratory infections[c]	118 (14.3)	21 (10.7)	54 (12.8)
Headache[d]	38 (4.6)	2 (1.0)	14 (3.3)
Injection site reactions[e]	37 (4.5)	15 (7.7)	12 (2.8)
Arthralgia	22 (2.7)	4 (2.0)	9 (2.1)
Diarrhea	13 (1.6)	3 (1.5)	4 (0.9)
Gastroenteritis[f]	11 (1.3)	4 (2.0)	4 (0.9)
Tinea infections[g]	9 (1.1)	0	0
Herpes simplex infections[h]	9 (1.1)	0	2 (0.5)

[a] Subjects receiving 100 mg of TREMFYA at Week 0, Week 4, and every 8 weeks thereafter
[b] U.S. licensed adalimumab
[c] Upper respiratory infections include nasopharyngitis, upper respiratory tract infection (URTI), pharyngitis, and viral URTI.
[d] Headache includes headache and tension headache.
[e] Injection site reactions include injection site erythema, bruising, hematoma, hemorrhage, swelling, edema, pruritus, pain, discoloration, induration, inflammation, and urticaria.
[f] Gastroenteritis includes gastroenteritis and viral gastroenteritis.
[g] Tinea infections include tinea pedis, tinea cruris, tinea infection, and tinea manuum infections.
[h] Herpes simplex infections include oral herpes, herpes simplex, genital herpes, genital herpes simplex, and nasal herpes simplex.

Adverse reactions that occurred in < 1% but > 0.1% of subjects in the TREMFYA group and at a higher rate than in the placebo group through Week 16 in PsO1 and PsO2 were migraine, candida infections, and urticaria. Specific Adverse Reactions *Infections* Infections occurred in 23% of subjects in the TREMFYA group compared to 21% of subjects in the placebo group. The most common (≥ 1%) infections were upper respiratory infections, gastroenteritis, tinea infections, and herpes simplex infections; all cases were mild to moderate in severity and did not lead to discontinuation of TREMFYA. *Elevated Liver Enzymes* Elevated liver enzymes were reported more frequently in the TREMFYA group (2.6%) than in the placebo group (1.9%). Of the 21 subjects who were reported to have elevated liver enzymes in the TREMFYA group, all events except one were mild to moderate in severity and none of the events led to discontinuation of TREMFYA. *Safety through Week 48* Through Week 48, no new adverse reactions were identified with TREMFYA use and the frequency of the adverse reactions was similar to the safety profile observed during the first 16 weeks of treatment. Psoriatic Arthritis TREMFYA was studied in two placebo-controlled trials in subjects with psoriatic arthritis (748 subjects on TREMFYA and 372 subjects on placebo). Of the 748 subjects who received TREMFYA, 375 subjects received TREMFYA 100 mg at Week 0, Week 4, and every 8 weeks thereafter and 373 subjects received TREMFYA 100 mg every 4 weeks. The overall safety profile observed in subjects with psoriatic arthritis treated with TREMFYA is generally consistent with the safety profile in subjects with plaque psoriasis with the addition of bronchitis and neutrophil count decreased. In the 24-week placebo-controlled period, combined across the two studies, bronchitis occurred in 1.6% of subjects in the TREMFYA q8w group and 2.9% of subjects in the TREMFYA q4w group compared to 1.1% of subjects in the placebo group. Neutrophil count decreased occurred in 0.3% of subjects in the TREMFYA q8w and 1.6% of subjects in the TREMFYA q4w group compared to 0% of subjects in the placebo group. The majority of events of neutrophil count decreased were mild, transient, not associated with infection and did not lead to discontinuation. Ulcerative Colitis TREMFYA was studied up to 12 weeks in subjects with moderately to severely active ulcerative colitis in a randomized, double-blind, placebo-controlled induction study (UC1) and a randomized, double-blind, placebo controlled, induction dose-finding study (UC3; NCT04033445). Long-term safety up to 44 weeks was evaluated in subjects who responded to induction therapy in a randomized, double-blind, placebo-controlled maintenance study (UC2) *[see Clinical Studies (14.3) in Full Prescribing Information]*. In the induction studies (UC1 and UC3), 522 subjects received at least one dose of the TREMFYA intravenous induction regimen (i.e., 200 mg at Week 0, Week 4, and Week 8). Clinical response was defined as a decrease in modified Mayo score (mMS) of ≥30% and ≥2 points from baseline with either a ≥1 decrease from baseline in rectal bleeding subscore (RBS) or RBS of 0 or 1. In the maintenance study (UC2), subjects who achieved clinical response after 12 weeks of TREMFYA intravenous induction treatment were randomized and received either TREMFYA 100 mg every 8 weeks (with the first dose given at Week 4 of UC2) or TREMFYA 200 mg every 4 weeks (with the first dose given at Week 0 of UC2), by subcutaneous (SC) injection for up to an additional 44 weeks. Respiratory tract infections occurred in ≥2% of subjects treated with TREMFYA and at a higher rate than placebo (8.8% TREMFYA-treated subjects vs. 7.3% placebo-treated subjects) through Week 12 in the induction studies (UC1 and UC3). Respiratory tract infections included COVID-19, influenza, nasopharyngitis, respiratory tract infection, upper respiratory tract infection, and viral respiratory tract infection. Adverse reactions that occurred in ≥3% of subjects treated with TREMFYA and at a higher rate than placebo through Week 44 in the maintenance study (UC2) are shown in Table 2.

Table 2: Adverse Reactions Occurring in ≥3% of Subjects through Week 44 in UC2

	TREMFYA[a] 100 mg Subcutaneous Injection N=186 n (%)	TREMFYA[a] 200 mg Subcutaneous Injection N=190 n (%)	Placebo N=192 n (%)
Injection site reactions[b]	2 (1.1)	17 (8.9)[c]	2 (1)
Arthralgia	8 (4.3)	15 (7.9)	13 (6.8)
Upper respiratory tract infection	6 (3.2)	13 (6.8)	8 (4.2)

[a] Subjects receiving TREMFYA 100 mg at Week 16 and every 8 weeks thereafter or TREMFYA 200 mg at Week 12 and every 4 weeks thereafter.
[b] Injection site reactions include administration site pain, injection site hematoma, injection site hemorrhage, injection site hypersensitivity, injection site erythema, injection site pain, injection site pruritus, injection site rash, injection site reaction, and injection site urticaria.
[c] TREMFYA 200 mg was administered as two 100 mg injections.

Postmarketing Experience The following adverse reactions have been reported during post-approval of TREMFYA. Because these reactions are reported voluntarily from a population of uncertain size, it is not always possible to reliably estimate their frequency or establish a causal relationship to TREMFYA exposure. *Immune system disorders:* Hypersensitivity, including anaphylaxis *[see Warnings and Precautions] Skin and subcutaneous tissue disorders:* Rash *[see Warnings and Precautions]* **DRUG INTERACTIONS: CYP450 Substrates** The formation of CYP450 enzymes can be altered by increased levels of certain cytokines (e.g., IL-1, IL-6, IL-10, TNFα, interferon) during chronic inflammation. Results from an exploratory drug-drug interaction study in subjects with moderate-to-severe plaque psoriasis suggested a low potential for clinically relevant drug interactions for drugs metabolized by CYP3A4, CYP2C9, CYP2C19 and CYP1A2 but the interaction potential cannot be ruled out for drugs metabolized by CYP2D6. However, the results were highly variable because of the limited number of subjects in the study. Upon initiation of TREMFYA in patients who are receiving concomitant CYP450 substrates, particularly those with a narrow therapeutic index, consider monitoring for therapeutic effect or drug concentration and consider dosage adjustment as needed *[see Clinical Pharmacology (12.3) in Full Prescribing Information]*. **USE IN SPECIFIC POPULATIONS: Pregnancy** Pregnancy Exposure Registry There is a pregnancy registry that monitors pregnancy outcomes in women exposed to TREMFYA during pregnancy. Patients should be encouraged to enroll in the registry by visiting www.mothertobaby.org/ongoing-study/tremfya-guselkumab, by calling 1-877-311-8972, or emailing MotherToBaby@health.ucsd.edu. Risk Summary Available data from literature, post-marketing reports, and ongoing pregnancy registry with TREMFYA use in pregnant women are insufficient to establish a drug-associated risk of major birth defects, miscarriage or other adverse maternal or fetal outcomes. Human IgG antibodies are known to cross the placental barrier; therefore, TREMFYA may be transmitted from the mother to the developing fetus. In a combined embryofetal development and pre- and post-natal development study, no adverse developmental effects were observed in infants born to pregnant monkeys after subcutaneous administration of guselkumab during organogenesis through parturition at doses up to 18 times the exposure (AUC) in humans administered 200 mg intravenously and 32 times the exposure (AUC) to the 200 mg dose given subcutaneously. Neonatal deaths in monkeys were observed at 4 to 18 times the exposure (AUC) in humans administered 200 mg intravenously and 7 to 32 times the exposure (AUC) to the 200 mg dose given subcutaneously *(see Data)*. The clinical significance of these nonclinical findings is unknown. All pregnancies have a background risk of birth defect, loss, or other adverse outcomes. 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 *Disease-Associated Maternal and Embryo/Fetal Risk* Published data suggest that the risk of adverse pregnancy outcomes in women with inflammatory bowel disease (IBD) is associated with increased disease activity. Adverse pregnancy outcomes include preterm delivery (before 37 weeks gestation), low birth weight (less than 2500 g) infants, and small for gestational age at birth. Data *Animal Data* In a combined embryofetal development and pre- and post-natal development study, pregnant cynomolgus monkeys were administered weekly subcutaneous doses of guselkumab from the beginning of organogenesis to parturition at a dose (50 mg/kg) resulting in exposures (AUC) 18 times the exposure in humans administered 200 mg intravenously and 32 times the human exposure at 200 mg given subcutaneously. Neonatal deaths occurred in the offspring of one control monkey, three monkeys administered guselkumab at 10 mg/kg/week (4 times the exposure (AUC) in humans administered 200 mg intravenously and 7 times the exposure (AUC) at 200 mg given subcutaneously) and three monkeys administered guselkumab at 50 mg/kg/week (18 times the exposure (AUC) in humans administered 200 mg intravenously and 32 times the exposure (AUC) following a 200 mg subcutaneous dose). The clinical significance of these findings is unknown. No guselkumab-related effects on functional or immunological development were observed in the infants from birth through 6 months of age. **Lactation** Risk Summary There are no data on the presence of guselkumab in human milk, the effects on the breastfed infant, or the effects on milk production. Guselkumab was not detected in the milk of lactating cynomolgus monkeys. Endogenous maternal IgG and monoclonal antibodies are transferred into human milk. The effects of local gastrointestinal exposure and the extent of systemic exposure in the breastfed infant to guselkumab are unknown. The developmental and health benefits of breastfeeding should be considered along with the mother's clinical need for TREMFYA and any potential adverse effects on the breastfed infant from TREMFYA or from the underlying maternal condition. **Pediatric Use** The safety and efficacy of TREMFYA in pediatric patients (less than 18 years of age) have not been established. **Geriatric Use** Of the 4303 subjects with plaque psoriasis, psoriatic arthritis, or ulcerative colitis exposed to TREMFYA, a total of 240 subjects were 65 years or older, and 23 subjects were 75 years or older. Clinical studies of TREMFYA, within each indication, did not include sufficient numbers of subjects 65 years of age and older to determine whether they respond differently from younger adult subjects. No clinically meaningful differences in the pharmacokinetics of guselkumab were observed based on age *[see Clinical Pharmacology (12.3) in Full Prescribing Information]*. **PATIENT COUNSELING INFORMATION:** Advise the patient and/or caregiver to read the FDA-approved patient labeling *(Medication Guide and Instructions for Use)* before starting TREMFYA therapy, and each time the prescription is renewed, as there may be new information they need to know. Hypersensitivity Reactions Advise patients to discontinue TREMFYA and seek immediate medical attention if they experience any symptoms of serious hypersensitivity reactions *[see Warnings and Precautions]*. Infections Instruct patients of the importance of communicating any history of infections to the healthcare provider and contacting their healthcare provider if they develop any symptoms of an infection *[see Warnings and Precautions]*. Immunizations Advise patients treated with TREMFYA to avoid use of live vaccines *[see Warnings and Precautions]*. Instruction on Injection Technique Instruct patients or caregivers to perform the first self-injection under the supervision and guidance of a qualified healthcare professional for proper training in subcutaneous injection technique. Instruct patients who are self-administering to inject the full dose of TREMFYA/TREMFYA PEN *[see Medication Guide and Instructions for Use]*. Instruct patients or caregivers in the technique of proper needle and syringe disposal. Needles and syringes should be disposed of in a puncture-resistant container. Advise patients and caregivers not to reuse needles or syringes. Remind patients if they forget to take their dose of TREMFYA/TREMFYA PEN to inject their dose as soon as they remember. They should then take their next dose at the appropriate scheduled time. Pregnancy Advise patients that there is a pregnancy registry that monitors pregnancy outcomes in patients exposed to TREMFYA during pregnancy *[see Use in Specific Populations]*.

Manufactured by:
Janssen Biotech, Inc.
Horsham, PA 19044, USA
US License No. 1864

For patent information: www.janssenpatents.com

cp-82994v6

HAPPENING TODAY

How to attain the gold standard in laser treatments

Preparation and precision are key for proper post-laser care.

Gabriela Maloney, DO, FAAD, a dermatologist with Forefront Dermatology in Brookfield and Oconomowoc, Wisconsin

U026 – The Do's and Don'ts of Fractionated Resurfacing Laser
3:30-4:30 p.m | Friday, March 7
Location: W314B

Fractionated resurfacing laser remains the gold standard for treating wrinkles, scars, and other textural irregularities. If performed correctly and safely, it can be life-changing for patients.

Yet, there's more to know about this approach, including how to identify disease candidates and prevent potential complications. All that and more will be the focus of today's session, **U026 – The Do's and Don'ts of Fractionated Resurfacing Laser.**

"The primary goal of fractionated resurfacing lasers is to rejuvenate the skin by creating controlled microthermal zones of injury, stimulating the body's natural healing process," said session director Gabriela Maloney, DO, FAAD, a dermatologist with Forefront Dermatology in Brookfield and Oconomowoc, Wisconsin. "This approach promotes collagen remodeling and regeneration while leaving surrounding tissue intact, which accelerates healing and minimizes downtime."

Fractionated lasers debuted in 2000 as an evolution of traditional ablative CO_2 laser technology. They can also correct pigmentation irregularities, such as sunspots, melasma, and post-inflammatory hyperpigmentation, while enhancing overall skin tone and radiance.

According to Dr. Maloney, these lasers are widely used for scar revision, including acne scars, surgical scars, and stretch marks, as well as for mild skin tightening to address early signs of laxity. By offering a customizable balance between efficacy and recovery time, fractionated resurfacing lasers provide patients with noticeable, long-lasting improvements in skin health and appearance, she said.

"By offering a customizable balance between efficacy and recovery time, fractionated resurfacing lasers provide patients with noticeable, long-lasting improvements in skin health and appearance."
– Dr. Maloney

Careful consideration

Despite all the attractive benefits, proper post-treatment care is essential, Dr. Maloney said. After CO_2 fractionated resurfacing, certain protocols ensure optimal healing and minimize complications.

First, dermatologists should emphasize with their patients the importance of a gentle skincare routine. For example, Dr. Maloney tells patients to cleanse with a mild, non-foaming cleanser and use sterile saline or diluted vinegar soaks to reduce inflammation, soothe the skin, and prevent infection.

Applying a thick occlusive, such as petroleum jelly or a specialized post-procedure balm, is critical to maintain a moist wound-healing environment, which accelerates recovery and reduces scarring risks. Likewise, sun protection is paramount, she said.

"Advise patients to avoid direct sunlight, wear broad-spectrum sunscreen (SPF 30+), and use physical barriers like wide-brimmed hats once the skin barrier has healed," said Dr. Maloney. "To reduce redness and swelling, recommend using cool compresses or an over-the-counter hydrocortisone cream sparingly, if approved. Oral antihistamines may also help alleviate itching during the recovery phase. Hydration and avoiding smoking will further support collagen remodeling and overall healing."

Follow-up appointments are necessary to monitor progress, address concerns, and guide the reintroduction of active skin care products like retinoids or acids, usually after four to six weeks, she said. For patients who have higher Fitzpatrick types or a history of post-inflammatory hyperpigmentation, Dr. Maloney said dermatologists should consider prophylactic topical agents, like hydroquinone or a mild steroid, during the recovery phase.

Setting realistic expectations and providing clear, detailed instructions can greatly enhance patient satisfaction and safety following CO_2 fractionated resurfacing.

RECOVERY TIPS:

- **Cleanse with a mild, non-foaming cleanser.**
- **Use sterile saline or diluted vinegar soaks.**
- **Apply a thick occlusive, such as petroleum jelly or a specialized post-procedure balm.**
- **Avoid direct sunlight/ use sun protection.**

Pitfall potential

To detect potential pitfalls and reverse complications, Dr. Maloney said it's crucial for dermatologists to thoroughly evaluate the following before initiating treatment:

- patients' medical history
- skin type
- lifestyle factor

Understanding the patient's Fitzpatrick skin type is essential as well, she said, as darker skin tones are more prone to post-inflammatory hyperpigmentation (PIH).

Dermatologists should also consider previous treatments and procedures, as these may influence skin sensitivity and healing capacity. During the procedure, Dr. Maloney recommends using conservative settings, especially for higher-risk patients, and adhering to evidence-based protocols to prevent complications such as burns, scarring, or delayed healing.

A detailed pre-procedure consultation should screen for:

- contraindications, such as active infections
- autoimmune conditions
- recent use of isotretinoin, which can impair healing

Formulating effective prevention and treatment strategies requires proactive measures, she said. This includes prescribing antiviral prophylaxis for laser resurfacing patients with a history of herpes simplex and recommending sunscreen and topical depigmenting agents (e.g., hydroquinone) for PIH-prone individuals. After a procedure, regular follow-up visits allow for early detection of complications such as infections, erythema, or hypertrophic scarring.

Changing course

In the event of reversal, Dr. Maloney said prompt interventions tailored to the complication are essential. For example, she recommends treating PIH with topical retinoids or chemical peels, addressing erythema with pulsed-dye lasers, or managing infections with appropriate antibiotics.

"Ultimately, clear communication and individualized care plans help dermatologists navigate complications effectively, ensuring both patient safety and satisfaction," said Dr. Maloney.

Reversal treatment recommendations

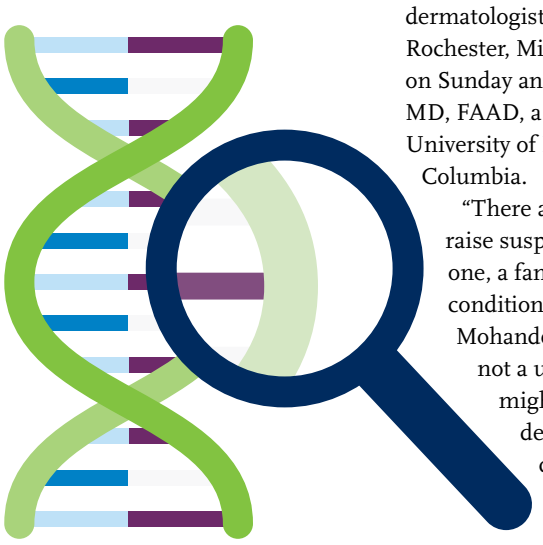
- **PIH** → Retinoids or chemical peels
- **Erythema** → Pulsed-dye lasers
- **Infections** → Antibiotics

Learning to read the clues

New session examines genodermatoses-related disorders in children and adults.

Nessa Aghazadeh Mohandesi, MD, FAAD, pediatric dermatologist at the Mayo Clinic in Rochester, Minnesota

U069 – What's New in Genetic Skin Disease?
8-9 a.m. | Sunday, March 9
Location: W304A



Myriad patient outcomes result from the challenge of diagnosing and treating a wide range of genodermatoses-related disorders in children and adults. Understanding how to spot the signs is important in overcoming and treating this common challenge.

In this new session, **U069 – What's New in Genetic Skin Disease?**, Nessa Aghazadeh Mohandesi, MD, FAAD, will share her expertise of when and how to recognize genetic skin diseases in both populations, while offering tools and insights for clinical practice.

Dr. Mohandesi, who is a pediatric dermatologist at the Mayo Clinic in Rochester, Minnesota, will lead the session on Sunday and be joined by Jonathan A. Dyer, MD, FAAD, a professor of dermatology at the University of Missouri School of Medicine in Columbia.

"There are several factors that should raise suspicion in clinical practice. For one, a family history of skin-related conditions is often the first clue," said Dr. Mohandesi. "Although common, this is not a universal finding, as a person might have a new or de novo variant, depending on the particular disease."

Another important clue is chronic, otherwise unexplained, or difficult-to-treat skin manifestations or a constellation of cutaneous, ectodermal, or systemic findings, she said. Those can include, but are not limited to, skin fragility or blisters, pigmentation abnormalities, unusual scarring, diffuse scaling, skin thickening, erythroderma, chronic non-healing wounds, recurrent skin infections, and hair/nail disorders, among others.

Still, another important clue is the consideration of monogenic or "syndromic" forms of common inflammatory diseases such as psoriasis or hidradenitis suppurativa, which are more widely recognized, Dr. Mohandesi said.

"I'd like to emphasize that, although we typically think of genetic skin diseases having an early or childhood onset, a significant portion of these conditions are diagnosed in adulthood, as many genetic disorders don't show symptoms until much later in life," she said. "Classic examples include Darier disease or Hailey-Hailey disease, which often have an adolescence onset, or hereditary disorders with an increased risk of cancer, which often don't manifest until later decades of life."

Hard at work

Spotting genetic skin diseases in children and adults is only half the challenge; treatment is the other half of the equation. Over the past decade, there have been significant breakthroughs that have transformed the diagnosis and treatment of genetic skin diseases. On the diagnostic side, next-generation sequencing (NGS) and whole exome/genome sequencing (WES/WGS) have made genetic testing faster, more accurate, and more affordable. This is particularly important for rare genetic skin diseases, and dermatologists are hopeful that these tests will become even more affordable and accessible in the future.

"Although we typically think of genetic skin diseases having an early or childhood onset, a significant portion of these conditions are diagnosed in adulthood, as many genetic disorders don't show symptoms until much later in life." – Dr. Mohandesi

Advances in patient databases and registries have also played a crucial role, Dr. Mohandesi said. The natural history of many genetic skin diseases, such as various types of epidermolysis bullosa (EB) and different subtypes of ichthyosis, is becoming better understood through a combination of more accurate genetic testing and longitudinal, multi-institutional cohorts. This progress is helping to improve disease management by providing better screening protocols and guidelines.

Additionally, she said the spectrum of hereditary cancers, particularly hereditary skin cancer syndromes, is expanding with improved diagnostics, which allows for earlier detection and better preventive measures for affected patients and their families.

Another exciting advancement is our growing understanding of the pathophysiologic and molecular pathways involved in genetic skin diseases, said Dr. Mohandesi.

"For the first time, we are now able to offer treatments for conditions that were once considered 'non-curable,'" she said. "This is a fascinating development for both patients and physicians."

Much to show

One of the most notable advancements has been the FDA approval of beremagene geperpavec (Vyjuvek®), a genetically modified herpes simplex virus (HSV-1) that delivers normal copies of the COL7A1 gene to the skin for treatment of dystrophic EB. The approval of beremagene geperpavec and birch triterpenes (Filsuvez®) for dystrophic and junctional EB marks a major milestone, as they are the first FDA-approved medications for patients six months of age and older who suffer from these painful, devastating genetic conditions.

Additionally, Dr. Mohandesi said more biologic and targeted therapies are being used in a range of genetic skin disorders. Medications such as dupilumab, IL-17/23 inhibitors, epidermal growth factor inhibitors, and JAK inhibitors are being used in management of various types of ichthyoses, Netherton syndrome, and palmoplantar keratoderma, among others. By targeting the underlying immune response, she said these therapies are offering better control over symptoms and significantly improving patients' quality of life.

More to come

Finally, according to Dr Mohandesi, there are multiple targeted treatments currently in research or on the horizon for conditions such as EB, ichthyosis, Netherton syndrome, pachyonychia congenita, ectodermal dysplasia, and others. Exciting advancements are also happening using artificial intelligence (AI) in genetic skin diseases and genome editing technologies like CRISPR-Cas9, which are showing promise in the near future for treating genetic skin diseases.

Dr. Mohandesi said the upcoming session is designed for a general dermatology audience and will provide attendees with real-world examples from both children and adults. It will also underscore the importance of pinpointing the exact genetic cause of a condition to clarify the diagnoses and pave the way for transformative, life-changing treatments.

"For many years, genetic skin diseases have often been seen as incurable, with genetic diagnoses considered 'good to know' but not particularly useful when it comes to treatment or management," she said. "This perception has sometimes led to a sense of therapeutic frustration, where physicians feel limited in how much they can truly help these patients.

Fortunately, advancements in genetic research and new treatment developments are beginning to change this outlook." ●

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American Academy
of Dermatology |Association
9500 W. Bryn Mawr Ave.
Rosemont, IL 60018-5216
Phone (847) 330-0230
Fax (847) 330-0050
www.aad.org

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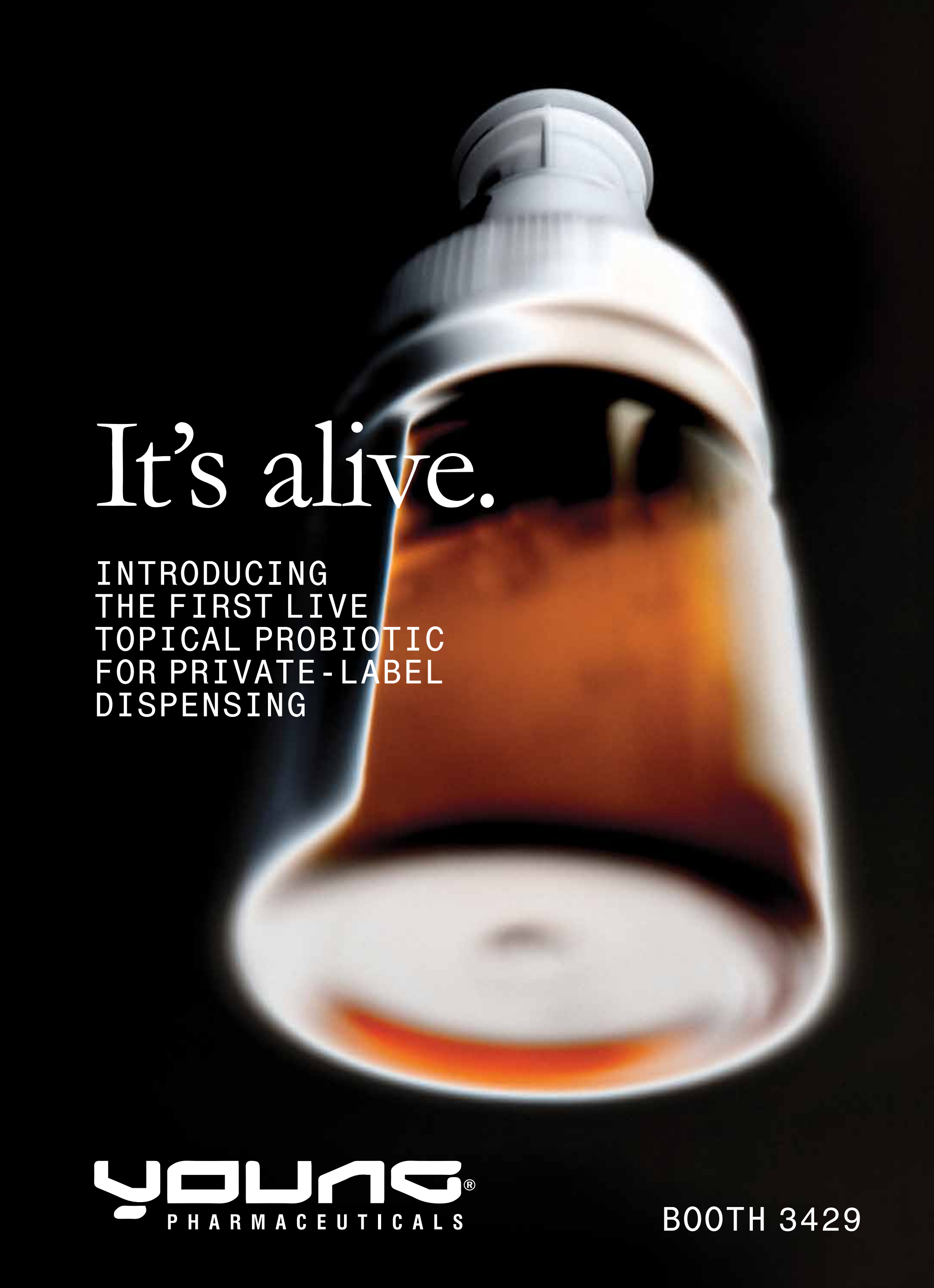
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