DermWorld meeting news

Saturday • March 8, 2025

A Publication of the American Academy of Dermatology | Association

See Exhibit Hall floor plan and exhibitor listing. **PAGES 10-12**

Daylight Saving Time (DST) begins tomorrow! Turn your clocks forward an hour tonight.

Late-Breaking in Orlando

S028 – Late-Breaking Research: Session 1
9 a.m.-noon | Saturday, March 8
Location: Chapin Theater

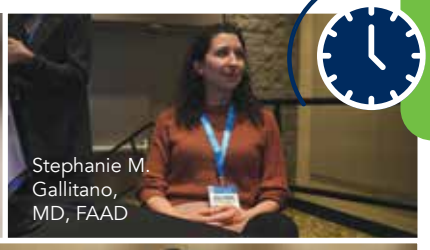
S040 – Late-Breaking Research: Session 2
1-4 p.m. | Saturday, March 8
Location: Chapin Theater

Late-breaking research presentations will reveal new data, discoveries, and developments across dermatology.

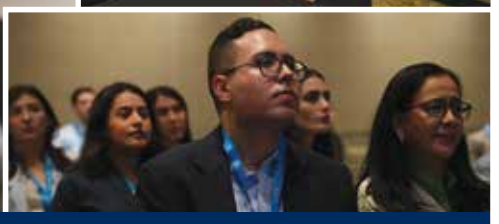
In today's two **Late-Breaking Research** sessions, be the first to hear investigators present their groundbreaking, unpublished scientific findings. The top-scoring abstracts will highlight the latest trial results and innovative industry advancements from across the specialty.

Hensin Tsao, MD, PhD, FAAD, associate professor of dermatology at Harvard Medical School, will moderate both sessions and help attendees translate the research into practical applications. Dr. Tsao and the presenters will also address conclusions and next steps, as well as the impact these findings will have on the future of dermatologic diagnoses, treatment, and/or disease management. ●

Melodi Javid Whitley, MD, PhD, FAAD



Stephanie M. Gallitano, MD, FAAD



The organs and the skin

Immunosuppressant treatments can lead to cutaneous skin concerns in transplant patients.

Organ transplants are becoming more common each year as surgical technology advances and contemporary immunosuppression regimens lead to longer life expectations for patients. Dermatologists are key players in managing the cutaneous complications that can arise from immunosuppressive medications.

In Friday's session, **U009 – Opportunistic Infections and Drug Rashes Oh My – Managing the Cutaneous Complications of Solid Organ Transplantation**, Melodi Javid Whitley, MD, PhD, FAAD, said dermatologists should learn about these new immunosuppressive treatments.

Specifically, the past 10 to 15 years have seen the approval of two different classes of immunosuppressants for organ transplant recipients: mTOR inhibitors (everolimus and sirolimus) and the CTLA-4 analogue belatacept. Even though they are not as commonly used as traditional immunosuppressants, Dr. Whitley said dermatologists should be on the lookout for potential adverse events.

"One of the major side effects of mTOR inhibitors that is especially relevant to dermatologists is poor wound healing," she said. "Dermatologists should be aware of this and discuss potential drug holidays or alternatives with their transplant physician colleagues when planning surgical procedures for their patients."

Dr. Whitley, who is assistant professor of dermatology at Duke University School of Medicine in Durham, North Carolina, said she commonly sees acne and folliculitis among patients on mTOR inhibitors.

"Belatacept seems to be quite well tolerated, however there have been some cutaneous side effects reported," she said. "These patients will benefit from expert care from a board-certified dermatologist."

Common cutaneous triggers

Stephanie M. Gallitano, MD, FAAD, director of yesterday's session, said there are opportunistic cutaneous infections that are overrepresented in the solid organ transplant community for several reasons, including decreased cell-mediated immunity among this patient group.

"Cell-mediated immunity is essential for recognizing and targeting viruses. Common viral infections, such as human papillomavirus (HPV) and molluscum contagiosum, are overrepresented in these patient populations due to their impaired immune response," she said.

Dr. Gallitano, who is assistant professor of clinical dermatology at Columbia University Irving Medical Center in New York City, said HPV infections such as common warts and genital warts can become extensive and recalcitrant. They can also potentially play a role in the development of skin cancers.

"Up to 80% of keratinocyte carcinomas in transplanted patients have HPV DNA, suggesting a role in the development of keratinocyte carcinomas," she said. "Beta-HPV subtypes can cause acquired epidermodysplasia verruciformis in solid organ transplant recipients. These cutaneous lesions may progress to squamous cell carcinoma."

Human polyomaviruses may also trigger cutaneous infections in solid organ transplant patients. Dr. Gallitano said trichodysplasia spinulosa virus and human polyomaviruses 6, 7, and 9 can all cause cutaneous infections.

"These viruses are detected with no clinical disease on healthy skin but may cause pathologic disease in [organ transplant patients]," she said. "Additionally, patients with immunosuppression are at greater risk of developing reactivation of human herpes virus infections, including varicella zoster and herpes simplex viral infections."

Ultimately, Dr. Gallitano said the key to diagnosing and treating these infections is high clinical index of suspicion and appropriate testing.

"Patients can be diagnosed with skin biopsies that demonstrate characteristic features," she said. "Trichodysplasia spinulosa virus and human polyomavirus 6 and 7 can also be detected through Karius testing, which is a blood test using next generation sequencing to detect and identify pathogens in the blood stream. VSV and HSV can be detected by routine viral polymerase chain reaction (PCR) tests." ●

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 2025 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.

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Easily vote using the personalized voting link beginning March 8.

Eligible voting members can easily vote using their personalized voting link starting March 8. Watch your email inbox for voting reminders that include this link. Members can access the AAD Election Connection at **aad.org/election** to view/print the election ballot book and learn more about the candidates. The AAD election closes March 22, 2025.

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

The eyes have it — and so do the face and neck

During Friday's interactive session **C001 – Live Demonstration: The State of the Art of Aesthetic Dermatology**, attendees watched experts from around the country demonstrate cosmetic procedures, such as FDA-approved fillers, neuromodulators, deoxycholic acid, chemical peels, and microneedling. Physicians treated patients in real time while discussing the procedures. The popular session, led by Seth L. Matarasso, MD, FAAD, featured more than a dozen skilled physicians demonstrating the fine art of cosmetic procedures.

Transforming melasma care

International leaders provide fresh perspectives and tailored approaches.

U035 – Melasma in Skin of Colour: 2025 Update
7:30-8:30 a.m. | Saturday, March 8
Location: W308A

People of all ages, races, ethnicities, and skin types can be born with or develop dermatologic diseases. But certain conditions impact populations with primarily darker skin pigmentation in significantly different ways.

This morning's session, **U035 – Melasma in Skin of Colour: 2025 Update**, returns with important, timely developments on the diagnosis, treatment, and management of the multifaceted ailment.

Session director Mukta Sachdev, MD, IFAAD, will lead the discussion alongside Andrew F. Alexis, MD, MPH, FAAD, and Kavita Mariwalla, MD, FAAD, providing a comprehensive overview and in-depth assessment of key updates, recent trends, and new strategies.

Mukta Sachdev, MD, IFAAD, head of dermatology at Manipal Hospital Bangalore and medical director of MS Skin Centre and MS Clinical Research in Bangalore, India

"Melasma is disproportionately common in individuals with skin of color, often leading to significant psychosocial and quality-of-life impacts," said Dr. Sachdev, who heads the department of dermatology at Manipal Hospital Bangalore and is medical director of MS Skin Centre and MS Clinical Research in Bangalore, India. She is a skin of color expert and global key opinion leader.

This enhanced burden on patients with higher melanin levels requires sensitivity and swift action on the part of dermatologists.

A progressing methodology

As scientific discoveries produce emerging clinical options for patients with melasma, dermatologists should remain open to new lines of thinking and bespoke strategies, said Dr. Sachdev.

"Over time, the dermatologic approach to melasma has shifted from one-size-fits-all treatments to a more tailored approach, emphasizing certain considerations," she said.

Contemplate Dr. Sachdev's suggestions to help formulate or adapt your own treatment plan.

Recognize triggers and disease chronicity, including hormonal, genetic, and environmental factors, as well as the likelihood of relapse.

Focus on skin barrier function, and understand the importance of reducing irritation and inflammation, especially in patients with skin of color.

Combine therapies or choose multimodal treatments, ranging from topical agents and oral medications to non-invasive procedures like microneedling and lasers.

Employ cultural and psychosocial empathy, paying greater attention to patients' individual needs, lifestyle practices, and aesthetic goals.

Putting it into practice

Once a personalized treatment plan is established, it's ready to be deployed and used when treating patients with melasma. Dermatologists should be ready to fine-tune their comprehensive approach as new evidence-based research and best practices are announced.

Dr. Sachdev said doctors should apply ongoing analysis to integrate medications and procedures to achieve synergistic outcomes. It's also important to remember that upon diagnoses, patients need to be educated or counseled on their disorder, such as how to achieve adherence, protect their skin from the sun, and avoid lifestyle and environmental triggers.

> "Managing melasma in these populations requires nuanced approaches to avoid exacerbating pigmentation or triggering post-inflammatory hyperpigmentation. New research and treatments are continually evolving, requiring dermatologists to stay updated on the latest evidence-based practices."
>
> *– Mukta Sachdev, MD, IFAAD*

Etiology of melasma

Dr. Sachdev said recent advancements have helped doctors better understand the pathophysiology of melasma and be able to recognize its contributing factors, common triggers, and preventable approaches. These dermatology-focused recommendations emphasize the importance of prevention, patient education, and a customized approach for managing melasma triggers.

Leading causations and risk factors:

Hormonal influences: Elevated levels of estrogen and progesterone, such as during pregnancy or with oral contraceptive use, can stimulate melanocytes, leading to increased melanin production.

Vascular abnormalities: Increased dermal blood vessels and elevated expression of vascular endothelial growth factor (VEGF) have been observed in affected skin, suggesting that vascular changes may promote melanogenesis. This factor is gaining a lot of focus from an etiological and management perspective.

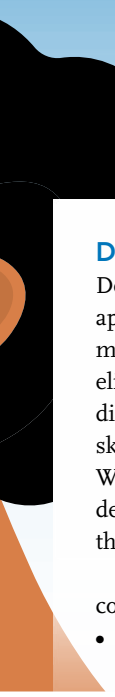
Skin type: Melasma is more prevalent in individuals with Fitzpatrick skin types III, IV, and V, which are common among people of African, Asian, and Hispanic descent.

Genetic predisposition: A significant number of individuals with melasma report a family history of the condition, indicating a genetic component.

Illumination damage: Researchers are examining the relationship among UV radiation, visible light, and infrared radiation to determine any correlation responsible for exacerbating melasma.

Avoidances:

- UV radiation/sun exposure
- Heat exposure and infrared radiation
- Oral contraceptives and hormone therapy
- Photosensitizing agents, like certain medications and topical ointments
- Cosmetic or dermatologic irritants
- Skin barrier disruption
- Hair removal methods



Determination of diagnosis

Dermatologists should perform appropriate assessments for facial melanosis differential diagnoses and eliminate related hyperpigmentary disorders that are prevalent in patients with skin of color. Tools, such as dermoscopy, Wood's lamp, and digital imaging, help determine depth, severity, and chronicity of the condition.

Examine patients for the presence of concerning physical signs, such as:

- **Symmetrical hyperpigmented patches:** Melasma typically presents as brown to gray-brown patches on sun-exposed areas of the face, such as the cheeks, forehead, upper lip, and nose. These patches are usually symmetrical, appearing on both sides of the face.
- **Color variations:** The pigmentation can vary from light to dark brown and may sometimes appear bluish gray, especially in individuals with darker skin tones.
- **Histological features:** This includes 1) epidermal type, characterized by increased melanin in the basal and suprabasal layers of the epidermis; 2) dermal type, identified by the presence of melanophages (melanin-laden macrophages) in the dermis; and 3) mixed type, combination of both epidermal and dermal types. Studies have reported that mixed-type melasma is more common among individuals with skin of color, with prevalence rates around 50–60%.

Medical management

Triple combination therapies are proven, including the trifecta of hydroquinone, retinoids, and corticosteroids. According to Dr. Sachdev, combination drug strategies reduce relapse rates by up to 30%. For melasma maintenance, she suggests a non-hydroquinone alternative, such as cysteamine, azelaic acid, or tranexamic acid (TXA).

Recent studies have found that off-label oral treatments of TXA can improve refractory melasma by roughly 50%.

Procedural management

Further evidence shows that Melasma Area and Severity Index (MASI) scores improve by 60-70% with combined medical and procedural interventions.

Patients with stubborn and/or chronic melasma may also benefit from laser treatments and chemical peels with agents like glycolic acid or mandelic acid. Several laser and light-based therapies have been customized for skin of color, including low-influence Q-switched Nd:YAG lasers and pico lasers. These options deliver less energy and gently target deep pigmentation without causing major surface damage.

Dr. Sachdev also stresses the importance of proper post-procedural care to minimize post-inflammatory hyperpigmentation or other complications, like persistent erythema, hypertrophic scarring, and keloid formation, which is more prevalent in darker skins. ●

A peek behind the Plenary

Plenary
9 a.m.-noon
Sunday, March 8
Location: Chapin Theater

Tomorrow's Plenary session begins with the Annual Business Meeting and continues through the morning with an impressive lineup of dermatology experts and industry leaders. *DermWorld Meeting News* got a glimpse at each speaker's prepared remarks.

Four individuals will accept awards and give lecture presentations on exciting clinical topics.

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, executive medical director at the University of Iowa Ambulatory Clinics

"It is a tremendous honor to receive the Clarence Livingood Award and Lectureship and an incredible privilege to work in this profession. As physicians navigate increasing financial payment pressures, administrative burdens, and burnout, we need to convey and convince policymakers with a compelling story. There are many threats to the patient-physician relationship, and we need both advocacy and leadership to impact change. I will also discuss how the medical educational system has trained us all to doubt ourselves and fear the act of vulnerability, which has contributed to loneliness and burnout in our profession."

Lila and Murray Gruber Memorial Cancer Research Award and Lectureship

"From Cell Atlases to Medicines With AI"

Aviv Regev, PhD, MSc, executive vice president and global head, Genentech Research and Early Development, Genentech/Roche

"As some of my cancer research has focused on better understanding melanoma, including metastatic melanoma and tumors that do not respond to promising treatments like immunotherapy, I am especially pleased to have the opportunity to deepen my connections to the dermatology community through this award and lecture. We are at a unique moment in time where multiple technologies — including high resolution massively parallel profiling and artificial intelligence/machine learning — are converging to make us much better at delivering new medicines to the patients who need them most, and I am excited to share more about this promising approach."

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, the Martin C. Mihm Jr., MD, and Shing-Yiu Yip Professor of Dermatology at Harvard Medical School, and vice chair for research, department of dermatology at Brigham and Women's Hospital in Boston

"Improving patient care is at the very center of [my team's] research efforts, and this recognition is therefore incredibly meaningful to me. Our patients are our best teachers — they show us how to live courageously with disease and their responses to therapy help us unravel the mysteries of human skin immunology."

John Kenney Jr., MD, Lifetime Achievement Award and Lectureship

"Vitiligo: A 45-Year Journey of Science and Service"

Pearl E. Grimes, MD, FAAD, director of the Vitiligo & Pigmentation Institute of Southern California, clinical professor of dermatology at UCLA, and president of the Global Vitiligo Foundation

"I have been involved in vitiligo research for 45 years. I was trained by Dr. Kenney, who was not only my mentor but a father figure as well. I view this award as a pinnacle of recognition of my life's work and my determination to advance the science of this disease. My objective is to share highlights of the history and rapidly evolving landscape of scientific advances regarding the pathogenesis and treatment of vitiligo."

Spring forward into DST tonight so you don't miss a minute!

Attendees will also hear from the outgoing and incoming leaders of the Academy to celebrate accomplishments and look forward to the future.

AAD President
Seemal R. Desai, MD, FAAD

"Serving as the president of the AAD this past year has been one of the greatest honors of my career. It has allowed me to witness firsthand the incredible dedication and passion that dermatologists bring to their work every day. My goal is to inspire and empower our members to embrace innovation and our continued advocacy, continue the advancement of our field, and enhance patient care by leveraging new technologies, research, and treatment options. I also want to focus on the importance of collaboration — both within the dermatology community and with other health care professionals — to achieve the best outcomes for our patients."

AAD President-Elect
Susan C. Taylor, MD, FAAD

"Recognizing the critical role dermatologists play in treating life-altering and life-threatening conditions, it is crucial that we continue to receive innovative and comprehensive support from the Academy. The Academy's ongoing commitment to expanding advocacy efforts and educational resources ensures that our members are equipped with cutting-edge knowledge, tools, and resources. This empowers dermatologists to effectively manage complex skin conditions, deliver exceptional patient care, and successfully run their practices."

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1. Bailey et al. *JCO PO*. 2023. 2. Jarell et al. *JAAD*. 2022. 3. Whitman et al. *JCO PO*. 2021. 4. Podlipnik et al. *Cancers*. 2024. 5. Gerami et al. *CCR*. 2015. 6. Ferris et al. *JAAD*. 2017. 7. Podlipnik et al. *JEADV*. 2019. 8. Gastman et al. *Head and Neck*. 2019. 9. Hsueh et al. *JCO PO*. 2021. 10. Arnot et al. *AJS*. 11. Only patients who had an SLNB performed from Whitman et al. *JCO PO*. 2021.

CASTLE BIOSCIENCES

Keeping all the balls in the air

Dermatologists who are also parents seek, and find, ways to manage it all successfully.

Being a parent is a full-time job. And when you have a full-time job on top of that — such as managing a dermatology practice — it can feel like you're juggling several balls while donning multiple hats. Finding the right balance for you is key to finding success and fulfillment both at home and at work.

Janelle Nassim, MD, FAAD, director of Friday's session, **U012 – Our Top Tips: Pearls From Our Practices and Parenthood**, has two children herself, so she knows a little something about managing the work-life balance. She said one of the solutions is to have support from those around you.

"Dermatology is an incredible career, and we are fortunate to work in a field with supportive colleagues who have walked this path before us," she said. "It's vital to share not only our successes but also our struggles and the strategies we've found for building fulfilling lives and careers."

Striking a balance

When her second child was born, Dr. Nassim, who is assistant professor and director of laser and cosmetic dermatology at Indiana University, said she experienced a postpartum coronary artery dissection, which led to a heart attack the week she returned to work. That experience dramatically altered her perspective as both a doctor and a mother.

"It is just as important to feel balanced and satisfied in life outside of medicine — and balancing it is not easy."
– Janelle Nassim, MD, FAAD

"It was a card I never expected to be dealt in life," she said. "Thanks to the gut instinct that so many of us moms have, and excellent medical care, I recovered and am doing well. But the experience brought a profound shift in perspective. Life is fragile, and everything can change in a moment."

One of the biggest lessons Dr. Nassim said she learned from the experience is that happiness and satisfaction in life cannot come from work alone.

"As physicians, we are conditioned to be achievement driven. In dermatology, we're fortunate to work in a field with such high career satisfaction, but fulfillment can't come solely from work," she said. "It is just as important to feel balanced and satisfied in life outside of medicine — and balancing it is not easy."

Finding support from your colleagues can go a long way toward achieving that balance. One way to do this, said Dr. Nassim, is using social media, which can make it easier to connect. But it does not always reflect the reality of what people are experiencing in their lives.

"Social media might show a highlight reel, but real life is messy and complicated and it's OK to lean on each other for support, advice, and solidarity," she said. "I've learned so much from colleagues who have shared their insights and experiences. After my health scare, I've become more passionate about seeking out and sharing the true luxuries of life: time, health, connection, and joy."

Making it work at work

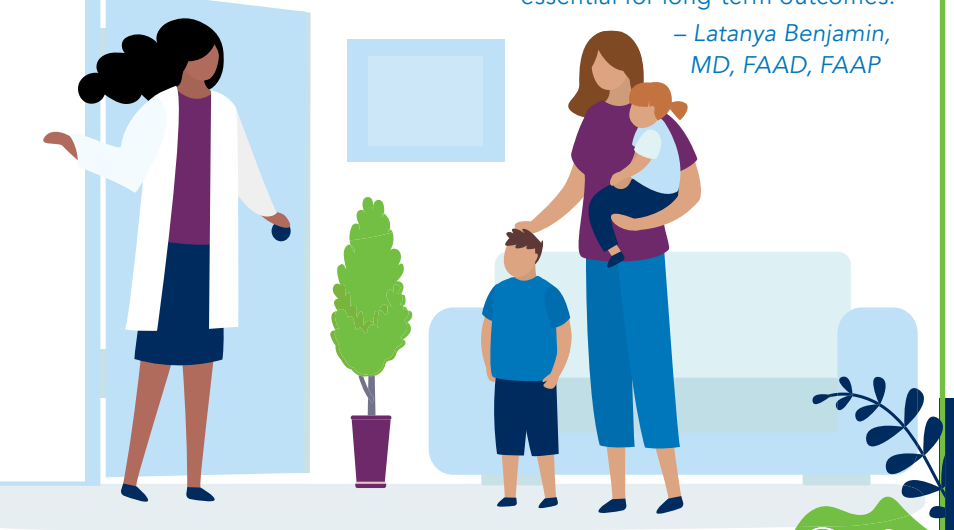
Latanya Benjamin, MD, FAAD, FAAP, president of the Women's Dermatologic Society (WDS), said it is important to have a meaningful community where physicians can connect with other supportive colleagues. Dr. Benjamin, who is also a solo private practice owner in Coral Springs, Florida, said it can be difficult managing a busy day in the clinic while wearing multiple hats.

"The demands are high and managing responsibilities efficiently is key," she said. "Staying organized, prioritizing tasks, and maintaining a healthful balance are the keys to making it all work. Ultimately, the goal is to provide the best cutting-edge medical care, even amid a demanding schedule, making for a truly gratifying day."

Dr. Benjamin said that one of her tricks to a successful work-life balance is learning to keep things running smoothly at work. And for her, that means making sure patients feel heard and driving compliance.

"One of my top tips revolves around communication — particularly the art of conveying treatment plans for patients of all ages," she said.

"As a pediatric dermatologist, I've found that my success rate stems from ensuring that my patients and caregivers leave the office with a clear understanding of their treatment, feeling empowered and hopeful. This approach not only strengthens the parent-patient-doctor relationship, but also enhances compliance, which is essential for long-term outcomes."
– Latanya Benjamin, MD, FAAD, FAAP



Bringing it home

Managing responsibilities at work is one thing, but balancing that work with parenthood is a challenge that is on the next level, especially for single mothers. Dr. Benjamin said combining self-care, home chores, and parenting in a fun way is key to making home life less overwhelming. She said it is important to integrate everything — whether it's making chores a family activity or finding creative ways to fit in self-care without feeling guilty.

"One of my key life hacks is creating a schedule in which you are not overbooking yourself," she said. "You need to know the real meaning of saying 'yes' and learn how to lean into your support system. When you lean into support, it makes everything much more manageable."

It may seem like you'd have to be a seasoned circus performer or even a superhero to make this all work, but Dr. Benjamin said to let go of that notion when you are tackling a new task or goal.

"Everything does not have to be perfect to start," she said. "Just make sure the first step you take is a meaningful one," she said. "Don't settle for just ticking off another easy, low-yield task on your to-do list. The first step should be something that truly moves the needle forward for you, lightens the emotional load, and makes a real impact."

In today's world, anxiety is on the rise and the pace of life has accelerated to the point where most people are constantly juggling multiple responsibilities. Dr. Benjamin said that's why finding balance between work and home is more critical than ever before.

"In such a fast-moving environment, balance becomes a necessary tool for preserving our well-being," she said. "We often feel like we don't have permission to pause, but it's vital to recognize that we need to take time to tend to our mental, physical, and emotional health — not just as another 'to-do' item, but as a way to sustain the kind of fulfilling and enjoyable life we all deserve." ●

Other presenters at the session included: Jennifer Lin, MD, FAAD; Sandy Tsao, MD, FAAD; Janelle Vega, MD, FAAD; and Fei-Shiuann Yang, MD, FAAD.

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.

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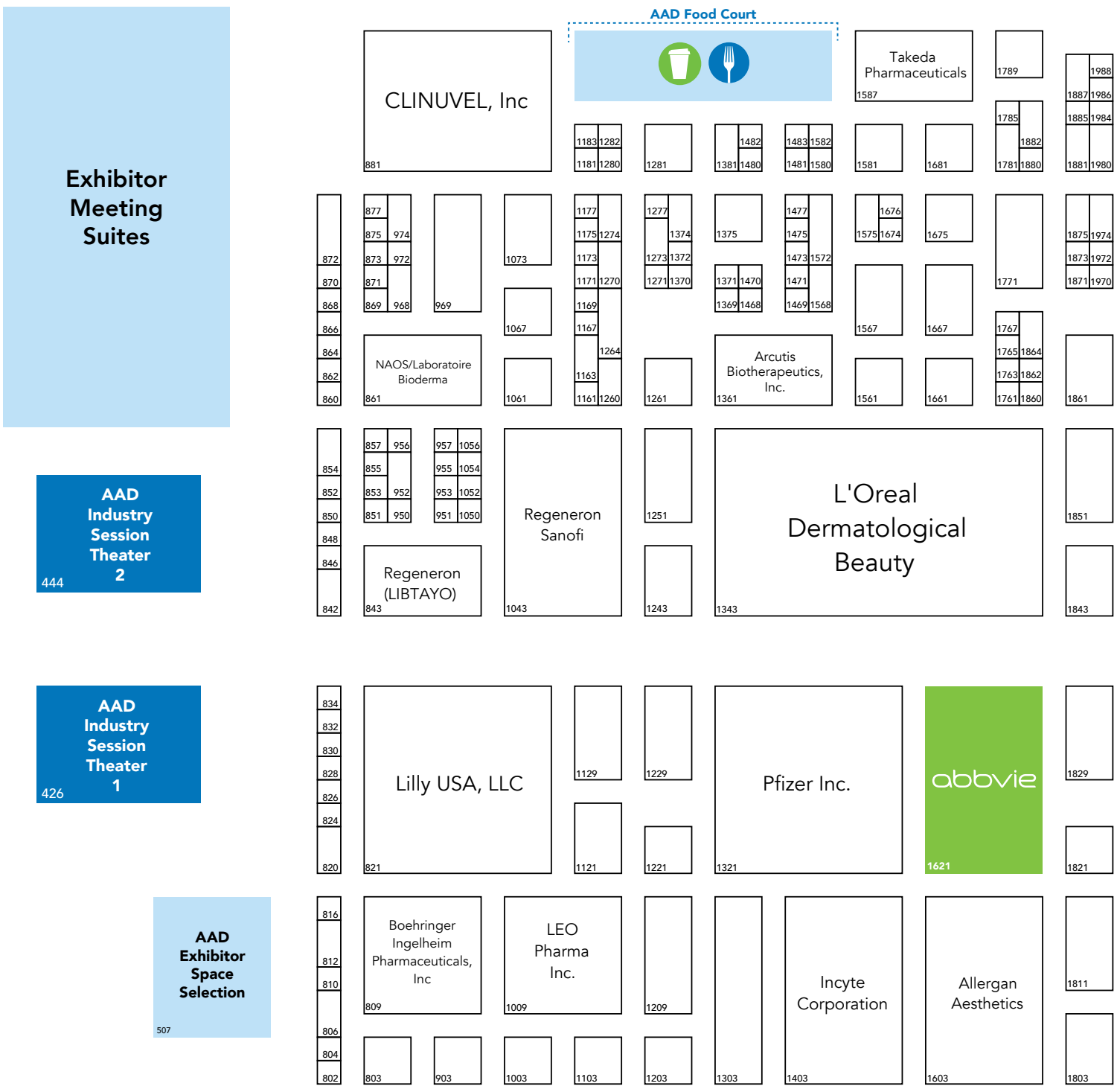

Exhibit Hall hours

10 a.m.-5 p.m. | Saturday, March 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

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!

HAPPENING TODAY

S027 – Residents and Fellows Symposium
9 a.m.-noon | Saturday, March 8
Location: W204C

Great research starts here

Attend today's Residents and Fellows Symposium to hear about the future from our future.

This morning, the Academy opens the floor to some of its youngest and brightest during the **S027 – Residents and Fellows Symposium**. Out of more than 100 applicants, 20 dermatology residents and fellows will be presenting research summaries on emerging concepts.

Cory A. Dunnick, MD, FAAD, will introduce the projects and presenters, who will each have eight minutes to share highlights and outcomes of their research. Topics range from DRESS syndrome, vitiligo, and pediatric atopic dermatitis to artificial intelligence (AI) and dermoscopy explainable intelligence (DEXI).

The symposium will conclude with a ceremony to recognize this year's Everett C. Fox Award winners for most outstanding clinical and basic science abstracts. The recipients, once announced, will split the $3,500 cash award. ●

The answer is...

Watch contestants compete to become Resident Jeopardy champion!

S038 – Resident Jeopardy
1-4 p.m. | Saturday, March 8
Location: W304A

All are welcome at this afternoon's **S038 – Resident Jeopardy**. Teams of dermatology residents will participate in the popular, interactive game show format, answering *Jeopardy*-style queries and image-based prompts that encompass the breadth of the specialty. The session will be led by Kassandra E. Holzem, MD, FAAD, and Lida Zheng, MD, FAAD.

Attendees can witness the 'mostly' friendly competition or join in the fun as they play along to put their own knowledge to the test. This perennially popular session is also a great chance to network with colleagues of all career levels from various institutions.

Come see who takes the trophy!

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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].*

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For patent information: www.janssenpatents.com

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New drugs mean new reactions

Knowledge of the side effects of new medications is a critical aspect of dermatologic care.

Adverse drug reactions are an inevitable part of any medical profession, and dermatology is no exception. Cutaneous eruptions are among the most common responses, especially with some of the newer drugs.

These eruptions — and how to treat them — were the focus of Friday's session, **F021 – New Drugs, New Rashes: An Update on Cutaneous Drug Eruptions**, led by Susan Burgin, MD, FAAD, associate professor of dermatology at Brigham and Women's Hospital in Boston.

Session director Susan Burgin, MD, FAAD

Cancer

New and emerging treatments for cancer — including chemotherapies, targeted therapies, and immunotherapy — can often produce cutaneous side effects such as rashes. Connie Shi, MD, FAAD, said one such drug is amivantamab, a monoclonal antibody targeting epidermal growth factor receptor (EGFR) and mesenchymal–epithelial transition factor (MET) that is currently used in the treatment of non-small cell lung cancer.

"EGFR inhibitors have been in use for decades and are known to be associated with acneiform rash, paronychia and nail toxicities, xerosis, and oral mucositis, among others. But amivantamab appears to have a higher prevalence of scalp toxicities, including scalp folliculitis and erosive pustular dermatosis," said Dr. Shi, an oncodermatologist at Brigham and Women's Hospital/Dana Farber Cancer Institute and instructor in dermatology at Harvard Medical School.

Dr. Shi said these scalp toxicities can be severe, pose significant challenges to the patient's quality of life, and limit their ability to continue therapy. For these reasons, it's important for dermatologists to know what to do when they encounter these adverse events.

"The rapid pace of innovation and change in the oncologic therapy space and the expanding indications for various chemotherapy, targeted therapy, and immunotherapy agents means that dermatologists will increasingly encounter cutaneous side effects of these treatments among our patients," she said.

Another cancer treatment that can produce cutaneous side effects is immune checkpoint inhibitors (ICI). Jennifer Choi, MD, FAAD, professor of dermatology and chief of the divisions of oncodermatology and medical dermatology at Northwestern University Feinberg School of Medicine in Chicago, said these drugs are classified into three main categories: PD-1 inhibitors (e.g., pembrolizumab, nivolumab); PD-L1 inhibitors (e.g., atezolizumab, durvalumab); and CTLA-4 inhibitors (e.g., ipilimumab).

"These work by blocking specific immune checkpoints to enhance T-cell activity, which can trigger autoimmune-like skin reactions," she said. "This can include a wide range of cutaneous side effects, such as maculopapular rash, pruritus, lichenoid dermatitis, psoriasisiform eruptions, bullous pemphigoid-like reactions, erythema multiforme, or Steven-Johnson-like syndrome."

Dr. Choi said the treatments can also produce rarer adverse events, including alopecia areata, and while most of the effects are mild-to-moderate, some may require the discontinuation of the therapy along with systemic immunosuppression.

"It is crucial for dermatologists to be aware of these drugs and their side effects because dermatologists play a key role in recognizing and managing these immune-related skin toxicities," she said. "Early identification can prevent severe complications and help oncologists identify whether the specific cutaneous side effect is life-threatening or not and determine if the immunotherapy must be stopped or can be continued."

Treatment strategies for these conditions can vary from topical treatments to systemic medications, depending on the severity. Dr. Choi said she prefers using steroid-sparing agents for difficult or persistent reactions, which can help prevent systemic immunosuppression in cancer patients.

Biologics

Biologic therapies are becoming more common in dermatologic settings, especially for treating psoriasis and atopic dermatitis. Jeffrey Cohen, MD, FAAD, director of the Psoriasis Treatment Program and assistant professor of dermatology at Yale University School of Medicine, said the paradoxical eruptions associated with these therapies, while relatively uncommon, can be a challenge to recognize and treat.

Dr. Cohen said paradoxical reactions occur when a treatment that is effective ends up generating a response that is the opposite of what is intended. These often have a classic appearance similar to other conditions, making them difficult to recognize.

"Biologics have revolutionized the treatment of inflammatory skin diseases like psoriasis and eczema," he said. "It's important for dermatologists to feel comfortable using these medications and managing any side effects that may occur. Therefore, it is essential for dermatologists to be able to adequately recognize and adequately manage paradoxical eruptions in patients on biologics."

TEN-like conditions

Toxic epidermal necrolysis (TEN) is a severe, life-threatening medication reaction. Drug-induced TEN-like conditions are a group of rare reactions that mimic TEN.

Dr. Burgin discussed some of those conditions, including TEN-like acute generalized exanthematous pustulosis (AGEP) and methotrexate-induced epidermal necrosis.

"Severe toxic erythema of chemotherapy may resemble TEN and while the immune checkpoint inhibitors have been reported to cause true Stevens-Johnson syndrome/TEN, a TEN-like condition known as progressive immunotherapy-related mucocutaneous eruption (PIRME) has also been reported," she said.

Even though these conditions are rare, Dr. Burgin said dermatologists should be able to differentiate between them and true TEN.

"As we know, TEN is a true dermatologic emergency and it may be life-threatening," she said. "Knowledge of the differential diagnosis and the side-effect profiles of newer drugs are vital when assessing such a patient. TEN-like conditions themselves are also frequently severe and they require active therapeutic intervention and often admission for optimal care."

Helena Pasieka, MD, FAAD, also gave updates on TEN in her presentation on severe cutaneous adverse reactions (SCAR). ●

Fear not the nails!

New session breaks down nail surgeries to help put dermatologists — and patients — more at ease.

For both the dermatologist and the patient, surgical procedures on nail pathologies can be as nerve-wracking as, well, nails on a chalkboard. But the reality is that many of these procedures can be managed in a general dermatology setting and, with proper preparation, they can go smoothly for both patient and physician.

One of the first steps toward treating nail problems is accurate diagnosis. In Friday's new session, **F011 – Nail Surgery: The Small Procedures to the Nail Apparatus That Frighten You**, session director Nathaniel Jellinek, MD, FAAD, FACMS, said the tangential shave technique boasts numerous advantages.

"It provides a full excisional specimen for histopathologic analysis and cure," Dr. Jellinek said. "It leaves decreased fibrosis and scarring, resulting in less postoperative dystrophy and less fibrosis, which can facilitate any subsequent surgery."

While this may sound daunting if you don't have much experience in the area, it's not much different than any other type of dermatologic surgery, said Dr. Jellinek, who is a Mohs surgeon and nail specialist at Dermatology Professionals, Inc., in Providence, Rhode Island.

Dermatologists use a scalpel or razor to remove a sample of the nail tissue for biopsy and evaluation. It is the most reliable diagnostic approach, he said, especially in cases such as longitudinal melanonychia, longitudinal erythronychia, and onychomatricoma.

"Generally, one can and should approach nail surgery and excisions in the same mindset as one would cutaneous surgery — with an emphasis on accurate and timely diagnosis while minimizing morbidity," he said.

Julia Baltz, MD, FAAD, a dermatologist in East Greenwich, Rhode Island, said one of the first courses of treatment dermatologists need to consider is anesthesia.

"Nails can present with significant morbidity and even mortality when neglected," she said. "Comfort with nail procedures starts with perfect anesthesia, something that all dermatologists can become proficient in with appropriate training and practice."

Dr. Baltz shared a big tip when using anesthesia for nail procedures: distraction.

"In my clinic, we listen to music and talk with the patient to cultivate a calm atmosphere," she said.

Once tension is eased and the patient is calm, she said medical considerations are equally important.

"We use cryogen spray and vibration devices to decrease the pain of injection," Dr. Baltz said. "My anesthetic of choice is ropivacaine. It has a relatively rapid onset of action, a long duration of action, and a vasoconstrictive effect. Bleeding is minimal during the procedure and patients have extended pain control (from 8-12 hours) after they leave the clinic."

Among the more common nail conditions dermatologists are likely to see are ingrown toenails and nails with transverse curvature. Nilton Gioia Di Chiacchio, MD, PhD, said one of the best procedures for treating these cases is a chemical matricectomy, which uses chemical treatments (such as phenol) to break down the lateral nail matrix horn allowing the nail to regrow properly.

"It provides us with a high cure rate and a low risk of postoperative complications," said Dr. Di Chiacchio, who is a dermatologist at the Hospital do Servidor Público Municipal in São Paulo, Brazil. "It is also an easy technique for dermatologists to learn."

Whether it's this technique or a more involved surgery, Dr. Di Chiacchio said nail surgery can be a frightening experience for both children and adults. One of the keys to making it a more calm and relaxing time is pain management.

"The knowledge of pain management before, during, and after a nail surgery — along with the principles of wound care — will give us not only credibility in front of our patients but reduces postoperative complications and makes the healing time less stressful for patients," he said.

Dr. Di Chiacchio said there are several techniques dermatologists can employ to make the surgical procedure a smooth one for their patients.

"Make sure to create a calm and relaxing atmosphere before nail surgery and avoid triggers that can cause pain. Make sure to ensure the correct anesthesia for each type of nail surgery and explain to the patient how to deal with the wound, depending on the type of surgery," he said. "Remember to be available to your patient during the postoperative period." ●

"We listen to music and talk with the patient to cultivate a calm atmosphere. Once tension is eased and the patient is calm, medical considerations are equally important."

– Julia Baltz, MD, FAAD

DermWorld meeting news

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Career insights

On Thursday, forward-thinking physicians flocked to the **AAD Career Insights & Employment Fair** at the Hyatt Regency Orlando. Attendees received expert tips on contract negotiations and were treated to a panel discussion exploring solo, group, and academic practices. Attendees also met with potential employers looking to hire.


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