DermWorld meeting news

A Publication of the American Academy of Dermatology | Association

Sunday • March 9, 2025

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

The future is bright

With more content than ever and abundant opportunities to connect, AAD members can feel confident in the direction dermatology is heading and the contributions they are making to create a bright future for physicians, clinicians, patients, and their families.

Beginning at 9 a.m., attend the **Annual Business Meeting**, which includes remarks from this year's President-Elect candidates. During the remainder of the **Plenary**, four talented experts will accept their awards and give lecture presentations on topics that impact the field and community.

Outgoing Academy President Seemal R. Desai, MD, FAAD, will also pass the torch to incoming Academy President Susan C. Taylor, MD, FAAD. Collectively, the leaders will reflect on the last year and preview the next one.

Later in the day, stop by the **AAD Resource Center** at Booth 3309 for exciting events, including Camp Discovery: More to Explore, noon-1 p.m., and Coding Power Hour, 1-2 p.m. Attendees can also sit down for a complimentary, new headshot, or mix, match, and string together a customized bracelet that celebrates being a member of the AAD.

Today is the final day to explore the **Exhibit Hall**, 10 a.m.-3 p.m., and network with more than 350 exhibitors and to view ePosters and Poster presentations, 7 a.m.-5 p.m. Following today, tune into Monday and Tuesday's incredible lineup of education sessions. Also, check out the 2025 Annual Meeting On-Demand and register for 2025 Innovation Academy coming up July 10-13 in Chicago.

In the spirit of AAD's current leaders, as well as those who paved the way and those who will follow in their footsteps, may we all continue to innovate, advocate, and advance the field of dermatology. The future is bright. ●

PHOTO GALLERY

View more photos online at the AAD Annual Meeting Photo Gallery

aadmeetingnews.org/photo-gallery

HAPPENING TODAY

Plenary lineup

9 a.m.-noon

Location: Chapin Theater

9-9:45 a.m.
AAD/A Annual Business Meeting

9:45 a.m.
Chair's Welcome
Kathryn Schwarzenberger, MD, FAAD

9:50 a.m.
Clarence S. Livingood, MD, Memorial Award and Lectureship
"Numbers and the Narrative: Leadership and Advocacy With Stories and Data"
Marta Jane Van Beek, MD, MPH, FAAD

10:15 a.m.
President's Address
Seemal R. Desai, MD, FAAD

10:30 a.m.
Lila and Murray Gruber Memorial Cancer Research Award and Lectureship
"From Cell Atlases to Medicines With AI"
Aviv Regev, PhD, MSc

10:55 a.m.
President-Elect's Address
Susan C. Taylor, MD, FAAD

11:10 a.m.
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

11:35 a.m.
John Kenney Jr., MD, Lifetime Achievement Award and Lectureship
"Vitiligo: A 45-Year Journey of Science and Service"
Pearl E. Grimes, MD, FAAD

Inside

ModMed

I am modernizing dermatology with an AI-powered practice

Introducing our AI-driven ambient listening solution, ModMed® Scribe. Integrated with our EHR, EMA®, it's designed to help you save hours on documentation by converting patient encounters into suggested visit note content.

"AI's greatest opportunity in healthcare today is freeing us from administrative tasks so we can focus on patient care.

Michael Sherling, MD, MBA, Cofounder and Chief Medical and Strategy Officer, ModMed

Streamline clinical, operational and patient engagement workflows with AI

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Get a hands-on demo and be entered for a chance to win an Apple Watch 10

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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.

President-Elect

Andrew H. Weinstein, MD, MPH, FAAD

Cyndi J. Yag-Howard, MD, FAAD

Vice President-Elect

Brad P. Glick, DO, MPH, FAAD

Thomas E. Rohrer, MD, FAAD

Board of Directors

Sandra M. Johnson, MD, FAAD

Maral K. Skelsey, MD, FAAD

David T. Harvey, MD, FAAD

Roman Bronfenbrener, MD, FAAD

Nominating Committee Member Representatives

Mark D. Kaufmann, MD, FAAD

Lara Wine Lee, MD, PhD, FAAD

Alina G. Bridges, DO, FAAD

Michael G. Wilkerson, MD, MS, FAAD

Hege Grande Sarpa, MD, FAAD

John Christopher Trinidad, MD, MPH, FAAD

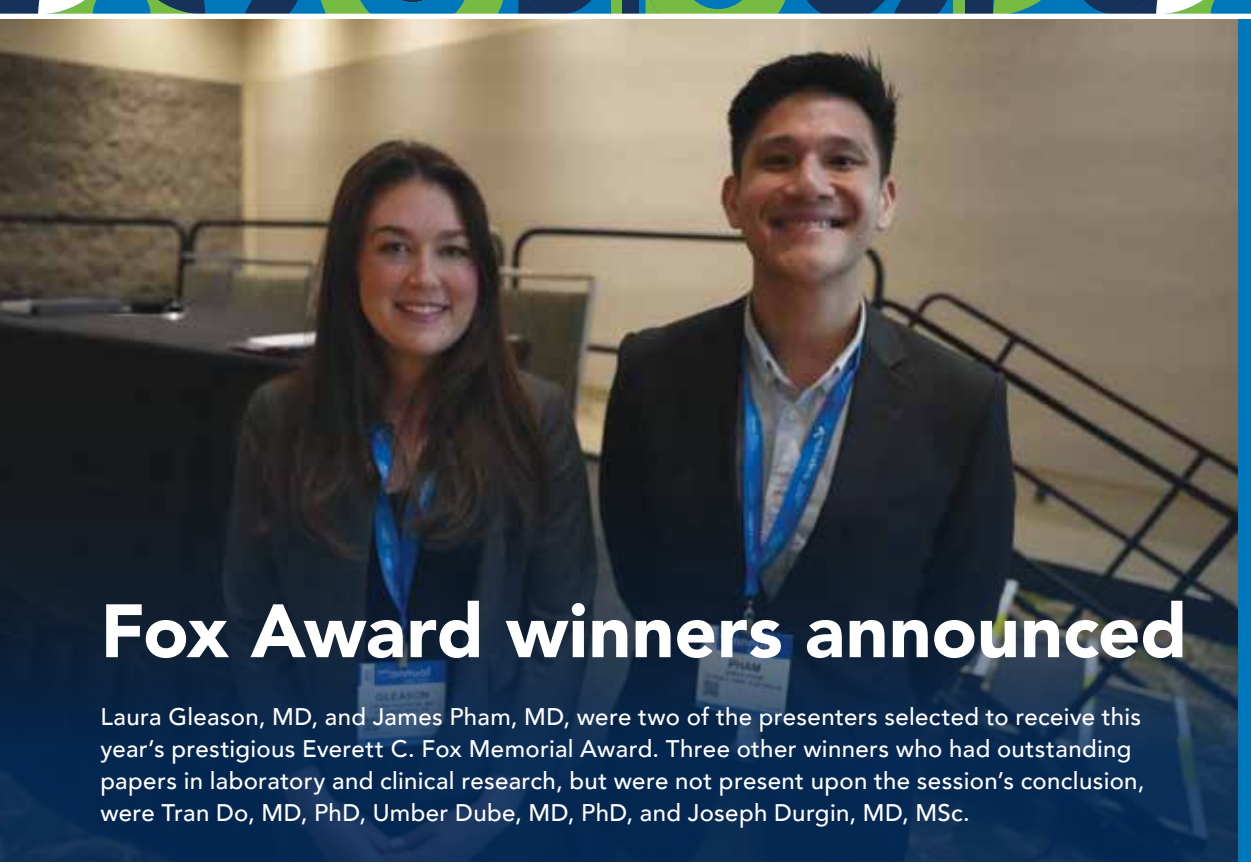
Easily vote using the personalized voting link starting today.

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



Fox Award winners announced

Laura Gleason, MD, and James Pham, MD, were two of the presenters selected to receive this year's prestigious Everett C. Fox Memorial Award. Three other winners who had outstanding papers in laboratory and clinical research, but were not present upon the session's conclusion, were Tran Do, MD, PhD, Umber Dube, MD, PhD, and Joseph Durgin, MD, MSc.

Congratulations to all who participated in the 2025 Resident and Fellows Symposium!

The five award winners and presentations were:

Tran Do, MD, PhD: Single-Cell and Spatial Analyses Reveal Distinct Subpopulations of Regulatory T Cells as a Major Producer of IL-26 Palmoplantar Pustulosis Lesions

Umber Dube, MD, PhD: Reversal of the Pheomelanogenic Phenotype of Cystinosis Following Bone Marrow Correction of the Gene Defect

James Pham, MD: Resident Memory T-cells Are Present in Lesions of Hidradenitis Suppurativa and Decrease With Interleukin-17 and -23 Inhibition In-Vivo

Joseph Durgin, MD MSc: Spatial Transcriptomics Reveal Dysregulation of Lipid Metabolism in Acne Vulgaris

Laura Gleason, MD: T-Cell Receptor Immunosequencing Reveals Heterogeneity in Distribution and Frequency of Dominant Malignant Clones in the Skin of Patients With Cutaneous T-Cell Lymphoma

Serving those who serve

Civilian dermatology aids the care of military service members, veterans, and their families.

Dermatology is committed to addressing the needs of those who serve our country. As the number of U.S. military active-duty dermatologists dwindles due to recent policy changes, civilian dermatologists are doing their part to address and assist the specialized needs of members of the military and their families.

During Saturday's session, **U040 – Dermatology on Duty: Managing Active-Duty Military Members in Your Practice**, Willis Hugh Lyford, MD, FAAD, led an inspiring discussion on current dermatologic concerns within this large population of U.S. military service members and their families. Dr. Lyford is an active-duty dermatologist stationed at Naval Medical Center San Diego, where he holds an assistant professorship of dermatology. He is also an adjunct professor of dermatology at the Uniformed Services University of the Health Sciences in Bethesda, Maryland.

Three active duty military members and dermatologists, including Willis Hugh Lyford, MD, FAAD, addressed and acknowledged their civilian counterparts in yesterday's session.

"Active-duty service members, reservists, veterans, and family members are a large part of the U.S. population who live and work in communities across our country, including yours," Dr. Lyford said.

"However, the reach for military and Veteran Administration (VA) clinics is more limited, especially for specialty care like dermatology. As a result, service members, veterans, and family members frequently will find themselves in our civilian partners' clinics for care."

Although recent legislation has taken steps to curtail the 2017 National Defense Authorization Act reduction, there is still a shortage of active-duty dermatologists. As a result, a growing number of military members and their families are seeing civilian dermatologists who must manage their often-unique medical care while keeping in mind their military status.

Factors affecting care

During the session, Dr. Lyford was joined by two experts in the field: Luke R. Bloomquist, MD, FAAD, and Peter Barnes, MD, FAAD. The panel addressed many factors that play a role in an active-duty military service member's health care, including:

- Deployment or Permanent Change of Station (PCS), where someone is ordered to move across country or even overseas
- Access to specialty clinics
- Presence of dermatologic conditions that can be exacerbated by service-related work or deployment.

"Members and their families can have unique needs reflective of their military duties, their deployment status, and access to medications or treatments in austere or overseas environments," Dr. Lyford said. "Family members' medical conditions can impact an entire family's ability to move frequently or live overseas. As a result, it is important for all our colleagues outside the military to be aware of how the treatment they render can impact a service member's career to provide holistic care."

The session was designed to equip

civilian dermatologists with the knowledge and confidence to work with all members of the military who are referred to their clinic and to offer them care that takes their extraordinary work and life circumstances into account, Dr. Lyford said.

Have you seen this?

Some dermatologic conditions that arise or are worsened from deployment may be first-time experiences for the civilian dermatologists. Similarly, there may be common conditions that present differently due to the nature of a military service member's job. For example, military grooming standards make conditions like pseudofolliculitis barbae, acne keloidalis nuchae, and traction alopecia more common, Dr. Lyford said. Additionally, certain work environments may expose members to unique contact allergens, which may not be elucidated on a standard contact allergen panel, he added.

Dr. Lyford discussed the high-yield topics dermatologists must understand to effectively manage service members and their dermatologic conditions. This included dialogues on treating service members with biologics or immunomodulators, pathways to obtain prior authorization approval, and each service branch's policy on biologics and assignment to special duty, deployability, and overseas duty assignments.

Dr. Bloomquist, who is stationed in Germany, emphasized the increased skin cancer risk service members and veterans carry due to their line of work. Receiving news of skin cancer can be very scary for anyone, but especially if it impacts your livelihood. Consider, he said, a patient starting out in the service or one who is nearing retirement and being concerned the diagnosis may prevent them from serving.

It is also critical, Dr. Bloomquist said, to prescribe specific limitations to service members following procedures, as they have strong work ethics and are not inclined to limit themselves.

Cutting through red tape

It's important to note, Dr. Lyford said, that U.S. Department of Defense (DOD) policy continues to evolve to better suit the needs of the respective service branches and balance the needs of service members with changes in our understanding of disease etiologies and pathogenesis and changes taking place in our society.

As civilian dermatologists come to treat more service members, they'll need to grasp the intricacies of DOD policy to ensure that their care will not inadvertently impact a member's ability to perform their work duties.

"Our goal is for clinical dermatologists to better understand the special circumstances soldiers, sailors, and airmen bring with them when they visit their office and ways that we, as their dermatologists, can more easily navigate their TRICARE health care network, interface with clinicians within the U.S. Department of Defense for consultations and follow-up care, and effectively start and manage therapies," said Dr. Lyford. ●

PUPPY BREAK

Attendees are enjoying the play and pet session at the Canine Cuddle Zone, sponsored by CareCredit. The four-legged friends will be here again today, **Booth 3487, from 11:30 a.m.-2:30 p.m.**

Using data to make a difference

Leveraging DataDerm™, new AI tool helps detect rare disorders early and advantageously.

All doctors know that correctly diagnosing and treating health conditions as early as possible can save lives. Now, a new artificial intelligence (AI) tool takes diagnostics to the next level. Patient Finder was the focus of Friday's Annual Meeting session, **U014 – Using Artificial Intelligence for Rare Dermatologic Diseases: Getting the Right Patients the Right Treatment at the Right Time.**

In the informative session, Marta J. Van Beek, MD, MPH, FAAD, shared how a group of dermatologists and data gurus collaborated to apply this groundbreaking tool to dermatologic diseases.

According to Dr. Van Beek, patients with rare dermatologic diseases often experience misdiagnosis with subsequent inappropriate treatments, which ultimately leads to prolonged patient suffering. Her presentation concentrated on patients who have generalized pustular psoriasis (GPP).

GPP is a challenging condition to diagnose, Dr. Van Beek said, as it is frequently confused with an infection when patients are not seen by a dermatologist. Patients are very sick, presenting with painful pustules on their skin and high white blood cell counts. This is a problem if a doctor doesn't know what GPP is or what else to consider, she said.

"They may put patients on an antibiotic and treat it as infection, but in reality, GPP needs therapy that targets the immune system," said Dr. Van Beek.

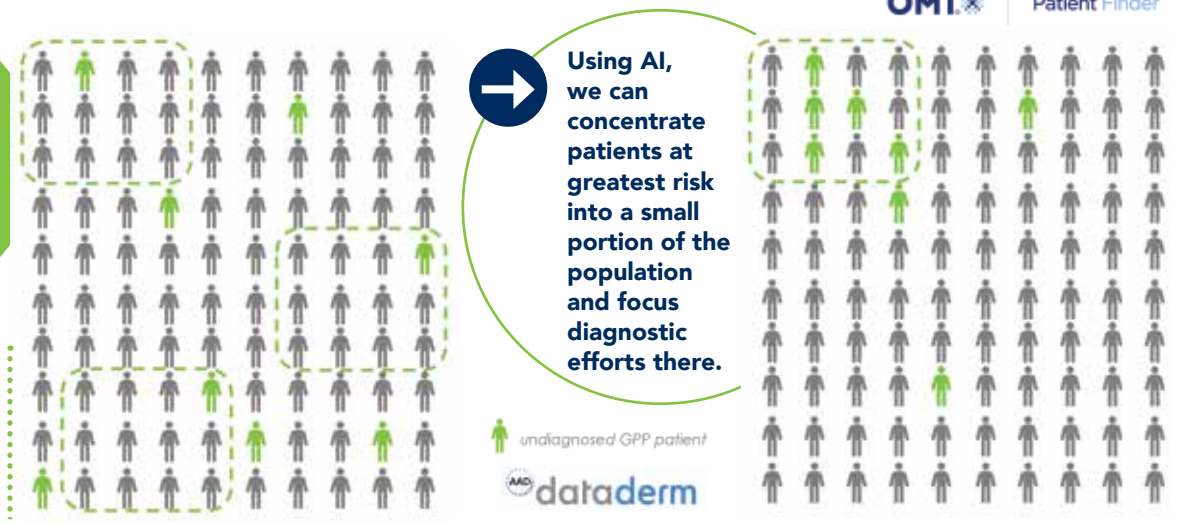
The good news? A few years ago, the U.S. Food and Drug Administration (FDA) approved spesolimab-sbzo (Spevigo) for the treatment of GPP in adults and children over the age of 12 years. And it's proven to be effective, Dr. Van Beek said.

The bad news? GPP and other rare dermatologic diseases remain very difficult to diagnose.

"Often in medicine, when there is no effective treatment for a disease, patients suffering from that disease don't seek health care. We then erroneously think the disease is rare because it doesn't get diagnosed or it is misdiagnosed," she said. "But once we find an effective treatment, patients seek care, and we realize the disease might be more common. Now is the time to actually identify these patients earlier."

Enter: Patient Finder.

"I think all of medicine is trying to figure out how AI fits into our workflows. Everyone wonders: Will AI be able to diagnose patient conditions, in addition to decreasing administrative burden? Will it be able to find the disease earlier in the patient's journey to get the right treatment at the right time?"
– Dr. Van Beek, executive medical director at the University of Iowa Ambulatory Clinics



Mind the data

With the help of reliable data sources and AI, dermatologists can employ modern resources to help accurately and proactively identify these perplexing ailments. Luckily, for Dr. Van Beek et al., they didn't have to look far.

A decade ago, AAD launched DataDerm™ — the largest dermatologic clinical registry in the world. "DataDerm was established to make sure [dermatologists] could tell our own story about our patients, whether it's for advocacy purposes, to find cures, or to improve patient care and outcomes," she said.

Patient Finder searches the more than 15 million patients stored in DataDerm, analyzing confirmed cases of GPP and looking for commonalities among patient populations to reveal individuals with a high probability of having or developing GPP.

Joseph Zabinski, PhD, MEM, a leader from health care technology company OM1, which developed Patient Finder, also participated in the panel. He said the AI model uses digital phenotyping to provide clues on at-risk patients who have gone undiagnosed or have been misdiagnosed and then accelerates the time to treatment.

"[Patient Finder] identifies patterns in patients' health histories associated with target diseases, based on training on billions of datapoints. The tool isolates phenotypic 'fingerprints' in the data, and we can study these fingerprints for new information about patient journeys and use them to screen others' data."
– Dr. Zabinski, vice president and head of commercial strategy and AI at OM1

Why AI?

AI continues to grow in popularity, and it is being developed and implemented in sectors around the world. Dr. Zabinski said it can have a strong impact on medical settings in a variety of applications.

"AI tools are growing very rapidly in maturity and clinical usefulness," he said. "They can bring analytic clarity and personalization to the conversations patients and physicians have, including those around diagnosis and decisions around treatment plans. ... [OM1 helps] demystify these tools and demonstrates how in collaboration with dermatologists, they can be tremendously helpful."

In addition to identifying at-risk patients, Dr. Zabinski said AI tools can learn from patient records and help physicians make more informed assessments. Consider a group of patients who responded well to a certain medication and compare them to another group that didn't respond well to the same medication. The tool can understand what each group has in common, then predict if a new patient with the same condition will or won't benefit from the drug based on captured characteristics.

Be selective and vigilant

In this case, Patient Finder has made the nearly impossible, possible. However, AI comes with risks, said Dr. Van Beek, particularly accuracy and bias.

An AI model can generate false findings or misleading results. This occurs when the data that trains the AI tool is inaccurate, insufficient, or prejudiced. And if these biases go unnoticed or the model isn't properly recalibrated, the hole keeps getting deeper.

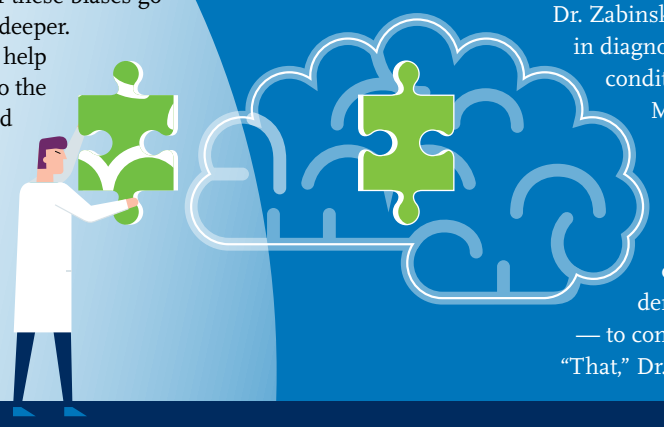
For example, Dr. Van Beek said other companies have pursued tools that help with diagnoses, but their catalogs of skin images lacked diversity. This led to the technology being unable to identify lesions on patients with darker skin, and it demonstrates the criticality of selecting an AI-training source that is rich and reliable.

While DataDerm is a leading resource for the specialty, using AI still requires ongoing regulation.

"We prefer not to call it artificial intelligence, but augmented intelligence," said Dr. Van Beek. "We don't believe AI should be used without human oversight. It can augment what you're doing, but it shouldn't substitute what you're doing. Health care is too precious."

Looking ahead

The testing period of Patient Finder recently wrapped up, said Dr. Van Beek. So, the next steps are still being finalized. It could be used as an educational tool, she said, or it may be deployed into individual practices so physicians can employ it within their own EMR and patient base.



Dr. Zabinski shared that Patient Finder has shown success in diagnostic and therapeutic areas of several other skin conditions. In fact, fellow speaker Steven Daniel Daveluy, MD, FAAD, reviewed how Patient Finder can assist in identifying patients who may have hidradenitis suppurativa (HS).

In the end, the panelists agreed that Patient Finder is an innovative tool that can shine light on patterns in patient populations, but it is the dermatologist who has the ability — and responsibility — to confirm diagnosis and assign the correct treatment. "That," Dr. Van Beek said, "can be lifechanging for a patient." ●

Editor's note: The GPP project described here was generously supported by Boehringer Ingelheim. The HS project described here was generously supported by Novartis. The AAD is grateful for the support of these two important demonstrations of the power of DataDerm.

Decision Dx SCC

Will your patient benefit from adjuvant radiation therapy (ART)?

Squamous cell carcinoma (SCC) patients who are at high risk of metastasis may benefit from ART. While clinicopathological factors long used in stage-based risk assessment of disease progression are used to determine ART eligibility, they do not reliably identify which of these high-risk patients will benefit from the treatment.

Now, the largest and second largest studies evaluating the benefit of ART in SCC patients, show that DecisionDx-SCC can **independently identify patients likely to benefit** from ART.

DecisionDx-SCC is a 40-gene expression profile test that addresses two critical clinical questions:

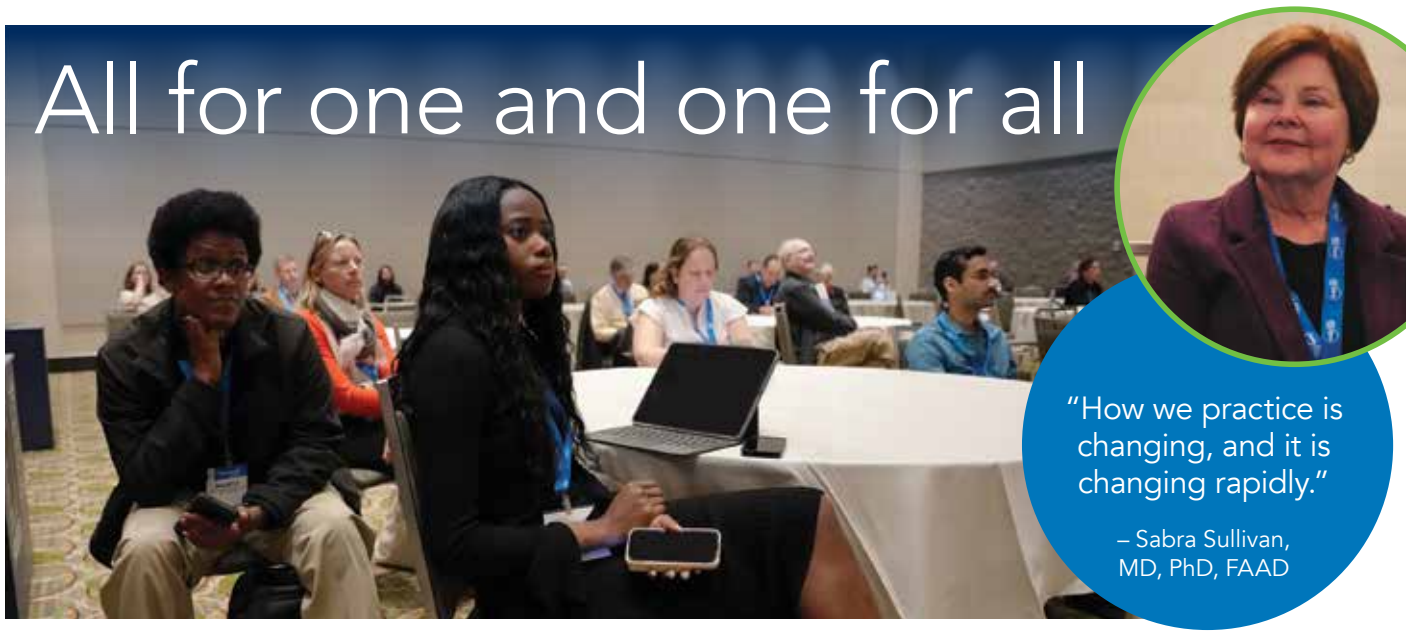
- What is your SCC patient's risk of regional or distant metastasis?
- Is your patient likely to benefit from ART?

Personalize patient treatment decisions with DecisionDx-SCC

GET STARTED

CASTLE BIOSCIENCES

All for one and one for all



"How we practice is changing, and it is changing rapidly."

– Sabra Sullivan, MD, PhD, FAAD

Dermatologists, Academy unite for the specialty and its future.

Dermatology is undergoing significant transformations driven by changes in practice styles, regulatory requirements, and technologic advancements. As dermatologists adapt to these shifts, understanding how to evaluate and manage resources effectively is crucial for preserving optimal practice operations.

Friday's session, **F001 – The Future of Dermatology: What Changes Are Coming and How Can We Prepare?** focused on essential tools that can help members stay informed and engaged to better serve their patients. That includes utilizing the Academy's library of resources as well as engaging in state and federal advocacy efforts.

Session director Sabra Sullivan, MD, PhD, FAAD, told attendees that by working together, dermatologists can navigate the challenges of a new normal and continue to provide exceptional care to their patients.

"Ten years ago, most dermatologists were in a small group or solo practice, and now many dermatologists are in large group practices or private equity practices," said Dr. Sullivan, a dermatologist and CEO of Dermatology Associates, LLC, in Jackson, Mississippi. "How we practice is changing, and it is changing rapidly. We also have rapidly changing regulations. Sometimes, it's hard to keep up with them and make sure you're in compliance, while still being able to deliver optimal care to your patients."

The full panel discussed a range of issues, including scope of practice and truth in advertising, challenges with private insurers and Medicare, access to prescription medication and over-the-counter products, artificial intelligence (AI), pediatric dermatology, and diversity in dermatology. Panelists included Bruce A. Brod, MD, MHCI, FAAD; Brett M. Coldiron, MD, FAAD; Thy Nhat Huynh, MD, FAAD; Jon Klint Peebles, MD, FAAD; and Melissa Piliang, MD, FAAD.

Regulatory compliance

Perhaps the primary challenge for dermatologists is keeping up with rapidly changing regulations and ensuring compliance with new laws. Practices must invest in updated technology and dedicated IT support to navigate these complexities. Similarly, the adoption of electronic medical records (EMRs) and other digital tools has transformed the way dermatologists document patient care, write prescriptions, and manage billing.

Dr. Sullivan said these systems can be costly and require ongoing maintenance and staff training. Many practices now require a dedicated IT administrator, as the complexities of managing a dermatology practice are ever-changing.

"If you bought one medical operating system or electronic system then you most likely have had to buy two or three more. They can be quite expensive and time consuming," said Dr. Sullivan. "Today, in this digital age, it can often take longer to jump through the hoops needed to get a medication for our patients. We have to be mindful of the time it takes away from patient care as we strive to deliver the best care possible to our patients."

Dr. Sullivan reminded attendees that the Academy offers members an array of tools and resources to support practice management, including billing and coding assistance, medication access guides, and live support. These benefits — all of which can be found on the Academy website — help dermatologists streamline operations and address common challenges.

The struggle for reimbursement

Another adversity, Dr. Sullivan said, is the ongoing struggle over Medicare reimbursement. Despite rising costs, physician reimbursement rates have not kept pace, leading to financial strain for many practices. The AADA actively advocates for fair reimbursement rates to ensure that dermatologists can continue to provide critical, high-quality care to Medicare patients.

"All physicians, not just dermatologists, have continuously been reimbursed less and less over the past 10 to 15 years," said Dr. Sullivan. "Although hospitals and other entities have received cost of living adjustments, physicians have not."

Dr. Sullivan credits Melissa P. Piliang, MD, FAAD, the AADA's Government Affairs and Health Policy Council chair, with working for the best interests of its members and the specialty. According to Dr. Sullivan, AADA leadership advocates on multiple levels to help address issues as they occur and avoid actions that are harmful to dermatology practices.

Advocating for all

The AADA isn't just advocating for dermatologists, it is advocating for patients as well. Ensuring patient access to dermatology care, Dr. Sullivan said, is of particular importance in rural and underserved areas. The Academy is working to resolve physician shortages and improve access to care through advocacy and support for policies that promote physician-led teams, she said.

Still, other issues — from lidocaine shortages and challenges in pediatric dermatology to newly established practices and overall practice management — have the attention of Academy leadership, said Dr. Sullivan. She reminded attendees that the Academy is a trove of resources and a united voice for the betterment of the specialty and its patients. And, she said, by educating the next generation of dermatologists on practice management and patient advocacy, the Academy ensures a strong future for the specialty.

"Each individual dermatologist can access Academy resources," Dr. Sullivan said. "We have a lot to offer, and remember, each of us can make a difference." ●

#YourDermatologistKnows

The **Resource Center (Booth 3309)** was bustling Friday during the **Your Dermatologist Knows** event, which celebrated the success of AAD's consumer positioning strategy. Attendees snagged t-shirts, created bracelets, and posed for photos with experts to post on social media using **#AAD2025**.

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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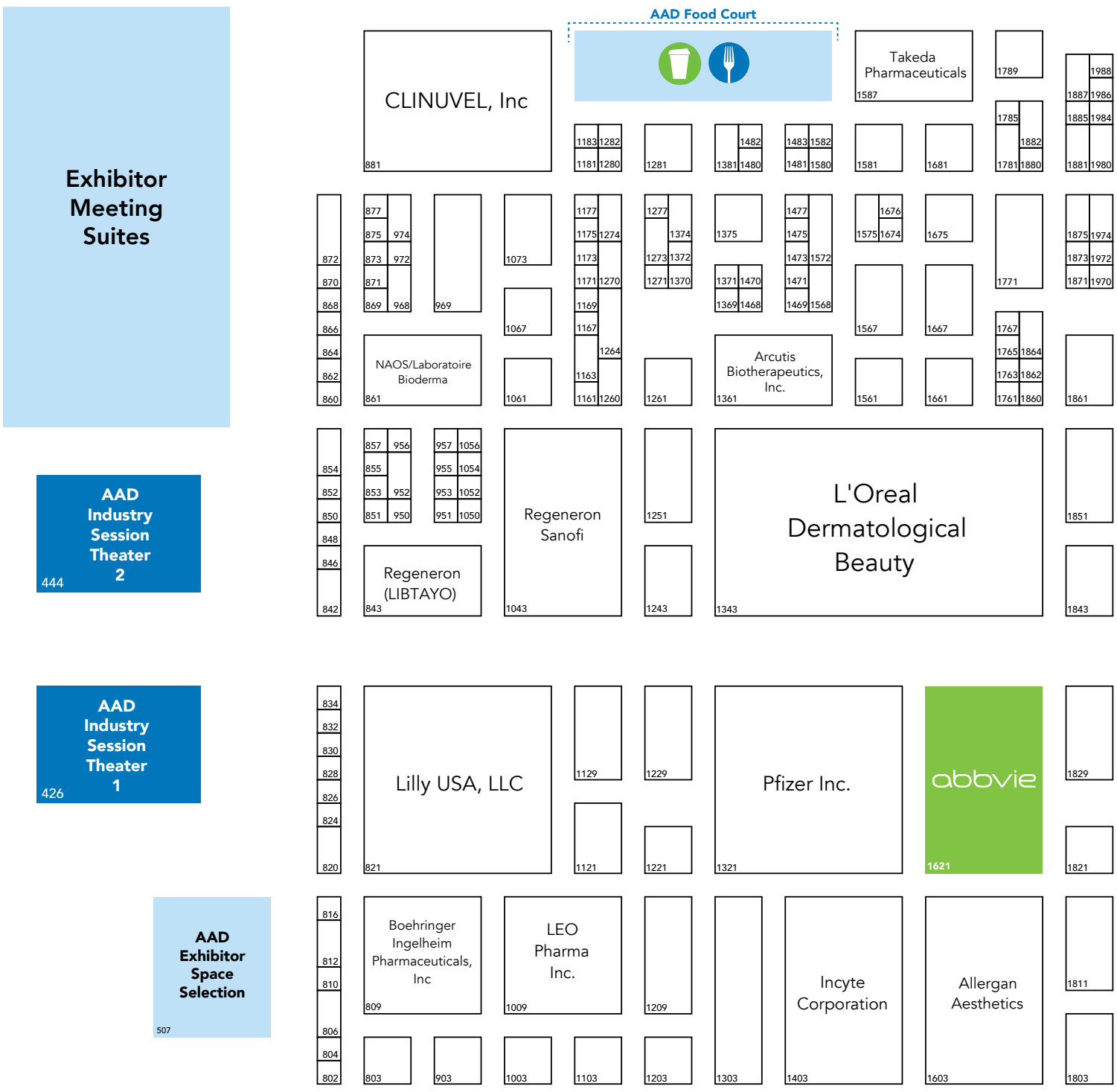


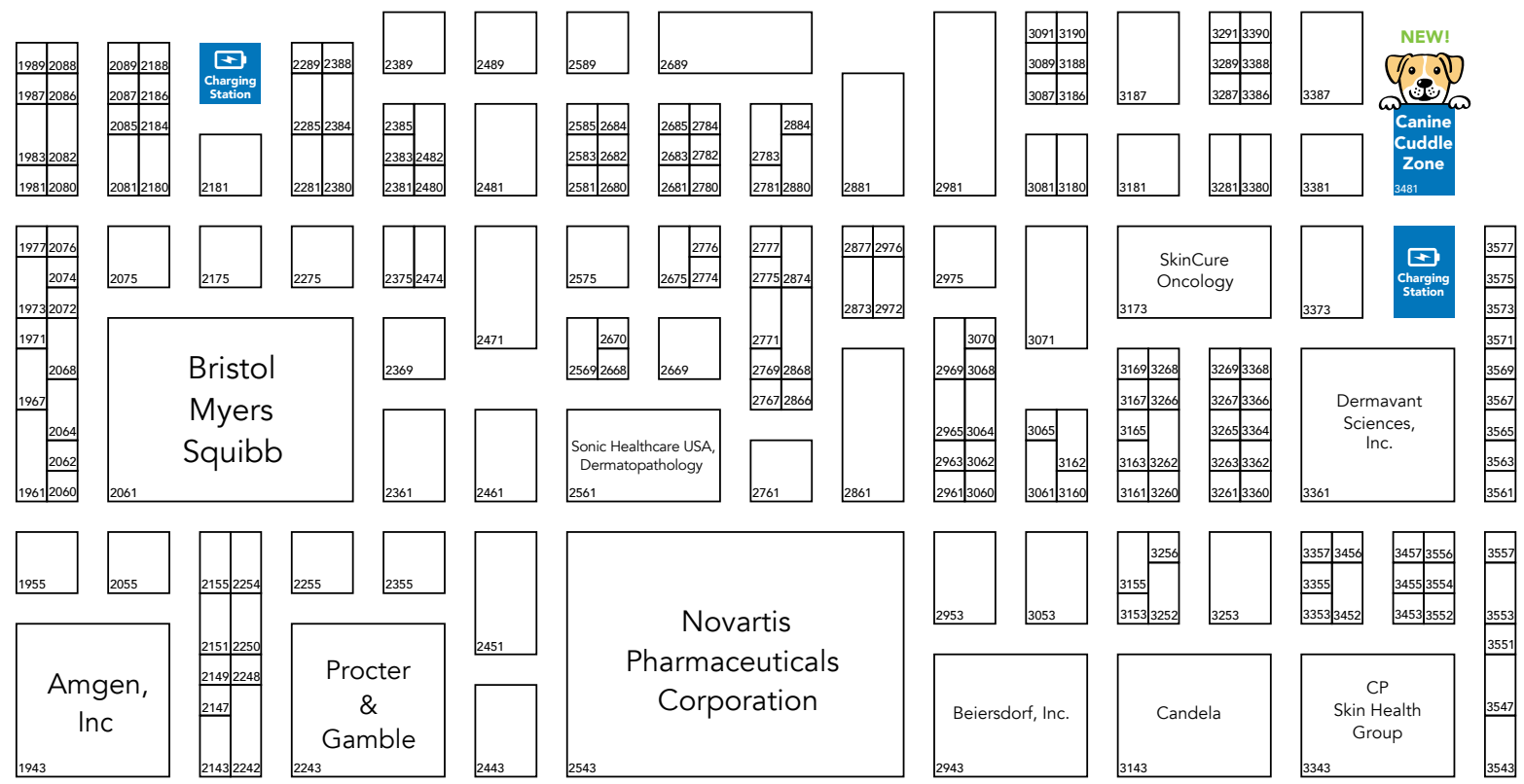
Exhibit Hall hours

10 a.m.-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

HOT TOPICS
to ignite your passion

Learn about dermatology's top issues and interests, as requested by AAD members.

Kenneth J. Tomecki, MD, FAAD, vice chair of the department of dermatology at the Cleveland Clinic

S055 – Hot Topics
9 a.m.-noon | Monday, March 10
Location: Valencia Ballroom A

In Monday's popular popular **S055 – Hot Topics**, attendees can take in a collection of dermatologic curiosities and concerns. Experts will review emerging and innovative therapies, medical and surgical developments, and advancements in technology and techniques. There will also be discussions on industry trends, including some with social and economic impact.

Kenneth J. Tomecki, MD, FAAD, vice chair of the department of dermatology at the Cleveland Clinic, will lead the symposium. Attendees can engage in essential subject matter and gain new evidence-based knowledge that they can implement into daily practice.

"The information presented in Hot Topics is established by registrant consensus and will be directly applicable to patient care, if not immediately, then in the near future," Dr. Tomecki said. ●

Learn how to survive and thrive

AAD's Leadership Institute sessions help dermatologist professionals acquire new skills and accomplish their goals.

The AAD's Leadership Institute (LI) provides training, mentoring, and networking opportunities to help dermatologists develop proficiencies that can make them successful in their careers and in life.

The last two LI sessions occur today:

F057 – Leadership Institute: Thriving in Chaos: Strategies To Get Control of Your Time and Your Life
1-3 p.m. | Sunday, March 9
Location: W312A
Directors: Nkanyezi Ngwenyama Ferguson, MD, FAAD, and Karolyn Wanat, MD, FAAD
It is not always easy to practice resiliency and maintain the ability to bounce back from adversity. Take this opportunity to analyze and apply some established and innovative strategies to manage the dynamics that make our lives feel out of control. Presenters will help attendees identify a new habit to practice and develop a realistic plan of action.

F066 – Leadership Institute: Know Thy Self: Unleashing Your Strengths for Effective Communication and Team Building
3:30-5:30 p.m. | Sunday, March 9
Location: W312A
Director: Charlene Lam, MD, MPH, FAAD
Find out what the PACE™ Palette assessment is and how you can reference it to discover your personality profile — or PACE color. This knowledge can help to modify your behavior by being able to recognize and understand how to better interact with patients, managers, and colleagues. ●

You ain't seen nothing yet

Look ahead to Monday and Tuesday's education sessions and events.

Although the traditional weekend concludes today, the 2025 AAD Annual Meeting still has plenty more in store. Attendees have more than 70 sessions to choose from on Monday, plus two concluding sessions on Tuesday morning.

U098 – Starting a Private Practice 101
7:30-8:30 a.m. | Monday, March 10
Location: W314B

This new session outlines the essential elements of starting an independent, private practice dermatology clinic, including basic requirements, strategic phases, and available resources, as well as non-clinical aspects to consider.

S053 – Consultative Dermatology for the Hospitalized Patient
9 a.m.-noon | Monday, March 10
Location: W313

A panel of dermatology hospitalists will examine the most prevalent skin conditions that present in the in-patient setting. Attendees will be able to equip themselves with immediately applicable skills and firsthand knowledge.

F080 – The Pregnant Pause: How to Evaluate and Treat Your Pregnant Patients
9-11 a.m. | Monday, March 10
Location: W304A

Certain dermatoses are common in or specific to pregnancy. Early recognition and effective management are important to prevent adverse effects on the fetus and/or mother. Learn about the greatest concerns, what differs in pregnant patients, and how to develop a treatment plan.

S063 – Advocacy in Dermatology With the Experts: Intersections to Safeguard the Specialty
1-4 p.m. | Monday, March 10
Location: W414C

Industry experts will discuss updates in key advocacy areas, such as payment reform and reimbursement, regulatory policies, patient access, climate change, and the physician-patient relationship. Attendees will learn how to engage in these efforts at multiple levels.

S069 – What's New in Dermatology
8-10 a.m. | Tuesday, March 11
Location: Valencia Ballroom A

This encompassing session includes key updates across the dermatologic spectrum, so there is sure to be something for everyone. Panelists will reveal new treatments for psoriasis, atopic dermatitis, and other inflammatory conditions; provide updates on surgical and cosmetic procedures; discuss therapeutic advancements in pediatric and adult skin disease; and demonstrate how to apply genetic testing to predict the prognosis of melanoma.

S070 – Therapeutic and Diagnostic Pearls
10:15 a.m.-12:15 p.m. | Tuesday, March 11
Location: Valencia Ballroom A

Clinicians of all levels of expertise can expect to take away new recommendations and alternative approaches that can be integrated into practice. Discover the latest research on medical dermatology, pediatric dermatology, contact dermatitis, skin of color, and dermatologic surgery. ●

Review the full list of upcoming sessions in the AAD Meeting App.

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.
- **Charging station** (all days)
- And, of course, **lots of swag and giveaways!**

AAD Resource Center Hours
10 a.m.-3 p.m.
Sunday, March 9

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, 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!

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

Remember to use the American Academy of Dermatology's (AAD) online Continuing Professional Development Transcript Program to document your CME and MOC activities to send to a licensing body. This service is a member benefit at no additional fee.*

** Excludes Adjunct and Corporate Individual Members*

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

Take the critical path

Brush up your dermatopathology skills and put them to the test in this high-yield session.

Randie H. Kim, MD, PhD, FAAD, staff dermatopathologist at Dermpath Diagnostics in White Plains, New York

Gillian Weston, MD, FAAD, assistant professor of dermatology at UConn School of Medicine and associate program director of the dermatology residency at UConn Health in Connecticut

F086 – High-Yield Dermatopathology for Residents
9-11 a.m. | Monday, March 10
Location: W303A

The dermatopathology subspecialty is a critical one, and it's not always fully represented or explored in medical school. That's according to Randie H. Kim, MD, PhD, FAAD, who teaches the nuanced subject to dermatology and pathology residents as well as dermatopathology fellows.

Dr. Kim, who is also a staff dermatopathologist at Dermpath Diagnostics in White Plains, New York, designed this new session to help attendees recognize and revisit dermatopathology at its fullest — whether you're a student preparing for exams or a resident looking to specialize.

The Monday morning session, **F086 – High-Yield Dermatopathology for Residents**, will include informative presentations from Dr. Kim and her colleagues: Chinmoy Bhate, MD, FAAD; Adnan Mir, MD, PhD, FAAD; Gillian Weston, MD, FAAD; and Di Yan, MD, MS, FAAD. The group of experts will reinforce key concepts, review biopsy techniques, and refine diagnostic approaches for various skin conditions and histological findings.

"As session director, I will be covering topics that I remember struggling with as a resident, such as alopecia, and providing clues that helped me remember certain differential diagnoses," Dr. Kim said. "I invited speakers who are primarily in their early- to mid-career stage who have taken the new boards exam so that they could provide additional insight and tips."

Attendees will review real clinicopathological cases and be able to "test their knowledge" by identifying disorders based on Kodachrome photos.

"Through clinical vignettes accompanied by histologic images, residents will gain practical experience, similar to what they will encounter on the Applied exam and in real-world practice as dermatologists," said Dr. Weston, who is assistant professor of dermatology at UConn School of Medicine and associate program director of the dermatology residency at UConn Health in Connecticut.

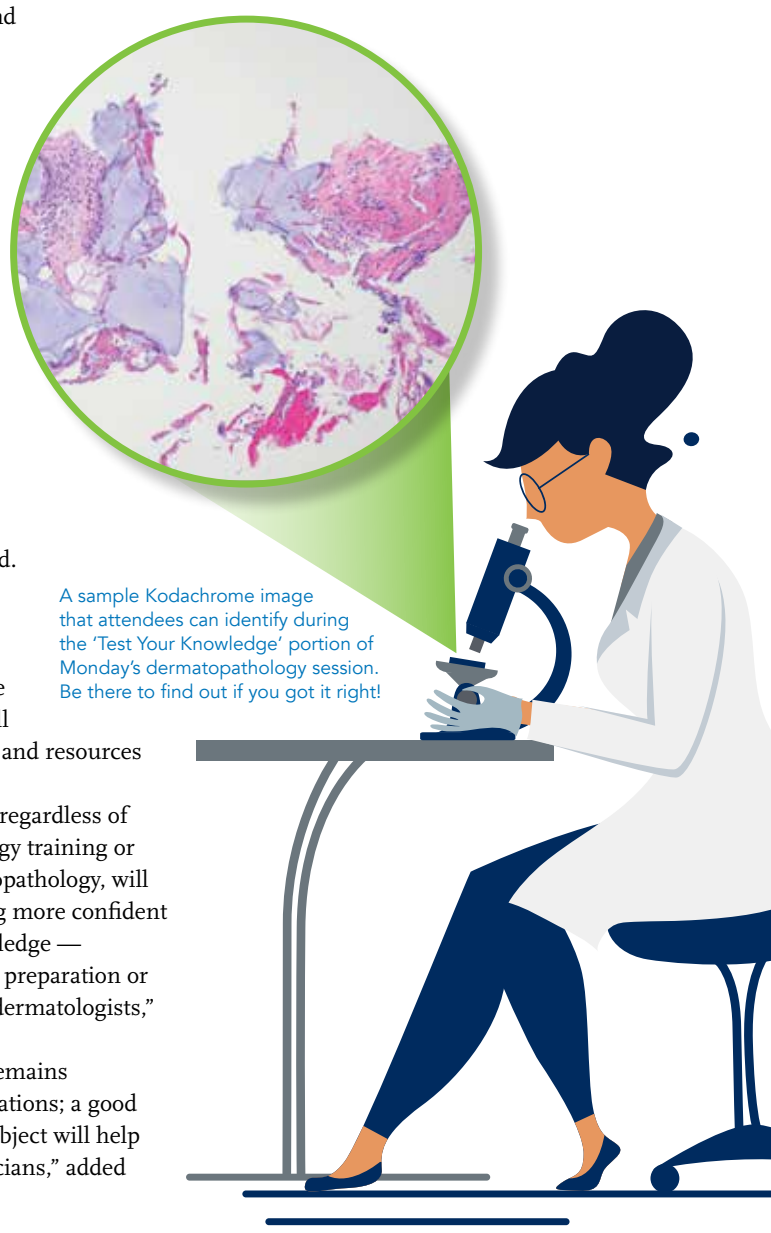
In her presentation, which is dedicated to Kodachromes, Dr. Weston will demonstrate patterns and pathologies that are immediately discernible once retained.

"Repetition is a cornerstone of learning dermatopathology, and these Kodachrome examples are designed to leave a lasting impression, serving as valuable reference points for attendees throughout their training and beyond," Dr. Weston said.

Dermatology residents and fellows are encouraged to take advantage of this unique session, in addition to all the other programming and resources the AAD offers.

"I hope all attendees, regardless of their stage in dermatology training or familiarity with dermatopathology, will leave this session feeling more confident in their dermpath knowledge — whether for board exam preparation or their future practice as dermatologists," said Dr. Weston.

"Dermatopathology remains relevant beyond examinations; a good understanding of the subject will help residents be better clinicians," added Dr. Kim. ●



A sample Kodachrome image that attendees can identify during the 'Test Your Knowledge' portion of Monday's dermatopathology session. Be there to find out if you got it right!

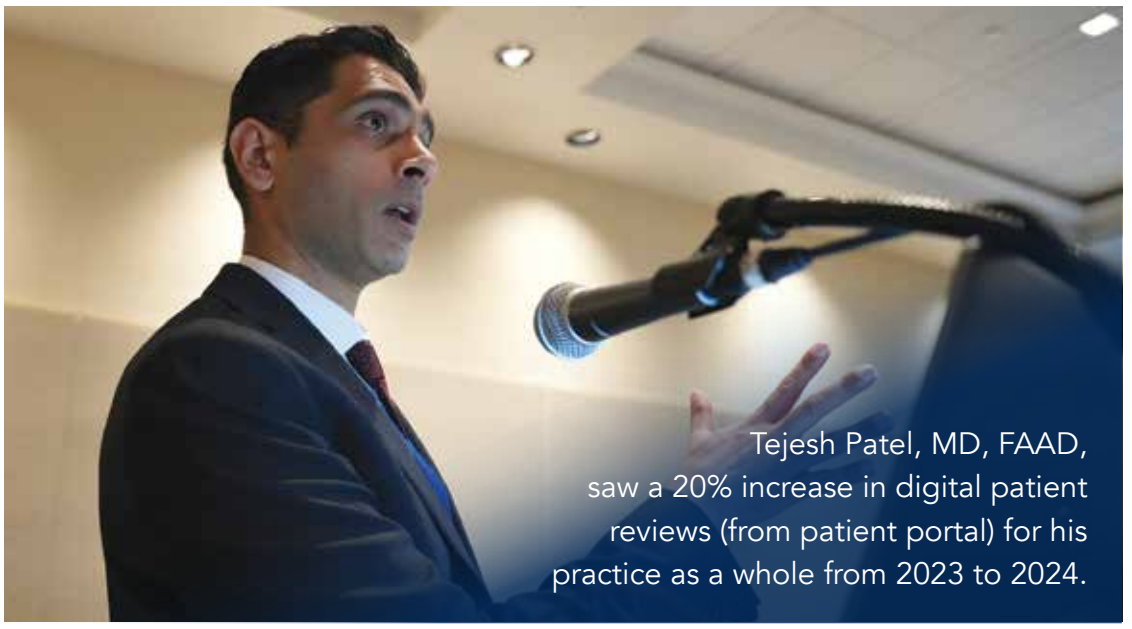
Consider the optics

How to foster trust through patient success stories and practice values.

Understanding the power of optics can help a dermatology practice's reputation. In the competitive field of dermatology, online reputation management and targeted digital marketing play a vital role in enhancing the visibility and credibility of dermatologists and their practices.

Saturday's session, **F032 – Building Your Digital Reputation: Strategies for Online Reviews and Effective Marketing in Dermatology**, detailed just how critical optics can be, from managing online reviews to implementing targeted digital marketing strategies. The interactive session featured experts in the field: Oyetewa Asempa, MD, FAAD; Dhaval Bhanusali, MD, FAAD; Muneeb Shah, DO, FAAD; and session director Tejesh Patel, MD, FAAD.

The panelists, along with AAD's social media senior manager Kara Jilek, shared effective reputation management and innovative marketing techniques tailored specifically for dermatology practices. They also discussed actionable insights to enhance patient engagement, build trust, and optimize an online presence.



Tejesh Patel, MD, FAAD, saw a 20% increase in digital patient reviews (from patient portal) for his practice as a whole from 2023 to 2024.

"We are incredibly fortunate to have an impressive lineup of speakers today, all of whom have made a significant and positive impact in the realm of dermatology online," Dr. Patel said when opening the session. Dr. Patel is the Amonette-Rosenberg chair and professor of dermatology at the University of Tennessee Health Science Center in Memphis.

"These experts have developed effective strategies for managing online reputation, engaging with the public and their patients through social media, and enhancing the visibility of dermatology as a specialty," he said. "Their experiences and insights are invaluable for anyone looking to build upon or improve their digital presence in today's increasingly online health care landscape."

Word of mouth

In today's digital era, Dr. Patel said, patients increasingly rely on online reviews and the experiences shared by others when making health care decisions. Positive reviews help build trust and credibility, showcasing the quality of care, patient satisfaction, and expertise. Conversely, negative reviews can deter potential patients, making it essential for dermatologists and their practices to manage their online reputation carefully. Engaging with reviews thoughtfully and professionally can influence patient choice by creating a strong, trustworthy online presence.

During the session, panelists shared tips for developing targeted strategies to respond to patient feedback and engage effectively with the dermatology community. They also reminded dermatologists to remain professional, empathetic, and objective when replying to patient feedback.

"Acknowledge concerns in negative reviews without disclosing personal health information (PHI) or engaging in defensiveness," Dr. Patel said. "Offer a solution or ask the patient to contact the office directly to demonstrate commitment to the patient's care and their satisfaction."

Let's talk success

Remember, too, that positive reviews can be shared as testimonials in marketing materials, social media posts, and website content, all of which build public trust, panelists shared. Likewise, they said that engaging with the dermatology community involves providing educational content, participating in online forums, and being proactive on social media to showcase expertise and foster dialogue within the field.

"Sharing testimonials and patient success stories with your audience ensure that all reviews reflect the values and standards of your practice," said Dr. Patel. "By consistently displaying positive feedback, dermatologists can build a positive public image, making them and their practice more appealing to prospective patients and increase engagement on platforms like Instagram and Facebook." ●

ONLINE REVIEWS

According to a 2021 study, "Patient Satisfaction of General Dermatology Providers: A Quantitative and Qualitative Analysis of 38,008 Online Reviews":

Online patient reviews are the leading forum for evaluating physicians. This **valuable real-time data can help measure patient satisfaction**, which has direct impact on clinical outcomes, patient retention, and medical malpractice claims.

38k reviews studied from 352 general dermatology clinicians across the country published on sites such as Google, US News, WebMD, Healthgrades, and Vitals

Average overall quantitative rating was **4.18 out of 5**
(out of 28,216 quantitative reviews)

77% positive
23% negative

Factors that scored the highest:
- Patient's perceived experience
- Physician's bedside manner
- Answered questions
- Diagnosis/competence

Factors that scored lower:
- Wait time
- Time spent with patients
- Office staff and space
- Costs

Suggests that a general dermatology clinician's **personality, compassion, empathy, and attentiveness** may overcome other issues to create an overall positive experience.

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