Experts cover hot topics

Attendees pinpoint topics they are most curious about

One of the most popular sessions at the Annual Meeting is “Hot Topics” because attendees help choose the subjects they want addressed. Friday, an expert faculty presented updates on the selected topics, including the announcement of the 2016 Contact Allergen of the Year, the use of digital dermatoscopes to document lesions, the latest research in sunscreens, and the importance of using biologics to treat psoriasis.

Cobalt named Allergen of the Year

With little fanfare, David E. Cohen, MD, MPH, announced cobalt as the 2016 Allergen of the Year, drawing a round of applause.

Commonly found in industrial products, including tools, engines, and magnets, the rate of reactivity is high at more than 7 percent, and irritant reactions on patch tests are common.

“We often see little peppered red signals under the cobalt pattern patch test. I wouldn’t over-read this unless there is a nice confluence of redness and some induration,” said Dr. Cohen, the Charles and Dorothea Harris Professor and vice chair for Clinical Affairs at New York University School of Medicine.

One recent study found that more than one-third of commonly used products — belt buckles, bracelets, earrings, necklaces, rings, and watches — were spot positive for cobalt. Darker colored metals have a higher rate of risk for having cobalt, he said.

A 2012 patch test study showed about two-thirds of patients reacted to at least one metal.

“If you want a patch test to determine metal hypersensitivity, it’s probably the best test we have right now. It’s certainly much easier to do it before someone has surgery, than afterward,” said Dr. Cohen, director of the allergic, occupational, and environmental dermatology at New York University. “There is no standard of care for this, and I do not advocate pretesting everyone.”

Melanoma update

Just as dermatologists have increased their use of dermatoscopes in the last five years, Allan C. Halpern, MD, said he predicts the next five years will show equal growth in the use of digital dermatoscopes.

“The reality is that digital dermoscopy has become commonplace because you can document lesions and follow them over time,” said Dr. Halpern, chief of dermatology service at Memorial Sloan Kettering Cancer Center, New York.

He pointed to the number of companies marketing dermatoscopes, which consumers can purchase at a reasonable price and attach to their smartphones.

“This will allow consumers to send their own dermoscopic image for a teledermatology diagnosis,” Dr. Halpern said.

“Not surprisingly, we all know there’s this proliferation of apps with hundreds out there claiming to educate people about melanoma. See HOT TOPICS, page 25

Saturday • March 5
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Patient Education Makes A Difference.

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• Oil glands become less active which can make it harder to retain moisture in the skin.

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Meet your 2016 slate of candidates

The American Academy of Dermatology has selected its candidates in this year’s election. The Nominating Committee voted to present the following slate of candidates (listed in random order) to the membership for the 2016 Academy election of officers, directors, and Nominating Committee member representatives.

Board of Directors

President-Elect  Vice President-Elect
Allan Wirtz, MD   Sandra I. Raad, MD
Suzanne Olbricht, MD   Ted Rosen, MD

Nominating Committee Member Representatives
Clay J. Cockrell, MD   Wilma F. Bergfeld, MD
Valerie D. Callender, MD   Michael Bigby, MD

Psoriasis guidelines to be discussed

Treatment advances and the development of guidelines have greatly improved the management of psoriasis. Learn about those advances during “Translating Evidence into Practice: Psoriasis Guidelines” (S024) from 9 a.m. to noon Saturday in Room 147A.

Led by Alan Menter, MD, and Craig A. Elmer, MD, the session can help expand your knowledge base and improve clinical confidence and effectiveness in treating patients with psoriasis and psoriatic arthritis. Studies have shown that high-quality guidelines can make important contributions to improving medical care. The session features eight presentations focusing on the various treatment approaches discussed in the guidelines of care and recent advances in systemic treatments for psoriasis and psoriatic arthritis.

- Current Concepts in Psoriasis Pathogenesis, Dr. Elmer
- Psoriasis Co-Morbidities and Prevention of Risk Factors, Joel M. Gelfand, MD, MSCE
- Phototherapy for Psoriasis with Case Studies, Henry W. Lim, MD
- Systemic Therapies for Psoriasis and Psoriatic Arthritis with Case Studies, Mark Lebwohl, MD
- Improving Physician Communication and Patients’ Adherence, Steven R. Feldman, MD, PhD
- New Developments in Psoriatic Arthritis, Alice B. Gottlieb, MD, PhD
- Biologic Therapies for Psoriasis and Psoriatic Arthritis with Case Studies, Craig L. Leonardi, MD
- Biosimilars in Our Psoriasis Therapeutic Armamentarium: The Future, Dr. Menter

Question of the Day

What was your ‘Hot Topic’ vote-getter?

“I wanted to hear more about the use of tofacitinib for alopecia areata. I picked that because it is an emerging treatment, and a lot of people are applying that medication to things in dermatology, so I want to see if anyone is doing anything else that is new.”
Lindsey Bordone, MD
New York

“I wanted to see more about sunscreens because patients read things on the Internet and they are not backed up by science. I also want to hear more about the new and emerging treatments for psoriasis.”
Kathryn Holloway, MD
Ocala, Florida

“I chose psoriasis, mostly because a lot of patients are coming in for that, and it is an important topic at the moment, with some new medicines being developed.”
Antoine Fauconneau, MD
Boudeaux, France
Residents take center stage in D.C.

Events mix fun and education

Have a little fun, assess your core competencies, and identify knowledge gaps to prepare for the board exam by attending “Resident Jeopardy” (S047) from a.m. to noon Monday in Room 146B. Presented in a format based on the iconic game show Jeopardy, “Resident Jeopardy” features teams from residency training programs that will compete in answering questions and image-based inquiries in all things dermatology. Audience members are invited to play along and test their own skills.

Residents, fellows to present research at Fox competition

See the latest research from residents and fellows on the pathophysiology and treatment of cutaneous disease at “The Residents and Fellows Symposium” (S034) from 1-4 p.m. Sunday in Room 102. All 26 presentations in the session will be made by finalists for the Everett C. Fox Memorial Award. The award was developed through an endowment from Dr. Fox, a leading dermatologist in Dallas and a faculty member at Baylor University and UT Southwestern University.

Session faculty members will form a panel to judge the presentations and choose the award winner.

‘Power Hour’ to address training topics for residents

Dermatology residents have the opportunity to take home answers to important training questions by attending “High-Yield ‘Power Hour’ for Residents” (F081) from 3:30 to 5:30 p.m. Saturday in Room 145. The session will feature six faculty members using image-based learning to share information about:

• Mechanisms of action and side effects of systemic dermatologic therapies
• Infectious disease dermatology
• Allergens associated with contact dermatitis
• Inherited and immunobullous disorders of the epidermal basement membrane
• Key concepts in pediatric and neonatal dermatology

Speakers will use multiple-choice questions to highlight take-home messages.

Following a action-packed day of board prep and sessions, residents kicked back at the Resident Reception at the Marriott Marquis. There they networked with fellow residents and met up with old friends.

Residents practiced for their boards using a simulated, abridged version of the American Board of Dermatology certification exam. Attendees practiced their timing for the exam as well as pinpointed any areas of weakness. With guidance of expert faculty members, attendees reviewed dermatopathology glass slides, surveyed digital images and answered written questions.

Learn from dermatology leaders

Residents can learn from leaders by attending a special panel discussion featuring experts in their chosen subspecialties of dermatology. “Masters of Dermatology” will share inspiring messages and key lessons from their careers. The session is an opportunity to learn from and meet role models in the profession. Panelists will remain for a half-hour following the session for an informal meet-and-greet with residents.
INDICATION AND USAGE
Enstilar® (calcipotriene and betamethasone dipropionate) Foam is indicated for the topical treatment of plaque psoriasis in patients 18 years of age and older.

Apply Enstilar® to affected areas once daily for up to 4 weeks. Patients should discontinue use when control is achieved. Instruct patients not to use more than 60 g every 4 days.

IMPORTANT SAFETY INFORMATION
For topical use only. Enstilar® is not for oral, ophthalmic, or intravaginal use. Instruct patients to avoid use on the face, groin, or axillae, or if atrophy is present at the treatment site, and not to use with occlusive dressings, unless directed by a physician.

The propellants in Enstilar® are flammable. Instruct patients to avoid fire, flame, or smoking during and immediately after using this product.

Hypercalcemia and hypercalciuria have been observed with use of Enstilar®. If hypercalcemia or hypercalciuria develop, patients should discontinue treatment until parameters of calcium metabolism have normalized.

Topical corticosteroids can produce reversible hypothalamic pituitary-adrenal (HPA) axis suppression with the potential for glucocorticosteroid insufficiency. Risk factors include use of high-potency topical corticosteroids, use over a large surface area or on areas under occlusion, prolonged use, altered skin barrier, liver failure, and use in pediatric patients. If HPA axis suppression is documented, gradually withdraw the drug, reduce the frequency of application, or substitute with a less potent steroid. Systemic effects of topical corticosteroids may also include Cushing’s syndrome, hyperglycemia, and glucosuria. Use of more than one corticosteroid-containing product at the same time may increase total systemic corticosteroid exposure.

Adverse reactions reported in <1% of subjects treated with Enstilar® in clinical trials included application site irritation, application site pruritus, folliculitis, skin hypopigmentation, hypercalcemia, urticaria, and exacerbation of psoriasis.

Patients who apply Enstilar® to exposed skin should avoid excessive exposure to either natural or artificial sunlight, including tanning booths, sun lamps, etc. You may wish to limit or avoid use of phototherapy in patients who use Enstilar®.

There are no adequate and well-controlled studies of Enstilar® in pregnant women. Enstilar® should be used during pregnancy only if the potential benefit to the patient justifies the potential risk to the fetus. Because many drugs are excreted in human milk, caution should be exercised when Enstilar® is administered to a nursing woman. Do not use Enstilar® on the breast when nursing.

The safety and effectiveness of Enstilar® in pediatric patients have not been studied.

Please see Brief Summary on following page.
Enstilar® (calcipotriene and betamethasone dipropionate) Foam, 0.005%/0.064% for topical use

Initial U.S. Approval: 2006

BRIEF SUMMARY: Please see package insert for full Prescribing Information.

INDICATIONS AND USAGE
Enstilar® (calcipotriene and betamethasone dipropionate) Foam is indicated for the topical treatment of plaque psoriasis in patients 18 years of age and older.

CONTRAINDICATIONS
None.

WARNINGS AND PRECAUTIONS
Flammability
The propellants in Enstilar® Foam are flammable. Instruct the patient to avoid fire, flame, and smoking during and immediately following application.

Hypercalcemia and Hypercalciuria
Hypercalcemia and hypercalciuria have been observed with use of Enstilar® Foam. If hypercalcemia or hypercalciuria develop, discontinue treatment until parameters of calcium metabolism have normalized. The incidence of hypercalcemia and hypercalciuria following Enstilar® Foam treatment of more than 4 weeks has not been evaluated.

Effects on Endocrine System
Systemic absorption of topical corticosteroids can produce reversible hypothalamic-pituitary-adrenal (HPA) axis suppression with the potential for clinical glucocorticosteroid insufficiency. This may occur during treatment or upon withdrawal of the topical corticosteroid. Factors that predispose a patient to HPA axis suppression include the use of high potency steroids, large treatment surface areas, prolonged use, use of occlusive dressings, altered skin barrier, liver failure, and young age. Evaluation for HPA axis suppression may be done by using the adrenocorticotropic hormone (ACTH) stimulation test. If HPA axis suppression is documented, gradually withdraw the drug, reduce the frequency of application, or substitute with a less potent corticosteroid. Systemic effects of topical corticosteroids may also include Cushing’s syndrome, hyperglycemia, and glucosuria.

Pediatric patients may be more susceptible to systemic toxicity due to their larger skin surface to body mass ratios. Use of more than one corticosteroid-containing product at the same time may increase total systemic corticosteroid exposure.

Allergic Contact Dermatitis
Allergic contact dermatitis has been observed with topical calcipotriene and topical corticosteroids. Allergic contact dermatitis to a topical corticosteroid is usually diagnosed by observing a failure to heal rather than a clinical exacerbation. Corroborate such an observation with appropriate diagnostic patch testing.

Risks of Ultraviolet Light Exposures
Patients who apply Enstilar® Foam to exposed skin should avoid excessive exposure to either natural or artificial sunlight, including tanning booths, sun lamps, etc. Physicians may wish to limit or avoid use of phototherapy in patients who use Enstilar® Foam.

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

The rates of adverse reactions given below were derived from three randomized, multicenter, prospective vehicle and/or active-controlled clinical trials in subjects with plaque psoriasis. Subjects applied study product once daily for 4 weeks, and the median weekly dose of Enstilar® Foam was 24.8 g.

Adverse reactions reported in <1% of subjects treated with Enstilar® Foam included: application site irritation, application site pruritus, folliculitis, skin hypopigmentation, hypercalcaemia, urticaria, and exacerbation of psoriasis.

Postmarketing Experience
Because adverse 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 drug exposure. Postmarketing reports for local adverse reactions to topical steroids include atrophy, striae, telangiectasia, dryness, perioral dermatitis, secondary infection, and miliaria.

USE IN SPECIFIC POPULATIONS
Pregnancy
Teratogenic Effects: Pregnancy Category C
There are no adequate and well-controlled studies in pregnant women. Pregnant women were excluded from the clinical studies conducted with Enstilar® Foam. Enstilar® Foam should be used during pregnancy only if the potential benefit to the patient justifies the potential risk to the fetus. Animal reproduction studies have not been conducted with Enstilar® Foam. Enstilar® Foam contains calcipotriene that has been shown to be teratogenic and betamethasone dipropionate that has been shown to be teratogenic in animals when given systemically.

Nursing Mothers
Systemically administered corticosteroids appear in human milk and can suppress growth, interfere with endogenous corticosteroid production, or cause other untoward effects. It is not known whether topically administered calcipotriene or corticosteroids could result in sufficient systemic absorption to produce detectable quantities in human milk. Because many drugs are excreted in human milk, caution should be exercised when Enstilar® Foam is administered to a nursing woman. Instruct the patient not to use Enstilar® Foam on the breast when nursing.

Pediatric Use
Safety and effectiveness of the use of Enstilar® Foam in pediatric patients have not been studied. Because of a higher ratio of skin surface area to body mass, children under the age of 12 years are at particular risk of systemic adverse effects when they are treated with topical corticosteroids. They are, therefore, also at greater risk of HPA axis suppression and adrenal insufficiency with the use of topical corticosteroids. Cushing’s syndrome, linear growth retardation, delayed weight gain, and intracranial hypertension have been reported in pediatric patients treated with topical corticosteroids.

Local adverse reactions including striae have been reported with use of topical corticosteroids in pediatric patients.

Geriatric Use
Of the total number of subjects in the controlled clinical studies of Enstilar® Foam in plaque psoriasis, 97 were 65 years or older, while 21 were 75 years or older. No overall differences in safety or effectiveness of Enstilar® Foam were observed between these subjects versus younger subjects, and other reported clinical experience has not identified differences in responses between the elderly and younger patients, but greater sensitivity of some older individuals cannot be ruled out.

PATIENT COUNSELING INFORMATION
[Advise the patient to read the FDA-approved patient labeling (Patient Information and Instructions For Use)]

Inform patients of the following:
• Instruct patients to wash face before use.
• Instruct patients not to use more than 60 g every 4 days.
• Discontinue therapy when control is achieved unless directed otherwise by the physician.
• Avoid use of Enstilar® Foam on the face, underarms, groin or eyes. If this medicine gets on face or in mouth or eyes, wash area right away.
• Wash hands after application.
• Do not occlude the treatment area with a bandage or other covering unless directed by the physician. Instruct the patients not to use other products containing calcipotriene or a corticosteroid with Enstilar® Foam without first talking to the physician.

Manufactured by: Cople Laupheim GmbH & Co. KG
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86% of clinical study participants showed an improvement in firmness and wrinkles.*

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After 12 weeks*

*As assessed by an expert grader, n=44, 35-60 years of age. Vitamin C Lotion 30% used once daily in A.M. in combination with Retinol Complete™ used once daily in P.M. Data on file. Results may vary.

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Skin Cancer

Less invasive treatment options
Nonsurgical options seek to get to the root of the problem

Patients are demanding less invasive skin cancer treatments with minimal downtime for recuperation. To deliver on their expectations safely, Anthony M. Rossi, MD, offered the best mix of therapy approaches Friday during “What’s Next: Nonsurgical and Adjunctive Treatment for Skin Cancers.”

“Dermatology is paving the way to catch up to what our patients want,” said Dr. Rossi, assistant attending at Memorial Sloan Kettering Cancer Center and New York Presbyterian Hospital. “The caveat is that not every skin cancer is amenable to nonsurgical or adjunctive approaches.”

Skin cancers conducive for nonsurgical approaches may include squamous cell carcinoma in situ, low-risk superficial or nodular basal cell carcinomas, and, in some circumstances, lentigo maligna.

A nonsurgical approach may be considered for certain cosmetically sensitive anatomical areas such as the nose and face. Nonsurgical treatment also addresses field cancerization issues by effectively treating large areas, such as an entire face or scalp, that are affected by actinic damage and superficial carcinomas.

Imiquimod, photodynamic therapy, and intraleisional chemotherapy top the list of nonsurgical treatments for low-risk skin cancers. For example, studies have shown that imiquimod for basal cell carcinoma produces a histological or clinical cure rate in the high 60 to low 80 percent range, depending on subtype.

“However, even if these responses occur, that doesn’t necessarily mean imiquimod is working for a specific patient,” Dr. Rossi said. “We must monitor patients closely for signs the tumor might be persisting or recurring. Close clinical follow-up with inspection, dermoscopy, and, in my clinic, reflectance confocal microscopy help detect persistence.”

As for imiquimod treatment of lentigo maligna, Dr. Rossi first determines the full scope of the damaged skin through whole-lesion and scouting biopsies to ensure it is not invasive melanoma. He also uses reflectance confocal microscopy to visualize below the skin to detect potential areas of subclinical melanoma and recurrence after treatment. The treatment regimen involves daily imiquimod application for at least 12 weeks for effective histologic clearance.

Photodynamic therapy (PDT) with amino-levulinic acid and either red or blue light can be a great nonsurgical treatment for squamous cell carcinoma in situ or early superficial/nodular basal cells.

“I really like PDT for many of my patients because it can treat early skin cancers as well as treat a large area of field cancerization,” Dr. Rossi said. “This usually requires two or three consecutive treatments spaced about one month apart. The healing and cosmesis is quite nice. I also tend to start PDT on patients after they have had multiple non-melanoma skin cancers to try to reduce their actinic burden. The goal is to prevent future occurrences, which really resonates with my patients.”

Radiation can serve as either a primary or adjuvant treatment for primary skin cancer, especially for basal and squamous cell skin cancers. Dr. Rossi adheres to specific radiation treatment criteria and fully discusses the benefits and risks of treatment with patients.

Adjunct radiation reduces the incidence of local recurrence by eradicating residual basal cell carcinoma. The goal is to target the deeper aspect of the tumor that may not have been cleared by surgery alone.

“The limitation of nonsurgical treatment is not visualizing the entire skin cancer and therefore just treating the tip of the iceberg, leaving the cancer roots mostly intact.”

Dr. Rossi said. “Still, it is important to explore these less invasive treatment options. What’s next will be a new wave of nonsurgical treatment options for skin cancer in the future.”

Mohs vs. radiation

Mohs surgery is the gold standard for many head and neck skin cancers, but Mohs is not ideal for all patients. Patients who are older, on blood thinners, have multiple medical co-morbidities, or have lesions on difficult-to-repair locations may not be good candidates for surgery. Some patients prefer nonsurgical treatment options. For those patients, superficial radiation treatment (SRT) is a valuable, yet seldom used, alternative.

“In a limited number of select lesions on select patients, radiation may be as good as, or better than, Mohs,” said Armand Cognetta, MD, professor and chief of dermatology at the Florida State University College of Medicine and founding partner of Dermatology Associates of Tallahassee. “Even though Mohs has a slightly better cure rate, it might not be the better choice for an older, infirm patient. And for areas that are difficult to repair cosmetically, such as the rim of the nostril, radiation may be superior because the cosmetic result is often better.”

Dr. Cognetta discussed the indications and limitations of SRT Friday during “Outpatient Radiotherapy of Skin Cancer: Back to the Future” (F033).

Mohs surgery has an outstanding cure rate, approaching 98 percent, he said. A 10-year study of superficial X-ray treatment for basal and squamous cell carcinomas showed about a 95 percent cure rate.

At present, relatively few dermatologists have access to a superficial X-ray platform, although state-of-the-art units are now readily available. Mohs surgery has been so successful that many dermatologists and dermatology teaching programs have abandoned other treatment modalities, or, in the case of radiation, relegated it to radiation oncology specialists.

Dr. Cognetta said that he sees good results using a fractionated five-treatment schedule for most patients.

The most appropriate patients for radiation are those who are not good candidates for surgery or those who have nonaggressive tumors and prefer nonsurgical treatment. Radiation oncology referral and electron beam treatment are more appropriate for deep, aggressive, or unseetable basal and squamous cell tumors, and those that exhibit large caliber nerve permeal invasion, Dr. Cognetta said.

See the AAD position statement on SRT at http://www.aad.org/superficialradiation.

Treatments of choice

Clinicians have several options to surgery for treating high-risk cancers. Following are some of the options being used.

Radiation

Radiation can be used as a primary or adjuvant treatment for primary skin cancer, especially basal and squamous cell skin cancers. It is best not to use it on patients under age 55 because of risk for skin cancers in the radiated field, or on the hands or legs because of the risk for skin breakdown.

Imiquimod

For basal cell carcinoma, a five-times-a-week imiquimod application for about six to eight weeks can be effective, and most patients will experience a significant skin response, including erythema, crusting, and skin breakdown. It also can be used to treat lentigo maligna after using reflectance confocal microscopy to detect potential areas of subclinical melanoma.

Adjuvant radiation

For squamous cell skin carcinoma, adjuvant radiation is effective in high-risk areas, such as scalp or head and neck. It also is an effective treatment for tumors deeper than 2 centimeters and with high-risk features on histology.

Intraleisional methotrexate chemotherapy

Keratoacanthoma forms of squamous cell carcinoma may respond well to intraleisional methotrexate chemotherapy. One to three rounds of methotrexate injections into the base and four quadrants of the keratoacanthoma lesion at four-week intervals can shrink the tumor considerably and even clear it entirely without surgery.

Anthony M. Rossi, MD: ‘The limitation of nonsurgical treatment is not visualizing the entire skin cancer and therefore just treating the tip of the iceberg, leaving the cancer roots mostly intact.’

Lesions of the head and neck

Mohs vs. radiation

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See the AAD position statement on SRT at http://www.aad.org/superficialradiation.
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Jeffrey Sobell, MD
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New AAD honorary members

The AAD is honoring nine physicians for their work in the specialty by naming them as AAD honorary members:

- James Q. Del Rosso, DO
- Charles N. Ellis, MD
- Norman Goldstein, MD
- Alice B. Gottlieb, MD, PhD
- Pearl E. Grimes, MD
- Maria K. Hordinsky, MD
- Douglas R. Lowy, MD
- Daniel M. Siegel, MD, MS
- John W. Weiss, MD

Climb a rock wall to battle skin cancer
Event to raise funds, awareness of SPOT Skin Cancer campaign

Meeting attendees can finish their weekends on a high note by visiting the rock wall climbing event in Hall D starting at noon Sunday. It’s also your opportunity to join the AAD in telling skin cancer to take a hike! The wall and the rock climbing event/competition, which is open to all, will help raise awareness and funds for AAD’s SPOT Skin Cancer™.

Where does the money raised go?
Funds raised will help:
- Expand free, nationwide SPOTme® skin cancer screenings
- Build more shaded, sun-safe outdoor areas
- Provide free skin cancer prevention and detection educational resources

About Skin Cancer, Take a Hike™
Skin Cancer, Take a Hike™ — the AAD’s signature fundraising event for SPOT Skin Cancer™ — will support shade structures in communities, continued skin cancer screenings to catch skin cancer at its earliest, most treatable stage, and education to the public to teach prevention tips and early detection of skin cancer.

In 2014, AAD member Ellen Marmur, MD, created the first Skin Cancer, Take a Hike™ event, leading a team of friends and colleagues to climb Mt. Kilimanjaro. Her vision and their team efforts brought significant media attention to skin cancer prevention and detection, and raised $150,000 to support the Academy’s SPOT Skin Cancer™ initiative. Since then, several regional hikes throughout the U.S. have taken place.

Please stop by the rock wall to find out more. It’s for a good cause. All in all, it’s not just another derm on the wall.

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Ask the right questions... ...find out what really patients think

You’re invited to listen in on a patient’s Inner Dialogue at Booth 1513.

Then change the conversation by joining us at the Renaissance Washington, DC Downtown Hotel on Saturday, March 5th at 6:30 pm for Enhancing HCP-Patient Dialogue to Optimize Treatment.

Notice: This event is conducted in accordance with the Pharmaceutical Research and Manufacturers of America® (PhRMA) Code on Interactions with Healthcare Professionals and is limited to healthcare professionals (HCPs). Attendance by guests or spouses is not appropriate. Government employees are subject to state and federal laws and ethics rules that may limit their ability to receive any gifts, including meals, from pharmaceutical companies. If you are a state or federal employee, it is your responsibility to seek guidance and prior approval from your employer or site ethics counselor to attend this or any Pfizer event. Your attendance will be considered confirmation to Pfizer that you have obtained any necessary approvals to attend this event.

This program is independent and is not part of the official American Academy of Dermatology (AAD) Annual Meeting, as planned by its Scientific Assembly Committee.

This program does not qualify for Continuing Medical Education Credit (CME).
Aesthetics

New lasers, new uses

Devices being used for more medical, cosmetic treatments

Lasers have become some of the most useful tools in dermatology. Laser-assisted drug delivery, body contouring, fractional resurfacing, scar therapy, and treatment of vascular lesions are only a few of the growing number of uses for both traditional laser instruments and more novel approaches.

“Over the years, lasers have grown to address an increasing number of medical and cosmetic issues,” said Arisa Ortiz, MD, director of laser and cosmetic dermatology and assistant clinical professor of dermatology at the University of California, San Diego. “We are not only building on new indications with previously existing technologies, but also expanding the scope of our field with new devices. Patients are more interested in noninvasive procedures these days. They are less interested in surgical procedures like neck lifts and other invasive procedures with increased risk of complications. They also want less downtime and a more natural look.”

Dr. Ortiz will explore new options in body contouring during “What’s New and What’s True in Lasers” (S041). Look for new platforms as well as new areas of interest.

One of the newest devices for body contouring is the SculptSure, made by Cynosure, a hyperthermic laser cleared by the FDA for noninvasive lipolysis. According to the manufacturer, the 1,060 nm wavelength is preferentially absorbed by adipose tissue and has minimal absorption in the dermis. Disrupted adipose cells are eliminated by the body. Initial results usually can be seen in four to six weeks, with optimal results after about 12 weeks.

The device is configured with up to four applicators to allow treatment of multiple areas in a single 25-minute session. Previous devices could take up to 60 minutes per session and allow treatment of just a single area at one time.

“As with all new technologies, skepticism should be high. Time will tell whether this product is effective,” she said of the SculptSure.

Another new device is the first hybrid nonablative plus ablative laser, the Halo, manufactured by Sciton. According to the manufacturer, this laser delivers 2,940 nm Er:YAG of ablative energy 100 microns into the epidermis and 1,470 nm diode to deliver coagulation from 100 to 700 microns in the epidermis and dermis at the same time. When fewer than 100 microns of ablation are used, the epidermis regenerates over 24 hours. The coagulated dermis regenerates over about seven days.

“You might think the combination of two wavelengths would lead to more downtime,” Dr. Ortiz said, “but the ablative wavelength creates tiny holes in the skin that allow the debris to extrude faster.”

One of the newest target areas in body contouring is submental fat. Deoxycholic acid injections were the first tool approved by the FDA to deal effectively with double chins, she said. Even as deoxycholic acid is being expanded to off-label uses in areas such as axillary fat, existing devices are being adjusted to target the submental region. CoolSculpting has a new applicator, the CoolMini, to manage submental tissue.

“Double chins haven’t really been addressed in the past except through neck lifts or liposuction,” Dr. Ortiz said. “Now there are multiple non-invasive options available to expand our armamentarium.”

Dr. Ortiz is a speaker for and serves on the advisory board of Sciton.

Tanning bed regs

The AAD is asking members to support the FDA’s efforts to toughen the regulation of tanning beds. AAD Members are encouraged to stop by the AAD Resource Center booth to send a letter to the FDA in support of the proposed indoor tanning rules which would restrict minors from using tanning beds and strengthen risk warnings.

Visit the advocacy booth in the Resource Center, part of The Connection in Hall D, through Monday.

The AAD is encouraging the FDA to finalize this proposed rule as it would be a historic victory in our nation’s fight to eradicate skin cancer.

Learning through live demonstrations

Two sessions use patients, cadavers to show procedures, review anatomy

Physician experts demonstrate on patients and cadavers how they use the latest tools approved by the FDA for a variety of treatments, present tips for procedures, and use dissection to review head and neck anatomy at two Live Demonstration sessions.

The morning session “Live Demonstration: Soft Tissue Augmentation and Neuromodulators — Simultaneous Cadaver Prosection and Live Patient Injections” (C011) will focus on demonstrating recently approved tools to augment nonsurgical rejuvenation. Live patient demonstrations will include augmentation with dermal fillers, treatment of submental fullness, and optimal use of neuromodulators.

Attendees will see live patient assessment and treatments next to the demonstration of pertinent anatomy on a dissected cadaver. Faculty members will show how techniques have evolved to require injections at various tissue planes, requiring an understanding of the anatomy to avoid complications and maximize patient outcomes.

Procedures that will be demonstrated are forehead and glabella rejuvenation, temple revolumization, and lip and perioral enhancement. Other topics will include full-face assessment, and using injectable lifting sutures, an injectable approach to submental fat, and a temperature-controlled radio frequency approach to submental fat.

The afternoon session “Head and Neck Anatomy — Cadaver Prosection” (C017) will review the basic principles of head and neck superficial anatomy as it relates to dermatologic surgery. Lectures as well as dissection and live demonstrations using cadaver specimens will be used to show important superficial head and neck anatomical structures important for dermatologists and dermatological surgeons.

The live demonstration of the prosected anatomy will be projected on several large screens for direct visualization of detailed structures. Clinical correlation of anatomy to dermatologic surgery will be emphasized.

Presentations will focus on superficial face and head anatomy, clinical situations and issues with anatomy, prosection of the face and scalp, and superficial neck anatomy.
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Dermatologist

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VISIT THE AAD RESOURCE CENTER IN HALL D!
Friday, March 4 – Monday, March 7 • 7 a.m. – 5 p.m. daily
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AAD's DataDerm™
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Claiming CME Credit

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Online Learning Center
Claiming CME Credit
Online
AAD's DataDerm™
New Clinical Data Registry

1:00 p.m. – 1:15 p.m.
DRB Student Loan Best Practices
Henry Schein Get to Know GPO's
CareCredit Talks Patient Financing
Officite Website Best Practices

2:00 p.m. – 2:15 p.m.
How to use AADCodingToday
AADCareerCompass.org
Job Seekers Professional CV Review
AAD’s DataDerm™ New Clinical Data Registry
Online Learning Center
Claiming CME Credit
Online
AAD’s DataDerm™ New Clinical Data Registry

3:00 p.m. – 3:15 p.m.
AADCareerCompass.org Employers—Finding the Right Fit
AAD’s DataDerm™ New Clinical Data Registry
Online Learning Center
Claiming CME Credit Online
AAD’s DataDerm™ New Clinical Data Registry

4:00 p.m. – 4:15 p.m.
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Syphilis: Skin talks

Dermatologists should watch for telltale signs of resurgent disease state

Syphilis is the comeback kid re-emerging throughout the United States, and dermatologists are in a prime position to detect the disease, which can include debilitating neurosyphilis and ocular syphilis even during early stages. However, dermatologists risk missing the diagnosis if they aren’t thinking about or considering syphilis as a possibility, warned Kenneth Katz, MD, course director for Friday’s session “Sex, Sores, Science, and Surveillance: Syphilis in the 21st Century.”

“Syphilis is often thought of as a disease we got rid of in the 20th century, but we are going back to the future with this illness,” said Dr. Katz, dermatologist for Kaiser Permanente of Northern California, Pleasanton. “In the past 15 years, the incidence of syphilis has more than tripled from approximately 6,000 new cases of primary and secondary syphilis each year to nearly 20,000 a year today.”

Syphilis is known as the great mimicker because it looks like some other dermatologic conditions. The disease should be in the differentials of diagnosis with the appearance of rashes on the trunk, spots on the hands, and sores in the genital or other areas. Congential syphilis also should be in the differential diagnosis for newborns with rashes on the body and other telltale signs, such as rhinitis with mucous.

Dr. Katz emphasizes the importance for clinicians to obtain a patient’s sexual history to determine his or her level of risk. Currently, the epidemic is especially widespread among men who have sex with men, particularly those living with HIV.

Because neurosyphilis and ocular syphilis can occur during any stage of syphilis, it’s critical to take a neurologic and ophthalmic history and, if indicated, conduct a neurologic and ophthalmic evaluation. To help prevent congenital syphilis, the CDC recommends screening pregnant women at their first prenatal visit and again at 28 weeks if they live in geographic areas with a high prevalence of the illness among newborns.

Every state requires that clinicians and laboratories report suspicious or confirmed cases of syphilis to public health authorities. Public health workers in many cases then reach out to syphilis patients to inquire about recent sex partners so they can be contacted for testing and treatment.

Dr. Katz recommends that clinicians inform patients about the public-health reporting requirement and about the likely outreach from public health workers, emphasizing how cooperating with public-health workers can help stop the chain of syphilis transmission and contribute to combating the epidemic.

The algorithm for serologic diagnosis of syphilis often starts with treponemal tests such as enzyme or chemiluminescent immunoassays. This newer “reverse-sequence” approach to serologic diagnosis of syphilis is often more cost-effective for laboratories.

The CDC-recommended treatment for adults with primary, secondary, or early latent syphilis without neurosyphilis is benzathine penicillin G in a single 2.4 million unit dose. Treatment is much more complicated for neurosyphilis, requiring intravenous infusion of aqueous crystalline penicillin G for 10 to 14 days.

“Because of the current syphilis epidemic, we really need to rekindle our ability to diagnose and manage syphilis and become expert syphilologists once again,” Dr. Katz said.

Managing patients with lupus, dermatomyositis

The understanding of the pathophysiology of rheumatic skin disease and the development of biologics have changed the diagnosis and treatment of these diseases. A Sunday session,

“Controversies in Management and Treatment of Cutaneous Lupus and Dermatomyositis Patients (U067)”,
1 CME Credit
7-8 a.m. Sunday
Room 103A

Controversies in Management and Treatment of Cutaneous Lupus and Dermatomyositis Patients,“ will examine advances in treating these conditions related to the autoimmune system.
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AAD13150

Visit Booth 1223
The true cost of drugs

Patients, dermatologists witness the price of innovation versus competition

Patients are feeling the pinch from the rising cost of drugs and reduced insurance coverage, and dermatologists are left wondering how to advocate for these patients amid this new and uncertain landscape.

During “The Impact of Drug Pricing on Access to Care: Demystifying the Landscape” (U013), a health care policy professional, economist, and representative from the Food and Drug Administration shared their perspectives of how market, legislative, and national agency forces influence drug pricing and transparency.

The AAD established the Task Force on Drug Pricing and Transparency last year because patients are hurting, said Bruce Brod, MD, chair of the task force and clinical professor of dermatology at the University of Pennsylvania Health System, Philadelphia. He co-directed the session with Shadi Kourosh, MD, MPH, director of community health in the department of dermatology at Massachusetts General Hospital, Boston.

“It's not just the cost of biologics. We understand they are high. It's the cost of basic drugs. Our office staffs are burdened by prior authorizations and step therapy. It's crippling us, in addition to all of the regulations we have to follow," Dr. Brod said.

Panelists sharing their expertise were Rodney Whitlock, a health care policy professional with more than 20 years of experience with the U.S. Congress; Len M. Nichols, PhD, director of the Center for Health Policy Research and Ethics and a professor of health policy at George Mason University; and Jonathan Jarow, MD, acting director of the FDA's Office of Medical Policy.

For Dr. Nichols, the Drug Price Competition and Patent Term Restoration Act of 1984, known as the Hatch-Waxman Act, cleared a path for generics so drugmakers don't have to perform redundant clinical trials and can get to market faster. However, the balance between innovation and competition is off balance, he said.

“Eighty-five percent of small molecule markets now are generic,” said Dr. Nichols, of biologics, “which sounds great if you're a generic customer, but not so great if you're a producer of drugs, and they've started investing almost exclusively in biologics.”

Most of the increase in cost is from the innovator side, said Dr. Jarow, adding that the FDA is seeing more breakthrough therapies.

It may not be a bad thing that drug costs have gone up if these drugs have value by saving someone’s life or avoiding costly surgery,” said Dr. Jarow, adding that roughly 1,300 molecular entities are on the market, and of those, 25 percent are protected by patent or exclusivity from Hatch-Waxman.

Breaking barriers with VDP
Technology proves key for education without sacrificing slides

The process of reading dermatologic slides has gone digital, giving way to several applications, including medical student and resident teaching, teleconsultations, multidisciplinary conferences, live interactive webinars, continuing medical education, and research.

An expert in the use of virtual dermatopathology (VDP), Ellen Mooney, MD, director of the Nordic Institute of Virtual Dermatopathology, Hafrarhjóður, Iceland, described the technology, its usefulness and challenges, and future applications during an interactive session Friday.

The first automated, high-resolution, whole-slide imaging system was developed in 1999. Today’s technology provides software-assisted manipulation of high-definition digital images of tissue sections, simulating the experience of examining glass slides under a standard microscope and allowing magnification up to 40 times.

“Because the technology is digital, viewing and consultations can be done on a computer, over a network, or over the Internet,” Dr. Mooney said.

She also noted that retrieval of previous skin biopsy digital images and split-screen comparison of two or more images from the same case or different cases with VDP will further help physicians make diagnoses.

VDP is not without challenges.

“Digital slides scanned by different brands of scanners and the software used for viewing the images may be incompatible. However, several types of software can accommodate most types of digital slides, regardless of origin,” Dr. Mooney said.

“Software using Flash Player is currently incompatible with certain tablet computers, including the iPad.”

VDP is ripe for the classroom.

“It provides students with access to slides from rare cases they would not traditionally see — and without the risk of breaking valuable glass slides,” Dr. Mooney said.

She shared several other teaching benefits, including:

• The addition of clinical information and photographs is useful in clinico-pathological correlations
• By attaching a discussion, multimedia, Web links, and references, usefulness of the images as a teaching tool and for CME can be enhanced further
• Once images and ancillary material are online, they can be accessed for review and further study
• With software, VDP can provide instant feedback, allowing participants to assess their performance and accrue CME

Dr. Mooney has used VDP in directing resident courses, online CME courses, and live CME courses. She and her co-investigators published two research studies in the May 2011 issue of “Skin Research and Technology” and the August 2012 issue of “Journal of Cutaneous Pathology.”

Antoinette Hood, MD, professor of dermatology and pathology, and director of dermatopathology at Eastern Virginia Medical School, Norfolk, was among the co-investigators of the second study.

There was no significant difference in the participants’ diagnostic ability using virtual slides compared to glass slides and in using virtual dermatopathology compared to photomicrographs.

She added that the FDA is expected to approve digital whole-slide imaging for routine surgical pathological/dermatopathological diagnosis to replace diagnosis using conventional light microscopy.

“Once approved, regulatory agencies in other countries will certainly follow suit,” Dr. Mooney said. “In the future, integrating the workflow of dermatopathologists with electronic medical records, including transmission of digital images to patients’ electronic charts and other links, will be achievable.”

Leading by design
Practice makes true leaders, not genes

In a presidential election, many candidates try to present themselves as born leaders. Brian Anderson, MD, disagrees with this premise, stressing that leadership comes with practice.

“Leaders are made, not born. Each one of us can improve with hard work,” Dr. Anderson, associate professor at Penn State Hershey Medical Center, said Friday during “Advance Practice Management” (C006), pointing to four leadership lessons:

• Leadership is everyone’s business. “It is your job to lead because individuals look up to you as a physician. But don’t mistake leadership with power. That is not leadership, that is fear.”
• Lead by example. “If you do not lead by example, you have no credibility. You have to be mindful and thoughtful with everything you say.”
• Your behavior is a model. “If you want an office that gossips, gossip. If you want an office that is punctual and on time, be punctual and on time.”
• Caring is at the heart of all of us. “It is easy to go to work and not have much interaction with those around you. It is much more fulfilling to have interaction.”

Ellen Mooney, MD

Shadi Kourosh, MD, MPH, co-directed an expert panel discussing the high cost of drugs on the access for care with Bruce Brod, MD, chair of AAD’s Task Force on Drug Pricing and Transparency.

Practice Management
A view of the Annual Meeting

Sunscreens and photoprotection
Prevention is key in battling skin cancers, with a greater emphasis on the use of sunscreens and non-topical agents, said Henry W. Lim, MD, chairman and C.S. Livingood Chair of the department of dermatology at Henry Ford Hospital, Detroit.

Further along in development are sunscreens, with four UVB filters, one UVA filter, and three UVB-UVA filters seeking FDA approval, Dr. Lim said.

Globally, the most widely used UVB filter is octinoxate, but it is not widely used because it destabilizes avobenzone, the only longwave UVA filter approved by the FDA.

The most common filter in the U.S. is oxybenzone, a benzophenone 3. Benzophenones were named the 2014 Allergen of the Year by the American Contact Dermatitis Society, and oxybenzone has been replaced by other UVA filters in Europe, mostly because of its negative effect on coral reefs.

Other problems with sunscreens that Dr. Lim discussed were:
- Photodamage in the dark: Dark CPD formation was linked in vitro to melanocytes, which may be carcinogenic while also being protective.
- Visible Light: Visible Light may play a role in conditions that are aggravated by sun exposure, and currently available UV filters are not sufficient to protect the skin.
- Antioxidants and sunscreens: Studies show that antioxidants used in combination with sunscreens work better than sunscreens alone in suppressing UV-induced pigmentation.
- Non-topical agents: Oral nicotinamide and niacin are the same as vitamin B3, which is being studied for prevention of UV-induced depletion of ATP.

Psoriasis
Psoriasis has been a hot topic in dermatology for several years because of advances in the development of biologic treatments. Dermatologists need to embrace the use of biologics, said Kenneth B. Gordon, MD, professor of dermatology at Northwestern University Feinberg School of Medicine.

“My favorite biologic? I run away from that question as fast as I can,” he said. “Every patient in front of you is distinct and different.”

The most commonly used biologics for psoriasis are apremilast and secukinumab.

Apremilast was approved by the FDA in 2014 and is popular because of its safety record, even though its PASI 75 clearance rates are lower than some other treatments, Dr. Gordon said.

Secukinumab has been in use for about one year and has PASI 75 clearance rates of about 77 percent. About one-fourth of patients achieve complete clearance, he said. In addition, it has a “clean record” with regard to side effects.

One concern is that it may irritate patients with inflammatory bowel disease or Crohn’s disease, Dr. Gordon said.
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- Best Photo Bomb (Honorable Mention)
  To be eligible to win, simply mention @AADmtgs in your tweets, and include the hashtag #AAD16photo. Also, please specify which category you are entering.

*Gift card will be awarded to the individual who submits the photo.

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**Results and patient experience may vary.**

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**Visit us at AAD Booth 3545 to learn more!**

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**Smile and say ‘Cheese’**

Enter a new kind of photo contest through the official AAD Meeting News Twitter feed @AADmtgs. The list of categories and winning prizes for each:
- Best Group Photo ($50 Starbucks card)*
- Mentor Appreciation ($25 Starbucks card)
- How Many Meetings? ($25 Starbucks card)
- Submit a photo that creatively shows the number of times you’ve attended an AAD Annual Meeting.

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**Product Spotlight**

Promotional Offer Booth 4105

**E-Z Removable Ink Skin Marker**

- Marking Consultations
- Botox®
- Injectable Fillers

**Promotional Offer: Booth 4105**

**Viscot Mini Skin Marker**

Small in size - Large in value!

- Perfect for Surgical Procedures
- E-Z removable - save 50%-75% vs a full size marker

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**Research, continued from page 1**

present the studies, and deliver a take-home message.

“It will be exciting to see lots of new data from different areas, and all aspects of dermatology will be covered. With research going on in any area you could potentially be interested in, there will be something for everyone in these sessions.”

Attendees should not be scared off by thoughts of basic science research focusing on genetics or mouse studies, Dr. Tsao said.

“Every abstract selected has very obvious clinical relevance to practice,” he said. “Whether the topic is epidemiology research, trials, or basic science, each presentation will have take-home messages that should be relevant to everyone. If you attend the sessions, you will understand.”

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According to Dr. Tsao, the sessions are part of the AAD’s increasing focus on highlighting the latest dermatology research at the Annual Meeting by covering topics from clinical trials to new agents to treatments for conditions, such as psoriasis and atopic dermatitis.

“These forums will showcase interesting new studies that speak to the way we will be practicing in one year or three years or five years,” he said. “People are excited to hear new things and the late-breaking abstracts will be an exciting component of the Annual Meeting. What a great forum for researchers making the big reveal of the first presentation of evidence at the world’s largest dermatology meeting.”

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Skin Tolerance Ratings at Week 2

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<th>Clinical Grading</th>
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As gentle as fragrance free
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Aveeno® SKIN RELIEF gentle scent lotion
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DERMATOLOGIST RECOMMENDED

*(In a clinical study tested on subjects with sensitive skin, n = 44)

Data on file.

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