Welcome to the 2018 AAD Annual Meeting

Are you ready for the exciting opportunities that await you here at the 2018 AAD Annual Meeting? Get started with today’s full schedule of education sessions, live demonstrations, and patient encounter workshops. In between sessions, take a walk through the Exhibit Hall to discover the latest products and services. Then finish off your day by connecting with colleagues and employers at the Career Networking Event.

The following five days are filled with learning experiences and opportunities, through panel discussions, hands-on workshops, and more. Whether you are here to improve your practice, learn new techniques, hear the latest in dermatologic research, or expand your involvement with the Academy, these action-packed days offer everything you need.

“With more than 350 sessions designed to address the educational needs and hot topics facing dermatology, the 2018 AAD Annual Meeting is (going) to be an educational cavalcade,” said Erik Stratman, MD, chair of the AAD Scientific Assembly Committee. “With a growing number of hands-on sessions, patient simulation assessments, and audience participation sessions, dermatologists are able to learn by ‘doing’ through active, adult-centered learning styles.”

In addition to the wide variety of educational presentations and sessions that run throughout the conference, be prepared to encounter these highlights as well.

• Hands-on workshops
• Live Demonstration courses
• Late-breaking Research sessions
• Standardized Patient Workshops: The Patient Encounter
• Plenary session
• Hot Topics (So48)

Educational sessions aren’t all the conference has to offer. Take advantage of the ample opportunities to meet vendors, connect with the Academy, and network with colleagues.

• The Exhibit Hall is open Friday, Saturday, and Sunday, with more than 400 exhibitors showcasing the latest products and services in the dermatology field.
• Meet the AAD Board of Directors between educational sessions. Get to know your representatives, find out about current initiatives and programs, and ask questions. The event takes place Friday and Saturday from 12 to 1 p.m. in The Connection, Hall A.
• The AAD Resource Center serves as a central location for all things AAD, and features AAD services and new products. Learn how the Academy can help you advance your career through CV/resume building and free professional headshots.
• The Connection offers lounges where you can take a break with colleagues, check email, charge your phone, vote in the AAD election, claim CME credits, and more.

“The AAD Annual Meeting offers an unparalleled opportunity to talk face-to-face with your peers, to network, and to challenge and celebrate with each other,” said AAD President Henry Lim, MD. “It is an exciting environment that creates a collective energy and reinforces our commitment to our profession.”

“It is an exciting environment that creates a collective energy and reinforces our commitment to our profession.”

— Henry Lim, MD
AAD President

See More Dermatology World Meeting News! aadmeetingnews.org
Rapid Relief in Real Time

Get a closer look at clinically proven AmLactin® Rapid Relief, the only patented formula to combine our powerful Alpha-Hydroxy Therapy and three ceramides, for 24-hour relief from dryness.

See the difference on your own skin by visiting our booth.

SUNBURN ALERT: This product contains an alpha-hydroxy acid (AHA) that may increase your skin’s sensitivity to sunburn. Be sun smart: Use sunscreen, wear protective clothing, and limit sun exposure while using this product and for a week afterward.
A sneak peek at AAD’s Plenary session

Behind the scenes with Sunday’s speakers

Dermatology World has compiled a “Who’s Who” of the great minds that attendees will hear from at Sunday’s Plenary session. Learn more about these seven individuals and what they plan to share in their presentations.

Mary-Margaret Chren, MD
“The State of (Measuring) the Art of Dermatology”
What is one insight you can share about the future of dermatology?
The delivery of health care is shifting to the ambulatory setting, where we treat most of our patients, and payment incentive systems increasingly reward value, not volume. The fact that we have robust and feasible ways to accurately measure the value of what we do is great news for the future of dermatology.

Jan T. Vlcek, MD, PhD
“Infliximab: How a TNF Inhibitor Advanced from Modest Beginnings to Unforeseen Therapeutic Successes”
What is the key point you hope members will take away from your presentation?
My presentation will focus on the contribution of my laboratory to the development of the drug Remicade (infliximab), used by dermatologists mainly for the treatment of plaque psoriasis. I hope to convey that continued support of basic research is essential for the development of new therapeutic agents.

Alan D. Irvine, MD, DSc
“Atopic Dermatitis”
What does it mean to you to be selected for and speak at this year’s Plenary?
This is a huge honor for me. Marion B. Sulzberger, MD, was a giant of our specialty, and one of the founders of modern dermatology. His approach to investigational dermatology changed the culture of dermatology and has endured to this day. I hope AAD members realize the outlook for atopic dermatitis is full of exciting promise, and that we will shortly be able to do so much more for our patients who deal with ‘this’ uncomfortable disease.

Jennifer A. Doudna, PhD
“CRISPR Systems: Nature’s Toolkit for Genome Editing”
What is the key point you hope members will take away from your presentation?
I am delighted to help spotlight fundamental scientific work being done to improve human health and the world we live in. My goal is for members to understand what CRISPR technology opens up completely new possibilities for how we live, but we must be mindful of its profound societal and ethical impact.

Abraham Verghese, MD
“The Pathology Within”
What does it mean to be selected as the guest speaker?
I’ve always had the greatest admiration for [dermatology]... I would like to think that my selection comes because some of the things I talk about and deeply believe in resonated with the membership. Such things as the importance of the patient-physician relationship, the need to not allow the electronic medical record to be intrusive, and the recognition that as routine as our work can seem, it’s never routine for the patient. I always like to remind myself and my students that we don’t have to do what we do, but instead get to do this. It’s a great privilege and an important distinction.

Suzanne M. Olbricht, MD
President-Elect’s Address
How do you plan to address challenges to the profession in your role as AAD president?
To quote Heraclitus, the only thing that is constant is change. The world today, including the health care environment, is enduring unprecedented turbulence in a very compressed timeline. The greatest challenge facing the profession is the external forces that narrow the opportunities to give patients the very best care we can. My goal is to keep the AAD relevant, energized, and working effectively to sustain and strengthen the practice of dermatology. I look forward to working with members to strategically focus the efforts of the Academy for forward momentum. Our patients depend on us!

Henry W. Lim, MD
President’s Address
What has been one of the greatest challenges to the profession in the last year?
In 2017, AAD continued to fight against cases where non-physicians advertise themselves as skin care doctors or experts, and the Academy has been persistent in advocating for truth in advertising and strengthened scope of practice regulations. We also developed a robust set of resources for members to educate, advocate, and communicate on these issues. Members can access these resources at www.aad.org/advocacy.
FRIDAY
7 a.m.-5:30 p.m.
AAD registration open
Location: Lobby D
8 a.m.-5 p.m.
AAD Resource Center open
Location: Hall A
9 a.m.-5 p.m.
Gross and Microscopic Symposium (S001)
Location: Room 9
11:11:45 a.m.
Industry Expert Session
• Spotlight on Mild-to-Moderate Atopic Dermatitis: An Update on a Steroid-Free Topical Prescription Therapy
Location: Exhibit Hall
Hosted by Pfizer Inc.
12:1 p.m.
Unopposed exhibit time
12:1 p.m.
Board Meet and Greet
Location: The Connection, Hall A
12:15-1 p.m.
Industry Expert Session
• Moving Beyond Topicals: Perspectives on Systemic Treatment for Psoriasis
Location: Exhibit Hall
Hosted by Celgene Corp.
1-3 p.m.
Boards and Beyond (F016)
Location: Room 1A
1:30-2:15 p.m.
Industry Expert Session
• The Importance of Facial Erythema of Rosacea
Location: Exhibit Hall
Hosted by Allergan
3:30-5:30 p.m.
Young Physician Pearls and Pitfalls: A Survival Guide for the First 10 Years (F042)
Location: Room 5B
4:30-6:30 p.m.
AAD Career Networking Event
Location: Pacific Ballroom 18/19, Marriott Marquis
5-6:30 p.m.
Resident Reception
Location: Grand Ballroom 5-6, Marriott Marquis
5-6:30 p.m.
Young Physician and New Member Reception
Location: Grand Ballroom 3-4, Marriott Marquis
5:30-7:30 p.m.
International Member Reception
Location: Grand Ballroom 6-7, Marriott Marquis
7 p.m. (6:30 p.m. registration)
Industry Non-CME Programs
• Guiding Your Patients’ Facial Aesthetic Journey
Location: Manchester Grand Hyatt, Seaport DE
Hosted by Allergan plc
• Spotlight on Hyperhidrosis: An Expert Panel Discussion
Location: Hilton Bayfront, Indigo A
Hosted by Dermira, Inc.
• Clinical Considerations for the Management of Psoriasis in Women
Location: Hilton San Diego Bayfront, Indigo B
Hosted by UCB Inc.
• Combining Deep Chemical Peels with CO2 Laser, featuring Zein Obagi, MD
Location: Hilton San Diego Bayfront, Sapphire CD, GH
Hosted by ZO Skin Health, Inc. by Zein Obagi, MD
NEW

FIRST & ONLY SPRAYABLE OINTMENT

Effective, long-lasting relief of dry, rough skin in patients with xerosis

% SUBJECTS IMPROVED
96% dryness
91% scaling
80% cracks

Study design: Double-blind, bilateral, clinical comparative study to assess the efficacy of Eucerin Advanced Repair Lotion vs CeraVe Moisturizing Cream (N=35). Statistically significant difference between treatments, p<0.05.

The lightweight lotion that WORKS LIKE A CREAM

Superior hydration with daily use vs CeraVe® Moisturizing Cream

Study design: Double-blind, bilateral, clinical comparative study to assess the efficacy of Eucerin Advanced Repair Lotion vs CeraVe Moisturizing Cream (N=35). Statistically significant difference between treatments, p<0.05.
New data, treatments in atopic dermatitis, psoriasis

A topic dermatitis (AD) and psoriasis are among the most common reasons patients visit a dermatologist. Management for both conditions is changing dramatically as years of research produce new agents, new strategies, and new concepts for both diseases.

“Clinicians have almost too many choices in biologics for psoriasis,” said Jashin J. Wu, MD, director of dermatology research at Kaiser Permanente Los Angeles Medical Center. “There are currently eight FDA-approved biologics for psoriasis with four more on the way in the next one to two years, plus five FDA-approved biosimilars for psoriasis. Atopic dermatitis is just entering the biologic era with one approved agent and more in development. Twenty years ago, you had methotrexate, cyclosporine, and acitretin, and now you have almost too many choices to keep track of.”

Dr. Wu will direct a forum discussion on “Psoriasis and Atopic Dermatitis: Advances in Therapy and Comorbidities” today from 9 to 11 a.m. Five speakers will explore the latest data on comorbidities; new oral, topical, and phototherapies; and recently approved biologics, including two new interleukin inhibitor classes.

Given the rapid progress in understanding AD, many of the principles learned in medical school have changed or are incomplete. Emerging evidence on epidemiology and comorbidities suggest that the disease burden is even greater than many clinicians realize, and that distinct differences in the skin barrier between young children and adults suggest different management strategies in these two populations.

The skin microbiome is emerging as a key factor in the development and progression of AD. Future treatments may focus on adding commensal bacterial species to the microbiome rather than simply trying to control the overgrowth Staphylococcus aureus.

Emerging topical and systemic treatments will continue to refine management strategies as new data on immune system involvement helps guide future research.

“These are common, lifelong skin rashes with no cure,” Dr. Wu said. “Almost 10% of the entire population has one of these two rashes. If you have a general dermatology practice, this will be one of the more practical sessions at the AAD Annual Meeting.”

“Psoriasis and Atopic Dermatitis: Advances in Therapy and Comorbidities” (F012)
Today, 9-11 a.m.
Room 23C

What would you do?
Discover reconstructive strategies, outcomes for curated surgical cases

In Saturday’s forum, “How Would You Reconstruct It?” session director Thomas Rohrer, MD, and other reconstructive masters will present a selection of cases with surgical defects. The speakers will evaluate various reconstructive options and review teaching points to illustrate what did and did not work for the particular situation.

“Psoriasis and Atopic Dermatitis: Advances in Therapy and Comorbidities” (F012)
Today, 9-11 a.m.
Room 23C

ATOPIC DERMATITIS ON THE RISE
A symposium focused solely on “Atopic Dermatitis” (S065) will follow the combined atopic dermatitis-psoriasis session on Monday from 1 to 4 p.m.

“Atopic dermatitis is a hot, hot area with considerable new data on its comorbidities, pathogenesis, and the impact of new therapies,” said symposium director Amy Paller, MD, professor and chair of dermatology and professor of pediatrics at the Northwestern University Feinberg School of Medicine. “This is an opportunity to hear and ask questions of the thought leaders who are conducting cutting-edge research.”

Advice to improve patient care

Patient has Mohs excision of basal cell carcinoma on left nasal tip. An east-west advancement flap was planned, drawn, and executed successfully. See results at four-month follow-up appointment.

Patient has defect following Mohs excision of recurrent basal cell carcinoma on right nasal tip and ala. A paramedian forehead flap was set in place over the cartilage graft and nasal mucosal advancement. See positive results at three-month follow-up appointment.

Patient has Mohs excision of recurrent basal cell carcinoma on left nasal ala, nasal sidewall, and cheek. The defect is closed with a tunneled island pedicle V-Y flap. See optimistic outcome at four-month follow-up appointment.

“Dermatologic Surgery Pearls: Optimizing Safety, Satisfaction, Efficiency” (S008)
Today, 9 a.m.—12 p.m.
Room 2

Learn more at: "Dermatologic Surgery Pearls: Optimizing Safety, Satisfaction, Efficiency" (S008)
For the treatment of mild-to-moderate atopic dermatitis (AD) in patients 2 and older

**INDICATION**

EUCRISA is indicated for topical treatment of mild-to-moderate atopic dermatitis in patients 2 years of age and older.

**IMPORTANT SAFETY INFORMATION**

**Contraindications**

EUCRISA is contraindicated in patients with known hypersensitivity to crisaborole or any component of the formulation.

**Warnings and Precautions**

Hypersensitivity reactions, including contact urticaria, have occurred in patients treated with EUCRISA and should be suspected in the event of severe pruritus, swelling and erythema at the application site or at a distant site. Discontinue EUCRISA immediately and initiate appropriate therapy if signs and symptoms of hypersensitivity occur.

**Adverse Reactions**

The most common adverse reaction occurring in ≥1% of subjects in clinical trials was application site pain, such as burning or stinging. Please see brief summary of Full Prescribing Information on adjacent page.

**STUDY DESIGN AND RESULTS**

Two multicenter, randomized, double-blind, vehicle-controlled trials (Trial 1 and Trial 2) treating 1522 patients (1016 EUCRISA; 506 vehicle) with mild-to-moderate atopic dermatitis. The primary efficacy endpoint was success in Investigator’s Static Global Assessment (ISGA) at Day 29. Success in ISGA, a stringent metric, is defined as Clear (0) or Almost Clear (1) AND at least a 2-grade improvement from baseline. In the pooled results from the 2 pivotal trials, success in ISGA at Day 29 was 32.1% for EUCRISA and 21.8% for vehicle. The most common adverse reaction occurring in ≥1% of subjects in clinical trials (1012 EUCRISA vs 499 vehicle) was application site pain, such as burning or stinging.

**Learn more at www.EucrisaHCP.com**

References:
1. EUCRISA® (crisaborole) Full Prescribing Information: October 2017.

PP-CRI-USA-0955-02 © 2017 Pfizer Inc. All rights reserved. Printed in USA/December 2017
EUCRISA® (crisaborole) ointment, 2%

Brief Summary of Prescribing Information

INDICATIONS AND USAGE
EUCRISA is indicated for topical treatment of mild to moderate atopic dermatitis in patients 2 years of age and older.

DOSAGE AND ADMINISTRATION
Apply a thin layer of EUCRISA twice daily to affected areas. EUCRISA is for topical use only and not for ophthalmic, oral, or intravaginal use.

DOSE FORMS AND STRENGTHS
Ointment: 20 mg of crisaborole per gram (2%) of white to off-white ointment.

EUCRISA is contraindicated in patients with known hypersensitivity to crisaborole or any component of the formulation. [see Warnings and Precautions]

WARNINGS AND PRECAUTIONS
Hypersensitivity Reactions
Hypersensitivity reactions, including urticaria and angioedema, have occurred in patients treated with EUCRISA. Hypersensitivity should be suspected in the event of severe pruritus, swelling and erythema at the application site or at a distant site. If signs and symptoms of hypersensitivity occur, discontinue EUCRISA immediately and initiate appropriate therapy.

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

In two double-blind, vehicle-controlled clinical trials (Trial 1 and Trial 2), 1012 subjects 2 to 79 years of age with mild to moderate atopic dermatitis were treated with EUCRISA twice daily for 4 weeks. The adverse reaction reported by ≥1% of EUCRISA-treated subjects is listed in Table 1. Table 1: Adverse Reaction Occurring in ≥1% of Subjects in Atopic Dermatitis Trials through Week 4

<table>
<thead>
<tr>
<th>Adverse Reaction</th>
<th>EUCRISA N=1012 n (%)</th>
<th>Vehicle N=499 n (%)</th>
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<tbody>
<tr>
<td>Application site pain</td>
<td>45 (4)</td>
<td>6 (1)</td>
</tr>
</tbody>
</table>

Refers to skin sensations such as burning or stinging. Less common (<1%) adverse reactions in subjects treated with EUCRISA included contact urticaria [see Warnings and Precautions]

USE IN SPECIFIC POPULATIONS
Pregnancy Risk Summary
There is no available data with EUCRISA in pregnant women to inform the drug's risk/benefit ratio for major birth defects and miscarriage. In animal reproduction studies, there were no adverse effects observed with oral administration of crisaborole in pregnant rats and rabbits during organogenesis at doses up to 3 and 2 times, respectively, the maximum recommended human dose (MRHD) [see Data]. The background risk of major birth defects and miscarriage for the indicated population is unknown. All pregnancies carry some risk of birth defect, loss, or other adverse outcomes. The background risk of major birth defects in the U.S. general population is 2% to 4% and of miscarriage is 15% to 20% of clinically recognized pregnancies. Data Animal Data Cat and rabbit embryo-fetal development was assessed after oral administration of crisaborole. Crisaborole did not cause adverse effects to the fetus at oral doses up to 300 mg/kg/day in pregnant rats during the period of organogenesis (3 times the MRHD on an AUC comparison basis). No treatment-related fetal malformations were noted after oral treatment with crisaborole in pregnant rats at doses up to 600 mg/kg/day (13 times the MRHD on an AUC comparison basis) during the period of organogenesis. Maternal toxicity was produced at the high dose of 600 mg/kg/day in pregnant rats and was associated with findings of decreased fetal body weight and delayed skeletal ossification. Crisaborole did not cause adverse effects to the fetus at oral doses up to the highest dose tested of 100 mg/kg/day in pregnant rabbits during the period of organogenesis (2 times the MRHD on an AUC comparison basis). In a prenatal/postnatal development study, pregnant rats were treated with crisaborole at doses of 150, 300, and 600 mg/kg/day by oral gavage during gestation and lactation (from gestation day 7 through day 20 of lactation). Crisaborole did not have any adverse effects on fetal development at doses up to 600 mg/kg/day (13 times the MRHD on an AUC comparison basis). Maternal toxicity was produced at the high dose of 600 mg/kg/day in pregnant rats and was associated with findings of stillbirths, pup mortality, and reduced pup weights.

Lactation Risk Summary
There is no information available on the presence of EUCRISA in human milk, the effects of the drug on the breastfed infant or the effects of the drug on milk production after topical application of EUCRISA to women who are breastfeeding. EUCRISA is systemically absorbed. The lack of clinical data during lactation precludes a clear determination of the risk of EUCRISA to a breastfed infant. Therefore, the developmental and health benefits of breastfeeding should be considered along with the mother’s clinical need for EUCRISA and any potential adverse effects on the breastfed infant from EUCRISA or from the underlying maternal condition.

Pediatric Use
The safety and effectiveness of EUCRISA have been established in pediatric patients age 3 years and older for topical treatment of mild to moderate atopic dermatitis. Use of EUCRISA in this age group is supported by evidence from two multicenter, randomized, double-blind, parallel-group, vehicle-controlled 28-day trials which included 1,313 pediatric subjects 2 years and older [see Adverse Reactions and Clinical Studies in Full Prescribing Information]. The safety and effectiveness of EUCRISA in pediatric patients below the age of 2 years have not been established.

Geriatric Use
Clinical studies of EUCRISA did not include sufficient numbers of subjects age 65 and over to determine whether they respond differently from younger subjects.

NONCLINICAL TOXICOLOGY
Carcinogenesis, Mutagenesis, Impairment of Fertility
In an oral carcinogenicity study in Sprague-Dawley rats, oral dosages of 30, 100, and 300 mg/kg/day of crisaborole were administered to rats once daily. A drug-related increased incidence of benign granular cell tumors in the uterus with cervix or vagina (combined) was noted in 300 mg/kg/day crisaborole treated female rats (1 times the MRHD on an AUC comparison basis). The clinical relevance of this finding is unknown. In a dermal carcinogenicity study in CD-1 mice, topical doses of 2%, 5%, and 7% crisaborole ointment were administered once daily. No drug-related neoplastic findings were noted at topical doses up to 7% crisaborole ointment (2 times the MRHD on an AUC comparison basis). Crisaborole revealed no evidence of mutagenic or clastogenic potential based on the results of two in vitro genotoxicity tests (Ames assay and human lymphocyte chromosomal aberration assay) and one in vivo genotoxicity test (rat micronucleus assay). No effects on fertility were observed in male or female rats that were administered oral doses up to 600 mg/kg/day crisaborole (13 times the MRHD on an AUC comparison basis) prior to and during early pregnancy.

PATIENT COUNSELING INFORMATION
Advise the patient or caregivers to read the FDA-approved patient labeling (Patient Information). Hypersensitivity Reactions: Advise patients to discontinue EUCRISA if skin irritation or medical attention if signs or symptoms of hypersensitivity occur [see Warnings and Precautions].

Rx only
This Brief Summary is based on EUCRISA Prescribing Information, issued October 2017.
Patient management roundtable

The session director and speakers of today’s symposium, “Common, Challenging, and Controversial Short Topics in Patient Management,” share valuable insight into managing patients.

**Topic: Psoriasis**

**COMMON** We have more biologic agents available to treat psoriasis than ever before. The real problem is selecting the agent that is most appropriate for each patient in an evidence-based fashion.

**CHALLENGING** There are a number of promising new agents in development. As dermatologists, we have to keep abreast of what is in the pipeline.

**CONTROVERSIAL** Psoriasis is a chronic disease. One of the most controversial aspects of treatment is understanding and evaluating how these agents will perform over the long term in our patients.

**Topic: Pediatric dermatology**

**COMMON** Moles are equally common in children as they are in adults, but they follow different rules. The approach that one might take with adult patients may not be appropriate for children.

**CHALLENGING** Molluscum is one of the most common viral skin infections in children. It is known to self-resolve, yet many parents come to dermatologists seeking treatment.

**CONTROVERSIAL** Common conditions can be the most troublesome and controversial because a clear answer isn’t available in terms of how to assess and manage. Evaluating the evidence behind the different modalities currently being employed can help defuse the discussions.

**Topic: Aesthetic dermatology**

**COMMON** We now have a variety of toxins to work with and new toxins are on the horizon. Selecting the right toxin for the right patient is an everyday issue.

**CHALLENGING** We’ve been flooded with unattainable ideals of perfection. A lot of young people are having cosmetic procedures and becoming deformed caricatures of themselves.

**CONTROVERSIAL** There are a lot of functional issues where these laser and radiofrequency devices could be of benefit, but a growing portion of the demand is not for functional issues. We have the expertise to treat safely, but it is just as important to know when not to treat.

**Instagram challenge!**

Participate in the AAD Instagram Challenge! Today through Monday, the Academy will share a new photo challenge on the @AADmember Instagram account. Enter daily by following @AADmember and sharing your photo on Instagram with the hashtag #AAD18photo. At the end of each day, the Academy will randomly select a photo from the daily submissions and declare a winner of a $100 Amazon gift card.

Today’s challenge: Take a selfie at the selfie station!

Go to The Connection in Hall A and take a photo with the JAAD, Dermatology World, or #AAD18 cutouts.

For rules and regulations, visit Dermatology World Meeting News at www.aadmeetingnews.org.

Questions? Contact Danielle Tokarz at dtokarz@aad.org.

*What are you most excited to learn about or see at the 2018 AAD Annual Meeting?*

My favorite part of the AAD is obtaining new knowledge that I can’t find in a textbook. It is an invaluable resource to be able to discuss new diagnostic and treatment modalities to take home to your own practice. Especially as a resident, I love interacting with some of the big mentors in the field and seeing how my colleagues practice.

*Lauren Boudreaux, DO*  
*Portland, Oregon*

I look forward to attending the session “Role of Dermatologist in Management of Skin Disease in Solid Organ Transplant Recipients,” as it’s always a very informative session with great lectures. The session provides me new perspectives in managing complex transplant patients in my high-risk clinic at UT Southwestern. I’m also looking forward to catching up with friends, previous co-residents, and mentors, and learning from great colleagues.

*Rajiv Nijawan, MD*  
*Dallas*

I am most looking forward to learning more about caring for challenging oncodermatology patients, especially those that have received stem cell transplants. As stem cell transplants are on the rise and patients are surviving much longer after transplant, we are seeing a steady increase in the number of patients with post-transplant complications, such as graft-versus-host disease.

*Mallory Shiver Abate, MD*  
*St. Louis*

Help your patients take a step closer to a more normal, healthy skin color

REDUCE THE REDNESS

For persistent facial erythema associated with rosacea in adults

First and only
The first and only α₁ adrenoceptor agonist approved for the topical treatment of persistent facial erythema associated with rosacea in adults

Lasting results
Significantly improved erythema through 12 hours on day 29. Results were seen in 12% to 18% of RHOFADE™ cream subjects vs 5% to 9% of vehicle subjects. Individual results may vary

Proven tolerability
Adverse reactions occurring at an incidence of ≥1% were: application-site dermatitis, worsening inflammatory lesions of rosacea, application-site pruritus, application-site erythema, and application-site pain

Register for samples and learn more at rhofadehcp.com

INDICATION
RHOFADE™ (oxymetazoline HCl) cream 1% is indicated for the topical treatment of persistent facial erythema associated with rosacea in adults.

IMPORTANT SAFETY INFORMATION
WARNINGS AND PRECAUTIONS
Potential Impacts on Cardiovascular Disease
Alpha-adrenergic agonists may impact blood pressure. RHOFADE™ cream should be used with caution in patients with severe or unstable or uncontrolled cardiovascular disease, orthostatic hypotension, and/or or uncontrolled hypertension/hypotension. Advise patients with cardiovascular disease, orthostatic hypotension, and/or uncontrolled hypertension/hypotension to seek immediate medical care if their condition worsens.

Potentiation of Vascular Insufficiency
RHOFADE™ cream should be used with caution in patients with cerebral or coronary insufficiency, Raynaud’s phenomenon, thromboangiitis obliterans, scleroderma, or Sjögren’s syndrome. Advise patients to seek immediate medical care if signs and symptoms of potentiation of vascular insufficiency develop.

Risk of Angle Closure Glaucoma
RHOFADE™ cream may increase the risk of angle closure glaucoma in patients with narrow-angle glaucoma. Advise patients to seek immediate medical care if signs and symptoms of acute angle closure glaucoma develop.

ADVERSE REACTIONS
The most common adverse reactions for RHOFADE™ cream were: application-site dermatitis 2%, worsening inflammatory lesions of rosacea 1%, application-site pruritus 1%, application-site erythema 1%, and application-site pain 1%

Please see brief summary of full Prescribing Information for RHOFADE™ cream on the following page.


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rhofadehcp.com RH0108251 06/17 171521
RHOFADE® (oxymetazoline HCl) cream 1%

**BRIEF SUMMARY—PLEASE SEE THE RHOFADE® CREAM PACKAGE INSERT FOR FULL PRESCRIBING INFORMATION.**

**INDICATIONS AND USAGE**

RHOFADE® cream is indicated for the topical treatment of persistent facial erythema associated with rosacea in adults.

**DOSEAGE AND ADMINISTRATION**

For topical use only. Not for oral, ophthalmic, or intranasal use. Prime the RHOFADE® cream pump before using for the first time. To do so, with the pump in the upright position, repeatedly depress the actuator until cream is dispensed and then pump three times. Discard the cream from priming actuations. It is only necessary to prime the pump before the first dose.

RHOFADE® cream tubes do not require priming. Apply a pre-sized amount of RHOFADE® cream, once daily in a thin layer to cover the entire face (forehead, nose, each cheek, and chin) avoiding the eyes and lips. Wash hands immediately after applying RHOFADE® cream.

**CONTRAINDICATIONS**

None.

**WARNINGS AND PRECAUTIONS**

**Potential Impacts on Cardiovascular Disease**

Alpha-adrenergic agonists may impact blood pressure. RHOFADE® cream should be used with caution in patients with severe or unstable or uncontrolled cardiovascular disease, orthostatic hypotension, and/or uncontrolled hypertension or hypotension. Advise patients with cardiovascular disease, orthostatic hypotension, and/or uncontrolled hypertension/hypotension to seek immediate medical care if their condition worsens.

**Potentiation of Vascular Insufficiency**

RHOFADE® cream should be used with caution in patients with cerebral or coronary insufficiency. Raynaud’s phenomenon, thromboangiitis obliterans, scleroderma, or Sjögren’s syndrome. Advise patients to seek immediate medical care if signs and symptoms of potentiation of vascular insufficiency develop.

**Risk of Angle Closure Glaucoma**

RHOFADE® cream may increase the risk of angle closure glaucoma in patients with narrow-angle glaucoma. Advise patients to seek immediate medical care if signs and symptoms of acute angle closure glaucoma develop.

**ADVERSE REACTIONS**

**Clinical Studies Experience**

Because clinical trials are conducted under 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.

A total of 489 subjects with persistent facial erythema associated with rosacea were treated with RHOFADE® cream once daily for 4 weeks in 3 controlled clinical trials. An additional 440 subjects with persistent facial erythema associated with rosacea were also treated with RHOFADE® cream once daily for up to one year in a long-term (open-label) clinical trial. Adverse reactions that occurred in at least 1% of subjects treated with RHOFADE® cream through 4 weeks of treatment are presented in the table below:

### Adverse Reactions Reported by ≥ 1% of Subjects Through 4 Weeks of Treatment in Controlled Clinical Trials

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<th>Adverse Reaction</th>
<th>Pooled Controlled Clinical Trials</th>
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<tr>
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<td>RHOFADE® Cream (N = 489)</td>
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<tr>
<td>Application-site dermatitis</td>
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<tr>
<td>Worsening inflammatory lesions of rosacea</td>
<td>7 (1%)</td>
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<tr>
<td>Application-site pruritus</td>
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<td>Application-site erythema</td>
<td>5 (1%)</td>
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<tr>
<td>Application-site pain</td>
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</table>

In the long-term (open-label) clinical trial, the rates of adverse reactions over a one-year treatment period were as follows: worsening inflammatory lesions of rosacea (5%), application-site dermatitis (3%), application-site pruritus (2%), application-site pain (2%), and application-site erythema (2%). Subjects with persistent erythema along with inflammatory lesions were allowed to use additional therapy for the inflammatory lesions of rosacea.

**DRUG INTERACTIONS**

Anti-hypertensives/Cardiac Glycosides

Alpha-adrenergic agonists, as a class, may impact blood pressure. Caution in using drugs such as beta-blockers, anti-hypertensives and/or cardiac glycosides is advised.

Caution should also be exercised in patients receiving alpha, adrenergic receptor antagonists such as in the treatment of cardiovascular disease, benign prostatic hypertrophy, or Raynaud’s disease.

Monoamine Oxidase Inhibitors

Caution is advised in patients taking MAO inhibitors which can affect the metabolism and uptake of circulating amines.

**USE IN SPECIFIC POPULATIONS**

**Pregnancy**

**Risk Summary**

There is no available data on RHOFADE® cream use in pregnant women to inform a drug-associated risk for major birth defects and miscarriage. A literature article describing intranasal decongestant use in pregnant women identified a potential association between second-trimester exposure to oxymetazoline (with no decongestant exposure in the first trimester) and renal collecting system anomalies. In animal reproduction studies, there were no adverse developmental effects observed after oral administration of oxymetazoline hydrochloride in pregnant rats and rabbits at systemic exposures up to 3 times and 72 times, respectively, the exposure associated with the maximum recommended human dose (MRHD). The estimated background risks of major birth defects and miscarriage for the indicated population are unknown. All pregnancies have a background risk of birth defect, loss, or other adverse outcomes. 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**

**Fetal/Neonatal Adverse Reactions**

Following repeated use of oxymetazoline hydrochloride solution nasal spray for the treatment of nasal congestion at a dose 5 times higher than recommended, one case of fetal distress was reported in a 41-week pregnant patient. The fetal distress resolved hours later, prior to the delivery of the healthy infant. The anticipated exposures for the case are 8- to 18-fold higher than plasma exposures after topical administration of RHOFADE® cream.

**Lactation**

No clinical data are available to assess the effects of oxymetazoline on the quantity or rate of breast milk production, or to establish the level of oxymetazoline present in human breast milk post-dose. Oxymetazoline was detected in the milk of lactating rats. The developmental and health benefits of breastfeeding should be considered along with the mother’s clinical need for RHOFADE® cream and any potential adverse effects on the breastfed child from RHOFADE® cream or from the underlying maternal condition.

**Pediatric Use**

Safety and effectiveness of RHOFADE® cream have not been established in pediatric patients below the age of 18 years.

**Geriatric Use**

One hundred and ninety-three subjects aged 65 years and older received treatment with RHOFADE® cream (N = 135) or vehicle (N = 58) in clinical trials. No overall differences in safety or effectiveness were observed between subjects ≥ 65 years of age and younger subjects, based on available data. Clinical studies of RHOFADE® cream did not include sufficient numbers of subjects aged 65 and over to determine whether they respond differently from younger subjects.

**OVERDOSAGE**

RHOFADE® cream is not for oral use. If oral ingestion occurs, seek medical advice. Monitor patient closely and administer appropriate supportive measures as necessary. Accidental ingestion of topical solutions (nasal sprays) containing imidazoline derivatives (eg, oxymetazoline) in children has resulted in serious adverse events requiring hospitalization, including nausea, vomiting, lethargy, tachycardia, decreased respiration, bradycardia, hypotension, hypertension, sedation, somnolence, mydriasis, stupor, hypothermia, drooling, and coma. Keep RHOFADE® cream out of reach of children.

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Skin of color boot camp

All skin of color patients who present to a dermatologist should be treated in a culturally competent manner with his or her problem diagnosed accurately and treated appropriately. If you have even one skin of color patient, consider attending “Skin of Color Boot Camp: What Every Dermatologist Should Know About the Patient With Darker Skin Tones.” In addition to learning about the types of skin conditions that skin of color patients commonly have, this session will give dermatologists confidence to assess, treat, and manage these conditions.

“Skin of Color Boot Camp: What Every Dermatologist Should Know About the Patient With Darker Skin Tones” (S060)
Monday, 2–4 p.m.
Ballroom 20A

Proper care for all skin colors

We are becoming a nation of minorities with a spectrum of skin colors from very pale to very dark.

Skin of color is defined as darkly pigmented skin. Most of the global population has darkly pigmented skin as compared to white or light skin tones found in many Northern Europeans.

The most common skin conditions in darker pigmented skin tones include hyperpigmentation, melasma, acne, keloids, acne keloidalis nuchae, and pseudofolliculitis barbae. Patients of African and Australian Aboriginal descent with tightly curled hair also have specific hair and scalp disorders.

BY 2020 more than half of children in the United States will be part of a non-Caucasian racial or ethnic group.

BY 2044 no single racial or ethnic group will dominate the population.

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Eskata
(hydrogen peroxide) topical solution, 40% (w/w)

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Visit booth #1861 or ESKATAHCP.com to learn more about availability, application, and more.
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STARTS WITH YOU

LEARN MORE AT ABBVIE BOOTH 4521
Annual Meeting exhibitors

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INDUSTRY EXPERTS THEATER
Join exhibiting companies as they present new research on products, detail products, conduct demonstrations, and highlight new products. See page 4 for the daily schedule.
THE CONNECTION

- AAD Resource Center
- Networking Lounge
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- Poster Presentation Theaters
- AAD Board of Directors
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Hear Expert Insights at Two Unique Industry Expert Sessions

**Session 1**

*Saturday, February 17, 2018*

1:30 PM – 2:15 PM Program

Industry Expert Theater

San Diego Convention Center • San Diego, CA

Please arrive at 1:15 PM to register.

*Lunch will be provided.*

**Presented by:**

Jeffrey Sobell, MD

**Session 2**

*Sunday, February 18, 2018*

11:00 AM – 11:45 AM Program

Industry Expert Theater

San Diego Convention Center • San Diego, CA

Please arrive at 10:45 AM to register.

*Lunch will be provided.*

**Presented by:**

Jerry Bagel, MD

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VISIT BOOTH 3739
Q & A

"Best Evidence-based Opportunities for Cost-effective Skin Care" (S003)
Today, 9 a.m.–12 p.m.
Room 25B

Empowering cost-effective skin care to benefit patients

Q: How can dermatologists provide more cost-effective skin care?
Dr. Kia: One important area is laboratory tests and the frequency with which we order them compared to the clinical necessity. We will have presentations on prescription rebate programs, the false way rebate cards make you think you are [being] helpful, and ways we can prescribe more appropriately now that topical steroid pricing has changed so dramatically. Providing cost-effective medicine is about spending less and getting more.

Q: What common tests might be overused?
One of our speakers will be addressing acne and isotretinoin. Historically, we have ordered monthly lab tests, but there is good data suggesting that dermatologists don’t need to monitor as frequently as we routinely do.

Q: Many dermatologists routinely prescribe generic topical steroids. Is there a problem with that practice?
The three topical steroids that most dermatologists grew up on are desonide, clobetasol, and triamcinolone. They used to be cheap, but generic prices have gone crazy in the last few years. Desonide and clobetasol, in particular, have gotten very expensive. Just two changes — triamcinolone 0.025 instead of desonide, and betamethasone instead of clobetasol — can generate huge cost savings that we write 10 to 30 times every day.

Q: What about prescription rebate cards?
Some clinicians prescribe branded topical steroids thinking they are doing something great for their patients. The reality is that rebate cards just raise the cost to the health care system on the back end. Prescribing the right generic topical steroids creates real savings. Simple changes to things you do routinely in practice add up to huge savings for patients.

Advice to improve patient care

Wound edge approximation is a basic tenet of dermatologic surgery. Following subcuticular suture placement, the skin edges should be apposed, and ideally pressing against each other. However, many neophyte and even experienced surgeons find their sutured wound edges are often several millimeters apart, a situation that requires the edges to be pulled together with an additional cuticular layer of sutures. This may result in more tension at the wound edges and a higher incidence of track marks. One cause of poor wound edge approximation is the presence of skin bevels. Excisions performed approximated without the need for the presence of bevels and result in higher incidence of track marks.

For common conditions like urticaria, there is a huge number of tests that could be ordered but there is little data to support the practice. When a patient comes in with onychomycosis, how much of a workup do you really need before and during treatment? We will be arguing that for many common conditions, we should keep our workup to an absolute minimum, using one or two lab tests at most. For the vast number of patients, additional tests have no impact on clinical decision-making or outcomes.

Kevin Kia, MD, is the co-director of today’s session “Best Evidence-based Opportunities for Cost-effective Skin Care.” He talked with Dermatology World Meeting News to share a few small practice changes in prescribing and practice patterns that can have a major impact on patient cost while maintaining or even improving clinical outcomes.

Dr. Kia is a clinical assistant professor of dermatology at the University of Texas Southwestern in Dallas.

Pick up your copy of the meeting guide

The 2018 Onsite Meeting Guide, Experience AAD in San Diego, is available in racks throughout the San Diego Convention Center. It has all of the vital information you need about the meeting, such as:

• Key elements
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• Education information
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You’re invited to join the discussion!

Moving Beyond Topicals: Perspectives on Systemic Treatment for Psoriasis

INDUSTRY EXPERT SESSION

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Friday, February 16, 2018 / 12:15 PM - 1:00 PM / Exhibit Hall
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TOP 10
Personal productivity tips

Skills centered on organization, prioritization, time management, and minimizing distractions are often not taught in school, but they are increasingly essential. In Saturday's session, “Getting Things Done: Productivity Tips for the Busy Dermatologist,” Jennifer Gardner, MD, will provide practical ways to improve efficiency. These tips can also help you avoid stress, anxiety, exhaustion, and eventual burnout.

1. “Doing it all” is a myth. Only say yes to what’s most important to you.
2. Go paperless. Get rid of the piles of papers, journals, and books. Think you might need it later? Scan it and save it all digitally.
3. Clear your head. Do a “brain dump” and get the “to-dos” out of your head. Develop a system to regularly capture and process tasks.
4. Lose the post-its. Get yourself a digital task manager you can trust.
5. Use your calendar. Schedule blocks of time on your calendar, as you would an appointment, to complete tasks on time. Give yourself realistic timeframes and deadlines. Don’t try to multitask; focus on completing one thing at a time.
6. Process email efficiently. Use the “touch it once” and “two-minute rules.” Touch each email only once. If it will require more than two minutes of your time, transfer it to your task manager.
7. Rethink “time management.” Consider alternative strategies for managing energy states and priorities, rather than simply time. Not all hours within a 24-hour day are created equal.
8. Keep calm and delegate. Preserve your energy, time, and attention by outsourcing or delegating any task you can.
9. Protect your system. Develop strategies to protect you from distractions, other people’s priorities, and your own psychology. For example, break your tech addiction. Turn off notifications on apps and electronic devices, and schedule email-processing blocks on your calendar.
10. Protect the asset. (Spoiler alert: You’re the asset!) Sleep, exercise, and meditation are essential components for keeping you mentally, physically, and spiritually at your best. It is critical to make time for you.

PEARLS FROM MEMBERS
Peter Randall Shumaker, MD
Chairman, dermatology department, Naval Medical Center San Diego

Dermatology surgeons reveal valuable secrets

For a variety of reasons, dermatologists are almost universally disengaged from the care of trauma patients. However, laser scar management is simply a modest rethinking of the tools and techniques that dermatologists have helped to pioneer. Treatment can be potentially life changing for the millions of patients worldwide who suffer from debilitating and disfiguring scars, and for the doctors who incorporate this group of patients into their practices.

“Getting Things Done: Productivity Tips for the Busy Dermatologist” (U046)
Saturday, 4:30–5:30 p.m.
Room 32B

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Don’t miss out on attending Industry Non-CME (INC) Programs being held in the evening from February 15-18, 2018, in San Diego, CA. At the sponsoring company’s discretion, these programs may be promotional or educational in nature.

Programs are held conveniently at the Hilton Bayfront and/or Manchester Grand Hyatt, and cover a range of topics.

For the latest information on specific INC program titles, times, locations, and registration go to aad.org/incprograms.

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Learn more at: “Pearls from the Masters of Dermatological Surgery” (S063)
Monday, 1–4 p.m.
Room 30E
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**Q&A**

**Quality improvement’s place in medicine**

“Rewards and Awards: How to Make QI Pay Off” (S033)
Saturday, 1–4 p.m.
Room 6B

**What are some lessons you’ve learned along the way about directing QI?**

The first lesson I’ve learned as I’ve tried to implement QI projects is that they work. QI principles are very applicable in medical care. It is something that has a lot of good opportunity in medicine. I’ve also learned the importance of team building to make it work. When a QI project begins, the most important step is identifying and recruiting stakeholders, the people who will be affected by whatever change we are trying to make. Get them engaged from the beginning, and they will be much more willing to be a part of it.

**How do residents impact the quality of care in a dermatology practice?**

Residents are often tasked with seeing to the care of the patient from the moment they walk in the door. Because residents know the details of the treatment, they are in a unique position to identify failures in the system. Residents impact care individually by being the ones specifically tasked with the responsibility to see that their patients get better. On a system-wide level, residents play a role in identifying areas of improvement. They play a great role in being one of the stakeholders who can rally the staff or get the attending physician to buy into the effort needed to make the improvement.

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**DERMATOLOGY WORLD MEETING NEWS • FRIDAY • FEBRUARY 16, 2018**

**PEARLS FROM MEMBERS**

**Adam M. Rotunda, MD**
Assistant clinical professor of dermatology, David Geffen School of Medicine UCLA and UCI Dermatology

Dermatology surgeons reveal valuable secrets

There is value in mastering surgical techniques ... but there is more to being a surgeon than that. Cultivate a practice that leaves patients wanting more. Recognize the value in personally calling your patients and being available to them 24/7 after surgery. Offer accoutrements, like a coffee and tea bar, daily lunch, and freshly baked chocolate chip cookies, and provide your patients with frequently used medications.

These little things can go a long way in transforming the way you practice medicine.

Learn more at: “Pearls from the Masters of Dermatological Surgery” (S063)
Monday, 1–4 p.m.
Room 30E

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**Why is QI important in a dermatology practice?**

Dr. Eliason: The concepts of QI all wrap around providing better care for our patients. If we can incorporate the principles of quality improvement into our practices, we can ultimately improve the way we can help patients get better faster. We can improve how we spend our resources doing it, and even improve physicians’ lives.

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**How do you implement QI in your own office?**

I try to identify areas in the processes of how we administer care to our patients and then work with the providers who directly play a role in that particular process. For example, we might look at the way most surgery is done. I might work with the surgeon to identify a specific thing that we want to improve, and then work with them and their staff to develop a strategy to come up with solutions. We implement those solutions, and then test to see if that implementation has resulted in improvement.

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**What is QI?**

Dr. Eliason: It’s the concepts of QI all wrap around providing better care for our patients. If we can incorporate the principles of quality improvement into our practices, we can ultimately improve the way we can help patients get better faster. We can improve how we spend our resources doing it, and even improve physicians’ lives.

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**Mark Eliason, MD, is one of several speakers in Saturday’s session “Rewards and Awards: How to Make QI Pay Off.” He talked with Dermatology World Meetings News to discuss quality improvement (QI) and its impact on patients and providers in a dermatology practice.**

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**Dr. Eliason is an associate professor in the department of dermatology at the University of Utah in Salt Lake City.**

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