Melasma hits and misses

Melasma is chronic and prevalent across the globe. Commonly affecting people with dark skin and women, melasma can mimic other pigmentary disorders of the face. Accurate diagnosis is critical for effective treatment.

“Many doctors make mistakes,” said Amit G. Pandya, MD, a dermatology professor at the University of Texas Southwestern Medical Center in Dallas, at Friday’s session, “What’s New in Melasma?” (F005). “You have to be a detective and ask a lot of questions. If you don’t diagnose and treat it correctly, you can make it worse.”

Characterized by gray-brown patches on the face, it typically covers the center of the forehead, over the eyebrow, the bridge of the nose, chin, upper lip, and stops at the jaw line. Its borders are curved.

It can be psychologically debilitating, affecting a person’s social and recreational quality of life and self-esteem.

“People with melasma don’t even feel like answering the door because they are ashamed and computer screens — can trigger it,” Dr. Pandya said.

“Treat melasma like diabetes. It has to be treated and then maintained because it’s a chronic disorder,” Dr. Pandya said.

Treatment

Topical application of hydroquinone is effective in treating the disorder 40% of the time. Triple-combination (TC) cream, comprised of fluocinolone acetonide, hydroquinone, and tretinoin is also effective.

Promising new research suggests that the use of oral tranexamic acid with sunscreen containing iron oxide is highly effective. Eunice Del Rosario, MD, MS, a clinical instructor at the University of Texas Southwestern Medical Center in Dallas, cited a recent study showing it was 43% effective in treating melasma compared to just 8% when using sunscreen alone. This treatment requires taking tranexamic acid twice a day for three months. It showed sustained benefits for three months after stopping and using sunscreen alone.

Discontinuing the birth control pill is recommended for treating melasma caused by estrogen. Data suggests all-natural, plant remedies are not effective.

Tranexamic acid injections and microneedling are also effective treatments. However, there is no significant difference between the two methods, Dr. Del Rosario said.

“I treat melasma like diabetes. It has to be treated and then maintained because it’s a chronic disorder,” Dr. Pandya said.
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.
Celebrating scientific, specialty highlights

Plenary presentations review achievements, advancements

Each year, the Plenary session serves as a high point of the AAD Annual Meeting. The Sunday session will feature a handful of presentations from selected lecturers, as well as a guest speaker. This year’s scientific experts will discuss a wide range of topics, including dermatology analysis, gene editing, infliximab, atopic dermatitis, and physician burnout and wellness. Academy President Henry W. Lim, MD, and President-Elect Suzanne Olbricht, MD, will also address attendees during the session, which occurs Sunday from 8 to 11:30 a.m. in Ballroom 20.

Clarence S. Livingood, MD, Award and Lectureship

Practicing dermatology well is undoubtedly an art. But this art is not simply meaningful for its own sake. Dermatologic care — if accurately measured and studied — can be used to understand the course of disease and improve public health.

Mary-Margaret Chren, MD, will share the progress that has been made in accurate, systematic measurement of skin diseases and dermatologic care in her presentation “The State of Measuring the Art of Dermatology.” Dr. Chren is professor of dermatology at Vanderbilt University.

Lila and Murray Gruber Memorial Cancer Research Award and Lectureship

Gene editing with CRISPR technology is transforming biology. Understanding the underlying chemical mechanisms of RNA-guided DNA and RNA cleavage provides a foundation for both conceptual advances and technology development.

In “CRISPR Systems: Nature’s Toolkit for Genome Editing,” Jennifer A. Doudna, PhD, will discuss how the technology inspires the creation of powerful genome engineering tools and enables advances in fundamental biology and applications in medicine. Dr. Doudna is professor and HHMI investigator at University of California, Berkeley.

Eugene J. Van Scott Award for Innovative Therapy of the Skin and Phillip Frost Leadership Lecture

Infliximab/Remicade was developed in a research laboratory and became the first TNF antagonist successfully used in patients. Its success spurred the development and regulatory approval of other TNF antagonists that are used in the treatment of numerous chronic inflammatory autoimmune diseases.

Jan T. Vlcek, MD, PhD, will disclose how his work demonstrates the value of university-based basic research for therapeutic advances and economic progress in “Infliximab: How a TNF Inhibitor Advanced from Modest Beginnings to Unforeseen Therapeutic Success.” Dr. Vlcek is professor emeritus and research professor, department of microbiology, at NYU Langone Health School of Medicine.

Marion B. Sulzberger, MD, Memorial Award and Lectureship

Atopic dermatitis (AD) is the most common inflammatory skin disorder in the developed and urbanized world. It is characterized by intense side effects that affect patients’ quality of life, and is associated with many physical and psychological health conditions.

In his presentation “Atopic Dermatitis,” Alan D. Irvine, MD, DSc, will examine the development of AD over the last decade and its rapid evolution to new and effective treatments that are on the horizon. Dr. Irvine is professor of dermatology at Trinity College Dublin in Ireland.

Guest Speaker

Physician wellness and burnout is the new epidemic in health care. The ramifications of burnout include a one in four probability of the physician leaving his or her work situation in the ensuing three years, not to mention the risk of intertemporal drug use or suicide.

Abraham Verghese, MD, will present “The Pathology Within: Burnout, Wellness, and the Search for Meaning in a Professional Life.” He will share personal narratives and scientific data on physician wellness to suggest a strategy for health care leaders to address this crisis in the profession and for individual physicians to renew their faith.

Dr. Verghese is senior associate chair at Stanford University School of Medicine and author of the New York Times bestseller Cutting for Stone.
Meet your 2018 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 2018 Academy election of officers, directors, and Nominating Committee member representatives.

The election is open today through Saturday, March 3. Vote online at www.aad.org/aadelection or from the 2018 AAD Meeting Mobile App.

**President-Elect**
Mark D. Kaufmann, MD, FAAD

**Vice President-Elect**
Neal Bhatia, MD, FAAD
Susan C. Taylor, MD, FAAD

**Board of Directors**

- Larry Green, MD, FAAD
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- Wilma F. Bergfeld, MD, FAAD
- Edward H. Yob, DO, FAAD
- Adelaide Hebert, MD, FAAD
- Tom Heim, MD, FAAD
- Andrew Aloia, MD, MPH, FAAD
- Brad P. Glick, DO, MPH, FAAD

**Nominating Committee Member Representatives**

- Edward H. Yob, DO, FAAD
- Adelaide Hebert, MD, FAAD
- Tom Heim, MD, FAAD
- Andrew Aloia, MD, MPH, FAAD
- Brad P. Glick, DO, MPH, FAAD

**Educational Objectives**
- Describe the pathophysiologic mechanisms and risk factors that contribute to atopic dermatitis development and persistence, with a focus on specific targets of current and emerging systemic treatments
- Assess patients with atopic dermatitis over time for uncontrolled symptoms, sleep disturbances, comorbid conditions, and treatment responses
- Describe the mechanistic rationales and clinical evidence for current and emerging biologic therapies in the treatment of moderate-to-severe atopic dermatitis
- Individualize long-term therapeutic regimens for moderate-to-severe atopic dermatitis to prevent exacerbations, manage comorbidities, maximize health-related quality of life, and minimize treatment-related side effects
- Communicate with patients and caregivers to improve their understanding of atopic dermatitis and the importance of treatment adherence and promote shared decision-making

**FLU SEASON IS NOT OVER**

If you feel flu symptoms, be smart — don’t stay in your hotel room or the convention center, seek medical attention.

**CLINICAL ISSUES IN ATOPIC DERMATITIS**

**DEBATES & DISCUSSIONS ABOUT MANAGING MODERATE-TO-SEVERE DISEASE**

**SUNDAY **
**FEBRUARY 18, 2018**

**6:30 PM—7:00 PM REGISTRATION AND DINNER**

**7:00 PM—9:00 PM EDUCATIONAL ACTIVITY**

**HILTON BAYFRONT**
Indigo Ballroom AB, EF • San Diego, California

**AMY S. PALLER, MD**

**JONATHAN SILVERBERG, MD, PhD, MPH**

**ERIC L. SIMPSON, MD, MCR**

**EDUCATIONAL OBJECTIVES**
- Describe the pathophysiologic mechanisms and risk factors that contribute to atopic dermatitis development and persistence, with a focus on specific targets of current and emerging systemic treatments
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- Communicate with patients and caregivers to improve their understanding of atopic dermatitis and the importance of treatment adherence and promote shared decision-making

**REGISTER NOW**

ExchangeCME.com/ADSanDiego
FIRST & ONLY SPRAYABLE OINTMENT

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

<table>
<thead>
<tr>
<th>% SUBJECTS IMPROVED</th>
<th>96% dryness</th>
<th>91% scaling</th>
<th>80% cracks</th>
</tr>
</thead>
</table>

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.

Beiersdorf
Data on file. Beiersdorf Inc. ©2017
San Diego snaps

Daily highlights of the AAD 2018 Annual Meeting

Did our camera catch you in the crowd? Attendees filled the session rooms and exhibit halls on Friday.
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.

**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.

**Adverse Reactions**

The most common adverse reaction occurring in ≥1% of subjects in clinical trials was application site pain, such as burning or stinging.

**References**


Visit us at booth 5139

For topical use only. Not for ophthalmic, oral, or intravaginal use.

The specific mechanism(s) of action of crisaborole in atopic dermatitis is not well defined.

PDE4 = phosphodiesterase 4.
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.

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.

Contraindications
Hypersensitivity to crisaborole or any component of EUCRISA 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
Fertility
There is no available data with EUCRISA in pregnant women to inform the drug-associated risk for major birth defects and miscarriage. Animal data are not available for use in patients age 65 and older for topically treated 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 1,131 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.

Pediatric Use
Clinical studies of EUCRISA did not include sufficient numbers of subjects age 65 and older 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 doses 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 postnatal development study, pregnant rats were treated by oral gavage during gestation and lactation (from gestation day 7 through day 20 of lactation). Crisaborole was associated with findings of stillbirths, pup mortality, and reduced pup weights.

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

Pharmacology
Application site pain

Adverse Reaction

Table 1: Adverse Reactions Occurring in ≥1% of Patients 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>
</tr>
</thead>
<tbody>
<tr>
<td>Application site paina</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 were headache, application site pruritus and contact urticaria (see Warnings and Precautions).

PATIENT COUNSELING INFORMATION

Test results should be interpreted with caution in the context of the patient’s medical history. These tests are only indications of potential issues and do not replace a thorough medical assessment.

PATIENT COUNSELING INFORMATION

Advise patients or caregivers to read the FDA-approved patient labeling (Patient Information). Hypersensitivity Reactions: Advise patients to discontinue EUCRISA at the first 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.

Download the new AAD Meeting Mobile App

The AAD Meeting Mobile App is back in 2018... and it’s better than ever! The app’s impressive functionality is easy to navigate and includes many useful features, including the following:

- **Session schedule**
- **Events**
- **Exhibitors**
- **E-posters**

For anyone using a platform other than iOS or Android, there will also be a mobile website with limited functionality. Mobile App assistance is available at the San Diego Convention Center in The Connection, Hall A.

Download the AAD Meeting Mobile App now in the App Store or on Google Play by searching for “AAD Meetings.” For more information on the app, visit www.aad.org/mobile.

For anyone using a platform other than iOS or Android, there will also be a mobile website with limited functionality. Mobile App assistance is available at the San Diego Convention Center in The Connection, Hall A.
‘What’s new in dermatology?’

In advance of Tuesday’s symposium session (S067), dermatologists identified some exciting news from across the specialty.

“What’s New in Dermatology?” (S067)
Tuesday, 8–10 a.m.
Room 4B

Mark Lebwohl, MD
Professor and chairman, department of dermatology, Icahn School of Medicine at Mount Sinai

Our ability to create targeted therapies called biologics has dramatically increased our ability to treat conditions like psoriasis. Multiple new biologics have been introduced in the past year. The newest agents target cytokines called IL-17 and IL-23. The ones that block IL-17 are very fast, appear to be quite safe, and are highly effective. There are patients who are born with deficiencies in IL-17, and the only thing they appear to get is yeast infections. That’s what we saw in the clinical trials of these agents, and it is the side effect that has emerged consistently. The first IL-23 was introduced only a few months ago. It has proven to be very effective, even though it requires far fewer injections than previous therapies. We anticipate several additional anti-IL-23 antibodies to be introduced in the next year or two.

Lawrence F. Eichenfield, MD
Professor of dermatology and pediatrics, and vice chair, department of dermatology, University of California, San Diego; chief, pediatric and adolescent dermatology, Rady Children’s Hospital, San Diego

There have been some fascinating developments in the world of pediatric dermatology. Atopic dermatitis is an incredibly prevalent disease that has a marked impact on the quality of life of affected children. The introduction of topical crisaborole, a topical PDE-inhibitor, gives us the first truly new product for AD care since 2001. A recently published paper on crisaborole reviews its use over six months to one year in more than 100 patients, giving us useful information to support the medication as a safe topical agent. Other interesting work in the field highlights the mental health effects of atopic dermatitis, especially its association with ADHD symptoms and diagnosis. A recent study displayed an association of antihistamine use with ADHD, something that is certain to create concerns among health care practitioners and patients.

Desiree Ratner, MD
Professor of dermatology and director, Comprehensive Skin Cancer Center, Mount Sinai Health System

The explosion in targeted therapies over the past few years has changed how we think about and treat aggressive cutaneous cancers. Molecular testing can now identify aberrant genes present in our patients’ tumors, enabling us to individualize their treatment. Vismodegib and sonidegib, which block the sonic hedgehog pathway, have shown promise in treating patients with previously inoperable and metastatic basal cell carcinomas. Cetuximab, an epidermal growth factor receptor inhibitor, is now used to treat advanced squamous cell carcinoma patients. A new group of drugs, known as programmed death 1 (PD-1) inhibitors, has been used successfully in patients with advanced melanoma and Merkel cell carcinoma, as well as with locally advanced squamous cell carcinomas. The future of cutaneous oncology has arrived, and for the most part, it looks very, very bright.

What in the world is this?
Everyday conditions are not always what they seem

Sadaf Hussein, MD, and colleagues present on a unique topic in Sunday’s session “You May Not Have Seen It, but It Has Seen You: Commonly Missed Diagnoses in Dermatology.” In addition to overlooked diagnoses, speakers will also tackle commonly misdiagnosed conditions within both pediatric and adult dermatology populations. Attendees should attend this focus session to learn how to diagnose skin disease more effectively and be able to ascertain appropriate systemic associations.

“You May Not Have Seen It, but It Has Seen You: Commonly Missed Diagnoses in Dermatology” (U058)
Sunday, 7–8 a.m.
Room 30B

Bacterial cultures and HSV-1 and 2 PCR are negative. What is going on?

Should I know what this condition is just by looking at it?

Do I need to biopsy and put a scar on this child’s face to get a diagnosis?

Are there any systemic findings associated with this lesion that I need to know about?

These photos provide a sneak peek of some of the common conditions that Dr. Hussein and faculty will address.

Direct-to-patient teledermatology is a rapidly evolving care delivery model enabling patients to have instant access to the most qualified providers of skin care. Recognizing that wait times for in-office visits are extended to beyond 30 days in many markets, direct-to-patient care further expands patient choice, promotes convenience, and reduces costs. It now allows dermatologists to offer a new service as an extension of their physical brick-and-mortar practices and keep the expertise of skin care within the discipline of dermatology, rather than patients having to go elsewhere. The quality of care should be held to the same standards as an in-person visit. As direct-to-patient teledermatology continues to take a foothold in the evolving integrated health care delivery model, dermatologists should collaborate and promote teledermatology quality measures to ensure patient safety, continuity of care, access to in-office care if needed, and transparency to provider choice.

Learn more at: “Teledermatology Pearls and Pitfalls from Challenging Cases” (F067)
Today, 1–3 p.m.
Room 4

From Members
Mark Patrick Seraly, MD
Private practice in McMurray, Pennsylvania; founder and chief medical officer, Diagnos, developers of DermatologistOnCall.com

Providers share insight into teledermatology

"What’s new in dermatology?’

‘What’s new in dermatology?’

‘What’s new in dermatology?’
For persistent facial erythema associated with rosacea in adults

REDUCE THE REDNESS

Help your patients take a step closer to a more normal, healthy skin color\(^1,2\)

First and only

The first and only \(\alpha_1\) adrenoceptor agonist approved for the topical treatment of persistent facial erythema associated with rosacea in adults\(^1\)

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 \(\geq 1\)% were application-site dermatitis, worsening inflammatory lesions of rosacea, application-site pruritus, application-site erythema, and application-site pain\(^1\)

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 uncontrolled hypertension/hypotension. Advise patients with cardiovascular disease, orthostatic hypotension, and/or uncontrolled hypertension/hypotension to seek immediate medical care if their condition worsens.

Potential 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 potention 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.


© 2017 Allergan. All rights reserved. All trademarks are the property of their respective owners.
**INDICATIONS AND USAGE**

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

**DOSAGE AND ADMINISTRATION**

For topical use only. Not for oral, ophthalmic, or intravaginal 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 pea-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 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.

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**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:

<table>
<thead>
<tr>
<th>Adverse Reaction</th>
<th>Pooled Controlled Clinical Trials</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>RHOFADE® Cream (N = 489)</td>
</tr>
<tr>
<td>Application-site dermatitis</td>
<td>9 (2%)</td>
</tr>
<tr>
<td>Worsening inflammatory lesions of rosacea</td>
<td>7 (1%)</td>
</tr>
<tr>
<td>Application-site pruritus</td>
<td>5 (1%)</td>
</tr>
<tr>
<td>Application-site erythema</td>
<td>5 (1%)</td>
</tr>
<tr>
<td>Application-site pain</td>
<td>4 (1%)</td>
</tr>
</tbody>
</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 (3%), 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 are 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**

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Effectively managing hidradenitis suppurativa

Christopher Sayed, MD

Hidradenitis suppurativa (HS) may be the most serious skin condition that dermatologists commonly treat. A few basic strategies can help improve management approaches and patient outcomes.

“We have multiple studies showing that hidradenitis is probably the worst disease that we commonly treat in the office,” said Christopher Sayed, MD, assistant professor of dermatology at the University of North Carolina. “You can have a dramatic impact on your patients’ quality of life when you improve your management skills and strategies.”

Dr. Sayed directed yesterday’s session “Advanced Management Strategies for Hidradenitis Suppurativa” (F011). He and his fellow speakers presented the latest details on medical management, laser management, and surgical management, as well as how to combine multiple strategies to maximize clinical yield.

Medical management
Topical and oral antibiotics are the mainstay of medical management for hidradenitis, but many patients need more intensive therapy. IV antibiotics are one approach. Biologics are another.

Adalimumab was approved by the Food and Drug Administration for moderate-to-severe hidradenitis in 2015, but there is growing literature to support the use of other TNF inhibitors, as well as at least one interleukin-1A antagonist, anakinra, Dr. Sayed noted.

Laser management
Laser treatment has expanded dramatically in recent years, he continued. CO2 lasers are widely used for excisions. Nd:YAG and alexandrite lasers are useful to destroy hair follicles that have become involved in hidradenitis.

“People will argue over CO2 lasers and blades for excisions,” he said. “Either tool is good with the proper training and experience.”

Surgical management
Surgical management plays a major role in treating hidradenitis, but it is often underutilized and limited to incision and drainage procedures in dermatology offices.

“Like any surgery, unroofing takes some practice as well as recognition of where lesions begin and end,” Dr. Sayed said. “That’s where specialized tools like a fistula probe are helpful, and tailoring the procedure to the disease the patient has. Surgical management can be highly effective, but it is more than just cutting out a large patch of skin.”

Combination management
The most successful approach combines multiple management techniques.

“Some patients can get by with just a single management technique, maybe medical for an early stage patient or surgical alone for a patient who has a single, isolated sinus,” Dr. Sayed said. “But the majority of patients need both the medical side and the procedural side, whether it is laser or surgical, to maximize clinical impact.”

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Jeffrey Sobell, MD

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Presented by:
Jerry Bagel, MD

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Pain management for the dermatologist

How to improve pain management:

Set expectations upfront. This includes expectations of symptoms, treatment, and side effects. Be able to characterize and explain the pain that corresponds with serious medical conditions. Differentiate whether a patient’s pain is acute or chronic. Understand what is reasonable or appropriate (a clinical key indicator), and what is out of the ordinary. Let patients know that pain medications are a temporary solution for a specific purpose, which is to treat a surgery or condition. Prescriptions do not include refills, doses should decrease over time, and long-term use is not recommended. Be transparent about possible side effects. If a patient has history of chronic pain, mental conditions, or addiction, assess the risks of prescribing an opiate that could be habit-forming. Establish an informative pain contract model. This is a structured way to provide patient education and get them to agree to pain medicine guidelines. It also prevents physicians from getting into challenging or awkward situations. Stay within your comfort zone. Do not attempt to treat pain that is outside your realm of expertise or scope of practice. Instead, refer the patient to a pain specialist. Be upfront with patients so that they understand your medical responsibility.

Pain is a commonly presented symptom to dermatologists, both in the acute and chronic settings. How to choose the appropriate pain management path was the topic of Friday’s session “Pain Management for the Dermatologist” (F013).

In acute presentations, such as surgery, dermatologists need to understand and observe proper preoperative, operative, and postoperative assessment and treatment protocols. “As a dermatologic surgeon, we are entirely responsible for pain control,” said session speaker Bryan Carroll, MD, PhD. “Our goal should be complete alleviation of pain and maximizing patient comfort.”

In chronic presentations, it is important for dermatologists to recognize conditions that are often painful or unbearable. Examples include ailments such as hidradenitis suppurativa, pyoderma gangrenosum, and vasculitis/vasculopathy of the skin. As experts of these conditions, dermatologists should be responsible for comprehensive treatment. Referring to a family physician or pain specialist, if not needed, can be wasteful, burdensome, and imprudent. “My basic philosophy,” said speaker Robert Micheletti, MD, “is that if we are treating patients with these conditions, we should be willing to treat the pain that goes with them, at least within our scope of practice.”

Below is a high-level guide to general pain management, including when to administer non-opiates versus opiates. The speakers also provided tips to identify opiate-seeking behavior and improve the pain management process for both physicians and patients.

### How to identify opiate-seeking behavior:
- Patient complain of pain that does not correspond with active symptoms, conditions, or surgery.
- Patient asks for frequent refills.
- Patient reports losing prescriptions.
- Patient avoids you, the physician, and tries to coerce staff.
- Patient is demanding or exhibits unreasonable behavior.
- Patient has a history of opiate prescriptions, particularly from more than one provider. Some states have opioid registries, where providers are required to report the patient and prescription details.

<table>
<thead>
<tr>
<th>Is the patient’s pain chronic or acute?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CHRONIC:</strong></td>
</tr>
<tr>
<td><strong>Is it general or related to a dermatologic condition?</strong></td>
</tr>
<tr>
<td>- <strong>No:</strong> Treat pain alongside the medical condition.</td>
</tr>
<tr>
<td>- Prescribe Tylenol or NSAIDs in appropriate doses, and decrease medicine over time as the condition and symptoms improve.</td>
</tr>
<tr>
<td>- <strong>Yes:</strong> Treat pain alongside the medical condition.</td>
</tr>
<tr>
<td>- Prescribe Tylenol or NSAIDs in appropriate doses.</td>
</tr>
<tr>
<td>- Consider the addition of medications such as gabapentin, which can titrate to control the amount and strength.</td>
</tr>
<tr>
<td>- Decrease pain medicine over time as the condition and symptoms improve.</td>
</tr>
<tr>
<td><strong>Condition:</strong> Assess the patient's symptoms. Is the patient's pain level mild to moderate or severe?</td>
</tr>
<tr>
<td>- <strong>No:</strong> Assess the patient’s medical history.</td>
</tr>
<tr>
<td>- Do they have a record of one or more chronic pain problems?</td>
</tr>
<tr>
<td>- Assess the patient’s mental state.</td>
</tr>
<tr>
<td>- Do they have depression or anxiety that could affect their perceived pain?</td>
</tr>
<tr>
<td>- <strong>Yes:</strong> Treat pain alongside the medical condition.</td>
</tr>
<tr>
<td>- The combination of Tylenol and non-aspirin NSAIDs is superior to Tylenol with codeine.</td>
</tr>
<tr>
<td>- Or you could consider a short-term prescription for tramadol.</td>
</tr>
<tr>
<td>- Prescribe pain medicine in appropriate doses, and decrease over time as the condition and symptoms improve.</td>
</tr>
<tr>
<td><strong>Condition:</strong> Does the patient’s pain correspond with the activity of the condition?</td>
</tr>
<tr>
<td>- <strong>No:</strong> Assess the patient’s medical history.</td>
</tr>
<tr>
<td>- Do they have a record of one or more chronic pain problems?</td>
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<tr>
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<tr>
<td>- Prescribe pain medicine in appropriate doses, and decrease over time as the condition and symptoms improve.</td>
</tr>
<tr>
<td><strong>Surgery:</strong> Perform a preoperative assessment. Determine the patient’s risk of pain by reviewing their pain history and evaluating their expected level of pain. Is the patient low-risk or high-risk?</td>
</tr>
<tr>
<td>- <strong>Low-risk:</strong> Follow your standard approach for injection techniques (cooling the site or using vibration, distraction, or buffered lidocaine) and medications.</td>
</tr>
<tr>
<td>- These include intraoperative NSAIDs and postoperative NSAIDs with or without Tylenol.</td>
</tr>
<tr>
<td>- Other care includes rest, elevation, and cold compress.</td>
</tr>
<tr>
<td><strong>High-risk:</strong> Add interventions to your standard operative and postoperative techniques.</td>
</tr>
<tr>
<td>- Start NSAIDs and Tylenol before surgery.</td>
</tr>
<tr>
<td>- Consider supplemental injection techniques, such as regional or long-acting local anesthetics.</td>
</tr>
<tr>
<td>- Rarely, axonolytics or narcotics (with a stool softener and antiemetics) are indicated.</td>
</tr>
</tbody>
</table>

| **ACUTE:**               |
| **Is it in relation to a condition or to a dermatologic surgery?** |
| - **No:** Treat pain alongside the medical condition.  |
|   - Prescribe Tylenol, NSAIDs, or other pain medicine in appropriate doses.  |
|   - Continue to closely monitor and adjust treatment as needed. Decrease medicine over time as the condition and symptoms improve.  |
| - **Yes:** Treat pain alongside the medical condition.  |
|   - Prescribe Tylenol, NSAIDs, or other pain medicine in appropriate doses.  |
|   - Continue to closely monitor and adjust treatment as needed. Decrease medicine over time as the condition and symptoms improve.  |
| **Condition:** Does the patient’s pain correspond with the activity of the condition? |
| - **No:** Assess the patient’s medical history.  |
|   - Do they have a record of one or more chronic pain problems?  |
|   - Assess the patient’s mental state.  |
|   - Do they have depression or anxiety that could affect their perceived pain?  |
| - **Yes:** Treat pain alongside the medical condition.  |
|   - The combination of Tylenol and non-aspirin NSAIDs is superior to Tylenol with codeine.  |
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| **Surgery:** Perform a preoperative assessment. Determine the patient’s risk of pain by reviewing their pain history and evaluating their expected level of pain. Is the patient low-risk or high-risk? |
| - **Low-risk:** Follow your standard approach for injection techniques (cooling the site or using vibration, distraction, or buffered lidocaine) and medications.  |
|   - These include intraoperative NSAIDs and postoperative NSAIDs with or without Tylenol.  |
|   - Other care includes rest, elevation, and cold compress.  |
| **High-risk:** Add interventions to your standard operative and postoperative techniques.  |
|   - Start NSAIDs and Tylenol before surgery.  |
|   - Consider supplemental injection techniques, such as regional or long-acting local anesthetics.  |
|   - Rarely, axonolytics or narcotics (with a stool softener and antiemetics) are indicated.  |
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Elena Hawryluk, MD, PhD, MGH dermatologist, at 2018 American Academy of Dermatology Annual Meeting participating in Acute & Inpatient Pediatric Dermatology and Lumps & Bumps in children today. @AADmember @MassGeneralNews #AAD18 @MassGeneralMDs

We’re so excited to be here! @WomensDerm

What’s the most exciting clinical development you’ve heard about recently?

“I do pediatric dermatology, and I heard about some exciting stuff with hidradenitis. It involves using topical resorcinol, which I had never known about as being an option for mild cases of hidradenitis. Even though it’s not common, I see it quite often.”

Jennifer Sorrell, MD Palo Alto, Calif.

“I love hearing about all the new drugs for treating diseases like psoriasis and atopic dermatitis. It’s a whole new world for the patients. I’m excited about all this new information. Last year, I learned a lot of new information and took it back to my practice. I’m always willing to learn more.”

Cristina Abdalla, MD Sao Paulo, Brazil

“The best clinical development I heard about was dupilumab for atopic dermatitis. It’s offering a clinical breakthrough for our problem atopic dermatitis patients. It offers something more than other systemic agents. I know it’s expensive, but it’s successful.”

Andy Basnet, MD, FAAD Honolulu

Join the #AAD18photo Instagram Challenge

Today’s challenge: take a selfie with a mentor, new friend, or someone who has influenced your career!
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Clearing up naturally
Herbs and gluten-free products offer natural alternatives for common issues

Reena N. Rupani, MD, shares her favorite herbal alternatives.

Conventional pharmaceutical agents are not the only solutions to common dermatologic problems. Natural products can offer practical alternatives for acne, rosacea, hair loss, immunologic disorders, and other common issues. “My three favorite herbs are chasteberry, neem, and ashwagandha,” said Reena N. Rupani, MD, dermatologist at Mount Sinai Beth Israel in New York, at Thursday’s “Natural Compounds in Addressing Common Dermatologic Problems” (U007). “These agents can be good choices for patients who don’t want to be on a ‘drug’ or who want something more natural.”

Chasteberry affects the pituitary, but is not anti-androgenic and can be used with anti-androgens. Dr. Rupani said, “It can be useful for hormonal acne, but can cause GI upset and should be taken with food. Chasteberry can also affect the effectiveness of hormonal contraceptives.”

Neem is an anti-inflammatory and anti-microbial that can help with seborrheic dermatitis and other inflammatory conditions. Neem seed oil is particularly helpful for dandruff and lice, but most neem products have a sulfurous smell that patients may find objectionable.

Ashwagandha, sometimes called Indian ginseng, is helpful when stress is a factor, including alopecia. There are few FDA-approved hair loss products, such as minoxidil for women and finasteride for men. Plant-based 5-alpha-reductase inhibitors — including pumpkin seed oil, saw palmetto, procyanidin B-2, and ginseng — all have some degree of clinical evidence.

“The study results are not as dramatic as minoxidil or finasteride, but these are viable alternatives,” said Nicole Elaine Rogers, MD, assistant clinical professor of dermatology at Tulane University in New Orleans. “It is useful to be able to offer natural alternatives to our patients.”

Acne and rosacea are increasingly recognized as immune reactions rather than infections. “Patients using alternative options want to fix the host, not kill the bugs and contribute to antibiotic resistance,” said Hilary E. Baldwin, MD, medical director of The Acne Treatment Research Center in Morristown, New Jersey. “Natural products for acne and rosacea are not only helpful, but often preferred by patients because they are more tolerable.”

Tea tree oil, resveratrol, aloe vera, and electro-acupuncture can serve as anti-microbial and anti-inflammatory agents and act as de-greasers or exfoliants. 

Providers share insight into teledermatology

When providing quality teledermatology care, it’s most important to be familiar with the local health issues in the community and the available medications for the patients being served, as well as the structure of the health care system. Teledermatologists should also know what resources are available to them for working up difficult patients, including biopsies, laboratories, and in-person dermatology visits. The most challenging patients seen in teledermatology may require a discussion between providers, a request for additional information, and a collaborative plan, rather than a simple visual diagnosis and treatment recommendation.

Learn more at: “Teledermatology Pearls and Pitfalls from Challenging Cases” (F067)
Today, 1-3 p.m.
Room 4

Going gluten free
A gluten-free diet can help some patients with dermatologic manifestations of celiac disease as well as non-celiac gluten sensitivity. “Gluten-free diet is the only long-term treatment for celiac and dermatitis herpetiformis,” said Matthew S. Goldberg, MD, assistant professor of dermatitis and pathology at the Icahn School of Medicine, New York. “It is easier than ever to keep a gluten-free diet in our current climate.”

Herbs and gluten-free products offer natural alternatives for common issues
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Q&A:

Current and future state of tumors and inflammatory skin diseases

George Han, MD, PhD, and Adam Friedman, MD, spoke with Dermatology World Meeting News to discuss some of the recent advances in treating tumors and inflammatory skin diseases and what could be coming next.

What is the hottest new treatment area in inflammatory skin diseases?

Dr. Han: Biologic medications are now widely being used for a number of approved indications, such as psoriasis and psoriatic arthritis. However, there is considerable opportunity to use these agents for other inflammatory dermatoses, particularly for those too rare to have gotten an indication or where numerous first-line treatments have failed. Biologics can help transform patients’ quality of life in conditions such as pyoderma gangrenosum, sarcoid, vitiligo, and other less common inflammatory skin diseases if you go off-label. Some of these biologic medications may have only a few indications on the label, but they can be used effectively for a lot more in a safe and rational manner.

How far have we come in treating autoimmune skin diseases?

Dr. Friedman: Targeting cyclic AMP and the enzyme that breaks it down, phosphodiesterase 4 (PDE4), has taken center stage in treating psoriasis, atopic dermatitis, alopecia areata, and other diseases. There may also be a role for immunotherapy in some of the horrific autoinflammatory conditions being studied at the NIH.

What is the latest in treating dermatologic tumors?

Dr. Han: We have new biologics for melanoma, which are giving us much more effective treatment options through immunotherapy. There is still considerable work being done in determining which patients may be the best candidates for each approach, with new treatment targets being identified as well. The hope is that we’ll be able to offer our patients who have had their melanomas excised numerous options with regard to both treatment and prevention of recurrence.

What surprises are in the development pipeline?

Dr. Friedman: There is tremendous potential for the utilization of cannabinoids in dermatology. Cannabinoids represent a broad class of chemical compounds originally comprised only of phytocannabinoids — cannabinoids produced by the cannabis plant. Now we have access to endocannabinoids and synthetic cannabinoids in addition to phytocannabinoids. Cannabinoids act as agonists on cannabinoid receptors (CB1) and cannabinoid receptor-2 (CB2), which have distinct distributions throughout the body. CB1 is seen predominantly in the peripheral and central nervous system and therefore is a good target for pain and itch. CBs is expressed by immune cells and keratinocytes, making it a great target for inflammatory and neoplastic diseases. Depending on the indication, you may want one to target one receptor or the other, or a mix of the two for the ideal clinical result.
Over 15 million Americans are living with hyperhidrosis?¹

Primary hyperhidrosis

is an idiopathic condition, marked by excessive sweating regardless of temperature, exercise or situation.¹,²

Hyperhidrosis is shown to have the highest prevalence in younger sufferers.¹

Approximately 50% of those with hyperhidrosis never consult an HCP¹

• 60% do not know it is a medical condition
• 47% do not believe there are treatment options available

70% say it frequently interferes with their daily activities.¹ The impact on quality of life has been equated to psoriasis and dermatitis.³

Up to 86% experience moderate to severe emotional impact such as feeling unhappy and reduced confidence.⁴

Could there be more behind your patients’ excessive sweating?

Join the conversation.
Dermira Booth 4947 at the AAD Annual Meeting

References:

*Ages 18-39.
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