The top concerns and interests of AAD members come to the forefront for the session “Hot Topics,” addressing those top-of-mind subjects established by registrant consensus.

The presentations and speakers are:

**Acne: What's New?**
Hilary Baldwin, MD

**Bioligics and Psoriasis: The Beat Goes On**
Mark Lebwohl, MD

**Atopic Dermatitis: New Developments**
Emma Guttman, MD

**Drug Eruptions: The Good, Bad, and Ugly**
J. Mark Jackson, MD

**Melanoma Update 2018**
Darrell Rigel, MD

**Hairy Matters: What's New in Alopecia?**
Natasha Mesinkovska, MD

**Cosmeceuticals: Naturally Absurd?**
Adam Friedman, MD

**What's New in Cosmetic Surgery?**
Anthony Benedetto, DO

If you can, filter out the “noise” of politics for a moment. The truth is, great work can happen in Washington, D.C., exemplified by the quality of education and events that make up this year’s AAD Annual Meeting. With a full schedule of education sessions, live demonstrations, and patient encounters, workshops, learning and networking among dermatologists is at its finest.

The next five days offer “a whirlwind of educational offerings with updates on the latest advancements from across the specialty,” according to AAD Scientific Assembly Committee Chair Bob Brodell, MD.

“We live in a world where a significant percentage of medical students eschew the classroom in favor of digital content. The 2019 AAD Annual Meeting is adjusting to these new realities,” Dr. Brodell said. “However, you will see more ‘hands-on’ coursework, self-assessment sessions, and presentations featuring creative topics and innovative techniques. Still, some things will not change! The Annual Meeting will always have a large number of people getting together under one roof to renew friendships, share knowledge, and learn.”

From panel discussions to a look at the latest products and services in the Exhibit Hall, myriad opportunities help dermatologists improve their practice, learn new techniques, hear the latest research, and expand their involvement in the Academy.

The AAD Annual Meeting features more than 350 educational sessions and hot topics, as well as opportunities to meet vendors, connect with the Academy, and network with colleagues.

The Exhibit Hall is open Friday, Saturday, and Sunday, with more than 350 exhibitors showcasing the latest products and services in dermatology.

The Connection, located in Hall D, offers lounges to meet colleagues, check email, charge your phone, vote in the AAD election, claim CME credits, and more.

Meet the candidates for president-elect and vice president-elect of the Academy during a live Town Hall on Friday, 12 to 1 p.m. in The Connection.

Meet and greet the AAD Board of Directors. Get to know your representatives, tell them what’s on your mind, and learn about current initiatives and programs. The event is Saturday, 12 to 1 p.m. in The Connection.

The AAD Resource Center serves as a central resource and features AAD services and new products. This includes CV/resume assistance and free professional headshots.

Connect with colleagues and employers at the Career Networking Event, 4:30-6:30 p.m. at the Marriott Marquis, Ballroom Salon 6.

“We’ve always seen the Annual Meeting as an opportunity — a chance to get out of my practice setting, learn the latest news and procedures, exchange ideas with fellow dermatologists, and work with my fellow members of the AAD to advance the specialty of dermatology,” said AAD President Suzanne Olbricht, MD. “I go home stimulated and ready to get back prepared to work to do the best job I can for my patients and my practice.”

Bob Brodell, MD
AAD Scientific Assembly Committee Chair
MORE THAN A MOISTURIZER

AmLactin® gently exfoliates plus deeply hydrates with beneficial levels of lactic acid

Experience the difference at booth #2925

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.

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A look at AAD’s Plenary session

Sunday’s speakers offer key insight

This year’s Plenary speakers cover a wide range of topics. Learn more about these seven individuals and what they plan to share in their presentations.

Paul Nghiem, MD, PhD
“Less Toxic, More Effective: A Win-Win for Merkel Cell Carcinoma”

What does it mean to you to be selected for and speak at this year’s Plenary?
Delivering the Van Scott/Frost Lecture is a career highlight for me because I have always hoped my research would have impact in the care of patients. More importantly, I believe this event should help us come together to ensure Merkel cell carcinoma patients get the best possible multi-disciplinary care. Lives will literally be saved and unnecessary toxicities will be avoided due to the awareness that can come from this session.

Boris D. Lushniak, MD
“I Acted and Beheld, Service was Joy”

What is one insight you can share about the future of dermatology?
We, as dermatologists, need to be fully engaged in paving the pathway for the future of dermatology as a 21st century specialty. Embrace technology but don’t forget the art, the personal interactions, and the service mission of medicine.

Crystal L. Mackall, MD
“Engineering T Cells for Cancer Therapy”

What is the key point you hope members will take away from your presentation?
I am hopeful that I can educate the members regarding recent progress in using engineered T cells for cancer therapy and convey to the members the basis for optimism regarding the potential of this novel class of therapeutics.

Robin Farmanfarmaian
“Patient Empowerment in the Digital Age”

What does it mean to you to be selected for and speak at this year’s Plenary?
I am incredibly honored to be selected for this year’s Plenary! As a chronic disease patient, as well as an entrepreneur working in health care, I have massive respect for physicians and other health care providers, and with good reason — they are the ones on the front lines working to save and improve other people’s lives. For decades, health care providers have helped me, and it is an honor to be able to give back to them in this small way.

Diane M. Thiboutot, MD, MBA
“In Search of the Next Isotretinoin”

What is the key point you hope members will take away from your presentation?
Acne remains an important disease that causes distress to millions of individuals and that analysis of large datasets in partnership with industry can accelerate drug discovery.

George J. Hruza, MD
President-Elect’s Address

How do you plan to address challenges to the profession in your role?
Dermatology has the fastest rate of burnout increase in medicine. I will make sure that the Academy is there to support our members through a beefed-up Practice Management Center and reinvigorated advocacy at the federal and state level. A new quality improvement center will help our members improve the care they provide their patients. We will perform an in-depth review of all of our programs to enhance our effectiveness, transparency, and responsiveness to our members and the needs of dermatology.

Suzanne M. Olbricht, MD
President’s Address

What has been one of the greatest challenges to the profession in the last year?
The future of dermatology is strong. Dermatologists are energetic, passionate, and innovative. Innovating is critical because the practice of medicine will be vastly different in five years due to the digital revolution and advances in augmented intelligence. I encourage AAD members to embrace change and focus on our vision statement: Advancing excellence in dermatology.
Q & A

In her session, “Patient Empowerment in the Digital Age,” plenary guest speaker Robin Farmanfarmaian will address a host of current breakthroughs in medical technology that are fundamentally changing the way patients interact with their health care and providers. These include wearable sensors, improved point-of-care diagnostics, augmented intelligence (AI), and virtual care. Farmanfarmaian will discuss methods for integrating these new services and revenue streams into the dermatology practice.

Q What is one insight you will share about the future of dermatology?

Farmanfarmaian: The use of AI will increase as more and more accurate data is aggregated for AI programs to learn. This is beneficial for the dermatology field, as one of the things AI is best at doing is pattern analysis. AI analysis programs serve as tools that can help physicians and patients catch some problems earlier, when they are easier to treat.

Q How is technology impacting health care?

Health care is shifting in two major ways. A combination of technology and costs is shifting the point of care to where the patient is located, versus the patient having to physically go to a brick and mortar clinic. Also, patients are becoming more empowered by these same forces — technology and costs — to be in control of their health care: When they want it, where they want it, and how they want it.

Q If virtual care is the wave of the future, what are the cons of virtual care?

While there are tons of benefits for using virtual care, like most things in life, there are also some cons. Physical human touch is important in the health care relationship, both on an emotional level for the patient and for assessment and diagnostics. If the physician is relying on data collected by the patient, such as vital signs, there is a risk the equipment is not being used correctly without a physician present. In addition, when the physician is able to see a patient in person, they may notice or catch things that either the patient doesn’t think to mention, or the patient doesn’t know is a symptom or a data point for assessment. Lastly, communication with any subject is always more effective in person, and this can be especially important when dealing with the complexities of health care.

Q As a non-physician looking in, what do you believe were the greatest challenges to physicians in the last year?

As someone with a high-level viewpoint of health care and technology, not in dermatology specifically, I believe the challenges to the dermatology profession are likely the same as the challenges faced in all other specialties: the high costs of medications and treatments for their patients. No specialty is immune to these rapidly growing costs, combined with reimbursement becoming even more complicated and at times, reduced. This isn’t a dermatology-specific challenge. This is the biggest challenge in health care today.

Currently, Farmanfarmaian is working with a few early stage start-ups: as COO for Arc Fusion Programs; as co-founder and former executive director for the Organ Preservation Alliance; as vice president of Business Development for Invicta Medical; and as president of i4j ECO, a summit to disrupt unemployment through innovation to create jobs and meaningful work for everyone. Learn more about Robin Farmanfarmaian at www.robinff.com.

Pick up your copy of the Onsite Meeting Guide

The 2019 Onsite Meeting Guide, Experience the AAD Annual Meeting, is available in racks throughout the Walter E. Washington Convention Center. It has all of the vital information you need about the meeting, such as:

- Key elements
- Daily highlights
- AAD honors and awards
- Education information
- Social media platforms
- Exhibit Hall floor plan and exhibitor lists
- Convention center maps

TODAY’S HIGHLIGHTS

7 a.m.-5:30 p.m. AAD registration open
Location: Grand Lobby – Street Level

The Connection
Location: Hall D
• View e-posters
• Charge your phone in the Networking Lounge
• Utilize e-center to access voting, claim CME, read emails, and check in for your flight home

8 a.m.-5 p.m. AAD Resource Center open
Location: Hall D

9 a.m.-5 p.m.
Gross and Microscopic Symposium (5008)
Location: Room 149AB

12-1 p.m. AAD Election 2019
• Meet the Candidates
• Live Town Hall
Location: The Connection, Hall D

Unopposed exhibit time
Location: Exhibit Hall

1-3 p.m.
Virtual Dermatopathology Self Assessment: Get Ready for Non-glass Slide Exams (F022)
Location: Room 143C

3:30-5:30 p.m.
Boards and Beyond (F034)
Location: Room 203AB

4-5:30 p.m.
Access to Care Learning Collaborative
Location: Georgetown University Room, Marriott Marquis

4:30-6:30 p.m. AAD Career Networking Event
Location: Marquis Ballroom Salon 6, Marriott Marquis, Washington DC

5:30-7 p.m.
International Members Reception
Location: Marquis Ballroom Salon 5, Marriott Marquis, Washington DC

Early Career Reception
Location: Marquis Ballroom Salon 7-10, Marriott Marquis, Washington DC

7 p.m. (6:30 p.m. registration)
Industry Non-CME Program: HANDS ON Psoriatic Disease: A Live & Augmented Reality Experience for Advancing Patient Care Despite Modern Time Constraints
Location: Renaissance Ballroom West A and B, Renaissance Washington, DC Downtown Hotel From Novartis

Industry Non-CME Program: PD-1 Targeting Therapy in Advanced Metastatic Cutaneous Squamous Cell Carcinoma (CSCC)
Location: Liberty M-P, Marriott Marquis Washington, DC From Sanofi Genzyme and Regeneron

Industry Non-CME Program: Understanding and Treating Psoriatic Disease in a New Generation of Patients
Location: Renaissance Ballroom East, Renaissance Washington, DC Downtown Hotel From UCB Inc.
Several Th2 cytokines, including IL-13, are key drivers of atopic dermatitis.¹


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Review the case at LEO Pharma Booth #3227

Empowering patients in the digital age
The translational revolution in inflammatory skin diseases

The scientific revolution in the understanding of inflammatory skin diseases as immune-mediated diseases that began in the late 1900s and early 2000s is evolving into a growing stream of new, revolutionary treatments. From initial breakthroughs in psoriasis to improved understanding of the pathogenesis of atopic dermatitis, alopecia areata, vitiligo, hidradenitis suppurativa, acne, and rosacea, the increased body of knowledge is advancing treatment results that patients and their physicians could only dream about a decade ago.

These advances in the mechanistic understanding of disease translate into the rapid development and testing of targeted treatments that are safer and more effective than traditional agents for long-term disease control.

Dermatologists who want to explore current disease understanding and treatment and future treatments for inflammatory skin diseases and the rationale for their use can find a comprehensive overview in Friday’s single symposium, “Inflammatory Skin Diseases: The Translational Revolution” that will feature some of the world’s leading experts in these diseases.

While conventional treatments may be effective to improve symptoms, they either harbor significant side effects — such as the risk of permanent kidney damage associated with more than one year of continuous use of cyclosporine — or are not feasible for many, such as phototherapy. The arrival of new agents that can realistically offer the prospect of long-term disease control is a clinical revolution for treating dermatologists and for their patients.

“I am excited to learn about novel therapies for difficult to treat dermatologic diseases. As a resident, learning new treatment modalities from leading innovators aids me in confidently shaping my own methods of clinical practice. I hope to gain insights and direction from mentors who share my interest in dermatologic oncologic surgery.”

Get social with AAD

Join the thousands of other dermatologists who are already following @aadmember, and be sure to use the official Annual Meeting hashtag #AAD19 in all your meeting-related posts and tweets.
Join us for these exciting events at this year’s AAD Annual Meeting!

Hear Expert Insights at Two Unique Educational Sessions

**Cosentyx**
(seukinumab)

**Discover the Complete Cosentyx Approach**
Booth #3021

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**Industry Expert Session 1**

**Friday, March 1, 2019**
2:45 PM – 3:30 PM Program
Exhibit Hall A
Walter E. Washington Convention Center
Washington, DC
Please arrive at 2:30 PM to register
*Meal will be provided.*

**Presented by:**
Ben Lockshin, MD, FAAD

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**Industry Expert Session 2**

**Saturday, March 2, 2019**
11:00 AM – 11:45 AM Program
Exhibit Hall A
Walter E. Washington Convention Center
Washington, DC
Please arrive at 10:45 AM to register
*Meal will be provided.*

**Presented by:**
Francisco A. Kerdel, MD, MBBS, BSc

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These Industry Expert Sessions are promotional activities and are not approved for continuing education credit. The content of these sessions and opinions expressed by presenters are those of the Presenting Company or presenters and do not represent an endorsement by, nor imply that the products have been evaluated or approved by the American Academy of Dermatology.
Eat, meet, and network at the AAD Food Court

11 a.m.–2:30 p.m.
Friday, Saturday, and Sunday.
AAD Exhibit Floor located at the back of Hall C

International food stands offering a variety of healthy and delicious options. Ample seating available. Cash or credit accepted.

Learn About a Topical Option for Mild-to-Moderate Atopic Dermatitis in Patients 2 Years and Older

Friday, March 1, 2019 • 1:30 PM – 2:15 PM • Industry Expert Theater, AAD Exhibit Floor

Please join us for a non-CME program presented by

Emily M. Becker, MD
Sonterra Dermatology
Driscoll Children’s Hospital
Assistant Clinical Professor in Dermatology
at University of Texas Health Science Center
San Antonio, Texas

Refreshments will be provided

This Industry Expert Session is a promotional activity and is not approved for continuing education credit. The content of this session and opinions expressed by presenters are those of the Presenting Company or presenters and do not represent an endorsement by, nor imply that the products have been evaluated or approved by the American Academy of Dermatology.

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State Laws and Pfizer Disclosure: The cost of meals and refreshments provided to US licensed Healthcare Professionals attending this Pfizer-sponsored program will be subject to public disclosure on www.pizer.com as part of Pfizer’s Healthcare Professional Disclosure policies, and may also be subject to disclosure by state governmental authorities pursuant to your state law and applicable federal law such as the National Physician Payment Transparency Program (otherwise known as “Sunshine”). Pfizer’s disclosure will allocate the cost of meals and refreshments equally across all attendees regardless of actual consumption. If you are licensed to practice in Minnesota or Vermont, we are prohibited from providing you any meals and/or refreshments due to your state limitation on meals, gifts or other items of value to HCPs and ask that you do not partake in the hospitality provided.

Download the new AAD Meeting Mobile App

Find the most up-to-date information at the AAD Meeting Mobile App. The app’s real-time functionality is easy to navigate and includes countless features, including the following:

Session schedule
List of sessions by day, type, category, and speaker. Bookmark sessions you like, take notes, or access session handouts.

Exhibitors
View the exhibit hall floor plan and search by name or category. Interactive maps. Explore floor plans for session rooms, events, and other areas.

Events
Find details on specific events, such as Council, Committee, or Task Force meetings, Affiliate and Reunion Groups, Industry Expert Sessions, and Industry Non-CME (INC) Programs.

Audience participation
Access Audience Response System sessions and provide feedback via your mobile device.

E-posters
Access e-posters and search by author, title, category, keyword, or poster number.

Vote
Cast your ballot for AAD leadership.

Network
Find and message colleagues to connect or stay in touch. Download the AAD Meeting Mobile App from the App Store or on Google Play. Search “AAD Meetings.” Or, visit www.aad.org/mobile. For platforms other than iOS or Android, there will be a mobile website with limited functionality. Assistance is available at the Walter E. Washington Convention Center in The Connection, Hall D.
Clinical Issues in PSORIASIS
Debates and Discussions About Pustular Disease Subtypes

SUNDAY MARCH 3 2019
6:30 PM – 9:00 PM
REGENCY BALLROOM A
Hyatt Regency Washington on Capitol Hill
Washington, DC • Dinner will be provided.

TARGET AUDIENCE
The educational design of this activity addresses the needs of dermatologists, clinical immunologists, and other clinicians involved in the treatment and management of patients with pustular psoriasis.

EDUCATIONAL OBJECTIVES
After completing this activity, the participant should be better able to:
• Describe the genetic and pathophysiologic mechanisms that contribute to the development of pustular psoriasis including factors that have informed the development of new therapies
• Comprehensively assess patients with suspected pustular psoriasis based on clinical manifestations, diagnostic criteria, and disease severity
• Describe the mechanistic rationales and clinical evidence for current and emerging biologic therapies for the treatment of generalized pustular psoriasis and palmoplantar pustulosis
• Individualize therapeutic regimens for pustular psoriasis, with a focus on generalized disease subtypes and palmoplantar pustulosis

PROGRAM AGENDA
7:00-7:10 Preactivity Questionnaire and Faculty Introductions
7:10-7:30 Introduction to Pustular Psoriasis Pathophysiology
7:30-7:50 Evaluating Patients With Generalized Pustular Psoriasis or Palmoplantar Pustulosis
7:50-8:20 Evolving Therapeutic Approaches for Patients With Pustular Psoriasis
8:20-8:40 Case Study Discussion: Prerecorded Patient Examples
8:40-9:00 Postactivity Questionnaire and Q&A Session

AMERICANS WITH DISABILITIES ACT
5. Event staff will be glad to assist you with any special needs (e.g., physical, dietary, etc. Please contact Christa Master prior to the live event at cmaster@integritasgrp.com.

This program is independent and is not part of the official AAD Annual Meeting, as planned by its Scientific Assembly Committee. This program does not qualify for continuing medical education (CME) credit.

PROGRAM OVERVIEW
Pustular psoriasis is a relatively rare form of psoriasis and has historically been classified into generalized and localized forms of the disease. Generalized pustular psoriasis is characterized by widespread sterile pustules on erythematous skin, recurrent fever, and systemic flushing and malaise. Palmoplantar pustulosis, a localized form, is characterized by erythema, pruritis, burning, and pain on the palms of the hands and soles of the feet. Recent evidence suggests that IL36RN mutations are the most common genetic aberration linked to pustular psoriasis, with the allelic frequency distinguishing generalized pustular psoriasis from palmoplantar pustulosis; the former shows a 4 to 1 increase versus the latter. Whether pustular psoriasis presents as localized or generalized, patients are subject to significant health risks and poor quality of life outcomes due to both skin and systemic manifestations. Patients may be subject to delays in diagnosis, in part because the disease states are relatively rare and there are little solid epidemiologic data. Dermatologists are faced with limited guidance on selecting therapies for patients with any of the pustular psoriasis subtypes. Biological agents for pustular psoriasis and palmoplantar pustulosis are being examined in clinical trials. These include some biologics approved for psoriasis as well as agents with novel therapeutic targets, such as an anti-interleukin (IL)-36 receptor antibody. This Clinical Issues symposium will use both lecture and faculty discussion among leading dermatology experts to explore many of these issues, with an emphasis on evolving diagnostic and management strategies for generalized pustular psoriasis and palmoplantar pustulosis.

REFERENCES

REGISTER NOW!
ExchangeCME.com/DC2019
Transient blurred vision may occur with QBREXZA. If this occurs, instruct patients to contact their healthcare provider, as QT interval prolongation has been observed with parenteral anticholinergic administration, which may result in additive interaction leading to an increase in anticholinergic adverse effects. QBREXZA is flammable, avoid use near heat or flame. Remind patients not to apply QBREXZA to other body areas or to broken skin. Instruct patients to avoid using QBREXZA with occlusive dressings. Using the same cloth, apply the medication to the other underarm, ONE TIME.

Because glycopyrronium is a quaternary amine which does not easily cross the blood-brain barrier, symptoms of anticholinergic effects may occur in the absence of sweating. Local skin reactions, including erythema (17%), burning/stinging (14%) and pruritus (8%) were also common.

INDICATION
QBREXZA™ (glycopyrronium) cloth is an anticholinergic indicated for topical treatment of primary axillary hyperhidrosis in adult and pediatric patients 9 years of age and older.

IMPORTANT SAFETY INFORMATION
Contraindications: QBREXZA is contraindicated in patients with medical conditions that can be exacerbated by the anticholinergic effect of QBREXZA (e.g., glaucoma, paralytic ileus, unstable cardiovascular status in acute hemorrhage, severe ulcerative colitis, toxic megacolon complicating ulcerative colitis, myasthenia gravis, Sjogren’s syndrome).

WARNINGS AND PRECAUTIONS
Worsening of Urinary Retention: QBREXZA should be used with caution in patients with a history or presence of documented urinary retention. Prescribers and patients should be alert for signs and symptoms of urinary retention (e.g., difficulty passing urine, distended bladder), especially in patients with prostatic hypertrophy or bladder-neck obstruction. Instruct patients to discontinue use immediately and consult a physician should any of these signs or symptoms develop. Patients with a history of urinary retention were not included in the clinical studies.

Control of Body Temperature: In the presence of high ambient temperature, heat illness (hyperpyrexia and heat stroke due to decreased sweating) can occur with the use of anticholinergic drugs such as QBREXZA. Advise patients using QBREXZA to watch for generalized lack of sweating when in hot or very warm environmental temperatures and to avoid use if not sweating under these conditions.

Operating Machinery or an Automobile: Transient blurred vision may occur with the use of QBREXZA. If blurred vision occurs, the patient should discontinue use until symptoms resolve. Patients should be warned not to engage in activities that require clear vision such as operating a motor vehicle or other machinery, or performing hazardous work until the symptoms have resolved.

ADVERSE REACTIONS
The most common adverse reactions seen in ≥2% of subjects treated with QBREXZA were dry mouth (24.2%), mydriasis (6.8%), oropharyngeal pain (5.7%), headache (5.0%), urinary hesitancy (3.5%), vision blurred (3.5%), nasal dryness (2.6%), dry throat (2.6%), dry eye (2.4%), dry skin (2.2%) and constipation (2.0%). Local skin reactions, including erythema (17%), burning/stinging (14%) and pruritus (8%) were also common.

DRUG INTERACTIONS
Anticholinergics: Coadministration of QBREXZA with anticholinergic medications may result in additive interaction leading to an increase in anticholinergic adverse effects. Avoid coadministration of QBREXZA with other anticholinergic-containing drugs.

INSTRUCTIONS FOR ADMINISTERING QBREXZA
Instruct patients to use one cloth to apply QBREXZA to both axillae by wiping the cloth across one underarm, ONE TIME. Using the same cloth, apply the medication to the other underarm, ONE TIME. Instruct patients that QBREXZA can cause temporary dilation of the pupils and blurred vision if it comes in contact with the eyes.

Instruct patients to wash their hands with soap and water immediately after discarding the used cloth.

USE IN SPECIFIC POPULATIONS
Pregnancy: There are no available data on QBREXZA use in pregnant women to inform a drug-associated risk for adverse developmental outcomes.

Lactation: There are no data on the presence of glycopyrrolate or its metabolites in human milk, the effects on the breastfeeding infant, or the effects on milk production. The developmental and health benefits of breastfeeding should be considered along with the mother’s clinical need for QBREXZA and any potential adverse effects on the breastfeeding infant from QBREXZA or from the underlying maternal condition.

Renal Impairment: The elimination of glycopyrrolate is severely impaired in patients with renal failure.

Please see Brief Summary of Full Prescribing Information on adjacent page.

Reference: 1. QBREXZA™ (glycopyrronium) cloth prescribing information, Dermira.
QBREXZA® (glycopyrronium) cloth, 2.4%, for topical use

The following is a Brief Summary; refer to Full Prescribing Information for complete product information.

1 INDICATIONS AND USAGE

QBREXZA is indicated for topical treatment of primary axillary hyperhidrosis in adult and pediatric patients 9 years of age and older.

2 DOSAGE AND ADMINISTRATION

For topical use only.

QBREXZA is for topical use in the underarm area only and not for use in other body areas.

QBREXZA is administered by a single-use pre-moistened cloth packaged in individual pouches. QBREXZA should be applied to clean dry skin in the underarm areas only. QBREXZA should not be used more frequently than once every 24 hours. Tearing open the pouch and pull out the cloth, unfold the cloth, and wipe it across the entire underarm once. Using the same cloth, wipe the other underarm once. A single cloth should be used to apply QBREXZA to both underarms.

Wash hands immediately with soap and water after applying and discarding the QBREXZA cloth. QBREXZA may cause temporary dilation of the pupils and blurred vision if it comes in contact with the eye. Avoid transfer of QBREXZA to the perioral area [see Warnings and Precautions (5.3)].

Do not apply QBREXZA to broken skin. Avoid using QBREXZA with occlusive dressings.

4 CONTRAINDICATIONS

QBREXZA is contraindicated in patients with medical conditions that can be exacerbated by the anticholinergic effect of QBREXZA (e.g., glaucoma, paralytic ileus, unstable cardiovascular status in acute hemorhage, severe ulcerative colitis, toxic megacolon complicating ulcerative colitis, myasthenia gravis, Sjogren’s syndrome).

5 WARNINGS AND PRECAUTIONS

5.1 Worsening of Urinary Retention

QBREXZA should be used with caution in patients with a history or presence of documented urinary retention. Prescribers and patients should be alert for signs and symptoms of urinary retention (e.g., difficulty passing urine, distended bladder), especially in patients with prostatic hyperplasia or bladder-neck obstruction. Instruct patients to discontinue use immediately if any of these signs or symptoms develop.

Patients with a history of urinary retention were not included in the clinical studies.

5.2 Control of Body Temperature

In the presence of high ambient temperature, heat illness (hyperpyrexia and heat stroke due to decreased sweating) can occur with the use of anticholinergic drugs such as QBREXZA. Advise patients using QBREXZA to watch for generalized lack of sweating when in hot or very warm environmental temperatures and to avoid use if not sweating under these conditions.

5.3 Operating Machinery or an Automobile

Transient blurred vision may occur with use of QBREXZA. If blurred vision occurs, the patient should discontinue use until symptoms resolve. Patients should be warned not to engage in activities that require clear vision such as operating a motor vehicle or other machinery, or performing hazardous work until the symptoms have resolved.

6 ADVERSE REACTIONS

The following adverse reactions are described in greater detail in other sections:

• Worsening of Urinary Retention [see Warnings and Precautions (5.1)]

6.1 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 [NCT02530281] and Trial 2 [NCT02530294]) of 459 subjects treated with QBREXZA once daily and 322 treated with vehicle, subjects were 9 to 76 years of age, 47% male, and the percentages of White, Black (including African Americans), and Asian subjects were 82%, 12%, and 1%, respectively.

Table 1 summarizes the most frequent adverse reactions (≥2%) in subjects with primary axillary hyperhidrosis treated with QBREXZA.

### Table 1: Adverse Reactions Occurring in ≥2% of Subjects

<table>
<thead>
<tr>
<th>Adverse Reactions</th>
<th>QBREXZA (N=459)</th>
<th>Vehicle (N=322)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dry mouth</td>
<td>111 (24.2%)</td>
<td>13 (5.6%)</td>
</tr>
<tr>
<td>Mydriasis</td>
<td>31 (6.8%)</td>
<td>0</td>
</tr>
<tr>
<td>Ophthalmic pain</td>
<td>26 (5.7%)</td>
<td>3 (1.3%)</td>
</tr>
<tr>
<td>Headache</td>
<td>23 (5.0%)</td>
<td>5 (2.2%)</td>
</tr>
<tr>
<td>Urinary retention</td>
<td>16 (3.5%)</td>
<td>0</td>
</tr>
<tr>
<td>Vision blurred</td>
<td>16 (3.5%)</td>
<td>0</td>
</tr>
<tr>
<td>Nasal dryness</td>
<td>12 (2.6%)</td>
<td>1 (0.4%)</td>
</tr>
<tr>
<td>Dry throat</td>
<td>12 (2.6%)</td>
<td>0</td>
</tr>
<tr>
<td>Dry eye</td>
<td>11 (2.4%)</td>
<td>1 (0.4%)</td>
</tr>
<tr>
<td>Dry skin</td>
<td>10 (2.2%)</td>
<td>0</td>
</tr>
<tr>
<td>Constipation</td>
<td>9 (2.0%)</td>
<td>0</td>
</tr>
</tbody>
</table>

Table 2 shows the most frequently reported local skin reactions, which were relatively common in both the QBREXZA and vehicle groups.

### Table 2: Local Skin Reactions

<table>
<thead>
<tr>
<th>Local Skin Reactions</th>
<th>QBREXZA (N=454)</th>
<th>Vehicle (N=415)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Erythema</td>
<td>77 (17.0%)</td>
<td>39 (16.9%)</td>
</tr>
<tr>
<td>Burning/stinging</td>
<td>64 (14.1%)</td>
<td>39 (16.9%)</td>
</tr>
<tr>
<td>Pruritus</td>
<td>37 (8.1%)</td>
<td>14 (6.1%)</td>
</tr>
</tbody>
</table>

*Patients with a post-baseline local skin reaction assessment

In an open-label safety trial (NCT02555738), 364 subjects were treated for up to an additional 44 weeks after completing Trial 1 or Trial 2. Adverse reactions occurring at a frequency ≥2% were: dry mouth (16.5%), vision blurred (6.7%), nasopharyngitis (5.8%), mydriasis (5.3%), urinary retention (4.2%), nasal dryness (3.6%), dry eye (2.9%), pharyngitis (2.2%), and application site reactions (pain [6.4%], dermatitis [3.8%], pruritus [3.8%], rash [3.8%], erythema [2.4%]).

7 DRUG INTERACTIONS

7.1 Anticholinergics

Coadministration of QBREXZA with anticholinergic medications may result in additive interaction leading to an increase in anticholinergic adverse effects [see Warnings and Precautions (5) and Adverse Reactions (6)]. AVOID coadministration of QBREXZA with other anticholinergic-containing drugs.

8 USE IN SPECIFIC POPULATIONS

8.1 Pregnancy

There are no available data on QBREXZA use in pregnant women to inform a drug-associated risk for adverse developmental outcomes. In pregnant rats, daily oral administration of glycopyrrolate (glycopyrronium bromide) during organogenesis did not result in an increased incidence of gross external or visceral defects. When glycopyrrolate was administered intravenously to pregnant rabbits during organogenesis, no adverse effects on embryo-fetal development were seen. The available data do not support relevant comparisons of systemic glycopyrrolate exposures achieved in the animal studies to exposures observed in humans after topical use of QBREXZA.

The estimated background risks of major birth defects and miscarriage for the indicated population are unknown. In the U.S. general population, the estimated background risk of major birth defects and miscarriage in clinically recognized pregnancies is 2-4% and 15-20%, respectively.

8.2 Lactation

There are no data on the presence of glycopyrronium or its metabolites in human milk, the effects on the breastfed infant, or the effects on milk production. The developmental and health benefits of breastfeeding should be considered along with the mother’s clinical need for QBREXZA and any potential adverse effects on the breastfed infant from QBREXZA or from the underlying maternal condition.

8.4 Pediatric Use

Clinical trials of QBREXZA did not include sufficient numbers of subjects aged 65 years and older to determine whether they respond differently from younger subjects.

8.6 Renal Impairment

The elimination of glycopyrronium is severely impaired in patients with renal failure.

10 OVERDOSAGE

Because glycopyrronium is a quaternary amine which does not easily cross the blood-brain barrier, symptoms of glycopyrrolate overdosage are generally more peripheral in nature rather than central compared to other anticholinergic agents. Associated signs and symptoms related to excessive anticholinergic activity may include flushing, hypertonia, tachycardia, ileus, urinary retention, loss of ocular accommodation and light sensitivity due to mydriasis.

In the case of overdose when symptoms are severe or life threatening, therapy may include:

• Managing per standard of care any acute conditions such as hypothermia, coma, and/or seizures, as applicable, and managing any myoclonus or choreoathetoid movements which may lead to rhabdomyolysis in some cases of anticholinergic overdose

• Managing severe urinary retention with catheterization if not spontaneously reversed within several hours

• Providing cardiovascular support and/or controlling arrhythmias

• Maintaining an open airway, providing ventilation as necessary

• Administering a quaternary ammonium anticholinesterase such as neostigmine to help alleviate severe and/or life threatening peripheral anticholinergic effects.

Topical overdosage of QBREXZA could result in an increased incidence or severity of local skin reactions. Administration of QBREXZA under occlusive conditions may result in an increase in anticholinergic effects, including dry mouth and urinary retention.

16.2 Storage and Handling

Store at room temperature 20° - 25°C (68° - 77°F); excursions permitted to 15° - 30°C (59° - 86°F) [see USP Controlled Room Temperature].

QBREXZA is flammable; keep away from heat or flame.

17 PATIENT COUNSELING INFORMATION

Advise the patient to read the FDA-approved patient labeling (Patient Information). Worsening of Urinary Retention

Instruct patients to be alert for signs and symptoms of urinary retention (e.g., difficulty passing urine, distended bladder). Instruct patients to discontinue use and consult a physician immediately should any of these signs or symptoms develop.

Control of Body Temperature (Risks of Overheating or Heat Illness)

In the presence of high ambient temperature, heat illness due to decreased sweating can occur with the use of anticholinergic drugs such as QBREXZA. Advise patients using QBREXZA to watch for generalized lack of sweating when in hot or very warm environmental temperatures and to avoid use if not sweating under these conditions.

Operating Machinery or an Automobile

Transient blurred vision may occur with QBREXZA. If this occurs, instruct patients to contact their healthcare provider, discontinue use of QBREXZA and avoid operating a motor vehicle or other machinery, or performing hazardous work until symptoms resolve.

Instructions for Administering QBREXZA

It is important for patients to understand how to correctly apply QBREXZA (see Patient Information).

• Instruct patients to use one cloth to apply QBREXZA to both armpit by wiping the cloth across one underwear, ONE TIME.

• Using the same cloth, apply the medication to the other underwear, ONE TIME.

• Instruct patients that QBREXZA can cause temporary dilation of the pupils and blurred vision if it comes in contact with the eyes.

• Instruct patients to wash their hands with soap and water immediately after discarding the used cloth.

• Remind patients not to apply QBREXZA to other body areas or to broken skin. Instruct patients to avoid using QBREXZA with occlusive dressings.

• QBREXZA is flammable, avoid use near heat or flame.

Manufactured for:

Dermira, Inc.
Menlo Park, CA 94025

Version 1, June 2018

PM-US-QBR-0029
New imaging technologies

New technologies and techniques are changing melanoma diagnosis and treatment.

Confocal microscopy: Reflectance confocal microscopy uses laser illumination to visualize cellular details of the superficial dermis and epidermis in real time.

Photoacoustics: A combination of sound and light frequencies.

Raman spectroscopy: Lesion identification based on its molecular makeup.

Molecular assays: Determining which genes are upregulated to predict tumor behavior via DecisionDx-Melanoma assays mRNA within a tumor.

Augmented intelligence: SkinVision is among the early commercial apps to diagnose skin cancer.

Shaping AI for dermatology

New technologies and techniques are changing melanoma diagnosis and treatment. Noninvasive biopsies, augmented intelligence (AI), novel detection strategies, and other technologies that sound like clinical dreams are already changing practice. This technological shift is as important as the paradigm shifts that followed the introduction of Mohs surgery and immunohistochemical staining in dermatology and skin cancer.

“Melanoma is the most deadly cancer in the sense that more life years are lost to it than to any other cancer,” said Eric Tkaczyk, MD, PhD, assistant professor of dermatology and of biomedical engineering at Vanderbilt University and director of the Vanderbilt Cutaneous Imaging Clinic. “Anyone can get it at any age. It is the flag that the entire community of dermatology gathers around because early diagnosis saves so many lives.”

Dr. Tkaczyk is among the presenters at Friday’s “Melanoma: The Future Is Now.” On Saturday, the session, “Predicting the Future: AI, Machine Learning, and Dermatology” adds more perspective.

Current data suggests AI is equal or better at diagnosing melanoma than most dermatologists. In 2018, the third Grand Challenge, sponsored by the International Skin Imaging Collaboration unveiled algorithms that can diagnose melanoma and six other types of skin cancers using skin images more accurately than 97% of expert dermatologist readers.

But don’t worry. More patients will be driven to see dermatologists.

“The reality is that the more computers can diagnose, the more people will be driven to see dermatologists, not fewer. The role of the dermatologist may change, but rather than being usurped, our role will be augmented,” said Allan C. Halpern, MD, chief of dermatology at Memorial Sloan Kettering Cancer Center. He is president of the ISIC.

Dermatologists who worry they may be replaced by apps should agonize less about the perceived threat and consider the opportunities that AI presents.

“We should embrace AI and help shape the changing environment, mold it in ways that benefit our patients and improve treatment,” said Roger S. Ho, MD, MS, MPH, assistant professor of dermatology at the Ronald O. Perelman Department of Dermatology at New York University School of Medicine.

One of the ways to shape AI is to help train dermatology algorithms so they can diagnose more accurately in more skin types. The problem is limited data sets.

What can the data tell dermatologists?

“You use a data set to teach the algorithm what is right and what is wrong, what is melanoma and what is not melanoma. If the data set is biased, say the majority of tumors are in light skin, the algorithm may miss potentially life-threatening tumors when presented with darker skin types,” said Adewole Adamson, MD, MPP, assistant professor of dermatology at Dell Medical School at the University of Texas at Austin.

AI engineers may not know enough about dermatology to recognize or remedy the problem. That’s where dermatologists help, says Clara Curiel-Lewandrowski, MD, professor of medicine and dermatology at the University of Arizona, director of the University Cutaneous Oncology Program, clinical director of the Skin Cancer Institute, and Alan and Janice Levin endowed chair in Cancer Research.

Responsibility lies with dermatologists

“As dermatologists we have the responsibility to lead the development and adoption of AI-based technologies into our field. It is up to us to transform the implementation of AI into an opportunity, not a threat, and to ultimately augment our clinical practice,” Dr. Curiel-Lewandrowski said.

We should embrace AI and help shape the changing environment, mold it in ways that benefit our patients and improve treatment.

Roger S. Ho, MD, MS, MPH
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These unique sessions provide exhibiting companies the opportunity to present new research findings on products, conduct demonstrations, detail products, and highlight new products. These sessions are solely promotional and are not eligible for continuing medical education credit.

**Hall D**

(Poster Exhibits, Resource Center, Networking Lounge)

**Hall A Entrance**

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**Hall A Entrance**

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<td>Epiphany Dermatology</td>
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<td>919</td>
<td>EunSung Global Corp</td>
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<td>100</td>
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Putting patients at ease

Cryotherapy for a wart, administering filler, and excising an atypical nevus can all bring some pain, discomfort, and anxiety. Using a combination of distraction techniques such as an iPad, topical anesthetics, and excellent local anesthesia (buffered, warmed, and injected slowly along with cooling and vibration to the area) can make an incredible difference. Beyond the patient’s comfort, there is real evidence that the success rate for procedures is actually higher when pain, anxiety, and discomfort are appropriately addressed.

Learn more at: “Pain-free Dermatology: Minimizing Discomfort in Procedures for Children and Adults” (U001) Friday, 7:30–8:30 a.m. Room 146B

Key updates in new guidelines

The 2010s have been an inflection point in the diagnosis and treatment of cutaneous melanoma. FDA-approved checkpoint inhibitors and targeted therapies spurred broad adoption of these new agents across a range of dermatology practices. As the use of these newer systemic agents grew in melanoma and other cancers, dermatologists began to see dermatologic side effects in their own patients, as well as broader populations of cancer patients.

Susan M. Swetter, MD, chaired the interdisciplinary AAD melanoma work group that devoted the last two years to updating the 2011 AAD guidelines. The current guidelines were published in late 2018 and use the eighth Edition of the American Joint Committee on Cancer melanoma staging system for pathologic diagnosis, as well as refer to National Comprehensive Cancer Network and other international guidelines for cutaneous melanoma. She will moderate Friday’s “Translating Evidence into Practice: Primary Cutaneous Melanoma Guidelines.”

This is a whole new era for melanoma as we advocate for our patients. A decade ago, we looked at melanoma as a surgically treated disease and hoped to one day find the magic bullet to treat the disease systemically. Now melanoma has become the poster child of cancer for the success of both immunotherapies and targeted therapies.

— Susan M. Swetter, MD

**Key updates in the 2018 melanoma guidelines**

AJCC staging changes impact patient selection for sentinel node biopsy in T1 melanoma. The eighth Edition of the staging system is based on a global data set and provides the most accurate long-term prognosis available to data. Based on tumor characteristics, patients may or may not be appropriate for adjuvant therapy.

Patients with resected stage III (lymph node) disease, including those detected by sentinel lymph node biopsy, can be treated using anti-PD1 monotherapy with nivolumab, as well as combination BRAF/MEK inhibitors dabrafenib or trametinib. These agents are more effective than previously FDA-approved high-dose interferon or high-dose ipilimumab and far better tolerated.

The role of genetic testing in melanoma is growing. Single gene and multi-gene testing can help guide treatment in hereditary risk melanoma and for detection and monitoring in cancer syndromes that may include cutaneous melanoma.

Dermatologists should understand the cutaneous toxicity of checkpoint inhibitors and targeted therapies. These agents are now used for melanoma, advanced cutaneous squamous cell carcinoma, and other cancers. The guidelines help clinicians manage these agents more effectively to maintain life-saving and potentially curative therapy.

The latest surveillance data was incorporated into new recommendations for biopsy techniques, pathology evaluation, baseline/surveillance studies, and surgical management, including Mohs micrographic surgery and other staged excision techniques for certain types of melanoma in anatomically challenging locations.

**PEARLS FROM MEMBERS**

Peter Lio, MD
Medical Dermatology Associates of Chicago

**Putting patients at ease**

Cryotherapy for a wart, administering filler, and excising an atypical nevus can all bring some pain, discomfort, and anxiety. Using a combination of distraction techniques such as an iPad, topical anesthetics, and excellent local anesthesia (buffered, warmed, and injected slowly along with cooling and vibration to the area) can make an incredible difference. Beyond the patient’s comfort, there is real evidence that the success rate for procedures is actually higher when pain, anxiety, and discomfort are appropriately addressed."
Novel Treatment Strategies and the Trial-Based Rationale for

PD-1 TARGETING THERAPY in

ADVANCED and METASTATIC

CUTANEOUS SQUAMOUS CELL

CARCINOMA (CSCC)

Focus on the Pathoimmunobiology, Clinical Trials, Translational and Immunotherapeutic Implications of PD-1 Checkpoint Inhibition in Advanced, Unresectable, and Metastatic Skin Cancers

A YEAR 2019, DERMATOLOGY-FOCUSED, BEST PRACTICE IMMUNO-ONCOLOGY UPDATE FOR THE DERMATOLOGY AND DERMATOLOGIC ONCOLOGY SPECIALIST

Program Chairman: **TODD E. SCHLESINGER, MD, FAAD**
Director, Dermatology and Laser Center of Charleston | Clinical Research Center of the Carolinas | Clinical Instructor, University at Buffalo Department of Dermatology | Assistant Clinical Professor, Medical University of South Carolina Department of Family Medicine | Clinical Preceptor, Medical University of South Carolina College of Health Professions | Charleston, SC

**Save the Time and Date:** Friday, March 1, 2019
Time: 6:30 PM – 9:00 PM | Program Registration and Dinner: 6:30 PM – 7:00 PM
Clinical Program: 7:00 PM – 9:00 PM
City: Washington, DC | Location: Marriott Marquis Washington DC | Address: 901 Massachusetts Avenue NW
Conference Room: Liberty Ballroom M/N/O/P

**REGISTER NOW:** www.reg-CSCC.com

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BOOTH 3801

2019 AMERICAN ACADEMY OF DERMATOLOGY ANNUAL MEETING
March 1 to 5, 2019
Washington, DC
Sliding into digital

The wave of change is here. Moving from glass to digital slides for self-assessment and exam settings, as well as electronic medical records and consultations, is happening. Dermatologists who haven’t made the transition will need training. Ellen Mooney, MD, director of the Nordic Institute of Virtual Dermatopathology, will provide the latest on what dermatologists need to know during this afternoon’s session, “Virtual Dermatopathology Self Assessment: Get Ready For Non-glass Slide Exams.” The session includes an introduction to digital pathology and the software that is integral to making the switch, a self-assessment exam that incorporates clinical information, clinical photographs, digital histopathological slides, and an exercise in clinical-pathological correlation. Attendees are given access to real-time training on their laptops.

“Virtual Dermatopathology Self Assessment: Get Ready For Non-glass Slide Exams” (F022)
Friday, 1-3 p.m.
Room 143C

• Software-assisted manipulation of high-definition digital images of tissue sections.
• Simulates the experience of examining glass slides under a microscope and magnification up to x40.
• Viewable by computer, over a network or via the internet.
• Can be used in internet-based exams, such as in the American Board of Dermatology Certification and Recertification Exams beginning in 2020.
• Cloud storage allows for global use across congresses, courses, and consultations.
• Can also be used on mobile devices and where available, in EMRs.
• Associated software can also be used to accrue CME credit.

“Rapid-fire” practice management

A TED-talks approach to improving practice management and quality improvement (QI) offers dermatologists a glimpse into the hottest topics facing their practices and their professional reputations within their communities. Amanda Fleming Marsch, MD, assistant professor of dermatology at the University of California San Diego, moderates the session, “Derm Rapid Fire: Putting Residents at the Center of QI Initiative,” covering topics of pressing interest, including patient reviews, DataDerm™. QI in the fee-for-service environment, business administration skills for optimizing health care, and teledermatology.

A dozen speakers who combine physician skills with MBA credentials will provide the foundation for the financial, analytical, crisis management, and leadership skills professionals will need to excel in their careers and optimize patient care.

At the close of the session, resident recipients of the “AAD Excellence in Patient Care Award” will present their QI projects.

“Derm Rapid Fire: Putting Residents at the Center of QI Initiatives” (S046)
Sunday, 1-4 p.m.
Salon G

Some physicians score higher than others in patient reviews. It may be dependent upon the populations served by the physician. There are some things physicians can control and some they cannot when it comes to scoring.

Demonstrating quality of patient care isn’t always easy. Yet, the game is changing with DataDerm, the Academy’s clinical data registry created by dermatologists, for dermatologists. It’s designed to transform a dermatology practice and elevate the specialty.

Don’t overlook the path to the bottom line. The only way to positively impact financial results is to focus on delivering quality.

Enhanced leadership skills and improved patient care can be achieved through QI projects, buy-in from all staffing levels, clear communication, budgets, cost analysis, and team management skills.

Teledermatology has its pros and cons. While it’s a cost effective method for connecting physicians and patients, convenient for patients, and reduces wait time, it does increase the risk of HIPAA violations, security breaches, and the potential for misdiagnosis when technology and imaging is poor.
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How to beat bureaucracy-induced burnout

Mark D. Kaufmann, MD

The frustration is real. For many dermatologists, regulatory red tape is the line in the sand. And an equal number of physicians are unwilling to cross it.

Mark D. Kaufmann, MD, chief medical officer for The Dermatology Group and associate clinical professor of dermatology at Icahn School of Medicine at Mount Sinai, identifies the regulatory, social, and professional forces leading to feelings of frustration, dejection, and hopelessness among dermatologists during Friday’s “Bureaucracy, Compliance, and Burnout: What it Means to Dermatologists.”

Autonomy, authority, and “burdens”

“We have two global problems. One is the loss of autonomy and the other is the loss of authority,” Dr. Kaufmann said. “The government is hitting us with regulatory programs, all the acronyms that dermatologists have learned to hate (EHR, HIPAA, etc.). Government has taken the fun out of practicing medicine. That’s a heavy burden on physicians today and explains why some physicians are considering early retirement.”

As part of the audience-focused symposium, experts will join Dr. Kaufmann to discuss a wide range of factors leading to frustration, anxiety, and dissatisfaction for dermatologists, including the impact of government bureaucracy, social media, non-dermatologist encroachment, and false advertising. These “burdens,” as Dr. Kaufmann calls them, take away from patient care.

“The prescription pad has become a suggestion pad. Today, all the regulatory hurdles in front of dermatologists have stripped away their authority,” Dr. Kaufmann said. “We’re supposed to follow the word of pharmacists and insurance payers. These are people with a fraction of the knowledge we, as physicians, have. Physicians feel frustrated and helpless.”

Creating solutions

It’s important to formulate strategies for lifelong success and happiness before bureaucracy and burnout take hold, Dr. Kaufmann said. One solution has been to parcel out non-patient care tasks to a third party. That can occur by either selling your practice or maintaining ownership in your practice and outsourcing certain business functions to a management service organization (MSO). Another solution, he says, is to pool your business resources with other dermatologists and transform into larger systems.

“Find a system you are comfortable in, minimize your non-clinical duties, and you will transform into a private equity group or contracting with an MSO, some physicians feel relieved to get back to practicing medicine. And that positively impacts patient care.”

“There’s a portion of physicians who are burned out and patients are at risk when physicians feel that way. They may feel as if they are getting the short end of the stick and not getting 110%,” he said. “It’s important to identify if you’re burned out. From my own personal experience, now that I’ve unloaded my burdens of the business portion of my practice life, I feel much less burned out and much better.”

Dr. Kaufmann predicts the “mom and pop” model of dermatology will continue to transform into larger systems. “Find a system you are comfortable in, minimize your non-clinical duties, and you will become happy again,” he said.

“Bureaucracy, Compliance, and Burnout: What it Means to Dermatologists” (S015)

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