New emerging therapies offer hope to patients

Hair loss is a really big deal. We [dermatologists] are expected to be more aware of it. And while men may say it’s no big deal to be bald, there aren’t many women who feel that way.

— Glynis R. Ablon, MD

New treatments and therapies available now and in the near future are bringing new hope to patients diagnosed with a host of skin disorders, including psoriasis, acne, rosacea, hair loss, atopic dermatitis, nonmelanoma skin cancer, and infections of the skin. Similarly, emerging therapies are showing new promise for the treatment and possible prevention of scars, as well as developing treatment algorithms to expand options for minimally invasive cosmetic dermatology.

A panel of presenters spotlighted the latest options during Friday’s "New Emerging Therapies" (S003). Among the presenters, Leon H. Kircik, MD, clinical associate and professor of dermatology at Icahn School of Medicine at Mount Sinai and Indiana University School of Medicine, discussed treatments for psoriasis, while Glynis R. Ablon, MD, associate clinical professor at the University of California Los Angeles, explored therapies and patient sensitivity to hair loss. Drs. Kircik and Ablon offered the following pearls from their experience:

**Alopecia**
- 70 million Americans suffer from hair loss. 20 million are female.
- Hair growth needs seeds (stem cells surrounding hair follicles) and soil (the environment around the cells) to stimulate their growth.
- There are approximately 256 studies in progress or in completion with ClinicalTrials.gov.
- Ask every patient you see if they are having an issue with their hair.
- New discoveries include Wnt signaling glycoproteins, signaling cytokine interrupters (such as JAK inhibitors), fibroblast growth factors, neural stem cells, prostaglandin inhibitors, and lactate dehydrogenase, transcription factors, regenerative cells (adipocytes, placenta, and umbilical cord matrix stem cells), and botanicals.
- Currently available treatments include FDA and non-FDA-approved prescription drugs, supplements, low-level light laser, platelet rich plasma (PRP), and scalp tattooing.

**Psoriasis**
- While psoriasis is under-treated, there are several effective and safe biologics for patients.
- A rich pipeline of small molecules, such as JAK and TYK inhibitors and ROR gamma inhibitors, is working its way through trials.
- Novel classes of drugs with different mechanisms of action will be a welcome addition to the armamentarium of psoriasis treatments.
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Meet your 2019 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 no random order) to the membership for the 2019 Academy election of officers, directors, and Nominating Committee member representatives.

The election is open through Saturday, March 16. Vote online at www.aad.org/aadelection or from the 2019 AAD Meeting Mobile App.

Nominating Committee Member Representatives

Mark Lebowi, MD, FAAD
Roy G. Geronemus, MD, FAAD
Naomi Lawrence, MD, FAAD
Cheryl M. Burgess, MD, FAAD
Hon. Pak, MD, MBA, FAAD
Murad Alam, MD, MSCI, MBA, FAAD
Kathleen Hectorne, MD, FAAD

President-Elect
Julie A. Hodge, MD, MPH, FAAD
Kenneth J. Tomecki, MD, FAAD
Neal Bharia, MD, FAAD
Robert A. Weiss, MD, FAAD

Vice President-Elect

Board of Directors

Meet your 2019 slate of candidates

Simpler nail surgery is possible!

Julie A. Hodge, MD, MPH, FAAD
Kenneth J. Tomecki, MD, FAAD
Neal Bharia, MD, FAAD
Robert A. Weiss, MD, FAAD

Use a glove as a makeshift tourniquet.
Cut the appropriate finger off of the patient’s glove and roll down the cut ends so that they’re tighter around the digit. The glove doesn’t always achieve complete hemostasis, but applying lateral pressure will help.

Dilute anesthesia in saline.
Use that first, and then follow with normal anesthesia. Dr. Zaiac said he uses epinephrine in his anesthesia.

Watch to see if the nail is blanching when administering anesthesia.
This indicates good anesthesia and good hemostasis.

If the lesion is smaller than 3 mm, you may not need to take the whole nail plate.
Keep the specimen as small as possible while still extracting the entire lesion. Spare the nail plate when possible, as this will promote healing, decrease pain, and deliver better cosmetic results. Also, note that if a lesion is larger than 3mm, there will probably be a nail deformity.

You can use Krazy Glue Liquid instead of Dermabond.
This can be purchased in small tubes at Home Depot. Buying the larger containers will lead to cross-contamination between patients, and you’ll have to dispose of all of the glue.

Instruct the patient to use Vaseline on sutures.
This keeps the area moist. The patient should keep the area clean and change bandages a few times a day. It’s not uncommon to be nervous about performing nail surgery, said Dr. Zaiac. “Don’t be afraid. Start simple, and just go ahead and do it. You’ll be surprised. After a couple, you’ll feel more comfortable,” he said.

Note: In Monday’s “Hot Topics” (S057): “Atopic Dermatitis: New Developments,” we inadvertently left off credentials for Emma Gutman, MD, PhD, and misidentified “Melanoma Update 2019,” by Darrell Rigel, MD, as 2018. We apologize for these errors.
Tips for caring for patients identifying as LGBT or transgender

Eliciting sexual and gender-identity histories gets easier with practice. If the questions are misinterpreted, apologize to the patient and ask questions differently. Patients are forgiving when interactions demonstrate respect. Many health care organizations are moving toward routine collection of sexual orientation and gender identity information, which should normalize this process.

Patients are more comfortable discussing their sexual and gender identity histories, when relevant, than many physicians anticipate. They appreciate that their doctors care enough about these aspects of their health to ask.

History-taking does not start with the dermatologist. Patients might be asked about their gender identity or their relationship with others by office staff before the appointment. Training staff to have cultural competence in interacting with patients who identify as LGBT is critical. Providing gender-neutral bathrooms and LGBT-friendly intake forms are also important.

People identifying as LGBT face important and unique health issues. Dermatologists can — and should — play an important role in mitigating these issues. In his Friday morning session, “Caring for LGBT Patients: What Dermatologists Need to Know” ($007), Kaiser Permanente dermatologist Kenneth A. Katz, MD, MSc, MSCE, says a better understanding of the disparities involved are essential to working effectively with LGBT patients.

Q: What are the health disparities, including dermatology, facing people who identify as LGBT?

Dr. Katz: According to the federal guide, “Healthy People 2020,” patients who identify as LGBT face several health disparities and lack access to social services and culturally competent providers. Dermatology-related disparities overlap, to some extent, with the overall health disparities above, including:

- Gay men and other men who have sex with men experience higher rates of HIV and other STDs, including syphilis. Kaposi sarcoma, outbreaks of invasive meningococcal disease and methicillin-resistant staphylococcus aureus infections, skin cancer (from sun exposure and indoor tanning), and high rates of mental health concerns among people with acne.
- Lesbian women and women who have sex with women experience lower rates of HPV vaccination initiation, however, and are at increased risk for HIV and other STDs.
- Female-to-male (FTM)/transgender men experience adverse effects of testosterone therapy, including acne and androgenetic alopecia, keloids after gender-affirming surgery, skin infections, and inflammatory disorders related to chest binding.
- Male-to-female (MTF)/transgender women experience higher rates of HIV and other STDs, adverse effects of estrogen therapy, including melanoma and keloids after gender-affirming surgery.

Q: What are the best practices for eliciting a history related to sexual orientation and gender identity from patients?

Eliciting these types of history from a patient is not a task that many dermatologists and other physicians are comfortable with. How we should do it — and why we should do it — hasn’t been emphasized or taught in dermatology training programs. When eliciting a sexual history from my patients, I try to normalize the discussion, because many patients might not be expecting to be asked about these potentially sensitive topics in dermatology settings. I tell a patient with a rash that I ask every patient with a rash about their sexual history. And then I’ll ask for permission, “Is that ok?” Once the patient has consented, I’ll ask about any aspects of sexual history I think are important to making a differential diagnosis. Then I let the patient know my thoughts about diagnosis and management, including discussing aspects of the history I’ve just taken that are relevant to my considerations.

With gender identity, I often just ask which pronoun I should use with a patient. Then I ask about aspects of gender identity — including gender-affirming medical and surgical treatments — that are relevant to the visit.

Q: What are the effect of gender-identity on dermatology?

Katz: The CDC has specific recommendations for screening for HIV and other STDs for men who have sex with men and some people who are transgender. Appropriate cancer screenings are important.

Also, the CDC has specific recommendations for vaccinations, including hepatitis A and B and HPV vaccination for men who have sex with men. In some areas, meningococcal vaccination is recommended. These recommendations apply to some people who are transgender.

The CDC has recommendations for HIV pre-exposure prophylaxis (PrEP) for men who have sex with men and for some people who are transgender. The CDC has recommendations regarding HIV post-exposure (PEP) that pertain to LGBT persons.

The American Academy of Dermatology has an Expert Resource Group (ERG) on LGBTQ/Sexual and Gender Minority (SGM) Health, which is open to all, regardless of sexual orientation or gender identity.

INTERSECTIONALITY

- Sexuality
- Occupation
- Education
- Race
- Religion
- Ethnicity
- Language
- Age
- Geographic Location
- Ability
- Income
- Gender
- Family Status
- Aboriginality
- Heritage/History

Patients have many characteristics with which they identify. LGBTQ status might be just one characteristic, as this graphic suggests.

Kenneth A. Katz, MD, MSc, MSCE, via Medium https://medium.com/gender-theory/the-failure-of-addressing-intersectionality-in-the-heineken-commercial-2e40f147f27f
Several Th2 cytokines, including IL-13, are key drivers of atopic dermatitis.¹

Review the case at LEO Pharma Booth #3227

Stay connected

TODAY’S TOP TWEETS #AAD19 @AADmember

Meet our Advocate of the Year, Dr. Kelley Redbord. She works incredibly hard on our advocacy issues, always at Legislative Conference, always at #SkinPAC events, involved federal, state, and local issues. Thank you, Kelley. #aadmember #AAD2019

@SuzanneOlbricht

Meet Susan M. Swetter, MD, said states that take on the War on Melanoma will have to consider each state’s population when raising awareness. For example, in California, a lot of the promotional language was changed to appeal to the people who live there. #AAD2019 @MDEdgeTweets

@jeffbcraven

The #AAD is a high quality meeting, and all due respect to other derm meetings, but I’d argue the strongest international derm meeting in the world. #AAD2019

@juleslipoff

Kira Seiger from @harvardmed presenting our work on private equity in dermatology to a packed house #AAD2019 @BrighamResearch @AMostaghimi

Susan M. Swetter, MD, said states that take on the War on Melanoma will have to consider each state’s population when raising awareness. For example, in California, a lot of the promotional language was changed to appeal to the people who live there. #AAD2019 @MDEdgeTweets

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Susan M. Swetter, MD, said states that take on the War on Melanoma will have to consider each state’s population when raising awareness. For example, in California, a lot of the promotional language was changed to appeal to the people who live there. #AAD2019 @MDEdgeTweets

@jeffbcraven

I’m excited to learn about immunotherapies in dermatology. Recently, a PD-1 inhibitor was approved for advanced cSCC. It’s a much-needed option for patients who are not candidates for surgery or radiation.

Tara Oetken, MD
Little Rock, Arkansas

Share your photos on Instagram to win big at the Annual Meeting!
The Instagram Challenge is back! Submit photos with friends and colleagues and have the chance to win big prizes! Use #AAD2019Challenge to enter.
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Face-to-face exam
Acknowledging the special concerns of transgendered patients can make a big difference in their outcomes and satisfaction. Linda Globerman, MD, a dermatologist from Irvine, California, demonstrates appropriate language and approach with Taylor Russell, who portrays a patient with skin concerns while transitioning from female to male.

AAD Resource Center
The place to experience, explore, and interact.

HOURS: Saturday-Monday
8 a.m.-5 p.m. | Hall D

Additionally, you can:
- Learn about AAD products and services.
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- Check out the Resident Corner to apply for membership or try out Board Prep Plus.
- Discover new tools in the AADA's Practice Management Center to help with coding challenges, combating burnout, and meeting HIPAA requirements.
- Renew AAD membership.
- Receive exclusive Meeting-only discounts on products.
- Explore Preferred Provider programs.

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Visit www.EucrisaHCP.com for more information
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.**

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**Jeffrey J. Crowley, MD, FAAD**
Bakersfield Dermatology and Skin Cancer Medical Group
Bakersfield, California

**Neil J. Korman, MD, PhD**
Professor of Dermatology
Department of Dermatology
Case Western Reserve University
Director, Clinical Trials Unit
Clinical Director
Murdough Family Center for Psoriasis
University Hospitals Cleveland Medical Center
Cleveland, Ohio

**Abby S. Van Voorhees, MD**
Chair, Department of Dermatology
Eastern Virginia Medical School
Norfolk, Virginia

**TARGET AUDIENCE**
The educational design of the 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 rationale 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
Evaluating 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**
Event staff will be glad to assist you with any special needs (e.g., physical, dietary, etc.). Please contact Christie 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 or 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 A20 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. Biologic agents for pustular psoriasis and palmoplantar pustulosis are being examined in clinical trials. These include several 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**

This activity is supported by a grant from Boehringer Ingelheim. There is no registration fee for attending this program, however, seating is limited. Premotion does not guarantee seating. We recommend arriving at the symposium location early.
The most common adverse reactions seen in ≥2% of subjects treated with QBREXZA when in hot or very warm environmental temperatures and to avoid use if not sweating under these conditions. Instruct patients to wash their hands with soap and water immediately after discarding the used cloth.

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 hesitation (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 (17.0%), burning/stinging (14.1%) and pruritus (8.1%) were also common. Co-administration of QBREXZA with anticholinergic medications may result in additive interaction leading to an increase in anticholinergic adverse effects. Avoid co-administration of QBREXZA with other anticholinergic-containing drugs.

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 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.

For patients aged 9 years and older with primary axillary hyperhidrosis

Once-daily QBREXZA is the first and only FDA-approved, topical anticholinergic cloth towelette1

Come Join Our Industry Expert Session and Raise the Bar for Your Patients With Primary Axillary Hyperhidrosis

March 2, 2019 at 2:45 PM | Industry Experts Theater | Booth #002

Reference: 1. QBREXZA™ (glycopyrronium) cloth prescribing information, Dermira.

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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 package in individual pouches. QBREXZA should be applied to clean dry skin on the underarm area only. QBREXZA should not be used more frequently than once every 24 hours. To prepare an application, open the pouch and hold it by the handle. Pull back the cloth, which folds the pouch in half. Place the cloth on the underarm skin with the moist side facing the skin. Apply by gently rubbing the cloth across the underarm. Discard the cloth after use. QBREXZA is flammable; avoid use near heat or flame.

6 ADVERSE REACTIONS
The following adverse reactions are described in greater detail in other sections

6.1 Worsening of Urinary Retention

Worsening of urinary retention has been reported during treatment with 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.

6.2 Storage and Handling

Store at room temperature 20°C - 25°C (68°F - 77°F). Excursions permitted to 15°C - 30°C (59°F - 86°F) [See USP Controlled Room Temperature]. QBREXZA is flammable; keep away from heat or flame.

17 PATIENT COUNSELING INFORMATION

Advise the patient to use one cloth to apply QBREXZA to both axillae by wiping the cloth across one underarm, ONE TIME.

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

7 DRUG INTERACTIONS

7.1 Anticholinergics

Co-administration 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 intraveneously 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

The safety, effectiveness and pharmacokinetics of QBREXZA have been established in pediatric patients ages 9 years and older for topical treatment of primary axillary hyperhidrosis. Use of QBREXZA in this age group is supported by evidence from two multicenter, randomized, double-blind, parallel-group, vehicle-controlled trials involving 180 pediatric subjects 9 years and older (see Adverse Reactions (6.1)). The safety and effectiveness of QBREXZA have not been established in pediatric patients under 9 years of age.

8.5 Geriatric Use

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

8.6 Renal Impairment

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

10 OVERDOSAGE

Because glycopyrrolate 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, hyperthermia, 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 hyperthermia, coma, and/or seizures, as applicable, and managing any myoclonic or choreoathetoid movements which may lead to thalamomegaly in some cases of anticholinergic overdosage
- 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.

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

<table>
<thead>
<tr>
<th>Adverse Reaction</th>
<th>QBREXZA (N=459)</th>
<th>Vehicle (N=232)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dry mouth</td>
<td>11 (2.4%)</td>
<td>13 (5.6%)</td>
</tr>
<tr>
<td>Mydriasis</td>
<td>31 (6.8%)</td>
<td>0</td>
</tr>
<tr>
<td>Oropharyngeal 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 hesitation</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>
<thead>
<tr>
<th>Local Skin Reactions</th>
<th>QBREXZA (N=454)</th>
<th>Vehicle (N=231)</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 (NCT02553798), 164 subjects were treated for up to an additional 44 weeks after completing Trial 1 or Trial 2. Adverse reactions occurring at a frequency ≥2.0%: dry mouth (16.5%), vision blurred (6.7%), nasopharyngitis (5.8%), mydriasis (5.3%), urinary hesitancy (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%).
Halting the damage to scalp health

Thanks to new options on the horizon, it’s possible to go from “permanent loss” to “hair regrowth” when treating scarring alopecias and achieving follicular rescue in scalp diseases. Amy J. McMichael, MD, professor and chair for the department of dermatology at Wake Forest Baptist Health, was among the panelists shedding new light on permanent scalp damage and offering hope for patients diagnosed with these conditions.

The focus of Friday’s session, “Folicular Rescue in Scarring Alopecias: Treating to Halt Disease Progression and Grow Hair,” was a discussion of lichen planopilaris, frontal fibrosing alopecia, traction alopecia, and central centrifugal cicatricial alopecia.

Look for dermatoscopic and pathology clues to determine what is impeding viable hair growth, including clinical treatments used in innovative combinations and newer treatments, such as Platelet Rich Plasma (PRP), laser therapy, microneedling, and scalp hair restoration, Dr. McMichael said.

Surgical scalp restoration in scarring alopecia
Hair transplantation could restore missing follicles and sometimes can be successfully performed in primary cicatrical alopecias. What do we need? Medical treatment, activity assessment, and surgical management.

Central centrifugal cicatricial alopecia (CCCA):
Treatment consists of anti-inflammatory medications. Treatment may allow hair follicles that are not affected by inflammation to remain intact and grow. Recruitment of remaining follicles contributes to the appearance of density in the affected scarred areas.

TODAY’S HIGHLIGHTS

12:01 a.m. (ET)
AAD Election opens

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

9-11 a.m.
Late-breaking Research: Procedural Dermatology (F056)
Location: Salon H

12-1 p.m.
Meet the AAD Board of Directors
Location: The Connection, Hall D

Unopposed exhibit time
Location: Exhibit Hall

1-3 p.m.
Young Physician Pearls and Pitfalls: A Survival Guide for the First 10 Years (F057)
Location: Room 154A

1-4 p.m.
Late-breaking Research: Clinical Trials (S034)
Location: Ballroom A
Resident Jeopardy (S030)
Location: Salon G

3:30-5:30 p.m.
Late-breaking Research: Clinical Studies/Pediatric (F078)
Location: Room 154A

High Yield “Power Hour” for Residents (F073)
Location: Room 154AB

7:30 p.m. (6:30 p.m. registration)
Industry Non-CME Program: Moments of Truth: Conversations on Unraveling Unmet Needs in Psoriasis and Hidradenitis Suppurativa
Location: Renaissance Ballroom West A and B, Renaissance Washington, DC Downtown Hotel from Celgene Corporation

7 p.m.
Industry Non-CME Program: Ongoing Experience With Taltz (ixekizumab) Injection Efficacy and Safety
Location: Renaissance Ballroom East, Renaissance Washington, DC Downtown Hotel from Lilly USA, LLC

3:30-5:30 p.m.
OtezlaTalk: Let’s Talk About an Option for Your Patients With Challenging Manifestations of Psoriasis
Location: Room 12/13/14, Renaissance Washington, DC Downtown Hotel from Celgene Corporation

7:30 p.m.
Industry Non-CME Program: Picking the Right Scale for Your Patients With Atopic Dermatitis
Location: Liberty M-P, Marriott Marquis Washington, DC from Sanofi Genzyme and Regeneron
SOMETHING NEW IS APPROACHING

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SUNDAY: 10 a.m.-3 p.m.  Unoccupied hours: 12-1 p.m.

AAD Food Court

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Dermatology Times
Dermatology News
Dermatology Foundation
Dermatologist, The
Dermatology World Meeting News
SATURDAY: 10 a.m.-5 p.m.  Unoccupied hours: 12-1 p.m.

Exhibit Hall Hours

SUNDAY: 10 a.m.-3 p.m.  Unoccupied hours: 12-1 p.m.

To Hall D
(Shown at right)

Data current as of Jan. 10, 2019.

Map sponsored by Abbvie
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Taking action against dietary triggers

Growing numbers of patients and clinicians have implicated dietary triggers in flares and exacerbations of acne, psoriasis, and other common dermatologic conditions. An increasing body of evidence supports the involvement of dietary and environmental triggers in a number of inflammatory conditions with dermatologic manifestations. In Friday’s session, “Dietary Triggers and Modifications of Common Dermatologic Conditions: An Evidence Based Approach,” Vivian Shi, MD, assistant professor of dermatology at the University of Arizona, said the evidence supports dietary interventions to improve the effects of more conventional treatments.

The evidence for dietary triggers of inflammatory conditions first emerged in integrative medicine associated with rheumatology and primary care. Dermatology has been slower to conduct the studies needed to confirm the involvement of dietary triggers and modifications. The gut-skin axis appears to affect a number of chronic inflammatory conditions, such as atopic dermatitis, acne, rosacea, hidradenitis, skin aging, and immune conditions.

Ask patients to keep a consumption and activity diary over several weeks to months and look for patterns that may link foods, activities, and physical locations with disease flares and improvement. It is unrealistic to ask patients or their parents/caregivers to remember the details.

Review the diary with the patient and discuss potential associations with disease activity.

Dietary modifications and environmental changes can improve therapeutic outcomes.

Suggest modifications to diet and environmental exposures that might discourage flares and encourage improvements.

Remind patients that diet may help improve their condition, but maximizing long-term outcomes depends on a combination of dietary and behavioral modifications and adherence to conventional treatment.

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 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**
- Look up and message colleagues to make connections or stay in touch.

**Eating options**
- Visit the Food Court for International food stands offering a variety of healthy and delicious options. Ample seating available. Cash or credit accepted.
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WHAT’S NEW

• Learn about dermatology’s premier clinical data registry, AAD’s DataDerm™.

• AADA’s Practice Management Center has new tools for 2019! Access content to help with coding challenges, combating burnout, and meeting HIPAA requirements.

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• Don’t forget our expert staff and Preferred Providers will be on-hand to assist you.

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Learn about dermatology’s premier clinical data registry, AAD’s DataDerm™.

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BOOTH 3801

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"All of us working in public or safety-net hospitals have seen far-advanced skin disease that ‘should have been’ cared for at an earlier point, but for many and often complex reasons, both extrinsic and intrinsic to the patient, the disease is allowed to go untreated."

Dermatology in the safety-net hospital

Safety-net hospitals provide care to those in need. Not surprisingly, dermatology has played a role in treating skin disorders that come through the doors of the nation’s safety-net hospitals.

What’s involved in safety-net hospitals?

Safety-net hospitals tend to be large teaching hospitals located in large cities. These hospitals care for patients who are underinsured or uninsured, including dermatologic cases. In Friday’s session, “Dermatologists to the Rescue — Great Cases from Safety-Net Hospitals,” (F013), speakers addressed the important contributions dermatology clinics within safety-net hospitals have made for patients challenged by insurance coverage.

“Some challenges of treating patients in safety-net hospitals include language and cultural barriers, patients with layers of psychosocial stressors and low medical literacy, which affects their ability to understand and adhere to treatment, a higher prevalence of underlying high-risk medical and psychiatric problems, problems with insurance, and limited drug formularies,” said Erin H. Amerson, MD, a dermatologist from the University of California San Francisco. “I get excited about showcasing our patients because they have so much to teach us.”

Real-life examples

Dr. Amerson presented two patient cases. One represented a body lice infestation, its complications, and treatment, while the other focused on how to use systemic immunosuppressive medications, such as TNF inhibitors, in background infections (hepatitis B, tuberculosis) that are common in immigrant and refugee populations.

Benjamin F. Chong, MD, MSc, an associate professor of dermatology at the University of Texas Southwestern Medical Center in Dallas, shared his own experience with the Parkland Dermatology Clinic at Parkland Memorial Hospital in Dallas. The hospital, which opened in 1894, is best known for having treated President John F. Kennedy when he was assassinated in Dallas in 1963.

“Our outpatient clinic handled 16,800 visits last year, providing phototherapy, dermatology surgery, patch testing, and teledermatology,” Dr. Chong said. “Parkland provided $1 billion in uncompensated care in 2018.”

Resources and public safety

There are resources to care for patients with limited means to help them afford dermatologic care, according to Roy Mitchell Colven, MD, a dermatologist at the University of Washington in Seattle. Dr. Colven says the Affordable Care Act has helped move many patients in Washington State onto its state Medicaid program, with access to medications that otherwise empty charity programs.

“All of us working in public or safety-net hospitals have seen far-advanced skin disease that ‘should have been’ cared for at an earlier point, but for many and often complex reasons, both extrinsic and intrinsic to the patient, the disease is allowed to go untreated,” Dr. Colven said. "I’m impressed by how dedicated everyone who works here is and how much ‘esprit de corps’ exists. That’s why I’ve been here for more than 20 years. Once you start at a safety-net hospital, you stay there forever."
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EVENT NAME: ONGOING EXPERIENCE WITH TALTZ (IXEKIZUMAB) INJECTION EFFICACY AND SAFETY—AAD UPDATE
MARCH 2, 2019 | 7:00 PM – 8:30 PM
Renaissance Ballroom East | Renaissance Washington, DC Downtown Hotel
Washington D.C.

PRESENTED BY
Craig L. Leonardi, MD
Adjunct Professor of Dermatology, St. Louis University
&
Jennifer Cather, MD, FAAD
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