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Updates in itch

Dr. Shawn Kwatra, MD, presented an update on itch, emphasizing its significant impact on quality of life, often surpassing that of conditions like stroke, asthma, and cutaneous T-cell lymphoma. He explained the itch-scratch cycle as driven by immune cells releasing cytokines that activate nerve fibers, which in turn release peptides that further stimulate immune cells. Dr. Kwatra highlighted prurigo nodularis (PN) as an underdiagnosed condition with diverse presentations, now treatable with two FDA-approved therapies: dupilumab, targeting IL-4Ra, and nemolizumab, an IL-31 inhibitor. Dupilumab demonstrated significant efficacy in clinical trials, with 60% of patients achieving at least a 4-point improvement in itch scores and a drastic reduction in nodule count by 6 months. Nemolizumab also showed promising results, with long-term extension studies revealing sustained itch improvement in more than 80% of patients. He further discussed emerging treatments like abrocitinib, a JAK1 inhibitor, which led to rapid lesion resolution and decreased inflammation markers by week 12. Dr. Kwatra concluded with insights into neuropathic itch, emphasizing the importance of identifying underlying causes, such as cervical spine degeneration, and highlighted novel interventions with promising results like occipital nerve blocks and ablations for refractory cases.

Cutaneous Toxicities - Immune checkpoint inhibitors

Dr. Meghan Heberton discussed the cutaneous toxicities associated with immune checkpoint inhibitors, emphasizing the importance of the CTCAE grading system in guiding oncologists' treatment plans. Dr. Heberton highlighted that PD-1, PDL-1, and CTLA-4 inhibitors have revolutionized melanoma treatment, with expanding FDA indications for other malignancies. She noted that many adverse events related to these therapies persist even after discontinuation and that rapid evaluation and treatment can have a significant impact on treatment outcome. Among the most common dermatologic toxicities are lichenoid eruptions, which can be managed with topical steroids, phototherapy, acitretin, or apremilast. She also addressed psoriasis, psoriasiform IRAEs, and bullous pemphigoid. Lastly, Dr. Heberton cautioned against over-attributing conditions to immune checkpoint inhibitors and underscored the need for close collaboration with oncologists to determine when rechallenging with these treatments is appropriate.

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Mast cell disorders

Dr. David Sloane, MD, EdM, provided an overview of mast cell disorders, emphasizing the heterogeneity of mast cells, which exist as mucosal and connective tissue subsets with distinct functions and tissue distributions. He explained the traditional mast cell-IgE paradigm, where allergen crosslinking of IgE on mast cells leads to the release of preformed mediators like histamine, newly synthesized lipid mediators, and cytokines. However, Dr. Sloane noted that mast cells can also be activated by non-IgE pathways, contributing to conditions like urticaria, angioedema, allergic asthma, and anaphylaxis. He highlighted chronic urticaria as often driven by autoimmune or autoinflammatory mechanisms, with patients producing IgG against IgE or its receptor, or having IgE autoallergens like thyroid peroxidase. Treatment focuses on antihistamines, corticosteroids, and biologics like omalizumab and dupilumab. Dr. Sloane further discussed complex mast cell disorders, including systemic mastocytosis, diagnosed via bone marrow biopsy and c-kit mutations; mast cell activation syndrome (MCAS), with a variety of atypical symptoms most commonly including gastrointestinal disturbance; and hereditary alpha tryptasemia, linked to neuropsychiatric symptoms such as brain fog and irritable bowel syndrome (IBS)-like presentations. He shared a study linking IBS-like symptoms to mast cell activation, as food injections triggered wheal and flare reactions in IBS patients but not healthy controls. He concluded by emphasizing targeted therapies, such as avapritinib for systemic mastocytosis, and the importance of epinephrine for anaphylaxis management.

PRP: Fact or Fiction

Dr. Marina Peredo discussed platelet-rich plasma (PRP), a cell-based therapy that concentrates platelets 2-5 times higher than normal plasma to promote angiogenesis and fibroblast differentiation. She explained that PRP contains growth factors, immune system messengers, and enzymes, making it useful in various medical fields, including sports medicine, urology, and dermatology. In dermatology, PRP is applied for skin rejuvenation, acne scars, melasma, hair restoration, and post-laser healing. Dr. Peredo noted that PRP's efficacy varies, with younger males responding best to hair restoration treatments, while postmenopausal women see the least benefit. She also highlighted emerging uses in chronic wounds, vitiligo, and psoriasis, though results remain inconsistent. Concluding her talk, she addressed exosome treatments and their potential to reduce pain following laser procedures. She emphasized that while PRP has scientific support for certain applications, it is not a universal solution.

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Pediatric dermatology: update on new drug approvals

Dr. Katherine Gordon provided an update on new drug approvals in pediatric dermatology, focusing on atopic dermatitis and alopecia areata. For atopic dermatitis, she highlighted systemic therapies such as dupilumab, tralokinumab, and lebrikizumab, alongside topical treatments like tapinarof, roflumilast, and ruxolitinib. Dupilumab, an IL-4 and IL-13 inhibitor, is now FDA-approved for children as young as six months, while tralokinumab and lebrikizumab, both IL-13 inhibitors, are approved for patients aged 12 and older. JAK inhibitors like upadacitinib and abrocitinib also show promise, though Dr. Gordon noted the need to monitor side effects, including acne. For alopecia areata, she emphasized the significant psychosocial impact on adolescents, highlighting the importance of ongoing drug development and the promise these new treatments hold for improving patient outcomes. She highlighted the FDA approval of ritlicitinib, a JAK3/TEC family kinase inhibitor, for adolescents, with the Allegro trial showing significant hair regrowth after 48 weeks. Dr. Gordon also noted the potential use of JAK inhibitors, including tofacitinib, upadacitinib, and baricitinib, for juvenile inflammatory arthritis and juvenile psoriatic arthritis. She emphasized that while many of these drugs have long been available for adults, their approval for pediatric use represents an exciting advancement in treatment options.

GVHD Updates

Dr. Meghan Heberton, MD, provided updates on graft-versus-host disease (GVHD), emphasizing that skin involvement is often the earliest and most common manifestation, making dermatologists essential in diagnosis. She explained that acute GVHD is typically seen in allogeneic stem cell transplants, with immune cells recognizing the graft as foreign. Staging is based on body surface area involvement, while grading is based on organ system involvement. Treatment of acute GVHD varies by severity, with topical steroids for mild cases, systemic steroids for severe cases, Ruxolitinib for steroid refractory cases. By contrast, chronic GVHD is defined by the interplay of innate immunity with alloreactive B and T cells. Chronic GVHD is not simply a continuation of acute GVHD, but acute GVHD increases the risk of developing chronic GVHD. Treatment of chronic GVHD is similar to that of acute GVHD, with Belumosidil also used for steroid refractory cases. Dr. Heberton stressed that full exams are crucial for GVHD patients, who also face a heightened risk of skin cancer due to immunosuppressive therapies. She concluded by emphasizing the vital role of dermatologists in collaborating with oncologists and a multidisciplinary team to manage GVHD effectively.

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Practical approach to cardiovascular prevention in dermatology

Dr. Brittany Weber, MD, PhD, provided a practical approach to cardiovascular prevention in dermatology, emphasizing the need for increased recognition and management of cardiovascular (CV) risk in patients with dermatologic conditions. She highlighted that inflammatory skin diseases, such as psoriasis, alopecia areata, rosacea, atopic dermatitis, and hidradenitis suppurativa, are cardiovascular risk enhancers, warranting closer monitoring and intensive management of traditional CV risk factors. Dr. Weber also noted that many dermatologic treatments can affect cardiometabolic health, for example including JAK inhibitors, which have been associated with increased venous thrombotic risk and elevated lipoproteins; TNF inihibtors, which should be avoided in patients with class III and IV heart failure; and cyclosporine, which can cause hypertension and nephrotoxicity. She emphasized the need for additional mechanistic data describing emerging therapies, as well as the importance of multidisciplinary care, including collaboration with cardiologists for CV risk assessment and treatment. Advanced cardiovascular imaging, such as coronary CTA, stress CMR, and myocardial blood flow assessment, can aid in risk stratification and early detection of atherosclerosis.

Practical pearls from a vulvar dermatology clinic

Dr. Melissa Mauskar, MD, discussed key insights from her vulvar dermatology clinic, emphasizing the unique challenges patients face in discussing vulvar concerns, often leading to delayed presentation. She emphasized the importance of incorporating genital exams into routine total body skin checks, noting that it takes only a few extra seconds but can significantly impact diagnosis and treatment. Notably, she highlighted that patients with vulvovaginal melanoma have a 5 year survival rate that varies between 24 and 79%. She addressed common conditions such as vulvar lichen sclerosus and lichen simplex chronicus, recommending potent topical steroids for initial treatment followed by long-term maintenance. Dr. Mauskar also stressed the role of proper vulvar hygiene, advising against over-cleaning and encouraging the use of gentle cleansers. Additionally, she underscored the need to support postmenopausal women experiencing vulvovaginal atrophy and urinary symptoms, advocating for the safe use of topical estrogen, even in patients with a history of breast cancer. Ultimately, she reinforced the necessity of normalizing conversations about vulvar health to improve patient outcomes.

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Atopic Dermatitis Update

Dr. Emma Guttman, MD, PhD, provided an update on atopic dermatitis (AD), describing it as the most common inflammatory skin disease, with about one-third of patients experiencing moderate to severe cases. She explained that AD is driven by both immune system dysregulation and skin barrier dysfunction, emphasizing the involvement of multiple immune cytokines including IL-4, IL-13, IL-22, and IFNγ. After decades of sparse treatment developments, targeted therapies have significantly advanced treatment of AD. Dupilumab, which inhibits both IL-4 and IL-13, has revolutionized AD management in adults and children. Dupilumab has an excellent safety profile, with approval down to 6 months of age. Tralokinumab and lebrikizumab, both IL-13 inhibitors, have also shown strong efficacy with favorable safety profiles. Emerging therapies include nemolizumab, which targets IL-31 to alleviate itch first and overall disease activity over time, as well as Rocatinlimab and Amlitelimab, which inhibit the OX40 pathway to impact T-cell differentiation and immune memory induction. While JAK inhibitors provide rapid symptom relief compared to biologics, they have a less favorable safety profile, particularly in older adults, smokers, and those on oral contraceptives. Dr. Guttman concluded by emphasizing the multifactorial nature of AD and the exciting rapid therapeutic revolution in AD due to research advancements.

Skin and Soft Tissue Infections: Empiric treatments and food for thought

Dr. Jason Frangos examined the empiric treatment of skin and soft tissue infections (SSTIs), questioned common assumptions about TMP-SMX, outlined reasons to avoid prescribing cephalexin, and discussed coagulase-negative Staphylococcus infections. He highlighted data demonstrating Bactrim's effectiveness, citing high sensitivity rates across multiple studies. Referencing guidelines from the Infectious Diseases Society of America, he supported his treatment approach and emphasized cefadroxil as a better alternative to cephalexin due to its BID dosing. Ultimately, he underscored the importance of incision and drainage for purulent SSTIs and the need for more comprehensive therapy in severe cases. For non-purulent SSTIs, Dr. Jason Frangos recommended cefadroxil or dicloxacillin monotherapy, while purulent infections should be treated with incision and drainage (I&D) along with TMP-SMX or doxycycline. In uncertain cases, options include cefadroxil alone, cefadroxil combined with TMP-SMX or doxycycline, or TMP-SMX alone for uncomplicated infections.

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Clinical trials

Dr. Leon Kircik, MD, discussed the significance of clinical trials in influencing treatment guidelines, provider recommendations, and healthcare policies, including reimbursement decisions. He emphasized that not all registration trials are equal and highlighted the importance of randomized double-blind control trials. Dr. Kircik explained that comparing different clinical trials or drugs is problematic due to variations in demographics, disease states, trial designs, and environmental factors affecting disease pathogenesis. He noted that most biologics are approved for moderate to severe cases and that the FDA now requires both "clear" or "almost clear" improvements in clinical assessments. Additionally, he reviewed assessment tools such as the Investigator Global Assessment (IGA) and Physician Global Assessment (PGA), addressing challenges in evaluating skin of color patients. He also discussed data analysis methods, favoring the Intent-to-Treat (ITT) analysis for its real-world applicability, while noting that non-responder imputation can present data conservatively. Lastly, Dr. Kircik highlighted patient motivations for clinical trial participation, including access to new treatments, contributions to scientific research, and financial incentives.

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Promise of treatment for dermatologic genetic disorders: present and future

Dr. Katherine Gordon, MD, discussed current and emerging treatments for dermatologic genetic disorders, with a focus on epidermolysis bullosa (EB). She highlighted dystrophic epidermolysis bullosa (DEB), caused by mutations in COL7A1, leading to collagen dysfunction and resulting in skin blistering, esophageal strictures, mitten deformities, and chronic wounds. One promising therapy is beremagene geperpavec-scdt (B-VEC), a topical HSV-1 vector-based gene therapy delivering the functional COL7A1 gene. In a phase 3 trial, B-VEC tripled wound healing rates compared to placebo, with 71% achieving complete healing by three months. Dr. Gordon also discussed birch triterpenes (birch bark extract) studied in the EASE trial, which promoted wound closure in DEB and junctional EB by enhancing keratinocyte differentiation. Emerging treatments include ABCB5+ mesenchymal stem cells, shown to improve lesions after three infusions, and diacerin 1% ointment, an IL-1β inhibitor with promising results for EB simplex. She emphasized that advances in molecular understanding have expanded treatment approaches, including replacement therapies, small molecules, repurposed biologics, and gene therapies targeting the underlying pathogenesis of genetic skin disorders.

Why drugs cost so much

Dr. Mark Kaufmann, MD, discussed the role of pharmacy benefit managers (PBMs) in driving up drug costs. Initially created to negotiate lower prices, PBMs have merged with insurance companies and now 80% of the market is controlled through Express Scripts, CVS Caremark, and OptumRx. He highlighted that these companies rank among the largest by revenue globally and have profited significantly from generic drug markups, using tactics like copay clawbacks, spread pricing, and rebates. Kaufmann referenced a Wall Street Journal article detailing a DOJ investigation into Medicare billing practices at UnitedHealthcare published earlier today. He also noted that previous efforts to redirect PBM kickbacks to patients were blocked by pharmaceutical lobbying, though there is hope the current administration may have more success in regulating them. He urged advocacy for legislative reforms, as PBMs remain major political contributors, and suggested resources like GoodRx and CostPlus for more affordable drug options.

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Updates in urticaria

Dr. Shawn Kwatra, MD, discussed the classification of urticaria, differentiating acute urticaria from chronic urticaria, which includes chronic inducible (triggered by external factors) and chronic spontaneous urticaria (occurring without a known cause). He described the condition as a sudden onset of intense itching followed by a rash and highlighted the role of mast cells, basophils, eosinophils, T cells, and B cells in its pathogenesis. Dr. Kwatra reviewed treatments such as omalizumab, an anti-IgE monoclonal antibody requiring epinephrine availability, and dupilumab, which targets IL-31 and is now used for chronic spontaneous urticaria. He also discussed remibrutinib, a Bruton's tyrosine kinase (BTK) inhibitor showing promise in phase 3 trials. Tools like the Urticaria Activity Score (UAS7) and Itch Severity Score (ISS7) help assess disease progression and treatment response. Dr. Kwatra emphasized the need for safe and effective biologic and oral therapies and predicted the development of more targeted treatments for chronic urticaria in the future.

Allergy 101 for the dermatologist: What to know, when to refer

Dr. David Sloane, MD, EdM, began his talk by discussing type 2 immunity and its relevance to allergic conditions. He outlined key scenarios for referral to an allergist for testing, including circumstances for patients with allergic asthma, allergic rhinoconjunctivitis, venom-induced anaphylaxis, food allergies, drug allergies, unexplained angioedema, or recurrent infections suggestive of immunodeficiency. He emphasized the overreporting of type 1 hypersensitivity reactions to beta-lactam antibiotics and the significant economic burden of inaccurately labeled allergies. Dr. Sloane also discussed when to refer patients for treatment, such as allergy immunotherapy, venom immunotherapy for venom-induced anaphylaxis, desensitization to food allergies, and targeted therapies for hereditary angioedema and immunodeficiencies. He reviewed which drugs can and cannot be tested for allergies, noting that many antibiotics, monoclonal antibodies, local anesthetics, and steroids can be tested, while NSAIDs, opioids, radiocontrast media, and drugs linked to scarring cannot.

Emerging uses of JAK inhibitors

Dr. Christopher Bunick, MD, PhD, discussed the emerging uses of JAK inhibitors across dermatologic conditions, including chronic hand eczema, psoriasis, psoriatic arthritis (PsA), hidradenitis suppurativa (HS), and alopecia areata. He highlighted promising treatments like delgocitinib (pan-JAK inhibitor), ruxolitinib (selective for JAK1/2), and abrocitinib (JAK1) for chronic hand eczema, with delgocitinib showing significant improvement in IGA scores, itch reduction, and long-term efficacy in the DELTA trials. In psoriasis and PsA, deucravacitinib, a TYK2 inhibitor, outperformed apremilast in PASI-90 responses, while next-generation TYK2 inhibitors like zasocitinib and ESK-100 are showing even greater efficacy in phase 2 trials. For HS, povorcitinib (JAK1) and upadacitinib (JAK1) are demonstrating meaningful reductions in abscesses and inflammatory nodules. Dr. Bunick also highlighted the growing role of JAK inhibitors in alopecia areata, including FDA-approved options like baricitinib, (JAK1/2) deuruxolitinib (JAK1/2/TYK2), and ritlecitinib (JAK3), as well as off-label use of upadacitinib and tofacitinib, all of which have shown significant hair regrowth in clinical trials. Dr. Bunick concluded by emphasizing that JAK inhibitors are transforming the treatment landscape for several challenging dermatologic conditions, offering targeted, effective options that continue to evolve with ongoing clinical research.

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AI: preventing physician burnout?

Dr. Ryan Stidham, MD, discussed the potential for artificial intelligence (AI) to alleviate physician burnout, particularly among dermatologists, by reducing administrative burdens. He highlighted that burnout, first defined in the 1970s, has become increasingly prevalent in dermatology, with excessive documentation, electronic health record (EHR) tasks, and patient messaging as major contributors. Dermatologists now receive an average of over 3,200 messages per year, with the top 10% of patients accounting for 41% of messaging. Dr. Stidham explained how large language models (LLMs), like ChatGPT, can streamline workflows by enabling ambient documentation, generating notes, billing codes, and insurance letters from patient-provider conversations. AI-powered chatbots are already being used for patient education, follow-ups, and procedural preparation, with studies showing their responses often match expert-level accuracy. While AI still has limitations, Dr. Stidham emphasized its potential to improve efficiency, reduce burnout, and allow physicians to focus more on patient care.

Technology update

Dr. Daniel Siegel, MD, discussed the growing risks associated with various apps and social media platforms that may compromise user data, noting that cybercrime reached $10.5 trillion in the past year. He introduced artificial intelligence (AI) advancements, such as DAX Copilot, while raising concerns about AI's excessive energy consumption, which is 100 to 1,000 times more computationally intensive than regular digital activities. He highlighted that Google's energy consumption doubled between 2019 and 2023, with AI data centers consuming millions of gallons of water. Dr. Siegel also reviewed useful healthcare-related applications, including ICD-10 Consult for medical coding, CPT Mobile for modifying CPT codes, and Doximity, which allows physicians to securely contact patients. Additionally, he discussed iPrescribe, an electronic prescription platform, noting that while it offers convenience for healthcare providers, it is no longer free. He concluded by emphasizing the need to check AI, as it is prone to errors.

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Updates in Immune-Mediated Hair Loss

Dr. Emma Guttman, MD, PhD, discussed alopecia areata (AA), an immune-mediated inflammatory disease with growing evidence linking it to Th2 cytokine circuits in addition to Th1. She noted that AA affects approximately 2% of the population, can lead to total scalp or body hair loss, and causes significant emotional distress. Current treatments remain limited, with many being off-label, having variable efficacy, side effects, and a high relapse rate. She reviewed systemic treatment options, including biologics and small molecules. Among biologics, dupilumab, which targets IL-4 and IL-13, has shown efficacy in AA, particularly in patients with atopy and/or high IgE. Other biologics under investigation include rosnilimab and daxdilimab. Dr. Guttman also highlighted JAK inhibitors as promising small-molecule treatments. Baricitinib, available in both 2mg and 4mg doses, has demonstrated superior efficacy at the higher dose, though it carries some side effect risk, including infections and acne. Ritlecitinib, another JAK inhibitor, is being explored for its safety and effectiveness in AA. Additionally, deuruxolitinib, particularly at an 8mg dose, has shown strong efficacy in clinical trials. Lastly, she discussed an ongoing NIH-funded study evaluating dupilumab in children with AA and mentioned brepocitinib, a selective JAK1/TYK2 inhibitor, which is being investigated for central centrifugal cicatricial alopecia (CCCA), frontal fibrosing alopecia (FFA), and lichen planopilaris (LPP).

RUC update

Dr. Daniel Siegel, MD, provided an update on the RUC (Relative Value Scale Update Committee), focusing on key coding changes, documentation requirements, and billing practices. He emphasized the importance of accurately documenting problems addressed during encounters, noting that conditions not at treatment goals, such as uncontrolled acne, psoriasis, or lichen planus, may justify higher-level visits (e.g., Level 4). He clarified the classification of surgery into minor or major based on clinical judgment and discussed the HCPCS code G2211, a complexity add-on for ongoing care of serious or complex conditions, which cannot be used for routine, time-limited services like mole removals. Dr. Siegel also reviewed telemedicine changes, including the deletion of codes 99441–99443, and highlighted a shift toward stricter billing practices for procedures, emphasizing that providers cannot bill separately for other aspects of the visit unless documentation supports a distinct E/M service that could stand alone as a separate note. He highlighted the need for clear documentation, stressing that if the EHR is not manually informed of the complexity level, it will default to a lower charge. Additionally, he warned that expensive disposables, such as skin cell suspension autografts, draw from the same payment pool as provider services. Dr. Siegel concluded by reminding providers to self-audit notes, maintain updated CPT books, and ensure documentation is complete and legible to avoid billing discrepancies.

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Why does hair turn gray?

Dr. David Fisher explored the mechanisms behind hair graying, beginning with a review of the hair follicle cycle and the role of stem cells in pigmentation. He explained that aging leads to a gradual loss of melanocyte stem cells, which eventually results in gray hair. Using mouse models, he demonstrated that various stressors, such as social isolation and pain, accelerate graying through neuroendocrine changes, particularly involving corticosterone and norepinephrine. Interestingly, administering pain relievers prevented graying, suggesting that the sympathetic nervous system plays a key role. While age-related graying is thought to result from accumulated stress, rare instances of hair repigmentation suggest that certain external stressors may temporarily disrupt pigmentation pathways. Dr. Fisher concluded by emphasizing the impact of emotional distress on immunotherapy outcomes and discussed potential future strategies for mitigating stress-induced stem cell loss and exploring new treatments for melanoma.

MFM/OB: When is a pregnancy considered high risk (when to refer)

Dr. Katherine Economy discussed typical skin changes in pregnancy, common dermatologic complaints, and conditions requiring urgent referral to maternal-fetal medicine. She outlined normal pregnancy-related skin changes, including melasma, striae gravidarum, and vascular changes. Dr. Economy discussed how pruritus impacts 40% of pregnant patients, often without a rash, as well as discussed the importance of differentiating between pregnancy-specific and coinciding dermatoses. She highlighted atopic eruption of pregnancy as the most common pregnancy dermatosis and polymorphic eruption of pregnancy (PEP) as a non-life-threatening but particularly symptomatic third-trimester condition. More serious conditions, such as pemphigoid gestationis and intrahepatic cholestasis of pregnancy, pose fetal risks, including growth restriction and stillbirth. Dr. Economy emphasized that the timing of dermatologic symptoms is crucial for diagnosis and concluded with case discussions on infections and genetic conditions such as parvovirus, varicella, and Ehlers-Danlos syndrome.