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Uveitis

Dr. Jennifer Cao, an ophthalmologist specializing in uveitis at UT Southwestern, provided an update on the workup and management of uveitis. She defined uveitis as inflammation of the uvea, classifying it by location into anterior, intermediate, posterior, or panuveitis. Anterior uveitis is commonly linked to HLA-B27 positivity, juvenile idiopathic arthritis, and IBD; intermediate uveitis is often associated with multiple sclerosis, Lyme disease, and sarcoidosis; posterior uveitis is typically linked to infections like toxoplasmosis and toxocariasis; and panuveitis refers to inflammation in all segments of the eye and may be associated with systemic conditions like sarcoidosis and Behçet's syndrome. Dr. Cao emphasized that recurrent or chronic uveitis warrants specialist evaluation and potential immunosuppressive therapy, especially when symptoms like eye redness, pain, floaters, and blurred vision persist. She highlighted the importance of targeted lab testing based on clinical suspicion and noted potential complications, including cataracts, secondary glaucoma, and phthisis. Treatment follows a stepwise approach, starting with corticosteroids and advancing to immunosuppressive agents like antimetabolites, TNF inhibitors, and rituximab, with the goal of achieving two years of corticosteroid-free remission before tapering therapy.

Pediatric Hemangiomas

Dr. Katherine Gordon initiated the talks by discussing pediatric hemangiomas, emphasizing that infantile hemangiomas (IH) are of the most common vascular tumors, with the most rapid growth occurring within the first three months of life. She outlined different patterns of IH, including focal, multifocal, segmental, and indeterminate, and highlighted that hemangiomas in the beard distribution can cause airway obstruction, while those in the diaper area are prone to ulceration and infection. Gordon recommended that patients with multifocal IH (five or more lesions) undergo ultrasound to screen for hepatic hemangiomas as well as screening for potential hypothyroidism. She reviewed treatment options, noting that propranolol, first evaluated in 2008 and approved following an RCT in 2015, remains the primary systemic therapy, with common side effects including agitation and sleep disturbances. Hemangeol, the first FDA-approved beta blocker, should be administered with food to reduce the risk of hypoglycemia. Gordon also mentioned the use of other beta-blockers, such as topical timolol for superficial IHs, while cautioning against nadolol due to its prolonged absorption in patients with infrequent stooling.

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SLE Considerations in Patients with CLE

Dr. Joseph Merola, MD, MMSc, from UT Southwestern, provided an in-depth update on cutaneous lupus erythematosus (CLE) and its association with systemic lupus erythematosus (SLE). He highlighted that cutaneous manifestations are often the first sign of SLE, with 29% of patients presenting initially to dermatologists and 55% of surveyed rheumatologists identifying skin disease as a key presenting symptom. Dr. Merola categorized CLE into acute, subacute, and chronic subtypes, noting that acute CLE, including localized and TEN-like forms, has the highest association with SLE, while subacute CLE (annular, papulosquamous, or drug-induced) carries an intermediate risk, and chronic CLE (discoid lupus, lupus panniculitis, and tumid lupus) has the lowest risk. He emphasized that progression from CLE to SLE typically occurs within one to two years of diagnosis, with a median progression time of 453 days, and is more likely in patients with severe skin disease, serologic abnormalities, younger age at onset, family history, and HLA-DR3/DR2 positivity. Dr. Merola stressed the importance of regular SLE screening, recommending clinical and serologic evaluations every three to six months and consideration of co-management with rheumatology for patients showing systemic features. He also reviewed the updated ACR/EULAR classification criteria for SLE, which require an ANA titer ≥1:80 and at least 10 points from other clinical and serologic criteria.

CLE Update

Dr. Joseph Merola, MD, MMSc, discussed the latest treatment approaches, emerging therapies, and monitoring strategies for cutaneous lupus erythematosus (CLE). He emphasized that first-line treatment remains antimalarials, particularly hydroxychloroquine (HCQ), due to their disease-modifying benefits and safety profile, though adherence and dosing can be monitored through HCQ blood testing. Second-line options include methotrexate, mycophenolate mofetil, dapsone, and acitretin, while newer biologics like anifrolumab, litifilimab, and deucravacitinib show promise in clinical trials. Dr. Merola noted that while belimumab has shown modest efficacy for CLE, its trials lacked valid skin-specific outcome measures, limiting its applicability. He also highlighted the potential for emerging therapies, such as CD19-targeted CAR-T cell therapy, as well as novel diagnosis and monitoring technologies such as RNA tape sampling. He concluded by addressing unique considerations, including drug-induced subacute lupus from medications like proton pump inhibitors and hydrochlorothiazide, as well as the variable success of intralesional sodium thiosulfate for calcinosis cutis.

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Dry eyes and ocular rosacea

Dr. Jennifer Cao, MD discussed the prevalence, symptoms, and treatment of dry eye syndrome and ocular rosacea. She noted that dry eye affects at least 20% of the global population and can lead to complications such as corneal defects, scarring, and neovascularization. She explained that the tear film consists of lipid, aqueous, and mucus components, and dry eye symptoms include redness, pain, itching, and blurred vision. Diagnostic methods such as fluorescein staining and Schirmer's test help assess tear production and ocular surface damage. Dr. Cao highlighted the multifactorial causes of dry eye, including incomplete eyelid closure, meibomian gland disease (blepharitis), aqueous deficiency, and global destruction of the tear apparatus. Treatment strategies include environmental changes (reducing screen time, using a humidifier in dry conditions, protective eyewear), using artificial tears four times daily, doxycycline for ocular rosacea, treating blepharitis with warm compresses and omega-3 supplements, and considering interventions like Intense Pulsed Light therapy or punctal plugs.

What's new in melanoma

Dr. David Fisher highlighted significant advancements in melanoma treatment, particularly in medical oncology. He noted that 15 years ago, stage 4 melanoma had a survival rate of less than 5%, whereas long-term survival now approaches 50% due to immune checkpoint inhibitors and targeted therapies. However, these treatments come with substantial toxicity, with approximately 40% of patients experiencing grade 3 or 4 toxicity. Fisher discussed recent developments targeting the LAG-3 checkpoint, where relatlimab combined with nivolumab has shown improved survival with minimal additional toxicity compared to CTLA-4 combinations. He also addressed the treatment of brain metastases, emphasizing that combining anti-PD1 and anti-CTLA4 therapies has led to notable benefits, particularly in asymptomatic patients. The most recent FDA approval involves tumor-infiltrating lymphocyte therapy, which has shown a 30% disease-free survival rate in patients who previously failed PD-1 inhibitors. Fisher further highlighted the growing role of systemic therapies in earlier-stage disease, with adjuvant and neoadjuvant treatments demonstrating significant relapse-free survival benefits, even in earlier melanoma.

Updates in Laser

Dr. Marina Peredo, MD provided an overview of the history and clinical applications of laser technology in dermatology. She explained that lasers are used for various treatments, including pigment reduction, hair removal, capillary removal, wrinkle reduction, and tattoo removal. While effective, she noted that lasers have limitations such as high cost, limited effectiveness, the need for multiple sessions, and discomfort during treatment. Dr. Peredo highlighted advancements in laser technology, including the first smart laser, which allows real-time high-resolution skin analysis. She discussed the new Accure Laser System (1726nm), which targets sebaceous glands to treat acne and is safe for darker skin tones. She concluded by emphasizing the future of laser treatments, predicting more precise, personalized, and painless procedures with greater efficiency and inclusivity for diverse skin types.

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Blistering Diseases

Dr. Kim Yancey provided an overview of blistering diseases, focusing on pemphigus vulgaris, paraneoplastic pemphigus (PNP), and bullous pemphigoid. He highlighted the evolution of pemphigus vulgaris treatment, from high-dose corticosteroids in the 1970s to the introduction of rituximab in the early 2000s, which revolutionized management. Rituximab, a CD20-targeting monoclonal antibody, has become first-line therapy, with studies like the Lancet Ritux 3 trial demonstrating significantly higher remission rates and fewer adverse effects compared to corticosteroids alone. Dr. Yancey also discussed emerging therapies, including CAAR-T cell therapy targeting desmoglein 3-specific B cells, though current trials show limited efficacy despite favorable safety profiles. In paraneoplastic pemphigus, he emphasized its association with B-cell malignancies and its potentially fatal complications, such as bronchiolitis obliterans, with mortality rates reaching 50–80%. For bullous pemphigoid, Dr. Yancey highlighted common triggers, including diuretics, DPP-4 inhibitors, and immune checkpoint inhibitors (ICIs), particularly PD-1/PD-L1 inhibitors. ICI-induced bullous pemphigoid often presents months after treatment initiation, affecting younger patients and sometimes involving mucous membranes. Management prioritizes high-potency topical corticosteroids, doxycycline, and dupilumab while balancing cancer therapy considerations.

Vasculitis

Dr. Scott Elman provided an overview of vasculitis, describing it as an inflammatory condition characterized by leukocyte infiltration of vessel walls with associated reactive damage to vessels. He discussed the Chapel Hill definitions, categorizing vasculitis into large, medium, and small vessel types. Large vessel vasculitis includes giant cell arteritis and Takayasu arteritis. Medium vessel vasculitis consists of polyarteritis nodosa and Kawasaki disease. Small vessel vasculitis is further divided into ANCA-associated vasculitis, which includes granulomatosis with polyangiitis, eosinophilic granulomatous angiitis, and microscopic polyangiitis, and immune complex vasculitis, which includes cryoglobulinemic vasculitis, IgA vasculitis, and hypocomplementemic urticarial vasculitis. Dr. Elman also reviewed the causes of cutaneous small vessel vasculitis, which include infections, drug reactions, autoimmune diseases, and malignancies, highlighting the importance of monitoring renal involvement in IgA vasculitis. He went on to present updates on treatment, noting that rituximab is a first-line option for ANCA vasculitis and discussing the use of secukinumab in a phase II clinical trial for large vessel vasculitis. He concluded by summarizing the diagnostic workup for vasculitis, including a review of systems, laboratory tests, and biopsy of recent lesions with direct immunofluorescence. Treatment options include topical and systemic steroids, colchicine, dapsone, and DMARDs.

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Wound Care: choosing the right dressing

Dr. Dennis Orgill discussed the challenges and considerations in wound care, emphasizing that while all wounds are treated, some inherently respond better to treatment than others. He outlined the primary types of wounds encountered, including arterial ulcerations, venous stasis ulcers, diabetic foot infections, and pressure injuries, noting that patient compliance is crucial for successful treatment. With over 1,500 different dressings available, he recommended familiarity with at least one product from each major category including gauze, foam, hydrogels, hydrocolloids, and transparent films. He highlighted the lack of significant comparative data on dressing effectiveness and explained the difficulties in designing such studies. Treatment approaches depend on wound characteristics, such as moisture level and depth, with fundamental principles including maintaining a moist environment, preventing infection, controlling edema, and ensuring adequate blood supply. He concluded by discussing emerging technologies, such as placental constructs and hyperspectral imaging, and emphasized the growing need for wound care due to increasing life expectancy, diabetes, and obesity.

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