UTAH DERMATOLOGY SOCIETY

MESSAGE FROM LEADERSHIP GROUP

"Earlier this year, we highlighted a theme that represents our society members and how they treat each other: "your name is safe in our office".
We continue to see this evidenced in many ways among our members. Thank you for the kind way you treat each other, both in person and not. Your ability to see the best in each other continues to make our state society the most welcoming, collegial one in the country. It is a privilege to get to associate with you all.

We look forward to many opportunities to enjoy your association as a state society in the upcoming months. We especially hope you'll join us for our annual meeting, November 18th-20th in Springdale/Zion National Park. We have worked hard to get support for the meeting so that we can keep our tuition fees low ($100-$150 – 9 hours of CME). Your attendance is key to being able to keep the meetings high quality. Please join us!

We are looking forward to the Webinar being held this Thursday, September, 23, 2021 at 6:30pm. It will be very informational, with speakers presenting on Pustular Psoriasis and Advances in Skin Cancer Diagnosis. It is not too late to register at www.rockpointe.com/UDS-Registration. It is free to register and 2 CME credits are available for attendees.

If any of your colleagues are not receiving this newsletter, please have them send their contact information to utahdermsociety@gmail.com so they can be included on the society member roles."

Jim Macdonald

PEARLS AND GEMS

Cutaneous Reactions to COVID-19 Vaccine (J AM Acad Dermatol. 2021 Jul;85(1):46-55)

- Most common reactions:
  - Delayed large local reactions
  - Local injection site reactions
  - Urticaria
  - Morbilliform eruptions
- Less common notable eruptions:
  - Filler reactions
  - Pernio/chilblains and erythromyalgia
  - PR-like eruptions
- Much more common in women and with Moderna vaccine (may be related to propylene glycol, thimerosal, neomycin)
- When it appears >4 hours after injection, not a contraindication to receive 2nd dose.
- Less than 50% of reactors to 1st dose had reaction after 2nd dose
- No cases of anaphylaxis or serious adverse events
- Reactions resolve in median of 3-4 days, generally don't require treatment

SOCIETY UPDATE

AAD Update

1. 2022 State Advocacy Grant Program

We're applying for a melanoma advocacy with some Utah based social media influencers to reach our broader population on Instagram and other social media platforms.

2. Sign up for the 2021 Legislative Conference Sept 23-28th (Virtual Attendance is possible!)
https://www.aad.org/member/advocacy/leg-conference?utm_campaign+AADA%20Advocacy%20Update

Thursday, September 23	8:00-9:00 p.m. (ET)	Welcome and keynote speaker – Jim VandeHei
Sunday, September 26	4:00-6:00 p.m. (ET)	Overview of legislative asks and advocacy training sessions
Monday, September 27	7:00-8:00 p.m. (Local time)	State coalition prep calls
Tuesday, September 28	9:00 a.m. – 4:00 p.m. (ET)	Calls with members of Congress

Current Clinical Trials

New Ichthyosis study for patients ages 12-75. If you have any patients that would be good candidates please send their information to Sean Wentland (sean.wentland@hsc.utah.edu).
Study Title: ANB019-206-Ichthyosis – A Phase 2, Randomized, Double-Blind, Placebo-Controlled Study to Evaluate the Efficacy and Safety of ANB019 in the Treatment of Subjects with Ichthyosis.
Principal Investigator: C. David Hansen, MD
Study Medications: ANB019 vs placebo.
ANB019 (400mg SC loading dose then 200mg SC thereafter) – is a humanized IgG4 (S228P)/kappa mAb that belongs in the class of anti-IL-36R mAb. Anti-interleukin 36 receptor monoclonal antibody.
Study Design: This study will investigate the efficacy and safety of a potential new subcutaneous treatment (ANB019) for patients with ichthyosis. There will be a 16-week placebo-controlled period where patients will be randomized 2:1, followed by a 16-week open-label extension period where all patients will be on the investigational drug, ANB019. Patients will be reimbursed $75 for each in-person visit.
Criteria: 12-75 years of age, with a confirmed diagnosis by genetic testing of ichthyosis via congenital ichthyosiform erythroderma (autosomal recessive congenital ichthyosis [ARCI]); Epidermolytic ichthyosis; Netherton syndrome; Ichthyosis en confetti; other subtypes may be included in which high levels of IL-36y expression in skin were confirmed by a ribonucleic acid [RNA] analysis (e.g., RNA sequencing {RNA-seq}, polymerase chain reaction {PCR}) as part of other studies. Confirmation of genetic subtype will be obtained prior to eligibility determination.

R668-BP-1902 Study – Bullous Pemphigoid – Principal Investigator: Jamie Rhoads, MD
Study Short Title: Evaluating Dupilumab in Bullous Pemphigoid
Study Full Title: A Multicenter, Randomized, Double-blind, Placebo-controlled, Parallel Group Study to Evaluate the Efficacy and Safety of Dupilumab in Adult Patients with Bullous Pemphigoid
Sponsor: Regeneron
Study Drug: Dupilumab (IL4 & IL13) vs Placebo
Dupilumab Dose: 600 mg SC initial loading dose, followed by 300 mg administered SQ every 2 weeks.
(Patients will take oral corticosteroids)
Study Length: The duration of this study is up to 69 weeks –

- Screening: up to 5 weeks
- Double-blind Treatment Period: 52 weeks
- Follow-Up Period: 12 weeks

Study Design: Patients will be randomized (1:1) to receive either dupilumab or placebo OCS tapering should begin when there has been 2 weeks of sustained control of disease activity. Patients will undergo a protocol-defined OCS tapering regimen as long as they maintain control of disease activity.
Pertinent Inclusion Criteria:

- 18-19 years old
- Histological and serological confirmation of BP (done at screening visit or within 3 months of screening visit)
- BPDAI activity score of ≥24

Pertinent Exclusion Criteria:

- No other forms of pemphigoid other than classic BP
- No prior treatment with an IL-4 or IL-13 antagonist (dupilumab, tralokinumab, or lebrikizumab)
- No known or suspected history of immunosuppresion
- No history of malignancy within 5 years (except completely treated in situ carcinoma of the cervix, or completely treated and resolved non-metastatic squamous or basal cell carcinoma of the skin)
- No contraindications to systemic corticosteroids

Required Medication Washouts:

- Systemic corticosteroids – 2 weeks before randomization
- Topical corticosteroids – 1 week before randomization
- Oral or Topical antihistamines – 1 week before randomization
- Antibiotic directed at the treatment of BP – 2 weeks before randomization
- Non-Steroidal immunosuppressive/immunomodulating drugs – 4 weeks before randomization
- Rituximab (cell depleting agents) – 12 months before randomization or until lymphocyte and CD19+ lumphocyte count returns to normal (whichever is longer)
- Other biologics – 5 half-lives, or 16 weeks prior to randomization
- Intravenous immunoglobulin – 16 weeks prior to randomization
- Live vaccine – 4 weeks before randomization

QUICK QUIZ

A Patient says they heard on the news about a study from a major scientific journal where scar-free healing was achieved in mice and excitedly ask if it is true.

What can you tell them about the study?

- Fibroblasts involved in scar formation express what key protein?
- Describe the pathway involved and what the initiating factor is in inducing fibroblasts to express this protein?
- What inhibitor was used to block expression of the culprit protein in scar-promoting fibroblasts?
- Million dollar question: *Will it work in humans?*

Please submit your answer to macdonjb@gmail.com First correct response wins a gift card to a Utah favorite!

Previous Quick Quiz Winner

Congratulations to Keri Holyoak! Her answers: Best sunscreen for melisma is a physical blocker rather than chemical blocker. Hawaii banned sunscree: oxybenzone and oxtinoxate

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MEMBER SPOTLIGHT – This quarter's member spotlight is Maggie Hammond, MD

How would you summarize your life that has led to where you are now?

My family moved to Provo, UT when I was a freshman in high school. I always knew I wanted to go into medicine, which led to my decision to study biochemistry at University of Washington. While I was there I loved volunteering in the child life department of the Seattle Cancer Care Alliance and I thought I wanted to be a pediatrician. My husband and I got married after I graduated from college, and then we moved to Cleveland, OH to start medical school and podiatry school together. I went to Case Western Reserve University and he went to Kent State University. It only took one time in a pediatric clinic as a first-year medical student to realize it wasn't for me. Luckily, a family friend was completing a dermatopathology fellowship at the Cleveland Clinic and talked me into writing a paper with him and considering dermatology. I started working on an atopic dermatitis microbiome project and realized how much I enjoyed dermatology. We stayed in Cleveland for residency and loved our eight years there, but the pull back west was too strong! It has always been an important aspect of my career goals to return to my home community and help young women feel empowered to pursue a career in medicine. It's also a perk to be close to family. I'm excited to be joining Utah Valley Clinic Dermatology with Intermountain Healthcare in Provo and Spanish Fork.

How has some of the adversity you've faced shaped you into the person you are today?

Experiencing adversity has made me a more compassionate person, I think. Where I might have been critical before, after experiencing challenges myself I can see how we are all doing our best and what people need is support and patience.

Tell us about the route of medical training that led to where you practice now?

My route has been pretty traditional, from biochemistry at UW to medical school at Case Western Reserve University, then a preliminary Internal medicine year, and finally dermatology residency. Through my research on the microbiome of atopic dermatitis and a terrific mentor, I developed an interest in dermatitis and patch testing, which I hope to make a cornerstone of my practice.

Tell us about a foundational experience from medical school or dermatology residency?

The COVID pandemic started about one week after my co-chief and I transitioned into our roles as chiefs in March 2020, so our first few months were very tumultuous. We were constantly revisiting resident assignments as clinics changed from in-person to virtual and back to in-person, as residents went out on quarantine, and as hospital administration sent new redeployment requests. This was a foundational leadership experience for me. We had to make decisions quickly while maintaining buy-in from eighteen residents, our program director, and program faculty, which was tough, but it helped me learn to approach a problem from the perspectives of many different stakeholders.

Having recently completed your boards, what study resources would you recommend for those preparing for recertification?

I thought the JAAD CMEs were very helpful; they seemed to align well with the content of the exam and are full of clinically relevant but also highly testable pearls. Through the CME section of the JAAD website, you can see more detailed explanations to the question answers than are printed in the journal.

For clinic, do you prefer scrubs or dress attire?

I might be in a minority here, but I prefer dressing up!

What are your favorite resources for continuing medical education (other than the Utah Dermatology Society meeting of course! – 8 hours of CME for $100 or $150!!)?

CME is a new world to me, so I'm not sure yet, but I don't think it gets better than a meeting at a national park!

What is your favorite skin condition to help your patients with?

I love treating severe dermatitis. These patients are just so miserable and itchy, and treatment can make such an impact on their wellbeing. I particularly enjoy allergic contact dermatitis because of the detective work and patient education that goes into patch testing.

If you were to make an art piece to hang on your wall out of a dermatologic condition, what would the image be of (clinical, dermoscopic or histopathologic)?

Wow, I love this question! I love the patterns we see in dermatology, so I think I would either pick a histopathologic image of a cylindroma or a clinical image of tinea imbricata or erythema gyratum repens.

Which dermatologic medication would you want all your family members to take?

If it were indicated, dupilumab!

Tell us about 3 pearls you've taken away from your office that apply to all aspects of life?

1. Wear good shoes! True in clinic and true in life. Everything goes better when your feet don't hurt.
2. Invest in your team, whether its nurses and medical assistants or family and friends.
3. Ask for help when you need it, and give help generously.

What advice would you give new dermatologists?

Well, I am pretty new myself, so I'm not sure I have much advice to give! If I could give advice to a new resident, though, I would say embrace the challenges of training, appreciate how far you've come, and look at lots of kodachromes!!