Elevate-Derm Summer 2025 Conference

Conference Top Clinical PEARLS

Day 1: Thursday, July 24, 2025

8:00-9:00 am From Report to Reality: Understanding Pathology Results: Ata Moshiri, MD

A pathology report is an opinion or interpretation of a biopsy rather than a statement of fact or truth.
When taking a biopsy, you should mark the lesion, take photos, include at least two anatomic markers and include patient identifiers in order to reduce wrong site surgery.
Clinical photos improve dermatopathology diagnosis of lesions and rashes.
A pathologist is looking at less than 1% of the tissue sent.
When biopsying a rash, always utilize a punch biopsy (not a shave) and be sure to take the sample from the most active area of rash.

9:00-10:00 am Contact Dermatitis Conundrums: A Panel Discussion on Challenging Cases: Walter Liszewski, MD and Kara Mudd, PA-C

When patch testing, always ask patients what they do for a living and what are their hobbies.
It is important to educate patients that natural substances can still cause allergic reactions.
When taking a history for pediatric patients with contact dermatitis, remember to ask about exposures at school.
There are some case reports of vasculitis caused by metal allergies. Think outside the box for metal source, for example a Copper intrauterine device contains copper but also contains nickel.
For patients who have HEMA (Hydroxyethyl methacrylate) allergies, dip nails, polish, and manicures are safe alternatives to gel polish.
The loss of cuticles is a common side effect of chronic hand dermatitis.
PPD and sodium thioglycolate are the only allergies that will involve the scalp.

Propylene glycol is highly allergenic. Three topical treatments that do not contain propylene glycol are: Triamcinolone 0.1% ointments, Tacrolimus 0.1% ointment, and Roflumilast 0.15% or 0.3% cream.

10:45 am-11:15 am Atypical Nevi: A Dermatopathologist's guide to Patient Conversations: Ata Moshiri, MD

Because of the controversy surrounding the term "dysplastic nevus" it seems appropriate to discontinue use of that diagnosis and describe these lesions as "nevus with architectural disorder" with a statement as to the presence and degree of melanocytic atypia (mild, moderate, or severe).
A higher genetic incidence of the BRAF mutation and a lower incidence of the CDKN2A tumor suppressor makes atypical nevi (precursor lesions) more likely to develop into malignant melanoma.
There is still an approximate 10% chance that an atypical nevus is still present even if margins are clear with biopsy,
Atypical nevi serve as dose-dependent risk markers for a potential melanoma in that patient.
All biopsy sites (of common nevi and atypical nevi with positive or clear histologic margins) need to be monitored for unusual growth and rebiopsied if this occurs. Patients should be educated about examining scars for warning signs of melanoma and when to notify the clinician for reevaluation.

11:15 -11:45 am 2025 Literature Review: Key Insights & Emerging Trends: Eileen Cheever, PA-C

It is important to emphasize strict adherence of contraceptive methods in patients with previous infertility due to metabolic syndrome that are on both GLP-RAs and isotretinoin since correction of metabolic syndrome and slowed gastric emptying increases risk of pregnancy.
The proportion of people over the age of 65 is expanding so it is important to be aware of the principles in geriatric dermatology care. There is a need to individualize care, to share decision making, to consider socioeconomic needs and to have a holistic approach to healthcare.
Povorcitinib is being studied for adults with moderate-severe hidradenitis suppurativa.
Patients on certain antihypertensive medications are potentially more susceptible to actinic keratosis and should have proactive dermatology management (skin exams).

Pinto beans were used to treat warts by taping a dry pinto bean to each wart overnight for 1-2 weeks and showed results similar to other wart treatment modalities.
Studies have shown that people use more sunscreen when it is at no cost to them, so it is important to consider sunscreen recommendations and emphasize the importance of broad spectrum sun protective habits to our patients.

12:30-1:30 pm Patch Testing Demystified: Distinguishing Positives from False Positives and Ensuring Relevance: Walter Liszewski, MD and Kara Mudd, PA-C

Patch testing basics include scheduling appointments for Monday, Wednesday and Friday, ensuring appropriate chamber filling and reading results at 96 hours. The use of antihistamines is okay, but avoid corticosteroids, IL-4, IL-13 inhibitors, JAK inhibitors and other systemic immunosuppressants used in atopic dermatitis.
When applying a patch test, avoid placement on the patient's spine due to risk of movement.
For a patch test to be positive it needs erythema with induration. If there is no induration then allergy is unlikely.
Metals (especially gold) often take longer to show an allergic reaction, so be sure to follow-up at the 96-hour mark in addition to the 48-hour mark.
CAMP is a Contact Allergen Management App that is available to members of the American Contact Dermatitis Society. Once a provider has access to CAMP they can use it to help patients understand their allergens.
Gold allergy will often cause an allergic reaction in areas other than where the gold is used. For example, a gold ring can lead to allergy on the eyelids.
Do not allergy test children to paraphenylenediamine (PPD), they are easy to sensitize. If it is included on the patch test, remove by cutting out the square before applying to pediatric patients.

1:30-2:30 pm Melanonychia: When to Biopsy and how to Decide: Ata Moshiri, MD

Non melanin-derived pigmentation in the nail can be due to: exogenous pigmentation (tobacco), subungual hematoma, fungal melanonychia, and bacterial melanonychia.
A nail unit melanocytic nevus in children can involve the skin in the nail fold (pseudo-Hutchinson's sign) and it is benign but a biopsy is still necessary to rule out melanoma.
Physiologic causes of melanocytic activation (melanotic macule) are ethnic melanonychia and pregnancy.
You should biopsy melanonychia if it is monodactylous, is located in the thumb or hallux, is a thick band greater than 3 mm, is changing over time, is irregular in width (triangle sign), is multicolored, the pigment extends onto cuticle/nail fold and/or there is nail dystrophy/destruction.
A nail matrix biopsy with full thickness excision is indicated with a nail with high likelihood of melanoma including wide bands.
Nail clippings can be utilized if a patient with concerning pigment in the nail is resistant to a nail matrix biopsy. If melanocytic remnants are present in the clipping, this is very concerning finding for melanoma.

3:15-4:15 pm Mucosal Dermatology: Oral and Genital Cases: Walter Liszewski, MD

Dentists receive very little training in oral disease and do not get training in oral biopsies.
Dermatology providers are clear to biopsy cheeks and lips, but ear/nose/throat or oral surgery providers should do all other oral biopsies.
Triamcinolone dental paste is not a good topical for oral lesions due to texture and taste. Consider Clobetasol or Flucinonide instead.
Vitamin B supplements can help prevent recurrent aphthous ulcers.
A patient with lichen planus needs to be evaluated by ENT yearly for oral cancer screening.
You should always examine gential area in psoriasis and hidradenitis suppurativa patients.
In male patients, treat lichen sclerosis with clobetasol. Explain that hygiene is very important. Circumcision can be done in refractory cases. Do not forget to ask about urethral stenosis.
If a patient with gential warts has not been vaccinated for Human Papilloma Virus, recommend they get vaccinated.

Encourage patients with anal warts to see colorectal surgery for anal Pap smears.

4:30-5:00 pm JAK Inhibitors: Practical Tips for Integration into Practice: Walter Liszewski, MD

Use caution in prescribing Janus Kinase Inhibitors in patients with any of the following conditions: a history of blood clots, over the age of fifty, a history of malignancy, a history of renal and liver disease or women of childbearing potential.
There are four Janus Kinases: JAK1, JAK2, JAK3, and TYK2.
Janus Kinase inhibitors are indicated for alopecia areata patients with a SALT score of at least 50.
Consider using a Janus Kinase Inhibitor in a patient with moderate to severe atopic dermatitis who failed at least one systemic agent, is systemic naive but has severe itch or is systemic naive but has both allergic contact dermatitis and atopic dermatitis.

5:00-5:30 pm Chronic Urticaria: Unveiling the Next Major Frontier in Dermatology: Walter Liszewski, MD

The pathophysiology of urticaria involves the release of histamine made by mast cells and basophils, which causes vasodilation. Then other immune cells are activated and recruited (lymphocytes and eosinophils).
Acute urticaria are hives that last six weeks are less. Chronic urticaria are hives that last daily or almost daily for at least six weeks.
In patients with chronic spontaneous urticaria consider the following labs: Hepatitis B and C, Helicobacter pylori, CBC, CMP, TSH and total IgE.
Patients with cold urticaria should be counseled to never swim alone.
Over one-third of chronic spontaneous urticaria patients experience angioedema.
Fexofinadine is best absorbed on an empty stomach.

Day 2: Friday, July 25, 2025

7:30-8:30 am Pediatric Dermatology in Focus: Kodachrome Case Studies: Jim Treat, MD

For infants who have dermatitis and clinically appear to have skin infections,be sure to check lymph nodes. A lack of lymph nodes upon palpation can be a sign of immunodeficiency.
Candida in a nail or multiple nails in a child can be a sign of immunodeficiency. Refer for genetic testing.
Clinical scenarios that suggest immunodeficiency are recalcitrant infections or exuberant infections.
The average time molluscum should last is 18 months. If a child comes in with molluscum that has been present for 3 or 4 years or if they have an unusually high number of molluscum or warts they need to see immunology.
Acute Generalized Exanthematous Pustulosis (AGEP) in pediatric patients is characterized by: fever, pustules, malaise, is self-limited (1-2 weeks), and the pustules resolve with peeling. AGEP is often triggered by antibiotic use.
If someone has a TH1 disease and a strong family history of autoimmune disease use caution before giving them a TH2 suppressing medication since it can upregulate their TH1 response.
Some birthmarks can now be treated with topical medications if the mutation can be identified. For example, topical sirolimus therapy can be used to treat nevus sebaceous.

9:15-10:15 am Treating High Impact Sites in Psoriasis: Tina Bhutani, MD

Patients with certain psoriasis phenotypes are at higher risk for progression to psoriatic arthritis. Patients at higher risk for joint involvement include those with psoriasis in the nail, intergluteal region, scalp, activity in three or more sites, or those with severe disease.
Patients with scalp psoriasis should be educated to wash scalp more often because it helps to gently exfoliate scales and improves the efficacy of topical medications.
Intertriginous psoriasis most commonly involves the groin (80-96% of cases), but can also be localized to the following areas: axillae, genital area, umbilicus, postauricular area, intergluteal cleft, inframammary creases, antecubital fossae and popliteal fossae.

In patients with palmoplantar psoriasis, combination therapy is often needed due to being a difficult to treat area. Using topical treatments under occlusion greatly increases efficacy and adding keratolytics or retinoids helps with hyperkeratosis.
Patients underreport inverse psoriasis. Educate patients with psoriasis by showing them pictures of inverse psoriasis to increase patient reporting of inverse disease involvement.

10:45 am-11:15 am Navigating Pediatric Vascular Anomalies: Diagnosis and Treatment Insights: Jim Treat, MD

At birth, hemangiomas are not fully formed and look like a faint red patch or bruise.
Fully formed “hemangiomas” at birth are not typical infantile hemangiomas, beware of sarcomas.
Segmental hemangiomas are associated with underlying abnormalities and hemangioma syndromes. Localized hemangiomas are typically isolated and not associated with abnormalities.
Lumbosacral hemangiomas are highly associated with tethered spinal cord.
It is important to recognize pediatric patients with multiple subtle pink patches, they may have arteriovenous malformation of the brain or spine.
If examining a pediatric patient who has a large nevus simplex on the face and cannot push tongue to the back of their mouth, the patient should be evaluated for Beckwidth-Wiedman syndrome.
A reticulated port wine stain can be a marker for a genetic syndrome and should be evaluated.
If the lesion looks like a port wine stain but becomes swollen or petechial (bruising): check labs to rule out Kasabach Merritt.

11:15-11:45am Pediatric Dermatologic Emergencies: Jim Treat, MD

Koplik spots are often present prior to the other symptoms of measles and the rash spreads from head to toe.
Live vaccines can be given to pediatric patients on dupilumab as long as there is shared decision making with the patient's family.
If a pediatric patient presents with a fever and a deeply red/purple morbilliform rash with swollen feet, hands, and ears be sure to consider Drug Reaction with Eosinopilia and Systemic Symptoms (DRESS) as a diagnosis. The patient should be referred to the emergency room for treatment.
Medications that can cause Drug Reaction with Eosinophilia and Systemic Symptoms (DRESS) include: Phenobarbital/Phenytoin/Carbamazpine, Lamotigrine, Zonisamide, Dapsone, Isoinazid, Minocycline, Abacavir, Nevirapine, Raltegravir, Sulfamethoxazole, and Sulfasalazine.
Reactive Infectious Mucocutaneous Eruption (RIME) can occur in patients with mycoplasma, influenza, COVID, and other infections. It presents with necrosis of lips, eyes and other mucosa. There are few or no skin lesions. It can lead to severe mucosal scarring.
A neonate with peeling of hands and feet is suggestive of congenital syphilis.

12:30-1:30 pm Recent Advancements in Atopic Dermatitis: New Insights and Treatment Strategies: Alexandra Golant, MD

Be aware of comorbidities associated with atopic dermatitis: asthma, allergy, allergic rhinitis, alopecia areata, osteopenia/osteoporosis, and some ties to vitiligo.
New American Academy of Dermatology guidelines for systemic treatment of atopic dermatitis state that systemic corticosteroids are not a viable treatment option for treating atopic dermatitis.
Delgocitinib cream is the first and only FDA-approved treatment of chronic hand dermatitis.
One study showed the proportion of patients 6-11 years old with lower stature at baseline showed a 5-percentile or greater improvement in height following 16 weeks treatment with dupilumab.
Lebrikizumab and Nemolizumab are approved for patients 12 years and older for the treatment of atopic dermatitis.
OX40 is a promising pathway being investigated in atopic dermatitis that may have a remittative effect on disease progression.

1:30-2:30pm Alopecia Update: What You Should Know in 2025: Amy Spizuoco, DO

Types of scarring alopecia include: Discoid Lupus Erythematosus (DLE), Central Centrifical Cicatricial Alopecia (CCCA), Lichen Planopilaris (LPP), Dissecting Cellulits (Follicular Occulsion Tetrad), and Folliculits Decalvans.
Systemic treatments for Central Centrifical Cicatricial Alopecia include: oral tetracyclines (anti-inflammatory), hydroxychloroquine (for rapidly progressing cases), oral minoxidil (adjunct therapy), and 5-alpha reductase inhibitors.
Treatment for lichen planopilaris should include high-potency topical corticosteroids and intralesional triamcinolone. In addition, you can use hydroxychloroquine or doxycycline/minocycline. For refractory or severe cases can consider methotrexate, mycophenolate mofetil or cyclosporin.
Follicultis Decalvans is characterized by tufted hair follicles and chronic neutrophilic inflammation. It typically occurs in the fourth or fifth decades of life and is predominantly seen in males.
A study showed that oral Minoxidil 5mg and topical Minoxidil 5% were equally effective in treating androgenetic alopecia.
When treating hair loss with Minoxidil, patients may have shedding the first two to four weeks of treatment. Patients will start to have visible improvements in two to four months with full results in six to twelve months.
Ketoconazole shampoo 2% may help patients with androgenetic alopecia, so consider adding it to your treatment regimen. It is not FDA approved for hair loss.

3:15-4:15 pm Skin as a Window: Identifying Cancer Syndromes through Cutaneous Clues: Anisha Patel, MD

Paraneoplastic pemphigus is an autoimmune, antibody mediated condition. It starts on the lips and spreads to the skin with hemorrhagic crusts and ulcerations, but skin findings can be variable. Diagnosis is made by indirect immunofluorescence.
Pyoderma gangrenosum is associated with acute myeloid leukemia, myelodysplastic syndrome and rheumatologic disease.
Dermatomyositis is associated with early malignancy, therefore patients with dermatomyositis should be referred for cancer screening. Dermatomyositis is particularly associated with ovarian cancer.

Cutaneous manifestations of Lynch Syndrom/Muir-Torre (Hereditary Nonpolyposis colorectal cancer) include sebaceous neoplasms that are off of the head and neck as well as keratocanthomas. If a patient has these skin findings, refer them to a genetic counselor, gastrointestinal specialist, and gynecologist for further evaluation.
A child developing several cafe au lait macules will need genetic testing for evaluation of neurofibromatosis.
Patients should be referred to genetic counseling if: multiple family members have the same or related malignancy, multiple family members with more than one primary malignancy, family members or self with cancer prior to 50 years of age, and patient has family members with a known mutation.
The scalp is a common site for solid tumor metastases.
Acute myeloid leukemia is the most common malignancy to metastasize to the skin.

4:30-5:30 pm My Approach to AD in 2025: Alexandra Golant, MD

The American Academy of Dermatology guidelines update gives a strong recommendation for topical ruxolitinib in the treatment of atopic dermatitis.
Studies show Dupilumab reduces risk of atopic march in pediatric patients versus conventional immunosuppressants.
Atopic dermatitis is classified as moderate or severe if patients have a 10% or more body surface area, involvement in high impact areas, or if atopic dermatitis is having a significant impact on quality of life.
High impact areas of atopic dermatitis include: hands, feet, face, axillae, groin, and genitals.
Delgocitinib cream is a Janus kinase inhibitor that has been approved for the treatment of hand eczema in adults and it does not have a box warning.
Be sure to include thorough documentation of atopic dermatitis severity including: investigator's global assessment, body surface area, and quality of life to help with medication coverage.

Day 3: Saturday, July 26, 2025

7:30-8:30 am Wake Up Dermatology: Its Time to Talk About Sleep: The Importance of Sleep for Skin Health and Skin Disease: Tina Bhutani, MD

Stages of sleep: awake, drowsy, stage 1 sleep, stage 2 sleep, slow wave sleep (stage 3 and 4 sleep), REM (rapid eye movement) sleep.
Sleep changes with age, over time total sleep time continues to drop.
Slow wave sleep serves critical functions for memory formation and immune functioning. The more we sleep, the better our immune system works.
Getting good sleep two days prior to a vaccine is vital for optimizing the vaccine response.
Sleep loss has short-term and long-term effects including increased risk of infections, increased stress response, decreased response time, increased obesity, increased risk of diabetes, heart attacks, strokes and mental health problems.
The ideal number of sleep recommended for adults is seven to eight hours.
Patients with psoriasis are at higher risk for developing sleep apnea, and also patients with sleep apnea are at higher risk for developing psoriasis.
One study showed that for each hour increase in average nightly sleep, patients with psoriasis have a 33% decrease in the odds of having a history of myocardial infarction. Another study showed that night shift work increases the risk of psoriasis.

9:15-10:15 am Immunotherapy in Dermatology: Innovations & Clinical Applications: Anisha Patel, MD

There are two forms of immunotherapy, suppression immunotherapy and activation immunotherapy.
MRNA vaccines activate the host’s immune system against specific tumor antigens.
Talimogene laherparepvec is an oncolytic vaccine used in dermatology that can be used in non resectable tumors. Other vaccines used in dermatology are MRNA vaccines.
Cellular therapies in dermatology focus on enhancing lymphocytes. Some examples of these are tumor-infiltrating lymphocyte therapy (used in melanoma) and chimeric antigen receptor T-cell therapy (used in melanoma and skin disease).
Immune checkpoint inhibitors are being used in dermatology to treat melanoma, cutaneous squamous cell carcinoma, basal cell carcinoma and merkel cell carcinoma.

Cutaneous adverse events caused by checkpoint inhibitors include: morbilliform drug eruption, eczema, psoriasis, lichenoid drug eruption/lichen planus, granulomatous dermatitis, vitiligo, bullous pemphigoid, and keratocanthoma/squamous cell carcinoma.

10:45-11:45 am Complex Medical Dermatology: Top Diagnoses You Can't Afford to Miss: Lauren Madigan, MD and Anisha Patel, MD

Solid organ transplant patients have increased risk of squamous cell carcinoma. Allogeneic hematopoietic stem cell transplant patients have an increased risk of basal cell carcinoma, malignant melanoma and squamous cell carcinoma. If combined with radiation treatment there is also an increased risk of basal cell carcinoma in the radiated area.
Azathioprine is an immunosuppressive medication associated with increased cancer risk, so sirolimus is a preferred alternative.
When evaluating a patient with pruritus without a rash systemic causes are common and should be prioritized in the differential diagnosis. Consider if the itching is caused by a metabolic, malignant, medication, neuropathic, chronic infection, psychogenic or cryptic issue.
Approach patients with pruritus without a rash, by doing a thorough history and review of systems, a full skin exam, and initiate laboratory evaluation.
Beware of a flare in a patient that has a well controlled chronic skin disease and gets "a flare". Make sure you are not missing a new or separate cutaneous issue.

1:00-1:30 pm The Evolving Landscape of STI's: Amy Spizuoco,DO

Penicillin G benzathine is the treatment of choice for all stages of syphilis. A single dose is recommended for early syphilis (infected for less than a year), if disease has been present for more than a year multiple doses of penicillin may be necessary.
In pathology, Henderson-Patterson bodies are pathognomonic for molluscum contagiosum; Koliocytes are pathognomonic for HPV.
Post-scabietic itch can last for weeks after successful eradication of mites and does not necessarily indicate treatment failure, however, recurrent or persistent symptoms should prompt evaluation for reinfestation, inadequate treatment or misdiagnosis.
Trichophyton mentagrophytes GenotypeVII is an emerging sexually transmitted dermatophyte.
Trichophyton mentagrophytes GenotypeVII is treated with oral terbinafine 250 mg daily for four to eight weeks. Recurrence is common.

1:30-2:00 pm Unraveling Chronic Itch: Douglas DiRuggerio, PA-C

The key neuropeptides in itch are: substance P, calcitonin gene-related peptide, vasoactive intestinal peptide, galanin, endothelin-1, and neuropeptide Y.
Patients' itch level can be self-reported with the peak pruritus numerical rating scale (pp-NRS) from 0-10, with 0 being no itch and 10 being the worst itch imaginable.
Predisposing factors to chronic itch in the elderly include: age-related changes in barrier function, neuronal changes and neuropathies, and immunosenescence.
Always rule out parasitic infection in a pruritic patient who has recently traveled and has elevated eosinophils.
If timing is right and biopsy shows interface dermatitis; drug is possible cause of dermatitis. The patient would need to discontinue the offending drug for at least 6 weeks to determine if it was the cause of the rash.
Topical treatment is the mainstay of therapy for pruritus with a goal of skin hydration and barrier repair.

2:00-2:30 pm Vitiligo for Advanced Clinicians: Key Takeaways: Naiem Issa, MD

Vitiligo patients with an affected body surface area greater than 5%, darker skin pigment, and/or facial or hand involvement have a high psychosocial on quality of life burden.
Ruxolitinib 1.5% cream is a potent inhibitor of janus kinase 1 and 2 and the first and only FDA-approved drug for non-segmental vitiligo. Alternatively, tofacitinib 2% is less expensive and could also be used.
The most common adverse events from vitiligo patients using Ruxolitinib are: acne, nasopharyngitis, pruritis, and dermatitis.
Use of topical Ruxolitinub 1.5% cream in combination with other therapeutic biologics (janus kinase inhibitors or potent immunosuppressants such as azathioprine or cyclosporine) is not recommended.
There is a high correlation with vitiligo and positive thyroid peroxidase antibodies, hypothyroidism, and autoimmune thyroiditis.
In adults, a halo nevus may indicate the presence of melanoma within the nevus or elsewhere on the body.

2:45-3:15 pm Optimizing Biologic Selection and Treatment Sequencing in Psoriasis: A Case-Based Approach: Megan Prouty, MC

Psoriasis severity can be categorized by body surface area. Mild is less than 3%, moderate is 3-10%, and severe is greater than 10% body surface area. However, disease may be severe even with a 1% body surface area if psoriasis is affecting a functional area such as hands, feet, or genitals.
Patients are NOT a candidate for methotrexate treatment if: possibly pregnant or breast feeding, they have chronic liver disease, are not willing to discontinue alcohol intake, have chronic cytopenia or chronic kidney disease.
Always refer psoriasis patients with axial joint symptoms to rheumatology on initial evaluation.
If a psoriasis patient has symptoms that are concerning for inflammatory back/hip pain, strongly consider starting treatment with a TNF-alpha inhibitor.

4:00-4:30 pm Interesting Cases from Inpatient Consults: Lauren Madigan, MD

Sweet's syndrome is characterized by the sudden onset of tender, erythematous papules or plaques with accompanying fever and neutrophilia. Consideration for an underlying malignancy is necessary, since the cutaneous eruption may be the first sign of an occult malignancy or relapse in a patient with a cancer history.
Pyoderma gangrenosum is frequently associated with systemic disease.
VEXAS syndrome should be suspected in a patient (particularly males over the age of 50) who has refractory systemic inflammation, hematologic abnormalities and characteristic cutaneous lesions (neutrophilic dermatitis, vasculitis and chondritis).
Vascular, infectious, and neoplastic ulcers are the most common mimickers of pyoderma gangrenosum, and failure to exclude these can lead to inappropriate immunosuppression which may worsen the underlying condition and precipitate severity of complications.

4:30-5:00 pm Kodachrome Case Studies: Lauren Madigan, MD

Linear immunoglobulin A is a rare autoimmune blistering skin disease that appears like a "crown of jewels." It can be drug induced by intravenous vancomycin.
Niacin deficiency can present with a "Casal's necklace." This dermatitis occurs around the neck and creates a distinct, collar-like pattern.
Monilethrix is a rare, inherited hair disorder that causes hair to appear dry, brittle and beaded.

Tongue telangiectasias can be seen in systemic sclerosis.
Always ask a patient with erythema ab igne why they are using heat on their skin, it could lead to a systemic diagnosis.
Rapid vitiligo-like depigmentation could be a sign of melanoma present elsewhere on the body. All patients with “vitiligo” should have a full body skin exam.

Day 4: Sunday, July 27, 2025

8:00am-9:00 am: Complex Psoriasis Cases: Navigating Diagnostic & Therapeutic Challenges: Megan Prouty, MD

If a patient has an active strep infection it is appropriate to treat, but antibiotics are not effective in clearing guttate psoriasis.
One to two doses of an interleukin-23 inhibitor are a convenient and highly effective way to treat new onset guttate psoriasis, dosed approximately a week apart. Often only one dose is needed.
In patients on a biologic medication with focal residual psoriasis involvement (approximately 3% or less), consider adjunctive therapies instead of changing biologic treatment.
For patients with a history of thromboembolic events, be cautious with janus kinase inhibitors such as upadactinib.
Mycosis fungoides/cutaneous T-cell lymphoma can appear identical in morphology to psoriasis. Consider biopsy of psoriasiform plaques in sun protected areas-especially if areas appear poikilodermatous or atrophic.
Retrospective data supports the use of biologics in patients with a history of malignancy as safe and effective. Interleukin-23 and intraleukin 12/23 are preferred in these situations.
Consider HIV testing in patients who present with erythrodermic psoriasis or psoriasis refractory to multiple treatments (particularly young men as this is the most frequent patient population in case reports). In conjunction with Infectious Disease, if a patient is on antiretroviral therapy, consider the use of Interleukin-23 or Interleukin-17 inhibitors.

9:00am-9:30 am The Art of Connection: Building Meaningful Rapport with Skin of Color Patients: Buchi Neita, PA-C

Implicit bias is a negative attitude or internalized stereotypes that unconsciously affect our perceptions, actions, and decisions.
By 2044, more than half of all Americans are projected to belong to a minority group.
To build rapport with skin of color patients, it is important to find a common ground. Take interest in your patient, discuss shared experiences and hobbies, personalize the encounter, and avoid generalizations or stereotypes.
Body language and tone are key aspects of making a patient feel comfortable. Sit down facing the patient at eye level and make eye contact, mind your tone and facial expressions, and mirror the patient's body language.
Utilize shared decision making. Present the full range of treatment options, discuss risks and benefits, ask what therapies the patient is open to and allow for questions, provide clear instructions, and understand that the patient may need time to make a decision and offer follow-up.
Recognize the higher risk of hyperpigmentation and keloids in skin of color patients. Approach all procedures with caution.

9:30am-10:00 am Dermatologic Conditions in Skin of Color Patients: Buchi Neita, PA-C

Volar/acral melanocytic macules and plantar pigmentation is a normal variation in skin of color patients. They are asymptomatic, hyperpigmented macules and patches on plantar surface in African American patients. Dermoscopy primarily reveals a homogeneous pattern.
Management of keloid scars include: intralesional steroids (high concentrations), 5-fluorouracil, cryotherapy, silicone gel sheets, and surgery with caution (adjunct treatment with surgery to prevent recurrence are radiation, intralesional steroids, pressure and silicone sheets).
Traction alopecia is a trauma-induced hair loss resulting from continuous and excessive pulling of the hair shaft. Management includes avoiding high tension hairstyles, topical and intralesional steroids, topical and oral minoxidil, oral antibiotics, and hair transplantation.
Patients may develop discoloration of the skin in sun-exposed areas when taking kratom in high doses.
Hydrochlorothiazide can cause drug-induced photodistributed hyperpigmentation. Consider referral to the patient's primary care provider to choose an alternate diuretic medication.

10:45-11:45 am Lessons Learned in Acne and Rosacea: Shanna Miranti, PA-C

The mechanism of action for isotretinoin is apoptosis of sebaceous and meibomian gland cells.
Patients that are candidates for isotretinoin therapy have moderate-severe acne vulgaris, have tried and failed appropriate American Academy of Dermatology options, are frustrated with lack of efficacy of current regimen, and/or are developing scarring.
Isotretinoin should be taken with a high fat meal (at least 20 grams of fat).
Topical tazarotene can be used post-isotretinoin therapy for acne maintenance/prolonging the results of isotretinoin therapy.
Pseudo-acne fulminans is the sudden onset eruption of nodules and ulcerative/crusted acne lesions.