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Avapritinib durably improves cutaneous involvement of indolent systemic mastocytosis in patients treated in the PIONEER study

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Background: Indolent systemic mastocytosis (ISM) is a clonal mast cell (MC) disease primarily driven by D816V-mutant KIT.[1–3] ISM is characterized by accumulation and hyperactivation of aberrant MCs in organs, including skin.[4] Patients with ISM typically show brown skin lesions as well as other skin symptoms such as pruritus and wheeling.[5]

Purpose: To characterize skin findings in patients with ISM treated with avapritinib, a potent, selective KIT D816V inhibitor, in the PIONEER study (NCT03731260).

Methods: PIONEER evaluated the long-term safety and efficacy in 226 patients with ISM who initiated avapritinib 25 mg once daily plus best supportive care. Skin symptoms were evaluated by the ISM-Symptom Assessment Form skin domain score (0–30) and individual skin symptoms (0–10) of spots, itching, and flushing from baseline to 48 and 144 weeks. Changes in skin lesions by photography were captured until 48 weeks.

Results: Mean (standard deviation [SD]) change from baseline in the skin symptom domain was −6.89 (7.11) at Week 48 and −2.48 (2.50), −2.45 (2.82), −1.95 (2.72) for spot severity, itching, and flushing, respectively. At Week 144, the mean (SD) change in skin symptom domain was −8.14 (7.86). Patients with paired photographs (n=51) showed a median percent reduction in lesion surface area in the most affected skin region of −60% after 48 weeks; 82% had lightened skin lesion color. Long-term follow-up (median 3 years, with some patients up to 5 years) demonstrated avapritinib was generally well tolerated with no new safety concerns observed.

Conclusion: Avapritinib provided sustained and durable improvements in skin manifestations of ISM and demonstrated a favorable benefit–risk profile in patients with ISM, highlighting the ability of avapritinib to achieve long-term disease modification.

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Best practices for genital psoriasis diagnosis and treatment: a progress report from the Genital Psoriasis Wellness Consortium consensus panel

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Background: Genital psoriasis (gPsO) poses several diagnostic and treatment challenges and remains underdiagnosed and undertreated despite its substantial impact on quality of

life (QoL).[1] Sensitive disease location and the absence of an International Classification of Diseases, Tenth Revision (ICD-10) code also complicates care. The Genital Psoriasis Wellness Consortium consensus panel, a multidisciplinary group of 13 US-based board-certified clinicians, previously developed consensus statements on gPsO diagnosis, patient communication, QoL impact, interpersonal relationships, and treatment decisions.[2]

Purpose: To refine best practices and expand guidance in 3 areas: 1) physical exam, diagnosis and patient conversations, 2) pediatric and adolescent treatment, and 3) adult and geriatric treatment.

Methods: A modified Delphi process with a nominal group technique was used to reach consensus. Subgroups were formed to address the 3 key areas. A systematic literature review informed discussion. Statements developed in subgroup virtual meetings were refined and voted on by the full panel. Statements were refined based on feedback and revoted on in a second round. Consensus was defined as ≥75% agreement (ie, score of ≥5 on a 7-point Likert scale).

Results: The panel emphasized the importance of routine comprehensive skin exams, including genital assessment, in PsO and encouraged empathetic, nonjudgmental language to reduce stigma and discomfort. Verbal consent and the option for a chaperone should be standard practice. Clinicians should consider lesion morphology and classify it as inflammatory, infectious, or neoplastic, as genital manifestations can differ from other areas. Pediatric care should use shared decision-making among parents and patients (as appropriate for age), and clinicians should guide treatment to foster satisfaction and adherence. Adherence strategies (eg, gamification) should be considered and incorporated into care plans. PsO care should align with routine pediatric care, especially vaccination schedules. For adults and older patients, treatment should be guided by comorbidities, concomitant medications, and health goals rather than age alone. Therapies with documented safety and efficacy in genital/intertriginous areas should be prioritized and long-term corticosteroid use minimized. Addressing access and insurance coverage–based barriers and using simple, durable treatment regimens can further support adherence, particularly in the context of polypharmacy or cognitive challenges.

Conclusion: This framework supports consistent, patient-centered evaluation and management of gPsO across age groups, optimizing diagnosis and treatment selection, and enhancing adherence. Future efforts should focus on implementation and equity in care access.

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Bridging haircare and healthcare: improving hair loss recognition and referrals in Black barbershops and salons

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Introduction: Hair loss conditions including central centrifugal cicatricial alopecia (CCCA), traction alopecia, and scarring alopecias disproportionately affect Black communities and are frequently diagnosed at advanced, often irreversible stages. Hair carries significant cultural, social, and psychosocial meaning, and for many individuals within Black communities, it is closely tied to identity and self-expression. Barriers to care include limited access to dermatology providers with skin-of-color expertise and cultural incongruence within clinical settings. Barbers and stylists maintain trusted, long-standing relationships with clients and may observe early scalp and hair changes before clinical presentation, yet no structured referral pathway exists to act on these observations. The purpose of this quality improvement project was to develop, implement, and evaluate a culturally responsive training and referral model to activate barbers and cosmetology students as community referral agents for hair loss care.

Methods: This single-site quality improvement project used a same-day pre-post design with an 8-week retention check. Twelve barber and cosmetology students in Houston participated in a 40-minute structured training session addressing pattern recognition of hair loss conditions relevant to Black clients, features of scarring alopecia, and culturally responsive referral workflows. A digital referral directory was developed and deployed as a community-facing tool linking clients to 10 verified Houston dermatology providers specializing in hair loss and skin of color. Presurvey, postsurvey, and 8-week retention survey measures assessed knowledge, confidence, and familiarity with 11 hair loss conditions. McNemar's test with continuity correction was used to evaluate changes in paired outcomes; descriptive statistics summarized participant responses.

Results: Post-training confidence in identifying hair loss increased from 50.0% to 91.7%. Familiarity improved across 10 of 11 conditions assessed, with the greatest gains observed in conditions with the lowest baseline familiarity. Eighty-three percent of participants correctly identified a scarring alopecia post-training, compared to limited recognition at baseline. Knowledge and confidence outcomes approached statistical significance on McNemar's testing, with effect sizes suggesting clinically meaningful improvement despite the small sample. The QR-based referral directory recorded 31 unique community visits during a 6-week tracking window (June 5–July 15, 2025) within the study period. Eight participants completed the Week 8 retention survey, suggesting knowledge retention.

Conclusion: A single structured training improved hair loss recognition among barbers and cosmetology students serving Black communities, with the most notable gains in scarring alopecias where delayed diagnosis can result in permanent loss. Findings support integrating hair loss education into cosmetology and barbering curricula and embedding community-based referral pathways to improve access to dermatologic care for underserved populations. The model is low-cost, requires no clinical infrastructure, and can be replicated across community settings. Future research should evaluate long-term referral outcomes and clinical follow-through in larger populations.

Dermatocast for 'on-the-go' dermoscopy training: a feasibility study

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Background: Skin cancer represents the most common malignancy in the United States, with approximately 5 million cases treated annually and associated costs exceeding $8.1 billion.[1] Early detection improves prognosis.[2] Yet, the shortage of dermatologists creates barriers to timely and accurate skin cancer diagnosis.[3] Dermoscopy, a noninvasive diagnostic technique that uses magnification and polarized light, improves diagnostic accuracy and reduces unnecessary biopsies.[4] However, the lack of access to structured dermoscopy training remains a significant limitation among residents and trainees.[5] Traditional training methods (such as lectures or shadowing) offer limited opportunities for simultaneous visual engagement between teacher and learner. Therefore, we developed the Dermatocast device, a novel dermoscopy screen attachment enabling shared, simultaneous visualization of skin lesions during clinical encounters.

Purpose: The purpose of this study was to assess the feasibility of Dermatocast. This innovation addresses the core educational limitation of single-user dermatoscopes, which hinders instruction. In typical dermatology settings, attendings must verbally describe dermoscopic findings to trainees—a process prone to a lack of alignment and miscommunication, resulting in a loss of important learning opportunities. The Dermatocast prototype integrates a beam splitter and a miniature high-definition camera into a standard dermatoscope, projecting real-time images to a tablet or monitor via Wi-Fi or HDMI. It allows both the educator and learner to view the same lesion simultaneously. The goal is to evaluate the usability, acceptability, and satisfaction associated with this new device among dermatology faculty, residents, and medical students. By bridging optical engineering and medical education, Dermatocast seeks to expand dermoscopy training opportunities, enhance diagnostic accuracy, and establish a scalable educational model for use in academic and community dermatology settings.

Methods: The Dermatocast attachment was collaboratively designed by the University of Arizona Department of Dermatology and the College of Optical Sciences. The device utilizes a beam-splitting mechanism that directs part of the optical path to a clinician's eyepiece and the other to a miniature high-definition (1080p) camera. Relay optics were custom-designed using optical simulation software (Optics Studio, Zemax) to ensure accurate beam conversion between the dermatoscope and the camera. Mechanical components were 3D-printed to ensure ergonomic integration with standard dermatoscopes. The device transmits images wirelessly to tablet computers or via HDMI to external monitors, enabling dual viewing. Prototype performance was evaluated based on imaging resolution (using the USAF resolution target) and color fidelity (using standardized color targets). After prototype optimization, Institutional Review Board approval was obtained for pilot testing among dermatology trainees and faculty. Ten participants from the University of Arizona Department of Dermatology, including one attending dermatologist and nine trainees (residents and medical students), were recruited for device testing under typical clinic conditions.

Analytical approach: This pilot feasibility study assessed usability, acceptability, and satisfaction. Quantitative evaluation included the System Usability Scale (SUS)[6] and the Technology Acceptance Model (TAM).[7] Qualitative data were collected through open-ended survey items addressing user experience, educational value, device integration into clinic workflow, and perceived skin cancer training value. Surveys were managed using REDCap.[8] Descriptive statistics were used to summarize participant demographics, usability, acceptability, and satisfaction. Given the small sample size, results focused on feasibility and implementation rather than inferential statistical significance.

Results: Participants demonstrated equal gender distribution, with a mean age of 28.7 years (range 23-36). Most participants identified as White (70%), and 30% identified as Hispanic or Latino. Dermatocast demonstrated strong usability, with a mean SUS score of 82.25 (SD = 12.93), corresponding to an A grade and an excellent usability interpretation (Cronbach's alpha = 0.85). User satisfaction was also high: 90% of participants reported that viewing lesions and conducting skin examinations with Dermatocast was easy, and 70% reported learning dermoscopic structures they might not have otherwise observed. Modified TAM responses indicated high to very high acceptability across several domains, including habit (M=6.40, SD=0.82), perceived usefulness (M=6.08, SD=1.11), perceived ease of use (M=5.99, SD=1.28), facilitators (M=5.93, SD=1.17), intention to use (M=5.93, SD=0.94), and attitude (M=5.93, SD=1.35). Subjective norm was moderately high (M=5.45, SD=1.32), while compatibility was moderate (M=4.48, SD=2.05). Overall, Dermatocast demonstrated promising usability, acceptability, and perceived educational impact among dermatology trainees and faculty. These findings suggest that Dermatocast could improve trainee diagnostic confidence and expand dermoscopy education in busy clinical settings. Larger studies are needed to provide statistical power, further refine the device design, evaluate its impact on dermoscopy skill acquisition, and explore future clinical and industry partnerships.

Conclusion: The Dermatocast technology represents a low-cost, practical innovation that supports the integration of dermoscopy into routine dermatologic and primary care practice. For educators, it enables bedside teaching without workflow interruptions or specialized imaging infrastructure. For learners, it offers a hands-on opportunity to correlate dermoscopic findings with clinical morphology in real time. Broader adoption of this tool might ultimately strengthen dermoscopy skills among trainees and non-dermatologist providers, improve early detection of skin cancer, and reduce unnecessary biopsies through improved diagnostic confidence.

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Dupilumab consistently reduced itch severity in patients with chronic spontaneous urticaria across baseline characteristic subgroups in a LIBERTY-CSU CUPID A and C pooled analysis

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Background: Demographic factors and disease characteristics might impact therapeutic response in patients with chronic spontaneous urticaria (CSU). Dupilumab, an interleukin-4/13 inhibitor, improved itch and hives in LIBERTY-CSU CUPID (NCT04180488) Studies A and C.

Purpose: To assess itch reduction with dupilumab across CSU patient subgroups based on age, sex, body mass index (BMI), and angioedema status.

Methods: Omalizumab-naïve patients (aged 6–80 years; CSU diagnosis >6 months before screening; itch/hives >6 weeks despite H1-antihistamine treatment; 7-day Urticaria Activity Score ≥16; 7-day Itch Severity Score [ISS7] ≥8) were randomized in 2 replicate, 24-week, placebo-controlled, double-blind, phase 3 studies (CUPID A and C). In this analysis (placebo/dupilumab, n=145/144), subgroups were defined by baseline age, sex, BMI, and angioedema status. Itch improvement was assessed by least squares (LS) mean change from baseline in ISS7 (range 0–21).

Results: Mean age of patients receiving dupilumab and placebo was 43.2 and 43.0 years, respectively, 61.1% and 75.2% were female, and 54.9% and 59.3% were White. Week 24 ISS7 improvement was greater with dupilumab treatment vs placebo across subgroups; treatment by subgroup interactions were nonsignificant ($P>0.05$). The improvement with dupilumab (−10.35; −9.01; −10.15) was consistently greater than with placebo (−6.27; −6.70; −6.57) irrespective of baseline BMI (<25 kg/m^2; ≥25 to <30 kg/m^2; ≥30 kg/m^2, respectively). Similar improvement was observed across patients with/without angioedema at baseline with dupilumab (−8.77/−11.17) vs placebo (−6.13/−7.53). For female and male patients, dupilumab reduced itch (−9.64 and −10.88, respectively) more than placebo (−6.27 and −7.88, respectively). Similarly, in patients aged <65/≥65 years, improvement was greater with dupilumab (−9.90/−10.69) compared with placebo (−6.77/−8.21). Safety was generally consistent with the known dupilumab safety profile.

Conclusion: Dupilumab consistently reduced Week 24 itch severity across patient subgroups regardless of age, sex, BMI, or presence of angioedema.

Dupilumab provides early and sustained improvement in urticaria activity in patients with chronic spontaneous urticaria: pooled results from LIBERTY-CSU CUPID Study A and Study C

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Background: Chronic spontaneous urticaria (CSU) is a chronic inflammatory skin disease characterized by wheals with or without angioedema, with associated itch and burning that adversely impact patients' quality of life. Dupilumab, an interleukin (IL)-4/IL-13 inhibitor, has demonstrated improvement in urticaria activity in antihistamine-resistant, omalizumab-naïve patients with CSU in LIBERTY-CSU CUPID Study A.

Purpose: Here, we assessed the efficacy of dupilumab vs placebo on urticaria activity over time in a pooled analysis of the replicate studies CUPID Study A and CUPID Study C.

Methods: LIBERTY-CSU CUPID Study A and Study C (NCT04180488) were replicate, 24-week, randomized, double-blind, placebo-controlled, phase 3 trials of dupilumab treatment in omalizumab-naïve patients aged ≥6 years with symptomatic CSU despite standard-of-care H1-antihistamine treatment (≤4-fold the approved dose). Patients were randomized to receive add-on dupilumab (pooled: 144 patients) 300 mg (adults, adolescents: ≥60 kg) or 200 mg (adolescents: <60 kg, children: ≥30 kg) or matched placebo (pooled: 145 patients) subcutaneously every 2 weeks. Efficacy endpoints included change in Urticaria Activity Score over 7 days (UAS7; range 0–42) over time, from baseline to Week 24. All *P* values were nominal, with no adjustments for multiple testing.

Results: Dupilumab improved urticaria activity (UAS7) over time compared with placebo, starting from Week 3 (least squares mean [standard error] change from baseline: dupilumab, −9.9 [0.9]; placebo, −6.9 [0.9]; nominal P=0.0066) through Week 24 (dupilumab, −19.3 [1.3]; placebo, −13.1 [1.3]; nominal P<0.0001). The occurrence of treatment-emergent adverse events (dupilumab vs placebo) was 53.5% vs 55.9%. Overall safety was generally consistent with the known dupilumab safety profile.

Conclusion: Dupilumab demonstrated early and sustained improvements in urticaria activity starting from Week 3, supporting dupilumab as a treatment for H1-antihistamine-resistant CSU.

Improvement in atopic dermatitis signs and symptoms with once-daily and proactive twice-weekly roflumilast cream: results from the 52-week phase 3 INTEGUMENT-OLE trial in patients aged ≥2 years

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Background: Roflumilast cream demonstrated efficacy and safety for atopic dermatitis (AD) in ≥2-year-old patients in randomized, vehicle-controlled, 4-week, phase 3 trials (INTEGUMENT-1/2; INTEGUMENT-PED).[1,2]

Purpose: Investigate long-term outcomes of roflumilast treatment in a phase 3, open-label extension (OLE) trial (INTEGUMENT-OLE/NCT04804605).[3]

Methods: Patients who completed INTEGUMENT-1/2 or INTEGUMENT-PED (parent studies) could enroll in INTEGUMENT-OLE; roflumilast cream 0.15%/0.05% (≥6/2–5 years) was applied once daily for ≤52 weeks. Patients achieving Validated Investigator Global Assessment for AD (vIGA-AD) 0 (clear) at/after OLE week 4 transitioned to proactive twice-weekly (BIW) application, which was continued as long as "disease control" (vIGA-AD 0/1 [clear/almost clear] and adequate AD sign/symptom control) was maintained. VIGA-AD, Eczema Area and Severity Index (EASI), mean body surface area affected (BSA), and safety were assessed.

Results: At OLE week 52, vIGA-AD 0/1 rates were 55.7% (117/210) and 63.1% (234/371) for INTEGUMENT-1/2 and INTEGUMENT-PED groups, respectively; mean EASI (10.45 to 2.79; 12.18 to 2.59) and mean BSA (14.8% to 3.7%; 22.3% to 4.9%) decreased from parent-study baseline. At/after OLE Week 4, 19.8% (130/658) and 30.2% (170/562) of patients in respective groups transitioned to BIW application with median durations of "disease control" of 281 and 238 days (Kaplan-Meier estimates). Treatment-related adverse events were reported for 4.7% and 2.5% of patients from INTEGUMENT-1/2 and INTEGUMENT-PED, respectively, and application-site pain adverse events for <1% of patients overall.

Conclusion: Roflumilast cream was well tolerated and provided long-term decreases in AD signs/symptoms for patients aged ≥2 years, supporting the use of roflumilast cream for long-term AD control, including proactive BIW application, without topical corticosteroids.

Funding/financial support: Sponsored by Arcutis Biotherapeutics, Inc.

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Quality of life of acne on young adults

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Background: Acne vulgaris is highly prevalent among young adults and is associated with psychosocial distress, yet the relationship between clinical severity and quality of life in this population remains incompletely understood.

Purpose: To evaluate changes in acne severity and dermatology-related quality of life among young adults aged 18 to 22 years and to explore whether improvement in clinical grading corresponds with changes in patient-reported outcomes.

Methods: A pre-post observational study was conducted with 16 participants. At baseline (Week 0) and after 8 weeks of treatment, acne severity was assessed using the Global Acne Grading System (GAGS), and quality of life was measured with the Dermatology Life Quality Index (DLQI). Descriptive statistics summarized demographic characteristics. Paired *t*-tests compared pre- and post-treatment scores, and correlation analysis examined the relationship between changes in GAGS and DLQI.

Results: Both acne severity and dermatology-related quality of life significantly improved over the 8-week treatment period; however, changes in GAGS scores were not significantly correlated with changes in DLQI scores, indicating that perceived quality-of-life improvement did not directly mirror clinical acne improvement.

Conclusion: Among young adults with acne, meaningful improvements in both clinical severity and quality of life were observed following routine treatment. The lack of correlation between these changes suggests that quality of life might be influenced by factors beyond visible lesion reduction, underscoring the importance of incorporating patient-reported outcomes into acne management.

Funding/financial support: No funding was provided for this study.

Risk of systemic adverse effects from topical and oral corticosteroids: time for a paradigm shift?

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Background: Corticosteroids (CS) are commonly prescribed by dermatology practitioners and clinicians in other specialties to manage inflammatory conditions. In 2023 alone, >15 million prescriptions for topical CS (any indication) were filled in the United States (US).[1] Cutaneous adverse events (AEs) have traditionally been the primary AE acknowledged and attributed to topical CS use, but growing evidence suggests that CS absorption might lead to a variety of systemic AEs.[2]

Purpose: To better understand the data on CS and the risks associated with their use, a targeted literature search was performed.

Methods: PubMed was searched from 2010 to 2025 for English-language studies and meta-analyses using a variety of MeSH terms, including corticosteroids, topical, glucocorticoids, guidelines, and specific AEs; reference lists of selected articles were also searched. Studies were organized into topical and oral CS use for review, as well as assessed by cumulative dose, daily dose, recency of use, duration of use, and CS potency.

Results: Topical CS: Cohort and case-control studies have shown that prolonged use of high-potency topical CS poses a modest, but clinically meaningful, systemic risk of type 2 diabetes, osteoporosis/osteoporotic fractures, and hypothalamic-pituitary-adrenal (HPA) axis suppression. Some doses of highly potent topical CS (eg, 49 g of high potency topical CS for 2 weeks) have been described as exceeding published thresholds for HPA axis suppression.

Oral CS: Short-term oral CS use (<30 days) is common, occurring in 21% of US adults across specialties and diseases. Findings from population-based studies and claims database analyses show that even short courses of oral CS use (≤5 mg/day for ≤6 months) can contribute to hyperglycemia, elevated blood pressure, mood changes, sleep disturbance, sepsis, fracture, and venous thromboembolism.

Conclusion: Available data reveal that CS-related AEs might be more impactful than traditionally thought. This underscores the importance of a more discriminating approach to CS use, especially given the increasing availability of novel, effective alternatives. Judicious CS prescription should include individual patient risk assessment, routine safety monitoring, and use of the lowest effective dose for only the necessary duration. This review identifies an opportunity for a new era where non-CS therapies are used as replacements for topical CS to minimize patient risk without compromising treatment outcomes, especially in higher-risk patients and when the disease requires.

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Roflumilast cream 0.15% and 0.05% effects on sleep in patients with atopic dermatitis

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Background: Symptoms of atopic dermatitis (AD), specifically sleep disturbance from symptoms such as pruritus, can negatively impact patient and family quality of life (QoL).[1] Once-daily roflumilast cream demonstrated efficacy and safety in patients with AD across 3 phase 3, 4-week, randomized-controlled trials (INTEGUMENT-1 [NCT04773587], INTEGUMENT-2 [NCT04773600],[2] and INTEGUMENT-PED [NCT04845620]).[3]

Purpose: Assess the impact of roflumilast on sleep outcomes for patients with AD.

Methods: Patients received once-daily roflumilast cream 0.15% (INTEGUMENT-1/2; aged ≥6 years) or 0.05% (INTEGUMENT-PED; aged 2–5 years; caregiver-applied) or vehicle cream for 4 weeks. Least squares mean (LSM) improvements from baseline to Week 4 were determined for Worst Itch-Numeric Rating Score (WI-NRS), and sleep items from SCORing AD (SCORAD), Patient-Oriented Eczema Measure (POEM), Children's Dermatology Life Quality Index (CDLQI; ages 4–16 years), Infant Dermatitis Quality of Life questionnaire (IDQoL; ages <4 years; INTEGUMENT-PED only), and the Dermatitis Family Impact questionnaire (DFI; ages ≤17 years). For POEM, CDLQI, IDQoL, and DFI, the Cochran-Mantel-Haenszel test on rank scores was used to evaluate the association between treatment and response.

Results: Roflumilast cream was applied to/by 884 and 436 patients and vehicle cream by 453 and 215 in INTEGUMENT-1/2 and INTEGUMENT-PED, respectively. At Week 4, roflumilast improved WI-NRS score vs vehicle (LSM improvement; INTEGUMENT-1/2: 2.6 vs 1.6, $P<0.0001$; INTEGUMENT-PED: 2.6 vs 1.6, $P=0.0002$). At Week 4, roflumilast vs vehicle had higher LSM improvement in sleep loss for SCORAD (0–10 visual analogue scale; INTEGUMENT-1/2: 1.91 vs 1.25, $P<0.0001$; INTEGUMENT-PED: 2.05 vs 1.29; $P=0.0005$) as well as greater proportions of patients with no impact on sleep loss/disturbance on POEM (5-point scale; no days with sleep disturbance: 55.6% vs 42.9%, $P<0.0001$; 39.9% vs 31.1%, $P<0.0001$), CDLQI (4-point scale; no effect on sleep: 59.4% vs 50.8%, $P<0.001$; 43.4% vs 35.9%, $P>0.05$), IDQoL (4-point scale; INTEGUMENT-PED: 0–15 minutes average time falling asleep: 37.3% vs 27.8%, $P>0.05$; <1 hour average sleep disturbance: 60.6% vs 54.8%, $P<0.05$) and DFI (4-point scale; no impact on sleep of others in family: 70.0% vs 64.1%, $P<0.01$; 49.6% vs 43.5%, $P<0.01$).

Conclusion: Itch symptoms and sleep disturbance were improved with roflumilast cream 0.15% and 0.05% in patients aged ≥6 years and 2 to 5 years with AD, respectively, across several patient/caregiver-reported outcomes. Roflumilast cream is a suitable treatment option for patients as young as 2 years of age.

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Symmetrical drug-related intertriginous and flexural exanthema after valacyclovir

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Case Presentation: A 58-year-old male patient with prior herpes zoster vaccination presented with a right buttock and groin rash after initiating valacyclovir for presumed shingles. He developed burning and tingling prior to rash onset and was diagnosed at urgent care. After 3 doses of valacyclovir, he developed a sharply demarcated, violaceous, symmetrical groin rash. Suspected Stevens-Johnson Syndrome prompted emergency referral, but contact dermatitis was diagnosed. He was prescribed prednisone, gabapentin, and amlodipine; only 1 dose of prednisone was taken before dermatology follow-up. Exam revealed grouped vesicles on the buttock and symmetrical groin erythema sparing genitals and buttocks. Valacyclovir was briefly resumed, but rash worsened. Suspecting a drug reaction, valacyclovir was discontinued, prednisone resumed, and famciclovir started. The rash resolved within days, supporting the diagnosis of symmetrical drug-related intertriginous and flexural exanthema (SDRIFE). SDRIFE is a T cell–mediated hypersensitivity reaction that can occur after first exposure to systemic drugs. This case highlights valacyclovir as a potential SDRIFE trigger.

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Systemic treatments outcomes for moderate-to-severe atopic dermatitis in children under 12 years old: 5-year results of PEDISTAD registry study

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Background: Real-world studies offer valuable insights into the long-term effectiveness and safety of systemic therapies in pediatric patients with atopic dermatitis (AD).

Purpose: The objective of this study is to report the long-term effects of systemic therapies on clinician-reported outcomes in children aged <12 years with moderate-to-severe AD enrolled in the PEDISTAD study.

Methods: PEDISTAD (NCT03687359) is an ongoing, international, observational 10-year registry for patients with moderate-to-severe AD aged <12 years at enrollment, who were receiving/were candidates for systemic treatment. Endpoints included the mean Eczema Area and Severity Index (EASI) total score and the percentage affected body surface area (BSA) for patients receiving dupilumab, methotrexate (MTX), and cyclosporine (CsA). The number of adverse events (AEs) and discontinuations was also evaluated. Data are presented as observed.

Results: In this 5-year (2019–2024) interim analysis, 360, 152, and 151 patients received dupilumab, MTX, and CsA, respectively. At first and last observation, the mean EASI (standard error [SE]) for dupilumab, MTX, and CsA were 17.7 (0.8) and 4.4 (0.3), 16.8 (1.1) and 7.5 (0.8), and 18.8 (1.0) and 14.3 (1.2), respectively. Mean percentage BSA (SE) at first and last observation for dupilumab, MTX, and CsA were 35.0 (1.4) and 12.1 (0.9), 34.0 (1.8) and 17.3 (1.8), and 39.6 (1.9) and 31.8 (2.4), respectively. The percentage of patients reporting AEs and serious AEs treated with dupilumab, MTX, and CsA were 28.8% and 1.4%, 28.6% and 0.6%, and 31.4% and 2.0%, respectively. For dupilumab, MTX, and CsA, the cumulative discontinuation rates were 31.6%, 71.1%, and 88.7%, respectively; and the mean (standard deviation [SD]) treatment exposure was 21.3 (17.4), 20.2 (16.9), and 13.6 (13.2) months, respectively. Safety was consistent with the known dupilumab safety profile.

Conclusion: Patients aged <12 years treated with dupilumab had a numerically greater improvement in clinician-reported AD signs and lower discontinuation rates compared with MTX and CsA.

Unraveling ulcerations: best practices in infantile hemangioma management

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Background: Infantile hemangiomas are the most common vascular tumors of infancy with an incidence rate of around 4%. Treatment is typically reserved for complicated infantile hemangiomas (approximately 15% of all). Complications include: those with imminent obstruction (eyes/nose), ulceration, or concern for permanent disfigurement. Currently, there are limited guidelines for the appropriate treatment and management of pediatric ulcerated hemangiomas.

Purpose: Provide treatment options, preventative measures, and clinical pearls for the specific patient population of infants less than 1 year old with ulcerated hemangiomas

Methods: Case studies will be displayed to further explain patient presentation and treatment implementation.

Results: Patients are less than 1 year old, presenting with moderate-to-large ulcerative hemangiomas. Our treatment steps were implemented and include medications, patient education, and wound care management. Photos show healed ulcerations.

Conclusion: Highlight the significance of following appropriate treatment and recommend management to provide best practice for infant ulcerated hemangiomas. Ulcerated hemangiomas are a time-sensitive condition that are difficult to treat. Therefore, having a source with concise guidelines would be helpful, especially for a newer dermatology provider. NPPA