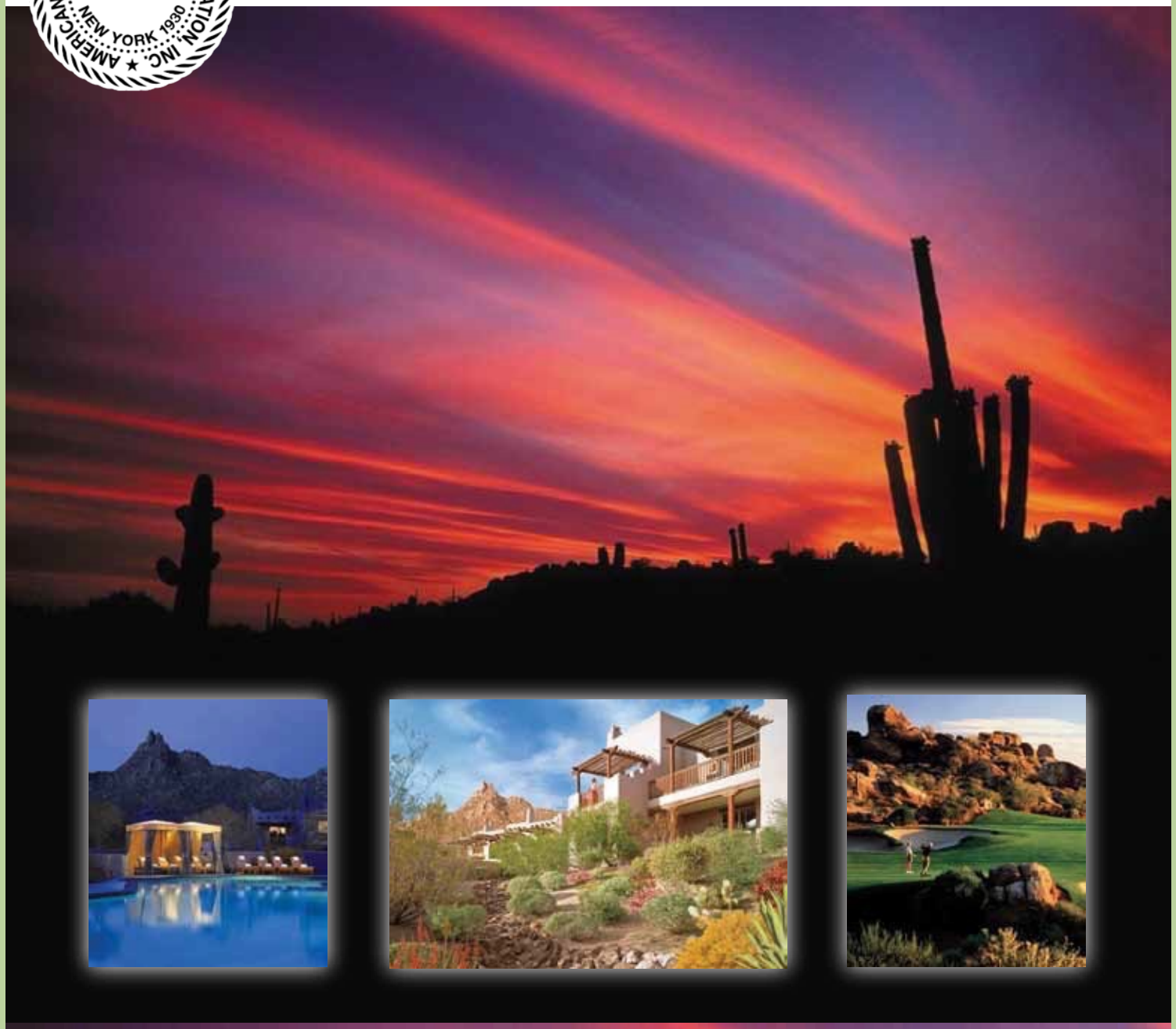
AMERICAN DERMATOLOGICAL ASSOCIATION



Program & Registration Information

PROGRAM OVERVIEW

Wednesday, September 18, 2013

8:00 am	**BOARD OF DIRECTORS MEETING AND BREAKFAST**	**MONUMENT**
12:00 pm – 1:30 pm	**BOARD AND GUEST LUNCH**	
4:00 pm – 7:30	**REGISTRATION**	**MESQUITE**
6:00 pm – 8:00 pm	**OPENING RECEPTION** DRESS: CASUAL	**SAGUARO BLOSSOM**

Thursday, September 19, 2013

7:00 am – 1:00	**REGISTRATION**	**IRONWOOD FOYER**
7:00 am– 8:00 am	**CONTINENTAL BREAKFAST FOR ADA MEMBERS**	**IRONWOOD FOYER**
7:30 am	**FIRST EXECUTIVE SESSION AND INDUCTION OF NEW MEMBERS**	**IRONWOOD A, B & C**
7:30 am	**Opening Remarks** *Eugene A. Bauer, MD, Secretary-Treasurer*	
7:45 am	**Induction of New Members: Active, Honorary, and International Honorary Members** *Rex Amonette, MD, President*	
8:30 am	**PRESIDENTIAL ADDRESS: THE FAMILY OF DERMATOLOGY** *Rex Amonette, MD, President*	
9:00 am – 9:20 am	**MEMBER BREAK**	**IRONWOOD FOYER**
9:20 am – 9:50 am	**YOUNG LEADERSHIP AWARD AND LECTURE** **"Skin Dendritic Cells and Cutaneous Immune Responses"** *Daniel Kaplan, MD, PhD*	**IRONWOOD A, B & C**

Daniel Kaplan, MD, PhD is Associate Professor in the Department of Dermatology at the University of Minnesota. He is a general medical dermatologist and has a strong basic science research interest. His research focuses on cutaneous immunology with a particular interest on the function of skin dendritic cells. During his residency/research fellowship at Yale University under the tutelage of Drs. Robert Tigelaar, Richard Edelson and Mark Shlomchik, he developed several unique mouse models that allowed for the study of skin dendritic cells in vivo. He was awarded Career Development Awards from the Dermatology Foundation as well as the NIH. At the University of Minnesota, he has been awarded the Dr. Al Zelickson Family Endowed Professorship in Dermatology. He currently runs a NIH funded laboratory that focuses on the basic mechanisms of skin immunology. His goal is to better understand the mechanisms of immune-mediated skin disease in an effort to prevent its onset and devise novel therapeutics.

9:50 am	**Questions/Comments**	
10:00 am – 11:15 am	**THURSDAY, FIRST SCIENTIFIC SESSION** **PROCEDURAL AND AESTHETIC DERMATOLOGY** *Session Moderator: Mary E. Maloney, MD*	**IRONWOOD A, B & C**
10:00 am	**Reconstruction Advances in Dermatologic Surgery** *Jeremy Bordeaux, MD, MPH **	
10:15 am	**Facial Reconstruction with Fillers and Neurotoxins** *Cheryl Burgess, MD **	
10:30 am	**Geriatric Generational Dermatology — A Model for Prevention** *Wendy Roberts, MD **	
10:45 am	**Lasers for Scars** *Keyvan Nouri, MD **	
11:00 am	**Aesthetic Complications: Physicians, Nonphysicians and the Law** *Mathew Avram, MD, JD **	
11:15 am – 11:30 am	**Questions/Comments**	

11:30 am – 1:00 pm	**THURSDAY, SECOND SCIENTIFIC SESSION** **BENCH TO THE BEDSIDE** *Session Moderator: Alice Pentland, MD*	**IRONWOOD A, B & C**
11:30 pm	**The Magic and Mayhem of Skin Resident T-cells** *Rachael Clark, MD, PhD **	
11:45 pm	**Genetic Testing in Dermatology** *Sharon Glick, MD*	
12:00 pm	**Psoriasis: Getting to the Heart of the Matter** *Joel Gelfand, MD, MSCE **	
12:15 pm	**A Tale of 2 Cytokines and Severe Inflammatory Disease** *Lars French, MD*	
12:30 pm	**Questions/Comments**	
12:45 pm	**SESSION ADJOURNS**	

OPTIONAL AFTERNOON ACTIVITY

1:30 pm	**MIM MUSICAL INSTRUMENT MUSEUM GUIDED TOUR** **Buses Depart at 1:30 pm SHARP!** (Pre-registration and payment required)	**Meet at parking lot in front of hotel lobby for transportation.**

EVENING ACTIVITY

6:00 pm - 10:00 pm	**DINNER HONORING NEW MEMBERS AND SPOUSES/GUESTS**	**IRONWOOD TERRACE**
	All ADA Members and Registered Guests (Attire: Western Wear - optional)	
6:00 pm	**Reception** Introduction of New Members and Spouses/Guests	
7:00 pm	**Dinner**	

* *New Member*

Friday, September 20, 2013

		IRONWOOD FOYER
7:00 am – 1:00 pm	**REGISTRATION** **CONTINENTAL BREAKFAST FOR ADA MEMBERS**	**IRONWOOD FOYER**
7:00 am – 8:00 am	**SECOND EXECUTIVE SESSION** **Election of Officers and Director** *Rex Amonette, MD, President*	**IRONWOOD A, B & C**
7:45 am – 9:00 am	**FRIDAY, FIRST SCIENTIFIC SESSION DRUGS AND DISEASES** *Session Moderator: Erik Stratman, MD*	**IRONWOOD A, B & C**
7:45 am	**Antibiotic Resistance 2013** *David Longworth, MD, Guest Speaker*	

David L. Longworth, MD, is Chair of the Medicine Institute at Cleveland Clinic. He received his undergraduate degree from Williams College and his medical school degree from Weill Cornell University Medical College. He completed training in Internal Medicine at the University of California in San Francisco followed by fellowship training in Infectious Diseases at Harvard Medical School and Brigham and Women's and Beth Israel Hospitals. Dr. Longworth joined the Cleveland Clinic in 1986 as a staff physician in the Department of Infectious Diseases. From 1992–2002 he served as Chair of the Department. He subsequently moved to Baystate Medical Center, the western campus of Tufts University School of Medicine, where he served as Chair of the Department of Medicine and as Professor and Deputy Chair of the Department of Medicine at Tufts University School of Medicine. He returned to the Cleveland Clinic as Chair of the Medicine Institute in 2011, where he also serves as the Team Lead to develop and execute the Clinic's Value-based Healthcare Strategy.

8:00 am	**The Future of Topical Therapy in Psoriasis** *Linda Stein-Gold, MD**
8:15 am	**Demodicosis: The Almost Forgotten Dermatosis** *Barbara Wilson, MD **
8:30 am	**The Names of Syphilis** *Carlo Gelmetti, MD **
8:45 am	**Questions/Comments**
9:00 am - 9:30 am	**BREAK** **IRONWOOD FOYER**
9:30 am – 12:20 pm	**FRIDAY, SECOND SCIENTIFIC SESSION POLICY AND POLITICS** **IRONWOOD A, B & C** *Session Moderator: Daniel Siegel, MD* **(OPEN TO MEMBERS, SPOUSES AND GUESTS)**
9:30 am	**Healthcare Reform and Accountable Care Organizations: What's Next?** *David Longworth, MD*
10:10 am	**Healthcare Reform and ACOs: What Dermatologists Can Expect** *Kathryn Schwarzenberger, MD*
10:25 am	**Questions/Comments**
10:40 am	**Health Care Reform** *Jack Resneck, Jr, MD*

* *New Member*

Friday, September 20, 2013 CONTINUED

11:20 am	**Questions/Comments**
11:35 am	**Practical Approach to Maintenance of Certification: Life Timer or Not** *Erik Stratman, MD*
12:05 pm	**Questions/Comments**
12:20 pm	**SESSION ADJOURNS**

OPTIONAL AFTERNOON ACTIVITIES (Pre-registration and payment required)

1:30 pm	**ADA GOLF TOURNAMENT (box lunch included)**	**MONUMENT COURSE AT TROON**
1:30 pm	**ADA ROUND ROBIN TENNIS TOURNAMENT**	**TENNIS COMPLEX AT THE SPA**
	***FRANK LLOYD WRIGHT'S TALIESIN WEST** Considered one of Wright's greatest masterpieces, Taliesin West, his world famous home was literally created out of the desert, with rocks and sand to keep the design in balance with the surrounding environment.	**Meet at parking lot in front of hotel lobby for bus transportation.**
	***First Tour – Buses leave at 1:30 pm sharp** ***Second Tour – Buses leave at 3:00 pm sharp** Please check your registration packet for your tour time.	

Saturday, September 21, 2013

7:00 am – 1:00	**REGISTRATION**	**IRONWOOD FOYER**
7:00 am – 8:00 am	**FIRST 5-YEAR MEMBER BREAKFAST SESSION** Note: This session limited to ADA members elected from 2009-2013 and Board members to discuss issues of common interest.	**TROON A & B**
7:00 am – 8:00 am	**CONTINENTAL BREAKFAST FOR ADA MEMBERS**	**IRONWOOD FOYER**
7:30 am – 11:15 am	**SATURDAY, FIRST SCIENTIFIC SESSION**	**IRONWOOD A, B & C**

DERMATOLOGY POTPOURRI
Session Moderator: James Grichnik, MD

7:30 am	**Is the Message Getting Through to the Youth of Today to Save their Skin?** *James Butler, MD*
7:45 am	**Improving Melanoma Risk Assessment Among Low Risk and High Risk Individuals** *David Polsky, MD, PhD **
8:00 am	**Crystalline Structures In Pigmented Lesions** *Ashfaq Marghoob, MD **
8:15 am	**Indoor Tanning Devices: Still a Burning Issue** *Jason Rivers, MD **
8:30 am	**Cutaneous T Cell Lymphoma: Beyond Mycosis Fungoides** *John Zic, MD **
8:45 am	**How the Skin Protects Itself** *Theodora Mauro, MD **
9:00 am	**Using the Skin to Modulate Systemic Immunity** *Jan Dutz, MD, FRCP **
9:15 am	**Role of Clinic-Pathologic Correlation in Skin Disease** *Jag Bhawan, MD **
9:30 am	**Questions/Comments**
9:45 am – 10:15 am	**MEMBER BREAK**
10:15 am	**Update in Elastic Tissue Disorders** *Leslie Robinson-Bostom **
10:30 am	**Hamartomas and Hair Follicle Regeneration** *Thomas Darling, MD, PhD **
10:45 am	**The Hair Follicle and Beyond** *Ulrike Blume-Peytavi, MD*
11:00 am	**Challenging Issues in Fractional Laser Resurfacing** *Jorge Ocampo-Candiani, MD **
11:15 am	**Alternatives in Skin Lightening — In Quest for the Truth** *Evangeline Handog, MD **
11:30 am	**Natural Retinoids for the Treatment of Aging Skin** *Dana Sachs, MD **

Session continued on next page

** New Member*

Saturday, September 21, 2013 CONTINUED

11:45 am **ADA History Update — Daisy Orleman Robinson, the First American Woman Dermatologist**

David Pariser, MD

Discovered in the ADA Archives: A woman dermatologist from New York who was a contemporary of Rose Hirschler. Careful research has indicated that Daisy Orleman Robinson preceded Rose Hirschler as the first documented woman dermatologist in the U.S. This presentation will introduce you to this most interesting woman and her career in dermatology.

12:05 pm – 12:55 pm **SATURDAY, SECOND SCIENTIFIC SESSION** **IRONWOOD A, B & C**

FIVE-MINUTE WOW SESSION

Session Moderator: Kenneth Tomecki, MD

The following ADA members have generously agreed to give us 5 minutes of their best: it may be an incredible case, what made them famous, a blunder that they learned from, a scientific breakthrough, an epiphany, a pearl, their all-time favorite patient/case/disease story in dermatology, or anything else that they wish to WOW us with.

William Abramovits, MD
Robert Brodell, MD
Erin Boh, MD
Brett Coldiron, MD
Jane Grant-Kels, MD
Kenneth Greer, MD
Stephen Mandy,
Ronald Moy, MD
Joyce Rico, MD
James Taylor, MD

OPTIONAL AFTERNOON ACTIVITY (Pre-registration and payment required)

2:00 pm – 4:30 **NEIGHBORHOOD BICYCLE TOUR** **MEET AT PARKING IN FRONT OF HOTEL LOBBY**

EVENING ACTIVITIES

Photo Session for New Members, Spouses and Board of Directors
(Attendance required) Pinnacle C - 5:30 pm SHARP!

President's Cocktail Reception & Dinner Dance

Attire: Black Tie

6:00 pm – 7:00 pm **President's Cocktail Reception** *(Pinnacle Foyer)*

7:00 pm **President's Dinner / Dance** *(Pinnacle Ballroom)*

Sunday, September 22, 2013

7:30 am – 11:00 am	**REGISTRATION**	**IRONWOOD FOYER**
7:30 am – 8:30 am	**BOARD OF DIRECTORS MEETING**	**VERDE**
	FAREWELL BREAKFAST BUFFET	**BOARDROOM**
	(ADA MEMBERS SPOUSES AND GUESTS)	
8:00 am – 9:50 am	**SUNDAY SCIENTIFIC SESSION**	**IRONWOOD A, B & C**
	WHAT'S NEW IN…..	
	Session Moderator: Michael Tharp, MD	
8:00 am	**Medical Dermatology**	
	Jeffrey Callen, MD	
8:25 am	**Procedural Dermatology**	
	Mary Maloney, MD	
8:50 am	**Pediatric Dermatology**	
	Elaine Siegfried, MD	
9:15 am	**Dermatopathology**	
	Evan Farmer, MD & Antoinette Hood, MD	
9:40 am	**Questions/Comments**	
9:55 am	**THIRD EXECUTIVE SESSION (ADA MEMBERS)**	**IRONWOOD A, B & C**
	Proposed New Members for 2014	
	Eugene Bauer, MD, Secretary-Treasurer	
	Suggestions for Next Year's Scientific Program	
10:25 am	**MEETING CONCLUDES**	

THE FOUR SEASONS, SCOTTSDALE, AZ
Thursday, September 19, 2013
8:00 AM - First Executive Session

Call Meeting to Order
Establishment of a Quorum
Report of the Board of Directors
Report of the Secretary-Treasurer
Report of the Historian
Report of the Nominating Committee
Report of the Committee on Membership

Introduction of New Active Members

Mathew Avram, MD	Boston, Massachusetts
Jag Bhawan, MD	Boston, Massachusetts
Jeremy S. Bordeaux, MD, MPH	Shaker Heights, Ohio
Cheryl M. Burgess, MD, FAAD	Washington, DC
Rachael A. Clark, MD, PhD	Boston, Massachusetts
Thomas N. Darling, MD, PhD	Rockville, Maryland
John P. Dutz, MD, FRCPC	Vancouver, Canada
Joel M. Gelfand, MD, MSCE	Penn Valley, Pennsylvania
Sharon Glick, MD, MS	New York, New York
Daniel H. Kaplan, MD, PhD	Minneapolis, Minnesota
Ashfaq Marghoob, MD	New York, New York
Theodora M. Mauro, MD	San Francisco, California
Keyvan Nouri, MD	Miami, Florida
David Polsky, MD, PhD	Ardsley, New York
Jason K. Rivers, MD, FRCPC	Vancouver, BC, Canada
Leslie Robinson-Bostom, MD	Chepachet, Rhode Island
Wendy E. Roberts, MD	Rancho Mirage, California
Dana L. Sachs, MD	Ann Arbor, Michigan
Linda F. Stein-Gold, MD	Bloomfield Hills, Michigan
Barbara Braunstein Wilson, MD	Charlottesville, Virginia
John A. Zic, MD	Nashville, Tennessee

Introduction of New International Members

James M. Butler, MB, BS	Melbourne, Australia
Lars French, MD	Zurich, Switzerland
Carlo Gelmetti, MD	Milan, Italy
Evangeline Handog, MD	Paranaque City, Philippines
Ulrike Blume-Peytavi, MD	Berlin, Germany
Jorge Ocampo-Candiani, MD	Monterrey, N.I., Mexico

Honorary Membership Recipients
Arthur Eisen, MD and Irma Gigli, MD

Unfinished Business

New Business

Adjournment

Matthew Avram, MD, JD

Aesthestic Complications: Physicians, Nonphysicians and the Law

Legal actions regarding lasers, light sources and other aesthetic procedures: an analysis of the US national data from 1985-2012 as it pertains to physicians as well as nonphysician extenders

Claims related to cutaneous laser surgery and other aesthetic procedures are increasing and result in indemnity payments that exceed the previously reported average across all medical specialties. From 1985 to 2012, there were 174 cases related to injury stemming from cutaneous laser surgery identified in a search of online public legal documents using a national database. The incidence of litigation related to laser surgery shows an increasing trend, with peak occurrence in 2010. Laser hair removal was the most common litigated procedure. Nonphysician operators accounted for the majority of these cases, with their physician supervisors named as defendants, despite not performing the procedure. Significantly, there has been a dramatic increase in claims related to nonphysicians performing these procedures. In fact, the incidence of legal action against nonphysicians doubled in a four-year period and now represents the large majority of such claims. This dramatic increase has tremendous implications for patient safety for elective cosmetic procedures. State law governs who may legally perform such procedures. These laws vary state to state. Nonphysicians performing these procedures will be held to a standard of care corresponding to an individual with appropriate training. If the nonphysician is employed by a physician, the physician is ultimately legally responsible for the actions of their nonphysician employees.

Jag Bhawan, MD

Role of Clinicopathologic Correlation in the Practice of Clinical Dermatology

The correlation of pathologcal findings with clinical data is crucial in arriving at a correct diagnosis and for proper patient management. Clinico-pathological Correlation (CPC) through open access dialogue between the clinician and the dermatopathologist is essential for the practice of dermatology and dermatopathology. Lack of or incorrect information can lead to improper diagnosis and therefore bad outcome for the patient. The importance of CPC through the discussion of cases collected over the span of many years in my academic practice as a dermatologist and a dermatopathologist in the greater Boston area will be presented. Attendees would know how to avoid common CPC associated pitfalls and how to better communicate with the dermatopathologist to improve patient care.

Ulrike Blume-Peytavi, MD

The Hair Follicle and Beyond

The human hair follicle, highly developed biological autonomous machinery with individual self-renewing capacities, produces keratin fibers possessing an incredible symbolic power for attractiveness, strength, gender definition, as well as emotional and physical well-being.

Today, the pilosebaceous unit is exemplary in successful translational research with the human being still remaining the best model to study and investigate hair cycling and growth behaviour. Targeted follicular delivery, using the unique role of hair follicle pathways in percutaneous penetration with drug delivery systems, has opened a new dimension in the development of hair growth therapeutics and adjacent indications such as transfollicular vaccination strategies.

Advances in experimental and clinical research enable us today to offer our patient innovative diagnostic tools and new testing devices and procedures. These in turn enable us today to validate and quantify efficiently new candidate molecules for treating hair disorders. Trichology today incorporates evidence-based guidelines established for the management of androgenetic alopecia, alopecia areata and hirsutism.

Cheryl Burgess, MD

Facial Reconstuction with Fillers and Neurotoxins

Facial defects are typically congenital in nature, the result of trauma or medical conditions and tumor extirpation and produce troubling cosmetic and functional morbidities for the patient if the appropriate reconstructive paradigm is not embraced. As the scope of treatment options expands, the advances in product technology, injection techniques and a better understanding of patients' needs have led dermatologists to think differently about non-invasive facial restoration. The use of neuromodulators and soft tissue augmentation in facial wasting, deformities and disfigurement in patients with complex medical conditions have become a safe and acceptable reconstruction options for patients.

Jeremy Bordeaux, MD, MPH

Reconstruction Advances in Dermatologic Surgery

"Flaps and Grafts in Dermatologic Surgery" written by Theodore Tromovitch, Samuel Stegman, and Richard Glogau was published in 1989. Groundbreaking for its time, this textbook help to introduce the concepts and groundwork for the sophisticated reconstructions dermatologic surgeons perform today. I will present some of my reconstructive cases that represent how far we have come in such a short period of time.

James Butler MD, FACD, FRACP, FRCP

Is the Message Getting Through the Youth of Today about Saving Their Skin

Considerable progress has been made in the education of High School students (up to the age of 18), in the area of sun protection, through various publicity campaigns; not so in the 18-25 year olds.

Sun exposure as evidence by recent sunburn and the use of solaria, is highest in this group.

Fortunately, in the State of Victoria, solaria will be banned from the end of 2014.

Fashion, including the trend to have shaved heads, increases sun exposure to scalp and the risk of SCC. Beards fortunately protect.

The medium to long term ageing effect of the sun is inevitable and often unglamorous. This message needs to be emphasized along with the risk of skin cancer.

Whilst the short term risks of tattoos are few, many individuals regret having them. The belief that even very large tattoos can be easily removed seems to be prevalent. Like sun damaged skin, tattoos do not improve with age.

More information needs to be available through channels other than traditional media.

Rachael A. Clark, MD, PhD

On Site Immunity: Resident Memory T Cells in Human Skin

Memory T cells are now known to accumulate both in blood and within peripheral tissues. Neonatal human skin has no T cells but by adulthood, human skin contains 20 billion T cells. We have found non-recirculating resident memory T cells in skin that are highly effective in protecting against infection, even in the absence of circulating T cells. T cells tropic for particular tissues (gut, lung or skin) are specific for the pathogens commonly encountered through that tissue. Human skin resident T cells have remarkable effector functions-up to 70% can produce IL-17, IL-9 producing Th9 cells amplify other T cell responses, and regulatory T cells are highly immunosuppressive. These resident T cells play critical roles in defending the skin but they can also contribute to the skin diseases-aberrant Th17 activation can lead to psoriasis, IL-9 producing T cells are found in atopic dermatitis lesion and regulatory T cells are recruited by squamous cell carcinomas to evade immune destruction. Human skin resident T cells have a unique biology distinct from that of T cells isolated from the blood. A better understanding of resident memory T cell biology may lead to novel therapies for inflammatory disease, autoimmunity and skin cancer.

Thomas Darling, MD, PhD

Hamartomas and Hair Follicle Regeneration

Hamartomas are benign growths composed of cells normally found in the tissue but in abnormal number and pattern. Angiofibromas are hamartomas that occur as solitary lesions in the general population or as numerous lesions in tuberous sclerosis complex (TSC). The pathogenesis of angiofibromas has been debated over the years, with most people in the past 5 decades emphasizing the connective tissue component rather than hair follicle involvement. In developing a xenograft mouse model for TSC skin tumors, we found that fibroblasts grown from angiofibromas were capable of inducing *de novo* hair follicle neogenesis in dermal-epidermal composites grafted to immunodeficient mice. These results suggest that the pathology of angiofibromas results from a suspended state of tissue morphogenesis, and provide important clues for enhancing skin regeneration.

Jan Dutz, MD, FRCPC

Using the Skin to Manipulate Systemic Immunity

The skin is replete with immune cells and immunologically active cells. The skin is also an accessible organ and the immune environment of the skin can easily be manipulated with topical agents. My laboratory has explored the use of the skin immune system to improve traditional vaccine outcomes and to develop antigen specific tolerance. We have demonstrated that topical toll like receptor agonists can alter and improve immune responses to standard vaccination in mouse models and in humans. Conversely, pre-treatment of the skin prior to vaccination with corticosteroids and vitamin D analogues as well as phototherapy can induce antigen specific tolerance. A better understanding of the immune effects of topical therapy can be used to improve the treatment of inflammatory disorders and in the prevention of infectious and malignant disease. Insights from the manipulation of the skin immune system can also lead to a better understanding of systemic and cutaneous autoimmune diseases.

Lars French, MD

A Tale of 2 Cytokines and Severe Inflammatory Disease

The Fas receptor (CD95), a cell surface death receptor regulates one of the two major cell suicide (apoptosis) pathways. Investigative dermatology has established a link between Fas-signaling and Toxic Epidermal Necrolysis (TEN, Lyell's syndrome). Indeed, necrolysis of the epidermis in TEN, is at least partly due to massive Fas-mediated keratinocyte cell death by apoptosis, and recent studies provide evidence of a molecular link between the culprit drug, drug specific T-cells and the onset of FasL-mediated keratinocyte apoptosis, as well as a rationale for experimental therapy with high-dose intravenous immunoglobulin.

Autoinflammatory diseases - a newly classified subset of diseases that are pathogenetically and clinically distinct from allergic or autoimmune diseases - are characterized by seemingly unprovoked episodes of inflammation, frequent presence of sterile neutrophilic tissue inflammation and dysregulation of IL-1 beta. New data provides a link between autoinflammation and selected severe inflammatory diseases with skin involvement, and targeting IL-1 beta signaling provides new means for controlling them. This tale of 2 cytokines in severe inflammatory diseases illustrates how translational research in dermatology can lead to new therapeutic possibilities.

Joel M. Gelfand MD MSCE

Abstract for ADA meeting "Psoriasis: Getting to the Heart of the Matter"

In the last decade tremendous advances have been made in understanding the relationship between psoriasis and cardiovascular disease. Current studies suggest that psoriasis patients, especially if skin disease is severe, have an increased risk of cardiovascular disease independent of traditional risk factors. Recent imaging and gene expression studies have provided new insights into the pathophysiology of psoriasis and how it may relate to vascular disease.

Emerging observational studies suggest that methotrexate and TNF inhibitors may hold promise for lowering CV event rates in psoriasis patients. The clinical practice implications of these findings will be highlighted.

Carlo Gelmetti, MD

The Names of Syphilis

The name "syphilis" was coined by Fracastoro in his poem titled *Syphilis sive morbus gallicus* (Latin for "Syphilis or The French Disease") in 1530 because Syphilis was first reported in Europe in 1494 among soldiers involved in a war between France and Naples that explain why the French called it the *Mal de Naples* or *Mal Napolitain* (French for "Neapolitan disease") The protagonist of the poem is a shepherd named Syphilus In addition, the Dutch called it the "Spanish disease", the Russians called it the "Polish disease" and the Turks called it simply the "Christian disease". These "national" names are clear examples of xenophobia. In the ancient times syphilis was also called *lues* (Latin from Greek lu-ein= to dissolve). However the Roman authors used the term "lues" for various destructive diseases not necessarily related to sexual behaviour. The old American-Spanish terms *bua* o *buba* are also coming from from Latin (*boa*, according to Pliny, means an eruptive skin diseases)."Patursa" is a (Latin) acronym from: "Passio Turpis Saturnina" that links illicit sex with bad astronomical influxes!

Sharon Glick, MD, MS

Genetic Testing in Dermatology

This session is going to focus on access to genetic testing in dermatology. The application of genetic testing in dermatology includes its potential to risk assessment, diagnosis, prognosis and treatment. One of the biggest challenges in genetic testing is the cost; ironically it can be less expensive to sequence the entire human genome than a single gene or gene family. The implications of genetic testing in dermatology will be illustrated through the use of case examples.

Evangeline Handog, MD

Alternatives in Skin Lightening: In Quest for the Truth

Coming from a tropical country where brown skin is actually beautiful, majority of my Filipina patients prefer to have fairer skin. For a multitude of reasons, one's interest in commercial skin lightening products becomes a hype and therefore hope comes easily as these commodities proliferate in the market and drugstores. They come in the form of creams, pills, soaps or lotions, many of which are bought because of tri-media advertisement or high profile endorsements. Unfortunately, some of these skin lightening agents don't really work or don't have sufficient studies to guarantee efficacy and safety.

A few of the trials on depigmenting agents done at the Research Institute of Tropical Medicine will be shared.

A. TOPICALS, to include tetrahydrocurcumin, indomethacin and rumex
B. Skin lightening agents thru enhanced delivery system, to include tranexamic acid solution via iontophoresis technology, glutathione via iontophoresis and glutathione via mesotherapy C. ORAL, to include Procyanidin and Glutathione.

Daniel Kaplan, MD, PhD

YOUNG LEADERSHIP AWARD RECIPIENT

Skin Dendritic Cells and Cutaneous Immune Responses

Skin-resident dendritic cells (DCs) are well positioned to encounter cutaneous pathogens and neoplasia. In dermis and epidermis there are several ontologically distinct DC subsets (i.e. Langerhans cells and several subsets of dermal DC) that all migrate to skin-draining lymph nodes and can initiate T cell responses. To understand the function of these DC subsets we examined T cell responses to a superficial skin infection with Candida albicans in several lines of mice lacking individual skin DC subsets. We also examined T cells responses when antigen was direct antigen to individual DC subsets using antibody/antigen conjugates. We found that Langerhans cells were both necessary and sufficient for the

development of Th17 responses that control extracellular bacterial and fungal infections. LC also promoted the development of T follicular helper cells (Tfh) that are required for antibody responses. In contrast dermal DC were necessary and sufficient for Th1 responses that are required for anti-viral and anti-tumor responses. These findings demonstrate a division of labor between skin DC subsets that has important implications for vaccine design and disease pathogenesis.

Theodora Mauro, MD

How the Skin Protects Itself

The mammalian epidermis is both an interface and a protective barrier between the organism and its environment. The epidermal barrier is, in fact, several overlapping barriers. These barriers serve to keep water and ions in, toxins and contact allergens out, repel infectious agents, and keep UV from damaging DNA but allow enough UV passage to synthesize vitamin D. Traditionally, the skin barrier has been viewed as a static structure, but it now is clear that active mechanisms are utilized to form the barriers described above. The original lipid barrier now has been shown to be augmented by barriers formed by tight junctions. Further, the epidermal barrier has been shown to sense and respond to immunologic challenges. These combined barriers combine biologic, structural and signaling mechanisms that change with age.

Keyvan Nouri, MD

Lasers for Scars

More than 70 million surgical procedures are performed annually in the US with the majority involving a skin incision. Almost all individuals in their lifetime will have one or more surgical procedures resulting in scars. Patients and surgeons alike are motivated to influence the scarring process and ultimately improve scar cosmesis. Several treatment modalities have been utilized to either alter the scarring process or improve the appearance of well-established scars. Most interventions achieve modest results at best Leaving much to be desired in current scar treatment options. To this end, lasers have been utilized with great success in several types of scars, including hypertrophic, keloidal, and burn scars, among others. This lecture will discuss the use of several different laser and light systems, both ablative and non-ablative for the treatment of scars. Specifically, an in-depth discussion of the use of the pulsed-dye laser (PDL) for surgical scar prevention will be included. Moreover, a special focus on the principles of fractional photothermolysis as they apply to scar remodeling and future scar therapies will be addressed.

Jorge Ocampo-Candiani, MD

Challenging Issues in Fractional Laser Resurfacing

Ablative methods are one of the most popular procedures in cosmetic surgery. CO2 laser has been the Gold Standard for ablative resurfacing of the skin for many years. Side effects as downtime, pain, erythema, redness, risk of infection and hypo or hyperpigmentation are negatively perceived from patients. In response, non-ablative and ablative fractional resurfacing laser techniques have emerged and become very popular, but multiple treatments are required and the results can be underwhelming and unpredictable. Fractional ablative resurfacing is a new laser treatment modality that creates numerous microscopic thermal injury zones of controlled width, depth and density that are surrounded by a reservoir of spared epidermal and dermal tissue, allowing for rapid repair of laser-induced thermal injury. We have found multiple challenging issues with this technology: depth of the condition (superficial or deep),anatomic area to be treated, patient comfort, energy ,density , number of passes, Post-care Indications, complications and how to avoid them. The way we approach each of these challenges will be discussed during this presentation. New methods in minimally-invasive laser technology are giving rise to possible advancements in the treatment of chronically photodamaged skin. It remains to be seen whether the combination of ablative and non-ablative fractional laser techniques will be a breakthrough in efficacy and safety.

David Polsky MD, PhD

Improving Melanoma Risk Assessment Among Low Risk and High Risk Individuals

Identifying individuals at increased risk for melanoma, especially those lacking an increased number of nevi, could potentially improve public health through targeted surveillance and early detection. Using 875 melanoma cases and 765 controls from the Minnesota Skin Health Study we compared the predictive ability of a clinical melanoma risk prediction

model (Model A) to an enhanced model (Model D). Model A used self-reported conventional risk factors including mole phenotype categorized as “nevus-prone” and “nevus-resistant”. Model D added melanocortin-1 receptor (MC1R) genotype and measures of indoor ultraviolet light (UV) exposure to Model A. Model A yielded an area under the receiver operating characteristic (ROC) curve (AUC) of 0.72 (95% CI = 0.69, 0.74). Model D was significantly improved with an AUC=0.74 (95% CI = 0.72 – 0.76, p=0.008).

We also found that the models performed differently in the nevus-prone versus nevus-resistant patient subgroups. These results demonstrate that adding MC1R genotype and UV exposure data to a phenotypic melanoma risk model results in a statistically significant increase in predictive ability.

Jason Rivers, MD, FRCPC

Indoor Tanning Devices: Still a Burning Issue

Annually, nearly 28 million people tan indoors, and 2.3 million of these are teens. These numbers are alarming given that among individuals under the age of 30, tanning bed use may be attributable for up to 75% of cases of melanoma in some populations. Although the exact pathogenesis of melanoma arising from tanning bed use is imprecise, exposure to UVA and UVB radiation is an acknowledged risk factor for all forms of skin cancer. Tanning devices emit a variable combination of high intensity UV light (typically 95% UVA and 5% UVB) to produce a cosmetic effect. In addition to long-term consequences such as photoaging and cutaneous malignancy, immediate adverse events can occur, including burns, infections, and ocular damage; as well, a potential for addictive behavior has been observed. Compounding the dangers of sunbeds is that tanning facilities commonly misinform consumers about associated risks, health benefits, and regulatory guidelines. In meeting this challenge, legislation is appearing in many jurisdictions throughout the US and Canada and, recently, the FDA poignantly selected Melanoma Monday in 2013 to propose strengthening of its regulation on sunlamp products to Class II (moderate risk device) designation and recommend against tanning bed use by minors under age 18.

Wendy Roberts, MD

Geriatric Generational Dermatology – A Model for Prevention

The term *geriatrics* comes from the Greek γέρων *geron* meaning "old man" and ιατρός *iatros* meaning "healer". Geriatrics differs from standard adult medicine because it focuses on the unique needs of the elderly person. The aged body is different physiologically from the younger adult body, and during old age, the decline of various organ systems becomes manifest. Previous health issues and lifestyle choices produce a different constellation of diseases and symptoms in different people.

Increased complexity

The decline in physiological reserve in organs makes the elderly develop some kinds of diseases and have more complications from mild problems (such as dehydration from a mild gastroenteritis). Multiple problems may compound: A mild fever in elderly persons may cause confusion, which may lead to a fall and to a fracture of the neck of the femur ("breaking her/his hip").

Usually, a familial generation is defined as the number of years equivalent to the average age of a mother at the times she has her children, which for the sake of convenience is traditionally regarded as 25 years; in short, a generation is 25 years.

Some define a familial generation as the average time between a mother's first offspring and her daughter's first offspring. Alternatively, the average generation length has been determined by the average age of women at first birth. In 2010, this number was 25.4 years old in the United States.

- The Lost Generation, also known as the *Generation of 1914* in Europe,[18] is a term originating with Gertrude Stein to describe those who fought in World War I. The members of the lost generation were typically born between 1883 and 1900.
- The Greatest Generation, also known as the *G.I. Generation*, is the generation that includes the veterans who fought in World War II. They were born from around 1901 through 1924, coming of age during the Great Depression. Journalist Tom Brokaw dubbed this the *Greatest Generation* in a book of the same name.
- The Silent Generation, also known as the "Lucky Few", were born 1925 through 1942.. Generally recognized as the children of the Great Depression, this event during their formative years had a profound impact on them.
- The Baby Boomers are the generation that was born following World War II, generally from 1946 up to 1964, a time that was marked by an increase in birth rates.
- Generation X is generally defined as those born after the Post–World War II baby boom ended. Demographers, historians and commentators use beginning birth dates from the early 1960s to the early 1980s.
- Generation Y, also called "Millennials" describes the generation following Generation X. early 1980s to the early 2000s.
- Generation Z or Tween is a name used (although other terms exist) for the cohort of people born from the early 2000s to the present day who are distinct from the preceding Millennial Generation.

Leslie Robinson-Bostom, MD
Update in Elastic Tissue Disorders

Elastic fibers are integral components of dermal connective tissue that are required for normal structure and function of the skin. Elastic tissue disorders are a group of rare inherited or acquired disorders that can be categorized into those with increased, decreased or degenerated elastic tissue. In this session, I will discuss several rare, more recently described elastic tissue disorders that mimic the primary lesions of pseudoxanthoma elasticum and Buschke-Ollendorff Syndrome. These include late onset focal dermal elastosis, pseudoxanthoma elasticum-like papillary dermal elastolysis, white fibrous papulosis of the neck, upper dermal elastolysis and papillary dermal elastosis. I will also review disorders resembling anetoderma (macular atrophy) and discuss its updated classification.

Dana Sachs, MD
Natural Retinoids for the Treatment of Aging Skin

Topical retinoids are used to combat aging skin. Of all available therapies to mitigate against the signs of aging, they have the most data supporting their use.

I will discuss the mechanisms by which topical retinoids work to improve skin's appearance. The natural retinoids retinol, retinaldehyde, retinoic acid and retinyl esters will be reviewed with respect to their relationship to each other. Though many cosmeceuticals contain a "retinoid" there are many reasons why certain preparations may not be effective. The use of retinol for aged skin will be discussed and why it may be the "best" natural retinoid. Retinoid dermatitis is the greatest limiting factor in topical retinoid use and leads to poor compliance for many patients. Though the mechanism of retinoid dermatitis is well understood, measures to eliminate it are not widely used. Ongoing research in our department to help determine optimal dosing and frequency regimens as well as ways to prevent the predictable irritation are underway.

Linda Stein-Gold, MD
The Future of Topical Therapy for Psoriasis

Psoriasis is caused by an aberrant immune system and responds to drugs that suppress the body's immune response. As our understanding of the pathogenesis increases, we are able to develop drugs that specifically target the immunologic abnormalities. Over 80% of our psoriasis patients have localized disease. The gold standard for treatment of mild to moderate disease remains topical therapy. Exciting technology holds promise to develop topically applied treatments with selective mechanisms of action and minimal systemic risks.

Barbara Wilson, MD
Demodicosis

Demodicosis is a group of rashes attributed to the follicle mite Demodex folliculorum. The most common demodicosis is pityriasis folliculorum (PF).

PF, described in 1930 by Samuel Ayres, presents as varying degrees of facial erythema, minute follicular papules and pustules, and follicular hyperkeratosis. Skin scrapings reveal numerous Demodex mites. Patients frequently complain of itching, burning and dry sensitive skin. Thirty years later, Dr. Ayres and his son wrote another article about demodicosis which they state was prompted by the "non recognition by many dermatologists" of this common entity.

I frequently see patients whom I diagnose to have Demodicosis. Many of these patients have been seen by dermatologists, have been diagnosed to have rosacea and have failed conventional rosacea treatment.

I present a patient with PF not only to remind dermatologists to think of this often forgotten condition when seeing patients with rosacea-like eruptions, but also to highlight a simple, effective treatment which has been used at the University of Virginia for many decades to treat patients with demodicosis.

John A. Zic, MD

Cutaneous T cell Lymphoma: Beyond Mycosis Fungoides

The cutaneous T cell lymphomas (CTCL) are a heterogeneous group of malignancies of the T cell where the skin is the primary organ of involvement. From Alibert's first description of mycosis fungoides (MF) in the early 1800's to the molecular genetics of the 21st century, dermatologists have played a pivotal role in the classification, diagnosis and management of CTCL. Because the variants of CTCL may mimic many common dermatoses, dermatologists need to recognize the cutaneous clues and the appropriate steps to confirm or rule out CTCL. Though classical MF is the most common type of CTCL, several variants of MF should be recognized: granulomatous slack skin, pagetoid reticulosis, and folliculotropic MF. Lymphomatoid papulosis and primary cutaneous anaplastic large cell lymphoma are part of the spectrum of CD30 lymphoproliferative disorders, a subgroup of CTCL with usually an excellent prognosis. Another emerging variant with an excellent prognosis is CD4+ small/medium pleomorphic CTCL. In contrast, there are several variants with a poorer prognosis including the clinically distinct Sézary syndrome, gamma-delta CTCL, and CD8+ epidermotropic cytotoxic CTCL.

In Memoriam

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134th ANNUAL MEETING

October 8th – October 12th, 2014
The Williamsburg Lodge
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See you there!