

Community Panel Meeting, Jan 23rd, 2023 Final Summary Report

Meeting Summary

MUHC COE AD: A-Topics Community Panel

January 23, 2023

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| **Participants** |  |
| **Dr. Kerri Purdy** (Meeting Co-chair)**Dr. Vimal Prajapati** (Meeting Co-chair)**Dr. Carolyn Jack, MD Dr. Yuka Asai****Dr. Catherine Besner-Morin Dr. Marc Bourcier****Dr. Chuck Lynde Dr. Lisa Iannattone****Dr. Rachel Asiniwasis Dr. David Adams****Dr. Marissa Joseph** | **Rohit Khanna** (Catalytic Health, Meeting Facilitator)**Patricia Jaroslawski** (Medical Writer) |

# Topic 1 Atopic Dermatitis: A Disease of Childhood?

Scientific Panel Lecturer: Aaron Drucker

Community Panelist: Yuka Asai, MD, MSc, PhD, FRCPC, DABD

# Comments Regarding Key points for: Dermatology Trainees

* Dr. Asiniwasis suggested writing out abbreviations for trainees (e.g., MF - Mycosis fungoides) at the bottom of each slide. Dr. Purdy agreed.

# Comments Regarding Key points for: General Practitioners

* Dr. Asai commented that she does not expect General Practitioner’s (GPs) to know, for example, the risk factors for AD
* Dr. Besner-Morin agreed, that saying that it was a very good point as patients and that GPs do not know what she is referring to when she says “atopic dermatitis” and tend to think that all eczema is the same
* Dr. Asiniwasis and Dr. Purdy agreed, with Dr. Purdy commenting that she tries to say “eczema coming from the inside or eczema triggered from something outside (i.e., ACD)” when talking to patients

# Comments Regarding Key points for: Adults and Adolescents

* Dr. Asai commented that the information is the same for each group, however the delivery is different

# Comments Regarding What Added Information is Needed

* Dr. Asai commented, in addition to the bullet on the slide:
	+ Regarding the variable nature of AD that GPs may not understand that they are seeing a snapshot of the patient’s AD on that particular day which may not reflect the severity of the disease
	+ Regarding how much steroid to use, she noted that patients may not be getting the information from the GP on how much they should be using therefore the GPs need more practical information to share with patients
* Participants commented:
	+ Dr. Purdy agreed, saying that patients might be furthered confused by instructions received at the pharmacy also
	+ Vimal H. Prajapati commented that pharmacists may frighten patients with warnings regarding steroids, even if the prescription is for a low potency steroid such as hydrocortisone valerate 0.2% cream
	+ Dr. Asiniwasis agreed, saying that she finds that the pharmacist often scares patients to sub optimally treat “use very sparingly, only if needed” and perpetuates corticosteroid- phobia

# Comments Regarding Three Points Most Relevant to my Practice/Points Relevant to my Practice Not Found and/or Irrelevant info

* Dr. Asai commented that it should be added that adult AD patients may not have a history or family history of AD and a patient can still have AD without a history of the disease
* Participants agreed with Dr. Adam commenting that adult onset AD patients never fulfill Hanifin criteria

# Key Takeaway: Vote Via Annotation

|  |  |
| --- | --- |
| **Slide** | **Results** |
| Graphical user interface, text, application  Description automatically generated | 1. Adult-onset AD-**6 votes**
2. AD resolution after childhood/AD can persist into adulthood, more than was previously thought/Predictors of persistent childhood AD-**5 votes**
3. AD drugs in the elderly-

**2 votes** |

**Overall Comments**

* Dr. Asai commented that the key messages were very clear and well-presented however also noted that the video was not meant for a patient audience and that different videos were needed for different audiences
* Regarding the question of whether there was any information missing from the presentation, Dr. Iannattone suggested that the association of AD with statins in the elderly should be added, including the importance of emollients and the potential for de-prescribing statins in the elderly
* Dr. Lynde suggested that it would be helpful to have a side by side table comparing AD in children and adults
* Dr. Bourcier commented that information specifically on AD in infants should be added as it can be a very big problem for parents
* All participants agreed that the information in the presentation was relevant for at least one of their patients, but noted that the level of the information in the presentation might be too high for patients
* Dr. Prajapati commented that it was a useful presentation and suggested noting that many pediatric patients do not grow out of AD as clinicians were taught in medical school,. He added that information on adult onset AD, especially in the elderly, was important to address for GPs/FPs as he gets many questions on this when giving talks.
* Dr. Asiniwasis commented that she thought that they have to encourage GPs to not dismiss AD as much as they do as “just a skin problem.” Although she noted that it was touched on to take patients seriously, she finds this is a common theme and GPs/FPs do not get as much medical education on skin as they do in other chronic disease areas.
* Dr. Asai remarked that the summary pictures of the distribution of AD in infant, child, adult, and elderly were very helpful, and Dr. Joseph agreed. Dr. Asai added that many do not realize to also look for hand and facial/neck dermatitis.

# Topic 2 Translational aspects in pathobiology of AD: Targeting molecular Pathway

Scientific Panelist: Professor Thomas Bieber, MD Community Panelist: Dr Catherine Besner Morin

# Comments Regarding Key points for: Dermatology Trainees

* Dr. Besner Morin commented that the presentation touched on some less well-known aspects such as the fact that the innate immune system is triggered which results in an adaptive immune response etc., as well as that the cycle may be different with age, different ethnic backgrounds and the cytokine profile may be different. She noted that because AD is an autoimmune disease, it does not necessarily need an external factor to be triggered.
* Dr. Besner-Morin also commented that if treatments are used early in the cytokine cascade, there is more potential for side effects as more is being blocked. Emerging therapies such as amlitelimab have the potential to stop the progression of the disease, keeping it at a mild level of severity or preventing its development in those genetically predisposed to AD.
* Dr. Asiniwasis commented that in indigenous patients she sees a lot of nummular and sometimes lichenoid morphologies (unpublished). Dr. Prajapati agreed, saying that he sees more nummular and lichenoid morphologies in Asian patients as well. Dr. Asai also agreed and Dr. Asiniwasis commented that this would be an interesting publication. She added that these patients still fit criteria for Hanifin and Rajka and UKWP for AD (typical pattern, etc.).
* Dr. Charles Lynde commented that this is noted in other richly pigmented patients.
* Dr. Prajapati commented that he is seeing more herpes simplex virus (HSV) in AD patients who are Asian than is reported in the literature, especially those on advanced systemic therapies.
* Dr. Purdy commented that she has noticed the same experience with her Mi'kmaq patients in Nova Scotia, in whom the nummular pattern is much more common.
* Dr. Jack agreed, adding that with nummular overlap, a study of staph prevalence would be relevant, to complement genetics and immunophenotype.
* Dr. Asai asked her colleagues if they thought it was the pigmentation itself that increased the risk, or whatever goes with/inherited with pigmentation.
* Dr. Jack replied that this was an interesting question, and she would predict that immunophenotype (types of cells) would relate to genetics more than pigment
* Dr. Asai agreed and said that the discussion made her wonder if anyone has looked at that in itself (eu/pheomelanin as immunomodulator or barrier effect).
* Dr. Joseph agreed, saying that it would be nice to have data contrasting HSV, staph (and even the microbiome) with different morphologies follicular, nummular, lichenification etc. but thought that it was likely largely tied to immunophenotype.

# Comments Regarding Key points for: General Practitioners

* Dr. Besner-Morin commented that they take for granted that everyone understands the atopic march, but after asking some GP colleagues she thinks this may not be true.
* Dr. Lynde was surprised that the concept of atopic march was still in question.

# Comments Regarding Key points for: Adults and Adolescents

* Dr. Besner-Morin commented that some environmental factors are within the control of the patient and therefore important to inform patients on these.

# Comments Regarding What Added Information is Needed

* Dr. Besner-Morin commented, in addition to the bullets on the slide:
	+ Dermatology trainees need to understand the upstream mechanisms
	+ Regarding “eczema school”, she noted that patients need a whole lecture to empower the patient and help them understand that AD will not go away with just emollients and understanding what treatment treats what aspect of AD pathophysiology can help.

# Comments Regarding Three Points Most Relevant to my Practice/Points Relevant to my Practice Not Found and/or Irrelevant info

* Dr. Besner-Morin commented that more information is needed on whether certain treatments would work better in specific ethnic populations due to cytokine profiles.
* Participants agreed with Dr. Adam commenting that adult onset AD patients never fulfill Hanifin criteria

# Key Takeaway: Vote Via Annotation

|  |  |
| --- | --- |
| **Slide** | **Results** |
|  | 1. Phase 2 adaptive immune response- **7 votes**
2. IL-13 is the skin cytokine in AD-**4 votes**
3. Amlitelimab/early treatment may stop the atopic march-**2 votes**
 |

**Overall Comments**

* Dr. Adam commented that he was unsure whether it was appropriate to include emerging treatments (e.g., amlitelimab**)** in the Phase 3 stage as drugs have failed in Phase 3 trials. He suggested not getting into detail about unlicensed therapies, but only addressing them conceptually. He added that the GPs/FPs he speaks to have no interest in learning about IL-13 etc. and suggested that discussing topics at this level will lose their interest, though it is definitely appropriate for dermatology trainees.
* Dr. Lynde agreed, saying that there is not a one size fits all approach for the three populations (Trainees, GPs and patients). He stated that dermatology trainees should have more

pathophysiology information, but GPs/FPs are not interested and are only interested in what new drugs are available, as are patients. He also agreed that the presentation should not include drugs that may not make it to the market.

* Dr. Prajapati commented that what he thought was very interesting was that while it was established that IL-13 is the main cytokine, the role of IL-4 in AD is often up in the air and there are different views on its role.
* Dr. Asai commented that she always gets nervous picking a “boss cytokine” because this not yet definitively established and more information is needed. Drs. Purdy and Joseph agreed.
* Dr. Besner-Morin commented that she asked colleagues and came to the conclusion that GPs are not interested in cytokines, saying that this lecture is more for dermatology trainees than any other group. She added that the slide deck that she would build for GPs and patients would include 1) Immune dysregulation: what treatment where, 2) atopic march/dysregulation and 3) genetics. She added that the lecture is well done, but it is too dense and goes into immune dysregulation too soon.
* Dr. Asiniwasis agreed, saying that it as not a good idea to lump all into one, as the audiences are too different with different levels of understanding. Dr. Asai also agreed saying that this was especially true as the barrier is what patients can action themselves and it would be worthwhile to spend a lot of practical time there.
* Dr. Asiniwasis suggested adding a visual for resident on the cytokine pathway.
* Dr. Purdy commented that the nitty gritty doesn’t matter directly to patients but she interprets the relevance in what she may consider when she sees patients and selects therapeutics. She added that this was a very basic science-directed talk but there were some clinical correlations with therapeutics
* Regarding what was missing, participants suggested that the core mutations should be included.
* Regarding whether this was relevant to their patients, Dr. Adam suggested that it was not as it was too detailed. Dr. Asai agreed that the details were not important to patients but the key point identified were: to explain to patients that they flared because they got a cold, used a fragranced soap or because their family is atopic. In this aspect she felty the presentation had relevance for patients. She added that the presentation was helpful for choosing therapeutics.
* Dr. Iannattone agreed, commenting that Gen Zs have a higher level of health literacy.
* Dr. Joseph agreed, stating that patients get a lot of competing information from their neighbors, naturopaths etc. and dermatologists need to compete with this information influx. She stated that greater patient understanding can help increase adherence as well as guide risk tolerance for advanced therapies.
* Dr. Lynde suggested that it provides patients with hope, saying that AD patients have suffered and telling patients that clinicians understand the pathophysiology of AD gives them hope and increases compliance.
* Dr. Purdy commented that she has recently taken over patch testing locally and the number of patients that have no clue as to why they are having it done and how it may relate to their clinical presentation is alarming.
* Dr. Besner Morin stated that she would not show patients the presentation because it is not

“digested “ enough for them but stated that pathophysiology is important for the patient, saying that it empowers them. She remarked that patients need another slide deck altogether and that the main point should be regarding skin barrier and inflammation. She added that having knowledge helps them protect them against misinformation.

* Dr. Asiniwasis commented that the question has become “How is it best translated from the granular basic stage to the patient level for understanding for what they deem important/their values?”
* Dr. Jack agreed with Dr. Purdy that information around the role of patch testing needs to be addressed.
* Dr. Asai commented that she once had a patient tell her “I think you just explained my whole life” when she gave them a summary of the pathophysiology. Dr. Jack had a similar experience with a patient.

**Topic 3 Shifting Guidelines for Treatment** Scientific Panel Lecturer: Dr Mark Kirchhof Community panelist : Marc Bourcier

# Comments Regarding Key points for: Dermatology Trainees

* Dr. Bourcier commented that it was important for dermatology trainees to be familiar with assessment tools such as POEM, ESAI and SCORAD even if these are not used routinely in practice.
* Dr. Jack commented that there are more up to date guidelines than the 2013 guidelines presented, noting that were no systemics in 2013. Several participants agreed, with Dr. Asiniwasis commenting that they did not even have “Dupixent available then just the old immunosuppressants. A very exciting decade for all of us, unprecedented in AD.”
* Dr. Jack stated that currently the most up-to-date and “rigorous” guidelines are those of with NICE in the UK, as well as the European and German Guidelines.
* Dr. Asai asked if it was expected that dermatologists would have to use POEM clinically in the future to obtain coverage for medications, noting that dermatologists only use these assessments if they are forced to. Several participants commented that they hoped that assessments such as POEM would not become necessary to obtain coverage for medications.
* Dr. Asiniwasis questioned if anyone used POEM outside of clinical trials. Several participants responded that they did not.
* Dr. Jack remarked that, regarding POEM, for adult MS patients the DLQI often doesn’t capture the impact whereas the POEM severity strata are more “sensitive.”
* Dr. Asai questioned if it was fair to ask trainees to” learn another measurement tool that we don’t use.”
* Dr. Purdy stated that for trainees she thought that the DLQI and EASI were necessary, for exam and practical reasons. Dr. Asai responded that while they know that the DLQI is not good for AD, they use it regardless. Dr. Asiniwasis agreed that the DLQI was limited in some ways.
* Dr. Jack noted that it is the measure recommended internationally [in chat, not specified which measure, POEM or DLQI].
* Dr. Asai responded that they would not be using DLQI or EAS if they did not have to, but would

simply ask the patient “Is it affecting your life?”

* Dr. Jack disagreed, saying that it helps her to strategize how likely the patient is to want to pursue the systemic path of treatment.

# Comments Regarding Key points for: General Practitioners

* Regarding the key point that GPs should review the 2020 JEADV Guidelines, Dr. Bourcier commented that they are simple and straightforward.
* Regarding the key point that GPs should be able to assess the severity of AD, Dr. Purdy remarked that she was not confident in their ability to do so as she gets many referrals for “rash” but conceded that this could be related to the fact that only half of her patients have access to primary care.
* Dr. Jack added that there is bias given that with the current state of healthcare, a physical exam, at least in Quebec, is beyond the scope for many GPs at the moment.
* Dr. Purdy commented that the role of the GP to add adjuvant therapies for sleep etc. may be of benefit but noted that GPs still use Benadryl extensively in her region.
* Dr. Joseph stated that while many GPs are great, they are overwhelmed when they see dermatological concerns and prescribe hydrocortisone for most dermatological concerns.

# Comments Regarding Key points for: Adults and Adolescents

* Regarding the key point that patients should be careful when self-diagnosing or searching for information on the internet, Dr. Bourcier commented that there is a lot of misinformation available to patients.
* Regarding the point 5c, “Controlling the disease in early life may reduce the risks of acquiring other related conditions in later life (example: asthma, chronic rhinitis)”, Dr. Jack asked if there was any evidence to support this [unanswered].

# Comments Regarding What Added Information is Needed

* Dr. Iannattone remarked that the old systemic therapies and phototherapy should be mentioned. Dr. Bourcier replied that they are mentioned in the guidelines and are touched upon in the lecture.
* Dr. Lynde asked if the lecture mentioned itch and sleep scores to which Dr. Bourcier replied that it did.

# Comments Regarding Three Points Most Relevant to my Practice/Points Relevant to my Practice Not Found and/or Irrelevant info

* + No participant comments.

# Key Takeaway: Vote Via Annotation

|  |  |
| --- | --- |
| **Slide** | **Results** |
|  | 1. Safety and efficacy of treatments for AD-**7 votes**
2. Guidelines in development for AD-**2 votes**
 |

**Overall Comments**

* No further participant comments.

# Topic 4 Novel Topical Therapies for the Treatment of Atopic Dermatitis

Scientific Panel Lecturer: Chih-Ho Hong Community panelist: Charles Lynde

# Comments Regarding Key points for: Dermatology Trainees

* Dr. Lynde commented that while there was a pathophysiology slide, he would have added where the 3 new treatments act on the pathway to this slide, He added that all the videos get muddled and it is difficult to decide who the audience is for each.
* Dr. Lynde also stated that more information than what was provided in the lecture would be needed for trainees to write the Royal College exams.

# Comments Regarding Key points for: General Practitioners

* Dr. Lynde commented that GPs want to know about new drugs; if they are efficacious and if they have few side effects.

# Comments Regarding Key points for: Adults and Adolescents

* Dr. Lynde stated that the lecture was “too dermatological” for patients.

# Comments Regarding What Added Information is Needed

* Dr. Lynde reiterated that more information was needed for trainees, particularly regarding immunological aspects of AD and the new treatments.
* Regarding the needs of GPs, Dr. Lynde remarked that many of the talks in the series focused on immunological aspects but did not place enough emphasis on or give a description of barrier function.
* Dr. Asiniwasis commented that she liked the idea of adding a medical illustration/cartoon (Regarding point 2c).
* Dr. Adam commented that when addressing patients, they need to balance the benefits of novel non-steroidal agents without denigrating topical steroids (Point 3a).

# Comments Regarding Three Points Most Relevant to my Practice/Points Relevant to my Practice Not Found and/or Irrelevant info

* Dr. Besner-Morin commented that she thought that it was important for family practitioners to know the most common side effects of topical treatments (other than the steroids) because if they are prescribing them than they need to communicate this information to patients. Dr. Prajapati agreed.

# Key Takeaway: Vote Via Annotation

|  |  |
| --- | --- |
| **Slide** | **Results** |
|  | 1. +Theseproducts have high efficacy…-**9 votes**2. New non- steroidal options with different NOAs will soon be available-**2 votes** |

**Overall Comments**

* Dr. Jack questioned if GPs will use the new topicals if they are restricted.
* Dr. Purdy stated that this talk was most suited to GPs.
* Both Dr. Asai and Dr. Jack noted that the incidence and prevalence data is variably cited. Dr. Asai suggested that the incidence and prevalence data be reviewed across the presentations for consistency or qualified (i.e., the prevalence was once thought to be…). She added that this would give an opportunity to also review the presentations for the identified gaps, such as the lack of information on older systemic therapies which are still a necessary part of AD management. Dr. Asai noted that patients may choose phototherapy, so it was important to have the information they need for this or other long established therapies.
* Dr. Asiniwasis also commented that there was a lot of different data on prevalence of AD, and that definitions of prevalence vary such as lifetime, point, one year etc. as well as vary in different countries. She noted that they have very little Canadian data, therefore she mostly goes by US data, but there is some prevalence data from Canada which is relatively recent although grouped with other international data.
* Dr. Lynde stated that it was a good video, but he wasn’t certain what audience it was targeted

at. He stated that it reached him at a “lower level.”

* Dr. Prajapati commented that knowing the top few most common side effects for each of the new topical therapies would be valuable, remarking on the need to address burning sensation with TCIs when speaking to GPs and some dermatologists.
* Dr. Prajapati questioned if there was any value on adding topical therapies that were not yet approved to the presentation. Dr. Lynde responded yes, but only for dermatologists and dermatology trainees.
* Dr. Bourcier asked if the speaker’s prepared the slides. Dr. Jack replied that they were given some parameters and asked to give a presentation.
* Dr. Adam commented that safety seen in clinical trials often does not translate into clinical practice, noting that burning with TCIs was not reported in the clinical trials. He suggested adding a footnote to address this.
* Dr. Purdy, commented that they told patients that crisaborole did not burn given the data but saw a different reality in practice. Dr. Asiniwasis agreed.
* Dr. Jack asked Dr. Besner-Morin how applicable the illustration and review of the barrier dysfunction in Bieber’s presentation were. Dr. Besner-Morin responded that she would say that her lecture, in general, was not for patients or the general practitioner. Most of the key points for patients and GP were influenced by what she thought is important to tell them and would need a simplified graphic.
* Dr. Jack asked Dr. Lynde what added information was needed to help prepare dermatology trainees for Royal College exams. Dr. Lynde replied “more oomph” saying that the presentation was short, but a resident was more likely to be asked for the pathophysiology of the new medications over EASI score. He stated that trainees need to know how these medications work, not EASI scores. Dr. Jack agreed that it was challenging to fit all the information into 20 minutes and asked if the MOAs were sufficiently addressed in the presentation covered by Dr. Besner- Morin. Dr. Besner-Morin responded that it was not as that presentation was primarily on the immune dysregulation. In answer to a question by Dr. Lynde if the presentation covered barrier function, she replied that while there was a picture shown, more information was needed to explain it. She suggested that there be one lecture for GPs and patients and a separate lecture for dermatology trainees.
* Dr. Jack agreed with Dr. Lynde that the concept of the barrier is highly relevant with the microbiome and emollients.
* Dr. Prajapati commented that the slide decks need tables to summarize for the dermatologists.
* Dr. Purdy remarked that in her opinion this presentation and Dr. Gooderham’s were applicable to GPs while Kirchhof/Drucker/Beiber’s presentations were applicable for residents, with the asthma presentation applicable to both audiences and all the presentations were bit too detailed for patients.
* Dr. Asiniwasis commented that many residents depend on Bolognia (Dermatology textbook, Dr. Jean Bolognia, editor) which is only updated every few years. She added that it would be worth checking the most recent content on these newer topicals to see if they reflected the advancements of the past few years of advancement and what is in the near-term pipeline.
* Dr. Asai suggested splitting the topic of pathophysiology into a general overview with additional more in depth treatment specific presentations.

# Topic 5 Novel Systemic Therapies for the Treatment of Atopic Dermatitis

Scientific Panel Lecturer: Dr. Melinda Gooderham Community panelist : Dr. Lisa Iannattone

# Comments Regarding Key points for: Dermatology Trainees

* Dr. Purdy reminded the group that a network meta-analysis is not a direct comparisons and should be taken with a grain of salt but agreed that it was a very succinct video. Dr. Jack agreed, adding that a grading system to evaluate the quality of meta-analysis was needed.
* Dr. Besner Morin commented that information about the targets of novel treatment are also stated in the lecture she covered, but she thought that it was better to only have it in this presentation to avoid redundancy. She added that this left more time to talk about pathophysiology.

# Comments Regarding Key points for: General Practitioners

* No participant comments.

# Comments Regarding Key points for: Adults and Adolescents

* No participant comments.

# Comments Regarding What Added Information is Needed

* Dr. Lynde asked in chat if they could switch within class [no response].
* Regarding Point 2c/3c Dr. Besner-Morin commented that “how long” was a good question, but questioned if this was actually known. She asked if there was data on if AD returned when dupilumab was stopped. Dr. Jack responded that there was data on withdrawal and the AD does recur. Dr. Purdy commented that Dr. Gooderham says in the lecture that she does not monitor CK but this may confuse people as it is in the upadacitinib Product Monograph.

# Comments Regarding Three Points Most Relevant to my Practice/Points Relevant to my Practice Not Found and/or Irrelevant info

* No participant comments.

# Key Takeaway: Vote Via Annotation

|  |  |
| --- | --- |
| **Slide** | **Results** |
|  | 1. +Several novel systemic therapies for AD are highly effective…-**6 votes**2. When comparing EASI scores upa 30 mg and abrocitinib 200 mg are the most effective agents followed by dupliumumab-**2 votes**3. 70%, 62% and43% of patients, respectively achieved 75% improvement-**1 vote**1. AEs of monoclonal antibodies

include…-**1 vote**1. Safety data for the JAK-1 inhibitors was generated from- **1 vote**
 |

**Overall Comments**

* Dr. Prajapati asked if anyone had any issues with the video. Participants responded that they

would like more practical tips such as “how do I choose?” and “what can patients expect?”

* Dr. Prajapati commented that he thought that efficacy and safety have to be discussed together, followed by benefit-risk profile.
* Dr. Purdy agreed with Dr. Prajapati’s comment regarding the order of the slides, suggesting 1) efficacy/safety, 2) vs. methotrexate/cyclosporin re efficacy and safety. Dr. Joseph and Dr. Asai agreed with Dr. Asai commenting that there needs to be an efficacy/safety comparison with traditional systemics.
* Dr. Bourcier suggested that a table with the novel treatments would be helpful.
* Dr. Adam commented that the issue of efficacy is also important to patients. He noted that primary endpoints differ from long-term studies. He also remarked that they need to make sure that the options are factored out without giving a conclusion and suggested talking about the dangers of cross-trial comparison. Dr. Asiniwasis agreed, saying that it should be mentioned that this a meta-analysis and not a direct comparison as well as the difference in study designs.
* Dr. Purdy agreed on the need for caution with meta-analysis and remarked that she found the

talk a little too “JAK-focused.”

* Dr. Besner-Morin commented that in her lecture 10-20 minutes were spent talking about JAK inhibitors and as there is a whole lecture on it, she would remove it from her lecture so that it only focusses on pathophysiology. She added that there are a lot of physiological functions of JAK and she struggles with learning about them all and identifying which are relevant for prescribing and side effects. She suggested that they needed to be clearer on which functions clinicians needed to be aware of.
* Dr. Purdy agreed noting that Dr. Gooderham remarks that she does not monitor CK and also talks about lipid profile changes but says that they are balanced. Dr. Iannattone agreed, saying that she felt that the side effects of JAK inhibitors were somewhat downplayed.
* Dr. Jack commented that as clinicians and educators there must be a balance between what they do in practice because of their clinical experience and what they teach to trainees.
* Dr. Asai commented that she realized that there was a lack of data with the traditional systemics that may be the issue with this type of talk, but she thought that there was enough anecdotal evidence from years of use that it could be brought to the discussion.
* Dr. Asiniwasis suggested emphasizing that real world evidence/phase IV is needed to clarify these associations especially with JAKs. She also noted that there was a lot of Phase IV data with dupilumab.
* Dr. Purdy commented that she monitors CK with JAKs, stopping if it remains stable, and always monitors lipids. Dr. Asai commented that she checks CK once. Dr. Purdy stated that a normal ratio is a useless metric and that if LDL and TG are elevated the patient needs a modified dose or statin/fenofibrate. She added that she has had many JAK patients that have had triglyceride levels increase 12-15 or higher from normal baseline.
* Dr. Besner Morin commented that it is completely different between reality and “what we

should monitor.”

* Dr. Asai suggested that a bit more nuance about lab monitoring might be helpful in the lecture
* Dr. Besner Morin suggested having a table with what the company recommend for monitoring for each JAK , and then verbally share their experience or what was seen in the trials. (e.g., same CK elevation compared to placebo). Dr. Adam, Dr. Joseph and Dr. Purdy agreed.
* Dr. Jack suggested that this would be a great topic for a discussion; real-world differences between populations as well as variability as she has had many internists telling her that they are moving away from treating triglycerides alone.
* Dr. Purdy responded that she would not treat a TG of under 10 but when it’s getting to 15 or higher and was baseline normal, that delta change could increase the risk of pancreatitis. Dr. Jack agreed. Dr. Purdy added that most of her JAK patients with elevated TG have a concordant increase in LDL, saying that high HDL is fine but high LDL that persists is worth managing and that it is not usually isolated hypertriglyceridemia.

# Topic 6 Addressing Co-Morbidities in Atopic Dermatitis Patients: Asthma, Sinusitis, and Other Complications

**Part 1: Asthma**

Scientific Panel Lecturer: Dr. R. Olivenstein

Community panelist: Rachel N. Asiniwasis, MD MS(HS) FRCPC FAAD

# Comments Regarding Key points for: Dermatology Trainees

* No participant comments.

# Comments Regarding Key points for: General Practitioners

* Dr. Jack commented that what was very interesting to her is how these populations overlap in prevalence but when severity is considered usually one epithelium dominates.
* Dr. Asai suggested that EoE should be mentioned by name, eosinophilic esophagitis, noting that it is often missed. Dr. Joseph agreed, saying that EoE is often missed and has picked up 2 or 3 in the past 2 years whereas previously had not seen any.
* Dr. Asai remarked that this was especially for primary care physicians because early intervention is key to avoidance of stricture and repeated dilations.
* Dr. jack agreed, saying that they need a GI recording and one for type I vs type IV HSS by A&I

# Comments Regarding Key points for: Adults and Adolescents

* No participant comments.

# Comments Regarding What Added Information is Needed

* No participant comments.

# Comments Regarding Three Points Most Relevant to my Practice/Points Relevant to my Practice Not Found and/or Irrelevant info

* Dr. Besner Morin commented that she realizes that she does not question patients enough about symptoms of asthma, but always asks about joint pain in psoriasis patients. Dr. Purdy agreed. Saying that she asks “do you have asthma or seasonal allergies” but leaves it at that and now thinks that this is not sufficient.
* Dr. Besner Morin agreed, characterizing it as something to help her find the diagnosis of AD but not about severity or symptoms and if they have the appropriate follow up or treatment.
* Dr. Asai stated that she does an MDC with allergy and the asthma educator. She added that in Ontario they could qualify for dupilumab if they have 2 episodes requiring prednisone.
* Dr. Bourcier commented that he liked the table.
* Dr. Purdy commented that she would like a “ask these three things” list to make sure she did not miss asthma etc. Dr. Besner-Morin agreed and added that if the clinician knows the basics of the recommendation, your patient might not have EASI score to get dupilumab, but they might reach the threshold with asthma.

# Key Takeaway: Vote Via Annotation

* Annotation exercise skipped for this presentation.

# Overall Comments

* Dr. Prajapati asked Asiniwasis her opinion of the presentation. She responded that while it was very well done, she thought that some of the nuances on which treatments to choose based on experience rather than literature were perhaps too much for dermatologists/GPs, noting that she had to look up certain things, like GINA. She thought that what was missing was a slide on “Co-managing with dermatology” saying that they need to look at it in the same way that they co-manage psoriasis/psoriatic arthritis with rheumatologists.
* Dr. Prajapati commented that he would like some screening questions that dermatologists could use to screen for comorbidities.
* Dr. Lynde agreed, saying he would like 3 important questions that he could ask patients to screen for asthma, EoE and nasal polyps.
* Dr. Jack commented that there was a lot of disagreement on what dermatologists should be screening for and suggested that screening for mental health issues might be the most important. She commented that it seems to be if the AD is severe, the asthma is not as severe.
* Dr. Asiniwasis responded that the entire lecture was built around severe asthma and this might be a point to discuss.
* Dr. Purdy commented that more and more patients do not have access to primary care so she finds that if she screens for things that are relevant she may be able to direct them to another physician if needed.
* Dr. Besner-Morin commented that it’s important to know which novel treatments helps with other atopic disease because it might influence the choice of treatment. Dr. Purdy agreed. Dr. Besner-Morin added that they do not need to ask the questions all in the same visit as they are

being followed long term. Dr. Purdy agreed, saying that she would ask at baseline and should the clinical situation changes.

* Dr. Asiniwasis remarked that this is where the role of the GP can also really be considered but agreed with Dr. Purdy that many patients do not have a primary care physician and so she tries to screen patients and direct them to other physicians as needed.
* Dr. Asai asked if they prescribe inhalers or refer patients onwards. Dr. Purdy responded that she usually refers onwards and Dr. Asiniwasis replied that she will prescribe refills for inhalers if

they have a diagnosis of asthma in their chart, need it and can’t get into their GP, and ask them to follow up or refer if she deems it necessary. Dr. Purdy agreed, saying that she will refill but not initiate treatment as she may not be up to date.

# Topic 6 Addressing Co-Morbidities in Atopic Dermatitis Patients: Asthma, Sinusitis, and Other Complications

**Part 2: Chronic Rhinosinusitis with Nasal Polyposi**

Scientific Panel Lecturer: Dr Tewfik Community panelist : David Adam MD FRCPC

# Comments Regarding Key points for: Dermatology Trainees

* Regarding Point 3c, approved biologics, Dr. Adam, commented that this was relevant because there was the potential for treating more than one condition with the same medication.
* Dr. Besner-Morin commented that it would be interesting to know how many of their patients with AD had allergic rhinitis that needed treatment. Dr. Jack replied that the overlap with allergic rhinitis was the highest coexisting comorbidity.
* Dr. Asiniwasis agreed, saying that she sees a lot of allergic rhinitis in adults,.
* Dr. Asai commented that allergic rhinitis also has a massive impact on quality of life.

# Comments Regarding Key points for: General Practitioners

* Dr. Adam noted that Point 3, Treatment of CRSwNP, was one point of differentiation between the GP and dermatology key points as the GPs need more information in order to be able to prescribe and give instructions to patients, noting that it was GPs who manage the treatment.
* Dr. Jack agreed with the need for specific names and instructions for corticosteroids, saying that this applies in AD as well.

# Comments Regarding Key points for: Adults and Adolescents

* Dr. Adam commented on the need to normalize and validate the disease for the patient as well as have them understand that it is a chronic disease.
* Dr. Purdy commented that uses a light switch analogy to explain to patients the concept of psoriasis as a chronic disease that will wax and wane. She expanded on this saying, “I say the light has been switched on. We can’t turn it off but we can dim the lights.”

# Comments Regarding What Added Information is Needed

* Dr. Adam remarked that he did not think that rhinitis is a concern/problem for patients that was sufficiently emphasized, noting its great impact on quality of life.
* Dr. Purdy agreed, referring to a Claritin advertising campaign that described how the patient felt and the impact of allergic rhinitis.

# Comments Regarding Three Points Most Relevant to my Practice/Points Relevant to my Practice Not Found and/or Irrelevant info

* Dr. Asai commented that from speaking with respirology/allergy colleagues she has found that for asthma they often don’t use the medication dermatologists use because they have established and effective alternative biologics that are easier for them to get. She remarked that because of this, they might have to educate their colleagues to look for and prescribe the medications dermatologists use in AD rather than the other way around. She was not sure if this was similar with ENTs. Dr. Jack responded that ENTs use dupilumab but also overlap therapies with asthma. Dr. Prajapati commented that they really like using mepolizumab. Dr. Purdy commented that in her area ENTs favour benralizumab.
* Dr. Asiniwasis suggested emphasizing role of GP whenever possible.

# Key Takeaway: Vote Via Annotation

|  |  |
| --- | --- |
| **Slide** | **Results** |
|  | 6. +Treatment of CRSwNP…-**7 votes**7. +Diagnosis of CRSwNP…-**3 votes** |

**Overall Comments**

* Dr. Lynde suggested having the comorbidities in one lecture with less detail.
* Dr. Besner-Morin commented that what was relevant to GPs was different from what was relevant to dermatology trainees. For dermatologists what is important to know is how severe, how common, what to ask and when to refer. For GPs it is great to have a resource online where they can learn not only about AD, but also about the comorbidities. They need to know what/how to write the prescription (exactly) for all the comorbidities at an entry-level. This type of resource is very valuable.

# Topic 7 Knowledge Translation: Using Tools to Facilitate Communication with Patients

Scientific Panel Lecturer: Carolyn Jack Community panelist : Marissa Joseph

# Comments Regarding Key points for: Dermatology Trainees

* Dr. Joseph commented that the content overall highlights two things, 1) extra-cutaneous disease presentation, particularly as it pertains to mental health and 2) looking at interventions

in a practical, scholarly, evidence-based manner. She commented that it was very well done and that the content for all three audiences was the same, but the lens was shifted

# Comments Regarding Key points for: General Practitioners

* Dr. Joseph remarked that GPs play an important role in terms of therapy and addressing mental health.
* Dr. Joseph suggested treating patients with AD similarly to those with chronic pain in terms of mental health.
* Dr. Asiniwasis added that she felt that Quality of Life impacts (Point #1) must be emphasized in order for GPs to take addressing mental health sequelae in AD (Point #2) seriously. Dr. Prajapati agreed.

# Comments Regarding Key points for: Adults and Adolescents

* Regarding point 1, Dr. Joseph remarked that it was important to validate the patient experience

and their need for “heavy duty” treatments.

* Dr. Joseph emphasized the point that mental health was part of managing eczema.

# Comments Regarding What Added Information is Needed

* Dr. Joseph suggested a brief overview of pharmacotherapies for dermatology trainees would be helpful, particularly those that may have interactions with medications used in AD such as JAK inhibitors (Point 1b).

# Comments Regarding Three Points Most Relevant to my Practice/Points Relevant to my Practice Not Found and/or Irrelevant info

* Dr. Joseph commented that she would have liked more resources on how to address anxiety/depression for those not experienced in mental health pharmacotherapy, more information on available mental health support, and information specific to younger pediatric patients and their caregivers with AD associated mental health issues.
* Dr. Charles Lynde asked if there were any important points for families [in chat, no response].
* Dr. Besner Morin commented that she was wondering if, in 20 years, they might know how to control AD so well that patients would not become severe for so long and there will be less depression and self-esteem issues. Dr. Prajapati agreed but remarked that some patients have depression and anxiety even when their skin is clear and that for some, the fact they have the disease and have to be on treatment bothers them.
* Dr. Asai commented that it is understandable because patients have spent their lives being unsure of when their skin may flare, what will trigger it, if it will occur at some important event etc. and this anxiety makes their eczema worse.

# Key Takeaway: Vote Via Annotation

|  |  |
| --- | --- |
| **Slide** | **Results** |
|  | 1. Approach to addressing mental health sequelae in patients with AD…-**7 votes**
2. Evidence based interventions for mental health sequelae in patients with AD-**1 votes**
3. A pilot program evaluating

wellness…-**1 vote**1. There is a significant negative impact on wellbeing in patients……-**1 vote**
 |

**Overall Comments**

* Dr. Asiniwasis commented that it in dermatology, they often deem psychodermatoses as psychological impacts of skin disease. These can be primary which they talk about a lot like trichotillomania, or secondary to skin disease. She remarked that she felt like they often just brush over the secondary to skin disease and they need to highlight this, just as Dr. Joseph mentioned, to include the mental health impact of this common disease, AD.

Appendix 1: Agenda

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| --- | --- | --- |
| Time (ET) | Topic | Speaker/Facilitator |
| 6:00–6:15 pm(15 minutes) | **Welcome, Objectives and Introductions** | **Rohit Khanna, Catalytic Health****Carolyn Jack, MD** |
| 6:15–6:35 pm | **Topic 1 Atopic Dermatitis: A Disease of Childhood?** | **Dr. Yuka Asai** |
| 6:35–6:55 pm | **Topic 2 Translational aspects in pathobiology of AD: Targeting molecular Pathway** | **Dr. Catherine Besner-Morin** |
| 6:55–7:15 pm | **Topic 3 Shifting Guidelines for Treatment** | **Dr. Marc Bourcier** |
| 7:15–7:35 pm | **Topic 4 Novel Topical Therapies for the Treatment****of Atopic Dermatitis** | **Dr. Chuck Lynde** |
| 7:35–7:50 pm | **BREAK** | **ALL** |
| 7:50–8:10 pm | **Topic 5 Novel Systemic Therapies for the Treatment****of Atopic Dermatitis** | **Dr. Lisa Iannattone** |
| 8:10–8:30 pm | **Topic 6 Addressing Co-Morbidities in Atopic Dermatitis Patients: Asthma, Sinusitis, and Other Complications** | **Dr. Rachel Asiniwasis (Part 1) and****Dr. David Adams (Part 2)** |
| 8:30–8:50 pm | **Topic 7 Knowledge Translation: Using Tools to****Facilitate Communication with Patients** | **Dr. Marissa Joseph** |
| 8:50–9:00 pm | **Closing Remarks, Key Takeaways and Next Steps** | **Rohit Khanna, Catalytic Health****Carolyn Jack, MD** |
| Time (ET) | **Topic** | **Speaker/Facilitator** |