ACD 57th Annual Scientific Meeting 2025 Conference Review™

Making Education Easy

31 May – 2 June, 2025

In this review:

Abbreviations used in this review:

BSA = Body Surface Area; **DLQI** = Dermatology Life Quality Index; **IGA** = Investigator's Global Assessment; **JAK** = Janus kinase; **mNAPSI** = Modified Nail Psoriasis Severity Index; **PASI** = Psoriasis Area & Severity Index; **QOL** = quality of life; **SALT** = Severity of Alopecia Tool; **SDDI** = sequential dermoscopy imaging; **TBP** = total body photography.

Welcome to our review of the 2025 ACD (Australasian College of Dermatologists) Annual Scientific Meeting held at the Brisbane Convention and Exhibition Centre, Brisbane.

This year ACD hosted its 57th annual meeting, with a number of exciting updates in dermatology research. Here I have selected 11 presentations which were particularly noteworthy and relevant for our readers. We begin with a pooled post-hoc analysis of the BRAVE AA1/AA2 trials which revealed that patients with severe alopecia areata who experienced early improvement at 6 months with baricitinib were likely to achieve a clinical response after 52 weeks of treatment, whereas those with very severe disease tended to require longer treatment. This is followed by an analysis of four phase 3/3b trials which showed that patients with plaque psoriasis achieved higher clinical responses with bimekizumab versus comparators, and these translated into numerically greater benefits in patient-perceived health-related QOL. Other abstracts of interest reported on a novel deep imaging phenotype to stratify individual melanoma risk, the efficacy and safety of long-term dupilumab in children with atopic dermatitis, and the use of prophylaxis antibiotics in patients with cardiac implants undergoing skin procedures.

I hope this review is valuable for your clinical practice and the lives of your patients, and I welcome your feedback. Detailed abstracts are available online here.

Kind Regards,

Dr Philip Tong
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Evidence-based data on how long to treat to achieve treatment response with baricitinib in severe alopecia areata

Speaker: Brett King (Dermatology Physicians of Connecticut, US)

Summary: In this pooled post-hoc analysis of the BRAVE AA1/AA2 trials, researchers evaluated the time needed to treat severe alopecia areata with baricitinib based on disease presentation at baseline. The analysis included patients randomised to receive baricitinib 4mg once daily for up to 52 weeks who were classified as having severe (SALT score 50–94) or very severe disease (SALT score 95–100) and disease duration <4 versus >4 years. In patients with severe alopecia areata at baseline, there was a plateauing of responses between 24 and 36 weeks of treatment, whereby a SALT score of 30 was achieved by 61%–70% and 63%–73% of patients, respectively. After 52 weeks of treatment with baricitinib, patients with severe disease who had achieved SALT scores of 30 at week 24 showed high clinical responses, with 75% and 65% of those with disease duration <4 years and >4 years achieving SALT scores of ≤20, respectively. The proportion of patients with very severe disease achieving SALT 30 continued to improve throughout 52 weeks of treatment with baricitinib, with no apparent plateau.

Comment: In Australian dermatology practice, baricitinib has emerged as a pivotal option for severe alopecia areata, yet patient expectations regarding speed of regrowth often misalign with clinical response. This analysis addresses a key unmet need: evidence-based timelines for response. The data demonstrate that patients with severe alopecia areata showing early signs of improvement at 6 months are likely to achieve meaningful regrowth by 12 months, while those with very severe disease may need to continue treatment beyond this. This is crucial for counselling, especially when patients or referrers expect rapid hair return. Informed timelines also help mitigate premature discontinuation and improve patient satisfaction.

Hair and nails
Abstract

Bimekizumab clinical efficacy in impactful body regions and health-related quality of life in patients with plaque psoriasis

Speaker: Annika Smith (St Vincent's Hospital, New South Wales, Australia)

Summary: These investigators analysed data from four phase 3/3b comparator-controlled trials to examine the ways in which complete skin clearance in plaque psoriasis in high-impact sites (nails, palms, scalp, soles) and other body regions was associated with improvements in patient-perceived health-related QOL. The study evaluated patients with moderate to severe plaque psoriasis with baseline PASI >0 for the relevant PASI body region (scalp IGA ≥3, mNAPSI >10 or palmoplantar IGA ≥3) who were administered bimekizumab versus comparators in BE VIVID/BE READY (bimekizumab n=670 vs. placebo n=169), BE SURE (bimekizumab n=319 vs. adalimumab n=159), BE RADIANT (bimekizumab n=373 vs. secukinumab n=370) and BE VIVID (bimekizumab n=321 vs. ustekinumab n=163). Overall, bimekizumab-treated patients showed higher clinical responses across each high-impact site and each PASI body region compared with comparators, and these higher responses were associated with numerically higher benefits in patient-perceived health-related QOL. At week 4, the proportions of patients achieving concurrent PASI100 and DLQI 0/1 were numerically higher with bimekizumab versus comparators for the head/neck (23.5%–37.2% vs. 0.6%–21.0%, respectively), trunk (18.7%–27.2% vs. 1.2%–13.8%), arms (16.3%–19.9% vs. 0.6%–9.2%) and legs (10.6%–16.1% vs. 0.6%–7.9%). Similarly, significantly greater proportions of bimekizumab-treated patients achieved concurrent DLQI 0/1 and scalp IGA 0 (22.7%–34.8% vs. 0.0%–23.1%) and concurrent DLQI 0/1 and palmoplantar IGA 0 (21.3%–31.1% vs. 0.0%–3.6%).

Comment: Psoriasis management in Australia demands treatment that addresses not just the burden of disease, but the impacts on QOL – particularly in visible body regions. This multi-trial analysis highlights bimekizumab's performance in clearing high-impact areas like scalp, nails, palms and soles, with early and sustained improvements. Importantly, the concurrent improvements in DLQI 0/1 show that this clearance translates into patient satisfaction. As Medicare and PBS access evolve, data like these may help to support biologic initiation in patients not meeting traditional PASI thresholds, but who are suffering major functional or psychosocial impairments due to regional disease.

Biologics/psoriasis
Abstract

The deep imaging phenotype for melanoma risk stratification

Speaker: Sam Kahler (University of Queensland, Brisbane, Australia)

Summary: In this presentation, Sam Kahler discussed a review on the development of the 'deep imaging phenotype' which was designed to improve objective melanoma risk stratification. The deep imaging phenotype utilises a combination of total body photography (TBP) and AI algorithms to evaluate the unique spatial distribution and severity of cutaneous risk factors for each individual patient, including freckling, photodamage, skin tone and naevus features (distribution, size, count). Sam Kahler reported that these measures are strongly linked with melanoma risk, and they may be a useful addition to current risk assessment in combination with traditional genomic and clinical risk factors. The approach has been well accepted by patients and physicians alike, although a number of key factors need to be addressed before it is implemented, including legalities, clinical guidelines and technology frameworks. It was noted that this risk stratification tool may inform timely management of at-risk patients, while providing evidence for resource allocation and decreasing rates of over-diagnosis in low-risk subgroups.

Comment: This work represents a critical evolution in melanoma prevention for Australia, where population-level skin checks are neither scalable nor targeted. By creating a quantifiable deep imaging phenotype that incorporates naevus distribution, clustering, skin tone and photodamage, this approach offers a precision-based method to stratify individual melanoma risk. For dermatologists, especially those using TBP, this framework enhances surveillance by moving beyond naevus count alone and leveraging AI to manage complexity. The use of automated naevus tracking and photodamage heatmaps supports reproducible monitoring and more informed decision-making around biopsy thresholds and review intervals. Importantly, it holds potential to alleviate pressures on public dermatology services by tailoring follow-up intensity to biologic risk. As skin cancer services expand across Australia's remote and urban regions, this approach could enable resource-efficient triage while preserving early detection outcomes. It also offers a research springboard into genotype-phenotype links using imaging as a biomarker.

Melanoma/oncology
Abstract

Melanomas detected during sequential dermoscopy imaging (SDDI)

Speaker: Marcela Alves Girundi (Melanoma Institute Australia, UNSW Sydney, Australia)

Summary: This retrospective single-centre study explored the long-term changes in all melanomas diagnosed via sequential dermoscopy imaging (SDDI) during 2024 at Melanoma Dermatology, Melanoma Institute Australia. Throughout a total of 162 identified melanomas, 62 (38%) were detected via SSDI (54 patients; 82% with prior melanoma). Excision occurred at a median of 14 months after first dermoscopic photograph (range 1–101 months), and a median of three photographs per melanoma (range 2–11). Overall, 11% of melanomas diagnosed via SDDI were excised after 3 months, while 25% were excised after ≥3 years of monitoring. Melanomas were predominantly in situ (88%), of which 66% demonstrated severe changes. There were seven invasive melanomas, and 71% of these showed severe changes. Researchers observed a weak correlation between time to excision and severity of morphological change (r 0.304; $p<0.05$).

Comment: This Australian study underscores the vital role of longitudinal dermoscopy in melanoma detection, particularly for morphologically bland or equivocal lesions. SDDI enabled the diagnosis of nearly 40% of all melanomas at this high-volume tertiary centre, most of which were in situ or early-invasive with low Breslow thickness – emphasising its effectiveness in early detection. Notably, 11% of melanomas required over a year of monitoring before detection, suggesting clinicians must resist the urge to discharge low-suspicion lesions prematurely. For dermatologists practising in high-risk populations, especially those with naevus-prone patients or ambiguous lesions that don't meet immediate biopsy criteria, this study supports the integration of SDDI into routine care. It also provides real-world evidence supporting the model of structured follow-up and digital surveillance. Whilst we await AI-assisted dermoscopy, combining human review with SDDI remains a best-practice approach for nuanced decision-making in melanoma risk management.

Melanoma/oncology
Abstract

TREMFYA has been shown to reduce tissue-resident memory cells to plaque-free skin levels‡

‡TREMFYA-treated lesional-skin TRM cell count was normalised to non-lesional skin level by week 68 (p=not significant) in the GUIDE exploratory analysis[c4,5] and by week 24 (p value not reported) in the ECLIPSE substudy.[d6]

[a]93% or greater mean improvement from baseline at each time point from week 52 to week 252 (n=468; observed data after applying treatment failure rules).[2] [b]Patients (n=329) who maintained PASI=0 for ≥156 consecutive weeks over 252 weeks of TREMFYA treatment.[3] [c]TRM=CD8+. n=63. A subset of patients received TREMFYA 16-weekly from week 20.[4,5] The recommended dose of TREMFYA is 100 mg at week 0, week 4 and every 8 weeks thereafter.[7] [d]TRM=CD8+CD49a+CD103+/-. n=11.[6]

Data from exploratory endpoints must be interpreted with caution. The small number of patients analysed may affect findings. No link between TRM cell levels and skin clearance has been established to date.

DLQI, Dermatology Life Quality Index; PASI, Psoriasis Area Severity Index; SD, standard deviation; TRM, tissue-resident memory.

References: 1. Reich K et al. Br J Dermatol 2021; 185: 1146–1159. **2.** Merola JF et al. Presented at European Academy of Dermatology and Venereology (EADV) Congress 29 September – 2 October 2021. (poster P1432). **3.** Puig L et al. Dermatol Ther (Heidelb) 2024; 14: 2539–2558. **4.** Angsana J et al. International Societies for Investigative Dermatology Meeting (ISIDM) 2023 (poster 587). **5.** Eyerich K et al. JAMA Dermatol 2024; 160: 953–963. **6.** Mehta H et al. J Invest Dermatol 2021; 141: 1707–1718.e9. **7.** TREMFYA (guselkumab) Australian approved Product Information.

PBS Information: Authority Required. Refer to PBS Schedule for full details.

Please refer to Product Information before prescribing. Product Information is available from www.janssen.com.au/TREMFYA_PI

Scan here to access the Product Information.

Scan here to access TREMFYA resources.

Johnson&Johnson

Dupilumab efficacy and safety up to 2 years in children aged 6 months to 5 years with atopic dermatitis

Speaker: John Su (Eastern Health, Monash University and Department of Paediatrics, Murdoch Children's Research Institute, Royal Children's Hospital, Melbourne, Australia)

Summary: There is a scarcity of data on the long-term efficacy and safety of dupilumab in children with atopic dermatitis. This phase 3 open-label extension study enrolled 180 children aged 6 months to 5 years with moderate-to-severe atopic dermatitis who had participated in previous dupilumab atopic dermatitis studies. All patients were administered subcutaneous dupilumab every 4 weeks, and topical treatments were permitted. The mean BSA score improved from 31.1 at baseline to 10.3 at week 52 and 7.7 at week 104, while the proportion of patients achieving EASI-75 improved from 29.4% at baseline to 85.1% at week 52 and 92.1% at week 104. There were no unexpected safety signals. Although 87.8% of patients experienced TEAEs, 24.4% and 52.2% of these were mild or moderate in intensity, respectively, while 11.1% were severe. The most common TEAEs related to dupilumab were conjunctivitis (2.8%), urticaria (1.7%), nasopharyngitis (1.7%) and allergic conjunctivitis (1.7%).

Comment: This study provides relevant long-term data on the use of dupilumab in a younger paediatric population with moderate-to-severe atopic dermatitis. The sustained clinical improvements observed over 104 weeks, along with the stable safety profile, are important for clinicians considering long-term biologic therapy in early childhood. While AEs such as conjunctivitis and nasopharyngitis were reported, most were mild or moderate and rarely led to discontinuation. These findings are broadly consistent with existing experience in older age groups and support the ongoing use of dupilumab as a treatment option in selected younger patients. In an Australian context where access to systemic therapy in children remains limited, these data may inform discussions around earlier intervention in refractory cases. However, individual patient factors and long-term disease trajectory should continue to guide decision-making.

Atopic dermatitis
Abstract

Insight into work-related musculoskeletal disorders amongst dermatologists, trainees and pre-trainees

Speaker: Celine Lee (Queensland Health, Australia)

Summary: In this session, Celine Lee reported on an anonymous survey of participants from the 2024 ACD rural dermatology meeting on their perspectives and practices regarding ergonomics and work-related musculoskeletal disorders. The survey included 23 questions and was completed by 15 dermatologists, five pre-trainees, four registrars and one general practitioner. At-work musculoskeletal injury/pain had been experienced by 15/25 respondents, including 9/15 dermatologists. Most respondents reported sitting at their desk for >7 hours per day. Neck pain was the most frequent type of pain, followed by shoulder pain, lower back pain and upper back pain. There were no associations between exercises/stretches and pain levels. Respondents described using a number of different ergonomic tools and strategies in their clinics; foam mats were used by all but one respondent, and other common devices included adjustable beds/chairs, overhead lights, surgical magnification eyewear and headlights.

Comment: This exploratory survey provides a useful early look into work-related musculoskeletal disorders among Australian dermatologists and trainees – an issue that remains under-recognised despite growing procedural workloads. The findings reflect common sites of discomfort (neck, shoulders, lower back) and highlight both the variable use of ergonomic equipment and the self-directed strategies clinicians use to manage strain. Conducted during a rural dermatology meeting, the small sample size and potential for responder bias limit generalisability, but the study draws attention to a practical occupational health concern relevant across both private and public practice settings. In Australia, where dermatologists often balance procedural lists with long consultations and limited support staff, addressing work-related musculoskeletal disorders has implications for workforce longevity and well-being.

Surgery for the general dermatologist
Abstract

The latest in managing cutaneous lupus: treatment pearls for clinical dermatologists

Speaker: Amanda Sacarino (St Vincent's Hospital Melbourne, Australia; University College London, UK)

Summary: While rheumatologists have often been the primary drivers of patient management and research on cutaneous lupus erythematosus, there has recently been a shift towards including dermatologists in this field. Dermatologists are now frequently consulted in clinical trials of systemic lupus erythematosus, and these trials are now describing outcomes regarding cutaneous lupus erythematosus. With an increased number of trials specifically focusing on cutaneous lupus erythematosus in the last few years, there has been an enriched understanding of clinical subtypes and molecular aetiopathogenesis. This is paving the way for future targeted, personalised treatments; for example, pre-treatment histological inflammatory signatures might predict patient responses to B-cell- (belimumab) and T-cell-directed treatments (dapirolizumab), IFN-directed treatments (anifrolumab) and novel plasmacytoid dendritic cell inhibitors (litifilumab). There is also potential for the future use of JAK inhibitors (baricitnib) and TYK2 inhibitors (deucravacitinib) in the treatment of cutaneous lupus erythematosus.

Scleroderma: What should a dermatologist know and do?

Speaker: Amanda Sacarino St Vincent's Hospital Melbourne, Australia; University College London, UK)

Summary: Here, Amanda Sacarino shared practical treatment tips for dermatologists managing patients with scleroderma, which incorporates both systemic sclerosis and morphoea (localised scleroderma). Amanda outlined how skin manifestations can inform early diagnoses of systemic scleroderma, while indicating internal organ involvement and progression. She also described the potential for morphoea to inflict irreversible functional impairment and tissue damage, and the lack of consensus on morphoea subtype classifications and best outcome measures. Amanda provided the latest evidence-based techniques for dermatologists to best improve scleroderma patient outcomes.

Comment: Amanda Saracino provided an immunological update on lupus and scleroderma, emphasising the need for better clinical classification and outcome measures, as well as providing an excellent overview of the immunological pathways involved in these conditions. For morphoea, the Padua classification system can classify 95% of patients. Treatment approaches include methotrexate, mycophenolate, hydroxychloroquine and abatacept, and her anecdotal experience with JAK inhibitors with deep but less inflammatory forms of morphoea. For cutaneous lupus, rituximab and belimumab show promise, with belimumab achieving a 50% response rate. Dapirolizumab has recently been shown in clinical trials to effectively reduce cutaneous lupus activity. Future research should focus on personalised treatments based on molecular subgroups to improve treatment outcomes.

Medical dermatology
Abstract

Antibiotic prophylaxis in dermatological surgical procedures: a guide for cardiac valve and device patients

Speaker: Sam Anderson (Gold Coast Hospital and Health Service, Southport, Queensland, Australia)

Summary: It was previously assumed that dermatological procedures had a relatively low risk of infection; however, recent updates to prophylactic guidelines have indicated that patients with significant cardiac history may have elevated risks. These investigators performed a review on the latest recommendations from the European Society of Cardiology and the American Heart Association regarding the use of prophylactic antibiotics in dermatological procedures for patients with cardiac implantable electronic devices and cardiac valve replacements. The review evaluated the data both for and against antibiotic prophylaxis in these patient populations, and researchers recommended the use of antibiotics for certain high-risk patients undergoing invasive procedures. Prophylactic antibiotics may also be advisable for certain patients undergoing skin excisions. The review discussed the importance of avoiding potential adverse effects with antibiotic overuse such as side effects and resistance, while also preventing risks of infection such as infective endocarditis.

Comment: Key points included the low incidence of prosthetic valve endocarditis (0.3%–1.2% annually), with a significant mortality rate (20%–40% within 5 years). Australians mostly follow the European Society of Cardiology guidelines for antibiotic use with class I recommendations (level B evidence) for high-risk dental procedures and class IIb recommendations (level C evidence) to use systemic antibiotics for high-risk patients undergoing invasive diagnostic or therapeutic procedures including the skin. Importantly, high-risk patients are those having prosthetic valves, recent valve repair, previous native valve infective endocarditis, unrepaired cyanotic heart disease or atrial/ventricular septal defect (ASD/VSD) closure devices. High-risk procedures are considered those involving the oral mucosa, lip biopsies and procedures on infected skin. In Australia, amoxicillin 2gm 60 mins before procedures is advised. Emphasis was placed on strict hygiene, timely infection treatment and avoiding unnecessary procedures. No prophylaxis was recommended for clean skin excisions or patients with electronic devices.

Surgery for the general dermatologist
Abstract

Pigmentation treatments demystified: unlocking laser strategies with a master in the field

Speaker: Philip Bekhor (Royal Children's Hospital Melbourne, Australia)

Summary: In this session, Associate Professor Philip Bekhor described the challenges and intricacies of managing patients with pigmentary conditions. He discussed his extensive experience in treating pigmentation disorders throughout his career, using both lasers and medical therapies. The key topics included in his presentation related to the management of iron infusion staining, melasma, post-inflammatory pigmentation, Hori's nevus, lentigo and poikiloderma of Civatte. Philip also spent considerable time exploring the ways in which different approaches can be individualised according to Fitzpatrick skin type.

Comment: Phil Bekhor discussed the complexities of treating pigment problems in adults, emphasising the importance of accurate diagnosis, particularly of lentigo maligna and speckled melasma prior to laser treatment for pigmentation. His tip is that a lentigo that rapidly reappears after laser clearance requires biopsy. Treating speckled melasma will be made worse with laser treatment. Bekhor stressed the need for standardised photographic systems and endpoints like frosting (q-switched lasers) and oedema and erythema (picosecond lasers) with tailoring of treatment strategy depending on Caucasian versus Asian patients. He also covered the use of tranexamic acid, hydroquinone and oral tranexamic acid for melasma treatment, with 500mg daily dosing preferred by the author over 250mg twice daily. The impact and treatment of iron extravasation staining and anecdotal personal experience of compression at the time of iron extravasation injury may limit the extent of the stain, through observation that areas under the bandage and dressings are not as affected.

Opening plenary

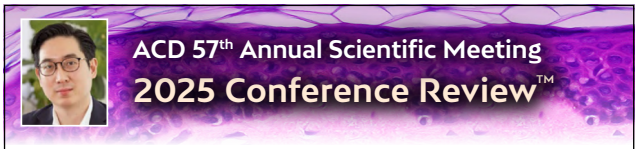
The control of melanoma and skin cancer: how are we doing?

Speaker: David Whiteman (QIMR Berghofer Medical Research Institute, Herston, Australia)

Summary: Professor David Whiteman was invited to speak during the opening plenary to provide attendees with an update on the burden of skin cancer in Australia. He shared that currently, skin cancer treatments incur more costs for Australia than any other cancer type, with hundreds of thousands of melanomas and keratinocyte cancers treated every year, incurring costs of nearly $2 billion annually. David discussed the current status of the three core skin cancer control strategies, specifically primary prevention, early detection and effective treatment. He also highlighted that there are a number of complexities and potential hurdles which may impact on how effectively these control strategies can be implemented in the future.

Comment: This keynote provided a comprehensive overview of Australia's progress and ongoing challenges in skin cancer control. Professor Whiteman highlighted the economic and public health burden of keratinocyte cancers and melanoma, reinforcing that primary prevention – especially minimising cumulative UV exposure – remains the most effective long-term strategy. The data presented suggested encouraging trends: melanoma rates are declining in younger Australians (likely reflecting sustained public health efforts), while excision rates for early melanomas have shifted toward thinner lesions. However, the rise in thick melanomas and the limitations of early detection, particularly in identifying biologically aggressive subtypes, underscore the need for better risk stratification and targeted screening. The plenary also reviewed the impact of newer systemic therapies, which have improved mortality trends but at high financial and QOL costs. For Australian dermatologists, this talk reinforced the importance of advocacy for prevention funding, continued vigilance in early detection, and thoughtful implementation of future risk-based screening models.

Opening plenary



Independent commentary by Dr Philip Tong

Dr Philip Tong became a Fellow of the Australasian College of Dermatologists after completing his dermatology specialist training in NSW as the inaugural Dean's Fellow in Dermatology, a joint initiative with The University of Sydney. He underwent world class-research and dermatology training at St Vincent's Hospital, Royal Prince Alfred Hospital, Liverpool and Westmead Hospitals. He also completed his PhD in advanced biomedical imaging and skin immunology at Centenary Institute during this time. Prior to obtaining his specialist qualifications, Dr Tong also received training in dermatology departments in Perth, Melbourne as well as in London at the world-renowned St John's Institute of Dermatology at Guy's and St Thomas' Hospital. He has lectured nationally and internationally on all aspects of skin and facilitates online learning modules for GPs and pharmacists. He is a VMO at St Vincent's Hospital in Sydney and in private practice in Bondi Junction. His early research focus was in melanoma, biomedical imaging and skin immunology, however he now focuses his energy in utilising technology to improve dermatology access to patients, GPs and pharmacists. He does this through a virtual care platform called DermScreen.