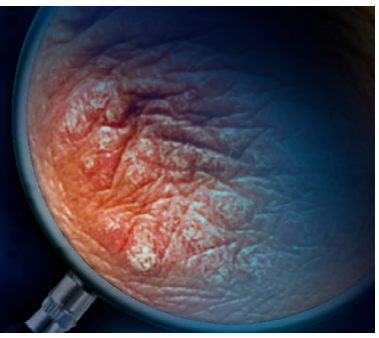
Dermatology Practice Review™



Making Education Easy

Issue 40 - 2025

In this issue:

Abbreviations used in this issue:

AI = artificial intelligence; **CPD** = continuing professional development; **CPP** = chronic plaque psoriasis; **JAK** = Janus kinase; **IL** = interleukin; **MBS** = Medicare Benefits Schedule; **PBAC** = Pharmaceutical Benefits Advisory Committee; **PBS** = Pharmaceutical Benefits Scheme; **PLHIV** = people living with human immunodeficiency virus; **PUVA** = psoralen + ultraviolet A; **TGA** = Australian Therapeutic Goods Administration; **TNF-α** = tumour necrosis factor alpha; **UVA** = ultraviolet A; **UVB** = ultraviolet B; **VAF** = variant allele frequency.

Welcome to the 40th issue of Dermatology Practice Review.

This Review covers news and issues relevant to clinical practice in dermatology. It will bring you the latest updates, both locally and from around the globe, in relation to topics such as new and updated treatment guidelines, changes to medicines reimbursement and licensing, educational, professional body news and more. Finally, on the back cover you will a summary of upcoming local and international educational opportunities including workshops, webinars and conferences.

We hope you enjoy this Research Review publication and look forward to hearing your comments and feedback.

Kind Regards,

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Clinical Practice

Practice guidelines for teledermatology in Australia

The *Practice Guidelines for Teledermatology in Australia*, developed by the Centre for Online Health in collaboration with the Australasian College of Dermatologists, provide evidence-based recommendations to support safe, effective and standardised teledermatology aligned with the Medical Board of Australia's 2023 telehealth guidelines and existing privacy and medico-legal frameworks. They apply to specialist dermatologists practising in Australia and cover store-and-forward, real-time video and telephone consultations, as well as hybrid models, including referred care, direct-to-consumer services, triage, and ongoing follow-up.

The guidelines emphasise that teledermatology should only be practised by appropriately credentialled dermatologists who understand both the capabilities and limitations of remote assessment, including constraints on physical examination and image quality. Clinicians are advised to confirm indemnity cover for telehealth, use professional judgement to determine when teledermatology is appropriate, and consider blended in-person and telehealth care when suitable. Telephone consultations are recognised as increasingly common, but video is preferred when visual assessment or non-verbal cues are important, or where engagement and communication would be enhanced.

Key domains include technology, privacy and environment; patient selection and consent; image quality; communication; documentation; and secure storage of images. Dermatologists are encouraged to use purpose-built secure platforms rather than consumer messaging tools, ensure encrypted transmission, and optimise videoconferencing and display specifications to maintain diagnostic quality while protecting visual and auditory privacy. Informed consent processes should clearly explain the nature, risks, and limitations of teledermatology, differences from in-person care, contingencies for technical failure, and billing arrangements, with responsibilities for consent varying across referred, direct-to-patient, and clinician-to-clinician scenarios.

The guidance provides detailed technical standards for clinical and dermoscopic image acquisition, including minimum resolution, camera settings, positioning, use of scale markers, and sequential imaging protocols, along with recommendations for reviewing images on suitable displays. Images are considered part of the medical record. They must be documented, stored, and retained in line with state and territory legislative requirements, ideally within a Picture Archiving and Communication System, vendor-neutral archives, or electronic medical records, using secure architectures, backup, audit trails, and cloud services that meet Australian cyber security guidance. Clear communication back to referrers, timely escalation of urgent findings, feedback on image quality, and use of tools such as image acquisition guides or mnemonics are promoted to support continuous quality improvement in teledermatology services.

https://tinyurl.com/449p93y2

Australia's national skin cancer scorecard 2025

Australia's National Skin Cancer Scorecard 2025 is a national, evidence-informed framework intended to coordinate and benchmark action on melanoma, keratinocyte cancers and rarer skin cancers across the prevention, early detection, treatment and survivorship continuum. It responds to Australia's high incidence of skin cancer, substantial health-system costs (estimated at $2.47 billion in 2023/24, mostly from keratinocyte cancers) and persistent inequities affecting younger people and those in regional, rural and remote communities. The Scorecard consolidates and updates prior national inquiries and reports and defines 16 priority items: 11 topic-specific and 5 foundational system enablers.

Prevention priorities include sustained national investment in targeted and mass media campaigns, strengthening sun protection policies in secondary schools, systematic shade planning in high-risk public spaces, and embedding sun-safe practices in outdoor sports. Early detection priorities centre on a National Targeted Skin Cancer Screening Program, now supported by a funded Roadmap project, and on stronger funding and regulation for teledermatology and AI-enabled digital tools to improve access while managing safety and overdiagnosis risks. Treatment items call for regular updating and expansion of clinical practice guidelines (including for rarer cancers), improved access to multidisciplinary team care using virtual platforms, and timely, equitable access to innovative systemic therapies via TGA/PBS pathways and clinical trial participation.

Supportive care items emphasise routine, equitable psychosocial assessment and support for patients and carers, including telehealth-delivered services, and meaningful implementation of melanoma and keratinocyte Optimal Care Pathways with a stronger focus on survivorship and patient-reported outcomes. Foundational items seek full implementation of the Australian Cancer Plan and Aboriginal and Torres Strait Islander Cancer Plan for all skin cancers, sustained investment in research (with greater attention to keratinocyte cancers), systematic and meaningful consumer involvement, a national surveillance strategy including keratinocyte registration and quality indicators, and strategic workforce planning and upskilling to address geographic maldistribution and capacity gaps. Overall, current progress is mixed: some domains (e.g. national campaigns, screening roadmap, access to medicines, cancer plan implementation) are rated as showing significant or some progress, while others (e.g. school policies, shade, multidisciplinary team access, psychosocial care, keratinocyte surveillance) require substantial further action and data development.

https://tinyurl.com/bdzn8zkm

Guidelines for phototherapy and PUVA service delivery in Australia

Recently published guidelines define minimum standards and a quality assurance framework for the safe, consistent delivery of phototherapy and psoralen + ultraviolet A (PUVA) across Australia, addressing a current gap in national guidance beyond existing narrow-band ultraviolet B (UVB) recommendations. Phototherapy is positioned as an effective option for a range of inflammatory and photosensitivity dermatoses, with the guidelines adapted from British standards to the Australian healthcare and Medicare context.

Phototherapy must be prescribed by a consultant dermatologist or supervised trainee, following a formal dermatological assessment that documents diagnosis, treatment goals, alternatives and justification for choosing phototherapy. A structured record of each course is required, including per-session dose, cumulative UVA/UVB exposure, and diagnosis, with explicit linkage to MBS Item 14050, which limits claimable treatments and clarifies reimbursable modalities. Pre-treatment assessment must capture prior phototherapy, photosensitising medications, comorbid photosensitivity, allergies, special needs, Fitzpatrick skin type, and results from minimal phototoxic dose or minimal erythema dose (MED) testing, where applicable.

Patients must receive written information and provide two-stage written consent, with dermatologists covering long-term risks and alternatives, and phototherapists addressing logistics, short-term adverse effects and expectations. Staff delivering treatment may be registered nurses or trained technicians. Still, all require supervised formal training, competency assessment and ongoing CPD, with services maintaining training records and professional oversight by a dermatologist.

Services must use documented, evidence-based protocols for initiation, dose escalation and adverse event management, supported by accessible records at each visit and appropriate dermatologist review intervals. Ultraviolet equipment requires regular calibration, dosimetry, and maintenance by suitably qualified personnel to account for device variability and ensure dose accuracy. Governance structures should include twice-yearly meetings, routine incident reporting with standardised erythema grading, and periodic reviews of guidelines and audits. The guidelines also recommend clear discharge instructions, long-term monitoring for patients at higher risk of skin cancer, and consideration of annual skin cancer surveillance beyond 200 PUVA or 500 UVB treatments, with individualised risk–benefit assessment for continued therapy.

https://tinyurl.com/46s6vwdu

Biologic and small-molecule therapies for chronic plaque psoriasis in people living with HIV

A recent narrative review examines the emerging evidence for biologic and small-molecule therapies in people living with HIV (PLHIV) who have chronic plaque psoriasis (CPP), highlighting that most pivotal psoriasis trials have excluded this population. Case reports, small series, and retrospective cohorts largely guide current practice.

Available data suggest that, in carefully selected PLHIV with well-controlled infection on antiretroviral therapy, biologics across several classes (TNF-α, IL-12/23, IL-23, IL-17 inhibitors) can achieve substantial skin (and sometimes joint) responses without meaningful deterioration in viral load or CD4 counts over short- to medium-term follow-up. A pooled safety analysis of 93 HIV-positive patients reported adverse events in around 14% overall, with lower rates for IL-23 inhibitors and higher rates for IL-17 inhibitors, although small numbers, heterogeneity and likely publication bias limit definitive conclusions. Real-world cohort data in 36 PLHIV treated with biologics showed stable HIV parameters over 12 months and infection rates similar to HIV-positive controls. Evidence for small molecules is scant; apremilast has been used in isolated cases with good skin responses and stable HIV indices, whereas deucravacitinib use is anecdotal and formal safety data in PLHIV are lacking.

The authors emphasise that reported patients generally had durably suppressed viral loads and adequate CD4 counts, and most were managed in specialist centres, so long-term safety beyond about 12 months and use in those with suboptimal HIV control remain uncertain. Serious opportunistic infections, including fatal events, have been described particularly with early anti-TNF use, reinforcing the need for cautious, individualised risk–benefit assessment. In practice, systemic biologic therapy should be reserved for moderate-to-severe, treatment-refractory disease, and initiated only in collaboration with HIV/sexual health or infectious diseases specialists. Emerging data tentatively favour IL-23 and IL-12/23 inhibitors over anti-TNF and IL-17 agents, which appear to have somewhat higher reported adverse event rates, but no formal guideline-endorsed class hierarchy exists. Recommended work-up includes a baseline CD4 count and HIV viral load, screening for latent tuberculosis and viral hepatitis, and ongoing monitoring for opportunistic infections and hepatitis reactivation where relevant. The article concludes that cautious, closely monitored use of biologics and selected small molecules is reasonable in well-controlled PLHIV with severe psoriasis, but calls for inclusion of PLHIV in clinical trials, the development of large registries and consensus guidance to address persistent gaps in long-term and class-specific safety data.

https://tinyurl.com/569xsvjd

Earn CPD

The Australasian College of Dermatologists (ACD) has approved all Dermatology Research Reviews for accreditation as a Category 1 Education Activities - Professional Reading and Study. Activity should be logged in hours. For further information please click here.

Australian College of Rural and Remote Medicine (ACRRM) Professional Development Program (PDP) participants can claim Educational Activity hours in the self-directed learning category for reading Research Reviews. More info.

The Royal Australian College of General Practitioners (RACGP) members can **Quick Log** (self-record) a CPD activity such as reading a Research Review publication or watching a video under the CPD activity type 'Educational Activites'. More information is available at RACGP - Your myCPDhome member resources

Diagnosing mosaic disorders affecting pigmentation

A recently published review outlines a practical framework for making a genetic diagnosis in mosaic disorders affecting pigmentation, which typically present as patterned hypo- or hyperpigmented birthmarks with variable risks of extracutaneous involvement, malignancy and germline transmission. A modular classification that combines developmental pattern, lesion type, and genotype is used to guide investigation and refine prognosis, therapeutic decisions, and genetic counselling.

Key conceptual points include understanding variant allele frequency (VAF) and the implications of mosaicism for test sensitivity. Mosaic variants are usually heterozygous and confined to a subset of cells, so the proportion of variant alleles in affected skin can be very low, particularly in flat macular lesions, necessitating high-depth next-generation sequencing (often ≥250×, ideally higher) rather than Sanger sequencing. Testing sensitivity thresholds must be interpreted against the expected VAF for a given phenotype, as a "negative" result at 5% VAF does not reliably exclude variants present at 1% or less.

The article provides stepwise, phenotype-driven guidance on sampling and testing. Clinicians should first exclude germline diagnoses (blood-based testing), then biopsy representative affected skin (preferably palpable lesions) for DNA extraction, avoiding formalin fixation where possible and not relying on cultured fibroblasts, which often do not harbour the causal variant. Deep targeted next-generation sequencing panels are recommended as first-line for most patterns, with chromosomal copy-number analysis prioritised initially for Blaschkolinear macular lesions and fusion-gene analysis considered second-line for nonsegmental dermal lesions if deep DNA sequencing is negative.

Known single-gene and chromosomal causes are summarised by pattern, and genes with variants compatible with germline life are highlighted, as these carry potential transmission risks and warrant discussion of preimplantation genetic testing. The review addresses interpretation challenges, including variants of uncertain significance, the need for secondary assay validation, and when to consider a second biopsy or future retesting as technologies evolve. Once a pathogenic mosaic variant is identified, combined phenotypic–genotypic labels (for example, BRAF-fusion mosaic nonsegmental congenital melanocytic naevus) are advocated to support precise, personalised management and counselling.

https://tinyurl.com/mthbxyj3

Regulatory News

Changes to MBS skin excision items to include healing by secondary intention

From 1 November 2025, 18 Medicare Benefits Schedule (MBS) items for skin excision will be amended to explicitly include wounds managed by healing by secondary intention rather than primary closure, flap or graft. Healing by secondary intention involves leaving the wound open to granulate and epithelialise.

It recognises the additional aftercare required, particularly for anatomically complex or high-tension sites such as the forehead, scalp, periocular and nasal regions, and below the knee and wrist. When secondary intention is used, only the relevant skin excision item should be claimed, and the changes do not apply to shave excisions, curette and cautery, or simple small excisions.

The amendments follow recommendations from the Dermatology and Skin Services Advisory Group and aim to align MBS funding with contemporary clinical practice while maintaining usual compliance and audit requirements. Clinicians should review the revised item descriptors, rules and explanatory notes on MBS Online before implementing these changes.

https://tinyurl.com/4r2jhtdc

Upcoming PBAC agenda items

At the next meeting, scheduled for March 2026, the PBAC will consider the following requests for new PBS listings relevant to neurologists:

- Four new higher concentration forms of **adalimumab** (Amgenvita®; Amgen Australia) that mirrors current PBS-listed adalimumab brands for a range of indications, including **CPP** and **hidradenitis suppurativa**.
- A new form of **adalimumab** (Yuflyma®; Celltrion Healthcare Australia) that mirrors the originator brand's current listings with the same form (20 mg in 0.2 mL pre-filled syringe) for a range of indications, including **CPP**.
- **Birch triterpenes** (Filsuvez®; Chiesi Australia) for the treatment of patients >6 months with partial thickness skin wounds caused by **dystrophic or junctional epidermolysis bullosa**.
- **Nemolizumab** (Nemluvio®; Galderma Australia) for the treatment of **moderate to severe atopic dermatitis** in patients aged ≥12 years who are eligible for systemic therapy.
- A new strength and form of **nivolumab** (Opdivo®; Bristol-Myers Squibb Australia) for the existing PBS-listed indications, including **malignant melanoma** and **squamous cell carcinoma of the head and neck** (except where nivolumab is administered three times a week in combination with ipilimumab).
- A new ustekinumab (**Ardelya®**; Sandoz) biosimilar for the treatment of **severe CPP** and severe psoriatic arthritis that mirrors the originator brand's current listings.

The PBAC will also consider a request to change an existing listing to allow the maintenance dose of **tildrakizumab** (Ilumya®; Sun Pharma ANZ) to be increased from 100 mg to 200 mg per administration (administered every 12 weeks) for the continuing treatment of **severe CPP**.

https://tinyurl.com/yvpa8294

Earn CPD

CPD Home. Subscribers can claim the time spent reading and evaluating research reviews as an Educational Activity: Professional Reading in the CPD Tracker. Please Contact Us for support.

The Skin College Australasia (SCCA) has approved Research Review as a quality CPD provider, meeting the Education category within the CPD Registration standard. Subscribers of SCCA CPD Home SkinPro CPD can record their time spend reading the review as a self-directed activity. Please click here to access futher CPD information.

Nursing and Midwifery Board of Australia (NMBA) Journal reading and watching videos (including Research Reviews') may be considered a self-directed activity set out in the NMBA Registration Standard: Continuing Professional Development. One hour of active learning will equal one hour of CPD. Details at NMBA CPD page.

News in Brief

Launch of AdvanceAD-Tx™ in the US

AdvanceAD-Tx is a non-invasive 487-gene expression profile test for patients ≥12 years with moderate-to-severe atopic dermatitis, designed to guide systemic therapy selection between Janus kinase (JAK) inhibitors and Th2-targeted agents. Validation data suggest that the test identifies a JAK inhibitor responder profile associated with greater and faster improvement in the Eczema Area and Severity Index, with 90% responses, reduced itch, fewer flares, and better quality of life by three months of JAK inhibition.

https://tinyurl.com/mrbeypff

ChatGPT alone is unreliable for producing cosmetic consent forms

Lori S. Kim presented data at the American Society for Dermatologic Surgery annual meeting (November 2025) on the quality and readability of ChatGPT-4-generated informed consent forms. Kim and colleagues evaluated the AI-generated consent forms for eight common laser and energy-based device procedures. These included ablative laser, non-ablative factional laser, laser hair reduction, pulsed dye laser, monopolar radiofrequency laser, radiofrequency-microneedling, Q-switched laser, and picosecond laser. While ChatGPT can rapidly generate informed consent forms for cosmetic dermatology procedures, the content exceeds the recommended sixth-to-eighth-grade reading level and contains inaccuracies. Thus, while AI can streamline documentation, clinician oversight remains crucial for ensuring accuracy, clarity and legal adequacy.

https://tinyurl.com/4kmstn4x

Conferences, Workshops, and CPD

The Australasian College of Dermatologists
DermNet New Zealand
Australian Dermatology Nurses' Association
COMS - Conferences and Meetings on Dermatology

Research Review Publications

Dermatology Research Review with Dr Warren Weightman

Hidradenitis Suppurativa Research Review with Associate Professors John Frew and Erin McMeniman

Melanoma Research Review with Professors Michael Henderson and Peter Hersey

Psoriasis Research Review with Associate Professor John Frew

Skin Cancer Research Review with Dr David Simpson

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