What's hot?

In this new monthly column, members of the Dermatology World *Editorial Advisory Workgroup identify exciting news from across the specialty.*

Annie Chiu, MD

A new article in *JAMA Dermatology* (2015;151(9):941-944) debunks the urban myth of monitoring potassium for **patients on spironolactone**. This is an effective medication for women with hormonal acne, and burdensome lab monitoring along with what appears to be fears without true merit of hyperkalemia induced cardiac arrhythmias and other adverse effects have probably affected its use in the treatment of adult female acne.

Jeffrey S. Dover MD, FRCPC

Until now the only effective treatments for submental fat were liposuction or surgery. Two new non-invasive technologies have recently been approved by the FDA for the **reduction of submental fat**. A series of deoxycholic acid injections, (Kybella, Allergan, Irvine, California) into the submental fat induces an inflammatory response resulting in a clinically significant reduction of submental fullness in about 80 percent of subjects. Side effects which are mild and reversible include pain, bruising, swelling, tenderness, and numbness of the treated area. Cryolypolysis is a completely non-invasive procedure which induces a cold panniculitis which yields reproducible fat reduction. A new small applicator has been designed to fit under the chin (Cool Mini, Zeltiq, Pleasanton, California). Results after two treatments were universally impressive. Self-limited, mild side effects included tenderness, bruising, swelling, and numbness of the treated area. These two exciting new developments will open up an entirely new area of non-invasive cosmetic treatments of the neck.

**Dr. Dover is on the scientific advisory board of ZELTIQ and has done research for Allergan (the present owner of Kybella).*

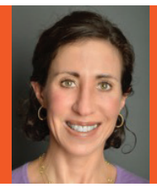
John Harris, MD, PhD

A number of exciting recent studies report using Janus Kinase (JAK) inhibitors for a variety of inflammatory skin diseases, including **vitiligo, alopecia areata, and atopic dermatitis** (*J Invest Dermatol* 2014;134:2988-90, *J Am Acad Dermatol* 2015;73:395-9, *JAMA Dermatol* 2015;151:1110-2), although they are only FDA-approved for rheumatoid arthritis (Xeljanz) and myelodysplastic syndrome/polycythemia vera (Jakafi). While these were open-label studies in a small number of subjects, the inhibitors target inflammatory pathways that are causative (*Nat Med* 2014;20:1043-9, *Sci Transl Med* 2014;6:223ra23), suggesting that we may see larger, controlled studies in the future. Both are currently expensive (Xeljanz is about $2k/month and Jakafi is $10k/month), but they may prove to be the first targeted systemic treatments for diseases like vitiligo and alopecia areata, which would put these neglected diseases on more equal footing with psoriasis. "Next-generation" versions may have better efficacy with fewer side effects, if not a better price tag.

Sylvia Hsu, MD

Many dermatologists check thousands of dollars' worth of labs in order to look for an underlying cause of **chronic urticaria**. This article will save us all a lot of unnecessary testing (*J Allergy Clin Immunol* 2014; 133(5): 1270-7).

After a history and physical examination, no diagnostic testing may be necessary for patients with chronic urticaria. Extensive routine testing for exogenous and rare causes of chronic urticaria or skin testing for inhalants or foods is not warranted. Routine laboratory testing in patients with chronic urticaria rarely yields clinically significant findings. Screening for thyroid disease is of low yield in patients without symptoms or a history of thyroid disease. Increased levels of anti-thyroglobulin or anti-thyroid antibodies in euthyroid subjects are commonly seen, but the clinical significance is unknown. Testing for autoantibodies to the high-affinity IgE receptor or autoantibodies to IgE is also not useful since it is unclear whether detection of these antibodies identifies a clinically unique group or will lead to a change in management.



Risa Jampel, MD

Brachytherapy may be coming to a location near you.

No sooner had I read the *JAMA Dermatology* Viewpoint on electronic brachytherapy (2015;151(7):699-700), the letter from the American Society for Therapeutic Radiation Oncology (doi: 10.1001/jamadermatol.2015.2006), and the response of the Viewpoint authors to ASTRO's letter (doi: 10.1001/jamadermatol.2015.2007), than I received marketing materials about brachytherapy from a radiation oncologist in my area looking for referrals to treat non-melanoma skin cancer. The brochure claims proven, safe, non-surgical treatment for skin cancer that spares normal tissue and has minimal to no down time. The Academy has written a position statement on this topic (available at **www.aad.org/Forms/Policies/ps.aspx**) and I think we will begin to hear a lot more about the pros, cons, and complications of this procedure in the next several years.

Rob Sidbury, MD

Two phase 3 trials from Anacor of their AN2728 non-steroidal topical agent for **mild to moderate atopic dermatitis** (now called crisaborole) suggest we will soon have a non-steroidal option unburdened by a boxed warning. Trials showed it working better and faster than vehicle with modest rates of application site reactions like stinging.

Time will tell where this new drug fits into our armamentarium but these trial results remind me of pimecrolimus trial data way back in 2001. The value of this to dermatologists may be modest; the value to a concerned parent for whom our mitigation of the black box is cold comfort? Tremendous.