National
Alopecia Areata
Foundation®

NAAF Webinar Transcript: Treatment Updates 2024

Maryanne Senna, MD

LISA ANDERSON, PHD: (00:00)

Let's get started. Welcome to the National Alopecia Areata Foundation's webinar, Alopecia Areata Treatment Update 2024. Joining us today is Dr. Mary Ann Senna, Director of the Leahy Hair Loss Center of Excellence in Burlington, Massachusetts. And I'm Lisa Anderson, Senior Director of Research for NAAF.

Before we start the webinar, I'd like to cover a few housekeeping details. We've disabled chat for this webinar session. Please post questions for Dr. Sena in the Q &A section. Please keep your questions as general as possible for the benefit of all audience members. This webinar is being recorded and all registrants will receive a link to the recording via email sometime tomorrow. And finally, please share your feedback with us. At the end of the webinar, a link to a short survey will pop up in your browser window.

Please complete the survey there.

This webinar is part of NAAF's You Are Not Alone education and empowerment webinar series. NAAF gratefully acknowledges the support provided for this series by our partners Pfizer, Eli Lilly & Company, and Sun Pharma.

Before we started, I'd like to tell you a bit about and our mission. The National Alopecia Areata Foundation is the leading advocacy organization for alopecia areata. NAAF's mission is to drive research to find a cure and accessible treatments for alopecia areata, support those impacted, and educate the public about the disease. NAAF's vision is an empowered community with a choice to embrace or live free of alopecia areata. To learn more about NAAF's support resources and research and advocacy activities, or to join us as an advocate or a supporter, please visit our website at naf.org.

And now on to today's webinar, Alopecia areata treatment update 2024. We're very pleased to have Dr. Mary Ann Senna back with us today. Dr. Senna is a board certified dermatologist at Beth Israel Leahy Health and assistant professor of dermatology at Harvard Medical School. Dr. Senna founded and directs the Leahy Hair Loss Center of Excellence and serves as principal of the research unit.

Prior to this role, she founded the MGH Hair Loss Clinic and Clinical Trials Unit, which she ran for nearly 10 years. She's widely published and recognized her clinical expertise, teaching, and research. Dr. Senna gives lectures nationally and abroad and has been quoted in top tier publications such as the New York Times and the Atlantic. Dr. Senna is on the board of directors of the Scarring Alopecia Foundation and American Hair Research Society.

and we are grateful to have her as a member of NAAF's Scientific and Medical Advisory Task Force. Dr. Sena, thank you so much for being here today. I'm going to stop sharing my screen and I will turn it over to you.

MARYANNE SENNA, MD: (02:48)

Great. Thank you so much for having me. I always enjoy doing these talks, and I really aim to try to empower patients so that they can hopefully use the information to make the best decisions for themselves and help them know which questions to ask and how to think about treatments and their response to treatments and things like that. So thank you very much for having me.

The outline for this talk will be to review the treatments that are FDA approved for severe alopecia areata, discuss the factors that are associated with efficacy and safety of the medications, and to then address some commonly asked questions. So I first want to make you aware of the fact that nearly two years ago now,

I did do a first patient webinar for NAAF. And this really offers an introductory of what JAK inhibitors are, how they work, sort of their mechanism of action. And at that time, we had just barocytinib FDA approved. And so most of the data is regarding barocytinib efficacy and safety data. But it reviews really how I and many of us think about the black box warnings. where the black box warnings originated from, who might be at higher risk for the side effects that are associated with the black box warnings, et cetera. And so you can still access that webinar on the NAAF webpage. You just look on the third page under webinars for the silly picture of me and you can access it. So if you need more of an introduction and more of a deep dive into where the black box warnings come from, that would be the webinar to look at. So as we know well, alopecia areata affects a significant proportion of individuals and this is something that occurs worldwide. And while 50 % of patients might develop a patch or several patches that spontaneously regrow within the first year, we know that at least 50 % of patients will go on to have more persistent disease with patches that come and go. And some of these patients might develop more extensive areas of hair loss. Some of these, while still alopecia areata, are given specific names. Like in this case, this pattern ear to ear in the back of the scalp is known as Ophiasis alopecia areata.

Some studies suggest that up to 20 % of patients will develop the most severe forms of alopecia areata, namely alopecia totalis, meaning complete scalp hair loss, or alopecia universalis, which means complete scalp and body hair loss. And when you have these most severe forms of alopecia areata, the likelihood of regrowing hair without any treatment at all is not impossible.

but it's very, very low. Studies suggest much less than 10%. And so the Janus kinase inhibitors or JAK inhibitors have really revolutionized our ability to treat severe alopecia areata and have brought a really meaningful change to so many people who understandably struggle with this condition. But it's really important to me as a dermatologist that

patients, like I said, feel empowered and really understand the efficacy of these medications and also the risks that they need to be aware of and some of the other things around this. So before I get too deep into the talk, I think it's important and forgive me if this is sort of...repetitive for some people, but I think it's important to make sure that everyone is on the same page and understands what the SALT score is. Because while it's not really something we do, right, day to day in clinic, it's something that insurances are increasingly asking us to document in our clinical notes when they're thinking about covering JAK inhibitors. We'll talk about that in a minute. But also, importantly, it's what's been used in clinical trials. So a lot of the data that I'm going to discuss with you talks about the SALT score. So SALT stands for Severity of Alopecia Tool. And basically you can think of a SALT score as approximating the percent scalp hair loss from alopecia areata. And so it ranges from a score of zero, which means the person has no scalp hair loss, to 100, which means complete scalp hair loss. In clinical trials that have been done in FDA approved treatments for alopecia areata, patients had to have a SALT score of 50 or higher or at least 50 % scalp hair loss to be eligible to participate. Because of this, a lot of insurance companies are saying, in order for us to cover your drug, you have to have a SALT of 50 or more or 50 % scalp hair loss or more. But is that really how we should be thinking about severity? We'll talk about that in a minute. On these clinical trials, clinically meaningful hair growth or what was considered a success that someone had responded to a drug that was being studied was to have a salt of less than or equal to 20, right? Or 20 % or less scalp hair loss, put another way, you get 80 % of the hair back on your head or more at a given time point. So before I get into the trial data, you know, what is severe? So I think just about anyone would agree that this is severe, right? This patient has no hair because of their alopecia area.

But what about a patient like this who's received every four to six weeks multiple painful injections over the scalp, might not have 50 % scalp hair loss, but isn't really responding to treatment. And this can be understandably quite disfiguring for someone. Or what about something like this? Not 50 % scalp hair loss, but...certainly a big enough area that could be very difficult to camouflage. And what I try to explain to people who don't treat alopecia areata all the time is sometimes something like this, the spatial the way to the right, can be extra hard because it can be harder to camouflage. You can't get a wig to stay on the scalp when you have hair coverage in other areas. so in various cases, this disease can be, understandably, very, very difficult to live with.

And so a group of us across the United States came together to develop something called the AASC or alopecia areata scale. And we came up with this scale in order to try to advocate for our patients so that they can get access to treatments despite whether or not they have exactly 50 % or more scalp hair loss if we felt it was necessary. And so the way that this scale works is we start with the extent of scalp hair loss.

And that large group of us agreed that mild alopecia areata is 20 % or less scalp hair loss. Moderate alopecia areata would be 21 to 49 % scalp hair loss, and severe alopecia areata would be 50 % scalp hair loss or more. But if you had mild or moderate alopecia areata just due to your percent scalp hair loss alone and had any one of the following four things,

It upgrades your severity level by one. And those four things are negative impact on psychosocial functioning resulting from AA, right? A child who's withdrawing from social activities or an adult or a child who doesn't want to go to school. A noticeable involvement of eyebrows or eyelashes. An inadequate response after at least six months of alopecia areata directed treatment. Or a diffuse multifocal positive hair pull test. So if someone's in front of you and yeah, they have hair, but with the rate that their hair is coming out, you know that they're gonna have rapidly progressive alopecia areata. So to give you an example of how this works, so if a patient comes into my clinic and they have 30 % scalp hair loss, by scalp hair loss alone, that falls into the moderate alopecia areata category. And this patient is responding well to scalp steroid injections, has no involvement of eyebrows or eyelashes, and is coping well, they stay moderate alopecia areata. Take another patient with 30 % scalp hair loss. so moderate alopecia areata, but in this case, they also have eyebrow loss and are avoiding social situations and he's finding it difficult to do his public facing job. That would be upgraded one level to severe alopecia areata. So often, if I'm getting a rejection from an insurance company, I reference this paper in my appeal letter and say, you know, this patient has severe AA given the following criteria.

And oftentimes that can be helpful in obtaining coverage for patients when needed. So when do I consider treatment with an oral JAK inhibitor in alopecia areata? I kind of follow that AA scale. know, typically a patient will have at least 30 % scalp hair involvement that's persistent or not improving despite the fact that we're doing other treatments, that has significant social withdrawal, psychosocial component or major life impact or if I see it's involving eyebrow, eyelashes, and especially if those things are causing more functional issues.

So I'm going to turn now to the three FDA-approved JAK inhibitors for severe alopecia areata. Right now, those three include baricitinib, and that comes in two doses, two milligrams and four milligrams, and the trade name is Olumiant It's a JAK 1,2 inhibitor. We also have ritlecitinib at a dose of 50 milligrams per day. That goes by the trade name Litfulo and all of these, by the way, are oral medications.

And that's a JAK3-TEK inhibitor. And most recently, we've had deuruxolitinib or Leqselvi approved at eight milligrams two times a day. And you can see in ∼ the middle column here the number of patients who are on the trials in each case. And importantly, when you're...

Thinking about the efficacy data and some of the other data I'm going to share, it's really important to know that while patients had to have 50 % or more scalp hair loss in order to be eligible for the trial, the vast majority of patients had much more extensive hair loss. So if we look at the average SALT scores or average approximate percentage scalp hair loss of patients when they started the study, we see 86, 90.4.

86.8 % scalp hair loss on average. And if we look at the percent of patients who had no hair on the scalp or body from their alopecia aerata, AKA alopecia universalis, we see 45%, 46%, 58.7%. So these were really severe patients. The other thing is, I hear from patients a lot, well, ritlecitinib M must be safer because it's approved down to age 12.

And yes, it's approved down to age 12. And as you'll see, the safety signals appear to be very similar between baricitinib and ritlecitinib. However, that doesn't mean that baricitinib is less safe. In fact, baricitinib, it's important to know, was FDA approved in rheumatoid arthritis in 2018? So we do have a number more years of safety data from that patient population.

The FDA also approved it down to age two for the treatment of severe COVID-19. And then of course, we got approval for severe alopecia areata in 2022. And also in Europe, baricitinib is approved down to age two for eczema and juvenile arthritis. And currently there are pediatric trials, I believe down to age six in the U.S. that are happening now for baricitinib.

Ritlecitinib had its studies for alopecia areata and it received approval for ages 12 and up in 2023. And duruxalitinib is the most recent one to have received its approval and that was just this past summer in 2024.

Now, if we look at the efficacy, and it's important to note that these efficacy rates were during the placebo-controlled portions of these clinical trials, we see, first it's important to note that with baricitinib, it was a 36-week trial, so somewhat longer than the 24-week trials done in ritlecitinib and deuruxolitinib. But what we see, if we look at the percentage of patients who reached the success level rate that were considered responders, which was 20 % or less scalp hair loss, or 80 % of the hair or more back on the head, we see that these rates are all kind of similar, right? The difference from placebo being 29.5%, 21.4%, 30.2 % at these various time points.

And so it's difficult to say, ~ this one has better efficacy than this one, or this one's gonna work better for this patient than this one. It's the type of thing where you really don't know until any given patient tries it. And as these medications are still relatively new, we're collecting data all the time to try to be able to answer those more difficult questions. Unfortunately, deuruxolitinib while it was FDA approved just this past summer. We recently learned in the past month that due to a legal issue regarding potential patent infringement, not due to safety concerns and not due to efficacy concerns, has unfortunately been hung up in the legal system and therefore will not be able to be commercially launched. So we will not be able to prescribe this for patients.

And it is really unfortunate because it is a good drug. They have the opportunity to appeal in April of 2025. So we'll hopefully learn more after that time point, but at least for the current period, this is not a medication that we're able to prescribe. So because of that, I will say that if you look at sort of the safety and things like that amongst these trials,

In general, they're all pretty similar, but because deuruxolitinib is not going to be available to us, I'm gonna focus mostly on baricitinib and ritlecitinib safety and black box warnings and some of the other questions that come up, not only because those are available, but also because they've been around a little bit longer and these additional analyses have been done that could help answer some of them more common questions that come up. So these are some of the really remarkable photos of patients who are responders, baricitinib, ritlecitinib, and then of course, deuruxolitinib. So what factors might impact the response to treatment?

Well, the first is the dose of the medication. And this is very clearly shown in the baricitin of the clinical trials where they looked at two different doses of the medication, four milligrams, two milligrams versus placebo. And it's clear to see that whether you're looking at a salt less than or equal to 20, right, 80 % scalp hair regrowth or a salt less than or equal to 10, 90 % scalp hair regrowth, the higher dose does better every time.

And so that's not to say that the two milligram dose can't work in some individuals, but certainly the dose of the medication is directly correlated to the proportion of patients who respond to the medication. The other thing that we've learned, particularly from the varicitinib data, and I think this is true for my clinical experience with the other JAKs as well, is that the severity of the disease at baseline, so before you start a treatment, can impact your response to a given treatment. So at least in the 36-week trial period, when Lilly looked at their data and they said, okay, let's look at the different response rates in our patients who had 50 to 94 % scalp hair loss at baseline on the left, and compare it to those patients who had complete or near complete scalp hair loss at baseline, 95 to 100 % scalp hair loss. And what you can see is that at the four milligram dose, the patients who had severe AA, 47.6 % of them were able to get 80 % or more of the hair back on their head at 36 weeks compared to 21.3 % of the patients with a very severe AA. So this says to me a couple of things. The first is that as dermatologists, we should not be waiting until people develop complete or near complete scalp hair loss in order to start thinking about using a JAK inhibitor. It's clear from this data that when you intervene earlier, you actually have better patient outcomes. The second thing though that it also says is that even in our most severe patients, even at as early as 36 weeks, there is still a decent proportion of patients who are responsible who are able to respond to these medications. We're gonna talk a little bit more about what longer ~ sort of data might look like, especially in patients with more severe disease. And then of course, the duration of the current episode can also impact medication efficacy. And so this is important to define. So duration of current episode is not when did you develop your first patch of alopecia areata? It is how long have you had this degree of severity of alopecia areata, right? So if you developed a first patch at five, but then re-grew and then had some more patches in your teens and then re-grew, but then in your twenties lost 50 % of your hair, you're not counting from eight, your first patch at age five, you're counting from your twenties, right? Whatever age that was. So that's what the duration of current episode means. And, you know, I always want to remind patients that when we're discussing things like this, not, we were taught very early in medical school,

Patients don't always read the data. They don't read the textbook, right? So there are always outliers to this data. This data just helps us to look at general trends, okay? So I don't want to suggest that, gosh, if you've had alopecia areata that's severe for more than four years, you better not even bother trying these medications, because there are patients who will respond, but sometimes it might take them a little bit longer. But what this does say is that if you intervene sooner again, right,

where someone has a duration of a current episode less than four years versus waiting till they've had the severe alopecia area for four years or more, you can see there's a decrease in the response rates from 39.5 % of patients responding to four milligrams at 36 weeks to 24.2 % of patients responding at 36 weeks. And so I often will use this when I'm talking with patients too because if it's someone who's sitting in front of me and they're struggling about whether or not to start a JAK inhibitor for their AA and they're like at three years, I'll say, unfortunately, the data doesn't suggest that you have unlimited amounts of time to make this decision and potentially still respond. The data suggests that when you treat earlier on in your course of disease, you tend to do better. even with treatment, if you regrow hair, you reset the clock.

So that duration of current episode, even if you get hair growth back with treatment, that resets the clock as you start from scratch again. Another thing that can be helpful in ~ promoting efficacy of these medications is using oral minoxidil, low dose minoxidil as well.

So this is something we see in our clinic all the time, but this was just a case that was reported of a patient who had been on a JAK inhibitor for six months, no improvement. They added ~ oral minoxidil and ~ it sort of helped the hair to regrow. So minoxidil is not an immunosuppressant. It does not suppress the immune system. We think it works by helping to push hairs to get into the growth phase and stay in the growth phase. that way it helps ~ in conjunction with reducing inflammation with the JAK inhibitor to get the hair to grow back in. Okay, so moving on now to side effects and monitoring. And remember that January, 2023 webinar, I really do a deep dive into the black box warnings and where they come from and sort of more of the like baricitinib side effects.

But for the purposes of this, I wanted to focus on the things that I see that come up again and again with my patients. So we know that these are some of the most common side effects that are seen with baricitinib, Olumiant, or ritlecitinib, Litfulo. And for the most part, there is a lot of sort of overlap with upper respiratory infections and acne and things like that, headache.

But there are a couple of things to be aware of that are different between the two medications. The first is that with Litfulo, about 10 % of patients in the clinical trials reported diarrhea and 4.6 % of patients developed urticaria or hives. The urticaria or hives tended to be mild and tended to self-resolve in most cases. but these are two things that we do not see with baricitinib or Olumiant. Whereas with Olumiant ~ we do have to monitor the cholesterol levels as there can be increases in both the good and the bad cholesterol levels. So we have to keep that in mind. And then about 1 to 2 % of patients on the clinical trials of baricitinib or Olumiant.

also noted some weight gain, and that tends to be something that we don't see with Litfulo or ritlecitinib Again, the percentages are low, but it's thought that the JAK2 inhibition somehow affects leptin that can account for those different side effects. Now, of course, the side effects that we are all most concerned about are the black box warnings, serious infections, mortality,

malignancy, major adverse cardiovascular events, otherwise known as MACE thrombosis. These are really terrifying side effects, right? So I wanna spend a lot of the time on this so that you all feel comfortable in sort of understanding these risks as well. So when we look at baricitinib, and we're gonna do the same thing in ritlecitinib in a moment, these were...just over 1,300 baricitinib treated patients who had a maximum exposure to baricitinib up to 3.6 years. In the brown or tan columns, these are the incidence rates of these adverse events of special interest. In other words, those related to the black box warnings in the placebo controlled portion of the trial. You can see the incidence rates here.

All the way to the right column, we have the all baricitinib column, which means they included all patients treated with any dose of baricitinib for any amount of time. So while the tan columns can help you understand what the differences are between placebo and baricitinib in the placebo control portion, they do it for sort of a shorter period of time, right? The 36 week period. Whereas the all baricitinib column

It's designed that way to try to capture less common events by looking at all the patients exposed to any amount of the drug for any amount of time. And while these side effects are not zero, you can appreciate that the incidence rates of these are quite low. Similarly, with Litfulo or Ritlecitinib, again, if we look at the placebo columns over 24 weeks,

we see the incidence rates. And then again, this was like just over 1600 ritlecitinib treated patients with at least one year or more of exposure to ritlecitinib. And again, that far right column is all ritlecitinib. So any patient treated with any dose of ritlecitinib for any amount of time, but it had to be over 50 milligrams or more of ritlecitinib. You can see again, that while the incidence rates of these various things are not zero, they remain low. Now what I love that Lilly did with regard to these scary adverse events is that they looked at the patients in their trials who developed these things and they said, let's look at the patients who developed these things and break them down between those who have at least one risk factor and those who have no risk factors.

And the specific risk factors that they looked at were whether or not people had atherosclerotic heart disease, diabetes, age 65 years or older, high blood pressure, a history of smoking or also current smoking, good cholesterol or HDL below 40, obesity or severe mobility impairment. And as this table shows, when patients had one or more risk factors,

While the incidence rates remained low, they more commonly happened in patients who had those risk factors. And so with this in mind, since this data came out, I have been asking patients who are going on JAK inhibitors to complete a screening checklist when they see me in clinic so that I'm sure that I have all the information I need to determine what that individual patients risk might be. And while there are a few things that I'll discuss in a minute that are absolutely like no-goes for a JAK inhibitor treatment, you know, in general, my approach is, you know, if someone has diabetes, I'm not going to say, oh, nope, you can't have a JAK inhibitor then, but I'm going to say to patients, know, when patients, you know, the incidence rates of these things, these scary things happening are low.

When they happen though, they tend to happen in patients with your risk factor or your risk factors. And we have a discussion together. And the patients, know, some will, any amount of increased risk for them is too much and they don't wanna do it. While others are like, you know what, you know, I'm willing to take on that low risk and, know, it's still so important to me, I need to treat this, it's something I want to do. And they understand the side effect ~ profile. and they are slightly increased risk. And so that's the way that I approach it. Of course, every dermatologist might be different, but that's sort of how I think about it. Who are absolutely not candidates for JAK inhibitors? There may be others, but these are the most common things that come up. People have something called factor V Leiden or antiphospholipid syndrome. So these are things that put people at higher risk of developing blood clots or any other clotting issue, a history of a cancer other than basal cell or squamous cell skin cancers, a history of a heart attack or stroke, an active serious infection or a history of multiple serious infections, or if they have severe liver or kidney dysfunction.

Now when it comes to monitoring at baseline, these are the various labs that I do. I also do something called an immunoglobulin E or IgE, which can be sort of a measurement of sort of like the allergy response in the body. It can be elevated in people with eczema or multiple food allergies. We'll talk about why I do that in a little bit.

I also screen for risk factors, as I mentioned, and then I always ~ try to advise people to be up to date with their age recommended screening exams, so things like colonoscopy, mammography, et cetera. For baricitinib, the requirement is that within three months, you have a repeat blood test, complete blood count, complete metabolic profile, and fasting ~ cholesterol panel.

And for me, I do this every six months thereafter to make sure our patients are doing well. That's not what's required, that's what I do. For relicinib, the requirement is that labs are done one month after starting. And then again, I do them every six months thereafter. And at one month, you do the complete blood count. And I also do a complete metabolic profile, although the complete blood count is what's recommended.

~ Again, the JAK-2 inhibition can be associated with hyperlipidemia and in rare cases, weight gain. And that's why we have to do the fasting lipid panel there. And the reason why you have to get labs at one month with Ritlecitinib is because while there's less chance for hyperlipidemia, you can have a significant reduction, which is very rare in the white blood cell count or platelets that can occur.

One other note about ritlecitinib that I think it's important just for patients to be aware of, these medications are not super frequently prescribed. And so it's rare that there are problems with interactions, but ritlecitinib cannot be given with certain medications that are metabolized or that affect CYP3A4.

CYP3A4 is an enzyme that basically helps the liver process certain medications when we take them. Some medications make that enzyme more active, induce it, it to clear the medications, help it to clear the ritlecitinib sooner. Some make it less active. So it makes it harder to clear the ritlecitinib Those are called inhibitors. And some of the common ones are listed here. This might not be an extensive all-inclusive list.

So the idea here is that if you're on ritlecitinib and a medication that's known to be a CYP3A4 inducer, you could have a loss of efficacy or reduced efficacy from ritlecitinib if you're taking them at the same time. In contrast, if you're on ritlecitinib and a drug that's an inhibitor of this enzyme, you can have increased drug levels of ritlecitinib.

~ And so, in rare cases, potentially again, I don't know that this has ever been reported, but it could potentially lead to toxicity, et cetera. So just something to keep in mind and be aware of if you're on Litfulo or ritlecitinib Okay, assessing response to treatment. And this is a bit tricky. And I think more recently data has been done for this as well in ritlecitinib. But with baricitinib data, again,

They looked at a way to try to predict the likelihood of a patient having complete hair regrowth by one year. So let's talk through this. So what they looked at here was how much time it took for a patient to have a 30 % improvement in their hair from baseline. So for example, if you had no hair at baseline,

the time it would take for you to have 30 % of the hair back on your head after starting baricitinib or JAK inhibitor. And what they saw and defined is that if you were an early responder, you would usually have a 30 % improvement in your hair growth at four to 12 weeks. That was about 33 % of baricitinib treated patients. If you were a gradual responder,

you would have that change, right, 30 % improvement in hair growth at 16 to 36 weeks, that was 28 % of patients. And then if you were a late responder, it took you more than 36 weeks to get 30 % improvement in your hair, and that made up about 8%. Of course, 31 % of the patients were non-responders. And what this showed was that...

If you were an early responder and you started having 30 % improvement in your hair early on by 12 weeks, 78 % of those patients at one year had 80 % of the hair back on their scalp compared to 51 % of the gradual responders and 20 % of late responders. So while we don't have a crystal ball and it's impossible to really predict how any one patient will do, this data sort of helps guide us a bit in understanding, based on a given patient's trajectory, what we might expect at least at one year.

So now we'll get into some commonly asked questions. I just want to make sure I'm doing okay on time. I'll try to speed it up a little bit here. So do topical JAK inhibitors work to treat alopecia areata? The short answer is no. The clinical trials in adults with moderate to severe alopecia areata showed no benefit. They'd studied Delgocitinib versus placebo ointment in patients with moderate to severe AA and saw that there was no statistically significant difference.

between the patients treated with placebo cream or the patients treated with the active delgocitinib JAK inhibitor cream. When, and they thought by the way that this was due to the fact that the drug, the topical drug might not penetrate deeply enough into the skin to reach the level of the bulb, which is lower down in the skin, which is where the inflammation is in alopecia areata. But when might I reach for this occasionally?

Well, it could be tried on facial hair because the skin on the face is thinner. And I've had some success in patients who are very young and very old because they think their skin is a little bit thinner. So this is an example of a six-year-old before and after topical tofacitinib 2 % cream and low-dose oral minoxidil. She did incredibly well with this for a year or two, but unfortunately, as she got older,

The cream I think just didn't penetrate as well anymore and she ended up losing efficacy again And now we're thinking about an oral JAK inhibitor for her this patient 92 year old male with a history of cancer at alopecia universalis treated with topical tofacitinib cream and he was thrilled with this response and he's continued to do well I think for over three years now

Another commonly asked question, can I taper my dose or stop the medication once my hair has regrown? So there's data to help us understand this. So on the paracetamide of alopecia areata clinical trials, patients who achieved 80 % scalp hair regrowth or more were randomly assigned and the investigators didn't know, the participants didn't know, it was totally blinded. They were just randomly assigned to either continue on four milligrams a day

or 50 % of them were dose reduced to two milligrams a day. So 50 % stayed on four milligrams, 50 % were reduced to two milligrams a day. And what we see is when these patients were followed over 100 weeks is that 88.6 % of the patients who stayed on the four milligram a day dose were able to maintain their response. Whereas the patients who were dose reduced, 58.5 % of them can. So what this says to me is, it's just important for patients to understand that while there is a good proportion of patients, at least 100 weeks out, who were able to maintain their hair growth, there still is a good chance, a decent proportion of patients who lose response. And approximately 37 % of patients who were dose-reduced to two milligrams a day had more than a 20 point worsening on the SALT score. So what does that mean? That means, for example, if a patient had 20 % scalp hair loss at week 52, after they were dose reduced by week 152, they went to 40 % scalp hair loss or worse. And what's important to note is that during this 100 week period, the side effects that occurred at a rate of 78.6 % of the patients baricitinib it at two milligrams and 77.3 % of the patients on four milligrams. So not a big difference in side effect that occurred. And the same is true if you look at the placebo control portion of the trial, there aren't huge differences between two and four milligrams. And so this is why if, patients really feel strongly about reducing the dose, I try to advise them against it.

And then what about if you stop baricitinib completely after regrowth? Well, at week 52, patients who responded to baricitinib, right, who had 80 % of the hair back on their head, were randomly assigned to either continue on baricitinib, four milligrams a day, or were taken off of baricitinib and given a placebo pill. And so again, investigators, patients didn't know which thing that they were being given. This was part of the consent process. They knew there was a chance that this could happen.

And notably for those patients who withdrew completely, right, were put on the placebo, only 20 % and 10 % of those patients on four milligrams and two milligrams respectively maintained response at week 152 compared to 90 and 89 % of the patients who stayed on their four milligram or two milligram dose. So this strongly suggests that while you get the occasional patient who might be able to maintain response over treatment like any other chronic condition or chronic disease, the body resets and goes back to what it is doing. And so in the vast majority of cases, these medications need to be continued to maintain efficacy. And so as I mentioned before, I really prefer to not taper people if I can.

A few more commonly asked questions. What if I have eczema or multiple allergies? Are there any other medications that could treat my alopecia areata? So this was a young girl that came to me years ago with severe alopecia areata and moderate eczema or atopic dermatitis. And we started her on a therapy and she had a really unbelievable response. And this medication was Dupilumab or Dupixent which is approved down to age six months in the US for eczema or atopic dermatitis. And it's a very targeted treatment. So there's no black box warnings. There are side effects like any medication, but they tend to be mild. There's a laboratory monitoring that's required, et cetera. So it's a really nice option. Here's another patient of mine for patients who fall into this category. And this was looked at in a clinical trial of 60 patients. And in this case, again, patients were pretty severe who entered the trial and they weren't looking at like a salt lesser or equal to 20 as the final endpoint. They were just looking to see like who had 50 % improvement, who had 75 % improvement, who had 90 % improvement. And you can see the rates of improvement of Dupilumab at week 24 and at week 48 here in patients who are on this trial. But importantly, and this is why I check the immunoglobulin E or IgE, right? That allergy sort of indicator blood test. It's because when baseline IgE levels were above 200, it actually was able to predict the likelihood of alopecia areata responding to therapy with 83% accuracy and you can see the percent improvement here and the differences between the patients who had an IgE above 200 and those that were below 200. In my clinical experience, I don't use IgE alone to determine someone's response or likelihood of responding to Dupillumab or Dupixin. I will also, I feel like it works best in patients who have active atopic dermatitis as well. So I tend to reserve it for those patients.

What if I'm older than 65 or JAK inhibitors contraindicated? So in the baricitinib clinical trials, they did not include men over the age of 60 or women over the age of 70. And in the clinical trials, they did allow patients who are 65 years or older, but they comprised only 3 % of the study population. Now there was this...retrospective study of patients treated with baricitin who were 65 and older and showed that the adverse effects were mild and there were no scary side effects reported and patients responded well. But the drawbacks of this is that there were only 14 patients. They were only followed for just under a year, 11.9

months. And so we really need longer term data and a larger study rate to really know for sure. But If we look at the ritlecitinib two-year safety data, and we're gonna look at the baricitinib two-year safety data too, we see the numbers of these scary things that occurred in individuals. And while some of them occurred in patients who are at or around the age of 65, we see too that some of the scary things happened in younger people. In fact, most of them were not occurring in patients who are age 65 and up.

And the same is true in baricitinib. Now, what is true of most of the patients who experienced these is that while they might not have had an age above 65 years, most of them had multiple, at least one and often multiple other of these specified risk factors. So for example, someone who had a pulmonary embolus, was obese and had a clotting issue and had diabetes, for example, or a history of smoking. In other words, there were multiple other things that led to that. So while we need larger studies and we need more data for age, and we don't have clear answers around that personally, I don't consider it a contraindication for treatment with the JAK inhibitor.

What about a patient who has some eyebrow and eyelash regrowth on the JAK inhibitor, but slow scalp regrowth? Is there a chance they'll regrow more hair? Well, Barracet and Nibdeda, they looked at this too. So they said at week 52, patients who haven't gotten 80 % of the hair back on their head, but say they have some eyebrows and eyelashes that have really come back nicely, or maybe at a prior visit, they had 80 % or more of the hair back on their head, but they don't now.

~ If they were continued on four milligrams of baricitinib out for an additional year, 39.1 % of those patients actually were able to achieve 80 % scalp hair regrowth. So what this says is, if you have eyebrows and eyelashes and your scalp hair is kind of slower to come in, if you leave patients on the medication for a longer period of time, it's likely that they will be able to regrow.

And then finally, what vaccine should I not receive on a JAK inhibitor? So if you're on a JAK inhibitor or really any immunosuppressant, you have to avoid live vaccines. The concern is that if you're on an immunosuppressant, you receive a live vaccine, you could develop that disease. And so the good news is that most of the vaccines that we receive are inactivated, not live vaccines.

Live vaccines ~ include measles, mumps, and rubella, so important for sort of the pediatric and adolescent population. Other ones are oral polio virus, oral typhoid vaccine, and yellow fever vaccine, as well as flu mist, so the flu spray. Flu shot, not a live vaccine.

So if there is a need to administer a live vaccine, say you're going someplace exotic that requires you to get a yellow fever vaccine, you either want to do that 30 days before you start a JAK inhibitor or you need to stop the JAK inhibitor for at least three months and then get the vaccine and then wait 30 days to restart. And we get questions all the time about COVID-19 vaccines. Do they cause alopecia areata? Can they make my alopecia areata worse?

There are case reports and case series. And as a physician, I am the opposite of an anti-vaxxer. But I think unlike other vaccines, there seems to be a small signal here with COVID-19 that I think this publication sums up nicely where they say vaccination against COVID-19 can influence a course of chronic inflammatory dermatosis or even be a trigger for the new onset of these diseases. In the literature, there are several reports of presenting flares or new onsets of various diseases, you can see here alopecia areata is included after COVID-19 vaccination. More studies are needed to understand the mechanisms of this and to establish clinical implications. So it's a tough question to answer. I think you have to consider an individual patient, their risk for severe COVID-19 and sort of take all that on a patient by patient basis. So with that, I will thank you so much and I'm happy to take any questions. And sorry, Lisa, I went a little bit over, so I'm happy to stay a few minutes longer to answer questions. I'll stop my share.

LISA ANDERSON, PHD: (49:04)

Thank you. We appreciate that. ~ Yes, because there was a wonderful talk. You answered many of the questions that have come in. So we'll try to find ones that touch on different topics. But thank you for all that information that you've shared with us today. So let's try to go through as many as we can. You may have touched on pregnancy. What happens if a person needs to stop a treatment and wants to become pregnant and during pregnancy. Someone's asking, can NAAF coordinate efforts on this?

MARYANNE SENNA, MD: (49:31)

Yep. So we actually have a manuscript with Brett King and Brett Krikula, which by the way, those two are amazing. Okay. They're the reason why we have JAK inhibitors. I love them. They're wonderful human beings. They've done so much for this space. Like I just, I could not admire them enough, but we have a manuscript in with them. That's being peer reviewed right now, where we looked at our patients, some of whom had multiple pregnancies and the take home is, yep in almost all cases, except for one of my patients who lost 30 % hair, all of them lost their hair again. But in all cases, after finishing breastfeeding, when they restarted, they re-grew their hair. They got the same response back. So I think it's horrible, it's heartbreaking for patients. They re-grow their hair, then they lose their hair again. But the good news is that at least in the cases that we have encountered, and there were a good number of them the patients all were able to recapture their response. It wasn't like they lost their ability to regrow hair on treatment.

LISA ANDERSON, PHD: (50:36)

And there'll be a publication on that topic soon. OK, great. This person has written with a question that comes from one of the social media sites that where patients on JAK inhibitors kind of communicate with each other. And there many reports of patients losing hair while still taking JAKs during the second year of taking medicine. So I think the question is about flares when you're still on JAK inhibitors. Do you see that?

MARYANNE SENNA, MD: (50:59)

Yep, so let me address that. So sometimes this happens randomly and we don't know why, but that is in a minority of cases. So there is something called telogen effluvium. And if you Google M-G-H telogen effluvium, T-E-L-O-G-E-N-E-F-F-L-U-V-I-U-M, telogen effluvium, M-G-H, my handout will come out and it'll talk to you all about this. But basically there are various things that in people without LAP Sheriata can cause hair two, three months later to shed. This has happened to me at least three times and you can lose 30 % of your hair, but it's sort of diffused. You don't develop patches. Common things are weight loss, even if it's intentional, 10 or more pounds, adjustments in thyroid medication, significant emotional stress. So not day-to-day stress, loss of a loved one, divorce, a major move, loss of a job, something like that significant illness with fever, entering menopause, stopping a birth control or hormone replacement therapy. These are common things that two to three months later, a lot of people will go through a shedding phase and then they will regrow. For patients who are prone to alopecia areata, this can trigger a flare in disease. And so the first thing that I do when someone's in and they're having a flare is I screen them, we screen them, we ask them all these questions. Did any of these things happen? And nine times out of 10, we can identify something. And sometimes we don't. But that can be really reassuring to a patient because then they understand like, okay, it's not just like this medication isn't working or something like that. It's because of this and I know it'll get better. And oftentimes for those patients, do, you we'll fill in with some intralesional steroids. This is totally off label, but sometimes I'll give some pulsed prednisone orally in addition to the JAK inhibitor to kind of get them back on track and then take them off the pulse prednisone. There are things that you can do depending on the degree of hair loss, but oftentimes there's a reason for that.

LISA ANDERSON, PHD: (53:00)

Okay, and so it's not, you're not thinking that the medication is losing efficacy over time. Okay.

MARYANNE SENNA, MD: (53:07)

With one exception, if someone say gains weight significantly, right, or a child grows quickly, right, and say they're on a lower dose of the medication or something like that, they might need a higher dose, but outside of that,

LISA ANDERSON, PHD: (53:21)

OK. Several questions about oral minoxidil, using it with the JAK inhibitor. Can you discuss your recommendations on that? And some dermatologists not recommending it for someone over 50 feels it could increase risk to heart health. Someone else is saying, my dermatologist is saying no. How do I convince them? I think that's an issue people are facing that they've heard about it through maybe NAAF or reading but then maybe there's pushback from the dermatologist.

MARYANNE SENNA, MD: (53:49)

Yep. So minoxidil in doses of 20 and 50 and higher milligrams oral, oral, oral has a right. Oral has a very scary side effect profile. I would give it to absolutely no one. OK. Things like fluid around the heart, fluid accumulation, EKG changes, palpitations, blood pressure crashing like no way. Right. But the doses that we use for hair loss are like 2.25 milligrams a day, 2.5 milligrams a day, five milligrams a day, sometimes upwards of like 10 milligrams a day, but way, lower. And the largest study that was done looking at side effects in hair loss patients, it was male and female pattern hair thinning. were 1,400 patients in the trial. And what they showed is that the doses that we use, those scary side effects, really like the cardiovascular type stuff doesn't happen until you get upwards of like 15 milligrams a day and higher.

And there have been follow-up studies looking at fluid around the heart. There was one that was just published, right? They looked at people on minoxidil, people not on minoxidil. What's the incidence of like mild fluid around the heart? And actually the people not on minoxidil as background rate had more fluid, had more rates of fluid around the heart than those on minoxidil. So all this just to say, at the doses that we use with very few exceptions, obviously if someone has congestive heart failure, if someone has a weird arrhythmia or some significant cardiovascular, background, I'm gonna check with your cardiologist. I'm not just gonna prescribe it out of an abundance of caution. But in general, we don't see those cardiovascular side effects. And I think it's just a matter of physicians knowing the data and being comfortable with prescribing it. But yeah, we give it to kids, adults. I mean, it's very well tolerated and safe.

LISA ANDERSON, PHD: (55:35)

Okay. And so people may have to refer to this webinar and share it with their dermatologist to have that discussion. Insurance companies are still denying this medication based on the fact that alopecia areata is cosmetic. Obviously every patient with AA would vehemently disagree with this. Do you see this changing in the future?

MARYANNE SENNA, MD: (55:53)

So I haven't encountered this in my own practice, thank God. But if I ever got a letter like that, if I ever got a rejection like that, I would absolutely write a very strong worded appeal letter citing the bullying, the increased rates of depression, anxiety, even God forbid suicide in patients who have AA and that this is chronic autoimmune disease.

You know, unfortunately, sometimes insurance companies will look for any reason to not cover a medication, but I think that's totally awful and should never be the case. know, patients who have commercial insurance should also be aware that Pfizer and Lilly both have patient assistance programs so that if your insurance does not agree to cover the medication and you have LLP-sharia for any reason,

These patient assistance programs can help make sure that you have access. So you need to make sure your physician knows about that as well.

LISA ANDERSON, PHD: (56:51)

Great, questions on that, please write to NAAF. We'll try to help you. We're also working on new resources to support patients in that process and answer some of those questions and hopefully a webinar on that topic in 2025. You addressed efficacy after sort of a window of not having hair and.

But there are lots of questions here about, know, I've had it. There's a range of questions. I've had it for 20 years. I've had it for 30 years. I've had it for 60 years. Is there a feeling of like, well, there's absolutely no chance someone could regrow hair? is there a, someone wrote, like, my son has alopecia universalis suffered for the last 13 years. I understand it's unlikely to have success with JAK inhibitors, but is it possible to get some results in terms of eyebrows and eyelashes?

MARYANNE SENNA, MD: (57:43)

So until you try it, you don't know. And here's the thing. When we sit around in these consulting meetings, those of us who see a lot of these patients, this topic will come up and we'll say, yeah, like in general, right, the data suggests.

starting earlier and not waiting many, many, many, many years is not a good idea. But some of these drugs didn't come out until people had it for a long time. And so we have off-label and now on-label treated people who have had it for much longer, 10 years, 15 years. And you will have patients who respond, who you might not think are going to respond. And so I never say, you've had this too long. I'm not going to bother. because you just never know until you try. But I think what's important is that patients are educated about this and have the right expectations going into it so that if you do have alopecia that's severe for that length of time, you understand, you and you're not like totally let down when you're not seeing the hair grow back right away. And the other thing is if you have that length of ~ duration of current episode, you need to give these medications time. at least a year. In fact, before switching, don't, I'm not really waiting to see like, is someone gonna respond or do we need to switch for at least nine months, if not a year. And so that's another important thing to keep in mind. You don't call it a failure after three or six months or something.

LISA ANDERSON, PHD: (59:08)

OK, great. Thank you. So we'll just go a little bit over since. ~ This person asks, is there, I don't know if you'll know the answer, is there any consideration to incorporation of systemic biomarkers for inflammation, HS-CRP or CXEL-9, into future clinical trials? And this person also notes that baricitinib says it ~ lowers CRP in the package insert.

MARYANNE SENNA, MD: (59:10)

Yeah, yeah, that's fine.

Yeah, so yes, that is something that is being looked at in current prospective clinical trials and different medications like Renvoq, Goropad, Acetinib, where they're also doing scalp biomarkers and things like that. And in a perfect world, God, would I love for these lab tests to be inexpensive and available so that I can, if someone comes in with a couple patches, know right away, is this more systemic? Is this localized? I would love to be able to do that.

As this person mentioned, it is more investigational right now. It's hard to do on a routine basis, but the more recent clinical trials have definitely done that. I actually don't know. haven't seen data to know. know there were obviously blood and stuff collected in the previous clinical trials. I just don't know specifically if they looked at biomarkers and what ones specifically they looked at, but I do know for the prospective clinical trials are doing it both in scalp and blood.

LISA ANDERSON, PHD: (1:00:29)

Okay, great. Something for future conversation. This person asks about a daughter who's 13 and a half. Can you tell us about patients at this age, specifically risks for teens going through puberty and long-term risks regarding pregnancy?

MARYANNE SENNA, MD: (1:00:33)

Yeah, so a couple of things. I have daughters who are 10 and almost 13. And every parent will think about this differently. But if I had, you my daughter who's 13 too, you she's in middle school, there's enough that middle school kids deal with that baseline. If she acutely lost all of her hair and didn't want to hang out with friends and was depressed and didn't want to go to school and her grades were suffering, man, I would give her a JAK inhibitor.

you know, without, you know, I obviously would be concerned and, you know, want you to think about the side effects and, it's natural when it's your kid. But knowing what I know, I think the harm of not treating and watching a child's life just kind of go spiral downwards is that risk is so much worse than any potential risk that I think these medications could cause. So that's how I think about that question.

The second, now there are some kids who cope beautifully. It's like their new identity, they love it, they rock it, they love the scarf, they love the wigs, they don't mind. That's a different discussion. That's a different thought process. The other thing about pregnancy. So I can't imagine with the biology of these, the way these drugs work, that it would impact future pregnancy. I don't think that that would be an issue at all. And there is a group called Mother to Baby, which collects data on inadvertent

exposure to drugs during pregnancy. So someone's on a medication for something, they get pregnant by accident, and then what happens? And so I am not at all recommending that you treat with JAK inhibitors while you're pregnant and breastfeeding. Absolutely not. But in inadvertent cases, the outcome was a healthy baby. And the few cases of small,

like birth defects and things like that, they were on in keeping with the general background rates of those things. Now, again, this is not saying, yeah, stay on your jacket and get pregnant. No, but just to answer like, how does it affect future pregnancies? It doesn't even affect babies, it seems, at least with the data that they're collecting, babies who are brought to term, who have been exposed. So I hope that's helpful.

LISA ANDERSON, PHD: (1:03:01)

Great, thank you. A couple of questions here on other treatments, finasteride, do you ever use that?

MARYANNE SENNA, MD: (1:03:08)

No, well, I use it in male and female pattern. Well, mostly male pattern hair loss. I don't use it in female pattern hair loss. Many people do. I just don't think it works very well. But you can if there's also male pattern hair loss that's involved, but not as a treatment for alopecia areata specifically.

LISA ANDERSON, PHD: (1:03:27)

and someone else asked about micro needling.

MARYANNE SENNA, MD: (1:03:30)

Yeah, so there's all this stuff on microneedling lately on the internet. It's kind of driving me cuckoo. So here's the thing. We did studies in microneedling when I was at MGH and female pattern hair loss. And there are studies in male pattern hair loss. And when it's done correctly, it works great. The problem is in doing it in grown adults with numbing cream, I mean, 99 % of them were in a lot of pain and were finding it hard to tolerate the proper treatment with microneedling. People are now promoting these at-home devices and you get a longer needle and this and that. I don't even know what they're talking about because in my experience, when patients are trying to do this at home, it's hard to inflict that much pain on yourself that it takes to do it properly to be able to stimulate hair growth. So most of it is being touted as a potential treatment for androgenetic alopecia female pattern hair thinning.

I think done properly, it certainly can help those things, but I don't think at home devices and people doing it to themselves is gonna get the right therapeutic level to be able to stimulate. And it certainly will not do anything for alopecia areata, especially without some sort of immune suppression also on board to reduce the inflammation.

LISA ANDERSON, PHD: (1:04:46)

Maybe one or two more questions. There are a few questions about switching JAK inhibitors. I you've already said that you kind of need to give it time. Can you talk about that a little bit? Are there situations when you would consider that or is there?

MARYANNE SENNA, MD: (1:04:57)

Yeah, so me and colleagues at various different medical centers are collecting cases now of patients who have switched between JAK inhibitors in the hopes of publishing a larger case series. And importantly, the patients that we're including have to have been on the initial JAK inhibitor for at least nine months before switching or more. Because again, like I said, if you don't respond at three months, that doesn't make you a non-responder.

It might just be that, you started this other one. And even though you were on the new one for three months, you've been on a jack and nip for six months. And maybe if you just stayed on the original for six months, you would have started to see some movement. So it's really important to give everything enough time. The other thing is it's not like, if you're on barriset and nib and you switch to lit-fool-o, you're always going to do better. Or the reverse is true. Some people, for whatever reason, will respond to one and not respond to the other. OK?

and vice versa. so, and sometimes you'll be on one and you'll switch to the other one for because of insurance reasons or whatever, and patients will continue to do well. Sometimes they might have a little decrease and you have to kind of do other treatments to kind of, you know, keep the hair growth there. But there's no clear cut thing that says if you do this and then you go to this, it's better than something else. If you're on one for at least nine months and you're not, anywhere, you're really not seeing any movement, then I think it's reasonable to consider switching to another one.

LISA ANDERSON, PHD: (1:06:28)

Two more questions on other treatments. you I think there's a reason why we're talking about JAK inhibitors because they have good clinical trial data. Someone's asking about light therapy treatments and Cell Cept.

MARYANNE SENNA, MD: (1:06:44)

Yeah, so I don't, I never have treated anyone with CellCept. I just don't think it works. You know, there might be an occasional patient who maybe gets lucky and it works for them, but I've never seen anything convincing about it working. There are, it depends on the light source. There are some studies using various ultraviolet uh... wavelengths like wavelengths along with photosensitizing medications to treat alopecia areata some of which have shown some promise but i think in general at the low level like devices don't waste your time they're not going to treat alopecia areata you know these helmets and hats and everything don't waste your time with them or money uh... you know i think at the end of the day if you have severe alopecia areata unless there's a reason to not take a JAK inhibitor and try one of these other things. I think of all the things we have in the toolbox, and there aren't that many things, nothing is really gonna come close to the efficacy that JAK inhibitors provide. It's just, unfortunately, not unfortunately, it's just the way it is.

LISA ANDERSON, PHD: (1:07:52)

Great. Last question. What's the outlook for 12 and under?

MARYANNE SENNA, MD: (1:07:55)

I think it's very good. Like I alluded to earlier, baricitinib's approved in Europe down to age two for juvenile inflammatory arthritis and think atopic dermatitis. The US FDA approved it down to age two for really severe COVID-19. There are trials happening now on baricitinib down to age six. And I believe, I believe ritlecitinib is doing trials in younger kids as well.

I have treated children off label, I think my youngest has been like eight and they've done incredibly well. So I think the future is bright for the treatment of alopecia areata in younger kids.

LISA ANDERSON, PHD: (1:08:37)

I think that's a very positive way to end it. Thank you for being here, sharing your expertise, wisdom with us, and for your contributions in this space too, because I know you've been involved with a lot of the research and the clinical trials. So I know we wouldn't be at this point in time without your work.

MARYANNE SENNA, MD: (1:08:54)

Well, we wouldn't be at this point in time without the wonderful, willing, enthusiastic patients who participated in the trials and also NAAF, which has done so much ~ to really help this patient population too. So the honors are shared amongst people, especially the patients.

LISA ANDERSON, PHD: (1:09:12)

Thank you so much. I am going to share my screen again and just go through a couple more slides about NAAF and then we'll wrap it up. But thanks for the extra time also.

MARYANNE SENNA, MD: (1:09:21)

my pleasure. Sorry, it went over.

LISA ANDERSON, PHD: (1:09:22)

No problem. Okay. Give me one second here. All right. Thank you again, Dr. Sena, and thank you to the audience for being here. We hope you'll share your feedback on today's webinar and help us plan for future presentations. Please complete the survey that's going to pop up after we end this webinar. Frequently on these kinds of presentations, we get questions about how to find a doctor.

that can help with your alopecia areata. We've created a tool to help. I want to bring your attention to the Dr. Finder, which is on the NAAF website. You can reach it through this QR code here. The Dr. Finder lists board-certified dermatologists, as well as dermatology nurse practitioners and physician assistants in the US with experience in treating alopecia areata. You can search the listings by state and to find a healthcare provider near you. So we will continue to add.

New name's the doctor finder. It's growing month by month. But we always check with the doctors to make sure we have their permission before we add them. But we invite you to check this resource out. I also want to let you know that it's not too early to start planning for the NAAF annual conference. We're hosting our 40th annual conference in Chicago from June 26 to June 29 in 2025. The conference is a great place to connect with the Alopecia Areata community, with educational programs, support sessions, research updates, social activities for all ages, including a children's camp. You get to mix and mingle with ~ experts like Dr. Sena. And we expect registration to open in February. So if you scan this QR code, you can sign up for our interest list and we will notify you when registration for the conference opens.

I also want to let you know that our next webinar is coming in December, Empowered Choices, Navigating Your Alopecia Areata Journey. Please join us for an empowering session with educator and counselor Dr. Juanita Hosh-Martin, focused on making choices while living with alopecia areata. Dr. Hosh-Martin will explore practical strategies to boost self-confidence and we'll discuss how to simplify decision-making, leverage past experiences and confidently celebrate your growth. Whether you're feeling overwhelmed or aiming to refine your skills, this webinar will guide you in making confident choices about managing appearance and identity, seeking emotional support, and adjusting your lifestyle with courage and joy. This webinar will take place on December 17th at 7 PM Eastern, 4 PM Pacific. And the registration for this webinar is now open. And as you can tell, there's a lot happening at NAAF.

We invite you to subscribe to our email list to get regular updates on alopecia areata news, research, get our monthly electronic newsletter, and keep up with webinars and other programs. You can sign up through this QR code or on our website. And then, of course, don't forget the resources that we have for the alopecia areata community, including support groups, the youth mentor, legislative liaison programs, Dr. Finder, clinical trial listings, and more.

So to learn more about NAAF and the resources we offer, please visit naf.org or email us at support at naf.org. And I think that's it. Thank you, everybody, for being here. Thanks for listening to the talk and to all of my NAAF slides. And we look forward to seeing you on the next webinar. Take care.