

From Familiar to Foundational: CME-Informed Learning Needs in Dermatologic Management of CSU, AD, and PN

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INTRODUCTION

Intense itch, type 2 inflammation, and impaired quality of life are part of the symptomatic burden of chronic spontaneous urticaria (CSU), atopic dermatitis (AD), and prurigo nodularis (PN).^{1,2} The shared immunological etiology of these dermatoses has led to the development of several targeted therapeutic strategies, creating the need for dermatology clinicians to stay abreast of evolving care approaches. To meet this educational need, CMEsquared[®] developed a year-long curriculum on CSU, AD, and PN management.

METHODOLOGY

Nine activities (5 CSU, 4 AD/PN) launched between October 2024 and March 2025, and endured until December 2025 to March 2026:

All activities were 45-minute satellite symposia, each accredited for 0.75 AMA PRA Category 1 Credits[™] by: 



- **Making the Connection Between Prurigo Nodularis, Atopic Dermatitis, and Itch** (Endured December 2024-2025)*
- **Say 'No' to Spontaneity: Treating Chronic Spontaneous Urticaria** (Combo Recording Endured March 2025-2026)*
- **Say 'No' to Spontaneity: Treating Chronic Spontaneous Urticaria** (Combo Recording Endured March 2025-2026)*
- **Evolving Therapies in the Treatment of Chronic Spontaneous Urticaria** (Endured December 2024-2025)*
- **Connecting the Dots Between Prurigo Nodularis and Atopic Dermatitis With Biologics** (Endured March 2025-2026)*

*Endured activities hosted on <https://dermsquared.org/cme-education>

Outcomes Data Collected:

Learner demographics, educational impact, intended practice changes, practice barriers, learner questions

Qualitative, Thematic Analysis of Learner Questions:

ChatGPT³ has demonstrated utility as an auxiliary tool in qualitative analysis, preliminarily generating themes from a data set once relevant prompts are provided. However, its limitations include a paucity of training data and a restricted context window for processing large data sets, thereby necessitating human intervention.^{4,5} For this analysis, learner questions were first sorted into themes using ChatGPT³ (examples of input and output at right). Themes and corresponding questions were then reviewed by the researchers and reclassified, as needed, to ensure accuracy of the analysis.

Could you please analyze this list into themes?

- Is nemolizumab impacting both itch and inflammation?
- Have you used dupilumab in a prurigo nodularis patient who also has multiple KAs?
- How do you decide when to switch to a different biologic? (Disease activity, Time period, etc)?
- Why not consider biopsy to confirm PN in Caucasian patients?
- How do you convince PN patients they don't have a parasite? Compliance and understanding is the biggest challenge.
- When would you consider using intralesional Kenalog injections (ILK) to treat PN lesions? How often should this be performed?
- Some insurances want node count. How do you document this?
- What is your typical workup for itch?
- How do you choose between JAK inhibitors and biologics?
- Can you have PN on genital skin?
- You have a patient that you have to put on a JAK inhibitor but there are a few risk factors like diabetes, hypertension... How do you handle that conversation?

Absolutely! Here's a thematic analysis of your list of questions and statements, grouped into key themes based on their content focus. Each theme captures common concerns or clinical considerations.

✔ **Treatment Strategies (Biologics, JAK inhibitors, Topicals, ILK, Phototherapy)**
Focus on decision-making around treatment types and sequences for Prurigo Nodularis (PN) and Atopic Dermatitis (AD).

- Is nemolizumab impacting both itch and inflammation?
- Have you used dupilumab in a prurigo nodularis patient who also has multiple KAs?
- How do you decide when to switch to a different biologic?
- When would you consider using intralesional Kenalog injections (ILK) to treat PN lesions? How often should this be performed?
- Is there data to support treating PN early with systemic therapy?
- How do you choose between JAK inhibitors and biologics?
- Which to try first, biologic or JAK inhibitor for AD?
- Has anyone on the panel utilized JAK inhibitors for PN? If so, what has been your experience?
- Is there data to support treating PN early with systemic therapy?
- How long should you wait to switch patients with PN and AD to a different biologic?
- What factors do you consider when switching to a different biologic for PN vs. AD?
- Please comment on phototherapy for AD and especially PN.
- When would you encourage patients to move past using a topical corticosteroid for AD or PN?

✔ **Diagnosis & Clinical Differentiation**
Questions about diagnosing, documenting, and distinguishing PN and AD from other conditions.

- Why not consider biopsy to confirm PN in Caucasian patients?
- Can you have PN on genital skin?

Example of ChatGPT Input

Example of ChatGPT Output

CONCLUSION

Educational initiatives must be tailored to clinical gaps and learner needs relevant to each dermatosis.

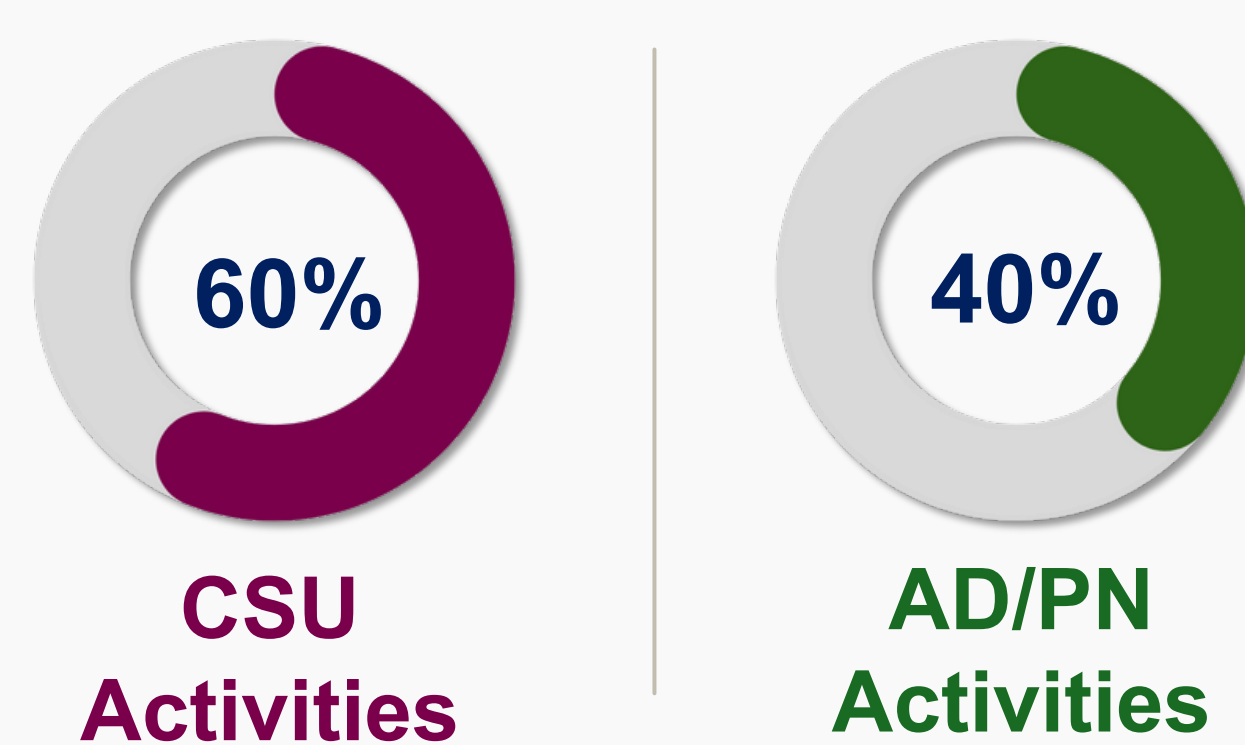
EDUCATIONAL NEEDS/INTERESTS:

- In CSU, education on *foundational knowledge* and the *place of systemic therapies in the current treatment paradigm* is needed. This aligns with the gradually increasing role of dermatology clinicians as front-line treaters of CSU⁶ and the barrier of seeing fewer patients with CSU in clinical practice.
- Dermatology clinicians, including those in practice for 10 years or less, have a more sophisticated understanding of AD and PN management. Clinicians are interested in AD/PN education that includes *patient-centered approaches to care that improve quality of life*. They also need administrative resources that support holistic care of patients with AD/PN.

RESULTS

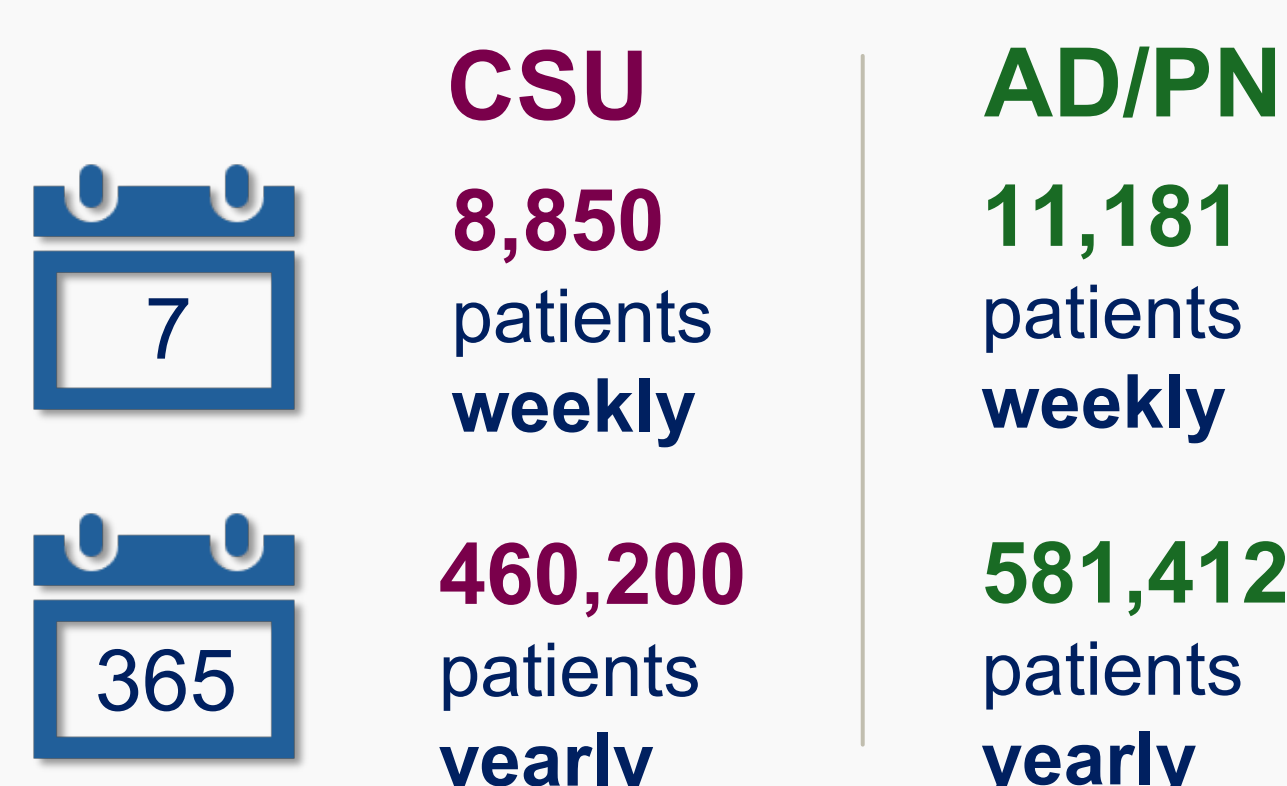
Learner Demographics:

5,383 Clinician Learners
2,352 Live + 3,031 Endured



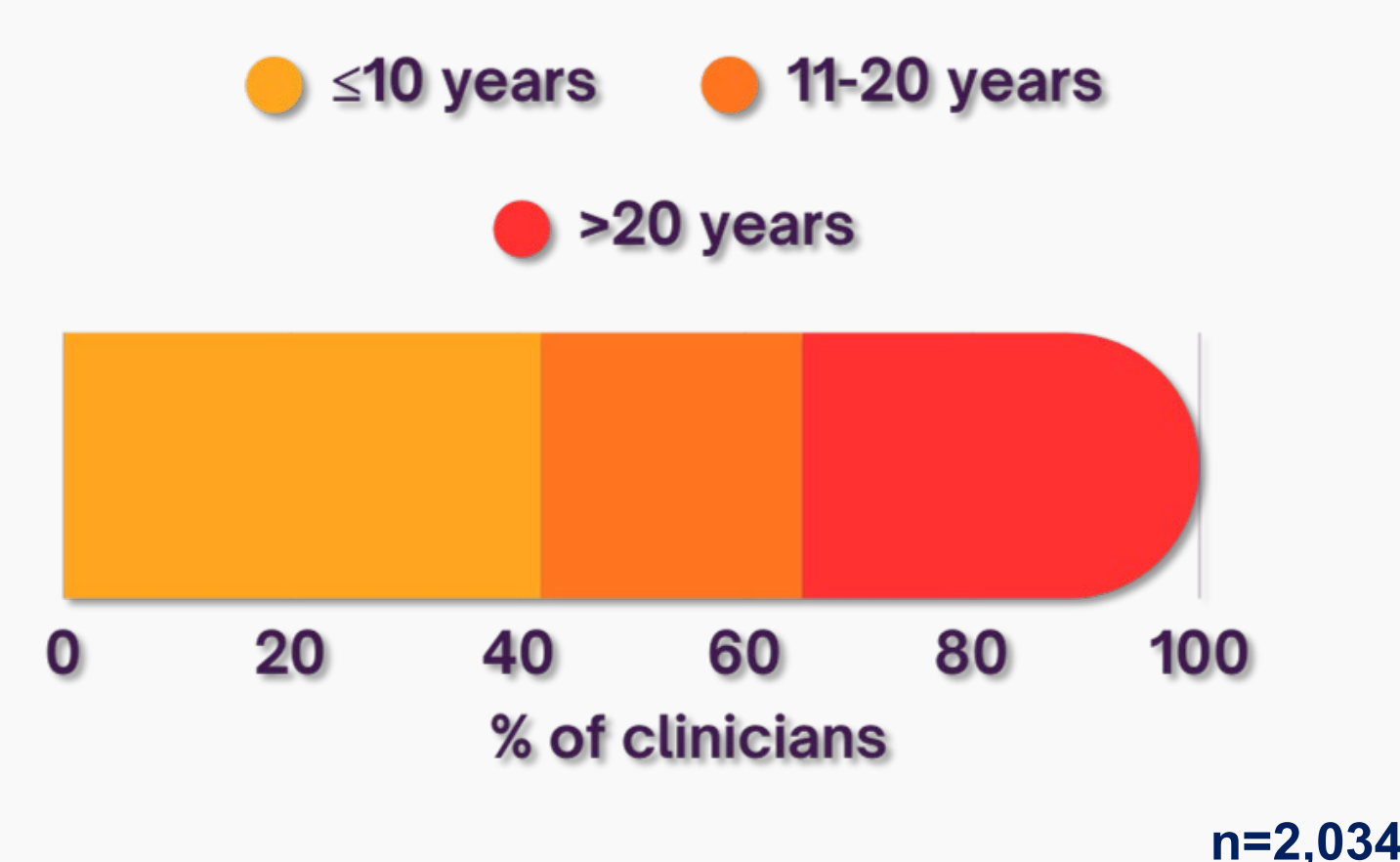
Impact of Education

>20,000 Patients Impacted Weekly



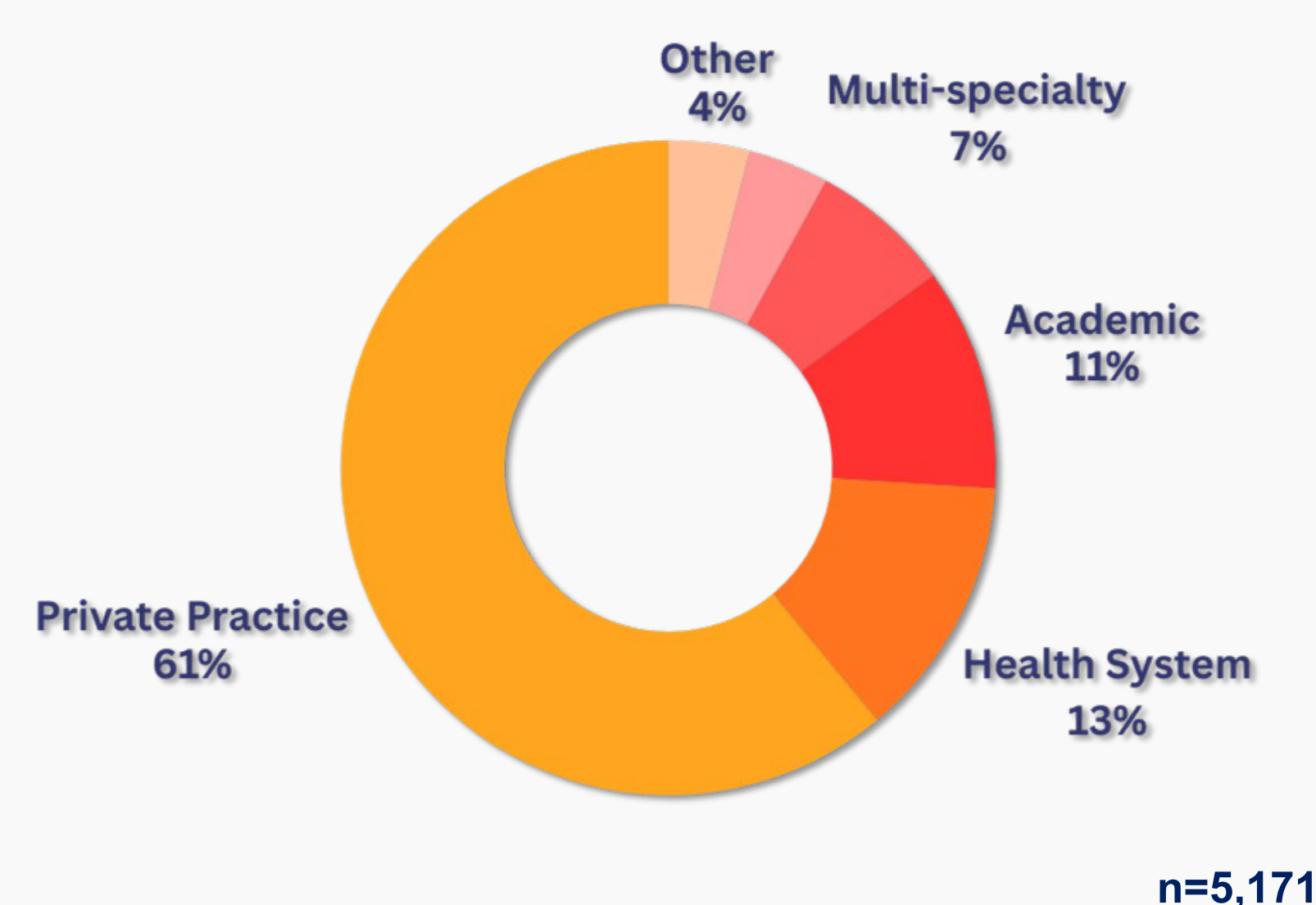
Years in Dermatology Practice

42% Early-Career Clinicians

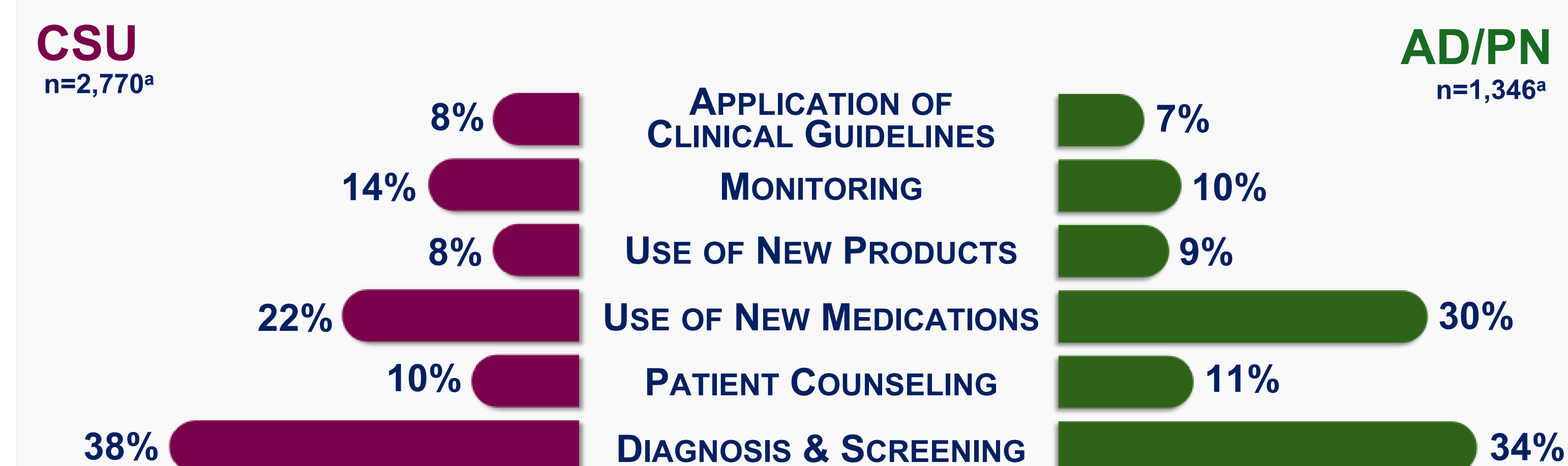


Practice Setting

61% in Private Practice (Solo or Group)

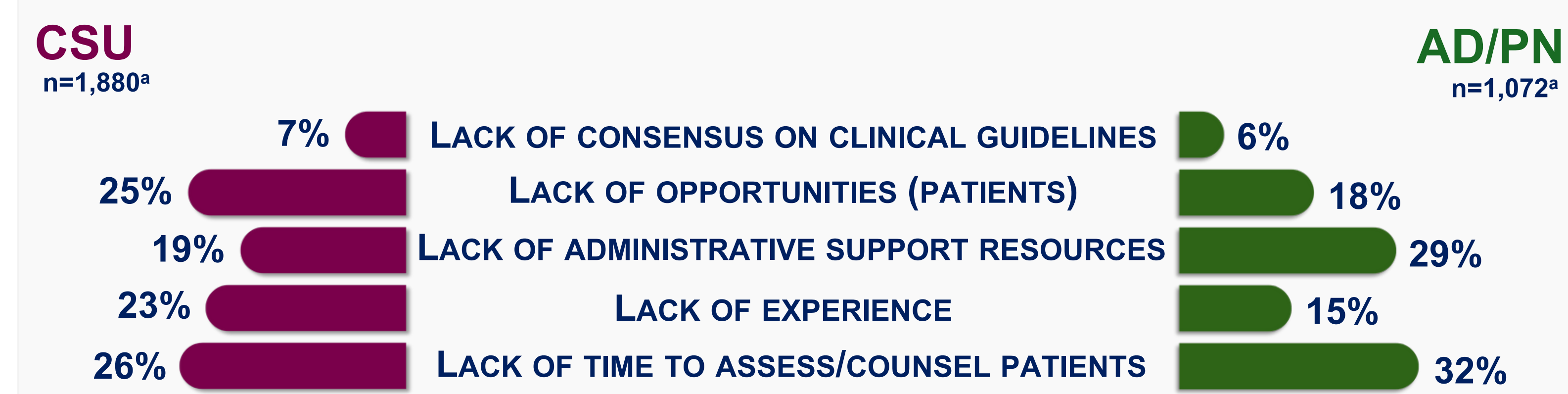


Intended Changes to Clinical Practice After Education:



TOP intended practice change for CSU & AD/PN was "TREATMENT"
Percentages shown above represent proportions of (total N [4,116] - "TREATMENT" n [1,280])
"APPLICATION OF CLINICAL GUIDELINES" was the lowest ranked practice change

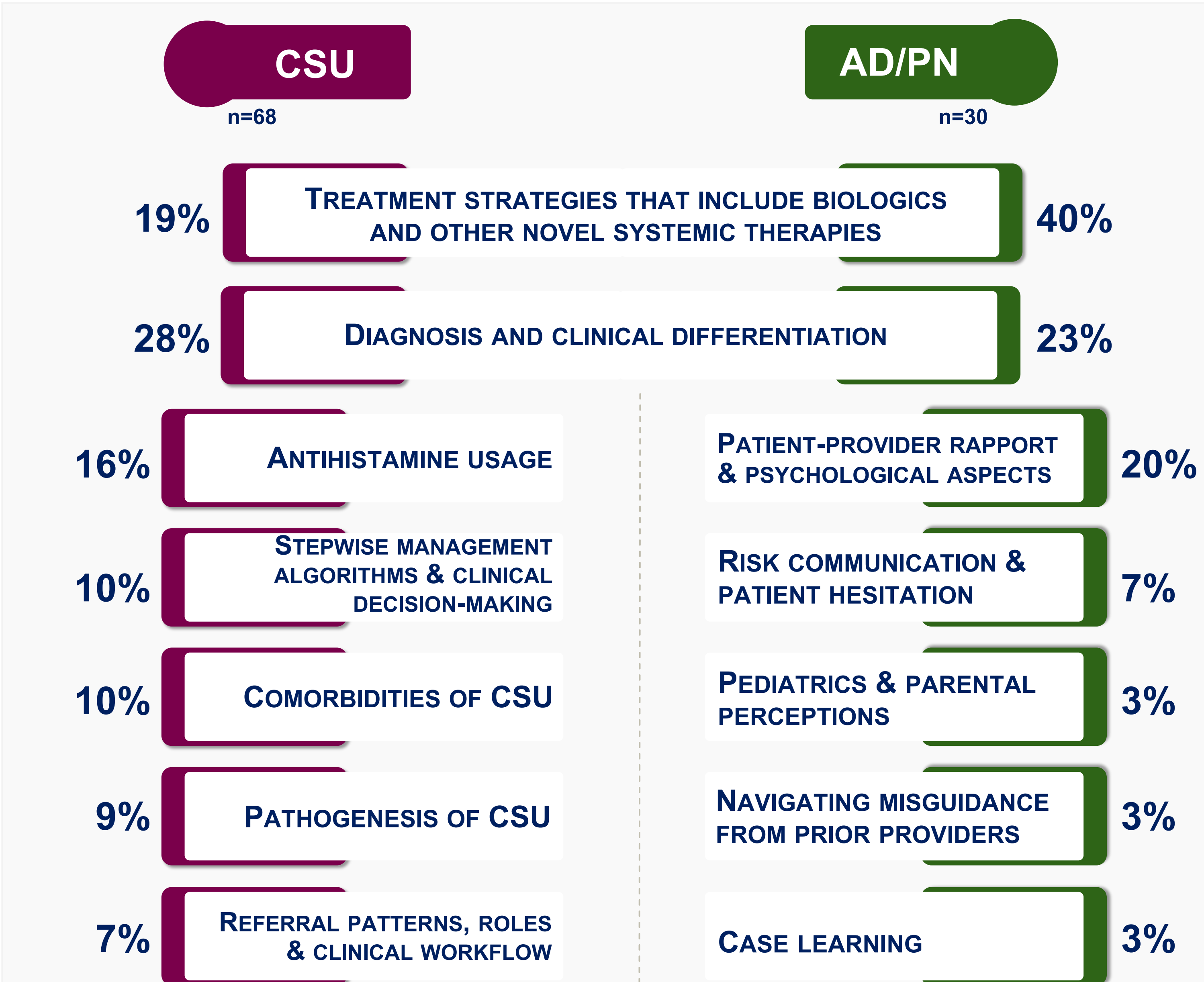
Barriers in Clinical Practice:



TOP practice barrier for CSU & AD/PN was "INSURANCE/REIMBURSEMENT ISSUES/COST"
Percentages shown above represent proportions of (total N [2,952] - "INSURANCE/REIMBURSEMENT ISSUES/COST" n [1,823])
CSU care: "LACK OF EXPERIENCE" and "LACK OF OPPORTUNITIES (PATIENTS)" were more of a barrier
AD/PN care: "LACK OF ADMINISTRATIVE SUPPORT RESOURCES" was more of a barrier

*Learners were asked to select all that apply, n reflects cumulative # of choices selected

Themes of Educational Needs from Qualitative Analysis of Questions:



CSU: Learner questions reflect interest in foundational knowledge and combining the standard of care with newer, systemic therapies.

AD/PN: Learner questions reflect interest in patient counseling and systemic therapies to improve patients' overall well-being.

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