Table I. Payments made to voting members of Food and Drug Administration drug committees by pharmaceutical companies*

Drug	Amount, $
Brodalumab	
Competitor payments	85,249.89
Manufacturer (Valeant Pharmaceuticals) payments	0.00
Total payments	85,249.89
Dalbavancin	
Competitor payments	210,478.76
Manufacturer (Allergan, Inc) payments	2,262.77
Total payments	212,741.53
Deoxycholic acid	
Competitor payments	218,910.73
Manufacturer (Kythera Biopharma) payments	0.00
Total payments	218,910.73
Dupilumab	
Competitor payments	44,226.33
Manufacturer (Sanofi & Regeneron) payments	29,587.09
Total payments	73,813.42
Peginterferon alpha	
Competitor payments	792,090.19
Manufacturer (Merck) payments	71,907.98
Total payments	863,998.17
Secukinumab	
Competitor payments	101,392.93
Manufacturer (Novartis) payments	0.00
Total payments	101,392.93
Tedizolid phosphate	
Competitor payments	212,762.97
Manufacturer (Cubist Pharmaceuticals) payments	0.00
Total payments	212,762.97
Ustekinumab	
Competitor payments	120,788.88
Manufacturer (Janssen Biotech) payments	218.76
Total payments	121,007.64

*Table excludes payments for research purposes.

because quality researchers are likely to be pursued by industry, and these mergers can lead to scientific advancements that benefit society.[2,3] Regardless of the ongoing debate, awareness of physician–industry financial ties is worthy of continued discussion. Future evaluations may help assess trends in post hoc advisory payments.

Stephanie L. Kuschel, BA,[a] Claudia M. Ricotti, BS,[b] Cory A. Dunnick, MD,[c,d] Jeremy Hugh, MD,[c,d] and Robert P. Dellavalle, MD, PhD, MSPH[c,d]

From the Indiana University School of Medicine, Indianapolis, Indiana[a]; the University of Cincinnati College of Medicine, Cincinnati, Ohio[b]; the Department of Dermatology, University of Colorado School of Medicine[c] and Dermatology Service, Rocky Mountain Regional VA Medical Center, Aurora, Colorado.[d]

Stephanie L. Kuschel and Claudia M. Ricotti are co-first authors.

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Reprint requests are available from Stephanie Kuschel, e-mail: skuschel@iu.edu

Correspondence to: Robert P. Dellavalle MD, PhD, MSPH, Dermatology Service, Rocky Mountain Regional VA Medical Center, 1700 N Wheeling St, Room E1-342, Aurora, CO 80045

E-mail: robert.dellavalle@ucdenver.edu

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Parental support for sun-protection policies in schools: A cross-sectional analysis

To the Editor: In 2014, the US Surgeon General issued a "Call to Action" for skin cancer awareness and prevention, recommending a community-wide effort that included providing shade, educating patients in a health care setting, and teaching children in school about sun safety.[1] Arizona was the first to mandate that a sun-safety curriculum be taught in all schools from kindergarten through eighth grade.[1,2] Since then, Washington, Oregon, Utah, Texas, and New York have enacted laws that support sun protection

Table I. Current sun-protective school policies reported by parents of children in kindergarten through eighth grade

Policies	n	%*
Structural policies		
There are play areas with shade structures.		
No	226	55
Yes	162	40
Don't know	21	5
There are play areas shaded by trees.		
No	227	56
Yes	165	40
Don't know	17	4
Play time is scheduled during nonpeak sun hours.		
No	267	65
Yes	83	20
Don't know	59	14
Behavioral policies		
Students are required to apply sunscreen.		
No	287	70
Yes	81	20
Don't know	41	10
Hats are required while outside.		
No	360	88
Yes	27	7
Don't know	22	5
Students are allowed to apply sunscreen.		
No	197	48
Yes	113	28
Don't know	99	24
Hats are allowed while outside at school.		
No	175	43
Yes	161	39
Don't know	73	18
Curriculum presence		
There is teaching about sun safety in the classroom.		
No	198	48
Yes	110	27
Don't know	101	25

*Percentages are rounded to the nearest whole number.

in schools. However, the majority of schools, especially in the US Midwest,[3,4] continue to lack sun-safety policies.

We sought to gauge parents' awareness of sun-protection policies in Minnesota schools and investigate associations between parental support for and parental/child characteristics associated with sun-protective policies in schools. The study was determined to be exempt by the University of Minnesota institutional review board (study no. 1605E87152).

Parents (N = 409) completed an online survey at the Minnesota State Fair in 2016. Multivariate logistic regression was used to calculate odds ratios and 95% confidence intervals for parent and child characteristics associated with support of various policies. Survey questions included previously published items.[5]

Parents reported lack of structural (e.g., shaded play areas), behavioral (e.g., sunscreen application), and curricular school policies (Table I). Regarding sunscreen and hats, parents were more likely to support requiring policies for younger children (kindergarten through fifth grade), likely because young children need more help with these behaviors. Similarly, parents of children with fair skin were also more likely to support sunscreen and hat policies, in part because they may have been more aware of increased skin cancer risk (Table II).

Parents of children who had sustained 1 or more sunburns in the last year were less likely to support a sun-protective policy, such as scheduled play during hours of nonpeak ultraviolet radiation levels, compared with parents of children who had no sunburns (Table II). This raises questions, specifically, about how these parents may perceive and prioritize the effects of sunburns, and may reinforce the concept that all ages could benefit from sun-safety education.

Our survey identified considerable support for sun-protection policies in schools, especially for policies that allow behaviors like sunscreen use or hat-wearing rather than mandating them. This information could help to guide schools toward implementation of sun-safety policies to reduce exposure to ultraviolet radiation in childhood.

Finally, our study failed to show an association between patient education by a medical doctor about sun protection and support for sun-safety policies in schools. The results of this study should empower health care professionals such as pediatricians, general practitioners, dermatologists, and others who advocate for pediatric health to communicate with and educate parents in their care about sun protection, to support implementation of sun-safe measures in schools, and to consider the benefits of future legislation to further encourage regulations regarding sun protection in schools.

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Anna Kozlowski, MD,[a,b] Erin Dodd, MD,[c] Brooke Hanson, MD,[d] DeAnn Lazovich, PhD,[e,f] and Ingrid Polcari, MD[f,g]

From the University of North Dakota School of Medicine, Grand Forks, North Dakota[a]; Gundersen Health, La Crosse, Wisconsin[b];

Table II. Predictors of parental support for sun-protective policies in schools*

	Require sunscreen			Allow sunscreen			Require hats			Allow hats			Schedule outdoor play time in nonpeak UV hours			Provide sun-safety teaching		
Characteristics	Support, %	OR	95% CI	Support, %	OR	95% CI	Support, %	OR	95% CI	Support, %	OR	95% CI	Support, %	OR	95% CI	Support, %	OR	95% CI
Parental sex																		
Female vs	63	1.26	0.75-2.13	96	2.95	1.18-7.37	40	0.81	0.45-1.44	94	2.73	1.19-6.23	58	1.02	0.59-1.78	94	2.48	1.06-5.80
Male	56			89			45			86			58			88		
Parent age in years																		
≥40 vs	60	0.81	0.51-1.30	95	1.06	0.42-2.66	40	0.81	0.49-1.34	94	1.61	0.71-3.61	55	0.72	0.44-1.18	95	2.04	0.88-4.70
<40	63			94			44			90			63			90		
Parent race																		
White vs	60	0.64	0.33-1.24	96	2.30	0.84-6.31	39	0.50	0.25-0.995	95	4.24	1.71-10.54	56	0.58	0.29-1.18	94	1.51	0.57-3.99
Nonwhite	67			87			57			78			70			87		
Parent education																		
B/M/D vs	61	1.01	0.63-1.62	95	1.81	0.73-4.50	38	0.76	0.46-1.26	95	2.13	0.94-4.83	54	0.63	0.38-1.03	94	1.53	0.67-3.50
Other	62			93			47			89			66			91		
Child grade																		
K-5 vs	67	1.63	1.00-2.64	94	0.81	0.31-2.11	50	2.07	1.23-3.48	94	1.73	0.73-4.14	62	1.27	0.78-2.08	95	2.16	0.88-5.32
6-8	55			95			33			91			54			91		
Child Fitzpatrick skin type																		
1/2 vs	67	1.72	1.07-2.76	97	2.97	1.02-8.69	45	1.47	0.88-2.46	96	2.35	0.96-5.76	62	1.51	0.92-2.49	97	2.93	1.10-7.80
3/4	55			93			36			90			55			91		
1/2 vs	67	1.15	0.47-2.83	97	3.92	0.85-18.00	45	0.62	0.25-1.53	96	2.07	0.50-8.60	62	1.09	0.45-2.61	97	3.99	1.03-15.45
5/6	63			89			57			89			62			86		
Physician discussed sun safety																		
Yes vs	65	1.48	0.93-2.37	96	1.60	0.63-4.05	40	0.89	0.54-1.48	94	1.35	0.60-3.07	58	1.07	0.65-1.75	92	0.45	0.18-1.11
No, don't know	58, 51			92, 95			45, 41			89, 95			61, 54			94, 97		
Number of child sunburns in past 12 months																		
≥1 vs	59	0.69	0.43-1.10	94	0.58	0.23-1.49	40	0.76	0.46-1.27	92	0.68	0.30-1.59	54	0.57	0.35-0.93	93	0.70	0.30-1.62
None	64			95			43			93			63			93		
Number of child sunburns at school																		
≥1 vs	64	1.11	0.68-1.82	95	1.00	0.37-2.74	44	1.08	0.64-1.81	94	1.50	0.58-3.93	57	0.90	0.54-1.49	95	1.45	0.55-3.81
None	60			94			41			92			59			92		

B/M/D, Bachelor's, master's, doctorate; *CI*, confidence interval; *K*, kindergarten; *OR*, odds ratio; *UV*, ultraviolet.

*Outcomes are grouped by *support* survey responses versus *oppose* survey responses, excluding *no opinion* survey responses. Adjusted ORs and 95% CIs are from logistic regression models with predictor adjusted for parental sex, parental age, education, and skin type unless one of these was the predictor of interest.

Department of Medicine, Division of Dermatology, University of Chicago, Chicago, Illinois[c]; and Department of Dermatology,[d] Division of Epidemiology and Community Health,[e] Masonic Cancer Center,[f] and Departments of Dermatology and Pediatrics, University of Minnesota, Minneapolis, Minnesota[g]

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Correspondence to: Ingrid Polcari, MD, University of Minnesota Department of Dermatology, Mayo Mail Code 98, 420 Delaware St SE, Minneapolis, MN 55455-0392

E-mail: ipolcari@umn.edu

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Patient-reported adverse effects after facial skin cancer surgery: Long-term data to inform counseling and expectations

To the Editor: The majority of outcomes data after dermatologic surgery are limited to physician-reported adverse effects in the short-term postoperative period. However, symptoms might persist for some patients, which can influence their perception about healing. Our goal was to characterize long-term patient-reported symptoms after facial skin cancer surgery.

A cross-sectional study was performed with patients ≥21 years of age who underwent facial skin cancer surgery during March 1, 2016-March 31, 2018. We administered the FACE-Q Skin Cancer Adverse Effects Checklist,[1,2] which addresses postoperative symptoms of pain, discomfort, sensitivity, numbness, tingling, tightness, itchiness, swelling, bruising, and difficulty with facial movements. Frequencies were calculated as the number of patients who reported a symptom during the specified time point; responses other than not at all were counted as a report of the corresponding symptom. Electronic medical records were reviewed to collect treatment information. Patient and surgical characteristics were evaluated by using descriptive statistics.

In total, 396 of 1049 eligible patients completed the questionnaire (response rate 37.8%). Responses were categorized on the basis of time between surgery date and survey completion: <6 months (average 15.7 ± 8.0 weeks), 6 months to <1 year (average 38.0 ± 8.3 weeks), and ≥1 year (average 84.7 ± 23.1 weeks). Patient demographics, tumor type, tumor location, and repair type are shown in Table I. The average age of survey responders was 65.6 ± 11.9 years; 51.0% (n = 202) were men, and 49.0% (n = 194) were women. The average age of survey nonresponders was 65.1 ± 13.8 years; 55.2% (n = 360) were men, and 44.8% (n = 293) were women. Demographic characteristics of responders were similar to nonresponders. Overall, frequency of postoperative symptoms was low (range 2.3%-43.4%) (Fig 1). The frequency of sensitivity, numbness, and tightness was highest <6 months and ≥1 year after surgery. Among repair types, flap or graft repair was associated with the highest frequency of symptoms, particularly numbness, tingling, tightness, and itchiness, ≥1 year after surgery. Among anatomic surgical sites, lip location was associated with highest frequency of symptoms, particularly numbness, tingling, and difficulty with facial movements, ≥1 year after surgery.

Although postoperative complications occur in <1% of cases of cutaneous oncologic surgery,[3] patients experience a range of symptoms after surgery. Although patients often experience pain in the short-term postoperative period,[4] milder symptoms, such as numbness, sensitivity, and tightness, are more common in the long term; the face is the most pressure-sensitive area of the body,[5] which might contribute to these findings. Similar to previous studies,[4] patients who underwent graft or flap repair reported the most symptoms. Those who underwent surgery on the lip reported more long-term symptoms and experienced a greater quality-of-life impact (ie, eating, speaking, and social interactions) after surgery compared with other locations.