Message from the President

Greetings from Texas!

As President of the AOCD, I welcome you to the Winter edition of DermLine.

Dr. Lin, our Immediate Past President, continues to support me in my role as President, ensuring I stay the course. I am grateful to each of you for your support throughout this year. Time flies at an unbelievable pace, and as I near the end of my term, I encourage you to continue your involvement in our college under the leadership of Karthik Krishnamurthy, DO, FAOCD, our President Elect.

Our meeting in beautiful Santa Monica, CA, was a powerful experience. The host of presenters and the myriad topics covered provided attendees with many new arrows for their quivers. Between Wednesday and Sunday, members received updates, new information, fellowship, and data. I hope those of you who missed our AOCD Fall Meeting will join us for the Spring 2017 meeting in Atlanta. I can assure you that you will find great value in attending it.

I am proud of who we are and where we are headed. My appreciation of our great organization is profound. The AOCD has nurtured me throughout my career and will continue to support members for generations to come. Please join me in working to preserve the AOCD. As osteopaths, our gift is our approach to understanding and healing the whole person. Let us not forget our purpose and those we serve!

The AOCD will remain a strong provider of service and support to dermatologists who chose osteopathy in preparation for their careers, providing high-quality professional development and support to our membership. Our publications will continue to share information and keep our members up to date on current topics. Our future will remain strong as long as we join together to keep the vision alive. Keep the main thing the main thing.

Please join us in Atlanta!

Alpesh Desai, DO, FAOCD
President, American Osteopathic College of Dermatology
Executive Director’s Report
by Marsha Wise, Executive Director

Greetings Everyone!

The year is quickly coming to an end, and it has been a very busy one. We had a great meeting in Santa Monica, with 300 registered!

The AOCD staff has been working to obtain ACCME accreditation in order to provide AMA credit for our CME meetings. The application has been submitted and we learned recently that we will be scheduled for our initial interview in February or March of 2017. By August 1, 2017 we will have an official determination from the ACCME on whether the AOCD qualifies to provide AMA credit. Wish us luck!!

Also in the CME Department, the AOCD staff participated in a webinar conducted by the AOA on the new CME reporting system. This system will allow us to DIRECTLY report the CME you earned from one of our meetings to your report. In the past, we have had to submit spreadsheets to the AOA and they in turn entered the data into your report. By allowing the specialties to report this CME directly, there should be a reduction in errors and allow us to report it faster to the AOA.

The Journal of American Osteopathic College of Dermatology (JAOCD) has plans to switch to an on-line publication. This is still in the planning stages. We are in the process of applying to the AOA to obtain 1B CME credit for reading the JAOCD. 1B credit for journal reading can be obtained by completing a quiz. This will all be done through our website. 1B credit DOES count for your Dermatology specific requirement. Look for the quizzes to begin by May 2017 as we are awaiting approval from the AOA CME Division.

The AOCD membership dues for 2017 are now due. The AOCD has made it easier for you to renew your dues by providing a link to our website for quick and secure renewal. Click here to go to our web site. To log in, your username is your email address you have on file with the AOCD and your password is “Aocd” followed by your AOA#. (case sensitive) Please contact our office if you have difficulty logging in.

Also on that page is a form to update your database information. This database is maintained on our web site so you can make changes to your membership information at any time. All changes you make will be recorded in the database and will also update the “Find a DO” section of the web site. Although you will see all of your information in your personal file, all inquiries will only see your office address, office telephone and fax number.

The Foundation for Osteopathic Dermatology is accepting applications for research grants. For more information, click here to visit the Foundation page.

Many AOCD members have been inquiring about OCC and OCAT. If you have not already done so, you must register. Click here to visit the OCAT website, where you can register. This is all mandatory for recertification. If you have any questions please refer to the website. Click here for OCC frequently asked questions on the AOBD’s website.

Save the Dates!

• The 2017 Spring Meeting will take place from March 29- April 2, 2017 at the Ritz Carlton Atlanta at 181 Peachtree Street, Northeast in Atlanta, GA.
• The 2017 Fall Meeting will take place from October 24-28, 2017 at the Intercontinental, New Orleans, 444 St. Charles Ave., New Orleans, LA 70130
• The 2018 Spring Meeting will take place from March 19-25, 2018 at the Hilton West Palm Beach, 600 Okeechobee Blvd., West Palm Beach, FL 33401
• The 2018 Fall Meeting will take place from October 9-13, 2018 at the Westin San Diego, Gaslamp Quarter, 400 West Broadway, San Diego, CA 92101

The AOCD staff wishes everyone a happy holiday season. Take time to enjoy your families!

As always, if you have questions or concerns, please feel free to contact me (see “Contact Us” at AOCD.org), and I will be happy to assist you. We appreciate your continued support of the AOCD.

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For eczema-prone skin

TWO ADVANCED TECHNOLOGIES.

HYDRATE

ONE REPLENISHING REGIMEN.

Cetaphil® RestoraDerm® products are the first and only regimen with advanced ceramide and Filaggrin technology™

To help restore the skin barrier in dry, eczema-prone skin, recommend the Cetaphil® RestoraDerm® regimen.¹


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GDATA-6186
Printed in USA 06/13
I appreciate having had the opportunity to thank several of our corporate sponsors for their continued support of the College and to welcome new exhibitors at the 2016 Fall Meeting. The AOCD is very fortunate to have corporate sponsors who join us as partners with a commitment to medical excellence. Our corporate sponsors remain committed to the College and continuing medical education (CME). It goes without saying that our corporate sponsors are critical to helping us accomplish our mission.

New and returning corporate sponsors are as follows:
• Sun Pharma (Ruby Level)
• Galderma (Diamond Level)
• Lilly USA, LLC, Valeant Pharmaceuticals (Platinum Level)
• AbbVie, Celgene (Gold Level)
• Allergan, Anacor Pharmaceuticals, DLCS (Bronze Level)
• Aclaris Therapeutics, DUSA Pharmaceuticals, Novartis (Pearl Level)

Sponsors/Unrestricted Grants were provided by Sun Pharma, Lilly USA, LLC, Novartis Pharmaceuticals and Valeant Pharmaceuticals.

The AOCD is grateful for the continued support from these companies in making our meetings a success.

Exhibitors for the 2016 Fall Meeting were as follows: 3Gen, Inc., AbbVie, Aclaris Therapeutics, Inc., Advanced Dermatology & Cosmetic Surgery, Allergan, Aurora Diagnostics, Bayer Healthcare, Cedars-Sinai Pathology & Lab Medicine, Celgene, Cleveland Skin Pathology Laboratory, Inc., Dermpath Diagnostics, Dermpath Lab – Central States, DUSA Pharmaceuticals, Elekta, Encore Dermatology, Galderma Laboratories, Genentech, Leo Pharma, Lilly USA, Myne Pharma, Medimetriks Pharmaceuticals, Novartis, Passion to Heal (ME to WE Trips, Inc.), ProPath Services LLP, Sensus Healthcare, Sun Pharma, and Valeant Pharmaceuticals

We hope that many of you had an opportunity to express your appreciation to our sponsors while you were in Santa Monica. The fact that they continue to support the College, many of them doing so for several years, speaks volumes about the value of their commitment to our organization.

NOW AVAILABLE.

Visit Our Booth
to learn more about Taltz

Discover more at taltz.com
Dear Colleagues,

Tis the season! I would like to wish all of you a very happy holiday season! Dermatology residency, while challenging, is a very special time of our lives. Remember to appreciate this moment, and make it great! We are only residents, once. As we start a new year, there are a few friendly reminders to share.

First, the upcoming In-Training Examination
- All residents are required to take the ABD In-Training Exam.
- Please ensure your program coordinator and/or program director received the email from the AOCD regarding instructions on how to register you for the exam. This email was sent out 9/2016.
- Also, please confirm your training institution is prepared to administer this exam for you.
- The registration deadline for the 2017 ABD In-Training Examination is Tuesday, November 15, 2016.
- The exam date for osteopathic programs is Monday, February 20, 2017.
- If you wish to take the exam on Thursday, February 16, 2017, with your allopathic colleagues at an affiliated allopathic institution, your program coordinator or director must contact the ABD to receive special permission for you to do so.
- Great study tools are: Derm-In Review and Jain Dermatology Study Guide and Comprehensive Board Review
- BEST OF LUCK! Rock it out!

Osteopathic Supplement for the 2016-2017 In-Training Examination
- A supplemental Osteopathic component will be given during the 2016-2017 year. All residents and program directors have been notified and provided with instructions. See pages 8-9 of this issue of DermLine for more details.

Second, the 2017 AOCD Spring Meeting, held at the Ritz-Carlton in Atlanta, GA 3/29/2017 to 4/2/2017
Ritz Carlton Downtown
181 Peachtree Street NE
Atlanta, Georgia 30303

- Residency Program 15 minute Presentations will take place March 29-31, 2017 in the Plaza Ballroom.
- These lectures should be designed to review board relevant material and the newest literature on your topic.
- Please refer to your email from John Grogan regarding your presentation date, time, and topic.

Third, society memberships and dermatology publications
- As a resident member of the College, you receive complimentary memberships in the American Academy of Dermatology (AAD) and the American Society for Dermatologic Surgery. With these complimentary memberships you should be receiving both the Journal of the American Academy of Dermatology, also known as the JAAD and Blue Journal, and Dermatologic Surgery.
- If you are not receiving either publication, please contact the societies (www.aad.org, www.asds.net) directly to inquire about your membership status.
- As a resident, you also are eligible for a complimentary subscription to Archives of Dermatology. This journal is published by the American Medical Association (AMA). Your physician number was set up by your medical school, and you need to contact the AMA directly to make sure the AMA has your correct mailing information as well as your specialty listed as dermatology. Please contact the AMA at 1-800-262-3211 or http://www.ama-assn.org.
- There are a number of publications that are available on a complimentary basis while you are in your dermatological training.
  - Journal of Drugs in Dermatology
  - Dermatology Times
  - Catis
  - Cosmetic Dermatology

Fourth, the Match.
- Good luck to all programs who are interviewing this year!
- February is quickly approaching! We all look forward to meeting our next generation of young osteopathic dermatologists in training!

Fifth, ACGME Accreditation
- As we all move towards ACGME accreditation, it is important to remember one way we can all preserve our osteopathic distinction is by applying for Osteopathic Focus. I strongly encourage all to do this. Our allopathic colleagues also have the option to apply for Osteopathic Focus. For those of us currently working on our application, our ACGME ADS support contact is Kevin Bannon. You can reach him by email here webads@acgme.org or by phone here 312-755-7111.

Last is the AOCD Resident Liaison position
- If there are any second-year residents interested in becoming active in the College, I recommend serving as the liaison. I have had fun serving the AOCD as the liaison, and am grateful for the opportunity that you all allowed me to have during the past year and a half.
- Please email me at the liaison account with your nominations.

Dimensional Dermatology

I would like to inform all of you about a brand new blogging website called Dimensional Dermatology, founded in May 2016 by Dr. Paul M. Graham, a senior dermatology resident at St. Joseph Mercy Dermatology in Ann Arbor, Michigan. This website
The stratum corneum (outermost layer of the skin) makes up the
Ceramides are a key player in skin barrier function and maintain
Optimal water content of the skin can be achieved with a

Winter is coming and so is the struggle with dry cracked skin.
Nothing feels better on a cold winter morning than a hot shower.
However, after reading this article, you may reconsider your decision
to take long hot showers as this often leads to the development
of significant skin dryness. The skin becomes dry and cracked in
the winter for several reasons: less ambient air moisture, cool
and dry outdoor air, and warm and dry indoor air. Because of
these changes, the skin’s natural ability to maintain hydration is
compromised. An extra effort in daily skin care is a must in the
winter. It is absolutely crucial to choose the right cleanser and
moisturize daily. Three properties important to consider when
choosing a good and effective moisturizer include: occlusion,
humectancy, and lipid restoration. In order to choose a suitable
moisturizer, a basic understanding of the skin barrier and the
three basic properties of a moisturizer is essential. This article aims
not only to educate about the skin barrier and the importance
of hydration, but also to provide a detailed discussion on the
important properties of moisturizers. Use this information to keep
your skin as smooth as silk during the harsh winter months.

THE BIG PICTURE
• The stratum corneum (outermost layer of the skin) makes up the
  skin’s barrier and prevents loss of water from the skin.
• Optimal water content of the skin can be achieved with a
  moisturizer with both occlusive and humectant properties.
• Ceramides are a key player in skin barrier function and maintain
  moisturized skin.

6 simple steps to prevent dry cracked skin in the winter?
1. Drink plenty of water.
2. Switch to a syndet body wash with a bath puff, such as Aveeno
  Body Wash.
3. Limit showers to 5-10 minutes, with luke-warm water.
4. Pat dry and immediately moisturize damp skin following baths
  or showers.
5. Two months prior to the start of the winter season, begin
  using a daily moisturizer with occlusive, humectant, and lipid
  replacing properties (CeraVe Moisturizing Cream).
6. Buy a humidifier for your home (must clean regularly).

Conmissions of a Dermatology Resident
By Laura Jordan, DO
A fast 4 months have somehow elapsed, and the derm-world remains abuzz in my mind. From
paper submissions, poster presentations, conferences, and journal clubs to pouring through
Ballognia, Elston, and Jain (all the while trying to keep the knowledge from spilling back out)...
then learning how to perform thorough skin exams, proper biopsies, excisions, and (egads!)
reading dermpath slides: derm residency is certainly not a disappointment!

We all face different challenges as we move through our residency programs. Some of us have
to focus on how to study properly again, others need a tutorial on suturing, while others just
need focus on ways to balance all that life entails. Certainly re-learning how to balance home, work, and studying while
attempting to stay fit and eat somewhat healthy feels very reminiscent of the exhaustion which coupled audition season in
medical school. Some uncertainty remains surrounding thoughts of where to practice when done, whether or not to pursue
a fellowship, the list is endless...

I remember when I asked a senior derm resident before I started residency what the most challenging aspect of residency
was for her. She responded, “Accepting the fact that you won’t know anything for 6 months at least.” That was one of the
best piece of advice I could have received. For all of us Type A personalities out there, of which I know are likely in the
majority given our specialty, it is definitely hard to accept when you don’t know something and most certainly frustrating
when you forget something you feel like you should know! I just have to keep reminding myself that I have 3 years to learn
derm and a lifetime to practice it.

At the end of the day, the week, the month, and ultimately the 3 years until I grow up to be a “real derm,” I remind myself
that residency is truly exciting. All of these pressures, tasks, goals, are here as tiny stepping stones on a path to the growth
and knowledge I hope to attain by the end of my residency. Remember: this is what you wanted ;)

Page 6
From hard-to-reach spots to large body areas...

WE’VE GOT YOU COVERED

The Only Triamcinolone in an Aerosol Spray

Indication:
Kenalog® Spray (triamcinolone acetonide topical aerosol, USP) is indicated for relief of the inflammatory and pruritic manifestations of corticosteroid-responsive dermatoses.

Important Safety Information:
Systemic absorption of topical corticosteroids has produced reversible hypothalamic-pituitary-adrenal (HPA) axis suppression, manifestations of Cushing's syndrome, hyperglycemia, and glucosuria in some patients.

Conditions which augment systemic absorption include the application of the more potent steroids, use over large surface areas, prolonged use, and the addition of occlusive dressings.

Children may absorb proportionally larger amounts of topical corticosteroids and thus be more susceptible to systemic toxicity (see PRECAUTIONS, Pediatric Use).

You are encouraged to report negative side effects of prescription drugs to the FDA at 1-800-FDA-1088 or www.fda.gov/medwatch

For topical use only. Please see adjacent page for full prescribing information.
For more information, visit www.kenalogspray.com

Reference:
2. After spraying, the nonvolatile vehicle remaining on the skin contains approximately 0.2% triamcinolone acetonide. Each gram of spray provides 0.147 mg triamcinolone acetonide in a vehicle of isopropyl palmitate, dehydrated alcohol (10.3%), and isobutane propellant.

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KS 1212
Hello everyone,

It was great to see all of you who were able to attend the Fall Meeting in beautiful Santa Monica. I hope you found value in the lectures presented, while enjoying the weather and scenery of southern California. Thanks to Dr. Reagan Anderson and Marsha Wise for all the time they spent putting together the program. A special thanks to Brandon Basehore, DO; Cassandra Beard, OMS-IV and Shane Swink, OMS-III, our student ambassadors for the Fall Meeting. They were each invaluable, going above and beyond, to help put on a great meeting.

2016 Resident Membership Renewal

With a new membership year approaching, it’s not too early to begin thinking about renewing your annual dues. These can be paid online through your member account at www.aocd.org. You can quickly and conveniently renew your membership online using these five easy steps:

1. To get started, click sign in at the top of the homepage.
2. Enter your username and password, and click sign in. [Note: If this is your first time signing in, you will be taken to a screen prompting you to verify your member profile options. Make any desired changes, click the Save Settings button, and proceed to Step 3.]
3. Click the yellow *** Renew Your Membership Now *** banner.
4. You will be prompted to update your contact information. If you have any changes, enter updated information in the appropriate field. When finished, click the Save Changes button.
5. Enter your billing and payment information, and click the Submit Securely button. If you have any problems logging in, please contact us and we will help you.

2017 Spring Meeting Presentation and 2nd Year Poster Due Dates

Keeping with the format of the 2015 resident presentations, residency training programs will once again prepare a single lecture as a group on an assigned topic. Programs with one or more third year residents will present one lecture of 15 minutes in length based on an assigned topic during the AOCD Spring Meeting. The program’s senior residents are to present the information, but all residents in the program must show proof of participation in the project. If more than one third year resident is training in the program, all third year residents will present the lecture as a group.

The presentation should be formatted as a board review lecture and be based on the most current literature.

The residency program director will review all oral presentations prior to submission. In addition, the residency program director will submit a signed and dated statement that the program’s oral presentation has been reviewed, thereby allowing the presentation to be included in the AOCD meeting program. The program director will confirm each resident’s participation in preparing the program’s presentation. Submission deadlines for the presentations are as follows:

- December 19, 2016: Program Presentation Information Form, Disclosure Statement and Presentation Needs Assessment Form submitted to AOCD office 14 weeks prior to the week of the meeting.
- February 15, 2017: Program Powerpoint and Program Director’s Statement submitted to AOCD office 6 weeks prior to first day of meeting.
- March 15, 2017: Any revisions of Powerpoint in AOCD Office 2 weeks prior to first day of meeting.

These lectures will be presented from March 29–March 31 in the Plaza Ballroom on the second floor of the Ritz-Carlton, Atlanta.

Residents are required to submit a poster during the second year of training at the Spring Meeting. This year, posters are due February 15, 2017. A completed poster submission form must accompany your poster. A few things to keep in mind when preparing your poster:

- This poster is an individual submission, not a group project.
- If you are required to prepare a poster for your program, you may submit a copy of that poster to meet this requirement. If your program does not have this requirement, you should follow the poster guidelines for either the AAD or the AOA in preparing this poster.
- Please submit the Poster Submission Form, signed by your Program Director along with your poster.
- Avoidance of Commercialism: All poster exhibits must avoid commercialism. No trade names should be used for drugs, devices and/or instrumentation, including lasers. Any medications or other substances referred to in the presentation material must be identified by their scientific names only. In addition, poster exhibits, the cost of which is underwritten to any extent by a pharmaceutical company or other commercial enterprise, should include a clear acknowledgment stating that a portion of its cost was underwritten and identifying the particular commercial company involved.
- Trade name violations or failure to disclose commercial support will result in the poster being denied acceptance for this AOCD requirement.
- The poster is to be submitted to the AOCD electronically, you do not need to print a copy of the poster to bring to the meeting. Simply submit the poster as a Powerpoint file.

2016-2017 In-Training Examination

As you may recall, the AOCD is not offering an In-Training Examination for the 2016-2017 academic year; however, residents are required to take the In-Training Exam given by the American Board of Dermatology (ABD). You or your program should have registered for the exam in mid-November to meet the registration deadline. The exam date for osteopathic programs is Monday, February 20, 2017. Please visit the ABD’s In-Training Examination page for additional details.

In addition to the ABD portion of the exam, a supplemental Osteopathic component will be given. This portion of the exam will be distributed and completed electronically. We will utilize a learning management platform called Schoology to facilitate the essay. Each resident must create a free Schoology account to receive and participate in the essay portion. Follow this link and click Sign Up to begin creating your account. The group code required during sign-up was sent to you via email on December 5.
Dr. Peter Saitta will act as the group's administrator and distribute the essay portion to the group. The exam will be released four days prior to the ABD In-Training Exam. All residents will have a total of seven days to write and submit their essays. This exam portion will be graded in the following manner: There are three components to the essay portion, and you must pass two out of three to receive a grade of pass. Otherwise, you will receive a grade of fail on the essay portion. Those components are:
1. Correct Diagnosis
2. Appropriate Treatment Plan
3. Osteopathic Treatments/Considerations

2017 Dermatology Grand Rounds Schedule
Each residency program, once again, is asked to provide a case for the Grand Rounds website. Click here to visit the Dermatology Grand Rounds on our website. Please contact me for the sign-on information to submit a case. The 2017 schedule is as follows:

- January 5, 2017
  - OPTI-West/Chino Valley Medical Center
- February 5, 2017
  - Still OPTI/Northeast Regional Medical Center

Northeast Osteopathic Dermatology Resident Society

The Northeast Osteopathic Dermatology Resident Society met recently. The society consists of residents from St. Barnabas Hospital, Palisades Medical Center, St. John's Episcopal Hospital and Lehigh Valley Health Network.

It was founded by former St. Barnabas Hospital resident, Marisa Wolff, DO. Following Dr. Wolff's graduation from residency, current SBH chief resident, Lacey Elwyn, DO, has worked to keep the society active. The group takes pride in being a part of the osteopathic community and values close networking amongst osteopathic dermatology residency programs.

I hope everyone has a happy and safe holiday season with family and friends. I look forward to seeing you all in Atlanta for the 2017 Spring Meeting.

2016 AOCD Fall Meeting Highlights

By Laura Jordan, DO; Brandon Basehore, DO; Cassandra Beard, OMS-IV; Shane Swink, OMS-III

The Classification and Treatment of Hand Eczema

Peter Saitta, DO, FAOCD

- Hand dermatitis
  - Entire palm involved with fissuring
  - Differential diagnosis: palmar plantar psoriasis has some sparing of the palm, yellow scale, and likely lesions present elsewhere
  - Vesicular hand eczema
  - Arrives like "an attack"; pruritic
  - Affects palms and soles, around the nails, sides of fingers

- Occurs in hands alone 46.8% (most of the time)
- Important to check the feet as half the time it is an ID reaction
- Pompholyx occurs once in a lifetime
- Dyshidrosis spares the instep versus pustular psoriasis which studs the instep
• Hyperkeratotic hand eczema: has no erythema versus palmar plantar psoriasis which is very erythematous
• Interdigital hand eczema
  • Starts with the dominant hand and then travels to the other hand
  • Usually secondary to wet work
  • Scaling and erythema present in the folds
  • Differential diagnosis: erosio interdigitalis (has erosions!); scabies has interdigital papules with burrow
• Fingertip dermatitis
  • Affects first 3 digits but spares others as people use these fingers to pick; associated with picking garlic, onion, etc.
  • If affects all fingers, likely not allergic in nature
• Nummular eczema
  • Affects arms and legs; middle aged men; palms and soles usually not affected
  • Important questions to ask
    • Do you touch liquids many times a day including water
    • Did you have childhood eczema, allergies
• Nickel is very common cause of hand dermatitis; try excluding first before expensive patch testing
• Treatment
  • Be aggressive from the beginning; don’t be afraid of systemic treatment
  • Don’t stop treatment if they get better
  • Occlusion should occur for at least a day
  • Moisturizers
    • Occlusive (blocks water from leaving); the best is petrolatum (Vaseline); works the fastest
    • Humectants (humidifiers that draw water into stratum corneum); glycerin is most effective
    • Lipid replacers (cholesterols, FFA, ceramides); ceramides decrease TEWL, increase cohesion, increase lamellar bodies, but this takes time
  • Ceramide moisturizer with topical hydrocortisone eliminates thinning of the epidermis
  • Recommend 1 a day dosing for 2 week intervals and use a superpotent topical steroid

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**Creative Ways to Maximize Professional Efforts Most Effectively and Avoid Practice Pitfalls**

Will Kirby, DO, FAOCD

- 10 Major Points
  1. Monitor state medical board updates
  2. Apply to be an expert reviewer in your state
  3. Review medical malpractice insurance policy annually
    • Make sure it covers all procedures that are in your practice
  4. Improve your informed consent
    • Have patients initial pertinent points and sign at end
    • Use layman’s terms
    • Offer alternatives (“no treatment” is an option)
    • Cover side effects and chances of occurrence
    • Acknowledge all questions have been answered
  5. Obtain proper training

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**The Business of Dermatology**

Eric Adelman, DO, FAOCD & John Ramm

- **Culture**
  - Customer service
    • The patient-physician encounter is only a small portion of the patient experience
    • Build a laid-back, comfortable environment for the entire office visit
  - Informal academic environment
    • Breaking down every aspect of the business and created instructions/“how-to”
    • Analyze errors made via formal process
      • Evaluate what went wrong and how to change it
      • Create a comfortable environment with all interactions during the visit—not a lecture or cold environment
    • Every interaction counts
      • Train every employee in creating a comfortable environment to create a cohesive, organized approach to healthcare
  - Structure
    • Management systems-quality control
    • Processes, protocols, and work instructions
      • Define expectations in advance and communicate those expectations early
    • Roles and responsibilities
    • Continuous improvement
      • Measure outcomes, analyze and make changes to improve
    • Training and development
      • Poor training is the number one cause of poor communication, inconsistent performance and error rates
    • The Business Bible (quality control manual)
  - Accountability
  - Consistency—extremely important
Melanoma: The Modern Black Plague
Rene Gonzalez, MD

Before the era of targeted therapy and checkpoint inhibitors, >90% mortality at 36 months
- 2002 BRAF mutation discover
- 2011 → Ipilimumab, vemurafenib
- 50% of melanoma patients have BRAF mutation
- Vemurafenib binds to BRAF as an inhibitor
  - Very high response rates (no tumor progression, or shrinkage of tumor)
  - Usually rapid and dramatic response
- Brain Metastasis
  - Extremely hard to treat
  - These drugs are effective but with slightly decreased response rates
- MEK inhibitors → trametinib
  - Increases survival
  - AEs: rash, diarrhea, ocular toxicity
  - Frequency of Acquired Resistant Mechanisms to BRAF Inhibitors
  - Tumor find pathways around the inhibitor
  - Addition of MEK can be used to block the progression farther down the pathway
- Vemurafenib + cobimetinib (BRAF and MEK inhibitors)
  - Synergistic inhibition of tumor progression, better response in combination than separate
  - Increased median survival ~2 years
- BRAF + MEK → Dabrafenib + trametinib
  - 3 year survival rate 38%
  - 2 year survival rate 51%
  - 1 year survival rate 80%
- Immunotherapy for Melanoma
  - Anti-CTLA-4 Antibody
  - Turns off the autoregulation of immune recognition of tumor cells
  - Median survival similar to placebo

Increased 3-4 year survival
- Can appear worse before better because T-cells infiltrate the lesion
- Anti-PD-1, pembrolizumab, nivolumab
- PD-1 → defense mechanism of tumor cell that binds to T-cells and suppresses immune response
  - Huge difference in survival compared to chemo
  - Higher response rates with higher expression of PD-1 on tumor
- Quite toxic
  - Higher with combination with IPI
- Diarrhea, colitis, hepatitis, rash, endocrine abnormality, pneumonitis, ↑ creatinine

Updates in Dermatology
Karthik Krishnamurthy, DO, FAOCD

Navigating the old biologics
- ORBIT- longevity of biologics
  - 40% on ustekinumab at 6 years
  - Best drug survivability because of PSAI75 response at week 16 (rapid response)
  - BMI >30 confers worse drug survivability across all biologics
  - 23 vs 37.3 month survivability
- Biosimilars
  - Almost identical copy of existing biologic product (reference product)
  - May need to be reversed-engineered
  - FDA approved via “fast track” pathway
  - Cannot show increased efficacy
  - Can be approved for all reference product indications, but not required to be studies in each condition
  - Can gain “interchangeable” status by FDA
    - Must meet 3 demonstrative criteria
      - Infliximab vs. infliximab-dyyb
      - Etanercept vs. etanercept-szzs
      - 30 biosimilars for Humira currently in development
- Brodalumab → anti IgG2 mAb against IL-17A Receptor inhibitor
- 6 suicides during clinical trials
  - 4/6 of these had a psychiatric history; 2/6 had no history and passed the Columbia Suicide Severity Rating scale
- AMAGINE-1 trial
  - PASI 100 is the new standard for psoriasis drugs
  - In week 12, 42% patients had achieved PASI 100
• AMAGINE-2 and AMAGINE-2 comparing bridalmumab vs ustekinumab
  • PASI 75 and PASI 100 scores higher with brodalimumab at 52 weeks
  • CLEAR Trial Secukinumab (IL17A inhibitor) vs ustekinumab
  • Secukinumab has his PASI 90 and PASI 100 higher than ustekinumab
  • PHOENIX 2 safety and efficacy of ustekinumab
  • PASI 75 and PASI 90 behaving similarly to AMAGINE and CLEAR trials
• UNCOVER Trials
  • Some risk of exacerbating IBD (de novo or exacerbation)
  • 2 suicide attempts in treated group, non-completed
  • Nautralizing Abs found in <5% of new drugs, but no clinical relevance
  • Secukinumab superior to ustekinumab
  • Brodalimumab superior to ustekinumab
  • Suicide risk is concerning
  • Ixekizumab & secukinumab also IL-17A inhibitors
  • Target molecule, but not the receptor (brodalimumad)
  • Clinical significance?
  • IBD is a concern for all IL-17 drugs
• Tofacitinib → JAK1/JAK3 inhibitor
  • Works on TH17 cell
  • Wider side effect profile
    • Dyslipidemia, CK elevations, neutropenia, naso-pharyngitis
    • FDA declines to expand approval for psoriasis; still approved for RA
• Efficacy mimics that of etanercept
• Indications
  • Atopic dermatitis
  • Vitiligo
  • Guselkumab (IL-23 only inhibitor)
  • PASI 75+ score superior to adalimumab
  • Using color Doppler US assessment of HS
  • New measure for staging, tailoring treatment, and assessing response objectively
    • Fistulas >0.1mm, edema, vascularity, fibrosis all identifiable
    • Hydrogen peroxide gel for SKs treatment
      • 70% clear or almost clear at week 6
      • Sonidegib for BCC
        • 12 months: 40-50% of patients had response to local disease
        • Vismodegib for BCC
        • Have more data on this drug than sonidegib
        • Tedizolid (abx)
          • 6 days tedizolid vs 10 days linezolid equally efficacious
  • Tedizolid better at clearance of cultures at 2 days
  • Ortavancin non-inferior to vancomycin in treatment of ABSSSI
  • Dalbavancin non-inferior to vancomycin in treatment of ABSSSI
  • TMP-SMX vs placebo for uncomplicated skin abscess
  • Standard of care is I&D without abx
  • 7% increase in cure rate with TMP-SMX
• OTC Retinoid
  • Differin gel 0.1% for acne
  • FDA does not believe topical treatment to be detrimental in pregnancy
  • Teaming up with Proactive
  • Laser for permanent fillers
  • 810 diode for granulomatous complications from a permanent filler

Pearls in Rheumatology-Dermatology
Karthik Krishnamurthy, DO, FAOCD
• ANA is a good screening tool
  • Good sensitivity
  • Low disease specificity
  • False positives
    • Elderly, pregnant, 1° relative with MCTD, drugs, chronic infections, neoplasm,
    • Healthy people: 1:40 in 32%, 1:80 in 13%, 1:160 in 5%
• Assay dependent
  • Immunofluorescence
    • Directed against nuclear antigens on Hep-2 cells
    • ↑ # of antigens, ↑ sensitivity, ↑ $$
    • Additional information from dot staining pattern
    • ELISA
    • Solid phase immunoassay
    • ↓ # of antigens
• Lupus
  • Chronic cutaneous LE
    • Discoid LE
      • Face, ears, scalp, associated with alopecia
      • No clear association with UV exposure
      • May have arthralgias
      • Follicular plugging
    • Longstanding chronic lesions may develop SCC
    • Remember to check the ears!
    • RF for developing systemic lupus in pts w/ DLE
      • More likely to progress in the first 2 years
      • + ANA
      • Abnormal UA
      • Presence of rheumatologic manifestation
      • Generalized DLE lesions
  • Tumid LE
    • Erythematous dermal plaques
    • Lack scale
  • Lupus Panniculitis
  • Chilblain LE
    • Red-purple papules and plaques on acral skin
Exacerbated by cold
- Subacute cutaneous LE
- Classic papulosquamous and annular variants
  - Predilection for UV-exposed areas
  - No follicular plugging or scarring
  - Many cases are drug-induced
  - Ro (SSA) antibodies (90% via ELISA)
- Neonatal LE
  - Erythematous thin scaly plaques
  - UV-sensitive
  - Newborns of (+) Ro, La, or RNP mothers
  - 3rd ° congenital heart block
  - Permanent, 20% mortality
- Hepatobiliary disease
- Thrombocytopenia
- Management: EKG, CBC, LFTs, aggressive sun protection
  - 20% risk with subsequent pregnancies
- Acute (systemic) LE
  - Malar rash, discoid lesions, diffuse non-scarring alopecia, Raynaud’s, nail fold capillaries, vasculitis, livedo reticularis, acrocyanosis, atriphié blanche
  - 4/11 criteria
  - Dopaminergash mnemonic
  - Bullous SLE
    - Abs to collagen VII
    - Overlap syndromes
  - Lichen planus/LE overlap
  - Can increase compliance by testing blood for hydroquinone
- Dermatomyositis
  - ~15% suffer from interstitial lung disease
  - Anti-tRNA synthetase Abs
  - Up to 50% risk of malignancy
  - #1= ovarian
  - Juvenile variants
    - Brunsting type (more common)
    - Banker type
      - Rapid and morbid
      - Workup
        - CK, aldolase, AST
        - EMG or MRI for myositis
        - PFTs
        - Malignancy screening (at the very least)
- Systemic Sclerosis
  - PSSc, Scc, Scleroderma
  - Localize and generalized
  - “If you don’t have Raynaud’s, you don’t have scleroderma, basically”
  - 90% prevalence in diffuse SSc
  - 99% prevalence in limited SSc
  - Management is difficult
- Multi-systemic damage, treat overall and system-based
  - Oral metformin ameliorates bleomycin-induced skin fibrosis
  - Mixed CT disease
  - Heavily associated with U1RNP Abs
  - If also Sm (+), then dx of SLE is made
- Juvenile idiopathic arthritis
  - Previously Still disease
- Adult Onset Still Disease
  - Fever in afternoon
  - Salmon-colored erythematous eruption
  - Koebnå phenomenon
  - Extremely high ferritin levels

Medical Marijuana: The Medical Uses of Cannabis
Marc Epstein, DO, FAOCD

Introduction
- Pros
  - Economy & Tax Benefits
  - Cost of the War on Drugs
  - Ineffective ban
- Types of marijuana
  - Sativa
  - Indica
  - Ruderalis
- History
  - Industrial hemp from C. sativa plant
  - One of the first plants spun into hypodermal needle
  - Medical Use began to decline around 1890
  - Opioids introduced to medical world
  - THC is metabolized by the CYP-450 enzyme In the liver
  - Much less physical withdrawal symptoms compared to other drugs such as alcohol, nicotine, alcohol, etc.
- Qualifying Diseases for obtaining a medical marijuana license (state specific)
  - Severe and chronic pain
  - Nausea associated with HIV or cancer chemo
  - Multiple sclerosis
  - Seizure disorders
  - Crohn’s disease
  - Glaucoma
  - Hepatitis C
  - Endocannabinoid System involves virtually every cell and tissue type and organ system
    - Endocannabinoids (EC)
    - Enzymes involved in EC biosynthesis or metabolism
    - Two G protein coupled EC receptors
  - 2 Major neuroactive cannabinoids
    - THC
    - CBD
  - Cannabinoids Exhibit Anti-tumor activity

Embryology For the Rest of Us
Derrick Adams, DO, FAOCD

- Basic germ layers:
  - Ectoderm, mesoderm, endoderm
  - Dr. Heinz Christian Pander = “Founder of Embryology”
  - Neurulation
    - There is a folding of the germ layers, creating the cephalocaudal folding of the embryo
  - Neural plate
    - Surface ectoderm: periderm and epidermis
    - The forming of the neural plate is an example of selective affinity of the basic germ layers
  - Periderm
    - Has multiple functions; eventually forms vernix; it prevents intrauterine adhesion
    - Made of keratin 6 and 17, very rapidly proliferating
    - First forms on the hands, feet, and around the mouth
    - When absent: peridermapathies (Prevents keratinocytes from fusing)
  - Component the vernix
    - Lanugo hair & sebum as well
    - Sloughs off around week 24
  - P63, P73-like transcription factors
  - Allows epidermis to stratify
  - Ectodermal dysplasia
• Over 180 varieties
• Most common: pachonychia congenital
• Commonly tested subject
• Difference between carcinoma and sarcoma?
  • Because carcinomas are derived from ectoderm, and sarcoma is made up of mesoderm, in general

• Somites
  • Made of mesoderm
  • Building blocks of the body, forming dermamyotomes and sclerotomes
  • Induce into dermatomes
  • Partially under the control of retinoic acid – which is why pregnant women don’t take isotretinoin!
• Humans have 40-43 somites, but some will involute with time

• Dermatomes
  • One section of the body innervated by 1 spinal nerve

• Mesoderm determines the differentiation/induction of the ectoderm
  • Dermis controls epidermis!

• Neural crest
  • Derivatives: Dentin, muscles of teeth, anterior tongue, many inner ear structures, cardiac conduction cells
  • Neurocristopathies: defects of the neural crest
  • Piebaldism: melanocytes fail to migrate anteriorly
  • C-KIT: controls migration of melanoblasts depending upon steel factor protein binding

• Melanocytes
  • Present in the 1st trimester, fully functional by 2nd trimester
  • Melanoblasts travel with peripheral nerves
  • Populate the skin through dorso-lateral migration, and ventral neural crest migration
  • Melanoblast reservoirs: bulge area, dermis, cutaneous nerve stem cells, Schwann cells
  • By week 20, all dermal melanocytes should be absent by conventional thinking, with the exception of the face, neck, sacral, and dorsolateral aspects of the extremities
  • Nevus of Ota strengthens relationship between melanocytes and Schwann cells
  • Merkel cells: NOT neural crest origin in mammals
  • Blaschko’s lines
    • 1 cell with 2 sets of DNA
    • Do not follow dermatomes, arteries, or really anything
    • Represents the “tire tracks” or epidermal migration

• It is NOT just taking vitamins or herbs
• Low cost, nontoxic system of medicine derived from plants, minerals, and animals, that are very dilute (distinguishes it from herbal medicine which is much higher concentration)
• Mode of activation is not known
• These solutions no longer work after being heated, freeze thawed, or ultrasonified
• Regulated by the FDA as drugs since 1938

• Example: Vitiligo
  • Recognized clinically fairly easily
  • Homeopathically, aim to discover what life events occurred prior to presentation
  • Ex: female patient presents with vitiligo and prior to presentation she was extremely humiliated
  • Treated with staphysagria (for suppressed anger) and vitiligo cleared

• Four most common types of homeopathic patient types. The personality determines the treatment (which is also the name of the type, i.e. treat pulsatilla types with pulsatilla)
  • Sodium chloride
    • Reserved, hide emotions, want to be alone to cry
    • Feel responsible for everyone else; worse with consolation
    • Ethical, honest, loyal, responsible, meticulous
    • Oily skin (face), warts, eczema, herpes simplex, intolerance to sun/heat
    • Crave salty foods
  • Pulsatilla
    • Gentle, mild, initially shy, many children fall into this type
    • Better in the outdoors
    • Do better with consolation
    • Desire creamy foods, do worse with rich fatty foods
    • Not very thirsty
    • Fearful of needles
  • Sulphur
    • Warm, hyperhidrosis
    • Desire sweets, cheese, spicy food, do not like eggs/milk
    • Extroverted, egotistical, get angry for short periods
    • Sloppy/untidy, loose stools in the morning, orifices are very red
  • Calcium Carbonate
    • 40% babies/infants
    • Chubby, stubborn
    • Crave eggs/milk
    • Constipated, cold sweaty hands/feet, chilly, better with warmth

How Classical Homeopathic Medicine Can Be Helpful for Children with Skin Diseases
Robert Signore, DO, FAOCD
• Homeopathic medicine may help to avoid painful/scarring procedures
• These approaches are also very cheap treatment options
• What is classical homeopathic medicine?
• Atopic Dermatitis and Cutaneous Adverse Food Reactions
  • Most common disease
  • Pruritus / Secondary pyoderma / Secondary Malassezia / Otitis / Pododermatitis
  • Secondary skin infections
  • Resistant S. pseudintermedius increasingly common; Malassezia dermatitis
  • Genetic mutations associated with impaired barrier function
    • ↓ Cornified envelope
    • Barrier function alterations
    • Altered biome
  • Antihistamines not beneficial in treatment
  • Total IgE’s not different between atopic and normal dogs, contrary to human counterparts
  • Hygiene hypothesis holds true
  • Sometimes the presentation is a secondary infection
    • Must treat the infection and also search for the instigating factor, because normal dogs do not get skin infections
    • Differential diagnosis: hypersensitivity disorders, Cushing’s, hypothyroid
  • Staph pseudintermedius comparable to S. aureus
  • Owners share their MRSA, dogs share their MRSP
  • Disease transferability depends on immune status
  • Diagnosis: history, clinical symptoms, exclusion of other pruritic diseases
    • Differential diagnosis: Food allergy/parasite hypersensitivity/dermatophytosis

• Treatment:
  • Supportive
    • Avoidance, bathing (weekly), antihistamines, fish oil
  • Glucocorticoid therapy
    • Most clients dislike the thought of giving steroids
  • Ciclosporine therapy
    • Calcineurin inhibitor thus decrease TH2 cytokines
    • Be aware of ADE
  • Allergen immunotherapy
    • Gold standard
    • Induction of IgG
    • Induction of T regulatory cells, IL10
  • Oclacitinib (Apoquel®)
    • Janus Kinase Inhibitor
      • Prevent activation of intracellular signal transducers and activators of transcription (STAT)
      • Decrease “itch cytokine” (IL31) and IL2, IL6, IL13
      • Effective in 85% of patients with AD
      • Excellent safety profile
      • Comparable to tofacitinib used for treatment of psoriasis
  • Canine Atopic Dermatitis Immunotherapeutic
    • Anti-IL31 monoclonal antibody therapy
    • Canined monoclonal antibody to bind to IL31
    • Safety profile unparalleled
  • Sarcoptes
    • Colorado/Utah
      • Transmitted via fox, coyotes, dogs; does not require direct contact
    • Humans and other animals can be transient carriers
      • Humans/owners often affected in chronic cases
      • Typically do not require treatment unless immunocompromised
  • Mimsic AD
  • Chronic disease becomes refractory to steroids and fails to respond to cyclosporine
  • Intense pruritus
  • Diagnosis: DTM most sensitive
  • Treatment: environmental cleaning, isolation of pet
  • Immune mediated diseases: pemphigus complex, unoeodermatologic syndrome, vasculitis
    • Pemphigus foliaceus
    • Most common
    • AutoAb to desmoglein-3
    • Pemphigus vulgaris
  • AutoAb to desmoglein-3
  • Non-inflammatory alopecia
  • Cushing’s / Atypical Cushing’s / Hypothyroid / Alopecia X / Seasonal Flank Alopecias
  • Owner topical hormone replacement
    • Must ask all owners about topical estrogen use regardless of age and sex
  • Post-grooming furunculosis
    • Pseudomonas contaminated shampoo
    • Comparable to hot tub folliculitis
  • Systemic Fluoroquinolone
  • Otic disease
    • Chronic otitis externa/otitis media/otic foreign bodies/otic masses
  • Neoplasia: SCC, cutaneous T-Cell lymphoma
  • Melanoma
    • Human tyrosinase DNA vaccine utilized for treatment of canine melanoma
    • Epitheliotrophic lymphoma
    • Solar induced keratoses
    • MRSA is a growing concern in veterinary medicine
    • Can be passed between animals and humans
  • MISC
    • Thermal burns
    • Dorsal thermal necrosis
    • Discovered on Dalmatian on hot day that had black spots more affected than white spots
    • Topical steroid overuse
    • Delusional parasitosis of pet owner
      • “Matchbox” sign
      • Treat all in contact animals

Dysplastic Nevi and Pigmented Lesions

Whitney High, MD

• Grading of dysplastic nevi varies greatly, and studies have shown when pathologists reread their own slides, only 35-58% are in agreement with original diagnosis
• There is no single “melanoma stain” to prove or disprove a nevus is a melanoma
  • MART-1 stain is highly specific, but not as sensitive for diagnosing melanomas
  • Many melanomas, but not all, have a lack of HMB-45 stain
  • P16 (tumor suppressor protein) is very useful for Spitzoid neoplasia
  • Combination Stain: MART-1/ Ki67 = KiMart
• Other tests employed to diagnose melanoma
• Comparative genomic hybridization
• Assesses entire genome for gain or loss of genetic material, NOT mutations
• FISH
• Checks for deletions
• Gene expression profiling
• Measures mRNA via qRT-PCR
• Looks at single genes known to be associated with melanomas
• Management of atypical nevi
• There is no clear consensus regarding this topic
• Points to consider
• Patients with AN are at increased risk for melanoma, lifetime risk of 1: 10,000 moles
• Spitzoid nevi
• What appears to be a Spitz nevus can be a Spitz tumor
• Spitz tumors have a high rate of sentinel lymph node deposits, but younger patients have favorable prognosis

Urticaria/Angioedema from an Allergist’s Perspective
Nathanael Brady, DO

• Acute urticaria is <6 weeks, chronic is >6 weeks
• Acute urticaria
• 10-20% of the population will experience at least 1 episode
• Related to mast cell and basophil activation from triggers
• IgE and non-IgE mediated
• IgE: allergenic proteins cross link IgE on mast cells/basophils leading to release of histamine and other mediators
• Diagnosis is largely clinical; biopsy shows dilation of small vessels, widening dermal papillae, flattening rete pegs, and swollen collagen fibers
• Treatment: eliminate offending agent, and first line is anti-histamine (second generation preferred because less sedating). First generation anti-histamines are useful to curb evening pruritus and help patients to actually get some sleep
• Steroids should be used only for poorly responding cases and for short time periods
• Chronic urticaria
• 0.5-5% of the general population
• Most common cause is idiopathic; rarely an allergic trigger
• Autoimmune disease is associated with thyroid disease
• Other causes: infection, vasculitides, malignant neoplasm, hormonal therapy
• Individual lesions usually fade 24-48 hours
• Can also present with angioedema
• A thorough history is key to identifying inciting triggers
• Testing is often not indicated for chronic cases
• Physical urticarias
• Subgroup in which patients have flares from environmental triggers
• Aquagenic: rare and independent of temperature
• Cholinergic: triggers are exercise, sweating, emotion, hot showers, saunas
• Cold: associated with systemic cold exposure
• Delayed pressure: onset up to +6 hours after exposure
• Dermatographia: most common of the physical urticarias
• Exercise provoked: occurs in cholinergic and also in exercise-induced anaphylaxis (ask about more history, i.e. food and medicine intake prior to exercise; wheat and celery are most common!)
• Solar: quickly appearance within minutes of sunlight exposure
• Vibratory: can be familial
• Management
• Avoidance of triggers
• Tropical steroids possibly effective for delayed pressure urticaria
• Step-care approach is the mainstay
  • 1st: monotherapy with 2nd gen antihistamine
  • 2nd: add one of more of the following: increased step 1 dose, add H2 antagonist, add leukotriene receptor antagonist
  (anecdotally not much benefit), add 1st gen antihistamine (for bedtime use)
• 3rd: dose advancement of potent antihistamine
• 4th: add an alternative agent: omalizumab, cyclosporine, dapsone, sulfasalazine, hydroxychloroquine, and colchicine
• Urticaria differential diagnosis
• Vasculitis
• Cutaneous T-Cell Lymphoma (CTCL)
• Angioedema differential diagnosis
• Hereditary angioedema
• Acquired C1 inhibitor deficiency
• ACE-I induced angioedema

The Physics of Perfect Skin: Enhancing the Integument Through Laser
E. Victor Ross, MD

• Laser Safety
• Eye hazards
• MUST wear eye protection (patient and provider)
• Also, must be sure everyone is wearing the correct type of goggles
• Cornea/lens hazard: 290-400 nm and 1400-10,600 nm
• Retina hazard: 400-1400 nm
• Skin hazard
• Electrical hazard
• Plume
• Laser safety officer
• Ensure safe environment
• Laser tissue interaction types
• Thermal
  • Thermal Relaxation Time: the time it takes for a structure to lose half of any applied energy by conduction to surrounding tissue
  • Mechanical
  • Chemical
• Plasma
• Selective photothermolysis
  • The right wavelength, duration, and energy, can target a lesion at the appropriate level
• Lasers are adding features to make lasers safer
• Application-driven menus
• Pigment meter → measures the assessment of melanin density of a selected portion of skin
• Gives you a range of settings that are reasonable for that patient
• Cooling devices to pre-cool skin
• Aesthetic laser wavelengths are an imperative concept to master to prevent
injury and to have good results with laser treatment
• Two peaks of absorption of hemoglobin, which can be exploited to target treatment of red spots
• Also, photon migration in tissue
• Temperature increase as a response of chromophore absorption
• Response of chromophore to treatment
• Radiant power or radiant flux: total power emitted in the form of radiation
• Irradiance: power carried per unit area (W/cm²)
• Radian exposure: energy delivered per unit area (Joule/cm²)
• Diode lasers from 400 nm to 4000 nm

Lasers: Lessons Learned
E. Victor Ross, MD

- Facial rejuvenation and acne scars
- Non ablative fractional- A
- Ablative fractional- A
- Conventional resurfacing- B
  • Great, except for side effects
- Visible light technologies that target vessels and pigment dyschromias
- Ablative fractional (tissue removal)
  • CO2
  • Erbium YSGG
  • Erbium YAG
  • Depth, diameter, and pitch/surface coverage
  • Treating “by recipe” and not by immediate results
- Non-ablative
  • No open wound, just redness post procedure
- Halo new hybrid laser
  • Two wavelengths: non ablative and ablative simultaneously
  • Built-in cooling device
- Vascular
  • KTP- A
  • PDL- A
  • IPL- A
- Can’t watch the vessels go away like you can with KTP
- Essentially have to wait for it to “cook” then remove laser device to see results
- Alexandrite- B
  • Can get scarring if too aggressive
  • 810 nm diode- B
  • 980 nm diode- B
  • Nd YAG (best for dark skin or deeper lesions) – B, but A for dark skin
- Tattoos
  • Q switched 532 nm, ruby, alex, and 1064 nm- B
  • Some colors don’t do well (purple, orange, yellow)
  • Risk paradoxical ink darkening
  • In “almost cleared” tattoos, can attempt ms domain lasers
- Epidermal pigmented lesions
  • Q switched 532 nm, ruby, alex, and 1064 nm- A
  • But PIH concern, esp 532 nm
  • Long pulsed 532 nm (KTP)- A
  • Risk for scarring
  • IPL- A
    • Tough to get lighter lentigines
  • 810 nm diode- B
  • Long pulsed alex- B
  • Hair removal laser used for pigment (turn cooling off)
- Tightening
  • Too difficult to predict results
- Loosening
  • Face
    • Solar elastosis
    • Loss of elasticity
    • Some methods to improve, but not complete
  • Loss of skin turgor
  • Facial bone atrophy
  • Lipoatrophy
- Forma
  • Heat skin gently (-42°C)
- Pelleve
  • Heat skin gently (-40°C)
  • No numbing because you want patient to report if its too hot
- Things we can be doing better
  • Melasma
    • Try topical first, or Q YAG, IPL, long pulsed KTP
  • Sebaceous hyperplasia
    • CO2 or erbium with very small spot
  • PDL food for red lesion
  • ALA/PDT only mildly improves unless ALA incubates for >3 hours
  • Hyfercation-only partial response
  • PDL with purpura
- Acne
  • More non-ablative than ablative
  • Mostly because patients are busy and don’t want down-time
  • Must do everything you can to mitigate the acne first
- Tattoo treatments
  • Striæ
  • Red- PDL
  • Old- Q YAG
- Acne scars and keloids
- Warts
  • Aggressive PDL (no cooling)
  • Multiple sessions
  • Stop PIH after laser
  • Better pain management
  • Lentigo in dark skinned pt
  • Q alex
  • Hydroquinone

Updates in Pediatric Dermatology
Lisa Swanson, MD

- Atopic Dermatitis
  • “Trickle down” healthcare – positive benefits for the entire family when the child’s condition is treated
  • Increased risk for anxiety, ADHD, injuries, and infections
- Treatment
  • Sensitive skin care
  • Topical steroids – always do OINTMENTS in little kids
  • There is no need to “soak and smear,” the skin can be wet or dry
  • Topical steroid burst for severe flares; this is as effective as oral prednisone without the side effects
- Calcineurin inhibitors
  • Numerous studies have shown there is no risk for systemic absorption and there is no evidence of lymphoma, malignancy, or immune system impairment
  • On the horizon
  • Crisaborole: boron based, steroid sparing, decreases pro-inflammatory cytokines, well tolerated and safe; very effective at improving the pruritus
  • Dupilumab: IM injection to decrease inflammatory response; tolerable and good side effect profile
- JAK inhibitors: approved for dog eczema in 2013; increases risk of herpes zoster
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• Natural therapy
• Coconut oil: doesn’t really help, but it doesn’t hurt
• Olive oil: does not work, really exacerbates eczema
• Sunflower oil: does appear to help, but hard to find (Aroma Workshop in Chicago is a good option)
• Prevention of eczema
• Pregnant mothers taking probiotics 2 weeks prior to having a baby and 3 months after has been shown to reduce risk in babies
• Vitamin D, some studies suggest that it can help eczema
• Transepidermal water loss in the first weeks of life is associated with eczema
• Peanut allergy association
• Early peanut exposure in eczema patients decreases the rate of peanut allergy
• Pulsed dye laser is very effective in treating keratosis pilaris rubra
• Contact Dermatitis
• TRUE test is helpful even in kids
• Don’t use Finn chambers (contain aluminum)
• 1 exposure to the triggering agent causes a rash for 3 weeks
• Wet wipes dermatitis
• Due to MCI/MF; there are 2 brands without this allergen
• Shin guard dermatitis
• Can be irritant or allergic; treat with drysol/shin guard liners and a potent topical steroid
• Pediatric Psoriasis
• Topical steroids are the mainstay for pediatric patients
• Systemic therapy is limited to cyclosporine, acitretin, and methotrexate
• There is no FDA approval for biologics
• Enbrel and Humira are currently pursuing a pediatric psoriasis indication
• Stelara has infrequent treatment making it a good choice for children; several case reports support safety and effectiveness
• This is a systemic disease: associated with obesity and aberrant blood pressure; possibly associated with hypercholesterolemia and diabetes
• Pediatric rashes
• Diaper rashes: most commonly irritant contact dermatitis and yeast
• Zinc oxide barrier cream is recommended; treat with either hydrocortisone or econazole, just pick one and go with it
• Less common in breastfed babies; superabsorbent diapers reduce the risk; cloth diapers cause rashes with more vesicles, bullae and erosions; candida is more common in babies treated with wet wipes
• Hand foot and mouth disease
• Annular red-purple-gray patches
• Previously coxsackie A16 and enterovirus 71 were the most common; coxsackie A6 has become the primary causative agent, producing a more severe rash, and even adults have been getting it
• Causes onychomadesis as well
• Tinea versicolor
• If topicals fail, use oral fluconazole 300mg Q wk x 2 doses
• DO NOT USE KETOCONAZOLE
• Baby carrier rashes
• Petechial and purpuric rash has been reported in babies carried in “legs out, forward facing” carriers on the medial thighs
• Appears children had a low grade virus
• Lichen sclerosis
• Probably doesn’t go away for most prepubertal girls
• Maintenance treatment is better than as needed treatment
• Acne
• Happening younger and younger; now considered abnormal prior to age 7
• Food associations
• Skim milk appears to be associated with increased acne but not other dairy products
• High glycemic index diets appear to worsen acne
• Changes in isotretinoin monitoring
• We have been “over monitoring” kids
• New recommendation is to check lipids and LFTs at baseline then at 2 months, and if normal then you can stop; no need to check CBC
• Topical meds on the horizon
• DRM01 - Topical sebum inhibitor
• FMX101 - Topical minocycline foam
• SB204 - Topical nitric oxide releasing gel
• SEB002 - Topical med to work with blue light
• OCPs
• Given to decrease use of antibiotics
• Best day to start is the Sunday after your period starts
• Many advantages to this treatment
• Retrospective review showed that all OCPs help with acne, but triphasics probably help more than the monophasics; the non estrogen component matters for efficacy
• Typically avoid in girls <14 years old or girls with periods for <2 years; rifampin and griseofulvin definitely decrease the efficacy of OCPs
• Major contraindications are age >35 with heavy smoking, and history of migraine headaches with focal neurologic defects including aura
• Progesterone only methods increase acne
• Spironalactone is helpful in patients with implanton or PCOS
• Hemangiomas
• Propranolol is still great!
• Always give with food to avoid risk of hypoglycemia
• Long term studies no developmental delay or growth impairment
• Recurrence rate is ~25%
• Topical timolol can work for superficial hemangiomas
• Growth hormone treatments can increase recurrence of hemangiomas
• Nadolol is an appropriate choice if child has sleep disturbances with propranolol
• Hyperhidrosis
• Robinsul wipes available via an online Canadian pharmacy
• Oral oxybutynin
• Effective for palmoplantar hyperhidrosis
• No monitoring needed
• Iontophoresis – Fischer MD1A is the best unit
• Topical Botox is on the horizon
• Topical oxybutynin is on the horizon
• Scabies
• If itch is out of proportion to the rash, consider scabies
• Check palms and soles for pustules
• In infants, the rash is a widespread “dirty” appearing rash
• Treatment
• Permethrin first, must treat entire family
• Ivermectin if rash is extensive
• Precipitated sulphur apply bid for 3 days, very stinky, but no resistance
• Pediatric Psoriasis
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Lessons Learned from 10 Challenging Cases
Lisa Swanson, MD

• Warts
  • Countless treatment options
  • Best thing is WartPeel
  • Nucara Pharmacy in Iowa; Sal acid + 5-FU
  • $89 and worth every penny
  • Ring phenomena is most common with cantharadin
  • Oral zinc is helpful, but causes severe nausea
  • Just waiting is an option; 80% clearance by 4 years
  • HPV vaccination: case reports show when teens get the vaccine their warts go away
  • Wart versus callus/corn?
    • Press on top, if it hurts, it’s a callus/corn
    • Squeeze the sides, if it hurts, it’s a wart
• Alopecia areata
  • JAK inhibitors are very promising
  • Ustekinumab has been reported to work
  • Simvastatin/ezetimibe (Vytorin) has showed success
• Vitiligo
  • 50% develop by age 20
  • 25% develop by age 10
  • Early onset prior to 3yo shows worse prognosis
• New potential treatments
  • Gingko biloba
  • Photocil activated by sunlight, administering nbUVB
  • Binatoprost
  • JAK inhibitors
  • Xtrac + calcineurin inhibitors is better than either alone
• Nevi in kids
  • Eclipse nevi
    • Darker center with light rim or vice versa; totally benign
• General skin education for kids
  • Tanning beds
    • Going once a week increases the risk for skin cancer by 40%
    • Going more than 10 times increases risk for skin cancer by 100%
    • If you go before age 35, you increase risk by 59%
• Kids post-transplant
  • These kids get more moles and they are more atypical
• Mosquito repellants
  • CDC recommends DEET as the most effective
  • OFF! Deep woods is the most recommended
  • Picaridin is considered 2nd best
• Additional biopsy of a nodule was done and showed the exact same results
• Rash seemed consistent with PAN but no other pathology or labs supported this
• 1.5 years later she presents with whitish skin changes around ankle consistent with livedoid vasculopathy and treated with baby aspirin
• Lessons
  • If you do appropriate workup and it shows nothing, it’s appropriate to watch and wait; often conditions will declare themselves over time
• 32-year-old female with 2 month history of rash on forehead and scalp
  • Treated previously with elidel and steroids, but it got worse
  • Red scaly annular patches, consistent with tinea faciei/capitis and was treated with griseofulvin
• Patient returns and rash is improved, JAK inhibitors
  • Rash continues to worsen with going more than 10 times increases
• Rash on left lateral chest wall and left upper inner arm
  • Biopsy showed changes consistent with eosinophilic pustular folliculitis
  • Rash continues to worsen with treatment for EPF
  • Patient actually had scabies
• Lessons
  • Don’t let a biopsy blind you from considering other possibilities
  • It patient isn’t responding as expected, reconsider the diagnosis
  • Learn from the experience!
• 17-month-old boy with history of eczema presenting with asymptomatic rash on his torso, “looking like a cheetah”
• Differential diagnosis included viral exanthem, weird PIM/anetoderma, atypical lichen planus, PLEVA
• Rash unchanged over 1 week; biopsy showed distored follicle with neutrophilic and lymphocytic inflammation and associated dermal whirled morpheaform collagen thickening
• Lessons
  • Common things are common and can present atypically
• 12-year-old girl with 1 year history of rash on her lower legs
  • Asymptomatic; nontender reticular red-purple patches on legs and violaceous area that are slightly palpable
  • Mild joint pains, more fatigue, tingling sensations in the legs; no GI issues
• 2 previous biopsies showed superficial and mid dermal perivascular dermatitis without features of panniculitis or vasculitis
• 5-month-old female presents with new rash on left lateral chest wall and left upper inner arm
  • Biopsy showed changes consistent with eosinophilic pustular folliculitis
• Rash continues to worsen with treatment for EPF
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  • Don’t let a biopsy blind you from considering other possibilities
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  • Learn from the experience!
• HPV vaccination: case reports show when teens get the vaccine their warts go away
• 4 years clearance by 4 years
• Rare reactions can happen; you can’t just not use medicine
• Gingko biloba
  • Best thing is WartPeel
• 50% develop by age 20
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Conditions with no known treatment warrant trying something that makes sense
Think outside the box!
4-year-old boy with lamellar ichthyosis presenting with facial rash
Eczematous patches/pustules with S. aureus culture positivity
Consistent periorificial dermatitis
Lessons learned
Just because someone has a rare disease doesn’t mean they can’t have a common disease on top of that
14-year-old male with severe acne who failed treatment and started isotretinoin
Patient developed depression and anger with suicidal ideation
This association is a little unknown and ambiguous
A few more patients (3) presented within the year with the same symptoms
Kids keep it to themselves until it becomes a huge issue
Lessons learned
There is possibly an association between Accutane and depression
Always examine the chest and arms in patients to evaluate for cutting
Seems to be a higher risk in male
4-year-old female with history of skin lesions started 2 years ago
Multiple biopsies showed granulomatous inflammation suggestive of infection but no other signs of infection
Diagnosed with ataxia telangiectasia; her lesions have become bigger
Other teams wanted pediatric dermatology to order more biopsies, which was not what the dermatology team wanted to do
Lessons learned
We are skin specialists for a reason
Stand up for your knowledge and practice the way you feel comfortable, even if you’re young
10-year-old girl with history of psoriasis for 5 years
Has only worsened over time
Systemic treatments were discussed with the parents
Patient started on ustekinumab; she is 100% clear and entire family is so happy
Lessons learned
See the opportunity to change a person’s life for the better
Listen to all patients, even kids
Be willing to take a responsible leap of faith
Always try to put yourself in the patient’s shoes

Image Guided Superficial Radiation Therapy (IG-SRT)
Daniel Ladd, DO, FAOCD

Depts of “Image Guided” technology
Photography (0.1 mm)
Reflect confocal microscopy (0.2-0.5 mm)
Optical Coherence Tomography (< 2 mm)
Epiluminescent Dermoscopy (2 mm)
High Frequency Ultrasound (5 mm)

Why Care?
New level of care for patients
Works well for BCC and SCC
Accurate staging of each tumor now possible before a biopsy is performed or a treatment is chosen

IGSRT
Enhances patient understanding
Sharing images with patients allows patients to be included in curative process
Reduces “minimization of skin cancer” by patients
Enhances patient compliance
Helps the patient “see” the problem in relation to normal skin
Becomes a visual guide that SRT or Image Guided Radiation Therapy (IG-SRT) or Image Guided Superficial Radiation Therapy (IG-SRT)

Why is SCC depth not taken into account in TNM staging?
Staging happens BEFORE surgery
Only method to achieve this is punch biopsy
Deep tissue tumors lack tissue integrity, so deeper punches can cause the specimen to break apart, reducing your accuracy
So the only accurate way to evaluate is with a surgical excision specimen, which occurs AFTER staging

TNM Staging and Depth (Veness article)
The current TNM tagging system for cSCC does not incorporate important prognostic factors such as thickness/depth of invasion when assigning T stage
With emerging data on high risk kcSCC and the risk associated with other factors there is a need to investigate an improves and more prognostic staging system
SRT-100 Vision could be our window into a better, more precise TNM staging system for SCC
Tumors can be measured BEFORE they are biopsied
Shave biopsy reduces our SCC THICKNESS measurement

SRT-100 Vision
Combines documentation of tumor volume with HER documentation of SRT treatments, hence the term IGSRT or Image Guided SRT
Other commercial devices that offer imaging or radiation of NMSC
Sonography devices
Probes are not designed for evaluation of skin because they are for imaging inside the body
MPTflex (European)
Flexible in-vivo multiphoton tomography
MelaFind
Melanocytic positive or negative
Vivascope 3000
Assist in clinical judgements
Esteya

SAFETY MEASURES
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Becomes a visual guide that SRT or surgery is working or has worked
Can use imaging prior to Mohs to assist in planning

Optical Coherence Tomography (<2mm)
Problem: there are no reimbursement codes for OCT
Why we really only see it in major research and academic centers
Reflective Coherence Microscopy (RCM)
Will be reimbursed by MC in 2017
RCM devices approved by the FDA

MelaFind
Vivascope
Literature on Ultrasound for NMSC
US reported morphology and thickness of tumors prior to surgery
Can recognize layers of involvement and vascularity patterns so helpful in BCC surgery planning
Can show primary tumor and provide detailed anatomic data
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Ultrasound allows us to evaluate the depth of SCC and BCC prior to biopsy, surgery, or SRT.

Real time visual images bring the patient into the skin cancer staging process.

US could improve our TNM staging of SCC.

Depth imaging makes us more comfortable in recommending SRT over surgery.

Depth imaging makes us more comfortable in preparing our patients for Mohs surgery.

Offering patients a non-invasive option is the right thing to do.

**Tips & Techniques to Improve from the Dermatopathology Point of View**

**Whitney High, MD**

- Biopsy rate ↑ 2.5x (>65 y/o)
- Melanoma ↑ 2.4x
- 2 most common sources of litigation
  - Failure to perform or delay in performing a diagnostic test
  - Misinterpretation of a diagnostic test
- General practice of dermatopathology
  1. Biopsy performed & fixed in formalin → to lab
  2. Accessioned in lab
    - Formalin can dissolve pencil on specimen labels
  3. “Grossed in”
  4. Tissue placed in cassettes for processing
  5. “Processing”
    - Water and fat removed with successive washes of ETOH and xylene
  6. Embedding
    - Voids in tissue replaced with paraffin so tissue may be sectioned

- Cutting the block
  - 3.5 micron sections
- Autostainer & coverslipper
  - Many potential areas for error
- Prevention
  - Multiple specimens in same bottle
  - Curetting of a pigmented lesion
  - Mismarking shaves, punches, excision
  - Be more specific when writing differential diagnosis on specimens
- Specimen requirements
  - Patient name, age, sex, race
  - Description
    - Biopsy site, color, symptoms, areas of involvement
    - Diseases and drugs (pertinent)
    - Duration of condition
    - Diameter of lesion or eruption
    - Diagnosis
      - “But this never happens”
      - So really what you need is to do biopsies in 3D
        - Description, diameter, diagnosis
- Trending toward smaller biopsies
  - ↑ # of shaves
  - ↓ volume of shaves
  - Impacts accuracy of diagnosis
- Partial Samplings
  - 16 fold increase of missed diagnosis of melanoma with punch biopsy vs. excision
  - 2.6 fold increase of missed diagnosis of melanoma with shave vs excision
- Biopsy technique
  - Do not “shave” biopsy suspected of DSFP
  - Do not shave suspicion of angiosarcoma
- Special techniques for special situations
  - Verrucous carcinoma
    - Subtype of SCC; Oral, genital, acral
  - Mycosis fungoides
    - Early → thin patches or plaques in double protected areas
    - Early disease difficult to diagnosis by histology alone
    - Diagnosis requires clinicopathologic correlation
  - Shave biopsy maximizes DEH available for inspection
  - Bullous pemphigoid
  - Errors in pharmacy, nursing, and medicine associated with
  - Hectic work environments
  - Interruptions and distractions
  - Path report
    - Initial check
      - Is this my patient?
      - Does the gross information & technique match?

- Was my history and clinical impression accurate?
- Is this a plausible diagnosis?
- Check the diagnosis, comments, gross description and microscopic description
- Levels or step sections
  - Cutting deeper into the paraffin block
  - Usually sets of 3
  - Critical in detecting the thin malignancies
  - Use of levels should be documented
- Use of immunostains or special stains
  - PAS for fungus
  - GMS for fungus
  - Gram stain (Brown Brenn) for bacteria
  - Fite or AFB stains for acid fast bacilli
  - Colloidal Fe stain for mucin
- Margins
  - Bread-loaf sections allow for inspection of well less than 1% of the overall margin

**Male and Female Pattern Hair Loss**

**Craig Ziering, DO, FAOCD**

- Non-surgical treatment options
  - Finasteride pills
    - Blocks production of DHT; suitable for men and post-menopausal women
  - Most effective DHT blocker on the market today
  - topical minoxidil
    - Many of the suggested uses decrease the use of this product
    - Recommendation: Use once a day, rub it in the scalp, and continue with hair styling, etc.
  - Laser therapy
    - Low level light therapy
    - Penetrates scalp and stimulates cells of the scalp to increase protein synthesis and production of ATP
• Comes in comb and cap devices
• Natural supplements
• ACell/PRP
  • ACell = matrix of growth factors
  • PRP = Platelet enriched plasma
  • This combination has been shown to be efficacious in treating hair loss
• Fibers, extensions and hair systems
• NOTHING
• Surgical treatments for hair loss
  • “Trichosculpture” – artistic arrangement and redistribution of hair
  • Recognize the entire head/face and sculpt the hair in a way to complement the patient’s features
• 4 steps to surgery
  • Donor harvesting
    • Options include STRIP method, follicular unit extraction (FUE), or robotic FUE
  • Micro dissection
  • Recipient site creation
    • Use a 19-gauge needle to create the sites for a 1 hair graft
  • Graft placement
    • Can be done individually or with a team
  • Post-op healing recovery times vary from patient to patient
• Robotic hair restoration
• ARTAS robotic FUE
  • Dramatically reduces physician fatigue compared to manual FUE
• Computer assisted, image guided, physician controlled precise system
  • On the horizon: robotic graft placement is coming in 2017

The Culture of Your Wound Culture
Derrick Adams, DO, FAOCD

• Bacterial Cultures
  • Detect roughly 1% of bacteria in chronic wounds

• Select for bacteria that thrive in nutritional and physical parameter set by a lab
• Anaerobes cultivation is problematic
• The great plate count anomaly
• Observation that most environmental microorganisms seen in the microscope cannot be grown under laboratory conditions
• Aerobic wound culture
  • Gram stain/Blood Agar /Chocolate Agar/CNA (gram +) /MAC (gram -) /Thiol
• Anaerobic wound culture
  • Gram stain/Brucella blood agar /CNA laked blood agar
  • Both cultures 24, 48, 72 hour reads
• Wound swabs
  • Tend to retain collected specimen
  • Sterile loop is diluted (+1, +2, +3, +4)
  • More testing= less material
• Infection is YOUR diagnosis, not the labs
  • Organisms cultured from wounds do not define infection
  • Antibiotics can have lasting effects
  • Sequence-based testing 16s rRNA
  • Gold standard among microbiologists
  • >500,000 in public database
  • 16s rRNA present in prokaryotes
  • Encodes part of a ribosome
  • Allows ID and amplification
• DNA/RNA sequencing
  • Pros
    • Eliminates bias of culture techniques
    • Not limited to bacteria
    • Microbial load and diversity
    • Cost is reasonable
    • Primer tailored
  • Cons
    • Possible human contamination
    • Viable vs non-viable
    • ID’d organism may not be clinically relevant
    • “Chain of evidence”
    • Primer bias
• Yeasts and molds
• Phenotypic variation within species
• Can take weeks
• 26s rRNA and internal transcribed spacer 1 and 2 regions (ITS1 & ITS2)
• Top 4 skin phyla
  • Actinobacteria
  • Firmicutes
  • Bacteroidetes
  • Proteobacteria

Osteopathic Dermatology
Reagan Anderson, DO, FAOCD

• Osteopathic Principles
  • Human being is a dynamic unit of function
  • Self-regulatory mechanisms are self-healing
  • Structure and function are interrelated at all levels
  • Rational treatment is based on these principles
  • i.e. Why do infectious disease doctors give antibiotics to a patient with an infection?
    • Because it creates an environment in which the body can heal itself
• Actinic Keratosis
  • “The body is a unit; the person is a unit of body, mind, and spirit”
  • AKs change appearance which affects spirit
  • P53 mutation secondary to sun-damaged skin
  • His office is located in the middle of his clinic for easy access and for the better care of his patients → structure and function are related
• Treatment
  • Observe
  • Field therapy
    • Imiquimod: 73% 1-year clearance rate
    • Immunomodulatory, best MOA for self-healing
    • 5-FU: 54% 1-year clearance rate
    • Cytotoxic effects, less osteopathic by principle
  • Cryotherapy
    • Low 1-year clearance rate (28%)
    • Isolated lesions versus diffuse involvement
    • Light therapy
    • Psoriasis
• Immune dysregulation (Th1 and Th17 helper cells)
• Comorbidities
  • Obesity
  • Cardiovascular
  • Stress
• Treatment
  • Individualize treatment, and be comprehensive
  • Topical treatments
    • Corticosteroids
    • Calcineurin inhibitors
    • Vitamin D analogs
  • Systemic therapy
    • Corticosteroids, retinoids, TNFα inhibitors, and others
• Acne
  • #1 diagnosis in dermatology
  • Follicular hyperkeratinization, proliferation and decreased desquamation, yielding microcomedones
• Treatment
  • Treat the structural problem (microcomedone)
    • Function will return to normal
  • Maintenance therapy treat the comedones and acne clears
  • Limit oral antibiotic use to 3-6 months
• Impact of diet (the body is a unit)
  • Low glycemic index is recommended; Dairy has testosterone precursors which can exacerbate acne by stimulating insulin-like growth factor, especially the lower fat the dairy is
• Scarring
  • Significant psychological impact
  • Many treatment options work by injuring the body so it can heal itself

**Therapeutic Update**

James Q. Del Rosso, DO, FAOCD

• Oral spironolactone for acne
  • Used in women with acne because it is anti-androgenic effect
  • In the same category as isotretinoin; should be taken with some food
  • It appears it is most effective for patients presenting with deep inflammatory papules/nodules on the lower face, anterior neck, and back; less effective for papular, pustular, and comedonal acne
  • PCOS is associated with adult acne, and it’s been shown recently that not all PCOS patients fit the typical central obesity and hirsuitism presentation
  • Once patients stop taking spironolactone, their lesions often return
  • To date there are negligible risks during pregnancy
  • Monitoring blood pressure is probably a good idea to avoid syncopal risks
  • Routine potassium monitoring may be unnecessary for healthy women
  • Evidence does not support monthly laboratory testing for use of standard doses of oral isotretinoin
January 2017 By-Laws and Constitution Ballot

The AOCD Board of Trustees met and discussed the following AOCD By-Laws and Constitution changes. The committee voted to approve these recommendations and are submitting them to the general membership for a formal vote. A 30 day review and public comment period is now open. Please send your comments to dermatology@aocd.org. An electronic ballot will be sent to you on Friday, January 13, 2017. Voting will be open until January 27, 2017. A paper ballot may be obtained if requested in writing. To request a paper ballot, please contact dermatology@aocd.org or write to:

American Osteopathic College of Dermatology
P.O. Box 7525
Kirkville, MO 63501

Please note, all ballots must be received by January 27, 2017. Ballots received after this date will not be counted.

BY-LAWS
ARTICLE II Board of Trustees and Standing Committees
Section 2. Meetings and Duties

The Board of Trustees shall meet at the annual meeting, and fall meetings. The Board of Trustees shall also meet on call of the President for the transaction of its assigned or regular business. Written notice of the time, place, and purpose of special meetings shall be mailed and emailed to each Board of Trustees member not less than fourteen (14) days nor more than thirty (30) days prior to the proposed meeting. A telephone conference of a Board of Trustee meeting may be called by the President with notice of not less than three (3) days by email. Eight (8) members of the Board of Trustees shall constitute a quorum at any officially sanctioned meeting.

ARTICLE III Meetings
Section 2. Fall ADDITIONAL Meeting

There shall be a full meeting of The College MAY SCHEDULE MEETING(S) for educational purposes and the transaction of business AT THE SOLE DISCRETION OF THE BOT.

CONSTITUTION
ARTICLE III Membership
Section 2. Eligibility, Rights, and Obligations

The eligibility requirements for and the rights and obligations of the members of each classification shall be as follows:

A. FELLOW: Any osteopathic or allopathic physician who has been certified by the American Osteopathic Board of Dermatology, or certified through the American Board of Medical Specialists by the American Board of Dermatology shall be eligible for fellow membership. Fellow members shall have full membership rights which include specifically, the right to vote, to hold office, to be assessed dues, and to accept appointment to committees and councils. IT IS RECOMMENDED THAT He/She must be a member in good standing of the American Osteopathic Association. Failure to maintain membership in the American Osteopathic Association or the Canadian Osteopathic Association will be due cause to lose membership and listing in the annual directory of the American Osteopathic College of Dermatology.

B. ASSOCIATE: Any osteopathic OR ALLOPATHIC physician who has successfully completed an American Osteopathic Association approved postdoctoral training program in dermatology, OR AN ACGME APPROVED POSTDOCTORAL TRAINING PROGRAM IN DERMATOLOGY shall be eligible for associate membership. Associates shall have all the rights and obligations of fellow members except they shall not be eligible to hold elected office.

D. AFFILIATE: Any physician who has completed a dermatology residency approved by the Accreditation Council for Graduate Medical Education (ACGME) of the American Medical Association or has completed a dermatopathology training program approved by the American Osteopathic Association Council on Postdoctoral Training or the ACGME or who is certified in Dermatopathology by the American Osteopathic Board of Dermatology or American Board of Dermatology or the equivalent pathology boards recognized by the American Osteopathic Association Council on Postdoctoral Training or ACGME shall be eligible for affiliate membership. A PHYSICIAN ASSISTANT CERTIFIED (PA-C) OR NURSE PRACTITIONER CERTIFIED (NP-C) WHO IS ACTIVELY IN A PRACTICE WITH AN AOBD OR AN ABD CERTIFIED DERMATOLOGIST MAY JOIN AS AN AFFILIATE MEMBER. Affiliates shall have all rights and obligations of fellow members except they shall not be eligible to hold elective office or vote.

I. STUDENT: Any osteopathic OR ALLOPATHIC medical student who is in good standing with the American Osteopathic Association OR AMA and interested in pursuing a career in the field of dermatology shall be eligible to become a student member. This membership status may be maintained for a maximum of three years after a student graduates. Student members shall have all rights and obligations of fellow members except they shall not be eligible to hold elective office or vote.

J. ACTIVE MILITARY: Any osteopathic OR ALLOPATHIC physician who is on active military duty and who has been certified by the American Osteopathic Association through the American Osteopathic Board of Dermatology, or certified through the American Board of Medical Specialists by the American Board of Dermatology, or who has successfully completed an American Osteopathic Association approved postdoctoral Dermatology training program, but not yet certified, shall be eligible for active military membership and are eligible for a reduced membership dues rate. Active military members who are Board certified shall have full membership rights which include specifically, the right to vote, to hold office, to be assessed dues, and to accept appointment to committees and councils. Active military members who are not Board certified shall have full membership rights except they shall not be eligible to hold office. IT IS RECOMMENDED THAT He/She must be a member in good standing of the American Osteopathic Association. Failure to maintain membership in the American Osteopathic Association or the Canadian Osteopathic Association will be due cause to lose membership and listing in the annual directory of the American Osteopathic College of Dermatology.
We are now accepting manuscripts for publication in the upcoming issue of the JAOCD. ‘Information for Authors’ is available on our website at www.aocd.org/jaocd. Any questions may be addressed to the editor at journalaocd@gmail.com. Member and resident member contributions are welcome. Keep in mind, the key to having a successful journal to represent our College is in the hands of each and every member and resident member of our College. Let’s make it great!

- Karthik Krishnamurthy, D.O., FAOCD, Editor
dermatology residencies, especially as the osteopathic dermatology future osteopathic medical students to ensure they have access to osteopathic dermatologists. The AOCD needs to advocate for technology to supplement our current meetings. As an instructor continue to improve CME offerings including using innovative feel like the AOCD exists to help each member. The AOCD should may arise during the practice of dermatology. Each member should help advocate for each member and help members with issues that arise. The AOCD leadership represents its members and the AOCD serves as a valuable resource for the members. The AOCD should continue to advocate for the AOCD, I currently serve on the Board of Trustees of the AOCD and chair of the Editorial Committee. This gives me insight into the inner workings of the AOCD already. As Program Director of the dermatology residencies at Northeast Regional Medical Center, I am aware of the issues that face our residencies and residents. In addition, our dermatology residency is applying for ACGME accreditation and I have a strong familiarity with this process and the potential outcomes of the ACGME merger. I am also an active assistant professor at the founding osteopathic institution, Kirksville College of Osteopathic Medicine – ATSU. I teach the dermatology class and am a member of the admissions committee. I am aware of what future dermatologists are experiencing at osteopathic medical schools as they look towards obtaining a dermatology residency. I believe this variety of experiences will allow me to add perspective to the AOCD leadership and membership as a whole.”

Please tell us why you want to serve on the Board of Trustees.
“I have a deep seated interest in dermatology, especially osteopathic dermatology. The AOCD has provided myself and the membership the ability to practice dermatology. The AOCD has evolved from a small group of osteopathic physicians who practiced dermatology into a constructively large organization that administers a formal curriculum and oversight of osteopathic dermatology residencies, provides first-class continuing medical education to members, and advocates for all osteopathic dermatologists. This was a significant and impressive transformation for which many of our past leaders deserve great credit. We now embark on another impressive transformation as the AOCD dermatology residencies transition to ACGME accreditation. As this occurs, the AOCD will also need to transform to continue to be a thriving organization that supports, advocates, and represents all osteopathic dermatologists. I want to help with this transformation to ensure all osteopathic dermatologists have a voice within dermatology, osteopathic medicine, and medicine in general. The AOCD represents and works for its members. I want to continue to ensure that the AOCD leadership represents its members and the AOCD serves as a valuable resource for the members. The AOCD should continue to advocate for each member and help members with issues that may arise during the practice of dermatology. Each member should feel like the AOCD exists to help each member. The AOCD should continue to improve CME offerings including using innovative technology to supplement our current meetings. As an instructor of dermatology at ATSU, I am keenly aware of the challenges that osteopathic medical students face as they look to become osteopathic dermatologists. The AOCD needs to advocate for future osteopathic medical students to ensure they have access to dermatology residencies, especially as the osteopathic dermatology residencies transition to ACGME. The AOCD has provided me the opportunity to practice dermatology and I will be forever grateful for that. I want to give back and contribute to the continuing advancement of the AOCD and its membership.”

Trustee Candidates

Steven Brooks, D.O., FAOCD
Location: Manhasset, New York
Nominated By: Peter Saitta, D.O., FAOCD

How do you feel the AOCD would benefit from your involvement on the Board?
“I am a proud practicing osteopathic dermatologist in NY. I am only one out of a few osteopathic voluntary faculty attendings at Columbia University Medical Center and New York Presbyterian Hospital. I strive to level the playing field between allopathic and osteopathic dermatologists. My goal is to make the AOCD current in the social-media age.”

Please tell us why you want to serve on the Board of Trustees.
“I want to continue to disseminate the value and expertise of board certified osteopathic dermatologist to the general public, including social media and popular cloud-based doctor booking companies like Zoc-doc. Zoc-doc does not recognize the AOCD as a governing physician board. I am currently in contact with them to add the distinction to the service and website. I am willing to be the social media guru, create and maintain AOCD Facebook and Instagram pages.”

Jonathan S. Crane, D.O., FAOCD
Location: Wilmington, North Carolina
Nominated By: Lloyd, Cleaver, D.O., FAOCD

How do you feel the AOCD would benefit from your involvement on the Board?
“There is a major paradigm shift and the AOCD needs new ideas to continue to thrive. I will have new ideas to work with. I would be glad to help and honored to help.”

Please tell us why you want to serve on the Board of Trustees.
“The AOCD needs new ideas, and I want to help the AOCD grow.”

Tejas Desai, D.O., FAOCD
Location: Houston, Texas
Nominated By: Michael Hohnadel, D.O., FAOCD

How do you feel the AOCD would benefit from your involvement on the Board?
“I completed a 1 year Procedural Dermatology Fellowship at Loma Linda University Medical Center, under the tutelage of Dr. Abel Torres. Dr. Torres is currently the American Academy of Dermatology President and has served on the ACGME committee. I am in constant contact with him and at the forefront of what it will take to produce the best AOCD programs to transition to the ACGME. We need more of our programs to stand out so our osteopathic philosophies and previous training...”
are honored and do not become obsolete. I am also part of the EEC, in which I can voice how our future dermatologists are to be trained and if standards are met. Furthermore, I have written articles on ethical and medico-legal issues in dermatologic and procedural dermatology, offering a different vantage point for the dermatologist.

Please tell us why you want to serve on the Board of Trustees.
“Dr. Torres has held multiple leadership roles that have influenced my decision to pursue this position. I am currently Program Director of the South Texas Osteopathic Mohs Micrographic Surgery Fellowship and have contact with several dermatology programs around the nation. I have immersed myself into the AOCD, being part of the EEC amongst other activities. At this point, I find this leadership role is not a choice, rather it has become an evolution of my academic past. These experiences have brought me here. I am looking forward to it!”

Ralph Fiore, II, D.O., FAOCD
Location: Chicago, Illinois
Nominated By: Richard Miller, D.O., FAOCD

How do you feel the AOCD would benefit from your involvement on the Board?
“I feel the AOCD would benefit from me being involved with the Board of Trustees because I can bring a fresh perspective on current and future concerns that we may face as an osteopathic dermatologist. I believe that having a background as a physician assistant, as well as a board certified dermatologist, I have the experience to help make sure that our patients get the best care, while making sure everyone on the team is fulfilled in their career choice.”

Please tell us why you want to serve on the Board of Trustees.
“I am interested in serving on the Board of Trustees as a way to give back to my profession and the AOCD. While serving the college as Resident Liaison, I saw how the Board of Trustees helped the college and fellow dermatologists in addressing the concerns of the members. Professionally, I am interested in fighting for our rights as both a physician and a dermatologist. I believe that this is the time to serve our college as we continue through the era of ACGME merger and helping to protect our osteopathic training programs through and after this process.”

Boris Ioffe, D.O., FAOCD
Location: Fort Worth, Texas
Nominated By: Rick Lin, D.O., FAOCD

How do you feel the AOCD would benefit from your involvement on the Board?
“I believe AOCD is facing a lot of challenges in the near future. As a young dermatologist in private practice, I feel my background and current situation reflects majority of the membership in AOCD. As AOCD is facing the merger between residency training, I would like to be an active participant in this transition as well as future of the organization. I have been involved in the teaching of the residents and feel the organization needs to continue to strengthen.”

Please tell us why you want to serve on the Board of Trustees.
“My interest in serving as Board of Trustees member comes from several angles. As a young dermatologist I would like to give back to the organization that allowed me to become a board certified dermatologist. I had a privilege and honor to be a member of the organization since I was a medical student. It has been amazing to see the organization grow in numbers as well as quality of membership and meetings. I think there are a lot of challenges that are facing our profession, and I would like to be more active in handling these hurdles. I am currently a member of EEC committee which has given me some insight in how the organization works. I feel it is very important to continue taking AOCD into the right direction in the future.”

Michael Whitworth, D.O., FAOCD
Location: Wyandotte, Michigan
Nominated By: Steven Grekin, D.O., FAOCD

How do you feel the AOCD would benefit from your involvement on the Board?
“As a member for the last 3 years, I have become familiar with the operations of the college and the challenges that lie ahead. I would like to use my experience to continue to push ahead and build a successful, viable college.”

Please tell us why you want to serve on the Board of Trustees.
“I would like to continue to serve the Board and the college that has given me so much. The next three years will serve as one of the most challenging times the AOCD has seen since its foundation in 1958. I would like to help move the college forward through ACGME merger so that we can remain viable and retain current and future members, meet the needs of current members, and provide CME with great meetings and other means. Lastly, experience and knowledge of past and current challenges and the business of the college is a great asset that I will capitalize on.”

AOCDF Staff Attends Event to Benefit Local Food Pantry
AOCD staff members recently attended an open house and charity event held at the Edward Jones branch office in Kirksville, MO. A food drive was held in conjunction with the open house to benefit the local food pantry. The AOCD staff is pictured below with Jon Peck, AOCD’s Edward Jones financial advisor.
Lackawanna Dermatology seeking a BC/BE dermatologist to join Northeastern Pennsylvania practice

A BC/BE dermatologist is being sought to join a well-established, busy independent, five physician private dermatology practice with offices in Scranton and Kingston, Pennsylvania.

Our practice consists of the full spectrum of general and cosmetic dermatology with a significant proportion of surgery including Mohs micrographic surgery. State of the art computer software system provides electronic medical records, billing, scheduling, and imaging modules. Our website is www.lackawannadermatology.com.

Lackawanna Valley Dermatology Associates is the largest and most-comprehensive dermatology practice serving the 1.1 million people of Northeastern Pennsylvania. Northeastern Pennsylvania is a modern, progressive area, offering a low cost of living, high quality of life, superior educational and healthcare systems and strong work ethics and family traditions.

We are a very family oriented practice with all of our physicians working just four days per week with normal patient hours from 7:30 a.m. to 4:00 p.m. There are no evenings or weekend hours. Your starting salary will be very competitive with a partnership option and earning potential in the highest tier nationwide. We will also provide you with a moving allowance to help with your relocation costs.

Please contact Kathryn Colombo, Practice Manager at lackaderm@aol.com.

Dermatology & Plastic Surgery of Arizona seeking BC/BE dermatologist

Southern Arizona dermatology and plastic surgery practice is looking of a board certified/board eligible, skilled physician to provide quality dermatology care to our growing communities. We pride ourselves in consistently providing patients with the highest quality of care in a friendly, inviting environment. Salary based compensation with bonus structure, 401K and healthcare. Contact Heather Hathaway at (520) 207-3100 or heather@dermoplasticsaz.com.