Executive Director’s Report
by Marsha Wise, Executive Director

Hello Everyone,

It’s hard to believe summer is here. Thank you to everyone who participated in our Atlanta conference at the Ritz Carlton, March 29-April 1, 2017. The staff and I were honored to celebrate National Doctor’s Day with you. The exhibitor bingo cards were very well received by attendees and our exhibitors, and we will be offering this again in New Orleans. Be sure to take part and enter your card in a drawing to win prizes. We are also planning a few other surprises, so you won’t want to miss this meeting. There might just be a mini-hurricane to be found!

Attendees at our Spring Meeting in Atlanta voted on Exhibit Booths in the categories of Best Customer Service, Most Informative, and Best Display. If the representative that visits your office is listed in Shelley Wood’s Corporate Spotlight column, be sure to thank them for participating in our conference!

Once again, the AOCD staff and I had some fantastic help in Atlanta. I would like to recognize our student ambassadors, Brandon Basehore, DO; Cassandra Beard, OMS-IV and Shane Swink, OMS-III. We would have been lost without them! Sadly, we are losing Dr. Brandon Basehore to a residency program this fall just as we did last year with Dr. Laura Jordan. While we are sad to lose their help, we are happy for their future. All four of these young osteopathic physicians would make excellent AOCD officers in the years to come!

On Thursday, March 30, 2017, our annual election was held, and Dr. Alpesh Desai passed the presidential gavel to Dr. Karthik Krishnamurthy.
Kramer, D.O., FAOCD; Ronald Miller, D.O., FAOCD; Stephen Kessler, D.O., FAOCD; James Franks, D.O., FAOCD; Darel Pruett, D.O., FAOCD; Joel Harris, D.O., FAOCD and Laurie Woll, D.O., FAOCD.

While we are speaking of fun and celebration, grab your calendars now and mark off March 19-25, 2018 and plan to attend the 2018 Spring Meeting, which will take place at the Hilton West Palm Beach at 600 Okeechobee Boulevard, West Palm Beach, FL 33401. The year 2018 will be AOCD’s 60th Anniversary, and plans are already underway for a grand celebration. This will be the first time for the AOCD to offer the State of Florida relicensure requirements courses. This is being planned for Sunday, March 25, 2018.

Just a reminder that we now offer Category 1B CME for reading the JAOCD. We also plan to begin to offer online category 1A CME after our 2017 Fall Meeting which will take place from October 24-28, 2017 at the Intercontinental, New Orleans, 444 St. Charles Avenue, New Orleans, LA 70130. The AOCD will partner with the Association of Osteopathic State Executive Directors (AOSED) to offer online, on demand Category 1A CME. More information will be sent in our weekly Thursday Bulletin email blasts.

The AOCD staff has been working to obtain ACCME accreditation in order to provide AMA credit for our CME meetings. The application for ACCME accreditation was submitted and we had our initial interview in June 2017. By December 2017, we will have an official determination from the ACCME on whether the AOCD qualifies to provide AMA credit. Wish us luck!!!

You may have noticed in our brochures lengthy disclosures regarding our CME activities and speakers. This notification is a requirement of the AOA and the ACCME. We continue to closely monitor any potential conflicts of interest to avoid any commercial bias during our CME activities, per standard 6 of the Standards for Commercial Support. A conflict of interest exists when an individual has an opportunity to affect CME content about products or services of a commercial interest with which he/she has a financial relationship.

“An individual must disclose to learners any relevant financial relationship(s), to include the following information: The name of the individual; The name of the commercial interest(s); The nature of the relationship the person has with each commercial interest.”

AOCD’s decisions regarding CME activities are made free of the control of any commercial interest, and all decisions regarding the disposition and disbursement of commercial support are made by the AOCD. If you are interested in learning more about the Standards for Commercial Support, click here.

Save the Dates!!
• 2017 Fall Meeting which will take place from October 24-28, 2017 at the Intercontinental, New Orleans, 444 St. Charles Avenue, New Orleans, LA 70130.
• 2018 Spring Meeting which will take place at the Hilton West Palm Beach at 600 Okeechobee Boulevard, West Palm Beach, FL 33401.
• 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.

Thank you for your continued support of the AOCD. Please call or email the AOCD office at dermatology@aocd.org if you need assistance.

Should you have questions pertaining to Board Certification, re-certification, or Osteopathic Continuous Certification (OCC), please refer to www.aobd.org. You may also contact Libby Strong with the AOA/AOBD at 312-202-8112.

The week of July 17, Dr. David Grice, Dr. Dan Ladd and Marsha Wise represented the AOCD at the 2017 AOA House of Delegates Meeting in Chicago. Key topics discussed at the meeting were AOA Board Certification, AOA CME and membership. Click here to view resolutions before the House.

Other AOCD members attending to represent their states were: Dr. Cindy Hoffman (NY), Dr. Suzanne Sirota Rozenberg (NY), Dr. Richard Johnson (PA) and Dr. Schield Wikas (OH).

AOCD By-Laws and Constitution Recently Revised
The AOCD held its 2017 By-Laws and Constitution ballot from January 13 - January 27. The AOCD membership voted to approve each proposed revision. The AOA voted to approve the changes in February.

Modifications to the governing document are now in effect and have been posted to our website. Click here to view or download the latest version.
Good Governance: What is Conflict of Interest

Regulatory agencies such as the Accreditation Council for Continuing Medical Education (ACCME) and the Office of the Inspector General (OIG) have intensified scrutiny of conflict of interest issues over recent years. Failure to disclose and appropriately manage financial ties with industry have also been highlighted in the media.

The fiduciary responsibility of elected and appointed leaders of organizations is to operate in a climate of trust, openness and objective decision making.

A conflict of interest is a situation where financial or other personal considerations have the potential to compromise or bias judgments and objectivity.

**Examples of possible conflicts are:**
1. Introducing or advocating for an activity for discussion and action that would benefit an individual’s own company or other organization in which the individual has a personal or financial interest, whether or not it is consistent with the mission of the AOCD.
2. Using Board membership or an association’s resources for personal or third-party gain or pleasure.
3. Unfairly taking advantage of an authoritative position to affect the commercial or professional standing of a company or organization in which an individual has a personal financial interest or that is a competitor.
4. Using information made available because of an individual’s position that is proprietary or confidential or otherwise not generally known to the public for personal advantage.
5. Withholding disclosure of relationships with industry, institutions and other organizations.
6. Presenting unsupported information or data that have been biased or unduly influenced by a personal or financial relationship.
7. Participating in discussions on policy issues relating to other professional organizations in which the individual has a fiduciary position.
8. Spouses or other first-degree relatives (children, parents and siblings) who are executives or have an interest in other organizations or companies.

**Disclosure and Resolution of Conflicts:**
Conflicts of interest must be recognized, identified and resolved. The AOCD also requests that NO promoting of business relationships or competing CME programs take place IN the lecture room. These types of conversations are best shared with others in the exhibit hall or registration area. Arrangements may be made for promotion of product(s) during AOCD’s exhibit hall hours.

All AOCD board members, speakers and CME planners are asked to sign conflict of interest disclosures for notification to our attendees. Any individual refusing to comply with this policy and/or not disclosing relevant financial relationships on a timely basis will not participate in, have control of or responsibility for: the development, management, presentation or evaluation of AOCD CME activities.

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Heartland Payment Systems

The American Osteopathic College of Dermatology has been using Heartland Payment Systems for credit card processing since October 2014. The switch to Heartland was seamless, and the system is very user friendly, secure, and loaded with features our old system did not offer. If you are interested in learning more about this system and the potential savings for your office, contact:

Tony Silber
tony.silber@e-hps.com
HeartlandPaymentSystems.com
facebook.com

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CELEBRATING
60 YEARS
American Osteopathic College of Dermatology
1958 - FOUNDED 1958 - 2018
1958 - CELEBRATING 60 YEARS - 2018
Corporate Sponsors Support 2017 AOCD Spring Meeting in Atlanta, GA

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 2017 AOCD Spring 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:

- **Galderma • Pfizer**
- **Lilly USA, LLC**
- **AbbVie • Valeant Pharmaceuticals**
- **Allergan • DLCS**
- **Aclaris Therapeutics • Dermpath Diagnostics**
- **Novartis • Sun Dermatology**

For the past several years, Dermatopathology Labs of Central States (DLCS) sponsored our meeting t-shirts and bags. We appreciate the continued support from Christine Anthony and DLCS.

Sagis Diagnostics sponsored our meeting lanyards.

Lilly USA, LLC has sponsored the Resident Research Paper Competition. Annual awards are presented to recognize the osteopathic dermatology residents’ papers which are judged as the best in this competition. The papers reviewed by the AOCD Resident Research Paper Competition Committee. Papers are judged for originality, degree of scientific contribution and thoughtfulness of presentation. Lilly has been a corporate sponsor and supporter of the AOCD the last couple years, this year being their first year as a Platinum Level Corporate Member. We appreciate all Ginger McWilliams, Tara Burke and Lilly does for the AOCD.

The AOCD also appreciates Lilly USA, LLC, AbbVie, Valeant Pharmaceuticals, and Pfizer for providing Product Theaters for our physicians.

Exhibitors for the 2017 Spring Meeting were as follows: 3Gen, Inc.; AbbVie; Aclaris Therapeutics, Inc; Advanced Dermatology; Allergan; Anne Arundel Dermatology; Aurora Diagnostics; Bayer Healthcare; Celgene; Dermpath Diagnostics; Dermpath Lab - Central States; DermTech; D-Path; Encore Dermatology; Galderma Laboratories; IntraDerm; Heartland Payment Systems; Hill Dermaceuticals, Inc.; Janssen Biotech, Inc.; Leo Pharma; Lilly USA, LLC; Medimetriks Pharmaceuticals; Novartis; Pfizer/Eucrisa; ProPath Services, LLP; Ra Medical Systems, Inc.; Sagis Diagnostics; Sensus Healthcare; Skin Path Solutions; Strata Skin Sciences; Sun Dermatology; Valeant Pharmaceuticals.

We hope that many of you had an opportunity to express your appreciation to our sponsors while you were in Atlanta. 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.

This year, we asked attendees to let us know who the best customer service, most informative, and best display. We had several ties for these topics. The companies and booth attendees are listed below. Congratulations to these companies and booth attendees.

**Best Customer Service Exhibit Booth**
Aurora Diagnostics and Galderma Laboratories tied for first place as the “Best Customer Service” at our Spring 2017 Current Concepts in Dermatology meeting in Atlanta, GA. Representatives from Aurora Diagnostics in attendance were Amber Curry, Amanda Norgren, Brittney Madrid and Gary Davis. Representatives from Galderma Laboratories in attendance were David Jones, Sharon Bridges, Jennifer Ellis, John Katz, Chris Townsend and Laura Taposci.

**Most Informative Exhibit Booth**
Lilly, USA received the most attendee votes as the “Most Informative Exhibit” at our Spring 2017 Current Concepts in Dermatology meeting in Atlanta, GA. Representatives from Lilly, USA in attendance were Wendy Collins Gandy, Ryan Readnower, Keith Fenton and Terry Ridenour.

**Best Exhibit Booth Display**
Novartis and Pfizer tied for first place as the “Best Exhibit Display” at our Spring 2017 Current Concepts in Dermatology meeting in Atlanta, GA. Representatives from Novartis in attendance were Cara Deckert and Carlos Torrents. Representatives from Pfizer in attendance were Tim Harrison, Kara Huckby, Paula Bendzsuk, Stephanie Taylor and Brandon Hokenstad.
If you are a US medical doctor with an active state license number, the value of the food, beverage, and/or educational item that you receive when attending this program may be disclosed on Eli Lilly and Company’s Physician Payment Registry and/or the National Physician Payment Transparency Program (NPPTP) Open Payments report under the federal Sunshine Act as a transfer of value made to you by Lilly. As a result of enacted state regulations, food and beverages will not be provided to healthcare professionals licensed in the states of Minnesota, Massachusetts, and Vermont. Additionally, educational items will not be provided to healthcare professionals licensed in Minnesota. Federal Veterans Affairs (VA) regulations and several states also prohibit state/government employees from receiving or being provided gift items, which may include educational materials and meals. Please consult your state regulations and ethics laws to see if such prohibition would apply to you. This medical presentation is intended only for invited healthcare professionals for whom the information to be presented is relevant to their practice. We regret that spouses or other guests cannot be accommodated. This is a promotional program and no continuing medical education (CME) credits are offered.

NOW AVAILABLE.

Visit Our Booth to learn more about Taltz

Visit the AOBD OCC Booth at the AOCD Fall Meeting in the Exhibit Hall:

Intercontinental New Orleans
444 St. Charles Avenue
New Orleans, Louisiana 70130

BOOTH HOURS
Wednesday, October 25 from Noon to 5 P.M.
Thursday, October 26 from 8 A.M. to 4 P.M.

Do you want to learn more about OCC and the recertification process?

Visit the AOBD OCC Booth at the AOCD Fall Meeting in the Exhibit Hall:

Intercontinental New Orleans
444 St. Charles Avenue
New Orleans, Louisiana 70130

BOOTH HOURS
Wednesday, October 25 from Noon to 5 P.M.
Thursday, October 26 from 8 A.M. to 4 P.M.

NOW AVAILABLE.

Visit Our Booth to learn more about Taltz

Discover more at taltz.com
Hello everyone,

I hope each of you have enjoyed the spring season and summer is off to a great start!

Documentation Needed for New Residents
New residents beginning training in July 2017 should submit all of their application materials to the national office. Dues should be paid at this time, if payment has not been made this year. Those who have already paid student dues for the current year owe a balance of $25 when they begin training in their residency program. If you are uncertain if you have paid this year, please feel free to contact me.

All residents are asked to provide the following documents:
• A copy of your medical school diploma (and exact date of graduation)
• A copy of your internship diploma (exact dates of attendance and name and address of hospital or institution)
• A copy of your state license
• 2 passport size photos
• A current CV

2017 Dermatologic Surgery in the Outback Paper Competition
Dr. Anthony Dixon, an Australian surgeon who specializes in skin cancer surgery, has been gracious enough to extend an invitation to the physicians and residents of the AOCD for a preceptorship “down under.” The preceptorship is limited to two physicians each year. One resident and one attending physician (AOBD board eligible or board-certified) will be selected for the preceptorship.

The resident selection is based on a surgical paper competition. All residents wishing to have the chance to go can prepare a surgical paper. This paper would be judged on the basis of its surgical application in dermatologic surgery, with an emphasis on cutaneous cancer. The paper should be based on principles of surgical treatments for skin cancer with emphasis on literature review and/or new techniques, with original research strongly encouraged. The AOCD Awards Committee along with Dr. Dixon will select the winning author. Participation in this competition is limited to second and third year residents only. The deadline for entry is September 15, 2017.

Submissions should be sent to the AOCD office in Kirksville. The winner would receive approximately $1,500 towards the cost of the trip to Australia, with additional funding to be determined on proceeds generated by the silent auction. This would not cover the cost of the entire trip but would pay a substantial portion of it. The approximate airfare is $1,200. Attending physicians are responsible for their own expenses.

Winners can essentially schedule their preceptorship for any time of year, pending no conflicts with Dr. Dixon’s schedule.

Finally, I would like to wish our graduating residents all the best as you begin your careers as attending dermatologists. It has been a pleasure working with you all. To the incoming first-year residents, congratulations on earning your positions. I look forward to working with each of you over the next three years.

Congratulations to Brittany Grady, DO, the new resident liaison for the 2017-2018 residency year. Dr. Grady is a third-year resident in the NYCOMEC/Hackensack University Medical Center at Palisades program under the directorship of Adriana Ros, DO, FAOCD.
We are very excited for our upcoming meeting in October in New Orleans! This city is best known for its fun and vibrant atmosphere, as well as its rich history. Your evenings will be filled with jazz music, homestyle Southern seafood and any number of activities that can entertain a group of friends out on the town or the whole family. The options are absolutely endless when it comes to the Big Easy!

First on our list of “Must Try” stops while in NOLA is a spot called Pat O’Brien’s. Pat O’Brien owned a speakeasy in New Orleans during Prohibition, and then opened it to the public as a bar on December 3, 1933, after Prohibition ended. Charlie Cantrell joined the business in 1942, and the bar moved to its current location at 718 St. Peter Street (less than a mile from the Intercontinental). Pat O’Brien’s is known for their world famous Hurricane drinks, invented by Mr. O’Brien himself! The location at St. Peter Street has The Main Bar, Piano Bar, and Patio Bar. There is another location on Bourbon Street that serves as the Courtyard Restaurant, offering hot wings, alligator bites, Cajun Shepherds Pie and other NOLA favorites. Please visit www.PatOBriens.com for all the details.

Our next stop in New Orleans is the Café Du Monde, located at 800 Decatur Street, just over a mile northeast of the Intercontinental Hotel on St. Charles Avenue. The Café Du Monde opened in 1862, open 24 hours a day and only closing its doors on Christmas Day. What started out as a traditional coffee shop has turned into one of the most well-known spots to visit while in New Orleans. The Café Du Monde serves coffee, Beignets (fried dough covered in powdered sugar), white and chocolate milk, and freshly squeezed orange juice. Be sure to stop in and experience this NOLA favorite!

If you are looking for something fun to do, why not visit the Audubon Aquarium of the Americas? This beautiful aquarium is host to a plethora of sea animals, including sharks, stingrays, fish, and even penguins! The Aquarium is located on the Mississippi River at 1 Canal Street, open daily from 10 a.m. to 5 p.m. Admission is $30 for adults and $22 for children.

Another aspect of New Orleans that sets it apart from many other places in the nation is its close proximity to the swamplands of the south. Cajun Encounters Tour Company is known for being one of the best touring companies in New Orleans. They offer day and night swamp tour options. If you would prefer to avoid the alligators, there are also options for exploring the city of New Orleans instead, including tours of historic streets and cemeteries—and even a ghost walking tour. Visit www.CajunEncounters.com for scheduling, tickets and pick-up location.

As always, please visit the Intercontinental Hotel New Orleans' website for further information regarding places to see and events happening while we are in Louisiana. If you need to schedule a car service, we recommend Audubon Limousine. Their website is www.AudubonLimousine.com or call them at 504-210-8340. (Please note: We have not been given any special group rate for their services.)
The Foundation for Osteopathic Dermatology (FOD) is accepting applications for research grants. Click here to the Foundation’s webpage for more information.

The FOD was founded in 2002 by the AOCD as a unique extension of the osteopathic dermatology community. Its purpose is to improve the standards of the practice of osteopathic dermatology by raising awareness, providing public health information, conducting charitable events and supporting research through grants and awards given to those applicants under the jurisdiction of osteopathic dermatology physicians. To date, $9600.00 has been awarded in various grants.

Contributors over the years include:

Roger Byrd, D.O., FAOCD - 2015
John Cangelosi, M.D - 2016
Eugene Conte, D.O., FAOCD - 2015

Foundation Officers
Eugene Conte, D.O., FAOCD, President
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Dwayne Montie, D.O., FAOCD
Jonathan Keeling, D.O., FAOCD
Suzanne Sirota Rozenberg, D.O., FAOCD
Bryan Sands, D.O., FAOCD
Marsha A. Wise, BS, Executive Director, Secretary-Treasurer

Pinnacle Table
Roger Byrd, D.O., FAOCD - 2015
John Cangelosi, M.D - 2016
Eugene Conte, D.O., FAOCD - 2015

Leaders of Osteopathic Dermatology
Martin Blackwell, D.O., FAOCD
Valerie Fuller, D.O., FAOCD
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Lawrence Paolini, D.O., FAOCD
George Schmieder, D.O., FAOCD
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Lloyd Cleaver, D.O., FAOCD
Marc Epstein, D.O., FAOCD
Valerie Fuller, D.O., FAOCD
Susan Kelly, D.O., FAOCD
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Bradley Glick, D.O., FAOCD
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Bill Way, D.O., FAOCD
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News from the Foundation for Osteopathic Dermatology
For eczema-prone skin

TWO ADVANCED TECHNOLOGIES.

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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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How D.O. Dermatology Started

BY A.P. Ulbrich, DO, November 1986

This article is the first in a series that will look back on the history of the AOCD and osteopathic dermatology.

First, I would like to apologize for writing this in first person. I have been asked several times to give an account of the history of the American Osteopathic College of Dermatology. About 1944, Dr. McCorkle and Dr. Gardner from California, Dr. Scardino, Sr. from Kansas City and Dr. Cressman from Philadelphia met. This apparently was instigated by the AOA on the basis that the AMA had an Academy of Dermatology and Syphilology; an Osteopathic Board of Dermatology was in order. The surgeons, orthopedists, proctologists and internists had examining boards.

California members of the AOA had established some boards and I tried to get information in regard to a derm board. Why Detroit was left out of this entirely, I don't know. I had taken a precepteeship in Boston with an AMA Certified Dermatologist, Dr. Cheever and Dr. Collotin, and had observed at Boston City Hospital and Peter Bent Brigham. This was at a tuition cost of $600 per month, plus living expenses, and that was 1942 dollars. I was sharing an office and practice with Dr. B.F. Dickinson and would go up to Boston for a month, and B.F. as we called him would go out to California for a month to work in surgery, and we'd alternate. In fact, it was after Dr. Dickinson came back from his first trip to California in 1941 and said "you know, we need a dermatologist," that I became motivated and started to investigate where and how to get derm training.

In 1946, I went to the AOA in New York and was informed by one of the members from California (Dr. McCorkle) that I had no right to attend the dermatology group. I came back to Michigan and contacted Hobart Moore, President of AOA and Dr. Roy Harvey, a vice-president. By their pressure, I was allowed to take the exam in 1947. My exam consisted basically in taking 200 pictures with me to the AOA Meeting and discussing the cases with the two board members present (Drs. Cressman and Scardino). My cost for taking the exam was $50 – [in 1986,] it is now $500. My Certificate of Certification is No. 8.

The next year they appointed Dr. James Stover from Detroit to the Board. He had a year with Dr. Cressman. Incidentally, Dr. Stover was the preceptor of our good member Dr. Bob Shimmel. D.O. dermatology then went dormant for two years.

I went to a convention in Dallas and located Dr. Gardner. Some of the AOA Board members suggested we should form a new Board. We had to have three dermatologists who were certified. I called from Dallas and spoke to Dr. Scardino in Kansas City and he agreed to serve on the Board, and with that nucleus, about 1951, we re-wrote all the requirements and set up standards. We followed the advice of the AOA in setting up the constitution and by-laws. I think Scardino was President; I was Secretary-Treasurer. We also set the groundwork for the American Osteopathic College of Dermatology. The problem was to verify training, etc. both the individuals being trained at the allopathic institutions and individuals to become preceptees. We had some cooperation in California with Dr. Gardner and the College there. In 1953, I believe it was in Washington, we had the first Derm College meeting. Dan Koprince was there as well as Bob Shimmel.

To establish a criteria for those taking the original exam, it was decided that one of the board should take the exam. Dr. Scardino obtained a copy of the AMA Board of Dermatology, along with the answers, and I was elected to take it. My grade was 87% and it was decided on the original exam that 75% of the 87% would be a passing grade.

Incidentally, all of the expenses of travel, hotel, etc. were entirely on the board members. Even secretarial cost, postage, etc. was the Secretary's expense (mine).

We hope you enjoyed this look at the AOCD's past. More will follow in the coming issues of DermLine.
Name That Nubbin
Lisa Swanson, MD

• Nubbin: something that is small for its kind, stunted, undeveloped, or imperfect
• Spider Angioma
  • Blanch with pressure from glass slide
  • Resolve spontaneously, can be treated with vascular laser
• Pyogenic Granuloma
  • Treat with shave or topical timolol (vasoconstriction)
  • Critical to follow up to ensure improvement (spitz nevi, even melanoma in differential diagnosis)
• Juvenile Xanthogranuloma
  • Form of non-Langerhan’s cell histiocytosis
  • Resolve spontaneously
  • Recurs if removed
• Lichen Striatus
  • Causes a linear streak of raised flat topped skin colored to pink papules, typically down an extremity
  • Can affect the nail on that extremity
  • Treat with topical steroids or calcineurin inhibitors
• Ring Phenomenon
  • Associated with cantheridin, sometimes liquid nitrogen
• Warts
  • Many treatment options
  • Wart peel= sal acid + 5FU from Nucara Pharmacy
  • 89% effective, works in weeks
  • Alternative therapies
    • Zinc sulfate 10 mg/kg/day (max 600 mg) x 2 months
    • Propolis daily x 3 months
    • Valtrex 1 gm daily x 60 days- just 2 cases (JDD Feb 2016)
    • Picato- couple case reports on using it for genital warts and epidermodysplasia verruciformis
    • Just wait- 200 kids- 65% resolved by 2 years, 80% by 4 years (SPD Sept/Oct 2015)
• Warts and HPV vaccination
  • Mounting number of case reports showing that when preteens and teens are given HPV vaccine, their warts go away
  • 3 approved HPV vaccines
    • Some concern about reports of MS, optic neuritis, transverse myelitis, regional pain syndrome, premature ovarian failure
  • Wart vs Callus
    • Press on top it, if it hurts=callus/corn
    • Squeeze it and it hurts= wart
• Pseudofurunculoid Molluscum
  • Look like pimples/boils
  • Not infected, just inflamed
  • Treat Id reaction with topical steroids, treat PF molluscum with oral antibiotics or bleach baths
  • Resolve in 2 years
  • Imiquimod/zyclara, zymaderm, candida injections, cantheridin, curettage, liquid nitrogen, topical retinoids
• Molluscum Dermatitis
  • Eczema-like rash around molluscum
  • Important to treat because it itches, kids scratch, molluscum spreads
  • Accessory Tragus
  • Benign, harmless
  • Can be removed (preferably by ENT)
• Solitary Mastocytoma
• Collection of mast cells that hive up when irritated
• Resolves spontaneously
• Urticaria Pigmentosa- numerous mastocytomas
• Dangerous Mast Cell Issues
  • Bullous Mastocytosis- presents as blistering in a newborn; differential diagnosis includes EB
  • Diffuse Cutaneous Mastocytosis- the skin is diffusely infiltrated by mast cells so it becomes yellowish and rubbery diffusely
  • Both confer increased risk of mast cell leukemia
• Aquagenic Syringeal Acrokeratoderma
  • Swelling, papules, increased wrinkling on palms following immersion in water
  • If young child, screen for CF
  • Kids outgrow it
• Gluteal Variant of Perioral Dermatitis
  • Consists of small pink papules and pustules on buttocks
  • Differential diagnosis includes keratosis pilaris and staph
  • Treat with clindamycin wipes, Elidel, amoxicillin
• Herpes Zoster
  • Patients are contagious to people who have not had chicken pox
• Bronchogenic Cyst
  • Classically in the sternal notch
  • Should be removed by peds ENT or peds general surgeon
• Nevus Anemicus
  • Reticular hypopigmented-appearing area, appears mottled
  • Slight decrease in superficial cutaneous blood vessels
  • Associated with NF-1
• Eclipse Nevi
  • Very common on scalp of children
  • Often read out as atypical on biopsy
• Bed bugs
  • Cause typical bug bite appearance, but often occurs in clusters of 3- “breakfast, lunch and dinner”
  • Home needs to be evaluated by professional exterminating service

2017 AOCD Spring Meeting Highlights
By Cassandra Beard, DO; Shane Swink, OMS-IV; Laura Jordan, DO
- Bugs come out when CO2 levels in the air indicate that we are asleep
- Pilomatricoma
- Demonstrates a positive “teeter totter” sign
- 2/3 resolve on their own, can be surgically excised
- Pediatric Onychomycosis
- Treat with terbinafine for 3 months, itraconazole in a pinch (pulse dosing)
- Griseofulvin does not penetrate nail bed
- Hyperkeratotic Lichenoid Papules of the Elbows and Knees
- Very common in kids age 4-12, boys > girls
- Kids outgrow it
- Can treat with AmLactin, Cerave SA
- Toddler (Infantile) Acne
- 6 months – 3 years
- Typically on cheeks
- Can scar, important to treat
  - Topical clindamycin, topical Adapalene, oral amoxicillin
- Pigmented Purpuric Dermatoses
  - sometimes benefit from topical steroids or UV light, but will resolve on own
- Lumbosacral Dysraphism
  - High Risk
    - >2 cutaneous stigmata • Lipoma • Acrochordon/pseudotail/tail • Aplasia cutis • Dermoid cyst or dermal sinus • Infantile hemangioma > 2.5 cm in size
  - Intermediate risk
    - Atypical dimple (> 5 mm) • Hemangioma less than 2.5 cm in size • Hypertrichosis • Can do ultrasound if child < 3 mos old, MRI if older than 3 mos old
  - Low risk
    - Simple dimple • Hyperpigmentation/hypopigmentation • Congenital nevus • Port wine stain • No imaging needed

Cutaneous Manifestations of Illegal Drug Use
Peter Saitta, DO, FAOCD

- Mixing alcohol with caffeine in adolescent mice stimulates cocaine receptors, but not in adult mice
- These same mice needed twice as much cocaine to have the same response as naïve mice
- Cutaneous infections in IVDU
  - Skin or muscle popping with injecting drugs into skin or muscles
    - Anaerobic metabolism in these tissues predisposes to infection
    - Speedballing (cocaine + heroin) increases risk of infection
  - Most frequently anaerobic isolates are clostridia
  - Aerobic is staph
- Drug-induced delusions of parasitosis
  - Rarely develop a delusion (they know why they are itching)
  - 30-40 lb weight loss during the period of skin eruption
  - Increased metabolism and hyperthermia
  - Worsening dental caries
- Cocaine-levamisole vasculopathy
  - Levamisole in >70% of cocaine in this country
  - Vasculopathy denotes thrombi formation in an arterial lumen
  - Distinctive rash of retiform purpura, classically ears
  - Vasculitis denotes inflammation of a blood vessel wall
  - ANCA positives
    - High titer with ANCAs against multiple antigens, most often p-ANCA
    - Antiphospholipid antibodies
    - Agranulocytosis
    - Prolonged cocaine use (>2 years)
    - Arthralgias of large joints
    - Persistent rhinorrhea or recurrent sinusitis
    - Paucity of organ involvement
  - Treatment
    - Withdrawal offending drug
- Drug-induced spore-forming infections
  - All are anaerobic
  - 75% of nations drugs are trafficked through the San Diego-Mexico border
  - 66% of all Mexican women arrested crossing the border for 1 year tested positive
  - 50% of men
  - Btar heroin primarily from Mexico
  - IV injection not suitable for spore germination
  - Occurs in skin and muscle popping
  - Drug induces soft tissue ischemia
  - Gentle heat is required for injection
  - Wound botulism
    - Appears sterile but with fever
    - Infection present 20 years before symptom onset
    - Descending flaccid paralysis
  - Injectional botulism
    - 2-14 days of infection before symptoms
    - Grossly infected wound with no fever
    - Most people dead by day 4
  - Tetanus
    - Muscle rigidity, painful spasms close to site of injury
- Anthrax
  - After human germination causes 3 types
  - Respiratory
    - Biphasic flu like symptoms → sepsis and fluid on lungs
  - GI
    - Mesenteric lymphadenopathy
    - Ascites, intestinal obstruction,
  - Cutaneous (MC)
    - Painless papules, extensive hemorrhagic edema, vesicles and bullae
    - Black eschar
  - Injectional anthrax has higher mortality rate,
    - Hemorrhagic edema, vesicles and eschars absent
    - Severe abdominal pain, lung edema, sepsis
- Xylazine
Local Flaps and Mohs Reconstruction and
When to Use Them

George Schmieder, DO, FAOCDS

- Animal tranquilizer in heroine
- Shooter’s patch
- Granulation tissue at bed of ulcer at injection site

- Two functions: repair upper lip and many nose defects to preserve the ala, ensure superior scar line is placed in the perinasal sulcus
- Time consuming and carries more risk
- Island pedicle flap
- AKA V to Y advancement flap
- Coding nightmare and CMS wants a named artery when using this closure and detailed photos of the course
- Most common on nasal and perinasal closures where free margins are at risk for distortion
- O-T/O-L Advancement Flap
- L-plasty or O-L is a single tangent flap
- Tissue redundancy created on the side of the defect opposite the flap incision and must be removed or sewn out
- Useful for large distal nasal sidewall defects
- East-West advancement flap
- Modified burrow advancement flap
- Extensively used for small nasal tip defects to disrupt the straight-line effect and create a more natural wave in the closure
- Many will require f-u dermabrasion or fraxel resurfacing
- Rotation flap
- Random pattern flap
- Primary movement is sliding of tissue about a pivot point into the defect
- Helps redistribute wound tension and tissue redundancy
- Variations include single and bilateral, as well as island pedicle flaps
- Single
  - Common on the cheeks; Sometimes necessary to take down the flap to the periosteum at the nasal sidewall-cheek junction to take pressure off the leading edge of the face, preventing webbing in the nasolabial fold
- Helical Rim Advancement Flap
- Repairs defects of the helical rim
- Bilateral advancement flap or H-plasty
- Useful for large scalp and forehead defects, sometimes good for eyebrows
- Challenging to hide cosmetically on the forehead
- Use only when having a hard time moving tissue
- Crescentic advancement flap
- Loose adjacent skin over an island of normal skin to the site of the Mohs defect
- Usually smaller than advancement and rotation flaps
- Scar consists of geometric broken lines that may be less noticeable than longer linear closures
- Utilize adjacent skin and provide excellent color and texture match
- Bilobed flaps
  - Highly technical and skill oriented
  - Two transposition flaps executed in succession which follow the same direction of rotation over intervening tissue
  - Premise is to fill defect with primary lobe and fill secondary defect with secondary love, leaving a triangular shaped tertiary defect to be closed primarily
  - Bilobed flaps
    - Random pattern finger shaped cutaneous flap
    - Tap into adjacent skin to borrow laxity and fill a defect
    - Most common planned as melolabial transposition to repair defects of the nasal ala or from the pre or post auricular area to close the defects on the ear
    - Minimize risk by designing rotation through an angle of 60-120° instead of the originally described 180°
    - Bilateral rotation flap
      - Tissue rotated into defect from two opposite sides
      - Vectors of rotation often may be mirror images of each other
      - Often used in large defects on the scalp
      - Vector of movement are in opposition, creates O-Z flap
    - Rhombic flaps
      - Designed by conversion of the primary defect into a 4-sided parallelogram with each size of equal length and tip angles of 60° and 120°
      - Rhombus forms the recipient site for the flap as well as the template on which to plan the flap incisions
    - Interpolation flap
      - Import pedicle tissue from a site distant to the defect
      - May be considered axial flaps that can support a larger mass of tissue compared to the other random flaps
• The vascular pedicle must be temporarily left in place to ensure adequate blood supply
• Requires more than one stage to complete the repair
• 1st stage involves the design and creation of the flaps
• 2nd stage involves the takedown of the flap where the pedicle is incised and removed, while residual tissue is sewn into the defect and the donor site is closed primarily
• Nasolabial interpolation flap
• Repairs defects of the ala in instances where cartilage grafting is required to restore the structural integrity of the alar rim
• Flap is harvested from the medial cheek and nasolabial fold is based on branches of the angular artery
• ABBE Flap
• AKA lip-switch flap
• Reserved for repair of large, deep defects, typically of upper lip
• Flap is harvested from ipsilateral lower lip and based on inferior labial artery
• Full-thickness including muscularis and oral mucosa
• Rotated upon a vascular pedicle that makes up the lateral aspect
• Donor site is undermined and closed first to facilitate freeing up the flaps
• Closed in layers
• Retroauricular flap
• 2-stage interpolation flap used for large defects of the helix
• Random flap not based on a large named artery
• Harvested from richly vascularized skin of the postauricular scalp and advanced over intervening intact skin to fill the helical defect
• Pedicle remains attached to posterior scalp for 3 weeks
• Flap often comes with post-op bleeding and discomfort
• Donor site not repaired until pedicle take-down and often left to heal secondarily
• Post-op care
• Meticulous wound care
• Verbal AND written instructions regarding home wound care
• Every interpolation flap needs a pressure dressing applied and left intact for 48 hours

Complications
• Bleeding, hematoma, pain, infection, flap necrosis, hypertrophic scar/keloid, erythema, telangiectasia
• Mohs Surgeon's best friend
• CO2 fractional laser
• Fraxel resurfacing laser
• IPL

Fermentation, Civilization and the Microbiome
Melinda Greenfield, DO, FAOCD

Fermentation- metabolic process in which an organism converts a carbohydrate, such as starch or a sugar, into acid, gas or alcohol; AKA a controlled rot
• Ethanol fermentation (beer, wine, bread)
• Yeast and certain bacteria perform ethanol fermentation where pyruvate (from glucose metabolism) is broken into ethanol and carbon dioxide
• Lactic acid fermentation (yogurt)
• The pyruvate molecule from glucose metabolism is fermented into lactic acid
• Lactic acid fermentation is used to convert lactose into lactic acid in yogurt production
• It also occurs in animal muscles when the tissue requires energy at a faster rate than oxygen can be supplied
• Fermentation’s effects- It’s believed that the establishment of fermentation facilitated the shift from a hunter/ gatherer society to an agricultural society because it allowed people to settle in one area and preserve food versus following the food sources

Fermentation of food
• For over 6000 years, humans have been preserving foods with the process of fermentation
• 1. Preserved food = improved food safety
• 2. Degrading of toxic components and anti-nutritive factors (phytic acid)
• 3. Enriching of diet with amino acids, vitamins, probiotics
• 4. Enhancing the bio-availability of nutrients
• 5. Enriching the sensory quality of foods
• 6. Multiple health benefits

Health benefits-fermentation/probiotics
• Manufacture of vitamins
• Support and increase the rate of metabolism
• Detoxification of chemicals
• Promote cell growth including RBC
• Enhance immune and nervous system function
• Increase production of enzymes
• Crowd out pathogenic organisms

All things fermented
• Bean-based: Cheonggukjang, doenjang, miso, natto, soy sauce, stinky tofu, tempeh, oncom, soybean paste, Beijing mung bean milk, kinama, iru
• Dough-based: Proofing-sourdough
• Grain-based: Batter made from rice and lentil prepared and fermented for baking idlis and dosas, Amazake, beer, bread, choujiu, gamju, injera, kvass, makgeolli, murri, ogi, rejuvelac, sake, sikhye, sourdough, sowans, rice wine, malt whisky, grain whisky, idli, dosa, vodka, boza
• Vegetable-based: Kimchi, mixed pickle, sauerkraut, Indian pickle, gundruk, tursu
• Fruit-based: Wine, vinegar, cider, perry, brandy, atchara, nata de coco, burong mangga, asinan, pickling, vijinatá, chocolate, raki
• Honey-based: Mead, mehglein
• Dairy-based: Some cheese also, kefir, kumis (mare milk), shubat (camel milk), cultured milk products such as quark, filmpjes, crème fraîche, smetana, skyr, and yogurt
• Fish-based: Bagoong, faseekh, fish sauce, Garum, Hākarl, jeotgal, rakfisk, shrimp paste, surströmming, shidal
Get to know EUCRISA

Learn more at booth 1

Visit www.EucrisaHCP.com for more information
• Meat-based: Chorizo, salami, sucuk, pepperoni, nem chua, som moo, saucisson
• Tea-based: Pu-erh tea, Kombucha
• Microbiome
  • Describes all the organisms that live in and on our bodies (bacteria, viruses, fungi, protozoa, helminths) along with their genes
  • Considered a counterpart to the human genome
  • During birth baby is colonized by bacteria- thus begins the evolution of our individual microbiome
  • Our unique microbial footprint develops over our lifetime and is altered by just about everything: C-section, vs vaginal delivery, breast milk vs bottle, food, hygiene, exposure to chemicals, pets, farm animals, toxins, medications and even emotions
  • The end result of our individual microbial salad is so unique and distinctive that it’s more specific than our own DNA
  • We have about 23,000 human genes and 8,000,000 microbial ones
  • Some studies suggest that gut bacteria play a critical role in carbohydrate metabolism, enzymatic detoxification and even determining whether or not a disease you are genetically predisposed to actually develops
    • This may explain why identical twins with inherited diseases don’t always manifest the disease; the genes may be the same but the microbes are different
  • Disruption of the microbial ecosystem can cause disease
    • As adults there are ways we can keep our microbiome healthy
    • As physicians, it is our duty to keep our patients’ healthy microbiome in mind
• Human Microbiome Project
  • Established in 2008
  • Funded by NIH
  • Goal: characterize the human microbiome and analyze its role in human health and disease
• Dermatology World
  • Certain diseases carry with them certain types of bacteria
  • Healthy skin shows a balance of bacteria
  • Dysbiosis causes an imbalance and results in a proinflammatory state
    • This leads to dysregulation of the immune system
  • NIH is currently evaluating trial of skin autologous microbiome transplant to decrease S. aureus colonization
    • The option of rebalancing and rediversifying the skin microbiome, instead of eliminating pathogens randomly will add to the arsenal of treating skin diseases
• Microbiome studies
  • Study Nature, 2006 “An obesity-associated gut microbiome with increased capacity for energy harvest” found that germ free mice colonized with the gut flora of obese mice became obese
    • They correlated this to fewer bacteriodetes than Firmicutes in gut flora
    • It’s postulated that the flora in obese mice is more efficient at extracting energy from food
  • In a similar study (published in Science in 2013) researchers at Washington University in St. Louis took gut bacteria from identical twins, one was lean and one was obese, and transplanted them into germ-free mice
  • Within a few weeks, the mouse that received the microbes from the obese twin became obese and the one who received them from the lean twin remained lean
  • What happens when you put the lean mice with the fat mice? Or vice versa?
  • As stated in the book, The Microbiome Solution, by Dr. Robynne Chutkan, “the microbiome has one of the biggest impacts on our genes, turning them on and off and determining which ones are ultimately expressed as disease”
    • She goes on to discuss how the study of “epigenetics” evaluates how the environment affects heritable traits without actually changing the DNA material in our genes, and suggests that the gut bacteria you inherit might be far more important than the genes you inherit
  • Studies have shown that children prescribed large amounts of antibiotics are at higher risk of obesity later in life
  • Antibiotic exposure before birth can affect children the same way
• Antibiotics
  • “Antibiotic” literally means “against life” from its Greek roots
  • Designed to stop or slow down the growth of microscopic organisms (bacteria, fungi, and some parasites), in turn treating potentially dangerous infections
  • Compared with previous recommendations, there are currently relatively few patient subpopulations for whom antibiotic prophylaxis may be indicated prior to certain dental procedures
  • In patients with prosthetic joint implants, a January 2015 ADA clinical practice guideline, based on a 2014 systematic review states, “In general, for patients with prosthetic joint implants, prophylactic antibiotics are not recommended prior to dental procedures to prevent prosthetic joint infection.”
• Antibiotics and the microbiome
  • 2016, Genome Med, “The effects of antibiotics on the microbiome throughout development and alternative approaches for therapeutic modulation”
  • Antibiotics influence the function of the immune system, our ability to resist infection, and our capacity for processing food, and storing energy
  • Now more important than ever to revisit how we use antibiotics
  • We have a better understanding of the long-term effects on diseases such as malnutrition, obesity and diabetes
• Antibiotic Overkill
  • Between 2000-2010 worldwide use of antibiotics has increased by 35%
  • US ranks #1 in per capita consumption
    • Average American child receives 17 rounds of antibiotics by their 18th birthday
  • Incidence of antibiotic resistant infections rising sharply-2015-over 50,000 deaths in US and Europe - expected to rise to 10 million worldwide by 2050
  • The resultant antibiotic resistance and the superbugs created are killing more Americans each year than murders and car accidents combined
  • One round of antibiotics can kill off over 30% of the bacteria in the gut and create an imbalance that can take months to years to recover from
  • How does the microbiome affect the immune system?
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

You can earn Category 1B CME for:
Development of Scientific Papers
and
Reading the JAOCD and Taking the CME Quiz

Remember, publishing papers meets the Scholarly Activity required by ACGME.
• The relationship between the mammalian host and its microbiota is symbiotic, and this shapes the host’s immune system
• There exists a type of ‘cross-talk’ between the two via the exchange of chemical signals
  • This allows the immune system to recognize bacteria that are ‘harmful’ and find ways to remove them while allowing the good bacterial to remain intact
• It is thought that the microbiome directly influences immune reactivity and targeting
• It is suggested that connections between the microbiome and a growing number of diseases exist, including:
  • 1. Crohn’s disease
  • 2. UC
  • 3. Irritable bowel syndrome
  • 4. Type 1&2 diabetes
  • 5. Rheumatoid Arthritis
  • 6. Periodontal disease
• *Am J Gastroenterol*, 2010- authors DJ Margolis, et al suggested that while the risk of IBD from Isotretinoin appears to be minimal, it appears that there is a potential association between the oral tetracycline class of drugs used to treat acne and inflammatory bowel disease
• They also found a hazard ratio of 2.25 for the development of Crohn’s disease with the use of doxycycline, with the risk evident only after 2 months of use
• How does this affect dermatology?
  • *JAAD*, February 2017, Patterns of antimicrobial resistance in lesions of hidradenitis suppurativa, Fisher, et al sought to determine the frequency of antimicrobial resistance in HS lesions from patients on antibiotic therapy
  • Cross-sectional analysis on 239 patients with HS seen at Johns Hopkins from 2010-2015
  • Concluded that antibiotic therapy for HS treatment may be inducing antibiotic resistance
  • Raised the question regarding the balance of antibiotic use versus potential harms associated with antibiotic resistance
• *Skin Therapy Lett*. 2013 Jul-Aug;18(5):1-4
  • A controversial proposal: no more antibiotics for acne!
  • Muhammad M, Rosen T
• Use of antibiotics, often for prolonged periods, has become the de facto standard of care for acne (and rosacea); however, the world is now facing a health crisis relating to widespread antibiotic resistance
• The authors provide current evidence to suggest that dermatologists should consider a radical departure from standard operating procedure by severely curtailing, if not outright discontinuing, the routine and regular use of antibiotics for acne
  • Trends in the treatment of acne vulgaris: are measures being taken to avoid antimicrobial resistance?
  • Kinney MA, Yentzer BA, Fleischer AB Jr, Feldman SR
  • CONCLUSION: The development of antibiotic resistance is of concern; greater awareness of retinoid use for maintenance therapy, using topical benzoyl peroxide to prevent resistance, and limiting use of oral antibiotics to as short a time period as possible are measures to contribute to better eco-responsible acne treatment
  • Systematic review of Propionibacterium acnes resistance to systemic antibiotics
  • Cooper AJ
  • Research since 1978 has suggested an association between poor therapeutic response and antibiotic-resistant propionibacteria; the overall incidence of P. acnes antibiotic resistance has increased from 20% in 1978 to 62% in 1996; resistance to specific antibiotics varied and was most commonly reported with erythromycin and clindamycin, tetracycline and doxycycline, and trimethoprim; resistance to minocycline is rare
  • CONCLUSIONS: In many patients with acne, continued treatment with antibiotics can be inappropriate or ineffective; it is important to recognize therapeutic failure and alter treatment accordingly; the use of long-term rotational antibiotics is outdated and will only exacerbate antibiotic resistance
  • 7 ways to embrace more microbes
  • Stay away from hand sanitizers
  • Exposure yourself to the great outdoors
• Stop destroying your personal army of microbes
• Make your microbes flourish with greens
• Get rid of artificial sweeteners and other chemicals
• Discover prebiotics- non-digestible short chain fatty acids that help your bacteria flourish-artichokes, garlic, beans, oats, onions and asparagus
• Protect your microbiome with probiotics
• Evidence-based reviews indicate that certain strains of probiotics help to balance the microbial colonies in the gut
• The inhibition of pathogenic bacteria may be due in part to pH as well as antimicrobial activity of the probiotic colonies (good guys vs bad guys)
• Touted for an array of diseases: eczema, acne, IBS, autism, food allergies, etc.
• In the US the products are unregulated and not subject to FDA oversight
• Very difficult to find products with consistent strains, dosages and populations of bacteria
• Nearly 40 billion dollar industry
• Benefits of probiotics:
  • *Eczema*
  • 2012 *Journal of Allergy and Clinical Immunology*: Infants whose mothers took probiotics during pregnancy and breastfeeding were less likely to develop eczema
  • 23 randomized, placebo-controlled studies examining the effects of probiotics on the development of eczema and food allergies- 60% of these studies show a favorable outcome during first year of life
• Antibiotic Associated Diarrhea
  • May 2013, review in the Cochrane Database of Systematic Reviews, looked at 23 studies testing a total of 3938 children 2 weeks to 17 years of age who received a probiotic along with an antibiotic
  • Probiotic usage was associated with a significant 64% reduction in the risk of AAD
• Brain activity?
  • June 2013, Gastroenterology, utilized a functional MRI that demonstrated women who consume probiotic-containing yogurt on a regular basis have altered activity in...
the regions of the brain that control central processing of emotion and sensation
• Not yet determined if these effects are beneficial according to the lead author, Kirsten Tillisch, MD
• Study funded by Danone Research

Skin
• Gut-brain-skin axis originally proposed over 70 years ago by dermatologists John H. Stokes and Donald M. Pillsbury
• Many studies show acne and rosacea patients are at higher risk for GI and emotional issues
• Theory: anxiety <-> GI issues! alter gut microbial flora !promotes local and systemic inflammation
• As early as 1961 there were published case reports showing the benefits of probiotics for the treatment of acne
• One study showed 80% clinical improvement when patients consumed a probiotic
• Other studies from Italy and Russia have also shown improvement
• 2008 study published in Clinical Gastroenterology and Hepatology noted that SIBO (small intestinal bacterial overgrowth) was 10 times more prevalent in rosacea patients, and correction of SIBO led to marked improvement in rosacea
• Other recent studies are looking at the topical application of probiotics for acne and rosacea

Looking into the future
• Our control over microbial disease is diminishing
• Pathogens are outsmarting every new antibiotic we develop
  1. Anti-quorum sensing
  2. Anti-toxin production
  3. Enhancing microbiota
  4. Fecal transplants
  5. Phage therapy
  6. Probiotics

20 Tricks to Finishing Your Office Day On Time
John Coppola, DO, FAOCD

Why does running on time matter?
• Finishing your day 15 minutes late, 5 days a week for 48 weeks a year (20 full days)
• Finishing an hour behind?

• 200 full days
• That’s 600 EXTRA work days!
• Era of Health Grades
• Online patient reviews are becoming a part of the future of reimbursements, contracts, reputations, and future career opportunities
• Bottom Line to your business
• Overtime pay
• Office morale and cuts back on staff turnover
• To have your lunch time to do what you need to
• So you can get home to your hobbies, dogs, kids, or spouse!
• Typical busy Florida practice
  • 35-45 patients a day with 3-6 surgeries daily
  • 25-35 biopsies daily
  • 8am-4pm Mon-Thurs, 8am-12pm Fri
• 10 min slots for both new and established patients
  • 5-12 new patients daily
  • 80% of all 10 min slots are FSEs with all necessary biopsies, LN2 of Aks, discussion of 5FU treatments, or minor rashes done at that appointment as well
• 30 minute slots for surgical procedures
  • (occasionally adjusted to 20 or 40 minutes)
• Not every tip will apply to you
  • Payer Mix
  • Demographics
  • Procedure Mix
  • Employee vs Practice Owner
• May require fundamental change to your patient flow to implement
• Some won’t happen overnight – 7th year in practice, 5th as an owner implementing changes
• Tip #1: Get to the office 20 minutes early
  • Get through your mail
  • Approve any refills you need
  • Sign off on lab & path reports
  • See your first patient 10 min early if they are there
  • You are now 10 min ahead!
• Tip #2: Write more generics and refills
  • Cuts down on interruptions during your day to you and to your desk nurses
  • Teach patients up front, give good pharmacy directions if you are concerned about overuse
• Too many call backs on generic doxycycline
  • Rx: doxycycline hyclate 100mg BID x 5 days
  • Pharmacy note in EMA: monohydrate/tablets if less expensive
• Too many call backs on generic class 1 steroids
  • Rx: clob prop .05% ointment BID x 7 days
  • Pharmacy note: beta diprop .05%/Fluocinonide ointment/cream if less expensive
• Too many call backs on prior auths in general
  • Make the patient call their insurance/pharmacy and figure out what they can be on
• Tip #3: Scheduled times for drug reps
  • No one at the last hour before lunch or end of day
  • No more than 3 a day in the office
  • Utilize your mid-levels for sample sign offs
  • Be honest and upfront
  • Are you ever going to write their drug?
The Florida Academic Dermatology Center at Larkin Community Hospital is one of the few inpatient dermatology units in the United States. Led by Dr. Francisco Kerdel, this department provides specialized care for severe dermatological conditions, including but not limited to: immunobullous disorders, collagen vascular diseases and papulosquamous disorders. In addition, we specialize in the care of cutaneous T-Cell lymphoma, and chronic graft versus host disease, providing photopheresis treatments for these conditions. Our services include Goeckerman treatments for psoriasis, narrow-band ultraviolet light therapy and whirlpools (for body & extremities).

We are proud to offer a wide array of state-of-the-art dermatological services, including treatments for: dermatitis, drug reactions, hidradenitis suppurativa, lupus, pemphigus vulgaris, psoriasis, severe skin infections, scleroderma, skin cancer and ulcers of the skin. Patient satisfaction is our top priority. We are committed to providing innovative, first-rate dermatological care. Our dedicated team of bilingual staff prioritizes catering to the needs of our patients, and their families, to establish a comfortable environment and foster lasting patient/client relationships.

Residents from any of the AOCD residency programs are more than welcome to set up a 1-2 week rotation at the inpatient facility at Larkin Community Hospital under the direction of Francisco Kerdel, MD. Those residents may contact Dereen Neil, RN at (305) 284-7516 or (786) 879-9551 to set up that rotation or may reach out to the Co-chief residents of the LCH/NSUCOM dermatology residency program under the directorship of Stanley Skopit, DO at dermatologylarkin@gmail.com.

CONTACT US
305.284.7516 | 786.879.9551
7031 SW 62nd Ave South Miami, FL 33143
New info?

Regular prescriber?

Be polite – they have a hard job and play an important role, but these rules are not hard to implement

Tip #4: Don’t have drug lunches and bring your own lunch

Lunch and Learns for staff for specific reasons

Buy lunch for your staff yourself on occasion

Bi-weekly potlucks

Allows you to have the time for yourself to catch up or close charts

Tip #5: Standing order in PMS for complicated patients

Work with schedulers to give more time with these patients

Tip #6: Surgery before lunch and last appointment of the day

If you need to squeeze in an emergency, this is when you do it

If doing enough surgeries, make last 2 appointments of day surgical

Tip #7: Don’t wait for the paperwork to be completed to bring the patient back

Use patient portal to try to have paperwork completed prior to arriving

They can complete paperwork after the appointment if necessary

Tip #8: Take the paperwork away in the exam room

Tip #9: Make your intake paperwork mirror your software

Makes it easy and efficient to transfer information

Tip #10: Don’t call back benigns/don’t send benign letters

“No news is good news”

MAs reiterate

Still have to know? Use your patient portal

FREE UP YOUR STAFF

Tip #11: Everyone needs a Michelle R.

Practice implementation & management of all regulatory programs

Medicare E.H.R. Incentive program, PQRS, Quality Payment Program and Physician Compare

Manage all of the regulatory submissions

Analyzing and interpreting new and revised regulations, policies and procedures

Maintain up-to-date knowledge and understanding of all MIPS Performance categories and their associated measure technical specifications

Raise quality scores through ongoing medical record audits; identify issues and trends in data abstraction, diagnosis coding and clinical documentation;

Provide quarterly reports assessing practices’ performance gaps and incentive payment readiness; create communication tools and workflow improvement strategies for helping clinical support staff and providers achieve incentive goals

Bachelor Degree in Business Administration & Health Information Management

Certified Medical Coder – RHIT, RHIA, CCS

Extensive knowledge of healthcare industry: medical terminology, CPT & ICD9/10 coding, clinical documentation, billing and medical office operations;

Medicare/commercial insurance guidelines

Knowledge of managed care data reporting and analysis such as HEDIS, Medicare Risk Adjustment, quality of care studies and benchmarking

Ability to proficiently read and interpret medical records

Understanding of clinical documentation guidelines

Extensive experience with Microsoft Excel, Access and/or SQL helpful

Tip #12: Management staff needs to be trained over and over

Invest in your staff

Biannual retreats for managerial staff

ADAMS training

http://www.ada-m.org

Local university managerial and leadership seminars

Bimonthly MA meetings

Quarterly provider and department head meetings

Quarterly share holder meetings

Lawyer and CPA

Tip #13: Your staff has really good ideas

“How can we make things better or run smoother?”

Tip #14: Don’t rotate your MAs

Pay a little more if you need to for them to travel with you

Builds loyalty and synergy in your patient flow

Fewer missed days of work

Can anticipate your needs (and quirks) better

Tip #15: Cross train everyone

Someone may have down time when someone else is swamped

Tip #16: Get rid of bad apples and don’t hire mediocrity

Harvard Business Review estimates that up to 80% of employee turnover is due to bad hiring decisions

Do working interviews and be able to not extend a job offer after 90 days

Tip #17: Be in the middle of everything and don’t walk far

“Dr. C runs on time” – at points of contact

Path logs maintained/logged out with a fraction of the work

Less referrals

More referrals

Refills in a flash

Allows you to have the time for yourself to catch up or

BUILD YOUR REPUTATION

30 people refer

30 that thank me and refer patients

10-minute window

Patients that habitually miss appointments are deferred to mid-levels or dismissed from practice

Hard to implement until you can run on time yourself

“Dr. C runs on time” – at points of contact

Once you do, it’s a game changer for your schedule and your reputation

Patients will come to you just because you run on time

For everyone patient that gets upset over this in my office, there are 30 that thank me and refer patients because of it
A Decade of Lessons Learned the Hard Way: Practical Knowledge for the Medical and Cosmetic Dermatologist and Practice Owner
Michelle Foley, DO, FAOCD

Case 1
45 y/o female (CPA) with weeks history of intense itching; Many visible excoriations; Only takes occasional Advil for headache

Seen by PA for this; PA does full H and P and due recent travel to Arizona, scabies prep that is negative; biopsy done that day

Patient sent home with topical steroid

Biopsy showed acantholytic dermatosis, no evidence of scabies or inflammatory cells

Patient treated for Grovers with some mild improvement

RTC to see me due to failure to improve after 5 weeks

Still with predominante excoriations on arms, legs, and back and few on abdomen Scattered urticarial-like lesions noted especially on her thighs

Biopsy done that day

Superficial and deep perivascular and interstitial dermatitis with eosinophils

Urticarial stage of pemphigoid possible

Ordered dif

Started on prednisone

Labs ordered

Elevated glucose and neuts, ANA neg, RF neg

Hep panel, Complement, Cryoglobulins all pending

Referral to Mayo Clinic - Jacksonville

Diagnosis → scabies 9 slides prepared with various scrapings and founds mites and eggs in axilla

Lesson 1
Go back to basics - take your own history
Form an ORIGINAL differential diagnosis without any preexisting bias
Don't get lost in the details
Information bias and overload is a REAL thing

Case 2
It’s May in Florida

Patient is in his garden daily

Does NOT recall injury but spots have been present for 6 weeks, 4 erythematous papules on upper extremity

Neighbor is a retired dermatologist from NY and made him come in

Punch biopsy taken and tissue culture sent

Punch biopsy: Suppurative and granulomatous dermatitis suspicious for infection; all stains negative

Culture: (isolated from enrichment broth only) Staph aureus

Quest Labs contacted; Tissue no longer available

Patient c/o new lesions

Empiric Itraconazole started suspecting sporotrichosis

Patient is not improving after 4 weeks of therapy and, in fact, has new lesions

Dose increased to 200 mg bid and second tissue culture taken

Another tissue culture; Quest: (isolated from enrichment broth only) Staph aureus

Quest manager: “I’m sorry for the inconvenience”

Call ID friend for help

Quant gold is positive

3rd tissue sample for culture taken

Patient aware I am using a possible “out of network” lab for culture this time and is agreeable

Hospital lab contacted and currier picks up tissue

Diagnosis finally made in October → M. marinum

Lesson 2

Be persistent

Be willing to discuss why a higher cost or out of network provider may be needed; (this is not always easy given time constraints and patients’ budgets)

This may be the case with labs, pathologists, surgeons, consultants

Phone a friend

Quantiferon TB Gold CAN be positive in non-TB cases to due to similar peptide antigens located on region of difference (RD1)

Case 3
77-year-old male with extensive sun damage and history XRT to head and neck for throat cancer; tough personality

Active tennis player

History of “laser” treatment to large “sun spot” on top of head

Old records obtained

Multiple sessions of IPL to treat unwanted spots on face and scalp, many of which were returning due to daily outdoor tennis, etc.

Took 2 years to convince him to allow us to do a biopsy

MMIS in all scout biopsies

Patient refused Mohs at Mayo Clinic

Underwent wide local excision x 3 to clear all margins under general anesthesia; no invasive component identified; large grafts placed

Remains clear today

Case 4
51-year-old Caucasian female

Biopsy proven eruptive-type granuloma annulare

Poor response to topical steroid, but excellent response to 21-day prednisone taper

Clear for over 10 months

Called for a refill on oral prednisone when new flare occurred

I wanted patient to be seen; Could not come in because of conflicting schedules but crying on phone because she can’t sleep secondary to the itching

Refilled her script and saw patient 6 weeks later

Patient had just undergone hip surgery for avascular necrosis

Lesson 3
You are the expert in your office, act like it!!
• Patients want what is easy, painless and convenient
• They can’t be bothered with rules, guidelines or protocol
• This, many times, conflicts with our duty as physicians
• Stand up for what you know or believe is right

Lesson 4
• Each patient is a unique individual, take the entire patient into consideration
• Age, immunosuppression, general health, wound care compliance
• Varying degrees of health and co-morbidities
• Forced to think outside the box and sometimes vary from classic standard of care
• Definitive treatment is not always possible
• Recognize pathergy when it’s happening, inform other doctors about it
  • JAAD 2009 Nov 61(5):892-7
  • First, do no harm

• Lower extremity SCC
• Extremely common in my patient population
• Very often pathergy related
• Many recurrent cases after EDC and or surgery
• Trouble comes when trying to follow consensus or “guidelines”

Cosmetic lessons
• Educate your cosmetic patients ad nauseam
• Sometimes you can inject one side, give the patient a mirror while you explain what you did before you do the other side
• ALWAYS - photos and consents; Nobody remembers what they looked like unless you take before and after pictures
• Document, Document, Document
  • I do mention “off label use”
  • Unpredicted outcomes will happen
  • Know when to say “NO”
  • Be confident and hold their hand

Education
• Have staff that are specifically trained to deal with cosmetic patients (consults, scheduling, follow-up questions)
• You must delegate; According to ASDS survey, 52% of consumers are considering cosmetic procedures
• Review patient photos or consults prior to scheduling procedures

• Be honest with patients and NEVER promise an outcome
• If you have concerns, have someone call to follow up
• Photos and consent
• Most cosmetic suits do NOT end in judgement against the doctor
• Informed consent does not prevent lawsuits
• Photos (before and afters) are life-savers
• Most patients that feel disappointed with outcome are more positive after reviewing their photos
• Sometimes it’s not about what they say it’s about

Document
• Make note of bruises and expected swelling–patient will call
• Ask patients what they think and document their response
• If patients ask for new Botox pattern, I document that this was at their request
• Frozen foreheads, heavy brows
• Off-label use
• My patient population is older
• Effects and risks may be “unknown”
• Outcome may be less predictable, especially in older patients
• Go slow and bring the patient back
• Rome wasn’t built in a day

• Unpredicted outcome
  • The Bio-film
    • Erythema and swelling 6 weeks after 66 y/o female had HA filler for ML.
    • Dental work 4 days before swelling started
    • Responded well to Doxy and low dose prednisone
  • FISH
  • Consider asking about upcoming or planned dental procedures
  • To refund or not refund?
    • Received a letter from a patient in 2016
      • 2 pages hand-written with recent photos
    • Patient last seen by me in 2011 (5 years and 8 months prior) for filler
      • (Radiesse and Juvederm)
    • Patient was requesting all money be refunded with interest or she would be seeking representation
  • Contacted our attorney
  • Ignore urge to be right
  • Do not engage
  • Did NOT refund
  • Practice lessons
    • You can’t prepare for everything, but do your best

Life lesson
• Freeze your credit!! Do it now, do it today!!
• Bureau of Justice Statistics 17.6 million Americans were victims of identity theft in 2014
• 3 out of 4 partners in my practice have had their identity stolen
• As a physician, your SS# is everywhere; every agency, insurance company, governing body and your staff may have access to it
• HOURS of time spent on the phone

CHALLENGES IN DERMATOLOGY
Larissa Chismar, MD

• Communication
  • Communication between the dermatologist and dermatopathologist is essential for a successful relationship
  • The dermatopathology requisition form is the primary way that dermatologists communicate information to the dermatopathologist
  • Including more information on the requisition form helps your dermatopathologist make the best diagnosis for your patient

• The Dermatology Requisition Form: Attitudes and Practices of Dermatologists
  • Larissa A. Chismar, MD, Nicole Umanoff, BS, Blair Murphy, BS, Kate V. Viola, MD, MHS, Bijal Amin, MD
  • Journal of the American Academy of Dermatology
  • Volume 72, Issue 2, Pages 353-5 (February 2015)

• What did we want to know?
  • Demographic information
  • Who fills out form?
    • Estimate of time spent on form
  • How important do you think it is it to include various pieces of information?
    • Location, color, size, duration, clinical differential diagnosis, treatment history, Fitzpatrick skin type, ethnicity, history of malignancy, history of organ/bone marrow transplant, history of HIV, history of Hepatitis B or C, other past medical history, history of melanoma
  • How often do you include the above pieces of information?
• How strongly do you agree with the following statements?
  • I am reluctant to add clinical information because I do not want to bias the dermatopathologist
  • I believe the dermatopathologist should be able to make a diagnosis without any clinical information

• Studies Regarding the Dermatopathology Requisition Form
  • Waller and Zedek, JAAD 2010;62(2):257-61
    – Looked at clinical information provided and microscopic diagnosis for 100 consecutive melanocytic lesions
    – Important information not always included on requisition form – Clinical morphology provided in 33%
    – No mention of any ABCDE criteria in 55%
    – Lesion size provided in 22%
    – Partial versus complete sampling of lesion specified in 0%
    – Only information on form “r/o X” in 29%
  • Comfere et al, J Cutan Pathol 2015;42(5):333-45
    – Survey of 598 dermatopathologists
    – Also focus groups at 2 national meetings
    – 42.7% rated overall quality of clinical information as fair or poor
    – 44.7% of dermatopathologists spend 30 minutes or more every day searching for relevant clinical information
    – Missing clinical information at least half of the time:
      • Melanocytic proliferations (53.7%)
      • Non-melanocytic proliferations (57.4%)
      • Inflammatory dermatoses (59.1%)
  • What information is important to include?
    • Lesion location
    • Patient age
    • Clinical impression/differential diagnosis
    • Partial versus complete sampling
    • Duration of lesion
    • Lesion morphology
    • Clinical symptoms
    • Previous treatments
    • Known clinical diagnoses
    • Previous dermatopathologic diagnoses (like history of melanoma)
    • Clinical photographs
  • Remember: The information you supply on the requisition form becomes a part of the patient’s medical record!

• Challenges with melanocytic lesions
  • Partial biopsies
  – 31% of US dermatologists (Survey 1995)
  – 27% of cases in Victoria, Australia (2000)
  – 30% and 22% of cases referred by GPs and dermatologists, respectively, to a UK surgical unit (2008)
  • Impact
    – Increased odds of false negative diagnosis in partial versus excisional biopsies – Shave: odds ratio 2.6% – Punch: odds ratio 16.6%
  • Concordance with excisional specimen
    – 96% of shave biopsies
    – 71% punch biopsies
  • It is not possible to exclude melanoma!
  • Sampling error
    – Melanoma arising in association with a nevus
    – Contiguous lesions in lentigo maligna
    – Skip areas or regression in MMIS
  • “… a partial biopsy may result in a partial diagnosis which may be a misdiagnosis.”
  • Surgical pathology claims to a US Medical indemnity provider
  • False-negative diagnosis of melanoma - single most common reason for filing a malpractice claim against a pathologist
  • Partial biopsy was responsible for over 50% of false-negative melanoma misdiagnoses

• Criteria for diagnosis of melanoma
  • Architecture
    – Asymmetry of silhouette
    – Lateral junctional borders
  • Distribution of melanocytes and nests at the junction
  • Distribution of pigment within the lesion
  • Distribution of inflammatory response
  • Epidermal alteration
  • Cyto logic details
  • Architecture – Other
    – Large dimension of the lesion
    – Poor delimitation of the lesion
    – Large confluent nests
    – Expansile nodules and solid growth pattern
    – Consumption of the epidermis
  • Lack of maturation
  • Cyto logic and other criteria
    – Cellular atypia
    – Cellular pleomorphism and mitotic figures
    – Pagetoid spread
    – Sun damage

Cases in Oncodermatology
Beth McLellan, MD

• Increasing awareness of dermatologic adverse effects
  • 14.5 million living cancer survivors
  • 1.6 million new cancer diagnoses in 2014
  • 52-87% cancer-related surgery
  • 24-35% chemotherapy
  • 47-61% radiation therapy
  • 67% feel dermatologic toxicities were worse than they expected
  • 84% were not referred to a dermatologist
  • 54% feel they would have felt better if they were referred to a dermatologist
  • Case #1
    – History colorectal cancer treated with multiple drugs
      – Regorafenib
      – Painful eruption on hands and feet
• Hand foot skin reaction due to multiple multikinase inhibitors
• Look like calluses in areas of pressure, but are extremely painful
• Occurs anywhere where there is friction or trauma, not just hands and feet
• Risk factors
  • Female gender, liver mets, 2+ organs involved, baseline WBC >5.5, time on therapy, hypertension, genetic polymorphisms in some populations (Japanese)
• Treatment
  • Avoid hot water, moisturize, thick cotton gloves, 20-40% urea
  • Clobetasol 0.05% ointment, 2% lidocaine, codeine, pregabalin for pain
  • Urea cream for prevention
  • Decreased all grade HSFR from 73.6% to 56%
  • Delayed onset of HSFR from 34 days to 84 days
• Other drugs include axitinib, cabozantinib, pazopanib, sorafenib, sunitinib
• HFSR mechanism
  • Dose-dependent
  • Dual blockade of VGFR and PDGFR
  • Interruption in vascularity
  • Case #2: Onycolysis
• Acute damage to nail bed epithelium
• Rarely photo-induced
• Caused by taxanes, most commonly (breast cancer)
• Docetaxel
• Up to 44% develop nail changes
• More than 32% have functional impairment
• 20% develop grade 2 change
• PATEO: periarticular thenar erythema with onycolysis
• Taxane induced
• Rule out fungal infection
• Proposed mechanism
  • Thrombocytopenia
  • Vascular abnormalities
  • Damage to peripheral nerves
  • Direct nail bed toxicity
• Treatment
  • Monitor for infection and culture any drainage
  • Antibiotics as needed
  • Soaks with diluted vinegar or bleach
  • Hand protection with gloves, moisturizers
  • Keep nails trimmed short
• Cryotherapy for prevention
• Incidence of nail changes in hands 51% to 11%
• Incidence of nail changes in feet from 21% to 0%
• Gel packs can be used over cotton gloves
• Case #3: Non-small cell lung cancer treated with Erlotinib; Itchy rash on face
• Papulopustular eruption due to EGFR inhibition
• Erlotinib, gefitinib, cetuximab, panitumumab, lapatinib, vandetanib, afatinib, osimertinib
• HER2 inhibitors cause similar symptoms
• EGFR in skin
  • Expressed in basal and suprabasal keratinocytes, sebocytes and ORS
  • EGFR lost as cells differentiate
  • EGFR inhibition induces apoptosis and increases cell attachment
• QOL and targeted therapy
  • More dermatologic adverse events than non-targeted
  • Range of adverse events
    • Mild to severe
    • Graded on scale from 1-5 based on body surface area
  • 1= papules and/or pustules covering <10% BSA +/- symptoms
  • 5= death
• Risk factors
  • Lower Fitzpatrick skin type
  • Concurrent chemo and/or radiation
  • Genetic polymorphisms
• Treatment
  • Photoprotection
  • Check for infection
  • Oral tetracycline
  • Low potency topical steroid
• Prophylaxis
  • Moisturizer
  • Sunscreen
  • 1% hydrocortisone
  • Doxycycline
  • All continued for 1-6 weeks of treatment
• Case #4: EGFR inhibitor with papulopustular eruption, then new rash on legs
  • Treated by culturing pustules to discover infectious cause
  • Consider infection in patients not responding to topical therapy
  • Increased risk for infection if on two different EGFR inhibitors
• Case #5: Erlotinib for lung cancer; Severe pruritus not responding to prednisone, antihistamines, topicals, or gabapentin
• Incidence 22.7%
• Pathogenesis
  • Unmyelinated C fibers/neurotransmitters
  • Receptor activation
  • Xerosis
• Treatment: Aprepitant
  • Neurokinin 1 antagonist
  • 87% of patients had no recurrence of pruritus
  • Cautions for drug interactions
  • Causes extreme drowsiness
• Case #6: Remote history breast cancer referred for itching around lumpectomy scar
  • Punch biopsy → cutaneous mets
  • 23.9% of breast cancer patients
  • 2% of all skin tumors
  • MC location is thorax
• Most often smooth, shiny, dome-shaped nodule
  • Usually asymptomatic, some cause itching, tension, pain
• Prognosis
  • Usually advanced stage
  • Flare simultaneously with EGFR inhibition
  • May indicate unknown primary cancer
  • Survival <1 year and less if multiple
• Case #7: Completed radiation for breast cancer
  • MC skin cancer she could develop?
    • BCC
      • 8% of childhood survivors have skin cancer by age 30
      • Might be as high as 60%
      • Monitor areas that have received radiation for BCC
      • Recommend yearly skin exams
• Case #8: History breast cancer with bilateral mastectomy; Itchy rash not improving with emollients after 6 months
  • Nummular dermatitis of the reconstructed breast
• About 3% developed this reaction
  • Only reviewed cases with breast implantation
  • Not always itchy
  • Not always after reconstruction
  • Biopsy to rule out cutaneous mets
  • Scrape to rule out fungus
• Usually respond to topical steroids
• Skin changes caused by radiation negatively impact well-being, body image, emotional well-being, functional well-being, and treatment satisfaction
HIV In Dermatology
Charles Gropper, MD

- History of HIV
  - July 1981
    - 26 initial cases of young men with unusual presentation of dermatologic findings reported by NYU
    - KS: not classical type
    - Oral Candidiasis
    - Chronic HSV
    - Now more likely to present with other STD such as syphilis
  - HIV facts and figures
    - More than 60 million people infected with HIV and more than half have died since epidemic began
    - 36.7 million people living with HIV globally
    - 40% don’t know their status
    - Less than half receive treatment
    - Downward trend for number of new HIV infections (all ages), yet remains high
    - About 2 million per year
    - Annual number of new HIV infections has remained stable
    - New infections remain high: Estimated 56,300 Americans get infected each year
    - More than 18,000 people with HIV die each year in the US
    - Upward trend in the number of people living with HIV
    - Stable number of new infections
    - People are living longer with HIV
    - HIV still a problem
    - Global
    - Living with HIV = 37 X 10^6
    - USA
      - Living with HIV = 1.2 x 10^6
    - 20% Rise in Unprotected Sex from 2005-2011
    - People are “zero-sorting”
    - Better treatment and bad economy lead to risky behavior
    - New infections still about 50,000/year
    - Government goal to decrease to 30,000/year
  - Travel and STDs
    - 5-50% short-term travelers engage in casual sex
    - At least half do not practice safe sex
    - Problem accentuated in travelers 18-30 years old
    - Pre-exposure prophylaxis
      - Used in those with “high-risk” of HIV
      - Typical to take preventative drugs DAILY
    - Study: 400 gay/bisexual men divided into those who took medication 2-24 hours before and 24 & 48 hours after unprotected sex versus placebo at same interval
    - Nine months: use “on demand” PrEP reduced HIV acquisition by 86%
    - Side effect: GI upset (14% vs placebo 5%)
    - Message: persons at high risk of HIV can take PrEP on an on-demand basis, and still be relatively unprotected
  - HIV Transmission: variable laws
    - California – Felony punishable by up to 8 years in prison
    - Missouri – Class B felony to expose a person to HIV; If complainant becomes infected, the charge is a class A felony; The use of a condom is not a defense
    - New York- Reckless endangerment in the first degree for engaging in conduct which creates a grave risk of death to another person
    - Texas – Aggravated assault laws whereby a person “intentionally, knowingly, or recklessly… uses or exhibits a deadly weapon as part of an assault”; Saliva of an HIV infected person is considered a deadly weapon
  - HIV and the Skin
    - Prevalence of cutaneous abnormalities approaches 100% in patients with HIV
    - Some cutaneous conditions are unique and pathognomonic for HIV
    - Example: Kaposi’s Sarcoma
    - Skin findings may be marker of disease stage
  - Example: EPF usually occurs in patients with T Cell Count
  - Key point
    - Dermatologists should still consider HIV infection in patients presenting with both common and rare skin abnormalities
  - Skin conditions frequently observed in HIV infected patients
    - AIDS defining mucocutaneous conditions
    - Non AIDS defining mucocutaneous conditions indicative for HIV-1-associated immunodeficiency
  - Categories of skin problems in HIV
  - Infections
    - Viral
      - Acute HIV Morbilliform Rash
      - Maculopapular rash which sometimes resembles P. rosea
      - Upper trunk, proximal limbs, palms, and soles
      - Oral erythema or erosions may be present
      - Usually resolves in 1-2 weeks
      - Patients may seronegative and most infectious at time of rash
    - Herpes Simplex
      - CDC Defined Index Infection
    - Clinical findings similar to non HIV patients if immune system relatively intact
    - Once immunosuppressed, HIV patients often develop chronic painful ulcer
    - Perianal, perioral, periungual
    - Treatment
      - Acyclovir, Famciclovir, Valacyclovir
      - Acyclovir-Resistant HSV Infection
      - Thymidine-kinase-negative, acyclovir resistant HSV-2
      - V: foscarnet and cidofovir
      - Topical: trifluridine, cidofovir, and imiquimod
    - Syphilis
      - Varicella/Zoster
      - Often precedes thrush and oral hairy leukoplakia
      - May be early sign of HIV
      - Duration, pain and amount of scarring may be more severe in HIV patients
      - Recurrences in up to 25%
      - Dissemination with widespread ulcers or hyperkeratotic, verrucous lesions may occur
• HPV
  • HPV infection more common in immunocompromised patients
  • Cervical dysplasia is common in HIV infected women
  • Increased risk of anal warts and anal carcinoma in homosexual men
• Oral Hairy Leukoplakia
  • Develops in about 25% of infected individuals
  • Predictor of rapid decline and AIDS progression
  • White plaques with hair like progressions
  • No malignant potential
  • May regress with antiretrovirals therapy
• Molluscum contagiosum
  • Extragenital molluscum contagiosum occurs almost exclusively in HIV-infected or immunocompromised patients
  • The following infections resemble molluscum-like lesions:
    • Coccidioidomycosis
    • Cryptococcus
    • Histoplasmosis
    • Aspergillosis
• Deep fungal infections
  • Cryptococcus
    • Presents with meningitis
    • May present as molluscum like lesions on the face and neck
  • Histoplasmosis
    • May represent reactivation of previous infection
    • Cases seen in NYC mostly in patients who lived previously in an endemic area
    • Variable skin lesions: pustules, acneform, ulcerations and plaques
    • May be fatal syndrome with sepsis, DIC, and pulmonary, CNS and renal failure
    • Disseminated cutaneous histoplasmosis in newly diagnosed HIV
  • Proc (Bayl Univ Med Cen). 2016 Jan;29(1):50-1
• Sporotrichosis
  • Asymptomatic pulmonary infection that spreads to the skin
• Widespread ulcers and SQ nodules
• Aspergillos
  • May be primary or secondary
  • Primary from local skin injury
  • Red plaques with pustules and ulcers or molluscum like lesions
  • Treatment with amphotericin B or itraconazole
• Bacterial
  • Bacillary angiomatosis
    • Bartonella henselae or B. quintana
    • Differential diagnosis: Kaposi’s Sarcoma
  • 4 Types of onychomycosis
    • Distal and Lateral Superficial (DLSO)
      • T rubrum and T mentagrophytes most common
    • Proximal Subungual (PSO)
      • Marker of HIV
    • Superficial White (SWO)
      • T mentagrophytes
    • Total Dystrophic (TDO)
• Inflammatory
  • Xerosis/Ichthyosis
    • Xerosis most prominent on lower legs
    • HIV patients often have refractory pruritus
    • Similar to atopic eczema seen in elderly
    • Worse in patients with atopic diathesis
    • Acquired ichthyosis is seen in advanced HIV (CD4+ <50)
    • Treatment with moisturizers and topical steroids
    • Often unsatisfactory
• Seborrheic dermatitis
  • Affects about 5% of non-HIV population
  • Most common skin disorder to affect HIV patients, up to 85% incidence
  • Usually affects the scalp and central face
  • With HIV, can be widespread or inverse
  • If exaggerated, sudden onset, or acute worsening, consider HIV infection
• Psoriasis
  • Overall incidence not increased with HIV
  • Similar clinical features with or without HIV
  • With HIV, may have increased intertriginous involvement and more dramatic presentation
  • Significant nail dystrophy and arthritis may be seen
  • Not uncommon to develop psoriatic erythroderma
  • Worsens with declining immune status
• Reiter’s Syndrome
  • All patients with newly diagnosed Reiter’s should have HIV testing
  • Commonly occurs in HIV patients with HLA-B27 after GU or GI infection
  • Palms and soles develop pustules and form keratotic papules
  • Coalesce until soles are thickened and scaled = keratoderma blennorrhagicum
  • Nails, groin & axilla, and oral (erosions, geographic tongue) & genital (circinate balanitis) regions often affected
  • Histology is identical to psoriasis and same treatment for both diseases
  • Papular Pruritic Eruption of AIDS
  • Marked pruritus
• Symmetrical, non-follicular papules, with secondary changes
• May be secondary to peripheral eosinophilia, hyper-reactive mast cells, or neural irritation from direct HIV infection
• May be on spectrum which includes eosinophilic folliculitis or response to arthropod Ag's
• Eosinophilic Folliculitis
  • Highly pruritic, follicular papulopustular eruption of the face, neck, trunk, and extremities
  • Cultures are negative
  • Peripheral eosinophilia may be present
  • CD4+ usually
  • Treatment with Betamethasone Valerate cream, erythromycin 2% solution, and ketoconazole cream
  • Much improved at 2 week follow-up
• Erythema Elevatum Diutinum
  • Chronic form of cutaneous LCV
  • CD4+ count <200
  • Necrotizing vasculitis with firm red - brown papules, plaques, or nodules, symmetrically on extensor surfaces
  • Asymptomatic or painful itching/burning (worse after exposure to cold)
• Treatment: Dapsone
• Photosensitivity
  • May be symptom of HIV or drug side effect
  • In some reported cases, photosensitivity was the first clinical sign of HIV
  • Occurs in 5.4% in sero-positive patients
  • More common in individuals of African descent
  • Most HIV patients are UBV sensitive
  • The most severely affected individuals are both UBV and UVA sensitive
• Reported cases of Photodermatitis with subsequent Vitiligo-like Leukoderma
• Theories:
  • HIV triggers immune dysregulation leading to autoimmunity against the skin
  • Viral-mediated melanocyte destruction
  • Koebner phenomenon induced by photodermatitis in susceptible people
• Kapost's sarcoma
• Neoplasm of endothelial cells
• Closely associated with HHV-8 infection
• Predominantly seen in MSM
• Initially red-brown macules; Small violaceous papules, large plaques, ulcerated nodules also seen
• Internal involvement in 72%, usually in GI tract and lymphatics
• Secondary lymphedema
• Poor prognosis, average survival time of 18 months
• 23 cases of KS in HIV infected persons
• 7/23 had CD4>300
• 5/23 had never had any prior treatment with HAART
• These cases cannot be directly attributed to immune reconstitution syndrome
• Conclusion: All patients with HIV should be screened for KS
• Lymphomas
  • CD4+ counts <200
  • Pink – violaceous papules, often ulcerate
  • In-patients with HIV:
    • Most are non-Hodgkin B-cell type
    • Younger age of onset
  • Extranodal (especially CNS) involvement at presentation
  • HIV+ children ↑ incidence of MALT lymphomas
• Decreased incidence lymphomas with HAART
• Lipodystrophy aka fat redistribution syndrome
  • HIV patients treated with HAART may have lipohypertrophy, lipoatrophy or a mix of both
  • Commonly have hypertriglyceridemia and insulin resistance
  • Lipoatrophy associated with:
    • Duration of treatment with thymidine analogues
  • HIV patients being treated with antiretrovirals may have
    • Lipohypertrophy
    • Lipoatrophy
    • Mix of both
• Lipohypertrophy
  • Enlarged dorsocervical fat pad
  • Circumferential expansion of the neck
  • Breast Enlargement
  • Abdominal Visceral Fat Accumulation
  • Peripheral fat wasting with loss of SQ tissue in face, arms, legs and buttocks
  • Face involvement is most common
  • May have social stigma
• Lipoatrophy
  • Lipoatrophy in HIV – Peripheral fat wasting with loss of SQ tissue in face, arms, legs and buttocks – Face involvement is most common
  • May have social stigma
  • Peripheral fat wasting with loss of SQ tissue in face, arms, legs and buttocks
  • Face involvement is most common - especially cheeks & temples
  • May have social stigma
• Stavudine (NRTI) associated with higher risk
• Substituting non-thymidine analogue for stavudine à gradual improvement
• Treatment: Pravastatin, pioglitazone for peripheral lipoatrophy; cosmetic sx
• Immune reconstitution inflammatory syndrome (IRIS)
  • Occurs with sudden increased CD4 count or decreased viral load
  • Flare of skin conditions with improved immune function
• Often follows start of HIV medications
• Skin Conditions which flare: EPF, KS, HSV, HZV
• The initiation of antiretroviral treatment for individuals with HIV may be accompanied by
  • A paradoxical flare of underlying inflammatory diseases
  • The recurrence of dormant infections
  • Worsening of prior treated opportunistic infections
• Medication Reactions
  • Patients with HIV have an increased incidence of cutaneous drug eruptions
  • Risk for TEN is 1000x greater in AIDS patients
• Drug-induced hyperpigmentation
  • Azidothymidine (zidovudine, AZT)
    • Causes hyperpigmentation of mucous membranes and nails in 10%
    • Typically occurs after 4-6 weeks of therapy
    • Increase in melanin in basal layer and dermal melanophages
    • Fades after discontinuation
• Eruptive Dermatofibroma
  • Common benign fibrous nodule that often arises on the lower legs
  • Multiple eruptive DF is rare but frequently associated with underlying immunocompromising disease
• Cellular dermatofibroma
• Introduction
  • Dermatofibroma – 2nd most common fibrohistiocytic tumor of the skin
First described in 1994, one of many subtypes of DF
Considered to be locally aggressive and have potential for metastasis
Epidemiology
- Rare, about 5% of all DF
- Occur in young to middle age adults, male predominance
- Overall rate of metastasis is unknown but thought to be very rare
- No reported cases in HIV or AIDS patients
Pathogenesis
- Unknown, possibly trauma however newer literature debates this reactive origin
- Eruptive DF associated with immunosuppression
- Potential for recurrence and metastasis
- Association with multiple chromosome abnormalities – DF of all types known to be eruptive in: autoimmune disorders, atopic dermatitis, immunosuppression (esp HIV)
- No reports of eruptive cellular DF in HIV or AIDS patients
- DF of all types known to be eruptive in: autoimmune disorders, atopic dermatitis, immunosuppression (esp HIV)
- No reports of eruptive cellular DF in HIV or AIDS patients
- Malignant dermatofibroma: clinicopathological, immunohistochemical, and molecular analysis of seven cases
- Examined 4 aggressive or metastatic cellular DF along with mixed type DFs
- All showed marked chromosomal abnormalities
- Recurrence occurred between 8 months and 9 years
- Metastasis occurred between 3 months and 8 years after diagnosis
- 2 patients died of their disease
- DNA copy number changes in tumor within the spectrum of cellular, atypical, and metastasizing fibrous histiocytoma
- Published in JAAD 2014
- Examined 5 metastatic cellular DF using array based comparative genomic hybridization analysis compared above to 5 non-metastatic cellular DF and normal DNA
- Showed that increased chromosomal abnormalities associated with metastatic potential
- Acknowledge that chromosome analysis is currently too costly to perform on all cellular DF
- Recommend cautious management of patients with large cellular DF
Clinical Features
- Appear clinically similar to benign DF
- Occur in upper extremities and nonclassical locations – face, ears, hands and feet
- Diagnosis made by biopsy
- Per published case series, most are larger (3+ cm)
Pathology:
- High cellularity, minimal intracellular collagen, abundant mitosis, extension into the subcutis and no cellular atypia or nuclear pleomorphism
- Central necrosis or infarction has been reported
- Variable expression of smooth muscle actin, seen much more frequently than in ordinary dermatofibroma
- Positive for factor XIIIa, negative for CD34
- Focal, peripheral expression of CD34 and desmin reported
Treatment:
- All literature recommends complete excision, no consensus on margins
- 1 publication reported 0.5 mm margin with fatal outcome
- Recurrence rate of 26-64% depending on source
- Rare reports of metastasis to lymph nodes, lungs, soft tissue, brain
- No consensus on treatment of metastatic disease beyond complete excision if possible
- Metastatic disease fatal in 32% of reported cases (7/22)
Follow up treatment options
- Patient has 2 large biopsy proven cellular DF
- Next step is to remove these 2 lesions
- As our patient’s CD4 count increased and her viral load decreased many of her previously nodular lesions have become macular
- Should these be biopsied?
- With >10 lesions, 2 biopsy proven cellular DF, is biopsy and excision of all lesions feasible without causing extensive disfigurement?
Conclusion
- Many skin findings are associated with HIV
- The prevalence of HIV is still high even as the incidence has waned
- Dermatologists should be aware of HIV associated skin conditions and consider HIV testing when there is suspicion of infection

HELP WANTED

NorthEast Dermatology, part of Carolinas HealthCare System is actively seeking a BC/BE General Dermatologist to join their thriving practice just 20 minutes north of Uptown Charlotte in Concord, NC. Candidates should have interest in general dermatology, surgical and cosmetic procedures and laser treatments.

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