Message from the President

Colleagues,

As we all get into the holiday spirit it’s worth looking back at the accomplishments of the AOCD in 2018.

We joined a broad coalition of dermatology societies including the AAD and ASDS in speaking out against the CMS proposal to slash our modifier 25 reimbursements. This was a huge victory not just for dermatology but for all of medicine.

Thanks to the hard work of our Executive Director Marsha Wise we were able to achieve ACCME status so that we can provide CME to DOs and MDs. This gives us the opportunity to grow our college in the future.

Finally, we voted to continue funding for our disease database app “Doctor Derm”. In February of 2018 Cutis reviewed 44 dermatology apps and our AOCD App was rated #1! Our college owes a debt of gratitude to Jere Mammino for creating and sustaining this AOCD jewel!

So enjoy your holidays as we celebrate the bright future of our AOCD!

Daniel Ladd, DO, FAOCD
President, American Osteopathic College of Dermatology

Executive Director’s Report
by Marsha Wise, Executive Director

Hello Everyone,

The holidays are upon us. Where did 2018 go? We hope you and your families have time to enjoy the season and make lasting memories. It was a busy summer and fall for the Wise family. Trips to the St. Louis Arch, Grant’s Farm and Harvestville Pumpkin Patch were all accomplished.

The end of the year also means it is time to renew AOCD dues. We appreciate your continued support, which enables us to provide quality CME programs for you. Look for new member services available through our website in the new year. We will also be updating the Doctor Derm app. We will let you know when it is available to view.

Many of you are asking if you must continue to pay AOA dues. As of November 1, 2018, the answer is yes; HOWEVER, continue to monitor your email for updated announcements on this. It is my understanding that an announcement will be made by the AOA in the next few months.

Our Fall Meeting is well behind us! Look for results from meetings surveys to be posted soon. We are looking to the future and the new year now. Our 2019 Spring Meeting, scheduled for April 11-13 in Orlando, is posted on our website. Check it out!
Save The Dates!!

Fall 2019
September 24-28, 2019
Omni Nashville Hotel
250 5th Ave. South
Nashville, TN 37203
Phone: 615-782-5300

Online Reservations
$294.00 per night plus tax.
Reservations must be booked by Aug. 26, 2019

Spring 2020
February 17-22, 2020
Hilton West Palm Beach
600 Okeechobee Blvd.
West Palm Beach, FL 33401
Phone: 561-231-6000

Online Reservations
$299.00 per night plus tax.
Reservations must be booked by Jan. 23, 2020

Fall 2020
October 8-11, 2020
Hyatt Centric Magnificent Mile
633 N St. Clair St
Chicago, IL 60611
Phone: 312-787-1234

Online Reservations
$299.00 per night plus tax
Reservations must be made by: Sept. 17, 2020

Spring 2021
February 22-27, 2021
Hilton West Palm Beach
600 Okeechobee Blvd.
West Palm Beach, FL 33401
Phone: 561-231-6000

Online Reservations
$299.00 per night plus tax.
Reservations must be booked by Jan. 28, 2021

Fall 2021
October 7-10, 2021
The Westin Denver Downtown
1672 Lawrence St.
Denver, CO 80202
Phone: 888-627-8435

Online Reservations
$239.00 per night plus tax
Reservations must be booked by Sept. 16, 2021

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 AOCD and The Shade Project pilot program is now available to the AOCD membership.

MELANOMA RESOURCE BOXES are a service you can provide to your newly diagnosed melanoma patients.

Resource boxes include:
1. A letter from The Shade Project providing support
2. National skin cancer resources
3. Sun safety information
4. Skin check reminders
5. Sunscreen samples
6. UV band
7. Lip balm
8. UV detector keychain
9. Coupons for sun safety items

Cost: $200 per year which is $16 per month. This provides 16 Melanoma Resource Boxes for patients. More boxes can be ordered from The Shade Project as needed. Contact: Diane Morgan, Executive Director / The Shade Project at 512-924-9543 or email Diane@theshadeproject.org
Patients expect their personal information to be kept private. In the retail world, customers expect their credit card and banking information to be kept private. There are Federal laws protecting these rights of patients and customers (see AOCD’s Privacy Policy on page 4).

What about rights and laws pertaining to the employment sector? Did you know employers are REQUIRED to post notices for employees to read regarding their employment?

Are you displaying the proper employment posters for your employees?

**Posters Required by the Federal Government:**
- Employee Polygraph Protection Act (WHD 1462)
- Employee Rights under NLRA
- Equal Employment Opportunity is the Law (EEOC-P/E-1)
- Fair Labor Standards Act: Minimum Wage (WHD 1088)
- Family and Medical Leave Act (WHD 1420)
- Job Safety and Health: It’s the Law Poster (OSHA 3165-12-06R)
- Uniformed Services Employment and Reemployment Rights Act
- Notice to Workers Concerning Unemployment Benefits (MODES-B-2)
- Workers’ Compensation Law (WC-106)
- Discrimination in Employment (MCHR-9)
- Missouri Minimum Wage Law (LS-52)
- Employer’s Employment Workers Under the Age of 16 List (LS-43)
- Discrimination in Housing (MCHR-6)
- Discrimination in Public Accommodations (MCHR-7)
- Notice to Workers Concerning Unemployment Benefits (MODES-B-2)

**FOR EXAMPLE, Posters Required by the State of Missouri:**
- Notice to Workers Concerning Unemployment Benefits (MODES-B-2)
- Workers’ Compensation Law (WC-106)
- Discrimination in Employment (MCHR-9)
- Missouri Minimum Wage Law (LS-52)
- Employer’s Employment Workers Under the Age of 16 List (LS-43)
- Discrimination in Housing (MCHR-6)
- Discrimination in Public Accommodations (MCHR-7)
- Notice to Workers Concerning Unemployment Benefits (MODES-B-2)

Is your office I-9 Compliant?
Since 1986, employers have been required by law to verify the identity and employment eligibility of employees. Did you know improper reporting and storage of these forms can lead to hefty fines?

- I-9 Violations Can Be Costly for Employers
  - “Employers are required by law to maintain for inspection original Forms I-9 for all current employees. In the case of former employees, retention of Forms I-9 are required for a period of at least three years from the date of hire or for one year after the employee is no longer employed, whichever is longer.”

  - “Form I-9 contains personal information about employees. When storing these forms (regardless of the format you choose), USCIS
Employee Handbooks
Finally, can your office employee handbook pass muster? Wait? What?? Your office doesn’t have one???

While there really aren’t any laws that say one is required, they are considered “Best Practice” and will help and protect you, the employer in the long run.


There are plenty of websites that can help with building an employee handbook. The Society for Human Resource Management offers a template and guide on their site.

“With state-specific filters and customizable fields offering pre-populated staff policies and procedures, the platform’s drag-and-drop, step-by-step interface is simple to use. The everyday policies offered in the SHRM Employee Handbook Builder reflect the latest federal and state workplace compliance guidance, as vetted by the platform’s legal partner, Jackson Lewis.”

Are you still wanting more information? National Seminars Training (NST) offers seminars, both live in your area, or on demand and a variety of subjects.

A company called Insperity also offers a software package called “Policies Now” that can help you build an employee handbook.

I hope this information has been helpful. Each employer is unique. Check your state’s requirements to be sure you are following the law when it comes to employment matters.

AOCD Privacy Policy
The American Osteopathic College of Dermatology (AOCD) is committed to maintaining the privacy of the personal information of visitors to its site, including AOCD members. We will never sell members’ personal information, including addresses, telephone numbers, and email addresses. Our policies are designed to disclose the information collected and how it will be used. The terms of the privacy policy do not govern personal information furnished through any means other than this website (such as by telephone or mail). We will make every attempt to only provide professional office addresses of our members, since these can be obtained through internet searches.

Email Address and Other Personal Information
Personal information such as postal and email addresses that you provide to the AOCD through our website may be used internally for maintaining member records, marketing purposes and alerting customers or members of additional services available. Such information may also be provided to selected vendors that AOCD believes may have products or services of interest to our members. Phone numbers that you provide may also be used by the AOCD when questions about products or services arise. Registered site members have the ability to conduct a “Member Search” to obtain contact information of fellow members. Members may adjust settings in the “Edit Bio” area of the website to dictate which portions of their contact information should be available in the “Member Search” area.

CME Activity Information
As part of our CME Program, we collect information to maintain a record of participation. We collect personal information, including your name, phone number and email address. We also collect responses to quizzes and tests to assess your understanding and performance. We may also collect information to assess the effectiveness of our programs, such as your achievement of the learning objectives, changes you plan to implement in your practice and your feedback on the course content and speakers.

Information Shared with Third Parties
We may share some of your identifiable CME data with AOCD-approved Third Parties of the CME Program. If you register for programs and request credit, we share your CME data with the Third Parties responsible for administering those activities. Your information may be shared with:
- Accrediting bodies external from the AOCD for which you seek credit.
- Credit card processing Third Party vendors for payment of registration fees.
- Any Maintenance of Certification program for which you register.
- Other service providers, if you wish to receive credit, with your permission.

Links
This site may contain links to other sites. The AOCD is not responsible for the privacy practices or content of such websites. Should you follow a link to another site, you are encouraged to review the privacy policy applicable to that website.

AOCD Dermatologists Named Top Doctors by Regional Publications
Recently, AOCD member physicians were were named “Top Doctors” in their regions.

5820, a publication covering the Denver area named Dr. Gregory Papadeas one of the area’s top dermatologists. Similarly, Drs. Alpesh Desai and Tejas Desai were named top dermatologists in the Houston area by Houstonia.
Hello everyone,

It was great to see all of you who were able to attend the Fall Meeting in San Diego. I hope you found value in the lectures presented and enjoyed your time on the west coast.

**2019 Resident Membership Renewal**

With a new membership year approaching, it’s not too early to begin thinking about renewing your annual dues. These can be paid online through your member account at [www.aocd.org](http://www.aocd.org), using these five easy steps:

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

**2019 Spring Meeting 2nd Year Resident Posters**

Residents are required to submit a poster during the second year of training at the Spring Meeting. This year, posters are due February 27, 2019. Completed [poster submission forms](#) must accompany your poster. A few things to keep in mind when preparing your poster:

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

- The poster is to be submitted to the AOCD electronically as a Powerpoint file. You do not need to print a copy of the poster to bring to the meeting.

**2019 Dermatology Grand Rounds Schedule**

Each residency program is required to provide a case for the Grand Rounds website. [Click here to visit the Dermatology Grand Rounds](#) on our website. Please contact me for the sign-on information to submit a case. The 2019 schedule is as follows:

- **January 5, 2019**
  - OPTI-West/Chino Valley Medical Center
- **February 5, 2019**
  - Still OPTI/Northeast Regional Medical Center
- **March 5, 2019**
  - PCOM/Lehigh Valley Health Network
- **April 5, 2019**
  - SCS/MSUCOM/Botsford Hospital
- **May 5, 2019**
  - LECOMT/Larkin Community Hospital Palm Springs Campus
  - CEMEPalm Beach Consortium for GME
- **June 5, 2019**
  - NYCOMECS/T. Barnabas Hospital
- **July 5, 2019**
  - NSUCOM/Largo Medical Center
- **August 5, 2019**
  - PCOM/North Fulton Hospital Medical Campus
  - OMNEESampson Regional Medical Center
- **September 5, 2019**
  - MWU/OPTI/Advanced Desert Dermatology
  - MWU/OPTI/Affiliated Dermatology
- **October 5, 2019**
  - Texas OPTI/Bay Area Corpus Christi Medical Center
- **November 5, 2019**
  - OPTI-West/Aspen Dermatology
- **December 5, 2019**
  - OMNEELewisGale Hospital – Montgomery
  - OPTI-West/Silver Falls Dermatology

I hope everyone enjoys a happy and safe holiday season with family and friends. I look forward to seeing you in 2019 for the Spring Meeting in Orlando.
Dear colleagues,

Greetings from your new resident liaison! Congratulations to all our 2018 graduates and those who completed their board certifying examinations! And secondly, a big congratulations to all our first year residents in their respective programs! It is hard to believe we are already halfway through the academic year. I hope everyone has a restful and enjoyable holiday season.

Here are some updates for the coming year:

**AAD Annual Meeting**
The AAD annual meeting will be held in Washington, D.C. from March 1-5, 2019. Discounted registration is currently open for residents and fellows for $225. This will be offered until January 23 so take advantage of the early bird special! After this time, standard fees will be $290. Registration and general information about the meeting can be found directly on the AAD website.[1]

**AOCD Spring Current Concepts**
The annual AOCD meeting will take place from April 9-13, 2019 at the JW Marriott Orlando Grande Lakes Hotel in sunny Florida! All information regarding accommodations, agenda, housing, and travel can be found on the AOCD website here. Should you have any questions please feel free to reach out to me directly.

**ABD’s Examination of the Future**
This past academic year, first year residents participated in the BASIC examination as part of the new structure for certification through the ABD. Those in programs that are ACGME accredited or are planning to become accredited will be eligible for the BASIC/CORE examinations again this year. In 2019 the BASIC examination for first year residents will be April 11. The CORE examination will be administered on March 28 for second year residents. Remote proctoring will be offered for second year residents. Several dates will be available for third year residents to take the online practice examination from March 11-March 29. Please find a comprehensive overview of the examination and the new certification pathway here.

If you have any comments, questions, or concerns, please feel free to email me at the AOCD resident liaison email account: aocdresident.connection@gmail.com. Have a wonderful rest of the year and a great start to the new one. I look forward to seeing you all at the upcoming meetings!

---

[1] 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 (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.

Visit Our Booth to learn more about Taltz
Corporate Sponsors Support 2018 AOCD Fall Meeting, San Diego

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 2018 AOCD Fall Meeting. The AOCD is very fortunate to have corporate sponsors who join us as partners with a commitment to medical excellence. Our corporate sponsors remain committed to the College and continuing medical education. 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 Laboratories, Pfizer (Diamond Level)
- Lilly USA, LLC (Platinum Level)
- AbbVie, Ortho Dermatologics (Gold Level)
- Aclaris Therapeutics, Allergan (Bronze Level)
- Dermpath Diagnostics, Novartis, Sun Pharma Dermatology (Pearl Level)

We would like to thank Tim Bentley and Aclaris Therapeutics for sponsoring the meeting lanyards. Thank you to Galderma Laboratories, Ortho Dermatologics, and Sun Pharma Dermatology for meeting grants. The AOCD also appreciates Pfizer, Aclaris Therapeutics, Lilly USA, LLC, and Regeneron and Sanofi Genzyme for providing product theaters for our physicians.

Exhibitors for the 2018 Fall Meeting were as follows: Abbvie, Aclaris Therapeutics, Aqua Pharmacueticals, Aurora Diagnostics, Bayer Healthcare, Biofrontera Inc., Brymill, Celgene, Dermpath Diagnostics, Dermatologists of Central State, Encore Dermatology, Galderma Laboratories, Lilly USA LLC, Neutrogena/Aveeno, Novartis, Ortho Dermatologics, Pfizer, Promius Pharma, Propath, Regeneron and Sanofi Genzyme, Skincure Oncology, Sun Pharma Dermatology, The Shade Project, Eclipse Rx, Xstrahl Inc.

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

Thank you to all who participated in our Fall meeting in San Diego and for being such great troopers when it came to the distractions outside.

A Note From Jose Garcia and Kurt Freese of Regeneron and Sanofi Genzyme

Good morning Shelley,

I hope this finds you well! I just wanted to say thank you for the hospitality and for allowing us the opportunity to support the AOCD conference October 11-13 in San Diego! Jose and I enjoyed meeting you and your team at the conference and look forward to working together in the future.

2018 AOCD Fall Meeting Highlights

By Angela Stepien, DO & Laura Jordan, DO

Bloodroot and Essential Oils: What You Need to Know

Derrick Adams, DO, FAOCD

- Essential Oils (EO)
  - Claim of “5 Cancer Fighting Essential Oils”
  - Celebrated online because it sells
  - Has not been evaluated by FDA, warning states: “These statements have not been evaluated by the Food and Drug Administration. This product is not intended to diagnose, treat, cure or prevent any disease.”
  - DSHEA, 1994: Dietary Supplement Health and Education Act
  - Draws a line in sand for FDA not to cross
- Basically says supplements are generally harmless
- Backed by Utah Senator Hatch
- John McCain proposed a new act in 2010
- All these result in the warning we have now
• DSHEA dramatically increased the availability to use essential oils
• FDA or FTC has no definitions
• “Essence” vs “Essential”
• Oils we already use
  • Menthol, methyl salicylates, camphor
  • Mouthwash, food flavoring, vapor rub, analgesic muscle creams, “medicated” lip balm, tea tree shampoo, lavender moisturizer
• PubMed listing for EO’s and Specific conditions include:
  • Psoriasis, seborrhea, tinea, antimicrobial, etc
• Some essential oils do have antimicrobial properties but making the jump to human use is extrapolation
• Melaleuca alternifolia (Tea tree)
  • Reported benefits
    • Acne, dryness, pruritis, re-epithelization, dandruff, anti-inflammatory, decolonization of MRSA
    • Standardized by international organization (ISO)
    • Tea tree oil as a sensitizer
    • 2% of population has sensitivity to tea tree oil
• Lavender oil
  • Reported benefits
    • Decreased pain during dialysis, wound healing; measured TGF, re-epithelization, hair growth promoting effects
    • Can cause gynecomastia and per endocrine society can act as an endocrine disrupter, has estrogenic and antiandrogenetic effects
• Lemon oil
  • No evidence in humans of antimicrobial effects
• Eucalyptus oil
  • Reported benefits
    • Increases penetration of hydrocortisone, chlorhexidine, 5FU
    • Sunscreen
      • 10 essential oils with natural SPF
      • Carrot seed oil SPF 38-40, from India, contains a lot of zinc oxide
      • Others: raspberry seed oil (SPF 28-50), wheatgerm oil (SPF 20), avocado oil (SPF 4-15), coconut oil (SPF 2-8), Olive oil (SPF 2-8), macadamia nut oil (SPF 6), almond oil (SPF 5), shea butter (SPF 3-6), jojoba oil (SPF 4)
    • MOA: EO is good at mimicking melanogenesis – this study was not done humans
• Peppermint oil
• OTC itch creams and topical analgesics
• Oil of wintergreen
  • Pain relief, improve digestion, antiseptic
  • Metabolizes into salicylate
  • 1 tsp = twenty 300mg aspirin tablets
• Frankincense and cancer?
  • Studies
    • Pancreatic cancer, cultured human breast cells, but these are all in vitro studies
    • All done Open Access, BMC studies
    • PMC feeds into PubMed but not in Medline (give Medline more weight)
  • Side effects of topical essential oils
  • Death, gynecomastia, allergic or irritant dermatitis
  • Center for poison control warning
    • “If, for some reason, you have bottles of essential oils at home, consider discarding them (safely) if you have young children. Otherwise, they MUST be locked up, out of sight and reach of children and pets – all the time.”
  • Can have phototoxic and photosensitive reactions
• So, do topical EO’s work?
  • Society is rooting for them
  • They work but depends on how you ask the question
  • Uncomplicated tinea, seborrhea, etc. work OTC
  • Effects are wildly exaggerated
  • Commercial EO companies: advocate caution
  • EO claims and comparable to OTCs? “Comparable” not sure what the jargon actually means
  • There are issues with conflicting mechanisms of the essential oils between companies
• EO marketing
  • Appeal to antiquity
    • Referring to Egyptian times, etc.
    • This doesn’t mean something, if someone used something a long time ago doesn’t mean it works
• History of Escharotic Agents
  • Bloodroot, zinc chloride black salve, Hoxsey’s paste, mohs paste, etc
  • Quackwatch.com: exposes inappropriate treatments
  • Black salve use leads to delayed diagnosis and ultimately massive reconstructive surgery
• History of EAs
  • Zinc chloride and bloodroot (popular around 200 years ago)
  • Harry Hoxsey - naturopath, claimed he could cure 80% of cancers, black salve, still open in Mexico
  • Mohs paste: 40gm stibnite, 10gm sanguinaria canadenesis (blood root), 34.5ml of saturated zinc chloride solution
  • ENTs in Japan use bloodroot
  • Dr. Norman Brooks, Dr. Leslee Brooks still use mohs paste, zinc chloride
  • Anti melanoma effects? 1998 study increased resistance in tumor challenge in murine melanoma model

Medical Dermatology Update
Francisca Kartono, DO, FAOCD
• Prevention: effective skin emollients since birth may prevent exposure to atopic dermatitis (AD) triggers, bacteria, microbes: 50% reduction in risk by 6-8 months of age
• BEEP trial (2017)
• When to initiate systemics: international eczema council
  • No scoring system alone to determine systemic therapy, need to exclude infections and contact allergens
• Phototherapy
• Dupilumab
  • No labs needed to monitor, eye symptoms
  • Other systemics
    • Need labs and understand risks
• Under age 1 with severe eczema
  • This group has high risk for peanut allergy (NIAID)
• LEAP study
  • Peanut consumption led to 81% relative reduction in likelihood of allergy
• FLG is found only in 15-46% of AD patients
• Meta-analysis: no good association between AD and cardiovascular risk disease
  • AD is not an independent predictor of CVD
• Systemic biomarkers: cyclosporine
  • Non-lesional skin already has abnormal cytokine profile
• Dupilumab, azathioprine, methotrexate, cyclosporine, Cellcept all can be used
• Side effects of Dupilumab
  • Conjunctivitis (15%) and injection site reactions (14%)
  • Scarring ectropion
  • Worsening psoriasis (JAAD case report)
  • No increased risk of malignancy, decreased skin infection
• National Eczema
  • Clinical trials of multiple biologics
• Psoriasis
  • Systemic disease
  • Overwhelming choice of biologics now
  • Need to consider special populations
    • Each psoriasis year means 1% increase in CV event risk (for pediatric patients)
    • RR of MI – highest risk is in young patients, more attenuated as you get older
  • VIP-U study with Ustekinumab presented at Annual AAD 2018 showed more promising results
• Biologics decrease overall inflammation burden vs MTX shows cardioprotective effect but long-term risks end organ damage
• Target for psoriasis treatment
  • Published in JAAD
  • Goal is within three months of aggressive treatment, we want to reach BSA of 1%
• Discuss expectations with patients
• National Psoriasis Foundation (NPF) is best advocacy network
• They have patient navigators
• Psoriasis.org/pocket-guide
  • Free teaching tool, good for residents
• 50% of patients with psoriasis are undertreated
• Oral molecules
  • Healthy patients with psoriasis: Adults, pediatric, pregnant
  • Complex patients with psoriasis
    • CV risk patients
    • Apemilast, MTX
    • AI patient
    • Apemilast, MTX, cyclosporine
  • Cancer and immunosuppressed
    • Acetretin
  • Certolizumab
  • Safest in pregnancy
  • Placental transfer of TNF inhibitors – transition
• Hidradenitis suppurativa
  • Underdiagnosed
  • Up to 4% of population affected
  • Mean delay in established diagnosis is seven years
  • Only one in five patients see a dermatologist
• HURLEY staging
• Comorbidities
  • Metabolic syndromes, smoking, PCOS, depression, substance abuse
• Syndromic HS
  • Trisomy 21, Crohns
  • Increased NMSC risk in perineal or gluteal HS
• Non-surgical treatment of NMSC
  • Electronic brachytherapy (eBx)
    • About <1% failure rate (recurrence)
    • Since 2009 been used on NMSC
    • Inclusion and exclusion on clinicaltrails.gov
    • Clinical trials so far are still looking at five year out data, educate patients
• Photomedicine
  • 10% solution versus gel
• PDT code updates
• Photolyase sunscreens better at reducing p53 expression and Ki67
• Spanish study
  • UV block was almost instant upon sunscreen application
  • Peaked and stabilized after ten minutes of application
• Polypodium leucotomos
  • Photoprotective effect against NBUVB
  • JAAD 2017
• OTC 240-480 mg, titrate up to 960mg if PMLE, vitiligo, or melasma

Sports Dermatology
Michael J. Scott, III, DO, FAOCD

• Boxing
  • Nose bleeds, cuts around nose and mouth
  • Doctors have authority to stop the fights
• Contact dermatitis in gloves (red dye)
  • Linear shaped lesions
  • Erythematous linear lesions
  • Common, if active lesion cannot compete that day
• Acne keloidalalis
  • Pustules and acne keloids from friction and pressure of head gear, difficult to treat at times
• Herpes simplex
  • Common, if active lesion cannot compete that day
• Acne keloidalalis
  • Pustules and acne keloids from friction and pressure of head gear, difficult to treat at times
• Tinea corporis
  • Can have advanced cases
• Fencing
  • Note sidedness of feet and hands, hard to defend the side of neck, 1 death reported
  • Erythematous linear lesions
  • Body and shoulders from saber sword through gear
• Nodular lesions on ventral wrist from sword
• Ecchymosis from sword impact, areas are prominent on dominant side
• Swords can go through the foot through the shoe
• Cycling
• Cement and wood tracks create abrasions from falls
• Swimming
• Most injuries are from warm ups
• Synchronized swimming
• Contact dermatitis due to gels used for hair, tinea
• Marathon
• Tight shoes
• Erythematous areas from pressure on heels
• Blisters and scarring
• Herniation of fat on the peel, papules
• Trapshooting
• Skin lesions from how they hold the guns made of wood with oil and vanish
• How the gun rests on their face causes dermatitis
• Can have atrophic skin on face
• Pistol and rifle shooters
• Grips made of wood cause dermatitis
• Weightlifting
• Talc for grip, a lot of calluses between webs and thumb and index fingers
• Hooking thumb leads to lesions – erosions and fissuring of thumb
• Pressure of bar across the neck and legs – superficial ulceration and scarring, also no hair on thighs from friction
• Petechial hemorrhages on heels
• Contact dermatitis on feet
• Anabolic androgenic steroid use – acne lesions on chest and back with muscular build
• Baseball
• Ecchymosis around the eyes, need to worry about orbital fractures
• Scuba diving
• Granulomatous like lesions from sea urchin spikes
• Can go through wet suit, get embedded in skin and break off
• X-rays or soft tissue images to see where they are
• Table tennis
• The balls hit skin and indent, so you only see the rim from the ball
• Subungual hematomas, scleral hematomas

Pediatric Dermatology: Vascular Tumors and Malformations

Joan Tamburro, DO, FAOCD

• Infantile hemangiomas (IH)
  • Propranolol helps us understand the mechanisms.
  • Vasoconstriction
  • Beta receptors blocked by propranolol inhibit vasodilation by adrenaline and cause vasoconstriction
  • Inhibition of angiogenesis
  • Induction of apoptosis by disengaging the inhibition of apoptosis
  • More than half of children with untreated IH experience residual changes that will need some further treatment
  • Use treatment early, use wisely, not for every IH, be detailed in expected goals, as always…think, how can we use it locally and not as a systemic medication
  • Proliferative phase
  • Rapid growth is prior to eight weeks of life
  • Propranolol is approved for five weeks and older
  • The time between their first pediatric appointment and the second can be crucial
  • Which IH need to be treated?
  • Stratifying risks, prognostic growth, weeks of life to evaluate
  • Risk stratification
  • Very high risk – Segmental face or perineal, PHACE, PELVIS
  • High risk – Bulky lesions face, central face, periorbital, oral and nasal, early white discoloration (close to ulceration)
  • Moderate risk – Lateral face, scalp, hand and feet, body folds, segmental greater than 5cm trunk and extremities
  • Low risk – Small red, superficial, scattered anywhere
  • Astigmatisms with the eye involvement
  • Propranolol
  • 2014 FDA approval
  • 0.6mg/kg/dose bid x 1, then increase to 1.1, then 1.7 ongoing
  • Doses are at least 9 hours apart.
  • Treat for 6 months
  • Monitor heart rate and BP for two hours after initial dose and when increasing dose
  • Contraindications

Propranolol is approved for five weeks and older. The time between their first pediatric appointment and the second can be crucial.

Which IH need to be treated?

• Stratifying risks, prognostic growth, weeks of life to evaluate
• Risk stratification
• Very high risk – Segmental face or perineal, PHACE, PELVIS
• High risk – Bulky lesions face, central face, periorbital, oral and nasal, early white discoloration (close to ulceration)
• Moderate risk – Lateral face, scalp, hand and feet, body folds, segmental greater than 5cm trunk and extremities
• Low risk – Small red, superficial, scattered anywhere
• Astigmatisms with the eye involvement

Propranolol

• 2014 FDA approval
• 0.6mg/kg/dose bid x 1, then increase to 1.1, then 1.7 ongoing
• Doses are at least 9 hours apart.
• Treat for 6 months
• Monitor heart rate and BP for two hours after initial dose and when increasing dose
• Contraindications

On January 1, 2019, new OCC plans go into effect
• AOA physician portal
• Register for OCC through the AOBID
• MIPS
For eczema-prone skin

TWO ADVANCED TECHNOLOGIES.

HYDRATE

ONE REPLENISHING REGIMEN.

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

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


cetaphil.com

© 2013 Galderma Laboratories, L.P. All rights reserved.

Cetaphil RestoraDerm®
• Corrected age less 5 weeks
• Weighing less than 2 kg
• Hypersensitivity
• Asthma or history of bronchospasm
• Pheochromocytoma

Side effects
• Less than three months: Concerned about blood sugars, in general need to be fed before dosing, if not or vomiting then hold dose
• Hyperkalemia, dental caries, sleep disturbance is number one side effect
• Atenolol
  • Hydrophilic selective beta 1 antagonist
  • Decreases chance of passing through blood brain barrier
  • Decreased pulmonary effects
  • Decreased chance of lower endogenous catecholamines which can correct hypoglycemia
• Standardized clinical assessment and management plan (SCAMP)
  • ECG, HR, BP
    • Start at 0.25mg/kg dose in office and do HR and BP two and four hours later, if tolerated then sent home with 0.25mg/kg/dose bid
    • After one week, increase to 0.5 and keep that dose to follow-up in 6-8 weeks
    • If patient is greater than 6 months and = or = 6.5 kg may go to qday dosing
    • Between 8 and 12 months you can let their weight wean them, try to wean in general starting at 12-15 months
• Side effects
  • Hypotension, sleep, constipation, diarrhea, can leave fine telangiectasias, let go to 3-4 years old then consider laser
    • At this time “they will be what they are going to be”
  • Lip common place if regrowth occurs after treatment – past 18 months
• Topical beta blocker
  • Timolol not FDA approved but articles to support
  • Best response in superficial and early
  • Check for corrected age and weight
  • Use it early, use it wisely, be detailed in expected goals (IH will grow up to 3 months)
• Vascular anomalies
  • Capillary, venous, lymphatic, AV
  • The answer is in the genes, as they are related to mosaic genetic disorders
  • GNAQ and GNA11
  • Capillary malformations, Sturge-Weber syndrome
  • Can cause isolated port-wine
• Sirolimus
  • Original development was for fungal infections
  • Mechanism of action binds cytosolic protein at FKBP12 which inhibits the mTOR which protein synthesis therefore proliferation
  • Brimonidine, timolol, Talaporfin all used
• PIK3CA, Glomulin common venous malformations
  • PIK3CA provides instruction for proliferation and movement
• Sirolimus
  • BYL719 (Alpelisib) works on mTOR pathway
• Propranolol
• PIK3CA – Lymphatic malformations, will grow with hormonal therapy or pregnancy, Sirolimus, Sildenafil (some studies say helpful)
• RASA1 – AV malformations, RASA1 helps regulate the RAS/MAPK signaling pathway, Sirolimus, Bevacizumab
• ISSVA classification for vascular anomalies

Burn and Traumatic Scar Rehabilitation: The New Standard
Nathan Uebelhoer, DO

• Ablative high energy fractional lasers: Erbium and CO2
  • Spot <400microns (um), pulse width (PW) <1msec, high energy, very low density
  • Very thin beam size, and wide density for rehabilitation of scars compared to cosmetic technique
  • Deeper laser but thin pulse improves ROM due to improvement of pliability to scar and skin around the scars
  • Collagen ratio becomes more like normal tissue on histologic level
  • Other lasers work for the scar but ablative helps with function and ROM
  • High energy, high density lasers will leave scars
  • Quick pulses to avoid scar and limited collateral damage
  • Can treat anywhere during maturation of burns/scars (months to years)
  • Can be used in pregnancy
  • Z-plasty within a scar can minimize tension
  • Can do combined same day laser and surgical contracture revision safely
  • Also has improvement in ulcers within scars which are at times chronic
  • Can use lower energy when going through the ulcerated area (i.e. 15mJ)
• Surgical wound post grafts
  • Laser was used to close
  • Mohs for Merkel cell on nose with large defect with paramedian forehead flap
  • 1-week post-surgery and then every 2 weeks with single pass
  • Used in keloids as well as hypertrophic scars
  • Cut the thickened scar and take scar out of the inside (to thin it) and then laser, then do Z-plasty
  • Helps with functionality
  • Goal is to rehabilitate the scar not eradicate
• T4097 code
Ancillary Diagnostic Tools in Dermatopathology
Nathan Cleaver, DO, FAOCD & Amy Spizuoco, DO, FAOCD

- Testing based on aberrations in cellular DNA material
  - CGH, FISH, genetic testing CDKN2A, BRAF
- Large scale
  - Amplifications, deletions
- Small scale
  - Point mutations
- Comparative genomic hybridization (CGH)
  - Screens the entire genome for gains and losses in DNA material
  - Pro: Can detect chromosomal abnormalities in affected tissue
  - Cons: False negative if tumor cells are not adequately sampled, unable to detect point mutations
- In melanoma
  - Loss of 9q, 10, and gains in 7
  - Regions containing oncogenes (BRAF and MITF) are frequently amplified while regions containing tumor suppressor genes are deleted
  - Compared to melanoma, most nevi lack or have isolated genomic aberrations
  - Spitz nevi exhibit gains in chromosome 11p
- Fluorescence in situ hybridization (FISH)
  - More specific than CGH
  - Pros: Detect point mutation, technical expertise less than CGH, may distinguish spitzoid nevi and spitz nevi
  - Cons: Can have false positive due to tetraploidy, some dysplastic nevi are positive, largely replaced by microarray
- BRAF
  - 50% of MM have this mutation
  - V600E most common
- CDK2NA
  - Strong family history associated with this mutation (FAMMM syndrome)
- Testing based on gene expression
  - Melanoma diagnosis
    - Main reason for test is prognosis
    - 31 gene expression profile test
    - Classifies patients as high or low risk (binary)
    - Must have 40% tumor density to perform
    - Cannot be performed on MIS
    - Results: Will give you results based on probability score. 1a-2b
- Myriad MyPath
  - Used for diagnosis
  - Use when cannot distinguish nevi from melanoma histologically
  - Aid for diagnostically challenging melanocytic neoplasms
- Epidermal Genetic Information Retrieval (EGIR)
  - “Tape stripping”
  - DermTech, Inc.
    - Pigmented lesion assay
    - Noninvasive adhesive patch biopsy
    - LINC50018/PRAME
    - Lesions followed for change, cosmetically sensitive areas, patients with potential risks
    - New 2019 CPT codes
    - Will not be a covered biopsy procedure
- Reflectance confocal microscopy (RCM)
  - Creates images by illuminating the skin with a low power laser, etc.
  - Does not go deeper than reticular dermis
  - Start to finish is 5-10 minutes
  - On RCM, dysplastic nevi have primarily ring-meshwork pattern with 1-2 atypical features
  - Melanoma often has greater than 2 atypical features on RCM
- MelaFIND
  - Multispectral computer vision system
  - Higher sensitivity/specificity than clinician (per company)
  - Binary output
    - Positive = Consider biopsy
    - Negative = Observe
    - Used light in 10 wavelengths from 430nm (blue) to 950nm (red)
    - Depth of 2.5 mm
    - 20-micron resolution

Proelia in Umbra: What We Can Learn From U.S. Navy Dermatologists
Thomas Barlow, DO

- 33 active duty dermatologists in Navy and 17 currently in residency
- Pay is half as much as community
- Training pipeline
  - Internship then general medical officer tour (surface warfare, fleet marine forces, flight surgeon, dive medical officer), residency, utilization tour, fellowship
- Safety of epinephrine in digital nerve blocks
  - Study from 2015
  - No evidence it causes digital necrosis
  - Most cases are not attributed to epinephrine
  - 40-50% of complaints from desert are dermatologic (i.e. Iraq)
- Leishmaniasis caused by phlebotomous sand flies
Discount travel and hotel room rates for American Osteopathic College of Dermatology Members that are up to 70% lower than any other public online travel website or hotel website at over 800,000 Participating Hotels and Resorts Worldwide.

**Guaranteed, as a part of being a valued member!**

In an effort to offer more value for our members, American Osteopathic College of Dermatology has secured preferred access to a discount travel booking site that offers our subscribers exclusive hotel room rates that are up to 70% lower than any other public online travel website or hotel website.

This travel booking website has over 800,000 hotels to choose from and the online search & booking process is identical to all the other popular travel websites so you can book with ease and absolute confidence that you’re getting the lowest possible rates. In addition to hotels, you can also book discounted flights, vacation rentals, cars, and entertainment tickets.

Individual registration to access this booking site is fast and easy only requiring a user name, password, and valid email address.

**Click here now to register** [https://www.bookingcommunity.com/aocd/](https://www.bookingcommunity.com/aocd/)

We are so thrilled to be able to offer this very unique and valuable benefit to American Osteopathic College of Dermatology Members! We hope you take full advantage of it for all your travel needs.
• Codes for lasers are in trial
• Currently reimbursing $250 per treatment if they are covered
• Importance of telederm
• Dermatologic care in developing countries
• Dermatologic complaints make up 6-23% of organ-specific reasons for visiting primary care
• In Fiji, 18.5-32% school children have scabies
• Two recurring missions each year
  • USNS Comfort T-AH 20 out of Norfolk, VA
    • Serves Latin America and Caribbean
  • USNS Mercy T-AH 19 out of San Diego, CA
    • Serves Indo-Asia-Pacific region
• Hospital ships
  • 12 operating rooms, ablative fractionated laser, ICUs, etc.
  • Services at two mobile medical sites
• The US adult population perceives that dermatologists spend more time on cosmetic procedures than the actual work force data supports
• Stay current on the diagnoses you don’t see everyday

2018 Psoriasis Therapy Update
Bradley Glick, DO, FAOCD

• Chronic, systemic, immune-mediated disorder with a polygenic predisposition induced by environmental triggers
• IL-22 correlates with disease severity
• Chemokines will be target of future therapies
• Therapy
  • Topical, UV/lasers, systemic, biologics
  • There are limitations of systemic therapy due to co-morbidities and context of patient’s health
  • Palmoplantar is more IL-6 disease
  • Apremilast is good entry way start drug
  • Need to discuss depression with patients
• IL-17 inhibitor side effects
  • IBD, candidiasis, neutropenia, if family history of IBD
• Piclidisonon
  • A3 adenosine receptor agonist which down regulates cytokines
• Biosimilars inflectra and Ixifi
  • Safety? Time will tell
• Psoriatic arthritis
  • Four biologics approved in 2017
• Treatments on the horizon
  • JAK inhibitor oral agents
  • BMS-986165
• Selective tyrosine kinase 2 inhibitor in phase 2 trials
• LAS41008 (Dimethyl fumarate)
• T cell immune dysregulation inhibitor
• Serloptiant
• Neurokinin 1 receptor antagonist
  • Reduces chronic itch in phase 2 for psoriasis mainly for pruritis
• Upadacitinib
  • Second generation selective JAK inhibitor
• Bimekizumab
  • One year away
• Avoid alcohol, gluten, coffee
• Indigo naturalis, curcumin, diet modification, fish oil, meditation can all be helpful
• Psoriasis is more than just a skin disease, consider the psychosocial interventions

Pain Management in Dermatology
Miranda Reed Cleaver, DO

• All pain meds should be prescribed PRN!
• WHO 3 step ladder
  • Begin with an non-opioid (Tylenol, Ibuprofen) and progress from weaker to stronger opioids (Step 1-3) for incremental pain severity
  • Always consider adjuvant meds (TCAs, etc), reassure your patients and give realistic expectations
• Nonopioid (+/- adjuvant)
  • NSAIDS: Anti-inflammatory, analgesic, and mild antipyretic effects.
    • Worry about renal and GI toxicity in elderly patients (Stage III and IV CKD)
    • Mobic is gentler on the GI tract
  • Acetaminophen
    • Analgesic and antipyretic
    • From a clinical side effect good antipyretic but weak anti-inflammatory and analgesic when taken PO
    • No more than 3gm in 24-hour period
    • If history of heavy drinking, decrease to 2gm
  • Tylenol 325 PO Q4-6 PRN pain
• Anti-convulsant
  • Most commonly used medication for neuropathic pain
  • Indicated for treatment of neuralgias
  • Gabapentin
    • Good side effect profile, lacks drug interactions
    • Very little metabolism of drug, renally excreted
    • First choice anti-convulsant for treating chronic neuropathic pain.
    • Adverse side effects include weight gain (need to caution about the water retention), also can have withdrawal seizure if abruptly discontinued
    • Max dose 3600mg/day
    • Indications for post-herpetic neuralgia 300-600mg PO Q8 hours, start low and can go up
  • Lyrica (pregabalin)
    • Max dose is 600mg/day
    • Goes generic next year and will be cheaper
• Side effects
  • Weight gain
• Dosing for PHN 150-300mg PO daily dose
• Tegretol, Trileptal
• Can be used for trigeminal neuralgia
• Opioid for mild-to-moderate pain
• Itching is a side effect, not an allergic reaction
• Opioid induced hyperalgesia
  • Can occur after prolonged administration and leads to increased pain
• No Lyrica or gabapentin in pregnant
  • Do not give pain meds to pregnant if don’t have to but if have to lowest dose and let them know the risks
• Reproductive age women
  • Talk to them and make sure not pregnant, do hcg in office
  • Methadone and suboxone are recommendations for pregnant women
  • Codeine in pregnant will break down to morphine
• Patients aged 65 and older
  • Everything slows down so be cautious because a lot of these patients have comorbidities and less is more in these patients
  • Consider less frequent dosing
  • Consider cognitive impairment and fall risk
• Clinical usage of opioids
  • Immediate acting formulations for acute pain post-surgery
    • First 24-48 hours important to control pain relief
  • Extended release formulations are used to treat chronic pain (malignancy and post malignant)
  • Clinicians should avoid increasing dosage to greater than or equal to 90 MME
• Acute pain
  • Use lowest effective dose of immediate release opioids and should prescribe no greater quantity than needed
  • 3 days or less will often be sufficient, more than 7 days will rarely be needed
• Prescription Drug Monitoring Program (PDMP)
  • Used to track controlled prescriptions
  • State boards and DEA look at this
  • Here to help as a tool for safety
  • State run, federal programs aren’t legally required to report to these
• Be careful with stigma regarding chronic pain patients but also have a high index of suspicion
• UDS to be done
• Low-to-high tier wise
  • Codeine
    • Mild-to-moderate pain
    • Can come in combo with acetaminophen and ASA (Tylenol #3, #4)
    • Conversion to morphine is highly variable
    • Avoid in renal failure
    • Max dose of codeine sulfate is 360mg/24 hours
  • Tramadol
    • Up to 400mg/day
    • Synthetic codeine analog that shares properties of both opioids and TCAs
    • Side effects
      • Be careful with seizure patients, do not put them on it because lowers the seizure threshold
• Opioid for moderate-to-severe pain
• Hydrocodone
  • Many different formulations
• A semisynthetic hydrogenated codeine derivative and opioid agonist with analgesic and antitussive effects
• Converted to hydromorphone by cytochrome P450 enzyme CYP2D6 (gets more potent as broken down)
• Norco is more common
  • Post-op pain 3-7 day limit
  • Up to Norco 10/325mg PO Q 4-6 hours PRN for pain
• Oxycodone
  • Different variations, straight and combos
  • Short acting for moderate to severe pain.
  • Liver metabolizes to small amounts of oxymorphone, the only active metabolite
  • Oxymorphone will accumulate in renal failure patients
  • Combination with acetaminophen (Percocet) is prevalent and has increased street value
• Morphine
  • Most commonly used opioid for treating severe pain
  • Be careful in renal failure
  • Divert these patients, you should not be taking care of these unless really comfortable; If patient needs more than Percocet then refer
• Hydromorphone (Dilaudid)
  • Divert these patients
• Benzodiazepines
  • Most overdoses are benzo and opioids
  • Increases risk of respiratory depression 4 fold if taken together
  • Should not be given by us post procedure
  • Xanax is being looked to be taken off the market
  • Pre-op valium (max 10) or Xanax (max 1)
  • Avoid long acting

---

**The Advantage of Leadership in Dermatology**

*James Warrick & Daniel Ladd, DO, FAOCD*

• Connect with people in new ways and inspire others in what they do (influence)
• Employees should be happy and focused on practice goals
• Aligned in the same direction, creating new solutions
• In medical industry, not just medical care needed
• Leadership is not defined by what you do, it’s defined by what others do in relation to you
• The skills to influence are based on what others do
• Commit to at least six months of training for yourself and key employees
• Be ready to change your thinking
• Work on building trust with employees
• Find out what problems employees see and how they see them
• Create mantra and repeat often
• Find a rallying cry/initiatives
• Collect feedback at all levels
• Empower change at all levels
• Sit back and enjoy the benefits

Draft
• Start with the higher levels and developing your best, then get everyone caught up
• Don’t focus on those not performing
• Shared vision + shared responsibility = shared leadership

Creative Ways to Maximize Professional Efforts Most Effectively and Avoid Practice Pitfalls
Will Kirby, DO, FAOCD

Ten action items to incorporate into your practice
1. Monitor updates from your state medical board
2. Apply to become an expert reviewer
3. Review your med-mal insurance policy annually
4. Improve your informed consent (and add an arbitration agreement if your state allows it)
5. Obtain proper training
6. Purge problem patients (dismiss properly and possibly provide medical records)
7. Add a refund release form to your practice
8. Hire an NP or a PA
9. Join the faculty of a dermatology residency program
10. Improve your online professional reputation and focus on social media

• Medical malpractice claims
• Lack of informed consent is number 1
• Informal (in the course of discussion) versus formal (signed document)
• Informed consent

• Layman’s term, offer alternatives including no treatment, side effects, chances of developing side effects, section for patient to say they understand, acknowledge that they aren’t under influence or coerced, acknowledge that all questions were answered, acknowledge that they requested treatment
• Arbitration agreement so you don’t have to go to court in frivolous cases
• Quantified training
• Accredited training that offers CME to quantify
• Find more free time
• Purge problem patients
  • 10 percent of your patients cause 90 percent of your problems
  • Make a list and legally dismiss them
  • Must provide letter to patient: USPS, certified, fax, email, must provide emergency care for 14 days, must provide info as to where they can also receive care, provide info on how to obtain medical records
  • Medical records: A copy, 14 days to provide, can and should charge, should always mail the records to the patient
  • Consider giving refunds anytime a patient complains but have them sign refund release form (no disparagement, no complaint to the medical board, no legal action, etc.)

• Online reputation
• Wide net versus efficient net
• Email patients a follow-up rating and if 5 circumvent to Yelp, Google, etc, if four or less email the case manager (can use a service such as reputation stacker - $100 per month)
• Social media
  • Never use the phrase “the best”
  • Don’t use brand names unless necessary
  • Educate the patients
  • Provide relevant but diverse content
  • Make the material personal
  • Hire a healthcare attorney

Purchasing organization, Career center (for residents), new beauty partnership, REAL
• Facebook, Instagram, IGTV, IG stories, Twitter, Snapchat, YouTube, Vimeo, Realself, Spotlyte, etc.
• You can target social media audience down to location and income
• Use social media to engage patients about your brand and promote in line with well-established sales funnels, events, etc
• i.e. Turn your practice logo pink in October for breast cancer awareness
• Promises and perils of social media
  • Promise
    • Group purchases, increased advocacy, cross-generational relationships, expertise (virtual grand rounds, practice management), catharsis and venting
  • Perils
    • Infighting, control by outside forces
    • Future of free EMR funded by pharma, watch advertisement every day, week, month, etc. in return for the EMR use
    • TBCD skincare line only to be sold by board-certified dermatologists
    • Almost 4000 dermatologists members, 3343 active on TBCD
    • Realphysicians.org
  • Not for profit (goal is excellence in medicine)
  • Residency educated, accredited, and licensed
  • Importance extends beyond dermatologists, vision for the future is to get this out to media that patients should be looking for providers who are board certified
  • Goal is patient safety, promote dermatologists as experts in dermatology

Atopic Dermatitis Update
Kari Martin, MD, FAAD

Social Media in Dermatology
Matthew Elias, DO, FAOCD

• Attract new patients, advertise services, inform patients of what is going on in your practice
• Importance of forms for social media consent when posting patient pictures
• The Board-Certified Dermatologists (TBCD) Facebook group, GPO (group purchasing organization), Career center

REAL
• Comorbidities and burden of disease
• New advances in pathophysiology understanding
• Therapeutics
• Atopic triad
  • Eczema, asthma, allergies
• Flares in asthma or allergies can worsen atopic dermatitis, although antihistamines do not help with the dermatitis
• Metabolic syndrome and CV disease
  • Similar increased CVD as seen in psoriasis
• Important questions to ask
  • Can they exercise
  • Do they get itchy and not just how they appear clinically
  • Also sleep, ask about it and treat their AD intensely enough to improve their sleep
  • If needed refer to primary care or sleep specialists
• AD is associated with an increased risk of psychiatric disease
  • Increased risk of depression, anxiety, and suicidal ideation but not psychiatry consults, hospitalizations, or suicide
  • Depending on study 1/5 or up to 50% of these patients have depression or anxiety
• Inside out vs outside in
  • Problem in barrier or genetic abnormality leading to cytokine disruption
  • Inside out
    • Primary abnormality is genetic
  • Outside in
    • Allergens coming in and filaggrin activated
    • What we think of now is catch all – genetic abnormalities and changes in immune system
    • Both can give you what we see clinically à atopic dermatitis
    • Move more toward precision medicine compared to one size fits all
• Barrier study
  • Infants less than three weeks
    • High risk for AD, control no emollients vs emollient (full body daily), cumulative AD incidence (RR of 50%, no AE differences)
  • Barrier study would fall into primary prevention
• Secondary prevention
  • Much less reliable, no great studies that we can stop the progression
  • Eczema varies based on age and how old lesion is
• Adult AD
  • Th2 gets larger in lesional skin
• Infant AD
  • Th2 is small and gets bigger as develop eczema
• Weidinger et al 2018: studied whether different treatments work better based on how long patient has had eczema
• Advances in AD therapeutics
  • Several in clinical trials (mostly in adults)
  • Topical
    • Crisaborole
      • PDE4 inhibitor, studied in mild to moderate down to age two
      • Consider cost to healthcare system vs actual clinical benefit of it
  • Targeted antibodies
    • Dupilumab
      • Blocks IL4 receptor alpha (IL4 and IL13) right now only approved for adults
    • Lebrikizumab & tralokinumab
    • Nemolizumab
      • In clinical trials
      • Directed against IL-31 receptor A subunit and this is specific for itch
  • Targeted small molecules
    • Omalizumab
      • Out for a while for urticaria and asthma
      • Binds to IgE in bloodstream
      • Meta-analysis 2 years ago
      • Patients with lower IgE statistically more likely to respond clinically
      • Most helpful in people that did not have filaggrin mutations
      • Not FDA approved for AD
    • JAK inhibitors:
      • Baricitinib, tofacitinib
      • Orals
      • Block IL4 and IL13 receptors but different location
      • In phase 3 clinical trials
    • Long term outcomes with pulsed treatment? Do Eucriza or Elidel and Protopic have a role here? We don’t know yet
• Certificate of added qualification by AOA
• Politics of Mohs Surgery
  • ACMS, ASMS, AAD (AUC for Mohs indication and MMS committee)
  • Certification versus accreditation
  • Medicare is the major payer for Mohs
  • Medicare fiscal intermediaries make the payment rules by issuing local coverage decisions (LCD)
  • LCDs can be influenced by those with a political agenda
• Reasons proffered in favor of subspecialty certification:
  • It will solidify the specialty
  • It will provide status for those who spend an additional year in fellowship
  • The public will demand it
  • It will aid in dialogue with insurers who seek to deny the procedure
  • It recognizes a “body of knowledge” in the field of dermatologic oncology
• Reasons in proffered opposition to certification:
  • Dermatology is a small specialty dividing it even further minimizes its influence
  • The goal is to reduce the number of dermatologists performing Mohs to minimize potential reduction in reimbursement
  • As one of its strongest advocates has stated publicly “We need birth control in Mohs surgery”
• Mohs surgery is integral to the practice of dermatology
• Fellowships for further training are valuable but they in no way should be identified as the only way to learn the procedure
Get to know EUCRISA

Learn more at booth 1

Visit www.EucrisaHCP.com for more information
• Dermatologic oncology is a large and integral component of the practice of dermatology and in no way should be confined to a “select group”
• While the five year “grandfather period” would be open to all who practice Mohs, certification will have devastating effects on those who come after us essentially gutting a major part of their training and ability to practice
• Insurers will have a built-in reason to deny coverage for both Mohs surgery and dermatologic oncology
• Micrographic surgery has not significantly evolved in decades
• Teaching methods for all aspects of “MDS” are available and actively employed
• Economic credentialing against nFT-MSs has already occurred and will worsen with MDS SC. MDS SC will create an economic/professional guild where only FT-MSs will eventually be able to practice MMS
• Sub-specialization is not supported by a significant percentage of dermatologists
• AAD MSDO Survey, May 2017
• MDS SC would be divisive for our small and vulnerable specialty
• If MDS is approved, what sub-group will be next? Cosmetic dermatology, lasers, medical, etc?
• Certification exam
• Anticipated one year after approval, the first exam would be given
• Exam will be given yearly, first exams (5 years) will be open to ABD certified derms who qualify via fellowship or experience/practice
• After those first exams only, those ABD certified dermatologists completing a MDS fellowship will be able to take the exam
• The creation of the AOA certification of added qualification took place more 20 years ago
• It was created in response to an ABD/ABMS effort to create a Mohs Surgery board subspecialty certification
• Requirement for osteopathic Mohs surgery board certification
• Need to be dermatologists, then two pathways
  • Applicant who has completed fellowship (they had minimum of 400 cases during the training period)
  • Osteopathic dermatologist who has completed “fundamentals of Mohs Surgery course,” has attained fellowship status within that organization, and has submitted a log of minimum 200 cases of MMS performed in clinical practice within period of time not to exceed three years
• “The future of free access to residency training in advanced dermatologic surgery including Mohs rests with all of us now”
• AAD MMS committee mission is to be a united voice of Mohs Surgery

Lauren Mazzurco, DO

65 years and older patient population will increase with aging baby boomers
• 48.54% of people above 65 have skin conditions (2.2 conditions)
• Value = quality/cost
• Increase value by increasing quality and decreasing cost
• Functional outcomes
  • Morbidity and mortality
• Cost
  • Burden of disease and others, costs of meds, social isolation
• Chronicologic age does not equal physiologic age
  • Significant heterogeneity of geriatric population
• Homeostasis + stenosis = homeostenosis
  • Physiologic reserves allow us to maintain homeostasis in presence of stress.
  • With homeostenosis, an insult that may be withstood in a younger person pushes the elderly beyond their functional capacity, causing decompensation, disease, or death
• There are social determinants of health
• Multimorbidity
  • As number of chronic conditions increases so does complexity
  • If six or greater comorbid conditions, 46% have 13+ physician office visits per year
  • In elderly, consider drug-drug, drug-disease and disease-disease interactions
• Consider hearing and vision impairment
  • Instructions in legible size/font, use of teach back technique, use lower tone
• Consider functional issues
• Polypharmacy
  • More than five medications (one in five may be inappropriate) increases treatment nonadherence
  • Single most predictor of harm is number of medications
• Complexity of drug management among older adults
  • High 1%, moderate 47%, low 34%
  • 1/3 of them said medications were a financial burden
• Function and cognition
  • Mobility, ADLs, IDLs,
• Medical decision making
  • Assessment (uCARE)
  • If lacking capacity, advanced directive completed, advance directive not completed
• Shared decision making
• Prognostication
  • Would I be surprised if this patient died in the next 12 months (helpful to ask yourself when dealing with high risk patients)

Jason Mazzurco, DO, FAOCD

Cases
• 101-year-old
• SCC removal on left cheek, hard to detect where spot was because was infected
• Treated with antibiotics then SFU
• 98-year-old
• BCC right temple bleeding lesion for a few years
• Oral hedgehog pathway inhibitor and palliative radiation
• 85-year-old
• BCC of scalp “indentation on scalp as long as I can remember”
• CT head with and without contrast cannot rule out bony involvement
• Homeostasis
• Rapid decline and died 6 months later with no treatment
• 97-year-old
• SCC on forehead
• Mohs surgery
  • Not cleared with 3 stages
  • Deep at peristeum, SCC positive extending to frontal bone deep
• Perineural inflammation
• Acell placement, healed by secondary intention
• Advantages and disadvantages elderly skin
  • Advantages
    • Increased laxity (sometimes), larger tissue reservoirs, plenty of lines to work with
  • Disadvantages
    • Decreased laxity (sometimes), thin skin, lax/moveable free margins
  • When layered primary closure won't work
    • Due to many factors including but not limited to size, location, depth, adjacent free margins/structures, tissue reservoirs (or lack), skin thickness, previous treatments/scar/radiation, function, cosmetic appearance
• Other patient factors include patient condition, comorbidities, care coordination/after care, transportation, financial, expectations, patient's preference/demand
• When layered primary closure won't work, consider flap, full thickness skin graft, partial thickness skin graft, secondary intention, partial/purse string closure with secondary intention, partial closure with burrow grafts, primary closure with use of strut/stent, skin substitutions (secondary intention/granulation aids)
• Secondary intention:
  • Advantages
  • Disadvantages
    • Easier, quick, good for concave surfaces, can recreate creases, cost effective
    • Often longer wound care, indention or volume deficit, distortion of free margins with contraction
• Partial/purse string closure with secondary intention
  • Use when close enough is good enough
  • Smaller surface area to heal by secondary intention
  • For every unit we decrease the size of the wound, we can significantly shorten the healing time
  • Leave in for 3 weeks and then granulation occurs
• Partial closure with burrow grafts
  • Utilize what you have
  • Use as much skin laxity as you can
  • Primary closure with use of strut/stent
  • Can be done on regular excisions for thin fragile skin
  • Inner adhesive layer, outer semi-permeable membrane
• Good environment for wound healing
• Using wound closure strips to suture atrophic skin
• Useful for thin or atrophic skin
• Wounds under significant tension
• Apply liquid skin adhesive
• Apply adhesive strips parallel to wound
• Suture through the fused skin/strip surface
• Skin substitutes
  • Secondary intention/granulation aids
  • What is the ideal skin substitute
    • Immediate replacement of epidermis and dermis
    • Resist infection
    • Provide barrier/resist water loss
    • Durable, long term stability
    • Lack of antigenicity
    • Easy to conform to wound surfaces
    • Easily secured and applied
    • Widely/easily available
    • Long shelf life and easy to store
    • Cost effective
• Types
  • Temporary versus permanent
  • Biological versus synthetic
  • Integrating versus non-integrating
• Brands
  • Dermagraft
    • Human fibroblasts, extracellular matrix, bioabsorbable polyglactin meshwork
  • Primatrix dermal repair scaffold
  • Bovine type I and III collagen
  • Acell devices (Cytal, MicroMatrix)
  • Porcine urinary bladder matrix, epithelial basement membrane
  • Oasis
    • Porcine extracellular matrix, small intestine submucosa
  • Apligraf
    • Bilayer, neonatal male foreskin, epidermal human keratinocytes/stratum corneum, human fibroblasts in bovine type I collagen
• Primatrix
  • Collagen matrix type III and I
  • 5 year shelf life
  • Ready in 60 secs
  • No inflammatory response
  • Good for surgical wounds and post Mohs
  • Can use more than one layer
  • Don’t use in bovine sensitivity, not indicated for 3rd degree burns
• Studies on Primatrix
  • Mostly diabetic ulcers, 76% healed by 12 weeks, those not healed reduced size by 71%, traumatic and surgical wounds
• Suspension sutures
  • Offset tension vectors
  • Fixation and attach to dermis
• Subcutaneous inverted cross mattress stitch (SICM)
  • Used in high tension wounds (scalp, lower extremity)
  • Combination of the buried vertical mattress and pulley stitch
  • Provides wound eversion and decreases tension at wound edge
  • “Locking” double, buried vertical mattress
• Two lobed advancement flap for cutaneous helical rim defects
• Good for superficial defects for upper to mid helix
• Heal in 2 weeks
• Superior helical rim defects
• Traditionally wedge closure, especially with cart affected, modified helical rim advancement flap now use crescentic cartilage removal (modified chondro)
• Erivedge can decrease basal cell carcinoma 35% before surgery cases

Decoding Delayed Hypersensitivity Reactions
Kari Martin, MD, FAAD
• Much more to ACD
• Patch testing is not FDA approved, only the T.R.U.E.
• Type I
  • Allergy and atopy
• Type IV
- Delayed type hypersensitivity
- Antihistamines don't affect this pathway
- Nickel is number one in kids and adults
- When to think about ACD?
  - Acute dermatitis
    - Patterned (i.e. acute bullous eruption on feet)
    - Face, eyelids, lips, dorsal feet, hands
    - High risk hobbies/occupations
    - Sports equipment, wood working, painting/arts, dental, healthcare, cosmetology, plants
  - Chronic dermatitis
    - Dermatitis of unknown etiology
    - Not responsive to treatment
    - Unexplained worsening of prior stable disease (psoriasis, seborrheic dermatitis, atopic dermatitis, etc.)
    - Prior to starting systemic immunosuppressive for dermatitis
- Allergen to leather is chromate, can go through socks, actually can be made worse with sweat, allergens can stay in socks through washing
- Gold allergy and contact dermatitis
  - Jewelry on hands + sunscreen (physical blocks), eyelids break out because skin is thinner and allergens can penetrate
- Eyelids are often first place to breakout
- Airborne exposure causes
  - Candles, Glade plug-in
- Pediatrics
  - Differences between ACD in peds and adults
    - 13-25% of healthy asymptomatic kids have allergen sensitization
    - 25-96% of kids with suspected ACD have allergen sensitivity
    - 48-57% of kids referred to tertiary centers for patch testing had relevant positive results
  - You can have atopic and allergic contact dermatitis at the same time. ACD is mostly Th1 driven
  - Kids have scattered generalized in 33%, adults are hands in 27%
  - Patterns of exposure
    - Self vs connubial/consort (exposed from someone else)
- Allergen source
  - Personal care products, articles of clothing, time spent in play versus work
  - Play music, bubbles, etc. to distract kids when patch testing
- Pediatric patch testing
  - Children ages >13 years old
    - Day 0: Place patches
    - Day 2: Initial read
    - Day 4-7: Delayed read
  - Children ages 6-12 years old
    - Day 0: Place patches
    - Day 2: Initial read
    - Day 4-7: Delayed read
  - Children ages <6 years old
    - Day 0: Place patches
    - Day 2: Initial read
    - Day 4-7: Delayed read
- Patterns of exposure
- Points and scoring systems for dietary
  - Topical products for treatment
  - Lotions that chelate the nickel ions
  - Antihistamines don't affect this pathway
- Methyl chloro isothiazolinone (MI)
- Nickel, bolts
- 20% of patients with dyshidrosis are allergic to nickel
- First baseline pediatric patch test published in August 2018
- Topical products for treatment
- Lotions that chelate the nickel ions as they come off the metal, work fairly well
- Wet wipes allergen
- Methyl chloro isothiazolinone (MI) “hypoallergenic”
- Runoff areas are first to show shampoo contact dermatitis, not the actual scalp
- Consider indirect exposure and occlusion causing ACD where it wouldn’t normally occur
- Positive patch test doesn’t mean that is the cause of ACD, see what is currently relevant to the patient
- PEAS
  - Preemptive avoidance strategy to use
dermatitisacademy.org takes top 10 allergens and finds products that don’t have them as ingredients for the patients
- Systemic contact dermatitis
  - First there is cutaneous sensitization, then second systemic exposure - oral, IV, IM, mucosal, or inhaled which leads to flares, widespread dermatitis, dyshidrosis, and intertriginous or flexural involvement
  - Nickel, cobalt, prop glycol, formaldehyde, antibiotics, corticosteroids, balsam of peru, propolis, compositae
  - Can test for individual components of balsam of peru and BOP foods
- Patient resources
  - CAMP through ACDS
  - SkinSafe supported by Mayo
  - Dermatitis Academy online (P.E.A.S)
  - Published papers
  - Alternatives published by NACDG
  - Point-scoring systems for dietary changes (takes the work out of looking at labels)

Dysplastic Nevii
Reagan Anderson, DO, FAOCD, Nathan Cleaver, DO, FAOCD & Amy Spizuoco, DO, FAOCD

- DN were first reported in 1978 by Clark and colleagues in melanoma prone patients due to family history
- Controversial term since first introduced
- Dysplastic is more of a histologic term
  - No consensus on how to grade
  - Atypia is more of a clinical term but no term has universal acceptance
  - Patients with history of melanoma, 34-59% have DN
  - Melanomas usually found on sun-exposed areas, DNs are found in sun exposed and non-sun exposed
  - “The reliability of a diagnostic test depends on the reproducibility of the result”
  - Agreed with each other 62% of the time in this study of benign, intermediate, malignant in 37 slides of 40 submitted slides
  - Histologic criteria (5) for dysplastic nevi: persistent lentiginous hyperplasia, melanocytic nuclear atypia, lamellar fibroplasia, concentric eosinophilic fibroplasia, sparse patchy lymphocytic infiltrates
Elder introduced dysplastic nevus syndrome after Clark

Ackerman said uniform definition is lacking, disagreed with Clark on staging and made a clear-cut diagnosis between nevi and melanoma

Various terms based on region of the US
- Clark's nevus in NY
  - Compound melanocytic lesion, nests in junctional component and dermis, shoulder phenomenon
- You won’t see single cells in upper dermis or mitotic activity in DN
- WHO: 2 major and 4 minor criteria
- Present day
  - Some don't grade atypia at all others grade mild, moderate, severe, third group divides lesions into high grade (cut it out) and low grade (leave it alone) lesions
- Interpretation is influenced by geographical preferences
- Interpretation influenced by training or “school of thought”
- Clark vs Ackerman
- False positives
  - DN read as MIS 17.6%, DN read as invasive melanoma in 3.2%
- False negatives
  - Melanoma read as DN in 12%
- Elston states, “One dermatopathologist’s moderately atypical nevus may be another’s melanoma.”
- Shave removal vs biopsy (to diagnose) when coding
  - When comparing shave to punch, shaves had 95.5% concordance with final diagnosis
  - Punches had 70.7% concordance
- DN do relate to a patient’s risk for developing melanoma (but perhaps not in an individual lesion)
- Someone with one DN has a RR of 1.6, someone with 5 or more DN has a higher RR
- More DN you have, the greater chance you will get melanoma, so serial surveillance is important
- DN are a clear marker for a patient’s risk of developing melanoma later in life
- 20% of melanomas arise from DN and the rest de novo - questionable
- Do DN turn into MM?
  - All over the place with this
- Guidelines: we excise too many DN, most do not turn into melanoma, moderate-severe and severe à excise, all others monitor
- With shave removals the dermatopathologist sees less than 1%
- Older dermatologists do not excise as frequently and use smaller margins, average RTC is 6-12 months
- Referenced the AJCC 8th from this year and the changes in staging and LN dissection study from last year

Patients Come Second

Steven Grekin, DO, FAOCD

- Patients come second, employees come first
- DNA of what we are trying to do and who we are starts and stops with your employees
- Whoever is the weakest link, train them up
- Leaders are vulnerable
- At John Deere, first day experience leaving the office thinking you belong and that the work they do matters, and that you matter to them
- Mission and vision statements
  - How to get employees to buy into the mission
    - You cannot simply encourage everyone to recite from a hymnal of catch phrases
    - It’s a never-ending process of trying, failing, reflecting, and above all learning
  - Need to teach you employees that they matter
  - Be a team of educators
  - Successfully caring for our patients and the practice is the duty of every team member
  - Be curious of the people you meet and what they want and value
  - Hire people smarter than you
  - Listen to everyone’s ideas, face toward problems, B-level work is bad for the soul, it’s more important to invest in good people than in good ideas
  - Educate your employees to be highly responsible
  - Act with purpose and sense of urgency to accomplish tasks and follow up with those involved
  - Focused on others
  - Make others around you feel important, appreciated, valued, and liked
  - Sticky note exercise
  - Write things about employees and have office managers distribute, so employees know that the guy at the top knows about the employees and that their managers knew them as well
  - “Nobody cares how much you know until they know how much you care” TR

Communication
- Need to be a good listener to be a good communicator
- KISS: Keep it simple silly
- To describe your office
  - Use words that you want your employees to use with your patients
  - Homelike, family, warmth, FUN
- The only guarantee in life is change
- Should go to bed every night thinking of how to make a paradigm shift in dermatologic care
- Embrace change, ask your employees what they would change
- Don’t accept complaints without a solution
- Action
  - Create, implement, and execute on solutions, empower your employees to act
- Integrity
  - You have to be impeccable with your word
- Equation for dermatology practice success exercise
- Ask your employees
  - What is the one thing that I don’t currently do frequently enough that you think I should do more often?
  - What can I do to make you more effective?
  - What is the one thing I should stop doing?
  - What is the one thing that I currently do that you would like me to continue to do?
- If employees and physicians are happy, you’ll get an increase in patient volume
- If you increase volume, you’ll find ways to decrease costs
  - With that, you’ll increase margin and able to invest in your employees
- Equation for success
  - Invest in staff, plan educational opportunities, engage them in the process, communicate, collaborate

Minimizing HIPAA Liability

Leslie Rojas, Esq.
• The key to risk is how the business manages the specific risk
• Common HIPAA breaches
  • From the office of civil rights 2015
    • 51% theft
    • 19% unauthorized access/disclosure (i.e. Curiosity viewing)
  • Electronic PHI needs to be protected
    • 21% laptop
    • 12% desktop computer
    • 22% paper records
• HIPAA breaches are inevitable
• Liability can result from a breach report
• Routine government HIPAA compliance audits
• Four main parts of HIPAA
  • Privacy rule
  • Security rule
    • This is where most practices are lacking
  • Breach notification rule
    • How to determine if you have experienced a reportable breach
    • If you know there is a breach you need to notify the government without unreasonable delay
    • If less than 500 individuals, you have at least 60 days after end of calendar year
    • Advice: Do not send in early
  • Compliance and enforcement rule
    • The government wants to see good-faith effort at basic HIPAA compliance
  • Documentation of efforts
• Pre-breach checklist
  • HIPAA Privacy Manual and Security Policies that are tailored to your practice
  • Annual employee HIPAA training
  • Updated notice of privacy practices
  • Updated after 2013? On practice’s website?
  • Updated medical record release authorizations
  • Updated after 2013?
  • Special rules for STDs, mental health, substance abuse
  • Look at forms and make sure updated since 2013, because most likely out of date if not
  • Annual security rule risk analysis
  • Hire an IT forensic expert
    • Have lawyer engage the IT expert to do the risk analysis (attorney – client privilege)
  • Business associate agreements
    • i.e. Third part billing company, IT company, healthcare attorney, EMR company, medical record storage company
• Does not include those with incidental exposure to PHI
• Documentation
• Follow-through
  • Do not have policies on paper that you are not going to follow
• Encryption
  • Not required by law but do it
  • Extra step but then the government knows you take HIPAA compliance seriously
• If possible breach
  • Prompt investigation, work with healthcare legal counsel and IT experts, document everything, rapid response and notification, two tracks
    1. Breach response (18 steps)
    2. Prepare for the investigation, getting everything in order
  • Bring outside IT experts for investigation, don’t want your internal IT team deleting what could be proof that a breach was unlikely
  • Files should never be deleted, moved, or altered in any way
  • If files are damaged/ altered, IT should create backup copies and store in a secure location
  • Should have a checklist for possible breach
  • Go through breach assessment to see if reportable breach has occurred before reporting
  • HIPAA Risk Assessment
    • If there is a reportable breach, after consultation with health care legal counsel, notify affected patients and the appropriate law
• Government investigation
  • OCR investigation
  • Best practices for response letter
    • Don’t underreact
    • Put your best foot forward
    • Don’t highlight, but don’t hide from weaknesses
    • Highlight the CE’s compliance barriers, but don’t rely on this too heavily
  • Three takeaways
    • Good faith efforts at HIPAA compliance before the government ever comes knocking will demonstrate that you take HIPAA seriously
    • This will lower your fines and may result in no fines at all
    • These include HIPAA privacy manual, HIPAA security policies, updated NPP on website, updated release forms, updated BAAs
• Proper handling of the potential breach response (with IT forensic experts and healthcare legal counsel) will ensure that you can put together an effective response to a government investigation
• Timely notification of a reportable breach (to patients, government, media) and a well-thought out response to an investigation
• This should include a response to the allegations, why you were lacking in certain compliance areas, in which areas you have robust HIPAA compliance (even if unrelated to the allegations), and the changes you have made since discovering the breach

Billing and Coding Update
Alexander Miller, MD

• January 1, 2019 biopsy codes will be new and reconstructed
• Tangential, punch, incisional
• How did we get here?
  • Medicare recognized misvalued codes, and high expenditure (aka we are using them a lot) so Medicare sent out surveys and they re-determined what the codes should be
  • It did not originally go well
  • There were bimodal results
    • Super fast and slow
  • Then question, are individual physicians doing different things?
    • AKA simple versus complex biopsies
  • Reconstructing then occurred, technique dependent biopsy codes came out
  • Technique based procedures for skin only will be effective January 1, 2019 (right now they include mucosa), new skin codes are 11102-11107
• All site specifics will stay
• Definition: procedure to obtain tissue solely for histopathologic examination (sampling of a lesion)
• You want to know what it is on histopathology, so you biopsy it
• Stratum corneum sampling by any method (scraping, tap stripping) is not a biopsy
• Shave removal will not always have histopathology done but for biopsies they will ALWAYS be done
• If you do multiple biopsies of the exact same lesion, which are too big to sample by trimming off the whole thing - all of those will count as ONE biopsy and you can only bill for one
• If you sample multiple contiguous lesions you can bill for more than 1
• 3 primary codes and 3 add ones which is similar to what we have now
• Tangential
  • Intent is to obtain tissue sample for diagnostic pathologic examination
  • Depth
    • May include epidermis only or epidermis and dermis
  • Histopathology
  • Always done
• Shave removal
  • Intent is therapeutic removal of epidermal or epidermal-dermal lesion
  • Depth
    • Not through dermis
  • Histopathology
  • May be done (your judgement)
• Punch
  • Full thickness removal of a skin sample (note that it does not say subcutaneous fat because you may not get it even though full thickness for example nasal tip), INCLUDING simple closure (although this is optional – aka when done) manipulation of the adjoining skin, such as removal of adjacent standing cones
  • Incisional
    • Sample, may include large fat tissue sample if required (ie. panniculitis)
  • Excisional
    • Entire lesion with margins
• Hierarchy
  • If doing more than one technique at a time then higher will be primary, incisional will trump the others and everything else will be secondary (add on) code
• Incisional>Punch>Tangential
• RVUs, Medicare national average payments
• Punch and incisional are higher reimbursements than previous codes
• Multiple procedures on the same date of service are still likely to be reduced under the MSRR
• Maximum reimbursement (by Medicare policy – very straight forward)
  • You can only bill primary once and then additional add-ons:
    • 11103 MUE 6
    • 11105 MUE 3
    • 11107 MUE 2
• Different coding issues (staying the same in 2019)
  • Simple repair
    • One-layer closure, doesn’t matter if deep or superficial (Depth de-relevant)
  • Intermediate repair
    • Layered closure (undermining not required)
  • Complex repair
    • Has extensive undermining, excision of standing cones (Burrow triangles, dog ears) does not justify a complex repair code although they may be included as a part of complex repair. Has to be layered closure plus extensive undermining, retention sutures, scar revision, debridement (for traumatic lacerations, avulsions)
    • Nothing is said in CPT about standing cone removal
  • Can’t just say “undermined” in your report you should say extensively undermined at least one edge because nowhere does it say both (can also say broadly)
  • Sum of lengths of repairs for each group of anatomic sites
  • Complex repairs (CPT 13100-13153) retention sutures are used to reinforce a single layer closure of atrophic, fragile skin
• Modifier 25
  • CPT: Significant, separately identifiable evaluation and management service by the same physician or other qualified health care professional on the same day of the procedure of other service (above and beyond usual preop and post op care included in procedure, service needs to be reasonable and necessary)
  • What is included in a procedural CPT code
• Evaluation of specific lesion for which a procedure is done
• Decision to perform a minor surgical procedure (0 and 10 day global)
• Certain elements of history pertaining to the lesion for which procedure is done
• Preop
• Uncomplicated post op care
• CPT 17260-17286 (malignant lesion destructions)
• CPT 17000 and 17110 (AKs)
• Conclusion
  • All procedures have some built-in EM component
• How to determine a level of EM separate from that of a concurrently done procedure
  • Subtract all EM included in the procedure from the total EM done
  • What is left determines level of potentially billable EM
  • Reminder: The separate service should be reasonable and necessary
• Global periods will stay the same for the new biopsy codes
• Other modifiers used during the global period
• Group practice and surgical follow-up
  • Not separately billable if different provider, same specialty but in global period
  • PA and NPs of same specialty in your group practice they are an extension of the same physician
• New patient is if haven’t seen in three years for billing purposes, but if you saw them before at a different practice and still within three years, they are still an established patient, even though you never saw them at the new practice
• OR/procedure room definition
  • Room exclusively used and staffed for procedures/surgeries, laser suite, your office procedure/surgery room if it meets the definition
• Not OR/procedure room
  • Patient exam room, multipurpose patient treatment room, any location not used exclusively for doing procedures/surgeries
• Conclusions
  • If a post op complication requires surgical treatment in the office setting, and that treatment is done in a room used exclusively for procedures/surgeries, then that treatment is billable with an appended .78 modifier
• Determine EM, determine ICD10 with CPT codes, select modifier if needed, document appropriately to justify billing

Mohs Reconstructions: Contours & Cartilage
Chris Weyer, DO, FAOCD

• Talk to patients about their cosmetic concerns and expectations
• Respect contours despite how long the scar
• Goals in reconstruction
  • In normal conversation, no reason to have attention drawn to them due to the reconstruction
  • Zone 1, 2, 3 of skin thickness
  • Internal nasal valve
    • Gets compromised during Mohs
  • Most narrow portion of the nasal airway
• External nasal valve
  • Basically entrance to nose
• Cases
  • Melolabial transposition flap
    • Has pincushioning due to 1 stage repair
  • Alar batten graft, nasal valve and rim stabilized
  • 2 stage flap to improve contours
  • Nasalis hinge flap
    • Nasalis is hinged down, inferior pedicle
• Cartilage grafts
  • Evaluate the defect for collapse and support, antihelix or conchal (posterior), may need more than one graft, watch for donor site hematoma (put pressure dressing on the ear immediately to avoid this), chondritis
  • Use of hinge flaps
    • Utilize local tissue, provide tissue volume and contour to defect

Body Contouring: Noninvasive and Beyond
Jamie Moenster, DO

• Body contouring
  • Goals focus on removal of unwanted fat, texture or cellulite, and skin tightening and resection
  • Liposuction is #2 cosmetic surgical procedure in US
• Non-invasive
  • Coolsculpt (Cryolipolysis) most common
  • Ultrasound 12 weeks after treatment revisit
  • Platysmal banding with Kybella
• Liposuction
  • Ideal patients are close to normal weight with fatty deposits or lipodystrophy
  • Contraindicated on anti-coagulation
  • Wetting techniques based on infiltrate and estimated body loss
  • Dry
  • Wet
  • Superwet
    • Most common 1:1 (infiltrate to aspirate)
  • Tumescent
  • Klein’s solution is most common
    • 1L NS with 50cc 1% lido, 1ml of 1:1000 epi and 2.5cc of 8.4% bicarb
    • Watch dose of lido and max dose of epi
  • Suction, power, ultrasound, laser, or radiofrequency assisted lipectomy
• Cannulas
  • Many different styles available
  • Most have openings on one side
  • Typically 3-4mm for body
  • 2mm for face
  • Larger for debulking
  • Different lengths of cannulas
• Inner thighs is the second thinnest skin on female after eyelids
• Back is one of the most forgiving areas for liposuction
• Liposculpting and etching of the abs can be done
• Cavitation
  • Ultrasonic cannula goes in space
  • Superwet to tumescent, a lot of fluid so sound waves can travel
  • Bubbles break the fat down
• Liposuction versus skin resection
  • Check for hernias
  • Check abdominal wall laxity (especially post-partum women)
  • Evaluate skin quality and elasticity
  • Better to under promise and over deliver with your results
• Free fat transfer
  • Fat autograft
    • 50-80% take
    • Easy to do in office for face or to correct contour deformity, scars, or for breasts or buttock
• Technique
  • Liposuction donor site
  • Process the fat
  • Reinject to recipient areas
• Equipment
  • Tulip system, centrifuge that’s also used for PRP
• Radiation dermatitis and fat grafting helps with the telangiectasias
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 Deree Neill, 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.