Greetings from Houston, Texas - again!

As President of the AOCD, I welcome you to another edition of *DermLine*. As I think about our recent past and the dramatic changes afoot, I recall Suzanne Sirota Rozenberg, DO, FAOCD, Past President of AOCD, commenting in the Spring 2014 edition of *DermLine* about the coming AOA/ACGME merger. As I stated previously, “Today, at this moment, we are living in yesterday’s future.” Our future has arrived. Because the AOA, along with the Accreditation Council for Graduate Medical Education and the American Association of Colleges of Osteopathic Medicine, have agreed to a single accreditation system for graduate medical education programs in the United States, our graduates of osteopathic institutions, along with graduates of allopathic medical schools will complete their residency and/or fellowship education in ACGME-accredited programs and demonstrate achievement of common milestones and competencies side-by-side. I hope you realize the power in the previous statement. Trained together, osteopathic and allopathic graduates will no longer be divided.

Perhaps the most exciting news to share is the AAD vote that just passed last month. This has been a battle we have been fighting for generations. The vote suffered defeat in 2004 and 2010. On both occasions, a majority of the membership voted in favor, but the required two-thirds majority required to approve a change to the bylaws fell short. I was told I would never see this vote go through in my lifetime. Today, however, our osteopathic physicians certified by the American Osteopathic Board of Dermatology will be recognized as Fellows in the AAD. This exemplifies what we all have known for a long time—we are equals with our MD counterparts. This vote gives us the ability to hold offices and serve on committees. I sincerely hope we all serve the AOCD and AAD in some capacity. By harnessing the strength of both organizations, we all can make a change.

However, our work is far from being done! More than ever, the preservation of our osteopathic roots will be critical. The AOCD remains a strong organization. I am proud of our heritage and mindful of the work that lies ahead. This great organization has nurtured me throughout my career and will do the same for generations of osteopathic dermatologists to come—if we believe in and support the AOCD. The AOCD brought us to where we are. Each of us emerged as dermatologists because of this great organization.

The AOCD will remain a strong provider of service and support to dermatologists who chose osteopathy for their medical training and philosophy. Our boutique organization is special. Our members are not lost among the masses. Our professional development will remain world-class. Our publications will continue to disseminate valuable information and updates. The person-to-person connection is what makes AOCD one of the greatest assets in our daily professional lives.

As you read this edition of *DermLine*, reflect on how fortunate we are to be osteopathic dermatologists. Our future will remain strong as long as we join together in keeping the vision alive, provide outstanding training and seminars to our members and never forgetting that our purpose is to serve patients.

I look forward to seeing you in Santa Monica!

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

30-April 3, 2016 at the Battery Park Ritz Carlton. The reviews coming in from this conference have been outstanding! It will be time for our fall meeting before you know it. Join us at the Loews Hotel in Santa Monica, CA, September 14-18, 2016. Online registration and hotel information is available on our web site. Remember to log in with your username and password to get the AOCD member rate.

The 2016-2018 CME guide for physicians is now available. AOCD members must earn one hundred twenty (120) CME credits for membership in the American Osteopathic Association within this three-year cycle, beginning Jan. 1, 2016 and ending Dec. 31, 2018. Of this total, 30 CME credits must be obtained in Category 1-A and the remaining 90 CME credit may be obtained with either Category 1-A, 1-B, 2-A, or 2-B credits.

To maintain your specialty certification, you must earn a minimum of FIFTY (50) specialty CME credits in each primary specialty held (e.g. dermatology) during the three-year cycle. For dermatology, as required by the AOBD, at least TWENTY-FIVE (25) of the required FIFTY (50) specialty credits must be Category 1-A. AOA Category 1-A credit is granted for formal face-to-face programs that meet the Category 1 quality guidelines, faculty requirements and are sponsored by AOA-accredited Category 1-A CME sponsors. The AOCD is a Category 1-A accredited sponsor for dermatology CME.

We are happy to share the results of the recent American Academy of Dermatology’s recent By-Laws amendment vote. The vote which passed with 69.42% voting in favor, will allow osteopathic physicians certified by the American Osteopathic Board of Dermatology (DOs) within the Fellow membership category of the AAD.

We want to stress to our members that this is only a status change. Both the AAD and the AOCD remain separate organizations and offer unique services to their respective members.

We continue to offer informational updates to our members via the Thursday Bulletin. When the bulletin arrives in your inbox, be sure to take a moment to review. We try to include reminders and updates on pertinent information as much as possible.

We recently announced that the AOCD was in the process of seeking initial accreditation with the Accreditation Council for Continuing Medical Education (ACCME). The staff and I are excited to get this project completed for the membership. Click here to learn more about the ACCME.

What does this mean for the AOCD? Once obtained, the AOCD will be able to grant AMA CME in addition to AOA CME. Getting to the Initial Accreditation will take work. Specific criteria must be met.

The Accreditation Criteria are divided into three levels. To achieve Provisional Accreditation, a two year term, providers must comply with Criteria 1, 2, 3, and 7–12. Providers seeking full accreditation or reaccreditation for a four-year term must comply with Criteria 1–13. To achieve Accreditation with Commendation, a six-year term, providers must comply with all Accreditation Criteria.

Criterion 1: The provider has a CME mission statement that includes expected results articulated in terms of changes in competence, performance, or patient outcomes that will be the result of the program.

Criterion 2: The provider incorporates into CME activities the educational needs (knowledge, competence, or performance) that underlie the professional practice gaps of their own learners.

Criterion 3: The provider generates activities/educational interventions that are designed to change competence, performance, or patient outcomes as described in its mission statement.
The provider analyzes.

**Criterion 4:** This criterion has been eliminated effective February 2014.

**Criterion 5:** The provider chooses educational formats for activities/interventions that are appropriate for the setting, objectives, and desired results of the activity.

**Criterion 6:** The provider develops activities/educational interventions in the context of desirable physician attributes [eg, Institute of Medicine (IOM) competencies, Accreditation Council for Graduate Medical Education (ACGME) Competencies].

**Criterion 7:** The provider develops activities/educational interventions independent of commercial interests. (SCS 1, 2, and 6).

**Criterion 8:** The provider appropriately manages commercial support (if applicable, SCS 3 of the ACCME Standards for Commercial SupportSM).

**Criterion 9:** The provider maintains a separation of promotion from education (SCS 4).

**Criterion 10:** The provider actively promotes improvements in health care and NOT proprietary interests of a commercial interest (SCS 5).

**Criterion 11:** The provider analyzes changes in learners (competence, performance, or patient outcomes) achieved as a result of the overall program’s activities/educational interventions.

**Criterion 12:** The provider gathers data or information and conducts a program-based analysis on the degree to which the CME mission of the provider has been met through the conduct of CME activities/educational interventions.

**Criterion 13:** The provider identifies, plans and implements the needed or desired changes in the overall program (eg, planners, teachers, infrastructure, methods, resources, facilities, interventions) that are required to improve on ability to meet the CME mission.

**Criterion 14:** This criterion has been eliminated effective February 2014.

**Criterion 15:** This criterion has been eliminated effective February 2014.

**Accreditation with Commendation**

**Criterion 16:** The provider operates in a manner that integrates CME into the process for improving professional practice.

**Criterion 17:** The provider utilizes non-education strategies to enhance change as an adjunct to its activities/educational interventions (e.g., reminders, patient feedback).

**Criterion 18:** The provider identifies factors outside the provider’s control that impact on patient outcomes.

**Criterion 19:** The provider implements educational strategies to remove, overcome or address barriers to physician change.

**Criterion 20:** The provider builds bridges with other stakeholders through collaboration and cooperation.

**Criterion 21:** The provider participates within an institutional or system framework for quality improvement.

**Criterion 22:** The provider is positioned to influence the scope and content of activities/educational interventions.

Disclosure of conflicts of interest by anyone involved with planning or presenting the CME program will be reviewed. Disclosure of ALL commercial support will also be required.

**Financial Relationships and Conflicts of Interest**

Financial relationships are those relationships in which the individual benefits by receiving a salary, royalty, intellectual property rights, consulting fee, honoraria for promotional speakers’ bureau, ownership interest (e.g., stocks, stock options or other ownership interest, excluding diversified mutual funds), or other financial benefit.

Financial benefits are usually associated with roles such as employment, management position, independent contractor (including contracted research), consulting, speaking and teaching, membership on advisory committees or review panels, board membership and other activities from which remuneration is received or expected.

ACCME considers relationships of the person involved in the CME activity to include financial relationships of a spouse or partner. The ACCME has not set a minimum dollar amount for relationships to be significant. Inherent in any amount is the incentive to maintain or increase the value of the relationship.

**Standards for Commercial Support:** Standards to Ensure Independence in CME Activities

**Standard 1: Independence**

**Standard 1.1:** A CME provider must ensure that the following decisions were made free of the control of a commercial interest. (See www.accme.org for a definition of a “commercial interest” and some exemptions.) (a) Identification of CME needs; (b) Determination of educational objectives; (c) Selection and presentation of content; (d) Selection of all persons and organizations that will be in a position to control the content of the CME; (e) Selection of educational methods; (f) Evaluation of the activity.

**Standard 1.2:** A commercial interest cannot take the role of non-accredited partner in a joint provider relationship.

**Standard 2: Resolution of Personal Conflicts of Interest**

**Standard 2.1:** The provider must be able to show that everyone who is in a position to control the content of an education activity has disclosed all relevant financial relationships with any commercial interest to the provider. The ACCME defines “relevant financial relationships” as financial relationships in any amount occurring within the past 12 months that create a conflict of interest.

**Standard 2.2:** An individual who refuses to disclose relevant financial relationships will be disqualified from being a planning committee member, a teacher, or an author of CME, and cannot have control of, or responsibility for, the development, management, presentation or evaluation of the CME activity.

**Standard 2.3:** The provider must have implemented a mechanism to identify and resolve all conflicts of interest prior to the education activity being delivered to learners.
Dr. Van Acker Wins Everett C. Fox Award at AAD Residents and Fellows Symposium

On March 6, 2016, Monica Van Acker, DO, (pictured third from the left) was awarded the Everett C. Fox Memorial Award at the Residents and Fellows Symposium of the American Academy of Dermatology Annual Meeting.

Dr. Van Acker, a second-year resident in the Saint Joseph Mercy Health System program, under the direction of Daniel Stewart, DO, FAOCD, was one of only eleven finalists chosen to present from all osteopathic and allopathic entrants. The finalists presented their papers at the symposium. A panel of faculty judges, led by Robert Dellavalle, MD, PhD, selected the top three papers presented in each of the eligible categories—clinical and laboratory, to receive the award.

Dr. Van Acker’s paper titled, “Transcriptional Analysis Confirms Dysregulation of the Th17 Pathway in Alopecia Areata,” won second place in the laboratory category.

The Everett C. Fox Memorial Award was established to encourage research by dermatology residents and fellows. The award is supported by an endowment provided by its namesake. Dr. Fox was an educator and dermatologist who practiced in Dallas, TX until retiring in 1975.

Dr. Posnick Wins Quiz Competition at Real World For Dermatology Residents Conference

David Posnick, DO, a third-year resident in the Palisades Medical Center program under the direction of Adriana Ros, DO, FAOCD took home top honors at the Real World Dermatology for Residents Interactive Quiz at the conference in Las Vegas. Over 200 osteopathic and allopathic residents from across the country took part in the competition. Competitors were tasked with buzzing in and answering 15 challenging clinical dermatology questions before their opponents.

Sunny Chun, DO, also a third-year resident in the Palisades Medical Center program, and Chase Scarborough, DO, a third-year resident in the O’Bleness Memorial Hospital program under the direction of Dawn Sammons, DO, FAOCD, placed in the top ten.

Dr. Posnick (pictured third from the left) was awarded a Bose headset, and all three placing residents won free registration and two-night hotel accommodations for the 2017 Winter Clinical Dermatology Conference in Hawaii.

Standard 3: Appropriate Use of Commercial Support

Standard 3.1: The provider must make all decisions regarding the disposition and disbursement of commercial support.

Standard 3.2: A provider cannot be required by a commercial interest to accept advice or services concerning teachers, authors, or participants or other education matters, including content, from a commercial interest as conditions of contributing funds or services.

Standard 3.3: All commercial support associated with a CME activity must be given with the full knowledge and approval of the provider.

Standard 3.4: The terms, conditions, and purposes of the commercial support must be documented in a written agreement between the commercial supporter that includes the provider and its educational partner(s). The agreement must include the provider, even if the support is given directly to the provider’s educational partner or a joint provider.

Standard 3.5: The written agreement must specify the commercial interest that is the source of commercial support.

Standard 3.6: Both the commercial supporter and the provider must sign the written agreement between the commercial supporter and the provider.

Standard 3.7: The provider must have written policies and procedures governing honoraria and reimbursement of out-of-pocket expenses for planners, teachers and authors.

Standard 3.8: The provider, the joint provider, or designated educational partner must pay directly any teacher or author honoraria or reimbursement of out-of-pocket expenses in compliance with the provider’s written policies and procedures.

Standard 3.9: No other payment shall be given to the director of the activity, planning committee members, teachers or authors, joint provider, or any others involved with the supported activity.

Standard 3.10: If teachers or authors are listed on the agenda as facilitating or conducting a presentation or session, but participate in the remainder of an educational event as a learner, their expenses can be reimbursed and honoraria can be paid for their teacher or author role only.

Standard 3.11: Social events or meals at CME activities cannot compete with or take precedence over the educational events.
Standard 3.12: The provider may not use commercial support to pay for travel, lodging, honoraria, or personal expenses for non-teacher or non-author participants of a CME activity. The provider may use commercial support to pay for travel, lodging, honoraria, or personal expenses for bona fide employees and volunteers of the provider, joint provider or educational partner.

Standard 3.13: The provider must be able to produce accurate documentation detailing the receipt and expenditure of the commercial support.

Standard 4: Appropriate Management of Associated Commercial Promotion

Standard 4.1: Arrangements for commercial exhibits or advertisements cannot influence planning or interfere with the presentation, nor can they be a condition of the provision of commercial support for CME activities.

Standard 4.2: Product-promotion material or product-specific advertisement of any type is prohibited in or during CME activities. The juxtaposition of editorial and advertising material on the same products or subjects must be avoided. Live (staffed exhibits, presentations) or enduring (printed or electronic advertisements) promotional activities must be kept separate from CME. For print, advertisements and promotional materials will not be interleaved within the pages of the CME content. Advertisements and promotional materials may face the first or last pages of printed CME content as long as these materials are not related to the CME content they face and are not paid for by the commercial supporters of the CME activity. For computer based, advertisements and promotional materials will not be visible on the screen at the same time as the CME content and not interleaved between computer 'windows' or screens of the CME content. (Supplemented February 2014; the information that follows previously appeared in ACCME policies. No changes have been made to the language.) Also, ACCME-accredited providers may not place their CME activities on a Web site owned or controlled by a commercial interest. With clear notification that the learner is leaving the educational Web site, links from the Web site of an ACCME accredited provider to pharmaceutical and device manufacturers’ product Web sites are permitted before or after the educational content of a CME activity, but shall not be embedded in the educational content of a CME activity. Advertising of any type is prohibited within the educational content of CME activities on the Internet including, but not limited to, banner ads, subliminal ads, and pop-up window ads. For computer based CME activities, advertisements and promotional materials may not be visible on the screen at the same time as the CME content and not interleaved between computer windows or screens of the CME content. For audio and video recording, advertisements and promotional materials will not be included within the CME. There will be no ‘commercial breaks.’ For live, face-to-face CME, advertisements and promotional materials cannot be displayed or distributed in the educational space immediately before, during, or after a CME activity. Providers cannot allow representatives of Commercial Interests to engage in sales or promotional activities while in the space or place of the CME activity. (Supplemented, February 2014; the information that follows previously appeared in ACCME policies. No changes have been made to the language.) For Journal-based CME, None of the elements of journal-based CME can contain any advertising or product group messages of commercial interests. The learner must not encounter advertising within the pages of the article or within the pages of the related questions or evaluation materials.

Standard 4.3: Educational materials that are part of a CME activity, such as slides, abstracts and handouts, cannot contain any advertising, corporate logo, trade name or a product-group message of an ACCME-defined commercial interest.

Standard 4.4: Print or electronic information distributed about the non-CME elements of a CME activity that are not directly related to the transfer of education to the learner, such as schedules and content descriptions, may include product-promotion material or product-specific advertisement.

Standard 4.5: A provider cannot use a commercial interest as the agent providing a CME activity to learners, e.g., distribution of self-study CME activities or arranging for electronic access to CME activities.

Standard 5: Content and Format without Commercial Bias

Standard 5.1: The content or format of a CME activity or its related materials must promote improvements or quality in healthcare and not a specific proprietary business interest of a commercial interest.

Standard 5.2: Presentations must give a balanced view of therapeutic options. Use of generic names will contribute to this impartiality. If the CME educational material or content includes trade names, where available trade names from several companies should be used, not just trade names from a single company.

Standard 6: Disclosures Relevant to Potential Commercial Bias

Standard 6.1: An individual must disclose to learners any relevant financial relationship(s), to include the following information: The name of the individual; The name of the commercial interest(s); The nature of the relationship the person has with each commercial interest.

Standard 6.2: For an individual with no relevant financial relationship(s) the learners must be informed that no relevant financial relationship(s) exist.

Standard 6.3: The source of all support from commercial interests must be disclosed to learners. When commercial support is “in-kind” the nature of the support must be disclosed to learners.

Standard 6.4: ‘Disclosure’ must never include the use of a corporate logo, trade name or a product-group message of an ACCME-defined commercial interest.

Standard 6.5: A provider must disclose the above information to learners prior to the beginning of the educational activity.

Thank you for your continued support of the AOCN. Please call or email the AOCN office at dermatology@aocn.org if you need assistance or have questions or concerns.
Corporate Sponsors Support 2016 Spring Meeting in New York

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

New and returning corporate sponsors are as follows:

- Sun Pharma (Ruby Level)
- Galderma, Valeant Pharmaceuticals (Diamond Level)
- Lilly USA, LLC (Platinum Level)
- AbbVie, Celgene (Gold Level)
- Allergan, Anacor Pharmaceuticals, DLCS (Bronze Level)
- DUSA Pharmaceuticals, Novartis (Pearl Level)

In addition to corporate membership, Sun Pharma, has had a long relationship with the College and continues to support us through generous sponsorships. Sun Pharma’s most recent sponsorship was for the Welcome Reception that was held Thursday, March 31, 2016 in the Manhattan Ballroom of the Ritz-Carlton Battery Park. The Welcome Reception gives exhibitors and physicians the opportunity to meet in an informal setting. We appreciate everything Steve Hecklein and Sun Pharma is doing for the College and CME.

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

ProPath Laboratories sponsored our meeting lanyards. ProPath Laboratories was a new exhibitor for the 2016 Spring Meeting. We look forward to working with ProPath in the future.

Lilly USA, LLC sponsored the coffee cups for the meeting. Lilly has been a corporate sponsor and supporter of the AOCD the last couple years, this year being their first year as a Platinum Level Corporate Member. We appreciate all Ginger McWilliams, Tara Burke, and Lilly does for the AOCD. Galderma has been a longtime supporter of the AOCD. This year, Galderma sponsored the product for the cosmetic lecture Dr. Suzanne Sirotta Rozenberg delivered. We appreciate the support Tom Fitzgerald and Galderma has given the college over the past several years.

The AOCD also appreciates Allergan for providing an evening product theater on Friday, April 1, 2016. Dr. James Q. Del Rosso spoke on “Introducing New Aczone (dapsone) 7.5% gel for the treatment of acne vulgaris”. The lecture was well-attended and highly-discussed among attendees.

Exhibitors for the 2016 Spring Meeting were as follows: Aclaris Therapeutics, Inc.; Allergan; Aurora Diagnostics; Aqua Pharmaceuticals; Bayer Healthcare; Celgene; Crown Laboratories, Inc.; Dermpath Diagnostics; Dermpath Lab – Central States; DUSA Pharmaceuticals; Encore Dermatology; EzDerm; Galderma Laboratories; George Tiemann; Heartland Payment Systems; Hill Dermaceuticals, Inc.; IntraDerm Pharmaceuticals; Janssen Biotech; Leo Pharma; Lilly USA, LLC; Medimetriks Pharmaceuticals; Novartis; PharmaDerm; Promius Pharma, LLC; ProPath Services, LLP; Ra Medical Systems, Inc.; Sun Pharma and Valeant Pharmaceuticals.

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

Greetings from your AOCD resident liaison! Spring is finally here! I hope this column finds you well and allows you to welcome the new beginnings!

Thank you to all residents who responded to Dr. Desai’s request in gathering our questions and concerns regarding ACGME accreditation and the future of our in-service training exams. Dr. Suzanne Sirot Rozenberg took the time to address all resident questions regarding these pressing issues. Her responses to your submitted questions will be summarized in this column. Dr. Rozenberg, we sincerely thank you for all your contributions. Moreover, I have much to share after attending the ACGME Q&A Session with Eileen Anthony, Executive Director of the ACGME Review Committee for Dermatology, during the 2016 AOCD Spring Meeting. Before doing so however, I would like to remind you of a few housekeeping items.

Housekeeping

- First, I would like to extend a friendly reminder that individuals who did not pay AOCD membership dues by April 1, 2016, are no longer members in good standing, which is a requirement for all residents.
- **In-Training Examination**
  - The AOCD will NOT be giving an in-training examination for the 2016-2017 academic year. In its place, all residents will be required to take the 2017 ABD In-Training Exam. Registration begins November 2016. The AOCD will give a supplemental essay portion, which will cover the osteopathic component.
- **2017 AOCD Spring Meeting – Atlanta, GA, March 29-April 2**
  - Resident attendance is required for all future Spring Meetings. For our upcoming Spring Meeting in Atlanta, GA, resident lectures will take place on Wednesday, March 29. The presentation of resident awards will take place at this meeting as well. I wish all programs the best in putting together future presentations!
- **2016 AOCD Fall Meeting – Santa Monica, CA, September 15-18**
  - This meeting is not required for residents; however, attendance is encouraged.
- **Attention third year residents**
  - Regarding AOBD certifying examination, please remember that all application materials are due by July 1, 2016 for the upcoming exam held on Saturday, September 17, 2016, at the Loews Santa Monica Beach Hotel. Once you register for login credentials on the AOBD website, you will find the course for the 2016 primary exam as well as any other necessary materials required for applying at aobd.instructure.com.
  - Remember to submit your annual publication prior to leaving your program, as well as your AOCD Annual Report within 30 days of leaving your program.
  - Congratulations for reaching your dreams of becoming a dermatologist! We are all sending you good luck vibes!!! Your sincere efforts and dedication are deserving of all the success sure to come your way!
- **First and second year residents**
  - Please do not forget to submit your annual publication.

The due date of the 2016 AOCD Resident Research Paper Competition has been extended to June 30.
- Be sure to keep your patient logs updated as this will make submitting your Annual Report as efficient as possible.
- Remember that at least once in your residency you must submit an abstract to the Gross and Microscopic Symposium held by the American Academy of Dermatology (AAD). This cannot be anything that was previously published or submitted for publication.
- Second year residents are required to submit an electronic poster at an AOCD meeting. This can be from a previously published or submitted work, including the AAD symposium.
- **Newly matched residents**
  - Congratulations on matching your dermatology residency! We are all so excited for you to join our family!
  - Please be sure to respond promptly to all requests from the AOCD.

End of housekeeping…

ACGME Accreditation: Our New Beginning

First, congratulations to the programs that have successfully received ACGME accreditation and to those pending accreditation who have submitted the application. This is an immense task, and I commend the program directors and residents that have accomplished this already!

As we all move towards ACGME accreditation, it is important to remember one way we can all preserve our osteopathic distinction is by applying for Osteopathic Focus, which can be completed after receiving ACGME accreditation. I strongly encouraged us all to do this. Our allopathic colleagues also have the option to apply for Osteopathic Focus.

For those of us currently working on our application, our ACGME ADS support contact is Kevin Bannon. webads@acgme.org, 312-755-7111.

If your residency program does not plan to apply for ACGME accreditation, you can put your mind at ease because the AOCD will work with all residents to ensure they complete their training program. The new AOA Standards set deadlines for programs to either apply for ACGME accreditation, or stop accepting trainees if the trainees cannot complete the program by June 30, 2020.

For dermatology, the last day a resident can begin training in a program without ACGME accreditation is July 1, 2017.

Editorial note: Per 10.6 of the newly updated AOA Basic Documents for Postdoctoral Training: AOA programs that do not have ACGME initial or continued accreditation as of July 1, 2019 must work with their OPTI and sponsoring institution to develop and submit a plan by September 1, 2019 for the potential transfer all trainees to an ACGME accredited program. The plan will be reviewed by the Specialty College Evaluating Committee (SPEC) and PTRC for approval. This does not negate continued application for ACGME initial accreditation.

The AOCD encourages program directors and prospective residency candidates to monitor the AOA’s website for policy and procedure updates regarding the AOA Match as the Single GME Accreditation System deadline approaches.
**Fellowships**

Once your program submits the complete, 2-part ACGME application, your program will be in Pre-accreditation status. At this time, all residents in your program will be eligible to apply for ACGME accredited fellowships. All osteopathic dermatology fellowships will have to apply for ACGME accreditation.

**AOBD Board Examination**

Residents graduating from solely AOA-accredited dermatology residency programs will only be allowed to sit for the AOBD board examination.

**ABD Board Examination**

Graduating residents will NOT be eligible to sit for the ABD board examination unless the program is fully accredited by the ACGME by the time of graduation. For those of us who receive ACGME accreditation before graduation, please refer to the ABD website for the requirements on taking the ABD exam. Once initially accredited via ACGME and the AOA accreditation is closed, your program is responsible only to the ACGME.

**CME/Recertification**

Requirements are determined by which board certification you have (AOBD or ABD) and the state in which you practice. Please refer to either [aobd.org](http://aobd.org) or [abderm.org](http://abderm.org). Current AOCD members boarded by AOBD must complete AOA requirements for CME. Of note, the AOCD has been approved to seek initial accreditation from ACCME to be able to grant AMA credit. It is important to mention that the AOCD is a separate organization and still will provide opportunity for CME to our currently board-certified members. The AAD is a membership organization only and we are all very excited that AOBD-certified physicians are now allowed AAD fellow membership! Congratulations DO dermatologists!

In conclusion, I hope this column finds you well and allows you to welcome the new beginnings! I am very excited for our future as osteopathic dermatologists. I thank you for allowing me to advocate for all of our osteopathic dermatology residents this year. If you ever have any questions or concerns, please email me at [aocdresident.connection@gmail.com](mailto:aocdresident.connection@gmail.com).

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**Join Us for the 2016 AOCD Fall Meeting**

**Loews Santa Monica Beach Hotel | Santa Monica, CA | September 15-18**

**Thursday, September 15, 2016**

**CLIA Proficiency Test**
Gregory Papadeas, DO, FAOCD

**What is an Osteopathic Dermatologist?**
Reagan Anderson, DO, FAOCD

**Rules, Regulations, Compliance and Medico-Legal Considerations for Cosmetic Medicine**
Will Kirby, DO, FAOCD

**Radiation and Oncology: Traditional and New Approaches of the Nuts and Bolts**
Tim Brant, MD

**EMR Lunch Lecture**
*Melanoma*
Rene Gonzalez, MD

**Updates in Dermatology**
Karthik Krishnamurthy, DO, FAOCD

**Pearls in Rheumatology-Dermatology**
Karthik Krishnamurthy, DO, FAOCD

**Friday, September 16, 2016**

**Dermatology and Marijuana**
Marc Epstein, DO, FAOCD

**Saturday, September 17, 2016**

**Laser Fundamentals and New Technology**
E. Victor Ross, MD

**Laser Lessons Learned**
E. Victor Ross, MD

**General Pediatric Dermatology**
Lisa Swanson, MD

**Sunday, September 18, 2016**

**Medical and Legal Implications of Being a Dermatologist in 2016**
Whitney High, MD

**Top 10 Dermatopath Diagnosis and Treatment Implications**
Amy Spizuoco, DO, FAOCD

**Business of Dermatology**
Eric Adelman, DO, FAOCD

**Acne: The Old and the New**
James Q. Del Rosso, DO, FAOCD
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†Study results for one application of Neotensil in a 16-hour durability study; 4% of patients saw results within 10 minutes and 70% of patients saw results within 1 hour; N=28.
‡Study results for once-daily application of Neotensil in a 2-week pilot study; N=25.


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Hello everyone,

It was great to see all of you who were able to attend the recent Spring Meeting, and I hope to see many of you this fall in Santa Monica. With summer just around the corner, it’s a great time for a few important reminders regarding residency requirements, annual reports and resident awards.

Annual Reports
It will soon be time for annual reports to be turned in. All forms can be downloaded from our website.

It is important for everyone to remember that handwritten reports and older versions of the report forms will no longer be accepted. If old versions of the reports or handwritten reports are received, they will be returned to the resident to resubmit in the approved format.

The resident’s annual report due to the AOCD office within 30 days after the end of each training year. Residents are encouraged to keep a copy of the report for their records.

One original copy of the report should be sent. The signature page must be signed by the resident, program director and director of medical education. It is an affirmation of complete and accurate reports. Once the reports are received by the AOCD, we will upload them to FileWorks, which is our online storage system. The Education Evaluating Committee (EEC) members will then be able to view each report as they are uploaded at their convenience, allowing them more time for review. Incomplete reports will not be uploaded. Please do not fax your reports, as these will not be accepted.

All reports submitted late are subject to a late fee penalty and will not be reviewed by the EEC until the fee is paid. The late fee schedule is as follows:

- $100 for all reports submitted 30 to 365 days past deadline
- $250 for all reports submitted 365 to 730 days past deadline
- $500 for all reports submitted 731 days past deadline

Late documents will delay the approval of each year of training by the EEC and the AOA’s Postdoctoral Training Review Committee. Board eligibility is granted only upon approval by both committees. Please do not staple the forms, bind them or use color paper. Please print single-sided only. Review your report before submitting it to ensure that it is complete. Finally, report packets should be sent to the locations specified below.

If using the US Post Office, please continue to send your reports to:
American Osteopathic College of Dermatology
P.O. Box 7525
Kirkville, MO 63501

If using any other parcel service, such as FedEx or UPS, please use the following address:
American Osteopathic College of Dermatology
2902 N. Baltimore Street
Kirkville, MO 63501

James Bernard Leadership Award
With a July 1 deadline, it’s a great time to begin thinking about nominations for the James Bernard, D.O., FAOCD, AOCD Residency Leadership Award.

The award offers third-year residents a future position on an AOCD committee. Among those committees with availability are the following: Ethics, Awards, In-Training Examination, Journal, CME, and Editorial/Public Relations.

Third-year residents must be nominated by their program directors. Nomination criteria are as follows:

- Integrity—Maintains the highest personal standards of honesty, fairness, consistency, and trust.
- Respect—Displays a professional persona and is open-minded and courteous to others.
- Empowerment—Provides knowledge, skills, authority, and encouragement to fellow physicians and staff.
- Initiative—Takes prompt action to avoid or resolve problems and conflicts.

In addition, the resident must be a member in good standing of both the AOCD and AOA.

Applications will be reviewed by the Awards Committee, which will forward its recommendations to the national office. Winners will be notified by mail. All correspondence concerning the program and/or awarded grants should be directed to the Awards Committee.

Winners of the award will be recognized at the 2017 Spring Meeting.

AOCD Resident Research Paper Competition
I also want to remind everyone that the entry deadline for AOCD Resident Research Paper Competition has been extended to June 30. Annual awards are presented to recognize the osteopathic dermatology residents’ papers which are judged as the best in this competition. All papers submitted will be reviewed by the AOCD Resident Research Paper Competition Committee. Papers will be judged for originality, degree of scientific contribution and thoughtfulness of presentation. Cash awards have been provided by Lilly USA, LLC for 2016.

Requirements for competition:

- The resident must be in an approved AOA/AOCD dermatology training program.
- Complete the enclosed cover sheet.
- Submit six (6) copies of the paper to be judged.
- Only one paper per year may be submitted.
- The paper must have been written and submitted while the resident is in training.
- The paper must be typed and suitable for publication.
- Authors’ names are not to be included on the paper itself, only include the title on the paper. Names of the authors are to be placed on the cover sheet only.
- Papers submitted for the competition do not automatically become part of your annual training reports. If it is to be used as your annual paper, it must also be submitted to the AOCD National Office with your annual reports.
- Do not ship or mail the papers in a manner that requires a signature for delivery.
Failure to follow the competition requirements will result in disqualification.

Submissions should be addressed as follows:
Dr. Gene Conte
271 Thoroughbred Drive
Prescott, AZ 86301

Once again, the deadline for submission is June 30. Winners will be announced at the 2017 AOCD Spring Meeting.

Koprinse Winners Announced for the 2015 Fall Meeting
Congratulations to the following programs who were selected as Koprinse Award recipients for their lectures presented at the 2015 Fall Meeting in Orlando:

- NSUCOM/Largo Medical Center for their presentation Pediatric Epidermal and Appendageal Tumors: An Update
- St. Barnabas Hospital for their presentation Pediatric Pigmented Lesions
- Texas OPTI/UNTHSC for their presentation Pregnancy Dermatoses
- University Hospitals Regional Hospital for their presentation Photodermatoses

Incoming Residents for 2016-2017
I would like to introduce the new residents joining our programs for the 2016-2017 year. The AOCD will welcome 55 new residents on July 1. The incoming residents (listed with their programs) are as follows:

- Advanced Desert Dermatology
  - Jonathan Bellew, D.O.

- Affiliated Dermatology
  - Dylon Howard, D.O.
  - Dustin Mullens, D.O.

- Botsford Hospital
  - Derek Hirschman, D.O.
  - Roxanne Rajaii, D.O.

- CEME/Park Avenue Dermatology
  - Alyssa Miceli, D.O.

- LECOM/Dermatology Residency of Orlando
  - Jeffrey Collins, D.O.
  - Elyse Julian, D.O.
  - Michael Noparstak, D.O.

- LECOM/Tri-County Dermatology
  - Olga Demidova, D.O.
  - Laura Jordan, D.O.

- Lehigh Valley Health Network
  - Carl Barrick, D.O.
  - Claire Otteni, D.O.

- LewisGale Hospital-Montgomery/VCOM
  - Nathan Miller, D.O.
  - Robert Murgia, D.O.

- MSUCOM/Lakeland Regional Medical Center
  - Ryan Jones, D.O.

- Still-OPTI/Northeast Regional Medical Center
  - Ryan Jackson, D.O.
  - Leslie Marshall, D.O.

- NSUCOM/Broward Health Medical Center
  - Trevor Batty, D.O.
  - June Kunapareddy, D.O.
  - Miguel Villacorta D.O.

- NSUCOM/Largo Medical Center
  - Meheera Farsi, D.O.
  - Kelley Segars, D.O.
  - Jason Solway, D.O.

- O’Bleness Memorial Hospital
  - Gabriela Maloney, D.O.

- Oakwood Southshore Medical Center
  - Rachel Cetta, D.O.
  - Sonam Rama, D.O.

- OMNEE/Sampson Regional Medical Center
  - Dana Baigrie, D.O.
  - Joseph Prohaska, D.O.

- OPTI-West/Silver Falls Dermatology
  - Devin Burr, D.O.
  - Seth Goodman, D.O.
  - Anne Nguyen, D.O.

- OPTI-West/Aspen Dermatology
  - Andrew Jensen, D.O.
  - John Howard, D.O.
  - Andrew Jensen, D.O.
  - Liz Levacy, D.O.

- O’Bleness Memorial Hospital
  - Gabriela Maloney, D.O.

- South Texas Osteopathic Dermatology
  - Ryan Scheuring, D.O.

- St. Barnabas Hospital
  - Monica Huynh, D.O.

- St. John’s Episcopal Hospital, South Shore
  - Vladyslava Doktor, D.O.
  - Shoni Rozenberg, D.O.
  - Adrian Tinajero, D.O.

- St. Joseph Mercy Health System
  - Felicia Ekpo, D.O.
  - Luke Killpack, D.O.
  - Adam Richardson, D.O.
  - Shahrzad Akbari, D.O.

- University Hospitals
  - Gregory Delost, D.O.
  - Emily Shelley, D.O.

- West Palm Hospital
  - Jessica Kim, D.O.
  - Matthew Uhde, D.O.

- OPTI-West/Silver Falls Dermatology
  - Collin Blattner, D.O.
  - Karsten Johnson, D.O.

Documentation needed for new residents
New residents beginning training in July 2016 should submit all of their application materials to the national office. Dues should be paid at this time, if payment has not been made this year. Those who have already paid student dues for the current year will owe a balance of $25 when they begin training in their residency program. If you are uncertain if you have paid this year, please feel free to contact me.

All residents are asked to provide the following documents:

- A copy of your medical school diploma (and exact date of graduation)
- A copy of your internship diploma (exact dates of attendance and name and address of school)
- A copy of your state license
- 2 passport size photos
- A current CV

Finally, I would like to wish our graduating residents all the best as you begin your careers as attending dermatologists. It has been a pleasure working with you all. To the incoming first-year residents, congratulations on earning your positions. I look forward to working with each of you over the next three years.
2016 AOCD Spring Meeting Highlights

BY LAURA JORDAN, D.O.; BRANDON BASEHORE, OMS-IV & SHANE SWINK, OMS-II

American Contact Dermatitis Society Core Allergen Series

Peter Saitta, DO

- 20% of all rashes in children are due to contact dermatitis
- Patch testing
  - The patch test reader influences the reproducibility rate
  - Baseline series based on populations and geographic areas
  - Not recommended in children 8 years and younger; follicular reactions can occur; chance of scarring; chance of anaphylaxis
- Thimerosal
  - Found in vaccines, ophthalmic, and nasal products
  - Controversy over if it causes autism; nothing to support this at this time
  - 4.53% with positive patch test reactions; none of these cases were relevant
- Metals
  - 10-15% of the world population has metal hypersensitivity
  - Patients often allergic to >1 metal
  - Nickel
    - Most common cause of ACD
    - Sources include stainless steel, cookware, metal jewelry, perspiration, food (soil, water)
    - Not all buttons and belts have sufficient nickel to cause ACD
  - Clinical presentations
    - ID reaction (acute and symmetrical, pruritic, red papules on LATERAL arms, legs, trunk, and neck)
    - Dyshidrosis
    - Systemic contact dermatitis (Baboon syndrome); macular and brighter rash; inner thigh, flexural folds
- Potassium dichromate
  - Sources include: metal alloys, cement (most common cause of sensitization in men), leather
- Palladium chloride
  - Component of white gold
  - Patients allergic to palladium are also allergic to nickel
- Cobalt
  - Found in dental metal alloys, blue and green pigments, vitamin B12
  - Poral effect: pinpoint follicular purpuric papules
  - Large percent of people allergic to cobalt are also allergic to nickel; very expensive to separate the two metals
  - Gold
    - 30% positive patches with only about half which hold relevance
    - Dermal contact dermatitis
    - Can have rash on eyelids or face because of handling
    - Chrysiasis: blue grey pigmentation (when gold seeps out of metal and dyes skin blue)
    - Dermatitis to metal implants
    - Local or generalized rash
    - Metal allergy diagnosed before implant surgery did not increase the risk of implant failure. After implant is in patients could develop delayed hypersensitivity reactions at the implant area.
    - Most common with knee arthroplasty
    - Pain is most common symptom
    - Anesthetics
      - Ester-sensitive individuals can safely use amide-derivatives and vice versa
      - Cross-sensitivity inconsistent in same group
      - Benzocaine 5% cross-reactions
        - Procaine hydrochloride
        - PPD
        - Sulfonamides
        - PABA in sunscreens
      - If patient is allergic to PPD and Benzocaine then they are allergic to all of the above
      - Caine Mix II 10%
      - Lidocaine 15% pet
      - Shoe dermatitis
        - Rubber adhesives is most common cause; followed by mercaptobenzothiazole, thiuram mix, and P-tert-buty-phenol
        - Clinical picture
          - Dorsal foot and toe involvement, sweat, thin stratum corneum; can be just one toe (great toe); toe webs spared; metatarsalphalangeal joint involvement
          - Sole involvement: spares instep, flexural toe creases, toe webs
          - Mercaptobenzothiazole 1%: rubber adhesive
          - Mercapto mix: rubber bands, adhesives
          - Carba mix: rubber accelerators
          - Thiuram mix: rubber accelerators; including antabuse
          - P-tert butylphenol formaldehyde: glue, neoprene adhesives, rubber shoe-lining

By Laura Jordan, D.O.; Brandon Basehore, OMS-IV & Shane Swink, OMS-II

Colgeene
Psoriasis Comorbidities
Jerry Bagel, MD

- Psoriasis is a psychological condition
- Plaque psoriasis
  - Accounts for >80% of cases
  - Common sites: elbows, knees, lower back
- Cardiovascular disease
  - Associated with multiple comorbidities that increase risk of cardiovascular disease: HTN, diabetes, dyslipidemia, and obesity. There is a 50% increased risk of mortality and 5 years of life lost in severe psoriasis.
  - Psoriasis is independently associated with MI; people with severe psoriasis, especially in younger age group, have greater association
  - 3 times as many people with psoriasis have DM compared to those without psoriasis
  - Age of psoriasis onset associated with earlier comorbidity and mortality (<25yo)
- Patients’ perception of disease severity doesn’t directly correlate with skin area involved (patients’ self-reported disease severity can be greater than their self-reported BSA)
  - Increase in anxiety, suicide, depression, and use of SSRIs in people with psoriasis
- DLQI (Dermatology Life Quality Index)
  - 60% of people with psoriasis believe it has an impact on their quality of life
  - Greater PASI reduction correlates to greater improvement in DLQI
- Employment
  - Full-time employment decreases with psoriasis severity
  - Job negatively affected by psoriasis
  - Severe psoriasis correlated to lower income

Problem Psoriasis
Mark Lebwohl, MD

- My patient is doing well. Should I give him a rest from his biologic? (drug holiday)
  - Retreatment of patients in an episodic treatment fashion can lead to development of antibodies. Studies have shown that loss of responders due to antibody formation is worse in infliximab and adalimumab than in etanercept and ustekinumab.
  - Many of these drugs improve psoriatic arthritis; however, these data are based on continuous therapy (and not taking drug holidays)
  - Answer: NO
- My patient is having major surgery; does he have to stop his biologic?
  - Consider suspending TNF blockers before surgery for four half-lives
- My patient has recurrent MRSA infections. Is she no longer a candidate for psoriasis therapies that suppress the immune system?
  - Correct the MRSA; MRSA eradication regimen
  - Antimicrobial body wash
  - Mouthwash
  - Hand disinfectant
  - Disposable combs
  - Disposable disinfectant wipes for surfaces
  - Mupirocin ointment to affected area
  - Change linens daily
  - Examine children, partners
  - 5 day regimen; 10 day regimen if it doesn’t work, coupled with oral antibiotics
  - Is it important to treat psoriatic arthritis early?
    - Answer: YES; those treated earlier did better
  - Note: Methotrexate doesn’t prevent joint damage on x-ray. Also, no evidence supports methotrexate improving synovitis.
  - What tests should I follow to monitor my patients on biologics? What vaccines should I administer?
    - Tests
      - PPD (before treatment and annually)
      - Hepatitis profile (before treatment, repeat if increased LFTs)
      - CBC (before treatment and every 2-6 months)
      - Chem (before treatment, every 2-6 months; if treated with IFX, then check Chem at beginning of each 1-2 infusions)

2016 Spring Meeting State and Regional Attendance Breakdown
• ANA (most don’t check but some perform before treatment)
• Vaccines
• Give primary immunizations before treatment
• Vaccinate household contacts
• Avoid live vaccines
• Increase of VZV in patients treated with TNFs; however, there is a possible association of lower rate of postherpetic neuralgia in these patients. This finding reduces some of the urgency to give the live shingles vaccine.

• How does biologic therapy affect my patient’s risk of malignancy?
• 50% increase in non-melanoma skin cancer in patients on TNF blockers
• In patients on biologics, for which malignancies is there evidence of an increase?
• NMSC
• MM
• Lung cancer in COPD
• Lymphoma
• NOT in most solid tumors
• For which patients should you raise the possibility of malignancy if they are started on a biologic?
• History of lymphoma, deep melanoma, multiple SCC’s, smoking/COPD, ANY non-cured malignancy, ALL patients

**Diagnosis and Treatment of Adnexal Tumors**
**Amy Spizzuco, DO**

- Hair follicle tumors
  - Trichofofficuloma
    - Benign, solitary; head and neck
    - Hist: dilated central hair follicles; usually contains keratinous material
  - Trochoadenoma
    - Benign, nodular; face and buttocks
    - Hist: dermal; epithelial islands; central cystic cavity with keratinous material
  - Trichoepithelioma
    - Benign; solitary, multiple, and desmoplastic variants; central face
    - BCC v. TE: CD34 negative within the tumor in BCC; positive in the stroma for TE
    - Papillary-mesenchymal bodies: cuplike proliferations of basoid cells
    - Brooke-Spiegler syndrome: germline mutations in the CYLD gene
    - Desmoplastic TE: benign; hist shows cords of small nests of basoid cells, scanty cytoplasm, horn cysts, comma-shaped epithelial projections
  - Paisley tie DDX: syringoma, microcystic adnexal carcinoma, BCC (morphoform)
  - Trichoblastoma
    - Benign; head and scalp
    - Hist: irregular nest of basaloid cells with pilar differentiation
  - Cutaneous lymphadenoma
    - Benign, rare, prominent lymphocytic infiltrate in tumor nests; face and legs in adults
  - Tumor of the follicular infundibulum
    - Is: follicular origin; benign; head, neck, upper chest
    - Hist: can resemble BCC, SM; pale staining, peripheral palisade of basal cells
  - Dilated pore of Winer
    - Benign; head and neck, upper trunk; commonly seen in elderly patients
    - Hist: dilated follicular pore extending into dermis; keratohyaline granules; acanthosis; no pilar unit
  - Pilar sheath acanthoma
    - Benign, upper lip
    - Hist: central dilated follicular cavity with keratin
  - IFK
    - Benign, derived from infundibulum
    - Hist: endophytic, finger-like projections
    - No mitotic figures; no atypical cells (versus SCC)
  - Trichelemmoma
    - Outer root sheath differentiation; clear cell change/glycogen; solitary
    - Cowden’s syndrome (multiple form): PTEN hamartoma syndrome
    - Hist: sharply circumscribed; one or more lobules; squamoid cells/glycogen vacuolization
  - Desmoplastic form
  - Pilomatrixoma
    - Calcifying epithelioma of Malherbe, benign; from hair follicle matrix, B-catenin gene mutation, teeter-totter sign; head, neck, and upper extremities
    - Variant is multiple seen in muscular dystrophy, Turner’s syndrome, trisomy 9, Sotos syndrome, Gardner’s syndrome
    - Hist: sharply demarcated, lower dermis, calcification; basophilic and eosinophilic cells present
  - Fibrofolliculoma/trichodiscoma
    - Seen in Birt-Hogg-Dube Syndrome: AD, FLCN gene
  - Benign; seen on face
  - Histo: FBF: cords of epithelial strands; TDC: fascicles

- Neurofollicular hamartoma
  - Commonly seen on the nose
  - Hist: Hyperplastic pilosebaceous unit

- Sebaceous tumors
  - Ectopic sebaceous glands
  - Fordyce’s spots and related ectopias; not associated with pilosebaceous unit
  - Hist: sebaceous glands without attached follicles
  - Folliculosebaceous cystic hamartoma
    - Composed of folliculosebaceous structures
    - Hist: infundibular structures, cystic; mesenchymal stroma tends to be fibrous
  - Sebaceous hyperplasia
    - Hist: mature sebaceous lobules grouped around one cystic duct
  - Steatocystoma
    - Benign; cystic structure lined by epithelium resembling sebaceous duct; seen in pachyonychia congenita; keratin 17 mutation
  - Muir-Torre syndrome [AD, subtype of HNPCC, associated with keratoacanthomas; MSH2 (90%) microsatellite instability]

- Apocrine tumors
  - Apocrine hidrocystoma: cysts lined by two cell layers
  - Syringocystadenoma papilliferum: benign; on histo will see duct-like structures, diffuse amount of plasma cells
  - Benign apocrine tumors
    - Hidradenoma papilliferum: partly cystic, partly glandular; ‘decapitation’ secretion
    - Tubular adenoma: benign; cheek, axilla, breast; circumscribed lobules; ‘decapitation’ secretion
    - Hidradenoma: stroma-hyalinized collagen, well-circumscribed
    - Apocrine mixed: benign, solitary, middle-aged to elderly males; epithelial component in a myxoid, chondroid, fibrous stroma
    - Cylindroma: benign, solitary; multiple are seen in Brooke-Spiegler; poorly circumscribed, irregularly shaped
    - Spiradenoma: benign, solitary, painful; found in head, neck, trunk, extremities; collection of basaloid cells in epidermis; many lymphocytes; trabecular arrangement
Our Goal Is Clear

Visit booth 261

Allergic Contact Dermatitis: North American Standard Series, Part II
Peter Saitta, DO

P-Phenylenediamine 1% (PPD)
- Hair dye prevalent; PPD is a hapten; found in almost all permanent hair dyes
- Three basic clinical presentations
  - Angioedema-like reaction
  - Eczematous reaction (14%, scalp margin, superior helix)
  - Long lasting reactions (50% remain at 3 weeks)
- There are about 100 ingredients in hair dyes; Cross reactions with PPD and P-toluenediamine and disperse orange
- Do reading on day 4 for patch testing if you can only do one reading. Perform reading on day 3 and day 5-7 if you can do two readings.
- 12/7% cross-sensitization with textile dyes; common with panty-hose
- Black henna tattoo
- Studies on hair dressers with hand eczema: initially ICD but later ACD; PPD is most common allergen

Glyceryl Thioglycolate 1% pet.
- Used as perming solutions; persistent chemic and can lasts for months to years after contact
- Used in depilatory agents (Nair, Veet products)

Formaldehyde 1%
- Ubiquitous; in everything; wrinkle-free clothing (rarely in now); paper products and smoke (in extremely sensitive individuals)
- 51% of patients with formaldehyde ACD have reactions for years
- If someone is allergic to formaldehyde they are not necessarily allergic to formaldehyde releasers and vice versa; but they should avoid formaldehyde releasers

Formaldehyde-releasing agents
- Quaternium 15 (releases the most amount of formaldehyde); most common cause of contact dermatitis in cosmetics
- Most common preservative in cosmetics; moisturizers (79%)
- Diazolidinyl Urea
- DMDM hydantoin
- Imidazolidinyl Urea
- Bronopol
- Paraben Mix 12%
- Most common preservative to cause contact dermatitis
- Found in foods and topical drugs used to treat leg ulcers or stasis dermatitis
- Avoid cross-reactions with: butyl, ethyl, methyl, propyl, and associated trade names
- Weakly positive reactions may actually be irritant reactions
- Methylchloroisothiazolinone/Methylisothiazolone 0.1% (MI/MCI)
- Combination found in rinse off products (shampoos, soaps, etc)
- Recently a decrease has been noted in this allergic reaction to MI/MCI combination
- Allergic response to MI increased because companies used MI alone in higher concentrations; thus, we missed noting allergic reactions as companies split MI/MCI and dispensed separately at higher concentrations
- If allergic to MI, avoid all isothiazolinones
- If allergic to MCI, may not be allergic to all isothiazolinones
- MI: found in paints; wet wipes (recurrent dermatitis on child’s buttock and face, hand in caretaker, Cottonelle and Huggies wipes

Clinical presentations
- Post-auricular seborrheic dermatitis presentation
- Caretaker hand dermatitis
- Impetigo-like presentation in a child (very vigorous presentation)

Methyldibromo glutaronitrile/Phenoxyethanol 2% pet
- Lubriderm products
- Demonstrates hyper-reactivity upon allergen re-exposure (found in this allergen and nickel); T-lymphocytes remain at location of reaction; upregulation of CCL27

Fragrance allergy
- Fragrance compound is used to neutralize odor (this can be called “fragrance-free”); when a fragrance is used to create a pleasant scent, then it is not “fragrance-free”
- Patch testing
  - Fragrance mix I and mix II (75% will test positive)
  - Fragrance mix I, mix II, and balsam of Peru (90% will test positive)
- Most common cause of ACD in cosmetics; most common cause is cinnamic alcohol (found in balsam of Peru)
- Hand dermatitis is most common reaction, followed by face and neck dermatitis

Pigmented contact dermatitis
- Non-eczematous; lacks sign of dermatitis (no itching, erythema, or scaling)
- Presents as hyperpigmentation on the face
- Histo displays PIH, accumulation of hemosiderin, and incontinentia pigmenti histologica (no epidermal spongiosis; basal layer destruction; accumulation of melanin pigment)
- Requires frequent and repeated contact with allergens (clothes, fragrances)
- Pigmented contact cheilitis: diffuse hyperpigmentation of lower lip; commonly caused by lipsticks, mustache hair dye,
green tea (high amounts of nickel)
• Not treatable with corticosteroids; must avoid allergen for months to years

Pitfalls and Pearls of Dermatology Practice 2016

Steven Grekin, DO
• Affordable Care Act (ACA)
  • General points
    • Studies demonstrate only modest benefit in patient outcomes
    • No actual decrease in healthcare spending
    • Actual IN Network, Out of Pocket maximum costs have increased
    • Deductibles, copays, and coinsurance have increased
    • 70 changes to ACA so far
    • The newly insured are unemployed, paying $60 a month, with a $5000 deductible
    • Marketplace exchange: provides a set of government-regulated and standardized health care plans from which individuals may purchase health insurance eligible for federal subsidies
    • The ACA will force more communication between physician and patient about costs of procedures; patients may opt out of services because of costs; costs are driving care
    • Increasing rules and regulations have limited practices
  • Merit-Based Payment Incentive System (MIPS)
    • Based on MU, PQRS, VBM, and clinical practice involvement
    • MIPS amplifies and consolidates the application of incentives and penalties while relying on the performance measurement rules of the three individual programs
    • The poorest performing physicians determined by their composite score will see their payments cut by up to 9%
  • Clinical practice improvement
    • Expanded practice access, population management, care coordination, patient safety and practice assessment, participation in APMs
    • Decreasing reimbursement
      • Independent payment advisory board: 15 members appointed by the President; aim is to reduce per capita growth rate in Medicare spending; physicians will be primary targets
      • Non-profit patient-centered outcomes institute: examines clinical effectiveness of medical treatment, procedures, drugs, and medical devices
    • Physician quality reporting system: AAD trying to develop meaningful quality measures
  • What’s the solution? Change
    • Consolidate—consider joining groups to spread out overhead and strengthen reimbursement, negotiations. This protects dermatology from primary care. Become the “big dog” in the room so that insurance companies must listen to you.
    • Stay informed—become familiar with practice realities; learn about different payment models
    • See more patients—add one more patient per day to fill gap. It’s your obligation to see more patients and to offer care.
    • Establish a dashboard—measure everything (open slots in schedule, no show rate, invest in resources that compare yourself to similar practices, assess practice patterns that may trigger an audit)
    • Calculate—what is the procedure value per hour; utilize non-physician clinicians and other ancillary personnel to full extent; free up physician to see more patients and generate more revenue; cut wasteful spending; analyze expenditures quarterly
    • Collect—collect co-pays upfront
    • Improve patient satisfaction—the customer is always right; prior experience is the most important antecedent of satisfaction; give them realistic expectations of treatment outcomes; use your patient’s name and details about personal life
    • Text and email reminders; send birthday cards to patients

Use of PAs in Successful Dermatology Practice
John Minni, DO; Jeff Johnson, PA
• History of the PA Profession
  • PAs
    • Trained under medical model
    • Must work under a supervising physician
    • Not now, or will ever be in direct competition with physicians
    • Defined: medical providers who are licensed to diagnose, treat, and prescribe medications to patients
  • Brief History
    • Take advantage of military-trained combat medics
    • Training modeled the fast track for Physicians in WWII
    • Design was for PAs to “think like a doctor”
    • Work closely with physicians
    • Duke University 1965 – first class of PAs
  • PA Education
    • Modeled on physician education: One year basic medical sciences; clinical phase training (specialties)
    • 2000 hours of supervised clinical practice
  • Scope of practice within physician-led team
    • A PAs scope of practice is determined by:
      • Individual training
      • State law
      • Facility policy
      • Agreement of responsibilities with supervising physician
  • Current status of the PA profession
    • Approx. 70,000 practicing PAs
    • 2800 currently in the field of dermatology; 3.6% of all practicing PAs
    • Since the inception of the profession, the PA commitment has been to a physician-led team of healthcare professionals
  • What’s the liability in hiring a PA?
    • Theory: PA school is shorter duration, which may lead to more errors of cognition and judgment
    • However, PAs may carry less litigation risk than physicians
    • PAs often treat patients with less acute conditions
    • More complicated patients are left to the physician
Advances in Metastatic Melanoma Therapy
Anna Pavlick, DO

- Overview of cutaneous MM
  - If caught early, it is 95% curable
  - 1 in 50 Americans will be diagnosed
  - One or more blistering sunburns as a child doubles melanoma risk
  - Use of tanning beds dramatically increases melanoma risk
  - Less than 5% of all patients survived for 5 years with metastatic disease prior to 2011
  - 50% with metastatic disease develop brain metastases
- Targeted therapies
  - Mutations in MM: BRAF (50%), NRAS (25%), MEK, KIT, GNAQ (ocular melanoma), GNA11 (ocular melanoma)
  - BRAF
    - Mutated in approximately 50% of melanoma; most common mutation is V600E; younger age, fewer markers of chronic sun damage in the trunk; worse overall survival

BRAFi: Vemurafenib, Dabrafenib
MEKi: Trametinib (adverse effects include extremely pustular acne when given by itself, lacy erythematosus rash, and erythema surrounding tattoos)
Combination of targets on BRAF and MEK increase efficacy duration
Possible adverse effects of BRAFi: arthritis, myalgias, rash, hepatotoxicity, hand foot syndrome, pyrexia (after about 4 weeks of therapy with dabrafenib), photosensitivity, new cutaneous skin cancers (when patients were on solo BRAFi versus combined therapy with MEKi); diffuse macular rash

Checkpoint inhibitors
- Anti-CTLA4 monoclonal antibodies for melanoma
  - Stimulate T cells to recognize cancer antigens and develop mechanisms for cell death
  - Break tolerance of T cells to self antigens in order to permit anti-tumor response
  - Potential side effects are autoimmune diseases
  - Ipilimumab
    - Augments T cell activation and proliferation by binding tightly to the CTLA-4 receptor and blocking CTLA
    - Toxicities include: thyroiditis (1.5-2.5%; begin as hyperthyroid), panhypopituitary hypophysitis (4%; present with central headache), adrenal failure (1.5-3%), ALT/AST rise (30%), hepatitis (4%), colitis diarrhea (30%), dermatitis (43.5%; usually very pruritic)
    - Endocrinopathies usually occur after treatment
    - Pseudo-progression: may occur when T cell infiltration causes tumors to flare or new lesions to appear upon imaging. If your scan looks bad, but your patient looks good---indication of pseudo-progression.
- Anti-PD1 Antibodies for melanoma
  - Targets PDL-1 and 2 receptors on tumor cells
  - As a single agent approximately 30% of patients with MM respond
  - Less side effects compared to ipilimumab
  - Given by vein every 2-3 weeks depending on PD1 compound
  - Side effects include rash, itching, diarrhea and pneumonitis
  - Anti-PD-1: Nivolumab, Pembrolizumab
  - Dual checkpoint blockade with anti-CTLA4 and anti-PD1
- Conjugated monoclonal antibodies
  - Glembatumumab
    - MOA: CR011=vcMMAE binds to GPNMB on the surface of cancer cells. After internalization, the valine-citruline linker is cleaved by endosomal enzymes. Free MMAE inhibits tubulin polymerization, leading to cell death.
    - Skin rash only occurs in warm and moist places; in folds

Manifestations and Treatment of Cutaneous Venous Hypertension
Ronald Bush, MD

- Spider Veins
  - Most spider veins are related to an area of venous HTN.
  - Reticular veins are the final pathway for transmission of venous HTN in the majority of patients but not all.
  - Reticular veins are usually connected to a deeper source
The branches of the reticular complex in the majority of clinical situations are the final pathway leading to cutaneous telangiectasias. The GSV, SSV, AAGSV, and thigh extension branch can transmit abnormal pressure to the skin if incompetent. Ultrasound: use the ultrasound at 2cm depth to trace reticulers to origin of HTN; all pathologic pathways will reflux. Pathogenesis of spider veins: Secondary to high venous pressure which causes dilatation of the smooth vessel wall of the venules in the reticular dermis; one constant finding in spider vein telangiectasia is vessel wall hypertrophy. Histological studies find that there is always an abnormal valve. Reticular veins are conduits of flow and pressure. Length of spider vein is directly proportional to the amount of pressure beneath the surface. Treatment of spider telangiectasia (4 steps): Unload cutaneous venous HTN: a punch biopsy disconnects the cutaneous telangiectasia; also the branch feeding the cutaneous pathology may also be removed at the same time. Treat spider vein. Assess collateral flow. Minimize sequelae. Evaluation of clinical and histo findings using varying sclerosant concentrations for the treatment of spider telangiectasia: Sclerosing agents: destroy endothelial cells and expose subintimal layers to the sclerosant with eventual fibrotic occlusion of the vein. Undesirable effects: vessel wall necrosis with extravasation of red cells, leading to inflammatory changes and/or angiogenesis. Agents included were Sotradecol and Asclera (Polidocanol). Evidence of muscle wall damage is visible on microscopic analysis of fibrin replacement of smooth muscle cells. Ideal concentrations were found to be Sotradecol 0.15% and Polidocanol 0.31%. Clinical findings: mild staining post treatment occurred in 50% of patients.

Venous Ulcers: Occur in 1% of the population. Increase in leg ulceration is directly related to post exercise venous pressure. Leukocytes accumulate in the leg under conditions of high venous pressure; this activates a cascade of events at the micro-circulatory level that may lead to ulceration. Treatment: Standard of care: compression (archaic); even with compression alone, there is still a high recurrence rate. TIRS (Terminal Interruption of Reflux Source): the percutaneous technique allows for the treatment of venous ulcers with or without the availability of an ultrasound. 3mL of foam is injected using 1% sclerosant; if the patient is anticoagulated use 3%. Rapid healing of ulcer in most patients within 4-6 weeks. Occupational and Environmental Dermatology

David Cohen, MD

Occupational skin disease is basically everything that general dermatologists deal with in the office every day. Skin disease is the number one organ affected by the workplace, and has been that way since the 1930s. Nowadays, skin disease is roughly 12% of work related disease, second to repetitive stress injury (carpal tunnel, i.e.). Because we got much better at recognizing and treating cases of contact dermatitis largely. Epidemiologic data across large populations is a major source of the strides made in this field. In the late 80s, there was an epidemic of rubber allergens from glove use. This coincides with the introduction of universal precautions. Then this epidemic decreased because glove production changed. In 1992 the German government outlawed hair permanents because of the increasing number of work related injuries due to the use of this chemical. Evaluating occupational causality: questions to consider/ask when talking with patients: Is the clinical appearance consistent with contact dermatitis? Are their workplace exposures to potential irritants or allergens? Is the anatomic distribution of the dermatitis consistent with cutaneous exposure in relation to the job task? Is the temporal relationship between exposure and onset consistent with contact dermatitis? Does dermatitis improve away from work exposure to the suspected irritant or allergen? Are non-occupational exposures excluded as probably causes? Do patch tests or provocation tests identify a probably causal agent? Follow up the criteria: 4 of the 7 must be positive to conclude occupational dermatitis.

Contact dermatitis:
- Most obvious and commonly affected area is the hands
  - "Common allergens cause contact dermatitis, commonly"
  - Prevalence is 5-10%
  - Twice as common in women
  - Those exposed to frequent hand washing or solvents is one of the most common causes
  - Atopic dermatitis is recognized as a top risk factor for hand eczema
  - Chronic hand dermatitis can lead to effacement of dermatoglyphics over the fingertips
- Predictive factors of hand eczema
  - Contact sensitization is an independent risk factor for hand eczema
  - Fragrances and isothiazolines
  - Other risks: atopy, xerosis, hay fever, filaggrin null mutations
- Hand dermatitis is the most common skin complaint reported in workers’ compensation cases; Adds up the greater than 1.5 billion dollars in lost work
  - Most common in: healthcare, custodial, and machinists
  - Most common allergens: rubber, epoxy
- Health care works evaluated for contact dermatitis
  - Most commonly allergic to preservatives and rubber
- Shoe induced dermatitis
  - Similar allergens than the hands, but not the same
  - Most commonly: glue used to make shoes, belts, and watches, chromium, rubber
For eczema-prone skin

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GALDERMA

Choosing the best patients to patch test

1st: Vesicular palmoplantar dermatoses >>> hand and foot dermatitis >> fissured > hyperkeratotic
Psoriasis has not been shown to increase or decrease the prevalence of occupational dermatitis

Thiourea
• Common component of rubber products that causes contact dermatitis
• Found in: sneakers, computer wrist rests, globes, rubber based automobile products, splints and foot supports, neoprene grip on gym equipment

Para-phenylenediamine (PPD)
• A common allergen found in hair dye and fur dye
• 75% of women admit to dying their hair and close to 20% of men
• This includes highlights!
• This exposure occurs at a median age of 16
• This is a common cause of occupational dermatitis in hairdressers. This is a critical component of their job, with the highest margins of profit for their work.
• This product is also found in temporary henna tattoos, which is a rising concern
  • It has more PPD than hair dye

Methylisothiazoline (MCI)
• Studies show up to 25% of patients have an allergy to this preservative
• All ages, including infants are affected
• Risks: hair and beauty, healthcare, painting, welding, machine operators, wipes, cleansers
• It can penetrate latex gloves
• Tell patients to wear two sets of gloves (one on top of each other) and to change them frequently. This will help to reduce the cases of contact dermatitis.
• When patch testing patients with suspected contact dermatitis, the results help to increase prognosis in 2/3 of patients

Polychlorinated biphenyls (PCBs)
• Colorless to dark brown thick liquids with low water solubility
• Great insulators often seen in transformers and heat exchangers often seen in hot water tanks (like in hotels)
• These were banned in 1977
• Over 1 billion pounds were manufactured, but half of that has leaked into the environment
• Chloracne lasts for about 4 years after exposure, but pitted scarring remains

Osteopathic Continuous Certification (OCC)
• Those with time limited certificates must do the OCC
• AOBD.org has been revamped and instructions/registration can be found there
• The upcoming AAD vote to give DOs full fellow membership ends on April 4th

Cases from “A Day in the Life of a Dermatologist”
• 59 yo female with joint swelling of fingers that retreated with raw diet
  • Erythema of the nose and left cheek was observed
  • Biopsy showed granulomatous dermatitis à sarcoidosis
  • Presents as lupus pernio, red lesions, notes, cheeks, and fingers
• 75 yo male, thick generalized scale since childhood, with strong familial presentations
  • Histopathology shows epidermolytic hyperkeratosis
  • Epidermolytic Ichthyosis
    • Bullous congenital ichthyosiform
    • Autosomal dominant disease
    • Treatment is really limited to emollients
• 35 yo male with reticulated poikiderma of neck, chest and shoulders, hypodontia, nail dystrophy, chronic skin and mucosal irritation
  • Atypical dentition is present
  • Biopsy showed chronic ulceration
  • Dyskeratosis congenital
    • Bone marrow failure syndrome. These patients are at high risk for squamous cell carcinoma and lymphoproliferative disease
• 39 yo male with ulcers on skin over three years, progressively worsening
  • Erosions have orange-brown coloration
  • Patient was a heroin addict, but on methadone chronically
  • This patient had a fixed drug eruption from omeprazole use
  • Follow up patient taking imiquimod
  • Red eyes, edematous and erythematous lips and tongue, mucosal erosion, vesicular palmar eruption, and generalized diffuse erythematous popular eruption, and some central eruption
  • Diagnosis is erythema multiforme induced by imiquimod
  • Treated with supportive care
• 69 yo female presents with history of skin dysesthesia and “substances” extruding through skin
Patient sends samples to be tested (bags and bags full of samples)

- Lots of notes documenting the "substance" extrusion
- Upon entering the room, the patient has subtle grayish-blue pigmentation of the face, nailbeds
- Biopsy shows brown/black stipling of eccrine gland
- Diagnosis is argyria
- Products marketed as dietary supplements can still contain silver despite FDA ban in 1999

- 68 yo female, hospitalized for sepsis, developed ARF during the stay requiring renal artery embolization with gadolinium contrast. She had hardening and thickening of skin 11 years later.
- Soft brown plaques over the legs; Biopsy shows infiltrates of fibroblasts in the dermis and a scant amount of mucin, and “lollipop bodies”
- Diagnosis was nephrogenic systemic fibrosis (NSF)
- Gadolinium is chelated by the kidney, but not in cases in chronic kidney failure; In these cases, it can spread to the other tissues of the body
- This particular patient had acute renal failure, and had returned to normal, however, she still had continuing developing lesions
- No evidence for efficacy of chelation therapy
- 20 yo female presents with scaling erythematous linear plaques on her legs since two months old
- Biopsy shows psoriasiform dermatitis
- Diagnosis: ILVEN
- Treatment: ablation therapy (not efficacious in this patient)
- Excimer laser was much more effective for these plaques
- 59 yo old male transferred to burn unit from outside hospital with history of b cell lymphoma presents with desquamation of the skin and blistering
- Extensive desquamation of the skin
- Frozen jelly roll shows in tact epidermis, some necrotic keratinocytes, but not full thickness
- Biopsy shows subepidermal clefting, acantholysis, dyskeratotic cells
- Diagnosis paraneoplastic pemphigus, but looks like TEN
- 70 yo female presents with brown spots on the cheeks
- Subtle black/brown pinpoint papules on the cheeks, both are involved
- Biopsy shows deposition in upper dermis of brownish discoloration and waxy ocher like deposition of material
- Urine negative for homogentistin acid
- Diagnosis is exogeneous ochronosis
- Hydroquinone is a common cause, rarely phenolic compounds (phenol, piric acid)
- vespheine IIse (2 phenylphenol) was the cause in this patient
- 25 yo male presents with facial rash with other involvement, spares nose, ear, and perioral area with sharp cutoffs
- Rash is a scaling white dermatitis that responded to topical steroids but would reappear with cessation
- No alopecia noted
- Biopsy shows perifollicular lichenoid infiltrate with exocytosis of lymphocytes
- Diagnosis is folliculotropic mycosis fungoides
- <10% of MF cases, with or without mucin, predilection for head and neck, follicular prominence
- Treatment is poor to respond, PUVA is an option, 15 year survival is 40%
- 60 something yo female has targetoid asymptomatic rash on her right thigh
- Histopathology did not show features of erythema migrans
- It did show diffuse erythrocyte extravasation
- Some cases have been reported of unconventional patterns of erythema migrans
- Diagnosis “Casino Carpet Dermatitis”
- Cleared up with doxycycline
- 78 yo male presents with keratotic papule on the arms
- Squamous cell carcinoma, cleared margins
- On follow up, a new squamous appeared next to scar with clear margins
- He presents with another keratotic papule, excised with clear margins, and the progression continues up to four excisions

- Field Cancerization
- Clusters and contiguous patches of altered cells in photodamaged skin; Multiple clonally related neoplastic tumors can develop.
- He was sent to radiation oncologist for xray therapy; He presented after treatment with even more lesions
- Intralesional 5-FU was used and the lesions eventually resolved
- Female presents with brown patch on her ankle
- Biopsy was consistent with tinea versicolor, with dark hyphae
- Diagnosis was actually tinea nigra (an uncommon superficial dermatomycosis) caused by Hortaea weneckii or Stenella araguata
- Often seen in tropical regions, relatively uncommon in the US
- Three cases occurred in northeast PA in a short amount of time
- Possible climate change or travel related exposures?
- Male presents with 18 year history of squamous cell carcinoma on the scalp, and was referred to neurosurgery

Atopic Dermatitis Update
Brad Glick, DO

- Chronic pruritic eruption, relapsing
- Factors contributing to pathogenesis: environmental, genetics, immunology, epidermal barrier dysfunction
- Most common chronic skin disease of children
- Persists into adulthood in 10-30% of cases
- Increased prevalence noted in industrialized countries
- Threefold risk in atopics to have asthma, rhinitis, food allergy
Non-allergic comorbidities: mental health, HTN, obesity, infections, sleep disturbances

Commonly affected areas
- Infants: face and extensor areas
- Children: flexural areas
- Adults: variable

Signs and symptoms: pruritus, eczematous dermatitis, xerosis, urticarial eruptions; lichenification at sites of chronic rubbing and scratching

Immunopathophysiology
- Excessive T cell response; Langerhans' cells thought to play major role; superantigens; imbalance of Th1/Th2
- Outside in hypothesis: FLG mutation associated with early onset AD and often more persistent and debilitating; fewer filaggrin repeats correlate with dry skin; reduction of skin integrity and greater TEWL; reduction and dysfunction of both skin surface proteins and ceramides
- Inside out hypothesis: associated with T helper cell dysregulation, mast cell hyperactivity, and IgE production; IL-31 associated with pruritus in AD; activity of cytokines persist
- Role of Phosphodiesterase: increased in AD; inhibitors of PDE increase IC cAMP and reduce inflammatory cytokines
- Antimicrobial peptides in AD: correlation with predisposition for cutaneous infection in staph carriage

Common triggers
- Anxiety, climatic factors, irritants, microbial organisms, contact or inhaled antigens
- Colonization with S. aureus; scratching results in bacterial adhesion; microbiome shifts occur

Clinical assessment
- Pruritis, erythema, edema, excoriation, lichenification
- Cutaneous hyperreactivity; variable and difficult to predict
- Variations: palmar/plantar, eyelid, hand, nipple, cheilitis
- In African Americans AD is more papular, follicular, PIH
- HSV and AD: eczema herpeticum

Management
- Monitoring IgE is not recommended as there is no correlation with disease severity
- Patient education is key
- Diagnosis and assessment: allergic contact dermatitis, CTCL in adults, scabies, seborrheic dermatitis, etc

Goals of therapy: control flares, minimize pruritus, intervene with topical steroids; restoring barrier; good skin care routines (soak and seal; short bathing time, emollients); wet wrap therapy (soaking three times per day for 15 minutes)
- Impaired barrier function limits treatment results
- Therapy in general is stepwise
- OCT/Rx topical corticosteroids are mainstay; beware of side effects such as striae, acne, rosacea, atrophy
- A bis when indicated
- Phototherapy: successful for chronic disease, requires multiple office visits
- Topical calcineurin inhibitors: second line; not in children younger than 2yo; should be used for short periods of time; not in immunocompromised patients; patients don’t suffer from the side effects that can occur in topical corticosteroids
- New topical therapies
- PDE inhibitors (Crisaborole): naturally occurring product; most common side effect is application site irritation; favorable safety profile
- JAK inhibitors (topical tofacitinib 2% ointment in phase II RCT)
- Calcineurin inhibitors
- Systemic therapies
- Indicated in severe AD
- Systemic steroids: generally advisable to avoid yet still frequently used in children because there aren’t any other options
- Cyclosporin: use short duration
- MTX: safe, underutilized therapy
- Azathioprine: variable responses; better on cost; use in children; check TPMT level before starting therapy
- Mycophenolate mofetil: trials not abundant, efficacy variable; disadvantages with long term use (congenital malformations, 17 cases of PML)
- Biologic therapy in AD
- IFN gamma: negative findings
- Mepolizumab,omalizumab (neg findings)
- TNF inhibitors
- Rituximab
- Targeted therapy (dupilumab)
- Targets against IL-4 and IL-13
- Significant improvement in SCORAD and IGA with dupilumab versus placebo
- New therapies
- Apremilast: PDE4 inhibitor; investigations underway in variety of systemic inflammatory immune mediated diseases; open label study underway for AD adults
- Ustekinumab
- Nemolizumab (CIM331) increased sleep efficiency and decreased use of hydrocortisone butyrate; improvement in skin was modest but significant reduction in pruritus

Adherence to Treatment
Steven Feldman, MD
- Getting patients to use their medicine is an easy way to clear up many conditions, such as atopic dermatitis; Think of it as “low hanging fruit”
- Do we need new drugs… or do we just need patients to use their medicines?
- Big reasons for poor treatment outcomes:
  - Poor compliance is most likely
  - 40% of patients admit to noncompliance
  - Many patients don’t even fill prescriptions, and psoriasis patients are some of the worst
- Studies monitoring patients usage of medication versus their reported usage shows that patients lie about their actual usage
- However, adherence rates decrease as time increases
  - Tachyphylaxis à the less you use the medicine so quickly is because their medicine, the less it works
  - In addition, increased visits increases patients usage of drugs and improves their overall condition
- You might suspect that patients with more severe diseases will use their medication more, but this is not the case
- Studies of adherence to biologics show that patients sometimes go months between doses
- What you can do is to ask patients if they’re keeping their extras refrigerated like they’re supposed to. If they say yes, you know they’re not taking them appropriately.
- Moving a follow up visit closer to an initial visit will increase compliance
- A major reason that patients stop using medicine so quickly is because their condition starts to clear up right away
- Encourage better compliance by
  - Good relationship
  - Involve patients in planning
  - Don’t scare them with side effects
  - Choose fast acting agents
  - Return visits are key
  - Clear, written instructions are helpful
• Keeping patients waiting and spending little time with them will decrease patient satisfaction, but only by a little amount. If patients think you don’t care about them, this more significantly decreases their satisfaction.
• A key to dermatologic therapeutics is to make patients feel like you care about them
• Interventions to appear caring
  • Sit down, examine patients carefully (palpate the rash, waive a magnifier over lesions), asking a few questions about the disease (“Your previous treatments have probably been frustrating…”), address psychosocial issues (use support groups), while washing your hands inform the patient they know you’re doing that to protect them from disease
  • Don’t look at your watch! Put clocks on the wall behind patients.
• Other pearls
  • Choose vehicles that patients will use; Patients prefer solution, foams, but the best choice is the one they’ll use
  • Simplify treatment as much as possible; Adherence is better with less products
  • Visits are you most powerful tool!
    • Kids with atopic dermatitis did much better with 1 week follow ups compared to 4 weeks
    • Makes people get the medicine and use it
  • Giving patients your cell phone number is a powerful statement of how much you care (whether you answer the phone or not)
  • Do NOT pre-print your cell phone number on your business card!
  • Electronic reminders to use medication does not seem to increase adherence
  • Teen psychology: watch out for oppositional defiant behavior. DO NOT tell them that many others are non-adherent (they want to be like others!)  
  • Side effects: “Sting means it’s working!” “Spironolactone is a diuretic…so you may notice some weight loss” 
  • Prescribe “all natural” treatments 
  • Do not use the word “steroid” with a mom. They are “all natural topical anti-inflammatory”
• The rate of hyperkalemia in healthy young women taking spironolactone (0.72%) for acne is equivalent to the baseline rate in the general population (0.75%)
• Conclusion: routine monitoring of K+ levels in healthy young women taking spironolactone is UNNECESSARY
• Laboratory Monitoring During Isotretinoin Therapy for Acne
  • Evidence from this study does not support monthly lab testing for use of standard doses of isotretinoin
• Acne in Adult Women
  • Conventional discussion on U-shaped pattern of inflammatory acne on lower face and submandibular-lateral neck
  • Therapeutic focus has been on use or oral contraceptives and spironolactone
  • Absence of studies on pathophysiology, presentations, and treatment in adult women with acne
  • Comparative efficacy and tolerability of Dapsone 5% in Adult v. Adolescent Females with Acne: Greater effects and better results seen in ADULTS
• Challenges related to evaluation of baseline and follow-Up Severity
  • Patients at either end of severity spectrum (high or low) are often left out of the studies
  • Visible difference in acne severity not captured by lesion counts or IGA
• Use of Antibiotics for Treatment of Acne
  • How to Use Antibiotics More Responsibly When Treating Acne
    • Recognize that abx are like knives, they are excellent tools when used properly
    • Accept that if you can avoid abx use and resistance, this is a good thing
    • Accept that abx resistance is an unavoidable consequence of use of abx and some antimicrobial agents (triclosan)
    • Ask yourself, “Is abx therapy needed for this patient?” If so, anticipate and discuss your “exit plan” from the outset
  • New oral abx?
    • Small, film-coated doxycycline 150 mg oval-shaped tablets and 75 mg round tablets purposefully designed to be easy to swallow; Film-coated tablets have decreased GI adverse effects
• Isotretinoin fasting v. fed absorption values
• Taking isotretinoin in a fed state (fatty meal) increases the bioavailability
• Absorica is pre-solubilized in fat; Difference in bioavailability of fed v. fasting state is small

Therapeutic Update
James Del Rosso, DO

• Potential Changes in Approaches to Laboratory Monitoring
  • The usefulness of potassium monitoring among healthy young women taking spironolactone for acne

My Approach to Cosmetic Dermatology
Laura Benedetto, DO

• Procedures
  • Neuromodulators: Botox, Dysport, and Xeomin
  • Fillers: HA’s, calcium hydroxyl apetite, poly lactic acid, silicone
• Aging changes
  • Intrinsic aging
  • Photodamage (sun exposure): wrinkles, surface changes, pigmenary changes
• Patient evaluation
  • Patients don’t know what they want really; don’t understand how their face ages
- Most point to nasolabial fold and marionette lines but just filling in these lines leads to poor cosmetic result (pudgy face)
- HA's
  - Are forgiving, go away, are immediate, can dissolve with hyaluronidase
  - Most popular fillers; best to start in
- Calcium hydroxyapatite (Radiesse)
  - Thicker product; watch for vascular occlusion; face and hands
- Available with and without lidocaine; With lidocaine creates a thinner product that is easier to massage in the hands
- Poly lactic acid
  - Synthetic polymer; results take months (2-3 treatments minimum); lasts years; highly technique dependent product
- Indicated for restoration and/or correction of the signs of facial fat loss in HIV patients
- Polylactic acid aesthetic (Sculptra) is intended for use in people with healthy immune systems for correction of shallow to deep nasolabial food contour deficiencies and other facial wrinkles
- Response to injection: involves several progressive phases; there is an immediate mode of operation related to injected volume and injection-related edema resolves in a few hours to days; tissue response includes foreign body reaction and gradual production of collagen as polymer degrades (collagenesis)
- Used for volume and lifting, duration (persist for up to 2 years), and biocompatibility
- Sculptra evaluation: examine and study face, mark off face, explain results will be gradual, multiple treatments will be needed, and ask patient to bring in photos from 10-20 years ago
- Adverse events: avoid lip vermillion, 1cm above lip, keloid formers; inject subcutaneous supraperiosteal; allow enough time in between injections, use adequate dilution
- Pretreatment care: discontinue aspirin, motrin, fish oil, vitamin E. Use arnica Montana two days before, day of and day after may reduce bruising. Eat pineapple two weeks before procedure. Make sure patient understands they may bruise. Application of topical anesthetic.
- Treatment: will need an assistant when administering Sculptra as you will need to work quickly
- Post-treatment: massage, ice, instruct patient to ice that day, have patient start massaging the next day (3 times per day/5 minutes for 1 week); concealer may be applied immediately after if bruising noted (Glo, Dermablend)
- Tips: never overcorrect; be conservative in younger patients; you have more leeway in older patients; harder to correct in older patients; younger people heal faster and they will have a more robust collagen response
- Avoid clogging: mix at least 24-72 hours beforehand; refrigerate after 72 hours
- Silicone
  - Permanent product; good for lips, scars and “fixed” scar like wrinkles; never goes away but patients age and need more because of more collagen loss
  - Tuberculin syringe with micro-droplet technique; usually requires 2-3 treatment sessions, 6-8 weeks apart
- Deoxycholic acid (Kybella)
  - Recently approved for treatment in submental fat in the neck
  - Requires several treatments
- Youthful face
  - Cheek bones heart shaped for women; male face is angular (keep it that way)
  - Face loses volume with structural changes, lifestyle changes
- Consult
  - Hand patient mirror and ask them what bothers them
  - Assess degree of damage, amount of improvement expected, timeline for improvement and budget
  - Come up with a plan

Superficial Radiotherapy Updates

David Herold, MD

- How radiation works: normal cells can repair DNA damage more effectively than cancer cells if only low doses are delivered with time in between fractions
- As the lesion grows in size, fractionate and give a smaller dose
- Brachytherapy:
  - Can treat large and small lesions, mobile truck, emerging data
  - But higher cost, source contracts, need vault/shielding, need physicist and doctor direct supervision
- Electronic brachytherapy
  - Small, inexpensive, minimal shielding
  - Scarce data
  - Need to know physics and radiobiology to best manage patients with this treatment. No therapy is without risks.

Medicare Fraud and the False Claims Act (FCA)

Ted Schiff, MD & Daniel R. Miller, Esq.

- History of the FCA
  - During the civil war, there were many problems the Union army faced that lead to many losses
  - One of President Lincoln's solutions was to establish the FCA in order to investigate these problems such as poor uniforms, sawdust mixed with gunpowder, and lame horses
  - This is the same law that impacts physicians today
  - FCA allows those to file suits against those claiming certain goods or services but not providing them fully
  - During WWII in 1943 the FCA was greatly weakened by congress against multiple filed suits
  - 1986 Reagan strengthened the FCA in response to overcharging by defense contractors
  - Financial crisis of 2009 significantly strengthened the FCA with a focus on financial institutions
  - The Affordable Care Act significantly strengthened once more the FCA, especially in relation to medical fraud
  - Since the late 1990s, healthcare fraud is the major focus of the use of FCA (80%)
  - It returns $20 for every $1 invested in health care related cases
- Process of filing a claim
  - Recognizing a problem, specifically fraud against the US government (Specifically in health care à Medicare/Medicaid fraud)
From hard-to-reach spots to large body areas...

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

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

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

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

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

For topical use only. Please see adjacent page for full prescribing information.

For more information, visit www.kenalogspray.com

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

KENALOG® is a licensed trademark of Bristol-Myers Squibb Company.

KS 1212
• Do an investigation
• Contact an attorney
• Collect evidence
• Round up witnesses and exhibits
• Claims are filed under seal
• After filing a claim
  • The DOJ would evaluate the claim. They may request an interview.
  • 90% of cases are declined by the government (many are just disgruntled employees who want to give their employer a headache)
  • If they intervene, the DOJ will investigate the case with multiple agencies
  • The US government is the plaintiff
• Internal organ involvement was most commonly observed in
  • Ro/SS-A antibody + patients with LE presenting with LE-nonspecific cutaneous manifestations
  • Ro/SS-A antibody + patients presenting with acute cutaneous LE and mucosal LE high risk (highest frequency of lupus nephritis and serositis)
• Approximately 50% of patients with subacute lupus erythematosus
• Patients with SLE (versus SCLE) have oral ulcers, + anti-dsDNA, + ANA, low complement
• Cutaneous lupus
  • Tumid lupus
    • Patients do not get systemic disease
    • Diagnosis: clinical (nonscarring plaques with a smooth surface in sun-exposed area)
    • Treatment: antimalarials, topical steroids/intralesional kenalog, dapsone, sun protection
  • DLE
    • Increased prevalence/severity in black/Hispanic peds
    • Can be seen without serologic or systemic manifestations of SLE
    • Follicular plugging
    • Chronic lesions may show hypopigmentation with atrophy
    • Most common in head and face
  • Management:
    • Spontaneous involution with scarring is common; rarely BCCs or SCCs may occur in scars
    • Treatment of localized disease with topical steroids or intralesional steroids (don’t go deep)
    • Photoprotection and Vit D supplementation
    • Generalized DLE requires systemic therapy with Plaquenil and if not effective add quinacrine
• Neonatal lupus erythematosus
• Dermatologic disease (transient effects; 50% of patients with NLE)
• Cardiac disease (permanent effects, responsible for mortality in 15%)
• Papulosquamous variant (most common); annular variant; raccoon eyes appearance
• Immunofluorescence staining pattern (homogenous, peripheral, speckled, nucleolar, centromeric)
• False positives: pregnancy; elderly persons
• Heart block seen in up to 50% of patients; permanent defect. Risk for mothers with subsequent pregnancies.
• Plaquenil clinical pearls
  • High affinity for melanin-containing tissue; <1% risk of eye damage; don’t need eye exam unless patient has been on medication for over a year
  • Increased chance for skin cancer with lupus patients who smoke
  • Treatment: alitretinoin for CLE (not approved in US yet); apremilast (PDE4 enzyme inhibitory)
• Sarcoidosis
  • “Great imitator”—should always be on your differential with funky things
  • Higher female preponderance; more likely to be chronic and fatal in black Americans
• Cutaneous disease in 30%
• Can occur in tattooed areas
• Lofgren’s syndrome (erythema nodosum)
• Heerfordt’s syndrome
• Darier-Roussy Disease (keep in your mind)
• Papulosquamous variant (most common); annular variant; raccoon eyes appearance
• Melorheostosis (candle wax dripping)
• Clinical: muscle weakness, shortens muscles, immobilizes joint, growth retardation in children; may effect trigeminal nerve and cause hemifacial atrophy
• En coup de sabre (unilateral on forehead; can involve underlying CNS conditions and cause seizures)

Dermatology Rheumatology: Lupus, Sarcoidosis, and Morphea

Adam Friedman, MD

• Autoantibodies
  • Positive ANA titer does not equal diagnosis; don’t give out diagnoses lightly
  • ANA screening tool; good sensitivity but low specificity

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We are now accepting manuscripts for publication in the upcoming issue of the JAOCD. ‘Information for Authors’ is available on our website at www.aocd.org/jaocd. Any questions may be addressed to the editor at journalaocd@gmail.com. Member and resident member contributions are welcome. Keep in mind, the key to having a successful journal to represent our College is in the hands of each and every member and resident member of our College. Let’s make it great!

- Karthik Krishnamurthy, D.O., FAOCD, Editor
• Treatment: topical tacrolimus, low dose UVA1, medium dose UVA1, NB-UVB, MTX, calcipatriol and betamethasone
• Pirfenidone gel (new antifibrotic therapy)

Allergic Contact Dermatitis: North American Standard Series, Part III

Peter Saitta, DO

• Sesquiterpene Lactone Mix 0.1% pet
• Plants from composite or asteraceae family
• Patients allergic to sesquiterpene may react to plants or pollen
• May produce contact dermatitis (type 4); can have recurring contact dermatitis from fall to frost
• Compositae family
• Arnica can also cross react with the ragweed group
• Chamomilla roman 1%
• Yellow dye extracted from dried flower heads of the compositae family, shampoo, vegetable hair dye, mirror manufacturing, drinking chamomile can flare original area of dermatitis
• Alpha-tocopherol 100%
• Oral vitamin E doesn’t cause systemic allergic reactions; topical can cause ACD and contact urticarial
• Lavender absolute 2.0%
• Obtained from steaming lavender plants; needs to be autooxidized in order to be allergenic
• When you do a patch test with lavender and you get a strong reaction, it is likely your patient is likely allergic to all the components in the mix
• Airborn dermatitis seen with aromatherapy
• Linalool 10%
• Factor of lavender Absolute 2.0%
• Tea tree oil 5.0%
• Main allergenic component is D-limonomae
• Propolis 10%
• Derived from tree resin; contains cinnamic acid and vanillin
• May cross react with Balsam of Peru
• Can have honey (non-reactive)
• Neomycin sulfate 20%
• Most common allergen for antibiotics
• Causes follicular contact dermatitis (can’t transcend the epidermis to form a normal rash because it is a large molecule; also seen in metals like cobalt)
• Triclosan 2%
• Ethylenediamine dihydrochloride 1%

• Occupational allergen
• Medication exposures: cross reacts with hydroxyzone; sensitized from Myoclog cream; only found in creams; bronchodilators
• Epoxy Resin 1%
• Sensitization only occurs in uncured epoxy resin
• Patients do NOT have to avoid plastics and rubbers (unless they use these in an industrial way)
• Tosylamide/Formaldehyde Resin
• Durability to nail polish and lacquer (not particular to any color)
• Clinique and Almay nail polishes do not have these resins
• Ethyl Acrylate 0.1% pet
• Glues; cross reactions among acrylates are common
• Ethyleneeglycol Dimethacrylate 2%
• Propylene glycol 5%
• Enhances absorption (water channels in epidermis connect and form channels in epidermal layer)
• Humectant (takes water from dermal BV and moves it to the epidermis)
• Preservative
• Can cause irritant contact dermatitis
• Intoxication in a premature infant when wounds were being dressed with propylene glycol
• Found in food: Duncan Hines cake mix, Durkee, Jello, Kraft, Pepperidge Farms, Pillsbury, Sara Lee
• Corticosteroids
• 3 clinical scenarios: chronic dermatitis, fails to respond to steroids, rarely dermatitis that worsens with steroid
• Co and cross reactions present
• Inhaled, oral, and intramuscular steroid exposure; systemic contact dermatitis, widespread purpura, widespread urticarial
• Need delayed readings for corticosteroid allergen testing (day 10), vasoconstriction, vasodilation (impalpable erythema at first reading), paradoxical edge effect (positive test; negative test for anything other than steroids), edge effect (usually considered an irritant reaction
• No animal studies on steroids; only clinical and molecular studies
• Group A, B, and D are highly co-reactive (ex. Buesonide)
• Group C does not cross react with other corticosteroid groups (Topicort/Desoximetasone, Clderm/ Clocortolone)
• Group D subdivisions
• D1 C16 methyl substitution and halogenation
• D2 lack prodrug
• D2 metabolites significantly cross react with group A and group B
• Sodium Metabisulfite 1%
• Antioxidant in pharmaceutical creams, printing, and photography
• Marker for sulfite allergy
• Sorbitan sesquioleate 20%
• Sorbitol based emulsifier; high to super potent topical steroids; baby products (Desitin)—recurrent diaper rash that won’t go away
• Must avoid ALL types of sorbitol
• Latex Allergy
• Type 4 reaction
• Type 1 reactions: contact urticaria
• Coaimdopropyl Betaine 1%
• Surfactant; irritant reactions
• Amidoamine 0.1%
• Used in synthesis of cocaimidopropyl betaine
• Contaminant
• Benzophenone
• Oxybenzone in sunscreens; immediate urticarial reactions; most common photosallergen in sunscreen
• Textile dermatitis
• Disperse dyes used to color synthetic textiles; azo dyes (disperse blue 106/124)
• Color of the dye has no bearing on color of the garment
• Dyes are metabolized by skin bacteria
• Cross-sensitivity with para-aminocompounds (P-toluenediamine; disperse orange)
• Rare; anterior/posterior axillary folds (sparing the vault); seldom itchy
• Dimethyl dihydroxylethylene urea 4.5%
• Permanent press clothing, low-formaldehyde releaser, 500-750ppm to induce ACD
• Lanolin alcohol 30% and amemorol L 101 00%
• Mixture of esters and polysters from sheep wool
• Composition can vary
• Uncommon to have reactions on normal skin; high non-reproducibility rate
• Eucerin products (aquaphor)
• Allergens in cleaning products
• Methylisothiazolinone; formaldehyde
• Fabric softeners: isothiazolinone
• Pine smell: citronella oil
• Laundry detergent is a very rare cause of contact dermatitis
Aero-allergen triggered atopic dermatitis

- Atopic patch test: allergens that elicit an IgE-mediated reaction; no antihistamines for one week prior to patch testing; remission of atopic dermatitis
- Aero-allergens exacerbate AD
- High reproducibility rate
- Black dermographism
- Depends on hardness of the metal; role of cosmetics; all metals can theoretically produce black dermographism; chlorides in sweat

Pediatric Dermatology
Sourab Choudhury, DO

- Hemangioma
  - Majority are not present at birth but appear in first few weeks of life
  - Some can be associated with respiratory problems; however, most do not require treatment
  - Propranolol can be used for treatment of severe hemangiomas of infancy
  - Important to get cardiac clearance before starting
  - Side effects: hypoglycemia, bronchospasm (don’t use in asthmatic patients)
- Atopic dermatitis
  - Basic treatment regimen
    - Daily bath 10-15 minutes
    - Mild soap: dove, cetaphil
    - Topical steroid
    - Moisturizer: aquaphor, eucerin cream
    - Oral antihistamine: benadryl, atarax
    - Topical immunomodulator: protopic, elidel
    - Barrier treatment and bleach baths are new to therapy
    - Atopic march
    - Be proactive with patients; find the minimum amount of treatment necessary to keep them from flaring

Cosmetic Dermatology
Suzanne Sirota Rozenberg, DO

- Treatment of staph aureus colonization in AD decreases disease severity. Bleach baths can help or swimming in the pool three times per week.
- Molluscum contagiosum
  - Dome shaped papules with central umbilication; very common
  - Basic treatment regimen
    - No treatment necessary usual course 1-2 years
    - Topical imiquimod
    - Cantharidin
    - LN2
    - Curettage
    - Oral cimetidine
    - Candida antigen immunotherapy
      - (1st treatment 0.1cc in 1 molluscum; 2nd treatment 0.2 cc in 2 molluscum; 3rd treatment 0.3cc in 3 molluscum)
  - Imiquimod injection: unpublished study found that it was not beneficial in treatment of MC; consider stop using
  - Gianotti Crosti Like reaction: inflammatory papules even where the MC exists
- Pigmentary disorders
  - Tinea versicolor
  - Topical selenium sulfide; oral diflucan for severe cases
- CARP
  - Minocycline treatment
  - Associated with obesity and insulin resistance
  - Progressive macular hypomelanosis
  - Topical antibacterials could be used for treatment as P. acne is thought to be involved
  - Hypopigmented MF in differential
- Bites
  - Bed bugs: “Breakfast, lunch, and dinner”

Approach to the aging face

- Knowing your facial anatomy is key!
  - It’s critical to know the function of the muscles you’ll be working with
  - All first time patients get numbing, and then it’s as needed per patient
  - “Botoxnatomy” is a great resource to correlate structure and function
  - Arterially: the main area of concern is the superior labial and transverse facial arteries near the alar sulcus. As well as in the glabella region. These are worrisome for developing necrosis.
  - Neuromodulators and fillers should be a normal part of your everyday practice
- Assessment
  - Be realistic with your patients and don’t set too lofty of goals
  - Know your patients pain tolerance
  - Assess the bruising risk,
  - Add volume to tissue to push out each smile, frown, or squint will contribute to wrinkles
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be minimized; But in these mirrors they are much more obvious
• Don’t be afraid to tell a patient no

Malignant Adnexal Tumors
Michael Nowak, MD

• Lesions should be classified so it’s easier to remember and to also understand their behavior based on appearance (Follicular, sebaceous, apocrine, and eccrine)
• Most of the adnexal tumors are highly malignant
• Benign versus malignant
  • Size, symmetry, circumscription
  • Cytological atypia, mitotic figures, architecture
  • Metastases
  • Rapid enlargement can also be a feature of malignancy
  • Immunohistochemistry does not define malignancy
• Adnexal versus epidermal
  • Epidermal continuity
  • Differentiation
  • Immunohistochemistry
  • When you don’t see epidermal connections on pathology, you should suspect adnexal tumors
• Adnexal versus metastatic
  • Also think about metastatic lesions – they are very easily mistaken with one another
  • Some may be ER/PR, so understand patient history and maybe refer to OBGYN
• Pitfalls to diagnosis
  • Poor sampling
  • Lack of differentiation
  • Benign and malignant components
  • Unable to recognize the benign component
  • Metastatic lesion (clinical history, P63, etc.)
• Malignant cylindroma
  • Occur in elderly patients predominately; Slight female predominance
  • Frequent recurrence and metastasis, can present with multiple cylindromas
  • Some of these lesions are classified in various lines of differentiation
    • Follicular, eccrine, and apocrine
  • Deep invasion, atypia, mitoses
  • Malignant poroma (porocarcinoma)
  • Occurs on the legs and feet, eroded red nodule
  • De novo or malignant transformation
  • Eroded, erythematous nodules; Deep infiltration at the base
• Borst-Jadassohn phenomenon: the epidermis has clones of cells in clusters
• Malignant spiradenoma
  • This is normally a deep dermal nodule without epidermal components
  • Seen in young adults, M=F
  • Associated with Brooke-Spiegler syndrome
  • Surgical excision is recommended due to recurrence and metastasis risk
• Malignant nodular hidradenoma
  • Clear cell morphology (mimics renal cell Ca)
  • Older adults, M=F
  • ER/PR, recurrence and metastasis common
• Malignant chondroid syringoma
  • Wide age range, F>M, extremities
  • Glandular and stromal component
  • Very high rate of recurrence and metastasis
• Carcinomas with follicular differentiation
  • Malignant proliferating trichilemmal tumor
    • Sudden scalp nodule, resembles SCC, no surface changes clinically
  • Trichilemmal carcinoma (not that rare, better prognosis)
    • Elderly, face/ears, indurated plaque with surface changes
    • Recurrence and metastasis are uncommon
    • Periodic Acid-Schiff positive clear cells
    • Associated Pagetoid pattern occasionally
    • Unusual in Cowden’s disease
• Pilomatrix carcinoma
  • Elderly, M=F
  • Cellular basaloid tumor
  • Symmetric and infiltrative
  • Shadow cells and cystic necrosis
  • Frequent recurrence and metastases
• Trichoblastic carcinoma
  • Middle age to elderly, M=F
  • Face and scalp > trunk and extremities
  • Really resembles BCC
    • Best way to recognize is to notice no refraction artifact
    • Frequent recurrence and metastases
• Clear cell tumors
  • Adnexal tumors
  • Metastatic carcinomas
  • Ballo ncell nevus and melanoma
  • Clear cell BCC and SCC
  • Clear cell DF and AFX
  • Salivary gland tumors
  • Sebaceous carcinoma
  • Ocular type
• 75% of sebaceous carcinomas. <1% of eyelid tumors.
• Upper eyelid, elderly, F>M
• Most common arises from meibomian glands
• High rate of metastases
• Easily mistaken for chronic chalazion
• Pagetoid spread
• Atypical cells show foamy cytoplasm (lipid)
• Oil Red O positive, CEA/EMA +
• Extraocular type
  • Head and neck; May have regional metastases, but don’t have a poor prognosis
• Muir Torre Syndrome
  • Variant of Lynch Syndrome
  • Associated with malignancies (GI and GU)
• Mutations in DNA mismatch repair genes and microsatellite instability
• Carcinomas with apocrine differentiation
  • Apocrine carcinoma
    • Very rare, but has all of the features of metastatic breast cancer
    • Axilla most frequently
  • Extramammary Paget’s Disease
    • Vulva most common, male genital area, perianal area, and axilla
    • Sharply demarcated erythematous patch, pruritus is common
    • Can be primary or secondary
    • Cytokeratin 7 positive
• Pagetoid Pattern DDx
  • Paget’s disease/Extramammary Paget’s disease
  • Melanoma/MIS
  • SCC in situ
  • Sebaceous carcinoma
  • Pagetoid reticulosis
• Carcinomas with eccrine differentiation
  • Classic type eccrine Ca
    • Extremely rare; Head and neck region; High rates of metastases
  • Syringoid eccrine Ca
    • Head and neck, low metastatic rate, perineural invasion and common recurrence; Deeply infiltrative
    • “comma and tadpole forms”
  • Micocystic adnexal Ca
    • Middle aged, F>M, upper lip, common recurrence but rare metastasis
    • Deeply infiltrative
    • Horn cysts in the upper dermis with perineural involvement
• Mucinous eccrine Ca
  • Elderly, F>M, head and neck with eyelid being most common
• Recurrence common, and metastasis is rare
• Strands of fibrous tissue, islands of atypical cells in a sea of mucin
• Mucopidermoid Ca
• Similar to the salivary gland counterpart of the same name
• Adenoid Cystic Ca
• Metastasis uncommon, perineural involvement, relatively uncommon
• Adenoid and cribiform patterns, resembles a BCC
• Aggressive digital papillary Ca
• Hands and feet, fingers and toes
• Young adults, M>F
• High rate of metastasis
• Cellular dermal nodule, can be deceptively bland
• Any glandular lesion of the digits should be considered a carcinoma

Outpatient Consultations in Complex Medical Dermatology Selected Aspects: 2016
Joseph Jorizzo, MD

• Possibilities for a patient who presents with a complex medical dermatosis and systemic signs and symptoms:
  • Clinicoopathologic diagnosis of dermatosis integrates all findings
  • Eg: sarcoidosis – skin, eye, lungs, etc.
  • Clinicoopathologic diagnosis reveals a reactive dermatosis – communication with internist or pediatrician will outline underlying medical conditions
  • Eg: vasculitis
  • No direct relationship
  • Eg: scabies/fibromyalgia
  • A patient wishes to know from the internet whether they need x or y therapy for their presumptive diagnosis
  • Instead it is important to not let the patient “drive” for their own benefit
  • Steps to follow
    1. Clinicoopathologic diagnosis: Caution influence of therapy on biopsy and clinical appearance
    2. Assess the extent (internal manifestations of disease)

3. Assess for etiology
4. Therapeutic ladder

n Cutaneous vasculitis

• Key features
  • Cutaneous signs of vasculitis are a reflection of the size of the vessels involved
  • Vasculitis can be limited to the small vessels of the skin or it can be a sign of life-threatening internal organ involvement
  • The clinical diagnosis of cutaneous vasculitis requires histopathologic confirmation and multiple biopsies may be required

• Vasculitis has many classification problems
  • Example of the ACR criteria
    • Age at disease onset >16
    • Medication at disease onset
    • Palpable purpura
    • Biopsy including arteriole and venule with histologic change showing granulocytes in perivascular or extravascular location

• Cutaneous small vessel vasculitis

• Key features
  • Palpable purpura, urticarial lesions, hemorrhagic macules or vesicles
  • Lesions favor the lower extremities, dependent areas or pressure points
  • Only involves small vessels (primarily postcapillary venules)
  • Evaluation for systemic involvement
  • Utilize the primary care internist or pediatrician
  • Where are immune reactants most likely to deposit?
    • Kidneys, pleura/pericardium, GI tract, CNS or PNS, joint synovia, retina, adrenal glands

• Therapeutic ladder: non-ulcerative cutaneous lesions
  • No therapy
  • Topical therapies (access to site of pathology)
  • Gradients support hose
  • Antibiotics
  • Pentoxifylline
  • Colchicine
  • Dapsone/sulfapyridine
  • Combination colchicine/dapsone

• Urticaria

• Key features
  • An inflammatory dermatosis resulting from vasodilatation, increased vascular permeability, and extravasation of protein and fluids
  • Individual lesions, by definition, last less than 24 hours

• Definitions
  • Urticaria (hives): reaction in the superficial dermis; lesions last <24 hours
  • Urticarial reaction: similar, but lesions last >24 hours
  • Angioedema: reaction in the submucosa, deep dermis, and subcutaneous tissue
  • Acute urticaria: <6 weeks
  • Chronic urticaria: >6 weeks
  • A personal classification of urticarial reactions
    • IgE-dependent urticarial and angioedema
      • Specific antigen identified
      • Physical urticarias
    • Non-IgE dependent urticarial angioedema
      • Direct mast cell effects
      • Arachidonic acid pathway effects
    • Angioedema related to complement
      • Hereditary v. acquired
    • Urticarial reactions probably related to immune complexes
    • Urticarial vasculitis
    • Serum sickness-like reactions
    • Idiopathic

• My evaluation of patients with chronic idiopathic urticaria
  • Complete H&P by PCP
  • Screening laboratory tests and follow up positives by PCP
  • Review medications and avoid all non-steroidal drugs
  • Circle lesions
  • Biopsy if circles lesion lasts more than 24 hours (not urticarial by definition therefore, exclude urticarial vasculitis)
  • Consider (3) day rice and water elimination diet
  • Review prognosis and limited chance for total cure
  • Consider activated charcoal therapy
  • Avoid (and/or taper to zero if already receiving) systemic corticosteroids
  • Recognize impact of disease on quality of life
  • Review that antihistamine will only flatten lesions and reduce pruritus not “eliminate the red” as corticosteroids do
  • Combine several antihistamines from different classes with different sedating potential and H1 and H2 blocking effects taking half-life into effect.
**OCC Processes for Time Dated Certificates**

It's the new CME cycle so it's time to register for OCC again with the American Osteopathic Board of Dermatology.

OCC registration is now due for the CME cycle 2016-2018. All time-dated certificate holders must register for OCC every CME cycle no matter when your recertification date is.

If you have already used Canvas in the past few years you will already have a login. Please use your login to register for OCC. If you have not used Canvas for testing in the past 2 years you will need to register for a login. To do so please go to www.aobd.org and register for the login. On the home page please see below as shown on that page and click on the blue link to register for application process for OCC.

### INFORMATION FOR TEST TAKERS

**RE-CERTIFICATION FOR TIME DATED CERTIFICATES**
- Physicians certified in 2004 and after will be required to re-certify beginning 2014.
- Physicians who take the re-certification examination (OCC Cognitive Assessment) one year prior to their expiration date.

**OSTEOPATHIC CONTINUOUS CERTIFICATION (OCC) ANNOUNCEMENT**
- All diplomates with time dated certificates are REQUIRED to participate in AOBDO Osteopathic Continuous Certification (OCC) to maintain certification.
- Click here to register for application process for OCC.

To complete the OCC registration process you will need to go to the aobd.instructure.com web page and login. Your login will be your email address and your AOA number is your password (unless you have logged in before and changed it). You will received the login after you have completed the above step within seven days.

Once you login go to the course OCC and then click on the assignments page. As you can see there are three assignments for 2016-2018. Two of the three are forms to download, print, sign, scan in and upload back into the assignment page. The payment page is for me to indicate once I have received the payment.

For those that are new to this system, this is the new testing system and the system where you can keep track of your OCC registrations. For those that are newly board certified, you need to make sure that you registered for OCC as well. Some of you did it by December 31.

### Registration
- Click here to register for the OCC application process.
- Registration fees:
  - For AOBDO members, the registration fee is $300 per three year cycle, made payable to the American Osteopathic Board of Dermatology or pay OCC fee by credit card.
  - For AOBDO non-members, the registration fee is $900 per three year cycle, made payable to the American Osteopathic Board of Dermatology or pay OCC fee by credit card.
  - Newly board certified diplomate registering by February 15 after their exams receive a discount. The payment must be postmarked by February 15 with payment of $150 to receive this discount.

If you have any questions at all regarding this process please email Renee at aobderm@gmail.com or Beth at brthompson@atsu.edu. The AOCD cannot answer questions about OCC. OCC is a part of certification and all question should be addressed to the AOBDO.

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**HELP WANTED**

**Seeking Experienced Dermatologist To Join Florida Practice**

We currently have immediate full-time employment opportunities for an experienced dermatologist to work in our Riverview and Tampa offices. Office hours are Monday – Friday 9 a.m. – 5 p.m. This position offers a competitive compensation package including bonus, benefits that include Health insurance, PTO, a 401K, Malpractice Insurance compensation and a setting that is conducive to further professional growth. Academic appointments and research available.

The job description of the position is as follows:
- Initial and subsequent dermatology medical history, physical exam, diagnosis and treatment, and planning
- Initiate and maintain all necessary documentation in the medical record
- Other measures may be initiated depending on the patient’s condition and judgments of the dermatologist
- Performing biopsies and cryo-therapy
- Uncomplicated dermatological procedures
- Other procedures which the dermatologist has been trained and/or educated to perform
- Prescribe medications

Candidates must have FL License, MD or DO License, DEA License and 1 or more years of experience working in a dermatology practice For more information and to apply, contact Kathy Jimenez at dermmgr1@tampabay.rr.com or (813) 880-7546.