Residents Join Medical Mission to the Amazon
see pages 18-19

Resident Receives Navy Medal
see pages 14 & 15

Mohs Micrographic Fellowship
see pages 10 & 11

Annual Meeting
San Diego, California
Sept. 30 to Oct. 4, 2007
see pages 20-23

Newsletter of the American Osteopathic College of Dermatology
American Osteopathic College of Dermatology
P.O. Box 7525
1501 E. Illinois
Kirkville, MO 63501
Office: (660) 665-2184
(800) 449-2623
Fax: (660) 627-2623
Site: www.aocd.org

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Is your contact information current? If not, you may be missing need-to-know news from the AOCD.
Visit www.aocd.org/members. Click on the red box on the right side of the screen to update your info.
Should you have trouble accessing your profile, you can fax the new information to the AOCD at 660-627-2623. Send the fax to the attention of Marsha Wise, Resident Coordinator.

Annual Meeting 2007
San Diego, Calif.
Sept. 30 - Oct. 4
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Upcoming Events
AOCD MIDYEAR MEETING
March 12-15, 2008
Monterey, Calif.
Hello Fellow Dermatologists and Residents,

This year has been passing by quickly.

Our AOCD Executive Director, Becky Mansfield, has been very busy representing you with items at the AOA summer meeting and getting us ready for our upcoming convention.

The AOCD has now reached a new high of 90 dermatology residents. We have 21 AOCD Dermatology Residency Programs across our great country.

I have recommended this year that we all strive to increase our ‘Excellence in Dermatology’ in our offices, as well as in all of our dermatology residency programs, and I can say that I believe that this is being done. This fall, we will be giving our residents a new type of resident-in-training examination to evaluate both the level of accomplishments for the residents, as well as the individual training program. Whatever the results, we will gain knowledge to improve all of our teaching programs.

Within the next few weeks we will, once again, gather as friends and colleagues to enjoy a wonderful time in San Diego at our AOCD Annual Convention. Dr. Jay Gottlieb has planned an outstanding educational meeting. I do hope you will make plans for you and your family to join us for this event.

I have learned this past year that life is very precious and may be short.

Message From The President

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Sincerely,

Bill V. Way, D.O., FAOCD
AOCD President, 2006-2007

AOA Installs Dr. Peter B. Ajluni as 111th President

Peter B. Ajluni, D.O., a board-certified osteopathic orthopedic surgeon from Bloomfield Hills, Mich., was installed as the 2007-2008 AOA president on June 22, succeeding John A. Strosnider, D.O., who passed away of pancreatic cancer on the previous day.

“In my over 35 years as an osteopathic physician, I have seen this profession experience immense success and have witnessed the AOA grow into a nationally recognized medical association,” Dr. Ajluni said. “I am very proud to serve as president of this organization and continue the work of Dr. Strosnider.”

An avid hiker and jogger who has participated in a number of marathons and triathlons, Dr. Ajluni chose “D.O.s: Fit for Life” as his presidential theme, which conveys the importance of osteopathic physicians serving as role models for their patients when it comes to health and fitness. In addition, he will extend that focus to make the AOA a healthier and more fit organization for its members and the US a better health care system for patients.

Dr. Ajluni is currently on leave from his position as a senior orthopedic surgeon at Mount Clemens Regional Medical Center, part of the McLaren Health Care System, in Michigan where he also served as former chief of staff. He continues to serve as vice chair of the board of trustees at Mount Clemens. Dr. Ajluni also held staff privileges at Henry Ford Bi-County Community Hospital in Warren and St. John NorthShores Hospital in Harrison Township.

Serving as AOA president-elect for the 2006-2007 term, Dr. Ajluni began his career on the AOA Board of Trustees in 1998 and was a member of the Execu-

tive Committee from 2000-2005. In addition, he served as chair of the Departments of Business Affairs, Educational Affairs, Professional Affairs, and Governmental Affairs. Aside from his involvement on the national level, Dr. Ajluni also has been an active member of state and local osteopathic medical organizations. He served as president of both the Michigan Osteopathic Association and the Michigan Osteopathic Academy of Orthopedic Surgeons.

After earning his degree in 1969 from the Chicago College of Osteopathy, now known as Midwestern University/Chicago College of Osteopathic Medicine in Downers Grove, Ill., Dr. Ajluni completed an internship and residency at Mount Clemens General Hospital.

He resides in Bloomfield Hills with his wife, Judy. They have three children, Noelle (Kurt) Cassel, Mark, and Matthew, as well as three grandchildren.

Photo by John Reilly Photography
Greetings from the “Windy City.” I am writing this from the Chicago Fairmont Hotel where the summer meeting of the AOA Board of Trustees (BOT) and the AOA House of Delegates (HOD) is being held. These two meetings establish policy for the AOA, specifically specialty affiliates and state affiliates. Prior to the opening of the BOT meeting several other smaller groups met to develop recommendations to the Board members and House delegates. Dr. Robert Schwarze is our delegate to the Council of Osteopathic Specialty Societies (COSS). All specialties are represented and have a vote. In addition to reviewing the proposed resolutions and making recommendations to the BOT and HOD, the COSS members can propose new policy. Dr. Lloyd Cleaver represents the AOCD at both the BOT and HOD meeting. As a voting specialty delegate, he attends all sessions of the House and the reference committee meetings. Any members interested in discussing any issues related to the AOA should contact me.

**Annual Meeting**
Dr. Jay Gottlieb has developed a diverse educational program that will be of interest to our members. I encourage all members to attend the lectures and all of the other activities in San Diego.

**Education Evaluating Committee**
The Education Evaluating Committee was scheduled to meet in St. Louis on September 8 to review all resident annual reports and inspection documents. They also were expected to review the revised AOA education documents that were approved at the AOA BOT meeting.

**Membership Survey**
Earlier this summer we sent the 2007 Membership Survey to all members. If you have not returned your survey to the national office, please send it to us by September 28. This survey allows us to determine the needs of all our members (students, residents, fellows, and retirees). The responses we receive will help the staff and Executive Committee plan the future of this great organization. A summary of the responses will be included in the next newsletter.

**Midyear Meeting**
Dr. Leslie Kramer, 3rd Vice President, is the program chair for the 2008 Midyear Meeting in Monterey, Calif. to be held at the Hyatt Regency Monterey. We have reserved a block of rooms for our conference (March 12-15) and I encourage everyone to make their reservations early. Reservations can be made either by hotel telephone (831-372-1234), reservations fax (831-372-4277), or reservations e-mail (hyattmon@redshift.com).

The AOCD staff welcomes your comments and suggestions designed to improve our organization.
Psoriasis Awareness Walk Set for San Diego

Student member volunteers

The National Psoriasis Foundation Walk for Awareness is scheduled to be held September 29 in San Diego, the day before the AOCD Annual Meeting begins.

The event is a nationwide program designed to generate awareness about psoriasis and psoriatic arthritis and raise money for the National Psoriasis Foundation’s education, advocacy, and research programs, according to Jonathan Richey, a fourth-year Kirksville College of Osteopathic Medicine medical student at Henry Ford Wyandotte Hospital in Trenton, Mich., who is a volunteer participant at this year’s walk.

Living with Psoriasis

A student member of the AOCD who plans to apply to dermatology residencies for 2009, Richey was diagnosed with psoriasis when he was 19 years old. He learned more about the chronic disease and treatment options through the National Psoriasis Foundation. When the foundation began organizing walks across the country this year to create awareness about the disease, Richey decided to get involved. “I was already set to go to the AOCD and AOA conventions, so this gives me the opportunity to do the walk and attend the annual meetings,” he says.

Having the disease has not only affected certain aspects of Richey’s social life, but also has impacted his career decisions. Even though he has patches of clear skin, the appearance of the disease especially on his arms and legs has limited his activities such as swimming. “I haven’t gone swimming for a very long time,” he says, adding, “In summer, I never wear shorts.” His diagnosis also motivated him to go into medicine, and specifically dermatology, rather than become a dentist like his father. “I have an understanding of how people with psoriasis, and skin conditions in general, feel and I also have an understanding of the difficulty in treating it because of my personal experience,” says Richey.

At the San Diego walk, he will serve triple duty as a committee member, team captain, and walker. As a committee member, Richey has been involved in the planning process to ensure for a successful event. The planning began in the spring of 2006. “I helped recruit and motivate walkers and organized a team to raise money and walk in the event,” he says. Richey also will lead the organizing committee for the Detroit Walk for Awareness in June 2008. “If you cannot participate in the San Diego walk, I encourage you to visit the foundation Web site and look for walks occurring in your own state,” he adds.

Raise Awareness of DOs

“This is a great opportunity to spread the word about DO dermatologists. If we attend and walk together, we can inform people who have psoriasis about osteopathic medicine and physicians,” notes Richey. “In addition, the new AOA President Peter B. Ajluni plans to promote fitness and healthy lifestyles throughout the year as part of his theme ‘D.O.s: Fit for Life.’ This is a great way for DOs attending the national convention to fulfill and promote Dr. Ajluni’s challenge.”

AOCD members can get involved either by walking or supporting a team or participant. Participants seek donations from friends, family, and associates. All fundraising is conducted prior to the walk, eliminating the need to collect pledges after the event. Each walker is asked to raise $100 in tax-deductible donations.

Walk Details

The registration fee is based on an individual’s age and participation level. The fees range from $10 for a youth who is walking and raising funds to $25 for an adult (18+) who is only walking.

Individuals interested in joining Richey’s team or contributing to it can do so by e-mailing him at jonathan.richey@gmail.com or visiting his walk Web site at walk.psoriasis.org/goto/pffp. The "pffp" stands for the team name “Physicians, Families, and Friends for Psoriasis.” He also can be reached at (559) 359-8237.

Registration begins at 7:30 a.m.; the walk begins at 9:00 a.m. The walk takes place at Mission Bay Park in North Mission Bay. There are two routes: the 1K is .62 miles and the 5K is 3.1 miles. A brief warm-up and cool-down for all walkers will be provided.

Each participant will receive a special gift bag after completing the walk, as well as a T-shirt. Additionally, participants will have several opportunities to enter a drawing for prizes. Live music will be provided by the band Grin’s Edge.

Fast Facts: Psoriasis

As many as 7.5 million Americans have psoriasis, according to the National Institutes of Health.

Between 10% and 30% of people with psoriasis also develop psoriatic arthritis.

Of the 5 types of psoriasis, plaque is the most common.

AOBD: Certification and Beyond

As the AOCD celebrates its 50th anniversary, we thought members would like to learn more about the American Osteopathic Board of Dermatology (AOBD), the group responsible for administering the certification examination for osteopathic dermatologists.

You may know that in order to receive certification in dermatology, you must pass an examination given by the AOBD. But did you know that the Board has an integral role in the development of maintenance of certification for osteopathic dermatologists? Did you know that the AOBD preceded the AOCD by more than a decade? Did you know that the longest serving Board member has served for more than three decades?

In 1945, five osteopathic dermatologists petitioned the AOA to form the AOBD. The five—Drs. Edwin Cressman, Cecil Underwood, Anthony Scardino Sr., Edward Brostrom, and Ronald MacCorkell—served for 13 years as the Board. During their tenure, only seven DOs were certified, and one was the brother-in-law of a Board member. The five—Drs. Edwin Cressman, Cecil Underwood, Anthony Scardino Sr., Edward Brostrom, and Ronald MacCorkell—served for 13 years as the Board. During their tenure, only seven DOs were certified, and one was the brother-in-law of a Board member.

In 1957, the AOCD was established primarily to revitalize the AOBD. In the spring of 1958, the then AOCD president, Dr. A.P. Ulbrich, formed a new Board in response to a request by the AOA. But according to James D. Bernard, D.O., FAOCD, who served as an ex-officio member of the Board when he was Secretary-Treasurer of the College, Dr. Ulbrich was having a difficult time getting certified, so he called upon a friend in the hierarchy of the AOA to form the AOBD. After the Board members realized that the newly formed College could nominate and elect new members to serve on the Board, they all resigned.

A New Credibility

The new Board consisted of three dermatologists: Dr. Scardino, who served as President; Donald Gardner, D.O., who was named Vice President; and Dr. Ulbrich who became the Secretary-Treasurer. That fall, the new AOBD gave its first exam in Washington, D.C. to eight individuals, all of whom passed.

In the 1950s, the AOA was trying to gain credibility with regard to its training, explains AOBD Chairman Charles G. Hughes, D.O., FAOCD. “In fact, all of the specialties in the AOA were attempting to do that,” he says. The purpose of Dr. Ulbrich reorganizing the Board was to have a more standardized approach to credentialing and certifying osteopathic dermatologists. After Dr. Ulbrich stepped down, the Board had a number of members come and go, but the officers for many years included the late Dr. Harry Elmets, as well as Drs. Daniel Kop prince, Tom Bonino, and David Brooks Walker.

Growing Responsibility

The AOBD, then and now, is charged with defining the qualifications of a certified osteopathic dermatologist, says Dr. Hughes, who has served on the Board for 24 years. The AOBD frequently reevaluates these qualifications based on AOCD membership surveys it sends out asking respondents about their scope of practice and training programs. “The surveys help the Board determine what our members believe is important in the practice of dermatology, what they’re doing, and how often they’re doing it,” he adds. The next step is to determine who meets those qualifications.

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“Serving on the Board is an awesome responsibility because we are given the task of assessing graduates of the training programs to see if they have met the criteria to be appropriate practitioners of their trade,” says Lloyd Cleaver, D.O., FAOCD, AOBD Secretary-Treasurer.

That responsibility has increased fivefold since Dr. Cleaver first began serving on the Board 13 years ago. In addition to analyzing the survey data to determine the level of information that needs to be used for the exam and the scope of practice that should be covered, the Board assesses the training programs to determine what things they are teaching and what things they should be teaching.

Is all of this reevaluating of the exam and training programs necessary? Absolutely, the Board members say. “Reevaluating the certifying exam’s content ensures that it remains a valid and reliable tool,” says Dr. Hughes.

Then there are the Certificates of Added Qualification (CAQs) in dermatopathology and Mohs Micrographic surgery that the Board has developed. The latest CAQ in pediatric dermatology is expected to be available in 2008.

Even writing the test has become a complex process. “When I started, we got together and each of us wrote our portion of the exam,” says Dr. Cleaver. Now, individuals who want to write test questions have to undergo psychometric training courses, which the AOA routinely offers. In fact, one such course is being offered on Sunday, Sept. 30 at the AOA Conference in San Diego. He encourages AOCD members who are interested in being involved with the Board to attend this course. “These item-writing sessions are educational and informative,” says Dr. Cleaver. “We’re looking for people to become involved with the Board and this is an excellent way to do that.”
Maintenance of Certification
The Board’s latest charge is developing maintenance of certification standards that must be implemented by 2011 as mandated by the AOA’s Department of Education and the Federation of State Licensing Boards. The process of maintenance of certification will require physicians to recertify after a certain number of years, rather than being certified for a lifetime as many were in the past. “They now want to have a higher level of assurance that people practicing medicine are doing so appropriately,” notes Dr. Cleaver. Physicians with lifetime certification will be encouraged to participate in the maintenance of certification program.

With the extra work that the maintenance of certification will require, the Board is contemplating expanding its membership, which currently stands at nine, in the future.

Down to Business
Currently, Board members serve three-year terms, while an officer serves a one-year term. This year, the method for electing AOBD members was changed because the Department of Education wanted to ensure that specialty colleges were not dictating Board policy. Nominations for AOBD membership now come from the Board itself, whereas they used to come from AOCD members. After College membership approval at the annual meeting, the nominations are sent to the AOA Board of Trustees, who then elect the AOBD members. Every year, three members’ terms expire and current members are either re-elected or new members elected. Officers are elected annually. To become a member, an individual must be AOA board certified, a practicing dermatologist, and in good standing with the AOA. Board members usually serve as officers of the AOCD prior to joining AOA. Board members usually serve as members, usually as a gatekeeper, but we try to make the process as fair as possible. For longer standing members, we need your ongoing help, especially when filling out the surveys so we can continue to be sure our exams and certification process are a true representation of what they should be.”

Dr. Cleaver concurs. “It used to be the Board was something you worried about when you finished your residency. But times are changing. We are trying to deal with regulations that are impacting us and at the same time, trying to protect AOCD members’ practice rights and licensure. Our concern is the practicing dermatologist, our colleague.”

Serving on the Board has been a labor of love, adds Dr. Cleaver. “We have some very dedicated people who spend an unbelievable amount of time on it. In addition, we rely heavily on consultants, including Terry TenBrink, Ph.D., a psychometrician who has provided invaluable assistance over the years,” he notes. “I would like to thank our predecessors for all of their hard work to make this such a quality organization.”

“It’s been an honor to serve on the Board for twenty-something years,” adds Dr. Hughes. “It has allowed me to interact with some of the best minds and certainly the most dedicated individuals in the College.”

How Well Do You Know the AOBD?

1. Who was the first osteopathic dermatologist certified by the AOBD?
2. Who has served as the AOBD Chair?
3. Who served the longest term on the AOBD, to date?
4. True or False: The AOBD grants certification for graduates.
5. To date, how many physicians have been certified by the AOBD?

(See bottom of page for answers.)
Dermatologists have been compounding since the specialty began, but the practice fell out of favor in recent years with the influx of pre-packaged pharmaceutical skin care products and cost containment efforts by insurance companies.

Still, compounding has many benefits. The primary benefit of compounding is the ability to gear the diagnosis to match the vehicle. The vehicle is very important with regard to penetration of the skin and aiding in the inflammation process. Additionally, compounding provides a larger quantity of topical medication at less expense over the long haul.

The three main issues surrounding compounding are as follows:
- the ability to assimilate or think through the disease;
- the bases that are used for compounding; and
- the corticosteroids that are added for the treatment, the disease, and the disease processes.

Understanding the spectrum of inflammation is essential when discussing the use of compounding. That spectrum ranges from an acute process to a chronic one. In the acute process of inflammation, wet dressings are recommended, followed by powders and lotions, aerosols, and sprays, and then creams, oils, and gels. For chronic inflammation, ointments, water in oil emulsions, and then inert bases are recommended in that order.

Acute Inflammation
Open wet dressings are ideal for treating inflammatory conditions, erosions, and ulcers. Water is by far the most important ingredient in wet dressings. Usually one tablespoon of salt to 16 ounces of water works well. Another option is a component of what is known as a Domeboro solution, which contains one part vinegar to four parts water.

Powders promote drying by increasing skin surface area. They are commonly used for intertriginous areas to reduce moisture, friction, and rubbing.

Liquid lotions are essentially suspensions of powder in water. Tinctures also fall into this category. Often, tinctures are alcoholic or hydroalcoholic solutions. As the lotion and tinctures dry and evaporate, they leave a uniform film of powder on the skin that aids in the drying process. Aerosols and sprays act in the same manner.

Chronic Inflammation
Creams are the compound of choice when moving lower on the spectrum toward chronic inflammation. Creams are basically emulsions of water commonly called oil in water solutions. As the oil increases and the water decreases, the mixture becomes closer to a classification of an ointment.

Gels are transparent, semi-solid emulsions that liquefy on contact with the skin, drying as a very thin, greaseless, non-staining film. Alcohols, such as propylene glycols and acetones, are usually found in these gels.

The greasiest compounds are ointments typically used for chronic inflammation processes. These consist of a phase of oil and small quantities of water commonly called water in oil solutions. The three major types of ointments are soluble in water, emulsify in water, and insoluble in water. Although pastes also are found as a mixture of powder in ointments, they are not a mainstay of treatment.

How Much
It is essential to have a working idea of how much of the topical medication is going to be used. The following chart provides an estimate of the amount needed:

<table>
<thead>
<tr>
<th>Area</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Entire body</td>
<td>30-60 grams</td>
</tr>
<tr>
<td>One arm</td>
<td>3 grams</td>
</tr>
<tr>
<td>Hands</td>
<td>2 grams</td>
</tr>
<tr>
<td>Anogenital</td>
<td>2 grams</td>
</tr>
<tr>
<td>One leg</td>
<td>4 grams</td>
</tr>
</tbody>
</table>

Common Compounds
Menthol, phenol, and camphor are commonly used compounds. For an itchy eruption,
anywhere from 1% to 2% is appropriate.

Regarding corticosteroids, hydrocortisone powder 1% to 2% and triamcinolone powder 0.1% to 0.2% is recommended. Liquor Carbonis Detergens also can be added. This is used as a purified tar for psoriatics. Another option is precipitated sulfur, which is an extremely good compound added to mild corticosteroids for perioral dermatitis in anywhere from 1% to 4% solutions.

Lactic acid can be used in areas over the feet and hands for cracking and fissuring, and for dryness of the skin. Although lactic acid works well, it can be extremely sensitive when applied to areas with cracks and fissures.

The beta-hydroxy acid commonly called aspirin—salicylic acid—works well for facial areas and provides good penetration of the keratin within the skin. In lotion form, strengths of 1% to 2% triamcinolone powder are recommended. In cream form, an addition such as Diprolene cream works well. A classic example is 60 grams of Diprolene cream added to Cetaphil cream, with a potential 1% menthol added. If 240 grams of Diprolene cream is being used, then 2.4 grams of menthol is appropriate. Moisturel lotion also can be added.

White petrolatum and Skin Barrier Repair creams are used in many compounds for psoriasis.

The final essential ingredient for use in compounding is good communication skills when working with the pharmacist. Having a pharmacy in the immediate area that can handle all of the practice’s compounding needs also is helpful.
The AOA has approved the first fellowship in Mohs Micrographic surgery (MMS) within the osteopathic profession.

The fellowship is a full-time, paid position based at the offices of Dermatology Associates of Tulsa, which is the practice of Edward H. Yob, D.O. The Fellowship is under the auspices of the Kirksville College of Osteopathic Medicine Osteopathic Postdoctoral Training Institute and Northeast Regional Medical Center in Kirksville, Mo.

**Program Highlights**
The subspecialty program emphasizes training in MMS for the treatment of specific cutaneous malignant neoplasms where the procedure has been documented to be of significant benefit, according to Dr. Yob, who will serve as the program director.

The training program includes comprehensive teaching in the principles of the following:
- cutaneous oncology,
- cutaneous surgical anatomy,
- appropriate diagnostic modalities,
- proper patient selection,
- preoperative evaluation,
- proper procedural documentation,
- surgical technique,
- instrumentation for dermatologic surgery,
- field block and local anesthesia,
- hemostasis,
- surgical microbiology,
- pertinent surgical dermatopathology,
- Mohs laboratory principles and procedures,
- surgical and laboratory biohazard safety principles and procedures, and
- surgical wound management utilizing recognized techniques such as secondary intention healing, primary closures, adjacent tissue transfer procedures (skin flaps), and skin grafting procedures.

Completion of the program also is expected to enhance the knowledge, expertise, and experience of the trainee in standard dermatologic surgery through comprehensive training in excisional surgery and repair, electrosurgery, cryosurgery, cutaneous laser surgery, dermabrasion, scar revision techniques, and therapeutic chemical peeling.

The training period is 12 continuous months for didactic and clinical training, which involves learning through observation and direct patient experience under the supervision of competent physician teachers, formal didactic sessions, and an organized reading program. The position will include a stipend, medical benefits, and medical malpractice coverage.

“The ultimate goal of the program is to allow the trainee to evolve into a knowledgeable and skillful Mohs Micrographic/dermatologic surgeon who has a sound understanding of cutaneous oncology and a thorough knowledge of the indications and methods of treatment of cutaneous malignancy, as well as expertise in surgical technique and laboratory procedures,” says Dr. Yob.

After completion of the program, the trainee will be expected to be prepared and eligible to complete subspecialty board certification examination in MMS given by the AOBD.

Dermatology Associates of Tulsa is located in a suite on the campus of SouthCrest Hospital. The practice has an on-site, highly complex MMS laboratory that is registered with CLIA, staffed by two full-time Mohs technicians. It also has an extensive on-site library. Additionally, the fellow will collaborate with other specialties including dermatopathology, radiology, reconstructive surgery, general surgery, radiation oncology, and medical oncology in the surrounding area.

Dr. Yob is certified in dermatology by the AOA through the AOBD, and holds a current Certificate of Added Qualification in MMS through the AOBD. He is a member in good standing of the AOA and AOCD and has served in various...
positions including president of the American Society for Moh’s Surgery. Dr. Yob has been in practice in dermatology and dermatologic surgery for 18-plus years and has completed more than 7,000 cases of MMS. He also is an associate professor at the University of Oklahoma–Tulsa.

Admission Requirements

- The trainee must be a graduate of an osteopathic medical school accredited by the AOA.
- The trainee must have completed an internship approved by the AOA.
- The trainee must have satisfactorily completed a three-year dermatology training program approved by the AOA and the AOCD.
- The trainee must be board eligible or board certified in dermatology by the AOA and AOBD.
- The trainee must be a member in good standing of the AOA and AOCD.
- The trainee must obtain medical licensure in the state of Oklahoma prior to starting the training.
- The trainee must meet the program requirements that are mandated or adopted by the program director and training institution.
- Prior to admission into this subspecialty program, the trainee must present a letter of recommendation from the Director of Medical Education at the hospital where he/she completed his/her AOA approved internship.
- The trainee must present a letter of recommendation from the program director of the dermatology training program he/she completed.

CMS Identifies Contingency Plan for NPI

If you’re among the physicians who did not meet the May 23, 2007 deadline for compliance with the National Provider Identifier (NPI) regulations, you’re getting a temporary reprieve provided that you show you are attempting to comply “in good faith.”

The Centers for Medicare & Medicaid Services (CMS) has implemented a contingency plan for covered entities (other than small health plans) that did not meet the May 23 deadline for the NPI regulations under the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

Providers will be allowed to use other legacy provider numbers (e.g., Medicaid provider IDs, individual plan provider IDs, UPINs) on HIPAA transactions in order to maintain operations and cash flow up until May 23, 2008. But only those providers who show they have been making a good faith effort to comply with the NPI provisions. In determining whether a good faith effort has been made, CMS will place a strong emphasis on sustained actions and demonstrable progress. Indications of good faith for a physician might include having obtained an NPI and having the ability to use it on HIPAA transactions. Meanwhile, CMS will not impose penalties on covered entities that deploy contingency plans in order to ensure the smooth flow of payments.

After it became apparent that many covered entities would not be able to fully comply with the NPI standard by May 23, CMS offered leniency on its enforcement approach to protect from financial penalties those who continue to act in good faith to come into compliance, recognizing that transactions often require the participation of two covered entities and that non-compliance by one may put the second covered entity in a difficult position.

However, the enforcement process is complaint driven and if a complaint is filed against a covered entity, CMS will evaluate the entity’s good faith efforts. Each covered entity will determine the specifics of its own contingency plan. Contingency plans may not extend beyond May 23, 2008, and entities may elect to end their contingency plans sooner.

For more information or to apply for the fellowship, contact Cindy Wilson, the administrator at Dermatology Associates of Tulsa, at (918) 307-0215 or cwilson@dermtulsa.com.

Meanwhile, Medicare will continue to accept claims using legacy numbers on transactions, accept transactions with only NPIs, and accept transactions with both legacy numbers and NPIs. However, as soon as Medicare considers the number of claims submitted with an NPI for primary providers sufficient, the agency will begin rejecting claims without the 10-digit number. Physicians will have at least one month of notice prior to the NPI-only requirement taking effect.

The NPI was established as the standard unique health provider identifier to be used on health care claims and other HIPAA transactions.

For more information about the NPI, visit the CMS Web site at www.cms.hhs.gov. The site also contains a document titled “Guidance on Compliance with the HIPAA National Provider Identifier Rule.”
Dermatologists Report Quality Measures for CMS Initiative

Were you one of the first dermatologists to participate in the Physician Quality Reporting Initiative (PRQI) when the Centers for Medicare & Medicaid Services (CMS) rolled it out this past July?

Although the initiative is voluntary, providers who do participate are eligible for a bonus payment, subject to a cap, of 1.5% of total charges allowed by Medicare’s Physician Fee Schedule.

The program, developed by CMS to provide a financial incentive bonus to physicians for reporting best practice quality measures, officially began capturing reported data on July 1. Dermatologists may report on quality measures for services provided between July 1 and Dec. 31, 2007 to receive the bonus payment in 2008.

Of the 140 quality measures spread across 34 clinical areas approved for use in 2007, three relate to melanoma. Dermatologists who report each of the three melanoma measures in at least 80% of the cases in which the measure is reportable are eligible to receive the incentive bonus.

The melanoma measures apply to current melanoma patients and patients with a history of melanoma. The CPT category II codes refer to asking about new or changing moles (Code 1050F); performing a complete skin examination (Code 2029F); and counseling the patient to perform a self-examination for new or changing moles (Code 5005F). Exception codes were developed to address situations in which it may be inappropriate to complete the measures. For example, if the patient is blind, the dermatologist would not advise the patient to check for new or changing moles.

CMS will capture the data for reporting physicians by using their National Provider Identifier number. Claims must be submitted no later than two months (by Feb. 28, 2008) after the end of the reporting period. The lump sum check for the reporting period will be issued in mid-2008.

For more information, such as how to calculate the bonus cap, visit the CMS Web site at www.cms.hhs.gov/PQRI/. An online tool kit designed to assist eligible professionals in successfully integrating the initiative’s measures into their practice can be downloaded. The American Academy of Dermatology also offers information about the PQRI specifically with regard to dermatology on its Web site at www.aad.org.

Membership Surveys Due

The AOCD urges those members who have not yet returned their 2007 Membership Survey to do so as soon as possible.

The survey, which was sent to all members in July, is a vehicle for the AOCD to determine the needs of all its members, including students, residents, fellows, and retirees, says Becky Mansfield, Executive Director. “The responses we receive help our staff and Executive Committee plan the future of this great organization,” she says. As an example, including the resident annual reports and the newsletter on the Web site were done in response to feedback received on the previous survey.

The surveys must be returned to the national office by September 28 in order to be reviewed by the Executive Committee meeting at the Annual Conference in San Diego. A summary of the responses will be included in the next newsletter.

Membership surveys are slated to be sent out every other year.
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We also are working on the Midyear Meeting for March 2008 to be held at the Hyatt Regency Hotel in Monterey, Calif. Intent-to-Lecture forms will be available in mid October. Resident lectures will be held from 1 p.m. to 5 p.m. on Wednesday, March 12.

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The one-year fellowship began this past July under the direction of Abel Torres, M.D., J.D.

“I chose to do the fellowship at Loma Linda University Medical Center because I wanted to obtain an in-depth perspective on dermatologic surgery including Mohs Micrographic surgery and cosmetic dermatology,” says Dr. Desai, who was a resident in the program run by David Horowitz, D.O. “More education and training are priceless.”

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by Marsha Wise, Resident Coordinator

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“Finally, I thank Dr. David Horowitz who has instilled in me a vast knowledge of dermatology. If it were not for him, my fellow and attending status at Loma Linda would not be possible.”

“Plus, I have the golden opportunity to have Dr. Abel Torres as my program director. He is well known and respected in the dermatology community, having served as Associate Clinical Professor of Dermatology at Harvard University. In addition, his law background and knowledge also have allowed me to learn medical law and its relation to dermatology practice.”

As part of the fellowship, Dr. Desai is serving as an attending physician, requiring him to teach dermatology residents at Loma Linda. “After they see patients, they sign out to me, and I offer assistance as needed,” he says.
Reagan Anderson, D.O., M.C.S., M.P.H., first-year Resident at Oakwood Southshore Medical Center in Trenton, Mich., recently received a Navy Marine Corps Commendation Medal from the Department of the Navy.

The medal was for meritorious service while serving as the First Reconnaissance Battalion Surgeon from June 2004 to September 2006 in the Al Anbar province of Iraq.

“Getting this award is humbling,” says Dr. Anderson. “But at the same time, it is difficult because it is mixed in with patients and experiences that I still dream about nightly. When I look back at all the situations in which I was involved and the hard decisions that I had to make, I look back and say I did the best I could, but I wish I could have done more.”

Within 48 hours of arriving at Camp Fallujah, the lieutenant was doing more than he expected as he was participating in combat operations. Among them was the first combat airborne insertion since Vietnam. “I was trained to deal with medical situations over there and how to handle physical abuse, but not kicking down doors, clearing fields or houses, and holding insurgents at gun point,” he says. “I learned the other things quickly.”

“Luckily, I never fired my weapon in two tours and for that I am exceedingly grateful,” says Dr. Anderson. “There were many situations in which it was close. At least I don’t have those nightmares.”

During mass casualties, Dr. Anderson was on call 24/7 for months on end. When he was not involved in direct patient care, he was facilitating blood drives, managing medical assets, and triaging combat wounded trauma patients. The latter allowed the surgical specialists to quickly prepare and accept patients to the surgical suites for life or limb saving operations. Dr. Anderson also developed a mass casualty plan.

As part of the medical care he provided, Dr. Anderson conducted daily “psych” rounds to keep the marines and sailors mentally and spiritually healthy. As a result, the battalion did not encounter one single psychological casualty during either deployment. He credits the psych rounds with keeping his battalion alive.

“Very few people in Iraq get injured or die because the insurgents are so skillful,” says Dr. Anderson. “The reason they die is because complacency sets in. Something horrible happens at home and people don’t have their head in the game. They’re not paying attention so they walk into a trap, something they normally would have spotted a mile away.” Because of the close bond he forged with the men...
in the battalion, Dr. Anderson was able to recognize when they were unfocused and was able to get them the care they needed.

During his deployments, Dr. Anderson coordinated several medical missions. Based on the purpose of the mission, he would either stay at the battalion aid station, which was basically a clinic, that Dr. Anderson set up in what is called a moving operating base; go on patrol with the battalion to provide medical coverage; or provide medical care to Iraqis. Oftentimes, the marines would rent a house in which to set up the clinic. “Usually the locals loved it because we paid them approximately one year’s salary to use their house for one or two weeks,” he says. “We left it cleaner than it was when they lived there.” The clinic was basically a room with a stretcher where he would treat casualties. “Having a walled structure was good and bad because it was stationary and that gave anyone who wanted to shoot at us a target. Being there one or two weeks gave them a lot of time to plan an attack,” says Anderson, adding, “We received rocket mortar and small arms fire every day. Luckily, they’re not great shots.”

On some missions, Dr. Anderson went on night foot patrols to local medical clinics and villages where he treated more than 100 Iraqis. On more than one occasion, Dr. Anderson left behind much needed medical supplies and conducted classes on how to use them. These night patrols were conducted under the constant threat of small arms fire.

During his second tour, Dr. Anderson coordinated and/or participated in more than 400 hours of medical coverage. Additionally, he managed six combat lifesaver courses while providing medical training for an elite battalion of marines in preparation for combat. Challenged with two combat deployments, he worked 18-hour days for several months taking the battalion far beyond its expected medical capabilities. Despite multiple engagements and numerous wounds to his marines, he returned the battalion with no loss of life or limb. During this time, he commanded and led 19 hospital corpsmen through more than 170 days of combat preparation and combat operations, shouldering responsibilities commensurate with those of a senior medical officer in charge of a regiment.

The Navy said of his performance, “Lt. Anderson has demonstrated himself to be a superior medical officer, unmatched by his peers, and admired by his supervisors….Simply put, he is not only an officer who provides more than his rank would suggest, but he is also a doctor who is unmatched among his peers in education, drive, accomplishments, and clinical acumen….Facing seemingly insurmountable odds, technical and tactical challenges, uninterrupted combat deployments, the inherent fog of war, and the stress of combat operations, his service, performance, and accomplishments have been nothing short of magnificent….He has served with distinction and with honor. His devotion to mission accomplishment and superb medical care has been selfless and absolute.”
Wellington Regional Medical Center Boasts Expert Rotations, One-on-One Training

You could say that the residents at Wellington Regional Medical Center/LECOM have 37 mentors, not just Program Director Brad Glick, D.O.

That’s because the LECOM residency program also has a Co-director, Richard Rubenstein, M.D., and the residents have access to the 35 dermatologists that belong to the same practice group that Dr. Glick does.

Expert Rotations

“Our residents get exceptional out rotations on a week-to-week basis with internationally recognized dermatologists who are experts in their fields,” says Dr. Glick, who has been Director since the program was established in 2002. “For example, Dr. Daniel Rivlin, M.D., is a multi-tasking, multi-talented doctor who performs Mohs Micrographic surgery and endovenous laser surgery in addition to cosmetic dermatology. When our residents spend a full day with him, they get a lot of out of that day.”

Others who contribute to the residents’ training include Carlos Nousari, M.D., who specializes in immunobullous diseases; Harold Rabinovitz, M.D., who performs cutaneous oncology, dermoscopy, and Mohs surgery; Marta Rendon, M.D., who conducts research on pigmentation disorders in addition to performing cosmetic dermatology; Francisco Flores, M.D., who is expert in dermatologic surgery, including Mohs; Harold Bafitis, D.O., who is a skilled plastic surgeon; and Stella Calobrisi, M.D., who specializes in pediatric dermatology.

“Dr. Rubenstein and I lay the foundation on a one-on-one basis for the residents’ dermatology training, but then all of these amazing clinicians who we happen to have here in south Florida build on that foundation,” notes Dr. Glick. “This array of clinicians and the caliber of the clinicians we have set us apart from others and makes for such a great balance of rotation, covering all the bases for the residents.”

They even receive excellent training in hospital dermatology, which is harder and harder to come by these days, thanks to Francisco A Kerdel, M.D., who is Chief of Dermatology at Cedars Hospital in Miami. “They get a good view of these patients and many of the residents follow-up in his office where they get to tend to these patients, as well,” Dr. Glick explains.

Other Activities

In addition to their hands-on patient care, the seven Wellington LECOM residents participate in weekly dermatopathology clinics at two different labs—Ameripath and Global Pathology.

On a monthly basis, they conduct a journal club. Usually the residents lecture on dermatologic topics as a board review and sometimes a guest lecturer is brought in.

Wellington Regional residents meet for a quarterly journal club with the Nova Southeastern University, College of Osteopathic Medicine/Broward General Medical Center under the directorship of Stanley E. Skopit, D.O., FAOCMD. “I really enjoy the comradery between our two programs,” says Dr. Glick. “These residents really help each other out and they even study for boards together.”

Then there are the Broward County Dermatologic Society meetings that the residents regularly attend. Recently, two LECOM residents were asked to present grand round cases at a meeting.

“Publish

“We encourage our residents to go well beyond the norm of publishing,” says Dr. Glick. Many have received accolades as a result.

Third-year Resident Jon Keeling, D.O., was awarded the Alan Scott, M.D Residency Award by the American Society of Cosmetic Dermatology and Aesthetic Surgery (ASCDAS) last year. His paper, which he presented at the annual ASCDAS meeting, received first place among the research papers submitted by MD and DO dermatology residents. The winning paper was entitled "The Use of Topical Therapies in Combination with Procedures for Treatment of Hyperpigmentation Disorders." In addition, he won the Ferndale Laboratories’ Caribbean Dermatology Resident Research Award from the Caribbean Dermatology Society in recognition of his paper entitled “Mequinol 2%/Tretinoin 0.05% Solution for the Treatment of Melasma in Male Patients.” As part of the award, he presented his paper at the Caribbean Dermatology Symposium held on Grand Cayman Island in January.

Although unrelated to a paper, Dr. Keeling was the recipient of an American Society of Dermatologic Surgery Preceptorship Award. As such, he spent one week in June with Leon Kirck, M.D., in Louisville, Ky., where he focused on Mohs Micrographic surgery, as well as cosmetic procedures, such as Botox® injections, fillers, and laser treatments.

Second-year Resident Marianne Carroll, D.O., not only published a paper on the utilization of Aldara® for the
management of superficial skin cancers, but she is beginning to be recognized as an expert on the topic. She and her mentor, Don Tillman, D.O., FAOCD, have spoken about it at several meetings and Dr. Carroll will even be going to the World Congress in Argentina in October to present on the topic.

Lynora Bassett, D.O., a third-year Resident won the Daniel Koprince Award for her paper on tungiasis and presented it at the AOCD meeting in 2005.

Third-year Resident John Perrotto, D.O., co-authored a feature article entitled “Ulcers Masquerading as Cutaneous Malignancies,” which was published in the October 2006 issue of Ostomy Wound Management, a peer-reviewed journal.

“Publishing, presenting, and conducting clinical research are crucial for the three-year education of dermatology,” says Dr. Glick. “I feel comfortable in saying that the residents are definitely getting that experience here.”

Resident Invited to Speak at AAD Conference

First-year Resident Keoni Nguyen, D.O., at Ohio University COM, O’Bleness Memorial Hospital in Athens, Oh., was selected to present an original study for the “What’s Hot: The Posters Symposium” at the summer AAD meeting this past August.

Dr. Nguyen presented his poster abstract entitled “Native American Dermatology: Does Percent Tribal Heritage Influence Cutaneous Disorders?” as part of a new symposium featuring the top 11 poster submissions selected for presentation.

“As a first-year dermatology resident, it was a great honor and pleasure to have been invited to speak on the topic of my original study about Native American dermatology,” says Dr. Nguyen, who was the only resident selected to present along with other prominent speakers such as psoriasis expert Kenneth F. Gordon, M.D., FAAD; immunodermatology expert Joseph L. Jorizzo, M.D., FAAD; and acne rosacea expert James Del Rosso, D.O., FAOCD.

Dr. Nguyen began collecting data for this study when he was a third-year medical student rotating with Eugene Conte, D.O., FAOCD. They decided it was time to update the literature given that the first observational study of this kind was done in 1958. Dr. Nguyen completed this study during his internship at Michigan State University, COM.

This observational study was conducted at the Phoenix Indian Medical Center in Arizona. The study reviewed data collected from 585 Native Americans of North America seen at a first office visit for a primary cutaneous disorder between June 2004 and December 2006. “The analyses showed correlations between prevalence of certain dermatologic disorders and Native American percent tribal heritage (NAPTH), as well as refuted previous reports about the occurrence of psoriasis and polymorphous light eruption within the Native American population,” says Dr. Nguyen. All subjects included in the study had their dermatologic diagnosis established through examination by Dr. Conte who is a consultant to the center. The NAPTH of each patient was verified through the medical record.

Statistical analyses showed the top six dermatologic disorders in the 50% or less and the 100% tribal heritage groups are dependent of each other. “Dr. Conte and I believe improved knowledge of cutaneous disorder prevalence and the correlations with NAPTH will serve to improve the diagnosis of these conditions,” he says, adding, “This study provided important insight into the prevalence of dermatologic conditions among Native Americans and hopefully will stimulate further research interest in this area.” They plan to use these data to create an educational paradigm for dermatologists and primary care physicians who serve Native Americans on a routine basis.

Not only was Dr. Nguyen honored by being asked to speak at the meeting, he found the didactics and symposiums to be incredible, and he was interviewed by a reporter from Dermatology Times for the October issue.
Residents Join Medical Mission to the Amazon

It wasn’t enough for the dermatology residents at Western University/Pacific Hospital in Los Angeles to crack open the books when they had to learn about tropical medicine. Instead, they headed to Ecuador.

Program Director, David Horowitz, D.O., co-Chief Residents Will Kirby, D.O., and Tejas Desai, D.O., plus first-year Resident Tony Nakhla, D.O., joined the Nova Southeastern University chapter of DOCARE International on a nine-day medical mission. A total of 11 physicians from various specialties, physician assistants, medical students, and volunteers comprised the team.

Starting out in the city of Quito, venturing to the cloud forests on Tena and eventually ending up in the rainforest of the Amazon, the team treated more than 2,500 patients during the course of the April trip.

Among the unusual dermatologic disorders encountered were leshmaniasis, orf, myiasis, atypical mycobacterium infections, neurofibromatosis in siblings, urticaria pigmentosa, acrodermatitis enteropathica, perforating neurotrophic ulcers, and a Marjolin’s ulcer arising from a burn scar, as well as numerous bacterial, fungal, and parasitic diseases.

“What impressed me the most, other than the variety of diseases we encountered, was how appreciative the patients were,” says Dr. Kirby. “Medical care in this part of South America is simply unaffordable and unavailable to those who need it most.”

Dr. Desai concurs. “Dermatologists can make a significant difference in these peoples’ lives by diagnosing a full gamut of conditions that would otherwise go unnoticed,” he says. While there, Dr. Desai enjoyed teaching dermatology to eager medical and physician assistant students. Not only would he commit to another mission trip next year, but Dr. Desai urges other dermatology residents to join DOCARE or other missionary groups as part of their residency training.

Dr. Nakhla performed an excision of a large congenital nevus located on the submental region of a 32-year-old

DOCARE International

Founded by an osteopathic physician in 1961, DOCARE International is a non-profit, tax-exempt organization whose primary objective is to bring needed health care to primitive and isolated people in remote areas of Western Hemisphere countries. Its all-volunteer membership includes DO and MD physicians, nurses, dentists, veterinarians, pharmacists, optometrists, podiatrists, physician assistants, and interested laypersons who contribute special skills.

Typically, missions occur during the Spring or Fall and last between seven and 14 days, depending on the availability of members and their schedules.

DOCARE medical missions have concentrated on Central Yucatan to serve Mayan Indians and to Ecuador, Guatemala, and El Salvador. However, in the past they have gone to northern Mexico to serve the Tarahumara Indians. Areas of focus change as the need changes and also depend on the improvement in availability of medical care locally.

To learn more about DOCARE International, visit its Web site at www.docareintl.org or call (847) 836-8022.
female, who became overwhelmed at the prospect of being rid of the lesion. “She explained how much she suffered from the lesion, which was clearly disfiguring,” he says. “When I offered to remove it, she burst into tears of joy.” Using a cautery pen, disposable surgical equipment, and a flashlight as a surgical lamp, Dr. Nakhla performed a modified M-plasty. “Although our surgical environment was suboptimal, the outcome of the procedure proved excellent,” he notes.

Dr. Horowitz was very impressed by the enthusiasm of the residents and the general medical knowledge of the medical students from Nova Southeastern University. With previous mission experience in Ethiopia, Mexico, and Africa, Dr. Horowitz is looking forward to participating in future missions with residents.

“This medical mission truly gave me a new perspective on philanthropy,” concludes Dr. Kirby. “I’m hoping to make our participation in this program an annual event.”
The theme of this year’s Annual AOCD Convention is Take it Home!

That’s because each speaker has been asked “to give pearls of wisdom that we may take back to our practices and residency programs,” says Jay Gottlieb, D.O., FAOCD, Program Chair. “Attendees will walk away from this meeting with a good idea of what it would take to institute new concepts or procedures into their existing practices and/or residency training programs.”

**Keynote Speaker**

Some of these concepts will come from keynote speaker, Dr. Anthony Dixon, who will be speaking about “Myths of Skin Cancer Surgery Outcomes—Which are True?” during the lunch lecture on Tuesday. An Assistant Professor (School of Medicine) at Bond University in Gold Coast, Australia, and Fellow of the Australasian College of Skin Cancer Medicine, Dr. Dixon is a nationally and internationally recognized authority on skin cancer surgery. He runs comprehensive training programs and education workshops to assist doctors in their skills managing skin cancer in Australia and overseas. Dr. Dixon also is involved in cutting edge research in skin cancer management. In particular, he is involved in progressing new techniques in reconstruction following tumor excision. He also is Vice President and Censor of the Australasian College of Skin Cancer Medicine and Director of Research for Skin Alert Skin Cancer Clinics in Australia.

**Guest Speakers**

Guest speakers are slated to speak on Monday and Tuesday.

Speakers (listed with their topics) scheduled to present lectures on Monday between 9:30 a.m. and 1 p.m. are as follows:

- **Ramsey Mellette, M.D.**
  - *Mob’s Reconstruction*

- **Simon Warren, M.D.**
  - *Bullous Diseases: What’s New*

**Speakers (listed with their topics)** scheduled to present lectures on Tuesday between 7:00 a.m. and 4:45 p.m. are as follows:

- **Edward Yob, D.O.**
  - *Incorporating Mob’s Surgery into a Dermatology Practice*

- **Gregory G. Papademas, D.O.**
  - *CLIA Quality Assurance Test*

- **Speakers (listed with their topics)** scheduled to present lectures on Tuesday between 7:00 a.m. and 4:45 p.m. are as follows:

- **Cindy Hoffman, D.O.**
  - *Great Cases from Osteopathic Teaching Programs*

- **Hilary Baldwin, M.D.**
  - *I-Pledge Update*

- **Sandy Goldman, D.O.**
  - *Endovenous Laser Treatment*

- **Shelly Friedman, D.O.**
  - *Hair Restoration: What’s New and How to Get Started*

- **Michael B. Morgan, M.D.**
  - *Deadly Diseases in Dermatology*

- **Nathan Uebelhoer, D.O.**
  - *Lasers and Lights*

- **Robert Greenberg, M.D.**
  - *Psoriasis Update*

**Resident Speakers**

Resident speakers (listed with their topics) scheduled to present lectures on Wednesday between 8:00 a.m. and 3:10 p.m. are as follows:

- **John Perrotto, D.O., 2nd Year**
  - *Wellington Regional Medical Center, West Palm Beach, FL*
  - *Xanthochromia Striata Palmars*

- **Billie Casse, D.O., 2nd Year**
  - *St. Joseph Mercy Health System, Clinton Township, MI*
  - *Annular Elastocytic Giant Cell Granuloma*

- **Julie Malchiodi-Jacobs, D.O., 3rd Year**
  - *Oakwood Southshore Medical Center, Trenton, MI*
  - *Oral Erosive Lichen Planus*

- **John Coppolla, D.O., 2nd Year**
  - *Botsford Hospital, Farmington Hills, MI*
  - *Cryptorchidism in a Patient with X-Linked Recessive Ichthyosis*

- **Jon Keeling, D.O., 3rd Year**
  - *Wellington Regional Medical Center, West Palm Beach, FL*
  - *Mequinol 2% Tretinoin 0.01% Solution for the Treatment of Melasma in Male Patients*

- **Joseph Schneider, D.O., 3rd Year**
  - *Pontiac Osteopathic Hospital, Pontiac, MI*
  - *Cutaneous Leishmaniasis*

- **Karthyk Krisnamurthy, D.O., 2nd Year**
  - *St. Barnabas Hospital, Bronx, NY*
  - *Clinical Dermatologic Applications of Intraliesional Blemycin*

- **Lawrence Schifman, D.O., 2nd Year**
  - *St. John’s Episcopal Hospital, Lindenhurst, NY*
  - *Atypical Pyoderma Gangrenosum*

- **Patricia Klem, D.O., 2nd Year**
  - *Wellington Regional Medical Center, West Palm Beach, FL*
  - *Scleroderoid Reaction to Infiltrate Chemotherapeutic Agent Nevantrane for MS*

- **Danica Alexander, D.O., 2nd Year**
  - *Columbia Hospital, Palm Beach, FL*
  - *Management of Perioral Dermatitis*

- **Brian Feinstein, D.O., 3rd Year**
  - *NSUCOM/N Broward Hospital, Ft. Lauderdale, FL*
  - *Linear Focal Elastosis*

- **Heather Higgins, D.O., 2nd Year**
  - *Oakwood Southshore Medical Center, Trenton, MI*
  - *Acrodermatitis Continua*

- **Tony Nakhla, D.O., 2nd Year**
  - *Western University/Pacific Hospital, Long Beach, CA*
  - *Cerclage Technique for Repairing Large Circular Defects of The Trunk: Case Report of a Staged Excision of a Plexiform Neurofibroma*
Kevin DeHart, D.O., 3rd Year
NSUCOM/Sun Coast Hospital, Port Richey, FL
*Formaldehyde Induced Allergic Contact Dermatitis*

Kevin Spohr, D.O., 3rd Year
Wellington Regional Medical Center, West Palm Beach, FL
*A Case of Curious Axillary Freckling*

Sanjay Bambri, D.O., 2nd Year
Valley Hospital Medical Center, Las Vegas, NV
*Epidermal Growth Factor Inhibitors: Dermatologic Implications*

Brian Stewart, D.O., 2nd Year
St. Joseph Mercy Health System, Clinton Township, MI
*Pyoderma Gangrenosum*

Lela Lankerani, D.O., 2nd Year
Frankford Hospital, Allentown, PA
*Eosinophilic Pustular Folliculitis*

Kristen Aloupis, D.O., MPH, 3rd Year
NSUCOM/N Broward Hospital, Hollywood, FL
*Dissecting Cellulitis of the Scalp Treated Successfully with Adalimumab*

Angela Leo, D.O., 2nd Year
Frankford Hospital, Allentown, PA
*Cutaneous Rosai-Dorfman Disease*

David R. Bonney, D.O., 3rd Year
NSUCOM/N Broward Hospital, Hollywood, FL
*Griseofulvin Induced Photoallergic Reaction*

Lunch lecturer: Timothy Kilpatrick, M.D.
*Mycosis Fungoides: Clinical Presentation and Laboratory Evaluation*

Matthew Smetanick, D.O., 3rd Year
Frankford Hospital, Allentown, PA
*Acrodermatitis Chronica Atrophicans*

Mollie Jan, D.O., 2nd Year
Frankford Hospital, Allentown, PA
*Erythema Annulare Centrifugum Treated with PUVA*

Adriana Ros, D.O. 3rd Year
St. John’s Episcopal Hospital, Lindenhurst, NY
*Case Report and Review: Bilateral Microcystic Adnexal Carcinoma*

Kristy Gilbert, D.O., 3rd Yr
Northeast Regional Medical Center, Kirksville, MO
*PDT in the Treatment of Acne*

William Kelly DeHart, D.O., 3rd Year
University Hospital/Case Medical Center, Cleveland, OH
*Eczema Herpeticum in a Postpartum Woman*

Elliot Love, D.O., 2nd Year
University Hospital/Case Medical Center, Cleveland, OH
*Nodular Amyloidosis*

Todd Kreitzer, D.O., 2nd Year
University Hospital/Case Medical Center, Cleveland, OH
*Eruptive Xanthomes*

Kaija Hanneman, D.O., 3rd Year
University Hospital/Case Medical Center, Cleveland, OH
*Catus Marmorata Telangiectatica Congenita with Macrocephaly*

Roger Sica, D.O., 2nd Year
Sun Coast Hospital, Port Richey, FL
*Childhood Dermatomyositis*

Daniel Marshall, D.O., 2nd Year
Northeast Regional Medical Center, Kirksville, MO
*Flaps for Nasal Reconstruction*

Christopher Buckley, D.O., 2nd Year
NSUCOM/N Broward Hospital, Hollywood, FL
*Toxic Shock Syndrome in a Patient with Hidradenitis Suppurativa*

Brian Kopitzke, D.O., 3rd Year
Genesys Regional Medical Center, Grand Blanc, MI
*A Case Report: Merkel Cell Carcinoma*

**Evening Events**
The welcome reception will be held between 6 p.m. and 8:30 p.m. on Sunday evening. The President’s Reception and Banquet will be held from 6 p.m. to 10 p.m. on Monday evening.

Welcome AOCD Fellows, Residents, Corporate Sponsors, and Guests:

As the program chairman for the 2007 Annual AOCD Meeting, I look forward to seeing all of you in glorious San Diego! The theme of this year’s meeting is Take it Home! Each speaker at this meeting has been asked to give pearls that we may take back to our practices and our residency programs. New concepts, procedures, and thoughts will be introduced. We will walk away from this meeting with a good idea of what it would take to institute a new procedure or procedures into our existing practices or residency training programs.

I encourage everybody to attend all of our lectures, visit with all of our sponsors, and attend all of our social events. There will be the welcome reception Sunday evening and our Presidential Reception and Banquet Monday evening.

We have an exciting lunch lecture on Tuesday with our entertaining Australian keynote speaker, Dr. Anthony Dixon. He will be discussing *Myths of Skin Cancer Surgery Outcomes—Which are True?*

Our AOCD residents have prepared presentations on a multitude of very interesting and educational topics. It would be great to see all of our members, resident members, and student members at these lectures supporting the residents.

Welcome to San Diego. *Live, Laugh, Learn…and Take It Home!!!*

Jay S. Gottlieb, D.O, FAOCD
Program Chairman
**JAOCD** Editor
President Elect AOCD 2007-2008
San Diego: From Natural Harbors to a Dazzling Downtown

The second largest city in California, San Diego comprises several charming and distinct neighborhoods to enjoy while attending the 2007 AOCD Annual Meeting slated for Sept. 30-Oct. 4.

Charming Neighborhoods
The eclectic Gaslamp Quarter is a 16.5 block historic district located around Fourth and Fifth Avenues. The quarter is filled with grand Victorian-era buildings that are home to more than 100 of the city’s finest restaurants, 40 nightclubs, and 100 retail shops, as well as theaters and art galleries. Cuisines to be savored include Afghan, Brazilian, Chinese, Indian, Italian, Mexican, Persian, Spanish, Thai, and more.

Downtown’s largest neighborhood encompassing 130 blocks, the East Village burst into life in the past two years. The revitalization of this once blighted warehouse district was fueled primarily by the building of PETCO Park, the San Diego Padres’ state-of-the-art baseball stadium that opened in 2004. Today, scattered throughout the village are restaurants, rooftop bars, cafes, boutique shops, galleries, and live music venues.

Located along Broadway and stretching toward the Broadway Pier on San Diego Bay, Columbia is composed mostly of commercial development interspersed with residential condos. However, it also is home to the Museum of Contemporary Art San Diego. Explore the rich Navy heritage of the city aboard the USS Midway Museum or the floating Maritime Museum of San Diego featuring one of the finest collections of historic ships in the world.

A multi-level, outdoor shopping and entertainment center, Horton Plaza offers 130 specialty shops, restaurants, a movie theatre, and performing arts theatre. Well known for its whimsical and vibrantly colored design, it was created to resemble a European market place and function like an amusement park with colorful pathways, bridges, and staggered levels.

Around Town
Although downtown San Diego is best explored on foot as it has short city blocks and most streets running one way in a grid pattern for easy navigation, alternate modes of transportation are available. The most popular are the San Diego Trolley light rail system, pedicabs, San Diego Tour Coupes’ and GoCar Tours, and converted British double-decker buses.

Although a Kayak tour won’t get you around town, it will get you a view of the amazing San Diego sunsets. Enjoy paddling in the La Jolla Sea Caves and witness the many sea lions sunning on the cliffs late in the day as they feed.

Places to Go
In addition to the 70 miles of beaches and one of the most beautiful natural harbors in the world, San Diego offers several attractions for those on the go.

The San Diego Zoo is one of the largest, most progressive zoos in the world with more than 4,000 animals on 800-plus species on 100 acres of parkland in Balboa Park, just north of downtown San Diego along Park Boulevard. Don’t miss the newest and most ambitious exhibit at the zoo, Monkey Trails and Forest Tails.

SeaWorld San Diego is celebrating America’s musical heritage with the Sea to Shining Sea Music Festival, Sept. 29-30 and Oct. 6-7. Ongoing shows include Journey to Atlantis, Shamu’s Happy Harbor, and Believe. Venture beyond the public exhibits for a unique interactive experience with the park’s arctic animals, including an in-pool personal encounter with beluga whales, as part of Wild Arctic Interaction.

Take a guided tour through remote Africa and Asia and see exotic animals in expansive habitats at the San Diego Wild Animal Park. The 1,800-acre wildlife sanctuary is home to more than
3,500 animals representing 429 species, including the largest crash of rhinos in any zoological facility and one of the only California condor exhibits in the world.

LEGOLAND California offers more than 50 rides, shows, and attractions. New this year, a recreation of the city of Las Vegas built out of more than two-million bricks and Captain Cranky’s Challenge, a ride that will test anybody’s sea worthiness.

The region boasts a variety of vineyards and large wineries that feature guided tours and gift shops. Most wineries are located off Interstate 15, approximately a 45-minute to an hour’s drive north of downtown San Diego. These include the Bernardo Winery, Falkner Winery, Fallbrook Winery, and Orfila Vineyards. If you don’t want to leave the area, visit the San Diego Wine & Culinary Center located in the heart of downtown. The center offers tours that feature an explanation of the winemaking process along with a barrel tasting.

**Things to Do**

With sunny skies (Don’t forget the sunscreen!) and temperatures in the 70s, the city is hopping the week of the Annual Meeting. The following is a sample of events.

The annual Fleet Week Parade of Ships is Sept. 30 on the Bay. Watch the parade of aircraft carriers, U.S. & international ships, Navy SEALs, Navy submarines, Coast Guard cutters, harrier jets, and helicopters. Tickets are $25.

Adams Avenue Street Fair on Sept. 29 and 30 is Southern California’s largest free music festival. It features more than 80 musical acts on seven outdoor stages. The fair that takes place on Adams Avenue, between Bancroft and 35th streets, also has more than 400 food, arts and craft vendors, and carnival rides.

The 6th Annual San Diego Film Festival to be held Sept. 27-30 in the Gaslamp Quarter are four days filled with 100 award-winning films, intimate gatherings with filmmakers and celebrities, high-powered industry workshops, and four nights of the city’s most glamorous parties. Tickets range in price from $10 to $250.

The AFC West Division Champion San Diego Chargers host division rival Kansas City at QUALCOMM Stadium at 1:15 p.m. on Sept. 30.

As part of the Old Globe Theatre’s renowned summer Shakespeare Festival, you can catch Measure for Measure, Hamlet, or The Two Gentlemen of Verona. If the Bard is not your taste, see the world premiere musical, A Catered Affair, by Tony Award-winner Harvey Fierstein at the three-venue complex in Balboa Park.

For more information on San Diego events, visit the Web site sandiego.org/event.

**Dr. Balazs Welcomes Baby Girl**

Congratulations to Kathy Balazs, D.O., and her husband, Brian Coffee, on the birth of their daughter Madison Elizabeth Coffee.

Madison was born on March 12th. She weighed 7 pounds, 8 ounces, and was 19.5 cm long.

Dr. Balazs is a practicing dermatologist at Beavercreek Dermatology in Ohio. She graduated in 2000 from Dr. Eugene Conte's program at Grandview Hospital in Dayton.
Recently I met a dermatologist at a dermatology meeting who mentioned that his office had a high staff turnover that was resulting in pecuniary penalties. His situation reminded me of a human resources book that I once read. It discussed several reasons for a high turnover rate, including low salary, insufficient benefits, lack of time off, restrictive vacation policies, and poor physical working conditions. However, the book emphasized the one reason that is sometimes invisible: office human dynamics. This dermatologist said that he left those issues up to his only long-time employee, his office manager. The book described a situation in which after an office manager had retired, the entire tone of the office became lighter. People worked more effectively, the patients felt more comfortable, and the office income increased.

According to Jennifer Forgle, managing partner of the On Point Consulting Web site (www.onpointconsulting.org), many managers are unable or unwilling to deal with performance problems often posing issues that cut across all types of businesses. Likewise, many bosses are slow in dealing with performance issues, which sends a subtle signal to employees that these issues are unimportant. Other leaders simply ignore such issues hoping that they will disappear.

In reality, not addressing performance problems evokes a negative reaction among co-workers whose behavior reflects company values. Typically, they grow increasingly resentful of people who “get away with” poor performance and attitudes. These poor performers are viewed as not doing their fair share of work.

All performance issues should be dealt with immediately. Managers who do not address them right away will live to regret their non-action, as will the other workers.

Employees leave their jobs because of the office culture, not because of compensation or benefits. The latter merely serve as hiring attractants. You’re not going to retain the best people if troublemakers create an unsavory workplace atmosphere and possibly even legal reprise.

The most common reasons for not formally identifying bad behavior, according to Forgle, are as follows:
1. It is easy to check the “meet expectations” box as part of the annual review. Although this may seem easier, it makes confronting an individual’s bad behavior more difficult in the long run.
2. Great revenue generators are difficult. My question is: But are the disruption and other employees’ resentment worth it?
3. Leaders can be vague on what defines bad behavior. My recommendation is to define it concretely and visibly so that all staff members know what constitutes bad behavior.

Finally, all human resource books indicate that poor behavior often escalates. Nipping it before it blooms will create a happier work environment for your employees, which will result in decreased anxiety and an increased bottom line.
AOA President John A. Strosnider, D.O., age 60, passed away of pancreatic cancer on June 21.

His presidential theme, “Back to the Basics,” exemplified his dedication to the proposition that DOs educated in a rural environment would remain in that environment, providing essential, quality health care to those in need.

“The osteopathic medical profession was built on a primary care philosophy, and we need to get back to those basics so that our patients in these areas have access to the distinctive health care promised by osteopathic medicine,” Dr. Strosnider said after being installed as AOA president last July.

As the founding dean of the Pikeville College School of Osteopathic Medicine (PCSOM) in Kentucky, Dr. Strosnider modeled the school with his “back to the basics” concept in mind. His vision that the school would produce primary care doctors committed to providing health care in underserved communities in Appalachia has become a reality.

Since 2001, 93% of the 280 graduates have chosen to enter internships and residencies in primary care and 79% are practicing in underserved areas.

“He was deservedly proud of his work at PCSOM in bringing an underserved community’s dream of a first-class medical school to reality,” says John B. Crosby, J.D., AOA Executive Director.

To honor his memory, AOCD President Bill Way, D.O., who referred to Dr. Strosnider as “a friend, classmate, and colleague,” suggests that osteopathic dermatologists provide graduating osteopathic medical students more quality training in dermatology. “Volunteer at our schools to teach a few lectures in dermatology and ask to have trainees come to your office and learn some dermatology,” he says. “Remember that physician means teacher. Let us all do our part by giving back to our profession and help fulfill Dr. Strosnider’s dream of improving osteopathic medicine by getting back to the basics, which in our case is teaching dermatology to our colleagues.”

Dr. Strosnider was equally as passionate about helping the AOA become a great organization. With this lofty goal in mind, he launched the AOA’s Greatness Campaign to get more members actively involved in helping to shape AOA policy; to record histories of living pioneers who made significant contributions to the profession; and to fund the association’s major goals such as a national advertising campaign or a campaign to improve health care for all Americans.

Dr. Strosnider’s career as an osteopathic physician gave him an opportunity to serve the profession in many ways: as a provider for his patients; as a leader for the Jackson County Osteopathic Medical Association in Missouri and the Missouri Association of Osteopathic Physicians and Surgeons, as well as the AOA; and as an educator at what is now the Kansas City University of Medicine and Biosciences College of Osteopathic Medicine and at PCSOM.

Dr. Strosnider is survived by his wife, JoAnn, and three children, John Adam, Alisha, and Paul, as well as his mother, Dodi.

In lieu of flowers, the family requests that a donation be made in Dr. Strosnider’s honor to the AOA Greatness Fund. These donations can be made by check (payable to the AOA with John A. Strosnider, DO, in the memo section) or through www.DO-online.org.

Sondra Darlene Way, the wife of AOCD President Bill Way, D.O., passed away unexpectedly on May 27, her 51st birthday.

Mrs. Way was active in local and Texas DO organizations. She also was a member of the Auxiliary of District 5. She loved her Yorkie dogs and horses, and enjoyed horseback riding, cooking, and gardening. But her greatest enjoyment in life was her family as Mrs. Way spent a great deal of time with her children and grandchildren.

She was a loving wife, mother, grandmother, daughter, and sister. Mrs. Way was preceded in death by her mother, Ethel Woods. She is survived by her husband of 21 years; daughter, Julie Rowe and husband Lance; son, Chris Ross and wife Vanessa; three grandchildren, Taylor Ross, Levi Rowe, and Nathan Ross; father, Herman Woods; two brothers, Jason and Clayton Woods and family; and an extended family, wonderful friends, and osteopathic family.

Donations to the Foundation of Osteopathic Dermatology may be made in memory of Mrs. Way.

Dr. Way wishes to express his utmost appreciation for all the prayers and caring that individuals have provided during this difficult time.
Mohs College Changes Name

The American College of Mohs Micrographic Surgery and Cutaneous Oncology has changed its name to the American College of Mohs Surgery (ACMS).

The primary reason for the name change is to make it more user friendly for the public, according to ACMS Communications Manager Erik Ebarp. “ACMS is just easier to remember,” he adds.

Although the ACMS membership and Board of Directors approved the name change at the annual meeting held this past May, it will not become official until October.

Additionally, the ACMS will introduce a newly designed and restructured Web site later this fall. The Web site remains the same: www.mohscollege.org.

The College, named after Frederic Mohs, M.D., who developed the procedure, was established in 1967. Currently, there are approximately 800 members.

A Call to Reform Osteopathic Medical Education

In order to prepare future physicians to meet society’s health needs, leaders at colleges of osteopathic medicine (COMs) and osteopathic graduate medical education programs must move “beyond the barriers” to effect curricular reform.

That according to an article published in a recent issue of the Journal of the American Osteopathic Association (JAOA).

The article discusses several barriers in both curricular and extracurricular areas of osteopathic medical education, beginning with the skeptics. These are individuals who cite excellent board scores, anecdotes of residency programs “loving our graduates,” and surveys of graduates and residency program directors as indications that osteopathic medical education is doing its job well.

Faculty resistance resulting from competing priorities, inertia, and the undervaluing of faculty development is another barrier to reform.

Ongoing reliance on the Flexner Report*, which the author contends lacks credibility due to decrepitude and Flexner’s lack of clinical experience, is another barrier. Although some call for students to have clinical exposure earlier in their training, while others call for more basic science in their later years, neither offer the integrated approach recommended by many of today’s experts. Shorter lengths of stay, advances in outpatient care, and hospital closings have diminished the value of quality medical education programs through hospitals. Therefore, the author asserts that medical schools should consider deemphasizing hospital-based training, while forging partnerships with ambulatory clinical training sites, assisted living facilities, and community health centers, among others.

Educators who do not integrate and build on the curriculum taught in other departments serve as a barrier to education reform. Along those lines, the teaching of osteopathic principles and practice are often fragmented in coursework, clerkships, and residency programs. An increase in osteopathic research at COMs in areas that complement their missions (e.g., osteopathic manipulative treatment, informatics, and interdisciplinary teams) would benefit the curriculum, as well.

Although the mission of COMs is to train compassionate physicians who are committed to service, and specifically to the practice of holistic medicine, very few osteopathic medical schools require students to take behavioral sciences courses in which they can learn those attributes. This barrier ties into another one related to the unspoken culture of medicine, which tends to be competitive, unemotional, hostile to human error, and contradictory to the notion of compassionate caring and healing. To relay the sense of compassion and redefine the culture of medicine, educators must expand humanities requirements and restructure learning environments, the author notes.

In order to move “beyond the barriers” to effect curricular reform, the author concludes that COMs and osteopathic graduate medical education programs need to do the following:

- Allow curricular evolution and faculty development
- Expand clinical learning and teaching
- Break down departmental walls
- Integrate osteopathic principles and practice
- Reevaluate admission requirements of COMs
- Eradicate the unspoken culture of medicine

The article appeared in the July 2007 issue of the JAOA, Vol. 107, No. 7.

* The Flexner Report written by Abraham Flexner, a teacher and principal, is credited with triggering much-needed reforms in the standards, organization, and curriculum of medical schools in the early 1900s.
**CORPORATE SPOTLIGHT**

**AOCD’s Greatest Impact: Patient Care, One-on-One Training**

Malcolm McCoy, Vice President of Sales and Marketing at PharmaDerm, Duluth, Ga., who has been in the pharmaceutical industry for 30 years (six with PharmaDerm), talks about the AOCD’s continued growth and greatest impact in light of the College’s 50th anniversary.

**Why is it important that specialty colleges, such as the AOCD, continue to grow strong?**

Right now, if you look at the demographics, there are not enough dermatologists to meet patient demand. This shortage is reflected in the average waiting time to see a dermatologist, which is approximately six weeks or longer. According to long-term projections, it’s going to be hard to shore up the dermatologist supply with patient demand. The continued growth of specialty colleges, such as the AOCD, is critical to meeting patient demand now and in the future.

It’s important for the College to continue to grow to have a cadre of osteopathic dermatologists who are qualified to train future DO dermatologists. As the College grows, so does the number of osteopathic dermatology residents graduating. I understand that the number of residents is now at 90, and that’s even up from a few months ago.

**During the last half century, the AOCD has grown to become a strong and influential specialty College. What is the College’s greatest impact?**

The AOCD’s greatest impact has been on patient care and education. Its members continue to inform the American public about diseases of the skin, particularly skin cancer, and the need to have an annual full body scan.

Regarding resident education, the College’s greatest impact has been its’ emphasis on the one-on-one training with individual dermatologists that its residents receive across the board.

PharmaDerm is a Diamond Corporate Member, and sponsor of the Welcome Reception at both the Midyear and Annual meeting in 2007.

**Corporation Spotlight**

Don’t Forget the Foundation

by Brad P. Glick, D.O., MPN, FAOCD

Like our counterparts at the American Academy of Dermatology, the AOCD has a dermatology foundation known as the Foundation for Osteopathic Dermatology (FOD).

The FOD was founded in 2002 with the intent of improving the standards of the practice of osteopathic dermatology by raising awareness, providing public health information, conducting charitable events, and supporting research (e.g., for residents in training) through grants and awards given to these applicants under the jurisdiction of osteopathic dermatologists.

As FOD President, I urge you to give generously to build our Foundation to a level that provides much to both the osteopathic dermatology community and the public at large.

In the coming months, be on the lookout for more information about the FOD.

PharmaDerm® is proud to be a Diamond-level sponsor of the AOCD

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Join us in
San Diego, California
for
The American Osteopathic Association’s
112th Annual Meeting
September 30, 2007 to October 4, 2007

Welcome to San Diego, California's second largest city. Where blue skies keep watch on 70 miles of beaches and a gentle Mediterranean climate begs for a day of everything and nothing. Bordered by Mexico, the Pacific Ocean, the Anza-Borrego Desert and the Laguna Mountains, San Diego county’s 4,200 square miles offer immense options for business and pleasure.

Relax, soak in San Diego. Let your surroundings dictate a new appreciation for all the good things San Diego has to offer. From thrilling ocean adventures to chilled-out siestas under the shadow of a palm tree, your San Diego experience will teach you a new way of life - full of fun, relaxation and beauty.

San Diego is also home to such world-famous attractions as SeaWorld, the San Diego Zoo, the Wild Animal Park and LEGOLAND California, as well as historic cultural gems Balboa Park and Old Town.