Midyear Meeting Presenters Cover Diseases to Practice Issues
see pages 6-11

Disability Insurance
see pages 18-20

St. Joseph Mercy: Young, but Accomplished Program
see page 16

Midyear Meeting Memories
see page 12
American Osteopathic College of Dermatology
P.O. Box 7525
1501 E. Illinois
Kirksville, MO 63501
Office: (660) 665-2184
(800) 449-2623
Fax: (660) 627-2623
Site: www.aocd.org

PRESIDENT
Donald K. Tillman, D.O., FAOCD

PRESIDENT-ELECT
Marc I. Epstein, D.O., FAOCD

FIRST VICE-PRESIDENT
Leslie Kramer, D.O., FAOCD

SECOND VICE-PRESIDENT
Bradley P. Glick, D.O., FAOCD

THIRD VICE-PRESIDENT
James B. Towry, D.O., FAOCD

SECRETARY-TREASURER
Jere J. Mammino, D.O., FAOCD

IMMEDIATE PAST-PRESIDENT
Jay S. Gottlieb, D.O., FAOCD

TRUSTEES
Mark A. Kuriata, D.O.  Suzanne S. Rozenberg, D.O.
Rick J. Lin, D.O.  Brian Matthys, D.O.

EXECUTIVE DIRECTOR
Rebecca Mansfield, MA

CONTRIBUTE TO DERMLine
If you have a topic you would like to read about or an article you would like to write for the next issue of DermLine, contact Ruth Carol, the editor, by phone at 847-251-5620, fax at 847-251-5625 or e-mail at RuthCarol1@aol.com.

UPDATE CONTACT INFORMATION
Is your contact information current? If not, you may be missing need-to-know news from the AOCD.
Visit www.aocd.org/membership. 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.

INDUSTRY SPONSORS

DIAMOND SPONSORS
Biopelle Inc.
Dermpath Diagnostics
Global Pathology Laboratory Services
Medicis
Neutrogena
Ranbaxy Laboratories, Inc.
Stiefel

PLATINUM SPONSORS
Graceway Pharmaceuticals
OrthoNeutrogena

GOLD SPONSORS
Galderma
Sanofi-Aventis/Dermik Laboratories

SILVER SPONSORS
Coria

BRONZE SPONSORS
Abbott Labs
Allergan
Centocor
Crystal Cove Wealth Management
Dermatopathology Laboratory of Central States
Intendis
Triax Pharmaceuticals

Upcoming Events
AOCD ANNUAL MEETING 2009
November 1-4, 2009
New Orleans, LA

AOCD MIDYEAR MEETING 2010
April 14-17, 2010
Sedona, AZ
Steamboat Springs was great! Those of you who didn’t attend the AOCD 2009 Midyear Meeting missed a wonderful time. Although the weather was a little warm, the skiing was as accessible as going out to your own backyard at the ski in/ski out Sheraton Steamboat Resort. Attendees who were not skiers (and there were some) enjoyed snowmobiling, snowshoeing, and hiking, as well as sitting by the fire and chatting with old friends. Some even ventured to the City of Steamboat Springs, whose streets are lined with unique shops and boutiques, and numerous restaurants.

Congratulations to Dr. Brad Glick for organizing an outstanding group of lecturers. We were honored and privileged to have many world-renowned speakers who not only delivered cutting edge information, but interacted on a personal level due to the small size of the meeting.

Again, I want to congratulate the residents who provided a diverse group of lectures on a variety of topics. It was encouraging to see so many members attend the resident lectures, which were five to ten minute presentations providing something of value for all.

I encourage the residents to take advantage of the grants and awards made available through the College to further their academic pursuits. In this issue of DermLine alone, articles announce the upcoming deadlines for the Intendis Call for Papers Competition and the A.P. Ulbrich Research Award.

At the Executive Board meeting, we had much discussion about the Pharmaceutical Research and Manufacturers of America, or PhRMA, guidelines that went into effect in January. Shirley Gottlieb, the AOCD’s Director of Development, has been working to ensure that the College is in compliance with the necessary requirements to continue obtaining the allocation of funding necessary to maintain the College and to continue its CME programs, such as the midyear meeting. It is becoming increasingly more difficult to raise money for academics, as well as meetings, and I am thankful for Shirley’s involvement and efforts in doing so. I encourage all of you to visit with your reps, and let them know that we do appreciate their support for our College.

As always, I welcome your e-mails to share your ideas and concerns, as it is one of my goals as president to see that communication continues to improve within the College.

Sincerely,

Donald K. Tillman Jr., D.O., FAOCD
AOCD President, 2008-2009
The New Year began with the AOA CME conference and Bureau of Osteopathic Specialty Societies, or BOSS, meeting held January 8-11 in Ft. Lauderdale, Fla. All AOA affiliated organizations must attend this conference to maintain their ability to provide CME. We spent three days in lectures and workshops with other specialty directors and staff, CME coordinators, and directors of medical education from across the country. The primary topic was the changes that are occurring in the way CME is provided and the major Pharmaceutical Research and Manufacturers of America, or PhRMA, regulation changes that are being developed. One example of the proposed changes is a restriction that meetings held on a property with the word “resort” in their name are not acceptable venues! It will be interesting to see how the final regulations are implemented.

The Education Evaluation Committee met on February 28 in St. Louis, Mo., to review new program applications, inspection reports, and a report from the AOA Council on Postdoctoral Training.

Attendance at the Midyear Meeting in Steamboat Springs, Colo., was very good. The lectures were outstanding and well attended. Dr. Brad Glick developed an excellent program that everyone enjoyed. Attendees were able to enjoy many outdoor activities including snowboarding, skiing, snowshoeing, sleigh rides, hot air ballooning, snowmobiling, and watching the Cowboy Downhill competition.

The 2010 Midyear Meeting will be held April 14-17 in Sedona, Ariz., at the Hilton Sedona Resort & Spa. Meeting details will be in the next newsletter, so mark your calendar now! Dr. Leslie Kramer is the program chair.

Happy New Year and Spring!

Do You Volunteer Your Time?

Whether you volunteer in the streets of San Francisco or the jungles of the Amazon, we would like to hear from you. We would like to feature your efforts in the "Volunteer Spotlight" in an upcoming issue of DermLine. Contact DermLine Editor Ruth Carol at 847-251-5620 or RuthCarol1@aol.com.
New Trustees Share Views

Encouraging membership participation, building cohesiveness among the residency programs, and creating equality with allopathic colleagues are the hot topics that recently elected trustees on the AOCD’s Executive Committee would like to address during the next few years.

Get Involved

“I would like to challenge all of our members to participate in the College because it best supports and nurtures the osteopathic dermatologist,” says Karen Neubauer, D.O., FAOCD, who was re-elected as a trustee at the 2008 AOCD Annual Meeting after having served a two-year run. By attending the Business Meeting, which is held at every annual and midyear meeting, members can get a good sense of the future directions the College is taking. Dr. Neubauer is hopeful that having the resident liaison attend the Executive Committee meetings offers a good opportunity for residents to get more involved, as well.

Rick Lin, D.O., FAOCD, would like the College to encourage more recent graduates, in particular, to step up their participation. “While residents are in their programs, they are very focused on completing them. After the residents finish their residencies, many times they become focused on establishing their practices,” says Dr. Lin, who has been a member since 2001 when he was a medical student. While this intense focus is very understandable, it doesn’t leave much time for them to get involved in College activities. It’s not until five or ten years later that many dermatologists decide to become more politically active. Dr. Lin, who served as resident liaison for two years between 2003 and 2005, would like to see that timeline moved up. Given that position, Dr. Lin believes that he brings a different perspective to the Executive Committee, that is, the concerns of recent graduates.

Residency Programs Unite

The continued growth and improvement of the residency programs should be a College priority because they are the foundation, as well as the future, of the AOCD, says Dr. Neubauer, who has been a College member since becoming a resident in 1993.

“The better the residency programs get, the more potential learning opportunities present themselves that enable us to improve them even more” she says, citing the more effective use of the pathology programs as an example. “The residency programs are graduating some of the best dermatologists from across the country and it’s important that they stay on the cutting edge.” One way to achieve that is to continue building cohesiveness across the programs, Dr. Neubauer says.

Suzanne Sirota Rozenberg, assistant program director of the St. John’s Episcopal Hospital, South Shore Residency Program, agrees. To ensure that all of the AOCD residents are moving in the same direction with regard to their education, she would like to see more consistency in the programs’ curriculum. For example, when residents join, they should be given an agenda on what they are expected to accomplish during the next three years. This agenda should be consistent for all of the programs.

Dr. Sirotta Rozenberg, who has been an AOCD member since 2002, would also like the College to improve its communication with the residents. Dr. Lin believes that expanded use of the website can serve as a vehicle to enhance communication among all of its members.

Create Equality with MDs

Improving the standing of the AOCD with the American Academy of Dermatology (AAD) is another priority. “It is imperative that osteopathic and allopathic dermatology residents are seen on an equal footing,” asserts Dr. Sirota Rozenberg. She is outraged by the fact that the AAD will not accept College members as full members with voting rights and the American Society of Dermatologic Surgery recently changed the status of AOCD members to affiliate. “And yet my residents sit side-by-side with allopathic residents,” Dr. Sirota Rozenberg notes. “This is one of a few fields in which a bias still exists. I would like to work toward reducing the prejudice that still exists in the dermatological world.”

Brian Matthys, D.O., FAOCD, believes that trying to create equality with allopathic dermatologists is one of the biggest challenges the AOCD faces. “Osteopathic and allopathic dermatologists need to be looked upon in the same light,” he says. But instead of trying to be like allopathic dermatologists, osteopathic dermatologists should embrace their osteopathic teaching, which calls for a different approach than that used by allopathic dermatologists. “We should just be who we are, which is leading physicians in our communities who are well recognized by our patients,” says Dr. Matthys, who has been an AOCD member since 2000.

“We have a great organization,” says Dr. Neubauer. “We need to remember and respect the founders and previous leaders of the AOCD because it is their vision that has allowed the College to grow and succeed. It’s an exciting time for the AOCD as we move forward.”
Psoriasis Biologic Review

Many patients with psoriasis have comorbid conditions that contribute to their risk of cardiovascular disease (CVD), noted Francisco A. Kerdel, M.D., director of the Florida Academic Dermatology Centers in Miami. For example, patients with psoriasis have a higher tendency than the general population to smoke and most psoriatic patients are overweight. The prevalence of metabolic syndromes, such as diabetes, hypertension, and CVD, in psoriatic patients is five times that of the normal population.

Dr. Kerdel reviewed several studies that showed the use of biologics had a positive impact on comorbidities in patients with psoriasis. The CVD risk in psoriatic patients may be decreased by the use of biologics, as suggested in these studies, but there is no hard data just yet, he concluded.

Regarding the etiology of psoriasis, Dr. Kerdel said it is believed to be a cell mediated immune dysfunctional disease. Although clinicians know about the Th2 and Th1 cells, they should be focusing more at the Th17 cells, he noted.

Dr. Kerdel then reviewed the five biologics approved to treat psoriasis. Among them are alefacept, efalizumab, infliximab, etanercept, and adalimumab. He also mentioned ABT-874 and ustekinumab, the latter of which is being evaluated in a series of phase III trials. Although the new drugs have a good future, Dr. Kerdel suggested that dermatologists should not dismiss the 15 years of clinical experience with millions of patients that have been obtained by the current biologics.

Laser Side Effects, Complications

Even experts with extensive experience using light-based therapies have patients who develop complications, said Daniel Buscaglia, D.O., FAOCD, director of the Cosmetic Vein & Laser Center in Williamsville, New York, and Clinical Instructor in the Department of Dermatology at the State University of New York at Buffalo, School of Medicine. That was not his own opinion, but in fact, the conclusion of a multicenter review evaluating complications of dermatologic laser surgery.

While lasers have a lot of potential to improve the skin’s appearance, they also are associated with potential risks, he said. Expected side effects may include redness, crusting, skin desquamation, and purpura. Unexpected or unwanted side effects are epidermolysis or non-specific thermal damage.

Complications can be categorized by clinical presentation, such as pigmentary, infectious, textural and keloidal, and follicular. They also can be categorized by etiology, such as energy that is either excessive or sub-therapeutic, or cooling that is either lacking or malfunctions, or is excessive.

Dr. Buscaglia reviewed several case studies of patients who experienced side effects and complications from lasers, suggesting the problem that caused them. For example, a herpes simplex virus infection could have been avoided in a patient who underwent resurfacing with a CO2 laser if an ablative or fractionally ablative laser was used instead, he noted. Often times, the problem is that the wrong laser is used for the wrong indication, said Dr. Buscaglia. Sometimes the technique and not the laser is the problem as was the case of a 55-year-old female who experienced hypertropic scarring following resurfacing of the neck. When doing this type of procedure, it is important to identify where the laser probes have been emitted so as not to overlap the area, he said.

“When everything goes right, lasers are great,” he concluded. That is why it is so important that dermatologists know how to prevent complications.

Interesting Cases from Deep South

Melinda Greenfield, D.O., of the Albany Dermatology Clinic in Georgia reviewed interesting dermatology cases from “the Deep South.”

Among them was the case of a 17-year-old girl with a six-month history of a progressive, pruritic rash. She did not respond to treatment with steroid and antifungal creams. A physical exam revealed hypopigmented, scaly plaques located extensively on the trunk, face, arms, and legs, not what is typically seen in the textbooks, noted Dr. Greenfield. The pathology report showed superficial perivascular lymphocytic
infiltrate with slight acanthosis and spongiosis of the overlying epidermis. Lymphocytes did not exhibit cytologic or nuclear atypia. The patient was successfully treated with ultraviolet light therapy and topical steroids.

Nine months later, the patient returned with symptoms. Dr. Greenfield treated the patient with bromelain, a crude pineapple extract. She cited a study on the efficacy of bromelain given to eight patients with pityriasis lichenoides chronica (PLC) who did not respond to conventional therapies. All patients experienced complete recovery after treatment and showed no side effects. Similarly, the patient never returned after treatment with bromelain. Although bromelain’s mechanism of action is unknown, its anti-inflammatory antiviral and immunomodulatory properties are presumably involved in the clinical response, she noted. Recent studies have suggested that parvovirus B19 may be implicated in PLC and bromelain has been shown to alter the parvovirus envelope.

Dr. Greenfield also reviewed case studies of patients with look alike conditions, such as a diagnosis of discoid lupus, which turned out to be seborrheic dermatitis, and a diagnosis of acne with escoriation on the face, which a biopsy revealed to be discoid lupus. A rash on the chin, which was non-responsive to any topical or oral acne treatment, turned out to be a nickel allergy that was triggered after the patient had a permanent retainer made of 14K gold, which contains only 58% gold, placed in her mouth.

Photodynamic Therapy

Thomas Bender III, M.D., FAAD, of the Eglin Air Force Base Hospital, Department of Dermatology in Florida, touted the benefits of photodynamic therapy (PDT). It is efficacious, safe, and cost effective, he said. In studies, patients undergoing PDT experienced 75% clearance of actinic keratosis (AK) lesions at eight weeks. After 12 weeks, patients experienced nearly 100% clearance. In studies comparing PDT with topical 5-fluorouracil (5-FU), patients undergoing PDT experienced a 73% reduction of AK lesions compared with those given 5-FU who experienced a 71% reduction. In a study comparing PDT with topical imiquimod, 90% of patients undergoing PDT experienced 100% clearance compared with 48% of patients given imiquimod.

Photodynamic therapy is a good option especially for patients who are not compliant with topical therapy, noted Dr. Bender. “The less work patients have to do, the better they’ll comply.” It’s easy for the dermatologist, as well, because there is no prescription to write. Plus, PDT has the added benefits of offering more rapid healing, having fewer side effects, and improving the appearance of hyperpigmentation. Although PDT is used for medical conditions, he said, it definitely has cosmetic outcomes that patients appreciate. Undergoing a PDT treatment is less expensive than both a dose of 5-FU and imiquimod, he added.

Pearls, Pitfalls of Dermatology

Iftikhar Ahmed, M.D., of Phoenix-based Caris Diagnostics, presented a half dozen unusual dermatology cases as he continued on page 8...
imparted “pearls and pitfalls” surrounding the diagnosis of each.

The first case was a 19-year-old white male whose initial diagnosis was sarcoidosis, but whose biopsy revealed granulomas. Three months later, the patient developed plaque-like T-cell lymphomas. He was diagnosed with granulomatous slack skin, which is a rare extracutaneous disease affecting the lymph node, bone marrow, thyroid, spleen, and bronchial tissue. Standard therapy is lacking as is an effective treatment. This patient underwent 12 months of radiation and did well. There was neither systemic disease nor nodule compartment involvement. “By convention, it should have been a classic case of sarcoidosis,” noted Dr. Ahmed. “You might think you’re dealing with a specific entity, but time proves you wrong.”

Another case he reviewed was that of a 33-year-old female with an atypical variant of a Spitz tumor. There is some debate in the literature about Spitzoid lesions because the tumors do not always live up to the classic definition.

With each example, Dr. Ahmed discussed the value of clinical and pathological correlations, spectral (multifaceted) nature of disease states, histological overlap between entities, importance of close prospective follow-up, need for repeating a workup despite initial negative results, and importance of ancillary techniques.

**Pediatric Dermatology**

Fred Ghali, M.D., of Grapevine, Texas, reviewed his Top 10 pediatric dermatology cases. He started with a strange urticaria for which the patient exhibited a fever, facial and extremity swelling, lymphadenopathy, and arthralgias. The main causes are cephalosporin and penicillins. Other causes could be viral. If the offending agent is found, it usually takes one to three weeks before the breakout, he noted. Treatment includes discontinuing the offending antibiotic. Most cases require oral steroids. If it is due to virus, it is trickier to treat, although steroids are effective. Oral antihistamines may help, as well.

Dr. Ghali reviewed common diaper rashes including folliculitis, irritant contact, allergic contact, and candida, as well as uncommon ones such as histiocytosis and acrodermatitis enteropathica. He also discussed various types of fungus in pediatric patients. Among them are inflammatory tinea faciale, tinea incognito, tinea capitis, and *M. Canis*.

Pseudo-acne and striae are two common conditions that commonly go away on their own. Probably the No. 1 referral is for retention keratosis, which can be confused with acanthosis nigricans. An otherwise normal-appearing child has dark spots that will not go away. The spots, which seem almost glued to the skin, can be removed by wiping them off with alcohol.

Dr. Ghali also discussed viral exanthems including unilateral thoracic exanthema and Gianotti-Crosti Syndrome.

Rounding out his Top 10 list were warts. Dr. Ghali discussed intralesional immunotherapy that involves either a candida, trichophyton, or mumps antigen injected locally into the base of the wart(s). Some reports show a 70% to 75% effective rate. The advantages are no scarring and minimal pain. The disadvantage is that some children become overly anxious about getting an injection. Using cryotherapy prior to the injection minimizes the pain. Some cases require multiple injections.

**Laser Surgery**

Offering aesthetic procedures can supplement existing practice income and improve relationships with patients, suggested Shino Bay Aguilera, D.O., FAOCD, during his presentation entitled *Aesthetic Laser Procedures for a Successful Practice.*
“The driving force of the market right now is baby boomers,” said Dr. Aguilera, whose oldest patient is 94. Eighty-five percent of his Fort Lauderdale-based practice comprises cosmetic dermatology.

Dr. Aguilera explained how lasers work, the different wavelengths, the difference between intense pulsed light and laser, laser tissue interactions, and thermal relaxation times. He also reviewed the different applications of the various types of lasers based on their wavelengths.

In order for a laser to provide an effective treatment, it should have a wavelength absorbed by the melanin/blood; sufficient energy to heat the structure to be destroyed while preserving surrounding tissue; large spot sizes for depth of penetration; and, the ability to treat a variety of skin types.

Among the applications Dr. Aguilera discussed were hair removal, resurfacing, and rejuvenation, as well as treatments for pigmented lesions, leg veins, facial veins, and acne scarring.

Contraindications include light sensitivity to the treatment wavelength, certain medications, seizure disorders triggered by light, recent sun exposure, pregnancy, and suspicious pigmented lesions. Complications include contact dermatitis, urticarial reaction, infections, increased hair growth, hyperpigmentation, hypopigmentation, and textural changes, among others.

**MRSA, VZV, HPV Updates**

How to manage methicillin-resistant Staphylococcus aureus (MRSA) was the focus of lecture presented by Jeffrey Weinberg, M.D., of the Department of Dermatology at St. Luke’s-Roosevelt Hospital Center/Beth Israel in New York City.

Because skin and soft tissue infections (SSTIs) are the most common systemic manifestation, incision and drainage is the key to dealing with MRSA, he said. Lesions less than 5 cm that are incised and drained do not require adjunctive antibiotic treatment.

In cases of mild SSTIs among otherwise healthy patients with no prior history of MRSA residing in areas with low MRSA prevalence, β-lactam antibiotics with anti-staphylococcal and streptococcal activity are still a reasonable initial treatment with careful follow-up. If the culture comes back indicating it is resistant, he said, then the antibiotic can always be switched. Patients with complicated SSTIs, involving deep tissue, should be admitted to the hospital.

Whether or not patients who have MRSA nasal colonization should be treated with mupirocin is controversial. The consensus, which continues to evolve, is that these patients should be treated with mupirocin, but only up to four weeks.

Prevention strategies include eradication of either the nasal carriage or body colonization. Hand hygiene is the most effective measure to prevent cross-transmission and reduce the spread of antimicrobial resistance whether it is done with soap and water or alcohol gels.

The Herpes Zoster vaccine has been underutilized because of a lack of information and knowledge surrounding it, and because Medicare’s coverage of it is unclear, said Dr. Weinberg. The number of cases in this country is increasing because the population is aging. Treatments include antiviral therapy, analgesics, and supportive care. The antiviral therapy does not change the course of the disease, he said, it just accelerates the healing. The zoster vaccine is indicated for the prevention of herpes zoster in individuals, 60+ years of age. In a large study, the vaccine reduced the incidence of shingles by 51%.

The latest developments in the human papillomavirus (HPV) vaccine is that it has been recommended for girls, adolescents, and young women by the American College of Obstetricians and Gynecologists. In several studies, the vaccine was found to be nearly 100% efficacious against HPV Types 6, 11, **continued on page 10.**
16, and 18. Although the HPV vaccine is currently indicated in girls and women between the ages of 9 and 26, Dr. Weinberg believes that it will be extended to women age 45. “There is very little reason not to give it,” he concluded.

Dry Skin
Corticosteroid use can cause dermal atrophy, explained Robert Lavker, Ph.D., Director of Dermatology Research in the Department of Dermatology at Northwestern University in Chicago.

When treating patients with high potency corticosteroids, the dermis loses its structure. Within three weeks of use, the dermis loses the stratum corneum. The elastic fibers become truncated and clumped. In six weeks, the dermis has only 30% of its normal thickness. The elastic fibers are gone. “The entire integrity of the dermis collapses upon itself,” he said. The skin appears shiny, transparent, wrinkled, thin, and fragile.

But if a barrier preparation is used to supplement the stratum corneum, the skin will potentially plump up. One of those barrier preparations is 12% ammonium lactate (Lac-Hydrin). Studies have shown that concomitant use of Lac-Hydrin with a potent topical corticosteroid results in a significant sparing of epidermal and dermal atrophy. This effect was observed whether the combination therapy was applied in an “open” or occlusive manner. The order in which the combination was applied did not significantly affect the steroid-sparing effect. The effect is not due to dilution of the steroid, Dr. Lavker said, but rather that Lac-Hydrin interferes with the action of the steroid. The antagonism may be due to the ability of Lac-Hydrin to elicit a hyperplastic response in the epidermis and dermis. Moreover, treatment of normal skin with Lac-Hydrin showed no adverse epidermal or dermal affects.

Attendees ended their Friday with a two-hour Dermatoscopy Workshop conducted by Harold Rabinovitz, M.D., FAAD, and Margaret Olivero, ARNP, of Skin Cancer Associates in Plantation, Fla.

Office Dispensing
“You see twenty to thirty patients a day and every one of them should go home with a product,” suggested Janice Lima-Maribona, D.O., in private practice in Miami.

Her reasoning is simple: Patients are overwhelmed by the number of skin care products available. And they get frustrated when expensive products they purchase do not work.

Product lines she discussed include moisturizers, sunscreens, and cleansers, as well as anti-aging and antioxidant products. Dr. Lima-Maribona recommended carrying light versions for acne prone skin, medium range ones for normal skin, and thicker ones for dry skin in each product category.

Start out by carrying a basic line of products, she said. Talk to colleagues to see what they recommend. Keep track of what products are selling and those that are not. Remove the latter. Consider putting together kits for specific skin conditions. Products can be displayed where patients check out. Have a tester for patients to try. If treating many patients with hair loss or nail problems, consider adding products to address their needs. Feature a “Product of the Month” with a 20% discount, or offer a free gift with a purchase or 50% off on the purchase of a second item. “Especially in today’s economy, people want to feel like they got a break,” said Dr. Lima-Maribona.

At the end of a visit, ask patients if they are happy with their skin care regimen or if they are looking to improve their complexion, she suggested. If the patient is interested in a product, offer a sample. Dr. Lima-Maribona cautioned against selling products just to sell them. “Sell what you believe in,” she said.

Dr. Schaeffer Wins Free Ride to 2010 Midyear Meeting

Laurie Schaeffer, D.O., FAOCD, of Newark, Ohio, was this year’s winner of the gratis registration for the 2010 AOCD Midyear Meeting to be held April 14-17 in Sedona, Ariz.

Each year, a drawing is held at the midyear meeting in which members can win free attendance to the following year’s midyear meeting.

“I am very happy to have won the gratis registration,” says Dr. Schaeffer. “I have never won anything in my life except for a fishing pole when I was a kid!”
“We are the experts on skin,” Dr. Lima-Maribona concluded. “We care about the quality of care our patients receive. Why not extend that to these products?”

**Botox Update**

While patients think they may want to see symmetry when they look in the mirror, the reality is that all people have facial asymmetries, explained Martin Zaiac, M.D., of the Greater Miami Skin & Laser Center and the Mount Sinai Medical Center in Miami Beach.

In fact, 80% of individuals have one higher eyebrow, he said. “It’s the asymmetries that give people their individual look. Part of treating a patient with Botox™ is explaining that so they do not have unrealistic expectations.”

“Patients have natural beauty and asymmetries,” Dr. Zaiac said, adding, “We need to maintain that.”

The key to getting a good result with Botox is using the least diluted amount possible, especially if using it in the lower part of the face, he said. But it is important to understand where the toxin will dilute to. For example, a scar can change the way the toxin will flow. “You have to be a sculptor, not just follow the textbooks,” said Dr. Zaiac. “A good treatment will change the balance of the muscle tone, not cause total paralysis of movement.” Not all injections should be performed the same way, either, he stressed. Treatments need to be individualized and the dermatologist needs to understand muscle anatomy. It is also important that patients return two weeks after treatment. That way, more injections can be made if necessary, which is better than overtreating the patient the first time and making him/her look like a statue, he said.

Although a few cases of neurotoxin safety concerns have fueled a media frenzy, the reality is that more than 3.5 million Botox cosmetic treatments have been performed in the United States with no clinical reports. It is important to note, however, that not all type A botulinum toxins approved for use in this country have the same molecular weight as Botox, Dr. Zaiac cautioned. If not appropriately diluted, they could cause allergic reactions in patients.

**Know the patient’s expectation,** he added. **Explain that it takes a couple of weeks to see the effect, which lasts a couple of months.** Dr. Zaiac recommended taking before and after pictures to show the patient the improvements.

“Botox is a great medication, but it is not a miracle drug,” he concluded.

**Vasculitis, Immunobullous Diseases**

Cutaneous vasculitis is a primary immunologic phenomenon whose clinical presentation and best classification is determined by the size of the affected blood vessels, explained Carlos Nousari, M.D., director of the Institute of Immunofluorescence, Dermpath Diagnostics in Pompano Beach, Fla.

In the dermatopathology report, the two components seen are inflammatory cells (ie, leukocytoclastic or LVC) and blood vessels (ie, necrotizing vasculitis). Just putting LVC on the report, however, is insufficient. “Each vasculitis has a name and a syndrome,” he stressed. Determining location in addition to size of blood vessels will help categorize the disease.

Dr. Nousari then reviewed the small size vessel cutaneous vasculitis including IgA vasculitis and hypersensitivity urticarial and the medium vessel vasculitis including polyarteritis nodosa. He noted that hypersensitivity urticarial should not be confused with idiopathic recurrent LVC because the former does not come back in 99% of cases unless there is recurrent contact with the trigger such as in patients with renal disease.

“Cryoglobulinemia is one of the worst vasculitides to have because it has a rheumatoid factor, so it destroys tissue,” Dr. Nousari said. In addition, there is always underlying disease such as an infection, rheumatologic disease, or neoplasm. He reviewed the spectrum of urticarial vasculitides from normocomplementemic to hypocomplementemic.

When discussing bullous diseases, Dr. Nousari noted that the most common is mucosal pemphigus vulgaris. Making the diagnosis when it is mucosal is better because only one antigen is involved. When it moves to the skin, then there are two antigens and diagnosis becomes more complicated. With regard to pemphigus foliaceus, Dr. Nousari noted there are four types: idiopathic, endemic, drug-induced, and erythematous. IgA pemphigus is rare and often misdiagnosed. In comparison, bullous pemphigus is very common and easy to treat when the lesions are seen, he said. Prior to prednisone, the mortality rate was 100%.
Resident Update
by Marsha Wise, Resident Coordinator

Remember to renew your AOCD dues. The membership year runs January 1 to December 31. To renew online and update your membership information, log on to www.aocd.org/membership.

The end of the year reports will soon be due. Forms can be downloaded from our website at www.aocd.org/qualify. For those of you who will be taking the Board examination in the fall, information regarding the application process will be sent to you in late spring.

In order to receive the grant for the AAD meeting taking place in March, residents must submit their airfare receipts, registration receipts to the conference, and lodging receipts. Certificates of completion also should be submitted. Lodging will be reimbursed at half the room rate for each resident rooming with another resident.

Residents interested in applying for the A.P. Ulbrich Research Award in Dermatology have until the end of the month to do so.

Applications must be received by March 30 to be eligible for consideration of the award during the following academic year (July 1, 2009 - June 30, 2010).

Residents celebrating birthdays in March, April, and May are as follows: Drs. Reagan Anderson, Ali Banki, Aaron Bruce, David Cleaver, Daniel Hansen, Michelle Jeffries, Susun Kim, Travis Lam, Angela Leo, Brent Loftis, Saira Momin, Bradley Neuenschwander, Jami Reaves, Rupa Reddy, Leah Schammel, Lawrence Schiffman, Amy Spizucco, Jennifer Stead, Prethi Sundaram, Andleeb Usmani, and Chris Weyer.

2009 A.P. Ulbrich Research Award Deadline Nearly Here

Residents interested in applying for the A.P. Ulbrich Research Award in Dermatology have until the end of the month to do so.

Recipients can use the grant to conduct a basic science or clinical research project that will make a significant contribution to osteopathic medicine and dermatology. Offered to encourage osteopathic resident physicians to engage in dermatologic research, the award is an educational grant sponsored by the AOC and funded through the College's Educational Research Fund. The $1,000 grant is distributed in three separate sums.

Applications will be entertained from osteopathic physicians in postdoctoral training programs and research fellowships in dermatology. Each grant supports one individual. Not more than two consecutive or non-consecutive grants may be awarded to the same individual.

Because the grant is not exclusive, the investigator may seek additional funding from other sources including the AOA Bureau of Research, governmental agencies, other outside agencies, a college, or hospital.

The types of research eligible for consideration can vary. For example, a resident may contribute to or take responsibility for a portion of an ongoing research project; seek support for conducting novel research after developing a feasible research project; or seek support to develop a research idea. In the last case, the resident should first conduct a complete literature search to determine the feasibility and need for the project. A research proposal must be developed by the end of the grant timeline.

All resident research must be conducted under the guidance of a research advisor (i.e. sponsor).

Once received, applications will be reviewed by the Research Committee, which will forward its recommendations to the AOC. Applicants are notified of the Committee's action by certified letter. Winners of the award will be honored at the 2009 AOC Annual Meeting.

For more information about the requirements for the A.P. Ulbrich Research Award in Dermatology, visit the AOC website at www.aocd.org/qualify.
Three residents tied for first place for the 2008 Daniel Koprince Award sponsored by Stiefel Laboratories.

The recipients are as follows:

Nicole Bright, D.O., second-year resident at Frankford Hospital in Allentown, Penn., won first place for her lecture entitled *Cutaneous Manifestations of Crohn’s Disease.*

Melinda Conroy, D.O., a second-year resident also at Frankford Hospital, won first place for her presentation about *Multiple Minute Digitate Hyperkeratoses*.

Rounding out the first place winners is Roger Sica, D.O., third-year resident at NSUCOM/Largo Medical Center in Port Richey, Fla., for his lecture entitled *All That is Hypopigmented is Not Vitiligo.*

Jason Mazzurco, D.O., second-year resident at St. Joseph Mercy Health System in Clinton Township, Mich., took second place for his presentation about *Mycosis Fungoides of the Nail.*

Another second-year resident, Joseph Laskas, D.O., at Frankford Hospital, took third place for his lecture on *Eruptive Kaposi Sarcoma in an HIV Negative Patient.*

The Koprince Award was established in 1986 to honor the work of AOCD member, Daniel Koprince, D.O., FAOCD, who passed away last October. The award recognizes the top lectures presented by residents during the annual meeting. They are evaluated for subject matter, audiovisual presentation, and speaking ability.

Recipients will be presented the award during the Presidential Banquet at the 2009 AOCD Annual Meeting.

Intendis Pharmaceuticals is calling on AOCD residents to submit their research papers for its 2009 Call for Papers Competition.

Papers will be judged for originality, degree of scientific contribution, and thoughtfulness of presentation. Deadline for submission is May 27, 2009.

Cash awards provided by Intendis are as follows:

- 1st Prize........$1,500
- 2nd Prize.......$1,000
- 3rd Prize .......$500

To enter the competition, residents must be in an approved AOA/AOCD dermatology training program, submit six copies of the paper to be judged, and complete a cover sheet that can be obtained by contacting Marsha Wise, resident coordinator, at the AOCD national office.

Papers should be sent to Eugene T. Conte, D.O., FAOCD, 8940 Kingsridge Drive, Suite 104, Centerville, Ohio, 45459.

Residents may submit only one paper per year. This paper must have been written and submitted while the resident is still in training. It must be typed and suitable for publication. Submission of this paper for review does not become part of the resident’s annual training reports. However, if the resident intends to use it as his/her annual paper, it must be submitted to the AOCD national office with the resident’s annual report.

Winners will be announced at the 2009 AOCD Annual Meeting to be held Nov. 1-4, 2009 in New Orleans.
Greetings from the Resident Liaison
by Reagan Anderson, D.O., M.PH., M.C.S.

The coming months will be full of third-year residents graduating, second-year residents trying to secure a job, and first-year residents starting their residencies. Some of us just attended a truly outstanding AOCD Midyear Meeting and the American Academy of Dermatology Annual Meeting.

During this busy time, there are a number of undertakings I would like to start. All of them will, in some way, attempt to strengthen the dermatology community.

One of the undertakings is trying to reignite interest in our website at www.doderm.com. Years ago, Dr. Rick Lin started the website so that residents could have a conduit to share information, Power Point presentations, and other educational material. During the last couple of years, however, this website has not been utilized to its fullest capacity. I am calling on all residents and attendings from across the country to upload whatever educational materials you have so that we can all become the most educated and informed physicians possible.

We have a strong and proud heritage of educating each other, rather than trying to obtain “a personal best” score on an examination by hoarding information. We are known for working together and sharing our time and resources. Sharing such resources will enable us, as a group, to offer the best possible medical care to our patients, in particular, and to society, as a whole.

To that end, I would like to gather our resources on www.doderm.com. You can help by sending information to me at the resident liaison account at aocdresident.connection@gmail.com, and I will post it to the website. I look forward to assimilating the wealth of knowledge we collectively possess.

Dr. Bhammad Places 2nd in Clinical Dermatology Competition
Sanjay Bhammad D.O., chief resident at the Touro University College of Osteopathic Medicine (TUCOM)/Valley Hospital Medical Center received an award for Second Place in the Dermatology Resident Presentation Competition at the recent Winter Clinical Dermatology meeting.

Dr. Bhammad's presentation was entitled Caciphylaxis: What The Clinician Needs To Know, based on a case seen during hospital consultation at Valley Hospital Medical Center in Las Vegas.

Ten dermatology residents from around the country were selected to participate in the competition held this past January in Kona, Hawaii. They attended from multiple programs including the University of Iowa, Downstate Medical Center, Harvard University, Brown University, and Yale University.

“We congratulate Dr. Bhammad for his excellent presentation and for so positively representing his residency program on a national level,” says Program Director James Q. Del Rosso D.O., FAOCD, who is also co-director of the Winter Clinical Dermatology meeting.

Photo: From left to right: Drs. Mark Lebwohl, Darrell Rigel, Sanjay Bhammad, and Jim Del Rosso. Drs. Lebwohl, Rigel, and Del Rosso are co-directors of the Winter Clinical Dermatology meeting.
The St. Joseph Mercy Dermatology Residency in Ann Arbor, Mich., may be young, but it has accomplished a lot in the nearly three years since its inception.

Started in 2006, the residency program will graduate its first two residents this June. Currently, the program has a total of nine residents.

A dedicated faculty is what Program Director Daniel Stewart, D.O., FAOCD, believes is the program’s most unique, and best, asset. “Our faculty comprises more than a century of caring for dermatological patients,” he says. “The faculty consists of 14 dermatologists that cover the span of the specialty from Mohs surgery, dermatopathology and cosmetic dermatology to immunodermatology. They regularly attend all of the didactic sessions and lead the weekly clinical reviews,” adds Dr. Stewart.

Clincs
In addition to being exposed to a wide range of faculty members, St. Joseph residents are exposed to various patient populations of multiple ethnicities through a variety of unique clinics.

Specifically, the residency program has its own in-house clinic. The facility, which opened in the fall of 2008, is a large clinic that offers general dermatology, Mohs micrographic surgery, and cosmetic dermatology based at St. Joseph Hospital, he says. Previously, the residency program was sharing a clinic with the Department of Medicine. However, the dermatology side of the clinic became so active that the institution built the dermatology residents their own clinic.

The best part of the clinic is that the patients are “the residents’ patients,” stresses Dr. Stewart. “The residents make the first decision and expectantly the last. We are their advisors, but the residents have total independence within that clinic setting.”

Academics
When not in clinic, the St. Joseph Mercy residents keep up a busy academic pace. Monday mornings consist of book and core curriculum reviews. One Tuesday a month the residents attend the “Krach Course” which is a multifaceted surgical and medical dermatology course taught by Kent Krach, M.D. Wednesdays consist of the residents’ continuity clinic as well as a dermatopathology review taught by one of three dermatopathologists, two of which have written chapters in Lever’s Histopathology of the Skin and the Textbook of Dermatopathology by Raymond Barnhill, M.D. Residents attend a clinical slide review session on Thursdays and round out the week with board review on Fridays. Additionally, residents attend a monthly Journal Club, which is well attended by members of the faculty.

In October 2008, the program initiated grand rounds with the presentation and discussion of six to eight patients. Active dialogue related to diagnosis, mechanism of disease, and suggestions for investigation and treatment of the patients is emphasized. Also in 2008, the residents started an annual Skin Cancer Screening Day at St. Joseph Mercy Hospital in Ann Arbor. The screening day coincides with the American Academy of Dermatology’s (AAD) Skin Cancer Screening Awareness campaign in May.

The residents not only join forces on the learning field, but also the playing field. They formed a kickball team this past fall, and even made it in the playoffs.

Rotations, Rounds
Rotations range in length from one to three months. Second and third-year residents are able to pursue electives outside the program. The Scripps Surgical and Anatomy Course along with the Chicago Board Review are attended in the summer along with elective rotations through Johns Hopkins University for pediatric dermatology, as well as the University of California, Los Angeles and Scripps Course for cosmetic surgery.

Other Opportunities
In 2009, for the first time, third-year residents had an opportunity to visit a third world country to learn about, and see first-hand, tropical and infectious diseases.

The St. Joseph residency program has a clinical research facility at which residents have conducted research on multifaceted diseases from psoriasis to eczema.

Presentations are common ground in this residency, with the residents presenting at the required AOCD meetings as well as meetings hosted by the AAD and the Michigan Dermatology Society.

Dr. Stewart believes so strongly in the combination of hospital-based and office-based residency program that he is writing a paper on the subject with his colleague, Bruce Deighton, Ph.D., the program’s educational director.

“When I look back at what we’ve accomplished in the two-and-one-half years,” says Dr. Stewart. “I’m more than proud because not only is the faculty very dedicated to the success of this program, but the residents have been most helpful to make sure that it is a progressive program.”
Three residents from NYCOM/St. Barnabas Hospital and one from Western University/Pacific Hospital presented at the 67th annual meeting of the American Academy of Dermatology (AAD) held this month in San Francisco.

Karthik Krishnamurthy, third-year resident/chief resident, presented with incoming first-year resident Kate Kleydman, who is also at the NYCOM/St. Barnabas residency program. The topic for presentation was **Angiokeratoma Circumscriptum with Overlying Shewanella Algae Infection.** Shewanella algae is a rare emerging human pathogen, notes Dr. Krishnamurthy, and it is important that practitioners are aware of its existence.

Dr. Krishnamurthy also presented with Joseph Del Priore, a first-year resident at the Western University/Pacific Hospital residency program, on **Blood Root Necrosis.** Currently available without control from the Food and Drug Administration, blood root is an herbal product that dermatologists should know about due to its accessibility, he says.

Ali Banki, a second-year resident at NYCOM/St. Barnabas, presented on the topic of **Dermatofibrosarcoma Protuberans Associated with Multiple Lipomas.** The simultaneous occurrence of these two tumors is rare, explains Dr. Krishnamurthy, and may point to a common CD34+ progenitor cell.

“We feel very lucky to have the opportunity to diagnose and treat these exceedingly rare dermatologic conditions unique to our training institution,” he says. “We are also proud to have our contributions recognized by the AAD. We are especially fortunate to have our Program Director Cindy Hoffman, D.O., FAOCD, to guide, encourage, and provide us these wonderful educational experiences during residency.”

The AAD’s annual meeting was held March 6-10.

---

**VCOM Starts Dermatology Interest Group**

The Edward Via Virginia College of Osteopathic Medicine (VCOM) in Blacksburg, Va., recently established a Dermatology Student Interest Group.

The group was started for the purpose of introducing the field of dermatology to interested students, according to Al Feucht, an AOCD student member and chair of the VCOM Dermatology Group.

“Nearly 20 students attended the first club meeting held in November. Some of those in attendance were from primary care fields interested in expanding their diagnostic skills with regard to dermatology conditions,” says Feucht, adding, “We were surprised to see so many people, given that it was our first meeting.”

“We discussed the dermatologist’s approach to describing skin lesions using the intro chapter of the Habif textbook,” he says, referring to *Clinical Dermatology: A Color Guide to Diagnosis and Therapy* by Thomas B. Habif, M.D.

The dermatology group plans to meet once a month to once every two months in the future, he says. Topics to be addressed include the dermatologic findings in all specialties of medicine, with special emphasis on primary care.

Future plans include an annual volunteer skin clinic for individuals who lack resources to see a dermatologist and a semi-annual suture practice session. The group wishes to support any student interested in entering the field of dermatology, says Feucht, and hopes to continue having 15 to 25 students actively participating.

The dermatology group is considered an interest group within the Internal Medicine Club. “In addition to having dermatology meetings,” says Feucht, “during each Internal Medicine Club meeting, we conduct an image quiz to help increase awareness of cutaneous manifestation of disease within the system of discussion.”
Breaking Down Disability Insurance

Approximately one in three individuals will suffer a disability that lasts at least 90 days at some point in their career.¹ Nearly one in seven of them can expect to be disabled for at least five years.

If that's not bad enough, consider the potential loss of earnings from a disability. As an example, a 45-year-old individual earning $50,000 a year who suffers a permanent disability could lose $1 million in future earnings.²

Own Occupation
The first rule in choosing an individual disability insurance policy is to understand the definition of disability.

Dermatologists should apply for an own occupation versus any occupation policy, says Steve Lopez, a financial representative with Crystal Cove Wealth Management, an investment management firm in Irvine, Calif. A policy that has an own occupation definition of disability will pay the dermatologist unable to perform his/her specialty due to an injury or illness even if the dermatologist chooses to work in another occupation. For example, a Mohs surgeon who is unable to perform surgery may be able to lecture about it to dermatology residents. With an any occupation definition policy, if a physician gets disabled but can flip burgers, the company may not pay for the disability because he/she can perform any occupation.

When defining own occupation, Lopez suggests to be as specific as possible. A Mohs surgeon performs different procedures than a cosmetic dermatologist. Their specific skills should be detailed in the policy. Don’t forget to include other duties related to office work that the dermatologist routinely performs. Ultimately, the insurance company will make the final determination based on an occupation classification, he adds.

When looking to purchase individual disability insurance, dermatologists should focus on five fundamental areas, according to Lopez. “They should look for a policy that pays for full, forever, and for total coverage, that is, the full amount of income, for as long as possible, and for full replacement value,” he says.

Amount of Risk
For starters, dermatologists should consider only companies that are willing to assume the risk, whatever that may be, and insure them with a quality product. That risk pertains to the dermatologist’s gender, age, health, and occupation.

The risk increases, for example, when the individual is older, smokes, or has a medical condition such as diabetes.

Elimination Period
The second item to be considered is the elimination period, which could range anywhere from zero to 120 days, or longer.

Often times, physicians are steered toward a 90-day elimination period because it is assumed that they have three months’ worth of savings they could live on until the disability insurance starts. The problem is that a resident or a dermatologist just starting out in practice may not have those funds. Additionally, a 90-day elimination period means that the disability insurance kicks in on Day 91. That means the dermatologist may not see a check for another month, Lopez explains.

Choosing a company that offers a flexible option enables the dermatologist to choose which elimination period best suits his/her needs. To make this decision, the dermatologist should know what amount he/she can live on while waiting for the policy to take effect. This amount will differ for a dermatologist just starting out versus one in practice for 15 years. The dermatologist should also understand that a 30-day elimination period may mean 60 days before receiving a payment, a 60-day elimination period may mean 90 days before receiving a payment, and so on.

Benefit Amount
The amount of benefits is dictated by several factors but the two biggest are: the dermatologist’s income and the federal government, which places certain restrictions on the amount.

Typically, the benefit amount is between 60 percent and 70 percent of what the dermatologist earns in gross reported income tax-free, says Lopez. “That’s pretty close to what the dermatologist earns after taxes,” he says.

Choosing a benefit amount that is full replacement value of one’s income is key, Lopez says, adding, “Getting approved for full replacement is where the challenge lies.”

Benefit Period
As a general rule, the longer the benefit period, the better it is, he says, because nobody knows how long a disability will last. “Dermatologists should look for companies that offer the maximum payment period,” suggests Lopez.

Only two companies offer lifetime disability payments. But other companies offer benefit periods of two years, five years, 10 years, or up to age 65.
Consider riders as policy options, says Lopez. And while many riders are necessary because of one’s occupation, others are not.

**Residual Definition.** One rider that dermatologists should consider is the residual definition rider, which allows the physician to take the necessary time to recover without losing benefits. Typically, a physician who returns to work after two years of being disabled will not make as much money as he/she earned prior to the disability. In another scenario, a physician may be able to return to work on a part-time basis while he/she is undergoing rehabilitation.

A good residual benefit allows the dermatologist to go back to work while leaving the benefits turned on, says Lopez. The second sign of a good residual benefit is the amount of time that the company allows the dermatologist to recover before turning off the benefits. “Some companies will pay you until you are able to earn seventy five to eighty five percent of what your annual income was prior to your disability, while other companies will set that amount at twenty percent,” he explains. The dermatologist should look for the maximum amount of residual definition.

**Cost of Living Adjustment.** The cost of living adjustment rider can add three percent to the dermatologist’s income to match the rate of inflation. This can occur on an annual basis.

**Automatic Increase.** An automatic increase rider allows the dermatologist to increase his/her coverage to match an increase in income. The increase is calculated automatically. This rider is beneficial for a dermatologist who is an employee contracted to earn x amount for the first year and an increased amount in the second year of employment.

**Future Increase.** A future increase rider allows the dermatologist to increase his/her coverage at a designated timeframe, usually on an annual basis. This option is good for a dermatologist who just started a solo practice and anticipates his/her practice growing, but will not know how much until after closing.

---

How Much Should It Cost?

What percentage of your income should you expect to pay for a disability insurance policy?

Dermatologists should expect to pay anywhere from one percent to seven percent of one year’s income, according to Lopez. Most physicians will pay between three percent and five percent.

The difference in cost depends on the dermatologist’s approval rating, individual needs and number of riders included in the policy. For example, a larger amount of risk assumed by the company, a shorter elimination period, and a longer benefit period all push up the cost of a policy.

Group vs. Individual Policy?

When choosing disability insurance, should dermatologists opt for group or individual coverage?

That depends on their individual circumstances. A resident in a residency program or a dermatologist working in a dermatology group or hospital will have to consider whether or not to join a group policy.

As a general rule, group policies use a restrictive definition of disability. Although they cannot be taken with when the dermatologist changes employers, sometimes they can be converted to an individual policy. Some group plan benefits are taxable unlike individual policy benefits, which are tax-free.

Be sure you understand the disability definition, whether you can take the policy with you, and the tax status of the benefits before signing on the dotted line.

---

Continued on page 20...
the books on the year, he says. At that point, the dermatologist can determine how much to increase his/her coverage.

Retirement Protection Plan. A retirement protection plan rider puts the same amount of money the dermatologist was putting into a retirement plan prior to his/her disability. That way, the dermatologist will not fall behind in his/her retirement plan investments.

Questionable Riders. One rider that dermatologists might want to avoid is an unemployment premium waiver, which states that a physician injured on the job as an employee is not required to pay the premium. But most dermatologists are in private practice, and as such, are not employees. Although this waiver pertains only to physicians who are employees, Lopez has seen them included in individual policies. “You shouldn’t pay for something that doesn’t protect you,” he says. On the other hand, a dermatologist who is an employee might want to consider including this rider.

The other is the group disability replacement rider. This is applicable for a dermatologist who starts out working for a dermatology group and is covered under a group disability insurance policy. After five years, the dermatologist sets out to establish a solo practice and wants to replace the group disability policy with an individual policy. This is not a beneficial rider for a dermatologist with an individual policy.

Choose Wisely
Disability insurance companies are rated by third-party companies. Among them are Standard & Poor’s, Moody’s Investor Service, A.M. Best and Company, and Fitch. The ratings, which range from A++ to F, can be obtained by a broker.

Although these ratings are important, Lopez notes, “An insurance company is only as good as its historical payout for its claims.”

When choosing a disability insurance policy, it is best to work with an independent or non-captive broker/agent who represents more than just one company.

“Your biggest asset is your ability to generate income now and in the future,” concludes Lopez. “You must protect yourself.”

Crystal Cove Wealth Management is a boutique, full service, financial consulting firm that services physicians and physician-owned practices nationwide. The company’s unique corporate structure gives it the ability to create customized financial plans involving investment management, asset protection, tax and legal planning, and real-estate and lending avenues.
Patients Use Internet for Health Information
Change Health-Related Behavior as a Result

Not only do patients use the Internet to gather health information, but some even alter their behavior based on that information, according to a recently published study in the Journal of the American Osteopathic Association (JAOA).

The study set out to describe on-line health information–seeking behaviors among patients, and then to evaluate the effects of this information on patient self-care and the patient-physician relationship.

One hundred and fifty-four patients at three osteopathic primary care medical clinics filled out an eight-question survey to participate in the study. Of the 154, 89 patients (58%) reported that they used the Internet to find health information. These behaviors were slightly more prevalent among individuals aged 31 to 45 years than those in other age groups.

More than half of these individuals—49 or 55%—reported a change in the way they think about their health as a result of that information. Specifically, they were more interested in their own health, felt more reassured about it, and took their health problems more seriously. These patients felt less confused about it, as well.

In addition, most of these individuals—41 or 46%—reported making subsequent health-related behavioral changes. They reported asking more questions during office visits, following physician advice more closely, and making self-directed dietary changes.

The majority of these patients—30 or 73%—informed their physicians of these changes. In fact, most Internet users—75 or 84%—believed that their doctors were willing to discuss the information they found on-line. Those who did not tell their physicians cited reasons such as having forgotten about the changes, believing that they were not significant enough to discuss given the time constraints of an office visit, and sensing that the physician would not approve.

The authors acknowledge, as cited in other studies, that Internet use among patients leads to an increase in questions from patients, which could place an increased work burden on physicians. However, overall obtaining medical information from the Internet may offer several benefits for the patient-physician relationship, including a better understanding of health information among patients, active patient engagement in health maintenance, and a proactive patient response to health challenges, according to the study authors.

The study entitled Impact of Internet Use on Health-Related Behaviors and the Patient-Physician Relationship: A Survey-Based Study and Review was published in the December 2008 issue of JAOA (Vol.8,#12).

Live Injection Workshop Slated for Annual Meeting

A live injection workshop using Botox™ and fillers will be conducted by Susan Weinkle, M.D., and Mary Lupo, M.D., FAAD, at this year’s AOCD Annual Meeting to be held Nov. 1-4, 2009 in New Orleans.

The three-hour workshop is scheduled for the morning session on Monday, according to Marc Epstein, D.O., FAOCD, who is the program chair.

In addition, a two-hour psoriasis symposium will be presented by Ken Gordon, M.D., and Jeff Crowley, M.D., on Wednesday morning.

Incoming American Academy of Dermatology (AAD) President David Pariser, M.D., has agreed to speak about AAD and AOCD relations.

Expect an unexpected venue befitting the heritage of New Orleans for the President’s Banquet.

More details to follow in the next issue of DermLine.
Nobody expects to become disabled. But when it happens, even for a short period of time, the consequences can be significant. Just ask AOCD members Leslie Kramer, D.O., FAOCD, and Mark Kuriata, D.O., FAOCD.

Like the majority of disabilities, Dr. Kramer’s and Dr. Kuriata’s disabilities were caused by illnesses, not serious accidents. As unexpected as the disability itself, was the response they received from their respective disability insurance companies. Theirs is a cautionary tale emphasizing the importance of knowing what is in one’s disability insurance policy, including elimination periods and exclusions.

**Dr. Kramer’s Story**

In November of 2008, Dr. Kramer was admitted to the emergency room of a local hospital with severe abdominal pain. A few hours later, she underwent emergency abdominal surgery. After a week long stay in the hospital, Dr. Kramer was discharged to her home, where she would recuperate over the next five weeks. “Once I realized that I couldn’t even walk after the week in the hospital, I looked into my disability insurance,” she says.

When Dr. Kramer opened her practice 15 years ago, she purchased two policies, one to cover her income and one to cover her business expenses. Consequently, Dr. Kramer was confident that her disability insurance would offset her loss of income and enable her to pay her staff and rent, and other expenses.

Unfortunately, Dr. Kramer’s policy had a 180-day elimination period. “I was surprised,” she says. “Here I am feeling bad, trying to recuperate, worrying about me and how to take care of my patients, and then I find out that I can’t get any benefits unless I am out of work for six months.”

Despite the fact that December is her busiest month, Dr. Kramer’s staff was able to reschedule all but one of the patients. “Only one out of one hundred patients wanted to see another dermatologist,” she says. “It was a new patient whom I had not yet seen. Overall, my patients were very understanding. Some even sent me flowers and gifts.”

Dr. Kramer would have preferred having a locum tenens* to take over her practice while she was out of commission, but there were none available in her area of Cedar Rapids, Iowa.

Fortunately, Dr. Kramer was able to resume her full practice once she returned to work in late December. But during her six-week recovery, she lost approximately $40,000 in income.

“I never thought something like this would happen to me,” Dr. Kramer adds. “It was the first time in fifteen years that I had to take off for such a long period of time. Hopefully, I can go another fifteen or twenty years, and then retire.”

**Dr. Kuriata’s Tale**

Dr. Kuriata’s disability was due to multiple complications from a right knee replacement performed in December of 2007. The initial surgery seemed to be successful, but a few months later, he dislocated his knee four times and underwent two surgical revisions to prevent further problems. Soon after the last surgical revision, Dr. Kuriata’s knee became infected with methicillin-resistant Staphylococcus aureus. As a result, he had to have the entire knee joint implant removed. Dr. Kuriata recently discontinued the vancomycin he received intravenously—after five months of infusions every eight hours—to clear the infection. Assuming the infection has cleared, Dr. Kuriata will be able to schedule another artificial joint replacement this month. That will be followed by several months of physical therapy, during which he will have to learn to walk again and rebuild his leg muscles.

In the meantime, Dr. Kuriata is homebound, except for doctors’ appointments. He uses a wheelchair to get around or a walker, but cannot put any weight on the leg as it lacks a joint.

“It may be June at the earliest before I can see patients again,” he says.

Like Dr. Kramer, Dr. Kuriata purchased two disability insurance policies, one for loss of personal income and one to cover business expenses. Five years ago, he purchased the policy as a condition of his mortgage for the new office he was building.

After filing all of the necessary paperwork, Dr. Kuriata’s disability insurance coverage was denied because of an exclusion related to his knee, an exclusion that he had forgotten about. The exclusion was added by the disability

---

* Taken from the Latin “to hold the place of, to substitute for,” locum tenens refers to a physician or nurse who is temporarily taking the place of another like professional during the latter’s absence.
insurance company because Dr. Kuriata had had three reconstructive surgeries on his knee in the mid 1980s related to a high school football injury.

“I had no recollection of the exclusion, but I am not necessarily disappointed in my insurance company as it was a very defined exclusionary rider,” he says. “From a business standpoint, I don’t think the company is in the wrong. But you would think when I contacted the insurance company and gave a summary of my situation over the phone that a red flag would have popped up instead of wasting my time and hope. In fact, the person told me it looked like everything was in order and he didn’t expect any problems.”

Dr. Kuriata has been able to keep his practice open with the assistance of a part-time, board-certified dermatologist from a locum tenens company. “The part-time locum tenens works a few days a month seeing general dermatology patients and is also available for the mid-level providers,” he says. His three physician assistants (PAs) and one nurse practitioner (NP) have continued to see patients under his supervision via telephone, which is required by Michigan state law. Dr. Kuriata keeps the phone at his side at all times. “I continue to work on patient charts and handle questions for them,” he says. “Any issues that I would normally handle are referred out to a dermatologic colleague.”

If Dr. Kuriata is able to return to work in June, his loss of income will be in the hundreds of thousands of dollars.

Advice

Based on both dermatologists’ experiences, it probably would not hurt to review one’s disability insurance policy periodically just to be certain of what it includes and what it doesn’t.

Although Dr. Kramer may not have had enough savings to withstand a 180-day elimination period, she did have enough to cover the six weeks she was out of work. “That’s why it’s important to know your expenses, including salaries, rent, and equipment,” she says. “And try to have some savings put away specifically for the practice in case you run into a snag.”

Dr. Kuriata suggests choosing a disability insurance policy that is as comprehensive as possible and to be very careful of any exclusions. “Had I anticipated my problem at all, I probably would have made more of a fuss about the exclusion or looked for another company that may not have required it,” he says. “At the time I wasn’t worried about it because I had told myself that I would never have another knee surgery. Of course, no one can anticipate the course that one’s life may take.”

“If it wasn’t for my great staff, mid-level providers, and the fact that I was fortunate to get a part-time locum tenens,” Dr. Kuriata states, “my family, practice, and I would be totally devastated.”

When Disability Extends Beyond 90 Days

Of those individuals who suffer a serious disability that lasts at least 90 days, many remain unable to return to work for years afterward.1 As an example, half of all individuals who are 45-years-old at the disability onset will remain unable to return to work for two years. Forty-four percent of these individuals will not return to work for three years. If the individual is 55-years-old at the disability onset, 66 percent will be unable to return to work for two years. Sixty percent of these individuals will not return to work for three years.

Fellows of Distinction: The Right Stuff

Is the honorary title of Fellow of Distinction in your future? Find out by submitting an application by July 1, 2009.

The Fellow of Distinction title may be conferred on AOCD members who have made outstanding contributions through teaching, authorship, research, or professional leadership to the College.

Criteria for a Fellow of Distinction require a candidate to:
- Be a member in good standing of the AOA for a period of not less than 7 years;
- Be a member in good standing of the AOCD for a period of not less than 7 years;
- Be a diplomate of the AOBD for a period of not less than 7 years;
- Be recognized as a leader among his or her peers by being active in the AOA, AOCD, and/or AOBD for at least 7 years;
- Have obtained at least 100 service points by working in an administrative or educational capacity of the AOA, AOCD, and/or the AOBD for a period of not less than 7 years; and
- Have obtained 200 cumulative service points prior to fellowship consideration.

Applicants must submit an application to the Fellowship Committee no later than July 1. If favorably reviewed, the candidate’s application will be presented to the Executive Committee at the AOCD Annual Meeting slated for Nov. 1-4, 2009 in New Orleans. Upon successful review by the Executive Committee, the applicant will be presented to the general membership at the College’s Business Meeting, which occurs during the annual meeting. Upon a 66% majority vote in favor of the candidate’s credentials by the general membership, the Fellow of Distinction candidate will be inducted during the Presidential Banquet at the annual meeting.

To obtain an application, either download one from the AOCD website (www.aocd.org) or contact the national office to request a copy.
It's amazing how our mind deceives us! When the stock market peaks, many people jump at the chance to enter this arena. Conversely, after the market plummets, people bail out or at least stop investing. Despite these past experiences, many people can't resist following the crowd.

I say resist the temptation to buy high and sell low! The reverse is the lucrative answer.

The lesson has been repeated ad nauseam over the years. For example, by March of 2000, the voracious technology funds purchases readied mega billions of dollars. In October of 2002, the Standard & Poor's had lost 50 cents of its value and the NASDAQ Stock Market crashed by seventy-five percent. Guess what the investors chose to do? They sold low and by October of 2007, the markets had reached new peaks.

The moral of this historical occurrence is obvious. The problem is how to survive the situation in the meantime.

Experience some of the world's best entertainers at the state-of-the-art BOK Center.

Visit one of Tulsa's 144 parks and discover Green Country at its finest. Take a bike ride along the Arkansas River before shopping at the charming Utica Square.

For more information about this dermatology opportunity, please contact Edward H. Yob, D.O., FAOCD, at eyob@dermtulsa.com or Cindy L. Wilson, practice administrator, at cwilson@dermtulsa.com. You may also call 918-307-0215 or 866-254-6647 to speak with either Dr. Yob or Ms. Wilson.

Financial Tidbits: Individuality in Investing

by Robert Schwarze, D.O., FAOCD

It's amazing how our mind deceives us! When the stock market peaks, many people jump at the chance to enter this arena. Conversely, after the market plummets, people bail out or at least stop investing. Despite these past experiences, many people can't resist following the crowd.

I say resist the temptation to buy high and sell low! The reverse is the lucrative answer.

The lesson has been repeated ad nauseam over the years. For example, by March of 2000, the voracious technology funds purchases readied mega billions of dollars. In October of 2002, the Standard & Poor’s had lost 50 cents of its value and the NASDAQ Stock Market crashed by seventy-five percent. Guess what the investors chose to do? They sold low and by October of 2007, the markets had reached new peaks.

The moral of this historical occurrence is obvious. The problem is how to survive the situation in the meantime.

One favored strategy is “dollar cost averaging,” which refers to investing a fixed amount at regular intervals (ie, monthly). This approach results in buying more product in lean months and less product in fat months. This, in turn, causes an average purchase price over time, which yields an average return. The visissitudes of this strategy can be argued, however, if you do your homework well, it should be way safe.

Another strategy is called “buy and hold,” which means buying stocks in solid fundamentals or mutual funds with excellent diversification and low expenses, and holding on to these stocks for the long term.

Both philosophies work well if you pick solid products. The moral here is to do your homework, separate yourself from the herd, and stay focused on the long term.
While core marketing concepts remain virtually unchanged over time, the advent of the Internet has presented many opportunities for business owners to extend their marketing reach. Physicians are no exception as they too can benefit from marketing in the era of the Internet.

**Focus on Your Brand**

What is your brand? This very important question is rarely considered by medical professionals. But your dermatology practice has an identity just like you do. Some dermatologists focus on Mohs micrographic surgery, as an example, while others focus on cosmetic dermatology. These two types of practices should present a different impression—or brand—to prospective patients.

Your brand is developed by the conscious and subconscious opinion a patient establishes...when walking through your office door, viewing one of your ads in the local newspaper, browsing your website, or viewing your business card. A good branding strategy builds on itself, reinforcing the brand every time a prospect or patient interacts with it. It is this interaction and consistent presentation of your brand that makes it memorable.

**Big Yellow Book Still Counts**

Contrary to popular opinion in the age of the Internet, the phone book yellow pages is still the first place a large percentage of the population looks to find local businesses. In fact, 30 percent of Americans still use the yellow pages as their primary source for locating businesses.¹ This compares to 31 percent who use Internet search engines and 18 percent who use Internet yellow pages.² The case for yellow pages advertising is won when you learn that more than 75 percent of those prospects chose to contact at least one business as a result of their flip through the big yellow book.²

To get more bang for your buck, go beyond the basic yellow pages ad. Increase your ad size and colors in crowded categories. Run ads in as many categories as are affordable. Sometimes less competitive categories can produce better results because there are fewer dermatologists available in that category. You probably have an ad under the very crowded heading of “Physicians-Dermatology,” but what about “Skin Care,” “Facials,” and “Acne,” or “Cancer Screening?” You can even request that categories be added to the book if the existing selection does not adequately address your practice. Remember to reinforce your brand in your yellow page ads.

**Search is King**

Build a website and they will come! Those of you who have invested good money following this principle know the reality is quite different. A website is little more than a very expensive brochure unless prospective patients can find it in search engines, such as Google and Yahoo. If your site does not contain the information that they are searching for, it will not be successful as a vehicle to attract new patients. If your site is packed with great information, but does not appear within the first or second page of search results, it will rarely live up to its potential.

“Paid search” can place your website on the all important first or second page of results. That’s right; you can pay the search engines to place your website on the results page. This is often a good strategy for either new websites or key search terms for which your website has been unable to achieve top ranking in the search results. Always set budget limits because new competition can quickly drive up per click prices.

**You’ve Got Mail**

E-mail marketing is one of the most cost-effective communication and business building tools in existence today.

The best strategy for obtaining a valid e-mail list is to build it yourself. Encourage existing patients to provide e-mail addresses. Offer website visitors something of value in return for their e-mail address, such as a monthly newsletter featuring new procedures or technology, or skin care and sun protection tips.
Keep your brand fresh in the minds of your patients by contacting them at least monthly via e-mail.

**Community Outreach**
Special events, if organized and executed correctly can provide immediate results. For example, dermatologists can work with local outdoor venues and event planners to offer free skin cancer screenings or local modeling and photography associations to offer free skin care seminars. Newspapers, and television and radio stations are particularly effective at promoting special events such as these.

Always ensure the event reinforces your brand and includes “take home material” such as brochures, sample products, or even gift certificates. Don’t be afraid to get creative.

Another benefit to this approach is that it is generally more cost effective to become part of an existing event or venue than to create your own.

While some dermatologists would target retirement homes, condominiums, and senior living communities, others might target local community colleges and universities.

**Track Results**
Some of the best advertising strategies come from the experience of trial and error. Know which ventures perform and which do not. Drop underperformers and reroute funds to new advertising ideas or high performing endeavors.

Often results are not immediately available. This might occur when you add new content to your website. Search engines can take weeks to index that information and begin displaying your page(s) in results. Your tracking method should be appropriate for the advertising in question.

**Plan for Success**
Developing a marketing plan should really be the first step, but you cannot create a plan unless you know what you are planning for.

Now that you know the marketing basics, sit down and develop a marketing plan for 2009. Be sure to include a budget in the plan. Start with realistic goals and add the appropriate marketing ventures to achieve those goals. You might decide to diversify your offering to include laser hair removal. That means marketing to your existing customers as well as attracting new ones. Set monthly, quarterly, and yearly check points to ensure your marketing initiatives are working to attract viable laser hair removal patients.

In the next issue of DermLine, learn how to develop a marketing plan and budget.

Roger Watson is a marketing and e-commerce consultant and owner of Creative Innovations. He has worked with the AOCD for more than seven years, designing the website, logos, and DermLine. Roger has vast experience with brand development, search engine optimization, and website design. Learn more about his capabilities at www.2create.com.

**What Does Your Logo Say?**
Consider the two logos below for the fictitious practice “Elite Dermatology.” Does your logo communicate an appropriate message?

This logo communicates a practice with a focus on the cosmetic benefits of dermatology. Soft appearance is appealing to female patients with disposable income.

This is a more traditional practice with a focus on general dermatology. Cosmetic procedures certainly would apply, but are not the focus. It is a gender and income neutral logo.

**Read, Listen, Watch**
Print, radio, and television advertising round out a basic marketing strategy, but they can be less effective than the other ventures. Additionally, results may be difficult to measure with the latter. Local newspapers, radio stations, and television stations are often good candidates, but don’t forget about community newsletters and local group directories, especially if those groups are composed of good prospects for patients.

References
2 Study conducted by Knowledge Networks on behalf of the Association of Directory Publishers. US population, including off-line households, surveyed between November 1, 2007 and April 30, 2008.
Journal of the American Osteopathic College of Dermatology-JAOCD.

We are now accepting manuscripts for the publication in the upcoming issue of the JAOCD. ‘Information for Authors’ is available on our website at www.aocd.org. Any questions may be addressed to the Editor at jaocd@aol.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!

- Jay Gottlieb, D.O., FAOCD