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American Osteopathic College of Dermatology

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

AOCD MIDYEAR MEETING 2010
April 14-17, 2010
Sedona, AZ

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. Enter your username and password then click the “Login Now” button. 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.

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May and June are beautiful months to visit western Kansas. Usually hot and arid, in May we had a lot of rain and the wheat looks great; there are many beautiful wildflowers lining the roads and fields. But you better come fast, because it won’t last long!

Increasing communication has been one of the goals of my presidency. This month, I want to highlight the AOCD website. For those of you who have not yet visited the site, please take some time to go to www.aocd.org. Dr. Jere Mammino has worked tirelessly in perfecting this site.

Our website will pop up on many Google searches. For example, last night I was googling actinic keratosis and the first website on the list was the AOCD’s site.

We are currently averaging more than 3 million visitors per year, who view approximately 4.5 million pages. Ninety-five percent of the visitors are viewing the dermatologic disease database, which was a collaboration of many members of our College. This database has a tremendous amount of useful information that can be shared with your patients to help explain diseases and treatments.

Our website is in the top 1% of all websites visited on the World Wide Web.

I encourage members to check out their profile under the “find a D.O. dermatologist” tab. Feel free to send us updates, corrections, or information that you want to add to your profile. This is a very cost-effective means of advertisement.

I, again, want to congratulate Jere, Roger Watson, and all those individuals who have helped organize and contribute to the AOCD website.

I continually respond to e-mails from the membership. I encourage you to e-mail either me at dtillmando@gmail.com or Becky at bmansfield@aocd.org regarding any questions or concerns about the College.

Sincerely,

Donald K. Tillman Jr., D.O., FAOCD
AOCD President, 2008-2009
Dr. Kirby to Serve on Boards

Will Kirby, D.O., FAOCD, is putting in some board time as of late.

He was recently appointed to serve as an expert reviewer for the Osteopathic Medical Board of California in the field of dermatology.

This appointment requires the recipient to possess medical knowledge, professionalism, discretion, and ethical value of the highest level. “I was honored to even be considered for the position,” Dr. Kirby says. “It’s flattering that they reached out to me and I’ll do my best to ensure that the dermatological care in California is of the highest quality.”

He also was asked to serve on the editorial advisory board of Skin & Aging magazine. This widely circulated monthly publication addresses practical and clinical issues in dermatology. “The opinions of osteopathic physicians are influencing the dermatology profession more and more each day and it’s important that we contribute to academic journals so that the medical community as a whole can benefit from our knowledge,” says Dr. Kirby.

In addition, Dr. Kirby signed a three-year contract with Neutrogena’s advanced science division, Neutrogena Dermatologics, to serve as the company spokesperson. He currently presents the company’s newest product—Retinol NX Concentrated Retinol Serum—on home shopping network QVC each month.

BOT Approves Change in Student Membership Category

The AOCD’s Board of Trustees has unanimously approved a wording change in the description of the student membership category in the College’s constitution.

The purpose of this change is to allow medical students who are not yet accepted into a dermatology residency program to remain AOCD student members until they can become resident members.

The new category would be as follows (with the change in bold):

“Any osteopathic medical student who is in good standing with the American Osteopathic Association and interested in pursuing a career in the field of dermatology shall be eligible to become a student member. This membership status may be maintained for a maximum of three years after a student graduates. Student members shall have all rights and obligations of fellow members except they shall not be eligible to hold elective office or vote.”

This proposed amendment will be voted on at the College’s Business Meeting held during the AOCD 2009 Annual Meeting scheduled Nov. 1-4 in New Orleans.
Support the Foundation of Osteopathic Dermatology (FOD) by placing an ad in the 2009 Ad Journal.

The ad journal, which will be presented during the Presidential Banquet at the AOCD Annual Meeting in November, honors the incoming and outgoing president as well as the AOCD residents and members.

“Your support is vital,” notes Shirley Gottlieb, the AOCD’s Director of Development. “Contributing to this journal offers you an opportunity to give back to the organization that made it possible for each of you to become practicing dermatologists.”

Monies for FOD

Founded in 2004, the purpose of the FOD is to improve the standards of the practice of osteopathic dermatology by raising awareness, providing public health information, conducting charitable events, and supporting research through grants and awards given to those applicants under the jurisdiction of osteopathic dermatology physicians.

The FOD instituted a research grants program to encourage and support scientific investigations into the potential causes of dermatological issues and other key aspects of various dermatological conditions. Research grants are provided to encourage improvement in treatment and potential prevention and/or cure in the related dermatology field. The two types of research awards available are the Resident Award and the Attending Physician Award.

In addition, multiple grants are available to an osteopathic dermatologist through the FOD. They include the following:

The FOD Resident Research Grant is awarded annually to an osteopathic dermatology resident in an AOA-accredited institution. The purpose of this grant is to foster research in dermatology medicine conducted by dermatologists at a graduate level.

The FOD Young Investigator Grant is awarded annually to an osteopathic dermatologist who is a graduate of an accredited dermatology residency and practicing dermatology in an accredited institution for five years or less. The purpose of this grant is to foster research among young dermatologists and is awarded to promising physician researchers meeting specified criteria.

The FOD Investigator Grant is awarded annually to an established osteopathic physician who is certified in dermatology and conducting research in dermatology at an accredited institution. The purpose of this grant is to sponsor or co-sponsor research in any area of dermatology.

The FOD Charitable Award is awarded annually to an osteopathic physician who is certified in dermatology and providing care in a developing country. The purpose of this award is to sponsor a dermatologist helping to improve the dermatologic needs of that specific country.

For more specific information about the FOD and the aforementioned awards, visit the AOCD website at http://www.aocd.org/aboutus/foundation_osteopathic_dermatology.html or contact Brad Glick, D.O., FAOCD, at 954-242-1632.

To submit an ad for the 2009 journal, contact Shirley at shirleygottlieb@aol.com or 954-963-5862.

Dr. Way Honored for Years of Service

Bill V. Way, D.O., FAOCD, was recently honored by his peers for 23 years of service in the House of Delegates of the Texas Osteopathic Medical Association (TOMA).

He was presented with an honorary certificate in May during the 64th annual meeting of the TOMA House of Delegates held in Austin.

During his 23 years of service in the House of Delegates, which is the legislative body of TOMA, Dr. Way actively participated in the discussion and debate of policy and administrative resolutions considered by that body. These resolutions determine the advocacy by the association for the betterment of quality health care, access to medical care, and safety of the public seeking osteopathic medical services for citizens across Texas. His participation has helped determine the direction of TOMA and its advocacy for the health care of all Texans.

An active member since 1983, Dr. Way is a TOMA past president. He also is a past president and active member of his divisional society, TOMA District 5. As a member of the AOA, Dr. Way was recently recognized for outstanding service as a mentor in the Association’s Mentor Hall of Fame.

The TOMA has represented osteopathic physicians in Texas since its founding in 1900. It currently represents nearly 2,300 members, including 588 osteopathic medical students at the University of North Texas Health Science Center in Fort Worth.
From the quality improvement initiatives introduced in the 1990s to today’s pay-for-performance arena, physicians have become accustomed to being graded for their performance. But now the tables are being turned and payers are the ones who are being graded.

How easy it is to do business with a health plan and how appropriate its reimbursement is are just some of the issues that payers are being graded on. Much of the data being collected, to date, are national in nature and applicable for physician services in general. The American Medical Association’s National Health Insurer Report Card on claims processing and athenahealth’s PayerView™ are two examples that come to mind.

However, one ranking service, the Center for Healthcare Reimbursement, a division of IQS Research, recently began collecting reimbursement data specifically for dermatology.

**Dermatology-Specific Data**
The Center for Healthcare Reimbursement began collecting reimbursement data in 2007. To date, the Louisville, Kentucky-based company has such data for five specialties in 15 major markets throughout the Midwest. This year, dermatology was added based on interest from the dermatology community, says Shawn Herbig, President.

The Center began collecting reimbursement data for 35 dermatology-related CPT codes this spring using a proprietary process that enables it to gather data directly from physician practices while adhering to Federal Trade Commission (FTC) regulations.

There are two types of data the company gleans. Dermatologists can use the *in market data* to compare their current reimbursement with other dermatologists in the same city. They can use the *across market data* to compare current reimbursement with their peers in the major Midwest markets.

“We have found, in general, that individual doctors and small practices are more concerned with the in market data whereas colleges, societies, and large industry trade groups tend to be more interested in the across market data,” he says, adding, “We would expect to see the same with dermatology.”

In 2010, there will be enough data collected to start showing some historic trends. “We will be able to tell over time if the reimbursement is increasing or decreasing overall, or increasing for certain codes and decreasing for other ones,” Herbig explains. “Every year, that data set will become richer.”

**Data-Driven Reports**
The Center provides an independent statement of the market average, 25th, 75th, and 95th percentiles for each of the top procedure codes. Then it distributes a practice summary report, which indicates whether the practice is above or below the market average with regard to the CPT codes and

**Figure 1 - Disparity by Carrier**

| Carrier | $53,618 | $3,683 | $45,464 | $5,715 |
| Carrier A | Carrier B | Carrier C | Carrier D |

Figure 1 illustrates a reimbursement disparity of $108,480, distributed by carrier, that a sample practice is experiencing. The bars show the amount of additional annual revenue from each carrier that the practice could earn if it were reimbursed at market average for all codes currently reimbursed below the average by that carrier.

**Figure 2 - Patient Volume vs. Disparity**

| Carrier | Patient % | Disparity % |
| Carrier A | 30% | 49% |
| Carrier B | 6% | 3% |
| Carrier C | 40% | 42% |
| Carrier D | 9% | 5% |

Figure 2 illustrates the patient volume for each carrier (blue bars) compared to the reimbursement disparity for each carrier (red bars).
reimbursement. “We look at utilization and reimbursement and then calculate a total dollar amount,” says Herbig. “The report is designed to simply say this is how much money the practice is off and this is how many codes contribute to that dollar amount. The first question every practice has is how does its reimbursement amount compare to the rest of the market. This report will answer that question.” (See Figures 1 and 2.)

After reviewing the practice summary report, if the dermatologist decides to find out exactly which codes are off, by how much, and what that is costing the practice on an annual basis, there is the practice profile. The latter report breaks down every single code and carrier and compares it to the Center’s benchmarks. “The dermatologist can look at it on a code-by-code basis or a carrier specific basis,” he explains. “It gives all the details the practice manager needs to go in and conduct a negotiation.”

If the practice wants a third-party to negotiate on its behalf, the Center can conduct a reimbursement analysis and give it to a company that specializes in negotiations. The Center is prohibited by the FTC from conducting negotiations.

“We believe that there should be timeliness and transparency in regard to what dermatologists expect to be reimbursed, but that’s not the reality,” says Herbig. “Without that, dermatologists are operating in the dark. By putting these benchmarks out there, we level the playing field. Dermatologists will have some information to help them make decisions that are in the best interest of the practice and their patients, as well.”

Other Ranking Services

At approximately the same time that the Center for Healthcare Reimbursement began collecting reimbursement data in the Midwest, other ranking services began collecting similar data on a national basis. PayerView™ is a national ranking of payers introduced by athenahealth in 2006. It uses seven metrics to rank health plans on a national and regional basis. The metrics are as follows: days in accounts receivable, first pass resolve rate, percentage of patient liability, denial rate, denial transparency rate, percentage of claims requiring medical documentation, and percentage of non-compliance with the national Correct Coding Initiative. In 2008, performance data were gathered from more than 12,000 medical providers and 30 million medical charge lines from 39 states.

Also in 2008, the American Medical Association launched its National Health Insurer Report Card on claims processing. The report card uses 14 metrics divided into five categories as follows: payment timeliness, accuracy, transparency of contracted fees and payment policies on payer web sites, compliance with generally accepted pricing rules, and denials. It provides an in-depth look at the claims processing performance of Medicare and seven national commercial health insurers: Aetna, Anthem Blue Cross Blue Shield, CIGNA, Coventry Health Care, Health Net, Humana, and United Healthcare. The data are based on a random sample pulled from more than five million electronically billed services.

Want In?

If you are interested in participating in the Center’s data collection process, it is open to all dermatologists in Louisville, Nashville, Kansas City, St. Louis, Cincinnati, Dayton, Columbus, Cleveland, Toledo, Detroit, Grand Rapids, Milwaukee, Minneapolis, Chicago, and Indianapolis.

Data collection is done electronically. Once the sample size is reached, the Center will e-mail a complimentary practice summary report to participating dermatologists. To learn more about the data collection process, visit the Center’s website at www.center.iqsresearch.com or call the office at 502-244-6600.

Baby News

Congratulations to Dr. Lloyd Cleaver on the birth of his new grandson, Brighton Harris Cleaver, born on May 5 to Jonathan and Tabitha Cleaver. Brighton weighed 7 lbs 14 oz and was 19 inches long. Jonathan Cleaver will be a first-year resident beginning July 1.
To Give or Not to Give: Empiric Coverage of MRSA in Dermatologic Surgery Patients

Dermatologic surgeons should withhold empiric coverage of methicillin-resistant *Staphylococcus aureus* (MRSA) unless there is a very high clinical suspicion or significant risk factors, concludes Roger Sica, D.O., a third-year resident at the NSUCOM/Largo Medical Center Dermatology Program, in his paper entitled “Prevalence of Methicillin-Resistant *Staphylococcus aureus* in the Setting of Dermatologic Surgery.”

In the paper, published in the March 2009 issue of *Dermatologic Surgery*, Dr. Sica set out to examine the prevalence of MRSA infections in the post-operative setting of dermatologic surgery. He performed a retrospective chart review of 70 patients who had bacterial cultures taken from January through December 2007. The mean age of the overall study population was 57 years, with the mean age of post-surgical MRSA-positive cases being 75.5 years.

Of the 70 total cultures, there were 21 post-surgical ones. Of the 21 cultures taken, 16 grew pathogen and 2 of the 16 pathogen-positive cultures grew MRSA. (See Table 1.) That means that MRSA was isolated from only 13% of the positive post-surgical cultures.

Patients with such risk factors as history of diabetes, residence in a long term care facility, and recent hospitalization, were observed in 6 of the 16 positive cultures (38%). Neither case of MRSA occurred in a patient with pre-existing risk factors.

With approximately 1,000 surgeries performed over the course of the year, Dr. Sica found that the overall infection rate for cutaneous surgery was 1.6% or 16 out of 1,000. He noted that this figure is concurrent with recent data, which cite overall incidence of infection in routine dermatologic surgery at 1.47%.1

### Table 1: Post-Surgical Cultures

<table>
<thead>
<tr>
<th>Total Cultures</th>
<th>Pathogen +</th>
<th>MRSA</th>
<th>MSSA</th>
<th>Other Pathogen</th>
</tr>
</thead>
<tbody>
<tr>
<td>21</td>
<td>16</td>
<td>2 (13%)</td>
<td>6 (38%)</td>
<td>8 (50%)</td>
</tr>
</tbody>
</table>

**Common Pathogens**

Historically, the most common pathogens isolated in cutaneous surgical wound infections are gram-positive organisms, *Staphylococcus aureus* and *Streptococcus pyogenes*. Gram-negative organisms, such as *Pseudomonas aeruginosa*, have been less commonly isolated in high-risk locations such as the ear or perineum, particularly in patients with a history of diabetes mellitus.

Methicillin-resistant *Staphylococcus aureus* developed as a result of antibiotic resistance through a variety of genetic and biologic mechanisms.2 It was first described in the United Kingdom in 19613 as a nosocomial pathogen.4 Since that time, MRSA has also become an increasingly prevalent pathogen in the community setting.5 It has been subdivided into healthcare-associated, which includes community-onset and hospital-onset subtypes, and community associated.6

Of particular interest to dermatologists, it is well documented that MRSA skin infections are increasing at an alarming rate in a variety of clinical settings. Examples include emergency departments7 and inpatient dermatology services8 as well as in previously healthy individuals, often presenting as spontaneous abscesses.5 Many authors have suggested modifying empirical therapy to cover MRSA in such situations if clinical index of suspicion is high.7,9,11

### Different Patient Populations

However, the patient population for which it is increasing is not representative of the population typically seen by dermatologic surgeons.

As an example, in a study of patients presenting in emergency departments with acute skin and soft tissue infections, the prevalence of MRSA was 59% overall, with a rapid increase in prevalence seen in Los Angeles from 2001 to 2004.7

Reported cases of MRSA at military medical facilities in San Diego from 1990 to 2004 showed that 65% of the cases were community acquired. Patients were younger and less likely to have concurrent medical conditions. Total MRSA isolates rose from 10 in 1990 to 632 in 2004, with the greatest increase occurring from 2002 to 2004.3

In a chart review of hospitalized dermatology patients in 2001, MRSA increased in leg ulcers from 26% in 1992 to 75% in 2001. For superficial wounds, MRSA increased from 7% in 1992 to 44% in 2001.8

In a chart review of patients who underwent operative debridement of skin and soft tissue infections at a Veterans Affairs hospital in Texas, an increase in MRSA from 34% in 2000 to 77% in 2006 was demonstrated.9

### Patients Seen by Dermatologic Surgeons

Dermatologic surgeons encounter an entirely different situation on a routine post-operative basis. Patients who undergo cutaneous surgery are generally otherwise healthy and not prone to developing MRSA infections.

Established common risk factors for community-onset and hospital-onset infections include a history of hospitalization within the past year, history of recent surgery, residence in a long term care facility, and history of MRSA infection or colonization.9 Other historical risk factors of skin infection in the post-
operative setting include patients with a history of diabetes or uncontrolled hypertension, and those who take chronic corticosteroids and are alcoholics, smokers, and malnourished or obese. All factors should be considered when choosing empiric antibiotics, noted Dr. Sica.

Other factors that Dr. Sica analyzed include the site of cutaneous surgery and type of repair. Because the majority of surgical cases undertaken during the course of the year occurred on the head and neck as opposed to the extremities, it suggests that the increased number of infections on the extremities, compared with other sites, is significant. This supports previous studies that demonstrated cutaneous surgery below the knee to be a significant risk factor of infection.1

Given that the prevalence of MRSA in the typical population following dermatologic surgery is quite low, the question becomes what to prescribe empirically in the setting of a post-surgical patient with whom MRSA infection is suspected.

Treatment Options
Providing empirical treatment following dermatologic surgery on a routine basis with MRSA-sensitive antibiotics (ie, trimethoprim-sulfamethoxazole, clindamycin or tetracycline derivatives) would be premature, Dr. Sica noted, and may only further increase the likelihood of creating antibiotic resistance, potentially losing these valuable antibiotic agents in the future.

Unless there is a very high clinical suspicion or the patient has multiple risk factors, he recommended continuing to prescribe the traditional antibiotics given for uncomplicated skin infections in the post-surgical setting. These include penicillins, cephalosporins, and aminoglycosides, among others. Dr. Sica also recommended obtaining a culture and adjusting the antibiotic therapy according to sensitivity. The empirical use of MRSA-sensitive antibiotics should be reserved for high-risk patients or locations, he concluded.

Dr. Sica received the Young Investigators Writing Competition Award from the American Society of Dermatologic Surgery for this paper and also presented the topic at the society’s annual meeting held last November.

References
New Orleans—host of the 2009 AOCD Annual Meeting—is an American city with a European flare.

Similar to other early American settlements, New Orleans served as a cultural gateway to North America. Unlike the others, it was here that the lives and customs of the American Indians and Africans, both free and slaves, intermingled with those of European settlers resulting in a culture unique to the Crescent City.

Established in 1718, a century after some of the other American settlements, New Orleans remained an outpost of the French and Spanish empires until Napoleon sold it to the United States as part of the Louisiana Purchase in 1803. Despite the fact that French Louisiana was connected by water to the rest of the country, it remained isolated and guarded in its way of life. While it became the South’s chief cotton and slave market, its influence was still largely foreign as more immigrants than Americans came to live in the city nearly until the beginning of the 20th century. The French, Spanish, and Cubans were later joined by the Irish and Germans. From 1820 to 1870, New Orleans was one of the main immigrant ports in the nation, second only to New York. The Crescent City also was the first American city to host a significant settlement of Italians, Greeks, Croatians, and Filipinos.

**Birthplace of Jazz**

One of the ways its many cultures were blended is reflected in the city’s music. Known as the birthplace of jazz, African drums were combined with European horns to create a new sound. Add to that, the music heard in churches and in barrooms, and a wild, jubilant music was born. The likes of Buddy Bolden, Jelly Roll Morton, and Louis *Satchmo* Armstrong carried the notes outside the city giving it worldwide popularity.

The tradition continues to the present day. Some of today’s world-renowned jazz musicians who call New Orleans home are Wynston and Branford Marsalis, as well as Harry Connick, Jr.

No matter what night of the week, you will find a jazz club with live music. Preservation Hall in the French Quarter serves up traditional jazz with neither a bar nor climate control. The music begins nightly at 8 p.m. with a line usually forming outside one half-hour before. Also in the Vieux Carré is the Funky Pirate, long time Bourbon Street hangout of Big Al Carson & the Blues Masters, featuring raunchy blues from late afternoon to the wee, wee hours. If you prefer going off-shore to hear music, the Steamboat Natchez features traditional jazz on its evening cruise, which includes dinner. (Reservations required.)

This classic Mississippi riverboat is also known for another kind of music, the Steam Calliope, which is a 32-note steam pipe organ. While walking through the French Quarter during the day, listen carefully at 11 a.m. and 2 p.m. to hear the lively music of a calliope, which is an exact copy of the original built 100 years ago. Follow the sound to the Toulouse Street Wharf and see the music coming from the calliope in the form of steam plumes shooting with each whistle played. There is a synchronized colored light show that occurs just before one of the Natchez’s daily treks down the river.

New Orleans Offers Cool Jazz, Hot Cuisine
When you’re taking that stroll, remember that November is technically winter in New Orleans. That means a high of 68 degrees and a low of 51 degrees. Rain is not uncommon for this time of year, so an umbrella might come in handy.

**Cajun, Creole Cooking**
The Crescent City also set its mark in the culinary world with its Cajun and Creole cooking.

A combination of French and Southern cuisines, Cajun food is robust, country-style food found along the bayous of Louisiana. The French, who migrated here from Nova Scotia 250 years ago, brought with them their heavy, one-pot dishes, such as jambalaya or crawfish étouffée, served over steaming rice.

Unlike Cajun fare, Creole food was created by New Orleans’ residents based on their European and African roots. Some would say Creole food is Cajun food’s more refined city relative. While the French influence is very strong, the essence of Creole is found in rich sauces, local herbs, red ripe tomatoes, and the prominent use of seafood caught in local waters. Common Creole dishes are rich, roux-based gumbo, shrimp creole, grits and grillades, and redfish courtbouillon.

Both types of cooking rely on the liberal use of chopped green peppers, onions, and celery. The most common misconception is that both are spicy, fiery hot. Both Creole and Cajun cuisines have a depth of flavor, borne of a blend of local herbs and (quite often) roux and may or may not be spicy.

Authentic Creole and Cajun delicacies can be found at one of the city’s 3,000 restaurants.

**Other Food Traditions**
New Orleans also has many coffee-houses. Whether you need a pick-me-up after a day touring the city or a night jazzing it up, a cup of coffee and sweet treat can be found around the corner. Probably the most famous is Café Du Monde in the French Quarter, which has been serving café au lait and beignets since 1862. Beignets are, of course, the pastries made from deep-fried dough and sprinkled with confectioner’s sugar. These French doughnuts were brought to New Orleans by the Acadians. Café Du Monde is a city landmark located directly across from Jackson Square and the Pontalba apartments. Many local coffee shops also serve light meals, such as sandwiches and salads.

Instead of having a regular sandwich, try a po’ boy (or poor boy), the traditional local submarine sandwich consisting of meat or seafood, usually fried, served on baguette-like Louisiana French bread. The key is the bread with a light and airy inside and crispy outside. A dressed po’ boy includes lettuce, tomato, and mayonnaise, with optional pickles and onion. The sandwich’s origin is said to result from a 1929 strike against the streetcar company. A former streetcar conductor turned restauranteur served his former peers free sandwiches during the strike.

Another local favorite is the muffuletta sandwich created by a Sicilian immigrant, Salvatore Lupo, in 1906 at the Central Grocery, which still operates in the French Quarter. A muffuletta is actually a type of Sicilian bread, similar to focaccia. The muffuletta loaf is split horizontally and covered with a marinated olive salad, layers of capicola, salami, mortadella, emmentaler, and provolone.

Another food tradition in New Orleans is Sunday brunch. Some of the more noted places serving up these midday meals are Brennan’s, Antoine’s, Arnaud’s Restaurant, and Court of Two Sisters Restaurant, all in the French Quarter. Remember, jacket may be required for brunch fare.

So take some time to enjoy the cool jazz and hot foods compliments of the blended cultures in New Orleans while at the 2009 AOCD Annual Meeting.

*In the next issue of DermLine, learn about the neighborhoods, including sites not to be missed, that make up New Orleans.*
Midyear Meeting Sites Set
by Dr. Schwarze

Warm and sunny convention sites have been chosen for the next two AOCD midyear meetings.

Next year, the AOCD Midyear Meeting will be held April 14-17 at the Sedona Arizona Hilton. This hotel, which is nestled among the gorgeous Arizona red rock mountains, is fabulous. It offers swimming, tennis, and spa services, and is 90 minutes from the Phoenix airport. The updated Flagstaff airport, which is a 15-minute shuttle ride away, now accepts large jets, as well. The town has great restaurants, golf courses, and even an outlet mall. A short drive to the mountains reveals a light skiing area (call the hotel or website for the conditions of the slopes before arriving). There also are many opportunities for hiking and trail riding.

In 2011, the midyear convention will be held at the Marco Island Florida Marriott situated directly on the Gulf of Mexico. The date has not yet been determined. The Marriott is approximately 100 minutes from the Miami airport or 30 minutes from the regional airport by shuttle. The hotel offers jet skiing, swimming activities, umbrellas on the beach at $20 a day, rental boats or cruises (with or without food), separate kid and adult pools, off-campus golf by hotel shuttle, great restaurants, shopping, a site-seeing trolley, and a museum, all within walking distance. A short drive could deliver one to outlet malls, Naples, and south Florida site-seeing. A Hertz car rental agency is located in the hotel.

These are great convention sites, and I am very excited to be able to return to them. See y’all there.

Annual Meeting: Live Injection Workshop, Psoriasis Symposium

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.

This year, resident lectures are slated for Tuesday and Wednesday afternoons.

The three-hour workshop is scheduled for the morning session on Monday, says Program Chair Marc Epstein, D.O., FAOCD.

In addition, Ken Gordon, M.D., and Jeff Crowley, M.D., will present a two-hour psoriasis symposium 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.
AOCD Implements FileWorks Online

The AOCD recently implemented the new FileWorks Online system, which stores files on secure servers and enables access to them through the Internet.

The AOA began using the system last March to upload various documents, instead of mailing them, to all of the specialty colleges.

For now, the AOCD’s Education Evaluating Committee (EEC) is using the FileWorks system to upload the residents’ annual reports. This will enable committee members to review the reports at their leisure. Previously, copies of the reports were carried to the EEC meeting in St. Louis where they were reviewed and then carried back to Kirksville. Thus, the use of Fileworks will eliminate the transporting of 100+-plus copies of these reports.

“This is still a learning process for us all and bugs are still being worked out,” notes Marsha Wise, resident coordinator.

Future expansion on how FileWorks will be used will be discussed at the 2009 AOCD Annual Meeting.

Inspectors Wanted

If you have five or more years of AOBD certification and are interested in becoming an inspector, the AOCD would like to hear from you.

Inspectors are the eyes and ears of our training programs for the Education Evaluation Committee (EEC), says Chair James Bernard, D.O., FAOCD. They are official representatives of the AOA and the AOCD. ‘The inspectors’ review and recommendations are extremely important in maintaining quality control and excellence in our current and future educational programs,” he adds. The inspectors’ reports are viewed by the AOCD’s EEC as well as the AOA’s Program Training Review Committee.

Inspectors are responsible for reviewing the AOCD’s current residency training programs as well as new program applicants.

Currently, the AOCD has five active inspectors, who review 20 existing programs every three to five years. After conducting an inspection, which takes one to two days on site, inspectors are required to write a summary report noting areas of strengths and weaknesses (if any). Through the inspection, the inspector verifies that the training program is following the Basic Standards guidelines.

Inspectors are expected to attend the quarterly EEC meetings that are conducted either in person or by teleconference. At these meetings, members review the inspection reports and other documents or training issues that arise, as well as the residents' annual reports. The EEC members then submit summary reports with recommendations to the AOA Council on Postdoctoral Training, which then approves or disapproves them.

Inspectors are reimbursed for expenses by the AOA per Association guidelines.

The EEC is chaired by Dr. Bernard. Lloyd Cleaver, D.O., FAOCD, is the vice chair. Members include Drs. Brad Glick, Susan Kelly, Steven Kessler, Leslie Kramer, Jere Mammino, Richard Miller, Robert Schwarze, Michael Scott, Stanley Skopit, Bill Way, and Schield Wikas.

If you are interested in becoming an inspector, you may submit a letter of introduction/application along with a current CV to the EEC at the AOCD office addressed to AOCD/EEC, P.O. Box 7525, Kirksville, Mo. 63501. The information also can be faxed to the AOCD at 660-627-2623.
Hello Everyone,

Winter is behind us (finally) and the spring and summer months will be busy here in the AOCD Office.

**Annual Reports**

It will soon be time for annual reports to be turned in! All forms can be downloaded from the AOCD website at http://www.aocd.org/qualify/annual_reports.html.

The Education Evaluation Committee (EEC) met this past February and reviewed the resident requirements for the annual reports and resident lectures.

The Resident’s Annual Report, Program Director’s Annual Report, Resident’s Annual Paper with two referenced questions, Documentation Submission Form for Publication, and AOA Core Competency Report are all due in the AOCD Office 30 days after the end of each training year.

Residents should send one original copy with an attached signature page. The signature page should be signed by the resident, program director, and director of medical education as it is a confirmation that the reports are complete and accurate. Once the reports are received by the AOCD, we will upload them to FileWorks, which is our new on-line storage system. (See page 13 for story on FileWorks)

The EEC members will then be able to view each report as they are uploaded at their convenience. This will give the members more time to review each report before the next EEC meeting slated this fall. Incomplete reports will not be uploaded.

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

The fee schedule is as follows:
- $100 for all reports submitted 30 to 365 days after submission deadline
- $250 for all reports submitted 365 to 730 days after submission deadline
- $500 for all reports submitted 730 days after submission deadline

Late documents will delay the approval of each year of training by the EEC and the AOA’s Postdoctoral Training Review Committee. Board eligibility is granted only upon approval by both committees.

**Lectures**

Intent-to-Lecture applications for the 2009 AOCD Annual Meeting are now being accepted.

Because there is a limited number of spots, application should be submitted as soon as possible. Resident lectures are slated from 1 to 5 p.m. on Tuesday, November 3, and from 1 to 5 p.m. on Wednesday, November 4.

The faculty disclosure statements and Intent-to-Lecture forms can also be downloaded from the AOCD website at http://www.aocd.org/qualify/annual_reports.html.

Upon recommendation of the Awards Committee, the following rules apply to the resident lectures.

Each resident must present two lectures of at least **15 minutes in length** (as stated in the current Basic Standards document).

Priority in scheduling will be given to second- or third-year residents to ensure that they have ample time to meet their training requirements. First-year residents will not be scheduled to speak at the annual meeting in the fall of their first year of training.

Also, the residency program director is responsible for reviewing all oral presentations and manuscripts for publication prior to the resident submitting them. In addition, the residency program director must submit a signed and dated statement that the resident’s oral presentation has been reviewed, thereby allowing the resident to be included in the AOCD meeting program.

The administrative requirements for resident oral presentations are as follows:
- **Call For Lectures/Papers 7 months prior** to the first day of the meeting
- **Intent-to-Lecture Form**: AOCD office notified by resident of intent to lecture **6 months prior** to the first day of the meeting or resident will not be placed on schedule
- The signed documents required to be in the AOCD office **8 weeks prior to the first day of the meeting** are as follows:
  - Disclosure Statement
  - Copyright Consent
  - Program Director’s Statement
  - Copy of completed PowerPoint presentation

If the PowerPoint materials are not received by the specified deadline date, then the resident will not be eligible for evaluation of the Koprince Award. If the materials are not received by the deadline, the resident will not be able to present at the meeting.
Sending the aforementioned items two months prior to the meeting will allow ample time for evaluation, review, and approval by CME accredited bodies.

The lecture schedule sign-up closes 12 weeks prior to the first day of the meeting. No last minute additions to the lecture schedule will be allowed.

This year, the lecture sign-up closes August 1, the documentation/presentations are due September 1, and the meeting start date is November 1.

Lectures are accepted on a first come, first serve basis. Any topics “to be announced” will be placed on the waiting list. Once slots are filled, anyone requesting to speak who has not been assigned a spot, will be placed on the list for the midyear meeting slated in March, 2010 and will be given priority scheduling.

Currently, a presentation on “How to Give a Powerpoint Presentation” is being developed. This session will take place either at an annual meeting or a midyear meeting for residents as well as any AOCD members who would like to attend.

In-Training Exam
The program directors continue to work on the in-training examination (ITE) questions for this year’s exam, which will be held on Sunday, November 1 in New Orleans. Residents’ dues must be current to sit for this exam.

The intent of the ITE is to identify knowledge-based strengths and weaknesses in both the training programs and the residents in a non-punitive manner. Participation in the ITE program is mandatory. The exam format includes the type of multiple-choice questions that appear on the certifying exam, such as one best answer, matching, and identification of images. The ITE is not meant to be a mirror of the actual board.

Residency Programs Grow
The AOCD residency programs continue to grow.

In July 2005, there were 80 residents. One year later, there were 87. In July 2007, there were 90 residents. One year later, there were 97. This July, there will be 97 residents.

To date, the following residency programs have accepted 29 new residents who will begin July 1. They are as follows:

Oakwood Southshore: Dr. Grekin
Peter Sattia, D.O.
Ari Goldsmith, D.O.

O’Brien Memorial Hospital: Dr. Drew
Kate Chilek, D.O.
Frank Morroco, D.O.

Genesys Regional Medical Center: Dr. Silverton
David Kasper, D.O.

St. Barnabas Hospital: Dr. Hoffman
Kate Kleydman, D.O.

Columbia Hospital: Dr. Allenby
Roxanna Menendez, D.O.
Kurt Grelck, D.O.

Northeast Regional Medical Center #2: Dr. Way
Helen Kaporis, D.O.

NSU-COM/BGMC: Dr. Skopit
Theresa Cao, D.O.
Roya Ghorsriz, D.O.
Jerry Obed, D.O.

Wellington Regional Medical Center: Dr. Glick
Betsey, Leveritt, D.O.
Danielle Manolakos, D.O.

Richmond Medical Center/Case Medical Center: Dr. Tamburro
Allyn Hatter, D.O.
Ligaya Park, D.O.

St. John’s Episcopal Hospital, South Shore: Dr. Watsky
Robert Levine, D.O.
Tara Whelan, D.O.

NSUCOM/Largo Medical Center: Dr. Miller
Angela Bookout, D.O.
Lana McKinley, D.O.
Khonnie Wongkittiroch, D.O.

COMP/Phoenix Area Dermatology: Dr. Kessler
Amanda Beehler, D.O.

TUCOM/Valley Hospital Medical Center: Dr. Del Rosso
Brent Michaels, D.O.

Northeast Regional Medical Center: Dr. Cleaver
Jonathan Cleaver, D.O.

Pontiac/Botsford Osteopathic Hospital: Dr. Mahon
Jonathan Richey, D.O.
Michelle Legacy, D.O.

St. Joseph Mercy Health System: Dr. Stewart
Amy Basile, D.O.
Ryan Jawitz, D.O.
Christopher Messana, D.O.

All residents are asked to provide the following documents:

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

Please remember to keep your address and e-mail address current. If you experience problems logging on to http://www.aocd.org, please let me know.
A recently published numerical scale can help dermatologists assess how many laser treatments it will take to remove a tattoo.

The Kirby-Desai Scale was developed by Will Kirby, D.O., FAOCD; Alpesh Desai, D.O., FAOCD; Tejas Desai, D.O., FAOCD; and first-year resident Francisca Kartono, D.O. In their study published in the March issue of the Journal of Clinical and Aesthetic Dermatology, the scale was determined to be a practical tool to assess the number of laser tattoo-removal sessions required.

More Tattoos, More Removals
Tattoos have become increasingly popular in the Western world. Current estimates suggest that more than 20 million people—or between 3% and 5% of the population—have at least one tattoo.\(^1\,2\) Also on the rise are tattoo-removal requests, as patients often regret getting this form of body art. Up to 50 percent of adults 40 years of age and older seek to remove their tattoos.\(^3\)

Lasers have been used to remove tattoos since the late 1970s. In recent years, they have become the treatment of choice due to their high efficacy and low incidence of deleterious side effects. However, due to the varying types of tattoos, it has been difficult to quantify the number of laser treatments required with certainty.

Currently, patients receive a poorly defined assessment of the number of treatments. As a result, they often engage in the process without full awareness of the potential success and cost.

The Scale
Consequently, the authors developed the Kirby-Desai scale to be used during pre-consultation. The scale was made with the assumption that the dermatologist is using a quality-switched Nd:YAG (neodymium-doped yttrium aluminum garnet) or Alexandrite laser incorporating selective photothermolysis with six to eight weeks between treatments.

To test the scale, the authors performed a retrospective chart review on 100 clinic patients who presented for laser tattoo removal between July 2004 and August 2008. Using an algorithm, they assigned a numerical score to each tattoo across six different categories (e.g., skin type, location, color, amount of ink, scarring, and layering). The cumulative score was proposed to correlate with the number of treatment sessions required for satisfactory tattoo removal.

Several factors within the aforementioned categories can affect the number of treatments required. For example, colors other than black can be twice the size of the black pigment, thus requiring more treatments. Amateur tattoos are typically placed unevenly in the superficial dermis and tend to contain less ink than those done by professional artists. As a result, amateur tattoos tend to respond quicker to laser treatment. When patients layer an undesirable tattoo with another, the second one tends to be larger and darker, thus requiring more treatments to remove.

The average number of treatments required to satisfactorily remove a tattoo was 10, with a range of three to 20, the study revealed. The number of treatments correlated well with the average Kirby-Desai scale of 9.87 with a standard deviation of ±2.45. (See Figures 1 and 2.)

Using the scale will enable dermatologists to better estimate the number of laser treatments required for tattoo removal, the study concluded, while decreasing the uncertainty of the process for patients.

References
As the program year comes to a close, all of us need to start thinking about the future regardless of whether we are graduating this July or we have a couple of residency years left.

To that end, I have asked one of our office managers at the Grekin Skin Institute, Amanda Lusk, what is typically required in order to be credentialed after residency. She recommended the following “to do” list:

**Ongoing Paperwork, Requirements**

- If you do not already have one, apply for a National Provider Identifier at [https://nppes.cms.hhs.gov/NPPES/Welcome.do.](https://nppes.cms.hhs.gov/NPPES/Welcome.do).
- Call your accountant to obtain a tax identification number and obtain information about how to start a practice.
- Call your hospital medical education department to obtain a “Malpractice Face Sheet” for every year you have been a physician.
- Check the Centers for Medicare & Medicaid Services website at [http://www.cms.hhs.gov/default.asp](http://www.cms.hhs.gov/default.asp) for details about Medicare participation. Guidelines for all states are available on this site.
- Create a credentialing packet that contains the following information:
  - Copies of all licensures
  - Copies of your Social Security card
  - Copies of your photo identification
  - Copies of all your degrees (starting with your bachelor’s)
  - Copies of anything in relation to your CME credits
  - Copy of your ACLS/BLS certification
  - Current CV
  - List of all publications in which you have published
  - Copies of any special certificates (Mohs micrographic surgery certification, military documents, etc.)

**Countdown to Graduation**

One year prior to graduation, you should
1. Begin contract talks with potential employers and establish where you want to practice.
2. Start checking on the cost of malpractice insurance and state liability requirements.

Six months prior to graduation, you should
1. Finalize your contract if you have not already done so.
2. Apply for a medical license within the state you plan on working.
3. Begin looking at insurance applications.
4. Call local hospitals and apply for privileges. Remember that insurance companies usually require that you have visiting or courtesy privileges before you are approved in a plan.
5. Call your local Medicare administrator and ask when you can begin the application process.

Three months prior to graduation, you should
1. Have a complete credentialing packet with current licenses, CV, and a tuberculosis test within the last year.
2. If you have not already done so, start Medicare and insurance applications.
3. Obtain a minimum of four letters of recommendation. Only one letter can be from a source such as a physician assistant or nurse practitioner.

At graduation, you should
1. Schedule boards and, if possible, obtain a letter from your Director of Medical Education indicating board eligibility.
2. Live a life less ordinary.
The two garishly outrageously painted, uncomfortable, fume-belching chicken buses precariously negotiated steep mountain passes as they carried a volunteer DOCARE International medical team to makeshift clinics throughout remote medically deprived areas of Guatemala.

The team consisted of medical students and faculty from the University of Kansas Medical School and the Kansas City College of Osteopathic Medicine. Tagging along with them on their third mission trip were myself and residents Drs. Tony Nakhla, Marian Shasafari, Joseph Del Priore, and Jack Griffith.

Base camp was the enchanting colonial mountain village of Antigua. Dating back to 1524, its seemingly endless cobbled streets traversed through open plazas and narrow alleys. Its unique, colorful architecture still reflects its rich Mayan heritage. Looming above this historical area are several ominous smoke spewing volcanoes that encircle the village.

Challenging Patients
More than 500 patients with multiple problems were treated by the medical teams each day. The dermatology residents were well prepared and were able to perform a variety of surgical procedures, including the amputation of accessory digits on an 8-month-old baby, the removal of multiple verruca from the tongue of a 10-year-old boy, the excision of a painful perirectal abscess, and the avulsion of a fingernail to eradicate an underlying pyogenic granuloma. I was amazed at the skills of the residents and by their adaptation to the primitive working conditions.

The dermatology residents were intrigued and challenged by the number of patients who presented with multiple presentations of photodermatitis. The spectrum included polymorphous light eruption, lupus-like malar rashes, actinic reticuloid, actinic granuloma, and photo contact dermatitis, among others.

Luckily, an ample supply of systemic antibiotics were available to treat cases of eczema, severe skin infections associated with uncontrolled atopic dermatitis, and cellulitis covering the scalp of an infant, as well as other difficult-to-treat skin infections.

Embrace the Unexpected
What makes trips like these so adventurous for me is to expect and embrace the unexpected when traveling to a Third World country. Examples of these assertions are streets too narrow to accommodate our bus trying to make a wrong way turn on a one-way street backing up traffic in all directions for more than 30 minutes, or running out of gas on a steep mountain incline on our way back from a hot, grueling clinic day. But, no problem; we can just siphon gas from the other bus. Good idea. So, that is what they did. So, let’s...
go. What? The engine won’t turn over. Now, the battery is dead. No problem. We will just borrow the battery from the other bus. Three-and-a-half hours later, we arrived back safely at our home base and were rewarded with the traditional cold shower.

Did I also mention that a good sense of humor and a cold beer with chips and salsa makes everything, for the moment, seem all right?

Now off for some restful sleep, only to be jolted awake every 15 minutes by the menacing convent gong that mercilessly clangs to mark the local time for the villagers without access to clocks and watches. But exhaustion eventually takes its toll, and sometime in the wee hours of the morning, you finally doze off until the 5 o’clock rooster in the outside courtyard announces that a new day has arrived. So much for sleep.

Worth the Trip
You might ask what makes a medical mission trip like this worthwhile. Well, it depends on whom you ask.

For Dr. Nakhla, it is witnessing the living conditions of people in Third World countries, which he finds astonishing and humbling. “It gives one a true appreciation for life in the states, and a great perspective about our small worries back home,” he said. Dr. Nakhla also was touched by the gratitude of the patients whom he encountered. He encourages all physicians to participate in this type of volunteerism. “It is an experience that rewards the physician as much as, if not more than, the patients who are treated.”

For Dr. Griffith, it was the warmhearted people with the smiling faces whom he encountered as he traveled throughout Guatemala that impressed him the most. “Despite their harsh social conditions and abject poverty, the Guatemalan people were some of the most friendly people I have ever met.”

Dr. Del Priore stated that this trip has definitely sparked his interest in future medical missions. “Guatemala is a country where most people do not have the resources to go to the doctor when they are sick; however, people show gratefulness in such ample amounts compared to the U.S. where it seems that entitlement predominates,” he noted.

Dr. Shasafari concurred. “It made me feel very fortunate for all that I have, and I will no longer take what I have for granted. I have never seen so much poverty, pollution, and lack of resources in one place coupled with some of the happiest people I have ever encountered. The dichotomy of wealth and poverty was almost comical.” She also was impressed by the extent to which common dermatoses can progress by the lack of care to make them almost unrecognizable. Dr. Shasafari found this trip to be a very humbling, but wonderful, experience. “I hope that all of my fellow residents get an opportunity for such an experience,” she added.

In a country enveloped in cultural contradictions, a rich historical heritage and widespread poverty surrounded by breathtaking natural environmental beauty intermixed with civil unrest and government greed there are still people, like you and me, who want the best for their children and are content with their place on this earth. What little that I did to improve their plight, or to quell a chronic itch if just for a moment or two, was expressed through smiling faces and unspoken gestures. Being able to share my limited medical knowledge and knowing that I might have helped to relieve the suffering of another human being in a far off place is enough for me to keep going back again and again.

Dr. David C. Horowitz is Director of the Dermatology Residency Program at Western University/Pacific Hospital of Long Beach. He and his residents went on this medical mission to Antigua, Guatemala from February 13-28, 2009.
The residents in the Palm Beach Centre for Graduate Medical Education (PBCGME)/Columbia Hospital Dermatology Residency Program in West Palm Beach, Fla., share a schedule packed with consults and grand rounds at multiple facilities not to mention seeing patients at a handful of clinics and rotations at various dermatologists’ offices.

But that’s not the only thing that they have in common. All of the residents have a medical background in something other than dermatology. In fact, most of them are board certified in primary care fields. “This allows each individual resident to contribute something different to the program,” says Program Director Janet Allenby, D.O., FAOCD.

To date, three residents have graduated from the program, which was established in 2003. One is expected to graduate in June. As of July, there will be a total of seven residents.

Rigorous Schedule
With so much on the schedule, mornings start at 7:15 a.m. with a review of chapters in Bolognia’s Dermatology. The program has a strong foundation in dermatopathology, notes Dr. Allenby. The residents attend weekly dermatopathology conferences at Dermpath Diagnostics in Pompano Beach reading slides with well-known dermatopathologists including Drs. Neal Penneys, Alexander Kowalczyk, Pascual Abenoza, Les Rosen, and Carlos Nousari.

But the dermatopathology lessons don’t stop there. The residents attend a rigorous and comprehensive weekly review of assigned chapters in Lever’s Histopathology of the Skin conducted by a local dermatopathologist, Dr. Michael Nowak.

Every other week, residents participate in providing care to patients at Dr. Nousari’s Immunodermatology/Bullous Clinic at NOVA Southeastern University in Fort Lauderdale. Various diagnoses of the patients at the clinic include pemphigus vulgaris, pemphigus foliaceus, epidermolysis bullosa acquisita, bullous pemphigoid, mucosal membrane pemphigoid, sarcoidosis, lupus erythematosus, dermatomyositis, urticarial vasculitis, and dermatitis herpetiformis.

On Wednesdays, residents participate in providing care for patients at a Volunteer Dermatology Clinic, which is part of the Caridad Clinic in Boynton Beach. The clinic serves migrant workers, who lack health insurance, and their families.

Residents have an opportunity to gain experience in dermoscopy with Dr. Harold Rabinovitz as an elective rotation and lectures.

They gain surgical experience both at the Veterans Administration Medical Center in West Palm Beach and at private offices with various Mohs micrographic surgeons.

A rotation with Dr. Allenby offers cosmetic, surgical, and general dermatology experience.

On Tuesdays, first-year residents see patients with Associate Program
Director Dr. Brent Schillinger. All residents participate in a monthly Saturday clinic.

Senior residents attend weekly dermatology grand rounds at the University of Miami. They also rotate with Dr. Francisco Kerdel, seeing both inpatients and outpatients at the University of Miami.

“We have a dynamic program that is constantly changing and reinventing itself,” says Dr. Allenby. “This allows us to provide a broad range of dermatologic experiences for our current and future residents.” To that end, the program is always recruiting faculty with a variety of dermatologic subspecialty expertise. As an example, the program will begin offering a weekly on-line interactive dermatopathology conference with Michael Morgan, M.D., in Tampa. Dr. Allenby is in the process of establishing both a Mohs surgery and pediatric dermatology rotations at the University of Miami.

**Clubs, Lectures, Papers**
The PBCGME residents present weekly lectures on various dermatology topics, including mastocytosis and histiocytoses, to internal medicine and pediatric residents as well as medical students.

The residents host dermatology grand rounds with Dr. Nousari on a biannual or quarterly basis. Dermatologists from the community are invited to participate in these discussions focused on difficult cases.

On a monthly basis, they host dermatology journal clubs for dermatologists in the community. Each resident presents a PowerPoint presentation of articles published in the *Journal of the American Academy of Dermatology* or *Archives of Dermatology*. Dr. Schillinger serves as moderator.

Once or twice a year, residents have an opportunity to participate in a surgical skills workshop at Nova Southeastern University to hone their cutaneous surgery skills.

Resident Dr. Brent Schillinger. All residents participate in a monthly Saturday clinic.

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Dr. Marshall Learns Dermatology Down Under

Third-year resident Dan Marshall, D.O., at the Northeast Regional Medical Center Residency Program in Kirksville, Mo., recently went down under to observe Anthony Dixon, M.B., B.S., Ph.D., Assistant Professor (School of Medicine) at Bond University in Gold Coast, Australia, and Fellow of the Australasian College of Skin Cancer Medicine.

Dr. Marshall won this opportunity by submitting the winning paper entitled “Work Horse Flaps and Nasal Reconstruction” in a writing contest sponsored by the College last year. The trip was supported by the silent auction held at the 2008 AOCD Annual Meeting.

Most of his time was spent observing Dr. Dixon as he treat patients in his private office in Deelong, one hour south of Melbourne. “Dr. Dixon is actually the busiest skin cancer surgeon in Australia,” says Dr. Marshall. “He sees two melanomas a week, on average, at his clinic.”

Dr. Marshall also attended a weekend dermoscopy conference in Brisbane given by Scott Menzies, M.B. B.S., Ph.D., Director of the Sydney Melanoma Diagnostic Centre and an Associate Professor in the Discipline of Dermatology, University of Sydney, Australia. “I was able to listen to the world-renown dermoscopist,” he says.

Two things struck Dr. Marshall about the experience.

One is how differently dermatologists treat skin cancer here and there, largely based on the respective country’s payment system. “They don’t do Mohs there because the government won’t pay for it,” he explains. “They don’t do as many biopsies as we do because they’re not well paid for them, either. If they think it looks like skin cancer, they do dermoscopy. If it looks like basal cells, they just excise it with margins. They have to cut wider margins, which leads them to do more flaps and graphs.”

The other is the prevalence of skin cancer, citing the Australians’ genetic make-up as a primary reason. “I noticed a lot more redheads and fair-skinned people there than what we see in the states and in Missouri for sure,” notes Dr. Marshall. “They also have access to warm, beautiful beaches year-round and participate in a lot of outdoor activities. I was amazed at how much sun damage they had and even in younger people.”

The three-week April trip wasn’t all work. Dr. Marshall was able to take in a few sites, such as the Great Ocean Road, which offers spectacular scenery of the coastline of southwest Victoria. An added bonus was having his wife accompany him on the trip. “The hospitality that Dr. Dixon showed us was amazing,” says Dr. Marshall. “He treated us like family.”

Overall, it was a great work opportunity, he says. The only negative part was him having to watch Dr. Dixon instead of assisting. “I was like a kid in a candy store. So many skin cancers, so much work to do, and I could only watch.”

Defining Financial Planning

Many people think financial planning means discussing their stock portfolio with a stock broker or their insurance policies with an insurance broker, but those are only two aspects of financial planning, according to Steve Lopez, a financial representative with Crystal Cove Wealth Management, an investment management firm in Irvine, Calif.

“Financial planning by definition is a comprehensive analysis of assets, liabilities, cash flow, and protection,” he says. It encompasses all of one’s wealth, which is different than income. Wealth is what a person has accrued over a lifetime. Income is his or her paycheck.

Conduct an Analysis

The first step in financial planning is to conduct an analysis of one’s assets, liabilities, cash flow, and protection.

Physicians may have several different types of assets. One is property, which can refer to a house, an office building that houses the practice, or buildings purchased for real estate investments. The practice itself, which includes the employees, is an asset. Other assets are a stock portfolio, life insurance, and disability insurance. An art collection, jewelry, and collectibles are another grouping of assets that physicians commonly own.

Regarding liabilities, taxes are a major one for physicians. Not only do they have to contend with a 33 percent federal tax, there is state and local tax, not to mention property taxes, and taxes on goods and services.

One’s debt-to-income ratio could be a liability if the physician owes more money than what he or she brings in. Property and the practice can also be liabilities. For example, if the physician owns an office building that is not being rented out, it can be a liability.

As a general rule, what determines if something is an asset or a liability is the resulting cash flow, explains Lopez. If the cash flow is positive, then it’s an...
asset. If the cash flow is negative, it’s a liability.

The next thing to be analyzed is cash flow. Physicians generate two kinds of income: non-passive and passive. Typically most of their income is non-passive, that is, they generate income by treating patients. But they also can generate a significant amount of passive income from owning buildings and renting them out. Both of these types of income can cause a significant number of taxable events in the form of capital gains and non-capital gains. “Cash flow can be very complicated for a physician because of the multiple streams of income that they typically have,” he says.

The last piece to be analyzed is protection, which comes in many forms. There is medical malpractice insurance, business liability insurance, and disability insurance, the latter of which the government sets limits on the amount. A partnership agreement with a buy/sell clause essentially allows the partnership to use resources to replace a physician if he/she becomes disabled or worse. Legal estate documents, such as wills and trusts, ensure in the event of a disability or death it is the family members, not the government, that are provided for.

**Recommendations**

Once all of these items are analyzed, a financial planner can provide recommendations on how to build one’s wealth. If the physician has trusted advisors, such as a certified public accountant, an insurance broker, or an attorney, they should be included in this process. If they do not, it would behoove them to work with a financial planner who has an ongoing relationship with these types of advisors, says Lopez.

Often times, physicians talk about growing their wealth by investing their money to get a better rate of return. While Lopez agrees that that is an option, it is not the only one. “Sometimes I can save more money by coming up with a better tax reduction strategy than I can by putting more money in the stock market, especially today,” he says.

Financial planners look to turn liabilities into assets. For example, if a physician owns five buildings outright and owns the deeds on five others, raising the rent by five percent should cover what the physician is spending to keep up the owned properties, he explains. That, in turn, would result in a positive cash flow.

By studying the physician’s business structure and possibly changing it, the physician could save a significant amount of money on taxes over a period of years, says Lopez. “Physicians can minimize their taxes by countering them with the expenses they have,” he says. In order to do that, they must have a top down view of what they’re worth. “To understand their wealth, they have to subtract their assets and liabilities to determine their net worth.”

Upon review, is it not uncommon that the liability insurance is determined to be inadequate, says Lopez, because it has not been updated over the years. The practice has literally grown out of its liability insurance. Beefing up the liability insurance enhances one’s protection.

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Many practices do not have partnership agreements with a buy/sell clause because they are complex and time consuming to execute, he adds. Having this type of agreement drawn up is another way to enhance one’s protection.

"The bottom line of financial planning is to become aware of your financial position in order to meet your financial goals," concludes Lopez. “There are many ways that this can be accomplished. It could involve reducing a tax liability, offering a better portfolio allocation, ensuring that the proper legal documents are in place, or making sure that your protection strategies are sound.”

**Six Phases of Life**

Recommendations for generating more wealth typically revolve around six phases of life. They are as follows: protection, education, retirement, distribution, long term care, and legal estate.

“Everyone regardless of whether they’re an employee at the local restaurant or they generate a half a million dollars worth of revenue a year, will hit these six phases during their lives,” says Lopez.

Because the government has taxable events at each one of these, it is imperative to be aware of the phases and have a financial plan to address them.
If you enjoyed a defined benefit plan in the past, I would venture a guess that your allowance of a maximum annual contribution has been stifled by recent market variances.

Still, if you are approaching retirement and are pecuniary privileged, a defined benefit plan allows you to make significantly higher contributions as compared to other types of retirement plans. As an example, the maximum annual target benefit that can be funded for the 2009 tax year is $195,000 whereas the maximum 2009 contribution to a solo 401(k) plan is closer to $49,000, depending on earnings and age.

Defined benefit plans based on a target account balance at retirement and a target retirement age, which are carefully worded by law, are prefaced on current balance, conservative economic estimates, and years until retirement.

This type of plan promises a specified monthly benefit at retirement. It does so, by paying out a “target” level of annual benefits from your account after you reach the retirement age specified in the plan.1

Typically, the benefit is calculated using a formula that considers such factors as salary and service. Sometimes the plan may indicate the benefit as an exact dollar amount per month of retirement. Specifically, the benefit may be based on a fixed percentage of your average salary or self-employment income over your entire career with your practice or over a certain number of years near the end of your working life; a flat monthly dollar amount, or; a formula based on years of service in your practice.1

Candidates for defined benefit plans are individuals who are highly compensated and have few or no employees. For example, physicians who can contribute $80,000 or more annually for at least five years and are in a solo practice employing three staff members. Because assets can be accumulated over a shorter period of time, individuals who have deferred saving for retirement can make up for lost time. Of course, the older you are and the closer to retirement, the larger the annual contribution.

On the down side, if your account balance at retirement surpasses your stated goal, penalties apply and others in the plan often take preference over you. However, if you already have a plan, you can amend it (eg, if you sell your practice, these monies could be applied to the defined benefit plan provided you retire within seven years). In addition, there are other amendments you can dictate as allowed by law. Of course, advisers charge for making changes to defined benefit plans.

Still, they are worth a consideration and you should talk to your advisor about this venue. Personally, I am biased as I don’t anticipate a market rebound for a long time, and see this as one investment option for those who wish to stay with stocks and bonds.

**Dermatologist Wanted in Iowa.**

Can a girl from Brooklyn be happy in the Midwest? You betcha!! Come see why I've made Iowa my home. Whether you're just starting out or have years of experience, Cedar Rapids Dermatology may be the place for you. Cedar Rapids Dermatology provides medical, surgical, and cosmetic dermatology services to residents living in the eastern Iowa communities. No HMO quotas or hassles. Practice dermatology the way it should be, the way you want it to be.

The Cedar Rapids-Iowa City corridor has it all. *Expansion* magazine gave the area its highest rating for the "quality of life." *Outlook* magazine ranks Cedar Rapids #2 in the nation for overall "quality of life," #1 "safest place to live," and #2 for "favorable drive times." Iowa is ranked the nation's most "livable state." Cedar Rapids has a diversified economy that has been little affected by the recent economic downturn. It is home to Quaker Oats, Rockwell Collins, and two major hospitals. This vibrant city has many unique attractions.

Iowa City, just a 30-minute commute from Cedar Rapids, is home to the University of Iowa, also known as "Home of the Hawkeyes." Iowa City offers the cultural and entertainment activities of a much larger city. As a university town, it has one of the highest educational levels in the country for its population. The children in Iowa schools score, on average, at the 75th percentile nationally on standardized tests, and Iowa City children average higher than that.

For more information, please contact Leslie Kramer, D.O., by e-mail at drleskram@ccr.net or Dawn Longwell, Office Administrator, at dawnlong@ccr.net or 319 362-3434.

**Seeking a general dermatologist to join group in Las Vegas.**

Desert Dermatology is a comprehensive dermatology practice providing medical and cosmetic dermatology as well as Mohs micrographic surgery. In addition, we have a busy, competent aesthetician onsite. We are looking for a full- or part-time dermatologist to join us. Mohs and cosmetic experience a plus. We offer a flexible schedule, either working four ten-hour days with a three-day weekend or alternating two- and four-day weekends, or five eight-hour days. There also is the option of early or late hours in this 24-hour town.

Desert Dermatology recently expanded its offices, which now include 16 examination rooms with two dedicated Mohs rooms. All rooms are equipped with state-of-the-art equipment. The office is cheerful, comfortable, and visually more than pleasant.

Regarding location, the office is well positioned near upscale Summerlin and Sun City on the west side of Las Vegas. We are just off the 215.

For more information about this dermatology opportunity, please call Carmen at 702-233-4569 or e-mail her at carmen954@aol.com. Check out our website at www.Desert-Dermatology.net.

**We are dedicated to helping patients attain a healthy and youthful appearance and self-image.**

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Your marketing plan and budget dictates the actions you will take to achieve your business objectives over a predetermined period of time.

Marketing goals and business goals are often closely connected. For the sake of this article, our business goal is to add an additional 50 patients and solidify our practice’s brand reputation within the community. Our marketing plan will include many of the core marketing principles discussed in the first article of this series entitled “How to Market Your Practice: Begin with the Basics” published in the Spring 2009 issue of DermLine. We will focus primarily on activities that will attract new patients and establish our brand. Further, it is assumed that our practice is focused on medical dermatology with minimal cosmetic procedures.

You will find a sample marketing budget, complete with notes and insight on page 27. Use it as a reference and starting point when creating your own budget.

Our budget will account for three percent of gross revenue. Four percent is the average for most businesses, so we are taking a more conservative approach. A new practice will invest much more money in marketing than an established one. Sometimes a startup business’s marketing budget can be as much as 25 percent of gross revenue. Once we know how much we have to spend, we can go about the business of developing the budget items.

An event-driven approach to developing a marketing budget may include community outreach, office presentations, special events, and related promotions. Practice expansion, hiring new associates, and acquiring new equipment can be promoted as events, as well. The benefit to an event-driven model is the ability to easily track results. Simply put, if the event is well attended, the marketing efforts were successful. If not, the marketing efforts should be improved before the next event. General expenditures, such as yellow pages and magazine advertising, do not typically fit well into an event-driven marketing plan.

Another approach features expenditures along a timeline, which is typically one fiscal year. This model is preferred when quarterly and/or monthly budgets are essential. Tracking results can be more difficult within this model, but can be done with careful data collection. A separate spreadsheet will be needed to quantify events and special promotions for which marketing expenditures spans multiple months. Marketing initiatives such as television and radio campaigns, yellow page listings, and billboard advertising are just a few initiatives that can span multiple months.

A hybrid budget is often the best choice for most small- to mid-sized companies including medical practices. This approach categorizes expenditures based on events and includes unrelated and yearly expenditures under separate line items. Tracking event-related expenditures is easy and seeing other expenditures is straightforward. Extrapolating monthly or quarterly budgets will require additional spreadsheets, additional layers of complication, and time commitments.

Our fictitious dermatology practice will be located in sunny central Florida and include the following elements in the marketing budget:

- Yellow pages advertising (yearly contract)
- E-mail newsletter
- “Importance of Early Melanoma Detection” in-office seminars
- Free melanoma screening at local July 4th Festival in the Park
- Free melanoma screening at American Cancer Society Relay for Life
- Free melanoma screening at city-sponsored 5k run
- Free melanoma screening at city-sponsored triathlon
- Free Melanoma Screening at National Surf Contest
- Free melanoma screening at Spring Training Opening Day
- Search Engine Optimization Consulting for existing website
- Google Adwords

We will support each melanoma screening and seminar with print and radio advertising. Additionally, our practice will receive advertising from all of the event presenters as they promote the screening as part of their respective events. Our logo will be displayed on event websites, print advertising, television ads, and t-shirts. Plus, we will have display space at the event and each participant will receive promotional literature from our practice. This strategic branding keeps our practice fresh in the minds of participants and certainly will influence them to choose our dermatology practice should a melanoma be discovered during a free screening.

Couple our in-person appearances and sponsorships with targeted yellow page ads, and a revamped website that is designed to capture natural search traffic and we will easily achieve our goal to attract 50 new patients. Moreover, our practice will solidify its branding and improve name recognition within the community, not to mention build significant good will.

In the next issue of DermLine, we will look at website designs that drive results.

Roger Watson is a marketing and e-commerce consultant and owner of Creative Innovations. He has worked with the AOCDS 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.
General Notes: We’ve front loaded expenses in the First Quarter because many of these items will be used throughout the year. Bulk printing business cards and brochures result in cost savings. We’ll be using these at appearances and screenings all year. Search engine optimization is extremely important and since it takes weeks or months to see good results, we have to do it as soon as possible.

Contact your local phone book publishers to get the deadlines for payment and copy.

Mass e-mail should never be sent from an office computer. Always use reputable mass email companies. Last year we hired a professional design firm to handle the design and layout of the template.

Our office works with one of our skin care vendors to create a presentation about a skin care regimen. At these sessions we educate patients and the general public on the key to maintaining youthful skin. At the end of the presentation products are available for purchase but this is not a sales presentation.

If your budget is very small you can substitute your time for money. Offer free skin or melanoma screenings at as many events and to as many groups as you can. Stay tuned-in to local radio as that’s where most events are advertised.

Disclaimer: This sample budget can be used to help you get started. The numbers have a root in reality but should not be considered “real world.” Every budget is different and your expenses may vary widely from those used here. Always consult an experienced marketing professional before committing budget resources to projects or items for which you have little experience. Like most business endeavors, the devil can be in the details.
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