American Osteopathic College of Dermatology

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Upcoming Events

AOCD ANNUAL MEETING 2010
October 24-27, 2010
San Francisco, CA

AOCD MIDYEAR MEETING 2011
March 16-19, 2011
Marco Island, FL

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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Hello Again My Colleagues,

I'm at the halfway point in my presidency and can tell you, as in life, we just don't know what's coming around the corner. It was a pleasure seeing many of you at our Midyear Meeting in breathtaking Sedona, Arizona. I would like to extend congratulations on behalf of myself and the College to our Second Vice President James Towry, who with the help of our executive staff and a little from the Board of Trustees, put on an outstanding meeting well worth the time and investment of the attendees. Overall, the meeting was successful and informative, however, as president it is my responsibility not only to recognize our College's accomplishments, but also to identify and address opportunities for improvement. In this letter I would ask, and encourage, all of us to step outside our comfort zone, as we recognize a critical problem. I realize what I am about to discuss may be unpleasant to some, but I feel it will ultimately benefit all of us, so we can grow as a College.

I would first like to acknowledge those members of our College who through their dedication and persistence, acted as pillars shouldering and supporting the College through its sometimes tremulous evolution and expansion. Our College is again at a crossroads, with 20-plus residency programs and the promise of graduating more than 30 board-certified dermatologists per year; the College has grown and so has its needs. Since it is no longer small, it is the responsibility of the entire membership to embrace the legacy of our founders. The time is now to volunteer as chairs and members of our committees to foster new ideas, infuse new insights, and provide new perspectives. The College can only be as strong as our membership’s support.

An important part of that growth relies heavily on the strength of our residency programs and their directors. To our College’s credit, we have many outstanding program directors who invest countless hours, energy, and effort in nurturing their residents. Being a program director requires a tremendous commitment and responsibility. Resident presentations, in part, represent the culmination of their dedication to the advancement of dermatology. As such, they reflect on the residents, their directors, their programs, and ultimately our College. If, and when, the quality of resident presentations is lacking, is it not our responsibility to ask why? Is it the quality of our residents? Is it a lack of guidance and instruction? Is it a lack of material or appropriate topic selection?

A primary focus of the College and its Board of Trustees is to ensure that our outstanding residents become the future leaders of our College and of dermatology. Should we not be asking the following questions?

- Are we as a College giving the necessary support to our program directors?
- Are the residents provided the opportunity to review their annual mock performance reports?
- Can the College and the residency directors take more of an initiative in suggesting and cultivating presentation topics?
- Are the residents receiving enough support as they prepare their presentations and papers?

An added benefit of our membership being more involved in the College is the assurance that the ACOD maintains its high level of commitment and excellence. In achieving this goal, I believe, as other members do, that our College will achieve parity with our MD counterparts, including in the eyes of the general public.

Another way to accomplish this is by becoming more involved in various allopathic academic meetings. Those members who are gifted in writing papers or lecturing are encouraged to participate at the AAD national level. Consider presenting a lecture or heading a focus session, leading a discussion group or symposia at an upcoming academic meeting, or authoring a paper for publication in a peer-reviewed allopathic journal. I am the first to admit that the first several lectures or papers are difficult, but the more you do, the easier they become. Taking advantage of these opportunities will not only elevate the status of our College, but also serve as an example to our residents. Being committed to achieving this goal is the missing piece of the puzzle, which will solidify the high academic standards of the ACOD while fulfilling without question our Osteopathic fellow status in the AAD.

Sincerely and fraternally yours,

Marc Epstein, D.O., AOCD
President, 2009-2010
Executive Director’s Report
by Becky Mansfield, Executive Director

Midyear Meeting
Although I was unable to attend for medical reasons, Rick reported that our Midyear Meeting in Sedona, Ariz., was great. The weather was wonderful and the scenery was beautiful. Everyone seemed to enjoy the location. Dr. Jim Towry conducted an outstanding lecture program and there were 123 registrants and 23 exhibitors.

Dr. Karen Neubauer is working on the program for the 2011 Midyear Meeting, which will be held at the Marriott Hotel on Marco Island, Fla., March 16-19, 2011.

Annual Meeting
Dr. Leslie Kramer is working diligently on providing an excellent lecture program for our Annual Meeting in San Francisco, Calif., on October 24-27, 2010. She also is planning an opening reception at the San Francisco Museum of Modern Art. The museum exists to collect, preserve, present, and interpret the best of contemporary and modern art for the purpose of enriching people’s lives through aesthetic and learning experiences. It should be an enlightening evening.

Nominating Committee
The Nominating Committee presented a proposed slate of officers for the ensuing year to the Board of Trustees for review. The slate will be mailed to all eligible voting members in late July.

The AOCĐ staff welcomes your comments and suggestions that will improve our organization.

Mrs. Mansfield is on medical leave.
Marsha Wise is acting executive director.

JAOCD Seeks Peer Reviewers

If you like to read about dermatology and enjoy critiquing others’ writing, why not become a peer reviewer for the *Journal of the American Osteopathic College of Dermatology (JAOCD)*?

Although the journal currently has 35 individuals serving as reviewers, the growth of the residency programs has resulted in an increase in the number of submissions to the *JAOCD*, notes Co-Editor Andrew Racette, D.O.

The journal receives 20 articles, on average, a month, he says. More than half of the authors submitting manuscripts are residents. Approximately one-third are medical students trying to build their CVs.

If you are a board-certified dermatologist and would like to be a peer reviewer, e-mail the editors at JAOCD@aol.com. Typically, reviewers are asked to review one paper every three to four months and report back to the editors. The reviews are performed on-line through Editorial Manager™, the web-based submission program that the journal has recently adopted.

“It doesn’t take a lot of time, but it makes a big difference in keeping the process running smoothly,” adds Dr. Racette.

Being a peer-reviewed journal adds credibility to the *JAOCD* and increases its chances of becoming listed on Pubmed. The latter will be a big step not only for the authors, but for the *JAOCD*, which is close to being able to publish quarterly, explains Dr. Racette.

“Without more peer reviewers we will have a difficult time meeting our goals for the journal.”
Deadline for Fellow of Distinction Application Approaching

The deadline for submitting an application for the honorary title of Fellow of Distinction is July 1.

Note that new criteria to apply for the honorary title went into effect this year. A candidate must now:

- Be a member of 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.

The honorary title is conferred on members who have made outstanding contributions through teaching, authorship, research, or professional leadership to the College.

Submitting the application by July 1 allows the Fellow Committee members enough time to thoroughly review the applicant’s qualifications and contributions in time for his or her induction at the 2010 AOCD Annual Meeting to be held Oct. 24-27 in San Francisco.

To obtain an application, either download one from the AOCD Web site (www.aocd.org/members/fellows.html) or contact the national office.

Residents Can Do Rotation with Dr. 90210

Will Kirby, D.O., has been appointed a clinical assistant professor in the Department of Internal Medicine, Division of Dermatology, at Nova Southeastern University by the Health Professions Division at the College of Osteopathic Medicine.

That means second- and third-year dermatology residents from any osteopathic dermatology training program may do a rotation in Dr. Kirby’s office. All they require is a valid California medical license. Third- and fourth-year medical students are welcome to do a dermatology rotation as well, but they will have to coordinate those through their respective medical schools.

For more information or to schedule a rotation, residents may e-mail Dr. Kirby, who is a featured physician on the cable television show Dr. 90210, at kirbydermatology@gmail.com.

If you’re not looking for a rotation or you never saw Dr. 90210, you can still catch Dr. Kirby on an upcoming episode of Showtime’s new series The Real L. Word. On the episode, which is expected to air in June, Dr. Kirby performs a laser tattoo removal procedure.

Dr. Way Honored for Years of Service for Texas Osteopaths

Bill V. Way, D.O., was recently honored by his peers for 24 years of service in the House of Delegates of the Texas Osteopathic Medical Association (TOMA).

He was presented with an honorary certificate on May 1 during the 65th annual meeting of the TOMA House of Delegates held in Austin.

During his 24 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 approximately 3,000 members, including 585 osteopathic medical students at the Texas College of Osteopathic Medicine in Fort Worth.
Dispensing: It’s Easier Than You Think
by Elliott Milstein and Matt Leavitt, D.O., FAOCDDD

Doctors have dispensed medicine directly to their patients for as long as they have practiced medicine. Dermatologists are no exception. In fact, they have been among the most prolific dispensers, due to their large, specialized armamentarium.

During the past 50 years, dispensing has waxed and waned depending on the economic and regulatory climate. Dermatological dispensing reached its height in the late 1990s and early 2000s as the perfect storm of new anti-aging agents, regulatory laxity, and economic need came together. With the advent of minimally invasive procedures, however, such as fillers and neurotoxins, dispensing has been on the decline.

Many dermatologists have come to believe that procedures can address all of the aesthetic needs and desires of their patients and should provide all of the potential additional income for their offices. Consequently, dermatologists have reduced or eliminated dispensing from their practices.

We believe this approach is mistaken. In our experience—from both sides of the process—many aesthetic products not only are important adjuncts to procedures, but they actually offer benefits that procedures do not.

We are aware that many dermatologists have found dispensing—especially in comparison with procedures—too complicated and labor-intensive to provide adequate income for the troubles involved. Unfortunate experiences may have driven them to this conclusion, but we have found that a few simple rules and practices can significantly reduce the complexity and time associated with dispensing.

**Biggest Problem**
The primary reason that dermatologists stop dispensing is inventory control. Typically dermatologists find that they are either constantly running out of product or have too much cash tied up in slow moving inventory. At worst, dermatologists find themselves with thousands of dollars’ worth of products that simply do not sell. The main reason the latter occurs is that the dermatologist has delegated product choice to the staff, either by design or by default. The reasoning is that “the staff will sell products they like.”

However, this reasoning is flawed in three ways. First, the staff has no financial incentive to control inventory. When you purchase inventory, the money does not come out of their pocket; so their choices are not financially relevant. Second, most staff buy or show a preference for a product not because they like the product, but because they like the company representative. Selling the product is therefore not a matter of preference but a favor to a rep, which is not nearly as strong a motivator. Third, staff turnover can leave you with a pile of product that no one in the office is interested in selling any more. Thus, the first rule of dispensing is to pick products that you believe in. Products that you know are effective and will be of benefit to your patients. Then, train and motivate the staff to sell those.

**Worth the Time**
The second reason for the decline in dispensing is the time it takes to manage inventory. That is why you should appoint or hire (depending on the level of dispensing that is occurring) a patient care coordinator who is solely responsible for inventory control. Then provide the coordinator with the tools to manage inventory. This can be a simple sheet that tracks inventory and allows the coordinator to determine how many units of each product is sold, on average, every month. Follow the simple rule of ordering one month’s supply, each month, when inventory is down approximately to one month’s worth. For instance, if you sell 24 units of Tensage ampoules each month, when the inventory dips to 24 units, order 24 more. They should arrive when approximately 12 units remain. That way, inventory will fluctuate between 12 and 36 units.

At first, an inventory of all products should be taken once a week, and then less often until it is taken once a month. Doing this will help control inventory and also has the added benefit of controlling shrinkage.

If this sounds like a lot of work, it isn’t, especially if you start with a few products and grow the inventory slowly. A common error that dermatologists make is starting out with too many products. When just starting out, order only three to six products at a time. Add one or two stock keeping units, known as SKUs, every quarter.

Resist the temptation to take on a lot of products at once. Sales reps are very convincing people; it’s their job to be. Create rules regarding inventory levels and live by them. Not breaking those rules is necessary for good inventory control and time management.

**Boosting Sales**
Finally, there is the usual complaint of lackluster sales. Many dermatologists get turned off dispensing when the products they thought were wonderful and “were going to sell like hot-cakes” just don’t move.

Look to yourself for the answer. What are you doing to sell these products? Remember, you picked products that you believe in, not your staff. If you believe in them, you should be selling them with the same conviction that you write a prescription. This will go a long way to solve the problem because as
you sell the products, your staff will gain more confidence in them and sell them, as well. If further incentive is needed, consider offering commissions, spiffs, and contests, either as regular compensation or occasional events. Sometimes vendors will contribute to such activities.

Regular training meetings with your staff can be both informational and motivational, and thus increase inventory turnover. The more your staff knows about the products, the more they will sell them. Meetings can be made fun as well as informative, covering selling techniques complete with the kind of role-playing professional pharmaceutical reps do. Staff can learn how to initiate a conversation on skin care that can lead to a sale...and a happy, satisfied patient. Of course, it’s imperative that the staff uses the products themselves. And by staff, don’t forget the front office employees; they are often more responsible for sales than your back office staff. Again, vendors can be counted on to assist in all these areas.

Demand can be created among your patients and in the community with open houses, mailings, in-office posters, brochures, samples, testers, specials, Product of the Month discounts, and patient reward points for purchases and referrals. And, yes, vendors will chip in on these activities, as well.

By applying these few simple rules and techniques, even the most modest aesthetic dermatologist can provide a significant benefit to patients with quality products as well as increase office revenue and patient loyalty.

Elliott Milstein is President of Biopelle, Inc. Matt Leavitt, D.O., FAOCD, is President of Advanced Dermatology & Cosmetic Surgery. Many of these points and others, along with forms and procedures, can be found in Biopelle’s manual entitled Dynamics of the Dispensing Office: A Training Manual for Monitoring, Motivating & Multiplying your Office Sales & Staff. A copy of this manual can be obtained by contacting Biopelle, Inc. at 1-866-424-6735.

New Resident Leadership Award Named for Dr. Bernard

The new James Bernard, D.O., FAOCD, Youth Leadership Award is a grant intended to encourage and enable recipients to organize and foster the ideals of the AOCD.

“Naming our new AOCD Award, The James Bernard, D.O., FAOCD, Youth Leadership Award, is a highly appropriate and fitting way to honor Dr. Bernard who has profoundly influenced and mentored many of us as dermatology residents and young members trying to follow in his deep footsteps toward becoming leaders in osteopathic dermatology,” says Michael J. Scott, D.O., Chair of the AOCD Awards Committee.

The grant, which is sponsored by and funded through the College, offers third-year residents an honorarium and future position on an AOCD committee. Among those committees with availability are the following: Ethics, Awards, Internet, In-Training Examination, Journal, and Editorial/Public Relations.

The award will be distributed as follows: $250 when the official notification is made and $750 upon accepting the AOCD committee’s invitation to serve. Each grant supports one resident.

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

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

“The selected criteria for award nomination includes integrity, respect, empowerment, and initiative, all of which reflect on the dynamic characteristics Dr. Bernard has exemplified in numerous leadership roles such as committee member, secretary-treasurer, advisor, and past-president of our College,” says Dr. Scott. “His long-time continuous participation in various activities of our College, always sharing his warm personality, diplomacy, humor, and inclusion is a remarkable achievement to emulate.”

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

Applications must be received by July 1 to be eligible for consideration. They will be reviewed by the Awards Committee, which will forward its recommendations to the AOCD office. Applicants will be notified by certified letter. The grant will begin during the Annual Meeting of any given year and end during the Annual Meeting of the subsequent year. All correspondence concerning the program and/or awarded grants should be directed to the Awards Committee.

Winners of the award will be announced at the AOCD Annual Meeting.

In response to this recognition, Dr. Bernard exclaims, “I feel very humble and appreciative of this award; and, as the Roman generals were admonished centuries ago, aware of the fact that all glory is fleeting!”
Bordered by the Muir Woods, the Bay and the Pacific Ocean, San Francisco with its steep hills and sophisticated architecture offers an exciting combination of natural and manmade attractions to peak everyone’s interest while attending the 2010 AOC&D Annual Convention.

Because the city is relatively small, seeing many of its sites is possible whether you choose to walk them or take advantage of public transportation.

Just around the corner from the Mascone Center, where the convention is being held, is the San Francisco Museum of Modern Art. You’ll have an opportunity to glimpse it during the AOC&D’s Welcome Reception on Sunday evening. The museum is celebrating its 75th anniversary this year. Among the exhibits you can take in are Exposed: Voyeurism, Surveillance, and the Camera, which explores voyeurism in nineteenth century photography and its relationship to street photography in the twentieth century; the first retrospective exhibition in this country of Henri Cartier-Bresson in 30 years; and Mika Rottenberg’s immersive video installations addressing issues of gender and labor through outrageous narratives centered around real women and their bodies.

Above the Moscone Center is the Yerba Buena Center for the Arts, which features art galleries, a movie theater, and a theater for live performances. Also there is the Yerba Buena Gardens, a beautifully landscaped garden with striking fountains. A section dedicated to Martin Luther King Jr., invites strollers to walk behind a waterfall as they contemplate quotations from both him and other assassinated leaders of the Civil Rights movement. Concurrent with exhibits are informative lectures and seminars, poetry workshops, and resident artist programs.

The Yerba Buena Ice Skating & Bowling Center features a year-round ice skating rink. The all-new facility offers recreational skating, including skate rentals, day and night as well as bowling in a facility with a glass wall that faces the downtown skyscrapers. Across the street, you can see the back end of the Metreon, Sony’s four-story, sixteen-screen entertainment megalith.

**Fisherman’s Wharf**

A trip to Fisherman’s Wharf on the Embarcadero is a must. The wharf—also known as Pier 39—consists of a long, coast side row of 110 specialty shops and 12 full-service restaurants serving seafood, California cuisine, and casual fare complete with beautiful bay views. Originally a major fishing pier, today the wharf remains one of San Francisco’s most popular tourist destinations.

One of the largest attractions is the Aquarium of the Bay, open daily. It offers visitors the opportunity to get up close and personal with sharks, sting rays, octopuses, jelly fish, and 20,000 aquatic animals, as well as some land-dwelling critters. Recent additions include the Giant Pacific Octopus exhibit, the Jellies exhibit showcasing graceful moon jellies and brown sea nettles, and the PG&E Bay Lab exhibits complete with blue-tongued skinks, pink-toed tarantulas, chinchillas, California King Snakes, and hedgehogs. Daily special events include animal feedings, naturalist presentations, and behind-the-scenes tours.

To view more sea creatures, check out the sea lions camped out in Pier 39’s west marina. These boisterous barking Sea Lebrities started taking over the docks in 1990. At first they numbered from 10 to 50, but due to a plentiful herring supply, available dock space, and the marina’s protected environment, the population grew to more than 300. Each winter, the population can increase up to 900 sea lions. During the summer months, the sea lions migrate south to the Channel Islands for breeding season, but in recent years a small group stays year-round on K-Dock. Staff from the Marine Mammal Center’s kiosk, located next to the sea lions, is happy to inform visitors about these fun, flippered animals. Each weekend, weather permitting, the Center provides volunteer docents at K-Dock who explain sea lion behaviors and answer visitors’ questions. More information and interactive exhibits are available on Level 2 of the pier.
at the Marine Mammal Center’s Interpretive Center and Gift Store.

While strolling the wharf, you will undoubtedly pass a street performer. These world-famous multi-talented tricksters, magicians, jugglers, comedians, and mimes cruise Pier 39 and entertain visitors for free daily at the Crystal Geyser Alpine Spring Water Center Stage. On your leisurely walk, be sure to see the San Francisco Carousel. This one-of-a-kind, hand-painted carousel, handcrafted in Italy, depicts famous city landmarks, including the Golden Gate Bridge, Coit Tower, Chinatown, Lombard Street, Alcatraz, and the famous sea lions.

Peer Beyond the Wharf
The wharf can serve as your starting point for more sight-seeing as the Pier 39 marina offers a variety of ways to experience the bay, including sailboat and powerboat rides. One-hour cruises take passengers on a scenic tour of the bay, a 90-minute journey under the Golden Gate Bridge around Alcatraz Island, or to Angel Island, the paradise across the bay.

World-Renowned Experts to Present at AOCD Annual Meeting

Get ready for some expert advice being delivered at this year’s AOCD Annual Meeting to be held Oct. 24-27 in San Francisco.

World-renowned dermatoscopic expert, Ashfaq Marghoob, M.D., will kick off the convention by conducting a dermatoscopy workshop on Monday morning as part of a multi-faceted surgical symposium. Dr. Marghoob is the Director of the outpatient Memorial Sloan-Kettering Skin Cancer Center in Hauppauge, New York.

The AOCD’s own Edward Yob, D.O., will serve as moderator for the surgical symposium.

One of the leaders in psoriasis, John Koo, M.D., is slated to discuss new research and treatments. Dr. Koo is a Professor of Clinical Dermatology at the University of California, San Francisco.

Nationally and internationally recognized authority on skin cancer surgery, Anthony Dixon, M.B., B.S., Ph.D., is scheduled to speak. Dr. Dixon is Assistant Professor (School of Medicine) at Bond University in Gold Coast, Australia, and Fellow of the Australasian College of Skin Cancer Medicine. In addition to running comprehensive training programs and education workshops to assist doctors in their skills managing skin cancer in Australia and overseas, Dr. Dixon is involved in cutting edge research in skin cancer management.

Ted Rosen, M.D., Chief of the VA Dermatology Clinic and Professor, Department of Dermatology at Baylor College of Medicine in Houston, will be presenting. “No matter the topic, Dr. Rosen is always entertaining and informative,” notes Program Chair Leslie Kramer, D.O.

“These are just a few in an exciting and educational line-up of lecturers to be presenting at our AOCD Annual Meeting this year,” she adds. “I hope this encourages you to register and join us for a great meeting, and great food, in beautiful San Francisco.”

Catch a glimpse of the city’s beauty at the San Francisco Museum of Modern Art for the Welcome Reception on Sunday evening. Meet up with your AOCD colleagues while perusing the many exhibits at the museum, which is celebrating its 75th anniversary this year.
Dr. Adams Gains New Perspective ‘Down Under’

One year after winning the silent auction held at the 2008 AOCD Annual Convention, Ben Adams, D.O., made the 14-hour trip to Australia.

There, he observed 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, in his clinic for a few days.

“The Dixon is very efficient with his surgery,” notes Dr. Adams. “It was fun to watch somebody who has that much experience.”

He also attended an advanced skin cancer surgery course that Dr. Dixon teaches twice a year. As part of the course, attendees viewed videotaped surgeries performed by Dr. Dixon in his office. “We watched them and then we went through them step-by-step. Then we practiced the procedures,” explains Dr. Adams. “It was a great way to learn some more surgical techniques.” As an example, he saw a nasalis muscle-based flap on the dorsal of the nose being performed for the first time.

“I really liked the course because I was able to spend time meeting with general practitioners from all over Australia, and getting their impression of treating skin cancer,” says Dr. Adams.
Different Roles
He found it interesting that the course was attended by general practitioners. Dr. Dixon was training general practitioners to be skin cancer surgeons and teaching them dermoscopy, which only dermatologists use in the United States, notes Dr. Adams.

“Down there, family practitioners and even physician assistants use dermoscopy to look at skin lesions,” he says. “The general practitioners are doing dermatologic surgery.” The dermatologists there deal more with rashes and blistering diseases and not so much with skin cancer, Dr. Adams observed.

Another difference is that Mohs micrographic surgery is not performed often there, largely because it is a government healthcare system, which has decided that Mohs is cost prohibitive, he says.

“They’re doing regular excisions, which are larger, and doing a lot more flaps and graphs.” When they do perform Mohs, it’s slow Mohs, taking a few days for a return read on a specimen.

Different Perspective
Dr. Adams was surprised by the high incidence of melanoma in Australia. “I was with Dr. Dixon for a couple of days and saw two to three good size melanomas. I saw patients in their early twenties with skin cancer,” he says. “That was shocking.”

The follow-up with skin cancer patients performed in Australia seemed much less compared with what is done in the states, notes Dr. Adams. For example, they don’t do sentinel node biopsies, laboratory work, or chest x-rays. They just assess the patient each visit, he says.

These differences made Dr. Adams wonder whether dermatologists here overdo Mohs surgery and follow-up with melanoma patients or whether they are just a byproduct of the American medical legal system that requires such decisive surgery and thorough follow-up. “Down there, they do these flaps and still seem to have great outcomes,” he adds.

“It made me think twice about some things I do as far as Mohs surgery. I might be more inclined to do wide excisions instead of Mohs on certain areas on the body,” notes Dr. Adams. “I think more about how I utilize medical care, with an eye toward being more cautious and cost friendly.”

Different Scenery
While there, Dr. Adams did get a chance to do some sightseeing with his father, who accompanied him on the trip. They drove along the Great Ocean Road where they saw the Shipwreck Coast and the Twelve Apostles, which are giant rock stacks that rise from the Southern Ocean. They also toured a rainforest, which had a system of bridges that enabled tourists to walk along the tree tops.

In addition, they spent a couple of weeks in New Zealand. “We did a lot of fly fishing, too.”

Looking back on the experience, Dr. Adams says, “I hope the AOCD continues to do this with Anthony. It is a great opportunity for our members to go down there and get a different perspective on treating skin cancer, and it’s a wonderful thing for our residents to get that exposure during residency.”

Dr. Miner Welcomes Baby Boy
Brandon Miner, D.O., Chief Resident in the Department of Dermatology at the Oakwood Southshore Medical Center, and his wife, Amy, welcomed their first son on February 12th.

Elam weighed 8 pounds, 4 ounces.

He has three older sisters. They are six-year-old Keziah, four-year-old Adelaide, and two-year-old Emeline.

Members Join Advisory Board of Magazine
Alpesh Desai, D.O., Tejas Desai, D.O., and Will Kirby, D.O., were recently appointed to the Editorial Advisory Board of ADVANCE for Healthy Aging magazine.

As members of the advisory board, Drs. Desai, Desai, and Kirby will assist editorial staff in planning issues, advising them on medical aesthetic trends, and occasionally contributing articles.

“We are excited about this opportunity and believe we are the first osteopathic dermatologists who have been granted this prestigious appointment,” notes Dr. Alpesh Desai.

The magazine publishes review articles summarizing published literature and practical thought on clinical issues of interest to physicians in medical aesthetics and age management medicine. Articles also discuss new and innovative approaches and treatments in medical aesthetics and age management medicine, as well as innovative management and marketing philosophies. Its mission is to provide credible, unbiased information so physicians can help their patients look good and feel good as they age.
Hello Everyone,

The spring and summer months are busy here in the AOCD office. The Midyear Meeting in Sedona was great. Thank you to Dr. Towry for putting together an outstanding program.

Thank you to our Arizona residents for making us all feel at home in Sedona and to Dr. Michelle Jeffries for providing attendees with a visitor’s guide to the area.

Annual Reports Due Soon
It will soon be time for annual reports to be turned in! All forms can be downloaded from our Web site at www.aocd.org/qualify/annual_reports.html.

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

One original copy with a signature page attached should be sent. The signature page must be signed by the resident, program director, and D.M.E. and is an affirmation of complete and accurate reports. Once the reports are received by the AOCD, we will upload them to FileWorks, which is our new on-line storage system. The Education Evaluating Committee (EEC) members will then be able to view each report as they are uploaded at their convenience. This new system will allow committee members more time to review each report before the fall EEC meeting. Incomplete reports will not be uploaded. Also, please do not fax your reports.

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

The late fee schedule is as follows:

- $100 for all reports submitted 30 to 365 days after the submission deadline
- $250 for all reports submitted 365 to 730 days after the submission deadline
- $500 for all reports submitted 730 days after the submission deadline

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

Resident Lecture Requirements
Intent-to-Lecture applications for the 2010 Annual Meeting are now being accepted. We have a limited number of spots so get your application in as soon as possible. I will send an e-mail once I find out the dates and times of the resident lectures. The faculty disclosure statements and Intent-to-Lecture forms can be downloaded from the AOCD Web site at www.aocd.org/qualify/annual_reports.html. For individuals interested, a handout on PowerPoint tips is available. E-mail me to request the tips.

Upon recommendation of the Awards Committee, the following will 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- and 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. The residency program director will review all oral presentations and manuscripts for publication prior to resident submission. In addition, the residency program director will 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.

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 is notified by the resident of intent to lecture 6 months prior to the first day of the meeting or the resident will not be placed on the schedule

Required signed documents must be in the AOCD office 8 weeks prior to the first day of the meeting. These documents include:

- Disclosure Statement
- Copyright/Consent
- Program Director’s Statement
- Copy of completed PowerPoint presentation
Residents Surpass 100 Mark

As of July 2010, 106 residents will be accepted into AOCD residency programs across the country.

Within the past five years, the residency programs have shown steady growth. In 2005, there were 80 residents. One year later, there were 87 residents. In 2007, 90 residents were on board. One year later, 97 residents signed up. Last July, the College reached a milestone 100 residents.

The number of residency programs also is on the rise. As of this July, there will be a total of 23 residency programs. Three of those programs are new in 2010.

If the resident’s PowerPoint materials, as defined by AOCD, are not received by the deadline date announced, the resident will be unable to present at the meeting and will not be eligible for the Koprince Award evaluation.

Receipt of these items two months prior to the meeting will allow ample time for evaluation, review, and approval by CME accredited bodies.

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 accepted. Lectures are accepted on a first come, first serve basis. Any “TBA” will be placed on a 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 following meeting (either Midyear or the next Annual) and will be given priority in scheduling for that meeting.

Required Resident Documents

With six new residents joining residency programs this July, the required documentation bears repeating.

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 www.aocd.org, please let me know.

Be sure to check out the Dermatology Grand Rounds on our Web site at www.aocd-grandrounds.org. Each residency program has been asked to submit a case.

Residents Must Pen Paper for Preceptorship ‘Down Under’

Residents interested in experiencing a dermatologic surgery preceptorship in Australia might want to choose a topic and begin writing.

That’s because resident selection for the preceptorship, which is being offered by 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, is based on a surgical paper competition. The paper will be judged on the basis of its surgical application in dermatologic surgery, with an emphasis on cutaneous cancer. The paper should be based on principles of surgical treatments for skin cancer, emphasizing literature review and/or new techniques. Original research is strongly encouraged. Deadline for submission is October 1, 2010.

The AOCD’s Education Evaluation Committee along with Dr. Dixon will select the winning author. Submissions should be sent to the AOCD office. The winner will receive approximately $1,500 toward the cost of the trip to Australia, with additional funding to be determined on proceeds generated by a silent auction, which will be held at the upcoming AOCD Annual Meeting. While this amount will not cover the cost of the entire trip, it will pay a substantial portion of it. The approximate airfare is $1,200.

The preceptorship is being extended to one attending physician (AOBD board eligible or board certified), as well. However, the attending physician’s selection will be based on the silent auction principal. The starting bid is $1,000 and the preceptorship will be awarded to the highest bidder.

Attending physicians will be responsible for their own expenses.

Winners can essentially schedule their preceptorship for any time during the year, pending any conflicts with Dr. Dixon’s schedule. The attending physician and resident are not required to travel simultaneously to Australia. Additional details will be addressed upon announcement of the winners and preparation for the trip.

For more information, contact Lloyd J. Cleaver, D.O., at lcleaver@atsu.edu.
Giving a presentation can be a daunting task for many residents, and even board-certified dermatologists for that matter. But it can also be a very rewarding one.

To make presentations more the latter than the former, I have written up the following suggestions. If they sound familiar, it’s because they are based on the “PowerPointers” presentation that Dr. Del Rosso gave at the Midyear Meeting in Sedona. Because many residents are now beginning to work on their presentations to be given at the Annual Meeting, these suggestions bear repeating. Even board-certified dermatologists working on their own presentations will find them of value.

**Share Your Passion**

Perhaps the most important part of giving a presentation is selecting a topic. It is difficult, if not impossible, to pull off an interesting presentation if you are not fully engaged in the topic. If the topic is assigned, it is important to find some aspect of it that ignites your passion. Immerse yourself, and create the passion, if necessary.

Start the presentation by telling the audience why you have chosen the topic, and what you hope to accomplish at the end of the talk. Ask yourself, “Does my topic answer a question or solve a problem that dermatologists routinely encounter?” A presentation is a reflection of you and your work. You want to make the best possible impression in a short amount of time. If you love the topic, you can captivate and lead your listeners through your story much more easily.

**Affect Through Visual Effects**

When designing the formation of your actual slides, remember to KISS, or keep it simple stupid. Use a plain background, as PowerPoint template backgrounds and themes are better suited for business presentations. Yellow font on a dark blue background has been shown to be the most visually appealing. Busy, graphic slide backgrounds can be distracting and are unnecessary. Remember to keep the focus on the important information you want to share.

Also remember that color combinations for font and graphics may look different when projected. Avoid red/green combinations since color-blind people may not be able to distinguish the colors. Use the color red to add emphasis, but be careful of overuse as the eye will go there first.

Use graphic to break up multiple text slides. The audience will be more captivated with differing visual aides including images, graphs, and charts. Avoid the overuse of busy, complicated tables or graphs that the listeners cannot interpret from their seat in the audience. Subtle, occasional slide transitions and animations can add dimension, but remember that you are not directing Star Wars or Avatar...leave that to Spielberg, Lucas and Cameron. Design slides for your audience in a lecture hall, not an individual at a computer screen; your audience is there to hear you and your topic, not be wowed by graphics. If possible, test your presentation on the projector to verify that all the components work well together visually.

**Fuss Over Fonts**

Use large, clear fonts that are easy to read and avoid abbreviations. You want the audience at the back of the room to be able to clearly read the text; a good standard font size is 32. Anything smaller than 28 will be difficult to read. Sans serif fonts look like stick letters. Because they are plain and simple, they work great on PowerPoint slides. Examples include Arial, Tahoma, and Veranda.

Serif fonts have curly tails. An example is Times New Roman. Thee are easiest to read when text is dense, which leads to my next point: avoid using a large amount of text on slides. Use the fewest number of words to make a point, which is what Dr. Del Rosso calls “a hammer.” This is as clear as it gets! Use bullets to separate ideas, and align bullets with the same left margin on each slide. Create open space and avoid crowding. Spacing between bullets should be adjusted on every slide, and should fill the text box. Filling the slide by increasing font size and spacing will only make your slides easier to read. With that in mind, be sure to leave ample margins. Empty space is essential to balance the amount of information. Keep the slides
consistent with no more than six words per line and six lines per slide. Each slide should express only one idea. Each slide should have a title in the same location. Remember that the human mind prefers visual symmetry.

**Say What You Mean**

After you have chosen the format of your slides, start building your PowerPoint by defining your objectives. Define your challenge and answer it by telling your audience the main points you want them to walk away knowing. This should be the second slide, following the title slide.

Continue with the content of the presentation, using information from multiple sources. Use superscripts with references on the same slide, as you would in a research article. Don’t include any information with which you are uncomfortable on a slide. When people get nervous, they tend to apologize. If you feel an apology is necessary, do not include the slide.

At the end of the presentation, be sure to list references using the American Medical Association format, which can easily be found on the Internet. When you are finished with the body of your talk, remember to spell check.

**Practice Makes Perfect**

In the words of my former cardiology attending, Dr. James Laws, “prior preparation prevents poor performance.” It is imperative to practice out loud before giving your presentation. Statements may seem to flow easily when reading them in your head; however, that is not often the case when reading aloud. Tongue twisters may be hard to spot if you don’t practice out loud beforehand.

It also will help eliminate the dreaded “umm” and highlight the need for verbal transitions that were not obvious when you were creating the slides. If possible, rehearse in front of someone who can give constructive criticism.

This also is a great way to practice timing; not too fast, not too slow. Talk in a loud conversational tone with voice inflections. Correct pronunciation of words is very important. If you are unsure how to correctly pronounce every word in your talk, be sure to look up the phonetics. There are multiple resources on-line including www.howjsay.com. One way to really embarrass yourself and stumble through your talk is to catch yourself mispronouncing words because you haven’t practiced.

**Everything But the Kitchen Sink**

Show up to your presentation prepared. Bring your laptop as well as a flash drive, and for good measure an additional CD with the presentation.

If possible, find out ahead of time which software is available on the equipment you will be using. Don’t prepare a presentation in Keynote on your Mac if the equipment you will be using is a PC running PowerPoint. If you do prepare on a Mac, make sure your theme uses Windows safe fonts. Also ensure software versions are compatible, as you may have to save a presentation in an earlier version of software, for example .ppt versus .pptx.

Be sure all necessary equipment is available and set up at the start of your presentation. Be prepared with a backup plan in case of equipment failure.

Consider getting to know the space that you will be using. Before the audience arrives, experiment in the final location with the lights, outlets, modem, network, and general environment. Stand at the podium and sit in different areas of the room. You will be much more comfortable than if entering the room for the first time to head directly to the podium.

**Just Give the Talk**

After much hard work and a lot of practice, the fact remains that you still have to get up in front of the audience and just give the talk. There are several strategies to make this part easier.

Before going to the podium, pump yourself up. Tell yourself that your presentation is excellent. You have practiced and know your information, and you are going to blow the audience away. A positive attitude will be apparent to your listeners.

Start by introducing yourself in a positive, upbeat manner. This is your time to sell your idea or research. Answer the question everyone is subconsciously thinking: “Why should I listen to you?”
Most importantly, know your information very well.

Open with a surprising statement that will get the audience to sit up and take notice. The most powerful introductions are often those that appeal directly to emotion—offer your listeners an awesome insight or scare the pants off them. The rest of the presentation will focus on bringing the awesome insight to life or preventing the scary observation from happening.

Do not take written notes to the podium as they may lead to confusion. Plus, the audience doesn’t want to listen to a presentation that is so unprepared it requires notes.

Your slides are a visual aid to the listeners; don’t let them distract you. Follow the 90-10 Rule: look at the audience while talking to them 90% of the time and glance at the computer screen to remind yourself of where you are 10% of the time. Make direct eye contact, and shift your gaze around the entire room, in all directions. Do not stare up at the screen, except to use your laser pointer to highlight a point. Use the slides to emphasize key points without reading them word-for-word. Tell the story by conversing with the audience.

Speak with more volume than is normally required and enunciate properly. Speak with enthusiasm, showing interest in the topic and respect for the audience’s interest. Remember that the listener’s attention is divided between you and the presentation aid. In a darkened room, more volume is required to hold attention. Engaging the audience will keep them attentive.

**Happily Ever After**

At the conclusion of your talk, be sure to summarize your key points and objectives. You started by telling the audience what you were going to tell them, in the body of the talk you told them, and in the summary you remind them of what you told them. How easy is that?

This is your final chance to make an impression on the audience and remind them that they were lucky to have the privilege of listening to your presentation.

Finish by thanking those who were helpful to you. For resident presentations, be sure to thank your program director and any student who may have been involved in your case or research.

**Q&A**

When you accept the podium, you accept the consequences. If you know your stuff and practiced, practiced, practiced, you will be prepared for questions.

Repeat questions aloud so that everyone can hear them. Rephrase the question if necessary.

Before answering, pause and think. Don’t babble; answer in ten words or less. If you cannot answer, a simple “I don’t know” will suffice. Try to find some way to follow up with the person to get an answer to him or her. Remember that some people will ask questions just to hear themselves talk, while others may act belligerent. In the latter case, handle yourself with composure, and if necessary, you may redirect the belligerent overzealous objector, or BOZO, by suggesting to “provide a more detailed response” one-on-one after the close of the talk. This will take away some of the pressure and allow you to respond coolly and professionally. The podium is no place for a screaming match.

**Be Yourself**

Through all of this advice, the simple fact is that if you are honest and true to yourself, your presentation will be a success. Always be sure you can back up what you say. If you are comfortable with your presentation skills, then you know all of the aforementioned suggestions can be modified, or even broken, to tailor your talk to your personal preferences. For example, it is perfectly fine to utilize a joke or anecdote if it helps to illustrate a point.

Throughout the building of your presentation, ask yourself “So what?” Also consider the question “Would I want to hear myself give this presentation?” If the answer is yes, the audience will undoubtedly agree.

As for “imagining everyone in their underwear”...that one hasn’t worked for me yet.

*Guyra Frambach, D.O., is the current AOCD resident liaison.*

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Khasha Touloei, a second-year medical student at the Western University of Health Sciences/College of Osteopathic Medicine of the Pacific (Western/COMP), recently raised $1,400 for the National Psoriasis Foundation (NPF).

While many people choose to raise money for the NPF through its Walk to Cure Psoriasis, Touloei took a different route. With the help of the seven members of the Dermatology Interest Group/Club at Western/COMP, of which he is president, Touloei held bake sales and hosted a poker tournament at the school. To raise seed money, he contacted the Western University Alumni Association. Touloei used its $75 donation to purchase lemonade and baked goods from local favorite Pomona Baking Co. Another donation from the alumni association was used to purchase prizes for the tournament, which cost $15 per person to enter. Twenty-five people participated in the tournament. The Western University Student Government Association, which typically provides money for students to attend conferences, donated an additional $300. Add to that the $400 that was raised the previous year when Touloei was a member and Cynthia Chen was president.

While it may have been easier for Touloei to just participate in the local NPF walk, which was held this past spring, he had a final examination the following Monday and the walk was held in Los Angeles, an hour away from him. Touloei is not concerned if next year’s walk conflicts with his schedule again because he arranged for the club to raise funds for the NPF on an annual basis.

Touloei became involved with the NPF—which offers information about this chronic, autoimmune disease and treatment options as well as support for the seven and one-half million Americans with it—last summer when he made a video for the organization while he was shadowing Bradley Glick, D.O., as part of the American Academy of Dermatology Mentorship Program. The video, which took him six months to make, has a dermatologist explaining the disease while several patients with severe cases of the disease are filmed. Finding people with psoriasis who would volunteer to be in the video took a long time, says Touloei. Patients with psoriasis are very self-conscious about showing their skin in public, and also it was very challenging to find patients who have the disease that was not being controlled with medication, he adds. The video, which can be viewed on NPF’s webpage at walk.psoriasis.org/site/PageServer?pagename=Media_Videos has received more than 1,000 views, to date.

“I made the video to show how bad psoriasis can get in an attempt to increase awareness about the disease,” says Touloei. It served as a tool to help raise the money. “A lot of people in the general public have no idea what psoriasis is. They don’t want to donate money to a disease that is not life threatening. But they don’t realize how serious of a disease it is.”

This past February, Touloei gave a speech to a lay audience at an NPF conference in Santa Monica. He was invited to speak about why he raised monies for the NPF and how he went about it, as well as also to inspire other people to fundraise.

“From my involvement with the National Psoriasis Foundation, I have come to understand the psychological impact the disease can have on people,” says Touloei, who would like to do a dermatology residency after he earns his DO degree. “I think it’s also important to focus on this aspect as a dermatologist when treating psoriasis patients.”

Whether you have raised monies for a skin-related cause or provided dermatology care here or abroad, we would like to hear from you. Contact DermLine Editor, Ruth Carol, by phone at 847-251-5620, fax at 847-251-5625, or e-mail at RuthCarol1@aol.com.
Financial Tidbits
by Dr. Schwarz, D.O., FAOCD

2010 is here and what is our tax future? We have a historic national debt and a very aggressive national agenda with legislators and a president promising to raise taxes.

What will we see? For starters, we will see an increase in federal taxes, state taxes, local taxes, and fees. Add to that tax deduction phase-outs and a potential phase-out of self employment taxes. Needless to say, your combined marginal tax rate might increase by nine percent or more. Individuals making more than $250,000 may see a possible 20% increase in taxes.

What can one do?

Traditionally avoiding partnerships and proprietorships helped avoid traditional tax traps. This year, however, these plans provide an extra opportunity to save taxes. Consider looking into the different options.

If you have an S Corporation, which more than 60% of medical practices are listed as, make sure it is not being treated like a C Corporation. Re-checking the compensation structure could save a lot in taxes under the new administration.

If you have an S Corporation, consider switching to a C Corporation as its unique tax-deductible benefits might be significant. I have heard of a few successful practices that are structured to use both an S and C corporation. This way, one can realize both tax reductions and asset protection.

Make an appointment with your accountant to discuss the aforementioned and other options that might be beneficial under the new administration.

Tax Deductible Benefits
Because most physician owners can’t afford high-cost employee benefit plans, they often use combined qualified and non-qualified plans and/or hybrid plans. There are many types of qualified retirement plans such as a 401(k), profit sharing, money purchasing, a defined benefit plan, 403(b)s, a simplified employee plan, and a simple individual retirement arrangement or IRA. However, many of these plans will be outdated thanks to the president’s proposed changes. One option might be to switch the emphasis of the benefits in a hybrid plan to your special situation.

Talk with your accountant about what benefit plans are available based on the Pension Protection Act of 2006 and discover the value of updating your plan relevant to the 2010 tax law changes.

Cole Diagnostics Offers Dermpath Rotation

Second- and third-year residents are eligible for a new grant offered by Cole Diagnostics to study dermatopathology for a two-week rotation in Boise, Idaho.

The grant covers the cost of travel and living expenses for the rotation with Ryan N. Cole, M.D., of Cole Diagnostics.

To request an application, contact Resident Coordinator Marsha Wise, who can answer any additional questions. A completed application must be returned for grant consideration.

Residents selected for the grant will be notified by mail or e-mail. They will receive additional instructions from Cole Diagnostics about scheduling the rotation.

Residents may be considered only once for this special rotation. Upon completion of the rotation, they must provide a five-minute summary to be presented at the next scheduled AOCD Annual Meeting.
Presentations at this year’s AOCD Midyear Meeting ran the gamut from cutting-edge topics such as skin eruptions post-bone marrow transplant and the concept of the medical home to the well known, but little understood, condition of alopecia.

Resident speakers kicked off the meeting held at the Hilton Hotel Resort and Spa in Sedona, Ariz., April 14-17, on Wednesday morning followed by guest lecturers presenting the following day.

The following offers a glimpse of the presentations.

**Photodynamic Therapy**

Tejas Desai, D.O., of Heights Dermatology in Houston, started his presentation on photodynamic therapy (PDT) by defining this therapy as involving activation of a photosensitizing agent by illumination of a light source in the visible spectrum.

The light source must meet three requirements in order to be effective, he explained. It must reach the desired depth of tissue penetration. The BLU-U light source, which Dr. Desai uses in his office, penetrates up to 2 millimeters, which is the thickness of the epidermis. “You don’t want to go deeper because it will cause scarring,” he cautioned. The light source must have enough power to produce a photodynamic response, which the BLU-U does. The light source wavelength must correspond to the wavelength that is absorbed by the photosensitizer. The BLU-U output is matched to the highest absorption peak for porphyrins. “If they don’t match up, they don’t react,” said Dr. Desai.

The BLU-U in conjunction with the Levulan Kerastick is approved by the Food and Drug Administration (FDA) for the treatment of actinic keratoses (AKs). It is a targeted therapy that destroys Grade I and II AKs. Only the BLU-U is cleared by the FDA for the treatment of moderate acne. It is generally indicated to treat dermatological conditions, he added.

Even though using the Kerastick requires a two-part process, it is very convenient to use, stressed Dr. Desai. That’s because you don’t need to debride any lesions, wear nitrile gloves to administer the topical solution, or refrigerate it. “If it gets on your skin, you just wash it off,” he said. Another benefit is that you control the therapy, which makes it more predictable than, for example, patients applying a topical such as Imiquimod.

Using a Kerastick Krusher™ is a must for maximizing the number of ampules you get out of the Kerastick, said Dr. Desai. The BLU-U light source is designed to deliver a uniform light dose and stable wavelength to the entire treatment area. It is uniquely designed to minimize light loss, he said. It does require you to wear protective eyewear and patients to close their eyes.

The first part of the process involves applying the Kerastick topical solution on the skin. It starts penetrating before the light source is used. After Dr. Desai’s patients typically wait 45 minutes to one hour in the waiting room, he then applies the BLU-U light source for 16 minutes and 40 seconds. Approximately half way through the procedure, check on the patient to make sure he or she is not uncomfortable. “It’s a loud machine,” he said. “Patients won’t be heard outside of the room.”

After treatment, patients should use a moisturizer and avoid the sun for 48 hours. Dr. Desai tells them to avoid the sun for 72 hours for safe measure. If they do go out, they should use sunblock.

Managing patient expectations includes informing them what to expect following the procedure, he said. Patients typically experience a sunburn-like response. If you attended the Midyear Meeting, you will be receiving an Outcome Evaluation in the mail shortly. Filling out the evaluation and returning it to the AOCD office as quickly as possible is greatly appreciated.
like reaction, but the skin heals right away. They also may experience pain or tingling, as well as some swelling. He has never had a patient discontinue treatment because of stinging or burning. No scarring has been reported with the BLU-U light source nor has Dr. Desai ever seen any kind of scarring on patients. He has, however, seen some minor skin discoloration.

Criteria for patient selection include the grade, location, and number of AKs as well as the patient’s ability to comply with treatment, post-treatment experience, and medical history. Always ask about photosynthesizing medications. If the patient has multiple lesions from head to toe, they can’t all be treated at one time, noted Dr. Desai. The more AKs that are treated simultaneously, the greater the reaction the patient will have. Upon follow-up, if the patient doesn’t have a lot of reaction, said Dr. Desai, you can treat more AKs the next time. Recovery begins when treatment ends.

High clearance is demonstrated in the majority of patients. One study shows an 88% clearance of Grade I AKs and a 78% clearance of Grade II AKs at eight weeks. “Even after eight weeks they’re still clearing,” he said. At 12 months, 78% of lesions were still clear.

A second treatment typically improves the response rate, and can be particularly beneficial for AKs on the hands and forearms. “I don’t see the kind of results there that I see on the face and scalp,” added Dr. Desai. He recommended using more than one Kerastick for the hands and forearms, and to break the treatment into two for better results.

Down time is patient specific, he noted. Erythema and edema typically resolve within the first four weeks following treatment. In the last year, Dr. Desai has had only three patients who anticipated less reaction than they actually had. Remember, the reaction is proportional to the amount of sun damage the patient has.

Overall, patients are pleased with the cosmetic response, rating it between good and excellent.

Dr. Desai noted that PDT can be used in conjunction with topical immunomodulators. In fact, sequential use of Imiquimod after PDT has demonstrated an improved reduction in AK lesions compared with the topical being used alone. “But don’t use them together because the patient could have a bad reaction,” he said.

In summary, PDT works on multiple lesions. “Although it’s not approved for this purpose, it is preventive for skin cancer because we know AKs will evolve into cancer,” concluded Dr. Desai. Because dermatologists guide its use, it is a predictable therapy.

Top 10 Diagnoses Not to Miss
Kim M. Hiatt, M.D., Associate Professor and Director of Dermatopathology at the University of Arkansas for Medical Sciences in Little Rock, reviewed the Top 10 diagnoses not to miss. “These diagnoses are not to be missed because they are life threatening or life altering versus being inconsequential,” she said.

Superficial fungal infections include trichophyton, microsporum, tinea, epidermophyton, and candida. These infections are keratinase secreting fungi in the skin, hair, and nails. They also present as marnas in the cell wall of fungi that decrease keratinocyte proliferation. After reviewing the clinical and histological presentation, Dr. Hiatt noted that the diagnosis can be missed because the histology is unremarkable. “Tinea gets overlooked because the eyes see what the mind knows,” she said. The clinical differential diagnosis for superficial fungal infections includes nummular and atopic eczema, pityriasis rosea, lupus erythematosus, psoriasis, erythema annulare centrifugum, secondary syphilis, mycosis fungoides, lichen simplex chronicum, and pretibial myxedema.

Dr. Hiatt then compared dermatophytosis with eczematous dermatitis, which is clinically and histologically similar to tinea, pityriasis rosea, lupus erythematosus, psoriasis, erythema annulare centrifugum, and secondary syphilis. Because she can’t biopsy for all of these, Dr. Hiatt uses periodic acid-Schiff (PAS) stains, especially for lesions that have not responded to treatment. “When it’s just not making sense, order a PAS.”

Patients being treated for underlying disease with systemic and topic chemotherapeutic agents may have a keratinocyte response. Drugs associated with causing this atypia, which may be full-thickness, resembling squamous cell carcinoma (SCC) include 5-fluorouracil, nitrogen mustard, bexarotene, and pegylated liposomal doxorubicin. The problem is that these skin erup-
tions can be easily misdiagnosed as SCC in situ. The absence of a history can make the distinction between reactive and malignant atypia impossible. Therefore, look for alterations in the eccrine apparatus such as squamatization.

Lichenoid keratosis is a solitary lesion that presents most commonly on the chest of women, said Dr. Hiatt. It is an intense host response to seborrheic keratosis, verruca vulgaris, AK, large cell acanthoma, and lentigo. But lichenoid keratosis may look exactly like lichen planus. If there is no history, then the diagnosis can be given with a comment such as “The histologic features are consistent with lichenoid keratosis, the end stage of a regressed keratinocytic proliferation such as verruca and seborrheic keratosis. However, if the disease is more extensive, lichen planus is an additional consideration. Clinical correlation is essential.” The dense inflammatory infiltrate may produce “pseudo nests” of keratinocytes. Using the S-100 and Mart-1 stain to demonstrate negativity is helpful.

All patients with calcific uremic arteriolopathy (CUA) have renal insufficiency, she noted. Predisposing factors include hemodialysis, more commonly than peritoneal dialysis; obesity and poor nutritional status; female; Caucasian; and Diabetes mellitus. Precipitating factors include corticosteroid, systemic immunosuppression, hypotensive episode, recent rapid weight loss, and albumin infusion. The precipitating factors are associated with a triggering event that causes the calcification, said Dr. Hiatt. The lesions start as reticulated erythematous patches on the thigh and buttocks that evolve to papules, bullae, and full thickness necrosis. Patients describe pain that is disproportionate to the initial clinical presentation. Histology slides reveal calcification of intima or media of small and medium sized vessels of deep dermis and subcutaneous tissue; dystrophic calcification, occlusion of the vessels, secondary to the calcification may be seen; thrombosis may be seen; and ischemic necrosis of the overlying epidermis. An accurate diagnosis relies on deep tissue biopsy, said Dr. Hiatt.

Sarcomatoid SCC is poorly differentiated neoplasms that fail to consistently express markers of terminal differentiation. The histologic differential diagnosis includes melanoma, SCC, leiomyoma, dermatofibroma, dermatofibrosarcoma protuberans, angiosarcoma, kaposi sarcoma, and atypical fibroxanthoma (AFX). The latter presents itself clinically as a solitary nodule on the head and neck. It is a diagnosis of exclusion, she said. Typically, AFX is negative for all immunohistochemical stains involved in the work-up. When dealing with AFX, confirm that the pan cytokeratin stain works with the expression of normal basilar keratinocytes.

Although Merkel cell carcinoma (MCC) is rare, Dr. Hiatt cited an eight percent increase in 15 years. It is very aggressive, with a 33% mortality rate. Similar to basal cell carcinoma (BCC), MCC presents as a painless, firm, rapidly growing nodule. It is smooth skin with satellite nodules. The eyelids are commonly involved. Merkel cell carcinoma starts out localized, but changes rapidly. It is most common on sun-exposed sites. Histology slides reveal hyper-chromatic and fine chromatin with numerous mitoses, a BCC-like clefting, a pagetoid spread, large cell morphology, and co-existing MCC and SCC. “It can look like a melanoma in situ,” noted Dr. Hiatt. “Be aware of co-existing lesions.” Beware of look-alike histology such as BCC and large cell lymphoma. An immunohistochemical profile is necessary to distinguish it from other diseases. While most MCCs express as CK20, CK20-negative MCC does exist.

Of the next diagnosis, she said, some Spitz nevi are very aggressive. However, there is a low recurrence rate even after incomplete removal. The diagnosis of spitz nevus should be...
based on a constellation of features, suggested Dr. Hiatt.

The different types of Spitz nevi are desmoplastic, atypical, malignant, and pigmented and spindle cell. The major histology criteria are symmetry, cell type, maturation of cells, absent pagetoid spread of single cells, and pale pink Kamino bodies. Although there is usually an absence of pagetoid spread, Pagetoid Spitz shows ordered growth, minimal atypia, no nesting, and is purely epidermal. Kamino bodies also may be seen in melanoma and benign nevi. Look for clefing. “We recommend excision of all Spitz nevi,” she noted. A recent study shows that HMB-45 staining can be helpful. When dealing with Spitz nevi, Dr. Hiatt suggested looking for well-established maturation and a symmetrical lesion with pushing deep border. Check for a proliferative index, if at all concerned. Finally, be leary of a patchy lymphocytic infiltrate.

“nevroid melanoma is the one I lose sleep over,” she said. It represents less than one percent of all melanomas. It shouldn't be confused with minimal deviation melanoma, a borderline tumor with uncertain biologic behavior. Clinically speaking, it is a tan nodule greater than one centimeter that occurs on the trunk and proximal extremities. Between 35% and 50% of patients, who tend to be younger in age, develop metastasis. Histologically speaking, nevroid melanoma closely resembles a benign nevus. It has a dome shape, is symmetrical, has a junctional component that is minimally proliferative, and apparent maturation. Also, there is subtle pleomorphism, sheet-like growth, dermal mitoses, and incomplete maturation. Dr. Hiatt suggested that no one feature is diagnostic. “Be concerned if you see sheet-like growth, nucleoli in deep aspect, and poorly established maturation,” she concluded.

The meeting wrapped up early on Thursday afternoon, at which time the Board of Trustees met for the rest of the day. That evening, Centocor hosted a non-CME dinner program at which psoriasis was discussed.

Cutaneous Eruptions Post-Bone Marrow Suppression

On Friday morning, Dr. Hiatt discussed her work in recruiting researchers and patients with multiple myeloma as part of the Myeloma Institute for Research and Therapy at the University of Arkansas for Medical Sciences, a bone marrow transplant center. Specifically, patients with leukemia, lymphoma, a solid tumor, immune deficiencies, and those who undergo myeloablative chemotherapy or radiation therapy are treated using stem cells for bone marrow reconstitution.

Typically within 100 days of the procedure, patients experience an eruption of the skin. With acute graft versus host disease (GVHD), there is a decreased risk of relapse, it can be curative, it can be induced, and cyclosporin suppresses the host. The risk of encouraging GVHD, however, is that it results in an attack on the patient’s tissue. “The lymphocytes start coming out and start attacking,” she said. Graft versus host disease occurs in 25% to 40% of HLA-identical sibling transplant recipients, and in up to 50% of single HLA mismatch recipients.

With acute GVHD, a morbilliform eruption commonly starts on the palms, soles, pinnae, and scalp. It has been categorized into four stages. Stage 1 is an eruption that involves less than 25%
of surface area. Stage 2 is an eruption that involves between 25% and 50% of the surface area. Stage 3 is characterized by erythroderma, and Stage 4 by vesicles and bullae. “We have become very good at treating it, so stages three and four are rare,” she said. A histologic grading system consists of five categories.

Prophylaxis prevention of GVHD is critical. Among the immunosuppressive regimens are cyclosporine, methotrexate, prednisone, and antithymocyte globulin. The latter two improve GVHD, but have no effect on survival. Therapy, most commonly used for Grade I or II, are observation and triamcinolone. For Grades II through IV, the original immunosuppression is continued while methylprednisolone is added. Resolution is typically seen in 30 to 42 days. Numerous newer therapies are currently in trials.

In addition to acute GVHD, there is chronic GVHD, the latter of which occurs in up to 40% of stem cell recipients. With chronic GVHD, there is a traditional division into lichenoid and sclerodermoid, morphea and fasciitis. But it is not as clear cut as the literature suggests, she cautioned.

It is impossible to distinguish persistent, recurrent or late acute GVHD from chronic GVHD by histology alone, stressed Dr. Hiatt. Because chronic disease responds to different treatments than acute disease, pathologists are still being asked to distinguish between the two. For example, chronic GVHD responds to thalidomide, PUVA, and pulse corticosteroids whereas acute GVHD responds to high dose corticosteroids and cyclosporine.

The National Institutes of Health developed a working group to provide an update for pathologists and clinicians about the interpretation of biopsy results to be used in the management of hematopoietic cell transplant patients. Among the recommendations are guidelines for biopsies that call for confirmation of active chronic disease. The guidelines also reassured pathologists that whatever findings they come up with are helpful, she said, as the decision to treat is not based according to the histological gold standard of a positive biopsy sample, but according to the overall clinical assessment.

No single histologic feature is pathognomonic of GVHD. The overall inflammatory reaction pattern needs to be considered in the final diagnosis.

It is followed by full immune reconstitution. The identification of this process allows prediction of immunologic recovery. In a study done at Johns Hopkins that reviewed such eruptions, all of them resolved over several days on their own, leaving only hyperpigmentation. Clinical characteristics of lymphocyte recovery are erythematous macules and papules variably distributed and occasional confluence to erythroderma. The histology is exocytosis, rare dyskeratotic cells, spongiosis (also seen in grade I GVHD), and upper dermal perivascular cell infiltrate. The diagnosis of an eruption of lymphocyte recovery relies largely on the association of increased peripheral lymphocyte counts and a new macular and papular eruption in a febrile patient.

Furthermore, there are drug-induced eruptions unique to bone marrow transplant centers. Granulocyte and granulocyte-macrophage colony stimulating factors, which are being used more frequently in the post-marrow ablation period, are triggering eruptions that resolve spontaneously. It appears that these drug-induced eruptions occur when the neutrophil count increases sharply.

Look at overall pattern and not isolated findings, stressed Dr. Hiatt. “It could just be an eruption, not GVHD.” All reports should include both histologic features and a final diagnosis. The latter should integrate the histopathologic result and the clinical context, indicating no, possible, consistent, or definite GVHD.

Patients with acute GVHD also may experience an eruption of lymphocyte recovery, an eruption of granulocyte/macrophage recovery, radiation dermatitis, chemotherapy-induced dysmaturation, and drug-induced eruption. “We don’t understand the pathogenesis or why only some patients get an eruption,” she said, adding that some proposed theories do exist.

An eruption of lymphocyte recovery is a papular eruption following a period of marrow aplasia and coinciding with marrow recovery. It is associated with fever that resolves in two to four days.
Enlarged macrophages are reported to occur after chemotherapy, as well. The histology for chemotherapy-induced eruptions is a loss of maturation, irregular nuclear contours, occasional dyskeratosis, rare basovaculopathy, and a lack of dermal lymphocytic infiltrate, and exocytosis.

Although the oncology team wants the biopsy as soon as possible, the histology is often not fully evolved, noted Dr. Hiatt. “Encourage them to wait another day.” If they need a diagnosis of GVHD, then encourage them to biopsy a macule as papules are often Grover’s disease. What looks like a drug eruption early on could be GVHD several days later.

**Laser Fundamentals**

“Know the target, select the weapon, and know the end point,” advised Eric C. Parlette, M.D., of SkinCare Physicians in Boston.

Lasers target cutaneous chromophores, which include hemoglobin, melanin, water, and exogenous pigments. Depending on how deep in the skin the laser penetrates, it can target any one of these chromophores, which absorb the light. “You can more than adequately and effectively treat patients with lasers if you know the absorption spectrum,” he said.

Selecting the appropriate laser begins with selecting the proper wavelength, asserted Dr. Parlette. Based on the principles of selective photothermolysis, the laser selectively heats the desired target while preserving the surrounding tissue. Wave-
Pulse stacking can be used for resistant vessels. It can be used for acne scar and post-surgical scars. However, edema is more common with pulse stacking.

Pulsed-dye lasers can be used to treat purpura, as well. Using it at a sub-purpuric level, which would be greater than six-nanosecond pulse duration, will cause a gentle simmering. The idea is not to create any more purpura, said Dr. Parlette.

When treating leg veins, you want to use the smallest spot size to accommodate vessel diameter, the lowest effective fluence, and a pulse duration between 40 and 60 milliseconds, he said. The treatment endpoints are either immediate vessel disappearance or visible intravascular thrombosis. Immediate reactions may include micro-thrombosis in larger vessels, and vessel rupture, the latter of which tends to happen with shorter pulse durations and higher fluence. Rapid reactions include mild erythema and edema at the treatment areas. These tend to be short-term, and can be minimized by using an ice pack and applying clobetasol cream following treatment. The most common side effect, hyperpigmentation, does go away. It is seen more commonly with shorter pulse durations, larger spot sizes, and vessels with thrombus formation, and in patients with a tendency to hyperpigmentation.

Other vascular lesions that are thicker require more depth of penetration, said Dr. Parlette. Those include angiomas and nodular papules of advanced Portwine stains. In these cases, the target is the melanin, the weapon is the Q-switched laser on a millisecond pulsed device, and the endpoint is subtle graying and peri-lesional erythema. “You have to tell the patients that it will look worse before it looks better,” he warned. These patients always require follow-up.

For exogenous pigment, the target is the tattoo ink. “You want to get rid of the ink and nothing else,” stated Dr. Parlette. The endpoint is a whitening of the tattoo. The easiest pigment to get rid of is black. When removing flesh-colored inks, you should reduce the ferric oxide to ferrous oxide or the tattoo could turn black. If there is dense pigmentation, start on the lowest possible fluence and increase it in little increments, he said. Do a test spot. Check it in a week to make sure there are no side effects. Although hyperpigmentation can occur, it’s usually slight. Be sure to use eye protection for you and the patient.

For hair removal, the laser needs to penetrate the skin deep enough to reach the hair, explained Dr. Parlette. “You are essentially targeting the melanin side of the hair shaft,” he said. The hair bulge is the likely primary target in laser hair removal, which requires a minimum of six treatments. A long pulsed Alexandrite or Nd:YAG can be used to remove hair. Other tips Dr. Parlette covered include when removing hair, the wavelength should be long. The longer wavelength means deeper penetration and less epidermal damage. A longer wavelength is better for darker skin. Shorter pulse duration is better for thinner hair. The bigger the spot size, the better.

Cryogen cooling, which is essential to use in hair removal, he said, as it
protects the epidermis and D-E junction, and destroys the shaft and follicular epithelium. In general, start with the lowest effective fluence and work up the energy, suggested Dr. Conroy. Start in an inconspicuous area. Watch the patient’s reaction and adjust accordingly. What you want to see is the superficial hair vaporize, some follicular urticaria, and some erythema. When treating darker skin, turn down the energy because more melanin is absorbed. Decrease the energy in patients with a history of hyperpigmentation and in thick dense areas.

For photorejuvenation, fractionated resurfacing heals quickly and it works well for the eyelids and around the lips. A fractional CO₂ laser works well on acne scars and melasma. Recovery takes five to seven days. Aquaphor can be used until the crust subsides. Superficial peeling and redness will occur. Patients typically need two to three treatments.

**Dermatology Update**

Within the last decade, a lot of research has been done on rosacea, yet the pathophysiology is still very poorly understood, noted James Del Rosso, D.O., of TUCOM/Valley Hospital Medical Center in Las Vegas. In the first half of his presentation on new therapies, Dr. Del Rosso reviewed recent rosacea research. Rosacea is no longer believed to be primarily an inflammatory disease. It is now understood that there are certain triggers that stimulate immunity. It’s this innate immune response that brings about rosacea. Typically rosacea patients are not treated with topical retinoids, he said, but dermatologists might consider it to see if the patients can handle them long term.

Studies done on innate immunity and vascular hyperreactivity don’t explain why rosacea patients flush and blush. But in recent studies on reactive oxygen species, said Dr. Del Rosso, it was demonstrated that patients with rosacea have an increased serine protease activity.

Although they look the same, it is not believed that demodex and rosacea are the same.

Epidermal barrier dysfunction, which is characterized by increased transepidermal water loss primarily in the central region of the face, explains why the skin of patients with rosacea is sensitive. This often causes their skin to sting and burn, even before treatment is given. Studies have shown that patients with rosacea lose more moisture in the central part of the face than individuals without the disease, explained Dr. Del Rosso.

Much of the current research in rosacea focuses on cathelicidins, he noted. Cathelicidins are antimicrobial peptides that protect the skin from infection when there’s a break in the epidermis. Studies have demonstrated that rosacea patients have more cathelicidins, which are broken down into different proteins, than individuals who don’t have the disease. Because cathelicidin expression is increased in patients with rosacea, they have a higher concentration of enzymes and inflammation. Researchers found that patients on tetracycline have decreased serine protease activity, resulting in less cathelicidins. These findings suggest why tetracyclines work in treating rosacea.

**AK Therapy.** The FDA approval of a generic Imiquimod cream will most likely be held up in patent lawsuits, predicted Dr. Del Rosso.

The problem with AK studies in the past is that they looked at small areas of the skin, which don’t correlate with real life therapy, he said. But a recent study evaluating a new formula of Imiquimod looked at the full face or scalp. One daily application was used in a shortened treatment duration between four and six weeks. The concentration was decreased in order to get reasonable tolerability. Patients will still experience redness and inflammation, but less than usual. In multiple studies, patients treated on a two-week cycle with 3.75% cream experienced an 82% reduction of AK lesions from baseline.

A recent study evaluated the use of diclofenac gel 3% for the treatment of AKs. The study followed patients using the gel twice daily for 90 days, with a follow-up for 120 days. When inflammation with diclofenac occurs, therapy tends to be longer, Dr. Del Rosso noted. The study found that 80% of patients experienced a 75% target lesion reduction. One year later, in an extension study, during which no treatment was provided, patients who were followed experienced a 95% reduction of target lesions from baseline.

In another study, ammonium lactate 12% lotion was found to reduce topical corticosteroid atrophy. Dr. Del Ross believes that it is best to hit the AKs hard and then come back with addi-
tionaltreatment. For example, use the lotion twice daily for two weeks and then treat them over a six-month period on weekends. The potential value of ammonium lactate is as a steroid-sparing agent, he added.

One study compared treatment of AKs using ammonium lactate combined with other agents. In a group of patients using ammonium lactate and halobetasol ointment on the weekends, patients maintained clearance for 17 weeks. When ammonium lactate was used with petrolatum on the weekends, patients maintained clearance for seven weeks.

In an unpublished study, patients gained the same result if they used ammonium lactate once a day versus twice a day.

A study looking at Vitamin D analogues demonstrated true efficacy with patients who had fairly extensive disease, noted Dr. Del Rosso. At the six-month point, nearly 53% of patients were almost clear or clear. At one year, six out of 10 patients had a marked improvement. What about long-term use? At three months, there was no hypercalcemia. In fact, there was a low overall incidence of hypercalcemia, he said.

**Interesting Cases**

In the second half of his presentation, Dr. Del Rosso presented various interesting cases in a lecture called “What is This?”

Among them was a patient with demodex, which he described as “night crawlers.” They were not found during the day or on scrapings, but rather three or four demodex were found on slides. The patient was treated with topical crotamiton and had an 80% clearance rate. However, he cautioned that some rosacea cases might actually be demodex.

A three-month-old baby presented with a rapidly enlarging mass on the left upper extremity. The child was irritable and cried easily, reported his mom, who also said he was born with a large hemangioma that is now “swelling.” The child was diagnosed with Kasabach–Merritt syndrome, also known as hemangioma with thrombocytopenia.

A 34-year-old white male presented with “bumps on his neck.” A fundoscopic examination revealed angiod streaks, which occur because the membranes have an abundance of elastic tissue, explained Dr. Del Rosso. The elastic tissue breaks down, fragments, and calcifies. The patient was diagnosed with pseudoxanthoma elasticum.

A 35-year-old male presented with multiple firm papules on the buttocks, thighs, and lower trunk that have been there for four years. He didn’t know when they first appeared. He also had sustained stippling of the bones. Some patients with Buschke-Ollendorff syndrome, with which this patient was diagnosed, have only skin or bone involvement, noted Dr. Del Rosso. When the bones are involved, they remain strong so the patient’s lifestyle is not affected.

A 44-year-old white female presented with a 10-year history of progressive dyspnea and worsening headaches. She was previously diagnosed with atypical migraines. The patient was diagnosed with Osler-Rendu-Weber disease, also known as hereditary hemorrhagic telangiectasia. People with this condition develop arteriovenous malformations in several areas of the body. On the skin, they are telangiectasias, but they also can develop in the lungs, liver, and brain.

**Hair Today, Gone Tomorrow**

“Hair represents youth, beauty, vitality, energy, and fertility. These are attributes that no woman wants to be without,” stated Melinda Greenfield, D.O., of Albany Dermatology Clinic in Georgia, who discussed a growing subset of patients in her practice: women with alopecia.

“You cannot tread light enough when speaking with a woman about hair loss,” she added. “The worse thing you can say is ‘You’re going to have to get used to it.’”

Practicing for 10 years, Dr. Greenfield has seen an increase of women with hair loss. Many of these women are easily diagnosed, starting with taking a history. An examination includes conducting a hair pull test and evaluating the distribution of hair loss, scalp inflammation, lice, and excoriations. Often times, patients come in with a zip lock bag full of hair, she said. Common causes for hair loss are hormonal, hereditary, physical, or systemic. Common diagnoses for women with hair loss are telogen effluvium, female androgenetic alopecia, alopecia areata, and traction alopecia.

A more difficult case was that of a 40-year-old woman who presented with shedding of the hair and other associated symptoms. Among them were fatigue, weight gain, facial edema,
insomnia, constipation, poor memory, and cold intolerance. Her TSH, which had been checked three times, was normal. She had been on two different anti-depressants, neither of which were helpful. The patient had been to three other doctors. “This woman wants an answer from you,” stated Dr. Greenfield.

She either could tell the patient that she can’t offer her anything else, send her to get her TSH levels checked a fourth time, offer her the name of a hair replacement center, or “learn to think outside the box and become a hero.” Dr. Greenfield opted for the latter.

Returning to her medical textbooks to review what she had learned about the thyroid function, Dr. Greenfield discovered that the TSH level is not an accurate measure of thyroid function. It appears that too many individuals fell outside the normal range for TSH, she said, so the range was expanded.

Furthermore, there are four thyroid hormones: T4, T3, Reverse T3 (RT3), and T2. It was thought that RT3 was functionless, essentially a dumping ground for unwanted T4. In fact, RT3 has been shown to increase during steady states of stress, either physical or psychological, which would be beneficial when a person requires a slower metabolism, such as in times of famine or serious injury. “This adaptive mechanism is now becoming maladaptive due to the constant stress that we’re putting our bodies under,” explained Dr. Greenfield.

Even though a patient’s level of TSH and RT3 is normal, the T3:RT3 ratio can be off. With an imbalance in the ratio, the RT3 is too high for optimal function. The patient is converting too much hormone to the RT3 pathway rather than the active T3 pathway. In essence, she is hypometabolic. If this patient is given synthroid, it will drop her TSH level, which will drop her T4 level and a little of the T3. The patient will, in turn, make more RT3 because she has a conversion defect.

Experts in the field have noted that the most common cause of failure of classic thyroid treatment using synthetic T4 is the excessive conversion of T4 greater than RT3. This has been called either RT3 Dominance, Conversion Defect, Low T3 Syndrome, Euthyroid Sick Syndrome, or Non-thyroidal Illness. “The bottom line is that the normal amount of T3 produced is not adequate to overcome the inhibitory effects of RT3,” stated Dr. Greenfield. One study has shown that only 60% of patients on thyroid medication were within the normal range. Another study demonstrated that patients felt better when taking a combination T3-T4 medication instead of T4 alone. Still, T4 continues to be the standard of care. The fact that millions of people are taking thyroid medications and still are not feeling well, nor are they in the normal range, indicates that we are failing these patients, she stated. Treating patients with synthetic T4 without checking their ability to convert it to T3, said Dr. Greenfield, is like sending cans of food to a starving nation without checking first to see if they have a can opener.

Other factors that impair conversion of T4 greater than T3 are aging, stress, diabetes, heavy metals, radiation, surgery, alcohol, and plastics. Factors that increase it are selenium, potassium, iodine, iron, zinc, high protein diet, an herb called ashwaganda, growth hormone, testosterone, insulin, glucagons, melatonin, and tyrosine, as well as Vitamins A, B-2, and E.

When treating patients with this conversion defect, she recommended the following goal parameters:

- TSH levels between 0.7 and 0.9 uIU/mL
- T4 levels between 0.7 and 0.8 ng/dL
- T3 levels between 3.4 and 3.8 pg/mL
- T3:RT3 ratio of 12±2

“Over time, I have found that these patients feel best when their TSH is less than 1 uIU/mL,” said Dr. Greenfield. “The most important thing is the T3:RT3 ratio.”

The goal is to get the thyroid gland functioning again using both T3 and nutritional support. Another is to resolve the symptoms. After six or 12 months, Dr. Greenfield said that the patient might be able to switch to a T3/T4 combination medication such as Armour Thyroid. The patients must realize that this is not a quick fix and that they will most likely need to be on medication for life.

Getting back to her patient, Dr. Greenfield started her on T3 supplementation. The two options for that are Cytomel or a compounded slow-release T3. Because Cytomel is rapidly absorbed in the intestines and must be dosed BID, she prefers the compounded T3 slow release formulation started at 7.5 mcg BID, and after
monitoring the symptoms, bumping up the dose every two weeks. Laboratory values should be checked after three and six months. Patients tend to do better on compounded formulas, she said. Dr. Greenfield also put the patient on nutritional supplements.

Of course, what the patient really wants to know is will this make her hair grow. The answer is eventually. “Give it time,” is what Dr. Greenfield tells patients. “Hair growth comes into play after the other things are corrected in the body. I have seen many patients improve. I have seen hair growth across the board.”

Unfortunately, some patients stop the regimen after a month and some go to an endocrinologist who tells them that a dermatologist has no business messing with the thyroid, she said. “Being on the cutting edge of the thought process doesn’t make you popular among your peers,” she said. “But these patients come to the dermatologist when they are at the end of their rope. You could be the doctor who can offer them something nobody else has.”

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E-Billing, Embezzlement Prevention

“Don’t let employees take control of the office,” warned Rick Lin, D.O., of Dermatology Clinic of McAllen in Texas, speaking about the benefits of electronic billing and how to prevent embezzlement.

“Doctors should be involved in every aspect of billing,” he stated. Because there are several steps in the billing process that can go wrong, it’s important to know all of them. The most important step is posting, which needs to be accurate and reflect what services are being provided. It’s also one where embezzlement can occur. If an employee gets behind in billing or is too lazy to track down a bill, the employee may write it off. “That is why you need absolute control of write-offs,” stressed Dr. Lin.

Additionally, all of the superbills must be posted daily. “You need someone you trust to close out the practice management software each day,” he said.

Electronic posting and electronic funds transfer can reduce the amount of posting, posting errors, and the number of people handling the practice’s checks. With electronic funds transfer, the checks go directly into the bank account. It also requires fewer staff members. If a mistake is made, it’s easy to review the claims being posted. Dr. Lin submits 2,000 claims, on average, each week and he does the electronic posting himself. Dr. Lin estimates that 80% of the money coming into his practice from insurance companies is posted electronically. Another benefit of electronic billing and posting is that it eliminates the need for a billing company.

And while most physicians have electronic billing, many do not utilize it to its full capacity, he said. For example, Dr. Lin has 15 examination rooms and each room has a work station with a computer.

With regard to loss prevention, Dr. Lin said that a few years ago, he had two receptionists who became friends. Both of them were reliable and continued to take on new responsibilities such as scheduling appointments. After they left his employment, Dr. Lin discovered that they had frequently turned patients away and didn’t appropriately follow-up with others. After they left, his practice experienced a 30% increase in patient load. It’s true that the longer employees are with you, the more efficient they become, he said. But it shouldn’t be because they cut corners to reduce their workload.

Employees can embezzle unintentionally, said Dr. Lin. An employee who makes data entry errors or who forgets to resubmit an unpaid claim is losing money for the practice. Employees embezzle by performing at a low productivity level, surfing the Internet when they should be working, using the telephone for personal reasons, and stealing supplies. By contributing to low office morale and office gossip, they can waste valuable work time.

And then there are those who intentionally embezzle. An office manager can embezzle by falsely billing people, paying bills to fictitious companies, or overpaying for supplies. If the office manager has control of the checks, he or she can create a secret account and deposit checks in it.

Fortunately for Dr. Lin his wife is his office manager, his sister-in-law is in charge of the reception area, and his brother-in-law is responsible for billing. “I know that sometimes people question working with family, but it has worked out for us,” he said.

Patients can embezzle the practice by submitting a fake insurance card. Check patient eligibility and the deductible prior to the appointment to avoid getting scammed, suggested Dr. Lin. Don’t see a new patient until the insurance is verified. It only takes a few minutes, he stressed. Collect the co-pay before the patient is seen. Ask for a driver’s license with the insurance card to verify the patient’s identity.

The insurance company and government can embezzle the practice through denials. As of January 1, 2010, Medicare stopped paying on a common code used in dermatology; 14300. Dr. Lin discovered this when reviewing explanations of benefits. He never received a letter from Medicare saying to substitute this code for 14301 to get paid $954. To eliminate loss of payment for modifiers, make sure you understand them. The most important ones are 79, 25, 24, and 59. “If you know those
modifiers, you can get by with ninety-nine percent of claims,” he said. Dr. Lin codes all Mohs surgeries himself because errors in Mohs coding are costly ones.

Optimally, physicians should do all of their own billing, he concluded. But at the very least, they need to understand the process. “If you don’t run your practice, your employees will, but they may not have your best interest at heart,” he said.

**Practice Management Tips for Newbies and Veterans**

From office location to customer satisfaction, Andrew Racette, D.O., of Omni Dermatology in Phoenix, reviewed practice management tips for newbies and veterans.

Office location is one of the most important things to consider when opening a practice, he noted. Dr. Racette recommended looking for an area with as few dermatologists as possible. Look for a medical building that has several primary care doctors. “This will give you a jump on referrals.” Always visit the building to make sure it is in a clean, nice, and safe area. “I have been to several offices where I was uncomfortable just parking and walking into the building,” he said.

To find a good office location, obtain population data from Google and also use Google maps to search for dermatologists in a zip code or city. Call each office to make sure the listing is current. Ask how long the wait time is for new and old patients to make an appointment. “This can alert you to an area of the city that is underserved.” You may think that setting up shop in a recently revitalized or expanding part of the city is ideal, but so do many others. That may result in several new offices springing up in a short period of time without enough patients to support them all.

You don’t need much in your first office, he said. “Save your money and keep your overhead low by moving into a small space.” Rent extra rooms from an existing office or find a small office. Two to three exam rooms, one small office for you, and a reception area that fits six chairs will last you two to three years in most circumstances. Look for a building that has different size offices so that you can negotiate to move to larger offices after a few years. If you have to leave that building, move within three miles.

Some offices have a better flow by design. As an example, they have a dedicated check-in and check-out counter with separate staff for each one. Set up the office so that patients move in one direction with a separate entrance and exit to the back office. This will reduce congestion. The exit should have an automatic closing door and be located right after the checkout station.

Many different venues exist for finding employees. Dr. Racette’s favorite is [www.craigslist.org](http://www.craigslist.org) because it is more effective and cheaper (at $25 per ad) than newspaper ads. Ask current employees and even patients if they know anyone who may be good for the job. Talk to recruiters at local billing and medical assistant schools about hiring an extern from the school who usually has to work for free for two to three months before graduating.

When hiring office personal, such as medical assistants and billers, he recommended that the person has at least a degree in that area, but it is not required. His biller neither had prior medical billing experience nor did she go to medical billing school. “I taught her everything about billing because I did it for the first year of my practice,” he said. Consequently, she doesn’t have any bad habits from her old job and she does her job exactly how I want her to. “However, if you are not familiar with billing, then you will want to hire someone who has prior experience and knows what to do.”

Interviews are a good way to get to know the potential employee better and evaluate whether or not you will get along with that person. You can ask all sorts of questions about past work experiences, but beware that some questions are considered illegal. For example, you can’t ask when the applicant graduated from high school, what his/herspouse does for a living, or how long the applicant plans to work until he/she retires.

However, here are ways to get around the questions that can’t be asked. For example, instead of asking if the applicant has children, you can ask if he/she is available to work overtime on short notice. Instead of asking if the applicant has ever been arrested, ask if he/she has ever been convicted of theft, fraud, etc. Always run a background check. Some sources include [www.eFindOutTheTruth.com](http://www.eFindOutTheTruth.com) and [www.USSearch.com](http://www.USSearch.com).
As a boss, you must mentor, motivate, challenge, praise, and monitor employees.

Now that your practice is getting busy, you may need to hire another practitioner. Whether it’s a dermatologist, physician assistant, or nurse practitioner, consider the following questions before doing so. Are you seeing at least 50 patients per day and working five full days per week? Are you booking at least two weeks out? If you can answer “yes” to both of these questions, then it makes sense to bring on a new associate provided you have an extra exam room.

Marketing your practice is essential, said Dr. Racette, and can be accomplished by meeting other doctors in your area, participating in local skin cancer screenings, joining professional associations, and asking patients to post on-line reviews.

At the end of the day, the patient will decide if you’re providing quality medical care. To keep a patient happy, consider using humor, free samples, providing typed instructions, and include personal notes in the chart such their occupation or an upcoming trip. “The patient will not remember exactly what you said or did, but the patient will remember exactly how you made him or her feel,” he concluded.

**Habits for Healthy Living**

“Can you modify disease with foods?” is the question that Robert Schwarze, D.O., of North County Dermatology in Florissant, MO., put to the audience when he stepped in for a speaker who was unable to make the meeting.

Food isn’t medicine, but some have been shown to be beneficial for people with certain diseases, he said. As an example, there is a great deal of information about the effect of diet on cancer.

Nobel laureate, Dr. Ott Henrich Whartburg, proved that the metabolism of malignant tumors depends on sugar. This activity increases insulin, which causes an increase in insulin growth factor. Remember that white flour is rapidly converted to sugar, noted Dr. Schwarze.

Dr. Zheng Cui at Wake Forest discovered a mouse that resisted tumor growth after being injected by 180 sarcoma cells, one of the most virulent cancer cells. Even after the mouse was injected with two billion cells, it lived. Why?

**Natural killer (NK) cells cause granzymes to enter the cell membrane and activate programmed cell destruction. This occurs especially in sarcomas, breast, prostate, lung, and colon cancer. In one study, individual tumors were cultivated with the patient’s own NK cells in 77 women with breast cancer. Only some patients with NK cells reacted. Twelve years later, 40% of the non-responders had died. Ninety-five percent of those had an intact immune system, including the NK cells, which survived.**

Inflammation drives cancer, he explained. Patient-derived growth factor produces cytokines, chemokines, prostaglandins, leukotrienes, and thromboxanes in response to traumas/poisoning. Cancer has exploited this repair process to invade the body and drive it to destruction. With inflammation, both the NK and white blood cells are neutralized.

Dr. Michael Karin at the University of Southern California in San Diego demonstrated that if the nuclear factor Kappa Beta is blocked, it makes most cancer cells mortal and stymies the metastatic process. In the journal *Science*, Dr. Albert Baldwin’s article mentioned two molecules that inhibit nuclear factor Kappa Beta. They are katicatchins, which are found in green tea, and resveratrol, which is found in red wine. Yet, the pharmaceutical industry has been unable to develop any inhibiting agents, noted Dr. Schwarze.

In the 1960s, Dr. Judah Folkman, coined the term angiogenesis to explain the formation of abnormal cells into a large mass. Dr. Michael O’Reily, working under Dr. Folkman, found angiotestin in mice urine. Soy, which has genistein, is also antiangiogenic. In an article in a 2004 issue of *Lancet* (Volume 364, p.10-21), green tea is said to prevent and treat cancer. All of these support...
the notion that by fighting inflammation and stimulating immune cells, cancers can be decreased with nutrition, he said.

Dr. Schwarze goes on to review various foods that inhibit and aggravate inflammation, as well as those that activate the immune system based on a book entitled Anticancer: A New Way of Life written by David Servan-Schreiber, M.D., Ph.D. In general, traditional Western diets are pro-inflammatory. Those that are anti-inflammatory include Mediterranean, Indian, and Asian cuisine.

The book classifies foods according to their effect on specific forms of cancer. As an example, foods boasting anti-angiogenesis properties include green tea, tofu, miso, raspberries, hazelnuts, strawberries, and the list goes on. Spices with anti-inflammatory properties are tumeric, ginger, thyme, rosemary, oregano, and basil.

Moreover, the book explains why foods are beneficial. For example, the problem with sugar is that it spikes, and cancer feeds on those spikes. So cancer patients should keep their sugar levels more even. They can do that by eating sweet potatoes. Although fruits have fructose, it is delivered slowly, making it a good alternative to foods laden with processed sugar. This classification helps patients seek out foods that will be beneficial for them, he said, adding, “It forces people to look at labels on everything.”

It’s not only about the foods, but how they are grown. Preservatives overwork the immune system to detoxify the body. When your body is taxed, it can’t improve the immune system. Foods that have anti-toxic substances are strawberries, raspberries, cherries, blueberries, walnuts, and hazelnuts.

The way foods are prepared is another factor. When tomatoes are heated, the process increases the level of lycopene, which has been suggested to prevent cancers, specifically prostate cancer. When fish is grilled, it loses its omega 3 oils, which have anti-inflammatory properties.

Dr. Schwarze noted that the diet in the book is similar to the Heart Healthy diet promoted by the American Heart Association.

Like all dermatologists, Dr. Schwarze sees his fair share of patients with cancer. “When I shared this information with one patient, that patient sent me ten more. Patients love this information because it enables them to be proactive.” Although he cautioned that food isn’t medicine, Dr. Schwarze noted that “it sure can help.”

After a day of presentations, attendees unwound at the President’s Reception held at the hotel. Guest speakers continued their presentations on Saturday morning.

**Vasculitis and the Dermatologist**

When dermatologists think vasculitis, they are primarily thinking about leukocytoclastic vasculitis (LCV), noted Michael Conroy, M.D., FAAD, of Dermatologists of Greater Columbus in Dublin, Ohio. It’s a histologic finding, not a diagnosis.

To determine the diagnosis, the histology is divided into Little 7 and Big 5. Little 7 involves post-capillary venules (PCVs). This occurs in classic LCV. “It’s what we think of clinically as palpable purpura, but that’s a bad tag because it’s not often palpable and not purpura,” he said.

The Big 5 is characterized by LCV of the bigger, deeper vessels involved, but it may include PCV. It’s characterized by neutrophils, red blood cell extravasation, and an antigen activating complex that gets deposited within the vessel walls. The goal of treatment is to inhibit that pathway.

Half of all LCV cases are idiopathic.

In reviewing the various types of LCV, Dr. Conroy described Henoch-Schönlein purpura (HSP) as an immunoglobulin A (IgA)-mediated vasculitis. It typically occurs in young adults. To diagnose HSP, don’t do a four-punch biopsy and split it, he said, do four punches. Splitting is not a good practice, in general. Give them bulk and let them do good biopsies. With HSP, Dr. Conroy recommends doing a lesional biopsy. Histologically, you see granular definition of IgA1. When renal disease occurs, it’s nearly always in the first three months, but it can happen any time. These patients should be followed up either weekly or every other week.

Drug-induced LCV can be caused by the penicillin family, NSAIDs, and TMP-SMX. When you see LCV and active lupus, you have to be suspect, he said. Dr. Conroy’s first thought is lupus erythema.

Another type of LCV is mixed cryoglobulinemia. Of the three types of cryoglobulinemia, mixed cryoglobulinemia — also known as Type II — and Type III are often associated with hepatitis C infection.

A workup summary for LCV includes a skin biopsy, urinalysis, complete blood cell count, complete metabolic profile,
stool guaiac testing, an antineutrophil cytoplasmic antibody serology, a hepatitis panel, HIV, post-exposure prophylaxis, and complement levels. If Dr. Conroy suspects systemic disease, he refers the patient to a rheumatologist.

“Most LCVs we see are just cutaneous vasculitis,” noted Dr. Conroy. “The bulk of patients will not have systemic disease.”

Dermatologists can offer supportive therapy. For example, if the patient is in pain or is itching, prescribe NSAIDs and antihistamines. But be careful with NSAIDs because of the potential for renal disease. “I use prednisone more than anything,” he added.

Rheumatoid vasculitis can be LCV or in medium-sized vessels. In these cases, the patient usually has rheumatoid arthritis that evolves into vasculitis.

Wegener’s granulomatosis involves upper airway and necrotizing glomerulonephritis. Saddle nose deformity is classic when you’re seeing obliteration of vessels, noted Dr. Conroy.

Some have associated another LCV called microscopic polyangiitis with HBV, but most think there is no association. It does, however, have lung and renal involvement, and can get severe very quickly.

Churg-Strauss Syndrome is a systemic vasculitis that is a triade of asthma, allergic rhinitis, and peripheral eosinophilia.

The Big 5 are much rarer than the Little 7s, concluded Dr. Conroy.

Migrating to an EHR Environment

What you want an electronic health record (EHR) to do for you will help determine which one you purchase, stated Edward H. Yob, D.O., of Dermatology Associates of Tulsa in Oklahoma.

The advantages of an EHR are many. It improves documentation, efficiency, communication; reduces costs and errors; avoids duplication; and offers decision support to help make a more accurate diagnosis.

The disadvantages are the expense, changes in practice flow, the long learning curve, staff resistance, and having to integrate current records. “The older you are, the longer the learning curve,” he noted.

Dr. Yob recommended learning as much about the product as you can before purchasing it. Determine if it will fit your practice style or if you will have to modify your style to fit the program. “Usually, it’s a little bit of both, but you want it to blend with your style,” he said. Visit a similar office to see how it has been integrated and witness the product in action.

Decide if the product is easy to use. Will an inexperienced office assistant be able to use the product efficiently within a couple of weeks? The criterion Dr. Yob uses is if he can train someone who knows nothing about it.

You want to be able to customize the EHR to suit your practice needs. Often times, these products are primary care modules with a few dermatology templates. You really want a product that is truly geared toward dermatology. For dermatologists, an EHR wish list includes the ability to draw using a built-in touch screen, scan documents, track lesions that have been documented, display the histology of a lesion, archive photos, compare photos side-by-side, annotate

anatomic drawings where topical medication was applied, view pathology reports, and incorporate DermLex and ICD-9 codes into available coding vocabularies.

Being able to integrate the product is helpful, too. For example, you want the program to be compatible with your existing practice management system. But some EHRs have their own practice management systems. Also, you want the data from your current system to be transferable to the new one.

Do you plan to install the program on your server or is the application service provider a better model for your needs? The application service provider hooks into the Internet so it automatically updates. The bad news is that when the Internet goes down, so does your EHR.

Having ongoing tech support is important, as well. Also make sure that the EHR is certified by the Certification Commission for Health Information Technology, the lead certification organization.

The American Academy of Dermatology (AAD) offers help on choosing and implementing an EHR. In addition to its HIT Dashboard Web site (www.aad.org/pm/hit/HITDashboard), the Academy offers dEHRm, a free online service (www.aad.org/pm/hit/dEHRm/index.html).

The cost for EHRs is all over the place, said Dr. Yob. But he cautioned against basing the purchase on cost alone, and rather making sure the money you spend is a good value. The government has set more than one billion dollars aside for health information technology under the American Recovery and Reinvestment Act of 2009. A dermatologist could potentially get $44,000 over time, he said, but the government has yet to define how you get this money.

Another piece to the electronic puzzle is e-prescribing, which has been
mandated by the Medicare Improvements for Patients and Providers Act of 2008. E-prescribing should improve patient safety, decrease time spent on pharmacy phone calls, automate prescription renewal requests and prescription authorization process, increase patient compliance, and improve drug recalls and surveillance.

E-prescribing comes with financial incentives of up to two percent for practitioners who use qualified systems. For those who fail to e-prescribe by 2012, there is a two percent payment reduction. However, the government has yet to indicate what a qualified e-prescribing system is, Dr. Yob noted. Moreover, a dermatologist set up to e-prescribe has to find a pharmacy that is also capable of doing so. “Right now, most pharmacies are not set up to e-prescribe, so it’s a work in progress,” he added.

In closing, Dr. Yob stressed the importance of trying out an EHR before purchasing it. “You should be able to determine if the product is easy to use in a 30-minute demonstration. Remember, it’s an investment in the way you practice.”

The Academic Integrity of Our Testing Practices
The AOCD/AOBD provides both an in-training and board certification exam, as well as certification of added qualifications for dermpath, Mohs micrographic surgery, and soon pediatric dermatology. Starting in 2011, AOCD members will be required to obtain osteopathic continuous certification (OCC), which the College also will oversee.

The AOCD is required to perform testing by the AOA, the Department of Education, the Federation of State Licensure Board, and public opinion, explained Lloyd Cleaver, D.O., of Northeast Regional Medical Center in Kirksville, Mo., when discussing the integrity of the College’s testing practices.

Testing is a complicated process requiring several steps, he stated. The exam is based on the job analysis that the AOCD completes every five years. The information is collated based on frequency, importance, and required skill levels. “The job analysis basically acts as a road map for test construction,” said Dr. Cleaver. Then members of the Education Evaluating Committee determine how much of the test should address those areas. The test looks for knowledge, but also application and comprehension. It includes core competencies, as well.

Once this information is compiled, it is time to write the questions. A good question takes more than one hour to write, he noted. Previously program directors, AOBD members, and AOCD Executive Committee members wrote the questions. But the AOCD recently formed an Item Writers Committee, which will hold its first meeting this July. Moving forward, committee members will be responsible for writing the questions for all of the aforementioned tests.

The AOCD continues to strive for reliability in all of its tests. Every effort is made to have the in-training exam more closely resemble the certification exam, stated Dr. Cleaver. In addition, the tests have to be psychometrically valid. The AOCD hires a consultant to do the latter.

The AOCD doesn’t actually grant certification, the AOA does, he explained. But there are multiple steps and entities, such as the Bureau of Osteopathic Specialists and the Board of Education, that get involved before certification is granted.

Regarding OCC, all certifications are now time-limited and individuals will have to obtain continuous certification. “This was not our decision, it was mandated by the AOA and the Federation,” said Dr. Cleaver.

Components of OCC include an unrestricted license, life-long learning of 50 hours worth of Category 1a over a period of three years, optional additional training through certified CME, a nine-year cycle corresponding to the three-year CME cycle, a proctered exam directed at more clinically relevant material than the certification exam, a clinical assessment program, and peer and patient review. A clinical assessment program has been used in the AOA for some time, he noted. It requires a standard method of collecting performance information using evidence-based measures to facilitate both practice-based learning and system-based care. The AAD’s melanoma measure is an example.

In an effort to continually improve the process, the AOCD will be surveying individuals who took the most recent test. “We are a service organization and we want to provide the best testing and customer service possible,” concluded Dr. Cleaver.

The Medical Home
The concept of a patient-centered medical home has its foundation in primary care, said Hollis Coblentz, D.O., the Associate Medical Director at Fallon Community Health Plan in Worcester, Mass. Patients are cared for by a physician who leads a medical team that coordinates all aspects of the patient’s healthcare needs using the best available evidence and appropriate technology. The use of an EHR is integral to the concept, she said.

The medical home concept actually dates back to the 1960s when it was developed by the American Academy of Pediatrics for children with special needs. The idea was expanded upon by the American Academy of Family Practice. In recent years, it has gained support from the AOA and the American College of Physicians.
In 2007, all four associations developed joint principles of the patient-centered medical home. These include a personal physician, a physician-directed medical practice, a whole person orientation, care that is coordinated and/or integrated, quality and safety as hallmarks, enhanced access, and payment that recognizes the added value.

Studies have shown that the use of a medical home increases coordination of care and decreases costs, said Dr. Coblentz. As an example, a 2004 Commonwealth Funds report suggested that medical homes are associated with lower cost per capita. Another one of its studies shows that medical homes can reduce or eliminate racial and ethnic disparities by improving access and quality for insured persons. Using a medical home, people would no longer need to enter the healthcare system through the emergency department. Patients with chronic diseases have fewer complaints, leading to fewer avoidable hospitalizations. According to the Center for Evaluative Clinical Sciences at Dartmouth, patients with chronic diseases who have relied more on primary care have lower Medicare spending, resource inputs, and utilization as well as better quality of care.

The National Committee for Quality Assurance is in the process of developing standards that will enable a practice to be certified as a Physician Practice Connections–Patient Centered Medical Home practice. It is expected to complete these standards by 2011.

One year ago, Dr. Coblentz became involved in a state initiative for a medical home pilot. Forty organizations joined forces to figure out how to structure a medical home, train people to work there, and receive reimbursement for their services.

Among the lessons learned are maintaining a persistent process of change is difficult; technology is necessary, but more difficult and time-consuming than envisioned; people experience change fatigue; and an adaptive reserve is necessary. “Sometimes you just need to back off because people don’t have the capacity to continue to make changes,” she said. “And remember that these are motivated practices running into these roadblocks. What about those that are not motivated?” Dr. Coblentz expects it will take another year or two before the pilot project is off the ground.

At this point, nobody knows where specialists fit in to the medical home, which is not supposed to serve as a gatekeeper, but rather to increase coordination of care, she said. It is anticipated that primary care physicians (PCPs) will have more time to look at all aspects of patient care, possibly resulting in fewer referrals. They may even start doing minor procedures themselves. It will require more integration of care and communication between the specialists and PCP. Innovative ways for specialists to partner with PCPs in a medical home may be to teach or triage e-referrals or conduct telemedicine, concluded Dr. Coblentz.

If you attended the Midyear Meeting, you may have noticed that there was WiFi in the lecture room on Thursday, Friday, and Saturday. This is the first time that the AOCD made this option available at one of its meetings. If you would like to have WiFi capabilities for future meetings, please e-mail Marsha Wise (mwise@aocd.org) at the AOCD office to let her know.
A CALL FOR PAPERS

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/jaocd. 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