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

AOCD ANNUAL MEETING 2011
October 30 - November 3, 2011
Orlando, FL

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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.
Message from the President

San Francisco is still fresh in my mind. I hope you all enjoyed it as much as I did. The turnout for the Welcome Reception at the San Francisco Museum of Modern Art was excellent and people stayed well past the scheduled time. It provided an opportunity for dress up, and the more than normal formal wear blended well into the museum environs. The dueling pianos at the Presidential Banquet arranged by Dr. Marc Epstein was a surprise ending to an excellent dinner.

There were so many highlights of the meeting that I can’t select any single one. But the presence of international guest speakers reflected the broadening scope of our College and its contribution to the AOA’s annual Osteopathic Medical Conference and Exposition. I was impressed with the quality of some of the residents’ presentations. However, others indicated a need for improved mentorship regarding PowerPoint preparation and presentation. Perhaps that’s an area where the College can provide some guidance in the future.

My experience in arranging this meeting was a hands-on learning opportunity. It was a great deal of work, but I had excellent help from Drs. Ed Yob and Lloyd Cleaver, Marsha Wise, and others. I hope you all were as satisfied with the results as I was. I believe the hard work that was required to put the program together was an opportunity for me to give back to the AOCD, an organization that has benefited me throughout the years. I hope my continuing efforts as president will add further value to our College. I look forward to working with the membership and in particular I want to encourage the newer members of the AOCD to find opportunities to become involved.

I thank you all for this opportunity provided to me to serve as your president for the coming year.

Sincerely,

Leslie Kramer, D.O., FAOCD
AOCD President, 2010-2011
This is the start of my sixth and probably last year as a voting member of your Board of Trustees (BOT). So it, as with any change, will be bittersweet in some ways. Change at times is not very easy. It tends to be harder yet as we grow more mature and set in our ways. We tend to be more liberal and open minded when we are younger, and more conservative and closed minded when we are older. Your BOT needs all of your input, younger and older members alike, in order to prepare our College for the changes and challenges that inevitably lay ahead. As government intervention of medicine continues to escalate, so is the need for physicians to unite as members of their respective colleges. Their united voices will be heard and listened to, as they will represent a majority of physicians. Gone are the days where physicians could not only survive, but thrive, as islands unto themselves.

Our residents are our College’s lifeblood and its future. They bring fresh new views and ideas on which the AOCD can grow and prosper. We need to foster and instill in them the importance of being involved in the College during their residency and throughout their careers. This responsibility falls on all of us; the residency directors, BOT members, and our fellows.

When I became your third vice president five years ago and was preparing for my first big responsibility as a Midyear Meeting program chair, I realized that the College had never had a live patient workshop at any of our educational meetings. I asked a now former BOT member why we never had one. He informed me that we would never be able to have a live workshop. Then he elaborated that workshops had been unsuccessfully attempted several times before. The viewpoint relayed was of a glass empty and not even half full. I would have approached mentoring a new vice president quite differently. I would have said, “Go for it, you may succeed where others have failed. I wish you luck and I’m here if you need advice.” If I had listened to this former BOT member, we would not have enjoyed and learned from two successful live patient workshops that were recorded and distributed to each residency program for future supplemental resident training. So change, in this case, was beneficial for the AOCD and its members.

I’m not sure if our residents and fellows, who are not former BOT members realize this, but the entire Presidential Banquet is the responsibility and vision of your outgoing president with the help of the executive director. Within the financial restraints and responsibilities of the College, the outgoing president can create a banquet that reflects on his or her personality and tastes. I decided that I wanted to restore the banquet to a celebration for the president, our BOT, fellows, residents, and honored guests. I felt the banquet should be something every member looks forward to and makes arrangements to attend. Attendees should expect and experience delicious food, libations, and desserts; good conversation; a modicum of tributes to the accomplishments of our residents, fellows, guests, and BOT; and then some excellent entertainment to enjoy and cap off another year of hard work. I hope those in attendance at this year’s banquet feel that I accomplished this task. I also encourage them to tell those who did not attend what a very memorable College event they missed out on. So again, change was beneficial, memorable, and enjoyable.

I also felt the need to make a few logistical changes in the banquet’s program in order to accomplish the task. So this year, I moved the resident awards to the general business meeting in order to foster better resident attendance.
AOA Installs First Female President

Like the AOCD, the AOA has a female president this year. Karen J. Nichols, D.O., has been installed as the 114th president of the AOA.

The first female AOA president will be tackling another first, that is, healthcare reform passed earlier this year. One way Dr. Nichols believes that the nation’s healthcare delivery system can be improved for the many more Americans who will now have access is through the wide-spread implementation of the patient-centered medical home—a healthcare model in which patients are cared for by a physician who leads a medical team, coordinating all aspects of the healthcare needs using the best available evidence and appropriate technology.

Moving forward with healthcare reform, Dr. Nichols, an AOA board-certified internal medicine physician, hopes to see a permanent repeal of the sustainable growth rate formula for Medicare physician payment. She also would like to see an increase in the number of osteopathic residency and fellowship positions.

Finally, we all achieved our goal of becoming physicians and then dermatologists largely by our own individual efforts in studying, observing and training. Only when we felt it was absolutely necessary did we ask for help from a fellow student, intern, resident, or attending. And even when it was offered without asking for it, we usually did not accept it. The unwritten, unspoken rule was that asking for or accepting help was in some way a sign of lesser intelligence or competence. We tended to do the same when it came to starting and running our practices. It has even carried over to leadership roles in various local, state, and national organizations. It has occurred within your own college’s BOT and executive committees. It is a learned and very bad habit that needs to change and the sooner, the better. How much more could we be, as individuals and as a College, if we asked for help when we needed it and genuinely offered it when we saw that it was needed? So I paraphrase great words of wisdom, as I did during my acceptance speech at the beginning of my presidency and at the end of my presidency during the banquet, “Ask not what your College can do for you, but what you can do for your College.” By our members helping and supporting the AOA, the College will be able to help and support you when you need it the most.

Sincerely and fraternally yours,

Marc I. Epstein, D.O., FAOCD
Immediate Past President
Executive Director’s Report
by Marsha Wise, Acting Executive Director

For those of you who could not attend the Annual Meeting in San Francisco this past October, the following reports are highlights of those presented by the various committee chairpersons.

As Acting Executive Director, I reported that the central office was undergoing some changes, and was appreciative of everybody’s patience. In addition to the changes being made to the basic standards for residents, the CME reporting requirements will undergo some changes, as well. In the meantime, the training programs are current with inspections. I urged the residents to sign up for lectures to be presented at the 2011 Midyear Meeting in Marcos Island slated for March 16-19.

Treasurer Report
Dr. Jere Mammino reported that the College’s total assets are $667,000 as of Sept. 30, 2010. He indicated that the current economy has affected corporate membership and corporate contributions, the latter of which is down to approximately $210,000 this year to date. To remedy this decline in revenue, Dr. Mammino presented one of the BOT’s options to increase membership dues as follows: raise general membership dues from $300 to $400; resident membership dues from $75 to $100; and student dues from $25 to $75. However, a member in attendance proposed keeping the resident and student memberships the same and raising the general membership dues by $125, which following some discussion, the membership voted to do.

AOBD Committee Report
Dr. Stephen Purcell reported that 32 in-training exams were administered on Sunday. He also talked about the question writing workshop offered by the American Osteopathic Board of Dermatology (AOBD) in collaboration with the College held this past summer. A group of approximately nine volunteers attended the training session to learn how to write test questions in a psychometrically valid fashion. Dr. Purcell indicated that improving the in-training exam is an ongoing process and praised the efforts of In-Training Exam Committee (ITEC) members. He encouraged members to join the ITEC.

Dr. Purcell reported that the AOBD is continuing to develop a plan for the Osteopathic Continuous Certification (OCC) to be in place by 2014. He anticipated that it will be either a nine- or 10-year cycle, which is dictated by the AOA. The OCC will consist of ongoing CME, a recertification exam, and a clinical assessment program. In 2014, the first test for dermatologists who graduated in 2004 will be given. However, the AOBD will have the test available in 2013 and Dr. Purcell suggested that individuals might want to take the test then to avoid failing the test in 2014 and then not being certified until 2015.

Awards Committee Report
Dr. Michael Scott presented Koprince Awards to the resident winners from the 2009 Annual Meeting in New Orleans as follows: Drs. Johnny Gurgen, Lyubov Avshalumova, Saira Momin, and Sabrina Waqar. Resident winners who presented at the 2010 Midyear Meeting in Sedona also were given their Koprince Awards. They are as follows: Drs. Michelle Jeffries, Julian Moore, and Susun Bellew.

Next, Dr. Scott presented winners of the Bernard Award. The third-year residents nominated by their program directors are as follows: Drs. Bellew, Gwyn Frambach, Albert Rivera, and Peter Morrell.

The winner of the Australian Surgical Award was presented to Dr. Rivera.

The Intendis Research Award for residents announced by Dr. Gene Conte was presented by Intendis representatives Keith Flanders and Matthew Zinsky. First place went to Dr. Avshalumova, second place went to Dr. Shari Sperling, a tie for third place went to Drs. Betsy Leveritt and Brook Bair.

The Ulbrich Research Award was presented to Dr. Angela Leo for her research on the use of botulinum toxin for treatment of nostalgia paraesthesia.

Dr. Stanley Skopit presented Fellow Membership Certificates. The following members were eligible: Drs. Danica Alexander, Sanjay Bhambri, Aaron Bruce, Christopher Buckley, Marianne Carroll, Billie Casse, John Coppola, Alice Do, Brian Feinstein, Marcus Goodman, Daniel Hansen, Heather Higgins, Mollie Jan, Todd Kreitzer, Karthik Krishnamurthy, Lela Lankarani, Angela Leo, Elliot Love, Joseph Machuzak, Daniel Marshall, Tony Nakhla, Bradley Neuenschwander, Ramona Nixon, Jami Reaves, Lawrence Schifflman, Allison Schwedelson, Roger Sica, and Brian Stewart.

CME Site Selection Committee Report
Dr. Robert Schwarze announced that the 2011 Midyear Meeting will be held at the Marriott in Marco Island, Fla.; the 2012 Midyear Meeting will be held at the Hilton in downtown Branson, Mo.; and the 2013 Midyear Meeting will be held in Winter Park, Colo. He said that the Marriott is on the beach in Marco Island. Naples is the closest airport. However, members could fly into Miami and drive down Alligator Highway to the site, which would take approximately 90 minutes. For the Branson meeting, Dr. Schwarze said that members could fly into Springfield, Mo., and take a shuttle to the hotel. They won’t have to rent a car to get to the site. He held up a newspaper clipping of Branson that refers to the city as a “mini Las Vegas minus..."
the gambling.” Dr. Schwarze is still researching hotels for the Winter Park meeting.

**Education Evaluation Committee Report**

Dr. James Bernard reported that the committee is working on revisions to the basic standards as well as the pediatric dermatology subspecialty program. He encouraged members to sign up to become inspectors to evaluate the residency programs.

**Foundation of Osteopathic Dermatology (FOD) Committee Report**

Dr. Bradley Glick reported that the FOD has $20,000 to fund research. He elaborated on his recent proposal to create a Circle of Giving with different levels of support named after founding fathers of the AOCD. For example, the Ulbrich Circle would be for members who contribute $10,000 (i.e., $1,000 over 10 years) honoring founding member Dr. A.P. Ulbrich. Dr. Glick declared himself the first member of the Ulbrich Circle, followed by Dr. Marc Epstein.

**Internet Committee Report**

Dr. Mammino reported that the AOCD website received more than three million visitors this year to date. It is in the top one percent of websites visited on the Internet. He also informed the members that he would be stepping down as the committee chair to be replaced by Dr. Rick Lin.

**ITEC Report**

Dr. James Towry reported that he hasn’t heard anything negative about the in-training exam given at this meeting. He credits ITEC members for the improved quality of the exam. Dr. Towry informed the members that he would be stepping down as committee chair.

**Nominating Committee Report**

Dr. Donald Tillman noted the importance of choosing trustees who become the College’s future leaders. He also encouraged newer members to join committees.

Dr. Tillman listed the Nominating Committee’s recommendations for the current officer slate; Dr. David Grice as Third Vice President, moving up from trustee; and Dr. Mammino as Secretary/Treasurer. As no nominations came from the floor, the membership voted in the current officers. (See story entitled “New Officers Inducted at 2010 Annual Meeting” on page 18.)

Then Dr. Tillman named the Nominating Committee’s list of candidates to fill two trustee positions as follows: Drs. Mark Kuriata, John Minni, Bryan Sands, and Valerie Gershenhom. However, he reported that Dr. Sands withdrew his name as a prior commitment would prevent him from attending next year’s meetings and Dr. Minni could not attend this year’s Annual Meeting as he had a prior commitment. Dr. Kuriata spoke briefly. Afterwards, a nomination for Dr. Alpesh Desai came from the floor. After Dr. Desai spoke briefly, the membership voted in Drs. Kuriata and Desai as the new trustees.

In other business, Dr. Frambach introduced the new resident liaison, Dr. David Kasper, a second-year resident at Genesys Regional Medical Center. After Dr. Leslie Kramer was announced as the winner of the raffled off dermatoscope, the meeting was adjourned.

**Baby News**

Congratulations to Jonathan Keeling, D.O., and his wife, Julie, on the birth of their second son, Nathaniel Lee Keeling. Nathaniel was born Sept. 12, 2010. He weighed 7 pounds, 12 ounces and was 21 inches long. Nathaniel has a brother, Jack, who is two years old.
Legendary football coach Lou Holtz, who turned several losing football teams into champions, elaborated on how to build a winning team during his keynote speech at the opening session of the AOA's Osteopathic Medical Education Conference and Exposition held this past October in San Francisco.

The coach began by recounting the time when he was named head coach at Notre Dame. Holtz said he remembers being told by his boss, “I can name you the head coach. I can give you that title, because titles come from above. But I can’t make you the leader.” Under his leadership, the team went on to become champions.

Holtz shared his methods and ideas, including the importance of having dreams. “Everyone needs a dream,” he said. “Everything begins with something to hope for.” To make his point, Holtz asked rhetorically if Martin Luther King Junior’s speech would have been as effective if he had said, “I have a strategic plan.” Holtz said the keys for building a winning team include a positive attitude, a passion to win, understanding your purpose, increased teamwork with increased challenges, constant improvement, and core values.

Regarding attitude, Holtz said it’s the most important choice every individual makes each day. “We’re all going to get knocked down sometimes,” he said. “You can have a great opportunity and not realize it, if your attitude is not right.”
AOCD Hits the Beach for 2011 Midyear Meeting

Mark your calendars for the 2011 AOCD Midyear Meeting slated for March 16-19. Come join your friends and colleagues at the newly renovated Marco Island Marriott Beach Resort Golf Club and Spa, nestled on three miles of pristine southwest Florida beaches.

A diversified CME program will focus on the art and science of dermatology. Didactic sessions will begin with the resident symposium on Wednesday and will continue Thursday through Saturday. Attending faculty will present a range of topics on dermatopathology, general, pediatric, surgical, and cosmetic dermatology.

Afternoons will be free to explore the many outdoor activities offered by the tropical surroundings. You may wish to go on a tour of the everglades, or watch the bottlenose dolphins, manatees, or more than 200 species of birds that call this area home. Charter fishing or sailing instructions also are available. Or you may prefer to stay near the resort and take in a round of golf or a relaxing massage.

So come and enjoy a break from your busy routine. Rekindle old friendships, make some new ones, and earn at least 20 CME credits in the process. Hope to see you there!

Karen Neubauer, D.O., FAOCD
Program Chair

DO Numbers Continue to Rise

The number of osteopathic physicians continues to increase, according to the AOA.

The total number of DOs is 70,480, which is up from 67,167 last year and from 44,918 in 2000. At the current rate of growth, it is estimated that more than 100,000 DOs will be in active medical practice by the year 2020, based on the AOA’s recently released 2010 Osteopathic Medical Profession Report.

In comparison to allopathic physicians, DOs comprise more than 10 percent of the physician population in 13 states, ranging from as far east as Maine and Delaware to as far west as Arizona and Nevada. In Michigan and Oklahoma, the proportion of DOs exceeds 20 percent. The highest percentage of DOs is practicing in Michigan, Pennsylvania, and Ohio.

Although DOs are licensed to practice in all specialty areas of medicine, more than half choose to practice in family practice and general internal medicine, the report indicates. Specifically, 39 percent practice in family and general practice, down from nearly 41 percent last year, while 11 percent practice in general internal medicine, up from 10 percent last year. The remaining portion is distributed across other medical specialties. Nearly 4,800 DOs are currently in residency programs, up from almost 3,300 last year.

In addition, more females are choosing to practice osteopathic medicine, the report shows, with almost half of all recent osteopathic medical school graduates being women.
Marco Island may be small in size at only four miles wide and six miles long, but it is large on lush tropical foliage and endless azure waters of the Gulf.

While attending the 2011 Midyear Meeting scheduled March 16-19, take an afternoon to visit one of the many surrounding natural attractions.

To the south of Marco Island lies the sprawling Ten Thousand Islands with more than 70 coastal miles of fishing heaven. You can rent a boat and fish offshore in the backwaters or fish the myriad canals that criss-cross the island, especially where and when the tidal currents are relatively strong. Or if you prefer, you can stake out a cozy spot near the two bridges connecting Marco Island with the mainland. There are plenty of marinas and tackle shops to meet your needs whether it is fly, spin, plug, or bait fishing.

Marco is the largest inhabited isle of the Ten Thousand Islands. The others have small fishing villages such as Goodland, Everglades City, Chokoloskee, and Flamingo. Explore the hospitality of laidback Goodland, which is home to approximately 200 residents. The stillness of the village, where cats and dogs can be found napping in the streets, changes drastically on Sundays when hundreds of residents and visitors make the pilgrimage to Stan’s for an afternoon of outdoor music, drinks, and dancing.

Included in this southerly stretch are a host of state parks where you can hike or bike trails, or tour the waterways via canoe or kayak.

The nearly 7,300-acre Collier-Seminole State Park lies partly within the great mangrove swamp of southern Florida, one of the largest in the world. Collier-Seminole also contains one of the three original stands of the rare royal palm in Florida. The park is the site of a National Historic Mechanical Engineering Landmark, the last existing Bay City Walking Dredge. Built in 1924, it was used to build the highway through the Everglades and Big Cypress Swamp, linking Tampa and Miami.

The Fakahatchee Strand Preserve State Park is a swamp forest, approximately twenty miles long by five miles wide. It hosts a wide array of habitats and forest types from the wetter swamps and prairies to the drier islands of tropical hardwood hammocks and pine rock lands. Its groves of native royal palms are the most abundant in the state and it is the only place in the world where bald cypress trees and royal palms share the forest canopy. The orchid and bromeliad capital of the continent, the park is home to 44 native orchids and 14 native bromeliad species. A haven for wildlife, Florida panthers still pursue white-tailed deer from the uplands across the wetlands. Florida black bears and Eastern indigo snakes, Everglades minks, and diamondback terrapins can still be found here, not to mention the resident...
and migratory bird life. West Indian manatees float about in slow motion while American crocodiles slip in and out of the tannic water to bask in the sun. There are canoes and kayaks for exploring nature up close. The water-weary can enjoy guided swamp walks.

The Big Cypress National Preserve features 729,000 acres of pines, hardwoods, prairies, mangrove forests, cypress strands, and domes. White-tailed deer, bear, and Florida panther can be found here along with the more tropical liguus tree snail, royal palm, and cigar orchid. For those of you who prefer a nice car ride, the Florida National Scenic Trail begins in the preserve and heads north through the state before it dead ends at Gulf Islands National Seashore near Pensacola.

The National Audobon Society’s Corkscrew Swamp Sanctuary is an 11,000-acre nature preserve featuring 225 species of birds, bobcats, alligators, and deer. Take the self-guided tour of the slightly more than two mile raised boardwalk that winds through four distinct environments: a pine upland, a wet prairie, a cypress forest, and a marsh. Allow two to three hours to fully appreciate it. If you don’t have that much time, there is an optional one-mile trail. Birds, reptiles, mammals, insects, and a variety of native plants including wild orchids may be seen from the boardwalk where volunteer naturalists await your questions.

The Everglades National Park is the largest subtropical wilderness in the United States with more than 1,000 species of plants, 40-plus species of mammals, nearly 400 species of birds, and more than 50 species of reptiles. The park stretches more than 100 miles from Lake Okeechobee and constitutes a total area of nearly 5,000 square miles. Numerous waterways, tidal bays, lakes, and streams dot the landscape. Sightings of alligators, crocodiles, turtles, manatees, snakes, black bears, deer, cougars, ibis, pelicans, white and blue herons, and a host of other exotic life are a daily occurrence. The park has been designated a Biosphere Reserve, a World Heritage Site, and a Wetland of International Importance.

Whether you are fishing in the backwaters, boating on the Gulf, birdwatching in the forest, or sashaying on the boardwalk in a state park, you can expect balmy breezes and sunny skies with a high of 82. Evenings, however, can bring on a chill with a low of 57.

To the north of Marco Island is the Rookery Bay National Estuarine Research Reserve. The reserve has a series of trails each approximately one-quarter of a mile long boasting its own native plant community complete with wildlife. The Shell Mound Trail follows a mangrove fringing shoreline. It runs adjacent to historical sites and an active habitat restoration project. Learn about the Calusa Indians who inhabited the island around 4000 BC. These native people are believed to be descendants of the Mayans. The Monument Point Trail has access to Henderson Creek and the Children’s Monument. The latter recognizes the efforts of school children in establishing the reserve. The Cat Claw Trail follows a natural storm berm that traverses through a tropical hardwood forest. It provides views of fringing red mangrove and black mangrove forests. The nature center features an elevated boardwalk to view a variety of wildlife, including more than 150 species of birds. You can also tour the area on a boat.

In the next issue of DermLine, explore the everglades and other activities to enjoy on Marco Island.
Melanoma is the most dynamic area of the specialty, noted Darrell S. Rigel, M.D., Clinical Professor of Dermatology at New York University Medical Center, who presented a melanoma update entitled *Melanoma Risk Factors and Diagnosis: What Our Patients Need to Know*.

Melanoma continues to be one of the fastest growing cancers with a doubling of incidence every 10 to 20 years, said Dr. Rigel, citing the latest figures from the Centers for Disease Control and Prevention. “The lifetime risk of developing melanoma is one in thirty-five,” he stated. “Eighty-seven hundred Americans will die from melanoma in 2010.”

While the number of individuals who develop melanoma continues to rise, so does the survival rate, noted Dr. Rigel. This is the result of early detection, which means that there is room for improvement when it comes to actually treating this cancer. Moreover, melanoma is one of the few cancers for which the cause—ultraviolet (UV) radiation exposure—is known and where simple behavior change—minimizing exposure—lowers the risk, he added.

Exposure to UV increases the risk of developing melanoma as it is a known carcinogen as identified by the Food and Drug Administration, stated Dr. Rigel, who cited numerous studies linking sun exposure to the risk of developing melanoma. Specifically, skin cancers exhibit p53 mutations that have been shown to be related to UV exposure. Moreover, carcinogenic changes in the skin are seen after only one unprotected UV exposure, he said. Regarding the relationship of melanoma to UV intensity: the higher the intensity, the stronger the link. Not surprisingly, the longer the exposure, the higher the risk of developing melanoma.

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60,000 tanning salons (with an average of four beds each) in the US. One million Americans visit tanning salons daily. Studies conducted in the 1990s were most likely inconclusive about the relationship between the use of tanning beds and the risk of melanoma development because of the latency from diagnosis to exposure, noted Dr. Rigel. Studies conducted after 2000, many of which he cited, show a direct correlation between the use of tanning beds and the risk of developing melanoma. In 2009, the World Health Organization declared that UV exposure from tanning beds is a significant carcinogenic.

Furthermore, science does not support the tanning bed industry’s claim that exposure to UV in tanning beds is safer than that from the sun. In fact, studies show that UV radiation in tanning beds is much higher than that in natural sunlight. Also contrary to the tanning bed industry’s claims, tanning beds do not increase Vitamin D levels in a healthy manner. The UV emitted from tanning beds is relatively ineffective in converting Vitamin D to its useable form, noted Dr. Rigel.

This year, the Federal Trade Commission filed suit against the tanning bed industry to rescind its claims that tanning beds are safe. The Tanning Bed Cancer Control Act, which would expand federal regulation of tanning beds by limiting the amount of UV rays emitted and the time consumers may be exposed to harmful radiation, also has been introduced in Congress. Although not a fan of the new healthcare law, Dr. Rigel was pleased that a 10% federal tax was placed on all visits to tanning salons, effective July 1, to replace the 5% tax on cosmetic procedures. The new tax is expected to raise an estimated $600 million annually. “Cosmetic surgery doesn’t raise healthcare costs, skin cancer does,” he noted.

"Early detection is important because melanoma is one hundred percent curable if caught early on," stressed Dr. Rigel. It is virtually incurable if caught in the late stage. Because survival is inversely correlated with Breslow thickness of the lesion, detecting melanoma before it reaches 1 mm is critical in reducing mortality from this disease, he added.

Studies consistently show that dermatologists are 80% accurate when it comes to diagnosing melanoma, said Dr. Rigel. Furthermore, dermatologists are significantly better than primary care physicians, even those assisted by computer systems, at diagnosing melanomas. The difference is in the dermatologists’ ability to recognize which lesions should be biopsied, he said. Still, Dr. Rigel would like to see the gold standard be set at 95%, which is where technology may help.

He then reviewed how the diagnosis of melanoma has evolved during the last 25 years. In the 1960s and 1970s, physicians evaluated symptoms, such as bleeding. In the 1980s, they looked at the clinical features using the “ABCD’s of Melanoma,” and eventually the “E.” Interest in cancer imaging as an aide to diagnosis has increased, as well. Melanoma is unique among cancers in that the imaging process is non-invasive, noted Dr. Rigel. In the 1990s, physicians began looking at subsurface features using dermoscopy, which he believes has improved sensitivity and specificity in a fairly dynamic way. The newest iteration is the multi-spectral digital dermoscopy, which "sees" at different skin depths using 10 spectral bands. In a recently published study—the largest prospective, blinded study ever conducted in melanoma detection—biopsy sensitivity was greater than 95%. The specificity of the dermoscope was 9.4%, statistically superior to the dermatologist evaluations at 3.7%.

Still, skin self examination and visual screening for melanoma remain the tried and true standbys. "Nothing replaces a good set of eyes for the diagnosis of melanoma," he said. This year, the two millionth individual was screened as part of the National Melanoma Skin Cancer Screening program.
run by the American Academy of Dermatology. Five years’ worth of data from screening has identified five factors that independently predict detecting a presumptive melanoma. They are a history of previous melanoma, age >50, absence of regular dermatologist, mole changing, and male gender. Having this information extrapolated to the clinical setting will greatly benefit dermatology patients, concluded Dr. Rigel.

Dermoscopy Update
New insights gained from the use of dermoscopy were the focus of the lecture presented by Ashfaq A. Marghoob, M.D., Director of Memorial Sloan-Kettering Cancer Center’s regional skin cancer clinic in Hauppauge, Long Island.

The Life Cycle of Nevi: In a study looking at background skin patterns of nevi in a population-based cohort of 5th graders, 40% had subtle dermoscopic patterns that could be recognized in the normal-appearing surrounding nevi. Individuals with reticular nevi background skin had a reticular pattern. Those with structureless nevi background skin had a homogenous structureless pattern. There also were “incipient” nevus nests in 1% of the cohort. Dr. Marghoob hypothesized that the incipient nests may be potential seeds from which clinically-apparent nevi arise and may be the origin of eruptive nevi in some cases.

Growth of Nevi: Most nevi grow in their own pattern that cannot be predicted, but there is a subset of nevi whose growth can be predicted, said Dr. Marghoob. Based on the Framingham SONIC study, 34% of children had enlarging nevi that retained the same dermoscopic pattern. Most did not have a peripheral rim of globules, which may be the most common pattern of growth in dysplastic nevus syndrome (DNS) patients. However, in children who have many moles and a family member with DNS, there is a predictable growth pattern on dermoscopy. This may be an early sign that the person will develop DNS, he added.

Involution of Nevi: Dermoscopic observations have shown that there are multiple ways that nevi can disappear, said Dr. Marghoob. Among them are halo nevus type regression, “peppering” type regression or apoptosis, and transepidermal elimination of nevi. The most common pattern is “simply, slowly fading away,” he noted.

Growth Rate of Melanoma: Dermoscopic observations have revealed the existence of “indolent” melanomas, said Dr. Marghoob. Slow growing melanomas grow at a rate of 1.2 or 0.5 mm per month. In a dermoscopy follow-up study of slow-growing melanomas, there was no significant correlation between tumor thickness and follow-up time or the proportion of in situ and invasive melanomas diagnosed over time. These melanomas don’t follow linear growth patterns, either. These findings suggest that some individuals have thin, indolent melanomas that may not progress to death, he said. Hence, slow growing melanomas can be categorized into two sub-types: slow growing lesions that eventually metastasize, and indolent and regressing lesions, noted Dr. Marghoob.

Three Roots to Melanoma: If the stem cell theory is correct, the stem cell will grow in the hair follicle, eventually spread to other hair follicles, and then develop a lesion, he explained. Dermoscopic observations support the concept of different stem cell populations giving rise to lentigo malignant melanoma, superficial spreading melanoma, and nodular melanoma.

Collagen is Altered in Melanoma: When melanoma is thin, it requires collagen to spread, noted Dr. Marghoob. This “collagen scaffold” enables the melanoma cells to grow vertically. The collagen is seen as chrysalis structures, which can only be seen with polarized light dermoscopy, not standard dermoscopy. The chrysalis structures appear to have more superficial basal cell carcinomas than nodular carcinomas. Consequently, this collagen alteration allows for the diagnosis of a new subset of melanomas, he explained.

Neoangiogenesis in Melanoma: When collagen is altered, atypical vascular structures can be seen using polarized light dermoscopy. In addition, it has been observed that when collagen is altered, neoangiogenesis occurs, said
Dr. Marghoob. Consequently, the use of polarized light dermoscopy can assist in diagnosing melanoma, for example, in thin melanomas, which represent 30% of all melanomas, he noted.

*Dermal-epidermal Junction Remodeling Occurs During Melanoma Progression:* The remodeling process in superficial spreading melanoma starts at the dermal-epidermal junction. Pathologists call this regression, but Dr. Marghoob believes that it is actually progression because it allows the melanoma to grow deeper. He is trying to get pathologists on board with his view. Dr. Marghoob noted that when tumors are in regression, they do well. When tumors are in progression, they don’t do well. This will eventually translate into how patients are treated.

“Dermoscopy has opened up a window into a new world of clinical research, which offers many new insights,” he concluded. “It’s an ideal instrument for translational research from bedside to bench and back. It holds answers to questions that we have not yet asked.”

**New Melanoma Staging Criteria**

“The reality is that staging is a process in evolution,” stated Merrick I. Ross, M.D. FACS, Professor, Department of Surgical Oncology, and Chief, Melanoma Section at the University of Texas, MD Anderson Cancer Center in Houston, referring to melanoma staging. He went on to review the changes that occurred in the American Joint Committee on Cancer (AJCC) Melanoma Staging System in 2009.

Goals for the AJCC Staging System are as follows: (1) Maintain the tumor-node metastasis anatomically-based framework, which should be relevant to contemporary clinical practice. (2) Identify the most powerful prognostic markers by expanding the multi-center database and conducting multivariate analyses. (3) Establish prognostic groupings in order to minimize prognostic heterogeneity and overlap. (4) Develop recommendations for routine reporting of histologic factors. (5) Develop an inclusive mathematical model that includes a number of risk factors.

To accomplish these goals, 14 melanoma centers in the United States, Australia, the Netherlands, and Italy contributed to the AJCC Melanoma Task Force Collaborative Database, which comprises nearly 50,000 patients. The task force developed and validated a predictive model that incorporates multiple and continuous prognostic variables for Stages I, II, and III.

Regarding approved changes in 2009, there were no major changes in classification recommended for tumor-node metastasis and stage grouping criteria for Stages I, II, and III as the earlier models were validated using the AJCC database.

For the Stage III population, changes to the staging system focus on the regional metastases process. Now the most important factor for Stage III is the number of positive sentinel lymph nodes, followed by ulceration, and tumor burden (microscopic versus macroscopic). “It is an evolving paradigm to look at microscopic disease,” stated Dr. Ross. Also, metastatic melanoma from an unknown primary site arising in lymph nodes, skin, and subcutaneous tissues has been categorized as Stage III rather than Stage IV.

Updates to Stage IV include the first of its kind international database analysis involving more than 10,000 patients from databases from the US, Europe, and Australia. The database’s initial goal is to validate the sixth edition of the AJCC Staging System with regard to M site categories and serum lactate dehydrogenase level, the latter of which is an important prognostic continued on next page...
factor for Stage IV patients. Although all patients tend to do poorly in Stage IV, there seems to be a difference in prognosis in the M site categories. Another goal is to identify potential changes for the seventh edition, of which there are none planned.

The AJCC Melanoma Task Force is in the process of developing an individualized melanoma patient outcome prediction tool based on the its database. The online tool will include covariates such as institution, age of stage IV diagnosis, gender, primary site, serum lactate dehydrogenase at stage IV diagnosis, M category, number of recurrent sites, Stage IV diagnosis, and disease-free interval. This is the next generation of analyses in process, concluded Dr. Ross.

Melanoma Workshop

After Drs. Rigel, Marghoob, and Ross completed their presentations, they reviewed interesting melanoma case studies in a panel discussion moderated by Edward H. Yob, D.O. The 17 cases submitted by attendees ranged from animal-type melanoma and congenital nevus to recurrent pigmented lesions within a skin graft on the sole of the foot to multiple in-transit metastatic lesions on a single limb. The panelists were asked to discuss such issues as treatment of melanoma in young patients, rapid progression of disease, implications of hormonal effect on melanoma, evaluation of congenital nevus on the sole of an infant’s foot, and imiquimod treatment of extensive lentigo malignant melanoma on the scalp, among others.

Genital Emergencies

Gynecologists and urologists don’t know much about genital skin, said Ted Rosen, M.D., of the Baylor College of Medicine in Houston. They try steroids to treat the skin condition, but they usually don’t use them in a strong enough strength or for a long enough time.

A genital emergency typically has an acute onset; has symptoms such as itching, pain, bleeding, or pussing; requires timely diagnosis and therapy; is associated with a risk of serious functional loss or loss of life. “For dermatologists, a genital emergency is a big hole, especially if it hurts or is a big bump,” he said.

“You shouldn’t have ulcers down there,” stated Dr. Rosen. “A series of holes could be caused by syphilis.” The incidence of syphilis has risen dramatically in the past five years, he noted. Luckily, it still responds to a standard dose of benzathine penicillin. Often times, patients don’t finish the prescription because the syphilis clears up so they stop taking the pills.

Specific disorders that fall under genital emergencies include Crohn’s disease on the genitalia, Fournier’s Gangrene, genital strangulation, and genital bite wounds.

Extra-intestinal metastatic Crohn’s causes long, linear erosions and ulcerations on the sides of the genitalia. It is acute in onset and usually painful. There are only 100 cases in the literature. “When patients present with cutaneous manifestations, there is almost always colonic involvement,” he said. Steroids will clear up the skin, but not the gut. Tumor necrosis factor blockers treat both the cutaneous manifestation and the gastrointestinal symptoms. Another treatment option is a high dose of metronidazole. These patients should be referred to a gastroenterologist.

A large bump can be basal cell carcinoma, Kaposi’s sarcoma, lymphoma, squamous cell carcinoma, or leiomyosarcoma. The largest bump is most commonly caused by squamous cell carcinoma, which is frequently asymptomatic, stated Dr. Rosen. The second most common cause is malignant melanoma. “For anything that is pigmented in the genitalia, at least consider a biopsy,” he said. “It could be a benign pigmentation or a nevus, but if you are unsure, biopsy it.” Genital skin heals very easily. An ancillary test, such as a smear or serology, is commonly necessary in order to diagnose the condition. “This is the rule, not the exception.”

Only 5% of all malignancies will manifest in the skin, he said. Metastases in the anogenital region are rare. On average, 24 months after the diagnosis is made, it metastasizes to the skin, which is a poor prognostic sign.

Fournier’s Gangrene, a necrotizing disorder of the genital or perineal skin and soft tissues, is almost always caused by local infection, such as E. coli or staphylococcal bacteria. The infection leads to tissue necrosis and loss, and can lead to sepsis and death. It usually originates in the gastrointestinal tract, skin, or urogenital tract. Patients present with swelling, pain, and erythema. There is some evidence of purulence, then thrombosis. The skin looks blue/black ischemic and ultimately it will slough because it’s dead. The necrotic tissue needs to be debrided to prevent the bacteria from getting into the blood stream. It can be treated with antibiotics based on the culture results.

Penile strangulation can be caused by such objects as a penis ring, rubber...
band, thread, wedding and other rings, clamps, hammerheads, and soda bottles. The object may need to be removed with cast cutters, a ring cutter, or a gigli saw. “It’s good to know an orthopedic surgeon, a jeweler, or a plumber in these cases,” said Dr. Rosen. If the object remains in place for 72 hours, venous outflow obstruction can lead to ischemia and necrosis.

Genital bite wounds can be accidental or deliberate, he said. They cause infection and lacerations that can very rapidly progress to necrosis. *Eikenella corrodens*, the gram-negative bacterium normally found in the human mouth, is responsible for the infection and should be treated with amoxicillin-clavulanate. The patient also should be given tetanus prophylaxis and the wounds should be irrigated.

**Great Residency Program Cases**

Cindy Hoffman, D.O., Program Director at NYCOM/St. Barnabas Hospital, opened the lectures of *Great Cases from Osteopathic Teaching Programs* with a case of unusual vulvar dermatosis, which turned out to be granuloma gluteale adultorum. The patient had previously been told she had syphilis by one doctor.

Richard Miller, Program Director of the NSUCOM/Largo Medical Center, presented a case of lepromatous leprosy. This was the first case he has seen in approximately 10 years.

Steven Grekin, D.O., Program Director at Oakwood Southshore Medical Center, presented a case of hidrotic ectodermal dysplasia or Clouston syndrome. The patient had short, thick hot pink nails in addition to hair loss. Genetic testing is the gold standard for diagnosis.

Stanley Skopit, D.O., Program Director at NSU-COM/Broward General Medical Center, discussed a case of sebaceous hyperplasia. The take-home message from this case is to submit all biopsies and excisions for histopathological confirmation.

Tanya Ernolovich, D.O., Program Director of Frankford Hospital, presented a case of palmar fasciitis and polyarthritis syndrome. This uncommon condition is often seen with ovarian cancer, which this patient had.

Schield Wikas, D.O., Program Director of Cuyahoga Falls General Hospital, discussed a case of pyoderma gangrenosum. This particular patient’s hands were affected, but it most commonly affects the legs. A literature review showed only 11 cases involving the hands.

Suzanne Sirota Rozenberg, D.O., Assistant Program Director at St. John’s Episcopal Hospital, discussed a patient who presented with inflammatory morphea. The patient was actually seeking treatment for poison ivy when this very early stage lesion was detected.

David Horowitz, D.O., Program Director at Western University Pacific Hospital, discussed two patients with epidermodysplasia verruciformis he encountered during a medical mission to Kenya he went on with his residents last year. There is a benign and malignant form of this disease, but the African form is usually benign.

Stephen Kessler, D.O., Program Director at Midwestern University/Alta Dermatology, discussed the use of porcine heterographs to close difficult wounds. He began using them approximately one year ago, and has had excellent results.

Bradley Glick, D.O., Program Director at Wellington Regional Medical Center, presented a case of disseminated superficial active porokeratosis. Although the patient improved using photodynamic therapy, he didn’t like the treatment. Next he tried medication with positive results within one month.

Daniel Stewart D.O., Program Director at St. Joseph Mercy Health System, presented four cases. They were as follows: mycetoma, leprosy, tungiasis, and phaeoacremonium species mycotic infection.

**Surviving Next 10 Years**

“In our profession, we discourage doctors from talking about money,” said Rick Lin, D.O., of the Dermatology Clinic of McAllen in Texas, during his presentation entitled *Surviving the Next 10 Years*. But he believes that there is nothing wrong with discussing money. The goal is to have total financial freedom, that is, “working because you want to, not because you have to,” said Dr. Lin. But you cannot achieve total...
financial freedom without careful planning.

Dermatologists get paid based on the number of patients they see. With only so much time in a day, dermatologists need to work smarter, not harder, he said. Learn to leverage your time by using technology, employees, and contractors. Dr. Lin recommended reading the book entitled *The Doctor's Wealth Preservation Guide* for tips on how to do that.

To illustrate how dermatologists will fare in the next 10 years, Dr. Lin went on to discuss a fictitious dermatology practice that grosses one million dollars a year. If that practice is in Texas, after paying 35% in taxes the dermatologist will pocket $357,500. If that practice is in California, after paying 45% in taxes the dermatologist will take home $302,500. After three to five years, the practice grows to gross 1.5 million dollars a year. In Texas, the dermatologist will pocket $650,000 whereas the dermatologist in California will bring home $550,000. So over the years, he said, the practice becomes more profitable.

But in 2011, dermatology practices will experience a crisis in cash flow because of a decrease in reimbursement as well as an increase in taxation, the cost of doing business, government regulation, and possibly inflation, said Dr. Lin.

In 2011, a 30% Medicare cut will translate into a 55% decrease in total revenues for new practices, he said. That means a new dermatologist practicing in Texas will pocket $162,500 in 2011, whereas a new dermatologist practicing in California will take home $137,500. For the three- to five-year old practice, a 30% Medicare cut will translate into a 45% decrease in total revenues. That means the dermatologist practicing in Texas will pocket $357,500 in 2011, whereas the dermatologist practicing in California will bring home $302,500.

The biggest of the tax changes is the expiration of the Bush tax cuts. But there also are the Obama tax increases, including a surtax on investment income, a Medicare tax on high wage earners, and additional Medicare taxes. Add to that the increased costs associated with increasing government regulations and the cost of doing business. The Medicare cuts combined with tax increases will translate into a 58% decrease of total revenue for a new practice and a 50% decrease for an existing practice. That means the new Texas dermatologist will pocket $150,000 whereas the new California dermatologist will take home $125,000. The existing practice in Texas will garner $330,000 for its boss compared with $275,000 for the dermatologist in California.

If the practice environment stays the course in the next 10 years, it will make no sense for new dermatologists to start their own practice, he said. New dermatologists working for someone else will begin to see a drop in their salary and bonuses. Existing practices will need to change their models in order to survive. Based on the economics alone, a government takeover is a real possibility in the near future, concluded Dr. Lin.

**The classic business model revolves around one’s reputation, good will, and intangible assets, he said. This model works well in the city in a competitive environment with educated patients, and when patients are more scarce than dermatologists. However, this model is vulnerable to cuts in reimbursement.**

The bleak economic picture favors a new business model of low profit and high volume, Dr. Lin noted. This model entails hiring new associates, not caring about one’s reputation, offering Walmart-style dermatology, and providing doc-in-the-box processing. Quality medicine is still possible with good quality control, he said. But patient satisfaction will suffer and the patient-physician relationship will deteriorate.

“You can practice the classic business model if you have already achieved financial freedom,” said Dr. Lin. To that end, he touched on methods for
achieving financial freedom, such as increasing efficiency, leveraging, expansion, tax and estate planning, and asset protection. As an example, strategies for increasing efficiency include using video cameras, managing employees, and using electronic medical records. Instead of buying a clinic building outright, own the building through a company that will lease the space to your practice. This can be written off as a passive income loss. Cash value life insurance can serve as an investment vehicle. The cash value can be borrowed against and paid back with death benefits. There is no income tax or capital gain tax on withdrawals. The taxation advantage makes it a worthwhile investment.

**Risk Management**

“Doctors who communicate the best get sued the least,” stated Abel Torres, M.D., Professor of Dermatology at Loma Linda University Medical Center in Calif.

Most lawsuits stem from poor communication, he added. Consequently, physicians need to learn to communicate effectively with patients. Establishing a doctor-patient relationship minimizes the risk of being sued, he said. Always ask the patient, “Have I answered your questions?” Make sure your staff is trained to either answer the patient’s question or find out the answer.

Consider informed consent as an opportunity for getting to know the patient. View it as a social interaction, said Dr. Torres, not as an obligation. Always review the risks as well as the benefits of any procedure. If the patient asks about your experience using a laser, for example, be honest about what it is. If a patient has unrealistic expectations, encourage him or her to seek a second opinion.

It’s nice to have informed consent in writing, said Dr. Torres. But that won’t stop the patient from saying, “I didn’t know what I was signing.” He includes a note in the consent indicating something unique to the patient. That way, Dr. Torres can bring it up in discussion if there is a question about the consent. Oral consent is as valid as written consent, he said, but the former requires a witness.

Dr. Torres used the pneumonic **COMPLICATIONS** to review the issues surrounding medical malpractice.

If a patient complains, acknowledge and investigate it, but never dismiss the complaint. It is okay to commiserate with the patient, but do not show remorse. Don’t accept responsibility, said Dr. Torres, because you may not have caused the problem. Stick to the facts, do not interject any Opinion. **Mitigate the damages** by addressing the patient’s needs. Offer Positive measures, that is, accept responsibility, but never Liability. Investigate what happened, never assume anything. Clarify any misperceptions. If the patient presents an incorrect fact, you should correct it immediately. Don’t criticize or point fingers. Consult other physicians, whom you trust, as needed. Be Accessible. Make sure the patient can reach you or a designated individual. The Truth cannot be overemphasized, he stated. Trust comes from honesty. **Inform** your malpractice carrier if the situation warrants. Discuss the option of writing off the patient’s fees. **Organize** a meeting to discuss the situation. **Note** and document the facts in the records, but never alter them. “Altering a record will lose you the case,” said Dr. Torres. If you need to change something, sign and date the change. **Save** the evidence. Never release the original records. “If you release them, you lose your protection.”

Regarding the question of apologizing when something goes wrong, he noted that the “I’m sorry works” movement used at many institutions is less effective for individual doctors. The whole apology process has to be done properly or it creates more problems, said Dr. Torres, adding, “It’s unclear that apology works as good as one thinks.” Dermatologists should check if they practice in one of the 34 states that have an apology law.

When a physician gets sued, his or her name gets entered into the National Practitioner Databank. However, if the doctor resolves the situation out of his or her own pocket, it’s not reportable to the databank. It might be worthwhile to do that, he said, but always consult an attorney.

Dr. Torres offered some strategies to keep lawyers at bay. Return telephone calls on your cell phone to ensure there is a record of them. Then document the phone conversations. Document what you didn’t do and why. Beware of patients and physicians who speak ill of others. Don’t take the patient’s word for something, such as she is not pregnant. Test to be certain.

Dermatology ranks 19th out of 28 specialty groups in the number of claims reported, according to the 2009 Physician Insurers Association of Amer-
ica’s Risk Management Review. The most common diagnosis error is missed melanoma, acne, dyschromia, and psoriasis, he said, adding, “We get sued for our bread and butter procedures, not cosmetic ones.”

In order to claim malpractice, there has to be a duty, a breach of it, causation, and damages. If you are approached by a person asking your opinion at a party, you can give advice, he said, but recommend that the individual go to a doctor. The standard of care as determined by an expert must be breached. Proximate causation shows that you are directly responsible for what happened. Damages must be an actual injury.

When going to court, Dr. Torres noted that a deposition can win or lose the case. Be familiar with the patient’s records. Don’t rush to answer questions or speak too much, he said. Listen to the entire question before answering. Never speculate. Talk about what you saw, heard, or did. Answer “yes” or “no.” Try not to use “I don’t know” too much. Don’t use “never” or “always.” Answering questions slowly helps collect your thoughts. Plus, it gives your attorney time to advise you. Ask to see all documents that are referred to. In addition to using neutral language, keep your composure, be respectful, and look the part. “Don’t get angry because it won’t accomplish anything,” Dr. Torres said.

**Sun Safety Lessons from Australia**

The only way to lower the melanoma rates, which are the highest in Australia followed by the United States, is to change the culture, stated Dr. Anthony Dixon, Assistant Professor (School of Medicine) at Bond University in Gold Coast, Australia, and Fellow of the Australasian College of Skin Cancer Medicine.

Australia has the worst possible solar risk because of its location. Plus, the sunny weather allows Australians to enjoy outdoor activities year-round.

In January 2009, Dr. Dixon started a melanoma awareness campaign in Australia. He targeted Surf Life Saving Australia, clubs set up across the country to promote voluntary lifeguard services and competitive surf sport. It originated in 1906 in response to drownings at local beaches in Sydney. There are 140,000 members, nearly 50,000 of which are children between the ages of five and 13 known as nippers.

Given that children are the most vulnerable because they play in the water and their sunscreen quickly washes off, Dr. Dixon focused on the clubs for nippers. The campaign called for keeping the children inside between the hours of 11 a.m. and 4 p.m. They should wear long sleeve shirts over their bathing suits and wide-brimmed hats when at the beach. The campaign promoted the use of sunscreen and tents on the beaches. A page about sun safety was even added to the 170-page life-saving manual distributed to all of the clubs’ members.

While many of the clubs responded, he said, others did not. Some of the reasons they couldn’t comply, Dr. Dixon was told, was because it was impossible for the children to wear wide-brimmed hats on the beach, parents complained that the new timing interfered with other activities, and the vendors wouldn’t sell as many sausages if the kids left the beach earlier.

At year’s end, Dr. Dixon went to observe club activities on three beaches. Only one of the three clubs he observed practiced sun safety. “If one beach can do it, they all can” he argued.

Sun safety must begin with pre-school age children because younger and younger Australians are getting diagnosed with melanoma. “We must teach them that the most dangerous thing on the beach is the sun,” Dr. Dixon emphasized. He noted that people are more informed about the dangers of being bitten by a shark than the importance of wearing sunscreen. “In Australia, there are more than 5,000 deaths from melanoma for every one shark attack,” Dr. Dixon said. “But the media loves shark attacks.”

He noted that the same lessons need to be learned in the United States.

The clubs recently polled parents asking what they can do better. The number one response was sun protection, said Dr. Dixon. “So we are getting somewhere. But we can do so much more to change this.”

**Psoriasis Update**

People with psoriasis are very fortunate because of the many treatment options now available, stated John Koo, M.D., Director of the UCSF Psoriasis Treatment Center. Today, there are topicals, phototherapy, systemic medications, and biologics.

Psoriasis must be treated with stronger topical steroids to yield results, said Dr. Koo, who has been treating the disease for 25 years. The problem is they can’t be used indefinitely. So studies are looking at how to minimize exposure to super potent topical steroids. One study found that halobetasol and ammonium lactate 12% used once a day was just as effective as using them twice a day, he said. The 12% lotion increases the duration of the halobetasol. However, the effect lasts only two weeks after discontinuing the steroid.
For long-term use, Dr. Koo recommended alternating two-week cycles. “This way, we use the strongest steroid and provide a holiday from it,” he stated.

Regarding phototherapy, there is not too much new about ultraviolet B (UVB) or psoralen plus ultraviolet A or PUVA. What is new is the UVB Excimer laser, which becomes more powerful and useful with time, said Dr. Koo. Instead of traditional phototherapy, supracerrethermogenic phototherapy with an Excimer laser is being introduced. One advantage of this new phototherapy is that instead of requiring 30 to 40 treatments, improvement can be seen in 10 treatments. In one study, 77% of patients with psoriasis on 20% of their body achieved a Psoriasis Area and Severity Index (PASI) score of 75 at 12 weeks. However, it is very tedious and not a good option for patients with type 1 skin because it blisters easily, he said. A follow-up at six months showed 82% of patients experienced a long-term remission.

Ongoing research is focusing on the concurrent use of UVB Excimer laser, clobetasol spray, and calcitriol ointment. “If you use all three, you can treat psoriasis effectively and quickly,” said Dr. Koo. There are questions about how aggressively to treat with the laser because patients could reverse. However, they are much less likely to burn because of the spray. Although the results are not final, so far patients have a PASI of 75 or better, he noted.

Studies are being conducted on the various biologics specifically alefacept, ustekinumab, briakinumab, etanercept, adalimumab, infliximab, and efalizumab. The majority of study patients are routinely achieving a PASI of 75 when being treated with these biologics. Eternecept appears to be pretty safe, but less efficacious than adalimumab or ustekinumab, said Dr. Koo. Adalimumab has higher efficacy than eterecept, quick onset, but no step down dose. The problem with infliximab is that it looses efficacy quickly. Both ustekinumab and briakinumab, which block interleukin 12 and 23 respectively, have demonstrated positive results in studies. However, there is some safety concerns with briakinumab.

Goeckerman Patier or black tar remains one of the safest and most effective treatments, he noted. In one study, 100% of patients had a PASI of 75 at 12 weeks. It also remains the most inconvenient treatment for patients. For dermatologists, black tar is getting more and more difficult to obtain.

**Leprosy Panel**

In 1894, patients went to the facility known as the Louisiana Leper Home to die because there was no treatment for leprosy, said James Krahenbuhl, Ph.D., Director of the National Hansen’s Disease Programs (NHDP), as part of a two-hour panel presentation on leprosy that closed out the Annual Meeting. In fact, patients were treated there until 2003 when the facility was closed. The NHDP moved to Baton Rouge to become the worldwide center for treatment and management of leprosy. “We do everything from reconstructive surgery and occupational therapy to the management of complications,” he said. There is a training and research program, as well. The research goal is to block transmission and understand the pathogenesis of leprosy.

The first big breakthrough for patients came in 1941 when a drug was developed to treat what Dr. Krahenbuhl referred to as “the most misunderstood human infectious disease.” There are approximately 6,500 cases of leprosy in this country with only 3,400 of them receiving treatment. Most individuals live in endemic countries. They see 150 new cases per year, 25% of which are US born endemic cases. The disease, which is prevalent in Texas and southern Louisiana, is linked to
The armadillo population. It is believed that armadillos transmit the bacteria to man. One way is through various craft items made of armadillos. However, 95% of the population is immune to the disease.

Leprosy is caused by the bacteria *M. leprae*, explained David Scollard, M.D., Ph.D., Chief of the NHDP Clinical Branch. However, it is unique in that it cannot be cultured. It is the slowest growing bacteria causing a profound delay in clinical diagnosis. Incubation is three to seven years, but may be as long as 10 to 20 years. Leprosy presents as cutaneous, but the lesions may vary significantly. It’s the only bacteria found in peripheral nerves, resulting in chronic infection of the skin and nerves. There are no diagnostic tests for it. The diagnosis is clinical. If leprosy is suspected, Dr. Scollard said that physicians can take a biopsy and send it to the NHDP where it will be reviewed for free.

Signs and symptoms of leprosy are hypoesthetic skin lesions, noted Barbara Stryjewska, M.D., Chief Medical Officer. There could be many, five or fewer, or no lesions. They could be asymmetrical or symmetrical. The lesions could be large or small, or have a vague or definitive edge. Patients with tuberculoid leprosy, considered the more benign type, usually have one lesion with well-defined margins with a scaly surface and local tender cutaneous or peripheral nerves. Patients with lepromatous leprosy typically have erythematous macules, generalized papular and nodular lesions, upper respiratory infiltration, nodules on conjunctiva or sclera, and motor loss.

Treatment involves taking two to three different antibiotics for one year for tuberculoid leprosy or two years for lepromatous leprosy. Even after the antibiotics kill the bacteria, which can take up to two years, they remain in the system. The longest Dr. Stryjewska has seen them is six years. Increasing the dosage of antibiotics doesn’t speed the process, she added.

The long-term problem with leprosy is neurologic, said Dr. Stryjewska. One-third of the 500,000 new cases reported worldwide will have nerve function impairment. Nerve damage can occur even after the bacteria are treated. However, an early diagnosis can mitigate nerve impairment, she noted.

Leprosy requires long-term management, said John Figarola, LOTR, CHT, Chief of the Training and Rehabilitation Branch. Between 30% and 40% of patients experience a disability, loss of protective sensation, and deformity. Sometimes these patients have clawed hands, which affect their dexterity and ability to grasp objects. They can experience muscle paralysis in the bottom of their feet, for example. This can cause deformity and eventually lead to amputation. The paralysis is related to the loss of sensation, he said, not the disease itself.

These patients may require special footwear and assistive devices to help with activities of daily living. They may require occupational or physical therapy, as well. It’s important to educate patients about how they will need to manage the disease by having their nerves and limbs assessed routinely by a physician and even conducting daily self-inspections, said Figarola.

“The physician’s initial reaction sets the tone of the patient’s recovery,” he noted, referring to the stigma associated with leprosy. People don’t realize that this disease is still around. When they are diagnosed, they are in disbelief, fearful, and confused. Sometimes they will ostracize themselves. “We need to educate the patient that the disease is curable and not easily transmitted,” said Figarola.
Hello Everyone,

It was great seeing many of you at the Annual Meeting. It’s hard to believe that 2011 is upon us.

The end of the year also means that the annual membership dues are now due. These can be paid online at www.aocd.org/membership.

In-Training Exam

Results from the 2010 In-Training Examination should arrive by year’s end. These will be sent to your program director.

Grand Rounds Online

Each program is once again asked to provide a case for the Grand Rounds website. The schedule will be as follows:

<table>
<thead>
<tr>
<th>Date</th>
<th>Presenters</th>
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<tbody>
<tr>
<td>January 5, 2011</td>
<td>Drs. Anderson and Kessler</td>
</tr>
<tr>
<td>February 5, 2011</td>
<td>Drs. Horowitz and Del Rosso</td>
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<tr>
<td>March 5, 2011</td>
<td>Drs. Cleaver and Way</td>
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<tr>
<td>April 5, 2011</td>
<td>Drs. Ermolovich and Tamburro</td>
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<tr>
<td>May 5, 2011</td>
<td>Drs. Silverton and Drew</td>
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<td>June 5, 2011</td>
<td>Drs. Grekin and LaCasse</td>
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<tr>
<td>July 5, 2011</td>
<td>Drs. Allenby and Glick</td>
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<td>August 5, 2011</td>
<td>Drs. Hoffman and Watsky</td>
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<td>September 5, 2011</td>
<td>Dr. Miller</td>
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<td>October 5, 2011</td>
<td>Dr. Stewart</td>
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<td>November 5, 2011</td>
<td>Dr. Skopit</td>
</tr>
<tr>
<td>December 5, 2011</td>
<td>Drs. Wikas and Hurd</td>
</tr>
</tbody>
</table>

The chief resident from each program is responsible for making sure that a case is submitted and notifying the AOCD when it is done. Please contact me for the sign-on information to submit your case.

Be sure to check out the Dermatology Grand Rounds on our website at www.aocd-grandrounds.org.

Next Intent-to-Lecture Deadline

As a reminder, the documentation/presentations for residents lecturing at the 2011 Midyear Meeting are due January 16.

Keep Info Current

Please remember to keep your contact information, such as your address and e-mail address, current. If you experience problems logging on to www.aocd.org/membership, please let me know.

Residents Update

by Marsha Wise, Resident Coordinator

June 5, 2011: Drs. Grekin and LaCasse
July 5, 2011: Drs. Allenby and Glick
August 5, 2011: Drs. Hoffman and Watsky
September 5, 2011: Dr. Miller
October 5, 2011: Dr. Stewart
November 5, 2011: Dr. Skopit
December 5, 2011: Drs. Wikas and Hurd

I am delighted to have the opportunity to represent you this year as the AOCD’s resident liaison. Having earned my MBA in Marketing and working for top pharmaceutical companies, I have worked with many different and unique personalities. My formal training taught me to understand how these individuals work together both positively and negatively. That is why this year, I would like to promote the AOA’s theme of Unity. Not only do we, the residents, need to unify and strengthen our relationship with our College, but we must better our relationship with other residencies and within each residency.

Webster defines unity as “the quality or state of being made one.” In order for us to become one, we must share our educational resources. One goal is to build a databank of outside electives that residents have found to be very educational so that others can partake in these opportunities. For example, I, along with a few other DO residents, have had the pleasure of working at the University of Pennsylvania, Department of Dermatology. This elective allows residents to participate in the Lupus, Psoriasis, Pigmented Lesion, General Dermatology, CTCL and/or Mohs clinics. The physicians staffing these clinics are thought leaders in the dermatologic field, hold high academic leadership positions within the American Academy of Dermatology, and have very unique and challenging cases not seen in most residency programs. It is imperative that we share these opportunities with each other because they can enhance our education and image while promoting the osteopathic profession.

My other goals will be to work with members of the Board of Trustees and the Education Evaluation Committee to better serve you and act as a conduit for your concerns.

It was a pleasure meeting everyone at this year’s Annual Meeting. This will be a fantastic year and I am pleased to be a part of it. I encourage you to share your thoughts, concerns, ideas, and solutions with me. I hope you will provide your input by responding to a few e-mails I plan on sending in the near future. I also encourage you to take an active role in the numerous committees within the AOCD. Let your voice be heard so that we can take part in shaping the College as we are the future of osteopathic dermatology.

I look forward to hearing from you during the course of this year. You may reach me at aocdresident.connection@gmail.com or call me at 717-648-5998.
Cole Diagnostics Offers Dermatopathology Grant

Cole Diagnostics is offering second- and third-year residents an opportunity to study dermatopathology for a two-week rotation in Boise, Idaho.

As part of the rotation with Ryan Cole, M.D., of Cole Diagnostics, residents will experience the speed, complexity, and intensity of a real-world dermatopathology practice. Being exposed to a high volume of cases will enable residents to recognize and understand information that will be valuable in practice and in studying for the board examination. Residents will be given personal study time to review lessons learned. Cole Diagnostics also will provide a formal curriculum supplemented by the use of teaching sets and board preparation materials.

The grant covers the cost of travel and living expenses for the rotation. Accommodations include a hotel in downtown Boise within walking distance of restaurants, entertainment, and shopping. For the outdoors type, the area offers beautiful rivers, foothills, and open space.

To request an application, contact Resident Coordinator Marsha Wise. For consideration, a completed application must be returned via mail, fax, or e-mail. The application should be mailed, sent to the attention of “Cole Diagnostics Dermatopathology Grant,” to the AOCD headquarters at PO Box 7525, Kirksville, Mo. 63501; faxed to 660-627-2623; or e-mailed to mwise@aocd.org.

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 rotation. Upon its completion, they must provide a five-minute summary to be presented at the next scheduled AOCD Annual Meeting.

Free Dermath Path Review Workshop Slated for April

Dermatopathologists and clinicians from Dermath Labs of Central States (DLCS) will offer a two-day workshop of challenging dermatopathology cases combined with clinical board preparation April 29-30 at Wright State University School of Medicine in Dayton, Ohio.

A half-day of clinical kodachrome lectures will be given on Friday and a full-day of unknown glass slides examination will be given on Saturday. The exam will be followed by a review. A reception will be held on Friday evening with food, cocktails, and door prizes.

The workshop is open to residents and dermatologists interested in sharpening their dermatopathology skills. Participants may opt to register for only the Saturday portion of the workshop.

Space is limited to the first 100 registrants. Registration is free. However, participants are responsible for travel and lodging fees. Discounted hotel rates will be arranged and travel information provided upon registration.

For more information, visit www.dermathlab.com or e-mail info@dermathlab.com. To register, visit the DLCS website at www.dermathlab.com.

Intendis’ ‘Call for Papers’ Competition Gets Underway

It’s not too early to start thinking about the Intendis Pharmaceuticals’ 2011 Call for Papers Competition.

Papers will be judged for originality, degree of scientific contribution, and thoughtfulness of presentation. Deadline for submission is May 25, 2011.

Winners may claim cash awards provided by Intendis as follows:

1st Prize—$1,500
2nd Prize—$1,000
3rd Prize—$500

Residents must be in an approved AOA/AOCD dermatology training program to enter the competition. They must submit six copies of the paper. Finally, they must complete a cover sheet that can be obtained by contacting Resident Coordinator Marsha Wise at the AOCD national office.

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

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

Winners will be announced at the 2011 AOCD Annual Meeting to be held October 30-November 3 in Orlando.
Dr. Mazzurco Travels ‘Down Under’ for Surgical Preceptorship

He attended lectures about dermatopathology, melanoma, skin cancer, and actinic keratosis. Dr. Mazzurco was even given an opportunity to present his paper.

One of the highlights was engaging in an active dialogue about how differently skin cancers are handled in Australia versus the United States. A debate ensued about evidence-based medicine (EBM) and the need to develop more EBM guidelines through large randomized, controlled studies in cutaneous oncology and dermatologic surgery. “There were a lot of questions that came up during that discussion,” he says. “It makes me want to delve more into cutaneous oncological surgery to start answering some of those questions. It was a great discussion for me as I was just entering practice,” adds Dr. Mazzurco.

After the workshop was finished, he spent three days shadowing Dr. Dixon in his office, which Dr. Mazzurco says functions purely as a skin cancer clinic. “It’s always refreshing to see new perspectives in how things are done surgically in cutaneous oncology, especially from a leader in the field.” As an example, physicians in Australia rarely perform Mohs Micrographic surgery, and rely much more heavily on the dermatoscope than we do in the States, he says.

Before he left the country down under, Dr. Mazzurco had an opportunity to take in some of its breathtaking beauty. His wife, Lauren, joined him for a three-day tour of the south coast of Australia. Dr. Dixon and his wife, Mary, served as travel guides through the rain forests and desert cliffs, which Dr. Mazzurco described as “incredible.”

He also used that word to describe the hospitality provided by Dr. Dixon and his wife. “They treated us like family. It is an experience that I will never forget.”

Jason Mazzurco, D.O., MS, attended a cutaneous oncology workshop this summer traveling nearly 20 hours and 10,000 miles to do so.

That’s because the workshop was in Australia. It was part of the dermatologic surgery preceptorship that Dr. Mazzurco was awarded for winning the Australian Surgical Paper Competition in 2009. When he won for his paper entitled Modified ‘Square’ Procedure for the Treatment of Lentigo Maligna and Lentigo Maligna Melanoma, Dr. Mazzurco was a third-year resident at St. Joseph Mercy Health System in Clinton Township, Mich.

Shortly after settling in on staff at St. Joseph, Dr. Mazzurco went to claim his prize: the preceptorship under Dr. Anthony Dixon, Assistant Professor (School of Medicine) at Bond University in Gold Coast, Australia, and Fellow of the Australasian College of Skin Cancer Medicine.

For starters, Dr. Mazzurco served as the chairperson of, and participated in, Dr. Dixon’s five-day Cutaneous Oncology Workshop for general practitioners and surgeons who treat skin cancers. Seventy percent of skin cancers are managed by general physicians in Australia, he says. Approximately 14 physicians from rural Australia and New Zealand attended. As a part of the course, Dr. Mazzurco and the workshop participants practiced performing numerous flaps and grafts on pig’s feet.
As a former psychologist, he prides himself on having a good rapport with people. “But when I go into a consultation with a female patient, nine times out of ten it ends up with crying,” Dr. Friedman says.

Women typically experience thinning of the hair, but don’t actually become bald. They also can camouflage thinning hair by wearing different hairstyles, wigs, scarves, and hats. In comparison, men’s hair pieces tend to look fake because they can’t show a hairline and they are made with more hairs per square inch than in the human head, let alone, a scalp that is thinning. Still, it is a much more sensitive issue for women than men. That is not to say that men take it lightly, Dr. Friedman says, but men can get away with not having any hair.

“Everybody has an Achilles heel, a part of the body that bothers them,” he says. “I think that hair is an Achilles heel for most people.”

Fortunately talking in public is not an Achilles heel for Dr. Friedman as he has appeared on local news programs and given interviews on local radio to promote his book during the past few months. Currently, the book can be purchased on Amazon.com, but eventually it is expected to be available for sale on other bookstore websites.

Dr. Friedman was compelled to write the book to dispel all of the misinformation out there. The myths include people go bald because they lack certain vitamins or always wear a hat. Hair loss is such a sensitive issue that people will purchase such gadgets as electric stimulation devices or scalp massagers in hopes that they will work, he says.

The Writing Process

Although Dr. Friedman had written several journal papers and articles for dermatologists, this was his first experience writing for a consumer audience. He had no idea how different the two endeavors would be. “When writing for your colleagues, you use a totally different vocabulary and vernacular,” says Dr. Friedman. “For the lay public, you have to break down all the words so that everyone can understand what you are trying to say. That is very difficult for physicians to do.” It is the difference between writing about androgenetic alopecia and hair loss. “Every medical word had to be translated into a lay word.”

Each time he would get pages back from the publisher to review, Dr. Friedman would start analyzing the words to make sure that they were at the appropriate reading level. “It got to a point where I couldn’t look at the book anymore because I kept editing it,” he says.

The best part about writing the book was being able to include photographs illustrating the positive results Dr. Friedman has achieved using either hair transplant or laser surgery.

How the Sexes View Hair Loss

The most difficult part was writing about women’s hair loss. “Hair loss is more poignant and devastating for women than it is for men,” says Dr. Friedman, who believes the difference in attitude is largely because of the emphasis that society places on women’s hair as a sign of beauty.

As a former psychologist, he prides himself on having a good rapport with people. “But when I go into a consultation with a female patient, nine times out of ten it ends up with crying,” Dr. Friedman says.

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With the press winding down on his current book, Dr. Friedman is considering writing another book, this one on cellulite.

40 million men and 30 million women in the United States suffer from hair loss.

As many as seven out of 10 people would trade a “treasured personal possession” for more hair, according to a 2010 survey published by the International Society of Hair Restoration Surgery.
It’s Friday evening and sounds of Lady Gaga, tambourines, and maracas fill the large dining hall. Rumors of crushes and whispers of who-danced-with-whom pass from ear to ear. Older chaperones sit on the sidelines, while the younger and much cooler chaperones join in on the DJ dance party.

Although this feels like your typical junior high school dance, the difference is that the kids attending this one all suffer from chronic skin conditions. Tonight, however, no one notices. It is graduation night at Camp Horizon in Millville, Penn., one of the Camp Discovery sites sponsored by the American Academy of Dermatology. Following a week of art projects, outdoor activities, and sports, tonight is the social event of the summer for these 8-year-olds to 13-year-olds.

The outrageous amount of energy on the dance floor is fueled by the campers’ lack of anxiety now that the talent show portion of the evening was over. After a week of practicing, they were no longer concerned about confusing a magic trick or missing a musical note. As the evening wore on, a definite sense of calm came over the group. This calm may just as easily be a misinterpretation of the exhaustion setting in after a full eight hours at Knoebels Amusement Park only a day earlier.

After a week of bonding and gossiping expected out of ‘tweens, tonight fully solidifies the reason Camp Discovery exists. Hair, or lack thereof, has no importance. Tonight dancing in a wheelchair may give you a special advantage with the ladies. Scales, papules, and bullae have no meaning. Perhaps the most touching moment was when an entire room of campers and counselors joined a beautiful young girl who is wheelchair bound due to a painful plantar keratoderma by sitting around her on the dance floor. Seated, we all danced side-by-side. It was a beautiful moment of togetherness that I will never forget. Later on, her camp crush, a junior counselor, swooped her up into his arms for a dance.

When I first arrived at camp this past August, I met one of the organizers riding on a golf cart. As it turns out, this is a very special privilege coveted by the campers. I found my cabin and chose a bottom bunk. There were 11 in our cabin: four counselors and seven campers. The daily 7:15 a.m. wake-up call brought us out onto a dewy lawn. After breakfast each morning, we listened to an inspiring thought for the day, followed by flag raising and the pledge of allegiance. Campers and seasoned counselors displayed their creativity with each new day’s theme. The hard work that was poured into the detail of costumes was rewarded with a showering of compliments and praise. My own costume for Unique Superhero Day may have gone unnoticed as I paraded as Pink Girl. We also
Activities were plentiful. We learned archery, painted artwork, swam, made candy, tie died t-shirts, and played sports from dawn to dusk. I even caught a 14-inch large mouth bass! We feasted on camp food, indulging in exorbitant amounts of delicious sugary snacks. After an intense evening of Minute to Win it, each group won a special prize. Our group chose an art lesson. However, other campers enjoyed private campfires, golf cart rides, special snacks, and evening swims to name a few. I hit the jackpot on casino night with two cotton candies and two blue snow cones, both my personal favorites. Each night, a new set of campers had the option to camp in tents under the evening stars. These evenings, the scent of burnt marshmallows wafted through the smoldering embers on the campfire.

Camps participated in campfire songs and scary ghost stories.

It is hard to imagine the amount of preparation that must happen throughout the year to make Camp Horizon such a seamless success. What started in 1995 as a four-day camp with 18 campers and a staff of approximately 15 volunteers has grown to a full week program with more than 80 campers and a staff of 65-plus volunteers. The 35-acre campsite features 10 sleeping cabins, a large mess hall, outdoor activity pavilions, a fishing and paddleboat pond, a low-ropes course, a pool, and a fully equipped infirmary simply known as the Med Shed.

The Med Shed and camp directors are the backbone of Camp Horizon, which is designed as recreation and respite to help the campers forget their chronic skin ailments. For this one week, the Med Shed and counselors assume this burden of worry. Overheating, exhaustion, and infection are constant concerns. Allergies abound in this outdoor setting with many of nature’s finest allergens. Constant vigilance is an absolute requirement, and children make their qd-tid Med Shed visits to ensure proper medical treatment throughout the week. The counselors, many of whom have serious skin conditions, offer support and advice to the campers. Activities staff provide constant entertainment for the kids, and were particularly invaluable on Sunday when we were stuck indoors with rainy weather.

I’m so thankful to each and every person at Camp Horizon for volunteering an entire week of their time away from home, family, and work obligations to give a week of much needed and deserved fun to kids with chronic skin diseases. And I am even more grateful to camp for reminding me to always be thankful for the beautiful, perfect skin wrapped around me.

Ortho Dermatologics Offers Resident Training, Board Review

Ortho Dermatologics offers several educational opportunities for AOCD residents.

For starters, the company’s Book Program provides residents with one free book each year of their residency for a total of three books. Residents can choose a book valued at $100 from a selected list. “We receive input from the field as to which books should make the list,” says Charles Hahn, Director, Market Planning and Professional Relations. “Many of them are used in resident training programs.”

For upcoming chief residents, Ortho Dermatologics offers AOCD residency programs the opportunity to send them to the Chief Academy, a weekend program focusing on practice management, personal development, and leadership skills. Lectures followed by panel discussions among the faculty and attendees comprise the program created by the Derm Education Foundation, a non-profit organization that develops educational software and products provided free-of-charge to students, residents, and physicians. The 2011 Chief Academy is scheduled for May 13-15 in Naperville, Ill.

In addition, Ortho Dermatologics helps DO residents train and prepare for the dermatopathology portion of their Board Exam by providing access to Virtual Dermpath. This virtual online microscope application uses streaming imaging techniques to duplicate the experience of using a light microscope. The virtual slide specimen is a digitally acquired image delivered over the World Wide Web in a format that enables residents to select from any number of diagnoses and view each at their leisure. This format enables residents to select fields of view necessary to make a diagnosis as opposed to being guided toward a diagnosis by examination of a series of pre-selected pertinent images. Virtual Dermpath also was developed by the Derm Education Foundation.

Finally, Ortho Dermatologics provides educational support for AOCD residents to attend various dermatology meetings across the country through a grant to the College.

“Ortho Dermatologics is a strong supporter of education and research in dermatology,” Hahn says. “The company believes that residents play a huge part in those endeavors, so if we can help them study for their boards or help them obtain better skill sets as they move forward in their careers, we take those opportunities.”

To learn more about these various opportunities, residents should contact their Ortho Dermatologics sales representative.

Los Angeles-based Ortho Dermatologics offers a line of anti-aging, anti-acne, anti-fungal, post-procedure care and specialty aesthetic brands that work to restore health and beauty to the skin.
The Pontiac/Botsford Hospital Dermatology Residency Program has been active in its community at home and at-large this past year.

**Summer in Michigan**

Twice this past summer, then second-year resident Fransica Kartono, D.O., and first-year resident Michelle Legacy, D.O., educated the Master Gardener’s Society of Warren County about safe gardening in the sun. During the gardener’s annual conference, Drs. Kartono and Legacy discussed basic skin anatomy, the relationship between sun exposure and skin cancer, ways to prevent cancer, and diagnosis and treatment options. They also demonstrated how to perform self-skin examinations. In addition, the residents reviewed plant-induced dermatitis and occupational hazards of being an avid gardener, including analyzing bugs from caterpillars to spiders that can be encountered in one’s backyard. While most people know that ticks cause Lyme disease, they don’t know that caterpillars can cause allergic and irritant contact dermatitis, says Dr. Kartono.

One afternoon this past June, then third-year resident Michelle Foley, D.O.; second-year resident Brooke Renner, D.O.; and first-year resident Jonathan Richey, D.O., MHA; lectured to Pontiac Osteopathic Hospital staff and employees about sun and skin safety, including pointers for individuals with darker skin types. The residents also set up a booth with free samples of sunscreen and passed out information about the controversy surrounding Vitamin D deficiency.

This year, the annual Skin Cancer Screening Event held by the residents was part of a multi-specialty cancer screening event sponsored by Botsford Hospital. The residents joined ear, nose and throat specialists; genetic specialists; gastroenterologists; and internists providing various cancer screenings. “We saw 107 people this year in one day of screening,” says Dr. Kartono. In addition, the residents provided lectures about sun safety. Next year, the residency program may offer two skin cancer screenings open to the public.

**Beyond Michigan**

In February, Drs. Kartono and Legacy and then third-year resident Derrick Adams, D.O., along with their Program Director Annette LaCasse, D.O., traveled to Guatemala as part of the DOCARE International medical mission that the residents participate in annually. Based in Tecpan, they branched out to rural communities, serving local villagers come to the clinic for medical care.
approximately 3,600 people during the course of their two-week stay.

Going to Guatemala allows residents to witness the progression of diseases in their natural course, which is academically beneficial, says Dr. LaCasse. Additionally, it underscores the importance of early detection and intervention to maintain a good quality of life in patients with dermatologic conditions.

Commonly seen dermatologic conditions included actinic prurigo, contact dermatitis, scabies, irritant dermatitis, and lichen simplex chronicus. The residents and Dr. LaCasse did their best to treat the common diseases with the limited supplies available to them, which included six types of topical medications, antihistamines, and antibiotics. “We couldn’t write prescriptions like we could back home,” says Dr. Kartono. “We had to make use of what we had. By the end of the day, we often ran out of supplies and sometimes compounded medications on site.”

Educating Guatemalans about the importance of protecting their skin, which is darker and is not prone to burning, was as important as treating their dermatologic conditions. “We would explain that they can get skin damage and rashes triggered by the sun even if they don’t burn,” she says. “The problem is that sunscreen is considered a luxury there. So we would try to convince them to buy long-sleeved shirts and stay indoors when possible.”

In 2011, both Drs. Legacy and Kartono plan to embark on another international adventure to Botswana as part of the American Academy of Dermatology’s Resident International Grant Rotation to learn more about teledermatology, as well as tropical and HIV dermatology. Dr. Legacy plans to go in February and Dr. Kartono plans to go in March.

AOCD Thanks Meeting Sponsors

The AOCD wishes to thank the following companies for their sponsorship at the 2010 Annual Meeting:

- Biopelle, Inc. for sponsoring the Welcome Reception held at the San Francisco Museum of Modern Art.

- Global Pathology Laboratory Services for sponsoring the Golden Gate Bridge-themed Presidential Banquet befitting the host city.

Intendis for support of the meeting and the Writing Award.

3Gen for the dermatoscopes the residents used for the in-training examination and boards.

Medicis-The Dermatology Company and Centocor-Ortho BioTech for providing travel grants for residents attending the meeting.

In addition, several companies provided educational grants, for which the AOCD is thankful. They are as follows:

- Amgen
- Astellas
- Biopelle
- Centocor-Ortho BioTech
- Coria
- Dermpath Diagnostics
- Galderma
- Global Pathology

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

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A CALL FOR PAPERS

Journal of the American Osteopathic College of Dermatology—JAOCDD.

We are now accepting manuscripts for the publication in the upcoming issue of the JAOCDD. ‘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