American Osteopathic College of Dermatology

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Upcoming Events

AOCD ANNUAL MEETINGS
Oct. 7-11, 2012    San Diego, CA
Sept. 30- Oct. 4 2013    Las Vegas, NV
Oct. 25-29, 2014    Seattle, WA

AOCD MIDYEAR MEETINGS
Jan. 23-26, 2013    Winter Park, CO
Feb. 20-23, 2014    Dallas, TX

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

Update Contact Information
Is your contact information current? If not, you may be missing need-to-know news from the AOCD.

Visit www.aocd.org/membership. Enter your username and password then click the “Login Now” button.

Should you have trouble accessing your profile, you can fax the new information to the AOCD at 660-627-2623. Send the fax to the attention of John Grogan, resident coordinator.

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Message from the President

As always, much has been going on with our College since we last communicated.

By far the biggest news is that the AOA approved the first-ever osteopathic dermatopathology fellowship with Ackerman Academy, a member of the New York College of Osteopathic Medicine Educational Consortium, (NYCOMEC), which serves as the program’s sponsor. Representatives from the AOCD, AOCP, NYCOMEC, and the Ackerman Academy worked tirelessly to get this fellowship started. I would like to thank Dr. Stephen Purcell who played a major role in the process. Congratulations to Drs. Amy Spizuoco and Sean Stephenson on being accepted as the first two fellows. I am sure they will make the AOCD proud.

The number of residency programs continues to grow, as well. Four new dermatology residency programs were approved at the Postdoctoral Training Review Committee meeting in Chicago this past April. Additional information regarding these programs will be made available in the fall issue of DermLine.

I hope all of you enjoyed Branson. I believe it was a successful educational Midyear Meeting. As I have said previously, I welcome any comments you may have regarding our meetings. I am in constant contact with our Board members. Additionally, I am working closely with Program Chairs Dr. Rick Lin (AOCD Midyear Meeting in Winter Park, Colo.) and Drs. David Grice and Suzanne Rozenberg (AOCD Annual Meeting in San Diego) on the coordination and planning of these meetings.

Speaking of the Annual Meeting, there will be a special lunch symposium about actinic keratosis on Wednesday, Oct. 10. The speaker will be Joseph L. Jorizzo, M.D., Professor and Former (Founding) Chair of the Department of Dermatology at Wake Forest University School of Medicine in Winston-Salem, North Carolina. Making a Paradigm Shift in the Management of Actinic Keratosis: Taking Treatment to the Next Level will focus on the pathophysiology of actinic keratosis and current approaches to its management. This will be a ticketed event, and attendees must pre-register for the symposium. (See page 31 for more details.)

For residents attending the Annual Meeting, Dermpath Diagnostics is offering a total of 10 travel vouchers each worth $1,000.00 per year for outstanding resident research presented at the meeting. The award will be selected by two of Dermpath Diagnostics distinguished dermatopathologists in attendance at the meeting on the basis of scientific merit in the fields of dermatology or dermatopathology, statistical validation, public health impact, and overall presentation quality. Specific criteria are still being developed on this and will be made available to the residents and Program Directors in its final form in the very near future.

In other College news, I attended the AOA Midyear Meeting in Miami Beach with our Executive Director Marsha Wise in March. The meeting focused on osteopathic medical education, current issues surrounding osteopathic exclusion from Accreditation Council for Graduate Medical Education training and the AOA’s mission to block such efforts, Osteopathic Continuous Certification, and the future of residency program inspections to be performed by professional inspectors. The meeting was informative. As a College, our voice was heard during a review and summary of resolutions. At the close of the meeting, Ms. Wise, on behalf of the AOCD, received a Certificate of Participation during a champagne toast honoring those Colleges attending the meeting. Congratulations AOCD, you are well represented!

In the meantime, your Board of Trustees (BOT) and various committees have been working weekly via teleconferences and emails to better our College. As an example, the BOT members have been working to protect the security of our website. The Finance Committee is focusing on assuring the financial stability of the AOCD. The Education Evaluating Committee is continuing to define and structure the strongest educational standards for our 22 residency training programs.

Membership dues were due January 1. If you have not renewed your AOCD dues, please do so as soon as possible to avoid being suspended from the AOCD membership.

We would like to include a list of dermatology meetings that may be of interest to our members in upcoming issues of DermLine. If you know of a meeting taking place that others may enjoy attending, send an email to John Grogan in the home office at jgrogan@aocd.org.

I am honored and privileged to serve as your AOCD President and will continue to work hard to keep you informed of the tremendous growth and progress of our College. Once again, thank you and please feel free to email me directly at spinksking1103@aol.com.

Fraternally yours,

Brad P. Glick, DO, MPH, FAOCD
Greetings everyone!

Our recent Midyear Meeting in Branson was a success. It was good to see everyone again.

The AOCD continues to grow and evolve. We are no longer considered a small organization and our procedures of operation need to meet that growth in order to better serve our members.

In 2013, in addition to our Midyear and Annual Meetings, we are planning a weekend continuing medical education (CME) event in an effort to provide our members with an additional opportunity to obtain CME. This weekend event will be held in a location easily accessible to a major airport. We hope to provide a minimum of 12 CME credit hours during this event. Our 2014 Midyear Meeting will be held at the Ritz Carlton Dallas and our goal is to provide 25 CME credit hours at that meeting.

AOA Meetings
At the recent Postdoctoral Training Review Committee meeting in Chicago on April 19, four new dermatology residency programs were approved. Additional information regarding these programs will be made available in the fall issue of DermLine. The AOA also approved the first-ever Dermatopathology Fellowship with the Ackerman Academy and the New York College of Osteopathic Medicine (NYCOM). Representatives from the AOCD, American Osteopathic College of Pathology, NYCOM, and the Ackerman Academy worked tirelessly to get this Fellowship started and Dr. Stephen Purcell played a major role in the process.

AOA Reports
As an affiliate of the AOA, the AOCD is required to submit various reports to the AOA. We recently submitted the Healthy and Viable Affiliate Organization Report (see the related article on page 5). This report requires the College to disclose our governing procedures. Transparency is the key word.

Updates on ACGME Issue
The latest information and AOA activity on the Accreditation Council for Graduate Medical Education issue can be found at http://www.osteopathic.org/inside-aoa/Pages/stop-ACGME-training-limits-for-DOS.aspx. A timeline of AOA efforts to address the issues can be found at http://www.osteopathic.org/inside-aoa/Pages/acgme-policy-timeline.aspx.

Upcoming Meetings
Information regarding our Annual Meeting in San Diego will be available soon. Check our website for updated meeting information.

Good Governance: Healthy and Viable Affiliate Organization Report

This is the fifth in a series of articles about the AOCD’s Good Governance Policies. Per AOA and Internal Revenue Service requirements, the College is required to disclose its policies for the purposes of transparency. This article focuses on the Healthy and Viable Affiliate Organization Report and the AOA/Specialty Affiliation Agreement.

All organizations affiliated with the AOA are asked to submit a Healthy and Viable Organization Report on an annual basis. The report provides information about the AOCD’s governing documents, operations, fiscal operations, insurance, personnel, and leadership.

The governing documents show that the state in which it is incorporated as an active entity (this must include proof of active status), its tax number and exemption are current, and the College’s registered agent and headquarters are up-to-date with the state. All of the AOCD’s legal documents must be readily accessible to leadership and membership. Copies of governing documents must be stored in a location separate from the office, but accessible to key staff and leaders. Governing documents must show that the bylaws were reviewed within the past 12 months by leadership, and if any changes were made, they were made in accordance with the AOCD’s bylaws and submitted to the AOA for approval. Additionally, they must show that the approved bylaws changes were submitted to the state for filing. Finally, documents must show that an updated strategic plan is not only in place, but is being implemented and reviewed throughout the year.

With regard to operations, the report must show that the AOCD’s policy manual is current and guides the affiliate’s actions. The personnel manual is updated annually, reflects state and federal laws, and guides the affiliate’s actions. The report must show that the College has a whistleblower policy, a schedule of authority, an antitrust avoidance policy, and a document retention and destruction policy. The report must indicate that each AOCD leader and employee has signed a conflict of interest statement within the past 12 months.

Finally, a disaster plan must be in place to rebuild the College after a catastrophe.

The report also addresses fiscal operations. It must indicate that the AOCD has an
annual budget that is consistent with its strategic plan and has been prepared and approved by the Board. Financial reports must be prepared according to Generally Accepted Accounting Principles. Bank statements must be reconciled monthly and reviewed by a second party other than the check signer. Two signers are required for checks over a set limit. Written financial reports must be distributed to the Board. Financial policies and procedures, such as reimbursement, investment, and processing must be reviewed, and if necessary, updated, within the past 12 months. The report must show that a compensation policy exists. This includes a process by which the Board directly reviews highly compensated employees. A certified public accountant must perform an annual audit, review, or compilation. All taxes regarding the previous fiscal year must be filed on time or within the approved extension period. An audit committee, which is separate from the financial committee, must review year-end financials. All accounting records must be readily accessible to leadership and membership. All new or revised contracts and legally binding documents must be reviewed by legal counsel. Finally, the Board must be aware of any agreements.

With regard to insurance, the report must show that various AOCD policies are current. These include a comprehensive general liability insurance policy; directors’ and officers’ professional liability, or similar insurance policy(ies); and the renters’/owner insurance. Employees must be covered through fidelity bonding. Meetings must have cancellation insurance. Insurance policies must be reviewed within the past 12 months to ensure sufficient coverage. Association management companies must have the proper insurance protection for the College’s intellectual and physical property.

The report addresses AOCD personnel issues, as well. Staff job descriptions must be on file and current. All staff must receive a written annual performance review. Association management companies must have current contracts that outline responsibilities. These contracts must be reviewed during the terms of the agreement and revisions made as necessary.

With regard to AOCD leadership, the report must show that the Board and committees are structured according to the bylaws (i.e. number of members, terms, etc.) and elections are held according to them, as well. The Board and committees must receive an annual orientation regarding roles, responsibilities, and operations. Officer, trustee, and committee chair job descriptions must be current, and part of orientation. The Board and committees must conduct self-evaluations to identify strengths/weaknesses and address any issues that arise. Finally, leadership receives an operating report from the executive director at least quarterly regarding the affiliate’s health, viability, and progress toward short- and long-term goals.

The report also must include the following documents: articles of incorporation (most recent version), constitution and bylaws (most recent version), letter of determination, proof of active state recognition for the current year, year-end membership report, and year-end financials (990 or Statement of Financial Position and Statement of Revenue/Expense).

AOA/Specialty Affiliation Agreement Approved

The AOA/Specialty Affiliation Agreement was approved by the AOA Board of Trustees at the 2011 Annual Meeting.

The document acknowledges the unique relationship that exists between the AOA and its specialty colleges and societies. It represents the culmination of a process that started in 2007 at the Specialty Summit—a meeting that convened the leaders and staff of the AOA specialty affiliated colleges and societies to discuss the nature of the relationship that exists between respective organizations. The Specialty Affiliation Agreement was vetted through the AOA resolution process in July 2011.

Purpose

The purpose of affiliation between the AOA and osteopathic specialty organizations is to ensure the health and viability of the osteopathic medical profession.

The AOA and affiliated specialty organizations are expected to support, assist, and/or participate with each other regarding all matters of common interest that further the fundamental and primary purposes of each.

The agreement to affiliate is made to:

• enhance the image of osteopathic physicians by fostering the profession’s intersociety relationships;
• have an effective national and affiliate network of trained volunteers who vigorously represent the osteopathic medical profession;
• promote and develop future affiliate and national leaders;
• support both the AOA and specialty affiliates in their activities and programs to benefit members and the osteopathic medical profession; and
• share information that helps to preserve and advance the livelihood of osteopathic physicians and the osteopathic medical profession.
Now is the Time to Get Involved
by James Young, D.O., FAOCD, Chair of the Bylaws Committee

My Colleagues and Friends,

I hope this note finds you well! We have had mild, lovely weather in South Dakota, and I pray it continues. May you and your family enjoy the season!

Many of you don’t know me. My, our College has grown! I was AOCD President 2000-2001. I have the current privilege of serving as parliamentarian and am currently struggling to learn the ropes on the AOBD. Pray for me!

I’ll come to my point. I was certified in 1991, and have served the AOCD in nearly every possible capacity. Fast forward 21 years, and the same people are serving on the committees and in other capacities as when I started. We are getting a little long in the tooth, and it is a simple fact of life that retirement, disability, and death will in the next decade (give or take) force us off the stage. The AOCD needs you!

The viability of the College depends on the vitality of member involvement. No organization will survive without the constant infusion of new talent and ideas. When I started there was no Internet and a mobile phone was the size of a brick. Now an organization needs online presence, apps, and a footprint on social network. The use of electronic medical records is mandatory in the next couple of years and the face of medicine is changing drastically. I can only imagine the face of medicine and the AOCD in 20 to 30 years!

Our College is loaded with talent. We are desperate as an organization for your engagement and integration. We do not ask you to step forward, we implore it!

None of us serving begrudge it. My very best professional friends are in the AOCD. I wouldn’t trade a minute of it, but the last and toughest lesson of leadership is identifying, training, and empowering the next generation of leaders, then releasing them to succeed. For the current generation of AOCD leaders that time has come.

I call upon everyone in our College to step up and get involved. Dermatology consistently attracts the best and brightest. I call on program directors and faculty to identify and encourage gifted residents to get involved in College affairs. I ask committee chairs to speak to their members. Our Board of Trustees, already doing so much, needs to be in touch with trainers and thought leaders to identify and raise up their successors.

Yes, it takes time. You’re already stretched thin. You don’t know if you’ll be any good at it. If you don’t, someone else will step up and do it. All true, and at the end of the day, all pretty lame excuses. Now, ignore them and volunteer! As my trainer and dear friend, Gene Conte, D.O., drilled into me, “The only place where success comes before work is in the dictionary.” I have said this quote by Winston Churchill before, but it seems appropriate to repeat it here: “You make a living by what you get, but you make a life by what you give.” Finally, consider the words of Mordecai to Queen Esther: Have you come to your position for such a time as this (see Esther 4:14)?

New Grants Coordinator Joins AOCD

Shelley Wood is the new Administrative Grants Coordinator. She joined the AOCD national office on June 1.

Ms. Wood will work to secure corporate sponsors and funding for the Midyear and Annual Meetings, as well as recruit and coordinate exhibitors at those meetings. She will assist with event coordination and post-event reconciliation, as well. Ms. Wood replaces Carmen Stanton.

She received an Associates of Arts degree in General Education from North Central Missouri College, and then went on to receive a Bachelor of Science degree in Liberal Studies from Hannibal-LaGrange College. At A.T. Still University, Ms. Wood served as an academic assistant in the Osteopathic Manipulative Medicine (OMM) Department at Kirksville College of Osteopathic Medicine. She worked with first- and second-year medical students, OMM residents, and OMM fellows. Ms. Wood returned to school to receive a Master’s Degree in Education, and taught math for several years at a small local high school. “I enjoyed working with a team of math teachers to create a common math curriculum for seventh and eighth grades, Algebra I, and Intermediate Math classes,” Ms. Wood says. With the diminishing educational budgets, however, she chose to go back out into the workplace. Prior to joining the AOCD, Ms. Wood worked for Lloyd J. Cleaver, M.D., in the front office.

“I am looking forward to the challenges that await me at the AOCD office and I look forward to working with the dermatologists, residents, and staff,” she says.

Outside of work, Ms. Wood is a wife and mother of three children who enjoy the outdoors, sports, dance, and traveling. She resides with her family in the Kirksville area.

Her email is swood@aocd.org.

Correction

In the spring 2012 issue of DermLine, an article about the Business Meeting listed the recent winners of the Koprince Award. Among the winners was Sevasti Margetas, D.O., whose name was misspelled. We regret the error.
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Speakers Deliver Updates, Pearls at Midyear Meeting

Even the most common dermatological conditions presented at this year’s Midyear Meeting seemed more extraordinary being relayed in the grandeur of the Ozark Mountains. Amid the dogwoods, redbuds, and wildflowers in full bloom, more than 20 presenters provided disease updates and pearls of wisdom at the Big Cedar Lodge in Branson, Mo. The following is a synopsis of half of the presentations.

**Dermatopathology Secrets**
Knowledge of what dermatopathologists do and a better understanding of the field can serve you and your patients better, said Clay Cockerell, M.D., a Clinical Professor at the University of Texas Southwestern Medical Center in Dallas.

He spoke about the importance of clinicopathological correlation as many dermatologic diseases demonstrate similar histologic reaction patterns, he stated. One study showed that the accuracy of diagnoses improves 23% when patients’ histology and clinical features are correlated. Another study reports that submitting digital photographs with a pathology specimen improves the accuracy of diagnoses.

Including as much information as reasonably possible on the pathology request form is essential for obtaining clinicopathological correlation for patients, Dr. Cockerell said. This includes specifying when you want margins; not asking for margins when they don’t matter; if there is a prior biopsy, including the prior number and diagnosis; filling out all demographic information because different conditions affect different populations; bringing the patient to consults or at least providing a photograph of the lesion; requesting a cut of your slide and looking at it; calling and discussing the case and; if the diagnosis doesn’t fit, asking for either recuts, special stains, or a second expert opinion.

When using periodic acid Schiff (PAS) staining of nail clippings, clip the nail plate as proximal as possible and submit keratinized material in a standard formalin jar, he suggested. This technique offers excellent sensitivity and good specificity with a quick turnaround time. It also allows you to diagnose other conditions that may simulate mycotic infection. The disadvantage is a false negative result if there is a sampling error. Always consider other causes when a negative result is obtained, Dr. Cockerell stressed.

Punches of broad neoplasms, especially possible melanoma, may give artifically negative results, he warned. Either a punch excision (greater than 5 mm) of the entire lesion or saucerization is preferred when ruling out melanoma.

With regard to special stains for fungi, Dr. Cockerell noted that PAS staining of tinea capitis and Majocchi’s granuloma may be artifically negative if the infected hair shaft itself is not sampled. Hyphae can usually be seen in the cornified layer in dermatophytosis without special stains. PAS staining to rule out tinea capitis is almost always negative. Biopsies taken from some areas of the body tend to demonstrate unusual features. For example, biopsies of the elbows, knees, and acral skin tend to show unusual patterns in inflammatory diseases. Sunburned nevi often simulate melanoma. Excisions of melanoma in situ often reveal a dermal component. Some neoplasms may demonstrate different features on re-excision. Things you are expected to know without being told are that margins on shave biopsies are not the same as margins on elliptical specimens or Mohs surgery. Also, all biopsies are prone to a sampling error.

The down side of requesting margins on biopsies is as follows: If the biopsy report reads “margins clear,” the payer may assume a re-excision of the lesion is unnecessary and fail to reimburse for it or the report may trigger an audit, he said. Margins on shave specimens are very unreliable for multifocal, poorly delineated neoplasms. Finally, it is very risky to ask for margins on a melanoma biopsy. Never assume a shave of a melanoma is adequate treatment, Dr. Cockerell stressed. If you are concerned about a diagnosis, especially melanoma, and the histologic diagnosis comes back benign, excise it anyway, he stated.

Regarding stains, Dr. Cockerell said that positive staining with HMB-45/Mart-1 and Mib-1 does not mean melanoma. Conversely, desmoplastic and spindle cell malignant melanoma are routinely negative for HMB-45 and Mart-1. Positive staining with CD-30 may be seen in inflammatory conditions. Discussing the use of immunofluorescence, he said that direct immunofluorescence is usually negative in DM, scleroderma, and most other connective tissue diseases.
Regarding infectious diseases, Dr. Cockerell noted that suppurative granulomatous inflammation that is highly suggestive of an infection commonly shows negative special stain results. With global climate change, diseases are appearing in unusual locations. As an example, leishmaniasis is now endemic in north Texas. Watch out for pseudocarcinomatous hyperplasia because the epidermis may become very hyperplastic overlying certain conditions and may simulate cancer. Make sure the diagnosis is correct before performing aggressive surgery.

When it comes to biopsy reports, Dr. Cockerell suggested keeping diagnoses simple and differential diagnoses few. Always use the language of clinical dermatology. He noted that it’s much easier to move from a benign diagnosis to a malignant one with additional sections and studies than vice versa. Find a consultant you know and trust.

For nail unit biopsies, don’t forget about performing an X-ray before the biopsy to evaluate underlying bone, Dr. Cockerell stated. The pigmented bands of the nail unit may look clinically more obvious than what is seen histologically. It may be extremely subtle and therefore require special stains for melanin and melanocytes. Make sure that there is no sampling error; a matrix must be sampled. If there is a questionable diagnosis, don’t be afraid to remove the entire lesion. Mohs is a good alternative.

Alopecia biopsies require clinical correlation because a number of these may appear similar, he said. Dr. Cockerell suggested to biopsy an early lesion and a fully developed lesion. Then submit multiple 4 mm punches so that horizontal and vertical sectioning can be performed.

Grading dysplastic nevi is controversial. There is no repeatable way to distinguish between mild and moderate lesions. Severe lesions may be difficult to diagnose and are often malignant melanoma or melanoma in situ, he said. Lesions do not “progress” to melanoma in the same way that actinic keratosis (AK) progresses to squamous cell carcinoma (SCC). Additionally, there is a lack of correlation between histologic features and melanoma risk. Beware of “blanket” recommendations to remove all lesions. The diagnosis of melanoma is challenging. Many unusual variants don’t always look like malignant melanoma while other benign lesions may simulate it.

Dr. Cockerell touched on emerging diagnostic techniques. Dermoscopy is somewhat better than unaided visual exam if the clinician is well educated in the technique and practice. Computer-aided dermoscopy is better than dermoscopy alone and is up to 95% accurate. In vivo confocal microscopy is only good for superficial evaluation, he said, because it’s slow and expensive, and the images are difficult to interpret. Fluorescence in situ hybridization (FISH) is a promising tool for evaluating melanocytic neoplasms that are difficult to diagnose histologically.

Comparative genomic hybridization detects abnormal gene copy numbers and when coupled with laser capture microdissection, it allows for the evaluation of specific portions of a neoplasm and the assessment of clonal expansion of neoplastic cells. He cautioned against becoming over-reliant on such new techniques; if it doesn’t fit clinically, don’t use it as a trump card.

**Photodynamic Therapy**

Photodynamic therapy (PDT) involves activation of a photosensitizing agent by illumination of a light source in the visible spectrum, explained Alpesh Desai, D.O., Program Director of the South Texas Osteopathic Dermatology Residency Program. The photosensitizer is ultimately converted into protoporphyrinogen IX, which is transferred into the cell to cause destruction. The light source, which in this case is the BLU-U light that Dr. Desai uses in his office, must meet three requirements for optimizing PDT efficacy, he said. It must reach the desired depth of tissue penetration and have enough power to produce a photodynamic response. Its wavelength also must correspond to the wavelength that is absorbed by the photosensitizer.

The BLU-U in conjunction with the Levulan Kerastick is approved by the Food and Drug Administration (FDA) for the
At 12 months, 78% of the lesions were still clear. A second treatment typically improves the response rate, and can be particularly beneficial for AKs on the hands and forearms. There is minimal recovery time. Overall, patients give it a high rating for cosmetic response and a high satisfaction rating. “I like that it is well tolerated,” he said.

Dr. Desai noted that PDT can be used in conjunction with topical immunomodulators (TIMs). In fact, sequential use of imiquimod after PDT has demonstrated an improved reduction in AK lesions compared with the topical treatment being used alone. It appears to be more effective than imiquimod for treating AKs of the dorsal hands. While PDT appears to be as effective as 5 fluorouracil (5-FU) for treating AKs on the face and scalp, the former seems to be better tolerated. Pretreatment with diclofenac prior to PDT has demonstrated higher sustained clearance than PDT alone.

A pharmacoeconomic analysis of treating AKs found that PDT was the least expensive treatment compared with 5-FU, imiquimod, and diclofenac, he said. Additionally, PDT was found to have increased tolerability, more clear and rapid response, higher reimbursement rates, good cosmetic results, and low down time compared with topical chemotherapeutic agents and TIMs. The illuminator can be used in a small space, the chair and light are very compact, and the treatment time is short, Dr. Desai noted.

criteria for diagnosing systemic lupus erythematosus (SLE) are malar rash, discoid lupus skin lesions, and photosensitivity. In ACLE, the malar or “butterfly” rash is erythematous and edematous over the cheeks and nose. The nasolabial fold is often spared. Most of these malar rashes are transient. They typically respond to pimecrolimus/tacrolimus, photoprotection, and hydroquinone for pigmentation. All lupus erythematosus (LE) patients are photosensitive; sometimes complaining of malaise and arthralgias after sun exposure.

Chronic cutaneous lupus erythematosus is the most common form of LE, most commonly presenting as discoid lupus erythematosus (DLE). These coin-shape lesions enlarge and often have prominent scales that extend into dilated hair follicles. Loss of scalp hair and pigment is common.
ulcers can be treated by keeping areas covered and moist with petroleum jelly or antibiotic ointment and keeping the hands warm. Other options are nitroglycerin paste, calcium channel blockers, and sildenafil.

The last connective tissue disease Dr. Cohen discussed was morphea, a localized fibrosis. Although rheumatologists call it localized scleroderma, morphea does not change into systemic scleroderma, he noted. The clinical presentations—morphea, and altered differentiation. Continued activation of immune cells and keratinocytes sustains the psoriatic lesions.

Today, we have drugs that can target the action of psoriasis and therefore control it better, he said. They offer better results with fewer side effects. Treatment options include topical therapy, phototherapy, laser therapy, and systemic therapy.

Topical therapies are good for adjunctive therapy, especially for treating mildly affected patients and those who can’t take systemic therapy or can’t afford biologics. Topical therapies can be beneficial even for patients taking biologics. Topical therapies, which have the least side effects, can be used alone or in combination therapy. Dr. Baum noted the pros and cons of various topical therapies. As an example, topical vitamin D is not very efficacious as a monotherapy and is expensive. Topical retinoids are irritating, expensive, and not very efficacious. While TIMs work well in sensitive areas, they can cause itching, stinging, and burning. In addition, TIMs have a slow onset, concern parents fearful of immunosuppression, and are expensive. Anthralin, bath solutions, coal tar, over-the-counter (OTC) moisturizers, and salicylic acid are messy, time consuming to apply, and not particularly efficacious. Topical corticosteroids are very efficacious, but have side effects, such as dermal atrophy. They are a short duration therapy and the brand names are costly.

Vehicle options include cream, ointment, gel, lotion, aerosol, foam, tape, solution, shampoo, powder, and oil. Choosing the vehicle should be based on the anatomic location where the therapy will be used, he said. The vehicle can greatly influence percutaneous absorption and therefore increase therapeutic efficacy, Dr. Baum said. With regard to topical steroids, brand name products have greater potency than generics. The high cost of topical steroids can be countered with the use of manufacturer coupons.

“Today, we have drugs that can target the action of psoriasis and therefore control it better, he said. They offer better results with fewer side effects. Treatment options include topical therapy, phototherapy, laser therapy, and systemic therapy.
esthetic properties and patient acceptance. “The patient has to like it or they won’t use it,” Dr. Baum added. The addition of emollients or humectants improves a product’s tolerability.

Treatment considerations should include side effects, the vehicle, cost, and duration of therapy. Focus on decreasing applications and steroid concentration, as well as using combination, rotation, or sequential therapy, he said. “Studies show that there is no silver bullet when it comes to treating psoriasis,” Dr. Baum added.

He had the following to say about monotherapy options. A re-engineered clobetasol propionate spray 0.05% was shown to be efficacious as both a monotherapy and add-on therapy in studies. Clobetasol propionate in a foam was reformulated to eliminate side effects. Patients like the vehicle because of its spreadability, ease of application, and quick absorption, as well as lack of fragrance, residue, or stickiness. In studies, the foam was shown to be effective and safe for the treatment of mild to moderate plaque-type psoriasis. In another study, patients treated for steroid-responsive dermatoses liked a 0.2% triamcinolone spray compared with creams and ointments, noting a cooling effect. A halcinonide 0.1% cream received high patient acceptance rates for clearing psoriasis as well as for its physical appearance, spreadability, and ability to improve skin conditions. Calcitrol ointment is a relatively new option that was safe, effective, and well tolerated in clinical trials. A calcipotriene foam, which will be available soon, was found to deliver two- to threefold more calcipotriene into the epidermis compared with an ointment and cream.

Topical combination therapies have the most potential for delaying plaque recurrence, Dr. Baum said. They also offer better efficacy and cost effectiveness compared with monotherapies. Sequential treatment therapies, such as a clobetasol propionate spray with a calcitriol ointment, have been shown to improve quality of life. Dermatologists have developed a number of treatment regimens designed to provide high efficacy while minimizing exposure to high-potency topical steroids, he noted. The excimer laser is being touted as a new safe and effective treatment for psoriasis of the palms and soles, which is difficult to treat.

Traditional systemic therapies should be used to treat psoriasis in patients who have poor or no response to topicals, UVB, or PUVA therapy; received the maximum “safe” cumulative PUVA dose; psoriasis covering more than 10% of their body surface area; more inflammatory forms of the disease; localized/recalcitrant disease; physical restrictions; and a poor quality of life.

In 2009, the American Academy of Dermatology issued guidelines for MTX dosing that call for routine blood tests. The major issue regarding MTX use is the possible need for liver biopsies in MTX-treated patients and the role of amino-terminal propetide of type III collagen in monitoring.

Indications for cyclosporine are severe, recalcitrant and disabling disease; erythrodermic or pustular-type psoriasis; failure or intolerance of other therapies; pyoderma gangrenosum; and rescue therapy. In summary, cyclosporine is a high performance, fast acting drug that has good utility, but requires proper monitoring and office follow-up. Patient selection is important, as well.

Phototherapy treatment options include UVB therapy, PUVA, and UVA-1. Phototherapy has been used since ancient times, offers temporary or long-term remission, can be used in combination therapy, can prolong remission when used as a maintenance therapy, is safe if properly implemented, is insurance friendly, and comes in various types. The cons are that it can burn, blister, cause photoaging, and increase the risk of skin cancer.

Phototherapy is inconvenient, not always efficacious, mainly used for plaque-type psoriasis, exacerbates herpes simplex virus, reverses the basal cell carcinoma/SCC ratio (PUVA specifically), and causes pruritus. There is also a list of contraindications, such as it can’t be used concurrently with immunosuppressives, or phototoxic systemic or topical medications, among others.

Biologics currently approved for the treatment of psoriasis are T-cell modulating agents, TNF-Alpha (TNF-α) antagonists, and Interleukin (IL) 12/23. Studies have shown good results with etanercept, particularly in pediatric patients. Infliximab works, but there is a high risk of infection associated with its use. “All biologics have pretty good results,” he said.
Patients with psoriasis have comorbidities that contribute to the risk of cardiovascular disease. Dr. Baum stated. Psoriasis itself appears to add to the cardiovascular disease risk profile. Biologics are said to decrease the chance of heart attack. Studies looking at long-term safety of biologics have not uncovered any new concerns. The main safety issues with anti-TNF-α agents are cardiac failure, infections, lymphoma, and neurologic issues. However, the risk of lymphoma is increased in all patients with psoriasis. Basically, biologics are safe. Patients on them will get their life back.

There are a lot of emerging therapies, he said. Among those Dr. Baum discussed were sotetrastaurin, a protein kinase C inhibitor; voclosporin, a calcineurin inhibitor; and apremilast, a phosphodiesterase-4 inhibitor. Then there are Janus kinase, or JAK, inhibitors, such as tofacitinib, ASP015K, and INCB18424, as well as human monoclonal antibodies, such as certolizumab, which blocks TNF-α; AIN457, which targets human IL-17A; and anti IL-23, which targets IL-23. “I like what’s out there that’s new, but I don’t love them,” he concluded.

Two resident presentations closed out the meeting. Roxanna Menendez, D.O., spoke about Red Indurated Plaque on the Face of a Newborn, and Arathi Goldsmith, D.O., discussed Verrucous Porokeratosis.

Attendees gathered at the Welcome Reception that evening under the gaze of 15 mounted deer heads.

**Alopecia in Women**

Damage to the permanent portion of the hair follicle can cause alopecia, stated Michelle Tarbox, M.D., Assistant Professor of Dermatology and Dermatopathology at Saint Louis University. Alopecia in women falls into two categories: noncicatricial and cicatricial. Noncicatricial alopecia includes telogen effluvium, anagen effluvium, androgenetic alopecia, alopecia areata, and trichotillomania. Cicatricial alopecia are lichen planopilaris (LPP), DLE, central centrifugal cicatricial alopecia, and traction alopecia.

**Telogen Effluvium** is characterized by excessive shedding of normal telogen club hairs that often occurs as a result of stress. Women will experience a dramatic shedding approximately three months after childbirth, for example, and typically recover slowly and gradually during the next six months, she explained. Treatment involves first pinpointing the cause, which also could be an endocrine issue, a nutritional issue, or inflammatory scalp disease.

Patients need proper nutrition to help the growth of new hair, rest because sleep deprivation may cause oxidative stress to the body, relaxation to normalize the stress response, and a discontinuation of behaviors that compromise their health. Their biggest fear is that they will go bald, Dr. Tarbox said. It’s important to reassure patients that recovery is likely because their anxiety about “not getting better fast enough” may shift them into chronic telogen effluvium. Minoxidil can help, she said, but some women refuse to use it. Anagen effluvium, which results from hair shaft fractures, is associated with chemotherapeutics.

Treating telogen effluvium is difficult because patients are distressed by the shedding. Dr. Tarbox said. Thus, they decrease activities that seem to exacerbate shedding such as washing hair. As a result, their scalp may become chronically dirty, which can cause bacteria and yeast overgrowth, or infections and secondary seborrhea.

Often, an underlying chronic and previously unnoticed alopecia is discovered during a telogen shed, she noted. This is most commonly androgenic alopecia, which only responds to minoxidil. Characterized by diffuse hair loss throughout the apical scalp, androgenetic alopecia is an androgen dependent, genetically determined trait. If the patient has hirsutism, menstrual irregularities, or acne, she should be evaluated for hormonal abnormalities.

Androgenetic alopecia with polycystic ovarian syndrome may be more severe than traditional androgenetic alopecia. The latter patients may require systemic therapy to correct hormonal abnormalities.

Alopecia areata is an autoimmune form of hair loss that primarily affects pigmented hairs, often sparing white hairs. It causes a rapid and complete loss of hair with one or more round or oval patches on the scalp or beard. Alopecia areata may affect eyebrows, eyelashes, or intranasal hair. It is also nonscarring and has the potential for recovery. However, alopecia areata patients may lose the ability to regrow hair, Dr. Tarbox said, especially if it has persisted for more than five years. Alopecia areata may remit on its own. Topical therapy options include anti-inflammatory or counter-irritants. Other options are topical minoxidil, intralesional triamcinolone, topical or oral PUVA, or a 308 nm excimer laser. Systemic therapy options include prednisone, MTX, and MMF.

Trichotillomania is the compulsive disorder of plucking one’s scalp, brow, or eyelash hair, resulting in irregular patches of alopecia. It often occurs in girls under the age of 10. Trichotillomania may be a manifestation of obsessive compulsive disorder or associated with depression or anxiety, she said. Treatment involves behavior modification, psychotherapy, and appropriate medications, such as selective serotonin reuptake inhibitors.

Cicatricial alopecias involve the permanent portion of the hair follicle. Cicatricial or scarring alopecia is alopecia plus the absence of follicular ostia, Dr. Tarbox said. The most common causes of these acute lesions are LPP, DLE, sarcoidosis, and folliculitis decalvans. The diagnosis is made using a 4 mm punch biopsy.

Lichen planopilaris is characterized by perifollicular erythema and small follicular papules, progressive scarring inflammatory
alopecia, and ivory white irregular patches of scarring. Treatments include topical corticosteroids, which may be adequate in a few patients; intralesional corticosteroids, which offer a good clinical response; oral corticosteroids for severe disease and; oral retinoids, which may be effective, she said. Oral medications used to treat lupus such as antimalarials, azathioprine, MTX, and MMF also may help. New proprietary PPAR-γ agonists optimized for topical administration are reportedly under development, Dr. Tarbox stated, but they have to be watched for side effects.

Scarring inflammatory alopecia, erythema, atrophy, follicular plugging, and mottled hyper- and hypo-pigmentation are characteristic of DLE. If treated early enough, permanent hair loss can be prevented, she said. Treatment options include potent topical steroids, intralesional corticosteroids, antimalarials, retinoids, dapsone, MMF, and MTX. Topical retinoids and topical calcineurin inhibitors tend not to work well for this type of alopecia.

Central centrifugal cicatricial alopecia encompasses hot comb alopecia, follicular degeneration syndrome, and central elliptical pseudopellade. It’s more common in African American women, affects the crown, spreads peripherally to form a central area of partial hair loss, is slowly progressive, and may have crops of crusts at the periphery, Dr. Tarbox stated. Traction alopecia is caused by prolonged tension on the hair, wearing the hair tightly braided or in a ponytail, pulling hair to straighten it, rolling curlers too tightly, and twisting the hair. It typically occurs on the periphery of the scalp and the temples, as well as above the ears. Treatment involves discontinuing chemical and heat processing, and reducing traction. It may respond to topical or intralesional corticosteroids. In cases with crusting, oral antibiotic therapy may be helpful.

**Surgical Pearls**

Patients won’t remember what you said or did, but they will remember how you made them feel, stated Roger Ceilley, M.D., Clinical Professor of Dermatology at the University of Iowa.

Dermatologists can improve patient experience by maintaining a sense of humor, he said. Providing samples and free medications, as well as supplies and instructions following a procedure also help. Having a dedicated check-in and check-out area as well as a communications center and user friendly website where they can obtain informational hand-outs are also a must.

During the actual visit, review the chart before going into the exam room. Patients expect you to know why they are there, especially if they told the nurse beforehand. “It’s okay to enter the room quickly, but always leave it slowly,” Dr. Ceilley said. In the room, sit down, make eye contact, listen twice as much as you talk, and show concern. “With more and more physicians using electronic medical records, we need to develop better systems so that we’re not just looking at the computer,” he said. Always ask if there is anything else they need. It may require another appointment, but at least they have had a chance to relay all of their concerns. Patients who have additional questions and have to be placed back into a room mess up the rotation.

Between visits, be sure to provide enough refills so that patients won’t have to call the office for refills. Providing patients with a body map can help them identify concerns between visits. Following a procedure, tell the patient you will call him/her in the morning, Dr. Ceilley said. This reduces the number of calls coming in after hours. Review treatment plans, risks, benefits, and costs, as well as discuss realistic expectations with patients. “Be careful not to do something the patient won’t be happy with,” he said. Be sure to obtain informed consent. “If you’re not comfortable providing a service,” Dr. Ceilley stressed, “don’t do it.” Finally, document everything for medicolegal and reimbursement reasons.

It’s just as important to get along well with, and be accessible to, referring physicians and staff as it is patients. Develop close relationships with dermapths, surgical consultants, and oncologists. “Don’t just send them your problem patients,” he said.

Regarding staff, take the time to hire the right staff, don’t settle. “It’s better to hire a temp than to hire the wrong person,” Dr. Ceilley stated. Have the individual shadow an employee in the office before offering the position. Positive characteristics for staff include intelligence, a good attitude, loyalty, stability, enthusiasm, good judgment, and technical ability. Experience is important, he said, but further down the list. Bosses should be trustworthy, consistent, and confident. “You should praise and challenge employees you want to keep, monitor and motivate those who are not as productive, and eliminate those who are neither productive nor ethical,” Dr. Ceilley said.

Moving on to surgical pearls, he uses a surgery checklist before each procedure. Among the items on the list are the referring physician’s name, who did the biopsy, a signed consent, a circled surgery site with patient verification, and a mapping card and photograph. The checklist also should verify and record pacemaker/defibrillator or other electronic implants, review allergies to any anesthesia/antibiotics/latex/bandages, and record anticoagulants, indicate if antibiotics are needed, record blood pressure and pulse, check for special health concerns, indicate anesthesia on the field, verify the pathology report, and indicate miscellaneous patient information/concerns. To prevent wrong-site surgery, it helps to have a preoperative photograph and accurate diagram and measurements from landmarks. “Always mark and verify the site having the patient hold up a mirror,” he suggested.

Every closure should be a cosmetic closure, Dr. Ceilley said. For example, put closures in the relaxed skin tension lines. Even if the patient says that he or she doesn’t care, a poorly done closure will reflect poorly on you, he said. Design the excision properly because suture techniques cannot overcome poor excisional designs. Dr. Ceilley likes to make them narrow, minimize tension, and undermine widely and evenly in the same plane. Regardless of the suturing technique, wound eversion is the goal. Bury subcutaneous knots and repair dog ears where there is lax skin, he advised. Where there is tension, use a buried suture. Staples are best for the scalp. Surgical glue is probably equal to sutures, but only when there is no tension.

Regarding surgical wound dressings, do them with pride, make them functional, and give the patient enough supplies for dressings and suggest sources to get more. “The dressing is your signature, it should look good,” Dr. Ceilley said. “Otherwise, you look sloppy.”

For postoperative care, he suggested providing instructions, handouts, and advice about acceptable activities, as well as warnings about swelling, hemotoma, drainage, and infection.
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Looking at Skin from a New Perspective

“Are we just putting out fires or can we modify underlying disease?” posited James Del Rosso, D.O., FAOCD, Clinical Assistant Professor of Dermatology at the University of Nevada School of Medicine, and Program Director at Valley Hospital Medical Center in Las Vegas. “It’s important to step back and think about what we’re doing after we get an acute case under control,” he added. Try to determine what is going on under the surface. “If you can change some things, you may be able to prevent flaring. Sometimes, we can’t. But we should at least try.”

Regarding atopic dermatitis (AD), potential pathogenic factors include immunology, genetics, and the environment. Epidermal barrier dysfunction is not just water loss, he said. It’s important to recognize that these people are deficient in some ceramides, which are important for water permeability in the stratum corneum (SC). Half of them are deficient because they have filaggrin gene mutations, Dr. Del Rosso explained. Without the filaggrin, which breaks down into natural moisturizing factor, they don’t have humectants to retain moisture in their skin. Many products now have ceramides, he said, but we don’t know if they are being delivered in the SC; the ceramides could be sitting on the surface. Studies have demonstrated clinical benefits of specific ceramides or pseudoceramides for the treatment of AD, but other products that don’t have ceramides also work.

There are a lot of different barrier responsibilities of the SC, Dr. Del Rosso noted. The permeability barrier is the one usually referred to, but there are also antimicrobial, antioxidant, immune response, and photoprotection barriers. The permeability barrier regulates transepidermal water loss (TEWL) to maintain the physiologic water level and flux. Without that, he said, the skin will become dry and itchy.

After a patient with AD is cleared, his/her skin visibly looks normal, Dr. Del Rosso said, but it isn’t. The skin requires special care afterward. “There’s no hard data to show that, but we have the suggestion of it,” he said. An AD patient’s skin is overstressed; the use of soaps and abrasive cleansers damage the fatty acids. Even if the ceramides are replaced, it will take time for the lipids to be created and incorporated into the SC. An occlusive is still necessary to obtain the blocking effect.

As it gets harder to get branded prescriptions to market, Dr. Del Rosso said that pharmaceutical companies will become more interested in OTC drugs. If they put ceramides in OTC products, the companies won’t have to conduct large, double blinded studies. These OTC formulations will focus on gentle cleansing, moisturizing, and barrier repair. Although some ceramide-containing products have demonstrated barrier recovery, he said, more studies are needed to show the benefits of these products and how they compare with others.

Other questions Dr. Del Rosso posed were: Why care about the status of the SC? Does how we manage TEWL make any difference clinically? Is occlusive therapy alone all that matters? Is it important to replace “deficient components” in the SC that have been associated with specific disease states?

With regard to rosacea, he asked why not evaluate and treat patients based on the clinical features they present with rather than forcing them to fit into a clinical pattern or subtype, as described in the literature. “Subtyping does not define what is going on with a given patient on a specific day,” Dr. Del Rosso said. Rosacea patients have different clinical patterns and different genetic processes going on. Consequently, some patients’ skin is hyper-passive to triggers and others is hyper-responsive.

One of the most revealing papers Dr. Del Rosso found discusses the vascular changes in the pathophysiology of rosacea. It starts with altered blood flow that moves to angiogenesis and then to permanent dilation of superficial vessels. “We do have disease-modifying treatments, but they are dependent on both catching it early and patients continuing to take their medications,” he stated. “But many times, we can’t get the underlying pathophysiology under control because patients stop their therapies. If we see patients in the first episodes, we could prevent flares.”

Interesting Cases
Whitney High, M.D., JD, MEng, from the Departments of Dermatology and Pathology at the University of Colorado, offered up interesting cases that he has come across as
part of his referral practice. “You get to see fascinating patients and those that nobody else wants to see,” he said.

A 46-year-old farmer presented with four “unremarkable” nodules on his ears that he wanted removed. It turns out the patient had metallosis of the skin that mimicked a malignant skin tumor. A few years later, a 48-year-old patient with end-stage renal disease presented with thickened fibrotic, dyspigmented skin with contracture of the joints. Dr. High found gadolinium deposited in the tissue. He published a paper showing that gadolinium is retained in the tissues of patients with nephrogenic systemic fibrosis, which lead to an FDA Black Box Warning for all gadolinium-based contrast agents used for magnetic resonance imaging.

A 68-year-old woman presented with strange hyperkeratotic lesions on her limbs. The lesions had unusual spiculas, Dr. High said. She was told she had an unusual case of syphilis. “She was not pleased with the diagnosis,” he recalled. It turned out she had multiple myeloma. Dr. High has since seen 16 such cases.

A 35-year-old female presented with verrucous plaques on her leg. She went to Dr. High for a second opinion as she was told she had SCC. She actually had pseudo epithelial epidermal hyperplasia in response to getting a tattoo. He had heard of the verrucous reaction with regard to red tattoos. It appears to be an immunologic phenomenon to a vegetable dye.

An 18-year-old female presented with a three-year history of purplish lesions on her face. It was granuloma faciale. Not only is it uncommon, especially in children, but it is usually just one lesion and she had several, Dr. High noted. Granuloma faciale is notoriously difficult to treat, but he did effectively treat it with dapsone. Another patient, a 63-year-old male, had been misdiagnosed with granuloma faciale. The patient didn’t have any neutrophils, which are abundant in granuloma faciale, he said. It turns out the patient had an unusual presentation of mycosis fungoides.

A 52-year-old male presented with urticarial plaques. He is very wealthy and ate a lot of ceviche, a popular dish in Central and South America that consists of fresh raw fish marinated in lemon juice, Dr. High explained. The patient developed gnathostomiasis also known as fish worm, which is an emerging pathogen. Although it is very rare, he said, it is now being found in Peru and Mexico. The patient was treated with an anti-parasitic medication. “It angered the worm, it came to the surface, and then they pulled it out,” Dr. High said.

A 42-year-old female, who called herself a “crackhead” presented with a bumpy red rash. Five days after last smoking a “funny tasting” crack, she developed the rash. Six months later, a 43-year-old male presented to the emergency department with black ears and fingertips. He developed these a few days after smoking crack, which he said he enjoyed now and then. Dr. High started reading about several reports of cocaine laced with levamisole, a veterinary anti-parasitic drug, which he believes they were exposed to.

Look for more coverage of Midyear Meeting in the Fall issue of DermLine.

**Earn Extra CME Credits at Annual Meeting**

The Annual Meeting held in conjunction with the AOA OMED 2012 meeting Oct. 7-11, 2012 in San Diego will offer attendees the ability to earn additional continuing medical education (CME) credits.

Attendees can earn a total of 26 1-A credits by attending OMED, Monday through Thursday. However, they can earn extra credit(s) by attending the Sunday sessions (a maximum of 9 1-A credits), four breakfast sessions* (one 1-A credit each), and the AOA dinner session (2.5 1-A credits). That brings the total number of possible credits that can be earned at OMED 2012 to 41.5 1-A credits.

Meanwhile, a variety of speakers including faculty from the University of Pennsylvania, Department of Dermatology, have been scheduled to present at the AOCD Annual Meeting. The CME Committee members are planning future Annual and Midyear Meetings using input from AOCD members to determine meeting locations, lecture topics, and meeting formats.

*Some breakfast sessions are tentative.
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Whether it’s urban playgrounds or sandy beaches you enjoy, San Diego has a special spot for you to visit while attending the 2012 AOCD Annual Meeting slated for Oct. 7-11.

If you find yourself between presentations and have a couple of hours to spare, make the most of it by checking out the host city. Take a walk along the waterfront with sparkling blue water, stunning city views, and life-size sculptures of fantastical trees designed and fabricated by local artists. You can pick up the waterfront path directly behind the Convention Center.

If you keep going north on the bayside path it will take you along the Embarcadero, home to Seaport Village, San Diego’s version of a quaint, seaside fishing village where you can find more than 50 one-of-a-kind shops, waterfront casual dining, and even street performers. The 14-acre waterfront complex features four miles of meandering cobblestone pathways bordered by ponds, lakes, fountains, and colorful, lush landscaping. There you will find the USS Midway Museum where you can learn about America’s longest-serving aircraft carrier with exhibits and tours exploring the city’s nearly 50-year naval history. The floating Maritime Museum of San Diego features one of the finest collections of historic ships in the world, including the Star of India, the oldest active sailing ship. Nearby is the inspiring Greatest Generation Collection, an art collection honoring those who served in World War II to present day.

On another day, you can cross the street at Fifth Avenue and head to the Gaslamp Quarter. This 16-block urban paradise includes some of Southern California’s finest dining, nightclubs, theaters, art galleries, and cutting-edge fashion all housed in grand Victorian-era buildings. When the sun goes down, the gaslamps light up with numerous nightclubs and hip rooftop lounges. You can have an upscale night out on the town or a casual evening with colleagues.

If you have time to spare, visit Horton Plaza, a multi-level, outdoor shopping and entertainment center with more than 130 specialty shops, restaurants, a movie theatre, and performing arts theatre. Well known for its whimsical and vibrantly colored design, the plaza was created to resemble a European market place and function like an amusement park with colorful pathways, bridges, and staggered levels.

Just a short taxi ride from the Convention Center is Old Town, considered the birthplace of California. The site of the first Spanish settlement, this neighborhood is replete with historic landmarks and attractions. Among them are Presidio Park and the Whaley House (said to be haunted). The Fiesta del Reyes is a historic shopping and dining experience. The Bazaar del Mundo captures the color and flavor of Old Mexico with a variety of boutiques offering handcrafted arts and gifts from Latin America and around the world, as well as authentic Mexican cuisine. You can also catch the San Diego Trolley’s blue line in front of the Convention Center to find your way there.

In fact, the Old Town Trolley Tour is the best way to see the city quickly. Catch it at the San Diego Marriott Marquis & Marina next door to the Convention Center. Another way to get in some sightseeing is to catch the Hornblower cruise ship near the USS Midway. The one- and two-hour narrated tours explore more than 50 local landmarks, natural wonders and military history, marine animals and seabirds, and environmental efforts. Reservations are not required.

If it’s a beach you’re looking for, San Diego has a few. Coronado Beach spans 28 miles with a waterfront path you can stroll or bike along. You also can enjoy ocean views and fine dining at the historic Hotel del Coronado. To get there, hop on the San Diego/Coronado Ferry at the Fifth Avenue landing behind the Convention Center or the Broadway Pier. A bit farther away is Pacific Beach, the quintessential West Coast beach for surfers. Once a counter-cultural hub in the ’60s, Ocean Beach now attracts a blend of young, old, and canine. You can go antiquing on Newport Avenue or take a walk on Ocean Beach Pier, the longest pier on the West Coast. La Jolla’s beaches offer some of the most picturesque views in San Diego. Windansea Beach offers incredible surf breaks for surfing buffs. The Children’s Pool is a tiny cove that serves as a haven for sea lions and a favorite spot for watching wildlife. La Jolla Shores is popular with families because of its wide sandy beaches, gentle surf, play area, and boardwalk. La Jolla Cove, which boasts some of the clearest water around, is a paradise for swimmers, divers, and snorklers alike. If you want to venture there, you will need a car as La Jolla is a 30-minute drive north of the Convention Center.

For more visitor information on San Diego, visit the city’s website at www.sandiego.org.
First Osteopathic Dermatopathology Fellowship at Ackerman Academy Approved

The first-ever osteopathic dermatopathology fellowship located at the Dermpath Diagnostics Ackerman Academy of Dermatopathology in New York City was approved by the AOA on April 19, 2012. Ackerman Academy is a member of the New York College of Osteopathic Medicine Educational Consortium, (NYCOMEC), which serves as the program’s sponsor.

Joan Mones, D.O., is the Program Director for the fellowship, and is also the Director of Osteopathic Medical Education. Dirk Elston, M.D., is the Director of the Ackerman Academy of Dermatopathology and the Chief Executive Officer of the fellowship. Brianna Ishibashi is the Administrative Director of Osteopathic Medical Education. The one-year fellowship is currently approved for two fellowship positions per year.

Amy Spizuoco, D.O., and Sean Stephenson, D.O., were accepted as the first two fellows.

“Establishing an osteopathic dermatopathology fellowship is a huge advance for the DO community,” says Stephen Purcell, D.O., who has been involved in this effort for the past three years. “Dermatopathology fellowship opportunities for osteopathic dermatologists are limited,” he notes. “With the recent edict by the Accreditation Council for Graduate Medical Education to limit DO opportunities, the openings in dermatopathology for DOs will be further limited or non-existent.”

Dr. Purcell adds that, “This fellowship could not have developed without the dedication of Dr. Mones and the forward thinking of Dr. Elston, who provided the critical mass that allowed this to come to fruition.”

Both Drs. Spizuoco and Stephenson are excited, honored, and grateful to have been accepted to this fellowship. As Dr. Stephenson put it, “The Ackerman Academy’s dermatopathology fellowship is world renown and one of the best in the country. To be one of the first osteopathic fellows and usher in the first osteopathic dermatopathology fellowship in the country feels amazing.”

In addition to becoming the best dermatopathologist possible, Dr. Stephenson would like to serve as a role model. “Amy and I both provide a positive example to other osteopathic trainees that achieving your educational goals and dreams are always possible.” He hopes that this fellowship helps build relationships between the osteopathic and allopathic dermatology communities.

After completing the fellowship in June 2012, Dr. Stephenson will join Dermatopathology Laboratory of Central States to establish a satellite dermatopathology laboratory in the Detroit metropolitan area. In 2011, Dr. Stephenson completed his residency at O’Bleness Memorial Hospital under the directorship of John Hibler, D.O.

Upon completing the fellowship, Dr. Spizuoco will serve as its Associate Director. “I will be working with Dr. Mones and Dr. Elston to improve the fellowship, and assist with applications and paperwork, as well as teaching,” she says. Dr. Spizuoco hopes to enhance osteopathic dermatology by being a part of the establishment of this fellowship and working to improve it moving forward. In 2011, she completed her residency at Alta Dermatology/LECOM under the directorship of Stephen Kessler, D.O.

Under the guidance of Drs. Elston and Mones, the fellowship program exposes trainees to all aspects of dermatopathology from routine cases through challenging consultations to medical-legal issues. During the year of training, dermatologists and pathologists are able to benefit from the approximately 100,000 accessions and more than 4,000 consultations received annually from all parts of the globe. Participation in everyday sign-out with the eight associates is another important component of the fellowship, allowing the fellows to experience dermatopathology in the setting of a busy practice.

They are exposed to hospital-based dermatopathology in an urban setting. The fellows spend half of their time for eight months in either the department of dermatology or pathology, and the rest of their time is spent in dermatopathology, depending on their prior training. For those already trained in dermatology, hands-on experience in the pathology laboratory, including grossing of specimens, learning histology techniques, and participating in daily sign-out enhances their capability for dermatopathology by clinicopathological correlation.
The International Hyperhidrosis Society (IHHS) will offer an educational seminar on September 8, 2012 in Hoboken, New Jersey.

The one-day program is designed for medical professionals and their staff who wish to attain optimal patient outcomes and practice efficiencies when treating hyperhidrosis. The program is designed to:

• explain the pathophysiology of hyperhidrosis and how it is classified;
• describe the indication for, techniques of administering, and potential complications of the current and emerging treatments for hyperhidrosis;
• describe the effects of hyperhidrosis on a patient’s quality of life;
• demonstrate the specific techniques for best outcomes for all treatment options and focal areas; and
• show how to incorporate tools into practice for optimal patient management, satisfaction, and loyalty.

The program includes lectures and a video demonstration, as well as live demonstrations of iontophoresis and onabotulinum toxin A injections for axillary and non-axillary hyperhidrosis.∗

The program will be led by noted physicians Dee Anna Glaser, M.D., FAAD, IHHS President and founding member, and David M. Pariser, M.D., FACP, FAAD, IHHS Secretary and founding member. Dr. Glaser, the Program Chair, is a Professor of Dermatology, Internal Medicine, and Otolaryngology, and Vice Chairman of the Department of Dermatology at Saint Louis University in Missouri. She is also the Director of Cosmetic and Laser Surgery in the Department of Dermatology and Director of Dermatology Research at Saint Louis University. Dr. Pariser is a Professor of Dermatology at Eastern Virginia Medical School in Norfolk. He is also the 2009 President of the American Academy of Dermatology.

Attendees may obtain a maximum of 6.5 AMA PRA Category 1 Credits™. For more information about the seminar or to register online, visit the IHHS’ website at www.SweatHelp.org.

∗Physicians licensed to practice in New Jersey may register for hands-on experience treating axillary and non-axillary hyperhidrosis with onabotulinum toxin A. To do so, register online as an injector and the IHHS will contact you with further details.
South Texas Medical Care Crisis Could Spread Across Country  by Rick Lin, D.O., FAOCD, and Michael Hohnadel, D.O., FAOCD

There is a medical crisis brewing in the Rio Grande Valley in Texas as a result of recent changes to the state’s Medicare and Medicaid reimbursement. We wanted to inform AOCD members of this situation because although it is a local crisis, what is happening here can happen to other physicians in other parts of the country.

The following changes in Medicare-Medicaid dual eligibility along with the implementation of Managed Medicaid in South Texas have recently occurred:

- Medicare, which is the primary health insurance for dual eligible patients, kicks in after the $140 annual deductible is met for the year. Previously, Medicaid paid the deductible at Medicare rates. Under the new system, Medicaid still pays the deductible, but at greatly reduced Medicaid rates. This means that a physician receives approximately half of the allowed deductible amount. To make matters worse, poor communication between Medicare and Medicaid programs has resulted in many physicians not being paid at all for the patient’s deductible for the first quarter of this year.

- Previously, once the deductible was met, Medicare paid for 80 percent of the patient’s charges while Medicaid paid the remaining 20 percent. Under the new system, Medicaid no longer pays any of the patient’s remainder after Medicare has paid its portion. In addition, since these patients are enrolled in the Medicaid program, the physician may not bill them for the remaining amount. This translates to a 20 percent cut in total reimbursements on all dual eligible patients.

- Local physicians are facing delayed payment and non-payment through the newly introduced managed care programs. With five companies serving the area, patients don’t know which plan they belong to and physicians don’t know which one to bill for services. Each new managed Medicaid program has its own system of prior authorization and covered services greatly complicating patient care and placing unnecessary burdens on local practices.

- Medicaid is now reimbursing local pharmacies for prescriptions at $1.35 rather than $6.35. In addition, pharmacies are faced with an increase in administrative time to obtain these medications via managed Medicaid.

As a result of these reimbursement changes, several physician offices are on the verge of closing or are planning to move. Pharmacies have already closed, and more are expected to follow. Job losses due to these closings will only put more patients into the managed Medicaid and Medicare-Medicaid dual eligible system. The decrease in physician accessibility will lead to sicker patient populations. This situation will take us to a critical mass in the near future.

It’s true that these changes disproportionately affect the Rio Grande Valley because the majority of the elderly patients here are dual eligible for Medicare and Medicaid and most of the pediatric patients are eligible for Medicaid or enrolled in the Children’s Health Insurance Program. Most physicians in large cities such as Houston, Dallas, and Fort Worth have a more varied insurance mix and thus, the financial impact is not felt by them…yet. But in the valley, these changes are affecting the public health of more than 400,000 individuals and threaten the very existence of our medical practices, and thus our ability to treat our patients.

Lehigh Valley Health Network/PCOM Residents Present Posters, Take Top Honors

Lehigh Valley Health Network/PCOM dermatology residents have been busy making poster presentations at various meetings, some taking top honors for their efforts.

Third-year resident Lusia Yi, D.O., won first place for her poster presentation entitled *Atypical Lymphocytic Lobular Panniculitis: A Distinct Entity in the T-Cell Lymphoid Dyscrasias.* She presented at the Pennsylvania Academy of Dermatology’s Annual Meeting held in September 2011 in Hershey. Second place went to second-year resident Tatiana Groysman, D.O., for her poster presentation entitled *Oral Fixed Drug Eruption Secondary to Isoniazid.*

This past March, Dr. Groysman presented a poster entitled *Congenital Smooth Muscle Hamartoma* at the American Academy of Dermatology meeting held in San Diego.

The following month, second-year resident Marie Lewars received third place in the Stelwagon Award Competition for her paper entitled *Common Tattoo Reactions: A Review of the Literature.* The annual competition among dermatology residents and fellows in the Philadelphia area was held at a meeting of the College of Physicians’ Section on Dermatology.

Also in April, many of the dermatology residents presented at the Lehigh Valley Department of Medicine Resident/Fellow Hospital Research Day, an annual symposium at which residents present interesting case reports, quality improvement efforts, or research. Dr. Yi presented two posters: *Evaluation of Patients with Cutaneous Flushing and Rapidly Progressing, Diffuse Violaceous Nodules as a Presenting Symptom for Aggressive Acute Myeloid Leukemia.* First-year resident Christian Oram, D.O., also presented two posters, one entitled *Livedoid Vasculopathy in the Setting of Disseminated Intravascular Coagulation Diagnosed as Thrombotic Thrombocytopenic Purpura,* and the other entitled *Atypical Vascular Lesion Arising in an Area of Previous Radiation Treatment on the Breast.* Additionally, Dr. Oram gave a presentation about his second poster topic. First-year resident Luis Soro, D.O., presented a poster entitled *A Case of Classic Kaposi’s Sarcoma Treated with Electron Beam Radiation Therapy.* Dr. Groysman presented her poster about oral fixed drug eruption.
Hello my fellow residents.

With summer around the corner, it means the end to the academic year is near. Just a friendly reminder to all the residents, please have your annual logs completed and submitted by July 1.

A few things happened at the Midyear Meeting in Branson of particular interest to residents. They are as follows:

- Dr. Stephen Purcell informed the AOCD Board of Trustees that he would present the issue of moving the official board exam to an earlier date at the next AOBD meeting this summer. While there seemed to be some technical and logistical issues with moving the exam, at least the AOBD will discuss the possibility of doing so at the next meeting. I will keep you informed about what takes place at the AOBD meeting. Until further notice, the board exam is scheduled to be given at the Annual Meeting in the fall.
- The Education Evaluating Committee will be discussing the upcoming match process and match day soon. As soon as I get the details, I will let you know them.
- Next year, there will be four new residency programs. As soon as the details are available, I will send an email to all the residents. Congratulations to the programs and welcome to the AOCD family.
- AOCD President Dr. Bradley Glick announced at the Welcome Reception that the first-ever osteopathic dermatopathology fellowship at the Ackerman Academy of Dermatopathology in New York will start this July. (See article on page 20 for details.)

As always, if there are any concerns or comments, please let me know. Have a great rest of the academic year and congratulations to the seniors as they complete their programs.

**Dermatologic Surgery in the Outback**

Anthony Dixon, M.B., B.S., Ph.D., Assistant Professor (School of Medicine) at Bond University in Gold Coast, Australia, and Fellow of the Australasian College of Skin Cancer Medicine, has extended an invitation to the physicians and residents of the AOCD for a preceptorship **down under**.

The attending physician’s selection will be based on the silent auction principle. The starting bid is $1,000 and the preceptorship will be awarded to the highest bidder. The auction will take place at this year’s Annual Meeting to be held Oct. 7-11 in San Diego. Attending physicians will be responsible for their own expenses. The funds raised will be used to provide financial support for the winning resident attendee.

The resident’s selection will be based on a surgical paper competition. The paper will be judged on the basis of its surgical application in dermatologic surgery, with an emphasis on cutaneous cancer. It should be based on principles of surgical treatments for skin cancer, emphasizing literature review and/or new techniques. Original research is strongly encouraged. The deadline for the paper is September 15, 2012.

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

Winners essentially can schedule their preceptorship for any time during the year, pending any conflicts with Dr. Dixon’s schedule. The attending physician and resident are not required to travel simultaneously to Australia. The preceptorship is limited to one attending physician (AOBD board eligible or board certified) and one resident each year.

For more information, contact Lloyd J. Cleaver, D.O., at lcleaver@atsu.edu.

**The Slopes Are Calling**

With summer just getting underway, you’re probably not thinking about snow. But it’s not too soon to start thinking about the 2013 Midyear Meeting scheduled Jan. 23-26 in Winter Park, Colo. Winter Park offers some of the best skiing and snowboarding terrain in the country. Winter Park Mountain Lodge is a mountain getaway with a ski area for all levels from beginner hills to challenging mountains. Other activities you may enjoy are going on a horse-drawn sleigh ride, snowshoeing, tubing hills, ice-skating, or snowmobiling to the top of the Continental Divide.
Deadline Approaches for Annual Reports

It will soon be time for Annual Reports to be turned in. All forms can be downloaded from the AOCD document portal at http://myweb.cableone.net/aocd.

In fact, several reports are due to the AOCD office within 30 days of the end of each training year. They include: the Resident’s Annual Report, the Program Director’s Annual Report, the Resident’s Annual Paper with two referenced multiple-choice questions, the Documentation Report Form, Proof of Submission for Publication, and the AOA Core Competency Report. Residents are strongly encouraged to keep a copy of the reports for their records.

One original copy with an attached signature page should be sent. The signature page must be signed by the Resident, the Program Director, and the Director of Medical Education (DME). It is an affirmation of complete and accurate reports. Once the reports are received by the AOCD, we upload them to FileWorks, our online storage system. The Education Evaluating Committee (EEC) members will then be able to view each report as it is uploaded at their convenience, allowing the members more time to thoroughly review each report before the fall EEC meeting.

Incomplete reports will not be uploaded. Please do not fax your reports.

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

The late fee schedule is as follows:
• $100 for all reports submitted 30 to 365 days past deadline
• $250 for all reports submitted 366 to 730 days past deadline
• $500 for all reports submitted 731 days past deadline

Additionally, late documents may delay the approval of each year of training by the EEC and the AOA Postdoctoral Training Review Committee. Board eligibility is granted only upon approval by both committees.

Please compile your reports in the following order:

Attestation Signature Form. Your report is considered incomplete without the signatures of yourself, your Program Director, and your DME.

Resident’s Annual Report. Answer all questions on the form and review it prior to submitting it. Remember to keep a copy for your records. Supporting documents of meetings attended are unnecessary to send, but do keep them for your personal files.

Program Director’s Annual Report. This is a two-page AOCD evaluation form.

Complete Core Competency Evaluation Form. Residents who are not graduating are not required to fill out the program “complete” summary final resident assessment form.

Resident’s Annual Paper Documentation Attestation Form. You will need to submit the following: a copy of the complete paper, proof of submission for publication, and two multiple choice (A-E) examination questions with answers including references.

Please do not staple or bind the forms, or use color paper or print anything in color. Review your report before submitting it to ensure that it is complete. Again, faxed or emailed reports will not be accepted.

Rules for Upcoming Lectures

All of the speaking positions available at the 2012 Annual Meeting have been filled. By default, all residents not speaking at the Annual Meeting have been filled. All of the speaking positions available at the Annual Meeting have been filled. No last-minute additions to the lecture schedule will be allowed.

Regarding the administrative requirements for resident oral presentations, the Call for Lectures/Papers begins seven months prior to the first day of the meeting. The Intent-to-Lecture form is due six months prior to the first day of the meeting. If the AOCD office is not notified according to the aforementioned timeframe, the resident will not be placed on the schedule.

Required signed documents must be in the AOCD office eight weeks prior to the first day of the meeting. These documents include:
• Disclosure Statement
• Copyright/Consent
• Program Director’s Statement
• Copy of Completed PowerPoint Presentation

If the resident’s PowerPoint materials, as defined by the AOCD, are not received by the deadline date announced, the resident will neither be able to present at the meeting nor be eligible for KoPrince Award evaluation.

Receipt of these items two months prior to the meeting will allow ample time for evaluation, review, and approval by continuing medical education accredited bodies. Lecture schedule sign-up is closed 12 weeks prior to the first day of the meeting. No last-minute additions to the lecture schedule will be allowed.

Please note the following newly implemented presentation requirements:
• Your presentation must be run from computers supplied by the AOCD.
• Presentations must be provided as Microsoft Powerpoint files (Powerpoint 2007 will be the oldest acceptable format).
• No changes to your presentation will be accepted 48 hours prior to your lecture.
• Your presentation will be loaded 24 hours prior to your scheduled presentation time.
• Your presentation will be shown at the speaker’s podium on a monitor. You will control your presentation using a hand-held presenter.
• Your presentation will be shown live with no notes or clock.
• You may use either a podium microphone or clip-on microphone.
• You may review your loaded presentation either one hour before the daily program starts or during the lunch hour.
• If you plan to use sound or video in your presentation, you must notify the AOCD office at the time you submit your lecture for review.

Dermatologic Surgery in the Outback Paper Competition
Don’t forget, it’s not too early to be drafting a paper for the Dermatologic Surgery in the Outback competition. Dr. Anthony Dixon has once again offered a preceptorship in Australia to an AOCD resident. Learn more about this exciting opportunity on page 23.

AOCD Welcomes New Residents
The AOCD welcomes 34 new residents to its dermatology residency training programs.

The new residents who will begin July 1, listed with their programs, are as follows:

Advanced Desert Dermatology (Dr. Vernon Mackey)
Wai Chan, D.O.

Botsford Hospital/Pontiac Osteopathic Hospital (Dr. Annette LaCasse)
Michael Centilli, D.O.
Cynthia Chen, D.O.

Columbia Hospital (Dr. Robin Shechter)
Jamie Bosma, D.O.
Sarah Ferrer, D.O.

Lehigh Valley Health Network (Dr. Stephen Purcell)
Sean Branch, D.O.
Ryan Owen, D.O.

LewisGale Hospital/VCOM (Dr. Daniel Hurd)
Ryan Skinner, D.O.

Northeast Regional Medical Center (Dr. Lloyd Cleaver)
Stephen Plumb, D.O.

NSU-COM/BGMC (Dr. Shino Bay Aguilera)
Michael Baze, D.O.
Kim Hull, D.O.
Yvette Tivoli, D.O.

NSUCOM/Largo Medical Center (Dr. Richard Miller)
Jamie Hale-Hollenback, D.O.
Rick Limbert, D.O.
Stacey Seastrom, D.O.

NSUCOM/Larkin Community Hospital (Dr. Stanley Skopit)
Bertha Baum, D.O.
Jessica Bernstein, D.O.
Ashvin Garlapati, D.O.

O’Bleness Memorial Hospital (Dr. John Hibler)
John Hibler, D.O.
Kasie Kudrewicz, D.O.

Oakwood Southshore (Dr. Stephen Grekin)
Renata Brindise, D.O.
Travis Hamblin, D.O.

Richmond Medical Center/Case Medical Center (Dr. Jenifer Lloyd)
Jennifer DelPr, D.O.
Jessica Galvin, D.O.

South Texas Osteopathic Dermatology (Dr. Alpesh Desai)
Angie Koriakos, D.O.

St. Barnabas Hospital (Dr. Cindy Hoffman)
Cherise Khani, D.O.

St. John’s Episcopal Hospital, South Shore (Dr. Marvin Watsky)
Steven Brooks, D.O.
Marina Matatova, D.O.

St. Joseph Mercy Health System (Dr. Daniel Stewart)
Kelli Mayo, D.O.
Katie Messana, D.O.
Theresa Zaleski, D.O.

Wellington Regional Medical Center (Dr. Bradley Glick)
Nadine George, D.O.
Alissa Tomaiolo, D.O.

Western University/Pacific Hospital (Dr. David Horowitz)
Leela Athalye, D.O.

New Document Portal on Website

The new document portal set up on the AOCD website allows members to easily and quickly access College documents and forms.

Currently, the online document repository includes the AOCD bylaws, administrative manual, policies and procedures, upcoming meeting information, forms for speakers, a collection of meeting minutes dating back to 1985, and the 2012 membership directory. The latest versions of the AOCD resident reports can be found there, as well. The 2012 Midyear Meeting survey results booklet is the most recent addition. Office staff members update and maintain the document portal, which can be found at http://myweb.cableone.net/aocd/.

For suggestions about resources you would like to see on the document portal, please let us know at membersupport@aocd.org. Member suggestions are always welcome.
Dermatology Adventures—the Philippines

We can barely keep up with the changes that occur around us and affect our daily lives. They come at us from all directions. Some we love, some we accept, some we hate, but be that as it may, that is the reality of the world that we live in. There are, however, some obscure areas in the world that have remained, in some ways, timeless. They still embrace their thousands of years of traditions, customs, and ancestral teachings. They, so far, have resisted the forces of change that may, someday, eventually come and could lead to their extinction. Sure, there have been some advances in these areas, but they do not come easy.

A medical team from the Western University Pacific Hospital Dermatology Program recently visited one such place. I along with two residents, Drs. Michael Kassardjian and Teresa Ishak, traveled to Palawan in the Island Province of the Philippines, and stayed in the capital city, Puerto Princesa. This meandering island is 250 miles long and 31 miles wide. It is dotted with rocky coves, islets, and sugar white sandy beaches. It was occupied by the Japanese during World War II and housed prisoner of war camps. It was eventually liberated from the Japanese during World War II and white sandy beaches. It was occupied by the Japanese during World War II and housed prisoner of war camps. The island’s 800,000 inhabitants are composed of 87 different cultural groups speaking 52 languages and dialects resulting in a diverse and very interesting environment. The climate is always hot, humid, and wet. It is an area like many Third World countries that demonstrates contrast and contradictions. There are vast areas where there are no electrical lines, plumbing, or porcelain toilets. There is no welfare system, no system of care for the aging, and a very meager healthcare system, the latter of which is mostly for those who can pay for the service. There is, however, an abundance of cell phones and motor bikes, as well as smiling, playful, barefooted children. There is also poverty, disease, and of course, hope for a better basic existence.

After enduring airline strikes, typhoons, and numerous delays, we finally arrived in Palawan. Our team worked in various outreach makeshift clinics where there were very few local physicians to serve these remote communities. We joined the Aloha Medical Mission Group from Hawaii, which also consisted of primary care physicians, dentists, nurses, and volunteers who organized the trip and the clinical sites where we attended to more volunteers who organized the trip and the clinical sites where we attended to more than 4,500 patients in seven days. We saw a host of skin conditions. Even the most common conditions that we face here in the United States present there in their most advanced forms as they are complicated by environmental factors, malnutrition, lack of hygiene, parasitic infestation, worms, and secondary infections. Skin biopsies and fungus cultures do not exist, so clinical skills are paramount to diagnosing an endless array of interesting and, at times, perplexing conditions. Nothing is simple, and little is treatable in the standard and traditional ways that we are used to. We were very surprised by the number of surgical cases that we saw each day.

Dr. Kassardjian recalls the makeshift clinics comprised of student school desks pushed together to form surgical beds. Headlamps and flashlights were used to illuminate surgical fields. Snacks consisted mainly of fish heads and chicken, with some of us being less adventurous and only consuming a can of Coke and power bars to avoid succumbing to food poisoning, which some of our colleagues experienced. During our brief and few breaks, we observed dental procedures such as tooth extractions and played with the large groups of children who were consistently energetic as well as very musical. Dr. Kassardjian was touched by the gratitude a patient expressed to him after he excised a large cyst on the back of his neck that had been hindering his life; affecting his functionality as well as his work. In the Philippines, this patient would have had to sell all of his livestock to pay for having his tumor removed. To know that you have made a difference in somebody’s life transcends everything else. We learn through these experiences that these patients are changing our lives, as well.

Dr. Ishak relates a specific experience after driving several hours to go to a remote town to set up another clinic at a school. After graciously turning down non-refrigerated mayonnaise filled egg sandwiches that were served for lunch, she found herself becoming weak. She was surgically removing a large epidermal inclusion cyst on the back of his neck and being less adventurous and only consuming a can of Coke and power bars to avoid succumbing to food poisoning, which some of our colleagues experienced. During our brief and few breaks, we observed dental procedures such as tooth extractions and played with the large groups of children who were consistently energetic as well as very musical. Dr. Kassardjian was touched by the gratitude a patient expressed to him after he excised a large cyst on the back of his neck that had been hindering his life; affecting his functionality as well as his work. In the Philippines, this patient would have had to sell all of his livestock to pay for having his tumor removed. To know that you have made a difference in somebody’s life transcends everything else. We learn through these experiences that these patients are changing our lives, as well.

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Dr. Ishak relates a specific experience after driving several hours to go to a remote town to set up another clinic at a school. After graciously turning down non-refrigerated mayonnaise filled egg sandwiches that were served for lunch, she found herself becoming weak. She was surgically removing a large epidermal inclusion cyst on the back of a farmer when its contents exploded into her face. She had to take a moment to step outside to regroup, and remind herself that she had no choice, but to move forward. With the little energy she had left, her obligation and duties as a physician to complete the surgical procedure—even under these adverse conditions—overcame her fatigue. She concluded the surgery and then felt great.
If you have an adventurous spirit and a keen interest in tropical diseases in remote exotic areas, love unusual and often indescribable foods, and do not mind being without the comforts of home, you might want to follow the path of the dermatology residents from Western University and visit the Philippines on a future medical mission. The Third World nations are in need of your expertise. I often hear these questions from skeptics, “What can you really do for the people on a medical mission in such a short period of time?” or “Aren’t you just only putting a band-aid on what seems to be an unending problem?” My answer to these questions is simple. It is not what you do for any one patient at any given moment in time. It is what you do for all of them over an extended period of time akin to the teaching that you provide for the medical extenders who carry on long after you have left for home. You have helped enable them to deliver better health care to those in desperate need of it.

Dr. Kassardjian noted after returning home that there is a sense of appreciation for all we have and, at times, may have taken for granted. But there is also a continued craving for additional medical missions and soon after returning, we began to plan for our next exotic destination. Dr. Ishak stated that being on a trip with others who share the same passion for service to mankind leads to lasting camaraderies, and helps us all to serve others and become better people as well as better physicians.

There are smiling, playful children everywhere in the world who are eager to learn, and are eager to improve their chance for a better future. They are the next generation of the world’s citizens. Can we help them? I certainly hope so.

In Memoriam: Dr. Nisenbaum Passes Away at Age 53

Layne Nisenbaum, D.O., FAOCD, died March 22, 2012. He was 53.

He was a member of the AOCD for more than 26 years. Dr. Nisenbaum also served as Program Director of the Columbia Hospital in West Palm Beach, Fla. “He was a sharp dressed physician who was beloved by his patients and his community,” says John Minni, D.O., who trained in Dr. Nisenbaum’s program.

Initially, Dr. Nisenbaum operated two practices, one in Fort Lauderdale and one in West Palm Beach. Later on, he focused solely on the Island Dermatology and Laser Institute, which he opened in the 1990s. Dr. Nisenbaum is a graduate of what is now Nova Southeastern University.

Dr. Nisenbaum suffered liver failure while waiting for a transplant, according to former U.S. Rep. Mark Foley, Dr. Nisenbaum’s partner of 28 years. “The joys of his life were his patients and his practice,” Foley is quoted as saying.

Survivors include his parents, Jack and Sandra Nisenbaum of Wellington; Mark Foley; his sister, Karen, and brother-in-law, Paul Beattie, and their son, Andrew; his brother, Dr. Robert Nisenbaum, sister-in-law, Dana Nisenbaum, and their children, Emma, Margo and Greyson; an uncle, Harvey Wagner, and an aunt, Arlene Wagner.

The AOCD extends its deepest condolences to the entire Nisenbaum family.

Nominees for New Officers, Trustees

New officers will be voted in at the Annual Meeting to be held Oct. 7-11 in San Diego.

Nominees to move up the officer list include the following:
• David Grice, D.O., for President
• Suzanne Rozenberg, D.O., for President-Elect
• Rick Lin, D.O., for First Vice-President

Members also will be asked to vote on proposed changes to the bylaws (Article II: Section 4: #R) with regard to the JAOCMD. The proposed change would affect the committee membership as follows: The committee will consist of the journal editor and a minimum of four additional members. This committee will oversee the content and publication of the JAOCMD.

Nominees for vacant positions include the following:
• Alpesh Desai, D.O., for Second Vice-President
• Karthik Krishnamurthy, D.O., for Third Vice-President


ICD-10 Compliance Date Delayed

Healthcare entities have until October 1, 2014, to comply with the diagnosis and procedure codes in the International Classification of Diseases, 10th Edition (ICD-10). Health and Human Services (HHS) Secretary Kathleen G. Sebelius postponed the compliance date by one year.
Last summer, Danica Alexander, D.O., went to camp for the first time.

She volunteered at Camp Dermadillo, which is held at Camp For All, in Burton, Texas. It is one of six camps that comprise Camp Discovery sponsored by the American Academy of Dermatology for children, ages 8-16, with chronic skin conditions.

Dr. Alexander has wanted to volunteer at Camp Discovery for a few years, but she was never able to find the time during her residency and then studying for boards. When a patient with Darier’s disease was raving about her camp experience, Dr. Alexander knew it was time to pack up her duffle bag.

The campsite is located between Houston and Austin in the hills of Washington County. Camp Dermadillo sits on 260 acres that was once part of a working ranch and features more than 100,000 square feet of facilities, two lakes, nature trails, wooded areas, and cleared areas for activities such as horseback riding and field sports.

She was charged with overseeing a cabin of 11-year-old boys. Her nine campers had such conditions as psoriasis, eczema, proteus syndrome, vitiligo, alopecia areata, polymorphous light eruption, and a large congenital facial nevus.

Each morning at 6:30 a.m., Dr. Alexander headed over to the boy’s camp to make sure all of her campers had their topical medications and sunscreens on. “After the first day, I realized that eleven-year-old boys need some guidance when it comes to putting on sunscreen,” she says. Dr. Alexander dispensed oral medications after breakfast. Some of the campers forgot their medications, as well, but the camp pharmacy had ample supplies of whatever medications were needed. And while great care was taken by all of the volunteer staff to make sure that the campers received their medications at the appropriate times, their skin conditions were under control, and that they did not overheat in the Texas August sun, the real purpose of Camp Dermadillo was to have fun. “We tried not to focus on the campers’ skin conditions, but rather let them play and enjoy themselves so that they could forget about their diseases for a while,” she says.

To that end, days were filled with activities such as horseback riding, canoeing, fishing, playing dodge ball, and doing arts and crafts. “After lunch, we often took a much needed swim to cool off,” Dr. Alexander says. Each night after dinner, there was a themed activity. The theme for the week was a Road Trip in the U.S. On the night they learned about Alaska, the camp brought in snow. “It was a hundred degrees outside, and we were sledding and having snowball fights,” she recalls. Another night, there was a rodeo.

During the day, Dr. Alexander interacted with her boy campers. But in the evenings, she returned to one of the girls’ cabins where she resided for the week. During cabin time, Dr. Alexander and the counselors played games with, or read to, the campers who had such conditions as lamellar ichthyosis and xeroderma pigmentosa. The other counselors she volunteered with were a physician assistant trained in dermatology, dermatology resident, teacher, and former camper.

On the last night of camp, there was a talent show and awards ceremony. “My cabin surprised me with a t-shirt signed by all of the campers and counselors, thanking me for all I did. It was very touching and gratifying.”

Equally as sweet was to see how the campers, who started out as strangers, bonded with each other in such a short period of time. They were so sad by week’s end to say goodbye, which was an indication to Dr. Alexander of just how much the camp experience meant to them. Then there was the transformation that some of the campers went through. One camper with a large congenital nevus that covered part of his face was very shy all week long. To everyone’s amazement, the last night of camp, he jumped up on the makeshift stage and danced the entire night. It also was inspiring to see how the campers dealt with their diseases, for example, the campers with xeroderma pigmentosa who had to dress up in what looked like a space suit that covered them from head to toe just to walk between buildings. “Once inside the arts and crafts building where these children spent most of their time during the day, their struggles vanished as they laughed and played with their friends,” she says. There are plans to build an indoor gym to accommodate future campers with this disease.

Dr. Alexander enjoyed her first camp experience so much that she is going back this year. This June, Dr. Alexander is packing up her duffle bag and reporting to Camp Little Pine in Minnesota.

For more information about Camp Discovery or to volunteer, visit the website at www.campdiscovery.com.
Launched in August 2011, Medicis created the Passion to Heal™ initiative to help bring specialized healthcare to underserved communities here and abroad.

“By making donations to non-profits, Medicis is helping these organizations send healthcare professionals to areas throughout the world where they can create their passion to heal,” says Medicis President Mark Prygocki. “That’s where we derived the name from. We realized that there were many healthcare providers who wish they could do more charitable work. We help provide them that avenue.”

Through this initiative, Medicis provides financial support to highly respected non-profit organizations, he explains. These organizations, in turn, underwrite costs associated with the volunteer activities of dermatologists, plastic surgeons, residents, and other healthcare professionals in these specialties. Medicis contributes funding, products, and services with a value of up to $2 from the sale of each prescription, vial, and syringe of its key U.S. dermatology and aesthetics products in support of Passion to Heal.

Passion to Heal currently supports the following non-profit organizations:

- Operation Smile, which has provided free reconstructive surgeries to more than 160,000 children with cleft lips and palates since 1982. Thanks to medical professionals and volunteers, Operation Smile is able to make a difference for children in more than 300 remote and urban areas worldwide.
- Free the Children, which funds mobile health clinics and basic medical supplies, trains healthcare workers, and offers healthcare workshops about preventable diseases. The organization’s programs have helped one million people gain improved access to clean water, health care, and sanitation.

Additionally, Medicis is working on a regional basis to identify domestic volunteer opportunities. “Over time, there will be a compliment of international and domestic opportunities,” Prygocki says.

The inaugural Free the Children trip to Kenya, supported by Passion to Heal, took place this past January. AOCD member Scott Drew, D.O., was among the group of 17 comprising medical residents, medical students, nurses, physician assistants, medical assistants, and Medicis employees who went. He learned about the initiative through his Medicis representative, and then Dr. Drew went on the website to learn more and applied as a volunteer with Free the Children. Knowing that Free the Children was selected as a funding recipient by Medicis gave it more credibility. He had wanted to volunteer in some capacity, but wasn’t sure how to go about it. “This was a ready-made opportunity. They had the facility, the transportation, and the patients,” Dr. Drew says, adding, “Because the logistics are taken care of, you can focus on what you’re there to do.” Of the 10-day trip in which the medical team treated 3,500 patients, he says, “It was the most affirming, positive experience in my professional life.”

To learn more about Passion to Heal, visit the website (www.passiontoheal.com).
Dustin Portela, a third-year medical student at Des Moines University in Iowa, not only runs the Outrun the Sun races, he helps organize them.

Last summer, the avid runner was watching a track meet on television when a public service announcement about Outrun the Sun aired. The eight-year-old foundation is dedicated to building national awareness of melanoma and other skin cancers, educating communities about preventive measures to reduce the incidence rate of melanoma, and raising funds for melanoma research leading to effective treatments and a potential cure.

Although there was no Outrun the Sun race in his city, Portela knew of another local race being run. The Lake Erie Shores and Islands Half Marathon was set to take place in August in Sandusky, Ohio, where he currently resides and has clinical rotations. After further inquiry, Portela discovered that the marathon organizers were looking for a charity for which to raise funds. He put the two together and the race was on to organize the event. Portela and other university students worked the water stations and the booth for skin cancer prevention and education where they handed out sunscreen samples. Between 200 and 250 runners raised approximately $400.

But Portela didn’t stop there. He became a medical student liaison for Outrun the Sun. “I thought it was a good group for which to become an activist because of the chance to work with people who are at a higher risk for developing melanoma but are otherwise healthy because they are physically active.” As a member of his high school track team, Portela remembers the cross country coach whose mother died from melanoma. “The coach always stressed the importance of wearing sunscreen when participating in any kind of outdoor activities,” he says.

This year, Portela assisted in organizing the first-ever Outrun the Sun Race in May, which kicked off on May 1. Runners and walkers registered online, took the Sun Safety Pledge and ran or walked on a day in May of their choosing to show their support for skin cancer prevention and education where they handed out sunscreen samples. Outrun the Sun came up with the idea for the virtual race because the Indianapolis office staff fields calls almost daily from people who have been affected by melanoma from all different parts of the country, Portela explains. They want to do something to support the organization, but they may not be able to attend the annual Outrun the Sun race in Indianapolis, the organization’s big fundraiser. “There are a lot of logistical considerations involved in organizing a large-scale race,” he says. “This is a way to host a race without having to get permits to use the designated space, volunteers to staff the race, and sponsors to support it, not to mention having to coordinate the event with local officials.” Virtual race partners include USA Track & Field, Independent Running Retailers Association, the Dermatology Nurses’ Association, Road Runners Club of America, the Running Network, Midwest Melanoma Partnership, MDSolarSciences, and Bristol-Meyers-Squibb.

As medical student liaison, Portela publicized the virtual race on social media, including various cancer and runners’ forums. He also contacted other medical schools to either generate runners for the virtual race or individuals interested in hosting a local race. In addition, Portela designed a website for the group of volunteers establishing a race scheduled for August 3 in Rochester, New York.

In June, Portela attended the 8th Annual Outrun the Sun race in Indianapolis. He worked the skin cancer prevention and education booth. Last year, approximately 3,000 participants raised more than $130,000. Fundraising efforts for this year’s race are on pace to exceed last year’s numbers, he says. More than 100 teams registered for both this and the virtual race.

Getting to know patients and families whose lives have been affected by melanoma has had a significant impact on Portela. “Seeing the impact this disease has had on people’s lives underscores the importance of prevention and additional research,” he says. “By working with this organization, I can help make a difference for them.”
**Position Available in Northeast Pennsylvania**

Busy dermatology practice seeks BE/BC dermatologist for 32-year-old, four physician, four physician assistant practice. General dermatology and subspecialty interest welcome. This position offers an excellent compensation, benefits, and partnership opportunity. Visit our website at [www.lackawannadermatology.com](http://www.lackawannadermatology.com) Please contact Kathryn Colombo, Practice Manager, by email at Lackaderm@aol.com or fax at (570) 207-5579.

**Dermatologist Wanted in Michigan**

Busy dermatology practice located in beautiful Saint Joseph, Mich., seeks an additional BC/BE dermatologist to practice general dermatology with an opportunity for dermatologic surgery, Mohs micrographic surgery, laser surgery, and cosmetics. We hope to build a long-term relationship with the right individual who is willing to participate in our new MSUCOM/Lakeland Regional Medical Center Dermatology Residency Program. We are offering an excellent compensation package with benefits.

This position offers state-of-the-art facilities and resources in a friendly and educational environment. Saint Joseph is located directly on Lake Michigan and offers access to some of the most beautiful beaches in the country. It is also a 90-minute drive to downtown Chicago and a 40-minute drive to the Notre Dame campus in Indiana.

Call Mark Kuriata, D.O., FAOCD, or Ken Richcreek, practice administrator, at Advanced Dermatology at (269) 429-6499. You may also fax your CV to (269) 429-0807.

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**AK Lunch Symposium at Annual Meeting**

*Making a Paradigm Shift in the Management of Actinic Keratosis (AK): Taking Treatment to the Next Level* is the focus of a lunch symposium to be held at the AOCD Annual Meeting.

This symposium will be held between noon and 1:15 p.m. on Wednesday, Oct. 10 at the San Diego Convention Center. It will be a ticketed event, and attendees must pre-register for the symposium.

This symposium will focus on the pathophysiology of AK and current approaches to its management, including selection of the most appropriate topical agents based on mechanism of action, efficacy, and safety, as well as the rationale for combining destructive therapy with topical field treatment. The speaker will be Joseph L. Jorizzo, M.D., Professor and Former (Founding) Chair of the Department of Dermatology at Wake Forest University School of Medicine in Winston-Salem, North Carolina.

After completing this activity, participants will be better able to:
- Describe the progressive nature of AK lesions and the rationale for treating all AKs.
- Differentiate the topical field therapies for AK based on mechanism of action, efficacy, safety, and tolerability.

- Explain the importance and benefits of a comprehensive combination therapy approach that includes destruction of clinical lesions and field therapy to treat subclinical lesions.

Attendees may obtain a maximum of 1.0 AMA PRA Category 1 Credits™.


This activity is supported by an educational grant from Medicis Pharmaceutical Corporation.

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The AOCD’s preferred mailing address is: **AOCD**

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All regular mail should be addressed to the post office box. The street address should only be used for Fed Ex and UPS deliveries. The mail box for our physical address sits on a street corner away from the office and is not a secure box.
JAOCĐ
A CALL FOR PAPERS

Journal of the American Osteopathic College of Dermatology - JAOCĐ.

We are now accepting manuscripts for publication in the upcoming issue of the JAOCĐ. '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., FAOCĐ