More Midyear Meeting Highlights
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Explore San Diego at the Annual Meeting
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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.

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Message from the President

My fellow osteopathic dermatologists, residents, students and administrative faculty, I hope all of you have had a tremendous summer. As your AOCD President, I can assure you that your Board of Trustees (BOT) and its representative committees were by no means on vacation this summer. Particularly, the Education and Evaluating Committee (EEC) has been working tirelessly with, on average, bi-weekly phone/email conferences to assure the quality of osteopathic dermatology residency and fellowship training programs. I would like to thank the entire BOT, all members of the EEC, and my fellow Program Directors for their ongoing efforts and assistance throughout 2011 and 2012.

The months of June and July were extremely busy. On June 7, 2012, I attended the first annual National Psoriasis Foundation (NPF) Tribute Award Gala honoring Mark Lebwohl, M.D., Chair of the Department of Dermatology at Mount Sinai School of Medicine in New York. Dr. Lebwohl was recognized for more than 30 years of contributions to the care of patients with psoriasis and psoriatic arthritis at this memorable event attended by more than 500 representatives from clinical and academic dermatology as well as the pharmaceutical industry. I would like to publicly thank Michael Bruce of Ranbaxy Pharmaceuticals and Steve Heicklen not only for their important roles in my ability to share in this evening as AOCD President, but also for their continued support of our College.

From New York, I traveled to Las Vegas to attend and participate as a speaker at the second annual Real World Dermatology meeting. This meeting was developed by James Del Rosso, D.O.; Roger Ceiley, M.D.; Darrel Rigel, M.D.; Clay Cockerell, M.D.; and Dr. Lebwohl as an up-to-date and leading edge conference for residents in their second and third years of training. Simply said, this is an excellent, well run meeting with a tremendous opportunity for attending faculty to interact and exchange ideas with resident attendees. Lloyd Cleaver, D.O., Program Director at the Northeast Regional Medical Center in Kirksville, Mo., presented a complex case of melanoma and associated lymphoma. Dr. Cleaver and I, as well as the residents representing our programs wish to thank Drs. Del Rosso, Ceiley, Cockerell, Rigel, and Lebwohl for this experience. We encourage osteopathic dermatology residency Program Directors and residents, when provided the opportunity, to attend this wonderful conference.

Joined by AOCD Executive Director Marsha Wise and AOCD Representative Dr. Cleaver, I attended the AOA House of Delegates (HOD) meeting July 19-22 in Chicago. For those of you who have never attended, the HOD is an enlightening and uplifting experience. Should you ever be in doubt as to whether the AOA works for you, I can assure you they DO. Hundreds of resolutions are reviewed, all with the best intentions to assure the protection of osteopathic physicians as well as preservation of the osteopathic concept. Rest assured your AOCD representatives were there making sure that all of our voices are heard. The highlight of the meeting was the installation of the incoming AOA President Ray Stowers, D.O. This whole experience and opportunity to represent the AOCD left me quite proud to be a DO and privileged to serve as your AOCD President.

Next month, the AOA OMED meeting will commence on Oct. 7-11 in San Diego. I encourage all members to attend the meeting. The AOCD host hotel is the Marriott Marquis (on the Convention
Center campus). This year’s meeting should prove to be one of the most academically sound in our College’s history. We are privileged to have AAD President Daniel Siegel, M.D., FAAD, who will provide a Health Care Policy and Cyber Medicine Update. We are pleased to bring back the second Annual University of Pennsylvania Symposium, which will feature four faculty members from the Department of Dermatology at this prestigious institution. Day 1 will be capped by the AOCD Business Meeting. I strongly encourage all of you to attend and participate in the meeting, which will include a presentation of the 2012-13 slate of AOCD officers, as well as committee updates, and a whole host of presentations to physicians, residents, and representatives of the pharmaceutical industry. PLEASE ATTEND and GET INVOLVED. Days 2 and 3 of the conference will be moderated by incoming AOCD President, David Grice, D.O., and Suzanne Sirota Rozenberg, D.O.

From a housekeeping standpoint, I would like to remind all attendees of the following events:

- The AOA Welcome Reception will be held from 6 p.m. to 9 p.m. on Sunday at the Manchester Grand Hyatt. As there is no AOCD Welcome Reception this year, let’s plan on meeting at this time-honored event. I plan to have an AOCD sign for those of you who would like to get together and catch up with colleagues.
- Non-dermatology residents, interns, and students who typically attend our Welcome Reception will have an opportunity to meet and greet AOCD Program Directors at the first ever Program Director – Dermatology Candidate Application Process Lecture Session to be held in lecture halls B & C (Marriott Marquis) on Sunday. Details to follow.
- Monday evening is the first ever Presidential Celebration – AOCD BOT member installations, Presidential presentations and citations, great food, music, and most important the swearing in of Dr. Grice as incoming AOCD President. (Don’t forget to register—this is a ticketed event.)
- At 11:45 a.m. on Wednesday, there will be a lecture on Actinic Keratoses. This ticketed luncheon conference, which is sponsored by Paradigm Medical, is by invitation only.

I will close by telling all of you how very much appreciative I am to have served this past year as your AOCD President. Congratulations in advance to Dr Grice, to whom I trust I will turn over the AOCD in calm waters. I would be remiss if I did not thank the staff of the AOCD John Grogan, Rick Mansfield, and Shelley Wood for their continued efforts to keep the College on a steady course. I wish to thank Ruth Carol, Editor of Dermline, for her exceptional efforts to assist our College in the production of a wonderful and well-received newsletter. Additionally, I must publicly thank Karthik Krishnamurthy, D.O., Editor of the Journal of the American Osteopathic College of Dermatology, for his hard work and dedication to one of only two AOA College journals. Jay Gottlieb, D.O., certainly has left our College with a tremendous legacy. With the excellent, current, and evidenced-based articles submitted by academicians, residents, and student physicians, the Journal is sure to continue to grow in a positive forward flowing direction in Dr. Krishnamurthy’s hands.

Finally, there is not enough that can be said about the phenomenal work and tireless efforts of Marsha throughout the past year. A BIG THANK YOU to Marsha for all that she has done and continues to do to assure that the AOCD stands firmly on solid ground and serves as a shining example of a forward moving and thinking organization under the guise of the AOA. Proud to be a DO! See you all soon in San Diego.

Fraternally,

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

It has indeed been a busy summer in the AOCD office. The College continues to implement new ideas and services, and update existing ones, in order to serve our members better and, we hope, faster. We began using a new provider for our email blasts. The new provider, Exact Target, is expected to allow us more flexibility regarding the information we can put into our email blasts. We also recently outsourced our accounting duties to a local Certified Public Accounting firm. The Internal Revenue Service has strict requirements when it comes to the accounting of not-for-profit organizations and this move will help the AOCD in our transparency to members and the public.

On June 21, 2012, the AOCD staff was invited to the groundbreaking ceremony for the new Cleaver Dermatology Office. The existing space, which consists of 8,400 square feet, will be remodeled and an additional 10,340 square feet will be added. The building will have four class A ASC rooms with offices and spa as well as 12 treatment rooms.

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The Accreditation Council for Graduate Education's (ACGME) proposed changes to its Common Program Requirements continues to be a hot topic. The ACGME has delayed its scheduled June vote on the proposed requirements until September to allow discussions between the AOA and ACGME to progress. The AOA has additional information on this matter on its webpage at the following link: http://www.osteopathic.org/inside-aoa/Pages/acgme-policy-timeline.aspx

The Society of Osteopathic Specialty Executives, or SOSE, also met this past July in the offices of the American College of Osteopathic Emergency Physicians on the 15th floor of the AOA building in Chicago. Those in attendance represented more than 300 years of osteopathic service. Topics discussed included Osteopathic Continuous Certification, ACGME, the Intern/Resident Registration Program also known as the Match, and methods to measure competency in residency programs.

For Drs. Glick, Cleaver and Wikas, and me, the week in Chicago ended with a visit to the AOA building and a meeting with Cynthia Hollis-Young, who is the AOA Residency Coordinator in charge of keeping track of dermatology programs. It is always great to be able to put a face to the voice on the other end of the phone line.

In addition to the AOA House of Delegates, I attended the Postdoctoral Training Review Committee (PTRC) meeting in August in Chicago.

At the April PTRC meeting, a total of five new residency training programs were approved by the AOA for a potential of 30 new residency slots. The new programs were eligible to begin taking residents on July 1, 2012. The complete list of our residency
programs can be found on the AOCD website at http://www.aocd.org/qualify/index.html

The AOCD will be participating in the AOA Match program, however, not until 2014. Planning with the AOA to iron out the details is ongoing, and Program Directors will be updated once everything is finalized.

Upcoming Meetings
You should have received information regarding our Annual Meeting in San Diego by now. Mark your calendars and join us at the San Diego Marriott and San Diego Convention Center Oct. 7-11, 2012. Plan to attend the AOCD General Business Meeting at 3 p.m. on Monday, Oct. 8. This will be your opportunity to vote for AOCD officers. The BOT are elected to represent you. Please attend this meeting, vote, and share your concerns and comments with the BOT members.

Members also will be asked to vote on the addition of a new committee to the AOCD at the Business Meeting as follows: The new standing committee will be for the Journal of the American Osteopathic College of Dermatology (JAOCD). This committee shall consist of the journal editor, and a minimum of (4) additional members. This committee shall oversee the content and publication of the JAOCD.

Our Historical Committee is working on a publication that will discuss the history of the AOCD as 2013 marks the College’s 55th anniversary. This information is slated to be presented at our Presidential Celebration on Oct. 8.

Our next two Midyear Meetings will be held Jan. 23-26, 2013 in Winter Park, Colo., and Feb. 20-23, 2014 in Dallas. Save the dates for these meetings! We anticipate a total of 22 CME credits to be offered at each meeting.

The AOCD is your organization! Please let the national office know what we can do to improve communications to you. I welcome your comments and suggestions.

I look forward to seeing all of you in San Diego.

AOA Names 116th President

Ray E. Stowers, D.O., an osteopathic family physician, was named the 116th AOA President this past July.

At his swearing in ceremony held in Chicago, Dr. Stowers encouraged all osteopathic physicians to be innovative as they look toward the future of health care and osteopathic medicine. He noted that nearly 140 years ago the osteopathic medical profession was built on a new concept of how to improve upon the current approach to medicine. Dr. Stowers called on DOs to continue initiating new ways of thinking from helping patients learn to make better choices for their health and taking the lead in promoting new healthcare delivery systems He promised that the AOA will continue to advocate for important issues such as fair Medicare physician payments and expansion of osteopathic graduate medical education training.

After graduating from what is now the Kansas City (Mo.) University of Medicine and Biosciences College of Osteopathic Medicine, Dr. Stowers established his practice in north central Oklahoma. During most of the 25 years that he practiced there, he was the only physician in the 300-square mile county. Dr. Stowers was an Associate Professor of family medicine and Director of the Division of Rural Health at the Oklahoma State University Center for Health Sciences College of Osteopathic Medicine in Tulsa, Okla. He then served as the Founding Director of the Oklahoma Rural Health Policy and Research Center. In 2005, he returned to his roots in Harrogate, Tenn, as the Vice President for health sciences and Founding Dean of the Lincoln Memorial University-DeBusk College of Osteopathic Medicine where he is helping groom future generations of DOs.

Advocating for the osteopathic medical profession at the national level, Dr. Stowers has served on the Board of Trustees since 2000. In addition, he has been involved with several other osteopathic medical organizations. Dr. Stowers is a past president of the Oklahoma Osteopathic Association, which honored him with the A.T. Still Award of Excellence in 2008, and a Board member of the Tennessee Osteopathic Medical Association (TOMA). In 2006, he was named Family Physician of the Year by the American College of Osteopathic Family Physicians. In 2011, TOMA honored Dr. Stowers with the Paul Grayson Smith, Sr., Physician of the Year Award.

A longstanding member of the AOA, Dr. Stowers has served on the Board of Trustees since 2000. In addition, he has been involved with several other osteopathic medical organizations. Dr. Stowers is a past president of the Oklahoma Osteopathic Association, which honored him with the A.T. Still Award of Excellence in 2008, and a Board member of the Tennessee Osteopathic Medical Association (TOMA). In 2006, he was named Family Physician of the Year by the American College of Osteopathic Family Physicians. In 2011, TOMA honored Dr. Stowers with the Paul Grayson Smith, Sr., Physician of the Year Award.

Dr. Ray E. Stowers. Courtesy of the AOA
Meet the Nominees for AOCD 2012-2013 Officers, Trustees

Members will be asked to vote at the 2012 Annual Meeting for new officers to serve on the Board of Trustees (BOT). The candidates talk about what they hope to accomplish as a member of the BOT and their role in shaping the future direction of the AOCD in the following excerpts:

Nominees for vacant officer positions include Alpesh Desai, D.O., for Second Vice-President and Karthik Krishnamurthy, D.O., for Third Vice-President.

Dr. Desai has been an AOCD member since 2002. His time and experience as a BOT member and role as a Program Director for the South Texas Osteopathic Dermatology residency program gives him different perspectives of how the College operates and functions. Developing and maintaining relationships with members and leaders are critical, he said, adding, “The quality of thought leaders that we have in the AOCD is incredible and I feel very fortunate to be intimately involved with the College.” Furthermore, his position as the Texas Medical Director for Dr. Tatoff, Inc. keeps him up-to-date on regulatory and other issues that affect the dermatology profession.

“My main goal, and I think it’s a universal goal for all of us who have put in long hours for the AOCD, is continuous improvement for the organization,” Dr. Desai said. Another goal is for members to realize how vital the College is for osteopathic dermatologists so that they never question why they are paying dues. “It’s my personal goal to improve the organization so that its vision is apparent.”

To that end, he would focus on improving transparency, reducing costs, and obtaining more corporate sponsors.

Dr. Krishnamurthy served as Resident Liaison in 2008, is the Chair of the Editorial/Public Relations Committee since 2010, and recently assumed Editor-in-Chief of the Journal of the Osteopathic College of Dermatology or JAOCD.

While Dr. Krishnamurthy believes that the AOCD is currently moving in very positive directions, he is focused on expanding resources. Among them are creating novel ways to increase the College’s visibility to the public, updating its website, developing continuous medical education (CME) opportunities, and creating more educational opportunities. “In a time when it may seem that opportunities are becoming unavailable to us, let’s change the game...let’s create all those opportunities for ourselves, right here, in our College,” he said. “Our senior members have already worked tirelessly to create both surgical and pathology fellowships so that our trainees can reach their career goals without political hindrance. I want to continue building on that, making the College a one-stop-shop for the professional needs of the osteopathic dermatologist.”


An AOCD member since 2002, Dr. Alexander currently serves on three AOCD committees: Items Writers, CME, and Editorial/Public Relations. She has served in leadership roles as Family Medicine Vice Chief Resident, Family Medicine Administrative Chief Resident, and Dermatology Chief Resident in West Palm Beach, Fla. In addition, volunteering for Camp Discovery, which is sponsored by the American Academy of Dermatology for children with chronic skin conditions, demonstrated the importance of serving one’s community and has inspired her to foster new volunteer opportunities for dermatologists and dermatology residents.

The AOCD has worked to improve its members’ education by enhancing residency training, CME programs, and the JAOCD. The College also has worked toward improving legislation and ultimately ensuring the best patient care. “When I joined the Items Writers Committee during its first year and saw the difference we made, I knew I wanted to do more for the College,” she said. “As we embark on our new endeavor with Osteopathic Continuous Certification and new challenges to our field, I want to be involved on the frontline.”

Dr. Anderson has been an AOCD member since 2007. He served as the Resident Liaison from 2008-2009, and is a member of the Finance Committee. “I would like to lead the College into the future and help it with the challenges that face our specialty, in particular, and medicine, in general,” he said.

Bryan Sands, D.O., hopes to fill an unexpired two-year term trustee position. He has been an AOCD member since starting his residency in 1994. Dr. Sands has served on the Internet Committee and has helped update the skin disease database on the AOCD website. He believes that serving as a clinical adjunct faculty member at Des Moines University for the last decade will help him in the role of trustee.

“The AOCD has come a long way in the last fifteen years, bringing awareness and acceptance of osteopathic dermatologists to the nation,” he said. “My hope is that I can help continue that trend as we face upcoming changes in healthcare and licensing.” In addition, Dr. Sands would like to aid in the smooth transition to Osteopathic Continuous Certification. “I look forward to giving my time and support to our College if elected,” he said.

Daniel Ladd, D.O., will run to fill an unexpired one-year term trustee position.
EHR Meaningful Use Deadline Approaches

October 3, 2012 is the last day for eligible professionals (EPs) to begin their 90-day reporting period to demonstrate meaningful use for the Medicare’s incentive program for electronic health records (EHRs). This deadline is tied to a $44,000 bonus.

If EPs do not implement by that day, the next deadline for implementation is October 3, 2013. At that point, the maximum amount of Medicare bonus they can receive is $39,000.

How to Begin
To initiate the meaningful use process, EPs must purchase a certified EHR system, Rick Lin, D.O., explained. Once the system is purchased, the provider must request an EHR Certification ID from the Centers for Medicare & Medicaid (CMS). The next step is to register for the meaningful use incentive program.

During the following 90 days, the EP must meet the meaningful use criteria. At the end of the 90 days, the provider can then attest to meeting the criteria. “You will want to make sure that your EHR keeps track of the compliance because CMS has started auditing for compliance and you want to make sure that you have documentation of your attestation,” he advised.

Meaningful Use Defined
The meaningful use requirements are expected to be divided into three stages phased in during a five-year period. Overall, CMS’ final rule is expected to phase in more robust criteria for demonstrating meaningful use with each stage.

Stage 1 established a core and menu structure for objectives that providers must achieve in order to demonstrate meaningful use. While EPs must meet all core objectives, they can select from a list of predetermined menu objectives. Under Stage 1, EPs must meet 15 core objectives and five menu objectives selected from a list of 10.

For Stage 2 criteria, which were published last month, most of the objectives introduced for EPs are core objectives. For many of the Stage 2 objectives, the threshold that providers must meet has been raised, that is, they must demonstrate meaningful use for an even larger portion of the patient populations. To demonstrate meaningful use under Stage 2 criteria, EPs must meet 17 core objectives and three menu objectives that they select from a list of six, or a total of 20 core objectives. Most of the new criteria introduced in Stage 2 are menu objectives. However, one new core objective introduced for EPs is the use of secure electronic messaging to communicate with patients on relevant health information. Stage 2 also replaces Stage 1 objectives to provide electronic copies of health information or discharge instruction and provide timely access to health information with objectives that allow patients to access their health information online. For EPs, they will have to provide patients the ability to view online, download, and transmit their health information within four business days of the information being available to the EP. Stage 2 criteria also emphasize health information exchange between providers to improve care coordination for patients. Additionally, new requirements call for the electronic exchange of summary of care documents. New Stage 2 menu objectives require EPs to record electronic notes in patient records, make accessible imaging results through certified EHR technology, and record patient family health history, as well as identify and report cancer cases to a state cancer registry, and specific cases to a specialized registry.

Stage 3 is expected to focus on achieving improvements in quality, safety and efficiency; focusing on decision support for national high priority conditions; patient access to self-management tools; access to comprehensive patient data; and improving population health outcomes.

Regarding the bonus payment, the provider will receive $18,000 the first year, $12,000 the second year, $8,000 the third year, $4,000 the fourth year, and $2,000 the fifth year.

The proposed penalty for non-compliance will begin in 2015. There will be a payment reduction of 1% in 2015, 2% in 2016, 3% in 2017, 4% in 2018, and 5% in 2019. “For a large practice, this is a significant financial loss when combined with future Medicare reimbursement cuts,” Dr. Lin said.

For more information about the EHR incentive program, including links to the final rule and criteria for Stages 1 and 2, visit http://www.cms.gov/EHRIncentivePrograms.

Upcoming EHR Deadlines

• October 3, 2012 – Last day for EPs to begin their 90-day reporting period for calendar year 2012 for the Medicare EHR Incentive Program.
• December 31, 2012 – Reporting year ends for EPs.
• February 28, 2013 – Last day for EPs to register and attest to receive an incentive payment for calendar year 2012.
Lloyd Cleaver, D.O., who serves as the American Osteopathic Board of Dermatology (AOBD) Secretary/Treasurer, provided an update of the five components of Osteopathic Continuous Certification (OCC) during a luncheon lecture that kicked off this year’s Midyear Meeting held this past April in Branson, Mo.

Beginning in 2013, individuals certified in 2004 and later are required to obtain OCC as mandated by the AOA, the Bureau of Osteopathic Specialty Societies, and the Federation of State Licensure Boards. Although physicians certified prior to 2004 have lifetime certificates and therefore are not required to obtain OCC, Dr. Cleaver noted that states may begin mandating OCC participation as part of Maintenance of Licensure, a program of continuous professional development for physicians proposed by the Federation of State Medical Boards. “So even if you don’t have to be involved in OCC for certification purposes, you may have to in order to maintain your license,” he said.

Component 1 requires you to have an unrestricted license. Component 2 mandates lifelong learning/continuing medical education (CME). You must fulfill a minimum of 120 hours of CME credit during each three-year CME cycle; 50 credit hours must be in dermatology with half of those obtained through the AOCD. Component 3 calls for a proctored examination (every nine years) assessing your medical knowledge of dermatology and core competencies in the provision of health care. The Component 3 exam is the equivalent of the current recertification exam already in place. Dr. Cleaver anticipates that these exams will be given at the College’s Annual Meetings. He recommended taking the exam a couple years in advance allowing you another opportunity to complete the requirement if you have to take the test again.

Component 4 addresses practice performance assessment and improvement. It requires diplomates to engage in continuous improvement by comparing their performance against national standards within the specialty. The AOBD is currently partnering with the AOA to develop Clinical Assessment Programs (CAPs) to meet the requirement for Component 4. Ideally, these modules will be a web-based resource available for dermatologists in 2013. Initial modules will be designed for assessing performance in the care of melanoma, acne, and atopic dermatitis. Component 4 must be completed twice in 10 years.

Currently, the AOCD offers the Mohs in lab self-assessment and is working to develop curriculum to be presented at future Annual Meetings to meet this component, Dr. Cleaver noted.

The AOAs Physician Continuous Assessment Database, or PCAD, will allow physicians to track the pulse of their own practice by using benchmarks, engaging in improvement methods, and using benchmarks to measure the improvement. The PCAD also will offer various surveys. “The PCAD was designed to be as flexible as possible, allowing you to be compliant with these requirements with minimal disruption to your daily practice,” he said.

Component 5 requires you to maintain AOA membership. All of the data collected for the OCC will be collected using standardized reporting every three years. After the data are analyzed, you will receive a certificate of excellence from the AOBD.

The OCC exam fee will probably be $1,800, said Dr. Cleaver, adding that the AOBD is trying to minimize costs. The AOA CAP modules run approximately $199 each. In addition, CME fees will vary.

The AOBD will start an OCC page on its website later this year where members can learn the latest information, he said.

“The OCC is a work in progress, but the process is quickly coming to fruition,” Dr. Cleaver concluded. “Our goal is to be supportive of your educational needs. While this may have been thrust upon us, it’s an exciting opportunity for us to demonstrate that we do a good job and we can improve care.”

Correction

In the summer 2012 issue of DermLine, an article announcing the new grants coordinator erroneously identified Lloyd J. Cleaver, for whom Shelley Wood had previously worked, as an M.D. Dr. Cleaver, however, is a D.O. We regret the error.
Complicated AD

Jack Cohen, D.O., Associate Clinical Professor in the Department of Dermatology at UT Southwestern Medical Center, focused on four challenges of treating complicated atopic dermatitis (AD).

“The first challenge is to get the diagnosis right,” he said. Atopic dermatitis is diagnosed on clinical signs and symptoms based on criteria outlined by Hanifin and Rajka. The criteria that Dr. Cohen finds most useful are:

- Flexural dermatitis
- Recurrent itching and rash
- Family history
- Dry skin
- Personal history of asthma
- Wool or label intolerance

The second challenge is to determine if it is something the patient is eating. Interpreting food testing performed by an allergist can be difficult. Testing for allergen-specific immunoglobulin E may not have any clinical relevance, he said. Negative patch tests to food allergens have high predictive value. But positive patch tests to food allergens have a 50% predictive value based on food challenges.

Regarding treatment, the majority of patients with AD can be adequately controlled with combinations of barrier repair/moisturizers, topical steroids, topical tacrolimus or pimecrolimus, antihistamines, and oral antibiotics for infections. Additionally, patients and their family members must be educated about the importance of controlling environmental factors, he stated. Education must be intensive and ongoing to be effective, Dr. Cohen stressed.

Whether or not to bathe is an ongoing debate. Whereas rehydration helps abnormal epidermal barrier in AD, he said, evaporation worsens the skin damage. Consequently, emollients and/or medications should be applied immediately after showers or baths while the skin is damp. Ceramide-containing moisturizers may be superior, he added.

The third challenge is educating the patient and family members. That involves the physician and nurse spending time with patients as well as providing them with pamphlets and written materials, Dr. Cohen said. A good source that patients can access is a website with a virtual curriculum for therapy education posted by the Pediatric Eczema Center at San Diego-based Rady Children’s Hospital.

He reviewed therapeutic options including a soak and smear technique, phototherapy, systemic immunosuppressive therapies, and biologic therapies. “Knowledge about the immunology of atopic dermatitis is increasing,” he said, “but is not fully understood and no directed breakthrough therapy has been developed.”

Systemic immunosuppressive therapies are used for patients with moderate to severe disease as well as patients who are unresponsive to conventional therapy. Systemic corticosteroids are the most common immunosuppressive used to control the moderate to severe flares of AD and also the most commonly mismanaged therapy, Dr. Cohen said. Patients typically experience rapid improvement, but rebound flares are common. Long-term use is generally not recommended because the moderate doses required for control result in side effects. Systemic corticosteroids can be combined with steroid-sparing immunosuppressive medication to decrease the dose and toxicity. Among those used are azathioprine, cyclosporine, and mycophenolate mofetil (MMF). Only small studies have reported on the use of MMF for the treatment of AD. Reports have been mixed on the efficacy of omalizumab for recalcitrant AD. The options, side effects, drug interactions, and risks of the various treatment options have to be weighed and individualized for each patient, Dr. Cohen concluded. Hopefully, the disease will improve and the patient can resume more conventional therapy.

Surgical Pearls

Quenby Erickson, D.O., Assistant Professor in the Department of Dermatology at Saint Louis University, discussed when to use purse strings, pulleys, and barbs using several real-life cases to illustrate these techniques.

In one case she reviewed, the patient was sent to her with exposed cartilage and positive margins on inter-operative frozen sections. He did have a good clear margin; the dilemma was how to cover the exposed cartilage and restore the appearance of the ear, Dr. Erickson said. She performed a temporal fascia flap and pre-auricular interpolation flap followed by a full-thickness skin graft and the use of xenograft.

Regarding another patient who had several surgeries to remove a multi-focal infiltrating basal cell carcinoma (BCC) that resulted in a very large defect, Dr. Erickson noted that “an aggressive tumor needs an aggressive margin.” Removing the BCC required her to perform several stages of Mohs over two days of surgery. She used a split thickness skin graft for tumor surveillance, allowing for the detection of recurrence.

Dr. Erickson reviewed several surgical dilemmas in which she used purse strings to close the defects. Among them were a large wound over a high tension area, a large wound over a highly mobile area, a wound in an area of extreme laxity that is not cosmetically sensitive, and a large wound on the chest. In some cases, she combined the purse string with a xenograft.

The next set of surgical dilemmas Dr. Erickson presented included recurrent squamous cell carcinoma (SCC) with multiple foci, a large primary SCC, a twice recurrent infiltrative BCC, and an infiltrative BCC. For these, she used pulleys for the repair. “They distribute tension over multiple points, so you can have increased force over two points rather than one,” Dr. Erickson explained. “The two buried vertical mattress sutures—sometimes three—can be tied with one knot. “This is my

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standard approach with these types of defects,” she added.

For some cases, Dr. Erickson uses barbed sutures. One type has barbs in one direction and one needle, but another type has barbs that change direction in the center and has two needles. When closing a defect, she puts the needle through the loop and pulls it down. “It’s literally like a zipper,” Dr. Erickson said. “You don’t have to tie any knots.” If you have suture left over, you can go in the reverse direction to use it as a closure, she said, adding, “You can seal it with adhesive glue; no follow-up care needed.”

**Contact Dermatitis Update**

Matthew Zirwas, M.D., Assistant Professor of Clinical Medicine at the Ohio State University, College of Medicine, and Director of its Contact and Occupational Dermatitis Center, focused on practical acute contact dermatitis (ACD) for the busy clinician.

“Ideally, every patient with suspected contact dermatitis should be patch tested,” he said. But patch tests miss the diagnosis 50% to 75% of the time. They are rarely useful if the patient has ACD, Dr. Zirwas noted. Patch tests are best used to confirm that the patient is allergic to a suspected allergen. He suggested starting patients on empiric treatment based on suspected etiology. Order a patch test only if the patient doesn’t get better or if the patient gets better, but the empiric treatment is not an acceptable long term solution, Dr. Zirwas said.

If he suspects ACD, then Dr. Zirwas questions what is likely to come into contact with that area. For example, if the patient’s eyelids are affected, the likely culprits are shampoo, conditioner, hair dyes, hand soap, hand moisturizer, or eye make-up or cream. Empiric management for suspected eyelid ACD includes using “super sensitive” cleansing products, low allergenicity moisturizers and cleansers for the face and hands, and low potency ointments. Patients should wash their face with a gentle cleanser after rinsing out the shampoo and conditioner, and avoid certain nail cosmetics, he advised.

Empiric management of suspected foot ACD includes addressing hyperhidrosis, if possible. If the dorsal foot is involved, the patient should stop wearing all of his/her shoes and buy a couple of new pairs to wear temporarily, Dr. Zirwas said. The ACD is likely due to retained allergens in multiple pairs of shoes. Use desoximetasone ointment for six to eight weeks. Then, reintroduce the old shoes one at a time for a week at a time. Use smooth sock liners, as well. If the planter foot is involved, replace all of the insoles with cork or felt.

If the hands are affected, the likely culprits if it’s ACD are gloves, hand soaps, moisturizers, over-the-counter/prescription topicals, and hair styling products. Empiric management of suspected ACD of the hands include using low allergenicity soaps and moisturizers, and desoximetasone ointment, as well as wearing vinyl gloves or those that are non-allergenic. Avoid using the hair products in question.

If a patient has widespread dermatitis caused by ACD, the likely culprits are clothing, hot tubs, soap/shampoo, moisturizer, or dietary nickel. Acetate linings and formaldehyde commonly used in uniforms are common allergens. If ACD is caused by dyes, he advises the patient to wear only 100% cotton clothing. If ACD occurs after using the hot tub, have the patient stay out of it for three months. If the ACD resolves, the patient is most likely allergic to the shock chemical used to clean the water, Dr. Zirwas said. Switching to a different chemical should solve the problem. If the patient presents with pапules on the extensor elbows, the ACD is most likely caused by a high nickel diet. Start the patient on a diet low in nickel; include vitamin C with every meal. Switch to a low/no allergenicity moisturizer, cleanser, shampoo, and topical steroid.

Educating patients about what they can use is the most practical and effective way to help them get better, he said. The American Contact Dermatitis Society has a new Contact Allergen Management Program on its website (www.contactderm.org) that enables physicians to print out
or email a list of safe products specific to patients. It also provides resources, links, and educational materials.

**Treating Skin of Color**

Unique clinical expression may be seen among people with darker skin tones based on differences in the epidermis, dermis, and hair follicles; varying physiologic responses; and cultural practices, noted Jacquelyn Garrett, M.D., Clinical Instructor at Barnes-Jewish/Washington University.

Racial and ethnic differences in skin color are due to variations in the number, size, and aggregation of the melanosomes within the melanocyte and keratinocyte, Dr. Garrett stressed. There are no biochemical differences in hair among African Americans, Caucasians, and Asians. African American hair typically has fewer elastic fibers anchoring the hair follicles to the dermis, lower total hair density, and lower total number of terminal hair follicles than Caucasian hair. Consequently, the hair follicles are more easily disrupted in African Americans than in Caucasians.

Skin of color has a greater incidence of pigment disorders, keloid formation, pseudofolliculitis, and certain types of alopecia, she said.

Precipitating factors for folliculitis keloidalis are tightly curled hair that is shaved short and transected sharply causing it to curve and penetrate back into the skin. If it goes untreated, folliculitis keloidalis will result in permanent hair loss, Dr. Garrett said. Treatments include topical steroids, topical retinoid gel, topical or oral antibiotics guided by cultures, imiquimod, or IL triamcinolone acetonide. Other options include punch excisions into the subcutaneous tissue allowed to heal by second intention, laser hair removal, or horizontal elliptic excisions to deep subcutaneous tissue or fascia that get below the follicles. Avoiding close haircuts as well as clothing and hats that traumatize the area can help prevent the condition, she noted.

Patients with pseudofolliculitis barbae should stop shaving until the inflammation resolves and use electric clippers, Dr. Garrett said. It can be treated with low potency steroids, chemical depilatories, topical tretinoin to reduce hyperkeratosis, efornithine hydrochloride cream, and laser hair removal.

The repeated use of blow dryers, hot combs, and flat or curling irons to thermally straighten hair results in chronic hair breakage, Dr. Garrett said. Additionally, 70% of African American women use chemical relaxers. Tight hair styles, braids, twists, cornrows, ponytails, and plaits, as well as heavy extensions cause traction alopecia. Traction alopecia can be treated with topical antibiotics and steroids in the early pustule/papule stage, oral antibiotics, topical minoxidil, intralesional corticosteroids, and hair transplants. Prolonged and repeated use of these hairstyles can lead to permanent alopecia, she warned.

Among the primary cicatricial alopecias she reviewed were dissecting cellulitis, central centrifugal cicatricial alopecia, and folliculitis decalvans. *Staphylococcus aureus* is implicated in the latter as an etiologic agent. Patients should minimize heat, oils, and greases applied close to or on the scalp as well as reduce the frequency or discontinue the use of chemical relaxers to prevent these conditions. Treatment options include rifampicin plus either ciprofloxacin, clindamycin, cephalaxin, or doxycycline. Nasal mupirocin is another option.

Regarding contact dermatitis, African Americans and Caucasians have an equal ability to mount an immunological response to antigens. Racial differences in the rates of positive patch tests are most likely related to differences in exposures to antigens, and the clinician’s ability to perceive erythema among various skin colors, she said.

Regarding acne in African Americans, follicles are more likely to keratinize and form comedones and less likely to rupture or form nodulocystic acne, Dr. Garrett said. Lesions can show significant histological inflammation even when their clinical appearance is non-inflammatory. Treatment options for acne-induced post-inflammatory hyperpigmentation are topical retinoids, hydroquinone, and azelaic acid. Pomade acne occurs when hair pomades, grease, and conditioners used to improve the texture and manageability of the hair are spread to the forehead and temples, Dr. Garrett explained.

The granulomatous variant of rosacea is more prevalent in African Americans and Afro Caribbeans. It presents with nodules and papules in the malar, perioral, and periocular region.

Melasma is more prevalent in African American, Hispanic and Asian individuals, Dr. Garrett noted. Hydroquinone has been considered the gold standard to treat hyperpigmentation. Supervised use of prescription topical hydroquinone appears to have no more than a theoretical risk of malignancy or developing ochronosis, and there is no substantial evidence to prove its carcinogenicity, she said. However, imported products used for facial lightening may contain clobetasol propionate and hydroquinone concentrations greater than 4% may trigger exogenous ochronosis or CD.

Skin of color has a lower incidence of skin cancer and different presentation of photo aging, she said. Melanoma most often arises on non-sun-exposed sites with less pigment such as on the palms, soles, and subungual areas on individuals with skin of color. When such individuals develop melanoma, they are more likely to have acral lentiginous melanoma compared with people with lighter skin types. Photoaging in skin of color tends to have inconsistent pigmentation and overall darker facial skin than non-sun-exposed skin.

Two resident presentations closed out the meeting. Scott Deckelbaum, D.O., spoke about *Eccrine Poromatosis*, and Frank Morocco, D.O., discussed *Enlarging Tumor in a Newborn*.

**AJCC/NCCN Guidelines**

Sean Stephenson D.O., a dermatopathology Fellow at the Ackerman Academy of
Dermatopathology, reviewed the Seventh American Joint Committee on Cancer (AJCC) Melanoma Staging Manual and discussed the current National Comprehensive Cancer Network (NCCN) Guidelines on Melanoma within the context of what the practicing dermatologist needs to know. Current staging is important to know because staging provides cancer patients and their physicians the critical benchmark for defining prognosis as well as the likelihood of overcoming the disease and determining the best treatment approach, he said.

Most of the changes that occurred from the sixth to the seventh edition of the manual, which was published in 2010, were related to melanoma, Dr. Stephenson said. Specifically, mitotic rate is now used as one defining criteria of T1b melanomas. Clark’s level is no longer used as an independent risk factor. For T1 melanomas, in addition to tumor ulceration, mitotic rate replaces level of invasion as a primary criterion for defining the subcategory of T1b.

With regard to nodes, the presence of nodal micrometastases can now be defined using either hematoxylin and eosin or immunohistochemical staining, he said. Previously, only the hematoxylin and eosin could be used. Nodal tumor deposits less than 0.2 millimeters in diameter (previously used as the threshold for defining nodal metastasis) are included in the staging of nodal disease as a result of the consensus that smaller volumes of metastatic tumor are still clinically significant.

Regarding sentinel lymph node biopsy, the task force recommends that it be performed as a staging procedure in patients for whom the information will be useful in planning subsequent treatment and follow-up regimens, Dr. Stephenson stated. Specifically, the procedure should be recommended for (or at least discussed with) patients who have T1b, T2, T3, or T4 melanomas, and clinically or radiographically uninvolved regional lymph nodes. In all prospective studies involving such patients performed to date, sentinel node status was one of the most powerful independent prognostic factors examined. The task force also strongly recommends that sentinel lymph node biopsy be required as an entry criterion for all melanoma patients presenting with clinical Stage IB or II disease before entry into clinical trials involving new surgical techniques or adjuvant therapy.

While the NCCN Guidelines do offer evidence and consensus behind currently accepted approaches to treatment, Dr. Stephenson noted that clinicians using them are expected to use independent medical judgment in the context of each patient's clinical circumstances when determining care or treatment. He reviewed the NCCN guidelines regarding principles of a biopsy, histopathologic reporting, principles of complete lymph node dissection, and common follow-up for all patients.

**Dermatopathology**

In the 1980s, dermpath methods focused on observing tissue reaction patterns and cells. Nowadays, they involve tagging molecules that change in disease and identifying mutations in DNA, RNA, and other proteins, stated Thomas Olsen, M.D. Advances in molecular diagnostics will enable providers to make more precise and earlier diagnoses.

“`The dermpath is only as good as the information that comes from the dermatologist,” he said. Providing demographic data, for example, helps the dermpath understand what is going on particularly in the inflammatory arena. Synergy between the two is extremely important.

Dr. Olsen illustrated the importance of communication using the example of a 38-year-old female who presented with a changing pigmented lesion. The biopsy suggested an atypical and inflamed lentiginous compound nevus with moderate/severe atypia. Based on communicating with the dermatologist, who believed it was melanoma, deeper sections were taken and melanoma was found. That’s not to say that everything needs to be recut, he said, but deeper sections can turn up additional findings. One study found that step sections used to demonstrate additional pathologic findings in biopsy samples initially diagnosed as actinic keratosis (AK) yielded additional findings in one-third of cases. Unpublished data show that additional findings were found in approximately 10% of cases.

“If the clinician is suspicious, he or she needs to communicate that with the dermpath,” Dr. Olsen said. Clinicians must alert the lab if they are considering diagnoses/conditions such as lichen amyloidosis, small vessel vasculitis, polyarteritis nodosa, alopecia nevus/melanoma, AK versus SCC or BCC, or urticaria pigmentosa.

Understanding the dermpath’s perspective will help dermatologists diagnose their patients, he continued. Using an example
of a 72-year-old female who presented with scaly plaques on her arm, Dr. Olsen noted that proliferative/spreading AK is not well recognized on biopsy. The key is that there is budding and follicular involvement that is not sparing. In this case, the report will read “sparing variant AK.” It helps if dermatologists understand the spreading variant of AK represents a lesion in which atypical epithelial cells extend into adnexal units, but the basement membrane remains intact, he said. These lesions can recur with incomplete excision and/or some form of surgical/chemical destruction.

Sometimes diagnoses can be made sooner with the use of special stains, Dr. Olsen said. Such is the case of nail fungus. The results of a nail plate aggregate in formalin can be obtained in 48 hours by using PAS staining. Be sure to inform the lab that it’s a nail because different agents are required to prep a nail. Not only is the diagnosis of onychomycosis revealed, he said, but the dermpath can determine if it’s caused by dermatophytes, candida, or saprophytes.

Dr. Olsen also reviewed newer dermpath methods including immunohistochemistry and fluorescent in situ hybridization (FISH). It is impossible to make a correct diagnosis of an undifferentiated malignant spindle cell neoplasm without immunohistochemistry, he said. Determining whether the neoplasm is melanoma, spindle cell SCC, atypical fibroxanthoma, or leiomyosarcoma is important as the treatment and prognosis of these are significantly different. Immunohistochemistry also is used to screen for Muir-Torre. Various stains can be used to diagnose different diseases, such as CD-34 for dermatofibrosarcoma protubersans, CK-20 for Merkel cell carcinoma, and Mart-1 red for lentigo maligna. Fluorescent in situ hybridization can be used for adjunct diagnosis of melanoma. Using FISH, disease-related mutations are detected as abnormal numbers of gene copies, he explained. Although its sensitivity is approximately 80%, which is not very good, its specificity is 98%. Technical difficulties and lab reliability continues to be improved with regard to FISH. It can be used to diagnose ambiguous and cellular pigmented lesions such as severely dysplastic nevi, melanocytic neoplasm of uncertain biologic potential, and spitz nevi in adults.

The importance of communication and dermpath concepts, the focus on reaction patterns and cells, and the use of special stains will be just as relevant in the next 30 years as it has been in the last 30 years, Dr. Olsen concluded. But we are just scratching the surface with regard to molecular diagnostics.

**Medical Management of AK, NMSC**

“We know that what is an AK today is probably SCC tomorrow,” stated Neal Bhatia, M.D., Associate Clinical Professor of Dermatology at the University of Wisconsin, who discussed non-surgical approaches to AK and non-melanoma skin cancer (NMSC). “That’s why we treat them.”

General risk factors for NMSC are age, skin type, sun exposure, and history of prior NMSC. Immunosuppression is a risk factor for organ transplant recipients. Additionally, we know that human papilloma virus (HPV) is more prevalent among immunosuppressed patients, he said. Because several types of HPV are linked to SCC, it is believed that HPV is most likely a co-carcinogen. HPV 21 is the closest subtype linked to the progression of AKs. This link raises the question of whether the HPV vaccine should be used for chemoprevention. “Maybe in the future, but not now,” Dr. Bhatia stated.

Indicators of progression from AK to SCC include the following:

- Dysregulation of p53—uncontrolled cell proliferation
- Expression of p16 oncogene
- Inducible expression of Fas (CD 95) ligand
- Tumor necrosis factor-related apoptosis-inducing ligand

It’s unclear what 30 years of ultraviolet light does to one’s immune system, he said. If the immune system is unable to fight off the cancer, then we need a medical therapy to treat AKs before they progress to SCC.

Treatment of AKs involves using liquid nitrogen to eliminate existing AKs, immune response modifiers to treat those on the way, and sunscreen to prevent the disease, Dr. Bhatia said. Understanding how the different therapies impact the disease state helps determine how they should be applied. For example, imiquimod makes the immune system work harder while topical 5 fluorouracil (5-FU) causes AKs to disintegrate locally.

He noted that imiquimod now comes in different strengths; 5%, 3.75%, and the new 2.5%. Dr. Bhatia suggested that perhaps the 5% could be used for solid tumors or more aggressive fields, 3.75% cycle therapies could be used for routine or initial courses, and the 2.5% could be used for low-grade maintenance. Ingenol mebutate is a topical gel derived from the *Euphorbia peplus* plant that is being studied for its effect on AK, he noted.

Systemic therapy to reduce the rate of tumor formation and progression should be considered for patients with significant NMSC. The decision to use them should balance the risks and benefits of systemic therapy against those of surgical and topical management alone, Dr. Bhatia said. In high-risk patients, the benefits of systemic chemoprevention outweigh the adverse effects. It augments, but does not completely replace surgical therapy. There will never be a trial for chemoprevention; the utility will always be off-label and up to us to decide, he stressed.

Dr. Bhatia answered commonly asked questions about photodynamic therapy (PDT) for the treatment of AKs. With regard to the appropriate incubation time for PDT, he said data show that there is 100% absorption within two hours. He cited a study that used a protocol for treating extremities in which patients were treated twice at eight-week intervals with an incubation time of two hours under occlusion. They wore gloves over occlusion to keep intact. The authors found good overall efficacy with the occlusion. Although PDT is currently not being used for chemoprevention of NMSC, Dr. Bhatia believes there is room for that. The best pre-treatment plan for PDT calls for retinoids.

In summary, topical 5-FU can be used for spot treatment, topical diclofenac for patients...
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who “don’t want to get red,” imiquimod for field AKs, topical retinoids for extensive photodamage, systemic retinoids for multiple AKs and SCC, ingenol mebutate for yet to be determined, and sunscreens for everyone.

Coding, Reimbursement
In the big picture, $2.2 trillion is spent on health care in this country, stated Scott Dinehart, M.D., Chair of both the Coding and Reimbursement Task Force and Heath Care Finance Committee of the American Academy of Dermatology (AAD). Spending on health care in the U.S. has been growing faster than the economy for many years. But now Medicare is going broke and is expected to be insolvent in 2024. “Realize that reimbursement is likely to decline,” he said.

While dermatologists are only 1% of all physicians, Dr. Dinehart noted, they take home 3.5% of all the Medicare reimbursement. Dermatology is a procedure-oriented specialty, with 73% of income coming from small procedures. It is a small specialty with many specialty specific codes and rapidly increasing utilization, he added.

“When spending shoots up, Medicare whacks it down,” Dr. Dinehart said. A few years ago, cardiology was the focus of Medicare cuts. Right now, dermatology is popping up. Consequently, dermatologists can expect intense reviews of frequently performed and/ or expensive procedures. Between 1995 and 2009, Mohs surgery is up 400%, removal of 15 or more AKs is up 1900%, and use of the CPT code 88305 is up 83%. The Relative Value Scale Update Committee, or RUC, automatically reviews any procedure that increases by 10% for three consecutive years. The RUC will most likely recommend trimming the reimbursement for several CPT codes, said Dr. Dinehart, adding that he expects a more significant cut for Mohs when it and other procedures come up for review in January, 2013.

Meanwhile, ICD-9 is being replaced with ICD-10, which is used by most of the rest of the world. This change was supposed to occur October 1, 2013, but has been deferred for one year. The Centers for Medicare & Medicaid Services (CMS) claims that ICD-10 will provide benefits such as increased specificity in clinical information that can lead to more accurate and timely reimbursements, better quality of patient care, and improved disease and care management. But he doesn’t know how. Dr. Dinehart anticipates that the switch will cost a lot of money and cause a lot of heartache just when physicians are trying to be more efficient.

Pay attention to the -25 modifier, which is for reporting significant, separately identifiable evaluation and management (E&M) service by the same physician on the same day of the procedure or other service, he warned. In cases where a service is typically furnished with an E&M service on the same day, CMS contends that “there may be overlap between the two services in some of the activities conducted during the pre- and post-service times of the procedure code.” The agency claims there is a one-third overlap and therefore, E&M reimbursement should be reduced by one-third. Other payers have begun to reduce reimbursement for E&M, some by as much as 50%, Dr. Dinehart said. Knowing that there is a controversy, he suggested separating the E&M from the procedure in the medical record (and document both). Don’t bill a -25 modifier unless you have two diagnoses, Dr. Dinehart added. Expand the chief complaint, when appropriate. Monitor the use of -25 modifier for overuse; have patients come back for procedures, if necessary. “If you’re using the modifier more than 50% of the time, that’s a problem,” he said. Talk with the Carrier Advisory Committee/Medicare medical director in your area, when possible. Appeal any audits.

Recovery Audit Contractors (RACs) are independent contractors hired by CMS to identify improper payments made on claims of healthcare services provided to Medicare beneficiaries. The RACs are looking at Mohs when it is reported with the pathology report on the same patient, the same day of service, and specifically the appropriate use of paraffin sections during Mohs. They also are looking for the -24 and -25 modifier used within the global period. The AAD’s RAC Audit Survival Toolkit provides information about how to handle an audit.

As of January 3, 2012, the RACs no longer issue the demand letters to providers. They now come from the Medicare Administrative Contractors. This change means that all administrative concerns/questions you have should be addressed to the Medicare Administrative Contractors, not the RACs. Dr. Dinehart encourages dermatologists to appeal any audits, pointing out that 44% of physician claims are overturned on appeal.

Incentive programs offered by CMS include one for electronic health records (EHRs). The Medicare EHR Incentive Program offers up to $44,000 for using an EHR in 2012. Dr. Dinehart questioned why dermatologists would want to spend a lot of money to get a little back. He noted that only 5,805 providers of 800,000 who are eligible have demonstrated “meaningful use.” The agency offers a separate e-prescribing incentive program. However, providers cannot collect a bonus for both EHR and e-prescribing; they must choose one. He recommends the latter. Dermatologists can participate in the Physician Quality Reporting System by reporting on three out of four quality measures. You must see at least one Medicare patient with a new diagnosis of melanoma to report on the coordination of care measure successfully, Dr. Dinehart said. Dermatologists must use a registry in order to participate. The new biopsy measure requires dermatologists to report the results to every primary care physician (PCP). Performing 40 biopsies a day as Dr. Dinehart does makes meeting the measure difficult. All of these incentives eventually turn into penalties for lack of participation. He suggests doing e-prescribing and quality reporting.

Dr. Dinehart defined accountable care organizations (ACOs) as consisting of “physicians, hospital, and other providers in various combinations that attempt to coordinate the care of Medicare patients with the goal of improving its quality while reducing costs.” The providers make a three-year commitment and care for at least 5,000 Medicare patients. Successful ACOs share in any savings they may produce for Medicare. Providers are required to report on 33 quality measures (down from 65 as first proposed) and ACOs are no longer required to have at least 50% of their PCPs qualify as meaningful users of EHR systems. An estimated 270 ACOs will form, he said. While it could cost CMS 1.1 billion in the first three years, it may yield as much as $2 billion in savings. Dr. Dinehart summarized ACO involvement as follows: The government wants you to practice in large groups that include PCPs, use EHRs, reduce the costs of the Medicare program, increase quality of care, and report a lot of stuff. He recommended observing the ACO momentum, keeping in touch with hospitals and PCPs, and analyzing how patients enter your practice.

Clinical Pearls
Stuart Brown, M.D., who is active in the AAD’s teaching program and Dialogues in


Dermatology, offered clinical pearls through an interactive question and answer session.

Treating AD doesn't have to be difficult, he said. Soaking and hydrating are the keys. Soaking will get all of the water into the patient's skin and using a moisturizer will retard evaporation. Patients also have to stop scratching the itch, he said, noting that, "Atopic dermatitis is the itch that rashes." Dr. Brown has treated AD with topical immunomodulators (TIMs), topical steroids, cyclosporine, and methotrexate (MTX), depending on the patient's symptoms.

For children with AD who have molluscum lesions, he shows parents how to remove them using toothpicks that can be purchased at a surgical supply store. The lesions should be gently pushed rather than stabbed, he explained. He also uses TIMs and topical steroids to treat molluscum lesions. Dr. Brown does not believe that topical steroids make them worse.

Regarding the "bathe or not bathe" debate for AD patients, he thinks they should bathe often, but not soak for extended periods of time. "It takes eight minutes to get fully hydrated," Dr. Brown said. Patients should get out of the bath when their fingers get puffy and moisturize immediately afterward.

He finds MTX and cyclosporine to be excellent treatments for managing recalcitrant psoriasis, particularly in older adults. Topical retinoids are beneficial for treating Grover's disease, Dr. Brown said, but they aren't a cure.

Biologics have shown promise for treating pyoderma gangrenosum. He likes to add benzoyl peroxide to a topical steroid ointment to serve as a barrier. Every dermatologist needs to find a pharmacist who knows how to compound medications, Dr. Brown stated.

He has used dapsone orally to treat patients with sarcoid, acne, certain granuloma anulares, pustular psoriasis, recalcitrant hand eczema, and some blistering diseases.

Spironolactone is very beneficial for treating acne in women in their 30s, Dr. Brown said. He also suggested putting these patients on the birth control pill to counter the side effects of spironolactone. It's important to ask about abnormal periods in these patients. In approximately one-third of the patients he has seen he found hormonal abnormalities. The abnormality isn't necessarily polycystic ovarian syndrome, but rather abnormal levels of free testosterone or dehydroepiandrosterone sulfate.

Rosacea Update

Guy Webster, M.D., a Clinical Professor of Dermatology at Jefferson Medical College in Philadelphia, started his presentation talking about potential causes of rosacea, which are still largely unknown. Some experts suggest that *helicobacter pylori* is a factor because patients treated with tetracycline for gastric ulcer disease have improved. Others suggest that Demodex mites could cause rosacea. Everybody has Demodex mites, Dr. Webster noted, adding the larger the hair follicle and older the person, the more they have. But very little is known about these mites because they don't show up on biopsy, he said. Data show that rosacea patients have higher counts of Demodex mites than people without the disease. "But we are a long way from Demodex mites being an important factor," Dr. Webster concluded. Another possible cause is a defect in the inflammation and innate immunity response. "We know that the blush reflex to thermal stimulation is more easily triggered in rosacea patients," he said.

A lot of research in rosacea is focusing on cathelicidins, which are antimicrobial peptides that protect the skin from infection. Studies show that patients with rosacea have more cathelicidins than individuals who don't have the disease. Additionally, the cathelicidins in rosacea patients cause inflammation, Dr. Webster said. Patients taking tetracycline have decreased serine protease activity, resulting in fewer cathelicidins, which could explain why tetracycline is an effective treatment for rosacea.

Tetracycline, doxycycline, and minocycline are all effective for treating rosacea. Doxycycline is probably the best, he said. Minocycline works well, but has problems with pigmenting skin. Ciprofloxacin works for some patients, but it's not good for long-term use. Off-label use of low doses of isotretinoin may be helpful in early stages of rhinophyma and nodular inflammatory disease. A combination of oral antibiotics and topical ones can be beneficial. Metronidazole and azelaic acid may diminish perilesional erythema. In clinical trials, topical vasoconstrictors, such as oxymetazoline and brimonidine, have shown excellent clinical responses in reducing erythema.

Dr. Webster believes that the overlap of patients with atopic/seborrheic dermatitis and rosacea is relatively common. These cases can be very resistant to the usual rosacea treatments, and TIMs may be useful for these patients.

Nowadays, he routinely asks patients about flushing and stinging. If their skin stings when they put on sunscreens or moisturizers it is indicative of a defective skin barrier, which is common in patients with rosacea. Dr. Webster also checks their eyes for symptoms of ocular rosacea, which may not be connected with the condition. Studies show that transepidermal water loss (TEWL) is increased in rosacea patients, and high TEWL conditions are known to activate serine protease. Consequently, he tries to block serine protease activation. A metronidazole gel has been shown to improve the skin barrier function of rosacea patients by decreasing TEWL and improving skin hydration.

Update: Lasers in Dermatology

William Cothern, D.O., Clinical Assistant Professor at the University of North Texas Health Science Center, has used lasers and light devices for 23 years. His practice comprises 80% general dermatology and 20% laser and cosmetic dermatology.

Dr. Cothern owns 12 lasers from CO₂ and Nd:YAG lasers to fraxel and excimer lasers. He uses them to treat conditions such as...
pigmented lesions, Portwine stains, vitiligo, and acne, as well as to remove tattoos. Additionally, Dr. Cothern owns five non-laser devices.

The costs associated with lasers are the cost of the actual laser, annual maintenance fees, advertising, and consumables. Dr. Cothern spends approximately $35,000 in yearly maintenance fees. Advertising fees can vary significantly from placing ads in papers to putting up billboards.

Currently, there are three laser and light devices competing for lipolysis, he said. Zerona is a low-level laser therapy that stimulates adipocyte mitochondria. Treated areas are reduced by a mean of 3.5 inches on the hips, thighs, and waist. Coolsculpting uses cryolipolysis to reduce subcutaneous fat cells. It is designed for contouring bulges, not weight loss. The apoptosis of adipose cells occurs during a two- to four-month period. Patients can expect a 20% to 25% loss of fat in one treatment. Liposonix is high-intensity focused ultrasound that results in one inch or 2.5 cm, on average, of fat loss. Fat cell death and macrophage engulfment takes between eight and 12 weeks. Dr. Cothern has a Coolsculpting machine, but suggests talking to different providers to find out which ones they have and why they like them.

He uses three different lasers to remove tattoos, depending on the color of ink being removed. Tattoo removal requires multiple treatments. It takes between three and six treatments to remove an “amateur” tattoo and up to 20 treatments to remove a professionally inked tattoo.

Lasers can be used to remove drug pigmentation, Peutz-Jeghers syndrome, onychomycosis, nevus spilus, and LLP. When using a laser to remove permanent makeup, it's important to know that white inks are frequently mixed in to obtain a desired color. Dr. Cothern explained. That white ink oxidizes when hit with the laser causing it to turn black. Lasers are effective in removing colloidal silver, resulting in a good response even in one treatment. The difficulty is the large size of the areas that need treatment. Laser treatment for hyperhidrosis may be an option in the future. In a small study using a long-pulsed Nd:YAG laser to treat hyperhidrosis during a nine-month period, three of six patients reported no sweating, two had significant improvement, and one had marked improvement.

The safest laser for treating skin of color is the 1064 Nd:YAG laser, he said. But the 800 nm diode laser is probably more effective. “Regardless of which one you use, start low and go slow,” Dr. Cothern advised. Use lower fluences and longer pulse widths.

He also has a diode laser with a vacuum system, which is anesthesia-like. The suction makes it more comfortable for the patient when using the laser over large areas, Dr. Cothern said.

There are approximately 36 types of fractional CO2 lasers. They can be used to treat lower eyelid rhytids and skin laxity. Second-generation fractional lasers offer four CO2 fractional patterns, that is, traditional CO2 resurfacing and two excisional modes. They also offer improved scanners and instant feedback about depth, heat, and target.

Two Residents Receive 2012 Koprince Award

Two residents were named Daniel Koprince Award winners for presentations given at the 2012 AOCDS Midyear Meeting held in April in Branson, Mo.

The recipients are as follows:

Arathi Goldsmith, D.O., a recent graduate of the residency program at Oakwood South Shore Medical Center in Trenton, Mich., won for her presentation entitled Enlarging Verrucous Plaques in the Gluteal Cleft of a 34-Year-Old Woman. Dr. Goldsmith was a third-year resident when she presented her paper.

Frank Morocco, D.O., a recent graduate of the residency program at O’Bleness Memorial Hospital in Athens, Ohio, won for his presentation entitled Enlarging Vascular Tumor in a Newborn. Dr. Morocco was a third-year resident when he presented his paper.

The Koprince Award was established in 1986 to honor the work of AOCDS member Daniel Koprince, D.O., who passed away in 2007. The award recognizes the top lectures presented by residents during AOCDS meetings. They are evaluated for subject matter, audiovisual presentation, and speaking ability.

Recipients will be presented the award during the General Business Meeting at the 2012 AOCDS Annual Meeting in San Diego.

Winner of Dermatologic Surgery in the Outback Paper Competition Named

Jonathan Cleaver, D.O., a recent graduate of the residency program at Northeast Regional Medical Center in Kirksville, Mo., won the Dermatologic Surgery in the Outback paper competition. His paper was entitled When to Radiate? A Review of Current Literature on the Use of Radiation Therapy for the Treatment of Basal Cell and Squamous Cell Carcinomas. Dr. Cleaver was a third-year resident when he presented his paper.
Annual Meeting Speakers to Cover ‘the Novel, Curious, Complex’

Speakers at the 2012 AOCD Annual Meeting will address dermatological issues from the novel, curious, and complex to the more common hand eczema and actinic keratosis (AK). But first the University of Pennsylvania Dermatology Symposium featuring four prominent academicians will kick off the meeting to be held Sunday, Oct. 7 through Wednesday, Nov. 11 in San Diego.

On Tuesday, 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, will provide a global perspective regarding photodynamic therapy for skin cancers and AK damage. On Wednesday, Joseph 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, will discuss complex medical dermatoses and common referral problems in medical dermatology. Resident lectures will be presented on both days.

For residents, the meeting will begin on Sunday with the In-Training Examination. The American Osteopathic Board of Dermatology Exam also will be given that day. While the residents are testing, the AOCD Board of Trustees will convene in a day-long meeting.

This year, the AOCD will not host a Welcome Reception on Sunday night as the AOA has asked affiliates to refrain from scheduling social events that evening. Due to this change, the College will host a Residency Program Meet and Greet for students and interns who would like to learn more about the AOCD’s residency training programs and directors. This event is scheduled for 4 p.m. to 6 p.m. at the San Diego Marriott Marquis Hotel. In addition, the AOA will host a Welcome Reception from 6 p.m. to 9 p.m. at the Manchester Grand Hyatt. All events will take place in the San Diego Convention Center unless otherwise noted.

Monday Speakers

Lectures will be presented between 8:30 a.m. and 3 p.m. on Monday. Before the speakers begin, Gregory Pappadeas, D.O., will offer the CLIA-Mohs Proficiency Testing. Next, American Academy of Dermatology President Daniel Siegel, M.D., will provide a Healthcare Policy and Cyber Medicine Update.

Returning for a second year, the University of Pennsylvania Symposium will feature panelists from the University of Pennsylvania Health System discussing various topics as follows:

Victoria Werth, M.D.
Update in Autoimmune Skin Disease

Brian Kim, M.D.
Atopic Dermatitis

Emily Chu, M.D., PhD
Newer Drug Reactions: An Update

Michael Ming, M.D., MSCE
Issues in Melanoma

Speakers (and their topics) following the symposium include:

Fred Ghali, M.D.
Novel Topical Dermatologic Treatments for the Pediatric Patient

Steve Grekin, D.O.
Cosmeceuticals

The General Business Meeting will be held between 3:15 p.m. and 5 p.m. The Presidential Celebration, which is a ticketed event, will be held from 6 p.m. to 9 p.m. at the San Diego Marriott Marquis Hotel. The Presidential Celebration will include a social hour, hors d’oeuvres, and a dessert reception. The installation of officers will take place as well as the presentation of Presidential Citations. Cocktail attire is requested. To obtain tickets for this event, members must register with the AOCD.

Tuesday Speakers

Speakers (listed with their topics) scheduled to present lectures between 6:45 a.m. and noon on Tuesday are as follows:

Cindy Hoffman, D.O.
Great Cases from Osteopathic Institutions

Melinda Greenfield, D.O.
Tats, Holes, and Landscapes: The Curious History of Body Art, Piercings, and Personal Grooming

Stephen Purcell, D.O.
Interesting and Unusual Dermatologic Cases

Michael Morgan, M.D.
DermPath Review

Anthony Dixon, M.B., BS, PhD
PDT for Skin Cancers and Actinic Damage - Australian and Global Experience

Residents will lecture for the remainder of the program. Resident speakers and their topics are as follows:

Mounir Wassef, D.O.
Alopecia Neoplastica Heralding a Diagnosis of Breast Cancer

Alison Himes, D.O.
Merkel Cell Carcinoma: A Case and Review

Sanjosh Singh, D.O.
Morphea Associated with Celiac Disease

Charlotte Noorollah, D.O.
Linear Psoriasis in Lines of Blaschko
Residents will lecture for the remainder of the program. Resident speakers and their topics are as follows:

Angela McKinney, D.O.
*Bones of Dermatology*

Alma AcMoody, D.O.
*Muscular Myiasis Endemic to Ohio: A Case Report*

Keith Robinson, D.O.
*Variant of Eruptive Keratoacanthoma*

Stephen Weis, D.O.
*Treatment of Anal Dysplasia with IRC*

Paul Aanderud, D.O.
*Generalized Fixed Drug Eruption in the Setting of Ceftriaxone Treated Gonococccemia*

Peter Knabel, D.O.
*Hyperplastic Response to Aldara*

Grace Kim, D.O.
*Oral Spironolactone for Post-Teenage Acne in Females*

Mari Batta, D.O.
*Acne Scar Lysing*

Jeremy Bingham, D.O.
*Adalimumab for the Treatment of Pityriasis Rubra Pilaris with an Overview of Disease Classification*

Helia Eragi, D.O.
*Primary Mucinous Carcinoma of Skin*

Tatyana Groysman, D.O.
*Hereditary Disorders of Cornification*

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**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.

*Some breakfast sessions are tentative.*
San Diego offers many unique options to explore the city by land, sea, or air while attending the 2012 AOCD Annual Meeting slated for Oct. 7-11.

One If by Land
Downtown San Diego is easily explored on land, with short city blocks and most streets running one way in a grid pattern for easy navigation. The San Diego Trolley light rail system offers routes running to various points throughout the downtown area. You can hop on and off the trolley to do a self-guided tour or take a trolley tour to a specific destination and/or attraction.

For those who want to escape tour buses, zip around town in a GoCar, a three-wheel mini-car. Up to two people can jump into these topless, miniature vehicles and enjoy a GPS-guided audio tour highlighting 100 city sites. Because the GoCar is guided by GPS, it always knows where you are, even if you don’t. As you drive, it tells you where to turn and what you’re passing, and it waits patiently if you want to stop. As soon as you turn your GoCar back on, the tour picks up where it left off.

In addition, you can hop on a converted British double decker bus. These ride through Old Town, Balboa Park, the Gaslamp District, and Seaport Village. They even go to the San Diego Zoo.

You can’t get much more environmentally friendly than sightseeing in a pedicab—also known as a bicycle rickshaw—powered by the driver’s legs. Pedicabs are available daily along most downtown streets, particularly in the Gaslamp Quarter and along the Embarcadero in the Columbia and Marina neighborhoods.

Equally environmentally friendly are walking tours, of which San Diego offers a multitude. If it’s the city’s historic sites, questionable past, ghostly inhabitants, or gastric delights that interest you, there is a tour for it.

Two If by Sea
Harbor cruises are another popular way to explore San Diego. Relax in comfort on the observation deck while learning about the city’s rich history, local points of interest, landmarks, marine animals and seabirds, and environmental efforts. If you have a bit more time to spare, consider a sightseeing dinner cruise.

Although a Kayak tour won’t get you around town, it will get you a view of the amazing San Diego sunsets. Enjoy paddling in the La Jolla Sea Caves and witness the many sea lions sunning on the cliffs late in the day as they feed.

If you can’t decide whether you want to go by land or sea, go by both in a SEAL tour, a combination tour bus and boat. These unique hydra-terra amphibious vehicles start out on the historic streets of San Diego before making their way into the Big Bay. In addition to gliding by navy ships, tugboats, and fishing vessels, you can have a close encounter with sea lions and other natural wildlife aboard the vehicle.

Three If by Air
When it comes to exploration by air, no city does it better than San Diego. Soar up to 5,000 feet in the sky in a hot air balloon to view a California sunset over Del Mar or a Temecula sunrise over the vineyards of the Southern California wineries.

Whether you want to see the beaches of La Jolla, Mission Bay, or San Diego, view the North County coastline, or lunch at a Temecula winery, there is a helicopter waiting to pick you up. Helicopter tours range from 30 to 120 minutes, or more.

Whatever mode of transportation you choose, enjoy all that San Diego has to offer while attending the AOCD Annual Meeting.

AK Lunch Symposium at Annual Meeting

Making a Paradigm Shift in the Management of Actinic Keratoses (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. Pre-register online at www.paradigmmc.com/ak.shtml.

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.
Corporate Spotlight by Shelley Wood, Grants Coordinator

As I write this, the Annual Meeting in San Diego is approximately two months away. This will be my first conference with the AOCD and I am looking forward to meeting our corporate and event sponsors, our Board of Trustees, and our members. I appreciate the opportunities to meet our sponsors and thank them for their support of the College. Despite an unsure economy, corporate acquisitions, and other challenges, the corporate pledge to medical excellence still exists and is essential in aiding us to achieve our objectives.

The AOCD is delighted to welcome our newest corporate member and first Pearl Level Corporate Member, Warner Chilcott. A New Jersey-based pharmaceutical company with corporate headquarters in Dublin, Ireland, Warner Chilcott manufactures one of the leading branded oral tetracyclines in the U.S. market, Doryx. Other products manufactured are Devonex cream and scalp solutions, Moisturel Sensitive Skin Cleanser, Moisturel Therapeutic Cream, and Moisturel Therapeutic Lotion.

Welcome aboard Warner Chilcott. We look forward to a prosperous future with you.

The AOCD also would like to welcome Tru-Skin Dermatology as one of our new sponsors. Tru-Skin Dermatology will be supplying t-shirts for the Annual Meeting. The t-shirts will feature the Shade Project, the company’s non-profit skin cancer prevention initiative that raises ultraviolet awareness through education and outreach, and by providing shade for children and families. The Annual Meeting portfolios will be sponsored by Valeant Dermatology. Thank you Tru-Skin Dermatology and Valeant for your support of the AOCD.

Medicis Helps Residents Attend Scripps Course

With support from Medicis, the AOCD was able to send 40 residents to the 29th Annual Hugh Greenway’s Superficial Anatomy and Cutaneous Surgery course held July 9 – 13, 2012 in San Diego.

The Medicis grant funds are restricted for the purpose of providing a stipend to AOCD second-year residents in support of their attendance at the Scripps Course. Funds are distributed equally among the total number of residents attending this course.

The AOCD would like to thank Medicis for its continued support of the College’s residents by enabling them to attend this prestigious course.

Winter Park Offers Premier Skiing, Snowboarding

It’s time to call on your inner skier as the 2013 Midyear Meeting is slated Jan. 23-26 at the Winter Park Mountain Lodge in Winter Park, Colo.

Winter Park offers some of the best skiing and snowboarding terrain in the country, and the lodge offers skiing areas for both beginners and avid skiers. In fact, every room at the lodge is located directly across from the Winter Park ski area. If you aren’t a skier, there are other activities you can enjoy while attending the Midyear Meeting.

Enjoy a centuries-old mode of transportation by taking a dog sled ride with experienced guides and dogs. Glide quietly over smooth trails through peaceful glades of aspens and pines, taking in breathtaking mountain views as several Siberian and Alaskan huskies pull you on a wooden sled while you stay snuggled in warm blankets. A private trail system on the edge of Winter Park offers excellent views of the valley and surrounding mountains. Depending on snow conditions, several operators throughout the area offer a variety of dog-sledding tours, ranging from 30 to 90 minutes.

Blaze your own trail in a snowmobile on either a guided or unguided tour. Guided snowmobile tours are recommended for beginner to intermediate riders, as well as for teenage drivers. Unguided snowmobile tours are for advanced snowmobile riders. Reservations required.

For a bird’s eye view, consider a hot air balloon tour. Spectacular flights over Winter Park and Fraser Valley offer a glimpse of the Continental Divide and all the beautiful mountains, lakes, rivers, and forests within.

Enjoy the classic winter pastime of ice skating, which takes on new pleasure when the backdrop is a mountain view as far as the eye can see. Winter Park boasts four ice skating locations: the Cooper Creek Square Rink, Devil’s Thumb Ranch, YMCA/Snow Mountain Ranch, and the partially enclosed Fraser Valley Recreation Rink. Not all locales offer rental skates; be sure to check before you venture out. The Fraser Tubing Hill, behind the Alco Shopping Center in Fraser, offers a fun tubing adventure for the whole family.

Thank you to our other corporate sponsors for 2012 with whom we look forward to continuing our partnerships in the future. They are the following:

Diamond Level:
- Galderma
- Medicis

Gold Level:
- Biopelle, Inc.

Silver Level:
- Ranbaxy Laboratories, Inc.
- Valeant Dermatology
- Stiefel, a GSK Company

Bronze Level:
- Abbott Laboratories
- Dermpathology Laboratories of Central States
- Ferndale Healthcare
- Sanofi-Aventis/Dermik Labs
- Triax Pharmaceuticals
Another year is upon us. Congratulations again to all the new residents and residency programs across the country. As we start a new year, there are a few issues that need to be addressed.

First, the upcoming In-Training Examination is scheduled for October 7, 2012. The day is reserved for the exam, and more details will follow with an official mailing from the AOCD. Details concerning the AOA OMED conference in San Diego as well as registration can be found at http://www.osteopathic.org/inside-aoa/events/omed-2012/Pages/Registration.aspx. This year, the registration fee is waived for residents, so please register for the conference so that you will be able to sit for the exam.

Second on the agenda are society memberships and dermatology publications. As a resident member of the College, you receive complimentary memberships in the American Academy of Dermatology (AAD) and the American Society for Dermatologic Surgery. With these complimentary memberships you should be receiving both the Journal of the American Academy of Dermatology, also known as the JAAD and Blue Journal, and Dermatologic Surgery. The initial list is sent by the AOCD and should be processed in the first few months of the academic year. If you are not receiving either publication by the Annual Meeting, please contact the societies (www.aad.org, www.aoads.net) directly to inquire about your membership status.

As a resident, you also are eligible for a complimentary subscription to Archives of Dermatology. This journal is published by the American Medical Association (AMA), and is related to your physician number the AMA has on file. This number was set up by your medical school, and you need to contact the AMA directly to make sure the AMA has your correct mailing information as well as your specialty listed as dermatology. The AOCD cannot change this information as it is part of your personal record at the AMA. Please contact the AMA at 1-800-262-3211 or http://www.ama-assn.org.

In fact, there are a number of publications that are available on a complimentary basis while you are in your dermatological training. The following is a short list of available publications and their corresponding websites:
- Journal of Drugs in Dermatology
  http://jddonline.com/
- Dermatology Times
  http://www.dermatologytimes.com
- Cutis
  http://www.cutis.com/
- Cosmetic Dermatology
  http://www.cosderm.com/

Honorable Mention

Karthik Krishnamurthy, D.O., was quoted in an article about new sun safety rules on the Yahoo! Health website this past May. He noted the importance of wearing sunscreen daily, even if it’s cloudy. Dr. Krishnamurthy countered the old rule that “a little sun helps your body produce vitamin D” by suggesting it’s easier to take vitamin D in a supplement or in one’s diet than getting chemotherapy for skin cancer because of “baking in the sun.” He also commented on the use of seaweed in wound dressings for an latimes.com article published the same month. Although its use in wound dressings has yielded excellent results, Dr. Krishnamurthy recommended reserving judgment about the benefits of seaweed as they are unfounded at this time.

Will Kirby, D.O., was the featured dermatologist in the December 2011 issue of Dermatology Times.

Were you quoted in a recent article, appear on a news segment, or speak on a radio show? Let us know so we can let your peers know.
Hello everyone,

The summer really flew by with all the annual reports, posters, and presentations coming in. We’re in the midst of Annual Meeting prep work, and it’s hard to believe that the AOA OMED meeting is just around the corner. I look forward to seeing you all. Until then, I have a few reminders and announcements.

In-Training Exam
The In-Training Examination (ITE) will be held on Sunday, October 7, 2012, commencing promptly at 8:00 a.m. Plan to arrive early, as no one will be admitted after 7:45 a.m., and the exam room doors will be closed at 7:50 a.m. Residents’ dues must be current to sit for both exams. I will provide room information as soon as it is made available to me.

Policy prohibits any electronic devices from being brought into the testing site. This includes cellular phones, personal digital assistants, and pocket organizers. All of these items should be left in your room prior to testing. If you bring any of these electronic media to the site, they will be collected. No allowances will be made for those on-site during the testing procedures or during bathroom breaks, etc.

An ITE is administered to dermatology residents each year during the AOCDD Annual Meeting. Taking the ITE, which is a practice test, is mandatory. The intent of the ITE is to identify knowledge-based strengths and weaknesses in both the training programs and residents in a non-punitive manner. The exam format includes only the types of multiple-choice questions that appear on the certifying exam (i.e., one best answer, matching, and identification of images). The ITE is not meant to be a mirror of the actual AOBD Exam.

Keep Current
Please remember to keep your address and email address current. If you experience problems logging on to www.aocd.org/membership, please let me know.

Resident Lectures
Resident lectures at the 2012 Annual Meeting will be held Tuesday and Wednesday, October 9 and 10. Lectures are scheduled from 2 p.m. to 6 p.m. on Tuesday and from 1:20 p.m. to 5:20 p.m. on Wednesday. The lectures will cover a broad range of topics. (See Annual Meeting Speakers to Cover ‘the Novel, Curious, Complex’ on page 20 for a list of resident speakers and their topics.)

Four of the five new residency training programs opened their doors this past July.

The programs, which were approved by the AOA this past April, filled four of the potential 30 residency slots that will open once the programs are operating at full capacity.

With nine resident positions, Aspen Dermatology under the directorship of Warren Peterson, D.O., will be among one of the larger AOCDD residency training programs. Nathan Peterson, D.O., is the first resident accepted to the Spanish-Fork, Utah-based program.

Also touting nine positions, NSUCOM/Larkin Community Hospital program is under the directorship of Stanley Skopit, D.O. The South Miami-based Larkin program welcomed three residents as follows: Bertha Baum, D.O.; Jessica Bernstein, D.O.; and Ashvin Garlapati, D.O. In addition, two residents transferred from the Duncanville, Texas residency program that closed this past June. They are Chief Resident Steffany Steinmetz and second-year resident Jordan Fabrikant. Dr. Skopit served as a Program Director for the NSUCOM/Broward General Medical Center in Fort Lauderdale from 1993 to 2010.

Salem, Ore., is home to the WUHS/Silver Falls Dermatology program slated for six positions.

This year, Program Director John Young III, M.D, welcomed residents Brandon Markus, D.O., and Cory Maughan, D.O.

The MSUCOM/Lakeland Regional Medical Center in St. Joseph, Mich., is under the directorship of Mark Kuriata, D.O. Resident James Yousif, D.O., filled one of three positions.

The Rocky Vista University/Colorado Dermatology Institute residency program will accept its first resident in 2013. Under the directorship of Charles Hughes, D.O., the program will fill a total of three positions during the next three years.
Sunless Tanning Products May be Viable Alternative to Indoor Tanning for Female College Students

Encouraging exclusive use of sunless tanning products (STPs) may be a practical strategy to prevent female college students from using indoor tanning beds, according to a recently published study that was co-authored by AOCD student member Monica Van Acker, BS.

The purpose of the study was to determine the use of, and attitudes toward, STPs among women who use indoor tanning beds, the third-year medical student at Michigan State University College of Osteopathic Medicine explained. The study, which used an online survey of 393 students at two Midwestern universities, was published in the July 2012 issue of Archives of Dermatology.

Despite more than 90% of respondents associating indoor tanning with skin cancers and photoaging, 85% of them had used indoor tanning beds in the past year. Increased indoor tanning bed use generally correlated with fewer sun-protective behaviors, according to the study that divided respondents into categories based upon their tanning habits.

“For the generation of women studied, many believe skin cancer and photoaging are not immediate consequences of their actions and that the instant gratification tanning offers is worth the risk,” Van Acker noted. Research has shown that graphic health warnings on cigarette packages substantially reduce smoking, she said. Consequently, beginning this September, the Tobacco Control Act will require graphic health warnings on cigarette packages. Eventually, the Food and Drug Administration will require these images to accompany the warnings, Van Acker explained. “This tactic also may be an effective mechanism for the anti-tanning community to employ sending a strong reminder to tanners about their increased risks for future cancers, scarring secondary to removal, and premature aging,” she said. “Proper promotion of STP usage along with warning text and images upon entering a tanning bed may be just enough to alter the hazardous decisions these women make.”

The majority of respondents (87%) used STPs in the past year, as well.

Bronzing powders were most frequently used (79%) followed by sunless tanning lotions (45.5%) and spray tans (14%). Respondents, who used STPs primarily to enhance their appearance, believed that such products were safer than indoor tanning. Conversely, reasons for not using STPs were streaked or orange-appearing skin.

Knowledge about the risk of indoor tanning and properties of STPs differed significantly among subtypes with regular tanners showing the least knowledge.

Users of STPs agreed more strongly than non-users that these products are safer than tanning beds. Regular tanners were more likely than event tanners to believe that STPs offer protection against harmful effects of the sun.

Van Acker believes that the study’s findings present an opportunity to educate patients about the dangers of indoor tanning and which products provide protection against skin cancer and photoaging. Dermatologists could stress that artificial ultraviolet tanning sources should be strictly avoided and women seeking a tanned appearance should resort exclusively to the use of STPs, she said. They also could inform their patients that only STPs indicating broad spectrum SPF 30 offer skin protection. With many regular tanners using STPs along with tanning beds to achieve the desired bronzed look, it may be worthwhile to include greater SPF coverage in daily use STPs, Van Acker added.

“Results from our study provide insights into tanning attitudes and behaviors of college age women,” she said. With the recent loss of a family member to melanoma, this is more than just a study to Van Acker; it’s an opportunity to help prevent skin cancer. “I’m hoping that the data will help dermatologists target certain groups of women and tailor interventions to more effectively persuade them from engaging in activities that cause unhealthy ultraviolet exposure. Because event tanners display the greatest knowledge of indoor tanning risks and most appropriate usage of STPs, this group should be targeted as they are most amenable to change.”
Dermatologist Wanted for Michigan Practice

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.
A CALL FOR PAPERS

Journal of the American Osteopathic College of Dermatology-JAOCD.

We are now accepting manuscripts for publication in the upcoming issue of the JA OCD. ‘Information for Authors’ is available on our website at www.aocd.org/jaocd. Any questions may be addressed to the Editor at journalaocd@gmail.com. Member and resident member contributions are welcome. Keep in mind, the key to having a successful journal to represent our College is in the hands of each and every member and resident member of our College. Let’s make it great!

- Jay Gottlieb, D.O., FAOCD, Founding Editor
- Karthik Krishnamurthy, D.O., FAOCD, Incoming Editor-in-Chief