Message from the President

Greetings from Houston, Texas!

As President of the AOCD, I welcome you to another edition of DermLine. I want to express my appreciation to Dr. Rick Lin, our Immediate Past President for his tireless efforts on behalf of the College. His friendship and his willingness to continue participating in a meaningful way will only make this year successful.

I appreciated our time together in Orlando on a number of different levels. First, the friendships that continue and the opportunity to develop new friendships and relationships are vital to our personal growth and development. Secondly, hearing new ways of doing things, discussing similar challenges, and hearing solutions to many old challenges was powerful. Finally, I believe there are no words to describe how special Orlando was personally to me. The attendees were so very caring! There is, inherent in this great organization, a camaraderie blended with the desire to help others. The kindnesses shown to me during this conference will linger long in my memory.

The year 2016 is upon us. It seems only yesterday I was entering the Kansas City University of Medicine and Biosciences in Kansas City followed by my internship and residency; these are now but distant memories. Soon another cycle will pass. New, excited doctors will emerge and enter residencies in dermatology. As director of the South Texas Dermatology Residency Program in Houston, I have borne witness to fine physicians honing their skills and expanding their knowledge in anticipation of launching their medical careers. We need to be mindful that the future of our organization rests squarely upon the shoulders of these new physicians we train. It is to the great benefit of the AOCD that we serve not only as mentors, but remain active in their development in both practice and science.

Our future residents and fellows will find an exciting new development awaits them. The AOA, along with the Accreditation Council for Graduate Medical Education and the American Association of Colleges of Osteopathic Medicine, have agreed to a single accreditation system for graduate medical education programs in the United States. When the new system is fully implemented in July of 2020, the graduates of osteopathic and allopathic medical schools will complete their residency and/or fellowship education in ACGME-accredited programs and demonstrate achievement of common milestones and competencies. No longer will there be a great divide in the practical training of DOs and MDs.

Clearly our world is changing! I suppose the greatest morsel I could share with you comes from one of my mentors, “Today, at this moment, we are living in yesterday’s future.” The changes in our practice of dermatology and medicine in general are profound. We spend great swaths of time dealing with electronic medical records and ICD 10. My challenge to you is to pause and remember why you chose medicine, and particularly, why you felt dermatology was to be your specialty. Then use that memory to ensure you look at your patients through that lens tinted with that memory. While we must tend to the busyness of EMRs, we must not forget our patients.

I look forward to serving you and the opportunity to meet all of you as you attend our meetings.

Alpesh Desai, DO, FAOCD
President, American Osteopathic College of Dermatology
Message from the Past President

It has been an amazing seven-year journey. It was approximately seven years ago when I was first elected a Trustee of the AOCD Board of Trustees on a last minute floor nomination. It seemed like a good idea at the time. My practice was growing and I was looking for another challenge.

Dr. Jim Young’s installation as the AOCD President had a lasting impression on me as a student member. Later, my own Program Director and role model, Dr. Bill Way, became the President. My admiration for the leaders of the College paved the way for me to aspire for a higher office beyond Trustee.

I also have to confess the aspiration was not consistent throughout. After I was accepted into a residency program, a certain amount of complacency set in. After three years of being a dermatology resident, the excitement slowly started to fade. It’s mandatory to attend the Presidential Banquet, which is a long night. I remember thinking that I couldn’t wait for it to be over so I could find out where Dr. Shino Bay was going to party that night. He always seemed to know where the best parties were.

Throughout my years as a Trustee and officer of the AOCD BOD, there were many discussions and disagreements among the Board members. Discussions can get heated at times, resulting in hurt feelings and bruised egos. Occasionally, the issues discussed can be very stressful. Sometimes, I didn’t even know if everything I was doing as an AOCD officer was making any difference. I was not sure if it was all worth it.

During the last few years leading up to be the presidency, I gradually understood the value of what I was doing. When I attended the American Academy of Dermatology (AAD) Gala and the Mohs Surgery Summit on behalf of the AOCD, I met with the upper echelon of leaders within the AAD. These wonderful leaders of organized dermatology welcomed me to the table for discussions and listened to what I had to say. I realized the reason why I was being treated with respect by these amazing leaders of dermatology is not because Rick Lin is awesome. After all, I am just a country doc practicing in a border town. I was being treated with respect because of who I was representing. Because the members of this College empowered me to represent them, I was speaking with other leaders on equal terms. As the AOCD President, it was no longer just about me anymore. It was, and is, about honoring all the College leaders before me and paving the way for the leaders after me.

During the past seven years, I have learned to respect the office and our College. Everything we do, whether it’s the long drawn out Board of Trustees and Business meetings or the President Celebration, it’s about paying homage to all the past and present AOCD members and leaders. It is not just a bunch of us old guys patting each other on the back. Through everyone’s dedication, there exists this institution that provided me the opportunity to become the dermatologist I am today. The AOCD has enabled me to do what I love every day and provide for my family just as it has done for countless other AOCD members.

I share my thoughts on this because I would like to encourage all of our younger members and residents to always keep an appreciation and admiration for this College, and to have the aspiration to be part of the AOCD leadership. And to one day, contribute your own energy and talent for the betterment of the College.

My seven-year journey to the end of this presidency, of course, has not occurred without personal sacrifice. I have traveled frequently for the AOCD, leaving my wife at home to stay with our three young daughters. I am thankful to my wife for allowing me to sacrifice some family time to fulfill my duty to the College.

I also want to mention my mother. Without her, I would not have been able to achieve my dream of being a dermatologist. She has been a role model to me and has instilled in me the values and work ethic of striving to be the best that I can be. I am forever thankful to her for everything.
To round up this year, I would like to thank Marsha and the AOCD staff for a year of hard work. I also want to thank my Board members for making this a memorable year for me.

There are many changes coming our way and we are sailing in uncharted water. During the next five years, the very mission and essence of the AOCD will be tested. Our relevance will be evaluated. Without careful planning and foresight, we may be deemed obsolete.

The Accreditation Council for Graduate Medical Education (ACGME) is slated to take over the AOCD’s role in graduate medical education. There are many misunderstandings, even within our membership, about the implications of this merger. Some of our members believe the merger will confer ACGME or MD board certification on us, and with that automatic AAD fellowship status. Nothing is further from the truth. The ACGME merger will leave us to be the group that is left behind. All of us with AOBD board certification now and in the future, will rely solely on the AOBD for future recertification. At this point, we are not eligible for recertification by the American Board of Dermatology.

With the ACGME merger, we will likely see the AOCD become a much smaller organization in the course of the next five to 10 years. The current pipeline of 50 AOCD residents every year may not be relying on the College for continuing medical education credit if the future osteopathic dermatology residents choose not to take the DO board examination. Consequently, the growth of the AOCD may be stunted. As an organization, we will need to re-invent ourselves and modify our vision to ensure our future survival. We will need the SUPPORT of all our members, young and old, to lead our College to new prosperity. To do so, we will need the participation of everyone involved. Our heritage and our own ability to practice dermatology are intimately tied to the survival of the AOCD.

In summary, we are our survival. We will need dedicated members and visionary leaders to guide us through the challenges. Incoming AOCD President Dr. Alpesh Desai is one of those leaders.

I remember the first College meeting I attended as a first-year resident. Dr. Desai was on stage giving one of his Koprince award presentations. That was more than 12 years ago. Most of the resident lectures at the time were case reports. But there was Alpesh presenting his original research on tomoxitfen and its potential application in the treatment of Melasma. The audience was dazzled! He had this Powerpoint presentation with all the animation and moving parts showing the mechanism of action.

I remembered that very moment telling myself that I must become his friend. This man is going places! I must follow him and ride the coattails of his success... because he is bound to be very successful. I was absolutely right.

During the past 12 years, I have learned a lot from Alpesh. He gives advice with many insights and has helped me out of many tight spots. Recently, I had the honor of becoming a dermatology residency Program Director. For five years leading up to this opportunity, Dr. Desai allowed me to be the Assistant Program Director at his Houston residency program. It was in that role that I was able to gain confidence and experience teaching residents, enabling me to accept a directorship position when the call came.

Alpesh is not just a friend to me; he also is my mentor and advisor. He is a man who possesses wisdom and great judgment. And while I leave the College in GREAT hands under his leadership, I urge each and every member to pay their dues, attend our meetings, participate in committees, and help keep the AOCD vibrant.

Rick Lin, DO, MPH, FAOCD
Immediate Past-President, American Osteopathic College of Dermatology
Greetings Everyone!

2015 has been a busy year.

Where do we go from here?

The single-unified accreditation system is moving forward. By June 30, 2020, the AOA will no longer accredit residency training programs. What will be the trickle-down effect of this? How will osteopathic medicine and our specialty college as well as others remain relevant? No one knows! What we do know is, this is something we all need to start working on now.

At the recent AOA Advocacy for Healthy Partnership meeting, topics on promoting osteopathic medicine and advocating for osteopathic equivalency were presented. The Dermatology World article from June 2015 on “Defining the DO” was one success story shared at the meeting which was attended by physician leaders and executive directors from various state societies and specialty colleges. Click here to read the article.

In October, the AOA launched a brand awareness campaign. Through the spring of 2016 you can expect to see these ads in both print and video. Click here to learn more about this campaign.

How will the ACOCD prepare for the future? Just like the American Academy of Dermatology, the ACOCD is also preparing for a By-Laws change.

On Thursday, October 15, 2015, the ACOCD Board of Trustees met and discussed a By-Laws change and a Constitution change. The committee voted to approve these recommendations and are submitting to the general membership for a formal vote. An announcement was made at the ACOCD General Business meeting on Friday, October 16, 2015, and again during the Presidential Celebration that same evening. The changes are as follows:

ACOCD By-Laws

Article II, Board of Trustees and Standing Committees

Section 1: Voting Members

The voting members of the Board shall consist of the President, President-elect, First Vice President, Second Vice President, Third Vice President, Secretary Treasurer, Education Evaluation Committee Chair, Finance Committee Chair, Immediate Past President, six (6) trustees and an appointed representative of the American Osteopathic Board of Dermatology. In addition, the Executive Director, and the Resident Liaison shall attend all meetings of the Board of Trustees as non-voting members.

Rationale: Removing the Finance Committee Chair’s ability to vote on BOT matters. Committee members felt the committee should remain neutral in order to provide oversight.

ACOCD Constitution

Article III, Membership

Section 2.A Fellow: Any osteopathic or allopathic physician who has been certified by the AOBD through the ABMS by the ABD shall be eligible for fellow membership. Fellow members shall have full membership rights which include specifically, the right to vote, to hold office, to be assessed dues, and to accept appointment to committees and councils. He/She must be a member in good standing of the AOA. Failure to maintain membership in the AOA or Canadian Osteopathic Association will be due cause to lose membership and listing.
Honorary AOOCD Staff Member, Stanley Lambchop, a.k.a. “Flat Stanley,” was adopted from Mrs. Kimberle Burnett’s Third Grade class at Corse Elementary School in Burlington, Iowa. Stanley Lambchop had a big bulletin board fall from the wall above his bed, flattening Stanley in his sleep. He survives and makes the best of his altered state. One special advantage is that Flat Stanley can now visit his friends by being mailed in an envelope.
Laser Tattoo Removal
Will Kirby, DO, FAOCD

• Physics behind
  • Audible “pop” during tattoo removal is the sound barrier being broken

• “Frosting” after tattoo removal
• Audible “pop” during tattoo removal is the sound barrier being broken
• “Frosting” after tattoo removal
• Lysis of ink bonds
• Microscopic carbon dioxide bubbles underneath epidermis
• Petechiae takes place only where the ink is
• Selective photothermolysis
• Term used when treatment directed at removing chromatophore (ex. tattoo removal; hair removal)
• Pre-care
• Sun avoidance
• No isotretinoin six months before
• Not performed on pregnant patients (no studies have been done, nor will they likely be done on pregnant women)
• Post-care
• Ice off and on
• Moisturize
• Avoidance of activities that would increase body heat
• No popping of blisters

Rationale: To allow Allopathic physicians to become Fellows in the AOCD. This is being done in anticipation of the Spring AAD vote which, if passed, will allow Osteopathic members certified by the AOBD to become full fellows in the academy.

Members have been asked to vote on whether to allow allopathic board certified dermatologists to become Fellows in the AOCD. An electronic ballot was presented to the membership on December 4, 2015. Members had until December 9, 2015 to respond. The AOCD Membership approved this change with 91% of votes submitted in favor and 9% votes submitted against.

This is not quite official, as the next step is to submit to the AOA Board of Trustees for final approval. We should have the AOA’s decision by the end of February 2016.

What other changes will take place for the AOCD? The CME committee is exploring online CME. A proposal will be presented to the Board of Trustees at their meeting in New York. Currently, the AOA allows up to nine online CME per cycle; however, this number may go up.

How can you as a member help? Get involved! Consider joining a committee, attend our CME sessions and most importantly, remain current on your AOCD dues. Your annual dues are important to the AOCD. They provide the majority of the funding for our CME conferences as pharmaceutical funding continues to decline.

Renew your AOCD membership dues for 2016 now. The AOCD has made it easier for you to renew your dues by providing a link to our website for quick and secure renewal. Go to our web site, http://aocd.org. To log in, your username is your email address you have on file with the AOCD and your password is “Aocd” followed by your AOA# (case sensitive) Please contact our office if you have difficulty logging in.

Also on that page is a form to update your database information. This database is maintained on our website so you can make changes to your membership information at any time. All changes you make will be recorded in the database and will also update the “Find a DO” section of the website. Although you will see all of your information in your personal file, all inquiries will only see your office address, office telephone and fax number.

Reminders
December 31, 2015 is the end of the current CME cycle. The new cycle begins January 1, 2016. I encourage everyone to check your CME reports and to monitor the AOA site for the new CME guide which has not been published. We are hearing that there will be changes in the requirements for the new cycle. Click here to find that information.

Many AOCD members have been inquiring about OCC and OCAT. Click here to register, if you have not already done so. This is all mandatory for recertification. If you have any questions please refer to the AOBD website.

Save the Dates!
• The 2016 Spring Meeting will take place from March 30- April 3, 2016 at the Ritz Carlton Battery Park, New York, NY
• The 2016 Fall Meeting will take place from September 15-18, 2016 at the Loews Santa Monica, Santa Monica, California.
• The 2017 Spring Meeting will take place from March 29- April 2, 2017 at the Ritz Carlton Atlanta at 181 Peachtree Street, Northeast in Atlanta, GA.

As always, if you have questions or concerns, please feel free to contact me (see “Contact Us” at AOCD.org), and I will be happy to assist you. We appreciate your continued support of the AOCD.

2015 AOCD Fall Meeting Highlights

“Frosting” after tattoo removal
• Lysis of ink bonds
• Microscopic carbon dioxide bubbles underneath epidermis
• Petechiae takes place only where the ink is
• Selective photothermolysis
• Term used when treatment directed at removing chromatophore (ex. tattoo removal; hair removal)
• Pre-care
• Sun avoidance
• No isotretinoin six months before
• Not performed on pregnant patients (no studies have been done, nor will they likely be done on pregnant women)
• Post-care
• Ice off and on
• Moisturize
• Avoidance of activities that would increase body heat
• No popping of blisters
Follow up with provider if suspected infections—do NOT go to ER after tattoo removal
Have patients fill out online survey after treatment
Consultation recommendations
Three “P’s” of any procedure
- Pain
- Procedure
- Price
“How many treatments does it take to remove a tattoo?”
Kirby-Desai Scale—takes six different parameters to determine number of treatments based on skin type, location, colors, amount of ink, scarring and tissue change, and layering tattoos
Q&A
- For a tattoo to be permanent it has to reside in the dermis

Female Hair Loss
Matt Leavitt, DO, FAOCD

Introduction
- Profile of female hair loss
- Psychosocial impact
  - Not many female role models with hair loss
- Etiology
  - Most women should have thorough workup as there are many etiologies
  - Scarring vs. non-scarring
  - Non-scarring: Diffuse and focal (ex. telogen effluvium, alopecia areata, traction alopecia)
Scarring
- Cicatricial alopecia (destruction of follicle)
- Primary scarring alopecia classification: lymphocytic (most common; ex. discoid lupus erythematosus), neutrophilic (most obvious), mixed, non-specific
- Lymphocytic
  - Lichen planopilaris (LPP)
    - Females 40-60 years old
    - Unknown etiology
    - Defining lesion: leading edge is perifollicular erythematous/violaceous papules and spinous/follicular keratotic papules
    - Atrophic, smooth shiny patches
    - Slowly progressive disease; must attack it quickly
    - Variant: frontal fibrosing alopecia (band across scalp) in women under 40 years old
    - Treatment: superficial 1-2cc Kenolog 10 injections every three to four weeks; low-dose doxycycline short-term for inflammation; pulse clobetasol topical solution; 50-60% could be potential transplant patients
- Pseudopelade of Brocq
- Central Centrifugal Cicatricial Alopecia (CCCA)
  - Lymphocytic attack of hair follicles
  - More progressive even after it appears to stabilize
  - Etiology unknown
  - Goal is to stabilize patients
  - 20% could be potential transplant patients
  - Treatment: similar to LPP
  - Symptoms: hyperpigmentation, scalp can be smooth and shiny, pins and needles, pruritus, tenderness
Neutrophilic
- Pustular eruption of the scalp
- Dissecting cellulitis: African-American men 18-40 years old; multifocal disease with interconnecting tracts treatment is oral steroids
- Mixed cell scarring alopecias: folliculitis keloidalis
Non-scarring
- Telogen effluvium
  - Visible and rapid progression of hair loss
  - Most common causes are post-partum, medication, stress (diet), thyroid disease
  - Shedding of hair vs. thinning of hair, which is more commonly associated with female pattern hair loss (FPHL)
  - Miniaturization: shortening of hair cycle; rapid turnover
  - Root of hair appears bulbous or onion-shaped
  - Treatment: clobetasol solution; injections to parietal areas of present; low level light therapy; minoxidil 5%
- Workup: primarily history and exam; labs include CBC, CMP, TSH, FSH/LH, testosterone, DHEA-S, iron, iron binding capacity; transferrin, ferritin
- Alopecia Areata
  - Find hair breakage in clinical exam; exclamation point hairs (distal tip larger than proximal tip)
  - Treatment: as it is a lymphocytic infiltrate treatment, treat the inflammation—pulsed steroid; superficial kenalog, minoxidil 5%
  - Chemical alopecia
  - Trichotillomania: ask patient why they are “scratching their scalp,” and come up with a reason to treat scalp
- Androgens – Women
  - Women can have baldness in presence of normal and high androgen levels
  - Pattern is different in women
  - “Thinning” problem more than a balding problem
  - Women treated with aromatase inhibitors experience FPHL
  - Slow onset and progression; hair loss is from root
  - Most follow Ludwig Pattern with widening part
  - Miniaturization
  - Treatment
    - Minoxidil 5% (opens potassium channels; vascular endothelial growth factor (VEGF); cell proliferation; apply when skin is dry)
    - Spironolactone (reduces androgen levels; start at 50mg) + clobetasol (pulse) will slow down FPHL
    - Low level laser therapy: emits red light with wavelength 630-670; minimal time commitment
- Female hair transplant assessment
  - Women often require more “listening” from physicians than “talking” during pre-op consultation
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Ask how patient currently styles her hair and how she hopes to style it in the future

Look at hair characteristics (color, texture, skin-to-scalp contrast, level of curl)

Warn patients that for the first few months will likely have more trouble styling than before

Solo Strategies: The Future is Still Bright

Daniel Ladd, DO, FAOCD

• Comfort level
• Working longer hours
• Financial risk
• What’s your personality?
• Patients are more concerned whether their ailments can be cured rather than the name of the illness

Important decisions
• Buying an existing practice vs. starting a new practice
• Embracing new technology
• Key decision—choosing an office manager

Location
• Rural vs. urban
• Urban/metropolitan areas
• Business starts slow due to competition
• City size

Business plan
• You must have a long term plan in order to be successful
• Important to think like a business person rather than a physician
• Very important to find a good office manager
• You must manage this person and they will manage the office
• Visit and meet every doctor in your area
• Helps to establish relationships so that you can get referrals
• The “connection” is more important than selling them anything

Changing landscape
• The increasing number of older patients (including baby boomers) is going to increase the demand for treating skin cancer
• Demand of treatment is greater than supply
• Healthcare delivery issues

Surface radiation
• Offer patients the option for surface radiation alone or in combination with Mohs
• Important to establish a relationship with a radiation oncologist
• Referrals can go both ways

Benign or Malignant: What Does the Pathology Say?

John Cangelosi, MD

• CD4:CD8 ratio greater than 3:1, consider malignant process
• CD4+ small medium sized pleomorphic t-cell lymphoma
• Rare, usually asymptomatic
• Solitary plaque or nodule on face, neck, upper trunk
• Favorable prognosis
• Benign lichenoid keratosis
• Short duration
• Predilection for face, forearm, dorsal hand
• Predominantly Caucasian
• More common in females than males

Paget’s disease
• + CK7, - CK5/6; Her2/Neu
• Almost always associated with breast carcinoma
• Results from tumor spread via lactiferous ducts to the surface epithelium
• Usually unilateral presentation
• Folliculotropic mycosis fungoides
• Preferential location is head and neck
• Follicular mucinosis
• Usually minimal epidermitropism
• Worse survival rate than classic mycosis fungoides

Psoriasis
• Arthritis in one-third of patients
• Least common on face
• Basal cell nevus syndrome
• Autosomal dominant
• Early onset, multiple Basal cell carcinomas (BCC)
• Odontogenic keratocysts, palmo-plantar pits, falk cerebri calcifications, medulloblastomas, hydrocephalus, cataracts
• Mutation of chromosome 9 in the PTCH gene
• Should consider biopsy of acrochordon-like lesions in young patients

Amelanotic melanoma
• Mart-1/Ki67
• Characterizes melanocytic and lymphohcytic proliferation of cells
• HMB45 melanocytic marker
• If retained past superficial layer is a worrisome sign
• 5% of melanomas
• Often misdiagnosed as eczema, seborrheic keratoses, Bowen’s, BCC, angiofibromas, etc.
• Often leads to poor prognosis when diagnosed late

Breslow thickness and ulceration are the most dominant predictors of survival
• Mitotic rate also plays a role in staging

Chromohyphomycosis
• Infection by a fungal family Dematiaceae
• Fungi with brown septated hyphae
• Decomposing vegetation and soil
• Trauma usually gateway to infection

Extramammary Paget’s disease
• Most are in situ malignancy derived from intraepidermal sweat ducts
• Minority are epidermotropic metastasis from distant malignancy
• One-third of perianal lesions are associated with a rectal adenocarcinoma
• Overall association with internal malignancy is 15%

Spitz nevus
• Benign melanocytic nevi
• 50% in children under ten years old
• 70% diagnosed during first two decades of life
• Differential includes atypical Spitz tumor and Spitz-type melanoma
• If older patient, additional molecular tests may be needed such as the NeoSITE Melanoma Test Proprietary FISH test
• Homozygous loss of 9p21 (Spitzoid melanomas)
• Gain of cMYC locus at 8q24 (amelanotic melanoma)
• Gene amplification at CCND1 region on 11q13 and RREB1 region on 6p25

Cutaneous lymphoid hyperplasia (CLH)
• Also known as “Pseudolymphoma”
• B-cell (typical CLH, angiolymphoid hyperplasia, Kimura’s and Castleman’s diseases)
• T-cell (T-cell CLH, lymphomatoid contact dermatitis)
• Both may represent exaggerated reactions to external antigens
• T/B cell gene rearrangement studies can help
• Follow for persistence at site or evolution of lesions elsewhere

Desmoplastic melanoma
• Rare variant of spindle cell melanoma
• Sun damaged skin in elderly
• Uncommon—less than 4% of melanomas
• Different clinical behavior than normal melanomas
• High tendency for persistent local growth and less nodal metastasis
• Five-year survival from 70-90%
Androgenetic alopecia
• Autosomal dominant, variable penetrance
• Approximately 40 million men and approximately 30 million women
• Sensitivity to androgen (versus having too much androgen)

History of hair restoration surgery
• In 1939, Japanese ophthalmologist, Dr. Shoji Okuda, performed first hair transplant
• In 1952, dermatologist, Dr. Norman Orentreich, performed first American hair transplant

Hair transplant principle for androgenetic alopecia
• Donor dominance: hair follicles maintain characteristics from the area it was taken from regardless of where in the scalp it is placed
• Recipient dominance: hair follicles when transplanted into a diseased recipient area will be affected by what damaged hair follicles in first place

Follicular unit transplantation (FUT)
• Hair transplanted from permanent zone where hair follicles are more resistant to balding
• Donor harvesting:
  1. Shave area
  2. Excise strip
  3. Suture close with continuous running stitch
  4. Techs cut into follicular units
• Grafts placed in coronal orientation and densely packed
• Post Op
  • Shampoo and place occlusive ointment to prevent scabbing
  • Laser therapy can also provide anti-inflammatory due to leukocyte inhibition

Follicular unit extraction (FUE)
• Method of graft harvesting in units
• ARTAS system
• High resolution digital imaging
• Minimally invasive

Advantages
• No linear scar in donor area
• Decreased healing time in donor area
• Virtually no limitations on strenuous exercise post-op
• Useful for patients with a greater risk of donor scarring (younger patients or very muscular patients)

Disadvantages
• Graft quality is not as good compared to FUT
• More fragile
• Size of single surgery is much more limited
• Usually more expensive than FUT

Possible to transplant eyebrows
• Warn patients they will need to trim their eyebrows more than usual
• New studies are showing though that the eyebrow transplants are starting to grow less, adapting to their new site

Non-surgical treatments
• Low level laser therapy (LLLT)
  • MOA
    • Photons act on cytochrome c oxidase producing an increase in ATP, resulting in a release of energy and stimulation of the metabolic processes required for hair growth.
    • Also releases nitric oxide, resulting in an increase in scalp blood flow
  • Long term effects of LLLT
    • Increases cell survival
    • Reverses follicular apoptosis
    • Reduces inflammation
    • Increases the anagen phase and decreases the telogen phase;
    • Increases hair tensile strength
    • Reverses miniaturization
    • 630-670 nm wavelength
    • Decrease in hair loss is usually noticed in first six months, after which they may see return of miniaturized hairs
    • CCCA: can increase growth of surrounding hair to give camouflage to areas of hair loss

Pharmaceutical treatments
• Minoxidil
  • Direct stimulator of follicular growth via VEGF and prostaglandin synthase
  • Stimulates proliferation of dermal papilla cells
  • Opens adenosine sensitive potassium channels in the dermal papilla of the hair follicle
• Finasteride
  • Inhibits action of Type II 5-alpha reductase
  • Stops or slows future hair loss
• Spironolactone
  • Slows down production of androgens in the adrenal glands and ovaries
  • Therapeutic dosage between 100-200 mg daily

Osteopathic Review in Dermatology and Practice Management
Suzanne Sirota Rozenberg, DO, FAOCD
• Applying Osteopathic Principles to the Diagnosis and Treatment of Dermatologic Diseases (key points)
• Don’t be afraid to touch the patients
• Principle 1: “The body is a unit”
• Mental illness may be first displayed as a skin condition
• It is important to consider psychiatric evaluation of certain patients because they may not be aware that their mental condition may be affecting skin conditions
• Principle 2: “The body is capable of self-regulation, self-healing, and health maintenance”
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Indication:
Kenalog® Spray (triamcinolone acetonide topical aerosol, USP) is indicated for relief of the inflammatory and pruritic manifestations of corticosteroid-responsive dermatoses.

Important Safety Information:
Systemic absorption of topical corticosteroids has produced reversible hypothalamic-pituitary-adrenal (HPA) axis suppression, manifestations of Cushing's syndrome, hyperglycemia, and glucosuria in some patients.
Conditions which augment systemic absorption include the application of the more potent steroids, use over large surface areas, prolonged use, and the addition of occlusive dressings.
Children may absorb proportionally larger amounts of topical corticosteroids and thus be more susceptible to systemic toxicity (see PRECAUTIONS, Pediatric Use).

You are encouraged to report negative side effects of prescription drugs to the FDA at 1-800-FDA-1088 or www.fda.gov/medwatch
For topical use only. Please see adjacent page for full prescribing information.
For more information, visit www.kenalogspray.com

Reference:
* After spraying, the nonvolatile vehicle remaining on the skin contains approximately 0.2% triamcinolone acetonide. Each gram of spray provides 0.147 mg triamcinolone acetonide in a vehicle of isopropyl palmitate, dehydrated alcohol (10.3%), and isobutane propellant.

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Prevention of skin disease is a key aspect of treatment. Sometimes medical intervention is the only way to encourage homeostasis so that the body can begin to clear certain disorders.

Principle 3: “Structure and function are interrelated”
Principle 4: “Rational treatment is based on understanding of the 3 main principles”

Osteopathic Manipulative Treatment
- Certain skin disorders may be treated by OMT
  - Neurocutaneous disorders
  - Edematous conditions
  - Conditions with pruritus

**Practical Practice Management**

**Suzanne Sirota Rozenberg, DO, FAOCD**

- Negotiate
  - Negotiating payments and leases will reduce costs
  - Negotiate with staff their expected responsibilities so that you don’t need to micro-manage them
- Location
  - The best location might not be where you want to practice
  - Must take into account population dynamics and the number of other practices in the area
- Office Meetings
  - Know the names of your patients and staff
    - Makes them feel like an individual instead of just another number
  - Don’t be afraid to delegate
- Specialty Services
  - Know whether drug representatives are a nuisance or whether they are helpful

**Osteopathic Continuous Certification (OCC)**

**Lloyd Cleaver, DO, FAOCD**

- AOA Certifications
  - An osteopathic physician must first hold a primary certification in their primary specialty
  - The physician may then complete a fellowship to achieve a Certification of Added Qualifications (CAQ), which cannot stand alone, and the physician must maintain their primary certification
  - After completing a fellowship, a physician may choose to obtain additional a certification of special qualifications (CSQ), and they may then choose to only maintain the CSQ and allow their primary certification to expire
- Until OCC was developed, physicians maintained their certification through participation in CME activities and taking recertification examinations
- External factors in the past decade made it apparent that osteopathic physicians must consider performance evaluations as part of its process
- Influencing factors on the development of OCC
  - Institute of Medicine reports on quality care
  - Patient perception
  - Allopathic Maintenance of Certification (MOC)
  - AOA Clinical Assessment Program
  - Performance improvement initiatives
- Why OCC/MOC?
  - Responsibility of the profession to the public
    - Self-regulation dependent on effective and credible assessment
    - Maintain competence
      - The real goal is continuous improvement
      - Assessment drives learning
  - How will OCC affect me?
    - It is voluntary for non-expiring certifications
    - Fulfill any maintenance of licensure requirements
    - Publicly demonstrate commitment to ongoing quality and assessment
- Continuous certification goals
  - High standards of patient care
  - Provide physicians ability to asses and improve abilities
  - Transparent to public and communicate info about physician competence
- Five Components of OCC to maintain licensure
  1. Unrestricted licensure
    - One of the 50 states or Canada
    - Adherence to AOA Code of Ethics
  2. Lifelong learning/CME
    - Minimum of 120 CME credits for every three year cycle with 50 of them in the specialty area of certification
  3. Cognitive assessment
    - Specialty board exams must be taken every ten years
  4. Practice performance assessment and improvement
    - Compares osteopathic physicians’ current practice with that of national benchmarks for the specialty
  5. Continuous AOA/FAOCD membership
- Core competencies
  - Osteopathic philosophy and osteopathic manipulative medicine
  - Medical knowledge
  - Patient care
  - Interpersonal and communication
  - Professionalism
  - Practice-based learning and improvement
  - Systems-based practice
- OCC summary
  - Assures high standards for patient care
  - Demonstrates commitment to continuous improvement
  - Is practice-relevant
  - Ensures osteopathic excellence

**Great Cases from Osteopathic Institutions**

- Cindy Hoffman, DO, FAOCD: NYCOM/St. Barnabas Hospital
  - Interesting cases with unique treatments
  - Chronic red eruption with gammopathy
For eczema-prone skin

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ONE REPLENISHING REGIMEN.

Cetaphil® RestoraDerm® products are the first and only regimen with advanced ceramide and Filaggrin technology™

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Cetaphil

RESTORADERM

- Histology showed urticarial dermatitis with rare neutrophils
- Atypical bi-clonal variant of Schnitzler syndrome
- Failed treatment with anakinra but was receptive to tocilizumab
- Generalized annular eruption
- Disseminated granuloma annulare
- Treated with adalimumab
- Chronic, non-healing ulcer
- Osteoma cutis
- Treated with sodium thiosulfate injections
- Matthew Elias, DO, FAOCD: PCOM/North Fulton Hospital
- Bug beneath bathing suit: seabathers eruption of CLM
- Papular urticarial/arthropod assault on biopsy
- Located directly beneath swimsuit (versus “swimmer’s itch” which is on exposed skin)
- CLM: hookworm infection; confined to epidermis in humans and have migrating, serpiginous tracts. Biopsy will usually be negative because it will not “catch” the worm
- Treatment: ivermectin

- Stephen Kessler, DO, FAOCD: LECOM/Alta dermatology
- Pityriasis rubra pilaris
- Histology: Thin preserved granular layer; thick club shaped rete ridges; thick suprapapillary plates; alternating ortho- and parakeratosis
- Treatment:
  1. Topical steroids, topical vitamin D3 analogs, tar shampoos without improvement
  2. Trial of methotrexate at 5 mg once weekly but discontinued as patient couldn’t tolerate
  3. Acitretin at 25 mg daily and emollients but patient couldn’t tolerate side effects
  4. Ten days of 0.75 mg of dexamethasone but experienced extreme side effects
  5. Increased Acitretin dose with alternating 50 mg and 25 mg
  6. Decreased dose of acitretin
  7. Initiated adalimumab with acitretin taper but did not experience improvement for two months
  8. Developed facial rash which was cultured as staphylococcus and treated successfully with cefalexin successfully
  9. Ultimately, decreased treatment of acitretin to 10 mg with improvement

- Jenifer Lloyd, DO, FAOCD: UH/ Richmond Medical Center
- Dercum’s Disease
  - Multiple painful, fatty tumors and growths
  - Generalized overweight/obesity with chronic, painful adipose tissue
  - 98% of patients had pain; all had easy bruisability
  - Greater than three months, symmetrical and disabling, burning or aching feeling
  - Varies from discomfort on palpation to paroxysmal attacks of pain
  - Etiology is unknown; most cases appear spontaneously
  - More common in females than males; 35-50 year old onset
  - Differential diagnosis: Madelung’s disease: benign symmetrical lipomatosis, fibromyalgia, familial multiple lipomatosis, lipoedema, panniculitis
  - Diagnosis: patient history; clinical presentation; unenhanced MRI can demonstrate “blush-like” findings
  - Treatment: non-specific; symptomatic; bariatric surgery; not many good treatment options; psychotherapy

- Daniel Stewart, DO, FAOCD: St. Joseph Mercy Health System
- Stewart-Treves Syndrome on the Lower Extremity
  - Elderly female with painful bleeding cutaneous lesions in the lower extremity with past medical history significant for diabetes mellitus and chronic kidney disease
  - Histology: epithelial hyperplasia and marked diffuse hemorrhage; interanastomosing vascular channels, CD31 stain positive: atypical endothelial cells lining the endothelial lumen
Diagnosis: cutaneous angiosarcoma in the setting of chronic lymphedema (Stewart-Treves Syndrome), a rare aggressive malignant vascular tumor

Location: head and neck (50% cases); prior radiation sites; chronic lymphedema

Non-healing eschar, palpable subcutaneous masses

Treatment: wide local excision/amputation, radiation, chemotherapy, mean overall survival rate is 2.6 years

Schield Wikas, DO, FAOCD: LECOM/Tri-County Dermatology

Pustular tinea ID reaction

Autoeczematization reactions occur secondarily to dermatophyte infections possibly due to hypersensitivity reaction to the fungus; can occur in many forms

Histology: evidence of pustular superficial dermatophyte infection; GMS demonstrated numerous fungal hyphae

Treatment: resolution of dermatophyte infection

John Young, MD: Silver Falls/Western University

Trichodysplasia spinulosa

Exclusively seen in immunocompromised patients; organ transplant recipients, cancer patients on immunosuppressants or chemotherapy

PE: folliculocentric papules on central face, ears, grow central keratin spines/spicules

Treatment: no universally accepted

Reagan Anderson, DO, FAOCD: Rocky Mountain/Colorado Dermatology Institute

Germline BAP1 mutation

Chiefly dermal melanocytic proliferation with desmoplastic and Spitzoid features, consistent with a melanoma of at least 1.3mm deep

Six months later: PET/CT revealed mass on left kidney; diagnosis of clear cell renal cell carcinoma

Two years later: had red-brown papule on upper back biopsied

Found to have germline mutation of BAP1 tumor suppressor gene (BRCA 1-associated protein-1 (BAP1))

Autosomal dominant inheritance

Tumor predisposition syndrome

Distinct melanocytic tumor with fleshtoned to reddish-brown papules. Histology illustrates predominantly intradermal collection of large epithelioid cells with abundant eosinophilic cytoplasm, nuclear pleomorphism and prominent nucleoli

Adriana Ros, DO, FAOCD: Palisades Medical Center

Subepidermal mucocutaneous bullous dermatoses in renal cell transplant patient

Treatment: IV methylprednisolone at 30mg BID

Epidermolysis bullosa acquisita

Autoimmunity against collagen VII against anchorin fibrils

Tense bullae similar to BP but often trauma-induced and heal with scarring or milia

EBA vs. BP

EBA: subepidermal cleavage

DIF linear IgG and or C3 along BM

IIF: IgG/C3 at the dermal side of SSS (versus BP which has IgG/C3 at the epidermal side of SSS or both epidermal and dermal)

EBA has scarring/milia versus BP which has minimal to no scarring

Richard Miller, DO, FAOCD: NSUCOM/Largo Medical Center

Cutaneous metastasis from colonic adenocarcinoma

Patient presented with indurated, erythematous plaques

Histology: atypical neoplastic cells; CK20 was positive (indicative of lower GI tract tumors); CKX2 stain was positive (indicative of GI origin carcinoma)

Rate of metastasis 4%; poor prognosis

Modes of metastasis: lymph/hem, direct extension, implantation following surgery

Location: most commonly on abdomen

Vernon Mackey, DO, FAOCD: Advanced Desert Dermatology

Radiation induced eruptive keratoacanthoma (KA)

Treatment options: surgery/radiation: radiation chosen due to age. However, patient experienced multiple lesions on left lower leg one week after radiation

Causes of KA: UV damage, trauma, drug exposure, genetics, post-radiation

Treatment of cutaneous malignancy with intralesional injection: interferon, 5FU, methotrexate, bleomycin

Consider injection when surgery/radiation are contraindicated; also consider when treating cosmetically sensitive areas

The Art of Radiotherapy: Skin Cancer

Removal Without a Trace

David Herold, MD

Considerations of function, cosmesis, and patient preference may lead to choosing radiation therapy as primary treatment

Patient selection for definitive radiotherapy: BCC/SCC/In situ

High surgical risk patients

Postoperative management: perineural/vascular invasion, positive or close margins, multiple recurrences, lymph node metastases, “insurance” surgeon uncomfortable

Cutaneous T-Cell Lymphoma, low grade B-cell lymphoma, Merkel cell tumors, preoperative or postoperative sarcoma, kaposi sarcoma, lentigo maligna (inoperable cases), postop melanoma

Keloids (post-operative ideal)

Contraindications

Pregnancy (absolute)

Scleroderma

Severe collagen vascular diseases (SLE)

Gorlin’s syndrome

Relative contraindications

Prior radiation to exact site

Young patients (under 60 years old)

Non-compliant patient

Overview of radiation therapy

Usually performed five days per week, less than three to five minutes; painless; delivered over two to six weeks

Fractionation: dividing course of therapy into smaller pieces; small dose each day rather than single large dose. Radiation damages cellular DNA. Normal cells can repair DNA damage more effectively than cancer cells

Penumbra: importance of adding margin to lesions to account for pathologic characteristics of lesion
• Definitions of therapy beams
  • Grenz rays (10-30 KV)
  • Superficial x-rays (35-200 KV)
  • Orthovoltage (200-500 KV)
  • Megavoltage (1000-2000 KV)
• Superficial/orthovoltage units
  • Pros: Relatively inexpensive, small footprint, minimal shielding needed, basic operation, can hypofractionate
  • Cons: Best for superficial lesions, limited field sizes/shapes, high surface gradient dose
• Megavoltage
  • Pros: Long term data, can treat deep lesions
  • Cons: Expensive, size, team needed, patients usually need 15-30 daily visits

Therapeutic Update
John Minni, DO, FAOCD

• Rosacea
  • Topical ivermectin
    • Indicated for inflammatory lesions of rosacea
    • Immediate and long term efficacy
    • Excellent vehicle which boosts its anti-inflammatory benefits
    • Significant improvement over metronidazole cream
  • Brimonidine
    • For persistent facial redness of rosacea
    • Alpha 2 adrenergic agonist which leads to peripheral vasoconstriction
    • Rebound can be great in some
  • Rosacea summary
    • Extended release doxycycline or doxycycline 20 bid
    • Various topical treatments: dapsone, metronidazole gel, azelaic acid, sulfur based therapies
    • Treat seborrheic dermatitis as well
    • Be sure to examine for atopic dermatitis in patients as this will aid in vehicle of their choice

• Acne
  • Adapalene and benzoyl peroxide indicated for acne vulgaris
  • Antibiotic use: for most patients a sub-antimicrobial dose of oral antibiotics should be used. If patient is on antibiotic for more than three to six months, a new regimen should be sought
  • Minocycline: Side effects include dizziness, pigment alterations, auto-immune hepatitis, drug induced lupus
  • Doxycycline: Side effects include photodermatitis, nausea/vomiting
  • Sulfamethoxazole/Trimethoprim: Side effects include life threatening drug eruption, contraindicated with methotrexate

HS:
• Adalimumab: recently received indication for hidradenitis suppurativa; different dosing plan than for psoriasis
• Psoriasis
  • Biologics: still good safety data; still not using enough of them for our patients
  • Apremilast: indicated for plaque psoriasis; inhibitor of phosphodiesterase 4 and also of TNF-alpha in synovium; many side effects in beginning (nausea, vomiting, weight loss, diarrhea, headaches, and worsening of depressed mood)
  • Secukinumab: inhibitor of interleukin-17A; Side effects (check for TB, infections especially yeast, exacerbation of Crohn’s disease, latex allergy); third or fourth line agent currently

• Atopic dermatitis
  • Topicals: PDE 4 inhibitors; JAK inhibitors
  • Oral PDE inhibitor
  • Dupilumab which blocks IL4 an 13; has effect clinically and at molecular level

• Cutaneous oncology
  • Melanoma
    • Nivolumab (PD-1) which is part of the checkpoint inhibitors (pembrolizumab) AND ipilimumab as part of a combination therapy
    • BCC
      • Sonidegib oral treatment for locally advanced BCC
      • Same hedgehog pathway as vismodegib
      • Sonidegib study is BOLT
      • Vismodegib study is STEVIE
    • AKs
      • Ingenol mebutate: new warning about severe reactions with the use of ingenol mebutate when not used correctly
• Alopecia
  • Female patterned: spironolactone
• Onychomycosis
  • Efinaconazole topical: not very effective
  • Tavaborole:MOA leucyl-tRNA synthetase inhibition
• Urticaria
  • Oral PDE inhibitor
  • Dupilumab which blocks IL4 an 13; has effect clinically and at molecular level
  • Urticarial Dermatitis: Urticaria or a Mimicker?
Carlos Nousari, MD

• Urticarial dermatitis
  • Erythematous-edematous papules and plaques; very pruritic
  • BUT consider duration, dyspigmentary changes, constitutional/extracutaneous symptoms, clinical and lab signs
  • If interpretation: real vs. artifact; relevant vs. irrelevant; specific vs. nonspecific
  • Chronic urticaria
    • Polymorphonuclear predominant (neutrophilic)
    • Papular urticaria
      • Pruritic lesions lasting longer than 72 hours
      • With or without dyspigmentary changes
  • Urticarial phase of bullous pemphigoid

Cosmetics
• BellaFill: bovine collagen and polymethylmethacrylate: first to be indicated for correction of acne scars on face in patients under 21 years old
• Omalizumab: indicated for chronic urticaria not responsive to antihistamine therapy and indicated for allergic asthma. Results were good
  • No issues getting covered

Urticarial Dermatitis: Urticaria or a Mimicker?
Call For Papers

We are now accepting manuscripts for publication in the upcoming issue of the JAOCD. ‘Information for Authors’ is available on our website at www.aocd.org/jaocd. Any questions may be addressed to the editor at 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!

- Karthik Krishnamurthy, D.O., FAOCD, Editor
Extremely pruritic; lesions last much longer than 72 hours, increased IgE and moderate eosinophilia; lack of C3 deposition; DIF can be negative
False negative traditional DIF can be reduced to 5-10% by:
- Performing a perilesional rather than lesional biopsy
- Increased concentration of probing
- IgG4: unique IgG- also Th2; IgE does not fix complement, it upregulates IgG4

Bullous pemphigoid
- Namely early, prodromal, urticarial, eczematous phase
- Screening for both isotypes IgG and IgE class autoantibodies: DIF, IIF, ELISA; provides a better diagnostic yield
- Role of IgE directed therapy: anti-IgE monoclonal antibody combined therapy to reduce exposure of systemic corticosteroids to BP patients

Hypocomplementemic urticarial vasculitis syndrome (HUVS)
- Clinically resembles Sweet's (large urticarial plaques on the trunk)
- 30% full blown and 70% smoldering SLE. Anti C1q antibodies
- Neutrophil predominant vasculitis of dermal small blood vessels

Schnitzler syndrome
- Neutrophilic urticaria
- Monoclonal gammopathy (IgM>IgM)
- Periodic fever
- Hyperostosis, arthralgias

**Treatment**
- Lymphocyte predominant
  - anti-H1 + anti-H2 + anti-leukotriene
  - + Low dose cyclosporine or sirolimus
  - OR + omalizumab
- Polymorphonuclear predominant
  - Anti-H1 + anti-H2 + anti-leukotriene + anti-neutrophilic: colchicine/dapsone
- Urticarial bullous pemphigoid
  - Prednisone +/- mycophenolate mofetil/sodium +/- rituximab +/- omalizumab
- HUVS
  - Prednisone +/- mycophenolate mofetil/sodium +/-
  - Schnitzler syndrome
  - Anti-H1 + anti-H2 + anti-leukotriene + colchicine/dapsone thalidomide/lenalidomide +/- anakinra

**Biologic Psoriasis Update**

**Brad Glick, DO, FAOCD**

- Across all treatments with Psoriasis Longitudinal Assessment and Registry (PSOLAR), patients had a cardiovascular history; major adverse cardiovascular events don't appear to be an issue
- Drug survival: may predict treatment success
- Ustekinumab has better adherence and has greater persistence
- ERASURE trial (secukinumab): good persistence of drug displaying Psoriasis Area and Severity Index (PASI) 75 at the end of 50 weeks (some fall off at 50 weeks; higher at 12 weeks)
- FIXTURE (etanercept comparator trial): robust data; but inferior to secukinumab
- TRANSFIGURE trials: 198 patients with plaque psoriasis with nail psoriasis; showed improvement in nail psoriasis for patients on secukinumab
- GESTURE: palmoplantar psoriasis improved on secukinumab
- Tofacitinib: fairly long time to relapse (approx. 16 weeks); retreatment with drug returned patients to PASI 75
- Tofacitinib is an effective agent; has some risk with infections
- Ixekizumab: IL-17A inhibitor; 75-100 mg is optimum dosage. Side effects rare but include upper respiratory tract infections. 52-week open-label study where patients received treatment every four weeks with almost 50% of patients resulting in clear skin
- Brodalumab (IL-17 receptor antibody inhibitor): treats severe psoriasis. Very durable drug
- Anti IL-23: tidakizumab and guselkumab (fully human monoclonal antibody against IL-23; 50-100 mg is ideal treatment). Show PASI improvement
- Golimumab and certolizumab approved for RA and may be approved for psoriasis in near future
- Biosimilars: are not chemically identical to biologics; offer potentially affordable treatments. Infliximab: psoriatic arthritis and psoriasis

**Osteopathic Dermatology in an Allopathic World**

**Mark Lebwohl, MD**

- A single unified voice provides a stronger advocacy positioning for anything that we do
- About the AAD and Why It is Important to Participate
  - The AAD plays advocate to a large amount of legislation that takes place in Washington D.C.
- SGR repeal
- AAD encouraged members to write to congress
- Global period codes
  - Estimated that dermatologists would lose about $100,000 each if this ‘Global Period Codes’ were removed
- How it was stopped
  - Representative Larry Bueshon, MD (R-Indiana) and Representative Ami Bera, MD (D-CA)
  - Bipartisan letter signed by 53 Representatives to Boehner and Pelosi
- American Academy of Dermatology Association (AADA) sent 4932 emails to their Representatives and Senators since March
- SkinPAC
- AAD Political Action Committee
  - Katie Jones (Assistant Director)
- Prescription drug costs
- Dermatology, along with rheumatology, is on the top end of specialties where prescription drugs will take the greatest hit in the number of drugs that will be able to be successfully prescribed
  - How do we get this to change?
    - Public outcry
    - Ironically, our allies are lawyers
- Access to prescription drugs on the state level
- AADA is an active member of the State Access to Innovative Medicines (SAIM) Coalition
- SAIM Coalition’s purpose
- Pursue step-therapy model legislation
- Pursue legislation that limits prescription drug out-of-pocket-costs
- AADA established a Drug Pricing and Transparency Taskforce
- Examining the issues of drug pricing and transparency
- Identifying partners for collaboration
- Advocating for achievable outcomes to help patients access needed treatments
• JAK kinase inhibitors: baricitinib in the future
• Adenosine CF 101 inhibitors in the future

The Best Malpractice Defense -- Informed Consent
Clifford Lober, MD, JD

• A surgeon who performs an operation without patient's consent performs an assault on patient’s body
• Fundamental right of self-determination regarding decisions pertaining to his or her own health, including the right to choose or refuse medical treatment
• CONSENT: an agreement to undergo a procedure made by a person who has the capacity to give agreement
• INFORMED: person giving consent has the knowledge of the reasonable alternatives available, including doing nothing, and the possible complications of each; informed consent is a process
• It is NOT a signed sheet of paper
• No consent = battery
• This is a civil and criminal offense
• Legally deficient consent = negligence
• What should be in a consent?
  • Not every complication needs to be disclosed as this may overwhelm the patient
  • Postulates regarding informed consent:
    1. Assume knowledge of patient and physician are not in parity
    2. Adults in sound mind has the right to determine whether or not they will consent
    3. Patients must know alternatives to consent to treatment
    4. Patient has an abject dependence upon the physician that transcends arms-length transactions
  • Should disclose all information relevant to making a meaningful decision (such as information that particularly applies to patient; potential for treatment ending in severe disability or death; and what a skilled practitioner of good standing would provide under similar circumstances
  • Specific consent requirements (ex. California requires specific consent for collagen injections)
• Who should obtain consent?
  • It is the responsibility of the physician to explain the procedure and obtain the informed consent of the patient
  • Cosmetic patients: “promise less and deliver more”
• Consent is not release from duty; procedure must still be done the correct way

Features of good consent
• Gives patient information to make good decision
• Individualized
• Stated in plain language
• Patient had opportunity to ask questions, and they have been answered to satisfaction
• Documented
• Informed consent exceptions: emergency exception, “extension doctrine,” therapeutic privilege, waiver
• Informed refusal
  • A competent patient has the right to refuse any and all medical care

What to do when things go horribly wrong
Clifford Lober, MD, JD

• Anticipate the possibility: appropriate training, compliance with office surgery rules, informed consent, rapport with colleagues, dismiss appropriate patients
• How do I deal with the patient?
  • Check the facts
  • Do everything you can to be available
  • Intentionally show concern, compassion, and empathy
  • Do not deny responsibility but absolutely never admit liability
  • Always be honest
  • Reiterate need for procedure and any positives outcomes if appropriate
  • Clear up misunderstandings
  • Mitigate damages
  • Consider offering a second opinion
  • Inform your malpractice insurance carrier
• Retain health care attorney
• Should you apologize?
  • It depends--do you come across as sympathetic or arrogant?
  • “Apology laws” prohibit expressions of regret, sympathy, or benevolence from being entered into evidence. Document apology in the chart
• Duty to notify a patient: timely, proper setting, accurate information, factual, responsive, document
• Medical records: never alter the records; never release original records--send copies; personally review what is sent out of your office
• Dealing with yourself: discuss situation with attorney; consider psychological counseling if emotional response is strong or persistent. Be careful of how you discuss with spouses and colleagues
New Updates in Pediatric Dermatology
Lisa Swanson, MD

- Atopic dermatitis
  - Standard treatment: sensitive skin care; topical steroids
  - Scalp options: DermaSmoothe oil at bedtime; clobetasol foam
  - Steroid sparing agents: Tacrolimus-generic; Elidel-philidor; black box warning (newest studies show no association between malignancy and pimecrolimus; patients with atopic dermatitis have slight increased risk of lymphoma)
  - Natural therapy: coconut oil (has good antibacterial properties but doesn't seem to help with eczema itself); sunflower seed oil (does seem to help with eczema)
  - Prevention of atopic dermatitis:
    1. If pregnant woman takes probiotics two weeks prior to having baby and for three months after having the baby, it reduces the risk of eczema in that baby by 20s-30s.
    2. Vitamin D: patients with vitamin D had more staph colonization
      - New therapies: AN2728 (boron based ointment); oat based sterile emollient cream
      - New therapies: Topical tofacitinib (JAK one-third inhibitor); cyclosporine weekend therapy; dupilumab (anti-IL-4)
  - Allergic contact dermatitis
    - Wet wipe dermatitis; Easter egg hunt dermatitis (nickel in chocolate)
  - Psoriasis
    - Topical steroids continue to be mainstay. Etanercept approved in US for kids with juvenile idiopathic arthritis (JIA) over two years; adalimumab is approved in US for kids with JIA over two years old and Crohn’s over six years old
    - Paradoxical psoriasis in kids on TNF inhibitors
  - Molluscum
    - Eclipse nevi: benign and common but often biopsied because of atypical coloring
    - Congenital melanocytic macules of the tongue: observe as benign
    - Alopecia areata treatments
      - Pulse IV methylprednisolone
      - Low dose IL-2
      - Fexofenadine
      - Tofacitinib being examined currently in two studies
      - Ruxolitinib being used in current trials
  - Nails
    - 20 nail dystrophy of childhood: 82% improve over time but some can persist up to a decade
    - Pediatric onychomycosis: evaluate for tinea pedis; treat with terbinafine for three months
  - Vascular lesions
    - Port wine stains: GNAQ gene mutation; pulsed dye laser treatment can cause permanent alopecia; topical rapamycin + pulsed dye laser is most promising combo but cost of topical prep is an issue
    - Hemifacial V1/V2 is most common site for port wine stain
    - Capillary malformation arterovenous malformation syndrome: RASA1 gene mutation; autosomal dominant; ultrasound any large or growing malformations
    - Patients should see neurologist, cardiologist, and orthopedist for evaluation
    - Infantile hemangiomas: propranolol is still helpful but note that it can cause hypoglycemia
      - Typically used during proliferative stage
    - Pyogenic granulomas: timolol provided great results with clearance after two to three months with the bleeding stopping instantly
      - Important to follow up to ensure improvement (as Spitz nevi and melanoma are on differential)
  - Genodermatoses
    - Neurofibromatosis I: nevus anemicus is newly discovered feature; tends to be on chest
    - Rapamycin: mTOR inhibitor; has immunosuppressant, anti-proliferative, and antiangiogenic properties
Vitiligo
- Rapidly progressive vitiligo: can treat with three weeks of oral prednisone to stop the flare
- Segmental vitiligo: excimer laser + protopic + short term oral steroids yielded best results

Rashes
- Lichen sclerosus: doesn't go away for most girls after puberty; treatment with clobetasol ointment bid for two weeks then once daily for two weeks, then follow-up; repeat course if needed until clear; then clobetasol MWF once daily for maintenance
- Hand foot and mouth disease: Coxsackie A6 is new primary causative agent; produces more severe rash
- Morphea: can mimic acquired port wine stain (very rare)

Mycoplasma associated SJS/EM Major: oral steroids are better than IVIG

Pigmented purpuric dermatoses: most common is Schamberg's purpura; idiopathic and treatment is difficult; self-limiting but can treat with topical steroids and UV light
- Herpes zoster: seen in children younger and younger
- Hemorrhagic edema of infancy: impressive rash but not serious; likely virally triggered; juicy red papules and plaques on face and distal extremities; self-limiting but can treat with prednisone
- Hyperkeratotic lichenoid papules of elbows and knees: kids outgrow it; can treat with AmLactin

Spots
- Pilomatrixomas: very common calcifying cysts; due to gene mutation in CTNNB1 which encodes beta-catenin; positive teeter totter sign
- Cranial dysraphism: any subcutaneous growth on head of infant can raise suspicion for this
- Lumbosacral dysraphism

Pyoderma gangrenosum
- Incidence is unknown; trauma can aggravate or produce a new lesion
- Clinical variants: ulcerative (most common), pustular, bullous, vegetative
- Pathery can develop
- Most common site is lower extremities
- Therapy: compresses/antibacterial agents/occlusive dressings; topical/intralesional steroids; cromolyn 2-4%; benzoyl peroxide; radiation; grafts; TOC cyclosporin
- Infliximab is possible treatment option
- Use of maggots to debride necrotic tissue (don't leave dressing on for longer than 48 hours)
- Gevokizumab (IL-1 beta inhibitor)
- Dermatomyositis
- Treatment: mycophenolate mofetil
- Generalized lichen sclerosis et atrophicus
- New therapeutic options: excimer laser, PDT, acitretin
- Intravascular B-Cell Lymphoma
- RCHOP; rituximab as both initial and salvage therapy
- Follicular center cutaneous b-cell lymphoma
- Treatment with excimer laser; other possibilities include interferon alfa injections, rituximab, chlorambucil
- Kaposi sarcoma

What is an Osteopathic Dermatologist Anyway?
Reagan Anderson, DO, FAOCD and Teodor Huzij, DO, FACN

Larkin Community Hospital Grand Rounds Cases
Francisco Kerdel, MD
- To share a case at grand rounds, email LarkinDermGR@gmail.com

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Actinic Keratosis
- Keep in mind the psychosocial components a patient with any dermatological condition might experience:
  - Depression, anxiety, lack of confidence.
  - Consider a patient’s experience as they go on a date, have a job interview, or large family function
- Treatments as they apply to the osteopathic principles
  - Cryotherapy: inducing localized destruction encourages the body to initiate its self-healing mechanisms
  - Light and field therapy: Certain medications or approaches will modulate the immune system in a way that encourages self-healing and works on the actual problem, rather than just symptoms
- Psoriasis
  - Immune modulators encourage the body to initiate its own self-healing mechanisms
- Acne
  - Antibiotics don't fully consider the osteopathic principles. They are temporary solutions and don't treat the underlying structure and function pathology (keratinization and prevention of oil motility). They are still good treatment options for short term, but consider longer-term options
  - Low glycemic index, (and possibly less dairy use) are more in line with an osteopathic approach to treatment
- It is important as osteopathic dermatologists to not forget our osteopathic training. Some DOs don't always use the osteopathic philosophy in their practice
  - The body is a unit; the person is a unit of body, mind, and spirit
  - The body is capable of self-regulation, self-healing, and health maintenance
  - Structure and function are reciprocally interrelated
  - Rational treatment is based upon an understanding of the basic principles of body unity, self-regulation, and the interrelationship of structure and function

Keep the osteopathic philosophy in mind as you treat patients
- Think if there are other treatments that are more in line with our osteopathic training
The Foundation for Osteopathic Dermatology is accepting applications for research grants. Click here to visit the Foundation page for more information.

The FOD instituted a research grants program to encourage and support scientific investigations into the potential causes of dermatological issues and other key aspects of various dermatological conditions. Research grants are provided to encourage improvement in its treatment, potential prevention and/or cure in the related dermatology field.

Applications will be entertained from osteopathic physicians in postdoctoral training programs and research fellowships in dermatology. Each grant supports one individual. Not more than two consecutive or non-consecutive grants may be awarded to an individual.

The grant is not exclusive and the investigator may seek additional funding from other sources such as the AOA Bureau of Research, governmental agencies, other outside agencies, college or hospital, etc.

All requests for grants are submitted in accordance with established guidelines and deadlines for the individual grants and are subject to review by established procedures of the Board of Directors of the Foundation. All areas of dermatology research will be considered based on their scientific merit. Researchers interested in applying for a research grant can download the application from the American Osteopathic College of Dermatology’s website.

There are multiple grants available to an osteopathic dermatologist. They include:

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

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

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

- **The FOD Institutional Grant** is awarded to an osteopathic physician who is certified in dermatology and providing care in a developing country. The purpose of this grant is to foster research among young dermatologists and is awarded to promising physician researchers meeting these criteria.

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

Submission Information
Applications must be typewritten or printed and contain all of the following:

1. Curriculum vitae: Limited to four pages. Include the following, listed in chronological order: employment, positions and honors, selected peer-reviewed publications (do not include publications submitted or in preparation), research experience;
2. A photo portrait (head and shoulders) of the applicant;
3. Budget: A budget detailing how the funds will be used;
4. Research proposal containing the following:
   - Introduction: Include description of the general concepts of the project, background information, preliminary work and observations or reference to existing literature;
   - 5. Major Methods: A detailed description of the research plan including methods and controls. Include a description of the proposed experiments or procedures; the techniques to be used; the number and type of subjects; the control population; the types of data expected to be generated; and the means by which the data will be analyzed and interpreted;
   - 6. Analysis of Results: Present an overview of the planned analysis and summary of the data;
   - 7. Conclusion: Provide a description of the significance of this research to the field of dermatology medicine (philosophy or practice) in general;
   - 8. Project Summary: The summary should provide a concise overview of the project (limited to one page).

Incomplete applications will not be accepted. Applications received after the deadline date will be returned unread.

Applications must be received by December 31 of each year to be eligible for consideration.

Applications for research grants are reviewed for validity and efficacy by the Board of Trustees of the Foundation. The Board will determine the selection of grant applicants and the amount of grant monies allocated based on funds available in the grant category. All applicants will be notified of the receipt of their application within ten days by the executive director.
Applicants receiving grants for any of the programs described in this brochure will receive their grant monies in two or more payments. At the end of the fiscal year, appropriate tax forms such as a 1099 will be sent.

Applicants will be ineligible to apply for subsequent grants for one year after receiving a grant.

Grant recipients are required to submit a report after 6 months and upon completion of the project as well as a full reconciliation of funds dispersed.

The Foundation for Osteopathic Dermatology members are Brad Glick, DO, Eugene Conte, DO, Gregory Papades, DO, John Minni, DO, Dwayne Montie, DO, Bryan Sands, DO, Jon Keeling, DO, Suzanne Sirota Rozenberg, DO, and Marsha Wise, AOCD Executive Director.

The Foundation approved the following grants in 2015:

• “Autoimmunity in Primary Cutaneous Lymphoma and Pseudolymphoma”
  Stephen Delost, Case Western Reserve Hospital, Cleveland, OH
• “Dermoscopy Research”
  Alexis Stephens, DO
• “Genomic Characterizations of Melanomas in the Hispanic Population”
  Karthik Krishnamurthy, DO
• “A Randomized, Double-blind, Multicenter Study of the Efficacy and Safety of AbobotulinumtoxinA Reconstituted up to 10 Weeks Prior to Injection”
  Matthew Zarraga, DO

Recently the Board of Trustees of the Foundation approved a new level of giving. The Pinnacle Table joins the already established levels of the Ulbrich Circle, the Koprince Society, the Leaders of Osteopathic Dermatology, the Scholars Circle and the Resident’s Forum.

Become a donor to one of the fastest growing Foundations in Osteopathic Medicine, the Foundation for Osteopathic Dermatology! Through your pledge, the Foundation can achieve its’ goals of providing public health information, funding research and charitable contributions! We can only do it with your support of a tax-deductible donation.

Categories Available:

• **Pinnacle Table** $25,000
  ($5000 per year over a five year period)
• **Ulbrich Circle** $10,000
  ($1000 per year over a ten year period)
• **Koprince Society** $1000
• **Leaders of Osteopathic Dermatology** $500
• **Scholars Circle** $250
• **Residents Forum** $100

The Foundation also updated its by-laws. Click here to view the recently revised by-laws.
Corporate Spotlight

Corporate Sponsors Support Fall Meeting

I appreciate having had the opportunity to thank several of our corporate sponsors for their continued support of the College and to welcome new exhibitors at the 2015 Fall Meeting. All the exhibitors where happy with the layout of the room and the time spent with the attendees. I have received positive feedback from several exhibitors. The AOCD is very fortunate to have corporate sponsors who join us as partners with a commitment to medical excellence. Our corporate sponsors remain committed to the College and continuing medical education (CME). It goes without saying that our corporate sponsors are critical to helping us accomplish our mission.

New and returning corporate sponsors are as follows:

- Galderma, Sun Pharma, Valeant Pharmaceuticals (Diamond Level)
- AbbVie, Celgene, Merz Pharmaceuticals, LLC (Gold Level)
- Lilly USA, LLC (Silver Level)
- Anacor Pharmaceuticals, DLCS (Bronze Level)
- Actavis, plc, Allergan, Dermath Diagnostics, DUSA Pharmaceuticals (Pearl Level)

In addition to corporate membership, Sun Pharma, has had a long relationship with the College and continues to support us through generous sponsorships. Sun Pharma’s most recent sponsorship was for the Presidential Celebration that was held Friday, October 16, 2015 at the Wantilan Pavilion. The Presidential Celebration gives exhibitors and physicians the opportunity to meet in an informal setting. We appreciate everything Steve Hecklein and Sun Pharma is doing for the College and CME.

Dermatopathology Labs of Central States (DLCS) sponsored our meeting t-shirts and bags.

LEO Pharma sponsored our meeting lanyards. Lilly USA, LLC sponsored the Resident Research Paper Competition. Dermath Diagnostics sponsored a resident dermatopathology review with Dr. David Barron. Allergan and Valeant Pharmaceuticals provided support by way of unrestricted grants to help support the meeting. The AOCD is grateful for the continued support from these companies in making our meetings a success.

The AOCD also appreciates the following company for providing breakfast Product Theater, Lilly USA, LLC. The breakfast lecture was given by Dr. Brad P. Glick on Friday, October 16, 2015. Dr. Glick spoke on The Pathophysiology of Psoriasis and the Role of the IL-17 Family.

Exhibitors for the 2015 Fall Meeting were as follows: AbbVie, Allergan, Aqua Pharmaceuticals, Aurora Diagnostics, Bayer Healthcare, Capillus, LLC, Celgene, Dermath Diagnostics, DLCS, DUSA Pharmaceuticals, Elekta, EZDERM, Galderma, Genentech, Heartland Payment Systems, IntraDerm Pharmaceuticals, Janssen Biotech, Inc., Leo Pharma, Lilly USA, Inc., Medimetriks Pharmaceuticals, Merz North America, Modernizing Medicine, Novartis Pharmaceutical, Promius Pharma, Sensus Healthcare, Sun Pharma, Inc., Syneron/Candela, Taro Pharmaceuticals USA, Inc., Topix Pharmaceuticals, and Valeant Pharmaceuticals.

We hope that many of you had an opportunity to express your appreciation to our sponsors while you were in Orlando. The fact that they continue to support the College, many of them doing so for several years, speaks volumes about the value of their commitment to our organization.

New Fall Meeting Exhibitors — Orlando, FL

Genentech — Considered the founder of the industry, Genentech, now a member of the Roche Group, has been delivering on the promise of biotechnology for over 35 years. Genentech became a member of the Roche Group in March of 2009. As part of their merger agreement, Roche and Genentech combined their pharmaceutical operations in the US. Genentech’s South San Francisco campus now serves as the headquarters for Roche pharmaceutical operations in the US. Genentech Research and Early Development operates as an independent center within Roche.

Genentech is a leading biotechnology company that discovers, develops, manufactures and commercializes medicines to treat patients with serious or life-threatening medical conditions. We are among the world’s leading biotech companies, with multiple products on the market and a promising development pipeline. Their website is: http://www.gene.com/.

IntraDerm Pharmaceuticals — IntraDerm is a specialty pharmaceutical company focused on innovative technologies and drug delivery platforms. Our mission is to develop high quality dermatological products that are affordable and accessible to most every patient. Their website is: http://intraderm.com/.

Medimetriks Pharmaceuticals, Inc. Medimetriks is a leading independent specialty pharmaceutical company dedicated to Dermatology and Podiatry markets. Medimetriks is committed to advancing patient care through the development, licensing and commercialization of innovative prescription skin care brands that fill unmet needs in the market. Medimetriks current portfolio of brands, which are promoted by our national sales force, treat conditions including acne, rosacea, atopic dermatitis, fungal infections, dystrophic nails and impetigo. Medimetriks is experts in commercialization, including creating brands, maximizing life cycles and generating value for biotech, generic and other development companies that may benefit from the depth and breadth of our relationships in Dermatology and Podiatry. Their website is: http://www.medimetriks.com/.

Sensus Healthcare — At Sensus Healthcare, we are devoted to making a difference in the lives of people who suffer from nonmelanoma skin cancer and unsightly keloid scarring. By designing and manufacturing safe and reliable state-of-the-are superficial radiation technology right here in the US, we are providing compassionate dermatologists and oncologists around the world with a non-surgical treatment option that empowers them to cure patients without compromising patient confidence, dignity or...
quality of life. Their website is: http://sensushealthcare.com/.

Topix Pharmaceuticals - For over 30 years, Topix Pharmaceuticals Inc. has remained dedicated to excellence, beginning with the research and development of quality skin care formulations. Topix products are developed using the highest quality, pharmaceutical grade ingredients; manufactured and tested to deliver safe, effective, results for all patient skin types. Topix chemists closely monitor and control each step of product development and manufacturing in our state-of-the-art, FDA registered manufacturing facility. Our outstanding skin care professional sales department and customer service representatives are committed to providing ongoing training, service and support for dermatology and plastic surgery skin care specialists. Topix offers an extensive product portfolio which provides physicians with numerous product options, enabling them the ability to provide “patient skin-type” and “condition driven regimens.” Their website is: http://topixpharm.com/.

2016 AOCD Spring Meeting
March 31 - April 3 | Ritz Carlton Battery Park | New York, NY
Invited Speakers and Topics

Surgical Repair Panel
Reagan Anderson, DO & Michael Whitworth, DO

Allergic Contact Dermatitis: North American Standard Series, Parts 1-3
Peter Saitta, DO

Psoriasis Co-Morbidities
Jerry Bagel, MD

Answers to Your Questions About Psoriasis
Mark Lebwohl, MD

Dermatopathology Update
Amy Spizuoco, DO

Pearls of Group Practice
Steven Grekin, DO

Use of PA’s in Successful Dermatology Practice
John Minni, DO & Jeff Johnson, PA

Effective Therapies in Melanoma
Anna Pavlick, DO

Cosmetic Dermatology
Suzanne Sirota Rozenberg, DO

Occupational and Environmental Dermatology
David Cohen, MD

Interesting and Educational Dermatological Cases
Stephen Purcell, DO

Atopic Dermatitis Update
Brad Glick, DO

Adherence to Treatment
Steve Feldman, MD

Therapeutic Update
James Del Rosso, DO

My Approach to Cosmetic Dermatology
Laura Benedetto, DO

Superficial Radiotherapy Updates
David Herold, MD

Medicare Fraud and the False Claims Act
Ted Schiff, MD

Dermatology Rheumatology
Adam Friedman, MD

Pediatric Dermatology
Sourab Choudhury, DO

Manifestations and Treatment of Cutaneous Venous Hypertension
Ronald Bush, MD

Dermatopathology
Michael Nowak, MD

Challenging Dermatologic Therapies and Management
Joseph Jorizzo, MD

Click here for complete meeting schedule and lecture times
Hello everyone,

It was great to see all the second- and third-year residents again and to meet our new residents. I hope you enjoyed the lectures and had a great time catching up with friends and networking with new colleagues.

Many people put in a lot of time and work to make this meeting all that it was. Thanks to Dr. Alpesh Desai and Marsha Wise for the many hours they spent putting together the program. A special thanks to our wonderful student ambassadors for the Fall Meeting, Laura Jordan, DO; Brandon Basehore, OMS-IV; and Shane Swink, OMS-II. Each was instrumental in allowing us to accommodate over 500 attendees at the meeting and went above and beyond what was asked. We couldn’t have asked for a better team.

2016 Resident Membership Renewal

With a new membership year approaching, it’s not too early to begin thinking about renewing your annual dues. These can be paid online through your member account at www.aocd.org. You can quickly and conveniently renew your membership online using these five easy steps:

1. To get started, click sign in at the top of the homepage.
2. Enter your username and password, and click sign in. [Note: If this is your first time signing in, you will be taken to a screen prompting you to verify your member profile options. Make any desired changes, click the Save Settings button, and proceed to Step 3.]
3. Click the yellow *** Renew Your Membership Now *** banner
4. You will be prompted to update your contact information. If you have any changes, enter updated information in the appropriate field. When finished, click the Save Changes button.
5. Enter your billing and payment information, and click the Submit Securely button.

If you have any problems logging in, please contact us and we will help you.

In-Training Exam

You should have received your scores from the 2015 In-Training Exam at the end of November or the beginning of December. The results are sent to all participating residents and their Program Directors. If you have not received your results, please contact me, and I will re-send them to you.

New Resident Liaison Named

Congratulations to Lacey Elwyn, DO, the new resident liaison for the 2015-2016 residency year. Dr. Elwyn is a second-year resident in the St. Barnabas Hospital program under the directorship of Cindy Hoffman, DO, FAOCD.

Grand Rounds Online

Each residency program, once again, is asked to provide a case for the Grand Rounds website. The 2016 schedule is as follows:

- January 5, 2016
  - OPTI-West/Chino Valley Medical Center
- February 5, 2016
  - LECOM/Alta Dermatology
  - Northeast Regional Medical Center
- March 5, 2016
  - Lehigh Valley Health Network
  - University Hospitals Regional Hospital
- April 5, 2016
  - O’Bleness Memorial Hospital
  - Botsford Hospital
- May 5, 2016
  - Oakwood Southshore Medical Center
  - West Palm Hospital
- June 5, 2016
  - St. Barnabas Hospital
  - St. John’s Episcopal Hospital
- July 5, 2016
  - NSUCOM/Largo Medical Center
  - UNTHSC/TCOM
- August 5, 2016
  - PCOM Mednet/North Fulton Hospital Medical Campus
  - OMNIE/Sampson Regional Medical Center
  - Palisades Medical Center
- September 5, 2016
  - St. Joseph Mercy Health System
  - Advanced Desert Dermatology
  - Affiliated Dermatology
- October 5, 2016
  - NSUCOM/Broward Health Medical Center
  - South Texas Osteopathic Dermatology
  - NSUCOM/Larkin Community Hospital
  - Texas OPTI/Bay Area Corpus Christi Medical Center
- November 5, 2016
  - LECOM/Tri-County Dermatology
  - OPTI-West/Aspen Dermatology
  - MSUCOM/Lakeland Regional Medical Center
  - LECOMT/Dermatology Residency of Orlando
- December 5, 2016
  - LewisGale Hospital – Montgomery/VCOM
  - WUHS/Silver Falls Dermatology
  - Colorado Dermatology Institute
  - CEME/Park Avenue Dermatology

The chief resident from each program is responsible for making sure that a case is submitted. He or she must notify the AOCD when it is submitted. Please contact me for the sign-on information to submit a case.

Be sure to check out the Dermatology Grand Rounds on our website at http://www.aocd.org/?page=GrandRounds.

I hope everyone has a happy and safe holiday season with family and friends. I hope to see you in New York for the 2016 Spring Meeting.
Now Hiring
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- Full benefits

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General/Cosmetic Derm Opportunities:
Full time

- Denver, Colorado
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- Deland, Florida
- Lakeland, Florida
- Ft. Myers, Florida
- St. Pete, Florida
- Towson, Maryland
- Traverse City, Michigan
- Petoskey, Michigan
- Dayton, Ohio
- Beavercreek, Ohio
- Mason, Ohio

Mohs* Opportunities:
Full time

- Dayton, Centerville and Mason, Ohio
- Philadelphia, Pennsylvania
- Orlando, Florida

* Multiple offices and Dermatologists feed into the Mohs surgery schedule

For immediate consideration, send your CV today!

Submit CV to Christie Knowles at crystal.knowles@leavittmgt.com or call 904-509-8537.