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Upcoming Events

AOCD MIDYEAR MEETING 2010
April 14-17, 2010
Sedona, AZ

AOCD ANNUAL MEETING 2010
October 24-28, 2010
San Francisco, CA

Contribute to DermLine
If you have a topic you would like to read about or an article you would like to write for the next issue of DermLine, contact Ruth Carol, the editor, by phone at 847-251-5620, fax at 847-251-5625 or e-mail at RuthCarol1@aol.com.

Update Contact Information
Is your contact information current? If not, you may be missing need-to-know news from the AOCD. Visit www.aocd.org/membership. Enter your username and password then click the “Login Now” button.

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Message from the President

I am looking forward to serving as your 53rd president. During my term of office, it will be my goal not only to preserve, but strengthen our organization.

We as a College have come a long way as has the osteopathic profession. As a profession, we arose from a Missouri man’s disbelief in the current medical dictum of his day. Andrew Taylor Still, M.D., became Andrew Taylor Still, D.O., standing by his convictions against the criticisms of his MD peers. It took nearly a century to overcome Dr. Still’s detractors to prove his actions and beliefs were indeed correct. Here we all are, my fellow members of the AOCD, descendants of a true Maverick MD.

Our College has been nonetheless brave for it was only at the persistence and dedication of our founding members and their subsequent residents that we are here today with 19 AOA-approved dermatology residency programs with one more just approved by our Education Evaluation Committee. It is exciting to note that the AOCD has approximately 100 dermatology residents graduating every three years. This is a monumental accomplishment given that when I applied for my dermatology residency in 1985 there were only two osteopathic dermatology residency programs.

We all know that we stand on the shoulders of those who have come before us. They have made our professional lives easier and fuller and now, with some exceptions, equal to our allopathic peers. I will strive over the next year to protect and preserve what we have already accomplished as a College and to advance and secure our mission and our equality as osteopathic dermatologists.

Advancing forward can only be accomplished when you know from whence you came. That is why I would like to restore and preserve on the AOCD’s website the dynamic history of the College. This will enable new and not-so-new members to be proud of, and not take for granted, what the AOCD has accomplished from its fragile, humble beginnings to its flourishing present as the direct result of the dedication of our very few founding members who took it upon themselves to personally provide one-one-one training for their residents.

Moving forward, I also will strive to be open and receptive to your needs and concerns as members of our College. However, if you do not voice those needs or concerns to me or your Board of Directors, then we will not be able to act on them. Anyone can make disparaging comments or criticisms that are neither helpful nor productive. But your Board of Directors needs to hear from you about what direction you want your College to take. We need your support…not just your monetary commitment in running our College, but in helping to guide its future and in preparing it for the needs of our future members. Our College’s effectiveness and survival depends on that support. So, as your new president, I am going to paraphrase what another new president challenged more than 49 years ago: ask NOT what your College can do for you, but what you can do for your College. It is your new Board of Directors’ hope that the members of this College will take a little time from their busy practices to help our College be all it can be for our membership.

Finally, in this new millennium, it is our obligation to educate our patients, the public, and future medical professionals about what we do as osteopathic dermatologists. In tribute to Dr. Still, each one of us should be a maverick in regard to our profession with a persistence and dedication in promoting the ideals of osteopathic dermatology.

Marc Epstein, D.O., FAOCD

AOCD President, 2009-2010
Executive Director’s Report
by Becky Mansfield, Executive Director

Greetings from the national office. The leaves are turning and the wooly worms are starting to appear in Missouri. This is a sure sign that fall is here and winter isn’t far behind.

Staff at the national office has been busy since the last newsletter planning for the Annual Meeting and putting the In-Training and Board Examinations together.

The Annual Meeting in New Orleans was a success. Dr. Epstein put together a well-rounded educational program for our membership. It was a pleasure to see so many of our members in attendance at the lectures and functions. The night at the Pharmacy Museum was a great success.

The Saturday before the conference began, the Program Directors, Education Evaluation Committee, Program Inspectors, and the AOBD met concurrently.

Twelve new student members have been approved since the Annual Meeting. I have talked with many students regarding their interest in the College. It was my pleasure to meet so many of our student members in New Orleans.

Congratulations to Drs. Dan Hurd and Monte Fox on their Fellow of Distinction awards presented at the annual awards ceremony during the Presidential Banquet. They have served the AOCD well and are to be commended for their commitment to our College.

I am looking forward to Dr. Jim Towry’s program slated for April 14-17, 2010 in Sedona, Ariz. This will be a great setting for our attendees and I encourage everyone to attend.

In closing, I wish everyone a joyful holiday season.

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

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Message from the Past President

I want to thank members of the AOCD for giving me the opportunity to be your president this year. It has been both rewarding and challenging. I am very appreciative and thankful for those who have preceded me, and want to acknowledge those who have given countless hours of time and energy to make our College great. I only wish I could name each of you individually and thank you for your outstanding contributions.

This year, I have gained an appreciation of the need for political involvement at the national, state, and organizational level. Change as promised by our leaders is inevitable. Healthcare reform will definitely impact the way we have traditionally practiced medicine. Although our direct reimbursement represents a small part of the healthcare dollars, we are an easy political target. At times, we enlarge the bull’s eye by our lifestyle, attitudes, and indulgence. However, it is unfair to single out our reimbursement as a leading cause for our healthcare crisis. Many people are actively working to restore and enhance our image politically. I encourage you to join those organizations and to encourage our patients to be vocally active in the issues we see as critical to providing quality health care.

The AOA has been given the duty of verifying maintenance of our certification. This will become an increasingly hot topic in the coming months. At the last annual Board of Trustees and House of Delegates meeting, the AOA put each specialty college in charge of developing a plan to verify certification of their members. This will certainly affect us all.

Within our own specialty, the introduction of an amendment of procedural subcertification threatened to further divide dermatologists and create another obstacle for the delivery of health care. If not for unprecedented grass root efforts, this amendment would surely have passed. I want to thank each one of you who wrote letters, became active in local societies, and spoke to many leaders at the AAD who opposed this proposed certification.

As a College we passed yet another milestone with the acceptance of 100 new dermatology residents this year. Our residency programs are becoming stronger and the training residents receive much broader than in years past. I am proud of all of our program directors and their staff for leading this charge. The future of the AOCD is certainly found in our new graduates.

I again want to thank you for allowing me the opportunity to serve as your president this year. It truly has been an extraordinary year. I have grown both personally and professionally from this experience. I have enjoyed getting to know so many of you and hope to continue to foster these relationships as time goes on. I plan to stay involved in the AOCD and encourage each of you to do the same. Thank you again. I want to wish Dr. Epstein all the best. I know he will serve the College well and will be an asset in this time of change.

Donald K. Tillman, D.O., FAOCD
Immediate Past President
This spring, the American Academy of Dermatology (AAD) will vote on a bylaws change that would grant Osteopathic Fellows their own membership category.

The addition to the bylaws would add an eleventh class of membership in the AAD. The Osteopathic Fellows would have the same rights of membership as the Fellow class.

Regarding the eligibility requirements for, and the rights and obligations of, the Osteopathic Fellow members, the bylaws would read as follows:

“Any osteopathic dermatologist who is a resident of the United States of America or Canada and who is certified by the American Osteopathic Board of Dermatology but whose training does not make him or her eligible for certification by the American Board of Dermatology or for certification in dermatology by the Royal College of Physicians and Surgeons of Canada shall be eligible to be an Osteopathic Fellow. Osteopathic Fellows shall have all the rights of Fellows. Osteopathic Fellows shall be obligated to pay all dues and assessments imposed on Fellows under Article XI of these bylaws and shall be obligated to observe all bylaws and administrative regulations of the Academy.”

If the amendments are passed, becoming an Osteopathic Fellow member will require an applicant to have successfully completed the examination in dermatology of the American Osteopathic Board of Dermatology and submit an official application form.

In October, the AAD requested its members to submit statements expressing support or opposition to the proposed amendments by December 1. The spring 2010 election ballot is expected to contain those statements.

Have you been asked to participate in a physician survey?

If so, you have the opportunity to partake in the first multi-specialty survey of America’s physician practices in nearly a decade. This survey is a coordinated effort between the AOA, the American Medical Association (AMA), and more than 70 other healthcare professional organizations.

It is designed to collect current characteristics of thousands of physician practices from virtually all specialties. Specifically, the survey is focused on collecting information on practice characteristics and provider hours worked.

The survey also seeks to quantify common professional expenses associated with medical practice (during 2006), participation in Medicare, and common characteristics of managed care plans. In addition, it explores current topics of national interest such as medical malpractice coverage and the use of electronic medical records. All of this information will remain confidential as no individuals or entities participating in this research will be identified.

The data will be used in efforts to positively influence national decision makers to ensure accurate and fair representation for all physicians and patients, according to the AOA. The data also will be used to further develop and refine AOA and AMA policy.

One section of the study that pertains to practice expenses and the amounts attributable to the physician is of particular importance to the Centers for Medicare and Medicaid Services (CMS), which has indicated that the results will be used to help determine physician payment. Practice data currently being utilized by the CMS and Congress are nearly a decade old for most specialties and therefore, are an inaccurate reflection of current experience.

The firm Dmrkynetec, which has extensive experience in collecting medical practice information, has been retained to administer the survey. The firm is contacting randomly selected physicians and practice managers.

A summary of the study may be published in the AOA’s publication, The D.O., as well as posted on its website www.do-online.org. In addition, survey participants will receive a data summary containing highlights of the study results.
Monte Fox, D.O., FAOCD, and Daniel Hurd, D.O., FAOCD, received the honorary title Fellow of Distinction at the 2009 AOCD Annual Meeting.

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

“I am very honored and humbled at the same time for this award,” said Dr. Fox. The Fellows of Distinction who have preceded me with this honor have done so much for the AOCD. My contribution to our College is only a small part of all the sacrifices that the Fellows of Distinction have given to our College throughout the years. I am privileged to be included among these members.” Dr. Fox has been an AOCD member since his residency in 1991. He trained under Eugene T. Conte, D.O., FAOCD.

Also trained by Dr. Conte, Dr. Hurd said of the honorary title: “The night I received this honor, I felt extreme pride to be included into such an exclusive group of outstanding individuals who have contributed so much to the AOCD and to dermatology as a whole. I was humbled. These individuals are my mentors and I would do well to continue to follow their lead.” Dr. Hurd has been an AOCD member since 1996.

To date, 49 members have been granted the title of Fellow of Distinction.
Members attending the AOCD Annual Meeting in New Orleans gathered to the sounds of a live jazz band at the Welcome Reception and even got a glimpse of Mardi Gras at the Presidential Banquet.

At this year’s meeting, guest speakers presented in the mornings on Monday, Tuesday, and Wednesday. Residents lectured on Tuesday and Wednesday afternoons.

A two-hour live aesthetic patient workshop using Botox® and fillers kicked off the Annual Meeting planned by Marc Epstein, D.O., FAOCD, who was sworn in as the 2009-2010 AOCD President at the banquet.

Applying for a Residency Program
But before the workshop got underway, Resident Liaison Reagan Anderson D.O., MPH, MCS, informed residents how to apply to a DO dermatology residency. After reviewing the programs and rotations, he focused on the application, personal statement, interview, and conferences.

“If you have more than one page, it’s too much fluff,” said Dr. Anderson referring to a CV. Volunteering and research grabs his attention as does a well worded and typo-free document. “The content should be perfect. If there are typos, I dismiss the whole application,” he stressed. Why? Patients demand exact results. “If you can’t spend enough time to proof your application, I don’t want you working on my skin,” noted Dr. Anderson. Give the CV to 10 different people over a couple of months to review. Finally, respect the deadline. If it’s turned in late, it’s out, he said.

The personal statement is where the resident should express his/her passion about practicing dermatology. What excites you about dermatology? Why do you want to do it? Why will my staff love you? Why will the patients weep when you go off to start your own practice? Why you? But don’t get overly personal, stressed Dr. Anderson. “If you have an experience that drew you to this field, that’s okay to tell us about. But we don’t want to hear about your herpes.” Another no-no: Don’t teach dermatology in the statement. It took Dr. Anderson three months to write his personal statement. “It should be well polished. It should excite the reader.”

When applying to a residency program, treat everything as an interview, he said. “I am not your friend,” he stressed. “I am your colleague.” Research the program to ensure that it is a good fit. Ask intelligent, relevant questions. Practice being interviewed, rehearse, practice, and rehearse again. “Caring too much” or “working too hard” is not a response he wants to hear when asked about your greatest weakness. “My greatest weakness was that I was military,” he said. “I don’t have a civilian mindset.” The next step is to explain how you will change that. Dress the part of a doctor. While there may be some difficult questions, always be honest in your answers. Don’t be afraid to show emotion as long as it is done in a professional manner.

Consider a conference to be another interview. Dr. Anderson encouraged residents to mingle and spend a little time with everyone as opposed to following a program director around the whole time. Conferences are professional meetings. Dress and act appropriately. Blow off steam with your friends, not your colleagues. “I know people who had amazing applications who didn’t get a spot because they behaved inappropriately at one of these meetings,” he warned. “You’re here to learn. Be noticed for your good attributes.”

Live Workshop
Several patients were treated during the live workshop with two large screen monitors catching details of the various techniques performed by instructors Mary Lupo, M.D., and Lisa Donofrio, M.D. As they worked on the patients, they talked about the different techniques and products they use and offered tips on how to use them. Among those demonstrated were the hatching technique, the fanning technique, the swish technique, and the airbrush technique. They did eye brow lifts, plumped up lips, and treated facial defects from crow’s feet to drooping jaw lines.

When working on a patient named Melissa, Dr. Lupo noted that the patient still had effects from a treatment done three months ago. “If you constantly touch-up Botox, you don’t get a good result. Do a touch-up approximately two weeks after the initial treatment and then wait until the regular time,” she said. It’s important to educate patients to do as full of a correction as they need at one time to avoid more frequent touch-ups. Dr. Donofrio said it seems like she uses less filler with each subsequent visit.

Some physicians always do Botox before using a filler, said Dr. Lupo. “I feel very strongly you do the filler first,” she said, adding that she is big on...
massaging after using Botox, but other physicians aren’t. Dr. Lupo noted that different physicians have different ways of using fillers and they don’t always agree on the best way. Case in point: Dr. Donofrio uses a filler first and then Botox because she uses anesthesia.

Dr. Donofrio noted that the photographs in the published literature illustrating how Botox should be set show it being done too high. Because it was approved by the Food and Drug Administration (FDA) using that literature, it is hard to get the photos changed.

Dr. Lupo uses Sculptra on 30% to 40% of her patients because it builds up over time. But she uses Juvederm for the lips. “I don’t want to give people sausage lips,” she said. “I just want to give definition to the lips.” The trick to plumping the lip is a buttressing technique. “Juvederm is my workhorse because it’s malleable and soft,” added Dr. Lupo.

Dr. Donofrio suggested picking a filler based on the tissue that it is being injected into. For example, she tends to use Radiesse mixed with anesthesia for the cheekbone or jaw line, but never for the lips. Patients tend to feel sore after being treated with Radiesse, as if they were punched, added Dr. Lupo, whereas Botox tends not to hurt.

Demonstrating on the patient, Susie, who has never had filler treatment, Dr. Lupo used Evolence mixed with lidocaine. She tends to use Evolence with first-time filler patients because, as a collagen, it causes the least soreness and bruising compared with other fillers. It also is a little less inflammatory. “You have to do quite a bit of massage. If you don’t do so immediately, it causes big time lumping,” cautioned Dr. Lupo. “It sets very quickly, and once it does you can’t do anything to correct it.” She also uses a post-filler massage product called Bruise Relief to ensure that the area is nice, smooth, and even.

Dr. Donofrio noted that she likes using Sculptra in the temple area. But she has also layered Restylane and Sculptra in the temple using a fanning technique for a good effect.

Working on a patient, Jackie, who has had previous Botox injections, Dr. Lupo noted that Jackie has overly arched eyebrows. “I don’t like to fix other people’s Botox injections.” Botox injected incorrectly will last longer. Similarly, a filler injected into the wrong plane will last longer, she said. “When you start injecting everybody like a cookie cutter, you don’t take into account a person’s individual anatomy.”

It is unclear how long fillers actually last, she said. The more hyaluronic acid used, the longer the effect. FDA trials show six months, 12 months, and even 18 months depending on the filler used. “Patients think a facelift is permanent,” she said, adding, “Nothing is permanent because the aging process continues.” Also, factors such as smoking and photoaging affect how long a filler’s effect will last.

Another question is how much filler to use. One vial of Botox can be used to treat one to five patients, said Dr. Lupo. The average is three patients.

Some considerations for choosing a filler are age, the defect, thickness of the skin, and the amount of photoaging. It takes more Sculptra to get a good effect in a patient in her 80s versus one in her 40s, she explained. The optimal patient is under the age of 50. Dr. Lupo recommends that patients do fillers and toxins earlier than they think they need them. “The younger they start,” she said, “the greater the duration and cumulative effect.” Then there is the defect the physician thinks should be corrected versus the defect the patient wants corrected. Thickness of the skin is an issue because some fillers do better with thicker skin. Photoaging weakens the skin integrity. That is why Dr. Lupo recommends using cosmeceuticals or retinoids before using fillers on patients with photoaging to improve the outcome and duration.

Photoaging does, however, improve dramatically with Sculptra. “You can do a bolus temple injection. The patient hears a squishy sound, but doesn’t feel anything,” she said. “Now here’s a little trick. You want to be under the muscle around the eye and mouth because if not, it causes bumping,” explained Dr. Lupo. “Do the same thing to build the cheekbone out. “If you draw blood, you need to reposition the needle. You should do a reflux maneuver because you don’t want to put any filler in a blood vessel.” These injections will offer a nice softening effect, she added.

Another consideration is budget. Older patients need more materials than...
younger patients, and therefore the cost goes up, said Dr. Lupo. “Older patients tend to like Radiesse because they get an immediate bang for their buck.” Some fillers offer immediate results and some, such as Sculptra, can be combined with quick acting fillers. Sometimes the duration of benefit is more related to how much is used, she added.

Also some medications can be a contraindication. If the patient is on an anti-coagulant, such as an aspirin, Dr. Lupo takes her off of it for 10 days. If the patient had a stroke or TIA, don’t take her off aspirin, she said, but explain that the patient will likely have bruising.

Sometimes physicians can get a better overall effect by using complementary procedures, Dr. Lupo said. For example, using intense pulsed light before fillers increases the duration of the effect.

Finally, the effect must be maintained with touch-ups. “It’s all about maintenance,” she concluded.

Great Residency Program Cases

Antiphospholipid Syndrome. Richard Miller, Program Director of the NSUCOM/Largo Medical Center, opened the lectures of Great Cases from Osteopathic Teaching Programs with a case of Blue toe syndrome secondary to Antiphospholipid Syndrome (APS). A 27-year-old Caucasian female presented to the emergency department with fever, flank pain, and foot pain.

A work-up revealed an obstructed renal calculus complicated by Proteus mirabilis urosepticemia. While in the hospital, the patient’s foot pain intensified and violaceous non-blanching patches appeared on all toes. She later developed multiple bullae on her feet. A past medical history revealed nephrolithiasis, ovarian cysts, depression, and a spontaneous miscarriage at 12 weeks. The patient’s condition improved following plasmaphoresis, surgical debridement, and a heparin IV.

APS is associated with recurrent venous and arterial thrombosis and/or fetal loss and elevated Abs against membrane anionic phospholipids. It may occur with other autoimmune diseases. Cutaneous findings include livedo reticularis, superficial thrombophlebitis, leg ulcers, painful purpura, and splinter hemorrhages. Clinical criteria include vascular thrombosis and pregnancy morbidity. Blue toe syndrome has an extensive differential diagnosis, Dr. Miller noted. It is important to consider APS in young females who present with blue toes and a past history of late spontaneous abortions.

Aquagenic Pruritis. Suzanne Sirot Rozenberg, D.O., FAOCD, Assistant Program Director at St. John’s Episcopal Hospital, presented a case report of a 27-year-old black male with a 15-year history of itching whenever he encountered water or moisture. Pruritis begins 5 to 10 minutes after water exposure and continues for an hour upon elimination of the water source. Both his general exam and skin exam were unremarkable. Blood work was done to rule out any organic causes of pruritis such as polycythemia vera, lymphoreticular malignancies or thyroid disease. The patient was diagnosed with Aquagenic Pruritis and started on cyproheptadine.

Aquagenic Pruritis usually begins in pre-adolescence, it’s intermittent and brought on by water or hormones. It may go dormant for years. The condition can be triggered by sweat, blowing air, temperature differences, changing clothes, contact with synthetic fibers, and lying down. Patients are often given referrals to psychiatrists because they are thought of as crazy as the pruritis is invisible to all, Dr. Sirota Rozenberg said.

“The treatment is almost anecdotal,” she added. “You have to see what works for the patient.”

Reflectance Confocal Microscopy. Stephen E. Kessler, D.O., FAOCD, Program Director at Midwestern University/Alta Dermatology, introduced Mari Batta, D.O., a research fellow in his office who presented the work they are doing with reflectance confocal microscopy, which is an emerging non-invasive diagnostic tool that provides in vivo tissue images at nearly cellular histological resolution.
Dr. Batta explained that they are using this technology to determine its applicability in a busy dermatology practice, in which a lot of Mohs Micrographic surgery is performed. She also reviewed several studies that have touted the technology’s ability to improve diagnostic accuracy.

“You can do the equivalent of an H&E biopsy without cutting the skin,” said Dr. Batta. The disadvantage is that it is a little difficult to learn how to read them. “It may be a part of our armamentarium in the future,” she concluded.

**Heterochromia of the Scalp Hair Following Blaschko Lines.** Steven K. Grekin, D.O., FAOCD, Program Director at Oakwood Southshore Medical Center, presented a peculiar case of the calico kid, referring to a 15-year-old male patient who had an oval patch of black hair in the midst of his blond hair. He was born with black hair, the majority of which turned blond by age one. “It looked like someone dropped a blotch of black ink on his head,” noted Dr. Grekin.

He didn’t have a previous trauma or inflammatory scalp disease and never used dyes or bleaching agents. All of his diagnostic tests were normal and he had no other cutaneous findings.

The literature had only two small reports, one of 4 patients and one of 5 patients with some similarities to the calico kid. The difference between this patient and the reports is that in all 5 cases the scalp hair slightly darkened with age, regardless of placement. Also this patient is unique because his hair changed from black to blond with a remaining black oval patch.

Dr. Grekin presented two theories explaining the benign occurrence of the hair disturbance: probable isolated heterochromia of the scalp or loss of heterozygosity. Instead of concluding which one was the diagnosis, Dr. Grekin posed the question of whether there may be a possible relationship between the halo nevi depigmentation and the scalp pigmentary disturbance.

**Birt-Hogg-Dube Syndrome.** Daniel Stewart D.O., FAOCD, Program Director at St. Joseph Mercy Health System, reviewed two unusual cases of Birt-Hogg-Dube Syndrome with extracutaneous manifestations. The first patient is a 54-year-old Caucasian male who presented for evaluation of a rapidly growing lesion on his forearm, which was found to be sporotrichosis. He had previously been diagnosed and treated for milia. The patient had four spontaneous pneumothoraces, and his brother had two spontaneous pneumothoraces. The second patient is a 74-year-old Caucasian male admitted to the internal medicine service with worsening renal function and bilateral renal masses. He had multiple spontaneous pneumothoraces. A pathology exam of a renal mass revealed characteristic changes consistent with a hybrid oncocytic neoplasm. In both cases, the patients had multiple whitish to skin-colored papules on the face, which when biopsied revealed fibrofolliculomas, a characteristic of Birt-Hogg-Dube.

This syndrome is an uncommon genodermatosis that may result from inactivation of a tumor suppression gene, Dr. Stewart explained. Key features for diagnosis are cutaneous lesions, renal tumors, and pulmonary complications. The constellation of the renal hybrid oncocytic neoplasm, history of multiple spontaneous pneumothoraces, and cutaneous fibrofolliculomas solidified the diagnosis. All first-degree relatives should be screened for kidney and lung manifestations, he said. Recent investigations have shown that some individuals with the syndrome could present with pulmonary involvement and/or renal tumors without skin lesions.

Treatment options include ablation of the cutaneous lesions. However, the lesions may recur. Nephron-sparing surgery (partial nephrectomy) is the treatment of choice for the renal tumors. Supportive care is necessary for other complications. If renal cancer is detected early and pulmonary sequelae are not debilitating, then there is a good prognosis, noted Dr. Stewart.

**Phakomatosis Pigmentovascularis.** Cindy Hoffman, D.O., FAOCD, Program Director at NYCOM/St. Barnabas Hospital, rounded out the great cases lectures discussing an eight-year-old female patient whose chief complaint was “coffee spots on her skin” since birth. Her father stated that the lesions were increasing in number.

A physical exam revealed a large brown patch containing darker brown macules on the right lateral neck (Nevus Spilus); diffuse tan macules and patches scattered across the trunk bilaterally (cafe au lait macules); a large tan patch containing a dark brown macule on the left mid-back and; a red-violaceous, blanchable patch on the left buttock, extending down the extremity over the lateral foot and dorsal toes (Nevus Flammeus). There was no evidence of neurofibromas, Crowe’s sign or Lisch nodules. This patient also had congenital vascular and pigmented nevi and was thus diagnosed with Phakomatosis Pigmentovascularis.

When making this diagnosis a thorough evaluation is needed to rule out any possible systemic abnormalities, Dr. Hoffman stated. Approximately 200 cases have been reported and 50% present with systemic involvement. The patient is being managed with regular follow-up to monitor for the development of systemic abnormalities.

**Great Cases**
Mark Lebwohl, M.D., Professor and Chairman of the Department of Dermatology at the Mt. Sinai School of Medicine, presented three Great Cases, starting with regional ileitis, which is associated with Crohn’s disease. This is a difficult diagnosis to make, he noted.
“Often, you find the ulcer first and then the Crohn’s. If there is pyoderma gangrenosum, be sure to biopsy so that it is not missed. “One diagnosis you don’t want to miss is a malignancy that you should have picked up on biopsy.”

Histologically, Sweet syndrome looks identical to pyoderma gangrenosum. But pyoderma gangrenosum occurs on the legs and not on the hands. Patients with Sweet syndrome should undergo a bone marrow study because this syndrome often progresses to acute leukemia.

The most common causes of pyoderma gangrenosum are ulcerative colitis and Crohn’s disease, said Dr. Lebwohl. Pyoderma gangrenosum starts out as postulates that break down into ulcers. “When you can identify fistula tracks, it’s pyoderma gangrenosum,” he stated. They can form anywhere on the body, but they are always on the legs or peristomal sites.

Intralesional steroid therapy seems to be an effective treatment, said Dr. Lebwohl. It should be injected around the rim of the lesion and then in the center of it. When tacrolimus is used topically, both the pust and the pain stop. However, there is a lack of studies to demonstrate that it works. Still, he uses it as part of treatment. Studies have shown cyclosporine works very well, said Dr. Lebwohl, and it is part of his routine treatment. Anti-tumor necrosis factor alpha monoclonal antibody and adalimumab therapy also work. After the first doses, typically the patient is better the following day.

He also discussed Lyme disease, which can result in serious complications. The most common is Bell’s palsy, but the most severe is a heart block. “If you see a rash, it’s Lyme,” he said. “If you see Bell’s palsy in the area known for Lyme disease, check for it.” A prophylactic dose of doxycycline given within 72 hours of tick removal can prevent Lyme disease.

There is an emerging tick disease, similar to Lyme, that is spreading rapidly in patients as far west as Missouri, noted Dr. Lebwohl. Patients are presenting with erythema migrans-like skin lesions, which seem to be caused by ticks infected with Borrelia lonestari. To date, there is no blood test to detect it.

**Verruca Vulgaris Treatment**

Karthik Krishnamurthy, D.O., FAOCD, Director of Dermatology at Jacobi Medical Center of the Albert Einstein College of Medicine in Bronx, New York, reviewed his research investigating intralesional dextrose for the treatment of verruca vulgaris.

When prolotherapy is injected into the joints, it stabilizes them, he explained. The mechanism of action is dextrose. Dr. Krishnamurthy hypothesized that the prolotherapy would be destructive, first causing the cells to shrink and then to die. It also may aid in wound healing, he said.

The first phase of the study involved treating 3 patients. Two of the patients’ warts cleared with 2 treatments, and one required 3 treatments. One patient had a scar that eventually went away. Side effects included discomfort with the injection and a pressure sensation for 10 minutes afterwards. The next phase of the study will assess dose strength.

“Intralesional dextrose is a promising treatment for warts,” he concluded.

Dr. Krishnamurthy received the A.P. Ulbrich Research Award in Dermatology in 2008 for the research he started conducting as a resident at NYCOM/St. Barnabas Hospital.

**What’s New in the Medicine Chest**

James Del Rosso, D.O., FAOCD, Program Director at Valley Hospital Medical Center, discussed What’s New in the Medicine Chest with regard to skin care, seborrheic dermatitis, actinic keratosis, topical steroids, vitamin D analogues, rosacea, and acne vulgaris. Dr. Del Rosso spends a lot of time reading clinical studies and reviewing information to distill the clinically useful information, he said.

People want to know how to care for their skin. They want information about everything from dermatological problems to disease states, he noted. “If we don’t provide that information, they’ll get it elsewhere.”

Skin needs moisture, and the new frontier for proper skin care seems to be the epidermal barrier, he said. Dr. Del Rosso reviewed various studies that look at products that replenish transepidermal water loss. Desonide hydrogel didn’t increase transepidermal water loss and neither did gels made of BP and clindamycin or BP and adapalene.

Ceramides focus on barrier repair while treticx address barrier protection, he explained. The new concept is to treat the barrier as a component of disease. Patients treated with a ceramide-based topical emulsion have turned around dramatically. Its efficacy is comparable to fluticasone propionate cream in atopic dermatitis. An aluminum-magnesium hydroxide stearate-based skin barrier protection cream has shown some benefit, as well.

Regarding seborrheic dermatitis, promisene worked well in studies targeting treatment of facial seborrheic dermatitis and azelaic acid has worked moderately well for patients with mild to moderate seborrheic dermatitis.
New research is being conducted for the treatment of actinic keratosis (AK), Dr. Del Rosso noted. The current objective for topical imiquimod therapy is to treat large areas, shorten the treatment regimen, use a simple dosing regimen, and decrease the concentration. Phase III clinical trials show a 2-week cycle reduced lesions 82% from baseline and a 3-week cycle reduced them 80%. Other studies show target lesion clearance in approximately 80% of patients and complete clearance of target lesions in approximately 50% of patients. The lower strengths were fairly well tolerated, he said, adding, “You can expect these to be coming.”

What’s new in topical steroids is ammonium lactate lotion, which in one study cleared or almost cleared psoriasis in 2 weeks. After that, it was used for a maintenance regimen. It was well tolerated. In another study, a clobetasol propionate spray used twice daily cleared/almost cleared 75% of patients in 4 weeks. Two out of 3 patients almost cleared using a triamcinolone spray over 28 days, according to another study. “It kicked in quickly,” he noted, with 84% of patients experiencing clearance within 7 days of the initial treatment. In another study, after 4 weeks of daily treatment with clobetasol shampoo, the percentage of subjects with severe scalp psoriasis decreased from 42% to 4%.

Regarding vitamin D analogues, Dr. Del Rosso noted that the expectation isn’t much different with the newer formulations. While patients reported marked improvement using calcitriol ointment, it took 26 weeks. They are slow, but they work, he said, and treatment requires a lot of ointment to be used.

There has been a lot of discussion about the FDA status of the different doses of doxycycline for the treatment of rosacea. The subantimicrobial and anti-inflammatory doses are not considered antibiotics. “Do you care if you give an antibiotic or not?” Dr. Del Rosso asked. The real question is does it work as good as a higher dose of doxycycline. One study says it does. When oral doxycycline was used in combination with a topical azelaic acid gel for maintenance therapy for rosacea, patients had a rapid response and it prevented relapse. Three out of 4 patients felt they were rosacea-free.

Lastly, a study on retinoid treatment for acne vulgaris hot off the presses shows long-term efficacy for minocycline extended-release tablets, he said.

**EHR and E-Prescribing Update**

Over the next 2 to 5 years, electronic health records (EHRs) will significantly change the medical business, stated Thi Tran, D.O., FAOCD, Medical Director of Village Dermatology & Cosmetic Surgery. “It’s time to start planning for the transition.”

To that end, Dr. Tran provided an overview of the government incentives for using an EHR, e-prescribing, and the Physician Quality Reporting Initiative (PQRI), as well as the pros and cons of adopting them.

The American Recovery and Reinvestment Act offers more than $17 billion incentives from the Center for Medicare and Medicaid Services (CMS) to physicians and hospitals for the meaningful use of a certified EHR system. However, meaningful use has yet to be defined, Dr. Tran said, and nobody knows what the certification requirements are. Currently, CMS is working with the Office of the National Coordinator and other parts of the Department of Health and Human Services to develop regulations that will govern the initial year of these incentives.

For e-prescribing, a physician must report one measure in at least 50% of the cases for which the measure is reportable during 2009. The measure can only be reported via the Medicare Part B claims process. Dermatologists who participate in PQRI may earn an incentive payment of 2% of their estimated total allowed charges for covered Physician Fee Schedule services under Medicare Part B provided during the reporting period. In order to qualify, dermatologists must report 1 of 3 melanoma measures in at least 80% of the cases in which the measure is reportable.

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There are advantages to both types of systems.

The advantages to EHRs are as follows:

- Improving quality of care and patient safety
- Helping document patient encounters
- Ordering and managing lab requests
- Providing reminders that help track follow-ups
• Coordinating referrals and consultation requests
• Increasing productivity
• Freeing up storage space
• Expediting the billing process
• Eliminating chart-pull and archiving costs

Advantages to e-prescribing are as follows:
• Improving patient safety and quality of care
• Reducing time spent on phone calls and call-backs to pharmacies
• Reducing time spent faxing prescriptions to pharmacies
• Automating the prescription renewal request and authorization process
• Increasing patient convenience and medication compliance
• Improving formulary adherence permits lower cost drug substitutions
• Allowing greater prescriber mobility
• Improving drug surveillance/recall ability

“You need to have a roadmap and a strategy,” said Dr. Tran. Dermatologists looking to purchase an EHR package must spend enough time upfront to ensure that the right package is selected, taking into consideration the practice’s office size, specialty, culture, etc, he advised. Work processes should be analyzed and optimized. “You want to fully take advantage of efficiencies made possible by the software,” stressed Dr. Tran.

Vendors must be fully vetted. Select one that provides solid implementation and project management services. “Be leary of a company that says it has a certified system,” he warned. The software is only as good as the implementation, cautioned Dr. Tran.

Interview references to gain an understanding of how things really work to gauge expectations. It is necessary to have at least one senior leader who is completely dedicated to the cause, understands the potential benefits, and will act as a cheerleader in the office.

The change that results from implementing these systems must be appropriately managed, he added. The implications to business processes/workflow must be understood and communicated. Adequate time must be set aside for staff training. Adequate support must be put in place, especially for the first 30 to 60 days. In other words, said Dr. Tran, expect some hiccups and be prepared.

Although the EHR will significantly change the medical business in the next few years, he assured attendees that there is no reason to panic. “But it’s time to start planning by identifying objectives, creating completion targets, doing the work to achieve the objectives, and tracking progress.”

Shedding Light on Rejuvenation

Jenifer Lloyd, D.O., shed some light on rejuvenation during *An Update on Laser and Light Therapy*, the first in a series of lectures on rejuvenation planned for future AOCD meetings. She reviewed various types of lasers including ablative, non-ablative, infrared, and fractionated ablative, as well as visible light sources, intense pulsed light, light emitting diodes, photodynamic therapy, and fractional technology.

Within the ablative laser category, traditional CO2 lasers are considered the gold standard in skin resurfacing, she said. Ablative procedures remove the entire epidermis. Although healing takes 2 to 3 weeks, erythema can last for months and 40% of patients develop hyper or hypo-pigmentation. Prominent demarcation lines are commonly noted between treated and untreated areas.

Non-ablative lasers spare the epidermis, showing gradual and subtle results. There is little to no downtime for the patients, but they are required to come back for multiple treatments. Of the non-ablative lasers and lights, Dr. Lloyd discussed infrared lasers, visible light, broadband, and non-thermal photomodulation. While there are numerous studies on all of these devices, they all involve a small number of patients, she noted. Study results are not reproducible due to differences in wavelengths, filters, and number of treatments, as well as treatment settings, intervals and areas. Overall, there is some improvement, but the changes are subtle and it’s hard to predict which patients will benefit. The results are often discernible on standard photographs. Some recommend using non-ablative lasers in combination with other treatments to achieve effective skin rejuvenation.

With fractional technology, the laser beam is broken up into many small microbeams of laser energy, which when applied to the skin, leave intervening areas of normal skin untouched. The areas of untreated skin allow for rapid re-epithelialization resulting in rapid recovery and healing with less risk of complication. “I think it’s great,” said
Dr. Lloyd. Fractional technology, in both non-ablative and ablative form, has been shown to demonstrate moderate to significant improvement in skin appearance. “Patients love this. They get it done on Friday and they are back at work on Monday,” she said. Three treatments are spread out 4 to 6 weeks apart. There are some cases of scarring, primarily on the neck, but none have been reported with a CO\textsubscript{2} laser. The Fraxel non-ablative laser is the new one that will be on the market soon.

Comparing ablative CO\textsubscript{2} to fractionated CO\textsubscript{2}, Dr. Lloyd said that both improve the texture and quality of the skin.

**Correlation of Dermoscopy, Histology**

For the lunch time lecture on Tuesday, Anthony Dixon, M.D., Assistant Professor (School of Medicine) at Bond University in Gold Coast, Australia, and Fellow of the Australasian College of Skin Cancer Medicine, offered some correlations between the histology and dermoscopy in cutaneous tumors, including malignant melanoma. Taking these correlations one step further, he likened them to famous scenic sites and landmarks in Australia and New Zealand.

For example, under the dermoscope, a junctional naevus has a honeycomb pigment network pattern. The abnormal pigmented pattern fits with the histology that shows pigmented rete ridges and non-pigmented dermal papillae. “The regularity of the pattern is striking,” noted Dr. Dixon, who likened it to the Bungle Bungles, a landscape of beehive-shaped sandstone formations, in Western Australia.

Blue naevus is a good example of color in dermoscopy and histology, he said. On the dermoscope, they appear a homogenous blue and the histology shows a deeper dermal nest of melanocytes similar to the Blue Mountains in New South Wales.

Haemangioma show up as red or blue lacunes under the dermoscope. Histologically, they are dilated cavernous blood vessels in the dermis that appear in a bunch akin to the red wine grapes produced in Australia and New Zealand.

Dr. Dixon reviewed 13 cutaneous conditions in all.

Regarding malignant melanoma, he suggested that it shows up in multiple colors on the dermoscope, not just shades of tan or brown. On histology slides, there are melanoma cells and pigmentation at levels from stratum corneum to deep dermis, similar to the Great Barrier Reef.

Dermoscopy may reveal a blue white veil, which correlates with compact melanoma cells and melanophages in mid-dermis with thickened compact stratum corneum on the histology slides. These correlate to Whitehaven Beach.

**Contact Dermatitis**

During the last 4 decades, allergy to nickel has significantly increased, reported Joseph Fowler, M.D., University of Louisville, Ky., during his lecture explaining *What’s New in Contact Dermatitis.* Pierced ears are a strong risk factor for nickel allergy as is body piercing. Nearly 82% of women have pierced ears and 17% of women have a nickel allergy. Moreover, nickel contact allergy may be associated with hand eczema in women. Combination therapy of topical steroid and Lac-Hydrin® counteracts steroid-induced cutaneous side effects and improves skin healing. Dr. Fowler said he often uses devices such as mimyx, atopiclair, eleone, epiceram, and neosalus foam as an adjunctive therapy for hand eczema. Other treatments for contact dermatitis include moisturizers and topical calcineurin inhibitors.

A recent epidemic of contact dermatitis, seen in Finland, England, and Canada was caused by dimethylfumarate found in fabric, which was traced to furniture manufactured in China. “This potent allergen permeates into the fabric and stays there,” he said. Another case was traced to fabric in clothing.

Other cases of contact dermatitis Dr. Fowler reviewed resulted in vulval pruritus due to benzocaine and tea tree oil; vulval allergic contact dermatitis due to herbal tea; and systemic atopic contact dermatitis related to balsam-containing foods, including tomatoes, chocolate, cola, and various spices.

One study set out to determine what would happen if patients who have undergone patch testing for nickel were given oral nickel. Twenty-four hours after the oral nickel challenge, although more reactions were seen at palladium patch test sites, many were seen at nickel sites. The flare-up reactions were mixed eczematous-urticarial reactions and those seen were at serial dilution patch test sites that were negative. These led the authors to conclude that nickel and palladium truly cross
Nickel isn’t the only metal causing contact dermatitis. Cases of dermatitis post-implant have been reported. When the implants were removed, the patients’ dermatitis improved. In some cases, the fracture site where an implant was placed didn’t heal, he said, but added that reports of joint failure and poor wound healing are few and far between. “It doesn’t always mean that you take out the implant,” stated Dr. Fowler, “because you can easily treat the dermatitis. Sometimes, patients even develop a tolerance.” He will conduct a pre-operative patch test when the physician or patient getting an orthoped requests it. If the metal patch test is positive, he tells patients they have a small chance that dermatitis may occur, and in very rare cases, joint failure may occur. Dr. Fowler recommends if there is no risk, that titanium or other implant absent allergenic metals can be used. If there is a slight risk, he suggests using the best material for durability and performance.

Lanolin, which has been suspected of being an allergen, is one, stated Dr. Fowler, based on studies including his own. However, many purified lanolin derivatives, especially those with low lanolin alcohol levels, are essentially non-allergenic.

Contact allergy to corticosteroids is underdiagnosed because anti-inflammatory activity of corticosteroid preparation masks the contact allergic reaction. Corticosteroid-sensitive patients often present with long-standing lesions that don’t respond to therapy. “When you have a patient being treated with corticoids who isn’t getting better and is getting a centrifugal spread, think allergy,” he said. Ninety percent of corticoid allergy in the US is to hydrocortisone. The betamethasone type corticosteroids are the safest to prescribe when allergy to the corticoid is suspected, added Dr. Fowler. Ointment or spray vehicles are safest when allergy to the vehicle is suspected.

Only one product—IvyBlock Lotion—is FDA approved to protect against atopic contact dermatitis.

Native American Dermatology Update
The medical literature looking at skin conditions prevalent in Native Americans is not only sparse, it is inaccurate, according to Eugene Conte, D.O., FAOCD.

For example, the literature dating back to the 1950s states that psoriasis is rare in the Native Indian population. As recently as 2003, studies show that psoriasis is rare in Native Americans.

Dr. Conte’s own study of dermatological disorders in the American Indian population in Phoenix paints an entirely different picture. Using a population sample of 1,179 patients, Dr. Conte studied skin conditions in the Top 10 tribes, the majority of which were Navajo.

Psoriasis was the second most common skin condition, he said. The mean age of the patient presenting with psoriasis was 45.

The most common skin condition was acne. The mean age of the patient presenting with acne was 24. From a cultural perspective, Native Americans do not consider acne an important issue, said Dr. Conte. As a result, teenagers do not seek treatment for acne. It becomes more of an issue for young adults, perhaps when they are getting married.

Seborrheic dermatitis, atopic dermatitis, and AK also made the top 10 in the list. He noted that a lot of intermarriage is diluting the gene pool. Consequently, some Native Americans are as white as Caucasians, and are experiencing similar skin conditions.

When treating the skin conditions of Native Americans it is important to be respectful of their use of cultural cures. “Never poo poo what the Medicine Man may give them because when you go on the reservation, you’re in a whole different world,” said Dr. Conte.

Given how inaccurate the current literature is, he suggested that this patient population needs to be studied more.

Healthcare Reform Update
Politics and presidential pressure are pre-empting prudent public policy, stated American Academy of Dermatology (AAD) President David Pariser, M.D., FACP, FAAD, speaking about healthcare reform. “Something will pass because the president wants it too, but it will be a patchwork of mish mash.”

Dr. Pariser characterized the House bill as “bad” and the Senate bill as “awful for physicians.”

The major components of the bill are insurance reform, PQRI, tort reform, and the public option. Insurance reform will eliminate pre-existing conditions and offer mandatory coverage for all. PQRI is a good idea as long as physicians are not going to be rated, he said. The trial lawyers will not allow tort reform to pass and the public option is “iffy,” added Dr. Pariser.

Physician payment reform is the component with the greatest impact on physicians. The Medicare’s flawed sustainable growth rate formula will cut the Physician Fee Schedule by 21.5%, effective January 1, 2010 if nothing happens, he stated. But even worse than that is the Independent Medicare Commission, a 12-person committee appointed to set physician fees for all services. “We have no input and no recourse,” said Dr. Pariser. A few weeks ago, the Office of the Inspector General began looking at specialties. Dermatology is on the top of the specialties list when it comes to having practice expenses associated with many of the services provided. For example, it may only take 20 minutes to freeze an AK,
but it involves practice expenses including gloves, mask, and gown. “We’ve been able to protect that fee, but it won’t get past the IMC,” he said.

The AAD has developed a close relationship with Senator Baucus’ staff because “if you’re not at the table, you’re on the menu,” stated Dr. Pariser.

He encouraged attendees to call and e-mail their senators and representatives, and stay informed through the AAD’s website (www.aad.org).

“Things are not good,” he concluded, adding, “The best thing to happen would be nothing.”

Hyperhidrosis
Speaking as a Professor in the Department of Dermatology, Eastern Virginia Medical School in Norfolk, Dr. Pariser discussed the emerging science and technology used in the treatment of hyperhidrosis. “When we treat patients, it improves their quality of life more than anything else a dermatologist can do.”

Treatment options are divided into those that are non-invasive, minimally invasive, and surgical.

Approximately 2 years ago, a new generation of over-the-counter antiperspirants were introduced. They cause less irritation, making them superior to the older ones. They are best applied overnight or for at least 6 to 8 hours on dry skin to avoid irritating acid formation. These should be washed off in the morning before sweating begins. They should be applied nightly until the desired effect is noted, and then their use should be decreased. When used correctly, the new antiperspirants can provide significant benefit, he said. Topical agents, such as glycopyrrolate, can be used as an adjunct to other treatments.

When topicals don’t work, the treatment of choice is iontophoresis. It has a long treatment history and should be considered for palmar and plantar disease. However, the success of iontophoresis treatment is highly dependent on the device used, patient administration techniques, and chemistry of the water bath. To date, no systemic medications have been tested in clinical trials nor are any FDA approved for hyperhidrosis. “What we have are case reports or small case series,” said Dr. Pariser. Systemic medications, such as propantheline, glycopyrronium bromide, and benztropine, may be more helpful in generalized hyperhidrosis or hyperhidrosis of spinal cord injury. Glycopyrrolate is preferred because it has the least penetration, he said. Propranolol can be used, but only in special circumstances, such as the need to be sweat-free for an event.

Patients love botulinum toxin type A injections, the minimally invasive treatment option. Studies have shown it to cause a clinically and statistically significant drop in sweating. One study showed an incidence of at least 75% reduction in sweat production.

Endoscopic thoracic sympathectomy is the surgical option with the goal of permanently stopping the sweating. It is very effective for palmar sweating (eg, 95% to 100%), but less effective for axillary sweating (eg, in the 50% range). Patient satisfaction rates are usually lower due to complications, such as compensatory hyperhidrosis and excessively dry hands. It is reserved for patients with very severe symptoms who have not responded to other treatments.

Overall, treatment of patients with focal hyperhidrosis can be easily learned and integrated into routine office practice, concluded Dr. Pariser. It is a perfect procedure for physician assistants to perform and is economically viable.

Gruesome Groins
In his presentation entitled **Gruesome Groins**, Ted Rosen, M.D., of the Baylor College of Medicine, reviewed cases of chancroid, syphilis, tinea cruris, Extramammary Paget’s Disease, acyclovir resistant HSV, and Hailey-Hailey.

Back in the 1980s, 5,000 cases of chancroid were reported annually. Now
there are 23 cases reported nationwide. This painful condition is commonly treated with antibiotics, he said, although there is no consensus for which one works best.

Although the incidence of syphilis peaked in 1991, it is on the rise in the last few years, said Dr. Rosen, largely due to gay men and inner city women trading sex for drugs. Benzathine penicillin is the treatment of choice. Various antibiotics have proven to be inadequate, in part, because there is no consensus on a proper dose. “We have longed for another single-dose therapy because of patient allergy to penicillin,” he said. Often times, patients don’t finish the prescription because the syphilis clears up so they stop taking the pills.

Regarding external genital warts, Dr. Rosen is a firm believer in the HPV vaccine. As of June, 25 million vaccines have been given, he said. It is indicated for girls, ages 9 to 26, and he recommends getting it as early as possible.

If a patient presents with tinea cruris, always check the patient’s feet. The overwhelming majority of patients with tinea cruris have onychomycosis for the simple reason that they get it from putting on their pants, explained Dr. Rosen.

Between 10% and 25% of Extramammary Paget’s is associated with internal adenocarcinoma. Although the work-up is unpleasant, you don’t want to miss internal cancer, he said. Treatment options include surgery, Moh’s surgery, and PDT. Surgery has a high recurrence rate and Moh’s surgery appears good. PDT is difficult to perform due to the location, said Dr. Rosen, and it has a 50% to 60% response with late recurrences. Imiquimod is useful for superficial epidermal neoplasms and can be used to highlight the involved areas pre-surgery.

Hailey-Hailey can be treated medically or surgically, he said. Topical or systemic antibiotics or steroids top the list. Others include dapsone, topical calcineurin inhibitors, topical Vitamin D analogues, retinoids, and biologics. His experience is that the analogues don’t work. In general, topicals don’t always work. Surgical therapies include excision and grafting, dermabrasion, CO₂ or erbium:YAG laser abraison, and electron beam. Recent research suggests that Botulinum toxin can reduce sweating, thereby reducing maceration and irritation. Based on hyperhidrosis experience, Botox has the potential to put Hailey-Hailey into remission up to 1 year.

Other blister diseases reviewed were erythrasma, inverse psoriasis, hidradenitis suppurativa. Treatment for erythrasma include oral erythromycin, single-dose clarithromycin, topical clindamycin/erythromycin, oxiconazole cream, miconazole or clotrimazole cream, and high-intensity RED light. Antibiotics are the best bet, noted Dr. Rosen. “If you don’t want to use pills, you can use topicals.” Topical calcineurin inhibitors work well for the treatment of inverse psoriasis, he said. Efalizumab was effective in clearing it, but now of course the drug is off the market. No therapy is uniformly successful in the treatment of hidradenitis suppurativa, said Dr. Rosen. Consequently, surgical removal is the treatment of choice for less severe or more localized disease.

Exogenous disorders he covered include genital bite wounds and genital self-mutilation. Genital bite wounds are accidental or deliberate, said Dr. Rosen. The wounds should be irrigated and patients given tetanus prophylaxis and antibiotics. “If it’s like nothing you’ve ever seen before, think genital self-mutilation,” said Dr. Rosen. Factitial disease is more common in women and genital lesions more common in men. The age range is 20 to 40 years of age. Sixty-percent of the patients are psychotic, others are neurotic. Some people perform genital self-mutilation for monetary gain or as part of a religious delusion or ritual.

New Psoriasis Frontiers

Wednesday’s symposia luncheon entitled New Frontiers in the Management of Psoriasis featured Kenneth B. Gordon, M.D., Clinical Associate Professor of Dermatology, University of Chicago, Pritzker School of Medicine, and Jeffrey J. Crowley M.D., Assistant Clinical Professor, Department of Medicine, University of California in Los Angeles.

Psoriasis is considered an immune disease, yet all of the elements are related to a skin response to the immune system and not the immune process, said Dr. Gordon in his lecture entitled Translating the Science of Psoriasis: Where Have We Been and Where are We Going? “We thought for years that we would find the antigen causing psoriasis and then biologics could be designed to attack and shut down
the T-cells,” he said. But this was not forthcoming.

Then in the late 1990s, clinical trials studying anti-TNF therapy for the treatment of Crohn’s disease and rheumatoid arthritis suggested that TNF therapy might be beneficial for treating psoriasis. However, making the connection between TNF and psoriasis continues to be difficult. TNF was known to be present in psoriatic plaques but its role was unclear, it was not central to the theories of type 1 immune reactions, and there was no good evidence that TNF plays a role in keratinocyte responses. Inflammatory models suggested that skin injury and inflammation can lead to new developments of the psoriatic immune process. Drugs that work most actively on inflammation—anti-TNF therapies—could work well in psoriasis. What was lacking is a connection between the inflammatory cells and keratinocytes.

In animal models, IL-22 was found to induce keratinocyte hyperproliferation and to increase cell cycling. Acanthosis was found to be associated with inflammation, though it was unclear as to which is primary. Other research has shown that T-cells can put out another cytokine, IL-17, to promote the process. Consequently, blocking IL-22 and IL-17 will be looked at in the future, said Dr. Gordon. Other theories suggest that anti T-cell agents could affect IL-17 as they would other T-cells or that anti-TNF agents could decrease activity of IL-17 or work directly on keratinocyte responses. If the IL-17 theory continues to prove accurate, other potential targets could be studied. STAT3 pathways could be targeted with small molecules, or IL-20 and IL-22 could block the link between immunity and the skin.

“Our understanding of the pathophysiology of psoriasis has changed greatly in the recent past, and new observations are being made that alter our theories about the disease,” he concluded. “As we learn more about the pathophysiology, we will have a better grasp on options for therapy.”

Dr. Crowley reviewed several studies for psoriasis treatments in his part of the symposium entitled From Pathogenesis to Patients: Applying Science to Your Practice.

Ustekinumab proved to be competitive with other treatments for psoriasis in a Phase III study, with patients experiencing a PASI response of 75 at week 12. In the next study phase, half the patients stopped the medication. When they went off the drug, the psoriasis slowly returned. Between weeks 52 and 76, they retained a PASI 75 response. Ustekinumab has been shown to work long-term for most patients, he said. In the second part of the study, patients who did not respond, either received a larger dose or received the same amount more frequently. Two-thirds of the patients had a PASI of 75 and the larger doses outperformed the smaller ones.

In a phase III, multi-center, randomized study comparing ustekinumab and etanercept in the treatment of moderate to severe plaque psoriasis, ustekinumab outperformed etanercept.

ABT-874 is shaping up to look like a very powerful agent, Dr. Crowley said. In a Phase II trial, patients given ABT-874 had a PASI 75 response at week 12. “We have to see how it will perform in larger and phase III trials,” he said. Phase III is coming next year.

Additional anti-TNF agents that might prove beneficial are certolizumab and gollumumab. A Phase II trial looking at AIN-457, an anti IL-17A antibody, is underway. Other molecules are in early development. “I think IL-17 antibodies are critical,” added Dr. Crowley.

For patients who don’t want to take biologics, researchers are trying to find non-biologic therapies. Among those in early trials are AEB-071, a protein kinase C inhibitor; Apremilast (CC-10004); and Voclosporin or ISA-247. “Targeting the immune cascade with non-biologics and small molecules can lead to dramatic improvements in psoriasis,” he concluded.
Known for its massive red-rock formations, abundant sunshine, and clean air, Sedona serves as a calming backdrop for the AOCJD’s Midyear Meeting slated for April 14-17, 2010.

The city of Sedona is so high in altitude and long on natural beauty that it will lure even the most venerable of couch potatoes off their feet to explore the vast Colorado Plateau.

**Arizona State Parks**

Much of that exploration will take place in the Coconino National Forest and the many nearby state parks.

**Slide Rock State Park.** Six miles north of Sedona in the heart of Oak Creek Canyon sits Slide Rock State Park. This natural water slide that eroded into a slick creek bed surrounded by massive red-rock walls makes this park a family favorite.

This 286-acre nature preserve and environmental education center offers 10 developed trails, meadows, picnic tables, and a visitors’ center.

The park offers many daily and weekly events. For example, a guided nature walk occurs daily. On Wednesdays and Saturdays, there are bird hikes for birding enthusiasts. On the second Sunday of the month, a park volunteer escorts visitors on a guided hike explaining the rock formations that create the scenic backdrop of the park. The geology hike includes the Eagle’s Nest trail for a great view of the park and the surrounding area. The moonlight hike allows you to enjoy the sunset and moonrise from an overlook and return by the light of the moon. Most of these hikes last approximately two-and-one-half hours. Don’t forget to pack appropriate hiking shoes and clothing.

**Dead Horse Ranch State Park.** This 423-acre park in nearby Cottonwood is very much alive, despite its foreboding name. The nearly 180-mile Verde River runs through the park, making it a popular venue for hiking, canoeing, picnicking, fishing, and wading.

It is one of the desert’s last free-flowing rivers sustaining a large regional wildlife population. Life along the river in the Verde River Greenway State Natural Area changes with the season, offering a glimpse of great blue heron, black hawks, coyotes, raccoons, mule deer, beavers, ducks, frogs, and toads. The area supports nearly 20 threatened or endangered species including river otter, southwestern bald eagles, southwestern willow flycatchers, and lowland leopard frogs. More than 300 birds fly through the park annually.

**Fort Verde State Historic Park.** This park is the best-preserved example of an Indian Wars period fort in Arizona. The fort served as a base for General Crook’s U.S. Army during the 1870s and 1880s. From 1865 to 1891, Fort Verde was home to officers, doctors, families, enlisted men, and scouts. Several of the original buildings—all furnished in the 1880s period—still stand and house interpretive exhibits and period artifacts.

**Homolovi Ruins State Park.** This 4,000-acre park serves as a center of research for the late migration period of the Hopi people between the 1200s and late 1300s. Archaeologists continue to study the sites and confer with the Hopi to unravel the history of Homolovi, which they consider to be part of their homeland. Visit the sites, various trails, and a campground with picnic tables. But keep in mind that this is a sacred place to the Hopi. Removal or damage of any site, artifact, artifact fragment, or rock art can incur penalties under state law.

In addition to the state parks, there are national monuments that are still considered sacred by many local tribes today.

**National Monuments**

**Montezuma Castle National Monument.** One of the best preserved cliff dwellings in North America, this 20-room high-rise apartment is nestled into a towering limestone cliff. Eleven miles away, more than one million gallons of water a day flows continuously into Montezuma Well, providing an aquatic habitat like no other in the world.

**Tuzigoot National Monument.** Tuzigoot is an ancient village or pueblo on 42 acres built by the Sinagua who were agriculturalists with trade connections that spanned hundreds of miles. The pueblo consisted of 110 rooms including second- and third-story structures built as early as A.D. 1000.

**The Great Outdoors**

No matter where you roam in Sedona, it’s easy to spend several hours exploring hidden canyons, enjoying red rock trails, or visiting the area’s sacred...
sites. Each network of trails has its own individual character as varied as their degree of difficulty, unique location, and historical significance. While some hikes lead to high elevations, some hug winding creeks and others afford breathtaking views of distant vistas.

**Trails to Hike, Bike, and Ride.** Three low-intensity hikes with beautiful views include the Bell Rock Pathway, Mystic Hills Trail, and Herkenham/Centenial Trail in West Sedona. The Mund’s Wagon Trail, Wilson Mountain Trail, Bear Mountain Trail, Brin’s Mesa Trail, and Long Canyon Trail are considered to be long and/or difficult.

Many of these trails serve double duty as biking trails. Plus new bike paths are being added all the time; the latest additions border the Red Rock Scenic Byway.

Another outdoor option is to see Red Rock Country on horseback. Some horseback rides include extras, such as creek crossings and outdoor dining.

**Fishing.** Fishing the waters of Oak Creek Canyon is another popular pastime. Whether you prefer lakes, streams, or creeks, Sedona offers a wide variety of sport fish species.

**Birding.** For a more relaxing outdoor activity, try bird watching. Sedona’s elevation of 4,500 feet combined with a distinct change of seasons and rich riverbanks results in a varied population of birds. The area attracts nearly one-third of the 900 species of birds in the United States and Canada—from the miniature hummingbird to broad-winged raptors.

Excellent birding sites in the area include the following: Lower Oak Creek in Page Springs; Tavasci Marsh, which adjoins Tuzigoot National Monument and Dead Horse Ranch State Park; Beasley Flat, a few miles south of Camp Verde; Camp Verde Riparian Preserve; Dead Horse Ranch State Park; Mingus Mountain; Montezuma Well; Oak Creek Canyon, and; Sycamore Canyon.

**Stargazing.** When the sun goes down and Sedona’s red rocks are blanketed by darkness, a heavenly light show begins. The haze-free, cloud-free skies and the transparency of the desert air increase visibility, offering some of the best viewing conditions in Arizona.

Take a stargazing tour to view the constellations or check with the resort as some offer nights of stargazing in their courtyards.

**Sedona’s Scenic Drives**
For those who prefer observing Red Rock Country rather than hiking or biking up it, Sedona offers several scenic drives.

**89A through Oak Creek Canyon.** Oak Creek Canyon is a picturesque, intimate canyon, carved by the perennially flowing waters of Oak Creek. A 14.5-mile paved, meandering road through the canyon (89A) links Sedona to Flagstaff, and offers memorable views from either direction.

Because the canyon has an elevation gain of nearly 2,500 feet from one end to the other, 89A traverses five ecosystems, which add great variety and their own signature beauty. At the top of the canyon, stop at the scenic overlook for a panoramic view.

**Red Rock Scenic Byway (Highway 179).** Red Rock Scenic Byway is one of only 27 roads in the country designated by the US Department of Transportation as an All-American Road for its exceptional and unique recreational, natural, and scenic qualities. The Gateway to Red Rock Country, this 7.5 mile byway winds through Coconino National Forest and the charming village of Oak Creek.

**Schnebly Hill.** Only the first mile of Schnebly Hill Road is paved. The rest is 10 miles of bumpy, steep, winding road with unparalleled views and historic interest. The road, which connects to Interstate 17, dates back to 1904; but it’s only open part of the year starting in April.

**Red Rock Loop Road.** Red Rock Loop Road on the western outskirts of Sedona is a winding, partially graveled drive with several scenic pull-offs and access to Red Rock Crossing/Crescent Moon Ranch and Red Rock State Park.

Other scenic drives near Sedona are Boynton Pass Loop and Page Springs Loop as well as the drive into Sedona from Cottonwood.

If you don’t feel like driving, consider taking a jeep or air tour, a hot-air balloon ride, or a scenic railroad.

In the next issue of DermLine, explore Sedona’s other attractions ranging from museums and art galleries to golfing and shopping areas. Plus learn about local activities and events.
Charles Hughes, D.O., FAOCD, received the Albert P. Ulbrich, D.O., Lifetime Achievement Award, the AOCD’s highest recognition, at this year’s AOCD Annual Meeting.

Presenting this award during the Presidential Banquet on behalf of the AOCD Awards Committee, Shelly Friedman, D.O., FAOCD, noted that Dr. Hughes has served on the AOCD Board from 1983 to 2008. He was elected president of the College in 1982 and when his presidency was over, he joined the AOBD. “That’s twenty-five annual board exams he has given. That’s twenty-five years of going to meetings. That’s the dedication that we are honoring with this award.”

“This award is not given lightly,” Dr. Friedman continued. “It is not an award that must be given. It is an award that is given when it is well deserved and it is our College’s highest professional honor.”

Other colleagues who spoke highly of Dr. Hughes’ professionalism and dedication to the AOCD were Drs. David Walker, Lloyd Cleaver, and Steve Purcell. Dr. Hughes completed a preceptorship in dermatology in 1979 with Dr. Walker. Dr. Purcell, who replaced Dr. Hughes as Chairman of the AOBD, noted how strange it was this year to walk into the room where the residents were taking their board exams without seeing Dr. Hughes already there setting up. Dr. Hughes will still be involved in the College, however, as he received the first AOBD Emeritus position.

Added Michael Scott, D.O., FAOCD, “Dr. Hughes is a great example of how one person can make a difference. He came up through the ranks, serving on committees and then working into officer positions and other leadership roles. One of his strongest traits is his very diplomatic manner, and he always strives to do what's best for the College.”

Upon his acceptance of the award, Dr. Hughes said, “I consider it a privilege to have had the opportunity to work with so many smart and dedicated College and Board members over the years. These colleagues made those years interesting and very rewarding.” Dr. Hughes added that he was particularly happy that his wife and sons were present at the award presentation to witness Drs. Walker, Cleaver, and Purcell and others saying so many nice things.

Dr. Ulbrich founded the AOCD in 1957 and formed the AOBD one year later. The Albert P. Ulbrich, D.O., Lifetime Achievement Award was established in 1989 after Dr. Ulbrich’s passing. It is awarded to osteopathic dermatologists who have not only dedicated their lives to dermatology, but also have dedicated a significant portion of their time to the College and to the advancement of osteopathic dermatology. Six other AOCD members have been given this prestigious award.
Dr. Kirby Inducted into AOA Mentor Hall of Fame

Will Kirby, D.O., FAOCD, was inducted into the AOA iLEARN Mentor Hall of Fame in September.

The Mentor Hall of Fame honors members in the osteopathic family for outstanding excellence in mentorship by promoting the spirit of osteopathic philosophy, principals, and practice to osteopathic medical students, interns, residents and new-in-practice physicians.

Dr. Kirby was inducted into the Mentor Hall of Fame as a result of being nominated for the AOA Mentor of the Year award (in association with Pfizer, Inc.). Dr. Kirby was honored to have received multiple nominations including those submitted by an intern and a resident currently enrolled in AOA post-graduate training programs.

To learn more about how to become a mentor or nominate an AOA member for this award, or see other nominees for this year’s award, visit the AOA’s website www.do-online.org and click on the “Mentor Recognition Program” link.

Dr. Papadeas Honored by Greek Orthodox Church

Gregory G. Papadeas, D.O., FAOCD, recently received a prestigious accolade in the Greek Orthodox Church. Last month, he was invested as an Archon of the Order of St. Andrew the Apostle in New York City. An Archon is an honoree acknowledged for outstanding service to the Church, and is a well-known distinguished and well-respected leader of the Greek Orthodox community. To be invested as an Archon of the Ecumenical Patriarchate is the highest honor a layman may achieve in the Orthodox Church. The number of new Archons is limited to approximately 20 annually.

“It is very humbling to receive this honor at a relatively young age,” says Dr. Papadeas. “It puts me in a class of people who have done extraordinary work for the church. It is a blessing for the whole Denver community.”

His All Holiness the Ecumenical Patriarch Bartholomew presided over the ceremony that took place on Nov. 1 at the Archdiocesan Cathedral of the Holy Trinity in New York.

Dr. Papadeas is a member of the Greek Orthodox Metropolis in Denver. He also is past president of the AOCD and the Colorado Dermatologic Society.

JAOCD Editors Call For Papers

The editors of the Journal of the American Osteopathic College of Dermatology (JAOCD) are now accepting manuscripts for the upcoming issue of the journal. Contributions from both members and resident members are welcome.

The “Information for Authors” is available on the AOCD website at www.aocd.org/jaocd. Any questions may be addressed to the editors at JAOCDAOL.com.

Honorable Mention

Will Kirby, D.O., FAOCD, filmed segments on two shows airing on cable television this September and October. The first was on E! Entertainment Television’s That Morning Show, during which he used Dysport to treat facial rhytides on the show’s host. The other taping was for TLC’s LA Ink, during which Dr. Kirby treated one of the star’s tattoos.

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. Contact DermLine’s editor, Ruth Carol, at 847-251-5620, fax her at 847-251-5625, or e-mail her at RuthCarol1@aol.com.
Hello Everyone,

It's been a busy year here in the AOCD office and it's hard to believe that the year is almost over. It was great meeting many of you at the Annual Meeting. Next year, 2010 promises to be equally busy.

The end of the year also means that the annual dues are now due. These can be paid on-line at www.aocd.org/membership. Please remember to keep your contact information current. Your username is the e-mail address you have given the AOCD and your password is "Aocd" followed by your AOA#. The next screen will allow you to change your username and password if you wish. If you have any problems logging in, please contact us and we will help you. The 2010 AOCD membership directory will be distributed to everyone later in the year.

In-Training Exam
Results from the 2009 In-Training Examination should arrive by December 25. These will be sent to your program director.

Grand Rounds On-line
Each program is once again asked to provide a case for the Grand Rounds website. The 2010 schedule is as follows:

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

In 2011, the schedule will start all over from the beginning for each program.

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

Basic Standards Changes for New Residents
As our residency programs continue to grow, it becomes necessary to make changes to accommodate everyone. The basic standards have been changed for all new residents, effective July, 2010. These changes were approved by the AOA’s Council of Postdoctoral Training in May and the AOA’s Board of Trustees, as well as the AOCD’s Board of Trustees in July.

The changes are as follows:

- Prepare one (1) manuscript or paper suitable for publication in medical journals during each year of training, under the direction of the program director. This manuscript/paper should be based on assigned topics that incorporate basic and clinical sciences.
- During the residency, at least once in the three-year timeframe, the resident must submit an abstract at the annual meeting of the American Academy of Dermatology. The resident must provide proof of the abstract’s submission along with his or her annual report.
- During the resident’s second year of training, he/she must submit a poster at the annual AOA meeting. This poster must be an individual submission, not a group project. Material derived from the work of others must be appropriately referenced.
- During the resident’s third year of training, ONE of the above manuscripts or papers must be presented at either the AOCD’s annual or midyear meeting.

Residents graduating in 2010, 2011, and 2012 will continue under the old standards.

Meeting Attendance. A review of resident attendance at the AOCD annual and midyear meetings has resulted in the Education Evaluation Committee’s (EEC) decision to make attendance mandatory. The EEC recommended and approved the following at its meeting held this September in St. Louis:

"Attendance for all residents will be mandatory for the educational components of the AOCD’s Annual Meeting (usually Sunday through Wednesday). Attendance at the AOCD’s Midyear Meeting (usually Wednesday through Saturday) is strongly encouraged yet optional for the educational components of the meeting."

Current Basic Standards state the following: The residency program may allow a maximum of twelve (12) months of elective rotations outside the parent institution during the three (3) year training program. A minimum of one month of this elective time shall be provided each year, exclusive of AOCD annual or midyear meetings. These rotations must be approved by the program director, and must meet the requirements of the training program and the AOA. The rotation template for each resident must be available for review.

Each program must allow residents to participate in the dermatopathology scholarship program, the Scripps course...
scholarship program, the AOCD annual and midyear meetings and the AAD annual meeting.

**Annual Reports**
The forms used for the Annual Report process are being updated. Residents will be notified when the new forms are ready for use.

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

The fee schedule is as follows:
- $100 for all reports submitted 30 to 365 days after submission deadline
- $250 for all reports submitted 365 to 730 days after submission deadline
- $500 for all reports submitted 730 days after submission deadline

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

All residents are asked to provide the following documents:
- A copy of your medical school diploma (and exact date of graduation)
- A copy of your internship diploma (exact dates of attendance and name and address of school)
- A copy of your state license
- 2 passport size photos
- A current CV

Information should be sent to the AOCD at P.O. Box 7525, Kirksville, MO, 63501.

**Midyear Meeting Presenters**
A reminder for those of you speaking at the Midyear Meeting in Sedona, the timeline for submitting your information is posted below. The program chair for the 2010 Midyear Meeting is Dr. James Towry. For this meeting, he has graciously made available some time slots on Thursday morning in addition to the time slated on Wednesday afternoon for resident lectures. This will allow even more residents to present.

Administrative requirements for resident oral presentations are as follows:
- Call For Lectures/Papers 7 months prior to the first day of the meeting
- Intent to Lecture Form: AOCD office notified by resident of Intent to Lecture 6 months prior

Required signed documents must be in the AOCD office 8 weeks prior to the first day of the meeting. These documents include:
- Disclosure Statement
- Copyright/Consent
- Program Director’s Statement
- Copy of completed PowerPoint presentation

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

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

Lecture Schedule sign up closes 12 weeks prior to the first day of the meeting. No last minute additions to the lecture schedule will be accepted.

The documentation/presentations for the 2010 Midyear Meeting is due February 14, 2010 as the meeting start date is April 14, 2010.
Three residents won the 2009 Daniel Koprince Award, sponsored by Stiefel Labs, for presentations they gave at the 2009 Midyear Meeting held in Steamboat Springs, Co.

The recipients are as follows:
- Rachel Epstein, D.O., now a second-year resident at NSUCOM/Largo Medical Center in Port Richey, Fla., won first place for her lecture entitled *Dermatoses from the Depths Down Under*.
- Shannon Campbell, D.O., now a third-year resident also at O’Bleness Memorial Hospital, won second place for her presentation about *The Prevalence of Dermatologic Disease in El Salvador*.
- Gwyn Frambach, D.O., now a second-year resident at St. Barnabas Hospital in Bronx, New York, took third place for her presentation entitled *To Urticate or Not to Urticate*.

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

Winners of the Koprince Award for lectures presented at the 2008 Annual Meeting were also given their awards during this year’s Presidential Banquet.

Winners of the Koprince Award for lectures presented at the 2008 Annual Meeting were also given their awards during this year’s Presidential Banquet. The previously announced winners include Nicole Bright, D.O.; Melinda Conroy, D.O.; Roger Sica, D.O.; Jason Mazzurco, D.O.; and Joseph Laskas, D.O.

Pictured (left to right): Drs. Gwyn Frambach, D.O.; Nicole Bright, D.O.; Melinda Conroy, D.O.; Janet Koprince, D.O. (daughter of Daniel Koprince, D.O., for whom the award was named); Joseph Laskas, D.O.; Jason Mazzurco, D.O.; and Rachel Epstein, D.O. Drs. Bright, Conroy, Laskas, and Mazzurco won the award for the presentations given at the 2008 Annual Meeting.
Three residents tied for third place in the 2009 Intendis Call for Papers Competition, resulting in a total of five winners.

The first place winner is Ali Banki, D.O., for his paper entitled Dapsone Gel in Dermatology: Review and Update. Dr. Banki was a third-year resident at St. Barnabas Hospital, Bronx, New York, when he submitted the paper. He received a $2,000 award.

Karthik Kirshnamurthy, D.O., received second place for his paper on Transcutaneous Absorption of Topical Preparations. Dr. Kirshnamurthy, who was a third-year resident also at St. Barnabas Hospital when he entered the competition, received a $1,500 award.

The three-way tie, with each winner receiving a $500 award, went to the following residents:

- Aaron Bruce, D.O., for his paper entitled Surgical Myths in Dermatology. Dr. Bruce was a third-year resident at NSUCOM/Largo Medical Center in Fort Richey, Fla., when he submitted the paper.
- Gwyn Frambach, D.O., for her presentation entitled To Urticate or Not to Urticate: A Case of TMEP and Review of Cutaneous Mastocytoses. Dr. Frambach was a first-year resident at St. Barnabas Hospital when she entered the competition.
- Roger Sica, D.O., for his review paper on Uses of Dermoscopy in Pediatric Dermatology. He was a third-year resident at NSUCOM/Largo Medical Center when he submitted the paper.

Winners were presented their awards at the 2009 AOCD Annual Meeting in New Orleans.

Intendis’ 2010 ‘Call for Papers’ Competition Gets Underway

Intendis Pharmaceuticals is looking for top notch research papers for its 2010 Call for Papers Competition.

Papers will be judged for originality, degree of scientific contribution, and thoughtfulness of presentation. Deadline for submission is May 25, 2010.

Winners may claim cash awards provided by Intendis as follows:
- 1st Prize—$1,500
- 2nd Prize—$1,000
- 3rd Prize—$500

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

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

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

Winners will be announced at the 2010 AOCD Annual Meeting to be held Oct.24-28 in San Francisco.
Register for Midyear Meeting

Registration for the 2010 Midyear Meeting to be held April 14-17 in Sedona, Ariz., is easy and fast. Simply visit the AOCD website (www.aocd.org), click on “Renewals & Marketplace” link, and fill out the on-line form.

Take advantage of early registration, which is until December 31, 2009. Don’t forget when you make your reservation at the Hilton Sedona Golf Resort & Spa to mention that you are with the AOCD.

The next AOCD Midyear Meeting will be held at the Hilton Hotel Resort and Spa in Sedona, Ariz., April 14-17, 2010.

Sedona is one of America’s most beautiful locales. In addition to the beautiful surroundings, our meeting promises to give relevant updates in clinical dermatology and dermatopathology. We will have an excellent faculty as well as the usual concise resident presentations on many diverse dermatologic topics.

Sedona presents a very pleasant blend of the Old Southwest and New Age harmonies. There will be many varied opportunities for relaxation, entertainment, and education quite unlike any you may have experienced in the past.

Please consider attending to not only update yourself in dermatology, but also renew your soul in a unique and beautiful environment. Hotel reservations can be made by calling 1-800-Hiltons or contacting the Hilton Sedona Resort & Spa directly at 928-284-4040. Be sure to mention that you will be attending the AOCD meeting to obtain the special meeting room rate. I look forward to seeing you there.

Jim Towry, D.O., FAOCD
Program Chairperson

A Call to Attend the 2010 Midyear Meeting

‘Clever Cleavers’ Win Second DermPath Bowl

For the second consecutive year, the “Clever Cleavers” won the DermPath Bowl played at the AOCD Annual Meeting.

Team members are Christopher Weyer, third-year resident; Bo Rivera, second-year resident; and Jonathon Cleaver, first-year resident at the Northeast Regional Medical Center under the directorship of Lloyd J. Cleaver, D.O., FAOCD.

The Dermpath Bowl, sponsored by Dermpath Diagnostics, made its debut at the 2008 AOCD Annual Meeting in Las Vegas. It was first played at the American Academy of Dermatology’s annual meeting in 2007.

Sixteen resident program teams competed head-to-head in this single elimination dermatopathology competition. Equipped with microscopes and clinical history only, each competing team diagnosed two cases. The declared winners advanced to the next round. The champions took home a $2,500 unrestricted educational grant.
DOs, DO Residents on the Rise

The number of osteopathic physicians and those in osteopathic internships and residencies is on the rise, making DOs one of the fastest growing segments of healthcare professionals in the United States.

Specifically, the number of DOs has increased by nearly five percent in the last year, according to the 2009 Osteopathic Medical Profession Report released by the AOA this September. By the year 2020, the AOA predicts that more than 100,000 DOs will be in the workforce. (See Table 1, which shows the exponential growth in the number of living DOs since 1935.)

Additionally, enrollment in osteopathic medical schools increased eight percent during the 2007-2008 academic year. The total number of DOs in osteopathic internships and residencies has grown by more than nine percent in the past year, which is new information included in this year’s report. Since 2003, five new osteopathic medical schools and three new branch campuses have opened to accommodate the need for more physicians, especially in rural and underserved areas.

Historically, DOs have served in a handful of states, such as Michigan, Pennsylvania, and Ohio. However, in recent years this pattern has decreased and DOs are gaining a presence throughout the 50 states.

To view a copy of the entire report, visit the AOA’s website at www.do-online.org.

AOCD Thanks Sponsors

The AOCD wishes to thank the following companies for their sponsorship at the 2009 Annual Meeting:

Biopelle, Inc. for sponsoring the Welcome Reception held at the Pharmacy Museum in the French Quarter. America’s first pharmacy complete with a medicinal herb garden served as the backdrop for welcoming members to the meeting and New Orleans.

Global Pathology for sponsoring the Mardi Gras-themed Presidential Reception befitting the host city.

Galderma for sponsoring the residents’ lunch held after the In-Training Examination.

Centocor-BioTech, Inc. for providing travel grants for the residents attending the meeting.

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

- Amgen and Wyeth Pharmaceuticals
- Allergan
- Centocor-BioTech, Inc
- Coria
- Dermatolopathology Laboratory of Central States
- Graceway Pharmaceuticals
- Ranbaxy Laboratories
- Sanofi-Aventis/Dermik
- Stiefel Labs
- Triax Pharmaceuticals

The AOCD also wishes to thank two companies for their supporting awards through educational grants. Stiefel Labs sponsored the Daniel Koprince DO Education Awards and Intendis sponsored the Resident Research Paper.

Finally, a special thanks to Allergan, BioForm, Inc., and Medicis for providing products for use at the Live Filler Workshop.
By now, you have a marketing plan and budget in place, own a well designed logo, and your website is complete. That means it is time to focus on building your website’s popularity and your practice’s presence on-line.

There are countless avenues you can use to market your website. This article will focus on those that my experience shows to be the most cost effective. Many require nothing more than a few minutes of your time.

Get Indexed
This one is simple, but don’t fall for those offers to automatically list your website in hundreds of search engines. This process is manual. Do it yourself or hire a competent Search Engine Marketer to do it for you. Google will drive the lion’s share of search traffic to your website, but Yahoo and MSN/Bing will also contribute to the overall success.

The process is simple; you tell each search engine where to look for your website (your domain name). Here are the important search engines along with the site submission page:

- **Google** - www.google.com/addurl
- **Yahoo!** - siteexplorer.search.yahoo.com/submit This submission is free, but I recommend using the paid option to submit your site to the Yahoo! Directory, as well. See the section on “directories” to follow.
- **MSN/Bing** - www.bing.com/docs/submit.aspx
- **What about AOL?** AOL no longer maintains its own search database. AOL results come from Google.

Don’t get too excited. It will take time for your website to appear in search results. Each search engine will vary, but typically your website home page will start to appear in a few weeks. It may take a few months or more for all of your web pages to be indexed.

**Hint:** Download the Google toolbar and activate the “Pagerank” feature. You’ll know if a page within your site is indexed by Google by checking the pagerank. Your goal is a pagerank of 3 or higher. Typically your home page will have the highest pagerank.

Get Local
Many of your prospective patients will be searching locally. Ensure that your web pages contain local municipalities and terminology. In addition to your website, many web savvy users will search the following:

- **YellowPages.com** – If you read the Marketing 101 article that appeared in the Spring 2009 issue, you know that yellow pages books and their web assets are still relevant. You should have at least one ad in the yellow pages.
- **Google Maps** – maps.google.com This is Google’s local component. Create a Google account so that you can update your location, create a profile, and offer incentives.
- **Yahoo! Local** – local.yahoo.com This is similar to Google maps. You should use all the marketing options available to you.
- **Other local directories and popular websites** – You know your town better than anyone else. Talk to your patients to find out how they use the Internet and put your practice where patients are looking. This also ties strongly into “Get Talking” discussed below.

Get Listed
Now that you have submitted your site to the key search engines, it’s time to build some relevancy into your website. This will help both humans and search engines. One simple way is to get listed in popular web directories. Some of them will charge an annual fee for your listing. Pay it as it’s worth the investment. In general, the more directories your website is involved with, the better. Here are a few of the major ones:

- **AOCD.org** – www.aocd.org/find_do If you’re a member with a website, but you haven’t created a profile yet, stop reading and do it now. The AOCD directory is very popular and a listing in it will build your own website’s popularity in search engines.
- **The Open Directory Project** – www.dmoz.org This directory will test your patience. It is managed by a group of volunteers who are typically underappreciated and overworked. Getting here might take one week or one year. It all depends on the category. Listing here is
worth the wait as Google is suspected to use this directory in its calculation of pagerank.

- **Yahoo! Directory** – ecom.yahoo.com/dir/submit/intro
  Remember the free submission to Yahoo! noted in “Get Indexed”? Submitting your website to the directory will cost you, but it’s well worth it as your submission is guaranteed to be added to the index as well as the directory in a very short period of time.

- **Business.com** – www.business.com/info/advertise
  This is another paid listing, but worth the cost as this directory is reputed to aid the overall legitimacy of your website in other search engines.

- **Best of the Web** – botw.org/helpcenter/submitcommercial.aspx
  This directory is one of the oldest on the Internet. I recommend the one-time payment.

- **Go Guides** - www.goguides.org/addrurl.html
  A popular directory with a small one-time fee. Your site should employ site maps to fully benefit from this listing.

*Hint: Many directories have a local component. Local listings will almost always be more beneficial for small businesses. Be sure to use the local listings, as well.*

### Get Talking

Blogs, forums, and editorials are all very effective avenues for self promotion.

- **Start a blog.** I recommend wordpress, but there are many others. The key is get started and get your blog linked with older more established blogs. A little leg work and courtesy go a long way. Remember to link to your primary website often.

- **Join a few forums.** Medical advice forums are everywhere. It’s common for people with various afflictions and skin conditions to seek free advice. Local (and national) forums can produce patients and build your reputation. Include a link to your website, when possible. But there is a caveat. Forums can be a double-edged sword, a bad reputation can be built just as quickly as a good one.

- **Write Articles.** With the proliferation of websites comes the need for content. Many sites will be more than happy to trade your articles for establishing you as a resident expert and including one or more links back to your dermatology practice website. You can link to the same articles from your website. This helps to establish credibility in the eyes of a prospective patient.

### Get Visibility

Paid search is a highly effective means to get your website listed in search engines at a guaranteed position, preferably top 10. Stick with the aforementioned major search engines, with an emphasis on Google. In each case, you will need to open an account using a credit card. You place bids on certain keyword phrases and typically only pay when someone clicks on your advertisement. These advertisements appear alongside the “natural” search engine results. Use a paid search listing for those keyword phrases that haven’t achieved high natural ranking or for terms that produce high profits.

Quick links to help you get started:
- Google Adwords - adwords.google.com
- Yahoo Search Marketing - advertising.yahoo.com/smallbusiness/yahoosearchmarketing
- MSN/Bing Search Advertising - advertising.microsoft.com/search-content-advertising

The downside of paid searches is that they can get expensive. On the upside, you have full control over how much you spend and how quickly you spend it. Always set a spending limit. You will be in control since you have already developed a marketing budget following the tips presented in previous articles.

There are no guarantees in the marketing business due to the subjective nature of the medium. But if you employ these five recommendations, your website will be on the right track. Success rarely comes quick, be patient and keep at it. Once these elements are in place, they will produce results for months or years to come, often at no additional cost.

Roger Watson is a marketing and e-commerce consultant and owner of Creative Innovations. He has worked with the AOCD for more than seven years, designing the website, logos, and DermLine. Roger has vast experience with brand development, search engine optimization, and website design. Learn more about his capabilities at www.2create.com.

### Get Your Marketing and Website Design Questions Answered

A series of articles explaining how to market your practice on-line and on the street has been published in this year’s issues of DermLine. These articles have taken you through the basics of marketing from determining a budget to getting your website to appear high in search results.

Now is your opportunity to get answers to any questions you may have about marketing your practice. Whether you’re just starting the process or you would like to fine tune your current efforts, ask our resident marketing and e-commerce expert, Roger Watson.

Send your questions to DermLine’s editor, Ruth Carol, at RuthCarol1@aol.com or fax them to 847-251-5625. Look for the answer in the next issue of DermLine.
Join us in Sedona, Arizona for the
Midyear Meeting
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With its massive red-rock formations, abundant sunshine, and clean air, Sedona serves as a calming backdrop for the AOCD Midyear Meeting.

Come to the meeting to keep current with the latest in dermatology. Stay to get a glimpse of some of the most scenic territory in this nation from the Coconino National Forest to the Red Rock Scenic Byway. There is enough natural beauty to keep the naturalist engaged, enough outdoor activities to keep the sports minded occupied, enough history and archaeology to keep the history buff enthralled, and enough museums and galleries to keep the culturally minded enchanted.

Natural endowments aside, you’ll also find world-class resorts and fine dining. So after enriching your mind at the meeting, kick back, relax…and just be…in Sedona.