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Upcoming Events
AOCD ANNUAL MEETING 2010
October 24-27, 2010
San Francisco, CA

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

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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Dear colleagues and friends,

Since there is a delay of approximately two months between the time I wrote this message and its publication, summer will be coming to an end, so I hope you all enjoyed it with family, friends, and colleagues. As fall is fast approaching, we should be turning our attention to our Annual Meeting in the grandly unique city of San Francisco. The fall season is rich with autumn colors and the harvest of our labors. Our President-Elect, Dr Leslie Kramer has been working very hard on every aspect of the meeting with the help of your executive staff, so we can enjoy the fruits of her labor. It promises to be another outstanding way for us to gather, once again, with colleagues and friends for several days of great CME, cuisine, and fellowship in a city noted for its food, culture, and diversity.

I would now like to share with you some significant highlights from a dinner meeting I attended this past July. Even though Astellas Pharma Inc. sponsored it primarily for urologists, other physicians writing for Astellas’ products, such as Protopic, were invited because the lecturer, Dr. George Ho, is a noted expert on healthcare reform. Although a Republican, Dr. Ho has been an invited guest of the White House several times. He also has been able to cut the overhead of his urology group practice from 57.2% to 28.1% within seven years by starting and heading up their own healthcare company and malpractice company as well as eliminating pay raises by instituting an incentive bonus performance ranking system for office staff.

You may be aware that the National Provider Identifier—or NPI—numbers have become a database for you to be compared against your fellow colleagues, Dr. Ho pointed out, but what you may not know is that your participation, or lack there of, in the Physician Quality Reporting Initiative (PQRI) is providing a five-star physician ranking system for the federal government’s use with the new Obama healthcare system.

As you may remember at our Annual Meeting last year, Dr. David Pariser, Immediate Past President of the American Academy of Dermatology, urged you to participate in the PQRI for the monetary Medicare bonus of 2% (from 2007 through 2010), down to 1% in 2011. If you do not participate in the PQRI by 2012, you will have earned a one-star ranking. As a result your patients, if you have any left, will be paying higher co-pays when they see you and you will have more prior authorizations to submit for them.

He noted that five-star doctors would have the lowest co-pays and prior authorizations for their patients. According to a national study, it only takes an increase of $6.75 in co-pay for a “loyal” patient to switch doctors. Starting in 2013, if you are still not participating in the PQRI, you also will be paying a penalty to Medicare for each patient visit by not doing so. I urge all of you who have not yet started participating in the PQRI to do so for 2010.

Now, if you think this is bad, Dr. Ho predicts that when the temporary Medicare reimbursement fix runs out at the end of this November if Congress loses its Democratic majority in the House, the Republicans may very well be “forced” to let the then 30% reduction in Medicare reimbursement go through in January 2011. This could very well happen in order to maintain their “fiscally responsible” image. The reason why the reduction number keeps going up is that the original reduction never occurred and the loan on those monies continues to accrue interest annually.

However, there were a few positive notes from Dr. Ho’s presentation regarding reimbursement. We can all charge for a level 1 visit, which does not require you to see the patient, if a federal patient calls after hours or on the weekend and you need to call in a prescription. The code is G8444. If you e-prescribe, the codes are either G8443 or G8445. Also, if you see and care for federal patients in an officially underserved area, you are eligible to receive an additional 17% multiplier.

Lastly, your Board of Trustees and I look forward to seeing you in San Francisco. We are working on a President’s Banquet that has a shorter business portion and a longer entertainment portion, so please make plans to attend the whole event.

Sincerely,

Marc I. Epstein D.O., FAOCD  
President, 2009-2010
Executive Director’s Report
by Marsha Wise, Acting Executive Director

Hi Everyone,

There have been many changes in the AOCD national office these past several months as we undergo many transitions. I would like to thank everyone for their patience during this time.

I recently returned from the annual summer meeting of the AOA’s Board of Trustees (BOT) and House of Delegates (HOD) held in Chicago, July 12-17. The BOT and HOD meetings establish policy for the AOA, specialty colleges, and state affiliates.

Prior to the BOT meeting getting underway, several other smaller groups met to develop recommendations to the BOT and HOD. One of them was the Bureau of Osteopathic Specialty Societies (BOSS), which met on July 11th. All specialties are represented in the BOSS and have a vote. Dr. Robert Schwarze is our BOSS delegate. In addition to reviewing the proposed resolutions and making recommendations to the BOT and HOD, the BOSS members can propose new policy.

On July 12, I attended the Society of Osteopathic Specialty Executives (SOSE), of which the AOCD also is a member. All specialties are represented in SOSE and have a vote in this organization, as well. Like the BOSS members, SOSE members review proposed resolutions, make recommendations to the BOT and HOD, and can propose new policy.

At the SOSE meeting, Diane Burkhart of the AOA’s Education Department presented an educational program on CME updates. Osteopathic Continuous Certification, Maintenance of Licensure, and CME issues including how the PharmaCode is impacting all CME providers were hot topics of discussion.

On a similar note, during the AOCD Midyear Meeting in Sedona, an ad hoc committee was formed to address CME needs of the AOCD. Dr. Marc Epstein is currently serving as the Chair for this committee. He along with BOT members, Drs. John Minni and Dwayne Montie, and me, are working to restructure the existing Meetings Committee into a more formal CME planning committee. Your input for future meetings is greatly appreciated, so please take a moment to fill out and return evaluation forms on the AOCD meetings that you have attended.

Executive Director’s Report

Next March, our convention is at Marco Island’s beach front hotel by Marriot. And yes, you can rent a dingy and cruise till you are exhausted. The area is a wonderful getaway 15 miles southeast of Naples, 53 miles south of Fort Myers, and 100 miles west of Miami.

Marco Island is reminiscent of a sleepy, albeit swanky, beachfront retirement community. When the sun goes down, you can hear a pin drop, with the exception of the AOCD Welcome Reception. But this is how the locals prefer it. There’s some nightlife here—a new comedy club for the night owls and some local watering holes. But if you’re looking for a club scene, Marco isn’t for you.

That said, Captain William Collier would still hardly recognize Marco Island if he were to come back from the grave today. In 1871, the captain settled his family on the north end of this island, the largest of Florida’s 10,000 islands. He traded pelts with the Native Americans, caught and smoked fish to sell to Key West and Cuba, and charged fishermen and other guests $2 a day for a room in his home. A few turn-of-the-20th-century buildings still remain, but Collier would be shocked to come across the high-rise bridge to the island, which is now sliced by man-made canals and virtually covered by resorts, condominiums, shops, restaurants, and winter homes. These are the products of an extensive real-estate development that started in 1965, which means...
**EEC Efforts**

At the Education Evaluating Committee (EEC) meeting in New Orleans last fall, the AOCD BOT approved expenditure for an Item Writer’s Workshop. Members of the In-Training Exam Committee and the AOBD attended this workshop in St. Louis this past July to learn the very latest about writing exam questions.

Dr. Jim Towry heads the In-Training Exam Committee. Other committee members include the following: Drs. Ryan Carlson, Shaheen Oshtry, Benjamin Adams, Marya Cassandra, Lloyd Cleaver, Merrick Elias, Jonathan Keeling, John Minni, Andrew Racette, Matthew Smetanick, Adam Wray, Danica Alexander, Nanda Channaiah, Tejas Desai, Tanya Ermolovich, Mary Beth Luca, Dwayne Montie, Suzanne Rozenberg, and Joan Tamburro.

In September, the EEC met again in St. Louis to approve the 100 residents’ annual reports for this past year as well as to discuss residency program issues. As you may know, the EEC is responsible for reviewing all osteopathic postdoctoral training programs in dermatology for any recommendations to the AOA’s Program and Trainee Review Council and to ensure the Basic Standards in dermatology education are being met.

**Annual Meeting**

Dr. Leslie Kramer has developed a diverse educational program that will be of interest to our members at the upcoming AOCD Annual Meeting. *Melanoma Monday* kicks off the meeting with a 4-hour symposium moderated by Dr. Ed Yob.

This year all physician awards, including the Koprince Award and the Intendis Research Paper Award, will be presented to the winners at the annual Business Meeting, which is scheduled to be held between 3 p.m. and 5 p.m. on Monday, October 25.

I look forward to continuing my work with the AOCD. Coming from a family filled with educators, I feel that maintaining the integrity of our residency programs and providing quality CME programs for our members is a priority and is vital to the future of the College.

Remember that the AOCD is *your* organization! Please let the national office know what we can do to improve communication with you. We welcome your comments and suggestions.

I look forward to seeing all of you in San Francisco and hopefully meeting more of our members.

And finally, “If you want to be successful, it’s just this simple. Know what you are doing. Love what you are doing. And believe in what you are doing.”

-Will Rogers

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**Updated Membership Directory Now Available**

The 2010 AOCD Membership Directory has been completed and mailed to all members. Please remember to keep us informed of any address changes. Members also are encouraged to periodically review their “Find a DO Dermatologist” listing at [www.aocd.org](http://www.aocd.org) for any updates needed.

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that Marco lacks the charm found in nearby Naples and on both Sanibel and Captiva islands. Much of the sales effort here was aimed at the northeastern states, so the island smacks more of New York and Massachusetts than of the laid-back Midwestern style of its neighbors.

Marco Island’s only real attractions are its gorgeous crescent-shaped beaches, access to the nearby colorful waterways running through a maze of small islands, its excellent boating and fishing, and its proximity to acres of wildlife preserves. Don’t forget the beautiful weather!

Marco is an hour’s drive from Miami (provided you don’t get a speeding ticket on Alligator Alley Drive). One could fly to Naples and catch a short ride in a cab or shuttle. Or maybe you prefer to forget the car in order to enjoy the shops by walking. It’s possible! Program Chair Karen Newbauer, D.O., believes the Midyear Meeting will be just as outstanding as is the locale.

With osteopathic continuous certification (OCC) a requirement for AOCD members in 2011, the American Osteopathic Board of Dermatology (AOBD) met the last weekend in July in St. Louis, Mo., to discuss its various components and how they will roll out.

All certifications became time-limited in 2004. Beginning next year, individuals who were certified in 2004 and later will have to obtain continuous certification as mandated by the AOA, the Bureau of Osteopathic Specialty Societies, and the Federation of State Licensure Board. To clarify, physicians with lifetime certificates will not be required to obtain OCC at this time. The College will be responsible for overseeing the OCC components for those members required to obtain it.

The component that dominated the discussion is the Clinical Assessment Program (CAP). This Web-based performance measurement program developed by the AOA measures clinical practices in the physician’s office and compares the outcomes to their peers and national measures. To do so, the CAP analyzes data abstracted directly from patient medical records.

The purpose of the CAP, according to the AOA, is as follows:
- To provide a structure for quantitative evaluation of current osteopathic care provided individually and in the aggregate by osteopathic physicians.
- To identify where quality-of-care improvements can be made in osteopathic physician’s offices and provide educational interventions.
- To provide osteopathic physicians with information on how they are treating their populations.

Clinical indicators selected for measurement represent evidence-based clinical practice standards derived from large randomized controlled clinical trials, single controlled observational studies, or expert consensus. Existing measure sets include coronary artery disease, diabetes mellitus, and women’s health screening. Examples of indicators appropriate for dermatology are the three melanoma measures developed by the American Academy of Dermatology.

The AOBD will be developing additional evidence-based protocols to help dermatologists identify areas for improvement, says Lloyd Cleaver, D.O., the AOBD Secretary/Treasurer.

Just as dermatologists using the three melanoma measures makes them eligible for the 2010 Physician Quality Reporting Initiative (PQRI) developed by the Centers for Medicare and Medicaid Services (CMS), so too will participation in the CAP. Therefore, College members who participate in the CAP may be eligible for the 2% bonus incentive from Medicare, says Dr. Cleaver.

The CAP will ease the transition to pay-for-performance by using clinically relevant methods that are not claims-based, he notes. In addition, physicians who participate in the CAP receive 20 hours of AOA Category 1-B continuing medical education (CME) credit for each measure set.

Osteopathic continuing certification will occur over a nine-year cycle corresponding to the three-year CME cycle. Components of OCC include the CAP, an unrestricted license, 50 hours of Category 1-A credit per three-year CME cycle, optional additional training through certified CME, a proctered exam directed at more clinically relevant material than the certification exam, and peer and patient review.
Committee Attends Question-able Workshop

If you think taking the In-Training Examination is difficult, try writing the questions for it.

That’s exactly what members of the In-Training Exam Committee (ITEC) did the last weekend in July when they met in St. Louis, Mo.

The ITEC members were invited to join the American Osteopathic Board of Dermatology (AOBD) at a two-day workshop focusing on how to write exam questions. The ITEC members who attended were Drs. Danica Alexander, Ryan Carlson, Merrick Elias, John Minni, Dwayne Montie, Shaheen Oshtory, Adam Wray, and ITEC Chair James Towry. In addition, AOBD members in attendance were Drs. Steve Purcell (AOBD Chair), Lloyd Cleaver (AOBD Vice Chairman), Eugene Conte, Gene Graff, Robert Schwarze, and Edward Yob.

To illustrate the importance of test question writing, guest lecturer and nationally renowned psychometrician Terry TenBrink, Ph.D., told the story of when he was consulting about the testing of dental school students with a dental school in Texas. When Dr. TenBrink was informed that they had just finished writing the exam for periodontists, he asked if he could take it. Based on his test results, Dr. TenBrink was qualified to be a periodontist. Although in reality he knew very little about periodontistry, Dr. TenBrink did know how to take tests, especially poorly written ones.

Dr. TenBrink, who is recently retired but served as the psychometrician at the Kirksville College of Osteopathic Medicine since 1986 and has worked with many post-graduate schools, reviewed examples of question writing, including do’s and don’ts. Some do’s are always have a positive question, end the question with a question mark not a colon or period, use at least three or four distractors (i.e., wrong response answers) in the answer, and make the distractors reasonable and comparable to the correct answer. The don’ts include “type K” questions (i.e., complex multiple choice), percentage questions, questions with multiple true or false answers, and questions with answers or distractors that do not follow grammatically from the question.

He also gave an in-depth analysis of the science of question writing. The science comes in after the test is taken by reviewing how the questions performed. An example, a question that everybody gets right or wrong is probably a poorly written question. Questions should cover more than just knowledge, but also comprehension and application. The latter type of question is much harder to write.

As part of the workshop, ITEC members had the opportunity to review questions written by members for previous exams. Also, each ITEC member in attendance had his or her respective work reviewed and evaluated.

“This was extremely valuable and informative for everyone and especially for those of us who have never had this kind of instruction before,” notes Dr. Towry. “There is no doubt that this will be a great help in the future not only for our in-training examinees, but also for the members of the ITEC.”

“Attending this meeting took a great deal of time and effort on the part of both our ITEC and AOBD members who each took time away from family, home, and work to be there,” he adds. Dr. Towry wanted to thank everyone involved in making the workshop a success, including the ITEC and AOBD members, Marsha Wise, Rick Mansfield, and Dr. TenBrink.

The ITEC members are discussing the possibility of participating in another similar meeting next year in order to continue the process of improving the In-Training Exam taken by AOCD residents.
“Ordered chaos” is how Shannon M. Campbell, D.O., Chief Resident at the Ohio University O’Bleness Memorial Hospital Dermatology Residency Program, describes her nearly six-week rotation at the Princess Marina Hospital in Botswana.

“The clinic has a set schedule, but there are always patients added or left off as the day progresses. You receive four consults from the hospital and a few from the clinic across town, or a group of twenty prisoners can arrive unannounced,” she says. “And you haven’t even seen the patients scheduled for the day. It’s a wonderfully frenzied, but productive, day.” The lack of assistance and supplies adds to the chaotic mix that is somehow balanced with the strong partnership between patient and physician.

Dr. Campbell trekked to the South African country this past March after being awarded the Residents’ International Research Grant by the American Academy of Dermatology, in conjunction with the Botswana-UPenn Partnership.

First Days There
Her excitement upon arrival quickly dissipated when Dr. Campbell was handed an HIV pill pack to carry at all times. “There’s nothing like the harsh slap of reality to put your romantic ideas of travel and saving the world into perspective,” she says. “However, it also reminded me that I had a job to do.”

Dr. Campbell’s first assignment was to update two months’ worth of skin biopsies. “I was shocked and overwhelmed at first,” she recalls. But after a couple of days, Dr. Campbell focused on the task at hand and completed it. She collaborated with the attending pathologist to develop a system with a separate bin for dermatology cases, an area designated solely for skin biopsies, and a running log in the office to follow the cases more closely. In addition, complicated cases can be reviewed at UPenn through a tele-dermatopathology program.

“I found it helpful to make goals practical and flexible, with the knowledge that I could not control what happened around me,” says Dr. Campbell, “but I could dictate how I would react to each bump along the way.” A key lesson as the bumps kept on coming.

Clinic Days
Clinic days were unpredictable, but highly educational. “Patients came in with everything from the very ordinary to the extraordinary,” she says. “When a patient would walk in, I’d sometimes be quietly thinking, ‘Wow, I’ve only seen this in Bologna.’” The 15 patients with albinism, the case of bacillary angiomatosis, and the three cases of Toxic Epidermolytic Necrolysis (TEN) in one week are prime examples.

Initially, the realization that Dr. Campbell did not have the safety net of an attending physician by her side was frightening. “Basically it’s a one-man show,” she notes. “But at the same time, I enjoyed the challenge and developed my own style of patient management here in Bots.”

Being efficient and providing quality care was not always an easy task. For example, many of the HIV cases turned out to be cutaneous tuberculosis. “You think you know what it is, but you’re waiting on the biopsy, and you can’t offer prophylactic treatment because you’re limited with supplies.”

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Determining the best treatment options were equally as challenging, says Dr. Campbell who saw several patients with extensive cutaneous malignancies. Without the option of referring the patient to a Mohs micrographic surgeon, otolaryngologist, or plastic surgeon, her only choice was to offer radiation. “I had to offer what may not be the best option for treatment and also revisit traditional methods of therapy, such as radiation, that have been replaced by newer or more exciting therapies in the US,” she says.

“With each day, I came to accept that Botswana is a country that runs on Murphy’s Law,” adds Dr. Campbell. “This realization made the daily trials and tribulations easier to accept. It’s just their way of life. My job there isn’t to judge it, but to work within it.”

She was most surprised by the partnership forged between patients and healthcare workers. The patients are very well informed about their health, largely because they are responsible for keeping their own medical charts. They take the charts home with them following visits and they take them to the pharmacy to get prescriptions filled, notes Dr. Campbell. In contrast, many patients in the States can’t remember their diagnosis or all the medications they’re on. She believes that the communication between patients and healthcare workers is partly responsible for the strong partnership.

Other Tasks
Next to assisting in providing dermatologic HIV care for both children and adults, another primary goal of the program is educating the medical community. To that end, Dr. Campbell created a PowerPoint presentation about cutaneous manifestations of HIV for the general house staff. It included how to identify, work up, and treat skin diseases associated with HIV. She gave the presentation in a four-part lecture series. In addition, Dr. Campbell lectured about skin hypersensitivity reactions, such as Stevens Johnson Syndrome and TEN, and HIV medications at community outreach clinics in Lobatse and Kanye.

Part of the challenge for new residents in the UPenn program is familiarizing themselves with the medications available at the hospital and learning how the system runs. To make the transition easier for new residents, she developed a formulary with the help of Dr. Jennifer Tan-Billet, a resident from Brigham and Women’s Hospital. They spent time with the pharmacist to find out what medications are available and in what form, how the residents can dose the medications, and what compounds the pharmacy can create.

Dr. Campbell also sent interesting cases back home to the O’Bleness residency program and Ohio State University, which were presented and discussed at weekly didactic sessions.

While Dr. Campbell gained a new appreciation for the health care available in the States, she also learned that there isn’t one right way to practice medicine. “The fundamentals of medicine are the same all over the world,” says Dr. Campbell. “But you learn how medicine truly is an art when you observe doctors treating patients with limited supplies and their own sense of creativity.”
San Francisco is home to more than 40 vibrant neighborhoods, each with its own claims to fame and local lore. While attending the 2010 AOCD Annual Meeting, take an opportunity to explore some of them. No two neighborhoods are alike and each is worth a closer look, so pick a direction and start walking.

**North Beach**

If you visit North Beach in the morning, be prepared to come across the regulars practicing tai chi in Washington Square. For a little more rigorous workout, climb Coit Tower on top of Telegraph Hill. Your reward will be a spectacular panoramic view of Nob Hill past the Golden Gate Bridge, Alcatraz, and the East Bay. On the inside, view the murals painted by 30 local artists in 1933. The hill is also home to a flock of wild parrots and is laced with stairways of lush gardens. North Beach’s defining feature is Saint Peter and Paul Church, an authentic Italian cathedral.

Enjoy chocolate from Ghirardelli’s, one of the top chocolatiers in the country and see how it is made. Visit both bread and pastry bakeries where you can enjoy freshly baked breads and watch them being baked on 130-year-old brick ovens. While being served up some of the best coffee and cappuccino around, you can see how coffee is roasted close up. Grab that coffee to go as you explore former Beat generation hangouts and even one remaining bookstore, City Lights, which features a collection of literature, poetry, and avant-garde theory and criticisms that you won’t find anywhere else. Visit the place where Bill Cosby and Steve Allen got their start and where Francis Ford Copola wrote the Godfather screenplay.

For the night owls among us, North Beach transforms into one of the city’s best playgrounds featuring numerous venues for live music and dancing.
Nob Hill
Nob Hill is one of San Francisco’s signature neighborhoods, renowned for its landmarks and famous hotels that border Huntington Park.

The area’s reputation of privilege dates back to Gold Rush times, when cable car lines made the hilltop accessible and the railroad barons and bonanza kings built their mansions there, far above the rowdiness of the bawdy waterfront. Luxury hotels now stand in the place of those original palaces, but some historic buildings still remain. Explore the Silver King Flood’s mansion that survived the 1906 earthquake and was restored. Walk around elegant ballrooms where Tony Bennett sang “I left my heart in San Francisco.” Amidst the Fairmont Hotel, the Nob Hill Masonic Center, and the Cable Car Barn (where cable cards are stored when not in service) are the lush cascades of bougainvillea and the genteel apartment buildings with their wedding-cake facades. The hill is dotted with vintage barber shops, old corner coffee shops, and cocktail lounges from bygone decades.

Be sure to head over to Lombard Street, between Hyde and Leavenworth streets. You’ll know when you get there because it’s “the crookedest street in the world.”

Take a scenic walk in Huntington Park where the sculpted beauty, the Fountain of Turtles from Rome, is situated. Visit California’s first cathedral, Grace Cathedral built in 1854 and filled with rare photographs of the 1906 earthquake. This replica of Notre Dame in Paris is famous for its stained glass windows, murals, and labyrinth.

Chinatown
Venture away from Huntington Square and the terrain starts to change. Chinese temples and small businesses spill over from Chinatown.

The entrance to Chinatown at Grant Avenue and Bush Street is called the “Dragon’s Gate.” Inside are 24 blocks of exotic shops, food markets, temples, and small museums. Strolling through the largest Chinatown outside of Asia and oldest one in North America, you can buy herbal remedies, enjoy samples at a tea bar, or order a dim sum lunch. Snack on mooncakes, traditionally eaten during the autumn for the Moon Festival, and see how fortune cookies are made at the oldest Chinese bakery in the city.

View ornately decorated buildings, such as the Sing Chong building, the Bank of Canton (formerly the Chinese Telephone Exchange), and the Bank of America. The exchange was closed in 1949 when technology changed from a switchboard-operator system to rotary-dial telephones. In 1960, the Bank of Canton bought and restored the building, which was the first Chinese-style building constructed in San Francisco. The Bank of America is adorned with gold dragons on its front columns and doors, along with 60 dragon medallions on its facade.

Union Square
Virtually every fashion label in the world has set up shop in and around Union Square, a landmark park in the heart of the downtown shopping and hotel district. Granite plazas, a stage, a café, and four grand entrance corner plazas bordered by the park’s signature palms, pay tribute to the Square’s distinctive history and offer a forum for civic celebrations. The cable cars head up Powell Street from here and flower stands populate every corner.

Thousands originally from Laos, Cambodia, and Vietnam have given new life to the Tenderloin, a 20-square-block district west of Union Square. A landmark church, an experimental theatre house, funky shops, jazz and blues clubs, restaurants, and cafes point to a neighborhood renaissance.

Mission District
Boasting some of the best weather in the city, the Mission District, Bernal Heights, and Potrero Hill take advantage of an abundance of fog-free days.

continued on next page...
Dear AOCD members,

As chair of this year’s Annual Meeting and soon to be president of the AOCD, I invite you to join our College in San Francisco for the Unified OMED 2010 Conference & Exposition.

An exceptional meeting has been planned that promises to be both educational and enjoyable, with world renowned speakers in the field of dermatology. New and relevant data will be presented to stimulate your thoughts, increase your knowledge, and enhance your expertise.

Regardless of your role in medicine; as a teacher, clinician, and/or accompanying guest, this meeting promises to be one of our best.

Our Welcome Reception will be held Sunday evening at the Museum of Modern Art or MOMA, one block from our meeting hotel. San Francisco is well known for its scenic beauty, diverse culture, and world-class cuisine. Cable cars, the largest Chinatown in the US, and the Golden Gate Bridge are just a few of the landmarks this city has to offer. Explore Union Square, North Beach, or Fisherman’s Wharf by foot. Less than a 30-minute drive north is Muir Woods where you’ll see coastal redwoods. Nearby are sandy beaches, dramatic cliffs, and Mount Tamalpais State Park. A mere 45 miles from San Francisco, you could experience intimate wine tasting, talk to a wine maker, or take a tram ride through the vineyards of Sonoma Valley.

Lastly, I’d like to thank the industry sponsors who have helped make this meeting possible. I encourage all of you to visit their exhibits during this meeting.

Hope to see you there,

Leslie Kramer, D.O., FAOCD
This year’s AOCD Annual Meeting will feature a new interactive Melanoma Symposium comprising an expert panel. In addition to providing updates on specific aspects of melanoma, panel members also will discuss interesting cases submitted by attendees.

Darrell S. Rigel, M.D., will kick off the Melanoma Monday symposium with a Melanoma Update, followed by Ashfaq Marghoob, M.D., who will offer a Dermoscopy Update, and Merrick I. Ross, M.D., who will review the Revised Melanoma Staging Criteria. All three dermatologists will review melanoma case studies in a panel discussion moderated by Edward H. Yob, D.O.

But that’s not the only expert advice being delivered at this year’s AOCD Annual Meeting to be held Oct. 24-27 in San Francisco. In addition to guest and resident speakers, a program on national leprosy awareness will be presented by the National Hansen’s Disease Programs (NHDP). Topics will include an overview of the NHDP and epidemiology of leprosy in the US, clinical/histopathological classification, management, and prevention of disability. Presentations will be held at the Moscone Convention Center.

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

The Welcome Reception will be held from 7:00 p.m. to 9:00 p.m. at the San Francisco Museum of Modern Art, which is celebrating its 75th anniversary this year.

**Monday Speakers**
Speakers (listed with their topics) scheduled to present lectures on Monday between 8:30 a.m. and 3 p.m. are as follows:

- Gregory G. Papadeas, D.O.
  *CLIA Quality Assurance Test & Review*

- Edward Yob, D.O.
- Ashfaq Marghoob, M.D.
- Darrel Rigel, M.D.
- Merrick Ross, M.D.
  *Dermoscopy Symposium: Melanoma Monday*

- Ted Rosen, M.D.
  *Genital Emergencies*

Following lunch on your own, the AOCD General Business Meeting will be held between 3:00 p.m. and 5:00 p.m. This year, the Koprince Awards and the Intendis Research Paper Award will be presented at the meeting. All members are encouraged to attend.

The President’s Banquet will be held between 6 p.m. and 9 p.m. at the Marriott San Francisco Marquis. It is a ticketed event for AOCD members only.

**Tuesday Speakers**
Speakers (listed with their topics) scheduled to present lectures on Tuesday between 7:00 a.m. and 5:45 p.m. are as follows:

- Cindy Hoffman, D.O.
  *Great Cases in Dermatology*

- Rick Lin, D.O.
  *Surviving the Next 10 Years: Various Topics on Business, Estate, and Tax Planning for Dermatologists*

- Anthony Dixon, M.D.
  *Australia Has the Highest Skin Cancer Incidents: Lessons for the USA*

- Abel Torres, M.D.
  *Risk Management for Dermatologists*

Following lunch on your own, resident speakers (listed with their topics) are scheduled to present as follows:

- Heather Volkman, D.O., 3rd Year Richmond Medical Center/Case Medical Center
  *Premature Facial Aging in a Monozygotic Twin with Chronic Graft vs. Host Disease*

- Denise Guevara, D.O., 3rd Year Wellington Regional Medical Center
  *Acremonium Mycetoma: A Case Report and Discussion*

- Shari Sperling, D.O, 3rd Year St. John’s Episcopal Hospital
  *An Unusual Presentation of Antiphospholipid Syndrome*
**Wednesday Speakers**

Angela Leo, D.O., will start out the morning by presenting the Ulbrich Research Award to one lucky resident. Next, five residents are scheduled to briefly present an unusual case based on their recent dermatopath rotations. The residents presenting are as follows:

- **Susun Bellew, D.O.**
  Cole Diagnostics

- **John Stoner, D.O.**
  Sevasti Margetas, D.O.
  Global Pathology

- **Kurt Greck, D.O.**
  Dermatopath Diagnostics

- **Jonathan Richey, D.O.**
  Global Pathology

Resident and guest speakers (listed with their topics) scheduled to present lectures on Wednesday between 8:00 a.m. and 5:45 p.m. are as follows:

- **Michelle Bruner, D.O.**, 3rd Year
  Oakwood Southshore Medical Center
  *Dermatitis Herpetiformis*

- **Leah Schammel, D.O.**, 3rd Year
  Oakwood Southshore Medical Center
  *Cyclical Dermatitis in a Middle-Aged Female*

- **Tara Whelan, D.O.**, 2nd Year
  St. John's Episcopal Hospital
  *Scleroderma in Childhood*

- **Rob Levine, D.O.**, 2nd Year
  St. John's Episcopal Hospital
  *Cutaneous Larva Migrans: A Case Presentation*

- **John Koo, M.D.**
  *Update on Psoriasis*

- **James Krahenbuhl, Ph.D.**
  David Scollard, M.D., Ph.D.
  Barbara Strijewska, M.D.
  John Figarola, LOTR, CHT,
  *The Need for Leprosy Awareness in the US*

After lunch on your own, residents (listed with their topics) slated to present are as follows:

- **Jonathan Cleaver, D.O.**, 2nd Year
  Northeast Regional Medical Center
  *Early Onset Atypical Mycosis Fungoides*

- **Brooke Renner, D.O.**, 3rd Year
  Pontiac/Botsford Osteopathic Hospital
  *Cutaneous Rosai Dorfman*

- **Brent Michaels, D.O.**, 2nd Year
  TUCOM/Valley Medical Center
  *Avoiding the Legal Blemish: Medicolegal Considerations in Dermatology*

- **Andrea Baratta, D.O.**, 3rd Year
  St. John's Episcopal Hospital
  *Multiple Juvenile Xanthogranuloma*

- **Payal Patel, D.O.**, 3rd Year
  Genesys Regional Medical Center
  *Juvenile Dermatomyositis*

- **Brent Loftis, D.O.**, 3rd Year
  Northeast Regional Medical Center, Texas
  *Pseudoaxanthina Elasticum*

- **Autumn Potaracke, D.O.**, 3rd Year
  Richmond Medical Center/Case Medical Center
  *Leukemia Cutis*

- **John Stoner, D.O.**, 3rd Year
  PCOM
  *Familial Basaloid Follicular Hamartoma Syndrome*

- **Lusia Yi, D.O.**, 2nd Year
  PCOM
  *Atypical Lymphocytic Lobular Panniculitis*

- **Francisca Kartono, D.O.**, 3rd Year
  Pontiac/Botsford Osteopathic Hospital
  *Teledermatology and Acne Vulgaris*

- **Sevasti Margetas, D.O.**, 2nd Year
  PCOM
  *Progressive Symmetric Erythrokeratoderma*
A Call for Papers

Journal of the American Osteopathic College of Dermatology-JAOCD

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

- Jay Gottlieb, D.O., FAOCD
Dermatopedia.com is the latest player to join the growing number of medical information websites, and in particular, skin disease sites.

Its creator is the AOCD’s very own Alexander Doctoroff, D.O., Assistant Chief of Dermatology at the Veterans Administration Medical Center in East Orange, New Jersey, who is also in private practice in Clark. But the creation of the website, which was launched this past January, occurred in a roundabout way.

A few years ago, Dr. Doctoroff was approached by an Internet company with several domains related to medical information. The company had a domain for dermatologic conditions and asked if he would be interested in overseeing the development of a website. Dr. Doctoroff agreed and began planning how it should look and what editorial content it should contain.

Next, he collaborated with Stephen Purcell, D.O., and the dermatology residents at the Philadelphia College of Osteopathic Medicine to write the initial copy for the website. “Dr. Purcell was instrumental in setting up the website,” notes Dr. Doctoroff.

“When Alex explained his idea to me, I was very excited,” recalls Dr. Purcell. “I was happy to help him with his project and fortunately, my residents volunteered to help, as well.” Dr. Purcell further praised Dr. Doctoroff for his fortitude in seeing the project to its conclusion in spite of initial obstacles. “Alex really did a nice job with this project.”

Over time, however, more and more advertising began appearing on the website. Often times, patients who went on the site were automatically directed to other sites that were selling related products. “Before you know it, it was all commercial,” says Dr. Doctoroff. “I realized that this was not my vision.” He amicably parted ways with the Internet company, which kept its website and allowed Dr. Doctoroff to move the content to a different site. Dermatopedia became the new name for the website. The goal of the website is twofold; first, to provide comprehensive medical information to patients, and second, to save time for busy dermatologists who are unable to cover all of the information on a particular topic during a short office visit, he explains. To date, the website defines nearly 60 diseases/conditions. It also explains medications, treatments, and procedures including medical, surgical, and cosmetic treatments.

As editor-in-chief, Dr. Doctoroff writes many of the articles, posts them, and even crops the pictures. Articles he doesn’t write, he edits. Dr. Doctoroff recently obtained a small amount of funding from two pharmaceutical companies, which he is hoping to use to delegate some of the computer tasks in order to concentrate on the editorial content.

Distinguishing Features

A few things set Dermatopedia.com apart from other websites that contain similar information. For starters, every article is written by a dermatologist whose name appears at the end of it. Dr. Doctoroff believes that including the author’s name adds credibility to the article. In addition, the dermatologist may include a link to his or her website.
Although the articles are written for a lay audience, dermatologists may find them helpful as well because they include what Dr. Doctoroff refers to as “a real life clinical approach to skin diseases.” For example, the article he wrote on imiquimod states that Aldara is not approved by the Food and Drug Administration for the treatment of squamous cell carcinoma (SCC). “Yet, in my practice, just like in many other dermatology practices, Aldara became a routine treatment for small and superficial SCCs,” the article reads. “The dermatologists can include whatever clinical judgment dictates,” he notes. Patients who research the Internet for medical information need to see that there are multiple approaches to treatment.

At the same time, the articles are written by experts who are able to reject inaccurate information, explains Dr. Doctoroff. Dermatologists can trust the information because it is written and reviewed by their colleagues, he adds. In fact, many of the articles were written by osteopathic dermatologists.

**Keeping Up**

Moving forward, Dr. Doctoroff plans to continue adding articles on new conditions/diseases and treatments to the website. He also would like to add new members to the current eight-member editorial board. Osteopathic dermatologists were involved in the inception of this site, notes Dr. Doctoroff, and he would like to see that tradition continue. (If interested in doing either, you may contact Dr. Doctoroff at elaldoc@doctor.com or at 732-574-1399.)

Every few months, he reviews the website to ensure that its format is user friendly. Dr. Doctoroff recently revised the format to include the diseases on the first page, rather than requiring visitors to scroll down menus and click on different pages before getting to that information.

To further build its credibility, Dr. Doctoroff, who is President of the Dermatological Society of New Jersey, recently established an affiliation between the website and the society. He is hoping that this formal affiliation will not only build the site’s credibility, but will raise the society’s profile.

The best part of the whole experience has been the opportunity to create something that is beneficial to patients, says Dr. Doctoroff. He hopes that the website will continue to grow and gain a reputation as a credible source to refer patients worldwide.

To visit the website, go to www.dermatopedia.com.

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**Adults Searching for Health Information Online**

The number of Americans who use the Internet to obtain information on health topics continues to rise, according to the latest Harris Poll.

More than 90% of those searching online believe that the information they found was reliable, based on findings from the Harris Poll of 1,066 adults surveyed by telephone between July 13, 2010 and July 18, 2010.

Slightly more than half of the respondents report that they have discussed information they found online with their physicians. In fact, half of them say that they searched for information on the Internet based on discussions with their doctors.

Statistics and excerpts taken from The Harris Poll® #95, August 4, 2010. Visit HarrisInteractive.com to learn more.
Hello Everyone,

It’s been a busy spring and summer in the AOCD office.

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

In-Training Exam

Both the In-Training Examination (ITE) and the Board Exam are being held at 7 a.m. on Sunday, October 24, 2010. The exams will be given at the Marriott San Francisco Marquis Hotel at 55 Fourth Street where the AOCD Annual Meeting will be held October 24-27. Residents’ dues must be current to sit for both exams. Plan to arrive early; no one will be admitted after 7 a.m.

Policy prevents any electronic devices from being brought into the testing site. This includes cell phones, personal digital assistants, and pocket organizers. These should all be left in your room prior to the testing. Any of these electronic media will be collected. No allowances will be made for those on-site during the testing procedures or during bathroom breaks, etc.

An ITE is administered to dermatology residents each year during the AOCD Annual Meeting. Each resident is required to take the dermatology ITE, which is a practice test.

The intent of the ITE is to identify knowledge-based strengths and weaknesses in both the training programs and the residents in a non-punitive manner. Taking the ITE is mandatory. The exam format includes only the types of multiple-choice questions that appear on the certifying exam (i.e., one best answer, matching, and identification of images). The ITE is not meant to be a mirror of the actual Board Exam.

Annual Meeting

Resident lectures at the 2010 Annual Meeting will be held Tuesday October 26 and Wednesday, October 27. Lectures are scheduled between 1 p.m. and 5 p.m. both afternoons and cover a wide variety of topics. (See “2010 Annual Meeting Opens with Melanoma Symposium” for a complete list of resident lectures on page 13.)

As soon as the AOA assigns room numbers to us for these events, you will be notified.

Information regarding function tickets was mailed in August. Please return the form to the AOCD office so we can have an accurate count for seating and meals. Residents will be charged a fee of $25.00 for the banquet and any guest of the resident also will be charged a $25.00 fee for the banquet.

This year, all resident awards will be presented during the Business Meeting to be held on October 25 from 3 p.m. to 5 p.m. This includes the Koprasne Award and the Intendis Research Paper Award.

Intent-to-Lecture

Intent-to-Lecture applications for the 2011 Midyear Meeting are now being accepted. There are a limited number of spots, so get your application in as soon as possible. Resident lecture dates will be announced at a later date. Residents slated to graduate in 2011 will be given priority in scheduling. The faculty disclosure statements and Intent-to-Lecture forms also can be downloaded from our website at www.aocd.org/qualify.

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

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 to the first day of the meeting or resident will not be placed on the schedule

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

Residents Update

by Marsha Wise, Resident Coordinator
If the resident’s PowerPoint materials, as defined by the AOCD, are not received by the announced deadline, 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 is closed 12 weeks prior to the first day of the meeting. No last minute additions to the lecture schedule will be allowed.

The lecture schedule is as follows:
- Call for Papers/Lectures with Deadline Information; September 16, 2010
- Intent-to-Lecture Forms Returned; October 16, 2010
- Lecture Sign-up Closed; December 16, 2010
- Documentation/Presentations Due; January 16, 2011
- Meeting Start Date; March 16, 2011

Residents who began their training July 2010 will be under new guidelines as follows:

Prepare one manuscript or paper, under the direction of the program director, during each year of training. This paper should be suitable for publication in medical journals and 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. Proof of an abstract submission must be provided along with the resident’s annual reports.

During the resident’s second year of training, the resident must submit a poster at the annual AOA meeting. This poster should 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 aforementioned manuscripts or papers must be presented either at the AOCD Annual Meeting or Midyear Meeting in a 20-minute lecture.

Grand Rounds Online
This is a reminder that each program is asked to provide a case for the Dermatology Grand Rounds on the AOCD website. The schedule for the remainder of the year is as follows:
- St. Joseph Mercy Health System - Program Director: Dr. Daniel Stewart - October 5
- Nova Southeastern University-COM/ Broward General Medical Center - Program Director: Dr. Stanley Skopit - November 5
- Cuyahoga Falls General Hospital - Program Director: Dr. Schield M. Wikas - December 5

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

In 2011, the schedule cycle will repeat this year’s schedule. Be sure to check out the Grand Rounds on our website at www.aocd-grandrounds.org.

Mandatory Attendance
The EEC has made attendance at the educational components of the AOCD Annual Meeting mandatory for residents. Additionally, attendance at the educational components of the AOCD Midyear Meeting is strongly encouraged. The latter, however, is still optional.

This directive from the EEC follows a review of resident attendance at both the AOCD Annual Meeting and Midyear Meeting. At the EEC meeting in September, committee members recommended and approved mandatory attendance.

The AOCD Annual Meeting is usually held Sunday through Wednesday, while the Midyear Meeting is usually scheduled Wednesday through Saturday.

Current Basic Standards
The current Basic Standards state that the residency program may allow a maximum of 12 months of elective rotations outside the parent institution during the three-year training program. A minimum of one month of this elective time should be provided each year, exclusive of the AOCD Annual Meeting or Midyear Meeting. 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.

100-Plus Residents Fill Programs
The AOCD residency programs continue to grow. Five years ago, there were 80 residents in our programs. This July, there are 108 residents.

The 40 new residents, listed with their programs, are as follows:
- O’Bleness Memorial Hospital (Dr. Scott Drew)
  Allison Himes, D.O.
- Richmond/Case Medical Center (Dr. Joan Tamburro)
  Ashley Kittridge, D.O.
  Blakely Richardson, D.O.
- NRMC-Kirksville (Dr. Lloyd Cleaver)
  Peter Knabel, D.O.
- NRMC-Texas (Dr. Bill Way)
  Steffeny Steinmetz, D.O.
- St. Barnabas Hospital (Dr. Cindy Hoffman)
  Libby Rhee, D.O.
- Oakwood South Shore Medical Center (Dr. Steven Grekin)
  Paul Anderut, D.O.
  Billy Bethea, D.O.
- PCOM (Dr. Tanya Ermolovich)
  Tatyana Groysman, D.O.
  Marie Lewars, D.O.

continued on next page...
Seven residents will be presented with the Daniel Koprince Award at the 2010 Annual Meeting this October in San Francisco for presentations they gave at the most recent Annual and Midyear Meeting.

The Koprince Award was established in 1986 to honor the work of AOCD member, Daniel Koprince, D.O., who passed away in 2007. The award recognizes the top lectures evaluated for subject matter, audiovisual presentation, and speaking ability.

The recipients who presented at the 2009 Annual Meeting in New Orleans are as follows:

Johnny Gurgen, D.O., who was a third-year resident at NSUCOM/Largo Medical Center in Port Richey, Fla., won for his lecture entitled Infectious Diseases.

Lyubov Avshalumova, D.O., who was a third-year resident also at NSUCOM/Largo Medical Center, was chosen for his presentation about EKV.

Saira Momin, D.O., who was a third-year resident at TUCOM/Valley Hospital Medical Center in Las Vegas, won for his lecture entitled Aberrant Loss of Differentiation in Metastatic Malignant Melanoma.

Sabrina Waqar, D.O., now a third-year resident at Columbia Hospital in Palm Beach, Fla., won for her presentation on Epidermolysis Bullosa Acquisita.

The recipients who presented at the 2010 Midyear Meeting in Sedona are as follows:

Michelle Jeffries, D.O., who was a third-year resident at MWU-Glendale/Alta Dermatology, won for her lecture entitled Purpura Fulminans-Type Necrosis in a 10-Year-Old Female.

Julian Moore, D.O., now a third-year resident at NSU-COM/BGMC, won for his presentation about Bullous Sweets Syndrome.

Susun Bellew, D.O., now a third-year resident also at TUCOM/Valley Hospital Medical Center, won for her lecture entitled Overcoming the Barrier to Ichthyosis Treatment: A Combination Therapy Approach.

Recipients will be presented their awards at this year’s Annual Meeting during the General Business Meeting.
Residents who want to experience a dermatologic surgery preceptorship in Australia have until October 1 to submit the winning paper.

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

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

The AOCD’s Education Evaluation Committee along with Dr. Dixon will select the winning author. Submissions should be sent to the AOCD office in Kirksville. The winner will receive approximately $1,500 toward the cost of the trip to Australia, with additional funding to be determined on proceeds generated by a silent auction to be held at the 2010 Annual Meeting. While this amount will not cover the cost of the entire trip, it will pay a substantial portion of it. The approximate airfare is $1,200.

Dr. Dixon also has extended this opportunity to one attending physician (AOBD board eligible or board certified) whose selection will be based on the silent auction principal. The starting bid is $1,000 and the preceptorship will be awarded to the highest bidder. Attending physicians will be responsible for their own expenses. The funds raised will be used to provide financial support for the winning resident attendee.

Winners can essentially schedule their preceptorship for any time during the year, pending any conflicts with Dr. Dixon’s schedule. The resident and attending physician are not required to travel simultaneously to Australia. Additional details will be addressed upon announcement of the winners and preparation for the trip.

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

Q-switched Lasers Can Initially Darken Pink Tattoos

The use of Q-switched lasers for tattoo removal may result in paradoxical darkening of pink ink, according to a case report published in the June issue (volume 9, issue 2) of the Journal of Cosmetic Dermatology written by Will Kirby, D.O., Alpesh Desai, D.O., and Ravneet Ruby Kaur, M.D.

The authors reviewed the case of a patient with a pink tattoo that initially darkened paradoxically, turning grey and black, following one treatment with a Q-switched laser, which has become the gold standard of tattoo removal treatment. After a second treatment, the ink lightened significantly. Subsequent treatments resulted in additional fading until the tattoo eventually completely resolved.

Such darkening of tattoo ink is most frequently reported in cosmetic, pink, peach, white, and flesh-toned ink. The darkening is believed to be caused by a reduction of ferric oxide to ferrous oxide. The Tyndall effect due to the ink pigments found in the dermis is another possible cause.

The authors suggest that dermatologists removing tattoos with such colors might want to discuss the possibility of paradoxical darkening with patients prior to performing the procedure.

They came to a similar conclusion in a more recently published retrospective study and literature review. Drs. Desai and Kirby are joined by Tejas Desai, D.O., and Angie Koriakos, D.O., MPH, in the August issue of Skin & Aging to suggest that patients should be informed that temporary, and possibly permanent, pigmentary changes can occur after treatment with a Q-switched laser. They reviewed the various types of undesired discoloration such as hypopigmentation, hyperpigmentation, and depigmentation that may occur, despite the treatment being considered a safe procedure.
This past May, Cynthia Chen, now a fourth-year medical student at the Western University of Health Sciences/College of Osteopathic Medicine of the Pacific (Western/COMP), traded in her short white lab coat for sneakers to participate in the fourth annual Miles for Melanoma 5k Run/Walk to benefit the Melanoma Research Foundation.

Back in 2007, fresh from running her second marathon and weeks before starting her first year of medical school, Chen and William Baugh, M.D., Medical Director of Full Spectrum Dermatology in Fullerton, Calif., organized the first Miles for Melanoma 5k Run/Walk. The goal was to raise funds for the Melanoma Research Foundation; an organization that supports medical research, educates patients and physicians about melanoma, and acts as an advocate for the melanoma community.

To get the word out about the race/skin cancer screening event, she and Dr. Baugh laced up their running shoes and ran through countless neighborhoods and to other running events handing out fliers. During that first year, there were approximately 200 participants and 25 screenings conducted, recalls Chen.

**Skin Cancer Screenings**

This year, she returned as assistant race director to organize the skin cancer screenings using materials provided by the American Academy of Dermatology. In addition, she recruited seven medical students from the Dermatology Interest Group/Club at Western/COMP, of which she was president in 2009, to help conduct the screenings. Tony Hoang, D.O., Clinical Director of Pacific Coast Dermatology in Chino, Calif., and Dr. Baugh were the attending physicians who oversaw the screenings. Somera Chaudhry, also weeks away from starting her first year in medical school, was this year’s primary race director, responsible for organizing all other race logistics.

On the day of the event, the screenings were conducted in an empty classroom at the race site. The night before, Chen along with several volunteers stayed late creating makeshift examination rooms so that participants could have some privacy while getting their skin evaluated.

The participants were first evaluated by either one or two medical students, and then by one of the dermatologists who would perform a thorough skin exam and recheck suspicious lesions. Every patient walked away with a handful of donated sunscreen samples and brochures on sun safety as well as the knowledge of how to look for suspicious lesions and appropriately take care of their skin, she says.

**Event Continues to Grow**

Nearly 1,000 participants ran or walked, and triple the number of skin cancer screenings were conducted at this year’s event.

“It has been very rewarding to see how much this event has grown in such a short time,” says Chen. “We have seen the same participants return year after year. They are telling their friends who are telling their friends and the response has been amazing.”

Chen attributes the event’s growth to individuals seeking more information about sun safety. “We live in a world in which people are obsessed with the sun, but there are risks involved that most people are unaware of,” she says. “We are here to provide education and empower the community to understand proper skin health.”

To date, the event has raised more than $80,000 for the Melanoma Research Foundation, which was chosen because melanoma is the deadliest form of skin cancer, growing at a rate faster than any other form of cancer, and it is an equal-opportunity killer, affecting people of all ages, colors, and races, notes Chen. “There is still so much that is not understood about this disease that it is necessary to provide researchers with the means to not just find treatments, but cures, for melanoma.”

Chen also is actively involved in melanoma research at the Los Angeles BioMedical Research Institute at Harbor UCLA in Torrance, Calif. She is expected to graduate in May 2011 and plans to apply for a dermatology residency in 2012.

For more information on the event, visit the website [www.fullspectrumdermatology.com/about/miles-for-melanoma](http://www.fullspectrumdermatology.com/about/miles-for-melanoma). For more information about the Melanoma Research Foundation, visit the website [www.melanoma.org](http://www.melanoma.org).
A few months into her one-year term as President-Elect of the Georgia Osteopathic Medical Association (GOMA), Melinda Greenfield, D.O., already has a handful of projects on which to focus.

As President-Elect, Dr. Greenfield’s primary responsibility is to serve as program chair for the fall convention in Atlanta and next summer’s meeting in Hilton Head, South Carolina. In addition to obtaining speakers and exhibitors, she will ensure that all of the presentations meet Accreditation Council for Graduate Medical Education guidelines in order for attendees to receive continuing medical education (CME) credit. At the actual meetings, Dr. Greenfield will be responsible for keeping the meetings running smoothly, including introducing the speakers and keeping them on schedule. On average, 150 members attend these meetings.

Dr. Greenfield, who was sworn in this past June at the summer meeting, has been a GOMA member for the past nine years, for as long as she has been practicing in Georgia. For the past five years, Dr. Greenfield served on the regional board for District 3, which is in the southwest part of the state. She started out as a delegate and moved up to Secretary/Treasurer, at which time Dr. Greenfield was asked if she would be interested in being President-Elect.

Dr. Greenfield named President-Elect of Osteopathic Society

Growing Local Presence

This past year, she held the first district-wide CME conference. “Rather than have just two big meetings a year, GOMA would like to provide more CME opportunities across the state,” says Dr. Greenfield. She is hoping that the model she established can be used by other districts.

Within Dr. Greenfield’s district, she also is working on a media kit. With the establishment of an osteopathic medical school just north of Atlanta a few years ago, Dr. Greenfield sees a lot of opportunity to inform the public about osteopathic physicians. “It’s not just about GOMA,” she says, “It’s about making Georgia a great state for DOs who are already practicing and for those we’re training.” Many people in small towns don’t know what a DO is, says Dr. Greenfield. Other GOMA districts could use the media kit as a template.

Other Efforts

In addition to working within GOMA, she has been on staff at the school since its inception. Dr. Greenfield developed the dermatology curriculum for all second-year students, “I like to have an active part in the education of DOs by teaching, publishing, and lecturing,” she says.

In her spare time, Dr. Greenfield runs marathons and triathlons, unrelated to chasing after her two children, eight-year-old Nathan and five-year-old Josie.

Her goal is to improve the practice environment for DOs in Georgia. Of Dr. Greenfield’s involvement with GOMA, she says, “It’s nice to feel a part of a group and nice to know that you’re contributing beyond seeing patients and having your own office.”

“It’s hard to find the time to get involved, but it is important to get involved at some level,” says Dr. Greenfield, adding, “You don’t have to be president of your state organization, maybe help out at the district level. If everybody did a little bit, we’d all be the better for it.”
It is not unusual for patients to travel three hours to see Anthony Benedetto, D.O., FACP. And after only one treatment, their lives are significantly changed.

Dr. Benedetto doesn’t have a magic potion. In fact, he treats many of these patients with Botox®. And no, he is not riddling them of wrinkles.

Dr. Benedetto treats nearly 50 patients with hyperhidrosis each year. “It is a severe problem for many patients,” he says. The good news is that treatment is relatively simple and extremely effective.

So why are patients coming from as far away as South Carolina to be treated at his Philadelphia-based dermatology surgical center?

The biggest problem is that many primary care physicians don’t know that hyperhidrosis is a pathologic entity, says Dr. Benedetto. Consequently, they don’t think it is something that needs to be treated. “Physicians often tell patients there is nothing they can do about it.” Of course, dermatologists know all about hyperhidrosis, he notes, but without a referral from the primary care physician, patients don’t know to seek out a dermatologist.

To help educate physicians and patients alike, Dr. Benedetto joined the faculty of the International Hyperhidrosis Society (IHHS) in 2006. “The Society is trying to increase the awareness of physicians and patients about this physically and emotionally debilitating problem,” he says, adding, “I wanted to be part of that.”

As a faculty member, Dr. Benedetto has lectured at IHHS continuing medical education events where the latest in research, diagnosis, and management is discussed. In addition, he has participated in live demonstrations of palmar and axillary Botox injections. This past February, Dr. Benedetto hosted an in-office teaching session for local physicians at his facility. After presenting a short lecture, he demonstrated how to perform injections and then coached six colleagues who practiced the technique on several volunteer patients.

Other physician educational tools the IHHS offer includes an overview of hyperhidrosis, guidelines for diagnosis, a disease severity scale, treatment algorithms, research opportunities, an online learning video library, and even patient brochures. Many of these tools can be accessed on the IHHS website at www.SweatHelp.org. In addition, the website has a plethora of information for patients from defining the condition to finding a physician. More than 45,000 individuals from 151 nations subscribe to the Society’s monthly e-mail newsletter called Sweat Solutions.

The recent opening of a hyperhidrosis clinic at The Children’s Hospital of Wisconsin in Milwaukee and the study being conducted at the Albert Einstein Hospital in Bronx, New York, looking to identify the genes responsible for the condition in hopes of developing a cure, point to the success of the IHHS in bridging the gap of information and help for both physicians and patients alike, says Dr. Benedetto. “The IHHS is providing a wonderful service for patients,” he concludes. “Until the Society was established, nobody had recognized and addressed these patients’ needs.”

It’s clear that the IHHS isn’t the only one providing a wonderful service for patients. In a thank you note to Dr. Benedetto, a patient writes, “You have no idea what the change has been and how it has improved my life. Prior to the treatment, I would shy away from events and other gatherings where I could not change my clothes or cover up my sweating. Now I do not have that issue. The change is amazing!”
Hyperhidrosis: No Need to Sweat It

For many, summer is synonymous with backyard barbeques, baseball games, and lazy days at the beach (with ample sunscreen, of course), not to mention the graduations and weddings. But for patients with hyperhidrosis, summer is the season of dread.

As many as eight million people—or three percent of the US population—is estimated to have this condition, according to the Pipersville, PA-based International Hyperhidrosis Society.

Excessive Sweating
Hyperhidrosis is a disease characterized by excessive sweating, beyond the normal amount required to maintain consistent body temperature. It is believed that patients with hyperhidrosis produce up to five times the average volume of sweat.

What causes hyperhidrosis is unclear. It is either an overproduction to a specific neurotransmitter in the sympathetic nervous system or sweat glands that overreact to normal levels of the neurotransmitter.

The two types of hyperhidrosis are primary and secondary. The former is not caused by another medical condition or the result of a medication. Primary disease is typically focal, affecting the soles, palms, axillae, face, groin, and other parts of the body. Patients usually begin experiencing symptoms in childhood or adolescence. Some suggest that it is an inherited condition and commonly, other members of the family also may be affected. Secondary hyperhidrosis can be generalized or localized. In secondary hyperhidrosis the symptoms are due to a medical condition, such as an endocrine disorder, neurological problem, use of certain medications, cancer, a chronic infection, a dermatologic syndrome, or a condition associated with excess catecholamine discharge. Unlike patients with primary focal hyperhidrosis, those with secondary disease experience generalized excessive sweating which also can be present while sleeping.

In a typical dermatology practice, the majority—greater than 95%—of patients seen suffer from primary, focal disease.

Significant Effect
Hyperhidrosis can significantly impact a patient’s quality of life, not only by causing physical discomfort and social embarrassment, but by negatively impacting occupational and daily activities.

Physical discomfort occurs from having to wear wet clothing and shoes. Skin maceration from constant wetness can lead to bacterial and fungal overgrowth. This overgrowth can lead to intertrigo in the axillae and groin and can be accompanied by bromhidrosis. Pitted keratolysis and gram-negative bacterial macerative infection of the feet also are constant problems.

Various surveys show that the disease affects patients’ emotional status, often causing a lack of confidence and frustration with daily activities. All of those can lead to feelings of unhappiness and depression.

Palmar hyperhidrosis, in particular, can interfere with patients’ activities of daily living as well as occupational tasks. For example, gripping tools, playing musical instruments, and using electronic devices can be difficult with sweaty palms. Additionally, dripping sweat on paper can cause staining and smeared ink. The need to change clothes frequently or anxiety about presenting in front of audiences because of sweat-stained clothing or visible sweating of the face can pose occupational challenges.

Treatment Options
Depending on the area to be treated, the treatment options differ, notes Anthony Benedetto, D.O., FACP. To further complicate matters, some treatments such as Botox®, can be used on any focal area to reduce sweating, but the duration of effect is different. For example, underarm treatment has the longest duration, that is, from six months to more than one year, whereas the treatment duration for palms can be as little as five months.

When treating hyperhidrosis, it’s important to always start with the least invasive treatment, he says.

Non-surgical treatments for primary hyperhidrosis include topical antiperspirants, iontophoresis, and systemic medication. Antiperspirants can be either prescription products or specially compounded solutions. Clinical strength antiperspirants are beneficial for patients with moderate hyperhidrosis, says Dr. Benedetto, and for those with severe hyperhidrosis who have been treated with Botox. Properly using a clinical grade antiperspirant appears to extend the benefit of the injections.

Iontophoresis—the passing of an ionized substance through intact skin by the application of an electrical current—can be used to effectively treat hyperhidrosis of the palms and continued on next page...
solos. While simple tap water iontophoresis is commonly used, systemic medications also have been delivered via this device. Iontophoresis has been reported to have an 83% success rate for palmar and plantar hyperhidrosis, he states. The rate would be even higher if providers used the best device and were properly trained regarding its use, adds Dr. Benedetto. Reliable home-use devices also are available.

Although systemic medications have been used to treat hyperhidrosis, many of those reported as being useful have not been studied in controlled trials. Moreover, doses likely to inhibit hyperhidrosis can cause serious enough side effects to limit their use. The most commonly used medications are anticholinergics including propantheline, glycopyrronium bromide, oxybutynin, and benztropine.

Minimally invasive Botox injections are beneficial for patients who fail to respond to the more conservative treatments. “When done correctly, it is very rare that someone with underarm excessive sweating will not respond to Botox injections and have an extended period of time of great relief,” he states.

Surgical treatments include endoscopic thoracic sympathectomy and excision of axillary tissue. Although sympathectomy has been shown to be very effective for palmar sweating, it is less effective for axillary symptoms. Additionally, the most common complication is compensatory hyperhidrosis of the abdomen, chest, back, thighs, and face, which affects more than 60% of patients, on average, who undergo this surgery.

For secondary hyperhidrosis, it is imperative to determine what is causing it, notes Dr. Benedetto. Once the underlying cause is determined, then a treatment plan can be put in place. It may be as simple as changing medications or as complex as treating diabetes.

“Patients should know that this condition is not uncommon and that there are avenues of help available, and the International Hyperhidrosis Society is a wonderful source of information and assistance for patients who have hyperhidrosis,” he concludes.
Triax Seeks to Create Value-Added Products

Seeking to provide solutions for unmet needs among dermatological practitioners and their patients, Triax Pharmaceuticals develops topical prescription skin care products that are unique in the market.

“We are looking for new treatment paradigms, focusing on unique products to which we can add value,” notes Peter Volk, vice president of Marketing.

This fall, the Cranford, New Jersey-based company is planning to introduce a new strength of tretinoin cream. The 0.0375% strength falls in between the currently available 0.025% and 0.05% cream strengths. “Most doctors start their patients on the lowest strength of tretinoin, but it may not be strong enough,” he says. “The 0.05%, however, may be too irritating. Now they have another option.” Currently the 0.0375% cream is available in a 35g tube. Triax intends to introduce a kit for the new strength later in the year.

Another example of uniqueness, Triax combined tretinoin cream or gel with cosmeceuticals to create the Tretin-X® kit for the treatment of acne. “When using a retinoid, patients are supposed to cleanse with a mild cleanser and use a moisturizer as all retinoids are known to irritate the skin,” he explains. The kit contains a mild, non-irritating, non-stripping foam cleanser with a non-greasy, hydrating moisturizer that contains botanical calming agents and tretinoin in either a cream or gel form. “This product is convenient for the doctor and adds value to the patient,” notes Volk.

Additionally, Triax is exploring a new foam vehicle for its Locoid® product line for the treatment of corticosteroid-responsive dermatoses. At 70%, the high lipid content of the Locoid Lipocream (hydrocortisone butyrate 0.1%) offers skin barrier protection for patients, says Volk. Because of the patent-protected technology, Lipocream has the efficacy of an ointment with the elegance of a cream. Similarly, the Locoid Lotion has high lipid content (15%) but it feels and acts like a lotion. It spreads really well over large areas of skin, including hairy areas. A foam vehicle will spread even more easily while requiring less pressure. “A foam product would be especially beneficial for kids,” Volk says, adding that Locoid Lotion and Locoid Lipocream are the only class 5 lotion indicated for the topical treatment of mild to moderate atopic dermatitis in patients as young as three months old.

Triax has been an AOCD sponsor since its inception in 2005. “DO derms are highly regarded by their patients and the medical establishment, contributing greatly to the science and practice of dermatology,” notes Volk. “The AOCD is a strong and influential specialty college that is dedicated to serving the needs of patients. Triax Pharmaceuticals is pleased to be able to help the AOCD in that effort.”
Being the Boss Takes Great Deal of Work, Effort
by Andrew Racette, D.O., FAOCD

A boss mentors, motivates, challenges, praises, retains, monitors, and mediates for his or her employees. In other words, being the boss of your own dermatology practice takes a great deal of work and effort.

To effectively manage employees, you must be trustworthy so they know that you will not take advantage of them, consistent in how you handle situations for each employee, and confident showing that you have control over any situation. You must be ethical and honest, as well.

A boss must motivate employees, knowing that they will have other things on their minds besides work. Remember that they do not own the practice, so when staff are talking on the telephone, texting, or surfing the Internet, it’s not hurting their bottom line. That’s why it’s in your best interest to make sure there’s a balance between their professional and personal life. Offering production bonuses based on revenue, the increased number of patients seen per day/month, or sales of cosmeceuticals is one way to motivate staff.

A boss should challenge employees. Nobody wants to do the exact same thing every day for the rest of their lives. Consider increasing their responsibility as well as the amount or scope of work. Cross-train employees so they know how to handle both the front and back office. For example, make sure medical assistants also know how to answer the phones, make appointments, check patients in, and create superbills. Set goals for the office and reward staff when these goals are met. An example may be to see more than 30 patients per day for an entire month. If you reach this goal, give everyone a small bonus of $75 to $100, treat your entire staff to a long lunch at a local restaurant they enjoy, or offer any other reward you think would be relevant for your number of staff.

The boss should praise employees’ efforts. Everyone wants to be appreciated. Tell them when they are doing a great job. Run an Employee of the Month contest with the winner receiving a prize, such as a $100 gift certificate, a bonus, or a dinner for two.

A boss must retain employees; a difficult task at best. If you hire good candidates and manage your employees well, then you should be able to retain them. One option is to consider giving raises on a regular basis, such as every six months. Even a small raise such as 25 cents an hour, which translates into $500 extra per year for one full-time employee, can make a big difference. Another option is to increase employee benefits. If you have medical and dental insurance, consider adding life insurance, a 401(k) plan, or profit sharing. Discuss the possibility of adding benefits at
staff meetings to determine what type of benefits they are most interested in and to let them know that you are thinking about adding these benefits in the future.

A boss must monitor staff, as well. Security cameras are an acceptable method to do so. Sometimes just knowing that you’re watching is enough. If the laboratory is close to your office, you can periodically watch the assistants sterilize, wash, and setup trays. The same goes for office staff with regard to watching them check the billing statements and explanations of benefits. Even though you trained them a certain way doesn’t mean they are still performing tasks that way. You should be the only one that has a key to the mailbox or gets the mail. Open all of your mail yourself and be sure to write down all checks received in a log book before handing them over to the billing staff. Once the checks are entered and returned to you, check them off when they are deposited. You should know the date, amount, and payer of each check.

A boss must be a mediator. There will be problems no matter how well you hire. Problems can occur between you and employees or between them because not everyone gets along. When problems occur, handle them immediately. Meet to discuss larger issues at department or staff meetings; use smaller meetings to address problems between you and specific employees. It always comes down to respect.

Creating a policy manual can be a helpful management tool. It’s best to create the manual yourself, but you can model it after an existing one. Ask a colleague or friend to review their manual. Give a copy to each employee with one week to read through it. Have the employee sign a sheet indicating that he/she has read it. Keep the sheet in the employee’s file. When the employee turns in the sheet, ask him/her 20 or so questions about what the manual says. If the employee fails the test, allow him/her to retake the test in one week.

Regarding training, personally train everyone in your office, if possible. Even if they have already worked in an office, you will want them to do certain tasks a certain way. Create a manual for each position to expedite training. When possible, you should cross-train staff.

Being the boss of a dermatology practice takes a lot of time and dedication, but to be part of a group of people who enjoy their work, do it well, and get along is well worth the sacrifice. It will make the office run smooth, creating a better environment for your patients, which will ultimately improve your bottom line.

Dr. Racette opened his own practice, Omni Dermatology in Phoenix, in July of 2008 and now has seven employees working for him.

Dr. Kirby Welcomes Baby Boy


We are dedicated to helping patients attain a healthy and youthful appearance and self-image.
Tax deferrals: Are they worth it?

When dermatologists discuss saving money on their tax bill, do they think that they are actually saving money? The reality is that they are really deferring payment of the tax. “Saving and never paying the tax” is nearly impossible.

That deferral, however, can create an enormous savings for the doctor based on how the funds are deferred. Some examples of deferral value will reveal to the physician the importance of paying taxes later, rather than now. By the way, this is not an entirely new concept. Ben Franklin demonstrated the value of compounding eons ago.

**Tax Deferral Options**

During the course of a taxable period, a doctor meets with financial advisors, accountants, and specialists for ideas regarding wealth management, legalities, and tax advice. Decisions are made concerning the acquisition of equipment, real estate, retirement planning, and other financial questions. When equipment is purchased, there is an immediate tax deferral, especially this year. Depreciation guidelines allow the doctor to deduct the cost of the equipment over various timeframes. If the tax, which is not paid due to the equipment acquisition, is invested, it will create additional income that can be used to pay the tax when it comes due and also to produce a profit.

The strength of tax deferral and the accumulation of income from it are the length of time the tax payment is delayed and the percentage of return on those funds. What is the length of the tax deferred from the acquisition of equipment? What *guideline life* is used for depreciation expense? It is from one year to six years, and longer in certain circumstances.

What about the purchase of commercial real estate, which has deferral written all over it? The guideline life for real estate depreciation is long-term up to 39 years, causing a nice annual deferment.

There is another newer method of depreciation known as *cost segregation depreciation*, which I personally do. It allows the components of a building to be depreciated such as the carpets, doors, hot water heaters, faucets, windows, heating and air conditioning units, and wall partitions. These components have shorter lives than 39 years and create a quicker and larger expense amount allocated to depreciation. This, in turn, allows for larger immediate tax deferrals that can be invested. This creates more income from the invested funds that were created by the tax deferral.

The creation of an employer-sponsored qualified retirement plan can allow an enormous deferral on a consistent basis. This is a tax deferral that I do, as well. Taxes are deferred year after year. The ability to invest these funds occurs constantly and the tax on the income earned is deferred as well until it is withdrawn from the account.

Based on one’s age and the continuation of payments into the retirement plan, an enormous amount can be accumulated from a long-term deferred payment.

The commonality of these examples of tax deferral is that funds are created...
by not paying tax today, but by paying it at a later date. The length of the deferral creates the ability to keep the payment of the current tax earning income until an event occurs when the tax must be paid. When that time comes, the earnings on the deferral will pay a large portion of that tax and there should be funds left over to retain.

**Rules to Remember**

Variability of **time amounts taxable** (i.e., a building has a different amortization time than a car) that has been deferred, will be due. Equipment typically has a shorter deferred term for the tax payment than real estate. Employer-sponsored qualified retirement plans can have the longest term of all based on the length of time the investments are held until their withdrawal.

If one remembers the **Rule of 72**, it will guide the value of the tax deferral. Any funds invested will double in value over a specific number of years by using this rule. If the interest rate being earned by the investment is divided into 72, that result gives the number of years it takes to double your money using a compounded effect. This does not take into account any tax on that income. For example, if you earn six percent, which divided by 72 equals 12, that means that at 10 percent, it will take approximately 12 years to double your money without any tax effect.

Of course, if the deferred tax is invested in a qualified employer-sponsored retirement plan, there is no tax until the funds are withdrawn so that form of deferral could be the best option.

Some people do not invest the deferred tax at all. They squander it. Of course that type of situation is the worst of all because the deferred tax will be due at a certain point. If the funds are spent and there is no money available to pay the tax when it comes due, the physician (heavens never me) will be in a terrible situation and probably can’t remember why the tax is due in such a large amount when combined with the current year’s tax.

**Follow a Solid and Consistent Approach**

When deferring taxes, it is of the utmost importance to validate one advisor’s credentials and intentions. The advisor must not only understand these concepts, but be able to impart his or her wisdom to you to ensure that the investment of the deferred tax liability is a reality and the funds are not spent.

Remember that there is almost no such thing as saving the tax that is not being paid today. You need to be sure that this concept fits your personality. The deferral is the concept and key to the accumulation of assets, as well as the wise investment of those funds that will ensure the ability to pay the tax later and profit from the transaction in the long term.

I suggest that you meet with a certified public accountant with experience in representing doctors and knowledge in the field of tax planning.
San Francisco
Catch the AOCD Annual Meeting in San Francisco, October 24-27, 2010