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EXECUTIVE DIRECTOR
Marsha Wise

Upcoming Events
AOCD ANNUAL MEETING 2011
October 30 - November 3, 2011
Orlando, FL

AOCD MIDYEAR MEETING 2012
April 19-22, 2012
Branson, MO

AOCD ANNUAL MEETING 2012
October 7-11, 2012
San Diego, 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.
Should you have trouble accessing your profile, you can fax the new information to the AOCD at 660-627-2623. Send the fax to the attention of Marsha Wise, resident coordinator.

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Message from the President

It was great to see those of you who attended our Midyear Meeting in Marco Island. The program was better than promised, thanks to Dr. Karen Neubauer’s hard work. The luau on the beach was great fun; the food delicious and plentiful. I look forward to seeing all of you in Orlando at our Annual Convention in October. What better place to spend Halloween than the Orlando/Disney area. It will be a great time for attendees of all ages.

Our College is definitely going through some growing pains. As our membership grows, so does the need for regulations/requirements to be in place and followed. We need to keep things lucid and transparent in both our meetings and medical practices. Inferences and assumptions cause confusion. As early as medical school we were told “if it’s not documented in the chart…it didn’t happen.” In these litigious times being concise and specific in all our dealings can only help. We are a group of well-trained professional dermatologists who work hard. We want both our medical practices and College to be beyond reproach. We come from all different races, religions, and preferences to join together to make the AOCD the best it can be.

I had the pleasure of attending DO Day on Capitol Hill for the first time. It was an unexpected, enlightening, and enjoyable experience. Most all of our osteopathic colleges were represented by an impressive group of students. Several specialty colleges were also represented by their presidents or executive directors. The breakfast briefing session was given by our AOA President Dr. Karen Nichols and Executive Director John Crosby, to name a few. Key talking points involved health issues of concern to DOs to be discussed with members of Congress and their staff. Each attendee was given a list with specific appointment times to meet with members of Congress and their staff from their registered voting area (zip code). Meeting with senators, congressman, and their staff individually or in small groups (10 or less) made this experience well worth the time spent. I recommend it highly to each and every one of you. The AOA organizes this event yearly.

I ask you all as members of our College to step forward and go the extra mile. The AOCD has come through for all of us to enable us to have the professions and lifestyles we’ve worked hard to obtain. We must continue to enhance and improve the College as times and technologies change and our membership grows.

Thank you,

Leslie Kramer, D.O., FAOCD
AOCD President, 2010-2011
Meet the Nominees for AOCD 2011-2012 Officers

Members will be asked to vote at the 2011 Annual Convention for three officers to serve on the Board of Trustees (BOT). The candidates talk about what they hope to accomplish as a member of the BOT and their role in shaping the future direction of the AOCD in the following excerpts:

Suzanne Sirota Rozenberg, D.O.: Third Vice President

Suzanne Sirota Rozenberg, D.O., is running for Third Vice President. She is the assistant program director of Dermatology at St. John’s Episcopal Hospital in Far Rockaway, New York. An AOCD member since 2002, Dr. Sirota Rozenberg has served on the BOT as a trustee for the past three years. Prior to entering dermatology in 2002, she was and still is a board-certified family physician. Dr. Sirota Rozenberg was active in the New York State Chapter of the American College of Osteopathic Family Physicians, serving as president for two years. She remains very active in teaching residents and medical students and is part of the adjunct clinical professor staff at the Touro College of Osteopathic Medicine that opened in Harlem in 2007.

“My goal is to further standardize our residency programs and establish a cohesive training model for all of our residents. I believe in strong faculty development and the growth of our profession. I believe that we as a College must believe in ourselves and the contributions we all make to dermatology. Our validation is through the AOCD. Being properly educated, through our residency standards and CME, will highlight our uniqueness. We must act from within and create a fine educational core. I believe wholeheartedly in the osteopathic approach to dermatology and reinforce this in my office and with my residents. We are special!

“I feel that I have offered much to the AOCD, and will continue to offer more in the capacity of Third Vice President.”

John Minni, D.O.: Trustee

John Minni, D.O., has been an AOCD member since 2005 when he started his residency. He is an associate editor for the JAOCD and recently joined the CME Committee being spearheaded by Executive Director Marsha Wise. The committee members are charged with updating the CME process and forms.

“There is a radical change afoot not only in dermatology, but medicine in general. I would like to help the AOCD with this transition. I also believe that making the AOCD more green should be a priority. In general, I would like to give back to the AOCD and assist in any way that I can.

“I relish and look forward to the chance of becoming a trustee. Drs. Bradley Glick and Jeffrey Martin have truly been a positive influence on me.”

Rick Lin, D.O.: Trustee

Rick Lin, D.O., has been an AOCD member for 10 years, starting as a student member. Serving on the BOT since 2008, he was recently appointed chair of the Internet Committee. During his residency, Dr. Lin served as resident liaison for two years. He also has been a speaker at recent AOCD meetings discussing such topics as electronic billing, financial planning, and electronic medical records.

“During the past three years as a trustee, I have had the chance of forming working relationships with many members of the College. Moving forward, I would focus on supporting the upcoming AOCD leadership. I would like to focus my contributions in areas that I feel to be personal strengths including the incorporation of new technology and the creation of a think-tank to exchange ideas about the business end of dermatology.

“I am concerned about our profession in the looming uncertain healthcare environment. I believe the best way to steer through the uncertainty is to prepare ourselves as best we can. One way is through the use of social networking or e-mail lists to exchange information. For example, I would like to facilitate the creation of an information network in which all AOCD members can share and exchange business-related ideas, such as the use of new laser technology, electronic medical records, billing changes, and coding practices. This concept can be applied to resident members to offer advice on job hunting and/or setting up a new practice, enabling our experienced members to mentor those just starting out. I believe that collectively as a group, we will thrive more effortlessly with fewer risks.

“I would consider it a tremendous honor to serve again on the AOCD’s BOT, especially to represent my peers in helping make decisions that will shape the future direction of the College. I will do my very best to serve in any capacity the membership allows me to serve.”
The 2012 AOCD Midyear Meeting will be held April 19-22 at the Hilton Branson Convention Center Hotel in downtown Branson, Mo.

This Midyear Meeting will run Thursday through Sunday instead of Wednesday through Saturday as in the past. In response to a recent survey, members requested the time change to accommodate office hours and resident time schedules.

Known as the Live Music Show Capital of the World, Branson offers more than 50 theaters featuring live performances, 12 championship golf courses, an international award-winning theme park, dozens of attractions and museums, an historic downtown district, and a full range of dining options.

Less than a day’s drive for one-third of all Americans and home to the new Branson Airport in addition to the Springfield-Branson National Airport 15 miles from the hotel, Branson is easily accessible.

The hotel is connected to the Branson Convention Center in the heart of the historic downtown. It is adjacent to the Branson Landing, a waterfront shopping, dining, and entertainment district featuring more than 100 specialty stores.
The same week, we submitted the Document Survey for our 2010 Midyear Meeting held in Sedona, Ariz. As a specialty college of the AOA that provides CME to its members, the AOCD is required to undergo a Document Survey every three years. The purpose of this survey is to determine the College’s accreditation status with the AOA.

As the AOCD’s three-year accreditation cycle is about to end, the AOA Division of CME chose the 2010 Midyear Meeting as the focus of the Document Survey. The AOCD was notified this past February and was given 30 days to submit the required information, which was completed in March. The information was then reviewed by the AOA Division of CME and then forwarded to the Council on CME to determine the AOCD’s accreditation status at the next CME meeting.

If the Council determines that serious quality problems exist, it will notify the AOCD, which must develop a plan of corrective action based on the cited

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Our recent Midyear Meeting in Marco Island, Fla., was a success. It was good to see and meet many of you. Several surveys were handed out asking for your input regarding the College, meeting sites, DermLine and the website, and how the AOCD can better meet your needs. Among the comments we received, members overwhelmingly would like the location of the Midyear Meetings to be within one hour from a major airport and some suggested rescheduling the meetings so as not to miss as much work. Respondents would like to be informed about Board of Trustee (BOT) meetings and alumni news, as well as more updates on coding, e-prescribing, and electronic health records in DermLine. They would like the website to be updated and include job listings as well as offer online meeting registration and CME credit. Regarding members’ needs, respondents said they would like to have more communication with the BOT and more industry support at the meetings, among other requests. If you attended the recent Midyear Meeting and have not returned your evaluation forms, there is still time to do so. We also are sending out a post-meeting outcome evaluation form in the mail shortly.

If you would like to become more involved with the AOCD, please consider applying for a committee appointment. See the AOCD website for a list of current committees and members.

AOA Meetings
In late March, I attended the Postdoctoral Training Review Committee (PTRC) and the Council on Postdoctoral Training (COPT) meetings in Chicago.

During the COPT meeting, an initial review was conducted on revisions for the Basic Standards. We submitted the revisions in February after receiving notification from the AOA in December of 2008 about a uniform Standard Revision requirement. After months of revisions and hard work on the part of our Education Evaluation Committee, our Basic Standards in Dermatology, Mohs, Pediatric Dermatology Fellowship, and Dermpath Fellowship standards were submitted. We are awaiting the final review.

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

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deficiencies. If it is a matter of missing documentation, the AOCD will be given 10 days to submit it before being penalized by losing points.

These points are used to determine the specialty colleges’ score. Colleges that score 90 points or greater (out of 100) are awarded three-year accreditation; 80 to 89 points, a two-year accreditation; and so on.

Failure to submit the required documentation or respond to deficiencies within the allotted timeframe may result in an on-site visit and survey, and/or the initiation of procedures that lead to the loss of AOA Category 1 CME Sponsor Accreditation status.

This is one reason why it is critical for all meeting attendees to return evaluation forms and signed attestations. This is especially true for the speakers as a lack of a CV or Disclosure Form could result in a deficient score.

In April, the AOCD was notified that it passed the Document Survey, receiving 100 points, and it will be accredited for another three years.

Upcoming Meetings
Information regarding our Annual Convention in Orlando will be available soon. Mark your calendars and join us at the Peabody and Orlando Convention Center October 30 - November 2, 2011.

The date has been changed for the 2012 Midyear Meeting in Branson, Mo. The meeting is now scheduled April 19-22. Lectures will be held from 1 p.m. to 6 p.m. on Thursday, 7 a.m. to 6 p.m. on Friday, 8 a.m. to 12:30 p.m. on Saturday, and 7:30 a.m. to 11:15 a.m. on Sunday.

FOD Gains Founding Members

Two more dermatologists have been named founding members of the recently redesigned Foundation for Osteopathic Dermatology (FOD).

AOCD President Leslie Kramer, D.O., and Stephen Purcell, D.O., are the newest Founding Members of the Ulbrich Circle, which is one of the FOD categories of support. They join Marc Epstein, D.O., and Bradley Glick, D.O.

Dedicated to providing grants for education and research in dermatology and related areas, the FOD’s new levels of support are as follows:

- The Ulbrich Circle: $10,000 over a ten-year period
  - Koprince Society: $1,000
  - Leaders Of Osteopathic Dermatology: $500
  - Scholars Circle: $250
  - Residents’ Forum: $100

The Ulbrich Circle and Koprince Society are named after founding members A.P. Ulbrich, D.O., and Daniel Koprince, D.O., respectively.

The first 10 members who commit to the Ulbrich Circle between now and the 2011 Annual Convention scheduled Oct. 30-Nov. 3 in Orlando will be forever known as the Founding Members of the Ulbrich Circle.

Contributors at all levels of support will be acknowledged in upcoming issues of DermLine and in JAOCD advertisements, as well as electronically at meetings and in e-mails.

“While the FOD’s support comes primarily from industry and members, its lifeline is the members of the AOCD,” says FOD Chair Dr. Glick. “We encourage all members to lend support to the FOD at any level and look forward to growing the Foundation that will continue to provide educational opportunities for osteopathic dermatology residents and members at large. We hope that with the slow improvement in our economy, these new opportunities for giving will encourage members to contribute with great pride to our College and the FOD.”
The AOCD is seeking individuals who would like to serve as volunteer members on the College’s various committees for 2011-2012. There are 21 committees that range in focus from training to history and public relations to the Internet. As an example, the purpose of the In-Training Exam Committee is to administer an in-training examination annually to dermatology residents during the AOCD Annual Convention. The focus of the Historical Committee is to oversee the College’s archives as well as maintain and update a general history annually. The purpose of the Editorial/Public Relations Committee is to review and assess Dermline. The Internet Committee is responsible for the development and maintenance of the AOCD website and other Internet-related activities. For a complete list of committees, visit the AOCD website. Please note that some of the committees, such as the Educational Evaluating Committee and the Program Director’s Committee, do not have open membership, per the AOCD bylaws.

Interested members should send or e-mail a letter indicating areas of interest, along with a CV, to President-Elect Bradley Glick, D.O., by August 1. The letter should be sent to Dr. Glick in care of the AOCD, P.O. Box 7523, Kirksville, MO 63501, faxed to 660-627-2623, or e-mailed to mwise@aocd.org.

Wanted: Committee Members

The AOCD is seeking individuals who would like to serve as volunteer members on the College’s various committees for 2011-2012.

Good Governance: Conflict of Interest Policy

This is the first in a series of articles about the AOCD’s Good Governance Policies. Per AOA requirements and Internal Revenue Service regulations, the College is required to disclose our policies for the purposes of transparency. This article focuses on the Conflict of Interest Policy.

The purpose of addressing conflicts of interest is to fully disclose any relationships that could present such a conflict. To that end, the AOCD has adopted a policy statement regarding conflicts of interest to which administrative and elected officers, trustees, appointed committee chairs, and committee members as well as general members must comply.

For Officers, Etc

This policy specifically prohibits trustees, officers, and employees from using their respective positions with the College to derive direct or indirect financial profit. Similarly, trustees, officers, and employees are prohibited from utilizing a position with the AOCD to achieve an unfair advantage in issues involving another entity with which they are involved as a board member, officer, and/or employee, or in which they have a substantial financial investment.

Therefore, all officers, trustees, and other appointed officers must submit a conflict of interest statement to the College on an annual basis. Additionally, these individuals are expected to update the statement should their circumstances change.

Members Included

This policy also applies to all AOCD members who may become involved in situations in which their loyalties are divided or their personal interests may conflict with their duty to the AOCD. Situations can also arise in which members may be tempted to act in violation of their duty of loyalty to the College. This policy sets standards to govern their conduct in such situations.

The concept of conflict of interest covers a wide range of situations in which what is at stake for an individual conflicts with his/her official responsibilities and the confidence vested in him/her. This type of interest may be related to, for instance, financial gain, professional advancement, academic promotion, commitments to third parties, and/or allegiance to institutions, as well as roles or responsibilities of a professional, administrative, or academic nature.

For the purposes of this policy, a conflict of interest is defined as follows:

An AOCD member is involved in a conflict of interest when:

• the member owes a duty of loyalty in some matter to act in the interests of a person, group of persons, or institution; and
• at the same time, the member has a personal interest in the matter or owes a duty of loyalty to act in the matter in the interests of a different person, group of persons, or institution.

A conflict of interest exists under this definition even if the action or decision called for under the first duty is identical with the personal interest or with the action or decision required under the second duty.

In the next Dermline, due diligence and transparency will be discussed.
Midyear Meeting Presentations Entice, Educate

Presentations at the 2011 AOCD Midyear Meeting touched on the controversial, delved into cutting edge topics, addressed bread-and-butter topics, and even made attendees laugh out loud when discussing the psychology of success.

Resident speakers kicked off the meeting held in Marco Island, Fla., March 16-19, with lectures Wednesday afternoon through Thursday morning. Guest speakers filled the last two mornings of the meeting. The following is a glimpse of what they said.

Medical Applications of Pulsed Laser
Suzanne Sirota Rozenberg, D.O., assistant program director of Dermatology at St. John’s Episcopal Hospital in Far Rockaway, New York, spoke about medical applications of a 0.65 millisecond pulsed Nd:YAG 1064 nm laser. Originally purchasing this laser for aesthetic use, she has treated patients for hair removal, telangiectasias, angiomas, rosacea, pigmented lesions, vascular lesions, and skin rejuvenation/lightening.

This laser is highly efficacious and safe to use for all skin types, said Dr. Sirota Rozenberg. The wavelength 1064 is deep heating and is uniquely absorbed in all three chromophores. Patients experience minimal pain or pigmenting risk. In addition, this laser is reasonably priced and compact enough to be transported between offices.

This laser is so versatile that she gradually began using it for medical purposes with positive results. As an example, Dr. Sirot Rozenberg treats patients with pseudofolliculitis barbae with the laser after non-laser treatments have failed. “The only way to treat pseudofolliculitis barbae is to get rid of the hair follicle underneath,” she said. The 1064 nm laser does that by being absorbed by the melanin in the hair follicle and shaft. The skin can handle two passes of the laser, said Dr. Sirota Rozenberg, who informs male patients that they won’t be able to grow a beard after laser treatments.

Regarding hair removal, in general, she tells patients that there is no such thing as permanent hair removal. Instead, Dr. Sirota Rozenberg talks to patients, many of whom are dissatisfied salon customers, about “permanent hair reduction.” “With three to four hairs in one follicle, if the bulb isn’t in a growth stage, you’re not killing it,” she said. Dr. Sirota Rozenberg gets significant response; the hair typically grows in slower and thinner, and much less maintenance is needed. It’s important to ask female patients about their menstrual cycles because women

Laser For Sale
The asking price for a 2003 Candella V-Beam laser, complete with the necessary paperwork to verify maintenance, is $20,000. For details, contact William Gray, D.O., at 231-548-5947 or nmderm@live.com.
Causation: How Do We Know the Drug Did the Deed?

Dr. Wolverton introduced the concept of causation in drug reactions and highlighted the need for careful consideration of the evidence. He emphasized that correlation does not equal causation and that personal experience can often be misleading.

Dr. Sirota Rozenberg, a dermatologist, shared her experience with treating warts and skin infections. She discussed the use of a laser to treat elderly patients, noting its effectiveness in promoting wound healing and its safety profile.

Other uses for the laser included treating vascular anomalies and destroying vasculature. The laser was also used for wound healing and treating onychomycosis, psoriasis, and warts. Its use for wound healing is pending.

Drug Reactions

When it comes to drug reactions, timing is crucial. A reaction occurring three to six weeks after starting a drug is likely due to the drug itself, whereas a reaction occurring after three to six days is more likely due to coincidence.

Dr. Wolverton also suggested that correlation does not equal causation. If a patient has a reaction three days after being given a steroid that isn’t enough to prove causation. Drugs can create and/or mimic a majority of inflammatory skin diseases and several neoplastic processes.

Reactions seldom start prior to 10 or 14 days at least for an initial drug course. If the reaction occurs in the first month, it’s most likely due to the drug. If a reaction occurs three to six weeks after starting a drug, it could be due to toxicity or hypersensitivity.

He suggested to challenge a drug reaction, by determining when the drug was started. Also be aware that a reaction can subside while the patient is still on the drug as the body does regulate itself, he said. De-challenge it by understanding that not all reactions stop, and if the drug is essential, the patient shouldn’t stop taking it. Re-challenge it by determining the response to restarting the drug. Be sure to exclude non-drug etiology.

Infantile Hemangiomas

Although they are the most common soft tissue tumors of childhood, much remains to be learned about infantile hemangiomas (IHs), noted Beth Drolet, M.D., professor and vice chair of Dermatology, professor of Pediatrics at the Medical College of Wisconsin, and medical director of Dermatology and Birthmarks and Vascular Anomalies Children’s Hospital of Wisconsin.
Their natural history is characterized by a proliferative phase followed by a plateau and involution phase, she explained. At birth, there may be some purple discoloration or small, red papules. They typically grow in diameter for the first month, stack up on top of each other, and then go away. When they remain, 80% of the growth occurs in the first five months of life.

Historically, IHs have been classified based on the depth of soft tissue involvement, that is, superficial, deep, and mixed, said Dr. Drolet, who is part of the Hemangioma Investigative Group comprising eight pediatric dermatology centers formed in 2001. But a more recent classification based on morphology has proven to be more predictive of complication risk and treatment necessity. The latter classifies IHs as segmental, which are at higher risk of complications and associated anomalies, and localized. Hemangiomas commonly occur on the head and neck, but can occur on the chest and shoulders, as well.

The majority of IHs are uncomplicated and do not require treatment. However, approximately 24% are associated with complications including functional impairment, ulceration, permanent disfigurement, and cardiac compromise, she said. Hemangiomas on the periorbital and retrobulbar are associated with visual compromise. The beard distribution of an IH is most commonly associated with airway complications; patients typically exhibit strider breathing. Ulcerations can cause pain, infection, bleeding, and permanent scarring. Risk factors for ulceration include a large size IH and those of the mixed subtype. Locations commonly associated with ulceration include anogenital, lower lip, and neck. Hemangiomas on the nasal tip and ear and large ones on the face are associated with cosmetic disfigurement and scarring. Infants at risk for PHACES syndrome have large, plaque-like, segmental IHs on their face.

Today, there is an increasing incidence of IHs, Dr. Drolet noted. Risk factors include low birth weight and increased maternal age.

Of those referral patients with complications, 38% require systemic therapy. Predictors of poor outcome include size, location, and segmental classification.

For many of her patients, Dr. Drolet does active non-intervention, that is, she educates the parents, conducts a follow-up in two to three weeks, and monitors the hemangioma’s growth.

Regarding medication, high doses of oral corticosteroids for long-term treatment can be effective. In her experience, the use of corticosteroids stops the IH growth in 70% to 80% of infants, and shrinks them in some cases. Larger lesions tend not to respond well to steroids. Prednisone doesn’t always work that well. Vincristine is an effective treatment typically reserved for patients who are resistant to corticosteroids or can’t tolerate them. Oral propranolol is widely used and tends to be more effective for younger patients, she said. But it doesn’t work well for ulcerations. Overall, propranolol seems to work better after a treatment of steroids, added Dr. Drolet. Working with a good surgeon and oncologist is useful to determine appropriate treatment.

Current Sunscreen Controversies

Steven Wang, M.D., director of Dermatologic Surgery and Dermatology at Memorial Sloan-Kettering Cancer Center at Basking Ridge, New Jersey, tackled several current sunscreen controversies during his presentation.

To address whether the use of sunscreen prevents skin cancer, Dr. Wang reviewed studies—complete with follow-up studies—demonstrating the use of daily sunscreen in significantly reducing the development of squamous cell carcinoma (SCC), SCC tumors, and melanomas. When the daily sunscreen participants did have melanomas, they were much thinner lesions. “Also, the longer sunscreen is used, the better protection you can attain,” he said.

However, the controversy arises because some studies show the use of sunscreen increases the risk of melanoma. The problem is that few studies control for cumulative sun exposure and participants often use low SPF sunscreens, said Dr. Wang. Moreover, sunscreens with an SPF of 16 really provide the equivalent of SPF 3 or 4 because individuals don’t use the correct amount. Also, not all sunscreens are effective. Based on a 2008 study, only 5 of 13 sunscreens achieved high UVA protection, based on FDA guidelines, which were new at the time.

Whether ultraviolet (UV) radiation causes melanoma was the next controversy, to which Dr. Wang said, “There is so much evidence of this that we should stop the debate.” It is known that UV radiation damages the DNA, resulting in the expression of p53 mutations. The use of tanning beds is also associated with increased melanoma risk. Studies have demonstrated that the first exposure to tanning beds before the age of 35 increases an individual’s lifetime risk of melanoma by as much as 75%. In a recent study, 76% of melanomas were attributable to tanning bed use for participants diagnosed with melanoma between the ages of 18 and 29 years. Moreover, the use of tanning beds was associated with an increased risk of early-onset melanoma.

Addressing the vitamin D deficiency controversy, Dr. Wang said that many people became vitamin deficient overnight because the dose of what was considered adequate was raised. A recent FDA study supports the use of
vitamin D for musculoskeletal health, but cites the evidence for the prevention of various cancers as inconclusive. At high doses, vitamin D can cause calcification and kidney stones.

Sunscreen does decrease vitamin D production if it is used properly, said Dr. Wang. A sunscreen with SPF 15 blocks 90% of UVB while a sunscreen with SPF 30 blocks 97% of UVB. But in order for that to happen, the user needs to apply 2 mg of sunscreen per centimeter square of skin, which is significantly more than the average person applies.

Dr. Wang reviewed a 2009 study that looked at how much sun exposure is necessary to get 400 IUs of vitamin D. If 25% of the body surface is exposed, you need 4 to 6 minutes to get 400 to 600 IUs, he said. Skin type, season, pollution, and altitude all play a role in how vitamin D is synthesized.

Some are now questioning the safety of sunscreens, oxybenzone, and retinyl palmitate. Overall, data from studies show these to be safe.

Therapeutic Update

“New isn’t always better,” said James Del Rosso, D.O., professor of Dermatology at the University of Nevada, School of Medicine, and program director of TUCOM/Valley Hospital Medical Center in Las Vegas, when discussing emerging information on the pathogenesis of common dermatologic disorders. The advantage of staying on top of new developments, however, keeps clinicians questioning why they do what they do. “That’s the only way to do something better.”

In addition to seeking treatments for skin conditions, patients want recommendations about which cleansers, moisturizers, and sunscreens to use. If you don’t provide that information, they will get it from somewhere else. Integrating such products into your therapy sets you apart as an expert in skin care, he said. Making such recommendations also enables you to

**Photodynamic Therapy**

The benefits of photodynamic therapy (PDT) were the focus of the lecture presented by Shino Bay Aguilera, D.O., of Shino Bay Cosmetic Dermatology & Laser Institute in Fort Lauderdale.

A chemical reaction activated by light energy, PDT can be used to selectively destroy tissue. Dr. Aguilera tends to use the blue light because it allows for the most absorption. Blue light is strongly absorbed, but has shallow tissue penetration. Green, yellow, and red light is less absorbed, but allows for deeper penetration.

While the Levulan Kerastic was approved in 1999 in the United States for the treatment of multiple actinic keratoses (AKs) on the scalp and head, Metvix was approved in Europe in 2001 for the treatment of AKs and basal cell carcinomas (BCCs). Levulan is more hydrophobic than the Metvix and uses blue light while the Metvix uses red light.

Studies have shown PDT to be very effective for the treatment of AKs and superficial non-melanoma skin cancer (NMSC), with a clearance rate of 75% to 100%, noted Dr. Aguilera. The phototoxic reaction improves epidermic signs of AK, dysplasia, and photodamage. It can be used to treat multiple lesions or a large surface area. This therapy also has the unique advantage to selectively treat dysplastic cells that are not yet visible. In essence, it is a proactive skin cancer prevention treatment, he said. In addition, it is comfortable and convenient for patients, and offers cosmetic improvement.

With regard to NMSCs, PDT can be used to treat superficial BCC, nevoid BCC syndrome, Bowen’s disease, or BCCs when disfigurement or poor healing may occur with conventional treatments. It is useful for patients who have contraindications for surgery or those who are immunosupressed with multiple lesions.

Photodynamic therapy is also very effective for photorejuvenation, he said. Studies have shown that PDT improves skin texture and pigment change caused by UV radiation.

Dr. Aguilera reviewed several off-label uses of PDT, including for the treatment of severe acne and scarring, sebaceous hyperplasia, hidradenitis suppurativa, psoriasis exhibiting localized plaques, T-cell lymphoma exhibiting extensive lesions or difficult areas to treat without systemic involvement, plantar warts in recalcitrant cases, and Port wine stains.

Contraindications for PDT include light sensitivity; photosensitivity due to medications; nodular, pigmented, or morpheaform BCC; and deep lesions of NMSC. Adverse reactions include edema, erythema, burning, pain; hyper or hypopigmentation; cutaneous abrasions; blisters; infections; herpes simplex activation; and photo toxicity.

Dr. Aguilera tells patients to avoid sunlight and/or bright light for 48 hours after treatment, and to wear sun protective garments for at least one week after treatment. Sun blocks do not protect from visible light, he cautioned.

In an ideal scenario, we would create a universal photosensitizer and have more defined treatment protocols, concluded Dr. Aguilera.
educate patients about the best products for their particular skin.

When treating patients with atopic dermatitis, Dr. Del Rosso believes in the concept of priming the skin first. Many times, patients are using unnecessary products that may be irritating their skin. “I want to correct this as best I can before starting treatment,” he said. That means treatment may begin with the use of cleansers and moisturizers to reset the skin barrier, followed by topical therapy. This philosophy also tends to ensure patient compliance because well-balanced skin responds better to therapy. In a study evaluating the impact of a ceramide-based moisturizer for patients with atopic dermatitis, patients fared best when using a cleanser and steroid to control their skin care.

Skin care products are beginning to target specific skin diseases such as ceramide-based moisturizers for patients with eczema or psoriasis. Dr. Del Rosso sees this as beneficial for dermatologists because it makes it easier to learn about and offer such products to specific patients.

As the concept of acne vulgaris changes, he said, treatment of the disease will likely be affected. As an example, he prefers the term “persistent” over “post” when referring to inflammatory changes, such as hyperpigmentation or erythema, because calling them “post” implies that the disease is over, but it’s not. Knowing that the disease continues beyond what’s erupted on the surface will likely impact how long a particular therapy is continued.

When it comes to post-teenage acne, Dr. Del Rosso is seeing more cases as of late. Oral spironolactone used as a monotherapy or combination therapy is highly effective in treating the condition. Whether the increased estrogenic effect puts patients at high risk for breast cancer is still being debated, he said.

Regarding new developments, Dr. Del Rosso reviewed a benzoyl peroxide 5.3% emollient foam for the treatment of truncal acne. Also discussed was a bleach bath in a foam format for treating methicillin-resistant staphylococcus aureus.

Under the “changing our mindset” topics, Dr. Del Rosso questioned the use of topical corticosteroids for dermatoses. It is thought that super potent steroids should not be used on certain body parts or for certain aged patients. He suggested that they can be used for short periods of time. The dogma is for people who don’t know how to use the drug, but dermatologists know how to use it, Dr. Del Rosso added.

The tissue must be processed before it can be reviewed under the microscope. The first step is tissue fixation. Fixatives can be physical or chemical. Physical fixatives are done through heat or desiccation. Heat is frequently used to enhance chemical fixation, as well. Chemical fixatives kill bacteria, penetrate tissue and harden it to some extent, and can enhance tissue staining. Formaldehyde is the most commonly used chemical fixative, but alcohol and acetone-based solutions are also used. The appropriate ratio of fixative to tissue is 10:1. If this step is performed improperly, said Dr. Plumb, it will result in poor histology.

The purpose of the three stages of tissue processing—dehydration, clearing, and infiltration—is to remove water from the specimen and replace it with a medium that solidifies in order to cut through the tissue sections. Alcohol is commonly used for dehydration and xylene is the most common agent used for clearing the tissue. Xylene is generally used for routine paraffin imbedding because it...
is compatible with a variety of tissue specimens.

Once the tissue has been processed, it can be embedded. This is typically done in a paraffin wax block that is then cooled.

The specimen is sectioned on a microtome, which moves the block across a very sharp blade. Typically, five micron sections are cut in consecutive ribbons of slides, he said. The sections are then placed on a glass microscope slide.

Next, the specimen is stained in order for the cellular structures and milieu to be identified, Dr. Plumb explained. The various stains allow contrasting colors to distinguish the nuclei and cytoplasm of the cells. Hematoxylin and eosin is the most common stain used for this purpose. Eosin is used as a counterstain to hematoxylin.

After the specimen is stained, it is cover slipped and dried. Either a resin-based or aqueous mounting medium can be used. The mounting medium is necessary for a crisp microscopic interpretation as it holds the specimen in place between the cover slip and the slide. Now, the specimen is ready for microscopic interpretation.

Today, thousands of stains exist. The use of immunohistochemistry, which was first demonstrated in the 1940s, revolutionized the diagnosis of disease in the 1980s, he said.

The key to quality processing is that each step must be done correctly, Dr. Plumb concluded. Cutting multiple specimens and imbedding them in the same way can be challenging.

**Cutaneous Manifestations of Bio Warfare Agents**

Biologic weapons are any organism or toxin found in nature that can be used to kill, incapacitate, or otherwise impede an adversary, stated Michael Morgan, M.D., professor of Pathology at USFCOM, and clinical professor of Dermatology at USFCOM and MSUCOM. They are characterized by low visibility, high potency, accessibility, and relatively easy delivery.

He used case studies to review cutaneous manifestations of bio warfare agents, beginning with the bubonic plague. Ultimately responsible for 200 million deaths, the bubonic plague was indirectly responsible for the church's decline due to the loss of clergy and socioeconomic changes resulting from the loss of workers. Today, 10 to 15 cases of bubonic plague, which is spread by yersinia pestis, are reported annually mainly occurring in the desert southwest. The most common clinical manifestations are fever, headache, and painful lymph nodes. With treatment, the plague can be arrested, but if it spreads to the lungs it is terminal.

Anthrax has three forms. Inhalation is the most rare and deadly form. Gastrointestinal anthrax is less common with a guarded prognosis. Cutaneous anthrax, which is deadly in 10% of individuals infected, is characterized by painless papule-central hemorrhagic bullae surrounding brawny edema following 1 to 10 days of incubation. One to two cases are reported in the desert southwest annually; 20,000 cases worldwide. Spores are acquired primarily in pastures and on animal products. All patients with the gastrointestinal or inhalation form should get a vaccine, which is unnecessary for the cutaneous form.

Dermatologists may be in the front lines to diagnosis smallpox. Cutaneous manifestations include involvement of the face more than the trunk and extremities. Usually smallpox is acquired through inhalation. Endemic in the 1960s, smallpox was eradicated in 1979. No natural infection for smallpox exists today, but bio warfare stocks are maintained in labs in both the United States and Russia. Following a 14-day prodromal phase in the lung, on the second day viremia to the skin coincides with a rash and flu-like symptoms. The rash starts as erythematous macules that turn to vesiculating papules, umbilicated pustules, and then healed scars. A diagnosis can be confirmed with PCR-based or fluorescent antibody assays or cultures, the latter of which are considered the gold standard. “It is thought that one person can spread smallpox to 100 people,” Dr. Morgan said. One-third of individuals succumb to complications. Only 10% of the population is vaccinated against smallpox, he noted.

Treatment for the plague, anthrax, and smallpox involves strict isolation and universal precautions, respiratory and hemodynamic support, and antibiotics. The Centers for Disease Control and Prevention (CDC) and the Federal Bureau of Investigation should be notified of cases.

A modern example of bio warfare occurred in the early 1990s when members of the Aum Shinrikyo cult released sarin, botulinum toxin, and anthrax on separate occasions. The most well-known incident was the release of sarin in the Japanese subway system in 1995; 12 people died and nearly 1,000 were hospitalized.

All clinicians should have a white powder biothreat collection kit on hand, he said. Follow the algorithm ICE to manage suspected bio warfare agents, that is, Isolate the patient/quarantine; Culture/confirm diagnosis; and give Empiric antibiotics. “We need to be cognizant about what to do...”
and how to respond to bio warfare attacks,” Dr. Morgan concluded.

Black Box Warnings
Some clinicians view the FDA’s black box warning as a sign to be careful when prescribing a drug that has one, while others think they should avoid using the drug altogether, noted Dr. Wolverton during his second presentation entitled *Those Pesky Black Box Warnings: Important Lessons Learned.*

“Just because a drug has a black box warning doesn’t mean that clinicians shouldn’t use it,” he said. “Use it, but with great caution.”

Reviewing the hierarchy of warnings, Dr. Wolverton said it starts with drug reactions followed by adverse reactions, warnings/precautions, and lastly a black box warning. The latter is often the step taken just prior to the drug being removed from the market. He urged clinicians to take these FDA letters seriously. When the warning mentions “monitor” and “drug interaction,” you need to evaluate the drug’s risks and benefits, Dr. Wolverton said. Most worrisome are the unpredictable adverse events.

When a drug “has been associated” with a specific side effect that means there is the possibility that the drug caused it, he said. “You don’t have to prove causation to list a black box warning,” Dr. Wolverton added. While a black box warning doesn’t mean guilt or proof, it does mean that there is enough suspicion for clinicians to proceed with caution.

Adverse events are commonly discovered after a clinical trial has been completed because picking up on all of the rare side effects during a trial is impossible, he said. Too few patients, complications, and co-morbidities contribute to warnings being issued late.

Determining which drugs should get a black box warning isn’t an easy task for the FDA. There are many false positives and false negatives, the latter of which is more common.

Informed consent becomes more important with the use of these drugs, he added. It’s better to mention side effects—even rare ones—and downplay them than not mention them at all. It’s also important to realize that informed consent is a communication process that is ongoing. “It’s not just a signature on a piece of paper,” Dr. Wolverton said. Clinicians must communicate the common and potentially severe side effects to their patients. They should reinforce this information with written materials. “Tell the patient to call you if something comes up,” he stated. “You may think you’ll get bombarded with calls, but you won’t.”

Understand that these warnings are moving targets, Dr. Wolverton said. Still, clinicians must keep abreast of this information. He suggested creating an electronic checklist, with a print back up, to keep current with all of the warnings.

“Being overly fearful of a problem happening is counterproductive to the practice of medicine,” Dr. Wolverton concluded. “You should have a reasonable approach for safety.”

Tanning Beds, Skin Cancer and Vitamin D
The incidence of melanoma and BCC is trending upward in younger women, most likely corresponding to their use of tanning beds, stated Melody Eide, M.D., of the Henry Ford Health System in Royal Oak, Mich. In the late 1980s, less than 1% of adults used tanning beds. In 2007, 27% of adults used them. College age women and rural teens are big users of tanning beds, but usage drops off significantly with age.

While more than 30 states adopted legislation limiting tanning bed use, most of which require parental permission for minors, studies have found that legislation hasn’t made a difference in usage. Patrons use tanning beds because tanning makes them feel more attractive, fit, and relaxed, noted Dr. Eide. Studies have shown that tanning is highly addictive and actually induces withdrawal symptoms when patrons stop going to the salon.

The claim that today’s tanning beds are safer than older versions because they emit UVA radiation, as opposed to UVB radiation, is another myth. Studies have shown that tanning beds emit as much as 5 times the amount of UVA radia-
tion and twice as much UVB radiation emitted by the sun on a summer day.

UVB rays are associated with sunburn whereas UVA rays are associated more with skin inflammation, Dr. Eide noted. But UVA radiation also triggers the production of the p53 mutation, so even when people don’t experience a sunburn, they are harming their skin. Low doses of repeated UVA exposure are known to cause cumulative damage. The most frustrating myth to fight, said Dr. Edie, is that indoor tanning is better because it prevents sunburn.

Early studies are inconclusive as to whether indoor tanning increases the risk of developing skin cancer. “However, the evidence is finally here,” she said. A 2007 meta-analysis conducted by the International Agency for Research on Cancer demonstrated that the first exposure to tanning beds before the age of 35 increases an individual’s lifetime risk of melanoma by as much as 75%. The World Health Organization decided the risk was so extreme that it categorized tanning beds as carcinogenic to human beings in 2009.

It’s hard to know the relationship, if any, between vitamin D and skin cancer, as recent studies have mixed results. Some studies show that melanoma patients have lower vitamin D levels with stage 4 disease compared with stage 1. They tend to have thicker tumors, too. Some studies suggest that supplemental use of vitamin D will decrease the risk of melanoma. “This is still being sorted out,” Dr. Eide said.

This inconsistency has raised the question of whether patients should go to tanning beds to obtain vitamin D. Studies have shown that tanning bed users have higher vitamin D levels. Given the carcinogenic risk associated with tanning bed use, the ability to obtain vitamin D through other sources, and the inconclusive evidence from various studies, indoor tanning is not the best way to get vitamin D, she said.

While there is not enough money and time to ensure that the tanning bed industry is compliant with the law, Dr. Eide concluded, there is enough mounting evidence to restrict the use of tanning beds and call for a national campaign to educate the general public about the dangers of tanning.

Pediatric Dermatology
Fred Ghali, M.D., of Pediatric Dermatology of North Texas in Grapevine, focused on pediatric dermatology conditions commonly seen in the clinic. When focusing on children, try to appreciate the location of where the rash is and isn’t, he said. As an example, papular and vesicular lesions located in the mid occipital scalp, as well as on both lower legs, upper thighs, and upper arms are the new pattern of contact dermatitis resulting from the car seat. More patients present with this rash in the spring, summer, and early fall, which could be attributed to sweating. Patients rapidly improve when a barrier is put between them and the car seat or the fabric on the car seat is changed. Topical steroids and/or antibiotics can be given for a secondary infection. With 30 such cases, Dr. Ghali believes this dermatitis could be caused by an allergy to the material used in the car seat, similar to sofa dermatitis.

Contact dermatitis buttocks looks like eczema, he said, but doesn’t occur in a common area. It is believed to be the result of contact with the toilet seat, possibly caused by an irritation or allergy to cleaning chemicals or

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wood in the toilet seat. Using a barrier is helpful. Allergic contact dermatitis in the buttocks and groin is due to the dye, elastic, or adhesive used in a diaper. Treatment involves changing diaper brands, possibly switching to cloth diapers, and a brief therapy of low potency topical steroids.

Among “Allergens of the Year” Dr. Ghali cited are dimethyl fumerate in 2011, neomycin in 2010, neoprene and mixed diakyl thioureas in goggles and rubber in 2009, and nickel in 2008. He has used protopic off-label to treat contact dermatitis caused by neoprene. Dr. Ghali gave an “honorable mention” to shinguard contact dermatitis commonly occurring in soccer players. Some patients have an id reaction on their arms and ear lobes. Treatment involves taking topical steroids, washing the shinguards, and duct taping the exposed surfaces inside the shinguards to remove the allergen.

Location is the biggest clue for diagnosing contact dermatitis, he stated. “It is important to recognize the pattern and look for symmetry.” For treatment, focus on avoiding the suspect contact. Consider topical steroids for limited cases or oral steroids for widespread cases or those associated with a strong id reaction.

Acrodermatitis enteropathica, also referred to as deficiency dermatitis, is a type of gastrointestinal dermatoses that Dr. Ghali is seeing more of in recent years. It is caused by a zinc deficiency either from the mother’s breast milk or poor diet as in the case of children adopted from other countries. Low alkaline phosphate is a clue, he said. Patients improve within two weeks after receiving zinc supplementation.

Dr. Ghali also reviewed neurocutaneous diseases, such as tuberous sclerosis, angiofibromas, and neurofibromatosis; connective tissue diseases, including juvenile dermatomyositis, systemic lupus erythematosus, discoid lupus erythematosus, lupus profundus, and neonatal lupus; and juvenile xanthogranuloma.

### The Psychology of Success

Successful individuals know how to manage themselves and others, said psychologist and humorist Bruce Christopher, who closed out the Midyear Meeting.

Managing oneself can be a difficult task, especially when life becomes challenging. In general, most people know how to manage themselves because they do it all the time at work. “There is the unwritten rule at work to leave your baggage at the door,” he said.

The entire spectrum of emotion has its etiology in the fight or flight response. Within each of us resides two people; the very respectful and calm one in the frontal lobe area, and the primal person in the reptilian level of the brain. When the rational brain gets hijacked, individuals resort to their primal beings and have emotional meltdowns.

Christopher discussed tools to “keep our emotions from getting the best of us.” One involves first training your brain to postpone your anger and then training it not to get angry. Another is finding the trigger that makes you blow up and avoiding it, especially when you are already angry. Think about something pleasant or do something pleasant when you are angry. “It’s hard to stay mad when you are walking on a beach or watching the sun set,” he said. Consider using “the 999 rule.” The next time, you get stressed, ask yourself will this matter in nine days, nine weeks, or nine months? “It probably won’t matter in nine minutes,” he said. Transitory things don’t matter; things that last a long time or a lifetime do matter. A psychologist who studied happy people for 20 years found that happiness is not an emotional state, but rather it’s a skill that people get better at with practice, added Christopher.

Helping others manage their emotions is also important for being successful, he stated. Techniques to do the latter include mirroring, which involves “projecting the emotion you want to see because emotions are contagious.” Empathizing involves reflecting back one’s emotions with understanding. Providing alternative perspectives helps someone in the grips of an emotional hijack see the big picture or an alternative point of view, Christopher said. Helping someone brainstorm creative options and choices helps them feel empowered.

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Pearls of Wisdom

The following are “pearls of wisdom” that attendees learned at the 2011 Midyear Meeting:

Hair removal in patients with polycystic ovary disease won’t work until the disease is controlled.

One percent rapamycin compounded into an ointment can be used twice daily to treat tuberous sclerosis.

Schamberg’s disease can be treated with intense pulsed light.

Propanolol is one of the new treatment options available for infantile hemangiomas, although it is not effective for all individuals.

The use of sunscreen has been shown in several studies to reduce the chance of developing melanoma.

Black box is still just a warning. However, you should inform the patient about it.

Exogenous ultraviolet radiation is not necessary for adequate vitamin D production.

Raise the SPF recommended to patients by two-thirds. If you were recommending an SPF of 15, raise that to an SPF of 45.

The Nd:YAG laser can be used for medical purposes.

Tanning beds confer an SPF of only 1.

Pearls of Wisdom

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Mole Patrol Targets Baseball Fans

What does a cancer center and major league baseball have in common?

If they are both in Florida, the answer is Spring Swing, a series of sun safety events held at pre-season games hosted by the Tampa-based H. Lee Moffitt Cancer Center and Research Institute in conjunction with the Tampa Bay Rays.

This past March, soon to be first-year resident Brooke Walls, D.O., and AOCD student members Alexandra Grob, MSIII, and Brandon Shutty, MSIII, volunteered at various Spring Swings on Moffitt’s Mole Patrol that has been offering free skin cancer screenings to Floridians for more than 15 years. Established in 1995, the Mole Patrol comprises a team of specialty trained physicians, cutaneous surgical oncologists, cutaneous oncologists, surgical oncology fellows, dermatologists, dermatopathologists, nurse practitioners, Moffitt employees, and numerous volunteers. In 2008, the Mole Patrol teamed up with the Tampa Bay Rays to offer screening services during the major league baseball spring training season.
“Just like vendors hawk popcorn, peanuts, and hot dogs at baseball games, Mole Patrol volunteers offer free sunscreen,” says Grob, who is currently attending Nova Southeastern University in Fort Lauderdale.

Although the Spring Swing locations differed, the routine was similar. They arrived at least four hours prior to the opening pitch to begin setting up and unloading the signature big blue bus. Tasks included setting up tents as well as strategically placing signs, educational brochures, and gallon tubs of Blue Lizard sunscreen outside stadium entrances. The latter was distributed to participants and non-participants alike. In addition, there was an interactive display about proper sun safety and protection.

Most of the skin cancer screenings took place outside the bus under the protection of the tents, explains Dr. Walls who plans to start her dermatology residency at the NSUCOM/Largo Medical Center under the directorship of Richard Miller, D.O., in July. “The volunteers were enthusiastic and welcoming,” she says. “They easily persuaded fans to stop by for a quick skin check and rub on some extra sunscreen prior to the opening pitch.”

Many participants had a suspicious lesion and having an expert inspect it was comforting, adds Dr. Walls, who is currently conducting epidemiology melanoma research at Moffitt, which opened its doors in 1986 as a comprehensive cancer center with specialized care in cutaneous oncology, among other areas.

Additionally, inside the bus were private screening rooms, if necessary, to ensure that all areas of concern were adequately inspected.

When suspicious lesions were noted, participants were given recommendations for follow-up and handouts describing their suspected condition. Additional handouts discuss common benign lesions and the importance of regular skin examinations. “The Moffitt handouts are designed to help participants differentiate benign from malignant lesions. They also discuss the importance of regular skin exams to note any changes in existing moles or lesions,” says Grob. “It felt good to be educating the public and making individuals active participants in their own skin health.”

She was surprised, however, at how many individuals used the Mole Patrol as their primary screening exam. “One patient had such a large exophytic growth on his forearm that he needed bandages to hide it. He had not previously seen any doctors for this lesion,” says Grob. “It was a good thing we were able to point him in the right direction for care and follow-up.”

This year, 539 individuals were screened; 654 suspicious and 1,808 benign lesions were found. (See Table 1 for more detail about the suspicious findings.)

In addition to Spring Swing, the Mole Patrol offers free screenings at various health fairs and other venues. Thus far, they have nine events scheduled this year. The three plan on volunteering at as many of the upcoming events as possible.

Seeing the total number of findings demonstrates the Mole Patrol’s impact in the community and in achieving its goal of making a difference with early skin cancer detection, says Grob. “This also was a great learning experience from a student perspective. It was a pleasure to work with the highly skilled professionals on the team, and something I was proud to be a part of.”

Dr. Walls was not only impressed with the medical students’ dedication to community service and learning, but the physicians who take their time to volunteer at these events. “These are some of the most well respected intellects in the field,” she says. “It is very impressive to rub shoulders with some of the leading research physicians in cutaneous oncology.”

For more information about the Mole Patrol and its scheduled events, visit its website www.moffitt.org.

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Orlando Doesn’t Stop at Theme Parks

Orlando is the vacation capital of the world, in large part because of its theme parks. But they are just some of the attractions that you can explore while attending the AOCD’s Annual Convention Oct. 30-Nov. 3.

The Peabody Orlando, the hotel in which the AOCD’s Welcome Reception and Presidential Banquet will be held, is conveniently located across the street from the Orange County Convention Center where OMED 2011 is taking place. It’s also conveniently located near many Orlando area attractions.

The big three theme parks—Walt Disney World, Universal Orlando, and Sea World—rate high on everybody’s To Do list when visiting Orlando.

The most famous of the three, Walt Disney World comprises four separate parks: Magic Kingdom (older Disney icons and rides), Epcot (world-fair style country pavilions), Animal Kingdom (African safari theme), and Disney Hollywood Studios (Tower of Terror, backlot, and shows), all within 15 minutes of the hotel. New to Epcot is The Sum of All Thrills, an attraction that lets you design the ride using an interactive touch screen.

Another crowd pleaser and only five minutes from the Peabody Orlando, Universal Orlando is divided into two parks: Universal Studios Florida and Universal’s Islands of Adventures. The studio’s rides and shows are themed to popular movies and television shows including Shrek 4-D, The Simpsons, Revenge of the Mummy, and Men in Black. Islands of Adventure continues the movie theme with Jurassic Park River Adventure, The Cat In The Hat, Spiderman, and the recently opened The Wizarding World of Harry Potter. The newest rollercoaster—the Holly-wood Rip Ride Rockit—is a high-tech, multi-sensory roller coaster that allows you to create your own ride. Universal also operates Wet ‘n’ Wild, the area’s original water park.

Sea World, also five minutes from the hotel, comprises three separate attractions: Sea World, Discovery Cove, and Aquatica. Sea World revolves around scheduled shows and rides. The best known, the Shamu show features killer whales performing in an open-air theater. Blue Horizons blends human acrobats with dolphin performers. Clyde and Seamore is the long-running sea lion slapstick show. Between shows, walk in a plexiglass tunnel through an aquarium filled with sharks, pet dolphins in a pool, take an indoor trip to the Arctic, and experience the rollercoaster rides. Visitors also can swim in heated pools with dolphins at Discovery Cove and enjoy water park rides at Aquatica. Omaka Rocka is the new water thrill ride featuring high-speed tubes and half-pipe funnels.

Moving beyond the theme parks, Orlando is home to other unique attractions.

Gatorland houses thousands of alligators, including a rare blue one, and crocodiles on its 70 acres. Breeding pens, nurseries, and rearing ponds are situated throughout the park, which also display snakes, toads, insects, turtles, and a Galápagos tortoise. Its 2,000-foot boardwalk winds through a cypress swamp and breeding marsh. Shows include Gator Wrestlin’, Gator Jumperoo, and Up Close Encounters. Younger kids will enjoy the train ride through the park; Lilly’s Pad, a wet and dry play area; and Allie’s Barnyard, a small petting zoo.

Fantasy of Flight is Orlando’s answer to the National Air and Space Museum. It is one man’s private collection of aircraft turned into a restoration facility. From the World War II bombers to famous American, British, Japanese, and German fighters and even flying boats, all of those on display can fly. Don’t miss the realistic simulation of a B-17 raid over Germany. Flying demonstrations and flights in hot air balloons and biplanes also are available.

From the claustrophobic one-man tin can capsules of the Mercury program to the 363-foot Saturn V rockets that launched Apollo astronauts to the moon, the Kennedy Space Center offers an inside look at the people and technology that conquered space. There are historic artifacts at every turn and interactive simulator experiences including a shuttle launch and a half-day astronaut training simulation. The center is approximately one hour east of Orlando. Shuttles and bus services make the round trip between the center and many Orlando hotels.

If you prefer nature parks over theme parks, Orlando is home to some of the most beautiful.

The Canaveral National Seashore is the longest undeveloped stretch of public beach on Florida’s east coast. There is a restored historic house, an interpretive museum devoted to the area’s Native Americans, and the tallest Turtle Mound in the nation standing higher than 50 feet. The top can be reached by hiking trails and provides excellent views of the Atlantic Ocean. What you won’t find are vendors or stores, so bring everything you need for the visit to what is considered one of the prettiest and most peaceful beaches in the state. From May through October, endangered sea turtles nest on
this beach; if you see wooden stakes in the sand and/or plastic fencing, they’re protecting a turtle nest.

Deeded to the city by a wealthy businessman, Harry P. Leu Gardens is 40 acres of formal gardens in Winter Park. Leu was an avid horticulturist and world traveler who brought home dozens of exotic species to plant. Especially fond of camellias, he bred several varieties that would thrive in Florida. Stone paths meander between hedges and beds thick with camellias, azaleas, bougainvillea, trumpet vine, canna lilies and other tropical plants, past a gazebo, a cottage and a large rose garden. There is a butterfly garden and museum, plus educational tours.

Clouded leopards, cheetahs, and black-footed cats are all endangered and all call the Central Florida Zoo & Botanical Gardens home. You’ll also see Asian elephants, black howler monkeys, siamangs, American crocodiles, and the largest collection of venomous snakes in the Southeast plus hundreds of other species. Recent additions include the alligator and crocodile viewing deck, an insect zoo, and toucan exhibit.

The 4,700-acre Crescent J Ranch is a nature preserve that offers guided tours to see native wildlife, Florida flora, and a working cattle ranch. Options include touring by horseback (requires a 24-hour advance reservation) or by safari coach, a buggy that puts riders on a perch 10 feet above sea level. There also is a pony riding ring, petting zoo, and hiking trails.

Annual Convention Offers Two Symposia

The 2011 AOCD Annual Convention will feature both a medical dermatology and dermoscopy symposium.

But before the symposia begin, Gregory Papadeas, D.O., will kick off the meeting as usual with CLIA/Mohs Proficiency testing. “This is an extremely valuable thirty-minute examination and review that leads to proficiency certifications—important to have for posting in your office,” notes Brad Glick, D.O., MPH, Program Chair.

Later Monday morning, the first-ever University of Pennsylvania Dermatology Symposium featuring four prominent academicians led by American Academy of Dermatology President William James, M.D., will be held. Speakers will discuss acne, rosacea, and hidradenitis, as well as unusual cutaneous malignancies and their management. In addition, a dermatology hospitalist will lecture. “This team of speakers will be tremendous,” says Dr. Glick, adding, “This is a must attend event.”

Tuesday’s program will be highlighted by a comprehensive Dermoscopy Symposium led by renowned dermatologist and cutaneous oncologist Harold Rabinovitz, M.D. This three-hour program will include lectures by osteopathic dermatology fellows.

The remainder of the program on Tuesday and Wednesday will feature lectures by prominent nationally recognized dermatologists such as Eric Billy Baum, M.D., who will discuss topical therapy for psoriasis and inflammatory dermatoses, and Jennifer Cather, M.D., who will lecture about psoriasis by gender. The program will conclude on Wednesday with sessions presented by resident faculty.

Members, residents, and recent graduates will have an opportunity to socialize at a low-key Welcome Reception to be held at the Peabody Orlando hotel Sunday evening. Attendees will have an opportunity to gather together again the following Monday evening, which happens to be Halloween, at the Presidential Banquet honoring outgoing President Leslie Kramer, D.O., and incoming President Dr. Glick.

Of course, you can enjoy one of the best shows in town without leaving the hotel. Five mallards, known as the Peabody Ducks, march into the lobby at 11 a.m. each morning, accompanied by their own red-jacketed Duck Master™ to the tunes of John Philip Sousa's King Cotton March. The ducks spend the day splashing in a marble fountain amid hundreds of onlookers. At 5 p.m., the procession is reversed as the Peabody Ducks march back to their special elevator and up to their fourth-floor penthouse; a ritual since the hotel opened its doors in 1986.

In the next issue of DermLine, learn about the artistic and cultural side of Orlando.

Check the AOCD website in the coming weeks for details. Program brochures will be mailed next month. To register online visit the AOA website (www.osteopathic.org).
Melanoma Skin Cancer Month: How Did You Observe?

This year Melanoma Monday was May 2, kicking off a month of special activities as part of Melanoma Skin Cancer Month. Here’s how a handful of your colleagues spent the day:

Charles Hughes, D.O., joined members of the local Colorado Springs Dermatology Society to conduct a free skin cancer screening on the Saturday before Melanoma Monday. This year marked the 24th annual event, which is conducted in association with the American Cancer Society. They conduct the screening on a Saturday to enable more individuals to attend. Between six and 12 local dermatologists participate each year, screening and educating hundreds of people. The American Cancer Society and a local community health clinic assist with staffing and provide the facility for the screening.

Residents at the Pontiac/Botsford Osteopathic Hospital Dermatology Residency Program held three skin cancer screenings on May 13 and 14.

Alex Doctoroff, D.O., held a free screening on May 2 for local firefighters, police, and municipal employees at his second office in Teaneck, New Jersey. He conducted the screening with the help of his physician assistants. In the past, Dr. Doctoroff held screenings for the public at his practice, but wanted to do something a little different this year to pay back the community that has supported his practice’s success and growth.

On Melanoma Monday, Monica Van Acker, OMS-II, a medical student at the Michigan State University, College of Osteopathic Medicine, presented her recently completed study at the 71st annual meeting of the Society of Investigative Dermatology. She conducted the study, which focuses on college age women and their decision to use indoor tanning, with the goal of establishing categories of tanners based upon their tanning habits and formulating effective teaching methods to prevent unhealthy ultraviolet exposure. She hopes that dermatologists can use the data to target certain groups of women and more effectively persuade them from engaging in indoor tanning. As part of the presentation, she handed out black melanoma awareness ribbons to attendees.

Have You E-Prescribed Lately?

In order to earn an incentive in 2011 and avoid a penalty in subsequent years, dermatologists should e-prescribe at least 25 times this year.

By reporting an e-prescribing measure through their claims at least 10 times between January 1 and June 30, 2011, dermatologists can avoid a 1 percent penalty in 2012, according to the Centers for Medicare & Medicaid Services (CMS) Electronic Prescribing Program. In addition, dermatologists who e-prescribe a total of 25 times from January 1 to December 31, 2011, and have at least 10 percent of their total Medicare Part B charges consist of denominator codes are eligible to earn a 1 percent incentive on their total Medicare Part B allowed charges.

Denominator codes include the following: 90801, 90802, 90804-90809, 90862, 92002, 92004, 92012, 92014, 96150-96152, 99201-99205, 99211-99215, 99304-99310, 99315, 99316, 99326-99328, 99334-99337, 99341-99345, 99346-99350, G0101, G0108, and G0109.

Moreover, dermatologists who successfully report the e-prescribing measure in 2011 also will be exempt from a 1.5 percent penalty in 2013.

This submission, however, must be performed through claims, that is, dermatologists are not allowed to use a registry or electronic health record (EHR) to avoid the penalty in 2012.

Exemptions from this requirement are available, but must be noted on claims prior to June 30, 2011. Exemptions apply to dermatologists who have fewer than 100 cases or less than 10 percent of cases containing a denominator code between January 1 and June 30, 2011. In these cases, the dermatologist should not report anything. The CMS will calculate this and exempt the dermatologist from the penalty in 2012.

Dermatologists planning to participate in the EHR incentive program in 2011 will not be eligible to collect the 1 percent e-prescribing bonus as CMS does not allow providers to collect both bonuses.

For more information, check with your local Medicare carrier or visit the CMS link at www.cms.gov/erxincentive.
Applications for the James Bernard, D.O., Youth Leadership Award must be received by July 1.

The grant is intended to encourage and enable recipients to organize and foster the ideals of the AOCD. Established in 2010, the award was named in honor of Dr. Bernard who has profoundly influenced and mentored many College members either as dermatology residents or young members to become leaders in osteopathic dermatology, according to Michael J. Scott, D.O., Chair of the AOCD Awards Committee.

The grant, which is sponsored by and funded through the College, offers third-year residents an honorarium and future position on an AOCD committee. Among those committees with availability are: Ethics, Awards, Internet, In-Training Examination, Journal, and Editorial/Public Relations.

The award will be distributed as follows: $250 when the official notification is made and $750 upon accepting the AOCD committee’s invitation to serve. Each grant supports a resident.

Third-year residents must be nominated by their program directors. Nomination criteria are as follows:

- Integrity—Maintains the highest personal standards of honesty, fairness, consistency, and trust.
- Respect—Displays a professional persona and is open-minded and courteous to others.
- Empowerment—Provides knowledge, skills, authority, and encouragement to fellow physicians and staff.
- Initiative—Takes prompt action to avoid or resolve problems and conflicts.

The selected criteria reflect on the dynamic characteristics Dr. Bernard has exemplified in numerous leadership roles such as committee member, secretary-treasurer, advisor, and past-president of our College, says Dr. Scott.

In addition, the resident must be a member in good standing of both the AOCD and AOA.

Applications will be reviewed by the Awards Committee, which will forward its recommendations to the AOCD corporate office. Applicants will be notified by certified letter. The grant will begin during the Annual Convention of any given year and end during the Annual Convention of the subsequent year. All related correspondence should be directed to the Awards Committee.

Winners will be announced at the Annual Convention in Orlando. Last year’s winners were Gwyn Frambach, D.O.; Albert Rivera, D.O., Peter Morrell, D.O., and Susun Bellew, D.O.

CAQ Applications Deadline Nears

July 1 is the deadline for receipt of applications for the Mohs micrographic surgery, dermatopathology, and pediatric Certificate of Added Qualification 2011 examinations.

The exams will be given on October 30, the first day of the AOCD Annual Convention to be held in Orlando.

For an application, please contact Rick Mansfield at rmansfield@aocd.org, 660-627-2623 (fax), or AOCD, P.O. Box 7525, Kirksville, MO 63501.

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Annual Reports Due Soon

It will soon be time for annual reports to be turned in! All forms can be downloaded from our website at www.aocd.org/qualify/annual_reports.html.

The Resident’s Annual Report, Program Director’s Annual Report, Resident’s Annual Paper with two referenced questions, Documentation Submission Form for Publication, and AOA Core Competency Report are due to the AOCD office 30 days after the end of each training year. Residents are encouraged to keep a copy of the report for their records.

One original copy with a signature page attached should be sent. The signature page must be signed by the resident, program director, and DME. It is an affirmation of complete and accurate reports. Once the reports are received by the AOCD, we will upload them to FileWorks, which is our online storage system. The Education Evaluating Committee (EEC) members will then be able to view each report as they are uploaded at their convenience, allowing them more time to review each report before the fall EEC meeting. Incomplete reports will not be uploaded. Also, please do not fax your reports.

All reports submitted late are subject to a late fee penalty and will not be reviewed by the EEC until the fee is paid. The late fee schedule is as follows:
• $100 for all reports submitted 30 to 365 days past deadline
• $250 for all reports submitted 365 to 730 days past deadline
• $500 for all reports submitted 730 days past deadline

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

Please compile your report in the following order:

Attestation Signature Form. Your report is not considered complete without the signatures of yourself, your program director, and your DME.

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

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

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

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

New Residents’ Paperwork Due

New residents beginning July, 2011, should be submitting all of their application materials to the national office. In addition, dues should be paid at this time. All resident dues must be current before becoming eligible to sit for the In-Training Examination in Orlando this coming October.

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

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

Instructions for Posters (Second-Year Residents Only)

For those of you who will begin your second year of training July 1, 2011, you are required to present a poster in place of a second lecture.

You may either submit your poster to the AOA using its criteria or to the AOCD either in electronic form or hard copy. If you are required to do a poster for your hospital or program, you may send the same poster to me. If you submit the poster to the AOA or to your hospital, please provide proof of submission to me. We would still like to publish the posters on our program syllabus/flash drive for our members to view.

The poster submitted to the AOCD must meet the same quality as one submitted to the AOA (or the OPTI’s or sponsoring hospital’s annual poster requirements).

Deadline to submit to the AOCD is the same as if providing a PowerPoint presentation for a lecture, that is, eight weeks prior to the start of the meeting.

The following link provides the abstract criteria for the AOA: www.osteopathic.org/inside-aoa/development/quality/research-and-grants/Pages/research-abstracts.aspx.
Hello everyone,

I hope this reaches you all well. I would like to congratulate our third-year residents in your transition to the real world. It must be an exciting time for you and your families to partake in these new endeavors.

Having recently heard some third-year residents discuss their contracts and future plans, I decided to write about some basic concepts regarding employment contracts. First, you should hire an attorney to review any legal document, especially when evaluating a physician employment contract. Second, everything is negotiable!

The following is a list of some basic concepts that you must be aware of before you negotiate a contract:

**Employment status** refers to whether you are being hired as an independent contractor or an employee. This is a very important distinction since there are many tax and malpractice liabilities that either you or your employer will assume based on this status. An independent contractor is an individual who performs a service for another entity, but retains control over the methods and means in carrying out that service or work. In this case, you will most likely be paying your own payroll taxes (quarterly), malpractice insurance, health insurance and other costs, such as attendance at conferences. An employee is a person who works for another individual or entity. In the latter case, the employer usually pays the aforementioned expenses.

**Bonuses** are usually received once a percentage of the physician’s collections are exceeded. Typically, the threshold is 2 to 3.5 times the annual base salary. The bonuses received are usually a percentage, such as 20% to 50% of collections in excess of that outlined threshold. For example, let’s say that you are given a salary of $200,000 plus a $50,000 benefits package and will receive a 50% bonus on overages once your threshold is obtained (this is called incentivizing). Thus, your employer thinks that you are costing him $250,000 just to employ you, not taking into consideration overhead (which typically runs 50%). Now, you will have to generate $450,000 ($200,000 base + $50,000 benefits + another $250,000 [50% overhead]) just to start collecting a bonus. If you generate $750,000 that year in revenue, the amount of bonus you will receive is as follows:

\[
\text{Your final salary (excluding benefits) would be:} \\
200,000 + 125,000 = 325,000 \\
750,000 - 325,000 = 425,000 \\
\]

Your final salary (excluding benefits) would be $200,000 + $125,000 = $325,000 for that year. Your employer would make $750,000 - $325,000 = $425,000 from hiring you that year. Make sure that the bonus structure and thresholds are specifically written and outlined in the contract.

**Benefits** usually include two weeks paid vacation and between 5 and 10 days of sick pay per year for a new hire. However, there is a newer concept known as **paid time off**, which addresses all types of absenteeism (i.e., sickness, vacation, CME, etc.) by lumping all of these days together to be used as you wish. Make sure that other provisions are discussed...
and written in the contract such as maternity leave, CME monies, 401k/retirement accounts, family deaths, etc.

Malpractice tail is one of the items to consider regarding malpractice insurance. If you are partaking in claims-made insurance, then you will have to acquire a malpractice tail to cover any liability in switching practices. This coverage typically is 1.5 to 2 times the yearly insurance premium. Who pays for this is another question. Nowadays, the employer is responsible for purchasing it in the event the employer dismises you. Likewise, if you decide to leave the practice, you will most likely be responsible. Again, make sure this is delineated in the contract.

Non-compete clauses are unenforceable in certain states. However, in those states that recognize them, the clause needs to be reasonable. For instance, a 10-mile non-compete clause is reasonable if you live in rural Pennsylvania, not New York City. Be careful as some lawyers state that some contracts have a breach is not a defense clause. This statement allows the employer to breach the contract, but still hold you to the non-compete clause.

Partnership—specifically when and under what circumstances it will be given—should be clearly written in the contract. Other items to consider are how much (if expected) is the buy-in; what duties are shared or allotted; what is the breakdown of profit sharing and overhead cost sharing; what are your voting rights, and; what assets (i.e., building, lasers, office equipment) you own, if any.

Miscellaneous duties the contract should mention include administrative duties, obligations, work hours, and new hire expectations. These concepts are not all encompassing, but rather they address some basic ideas that should be taken into consideration when signing a contract. More importantly, this is not meant to serve as legal advice. As previously mentioned, always consult an attorney specializing in medical contracts. Also, speak with your trusted colleagues and program directors to help you make well-informed decisions.

This is a very important time in your life. Make sure you are comfortable with the decisions that you make. By working in a healthy and happy environment, you will be successful personally and professionally. In turn, you will enjoy working while treating patients with the respect they deserve. Congratulations and best wishes in your new beginnings!

Position Available in Long Island, New York

Dermatologist in solo practice seeks to add a FT/PT BC/BE D.O. to an established general dermatology practice located 35 miles from midtown Manhattan.

Candidate will be involved in the continued growth of a busy clinical practice encompassing medical, surgical, and cosmetic dermatology. This high-volume general dermatology practice has an Xtrac laser and UVA/UVB booth.

Compensation is commensurate with production. This position offers a tremendous opportunity to succeed. Please e-mail CV to skindeepdo@aol.com.

Position Available in Centerville, Ohio

Busy dermatology practice located in Centerville, Ohio, (a suburb of Dayton) seeks an additional BC/BE dermatologist to practice general dermatology with an opportunity for dermatopathology, Mohs microscopic surgery, cosmetics, and lasers. We are seeking a long-term relationship with the right individual. This position offers an excellent compensation package, including extensive benefits.

Drawing from a population of more than one million, Dayton offers excellent educational facilities, an abundance of recreational amenities, and world class performing arts. Dayton also is home to several Fortune 500 companies and the birthplace of aviation.

Contact Eugene T. Conte, D.O., or Joy Moore, Office Manager, Advanced Dermatology of Ohio, at 937-436-1433 option #4. You also may fax your CV to 937-439-7443.
A CALL FOR PAPERS

Journal of the American Osteopathic College of Dermatology—JAOCĐ.

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

- Jay Gottlieb, D.O., FAOCD