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DermLine
Newsletter of the American Osteopathic College of Dermatology

S P R I N G  2 0 1 2

The Ozarks Await in Branson
see page 7
American Osteopathic College of Dermatology

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Upcoming Events

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 email at RuthCarol1@aol.com.

UPDATE CONTACT INFORMATION
Is your contact information current? If not, you may be missing need-to-know news from the AOCD.
Visit www.aocd.org/membership. Enter your username and password then click the “Login Now” button.
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 John Grogan, resident coordinator.
Message from the President

Dear Fellow and Resident members of the AOCD,

Happy New Year to you all and greetings from South Florida!

Thank you for the opportunity, honor, and privilege to serve as your AOCD President. Much has occurred since commencing my term in office. I began the presidency working closely with our Board of Trustees to counter an allegation by a website claiming a copyright issue related to a topic in our AOCD website database. The allegation was, of course, proven false. The positive outcome in this matter reflects how our Board works in a collaborative manner toward the continued well-being of our College.

In December 2011, with the assistance of Executive Director Marsha Wise, I produced the first AOCD e-Wire, a monthly report to our members providing an update of the goings on of our College, including a brief summary of the activities of some of the committees whose members work so diligently for our membership. I encourage ALL members to get involved and actively participate in one of the many committees available through the AOCD. You will soon receive an email regarding AOCD committees that will list all Chairs and provide all AOCD members with a link to receive more information on the College’s committees. I truly hope that all of you will get closer to the College and join a committee of your choice.

From January 12-14, Marsha and I as well as our new Continuing Medical Education (CME) Committee Co-Chairs, Drs. John Minni and Dwayne Montie, attended the Annual AOA CME Meeting in Ft. Lauderdale. This was one of the most enlightening meetings I have ever attended in that it provided the most current information available for the proper development and organization of our Annual and Midyear Meetings. This meeting also enabled us to establish potentially collaborative relationships with Executive Directors and CME Committee members from other organizations and Colleges within the AOA.

On January 29, I joined our Executive Director and Bureau of Osteopathic Speciality Societies (BOSS) Committee Chair Dr. Robert Schwarze in Chicago at the quarterly AOA-BOSS meeting. This AOA Committee reviews the educational standards for all specialty societies. Current issues related to the Accreditation Council for Graduate Medical Education and Osteopathic Continuous Certification were discussed and provided helpful information for us to bring back to the College.

I also would like to report that Dr. David Grice, Program Chair, has compiled a tremendous group of speakers for our Midyear Meeting in Branson, Mo., in April. Don’t forget to block out your schedules for this meeting. In October, the Annual AOCD Meeting/OMED 2012 will be held at the San Diego Convention Center and our Board is already working diligently to develop one of the most memorable AOCD conferences on record.

I am enjoying my work as President of the AOCD, and remind all of you that I am always available to discuss any matters related to our College. All the best to you and your families throughout 2012 and always. See you in Branson!!!

Fraternally,

Brad P. Glick, D.O., MPH, FAOCD
AOCD President, 2011-2012
Hello Everyone,

With 2011 behind us, 2012 is shaping up to be a busy year for us at the AOCD.

ACGME’s Proposed Requirements
A topic that will impact our residency programs are the new Common Program Requirements proposed by the Accreditation Council for Graduate Medical Education (ACGME). If implemented, these requirements will restrict the entry of DOs into ACGME residency and fellowship programs. The AOA sent two letters of opposition to the ACGME’s Council of Review Committee, the body proposing the new requirements. The AOA has set up a unique page on its website to give specialty colleges, students, interns, and residents, as well as others access to information regarding the recent proposals by the ACGME. The letters of opposition can be viewed on the AOA’s webpage: http://www.osteopathic.org/inside-aoa/Pages/stop-ACGME-training-limits-for-DOs.aspx.

The AOA has set up a unique page on its website to give specialty colleges, students, interns, and residents, as well as others access to information regarding the recent proposals by the ACGME. The letters of opposition can be viewed on the AOA’s webpage: http://www.osteopathic.org/inside-aoa/Pages/stop-ACGME-training-limits-for-DOs.aspx.

The AOA is actively working to have these proposed policies recalled so that osteopathic physicians will continue to benefit from additional career opportunities. View a timeline documenting recent efforts by the AOA to address the ACGME’s proposed Common Program Requirements at http://www.osteopathic.org/inside-aoa/Pages/acgme-policy-timeline.aspx. (For more information, see article entitled Update to ACGME Proposed Rule Changes on page 27.)

CME Requirements
In January, Dr. Glick and I attended the Continuing Medical Education (CME) Sponsors Conference in Fort Lauderdale. This conference is required by the AOA for all accredited CME sponsors. This was Dr.’s Glick first opportunity to network with key people at the AOA level on behalf of the College as your AOCD President.

The requirements in the CME world are constantly changing and CME providers are being called upon to justify why topics are being offered. The AOCDE is looking at the planning of our didactic sessions and implementing changes to meet and exceed these requirements. A new requirement for the 2013-2015 CME cycle deals with outcome measurements. One program must be outcomes based in the CME cycle starting in 2013. To prepare everyone to meet this requirement, the AOA has asked that each sponsor conduct a trial run in 2012. Our Annual Meeting in San Diego will be our trial run. Our CME Committee will be preparing pre- and post-tests as well as post post-tests. The AOA requires us to submit proof of this documentation. Your responses and feedback are vital! Members are encouraged to fill out all evaluation forms from our meetings.

The BOSS has 24 seats; one for each of the 23 specialty affiliates and one representative from the AOA’s Bureau of Interns and Residents (BIR). The AOA president appoints the representatives from nominations submitted from each specialty and the BIR. The BOSS provides the AO specialty affiliates with a direct link and structured opportunities to participate in the AOA’s policy development process. It also provides the affiliates with a forum to exchange information. The BOSS is designed for the specialty affiliates to advise the AOA on pertinent issues, to gather and disseminate relevant information, to review and provide input into the AOA House of Delegates’ resolutions, and to educate and mentor each other.

BOSS Committee Meeting
Dr. Glick, Dr. Robert Schwarze, and I all attended the Bureau of Osteopathic Specialty Societies (BOSS) Committee meeting in late January.

The BOSS provides the AOA specialty affiliates with a direct link and structured opportunities to participate in the AOA’s policy development process. It also provides the affiliates with a forum to exchange information. The BOSS is designed for the specialty affiliates to advise the AOA on pertinent issues, to gather and disseminate relevant information, to review and provide input into the AOA House of Delegates’ resolutions, and to educate and mentor each other.


We are now in the third year of the three-year CME cycle. The CME Guide for Physicians — 2010-2012 can be found on the AOA's website (www.osteopathic.org). All members of the AOA, other than those exempted, are required to participate in the CME program and to meet specified CME credit hour requirements for the 2010-2012 CME cycle. You should continually monitor your CME activity with the AOA.

Important CME Changes. Beginning with the current CME cycle ending December 31, 2012, AOA members will have five months to fulfill their CME requirements. Previously, members were allowed 17 months following the close of a cycle to fulfill their CME requirement and maintain their AOA membership and board certification. If you have questions about the change, contact the CME Service Center at cme@osteopathic.org.
that they permeate the organization and for setting ethical standards and ensuring by ethical standards that promote the public expects a charity to abide and Destruction Requirements was discussed. Dermline, the topic of Document Retention Code of Conduct. In the previous issue of Whistleblower Policy, and Board Member of transparency. This article focuses on Ethics, required to disclose its policies for the purposes Service (IRS) requirements, the College is AOA requirements and Internal Revenue the AOCD's Good Governance Policies. Per this is the fourth in a series of articles about the AOCOD's Good Governance Policies. Per AOA requirements and Internal Revenue Service (IRS) requirements, the College is required to disclose its policies for the purposes of transparency. This article focuses on Ethics, Whistleblower Policy, and Board Member Code of Conduct. In the previous issue of Dermline, the topic of Document Retention and Destruction Requirements was discussed. The public expects a charity to abide by ethical standards that promote the public good. An organization’s governing body bears the ultimate responsibility for setting ethical standards and ensuring that they permeate the organization and inform its practices. The IRS encourages a charity’s board or trustees to consider adopting and regularly evaluating a Code of Ethics that describes behavior it wants to both encourage and discourage. This code will serve to communicate and further a strong culture of legal compliance and ethical integrity to all persons associated with the organization. The IRS encourages an organization’s Board of Directors to adopt an effective policy for handling employee complaints and to establish procedures for employees to report in confidence any suspected financial impropriety or misuse of the charity’s resources. Such policies are sometimes referred to as whistleblower policies. The IRS will review an organization to determine whether insiders or others associated with it have materially diverted organizational assets. Organizations that file Form 990 will find that Part VI, Section B, Lines 5 and 13 ask whether individuals within the organization became aware during the year of a material diversion of its assets, and whether an organization has a written whistleblower policy. Finally, we hope to see you in Branson, Mo., April 19-22 for our 2012 Midyear Meeting. We have many great speakers lined up and will be having a not-to-be-missed session on Osteopathic Continuous Certification. The meeting schedule can be found on our website. (See a list of speakers on pages 8-9.) The AOCD is your organization! Please let the national office know what staff can do to improve communications to you. I welcome your comments and suggestions.
and responsibilities in accordance with governing documents.

**Confidentiality**

Board members and staff will have access to information, that if revealed to outsiders, could be damaging or sensitive to other members or staff, harmful to the best interests of the AOCD, or even create legal liability. Information provided to the Board members and staff may concern personnel, financial, contractual, membership, or legal matters. It will often be confidential and is intended for use in decisionmaking and governance. Information shall be held in the strictest of confidence and shall not be divulged to any outside party, including other members, without authorization of the Board Chair or the Executive Director.

**Conflicts of Interest**

Board members and staff owe a high fiduciary duty to the AOCD. Thus, no Board or staff member should maintain any business enterprise or other activity that directly conflicts with the interests of the College. Staff members should not solicit members for any reason that is not directly related to official business.

**Violations**

Violations of the Code of Conduct may result in disciplinary action in accordance with the governing documents. Discipline may include removal of a Board member from office or termination of a staff member.

**Board Member Commitment**

Each member of the Board of Trustees will commit to do the following:

- Perform duties so as to honor the trust of the membership.
- Comply with all applicable statutes and regulations applying to non-profit organizations and the terms of the Articles of Incorporation, the bylaws, and the policies adopted by the Board.
- Protect the interests of the AOCD as determined by its Board, mission, and prudent business practice.
- Refrain from using his/her personal position on the Board for his/her own personal advantage or the advantage of any special interests inside or outside of the College.
- Protect the confidentiality of private or confidential information (ie, member lists, financial information, public policy goals, etc).
- Refrain from asserting authority as a Board member except when participating in a Board meeting or as a Board delegate; recognizing that the Board Chair has the final authority.
- Attend the meetings of the Board and Board committees to which he/she has accepted appointment.
- Review all information and materials sent in connection with Board business and provide to the Board his/her best attention and judgment.
- Conduct him/herself so as to reflect credit on the AOCD and the Board of Trustees.
- Respect the integrity and abilities of fellow Board members and strive to advance the unity and harmony of the Board, recognizing that all actions, whether or not personally agreed to, belong in one to the Board and not to individuals.
- Tender one’s resignation from membership on the Board if he/she is unable to serve in accordance with the provisions of this commitment.

**Notification of Time-Dated Certificates**

Physicians who were certified by the AOBD in 2004 and after are now required to re-certify with the AOBD beginning in 2014. Contact Rick Mansfield at the national office, at either (660) 665-2184 or rmansfield@aocd.org, for further information.

In the next issue of DermLine, the AOA’s Healthy and Viable Affiliate Organization’s Program and the AOA/Specialty Affiliation Agreement will be discussed.

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**Dr. Krishnamurthy Named New Editor-in-Chief of JAOCD**

Karthik Krishnamurthy, D.O., has been named editor-in-chief of the *JAOCD*. He will replace Jay Gottlieb, D.O., who has served as the journal’s editor-in-chief for the past 10 years. Earlier this year, Dr. Gottlieb announced that he was stepping down. He will, however, stay on through this year to ensure a smooth transition.

Dr. Gottlieb, who founded the *JAOCD*, is pleased that it will continue under new leadership. He also is pleased at how far the journal has come since its debut.

“I am leaving the *JAOCD* financially solvent with an excellent copy editor who manages the day-to-day requirements of the journal,” Dr. Gottlieb says. “In addition, we are currently in the process of getting the *JAOCD* indexed with PubMed.” The application has been submitted and the journal has been issued both an online and print ISSN number.

Dr. Krishnamurthy says of his new position, “The *JAOCD* is a high quality publication thanks, in large part, to Dr. Gottlieb. I look forward to taking the *JAOCD* into its second decade with the assistance of the associate editors whose continued support is instrumental in fostering the journal’s maturity.”
The Ozarks Await in Branson

Sure Branson, Mo., is known for its live entertainment, but Mother Nature puts on her own spectacular show in the Ozarks. With the dogwoods, redbuds, and wildflowers in full bloom, and a high of 68 degrees and lows in the mid-40s, you might just find yourself yearning to explore the mountain ranges.

The Branson area features nearly 1,000 miles of trail in its state parks for hiking, biking, and horseback-riding.

The Lakeside Forest Wilderness Area sits on 130 acres featuring rugged hiking trails of varying degrees, a scenic observation deck overlooking Lake Taneycomo, two miles of the Lake Taneycomo shoreline, and 315 hand-lain stone steps that descend to the lake.

The Ruth and Paul Henning Conversation Area boasts five trials, ranging from one-third of a mile to more than three miles. The area protects a unique series of natural features called balds. Open glades along the slopes and tops of the hills, the balds were used as meeting places for post-Civil War vigilante groups known as baldknobbers.

At Table Rock State Park, you can hike or bike on the trails. If you’d rather use your sea legs, you can rent a ski boat or personal watercraft, parasail, or take an excursion on a 48-foot sailing catamaran in Table Rock Lake. Kayaks, pontoon boats, and fishing boats also are available to rent. The lake is nationally known for its bass fishing, along with opportunities to catch crappie, sunfish, and catfish. It’s also a popular place for scuba diving. Diving equipment can be rented at the marina and a scuba course is offered for beginners. Although there is no designated beach, swimming is available at several areas of the park. The marina store features sportswear, sports gear, food/beverage, bait and tackle, fuel, and convenience goods.

For those who want to venture underground, visit the Talking Rocks Cavern where you can see rock outcrops, glade and forest environments, a spring, and Powell Cave. The hour-long tours of the cave depart frequently throughout the day. Or perhaps you would like to visit the more than two-mile long Indian Creek Caverns, which is the longest cave in southwest Missouri. This potentially muddy tour takes between four and six hours. There are as many activities to do on the surface of the cavern as there are underground. Hike the 400-acre nature preserve; crawl the SpeleoBox maze, which is a 150 feet of twisting, winding passages used by cavers to practice safe caving; climb a 40-foot treetop tower; or mine for gemstones.

For a bird’s eye view of the Ozark Mountains, take one of the many zipline tours. You can soar through the tree tops using multiple ziplines and skywalks for a breathtaking tour. Tours vary in length; anywhere from 90 minutes to three hours. Some of the tours can be taken during the evening.

If the only trek you want to make is on the fairway, you’re in luck as Branson is home to several golf courses, many of which have been designed by world-class pros. Among them are Payne Stewart Golf Club designed by Bobby Clampett. This 18-hole course is conveniently located near the Branson Convention Center. The John Daly’s Murder Rock Golf Course is an 18-hole championship golf course that incorporates the landscape of the Ozarks. The Top of the Rock Golf Course is a nine-hole, Jack Nicklaus-designed par three golf course set high above Table Rock Lake. The Branson Creek Golf Club features a challenging Par 71 championship layout, with five sets of tees, etched into the Ozark landscape.
Lloyd Cleaver, D.O., will kick off this year's Midyear Meeting, which will be held April 19-22 in Branson, Mo., with an update about Osteopathic Continuous Certification (OCC).

This is a not-to-be-missed presentation as all AOCD members who hold a time-limited certificate will be required to participate in the OCC process in order to maintain their board certification. The OCC goes into effect for all AOA specialty boards on January 1, 2013.

Other speakers will offer updates for some of the more common dermatological diseases, such as psoriasis and rosacea, and review some of the more unusual ones, such as verrucous porokeratosis and eccrine poromatosi. Office-related topics, such as coding and reimbursement, will be addressed, as well.

The schedule of lectures and events for the Midyear Meeting is as follows:

On Thursday, registration and coffee with the exhibitors will be held from 10 a.m. until noon. Next, Dr. Cleaver will give his OCC presentation during lunch.

Guest speakers are slated to begin presentations at 1 p.m. lasting into the early evening. The speakers and their topics are as follows:

- **Jack Cohen, D.O.**  
  Sorting Out Connective Tissue Diseases

- **Alpesh Desai, D.O.**  
  Photodynamic Therapy

- **Clay Cockerell, M.D.**  
  Dermatopathology Tips for the Practicing Dermatologist

- **Eric Billy Baum, M.D.**  
  Psoriasis from A to Z

- **Roxanna Menendez, D.O.**  
  Red Indurated Plaque on the Face of a Newborn

- **Arathi Goldsmith, D.O.**  
  Verrucous Porokeratosis

The Welcome Reception will be held from 6:30 p.m. to 8 p.m.

On Friday, guest speakers are scheduled to begin at 7:30 a.m. and last through the early evening. The speakers and their topics are as follows:

- **Michelle Tarbox, M.D.**  
  Review of Alopecia in Women

- **William Cothern, D.O.**  
  Update: Lasers in Dermatology
FDA Approves First Treatment for Metastatic BCC

The U.S. Food and Drug Administration (FDA) recently approved its first drug—vismodegib—for the treatment of patients with metastatic basal cell carcinoma (BCC). It is intended for use in patients with locally advanced BCC who are not candidates for surgery or radiation.

Vismodegib is a pill taken once daily that works by inhibiting the Hedgehog pathway, a pathway that is active in most BCCs and only a few normal tissues, such as hair follicles.

The scientific community’s understanding of molecular pathways involved in cancer, such as the Hedgehog pathway, has enabled the development of targeted drugs for specific diseases, according to Richard Pazdur, M.D., Director of the Office of Hematology and Oncology Products in the FDA’s Center for Drug Evaluation and Research. “This approach is becoming more common and will potentially allow cancer drugs to be developed more quickly,” he is quoted as saying. “This is important for patients who will have access to more effective therapies with potentially fewer side effects.”

Vismodegib was reviewed under the FDA’s priority review program that provides for an expedited six-month review of drugs that may offer major advances in treatment.

The safety and effectiveness of vismodegib was evaluated in a single, multi-center clinical study in 96 patients with locally advanced or metastatic BCC. The study’s primary endpoint was objective response rate or the percentage of patients who experienced complete and partial shrinkage or disappearance of the cancerous lesions after treatment. Of the patients with metastatic disease receiving vismodegib, 30 percent experienced a partial response and 43 percent of patients with locally advanced disease experienced a complete or partial response. The most common side effects were muscle spasms, hair loss, weight loss, nausea, diarrhea, fatigue, distorted sense of taste, decreased appetite, constipation, vomiting, and loss of taste function in the tongue.

Vismodegib is being approved with a Boxed Warning Alert about the potential risk of death or severe birth effects to a fetus. Pregnancy status must be verified prior to the start of vismodegib treatment. Patients should be warned about these risks and the need for birth control.

Last year, the FDA approved two novel therapies that were demonstrated to extend overall survival of patients with late-stage melanoma. The two treatments, ipilimumab and vemurafenib, are not only unique because of their ability to improve overall survival rates, but also their ability to attack the cancer itself. Ipilimumab blocks a molecule known as cytotoxic T-lymphocyte antigen or CTLA-4 and works with an individual’s immune system to recognize, target, and attack cells in melanoma tumors. Vemurafenib is for the treatment of patients with melanoma whose tumors have the BRAF V600E gene mutation. With the aid of an FDA-approved test, patients can be selected to receive treatment with the drug that blocks the ability of mutated BRAF to make tumors grow.

Melanoma Skin Cancer Month: How Will You Observe?

This year Melanoma Monday is May 7, kicking off a month of special activities as part of Melanoma Skin Cancer Month. If you are participating in a special event to bring public awareness to the day or month, let us know at DermLine. Contact the editor, Ruth Carol, at 847-251-5620 or email her at RuthCarol1@aol.com.
Attendees at the 2011 AOCD Annual Meeting were privy to the first-ever Annual University of Pennsylvania Dermatology Symposium moderated by Immediate Past President of the American Academy of Dermatology William James, M.D., and a Dermoscopy Symposium led by renowned dermatologist and cutaneous oncologist Harold Rabinovitz, M.D. In addition, they heard prominent speakers from across the country discuss topics ranging from unusual tumors and cosmetic dermatopathology to metabolic syndrome and cardiovascular disease (CVD) in psoriasis. Other speakers offered therapeutic updates for cutaneous T-cell lymphoma (CTCL), pruritus, and psoriasis while our very own program directors presented great cases.

Following the CLIA-Mohs proficiency testing given by Gregory Papadeas, D.O., panel members convened for the University of Pennsylvania Symposium. They included Ellen Kim, M.D.; Christopher Miller, M.D.; and Misha Rosenbach, M.D.; all of whom are from the University of Pennsylvania Health System.

CTCL Therapeutic Update
How to optimize phototherapy and topical chemotherapy as well as when to combine therapies for CTCL was the focus of Dr. Kim's presentation. CTCL is believed to be caused by a variant of indolent non-Hodgkin's lymphoma of mature skin-homing T-lymphocytes, she said. Newer data suggest that mycosis fungoides (MF) and Sezary syndrome (SS) are not the same disease, accounting for their different responses to treatment. Although Dr. Kim suspects that CTCL is underreported, it is still a very rare disease with an incidence of 0.6 cases per 100,000 persons annually.

Diagnosing CTCL is challenging and can take years and multiple biopsies, in large part, because it is one of the “great imitators” of eczema, psoriasis, and drug reactions, she noted. Additionally, early biopsies are non-specific and early on in the disease process the host immune response is intact. Some patients have a pre-CTCL state and not full blown MF. In the 1970s, CTCL was treated with psoralen plus ultraviolet A (PUVA) and in the 1980s extracorporeal photopheresis (ECP) was developed. In the past decade, four systemic agents have been approved for its treatment.

In addition to providing expertise in cutaneous lymphomas, the goal of the Penn Cutaneous Lymphoma Program is to pioneer studies on new therapies and study the immunobiology of CTCL, Dr. Kim said. “The challenge is that it is a truly heterogeneous disease.” While stage 1A disease doesn’t affect overall survival, stage 1B or higher does. Between 60% and 70% of patients will be diagnosed with early stage disease. Progression occurs in 34% of patients. Overall survival is 74.5%. In general, patients with patches do much better than patients with plaque. She noted that most therapies for MF/SS are not approved by the Food and Drug Administration (FDA), and that it is difficult to get approval for single therapies, even phototherapy, to treat it. However, the National Comprehensive Cancer Center (NCCN) has developed practice guidelines for the treatment of both that are available on its website.

Regarding treatment, dermatologists must educate patients about the chronicity of CTCL, which requires long-term therapies. She suggested to start slow and to use agents that preserve the immune system first. For example, chemotherapy will work, but it won’t last long because it depletes the immune system, Dr. Kim noted. Review the consensus guidelines from the NCCN and others. Then discuss with patients the benefit and risk of treatment as well as the cost.

Topical corticosteroids as part of a “soak and smear” regimen is an “old fashioned” short-term management treatment, she said. But it is the first line of defense and is well tolerated. Using a sauna suit increases their efficacy. From the dermatologic perspective, systemic therapies include retinoids, interferons, Histone Deacetylase-inhibitors, ECP, denileukin diftitox, and methotrexate (MTX).

“When you are chasing lesions,” Dr. Kim said, “it is time to switch to whole body therapy.” Although there are no studies to determine whether phototherapy or topical chemotherapy is better, the literature suggests the response rates are similar. Both can cause new subclinical lesions to disappear in the first month of treatment. The first response often occurs at two months. The lower body as well as the legs and feet are the last to improve. If the patient relapses, which is common, she recommended pursuing a maintenance approach. The main disadvantage of phototherapy is that it misses sanctuary sites, so a topical agent should be added to the treatment regimen. Topical
chemotherapy is a compounded ointment that is messy and expensive and must be applied nightly.

Radiation therapy is the first line of treatment for tumors. “For patients with ulcerated plaques, who have a higher risk of sepsis, you want to gain quick control,” Dr. Kim said. Localized radiation therapy should be followed by PUVA as plaque tends to respond to the latter. Adjuvant topicals should be continued even when patients are taking mid- to low-dose biologics, she added.

Combination therapy is appropriate for certain stages of CTCL, Dr. Kim encourages the use of bexarotene because the oral retinoid is extremely effective. However, these patients’ labs should be checked monthly. When combining phototherapy and interferon alpha-2b, she uses a low dose of the latter, which is generally well tolerated. Patients tend to be fatigued and have flu-like symptoms that resolve after one month. Some patients develop an autoimmune tendency from taking interferon. Often they require maintenance therapy because if treatment is stopped, the disease recurs.

Treatment is required for six to 12 months for a full response. It should be continued for one to three months after the CTCL has clinically cleared, Dr. Kim said. Maintenance therapy is important for high-risk subtypes and advanced stage cases. For Stage IIIB or higher, a cure is rare. There are clinical trials and allogeneic stem cell transplants, the latter of which is associated with a 20% transplant-related mortality.

Mohs for Non-melanoma Skin Cancers, Unusual Tumors

“We see what we expect to see,” stated Christopher Miller, M.D., referring to non-melanoma skin cancers and unusual tumors. When hunting for tumors, it’s important to look at the debulked excision and the tumor itself. He defined unusual tumors as uncommon, those with a difficult histology, and at high risk for recurrence or metastasis. A sharp contrast is easier to see than subtle differences, Dr. Miller said. When a tumor has a difficult histology, it may be necessary to supplement the hematoxylin and eosin or toluidine blue with immunostains or to view the slides using a different perspective.

“The main advantage of Mohs surgery is that you are looking at 100% of the margins,” he stated. The disadvantage is if all you look at is margin, you don’t see the tumor. With standard tissue processing, however, you see the tumor itself. The disadvantage with the latter is that the sample is only a portion of the margin, making it easy to miss tumor at the margin. Tumors to be worried about are those with more subtle histology as tumor can be missed in the sections. Combining Mohs with the standard bread-loaf technique of tissue processing capitalizes on the advantages of each technique.

As an example, dermatofibrosarcoma protuberans is an uncommon tumor that is known to invade fat and extend beyond the margins. To clear the margin, it should be removed down to the deep fascia. To do so, carefully outline the clinically apparent tumor. Debulk the tumor to the deep fascia with the peripheral margin of normal skin. Then take the Mohs layer around that. Using Mohs allows you to see the relationship of the tumor to the margin. Dr. Miller finds the CD-34 stain easier to read than hematoxylin and eosin.

When reviewing how to process Mohs layers, he said to relax the specimen so that the entire surgical margin lies in a single plane. Making relaxing incisions on the specimen causes the tumor to lie flat. Then you can view sections of it under the microscope.

Moving on to extramammary Paget’s disease, Dr. Miller said that the recurrence rate with Mohs is lower than excision. Typically, Paget’s disease has an intraepidermal growth pattern. He finds the CK-7 stain to be extremely valuable in diagnosing it. “Dermal invasion is rare with Paget’s,” Dr. Miller said, “but you won’t know if you don’t look.” Squamous cell carcinoma (SCC) and basal cell carcinoma (BCC) are much more common. As such, it is easier to identify those that are unusual. For example, metastatic BCC is rare and only 2% to 5% of SCCs metastasize. “The challenge with these is how to predict which ones will metastasize,” he said.

However, more advances have been made with regard to melanoma. There is the American Joint Committee on Cancer (AJCC) Melanoma Staging System and its staging manual now in its seventh edition. Additionally, 14 melanoma centers in the United States, Australia, the Netherlands, and Italy have contributed to the AJCC Melanoma Task Force Collaborative Database, which comprises nearly 50,000 patients. These
Typically, consults involve treating patients with benign dermatological conditions. He noted that 77% of patients have missed skin findings of the new staging system is that it doesn’t include in-transit metastases, Dr. Miller noted, “but it is the best of what we have right now.”

Inpatient Consults
Inpatient consultative dermatology drifts in and out of popularity, stated Misha Rosenbach, M.D.

With less than 50% of dermatologists seeing inpatients, there are a lot of non-dermatologists treating patients with dermatologic conditions. He noted that 77% of patients have missed skin findings and 60% of dermatology consults result in changes in either diagnosis or treatment. Typically, consults involve treating patients who are underserved.

Treating inpatients and consulting with other doctors is very rewarding, Dr. Rosenbach said. It affords an opportunity to work as a team as well as educate and learn from colleagues. “Plus, you see really challenging patients.”

Inpatient dermatology is the last line of defense and the front line of attack, he noted. “In hospitals, we get asked to do consults earlier on,” Dr. Rosenbach said. Consulting dermatologists see patients with severe forms of cutaneous diseases, are exposed to patients with infectious diseases, and treat those with side effects from novel therapies.

When evaluating patients with disease flares, such as severe psoriasis, consulting dermatologists determine not just what went wrong with therapy, but what triggered the flare. Because of the link between psoriasis and CVD, dermatologists may recommend that certain patients be evaluated by their primary care physician (PCP) for the latter. Acute flares may identify systemic disease as in the case of patients with eczema who have CTCL or those with a particular rash who have systemic lupus. Thus, dermatologists can help make new diagnoses for patients and help transition them to an outpatient center to receive the appropriate care. Advanced diagnoses that Dr. Rosenbach has worked on include graft-versus-host disease (GVHD) in a transplant patient and a rare translocation of leukemia. Dermatologists can identify lesions resulting from severe drug reactions such as Stevens-Johnson syndrome. Then there are the emerging infections, such as polyomavirus allograft nephropathy, resulting from immunosuppressive agents given to kidney transplant patients. Dermatologists can identify side effects of novel therapies such as acneiform rashes, toxic erythema, Hand-Foot syndrome, and BRAF mutations in metastatic melanoma.

“Consulting dermatologists work with internal medicine and primary care physicians to provide a fresh set of eyes for patients with dermatological diseases,” said Dr. Rosenbach, adding that he has also worked with infectious disease specialists and oncologists.

When describing an approach to consulting, he noted, “You have to know a little bit about everything in dermatology.” Having a broad differential diagnosis is critical; starting with larger categories and working toward specific ones. Always question yourself, Dr. Rosenbach suggested, understanding that “experts” get a diagnosis correct approximately 50% of the time. Questions to ask include “What is not the likely diagnosis?” and “What will kill the patient if it’s missed?”

Consulting dermatologists see the gamut of diseases in patients. When seeing inpatients with benign dermatological conditions for which the diagnosis is known, he recommended reassuring the patient. For an unknown diagnosis, monitor the patient until a diagnosis is made. “When evaluating...
immunosuppressed patients, if you see something purple on the skin, you have to take it seriously,” Dr. Rosenbach said. Then there are the true dermatology emergencies, such as fungal infections, that require immediate therapy or the patient could die. The sickest patients, however, typically get better the quickest, he concluded.

**Rosacea, Acne, Hidradenitis Suppurativa**

While classic rosacea is easy to diagnose, there is a wide spectrum of the disease, stated Dr. James. Primary features are flushing (transient erythema), non-transient erythema, papules and pustules, and telangiectasia. Having one or more of these features is necessary for diagnosing rosacea; many of the patients he has seen have persistent facial erythema. Secondary features include burning or stinging, plaques, dry appearance, edema, ocular manifestations, peripheral location, and phymatous changes. Primary and secondary features are not deemed to be essential or specific, Dr. James said, but a clustering of them helps categorize patients into subsets that help determine appropriate therapy.

Rosacea subsets are erythematotelangiectatic, papulopustular, phymatous, and ocular. Two types of patients have erythematotelangiectatic rosacea, he said. One has been flushing and blushing all of his/her life, has a family history of rosacea, and is fair-skinned. The second type is the 40-year-old adult who has no history of past problems. Sun damage is a component for these patients who can usually cite the date the rosacea started, Dr. James noted. Some of these patients may suffer from depression, which should be treated, as well. Papulopustular rosacea is characterized by erythema of the central face with transient postules and papules.

Endoscopic transthoracic sympathectomy has been used successfully to treat the blushing, he said. Also newer agents are being tested in trials. Regarding treatment, medications are the least helpful. Other therapies include sun protection, relevant trigger avoidance, laser and light devices, and skin barriers. Pimecrolimus and tacrolimus are used topically. Start with a steroid for one week and overlap it for one week with a topical calcineurin inhibitor, Dr. James suggested. Studies comparing intense pulsed light with pulsed dye laser show high patient satisfaction for both. However, pulsed dye laser was better for treating background erythema and telangiectases.

Although considered a subtype of rosacea, Dr. James believes that phymatous rosacea is simply a finding with therapeutic implications. It may include thickening skin, irregular surface nodules, and enlargement. Patients with phymatous rosacea have inconsistent flushing, and low or absent telangiectases. It occurs most often in men with a history of acne, making him believe that there is likely an androgenic influence. Therapy is focused on controlling the inflammation and lesions. Topical and systemic antibiotics are useful as is benzoyl peroxide. Low doses of isotretinoin are helpful. Spironolactone works well for women.

Dr. James also provided an acne/isotretinoin update. Between 40% and 60% of patients given the drug for a long enough period of time will have a remission, he said. Young teenagers likely need three to four courses of isotretinoin. Side effects in patients who have undergone repeated treatments were unchanged. Still, it’s important to inform patients and their parents about side effects. Teenagers who have cystic or very inflammatory disease tend to have the best results and are the happiest patients, he said. They also have the fewest complaints about side effects.

In patients with explosive disease, the goal is to calm the acne with prednisone. Start them on isotretinoin slowly and build up their tolerance, Dr. James recommended.

These patients tend to do very well, but it will take a while until they look better. He treats women, 25 to 55 years of age, with one treatment of isotretinoin, but informs them that there is a high rate of relapse. If they relapse quickly, Dr. James treats them with spironolactone, which is often used in combination with birth control pills. Men in the same age range, often do well with isotretinoin, but usually need maintenance therapy. The acne can recur six to 10 years later. In patients with mild disease, the isotretinoin works well. Patients who relapse quickly or have more side effects than from a previous treatment are not good candidates for isotretinoin. Patients 55+ get excellent results with low-dose isotretinoin. Regarding pregnant patients, he said that dermatologists should adhere to the iPLEDGE program.

Regarding depression, the literature is unclear. Initially studies showed no changes in risk of suicide or depression, Dr. James stated, but now two studies suggest that there is a small risk. He believes that the numbers are low and pointed out that acne itself is associated with depression, suicidal ideation, and social impairment. Most patients feel better about themselves when their acne clears, Dr. James said. He uses low doses for a longer period of time, noting that some believe the side effects are dose related. Regardless, dermatologists must educate their patients thoroughly
could have been injected years ago and the filler at the same site. Additionally, the filler sometimes multiple fillers have been used adverse reactions, stated Les Rosen, M.D. dermal fillers and implants responsible for Cosmetic dermatopathology helps identify preventive measures are helpful, as well. Nd:YAG laser is an effective treatment. results. Some advocate excision for severe spironolactone fairly frequently with good term and most patients relapse. He uses isotretinoin needs to be used long to diagnose because it is often hidden by scarring, fibrosis, and lymphedema. He stressed that hidradenitis suppurativa is different from acne. Biologic therapies used to treat it include infliximab, etanercept, adalimumab, and ustekinumab, all of which have had some success in small case reports/studies. In Europe, clindamycin and rifampin are used to treat the disease. Dr. James has not found dapsone to work. Isotretinoin, including links to inflammatory bowel disease.

Today, there are more options for combination therapies, which are effective, and lead to better compliance. Other treatment options he mentioned include topical dapsone, which has been shown to be safe, but Dr. James doesn’t find it to be that effective. Isotretinoin alternatives for patients fearful of side effects include amoxicillin, trimethoprim/sulfamethoxazole, trimethoprim, and spironolactone. Another option is long-term use of antibiotics. Although more upper respiratory illnesses may be associated with the latter, there is no evidence of Staphylococcus aureus resistance. “Your gut flora will become resistant to the antibiotics, and it reverts after they are stopped,” he said. To keep the skin flora from getting resistant, patients can use benzoyl peroxide. Although long-term antibiotics may not be a preferential treatment, it does provide patients with an option.

Moving on to hidradenitis suppurativa, Dr. James noted that there is 2% to 4% prevalence. The onset of the disease occurs at age 32. It is more common in women and smokers as well as individuals with elevated body mass and arthritis. Individuals with hidradenitis suppurativa are five times more likely to develop SCC. It can be difficult to diagnose because it is often hidden by scarring, fibrosis, and lymphedema. He stressed that hidradenitis suppurativa is different from acne. Biologic therapies used to treat it include infliximab, etanercept, adalimumab, and ustekinumab, all of which have had some success in small case reports/studies. In Europe, clindamycin and rifampin are used to treat the disease. Dr. James has not found dapsone to work. Isotretinoin needs to be used long term and most patients relapse. He uses spironolactone fairly frequently with good results. Some advocate excision for severe cases. Recent studies have shown that the Nd:YAG laser is an effective treatment. Preventive measures are helpful, as well.

**Cosmetic Dermatopathology**

Cosmetic dermatopathology helps identify dermal fillers and implants responsible for adverse reactions, stated Les Rosen, M.D. Sometimes multiple fillers have been used at the same site. Additionally, the filler could have been injected years ago and the patient may not remember what it was.

He suggested using a punch biopsy to determine which filler was used.

Dr. Rosen proceeded to review a list of injectable fillers and show what they look like under the microscope.

Originally used to treat acne scars, bovine collagen is typically used to correct deep labial folds. It can last up to six months, but the timeframe varies. Brand names include Zyderm and Zyplast. It differs from human collagen; it bundles thicker and has a homogenous appearance, he said. Patients can get a granulomatous reaction to bovine collagen.

Human-derived bio-engineered collagen is similar to bovine collagen. It can last up to six months. Brand names include CosmoDerm and CosmoPlast.

Hyaluronic acid dermal fillers can last from six to 12 months. Although they rarely cause allergic reactions, Dr. Rosen said, they can produce a granulomatous reaction to a foreign material. Brand names include Restylane and Juvederm. Under the microscope, they show up as the presence of basophilic materials that do not polarize. Sometimes, there is a blue gray or dark blue material, or purple spherical particles. He sees this once or twice a year.

A synthetic poly-L-lactic acid dermal filler can last 24 months. It is biocompatible and biodegradable, but can cause granulomatous reactions. The brand name is Sculptra and New-Fill. Under polarized light, it can show up as translucent particles of different sizes and fusiform or spikey shapes, Dr. Rosen noted.

The other synthetic, biocompatible substance that he sees more frequently, approximately once a month, is a calcium hydroxy-lapatite dermal filler. This one lasts 12 months and goes by the brand name of Radiance or Radiesse. It appears under the microscope as tan or brown spheres that are round to oval in shape.

Dr. Rosen has seen nodules on the lower lip caused by paraffin. It was more commonly used for breasts, penis, buttoks, and calves, but is no longer used because of the frequency of adverse reactions, he said. Paraffin appears as cystic spaces that vary in size and shape, and often times has a Swiss cheese appearance. Silicone liquid, oil, and gel are all similar in appearance to paraffin.

Dr. Rosen also has seen his share of injectable biphasic fillers that are considered permanent. Among the brand names are Bioplastique, DermaDeep, DermaLive, Artecoll, ArteFill, and Artiplast. Histologically speaking, Bioplastique presents as irregularly shaped cystic spaces that contain translucent, jagged, popcorn-looking particles. DermaLive and DermaDeep appear as numerous cystic spaces with polygonal, pink, translucent foreign bodies. Artifill, Artecoll, and Artiplast have granulomatous infiltrate that do not polarize. Aquamid polyacrylamide gel is a permanent translucent gel, which has basophilic amorphous granulomatous material on histological exam.

Facial implants made of Gor-tex, an expanded form of polytetrafluoroethylene, present as lamellated and tubular shapes under the microscope, he said. Softform is the brand name. Silicone lip implants can easily be removed if complications arise. “You can’t run or hide,” Dr. Rosen concluded. “We know what you are injecting and implanting.”

**Pruritus Update**

Although pruritus is considered to be a benign symptom, it can severely adversely impact patients, noted Richard Rubenstein, M.D. In fact, patients rate pain and itch as an equivalent burden of life. If a patient is unable to sleep at night because of an itch, then it is a significant problem that demands our time and attention, he added. Although pruritus is among the most common dermatological complaints and everyone knows the sensation of itch, Dr. Rubenstein said, it is elusive to define.

Itch has been categorized into four classifications: cutaneous, neuropathic, neurogenic, and psychogenic. Cutaneous itch is caused by inflammation of the skin. Neuropathic itch arises anywhere along the afferent nerve pathway due to damage of the nervous system. It is seen in herpetic neuralgia, multiple sclerosis, and brain tumors. Neurogenic itch originates centrally without evidence of neuronal pathology as seen in cholestasis. Psychogenic itch is associated with psychological factors and delusional states. Like pain, pruritus has a profound psychological component, he stated. Patients who appear outwardly
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calm could be hiding hurt, anger, or depression. Scratching may represent pent up resentment or self punishment. Telling patients that the itch is in their head, however, will not help, Dr. Rubenstein said. Instead, they should be educated about the nature of psychogenic itching, and may require a psychiatric referral.

The three main causes of itch are dermatological, psychological, and systematic. A history and physical can help identify common conditions such as atopic dermatitis, psoriasis, lichen planus, contact dermatitis, and fungal infections, he said. Xerosis is itself a significant cause of pruritus. In elderly patients, it is worsened by cold air, low humidity, or central heating. Consider scabies, Dr. Rubenstein suggested, even if it is doesn’t present with the typical findings, such as in patients who may have excoriations but no primary lesions. Fiberglass is a rare, but important skin irritant. Patients who have put fiberglass curtains in the washing machine, and then washed their clothes that subsequently became impregnated with the fibers have developed pruritus.

Patients with an itch but no rash should be evaluated for systemic disease, he said. Chronic renal failure is the most important cause of persistent generalized pruritus. Itch can be the presenting symptom in up to half of all cases of hepatic cholestasis, which occurs in nearly all patients with primary biliary cirrhosis. As many as 50% of patients with Hodgkin’s disease have pruritus and it is considered to be a bad prognostic sign compared to those without it.

Pruritus appears as a side effect of practically every drug in the Physicians’ Desk Reference, Dr. Rubenstein said. He tries to determine the onset of the itch and when the patient began taking the medication. But just because the patient is taking a drug doesn’t mean it’s the cause of the itching. If the patient has been taking a medication for nine years and recently started itching, it’s probably not caused by the drug, Dr. Rubenstein said. He usually looks at the last drug the patient was prescribed and then contacts the PCP asking to stop all non-essential medications.

Regarding treatment, antihistamines is the primary one. The second-generation antihistamines work as well as the first-generation ones, but are non-sedating. Most patients can tolerate increased doses, Dr. Rubenstein said. Doxepin is more effective in urticaria than antihistamines and the former can be given orally or topically. Topical therapies include skin hydration. Patients should use emollients, especially immediately after showering, as well as mild soaps. They should avoid irritants. Cold or ice compresses or cold gel packs may help. Although hot water is counter intuitive, he noted that the pain fibers temporarily overwhelm the itch fiber in some patients. Menthol and phenol creams may help. It’s best to put them in the refrigerator first and then apply. Capsaicin cream seems to desensitize neurons, Dr. Rubenstein said, but it can cause burning in some patients. It’s good for localized notalgia parasthetica and brachioradialis.

If initial therapy fails, he recommended doing a complete blood count with differential to screen for any hematopoietic disorders. A basic chemistry panel will rule out the possibility of diabetes mellitus and renal dysfunction. A urinalysis is always helpful. A liver function test will rule out cholestatic disorders. A chest X-ray may show if there is any mediastinal enlargement, which is associated with Hodgkin’s disease. A thyroid-stimulating hormone blood test is optional. An HIV antibody test may be appropriate.

Systemic therapies include opioid receptor antagonists, anion exchange resins, selective serotonin reuptake inhibitors, kappa opioid receptor antagonists, antidepressants, glutamic acid derivative, and gamma-aminobutyric acid analogue. Narrowband ultraviolet B phototherapy is effective in uremic and cholestatic pruritus. Dr. Rubenstein recommended trying at least four to six treatments, starting low and slowly increasing it. Patients typically respond by the third treatment. When phototherapy helps, he said, patients have a very dramatic response. Cutaneous field stimulation is a new technique that electrically stimulates the C fibers that carry the itch sensation. It is most effective for localized disease because it reduces itch and degenerates epidermal nerve fibers, Dr. Rubenstein added.

In summary, pruritus is a common yet complex problem in dermatology with no specific mediator and multiple causes and treatments.
GVHD
A complicated systemic disease seen in transplant patients, GVHD can mimic more common dermatologic conditions, noted John Minni, D.O.

The two forms of the disease are acute, which usually occurs within three months of transplant, and chronic, which classically occurs 100 days following transplant. The risk for chronic GVHD increases 10-fold if the patient experiences acute GVHD. Risk factors include unrelated but matched donor, related donor with mismatched HLA, unmodified T-cell graft, older age of donor or recipient, and female donor with male recipient.

Regarding pathogenesis, it is still up for debate as to which T-cell is at fault, he said. While tumor necrosis factor-alpha (TNFα) seems to play an integral role, the role of Interleukin-12 remains controversial. Chronic pathogenesis is characterized by a predominantly lichenoid infiltrate of post thymic CD4+ T-cells and an abundance of mast cells that may lead to sclerosis with increased production of collagen.

Clinical features of acute GVHD include morbilliform exanthem with a quick onset and a folliculo-centri pattern. It affects palms and soles as well as mucous membranes, and can have a generalized pattern mimicking toxic epidermal necrolysis.

Chronic clinical presentations include morphea-like lesions often favoring areas of pressure, such as the waist band and bra as well as in old zoster areas. Dr. Minni said. It can affect genitals and Blaschko’s lines, and have deeper sclerotic lesions resembling eosinophilic fasciitis. There is restriction of the oral commissure. There are a variety of different rash patterns seen. For example, it can appear like dermatomyositis and tell-tale chronic lesions resemble vitiligo. Gastrointestinal and hepatic manifestations are often the first systemic manifestations to occur.

If left untreated, chronic systemic disease will lead to hepatic fibrosis and bronchiolitis obliterans, he said. The musculoskeletal system will be affected, as well. The primary cause of death is infection from chronic immunosuppression.

There is a wide spectrum to the dermatological differential diagnosis as each acute case has variants including scabies, toxic epidermal necrolysis, viral exanthema, and drug eruption, Dr. Minni noted. The differential diagnosis for chronic GVHD includes any cell rich lichenoid dermatitis and morphea/LSetA.

Clinical staging for GVHD is based on body surface area involvement, liver involvement, gastrointestinal symptoms, and histological grade. Of the four stages, one is mild and four is severe.

Clinical findings suggest that the presence of acute GVHD diminishes survival profoundly, he said, adding, “Rapid diagnosis and response can truly affect patient survival.” The presence of acute GVHD increases the odds of chronic manifestations.

Treatment is largely prophylactic. Cyclosporine and MTX are the standard treatments. However, newer data demonstrate comparable outcomes and improved morbidity by using mycophenolate mofetil in place of MTX, Dr. Minni noted. Rapamycin is increasingly being used for prophylaxis.

Treatment for acute GVHD includes prednisone and topical therapy, the latter for cutaneous only symptoms. Patients with systemic manifestations require systemic therapy including prednisone and cyclosporine. Those with extensive and recalcitrant cases require anti-thymocyte antibody therapy. Thalidomide and mycophenolate mofetil also are used for the latter cases.

Dermatologic treatments include PUVA for chronic lichenoid, and etretinate or ECP for sclerodermod lesions. For oral lesions, topical calcineurin inhibitors, cyclosporin, and steroids are all beneficial. Some data suggest that TNF inhibitors and Interleukin-2 anakinra and rituximab are beneficial, Dr. Minni said, adding that more data on that is expected in the future.

The President’s Reception and Banquet was held Monday night.

Great Cases
Cindy Hoffman, D.O., Program Director at St. Barnabas Hospital, kicked off Tuesday’s lectures of Great Cases from Osteopathic Teaching Programs with a patient whose chief complaint was orange-yellow round patches growing on her scalp. A biopsy showed nodular amyloidosis. An oncologist further tested the patient for Sjögren syndrome, which is associated with up to 25% of nodular amyloidosis cases. The patient was treated symptomatically. This patient did not present with the typical nodular lesions to indicate either nodular amyloidosis or Sjögren syndrome, Dr. Hoffman said, emphasizing the importance of evaluating patients for systemic disease.

Richard Miller, Program Director at the NSUCOM/Largo Medical Center, presented four cases of spitz nevus. He recommended observation for two cases and excision for the other two because of atypia noted in the histology. Although dermoscopy has helped with the diagnosis of spitz nevus because of the characteristic starburst pattern, Dr. Miller still recommends doing a biopsy.
Immunohistochemistry also is helpful. He noted that the diagnosis is not always simple and treatment should be based on pathology.

Tanya Ermolovich, D.O., Program Director at Frankford Hospital, presented a case of oral fixed drug eruption. Her approach was to identify the causative agent and discontinue it. The oral rechallenge is probably the best test to identify suspected agents, she said. When doing a workup for oral ulcers, don’t forget about the patient’s drug history, Dr. Ermolovich concluded.

Schield Wikas, D.O., Program Director at Cuyahoga Falls General Hospital, discussed potential complications of psoriasis therapy. A patient who Dr. Wikas had been treating for psoriasis for five years developed flu-like symptoms that wouldn’t go away. After two months, Dr. Wikas treated him with an injection of etanercept. The patient was subsequently hospitalized and diagnosed with catastrophic antiphospholipid syndrome. Sixty-six percent of patients who survive the initial event are free of disease, as was the case with this patient. Dr. Wikas believes that the injection played a part in the patient’s diagnosis.

Daniel Stewart D.O., Program Director at St. Joseph Mercy Health System, presented a rare case of paraneoplastic pemphigus, an autoimmune blistering disease that is associated with an underlying malignancy. Prophylactic surgery is recommended as is genetic counseling and testing. The patient passed away.

Robert Harla, D.O., Program Director at TCOM Dermatology, discussed a patient who was previously given various antibiotics and medications to treat ulcerations on her legs. When her symptoms worsened, he was asked to consult. Dr. Harla diagnosed the patient with bilateral cellulitis. He stopped all antibiotics and treated her with flurandrenolide lotion. The symptoms disappeared in seven days. Dermatologists understand skin manifestations, Dr. Harla said, which is why dermatology consults are necessary.

Dan Hurd, D.O., Program Director at Montgomery Regional Hospital/VCOM, presented a case of subcutaneous panniculitis-like T-cell lymphoma. He first saw this patient six years ago when she presented with several inflamed lesions on her calves and thighs. A biopsy didn’t reveal a clear cut diagnosis. The diagnosis was delayed because the disease had not sufficiently developed at that time, he said. Dr. Hurd performed a deep skin biopsy and used immunochemistry to diagnose the patient. Treatment is similar to that for non-Hodgkin’s lymphoma.

Angela Combs, D.O., Program Director at NSU-COM/BGMC, presented a case report of primary cutaneous diffuse large B-cell lymphoma of the scalp. The tumor cells were CD-20 positive. There is an emerging pattern of aggressive B-cell lymphoma common in non-Hodgkin’s lymphoma, she noted. The skin is the second most common site. Although rituximab has shown promise for the treatment of all B-cell lymphomas, Dr. Combs said, there is a high relapse rate.

Suzanne Sirota Rozenberg, D.O., Assistant Program Director at St. John’s Episcopal Hospital, presented a case of granuloma annulare. This benign inflammatory dermatosis occurred in a teenage male after...
getting a red-inked tattoo. The patient had existing tattoos, but none with red ink. She is seeing many cutaneous reactions to tattoos, especially to those with red ink.

Bradley Glick, D.O., Program Director at Wellington Regional Medical Center, presented a case of herpes gladiatorum in a martial arts specialist. The National Collegiate Athletic Association estimates a 40% incidence of herpes gladiatorum. The risk of spreading it is substantial and 24% of patients experience recurrences as frequently as once a month. Patients should consider prophylaxis because of the high recurrence rates, he said. Athletes should not compete for at least 10 days after diagnosis. Without a cure, treatment involves suppressing the clinical manifestations of herpes gladiatorum, which can become systemic.

Steve Purcell, D.O., presented the A.P. Ulbrich Award to Francisco Kartono, D.O., who presented her research findings about teledermatology and acne vulgaris. She conducted this study as a third-year resident. If patients don’t have access to a dermatologist, teledermatopath and teledermoscopy can be used to fill the void, Dr. Kartono said. She studied 50 patients comparing their management. Survey respondents indicated that there was no significant difference in approach between the in-office group and the teledermatology group. All participants favored having an initial in-office visit, but if they could see the dermatologist sooner using teledermatology, they wouldn’t object to that. Acne patients, especially teenagers, were open to teledermatology.

**Dermoscopy Symposium**

The first annual Dermoscopy Symposium moderated by Dr. Rabinovitz included panel members Margaret Oliviero, ARNP; Lise Brown, D.O.; Theresa Cao, D.O.; Shauntell Solomon, D.O.; and Kimberly Hull, D.O.

“When you see an isolated pigmented lesion, think melanoma,” said Dr. Rabinovitz. “But not all melanomas clinically look the same. That’s why we need additional diagnostic devices, such as dermoscopy, in the office.”

The dermoscope is a valuable instrument to help diagnose early melanoma and nonpigmented cutaneous malignancies, Dr. Brown noted. The two types of dermoscope are those that use non-polarized light and those that use polarized light. Non-polarized light dermoscopes require skin contact and fluid. She recommends using alcohol. Polarized light dermoscopes use filters to cancel out the reflected light. One is not better than the other, Dr. Brown said, adding that they complement each other. Chrysalis signs, vessels, and red areas are seen best with a polarized dermoscope. Some dermoscopes can take digital images. They tend to take darker pictures, but they capture the entire lesion and compared fairly well with cameras.

The nuances of color are important when evaluating a lesion dermoscopically, Dr. Hull stated. Black, brown, blue, or grey often correspond to melanin. For example, black is due to melanin in the outer epidermal layer or all layers; brown is junctional melanin. The higher the concentration is, the darker the color. Melanocytic lesions are composed of three structures, most commonly a pigmented network. But they also appear as globules similar to dots and dark structureless areas or blotches. Atypical pigmented networks include radial streaming and pseudopods. A negative pigmented network is the reverse of a pigmented network and contains chrysalis structures.

Dr. Solomon reviewed a two-step dermoscopy algorithm. The first step is to distinguish melanocytic lesions from non-melanocytic lesions. If the lesion is melanocytic, the second step is to determine if it is benign or malignant. Next, decide which vascular pattern it is. Benign and malignant melanocytic lesions have one or more of the following characteristics: a pigmented network, aggregated globules, streaks, homogeneous blue pigmentation, or a parallel pattern. If it doesn’t match any of these characteristics, it may be non-melanocytic. Non-melanocytic lesions include pigmented BCCs, seborrheic keratoses, and hemangiomas. The most common non-melanocytic lesions we see are SCC *in situ*, she added.

The many faces of nevi and malignant melanoma make it difficult to diagnose melanoma, noted Oliviero. But dermoscopy has enhanced the ability to recognize different clinical patterns as well as benign melanocytic neoplasms from melanoma, she said. Using dermoscopy, lesions are evaluated by color, symmetry and organization. In general, benign lesions have three or fewer colors whereas malignant lesions have more than three colors. Benign lesions tend to have bi- or mono-axial symmetry of pattern. In contrast, malignant lesions have biaxial asymmetry. Regarding uniformity of structure and location, benign lesions are organized compared with malignant lesions that are not. Both can have parallel patterns. Nevi tend to grow symmetrically in children, but they should be watched in adults.

Nevi are symmetric in pattern, but not in shape, said Dr. Rabinovitz when discussing the classification of nevi. Look for the common features of nevi. What is the network? Color? Is the lesion symmetrical or asymmetrical? Does it have any feature of melanoma? Acquired melanocytic nevus has specific patterns as follows: global, reticular, global, globular, globular, homogeneous, reticular, reticular, and reticular, homogeneous, and homogeneous.

The majority of congenital nevi favor patterns that are global, he said. They come in four global patterns: reticular, global, starburst, and homogeneous. Blue nevi are characterized by a uniform structureless, steel blue lesion. The two most common patterns for the Reed nevi are the starburst pattern and central dark structureless areas.

It’s important to hone in on lesions you need to biopsy, Dr. Rabinovitz stated. Atypical melanocytic nevi look like melanoma from a clinical and dermoscopic perspective. If only using one’s eyes to diagnose the lesion, you could use the ABCDE method, or the Bologna or “ugly duckling” sign, he said. But the lesion should be biopsied. If you are using dermoscopy, and the lesion has a common benign pattern, it could be a Clark’s nevus.

The subtypes of melanoma are distinguished by their growth patterns, Dr. Rabinovitz said. They include superficial spreading, lentigo maligna, nodular, and acral lentiginous. Melanoma on sun-damaged skin grows in the classic lentigo maligna pattern. Lentigo maligna melanoma is slow growing. Some melanomas arise de novo, he noted, but many melanomas develop in association with nevi. “With older patients, stop looking at benign nevi and start looking at brown spots,” he advised. “If you look with the dermatoscope, you’ll be able to pick these up.” Regression suggests
can hide scars in them,” he explained. “Skin tension lines are your friend as you where the most tension is, he suggested. When looking at the defect, figure out which one will look best, restore functionality, and cause the least morbidity,” Dr. Buckley said. If there is no skin reservoir, consider primary repair, flaps, and skin grafts. Combination repairs involve two or more closure types. “When I have a defect, I go through the list to determine which one will look best, restore functionality, and cause the least morbidity,” Dr. Buckley said. If there is no skin reservoir, consider second intention healing, a skin graft, or an interpolation flap.

When looking at the defect, figure out where the most tension is, he suggested. “Skin tension lines are your friend as you can hide scars in them,” he explained.

Junctional lines also hide scars. Try to keep flaps from falling into multiple cosmetic units and maintain boundary integrity, he advised.

It’s very important to discuss expectations with the patient prior to the procedure, Dr. Buckley stressed.

He then reviewed reconstructive options for defects on various parts of the body. Sometimes lesions on the scalp do very well with second intention healing. For lips, the junctional lines tend to get blurred after anesthesia. Mark out the vermilion border, and then use an extended Burow’s triangle to reconstruct border lines. That way, the cosmetic unit isn’t crossed. “Don’t hesitate to extend a Burow’s triangle as much as you need to,” he said, adding that a longer scar line looks better than cosmetic distortion. For defects at the vermilion border, lip, and nasolabial fold, reconstruction can distort the lip easily. Mark out the border before performing Mohs. You can’t take reservoir from the medial lip or adjacent skin because that will distort the border. The best option is to incorporate the junctional line of the nasolabial fold into the lip using a transpositional flap. The dorsal nasal flap is good for defects of the nasal tip without contracting and pulling up the nasal alar. A transpositional flap from the temporal area can be used to close a defect adjacent to the upper eyelid from a tumor on the eyebrow that goes down to the peristeum. A graft works well for large defects on the helix and antihelix of the ear. A pedicle flap can be used to cover the primary defect. The skin looks the same because it is from the same part of the body.

Next, Dr. Eduardo Weiss, M.D., reviewed injectable dermal fillers, and in particular, adverse reactions to them. Paraffin actually dates back to the 1890s, he noted. Introduced in the 1940s, silicone has recently made a comeback after the use of illegal sources caused complications. Silicone works well on the lips as well as for acne scarring and indentations due to surgical defects. The 1980s saw bovine collagen, which was the gold standard for a long time, Dr. Weiss said. Recent advances in filler technology cause very little reaction, he said, adding that they are very safe and easy to use.

In 2005, the global filler market was $42 million. Their use is a growing trend because it does not involve a major procedure, he noted. Fillers are the second most common cosmetic procedure performed.

There is no standard classification for fillers. They can be classified according to source, duration of effect, biodegradability of components, or mechanism of action, Dr. Weiss said. Some fillers last longer so they don’t have to be injected as often. On the flip side, complications as a result of filler use will last longer too. Bovine collagen, for example, can cause immune reactions while human-derived collagen does not.

Adverse reactions may be caused by bacterial biofilms that may play a role in the activation of quiescent granulomas, he explained. Biofilms, which are relatively new in dermatology, are encountered in patients who have long-term filler implants. As an example, a patient who had a filler injected 30 years ago suddenly develops granulomas. Biofilms can form in different situations in the body and are difficult to treat as they will create a resistance if treated with antibiotics, Dr. Weiss said. Also, cultures come back negative.

“Dermatologists must understand the role of infection and biofilms as a complication of filler injections,” he stated. Additionally, they must avoid injecting any bacteria into the skin when using fillers.

Hyaluronic acid revolutionized the field. For patients who experience adverse reactions, Dr. Weiss said, it can be easily reversed by using an injection of hyaluronidase.

Nodules can be an adverse reaction to injectable poly-L-lactic acid. But he believes that if it is diluted properly and injected deep, nodules can be avoided. The nodules can be broken up with a sterile saline solution.

Calcium hydroxylapatite causes the most severe adverse reactions, commonly yellow nodules, when injected into the lips. Consequently, Dr. Weiss recommends not using it on the lips. The calcium hydroxylapatite can be squeezed out.

Other adverse reactions include undert/over correction, implant visibility, and vascular compromise. Some patients may have a reaction to the topical treatment, such as lidocaine, used to relieve discomfort from the injection, he said.
When complications occur three to 14 days following the injection, Dr. Weiss suggested first ruling out infection and treating the patient with antibiotics. If there is a delayed onset of nodules, for example, rule out biopolymers.

**Metabolic Syndrome, CVD Disease in Psoriasis**

Psoriasis is an inflammatory disease. But why in three-quarters of patients does it affect the skin and in one-fourth the other organs? “We’re just learning about that now,” Alan Menter, M.D., said. “We as dermatologists will continue to play a role in systemic diseases such as psoriasis.” Because dermatologists already treat patients with psoriasis, they are able to diagnose them with metabolic syndrome and CVD sooner, he added.

In 2006, an interdisciplinary conference of experts from dermatology, cardiology, hepatology, pharmacology, and rheumatology met to discuss the physical, psychological, and psychosocially disabling impact of psoriasis; common pathophysiology with obesity; increased CVD risk of both psoriasis and obesity; and the possibility of psoriasis and obesity deriving from an underlying inflammatory state, suggesting that psoriasis is a component of greater systemic disease. If psoriasis is a greater systemic “skin” disease, he said, the question is, “Will reducing skin inflammation also reduce CVD risk?

Comorbidities associated with psoriasis include obesity/metabolic syndrome, psoriatic arthritis, autoimmune diseases, psychiatric diseases, CVD, sleep apnea, smoking, cancer/lymphoma, steatohepatitis, chronic obstructive pulmonary disorder, and increased mortality. “Which spectrum of psoriasis relates to these comorbidities, we’re still learning,” Dr. Menter said. But the disability is not just physical, he said, noting that there is a quality of life issue as many patients with psoriasis experience depression, suicide ideation, and fatigue. It can be devastating, especially among younger patients.

Dr. Menter reviewed current knowledge linking psoriasis and obesity to metabolic syndrome. Psoriasis and metabolic syndrome are both systemic inflammatory states. Obesity, particularly visceral adiposity, contributes to clustering of other risk factors. These patients produce a significant number of cytokines over their lifetime and also have an increased TNFα concentration in their skin and joints. What’s unclear is whether the obesity or psoriasis as well as the development of lifestyle modification plans to improve patients’ general health and their psoriasis.

Recent studies have proposed similar immune pathogenic mechanisms for psoriasis and its comorbidities, he said. It is likely that this multi-organ immune mediated disease has a common genetic and immunopathogenic basis. We now understand that cytokines play an important immunopathogenic role in the development of CVD, diabetes, obesity, Crohn’s disease, and dyslipidemia, Dr. Menter said. Genes that regulate some of these cytokines may be linked to psoriasis and its comorbidities.

It is now understood that treating the immune-mediated inflammation may decrease the risk of comorbidities such as CVD, he added. It is hoped that early treatment with systemic or biologic therapy may delay or even prevent the onset of these comorbidities and decrease the risk of premature mortality.

The psoriasis came first. What is known is psoriasis patients lose weight very slowly, he said, raising the question of a genetic link.

Psoriasis and CVD also are linked. Several studies suggest that certain CVD risk factors may be more prevalent among psoriasis patients. Among them are hypertension, diabetes mellitus, hyperlipidemia, and smoking. Moreover, systemic inflammation is a risk factor for developing CVD. Psoriasis may be an independent risk factor for myocardial infarction and is being independently linked to atherosclerosis, Dr. Menter noted. Psoriasis and atherosclerosis are known to have common pathways.

“Primary care physicians don’t know about this yet,” he said, “That’s why we have to work in consult with them.” In fact, exploring the association between CVD and other disease-related risk factors in the psoriasis population requires an increased understanding across the medical community, Dr. Menter said. The goal is to identify mechanisms linking psoriasis with obesity, metabolic syndrome, diabetes, CVD, and non-alcoholic fatty liver disease. This collaboration will lead to routine screening for multiple susceptibility risk factors and comorbidities associated with psoriasis.

Treatment considerations for psoriasis revolve around their potential impact on comorbidity outcomes. Measures that reduce disease activity should reduce disease-related outcomes, Dr. Menter said. A reduction of inflammation, C-reactive protein, and TNFα might reduce CVD morbidity/mortality. In patients with rheumatoid arthritis and psoriasis, anti-TNFα treatment is associated with a trend toward reduced rates of myocardial infarction and cerebral vascular accidents. There is evidence to suggest that patients on MTX have a systemic reduction of CVD risk factors. “We do believe MTX has a role in reducing systemic inflammation,” he said. Dermatologists became concerned about preliminary reports of an association between biological therapies for chronic plaque psoriasis and cardiovascular events in randomized clinical trials of ustekinumab and briakinumab in psoriasis patients. However, it is expected that major adverse cardiovascular events will decrease when systemic inflammatory diseases are treated, he said.

“The majority of patients present with psoriasis before the age of 40. We need a plan for their lifestyles,” said Dr. Menter.

**ICD-10 Compliance Date Postponed**

Health and Human Services Secretary Kathleen G. Sebelius has postponed the date by which certain healthcare entities must comply with the diagnosis and procedure codes in the International Classification of Diseases, 10th Edition (ICD-10).

The final rule adopting ICD-10 as a standard was published in January 2009 and set a compliance date of Oct. 1, 2013. The HHS Secretary has not yet announced a new compliance date.
who tells patients, “I hope to improve your skin and lifespan by reducing your cardiovascular disease risk factors.”

**Topical Therapy for Psoriasis**

In the 1970s, psoriasis was thought to be a disease of the epidermis, but now it is considered to be an immune disorder, noted Eric Billy Baum, M.D. In reviewing the pathogenesis, he explained that abnormal activation of leukocytes leads to an accumulation of T-cells and other immune cells in developing psoriatic lesions. These T-cells secrete proinflammatory cytokines that cause keratinocyte hyperproliferation and altered differentiation. This results in the epidermis turnover time jumping from approximately 28 days to three days. Continued activation of immune cells and keratinocytes sustains the psoriatic lesions.

Treatment options include topical therapy, phototherapy, laser therapy, and systemic therapy including traditional agents and biologics. But even patients taking biologics have hot spots, Dr. Baum said, making topical therapy a necessity. Traditional agents are being used less often with the increased use of biologics. Topical therapies are good for adjunctive therapy, especially for treating mild patients and those who can't take systemic therapy or can't afford biologics. Topical therapies, which have the least side effects, can be used alone or in combination therapy.

Dr. Baum noted the pros and cons of various topical therapies. As an example, topical vitamin D is not very efficacious as a monotherapy and is expensive. Topical retinoids are irritating, expensive, and not very efficacious. Topical immunomodulators work well in sensitive areas, but can cause itching, stinging, and burning. They have a slow onset, concern parents fearful of immunosuppression, and are expensive. Anthralin, bath solutions, coal tar, over-the-counter moisturizers, and salicylic acid are messy, time consuming to apply, and not particularly efficacious. Topical steroids are very efficacious, but have side effects and a short duration, and are costly.

Vehicle options include cream, ointment, gel, lotion, aerosol, foam, tape, solution, shampoo, powder, and oil. Choosing the vehicle should be based on the anatomic location where the therapy will be used, he said. With regard to topical steroids, brand name products have greater potency than generics. Additionally, the vehicle can greatly influence percutaneous absorption and, therefore, increase therapeutic efficacy, Dr. Baum said. The high cost of topical steroids can be countered with the use of manufacturer coupons.

The vehicle can make or break the product, he noted. Vehicle formulation can affect the product’s potency, penetration, stability, ability to be combined with other products, and side effect potential, as well as esthetic properties and patient acceptance. Moisturizing bases and clever vehicles improve tolerability by adding emollients or humectants. “It’s good to give a sample because if it doesn’t work, patients will be upset with you, not the pharmaceutical company or pharmacist,” Dr. Baum added.

Dr. Baum had the following to say about monotherapy options. Clobetasol propionate spray 0.05%, which has been re-engineered, was shown to be efficacious as both a monotherapy and add-on therapy in studies. Clobetasol propionate in a foam was reformulated to eliminate side effects. Patients like the vehicle because of its spreadability, ease of application, and quick absorption, as well as lack of fragrance, residue, or stickiness. In studies, it was shown to be effective and safe for the treatment of mild to moderate plaque-type psoriasis. In another study, patients treated for steroid-responsive dermatoses liked a 0.2% triamcinolone spray compared with creams and ointments, noting a cooling effect. A halcinonide 0.1% cream received high acceptance patient rates for clearing psoriasis as well as for its physical appearance, spreadability, and ability to improve skin conditions. Calcitrol ointment, which contains a naturally occurring active form of Vitamin D3, is a relatively new option that was safe, effective, and well tolerated in short- and long-term Phase III studies. Dr. Baum likes it for combination therapy, but noted it was slower to work than corticosteroids. A calcipotriene foam, which will be available soon, was found to deliver 2- to 3-fold more calcipotriene into the epidermis compared with ointment and cream. It offers greater skin penetration because it’s a foam, he said.

Topical steroids appear to effectively resolve lesions, but once treatment is discontinued, many patients relapse within one or two months. Addressing cell differentiation may help delay plaque recurrence, Dr. Baum said, adding that topical combination therapy has the most potential for doing so. Among them are a calcipotriene ointment and corticosteroid topical suspension combined into a once-daily formula as well as a 0.05% halobetasol propionate ointment or cream and 12% ammonium lactate in a lotion. Sequential treatment therapy, such as a clobetasol propionate spray with calcitriol ointment, has been shown to improve quality of life. Dermatologists have developed a number of regimens designed to provide high efficacy while minimizing exposure to high-potency topical steroids, he noted. “The majority of patients can do well, you just have to determine the best regimen for them,” Dr. Baum said. The excimer laser is being touted as a new safe and effective treatment of psoriasis of the palms and soles, which is difficult to treat.
AOCD Business Reviewed at Annual Meeting

2011 AOCD President Leslie Kramer, D.O., opened the Business Meeting at the Annual Meeting by thanking the members for letting her serve the AOCD this past year as well as thanking those who have served the College. She also encouraged the residents to get involved either as a committee member, trustee, or officer as a way to “give back” to the organization that afforded its members to practice high quality medicine. She then introduced new staff members, John Grogan and Carmen Stanton.

Jere Mammino, D.O., the Secretary/Treasurer, reported that the AOCD’s funds total $632,943 as of September 30, 2011, up approximately $8,000 from earlier in the year. He attributed the increase to an increase in membership dues as well as recent fundraising and cost-cutting efforts.

For the Executive Director’s report, Marsha Wise said that she has spent the last year getting the AOCD’s “ducks in a row,” in reference to the AOA’s 2010 Advocacy for Healthy Partnerships Workshop that Wise and Dr. Kramer attended. When Grogan and Stanton began their new roles this past June, “a tremendous load was lifted” she said. The AOCD will be working on some new ideas in the coming year to get the membership pumped up, Wise concluded.

Thirty-six new candidates took the Board Examination, stated Stephen Purcell, D.O., AOBD President. Members re-nominated for AOBD positions were Lloyd Cleaver, D.O., and Robert Schwarze, D.O. Members newly nominated include Dr. Kramer; Mark Kuriata, D.O.; and Ronald Miller, D.O. Dr. Purcell informed the membership that Eugene Conte, D.O., is stepping down as an AOBD member. With the additional new members, the AOBD will number 12 as it was recently expanded. Dr. Cleaver spoke briefly about the Osteopathic Continuous Certification. It will consist of ongoing continuing medical education (CME), a recertification examination, and a clinical self-assessment program, the latter of which will assess clinical activities in the office. The AOBD is trying to make it as easy and palatable as possible, Dr. Cleaver said, while ensuring that it offers appropriate assessment. A lecture about the Osteopathic Continuous Certification is slated for the 2012 Midyear Meeting in Branson, Mo.

Chair of the Awards Committee, Michael Scott, D.O., announced the recent winners of the Kopprince Award. For the 2010 Annual Meeting, the winning residents were John Stoner, D.O.; Amy Basile, D.O.; Srivasky Margatis, D.O.; Susan Bellow, D.O.; Brooke Rennen, D.O.; and Jonathan Cleaver, D.O. Winners for the 2011 Midyear Meeting were Michelle Legacy, D.O.; Kate Kleydman, D.O.; and Rachel Epstein, D.O. The 2011 Intendis Call for Papers Competition winners were as follows: David Judy, D.O., won first place; Drs. Basil and Epstein tied for second place; and Jessica Borowitz, D.O., won third place. Winners of the James Bernard Residency Leadership Award were Angela Brokaw, D.O.; David Kasper, D.O.; Peter Siata, D.O.; and Drs. Stoner, Legacy, and Cleaver. Dr. Purcell presented the A.P. Ulbrich Research Award to Francisco Kartono, D.O.

Next, Stanley Skopit, D.O., Chair of the Fellow of Distinction Committee, presented the Fellow certificates to members who passed the board in 2010. Dr. Kramer was unanimously voted as a Fellow of Distinction. Dr. Skopit urged members who would like to apply for Fellow of Distinction to learn about the criteria and obtain an application on the AOCD website.

As Program Chair for the 2011 Annual Meeting, Bradley Glick, D.O., reported that the meeting was going well. He was especially pleased with the First Annual University of Pennsylvania Symposium led by William James, M.D., immediate past president of the American Academy of Dermatology. David Grice, D.O., invited the membership to the 2012 Midyear Meeting, of which he is Program Chair. He noted the meeting will begin on Thursday, instead of Wednesday as in the past, so that members had one less day they would be away from their office. Dr. Grice said he was thoroughly impressed during his site visit to Branson this past July. “It’s not your grandmother’s place to visit,” he noted. “There is golfing, shopping, and shows. And it is a good time of year to be there.”

Switching gears, Dr. Glick spoke about the Foundation of Dermatology, which has available funds for researching educational advances for College members. He plans to earmark some money for the upcoming dermatopathology fellowship in 2012. In 2011, 15 members became part of the Ulbrich Circle, one of the five levels of support. (See article on page 31.)

Chair of the Bureau of Osteopathic Specialty Societies Committee, Dr. Schwarze, reported on the recent meeting. At that meeting, AOA President Karen Nichols, D.O., noted a 15% increase in enrollment at osteopathic colleges. With that type of growth, there is a need for more residency programs, she said.

Regarding locations for upcoming Midyear Meetings, Dr. Schwarze, who is also Chair of the Site Selection Committee, described Branson, Mo., as “a sleeper town” full of theatres and restaurants. In 2013, the Midyear Meeting will be held in Winter Park, Co., which is 90 minutes from the Denver airport. In 2014, the meeting is slated for South Padre Island, Texas.

The Education Evaluating Committee met four times in 2011, noted committee Chair James Bernard, D.O. The committee is working on residencies and fellowships in the AOA as well as reviewing the basic standards. Currently, there are 23 residency programs and 109 residents.

Rick Lin, D.O., Chair of the Internet Committee, reviewed updates to the website, which continues to receive a significant number of hits. The Grand Rounds online will be celebrating its 10-year anniversary. The AOCD osteopathic dermatology portal, www.doderm.com, which started out as a bulletin board, will soon be made available to residents. In addition, a forum for medical students will be added. An IPhone App called Doctor Derm, which includes a disease based website, can now be downloaded.

James Young, D.O., Chair of the Bylaws Committee proposed changes to the bylaws to create gender neutral language. Members voted to pass the changes.

Marc Epstein, D.O., Chair of the Nominating Committee, reviewed the slate of nominees and the members voted. (See articles about new officers on page 18 and new trustees on page 24.)

Upcoming Meeting
The American Dermoscopy Annual Meeting will be held June 23-24 in Jackson Hole, Wyoming. 13 CME credits are being offered.
New Trustees Hope to Shape AOCD’s Future

The new members of the Board of Trustees have two things in common: they have been resident members since 2006 and they hope to serve as a positive influence as the College grows.

Karthik Krishnamurthy, D.O., hopes to bring a fresh, modern perspective as a trustee while seeking guidance from current and past board members as well other senior members of the College. “It’s important to understand how we got where we are today and protect the positive visions of those stewards while forging ahead,” he said. “There’s a healthy number of newbies on the Board, and one day the duties of operating and protecting the AOCD will be ours. It’s really exciting to be a part of the flow, but also very humbling,” adds Dr. Krishnamurthy, who served as Resident Liaison in 2008 and 2009, and Chair of the Public Relations and Editorial Committee since 2011.

“I want to lead the College into the future and help it with the challenges that face our specialty, in particular, and medicine, in general,” adds Reagan Anderson, D.O., who served as Resident Liaison in 2009.

While Dr. Krishnamurthy believes that the AOCD is currently moving in very positive directions, he would like to work on a few areas as trustee. Among them are creating novel ways to increase the College’s visibility to the public, updating its website, expanding continuous medical education (CME) opportunities, maintaining the highest residency training standards, creating more opportunities for resident academic scholarship, and eliciting and implementing suggestions from the membership.

John Minni, D.O., has set his sights on educational endeavors, such as streamlining CME as it relates to Osteopathic Continuous Certification. Dr. Minni serves on the CME Committee, the In-Training Examination Committee, and the Item Writers Committee. Modernizing the College and getting newer members to become active are his other priorities.

Dr. Krishnamurthy concurs. “Consider joining a committee; we have tons to choose from. Pick one that fits your strengths and interests,” he says, adding, “Seriously, from personal experience, it really won’t take up too much of your time and you’ll feel good about it.”

Dr. Minni sums it up for all three new trustees: “It is an honor to be elected and a privilege to give back.”

July Deadline for Dr. Bernard Residency Leadership Award

With a July 1 deadline, it’s not too soon to start thinking about nominations for the James Bernard, D.O., FAOCD, AOCD Residency Leadership Award.

The award, 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 the following: Editorial, Internet, In-Training Examination, Historical, and Continuing Medical Education.

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.

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 national office. Applicants will be notified by certified letter. The grant will begin during the Annual Meeting of any given year and end during the Annual Meeting of the subsequent year. All correspondence concerning the program and/or awarded grants should be directed to the Awards Committee.

The award was established last year to honor Dr. Bernard who has profoundly influenced and mentored many dermatology residents and young members, according to Michael J. Scott, D.O., Awards Committee Chair. The selected criteria for award nomination is a reflection of the dynamic characteristics that Dr. Bernard has exemplified in numerous leadership roles throughout his years of service to the College, Dr. Scott says.

Winners of the award will be announced at the 2012 Annual Meeting.
Since 1984, Dermatopathology Laboratory of Central States (DLCS) in Dayton, Ohio, has been dedicated to providing convenient, quality dermatopathology to dermatologists nationwide. The laboratory’s six board-certified dermatopathologists comprise a highly qualified team with decades of expertise in both dermatopathology and dermatology.

As the industry landscape becomes increasingly corporate, DLCS is proud to remain an independent laboratory. This independent status allows for full control over its bottom line: patient care.

DLCS is able to provide fast, quality pathology results paired with specialized customer service, billing, and technical teams. Connectivity solutions, such as electronic medical record interfaces and paperless requisitioning, help streamline the biopsy process. Billing options, such as client billing, offer flexibility. Molecular innovations such as FISH, in-house HPV, and BRAF testing are just some of the scientific developments that put DLCS on the cutting edge.

Osteopathic Connection
For more than 20 years, DLCS has been involved with osteopathic teaching. Residents from the osteopathic dermatology programs in Ohio and Virginia are taught on a regular basis by DLCS dermatopathologists. In Ohio, two of the dermatopathologists meet monthly with residents in the O’Bleness Memorial Hospital dermatology residency program under the directorship of John Hibler, D.O. DLCS is the official dermatopathology teaching facility of the Virginia College of Medicine (VCOM). Dermatopathologists teach the residents from the Lewis Gale Hospital-Montgomery/VCOM dermatology residency program under the directorship of Daniel Hurd, D.O., on a weekly basis via virtual conferences.

DLCS offers the Visiting Residency Program, in which residents receive one-on-one teaching from dermatopathologists at the lab. Its high volume lab provides exposure to a variety of cases and access to an extensive unknown glass slide collection. Additionally, DLCS has made available funding for the program to help offset attendance costs for residents.

DLCS also offers additional free resources for residents including a two-day workshop and an online slide study set program. Dermpath 100 is a two-day workshop of challenging cases and clinical training relevant to board preparation and daily practice taught by dermatopathologists and clinicians on faculty at DLCS. This year, Dermpath 100 will be held April 27-28 in Dayton. Although the workshop is free of charge, attendance is limited to 100 participants. Also, residents can review cases of unknown diagnoses that are organized into study sets presented in a digital format. These cases can be uploaded for review at the resident’s convenience. Residents can register for the program on DLCS’ website.

Exclusive to AOCD residents, DLCS faculty will be teaching a new mini-workshop at this year’s Midyear Meeting in Branson, Mo. In addition, lab faculty will present a slide review at the AOCD Annual Meeting in San Diego.

“Dermatopathology training of osteopathic dermatology residents has been a priority for DLCS for 25 years,” notes Tom Olsen, M.D., DLCS’ Lab Director. “Whether the experience is hands-on daily sign-outs or weekly virtual conferences, we believe that residents leave our rotation having learned important fundametals and much more in the field of dermatopathology.”

To learn more about DLCS and its opportunities for residents, visit the lab’s website at www.dermpathlab.com.
Another new year is upon us and hopefully everyone had a safe and happy holiday season. We just finished another application season and next year will mark the first year with the computer match for the incoming applicants. Thanks again to Dr. David Kasper, last year’s Resident Liaison, for helping make this happen. At this time, I have no new information to report on the match. But when I do, I will forward it to the programs.

For the graduating seniors, congratulations on almost being finished with your training. I am sure that you are counting the days until graduation. You will soon be entering the workforce and taking the Board Examination this coming fall. Good luck and I wish you all the best in your future endeavors. There are a few last minute reminders that you need to know before you graduate from your program. They are as follows:
• Sign up for the Board Exam through Rick Mansfield at the national office by the deadline to ensure that you are able to sit for the exam. You must pay for the exam at the time of registration.
• Remember to fill out your AOCD Annual Report and submit it by the deadline of 30 days after the end of the academic year.
• Make sure your last paper is submitted prior to leaving your program.

For the rest of the residents, the following is a list of the upcoming obligations and requirements you have for the AOCD during the next year.

For current second-year residents (2010-2013):
• Please submit your papers for both of your second-year requirements. When submitting your AOCD Annual Reports, provide the appropriate documentation of submission.
• During your third year of training, one of the aforementioned manuscripts or papers must be presented as a 20-minute lecture at either the AOCD Annual or Midyear Meeting. This presentation is considered a major presentation and should be referenced and of professional quality. There will be 20 slots at both the Annual and Midyear Meeting for these presentations.
• If you have not completed an American Academy of Dermatology (AAD) poster, please submit one this year. The AAD will be sending out an email with a request for abstracts. Look for the email this May to ensure that you meet this requirement.
• If you have not submitted a poster to the AOCD, please do this in an electronic format so it can be added to the jump drive for the upcoming AOCD Annual Meeting. You can submit the same poster you used for your AAD requirement, or any poster you presented for your hospital or residency program.
• Keep your logs up to date and have your AOCD Annual Report completed and submitted by the deadline of 30 days after the end of the training year.

For current first-year residents (2011-2014):
• Make sure that your first-year paper is submitted before the end of the academic year. The proof of submission must be included with your AOCD Annual Report.
• If you are presenting a poster at the upcoming AAD Meeting in San Diego, fill out the appropriate paperwork included in the AOCD Annual Report to receive credit.
• Please have a poster ready for submission to the AOCD for presentation at the upcoming Annual Meeting in San Diego. If you are presenting this year at the AAD, you may submit your electronic version of the poster to complete both the AAD and AOCD poster requirements. If you are not presenting at the AAD this year, you must submit another poster that you presented for your program or hospital from your first year.
• Keep your logs up to date and have your AOCD Annual Report completed and submitted by the deadline of 30 days after the end of the training year.

For newly matched residents (2012-2015):
• Congratulations and welcome to the AOCD family.
• The AOCD will be sending out forms in the near future so you can become a registered member of the College. Please fill out all forms and submit the appropriate paperwork included in the AOCD Annual Report along with resident membership dues in a timely fashion.
• Relax and enjoy time with your friends and family. There will be a lot of expectations both from your programs and the AOCD during the next three years.

If you have any questions or concerns, please have your chief resident forward them to me. To all of you who are attending the Midyear Meeting in Branson, Mo., I look forward to seeing you soon.

Celebrate NOM Week

Consider celebrating National Osteopathic Medicine (NOM) Week this April 15-21 by handing out the What is a DO? brochure to your patients or setting up a table at a local hospital or other community facility to distribute information about osteopathic physicians.

NOM Week unites the osteopathic medical profession to focus on one common goal—increasing awareness of osteopathic medicine and DOs in communities across the country.

You can access a number of different tools to engage your community from posters and press releases to a mini-medical school toolkit. These resources can be found in the Osteopathic Public Awareness Network—OPAN—section of the AOA website at www.osteopathic.org.
May Deadline for Intendis Call For Papers Competition

The deadline for submitting a paper for the Intendis Pharmaceuticals’ 2012 Call for Papers Competition is May 27.

Papers will be judged for originality, degree of scientific contribution, and thoughtfulness of presentation.

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

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

Papers should be sent to the AOCD at P.O. Box 7525, Kirksville, Mo., 63501.

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

Winners will be announced at the 2012 Annual Meeting.

Update to ACGME Proposed Rule Changes

In ongoing efforts to preserve training opportunities for osteopathic physicians, the AOA and American Association of Colleges of Osteopathic Medicine (AACOM) leadership met with the leadership of the Accreditation Council for Graduate Medical Education (ACGME) to discuss the proposed changes of the Common Program Requirements.

The proposed policy changes would limit future DOs from being able to train in ACGME programs. They include:

- Requiring an ACGME-accredited residency program as a prerequisite for clinical education for entry into an ACGME-accredited residency program or a Royal College of Physicians and Surgeons of Canada (RSPSC)-accredited residency program located in Canada. This would limit DOs who have completed an AOA-accredited internship from proceeding to an ACGME program unless they repeat their internship year in an ACGME-accredited residency program.
- Requiring an ACGME-accredited residency program or RCPSC-accredited residency program in Canada as a prerequisite for clinical education for entry into an ACGME-accredited fellowship program.

At the January meeting, the ACGME leaders stated that they will follow the process involved with proposed rule changes. If the Council of Review Committee decides to amend the proposed rule, the amended rule will be forwarded to the Committee on Requirements, which will meet next in June. At that time, a public hearing will be held at which AOA, AACOM, and others will be permitted to submit additional testimony before the Committee takes final action.

In the meantime, the AOA urged the ACGME to send a letter to its program directors clarifying that the requirements are only proposed at this time. The AOA hopes that this move will reduce the number of withdrawn interviews. The ACGME indicated that they would respond to student and resident concerns. Those who have questions regarding the proposed rules should contact Marsha Miller, Associate Vice President of Resident Services, at (312) 755-5041 or mmiller@acgme.org. To issue a complaint about a withdrawn interview, contact Miller or fill out a complaint form available on the ACGME website (www.acgme.org).

Note that there is no uniformity in ACGME standards regarding DO graduates. Some specialties allow it; others have an established policy against it. Just because a specialty says “no” does not necessarily mean that it has violated its policies, but checking to be certain may be worthwhile.

The AOA will work to have these proposed policies recalled so that osteopathic physicians will continue to benefit from additional career opportunities.
Hello everyone,

Through the winter months, we have been busy in the AOCD office completing follow-up work from the 2011 Annual Meeting, processing membership renewals, updating member information in our databases, and planning the 2012 Midyear Meeting in Branson, Mo.

Now it is time to focus on the addition of new residents starting July 1. Many of our program directors have notified us of their new residents. At the time of writing, we have 30 incoming residents joining our programs. First-year informational packets have been emailed to new residents.

All residents are asked to provide the following documents:

- A completed copy of the Resident Membership Application form
- 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 medical license
- 2 passport-sized photos
- A current CV

**Membership Dues Due**

Remember to renew your AOCD dues. The membership year runs January 1 to December 31. To renew online and update your membership information, log on to www.aocd.org. Please remember to keep your address and email address current. If you experience problems logging on, please let me know.

**Opportunities Available to Residents**

Are you taking advantage of the many opportunities available to AOCD residents? Consider participating in the following:

The Scripps Course scheduled for July 9-13, 2012. For more information, visit the website at cme.ucsd.edu/superficialanatomy. There is minimal funding available for third-year residents to attend this course.

A dermatopathology rotation is being offered by Cole Diagnostics in Boise, Idaho. To learn more, visit www.colediagnostics.com/contacts.html. Contact the AOCD office for an application.

Dr. Michael Morgan’s dermpath diagnostics sessions can be accessed by going on the resident section of the website at www.dermpathdiagnostics.com/residents. To access Dr. Morgan’s Monday telepath sessions, click on “Telepathology” and follow the directions.

To learn about the various programs designed to assist residents in the dermatopathology aspect of training offered by Global Pathology Laboratory Services, visit the company’s website at http://www.globalpathlab.com/#residents.php.

The Koprince Award was established in 1986 to honor the work of AOCD member, Daniel Koprince, D.O., FAOCD, who passed away in 2007. The award recognizes the top lectures presented by residents during the Annual and Midyear Meetings. Presentations are evaluated for subject matter, audiovisual presentation, and speaking ability. Information about this award is in your packets.

Other resident opportunities you can read about in this issue of *DermLine* include the James Bernard, D.O., FAOCD, Residency Leadership Award, the Intendis Paper Competition, and the Dermatopathology Laboratory of Central States’ free two-day workshop.

I look forward to seeing many of you again at the Midyear Meeting. Until then, if you need anything, please don’t hesitate to let me know.

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**Dr. Kleydman: First DO Resident Awarded Mt. Sinai Fellowship**

Kate Kleydman, D.O., is the first osteopathic dermatologist to be accepted into a procedural/Mohs surgical fellowship at Mount Sinai Medical Center in New York.

“I am very excited about this opportunity because I would like to further my training, and this is one of the most sought after fellowships in New York,” says the Chief Resident at the St. Barnabas Hospital residency program under the directorship of Cindy Hoffman, D.O.

The Mount Sinai fellowship offers training in Mohs surgery, as well as training in reconstructive and cosmetic surgery; not all fellowships offer both, she says. It was her first choice because it offered her an opportunity to train with the most renowned faculty.

“I’m very proud that one of my residents applied for and got accepted into this prestigious fellowship,” says Dr. Hoffman, adding that Dr. Kleydman was up against many qualified applicants. “Kate really wanted this and she spent many hours working with the Mount Sinai attendings, assisting with Mohs surgery, and helping them get published.”
The MWU/Advanced Desert Dermatology Residency Program is approaching its second anniversary.

The first resident, Jeremy Bingham, D.O., began July 1, 2010. He was joined by Ray Knisley, D.O., last July. The program is approved for three residents, the third of which will be accepted this July.

The program, which is named after the practice—Advanced Desert Dermatology—is under the directorship of Vernon “Tom” Mackey, D.O. The difficulty of obtaining a dermatology residency, given the limited number of programs and the growing number of applicants, was the primary reason that motivated him to start a program.

Clinic Experience
Residents see a wide array of patients and dermatologic disease states in this very busy practice that consists of three locations and three dermatologists. Two clinics are in the Phoenix metropolitan area, and the third is in Sierra Vista, approximately 190 miles south of Phoenix. Between 40 and 45 patients are seen daily, with three to four surgeries being performed at the Peoria and Mesa locations as well as the office in Sierra Vista, home to a large U.S. Army base and a big retirement community. Given its population base and only one full-time dermatologist, Sierra Vista is an underserved area in the specialty of dermatology, Dr. Mackey says.

Given the sunny location, the residency program emphasizes managing the treatment of cutaneous malignancies, he states. Residents see a lot of skin cancers and receive a significant amount of training in Mohs micrographic surgery. “Many programs rely on an extra procedural year after residency to provide that Mohs experience, but I hope to give that to the residents while they are here,” Dr. Mackey says.

“Residents have opportunities in each of these clinics that allow them to grow their clinical experience and develop confidence to begin their own practice,” he adds.

Academic Atmosphere
“Residents bring an academic atmosphere, which will encourage me to spend more time in the acquisition of new knowledge,” Dr. Mackey notes.

In preparation for the residency program, he began attending osteopathic graduate medical education, or OGME, meetings to learn how to improve training programs. Dr. Mackey also pulled out all of his old board examination study materials and began reviewing the information. “I believe in helping the residents do well on their in-service exams and pass the board,” he says. “That means I have to make sure that they are learning the right information and I am staying up with the most current information.”

Daily didactic sessions are a key component of the program. For example, Dr. Mackey has daily morning reports during which the residents present on topics they were given information on the night before. In addition to weekly grand rounds within the program, the residents attend grand rounds with the University of Arizona’s dermatology program twice a month. There is a weekly dermatopathology lecture and the journal club meets on Fridays.

The Trainers
Dr. Mackey, who spent the first 13 years of practice as a family practitioner, sought additional training as a dermatologist in 2001. Three years later, he became board certified in dermatology. Consequently, Dr. Mackey has some insight into certain disease processes and how they interact with the skin. His residents will, no doubt, benefit from that broadened perspective. Dr. Bingham felt right at home given that he wrapped up a family practice residency shortly before joining the program.

Dr. Mackey is joined by Ronald Glick, D.O., and Angelo Petropolis, M.D., in training the residents. Dr. Petropolis, who is a Mohs surgeon, regularly gives general dermatology lectures to interns at the Sierra Vista Regional Community Hospital. He is very involved in the education of both the externs and the interns at the hospital.

The advantage of having three trainers, as Dr. Mackey sees it, is that the residents can incorporate the best practices from each one. “Seeing how a few dermatologists practice will enhance the residents’ skills,” he says.

Reflecting on his nearly two years as program director, Dr. Mackey notes, “I am enjoying teaching residents and seeing them reach their full potential as they too become board certified dermatologists.”
When student members Brandon Shutty (MSIV) and Summer Moon (MSIII) aren’t cracking the books for class, they are busy educating the public about sun safety.

Walking along the beach two summers ago, Shutty saw a skin cancer screening event sponsored by Tampa-based H. Lee Moffitt Cancer Center and Research Institute. He asked if they needed help and has since volunteered at Spring Swings on Moffitt’s Mole Patrol, which has been offering free skin cancer screenings to Floridians for 17 years. 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. Four years ago, the Mole Patrol teamed up with the Tampa Bay Rays to offer screening services during the major league baseball spring training season, which have come to be known as Spring Swings. Along with the other volunteers, Shutty and Moon helped set up tents under which the screenings were held, and strategically placed gallon tubs of Blue Lizard sunscreen around the stadium. They spoke to individuals about sun safety and passed out educational pamphlets and materials.

Shutty was especially pleased to be presenting information to other students. “We live in Florida where people, especially younger people, go to the beach all the time,” he says. “They think the sun is good for them, that they can get vitamin D from it. They don’t know that sun damage is cumulative.” Even among his classmates, many don’t practice sun safety. Before taking dermatology rotations, Shutty admits that he, too, was more cavalier about it. “That’s why I think it’s really important to reach younger individuals.” To that end, he is trying to schedule a skin cancer screening event at LECOM.

A few months ago, the two set up shop at a local business. After an employee was diagnosed with melanoma, the owners contacted the ACS to send someone out to educate their employees about sun safety. A dermatologist conducted skin cancer screenings onsite, as well.

No matter where they go, they receive a warm welcome from the community, Shutty says. But it’s the responses to their questions they sometimes hear that are troubling. As an example, approximately half of the people they come across have never seen a dermatologist. “These are people who live in Florida where the sun can be quite intense,” he notes. Similarly, only approximately half of the people know to use sunscreen. But they don’t necessarily know to apply it at least 30 minutes before going outdoors, to reapply it every two hours or after going in the water, and to use an SPF of 30 or greater, Shutty says.

The students are looking forward to volunteering again with Moffitt’s Spring Swing that kicks off in March. Next month, the two are scheduled to volunteer at the Relay-for-Life in St. Petersburg. “I remember hearing that Florida has the second highest incidence of melanoma in the United States,” Moon says, “so it’s great that we can help catch it early while we are living here.”
The number of members contributing to the Foundation for Osteopathic Dermatology (FOD) continues to grow.

The FOD, which is dedicated to providing grants for education and research in dermatology and related areas, has various levels of support. They are as follows:

- The Ulbrich Circle: $10,000 over a 10-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 Founding Members of the Ulbrich Circle were acknowledged at the 2011 Annual Meeting in Orlando. They are as follows:

- Ted Van Acker, D.O.
- Jim Bernard, D.O.
- Roger Byrd, D.O.
- Marc Epstein, D.O.
- Tracy Favreau, D.O.
- Bradley Glick, D.O.
- David Grice, D.O.
- Cindy Lavery Henry, D.O.
- Leslie Kramer, D.O.
- Matt Leavitt, D.O.
- Jere Mammino, D.O.
- Gregory Papadeas, D.O.
- Steve Purcell, D.O.
- Jim Towry, D.O.
- Bill Way, D.O.
- Craig Ziering, D.O.

Other members who have contributed at various levels include David Grice, D.O.; Lloyd Cleaver, D.O.; and Suzanne Sirota-Rozenberg, D.O.

Position Available in Long Island, New York
Dermatologist in solo practice seeks to add a FT/PT BC/BE DO 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 email CV to skindeepdo@aol.com.

Florida Practice Seeking Dermatologist
Waters Edge Dermatology with locations in Palm Bay and Sebastian, Fla., is seeking a dermatologist interested in general dermatology, dermatologic surgery, Mohs surgery, and fillers and Botox to join the practice.

Enjoy the unsurpassed lifestyle of coastal Florida as part of an established, growing multi-location dermatology practice. We have recently opened offices in Palm Bay and Sebastian and would like you to work in both offices. This is a great opportunity to build a practice and establish yourself while not having to deal with the financial responsibilities and headaches of running your own practice. Sebastian and Palm Bay are havens for seniors and great places for families to live.

Our beautiful state-of-the-art facilities include fully equipped offices with the latest technology for medical and cosmetic dermatology, including cutaneous surgery, Mohs surgery, and a full-service dermatopathology laboratory. If skin cancer is your interest, then please explore this opportunity.

We offer a generous guaranteed salary and a percentage of collections, whichever is greater, as well as full benefits and partnership opportunities. This is a great opportunity for residents or experienced dermatologists.

Please visit our website at www.wederm.com to learn about Waters Edge Dermatology and our practitioners. For more information, please contact Lewis Bergman, Practice Administrator, via email at lbergman@wederm.com or by phone at (561) 694-9493.
JAOC\textsuperscript{D}

A CALL FOR PAPERS

Journal of the American Osteopathic College of Dermatology-\textit{JAOC\textsuperscript{D}}.

We are now accepting manuscripts for publication in the upcoming issue of the \textit{JAOC\textsuperscript{D}}. ‘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. \textit{Let’s make it great!}

- Jay Gottlieb, D.O., FAOC\textsuperscript{D}