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07.2018
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I love a good disaster movie.

Epic, poorly overacted tales of impossibly large hurricanes, tsunamis, tornados (even sharknados), and cataclysmic blizzards amuse me like no other movie genre. Like most of us, though, I prefer my disasters on a movie screen, rather than in my own backyard. Lately it seems like we are experiencing more real than fictional natural disasters, many of which have personally affected some of our members. We also see their impact in our practices. Emily Margosian discusses our changing world and explores the role dermatologists may play in responding to public health issues that may arise from climate change and natural disasters, including new and old, but reemerging diseases once thought to be eradicated. Many of these conditions primarily involve the skin, so like it or not, dermatologists are likely to be involved. It is critically important that we recognize and manage diseases with public health implications. Do you know what to do in a public health emergency? Are you reporting infectious diseases correctly? We can help. We even offer a way to help your community in times of crisis: Channel your inner Girl/Boy Scout and consider joining your local Medical Reserve Corps.

Our population is aging as millions of us Baby Boomers enter our “prime time.” Providing dermatologic care for older patients can be complicated, as we must adeptly manage not only their medical conditions, but also, social and legal issues that impact care. Even with Medicare coverage, financial restrictions may limit the care to which our elderly patients have access. Victoria Houghton offers a thought-provoking look at many facets of caring for elderly patients, including some difficult topics you may prefer never to have to consider, including recognizing signs of elder abuse. However difficult it is to consider, recognition of skin signs that suggest abuse may be life-saving. Other crucial factors that impact medical care in the elderly include treatment adherence and patient comorbidities that impact a given patient’s ability to comply with your treatment regimen. A realistic treatment regimen in a younger patient may be physically impossible in an older one. And make sure that you and your older patient share common goals of care. Our medical training teaches us to cure diseases, a lofty goal we can sometimes accomplish in our younger patients. This is not always possible, or even necessarily desirable, in older patients, for whom the costs of treatment may outweigh the benefits of the “cure.” Without knowing what our patients really want, we risk inadvertently failing to provide them the care that they need and deserve.

To end on a positive note, we thought we’d catch you up on the political happenings of the first six months of 2018. Many of the changes we have been watching for, such as development of alternative payment models, seem to be on hold; however, efforts to dismantle the ACA continue to move forward piece by piece. Our feature article on health policy issues will help bring you up to speed on recent happenings. Regardless of your chosen political party affiliation, it’s been an interesting time to follow politics. The AADA remains our staunch advocate, fighting for the good of our specialty and patients. Many thanks to all the members who volunteer their time, effort and expertise serving on relevant committees on behalf of all of us.

Enjoy a safe and happy Fourth of July!

KATHRYN SCHWARZENBERGER, MD, PHYSICIAN EDITOR
07.2018 | CONTENTS
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Don’t miss bonus online content at www.aad.org/dw!
How did you become involved as a judge for the Aspire Higher program?

I was approached by Ortho Dermatologics, and I thought it was a wonderful opportunity. I really liked that they were giving back to the community and that I could help people who want to further their education.

What is your favorite part about being a judge for Aspire Higher?

I really enjoy the whole experience, but two things come to mind: Seeing the impact the scholarships have on the lives of the people who win, and reading their stories.

One of last year’s winners left a voicemail for the judges. I was in the middle of grocery shopping when I heard it, and I started crying because it was so touching. Also, reading about how a problem with a person’s skin impacts each aspect of their life urges us to seek the best possible treatment for our patients even more. I think that what Ortho Dermatologics is doing is exceptionally worthwhile.

What are your thoughts about Ortho Dermatologics’ commitment to the dermatology community through this scholarship program?

I’m thrilled to be part of it. I’m thrilled to have had the opportunity to hear the patients’ stories, to understand their journey, and to be part of making their educational dreams come true. I think this is a major gift that Ortho Dermatologics gives back to the community, and it’s important to get the word out to our patients that this is available. Ortho Dermatologics really does care about our specialty.

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What technology do you use to educate patients in your practice?

“” We still utilize good ‘ole patient handouts during office visits, but I also enjoy using social media for wider reach to the general public.””

– Lauren Kyle, MD, Overland Park, Kan.

“” We use multiple modalities to educate patients in our practice. The one we use the most is the iPad, which stores multiple patient education videos. We have our Mohs consultation patients view the American College of Mohs Surgery video. We also have procedure-specific videos stored on the iPads. Lastly, we use social media such as Instagram and Facebook to educate our patients and provide commentary on dermatology topics that are in the news.””

– Jerome Potozkin, MD, Danville, Calif.

“” Downloading and demonstrating the application, CompariSkinFree, which provides education on moles, mole mapping, and risk factors. I feel education is key to compliance, and spend a significant amount of time informing my patients on their skin disorders. Additionally, our office provides handouts generated by EHR, and video screens streaming information on various disorders and procedures.””

– Gary Lichten, MD, Fairlawn, Ohio

“” VisualDx.””

– Laura Garzona Navas, MD, San José, Costa Rica

“” Paper handouts to take home, PowerPoint presentations, and educational videos.””

– Shawn Richards, MBBS, Westmead, Australia

“” We have found our website to be very useful in educating our patients on different medical conditions and procedures. But social media — particularly Instagram — is my favorite way to connect with and educate patients in a fun, interactive, and non-intimidating way.””

– Jennifer Trent, MD, Sarasota, Fla.

Next month’s question

Next month, Dermatology World’s Water Cooler column wants to know...

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Made by dermatologists for dermatologists.
What’s hot?

In this monthly column, members of the Dermatology World Editorial Advisory Workgroup identify exciting news from across the specialty.

“SPF 30 or higher” is the classic, impulse response that we often give when asked about sunscreen recommendations. However, a recent study demonstrates proven benefit with higher SPF. A total of 199 skiers in Vail, Colorado participated in the randomized, double-blind, split-face study. Each skier wore both SPF 50+ and SPF 100+ throughout the day and was then blindly evaluated the next day for sunburn erythema. SPF 100+ was found to be significantly more effective in protecting against sunburn than SPF 50+. Why the benefit? Most consumers apply only half of the recommended amount of sunscreen and thus in actuality receive less SPF than on the label. In this way, higher SPF likely compensate for what is lost in real-world application.

So, is higher SPF always better? The answer is not so simple. The standard set by the U.S. FDA for sunscreen labels is less stringent than that of Europe, and neither SPF (a primary measure of UVB) nor “broad-spectrum” status (achieved by meeting a critical wavelength of 370 nm) ensure adequate UVA protection for the U.S. consumer. A 2017 study found that only 55% of U.S. sunscreens met European standards for adequate UVA protection and higher SPF did not correlate with improved UVA protection. These differentials have been well described in the literature, however it is little known that discoid lupus erythematosus and subacute cutaneous lupus erythematosus can also show findings that resemble cutaneous lymphoma. A recent paper by Lorenzo Cerroni’s group described 15 cases of cutaneous lupus erythematosus (not tumid or panniculitic types) that either mimicked lymphoma or were misdiagnosed as an atypical lymphoid process. All cases had known lupus in other lesions. In their case series, they found that the lupus could be misconstrued as marginal zone lymphoma, angiocentric lymphoma, cutaneous lymphoid hyperplasia, or mycosis fungoides. These cases could have a nodular, lichenoid, or angiocentric pattern, as well as cytological atypia of lymphocytes. Features that proved helpful in confirming the diagnosis included: interface dermatitis, clusters of CD123(+) plasmacytoid dendritic cells, or mucin deposition. As a dermatologist, it is important to recognize this differential diagnosis. In cases where there is clinicopathologic disparity, taking multiple samples and asking your pathologist to do additional special stains or T cell gene rearrangement studies may be beneficial in confirming a diagnosis.

Do you think that your pathologist can confuse lupus erythematosus and an atypical lymphoid infiltrate? It sounds crazy, but this problem may be more common than you realize. The differential diagnosis of lupus erythematosus and cutaneous lymphoma may bring to mind the problem of differentiating lupus panpaniculitis and subcutaneous panpaniculitic T cell lymphoma, or possibly tumid lupus erythematosus and cutaneous marginal zone lymphoma. These differentials have been well described in the literature, however it is little known that discoid lupus erythematosus and subacute cutaneous lupus erythematosus can also show findings that resemble cutaneous lymphoma. A recent paper by Lorenzo Cerroni’s group described 15 cases of cutaneous lupus erythematosus (not tumid or panniculitic types) that either mimicked lymphoma or were misdiagnosed as an atypical lymphoid process. All cases had known lupus in other lesions. In their case series, they found that the lupus could be misconstrued as marginal zone lymphoma, angiocentric lymphoma, cutaneous lymphoid hyperplasia, or mycosis fungoides. These cases could have a nodular, lichenoid, or angiocentric pattern, as well as cytological atypia of lymphocytes. Features that proved helpful in confirming the diagnosis included: interface dermatitis, clusters of CD123(+) plasmacytoid dendritic cells, or mucin deposition. As a dermatologist, it is important to recognize this differential diagnosis. In cases where there is clinicopathologic disparity, taking multiple samples and asking your pathologist to do additional special stains or T cell gene rearrangement studies may be beneficial in confirming a diagnosis.

Although shave biopsies of suspected BCCs are intended to be diagnostic only, it is common that pathologists will comment on the margin status. This could lead to confusion, as the phrase “negative in the sections examined” could imply that the lesion was entirely excised. Prior studies have shown that only 1-2% of the margin of a biopsy specimen is assessed with standard processing, so it is possible that the margin status of these few sections are not representative of the whole. In an article in press with JAAD, Willardson, et al identified 134 biopsies diagnosed as basal cell carcinoma with negative margins and then sectioned the corresponding excision blocks at a 150 micrometer interval until either residual disease was found or until it was exhausted (doi: 10.1016/j.jaad.2017.12.071). They found that BCC biopsies with negative margins had residual disease in the excision block 24% of the time. In 91% of the cases the residual disease found was of the superficial subtype. There are two main implications of this article: margin status of BCC biopsies is not predictive of true margin status and therefore these lesions should be treated. Secondly, when presented with this pathology result a clinician could consider topical therapy or ED&C if the lesion is in a difficult anatomic location and if the entirety of the visualized lesion was biopsied initially.
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For clinical preventive services in the United States, that task largely falls to the U.S. Preventive Services Task Force (USPSTF), a volunteer panel of national experts in prevention and evidence-based medicine. Importantly, USPSTF recommendations bearing Grade “A” or “B” must be covered by insurance without co-payments.

In March 2018 USPSTF released updated recommendations, for persons without a skin cancer history, on behavioral counseling for skin cancer prevention and screening for skin cancer with skin self-examination, as follows:

- Young adults (through age 24), adolescents, children, and parents of young children with fair skin type: Counsel about minimizing UV radiation exposure (Grade “B”: provide this service).
- Adults older than 24 years with fair skin type: Selectively offer counseling about minimizing exposure to UV radiation (Grade “C”: selectively counsel based on professional judgment and patient preferences).
- Self-skin examination in adults: No recommendation (Grade “I”: evidence insufficient to assess balance of benefits and harms).

This updated recommendation expands the age range for behavioral counseling and maintains the Grade “I” recommendation, from 2009, for skin self-examination.

There is accumulating evidence of the significant associations between rosacea and systemic comorbidities. Haber et al (J Am Acad Dermatol. 2018 Apr;78(4):786-792.e8) conducted a systematic literature review of 29 studies and found a statistically significant relationship between rosacea and depression, hypertension, cardiovascular disease, anxiety disorder, diabetes mellitus, migraine, rheumatoid arthritis, Helicobacter pylori infection, ulcerative colitis, and dementia. The review suggests a possible correlation between the severity of rosacea and the incidence of comorbidities and that the chronic inflammation seen in rosacea can be systemic.

How does that impact your patient care?

Optimal care would include assessing patients for cardiovascular risk factors as well as GI and psychiatric morbidity, especially in patients with more severe disease. Recent data showed a decreased risk of vascular events in rosacea patients treated with tetracycline. It is thought the anti-inflammatory properties of tetracyclines led to beneficial effects on the cardiovascular system. Examples of CVD screening questions would include screening for personal and family history of CVD, calculating BMI, checking blood pressure, running a fasting lipid panel and fasting glucose of HbA1C; and suggesting aspirin or low-dose doxycycline in patients with several risk factors.

Lab monitoring and ophthalmologic exams during hydroxychloroquine therapy: too much, too often? According to American College of Rheumatology guidelines (Arthritis Rheumatol. 2016;68(1):1-26), no laboratory monitoring is recommended for patients taking hydroxychloroquine after baseline labs. An American Academy of Ophthalmology statement (Ophthalmology. 2016;123:1386-1394) recommends a baseline fundus examination in the first year of therapy. If the baseline exam is normal, no ophthalmologic exam is needed for the next 5 years for patients on acceptable doses without risk factors (liver disease, age > 60 years). Daily dosage should be <5 mg/kg actual weight; previous recommendations to use ideal body weight for dose calculation resulted in over-dosage in thin individuals.

There are no comparable data for chloroquine toxicity. The mechanisms of action are presumed to be similar for both drugs, and older literature equated 3 mg of chloroquine with 6.5 mg of hydroxychloroquine. With this estimation, the equivalent of 5 mg/kg hydroxychloroquine would be 2.3 mg/kg chloroquine. Many reports suggest that chloroquine is somewhat more toxic than hydroxychloroquine, but there are no good data on pharmacologic equivalence. The higher toxicity of chloroquine may be an artifact of prescription practices, which have been biased by the tablet size (250 mg). Almost any patient taking 1 tablet of chloroquine will receive more than 2.3 mg/kg.

Because hydroxychloroquine is available in 200 mg tablets and chloroquine is available in 250 mg tablets, it may seem difficult to prescribe intermediate doses. However, blood levels of these drugs stabilize over many weeks, so variable dosing will average out over time. Intermediate doses can be obtained by splitting tablets or by skipping a tablet on certain days of the week.
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Key components of evaluation and management: Physical examination

BY ALEXANDER MILLER, MD

Alexander Miller, MD, addresses important coding and documentation questions each month in Cracking the Code. Dr. Miller, who is in private practice in Yorba Linda, California, represents the American Academy of Dermatology on the AMA-CPT® Advisory Committee.

There are three “key components” used to determine levels of Evaluation and Management (E/M) services. The first is history, which has been discussed in the two preceding Cracking the Code articles. The second is the examination and the third is medical decision making, which will be covered in next month’s article.

When trying to determine levels of examination, one is faced with determining which documentation guidelines to use: the 1995 or the 1997 version. One must adhere to one or the other version for each encounter; commingling the two is not appropriate. Although Medicare will accept either guideline (whichever provides greater advantage to the provider), insurers are more likely to use the 1997 version for claims adjudication purposes. So, let’s focus on the 1997 guidelines.

The CPT® lists four types of examinations to be used for determining levels of E/M services. These are:

- **Problem focused:** A limited examination of the affected body area or organ system;
- **Expanded problem focused:** A limited examination of the affected body area or organ system and any other symptomatic or related body area(s) or organ system(s);
- **Detailed:** An extended examination of the affected body area(s) or organ system(s) and any other symptomatic or related body area(s) or organ system(s); and
- **Comprehensive:** A general multi-system examination or complete examination of a single organ system.

The 1997 documentation guidelines base examination coding on organ systems and “bullets” of data collected from each organ system. Below is a listing of recognized organ systems:

- Constitutional
- Eyes
- Ears, nose, mouth, throat
- Neck
- Cardiovascular
- Chest (breasts)
- Respiratory
- Gastrointestinal (abdomen)
- Genitourinary (male, female)
- Lymphatic
- Musculoskeletal
- Skin
- Neurologic
- Psychiatric
- Hematologic/lymphatic/immunologic

As dermatologists, which of the above are we most likely to evaluate? The organ systems and bullet points most likely to be pertinent to various dermatologic disease evaluations are listed in the table below.

<table>
<thead>
<tr>
<th>Constitutional</th>
<th>Eyes</th>
<th>Ears, nose, mouth, throat</th>
</tr>
</thead>
<tbody>
<tr>
<td>General appearance</td>
<td>Vital signs (list at least three)</td>
<td>Lips, teeth, gums inspection</td>
</tr>
<tr>
<td>Conjunctivae and lids</td>
<td>Oropharynx, oral mucosa, salivary glands, palates, tongue, pharynx examination</td>
<td></td>
</tr>
<tr>
<td>Examination of Thyroid (e.g., enlargement, tenderness, mass)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
How do the above bullets relate to levels of examination? Below is a chart specifying the 1997 guidelines criteria:

<table>
<thead>
<tr>
<th>Examination Type</th>
<th>Bullets Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problem focused</td>
<td>1-5</td>
</tr>
<tr>
<td>Expanded problem focused</td>
<td>6 or more</td>
</tr>
<tr>
<td>Detailed</td>
<td>At least 12</td>
</tr>
<tr>
<td>Comprehensive</td>
<td>2 from each of nine organ systems (uncommon for a dermatologic skin exam)</td>
</tr>
</tbody>
</table>

During data entry and code selection one should keep in mind that the extent of the physical examination should be commensurate with the patient's problem(s). Aggregated physical examination data not relevant to a patient's clinical state will be rejected upon chart audit, and will not count toward determinations of visit complexity. Such audits may reveal patterns of upcoding, and could result in, at best, a request for a refund, and at worst, further audits and investigations.

Appendix C of the CPT® provides a variety of dermatology-specific patient care vignettes illustrating various levels of E/M. This can serve as a general guideline, but should be used with caution, as the diseases/conditions illustrated serve as examples of applicable levels of E/M services, but do not mean that every such patient scenario should lead to an identical level of E/M service. The E/M level of service should be individualized to the medically necessary degree of service appropriate to the patient's clinical presentation.
Example 1
You do a complete skin examination of a patient with a past history of malignant melanoma, palpate lymph node basins in the neck, axillae, and groin, examine the eyelids and conjunctivae as well as the lips, gums, oral mucosa, and tongue.

How many examination bullet points have you accumulated?

Answer: 14. Based upon the above scenario, 14 bullet points were accumulated from 4 organ systems: skin (10), lymphatic (1), eyes (1), ears-nose-mouth-throat (2). This reaches a ‘Detailed’ level of examination.

Example 2
You do the above examination and document a “complete skin examination” as your description of the skin examination. This charting validates the accumulation of 10 skin bullet points.

Answer: Incorrect. Each of the examined skin areas characterized by a bullet point are best listed individually in the patient record. This validates their examination. “Complete skin examination” or “full skin check” may seem to characterize what was done, but upon chart audit is likely to be rejected as inadequate documentation or counted as one system.

Example 3
The following appears in a patient record: Well-developed, well-nourished male appearing comfortable and in no distress, oriented, and conversational. Complete skin examination done including the head, neck, chest, abdomen, genitalia, buttocks, back, all four extremities, nails and nail beds, lips, tongue, gums and oral mucosa, eyelids, and conjunctivae. An 8 by 6 mm asymmetrically bordered, brown to black, irregularly pigmented macule is present on the left mid back. Palpation of neck, axillary and groin lymph node basins reveals no palpable nodes.

Which type of examination is reached in the above scenario?

Answer: Detailed. The 6 documented organ systems are: Constitutional, Psychiatric, Skin, Musculoskeletal, Ear-nose-mouth-throat, Eyes. From these there were 16 extractable bullet points.
For more than 15 million Americans, hyperhidrosis is more than just an inconvenience.\textsuperscript{1,2}

Primary axillary hyperhidrosis impacts a patient’s emotional and social well-being. Despite the embarrassment and low self-confidence sufferers feel, about 70% remain undiagnosed and untreated.\textsuperscript{1,3}

\begin{itemize}
  \item \textbf{85\%} EXPERIENCE EMBARRASSMENT\textsuperscript{1}
  \item \textbf{70\%} REPORT IMPACT TO DAILY ACTIVITIES AND LACK OF TOLERABILITY\textsuperscript{1}
  \item \textbf{63\%} SAY IT LIMITS THEM AT WORK\textsuperscript{2}
\end{itemize}

It is hard for your patients to talk about sweat.\textsuperscript{1}

Visit CheckTheirSweat.com for resources to manage hyperhidrosis.

The American Academy of Dermatology Association is tracking nearly 100 pieces of legislation related to scope of practice in 2018. The AADA advocates for physician-led, team-based care and appropriate supervision of physician assistants and nurse practitioners, and opposes inappropriate scope expansions of other non-physicians, such as naturopaths, estheticians, and optometrists. 2018 has been a largely successful year in defeating scope expansion legislation, after nearly 10 dangerous bills were killed.

**Alabama**
Bill #: HB 443  
Overview: Would have removed the requirement that nurse practitioners and nurse midwives practice in collaboration with a physician, and would have allowed them to prescribe medications within the scope permitted by the Board of Medical Examiners.  
Status: Killed before a hearing in committee could be held and failed upon adjournment

**Arizona**
Bill #: HB 2378  
Overview: Would have loosened supervision of cosmetic lasers by allowing the definition of “directly supervised” to include “laser safety officer.” A Laser Safety Officer is defined as “a person who has the authority and responsibility to monitor and enforce the control of laser hazards and to effect the knowledgeable evaluation and control of laser hazards.” Laser Safety Officer certification is available online with a three-hour course.  
Status: The Arizona Dermatology and Dermatologic Surgery Society was successful in killing the legislation before it could be heard in committee.

**Connecticut**
Bill #: HB 5294, SB 300  
Overview: HB 5294 would allow the Department of Public Health and the State Board of Naturopathic Examiners to establish educational and examination requirements or other qualifications to permit a naturopathic physician to prescribe, dispense, and administer prescription medicines consistent with their scope of practice, and establish a naturopathic formulary of prescription medicines that naturopaths may use consistent with their practice and training.  
Status: HB 5294 and SB 300 heard in the Joint Committee on Public Health

**Florida**
Bill #: HB 965, SB 744  
Overview: These bills would transfer regulation of electrology from the Department of Health to the Department of Business and Professional Regulation and provide certification requirements for licensed electrologists who perform laser hair removal or reduction, and would remove direct supervision of electrologists performing laser hair removal.  
Status: HB 965 passed the House and died in Senate Health Policy Committee; SB 744 passed Senate Health Policy and Appropriations but died upon adjournment.

**Illinois**
Bill #: HB 5871, SB 3606  
Overview: HB 5871 and SB 3606 would remove authority of the Department of Health to establish the educational requirements for performing advanced optometric procedures by rule and provides that the practice of optometry includes advanced optometric procedures only upon successful completion of an
2018 scope of practice legislation

advanced optometric training and testing program approved by the Department of Financial and Professional Regulation. The bills would allow optometrists to inject potent pharmaceuticals and use scalpels to remove skin tags, lesions, and foreign bodies, and would allow them to incise and drain cysts.

**Status:** Newly introduced, not yet referred

**Indiana**

**Bill #:** HB 1302

**Overview:** Allows an advanced practice registered nurse (APRN) to operate without a collaborative agreement with a practitioner if the APRN has operated under a collaborative agreement with a practitioner for at least five years and in the same medical specialty, which may be acute care, family practice, pediatrics, mental health, or obstetrics and gynecology.

**Advocacy:** AADA assisted the Indiana Academy of Dermatology with their efforts to oppose the bill.

**Status:** Died in Committee on Public Health

**Minnesota**

**Bill #:** SF 2976, HF 3322

**Overview:** The companion bills would enter Minnesota into the Advanced Practice Registered Nurse Compact (APRN Compact), which is intended to create license portability, but in the process would allow an APRN who obtains the multistate license to practice independent of a supervisory or collaborative relationship with a physician.

**Advocacy:** AADA recently signed on to a coalition letter led by the American Medical Association urging the National Council of State Boards of Nursing (NC-SBN) to reconsider certain provisions of the compact that alter state laws related to the scope of practice of APRNs.

**Status:** SF 2976, referred to Committee on Health and Human Services Finance and Policy; HF 3322, referred to Health and Human Services Reform

**Mississippi**

**Bill #:** HB 1275, HB 114, HB 994, HB 398

**Overview:** HB 1275 and HB 114 would delete the requirement that APRNs must practice within a collaborative or consultative relationship with a physician; HB 994 and HB 398 would not require certified nurse practitioners with more than 3,600 hours of clinical practice to have a written collaborative agree-
ment with a physician or submit patient charts to a physician for review.

**Advocacy:** AADA sent out a grassroots action alert urging members to contact their state representatives in opposition of the bills.

**Status:** Failed in the House Committee on Public Health and Human Services

**Missouri**

**Bill #:** HB 1574, HB 1502

**Overview:** HB 1574 would allow a physician to enter into collaborative practice arrangements or supervision agreements with a total of six full-time-equivalent APRNs, assistant physicians, or physician assistants, in any combination thereof, and would extend the mileage requirements for supervision from 50 miles to 75 miles. Currently, a doctor can work with up to three APRNs and three physician assistants at one time. HB 1502 would allow an APRN to practice independently after working under a collaborative practice arrangement for two years.

**Advocacy:** AADA sent an action alert to members in Missouri asking them to urge their state representative to oppose HB 1502.

**Status:** HB 1574 passed House, heard in Senate Committee on Professional Registration; HB 1502 passed Committee on Professional Licensing

**Nebraska**

**Bill #:** LB 687

**Overview:** Would enter Nebraska into the APRN Compact, which is intended to create license portability, but in the process would allow an APRN who obtains the multistate license to practice independent of a supervisory or collaborative relationship with a physician.

**Status:** Failed in the Health and Human Services Committee

**Oklahoma**

**Bill #:** SB 570

**Overview:** Would remove the requirement for a supervising physician for nurse practitioners, and allow them to diagnose, treat, prescribe drugs, and serve as a primary care provider of record.

**Advocacy:** AADA sent an action alert to all members in Oklahoma asking them to urge their state senator and representative to oppose the bill.

**Status:** Passed Senate and House, defeated in conference committee upon adjournment

**Pennsylvania**

**Bill #:** HB 100, SB 25

**Overview:** The bills would allow certified nurse practitioners who have engaged in the practice of professional nursing in collaboration with a physician for a period of at least three years and 3,600 hours to practice independently.

**Advocacy:** AADA sent a grassroots alert asking members to urge members of the House Professional Licensing Committee to oppose the bills.

**Status:** HB 100 and SB 25 remain in the House Committee on Professional Licensure

**Virginia**

**Bill #:** HB 793

**Overview:** Eliminates the requirement for a practice agreement with a patient care team physician for a licensed nurse practitioner who has completed the equivalent of at least five years of full-time clinical experience and submitted an attestation from their patient care team physician. The bill requires the Boards of Medicine and Nursing to jointly promulgate regulations governing the practice of nurse practitioners without a practice agreement.

**Status:** Enacted, effective July 1, 2018

**Virginia**

**Bill #:** SB 511

**Overview:** The bill began the session as a scope expansion for optometrists, allowing them to perform surgery to treat styes, chalazia, and anterior segment lesions, but was ultimately amended to state that the practice of optometry does not include treatment through surgery, including laser surgery, other invasive modalities, or the use of injections, including venipuncture and intravenous injections.

**Advocacy:** AADA sent a letter opposing the original version of the bill, which would have allowed for optometric surgery.

**Status:** Enacted after negotiations with medical society, effective July 1, 2018

**West Virginia**

**Bill #:** HB 4413

**Overview:** The bill authorizes physician assistants to perform any specific function or duty delegated to those persons licensed as a doctor of allopathic or osteopathic medicine without the further requirement of a collaborating physician and practice agreement if the physician assistant has practiced at least three years under supervision under a duly-documented practice agreement relationship with a collaborating physician.

**Status:** Died without movement in the House Health and Human Resources and Judiciary Committees

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(apremilast)

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Please visit us at the Otezla Booth 1321!

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For patients with moderate to severe plaque psoriasis

**RESULTS**

**the way**

**THEY WANT THEM**

Otezla has a proven efficacy and safety profile, oral dosing, and no label-required lab monitoring—making it a treatment experience patients can respond to

---

**ESTEEM® Study Design**

- Evaluated in 2 multicenter, double-blind, placebo-controlled trials of similar design. Patients with moderate to severe plaque psoriasis (N = 1257) were randomized 2:1 to Otezla 30 mg twice daily or placebo for 16 weeks after a 5-day titration.
- Selected inclusion criteria: age ≥18 years, BSA ≥10%, sPGA ≥3, PASI ≥12, candidates for phototherapy or systemic therapy.

**INDICATIONS**

Otezla® (apremilast) is indicated for the treatment of patients with moderate to severe plaque psoriasis who are candidates for phototherapy or systemic therapy. Otezla is indicated for the treatment of adult patients with active psoriatic arthritis.

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**IMPORTANT SAFETY INFORMATION**

**Contraindications**

- Otezla® (apremilast) is contraindicated in patients with a known hypersensitivity to apremilast or to any of the excipients in the formulation.

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**Warnings and Precautions**

- Diarrhea, Nausea and Vomiting: Cases of severe diarrhea, nausea, and vomiting have been reported with the use of Otezla. Most events occurred within the first few weeks of treatment. In some cases patients were hospitalized. Patients 65 years of age or older and patients taking medications that can lead to volume depletion or hypotension may be at a higher risk of complications from severe diarrhea, nausea, or vomiting. Monitor patients who are more susceptible to complications of diarrhea or vomiting; advise patients to contact their healthcare provider. Consider Otezla dose reduction or suspension if patients develop severe diarrhea, nausea, or vomiting.
- Depression: Treatment with Otezla is associated with an increase in depression. During clinical trials 1.3% (12/920) of patients reported depression, compared to 0.4% (2/506) on placebo. Suicidal behavior was observed in 0.1% (1/1308) of patients on Otezla, compared to 0.2% (1/506) on placebo. Carefully weigh the risks and benefits of treatment with Otezla for patients with a history of depression and/or suicidal thoughts/behavior, or in patients who develop such symptoms while on Otezla.

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Otezla® (apremilast) significantly increased PASI-75 response (n = 562) at week 16 (primary endpoint) vs placebo (n = 282) (33% vs 5%; P < 0.0001) in ESTEEM 1,2
Otezla. Patients, caregivers, and families should be advised of the need to be alert for the emergence or worsening of depression, suicidal thoughts or other mood changes, and they should contact their healthcare provider if such changes occur.

- Weight Decrease: Body weight loss of 5-10% occurred in 12% (96/784) of patients treated with Otezla and in 5% (19/382) of patients taking placebo. Monitor body weight regularly; evaluate unexplained or clinically significant weight loss, and consider discontinuation of Otezla.

- Drug Interactions: Apremilast exposure was decreased when Otezla was co-administered with rifampin, a strong CYP450 enzyme inducer; loss of Otezla efficacy may occur. Concomitant use of Otezla with CYP450 enzyme inducers (e.g., rifampin, phenobarbital, carbamazepine, phenytoin) is not recommended.

**Adverse Reactions**

- Adverse reactions reported in ≥5% of patients were (Otezla%, placebo%): diarrhea (17, 6), nausea (17, 7), upper respiratory tract infection (9, 6), tension headache (8, 4), and headache (6, 4).

**Use in Specific Populations**

- Pregnancy and Nursing Mothers: Otezla is Pregnancy Category C; it has not been studied in pregnant women. Use during pregnancy only if the potential benefit justifies the potential risk to the fetus. It is not known whether apremilast or its metabolites are present in human milk. Caution should be exercised when Otezla is administered to a nursing woman.

- Renal Impairment: Otezla dosage should be reduced in patients with severe renal impairment (creatinine clearance less than 30 mL/min); for details, see Dosage and Administration, Section 2, in the Full Prescribing Information.

*Following a 5-day titration, the recommended maintenance dosage is 30 mg twice daily.

† To receive a free bridge supply of Otezla, patients must have an on-label diagnosis and be denied or waiting for coverage. Patients in Massachusetts are not eligible to receive bridge.

‡ Certain restrictions apply; eligibility not based on income, must be 18 years or older. This offer is not valid for persons eligible for reimbursement of this product, in whole or in part under Medicaid, Medicare, or similar state or federal programs. Offer not valid for cash-paying patients. People who are not eligible can call 1-844-4OTEZLA to discuss other financial assistance opportunities.

BSA, body surface area; ESTEEM, Efficacy and Safety Trial Evaluating the Effects of Apremilast in Psoriasis; PASI, Psoriasis Area and Severity Index; sPGA, static Physician Global Assessment.


Please turn the page for Brief Summary of Full Prescribing Information.

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INDICATIONS AND USAGE
OTEZLA® (apremilast) is indicated for the treatment of patients with moderate to severe plaque psoriasis who are candidates for phototherapy or systemic therapy.

CONTRAINDICATIONS
OTEZLA is contraindicated in patients with a known hypersensitivity to apremilast or to any of the excipients in the formulation [see Adverse Reactions (6.1)].

WARNINGS AND PRECAUTIONS
Diarrhea, Nausea, and Vomiting: There have been postmarketing reports of severe diarrhea, nausea, and vomiting associated with the use of OTEZLA. Most events occurred within the first few weeks of treatment. In some cases patients were hospitalized. Patients 65 years of age or older and patients taking medications that can lead to volume depletion or hypotension may be at a higher risk of complications from severe diarrhea, nausea, or vomiting. Monitor patients who are more susceptible to complications of diarrhea or vomiting. Patients who reduced dosage or discontinued OTEZLA generally improved quickly. Consider OTEZLA dose reduction or suspension if patients develop severe diarrhea, nausea, or vomiting.

Depression: Treatment with OTEZLA is associated with an increase in adverse reactions of depression. Before using OTEZLA in patients with a history of depression and/or suicidal thoughts or behavior prescribers should carefully weigh the risks and benefits of treatment with OTEZLA in such patients. Patients, their caregivers, and families should be advised of the need to be alert for the emergence or worsening of depression, suicidal thoughts or other mood changes, and if such changes occur contact their healthcare provider. Prescribers should carefully evaluate the risks and benefits of continuing treatment with OTEZLA if such events occur. During the 0 to 16 week placebo-controlled period of the 3 controlled clinical trials, 1.3% (12/920) of patients treated with OTEZLA reported depression compared to 0.4% (2/506) treated with placebo. During the clinical trials, 0.1% (1/1308) of patients treated with OTEZLA discontinued treatment due to depression compared to none in placebo-treated patients (0/506). Depression was reported as serious in 0.1% (1/1308) of patients exposed to OTEZLA, compared to none in placebo-treated patients (0/506). Instances of suicidal behavior have been observed in 0.1% (1/1308) of patients while receiving OTEZLA, compared to 0.2% (2/506) in placebo-treated patients. In the clinical trials, one patient treated with OTEZLA attempted suicide while one who received placebo committed suicide.

Weight Decrease: During the controlled period of the trials in psoriasis, weight decrease between 5%-10% of body weight occurred in 12% (96/784) of patients treated with OTEZLA compared to 5% (19/382) treated with placebo. Weight decrease of ≥10% of body weight occurred in 2% (16/784) of patients treated with OTEZLA 30 mg twice daily compared to 1% (3/382) patients treated with placebo. Patients treated with OTEZLA should have their weight monitored regularly. If unexplained or clinically significant weight loss occurs, weight loss should be evaluated, and discontinuation of OTEZLA should be considered.

Drug Interactions: Co-administration of strong cytochrome P450 enzyme inducer, rifampin, resulted in a reduction of systemic exposure of apremilast, which may result in a loss of efficacy of OTEZLA. Therefore, the use of cytochrome P450 inducers (e.g., rifampin, phenobarbital, carbamazepine, phenytoin) with OTEZLA is not recommended [see Drug Interactions (7.4) and Clinical Pharmacology (12.3)].

ADVERSE REACTIONS
Clinical Trials Experience in Psoriasis: Because clinical trials are conducted under widely varying conditions, adverse reaction rates observed in the clinical trial of a drug cannot be directly compared to rates in the clinical trials of another drug and may not reflect the rates observed in clinical practice. Diarrhea, nausea, and upper respiratory tract infection were the most commonly reported adverse reactions. The most common adverse reactions leading to discontinuation for patients taking OTEZLA were nausea (1.6%), diarrhea (1.0%), and headache (0.8%). The proportion of patients with psoriasis who discontinued treatment due to any adverse reaction was 6.1% for patients treated with OTEZLA 30 mg twice daily and 4.1% for placebo-treated patients.

<p>| Table 3: Adverse Reactions Reported in ≥1% of Patients on OTEZLA and With Greater Frequency Than in Patients on Placebo; up to Day 112 (Week 16) |
|---------------------------------|-----------------|-----------------|</p>
<table>
<thead>
<tr>
<th>Preferred Term</th>
<th>Placebo (N=506)</th>
<th>OTEZLA 30 mg BID (N=920)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diarrhea</td>
<td>32 (6)</td>
<td>160 (17)</td>
</tr>
<tr>
<td>Nausea</td>
<td>35 (7)</td>
<td>155 (17)</td>
</tr>
<tr>
<td>Upper respiratory tract infection</td>
<td>31 (6)</td>
<td>84 (9)</td>
</tr>
<tr>
<td>Tension headache</td>
<td>21 (4)</td>
<td>75 (8)</td>
</tr>
<tr>
<td>Headache</td>
<td>19 (4)</td>
<td>55 (6)</td>
</tr>
<tr>
<td>Abdominal pain*</td>
<td>11 (2)</td>
<td>39 (4)</td>
</tr>
<tr>
<td>Vomiting</td>
<td>8 (2)</td>
<td>35 (4)</td>
</tr>
<tr>
<td>Fatigue</td>
<td>9 (2)</td>
<td>29 (3)</td>
</tr>
<tr>
<td>Decrease appetite</td>
<td>5 (1)</td>
<td>26 (3)</td>
</tr>
<tr>
<td>Insomnia</td>
<td>4 (1)</td>
<td>21 (2)</td>
</tr>
<tr>
<td>Back pain</td>
<td>4 (1)</td>
<td>20 (2)</td>
</tr>
<tr>
<td>Migraine</td>
<td>5 (1)</td>
<td>19 (2)</td>
</tr>
<tr>
<td>Frequent bowel movements</td>
<td>1 (0)</td>
<td>17 (2)</td>
</tr>
<tr>
<td>Depression</td>
<td>2 (0)</td>
<td>12 (1)</td>
</tr>
<tr>
<td>Bronchitis</td>
<td>2 (0)</td>
<td>12 (1)</td>
</tr>
<tr>
<td>Tooth abscess</td>
<td>0 (0)</td>
<td>10 (1)</td>
</tr>
<tr>
<td>Folliculitis</td>
<td>0 (0)</td>
<td>9 (1)</td>
</tr>
<tr>
<td>Sinus headache</td>
<td>0 (0)</td>
<td>9 (1)</td>
</tr>
</tbody>
</table>

Two subjects treated with OTEZLA experienced serious adverse reaction of abdominal pain.

Severe worsening of psoriasis (rebound) occurred in 0.3% (4/1184) patients following discontinuation of treatment with OTEZLA (apremilast).

DRUG INTERACTIONS
Strong CYP 450 Inducers: Apremilast exposure is decreased when OTEZLA is co-administered with strong CYP450 inducers (such as rifampin) and may result in loss of efficacy [see Warnings and Precautions (5.3) and Clinical Pharmacology (12.3)].

USE IN SPECIFIC POPULATIONS
Pregnancy: Pregnancy Category C: OTEZLA should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus. Pregnancy Exposure Registry: There is a pregnancy exposure registry that monitors pregnancy outcomes in women exposed to OTEZLA during pregnancy. Information about the registry can be obtained by calling 1-877-311-8972.

Nursing Mothers: It is not known whether OTEZLA or its metabolites are present in human milk. Because many drugs are present in human milk, caution should be exercised when OTEZLA is administered to a nursing woman. Pediatric use: The safety and effectiveness of OTEZLA in pediatric patients less than 18 years of age have not been established.

Geriatric use: Of the 1257 patients who enrolled in two placebo-controlled psoriasis trials (PSOR 1 and PSOR 2), a total of 108 psoriasis patients were 65 years of age and older, including 9 patients who were 75 years of age and older. No overall differences were observed in the efficacy and safety in elderly patients ≥65 years of age and younger adult patients <65 years of age in the clinical trials.

Renal Impairment: Apremilast pharmacokinetics were characterized in subjects with mild, moderate, and severe renal impairment as defined by a creatinine clearance of 60-89, 30-59, and less than 30 mL per minute, respectively, by the Cockcroft–Gault equation. While no dose adjustment is needed in patients with mild or moderate renal impairment, the dose of OTEZLA should be reduced to 30 mg once daily in patients with severe renal impairment [see Dosage and Administration (2.2) and Clinical Pharmacology (12.3)].

Hepatic Impairment: Apremilast pharmacokinetics were characterized in patients with moderate (Child Pugh B) and severe (Child Pugh C) hepatic impairment. No dose adjustment is necessary in these patients.

OVERDOSAGE
In case of overdose, patients should seek immediate medical help. Patients should be managed by symptomatic and supportive care should there be an overdose.

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Should systemic steroids be avoided in atopic dermatitis?

BY KATHRYN SCHWARZENBERGER, MD

In this month’s Acta Eruditorum column, Physician Editor Kathryn Schwarzenberger, MD, talks with Jonathan I. Silverberg, MD, PhD, MPH, about his recent Journal of the American Academy of Dermatology article, “A systematic review of the safety and efficacy of systemic corticosteroids in atopic dermatitis.”

Dr. Schwarzenberger: In your recent JAAD article, you and your colleagues reviewed the safety and efficacy of systemic corticosteroids in atopic dermatitis. What led you to look at this?

Dr. Silverberg: I have unfortunately had many patients with atopic dermatitis who experienced terrible adverse events from use of systemic corticosteroids. Yet, in my anecdotal experience, systemic corticosteroids are still widely used for the treatment of atopic dermatitis. I sought to examine the extant literature on the safety and efficacy of systemic corticosteroids to provide an evidence-based review of their role in the management of atopic dermatitis.

Dr. Schwarzenberger: What were the most worrisome safety concerns that you identified in your study? Were you surprised by any of these?

Dr. Silverberg: Perhaps the most concerning were opportunistic infection, malignancy, thrombosis, diabetes, and hypertension. However, there were many other adverse events identified. Most of these were not surprising. However, a recent large-scale study identified in the systematic review showed that even short courses of systemic steroids increased the risk of sepsis, fractures, and venous thromboembolism. Short courses of systemic steroids are often regarded by providers as being benign and without adverse event. This study challenges some of those assumptions by demonstrating safety concerns even with short-term use of systemic corticosteroids.

Dr. Schwarzenberger: I think most dermatologists worry about rebound flares after stopping systemic corticosteroids. Did you find evidence to support this concern?

Dr. Silverberg: Yes. Rebound flares after discontinuation of systemic corticosteroids were noted in 24 articles.

Dr. Schwarzenberger: Adrenal suppression from steroids — did your study help us better understand when we need to worry about this? Are there best practices to follow?

Dr. Silverberg: A prior meta-analysis of systemic corticosteroid use for various medical disorders that was included in our systematic review showed a significantly increased risk of adrenal insufficiency with more than one month of use, as well as with medium- and high-dose corticosteroids. Only half of patients had resolution upon retesting one month later. Some studies found that even shorter courses of systemic steroids resulted in adrenal insufficiency, but it was only transient. It appears that patients being treated with less...
than one month of systemic steroids do not warrant routine screening for adrenal insufficiency.

**Q** Dr. Schwarzenberger: Glancing at your extensive bibliography, it looks like studies from Europe may have outnumbered those from the U.S. Did you get a sense from your study of who is actually using systemic corticosteroids to treat atopic dermatitis?

**Dr. Silverberg:** We did not specifically examine patterns or regional differences of systemic steroid use. However, several recent studies found that systemic steroids are commonly used to treat atopic dermatitis both in the United States and internationally.

**Q** Dr. Schwarzenberger: Do you have any other words of wisdom that you learned from this review? Will it change your practice?

**Dr. Silverberg:** It is important for clinicians to recognize that if systemic steroids are used, they should be limited to short courses as a bridge to steroid-sparing therapies. It is also important to recognize that even a short course of systemic steroids can be associated with considerable adverse events. 

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The “Sunshine Act” as it has come to be known (stemming from Sen. Charles Grassley’s position that sunshine is the best disinfectant) is one of the more recent additions to the constellation of rules intended to ensure that the patient-physician relationship is untarnished. This article examines the background of the Sunshine Act, addresses how it is applied and its general requirements, addresses how data is actually reported and physicians’ ability to dispute inaccurate information, and examines the Act’s impact on dermatologists.

Background and what gets reported
Although it was originally proposed in 2007, the Physician Payment Sunshine Act of 2009 was passed as part of the Patient Protection and Affordable Care Act of 2009, with regulations published in 2013. The Act and its regulations generally require device and pharmaceutical manufacturers and group purchasing organizations (GPOs) to report to the Centers for Medicare and Medicaid Services (CMS) on: (1) direct and indirect payments or other transfers of value that are provided by the manufacturer or GPO to “covered recipients” or to third parties on behalf of such covered recipients during the previous calendar year, and (2) ownership and investment interests in the manufacturer or GPO held by “physicians” (as defined under Medicare, meaning any MD or DO, dentists and dental surgeons, podiatrists, optometrists, and chiropractors) or their immediate family members during the prior calendar year.

“Covered recipients” include physicians (except those employed by the manufacturer reporting the payments) and teaching hospitals. The type of data that must be reported include: the recipient’s name and primary business address; for physicians, the physician’s specialty, National Provider Identifier number, state professional license number and the state where the physician is licensed; the amount and date of each payment; the form and nature of the payment; the name of the related drug, device, or biological or medical supply, as well as its therapeutic area or product category; payments to third parties; and, payments to physician owners or investors, or their immediate family members. The information reported is posted on a website maintained by CMS, openpaymentsdata.cms.gov.

The reportable form of payment (or transfer of value) is categorized as: cash or cash equivalents; in-kind items or services; stock; stock options; other ownership interests; dividends, profits, or returns on investment. Reporting entities must also report the nature of the payment or transfer or value, which is categorized as: consulting fees; compensation for other services (e.g. serving as faculty or a speaker at an event other than a continuing education program); honoraria; gifts; entertainment; food and beverage; travel and lodging; education; research; charitable contributions; royalties or licenses; current or prospective ownership or investment interests; compensation for serving as a faculty or as a speaker for accredited or certified continuing education programs (as well as a separate category for unaccredited and non-certified programs); and grants.

A manufacturer or GPO’s failure to report can result in penalties of a minimum of $1,000 and a maximum of $10,000 per payment or other transfer of value or ownership or investment interest not reported timely, accurately, or completely, with total annual penalties capped at $150,000. Knowing failures, on the other hand, are penalized much more severely, with a minimum penalty of $10,000, a maximum of $100,000, and an annual cap of $1 million.
How data appear online and disputes over data

The good news for physicians is that there are no reporting requirements for them — and thus no associated penalties for failing to report — only manufacturers and GPOs must report. The other news is that information about the money they receive from industry is now a matter of public record. The “Open Payments” website allows users to search by the physician’s name alone, or by name, city, state, street address, and/or specialty. Actual data for a given physician includes name, street address, and specialty (e.g., “Allopathic or Osteopathic Physicians/Dermatology”).

The data also include information on payments broken down by reporting year. The payment information includes the total dollar amount of payments made during the year, the total number of transactions during the year, and includes the following sub-categories: research payments, ownership and investment interests, associated research, and disputed payments. The site also indicates whether the total dollar amount and total number of transactions were above or below the national mean and national median, as well as the specialty mean and specialty median. Users can also examine the specific payments to see the reporting entities that made the payments, the total amount per entity, the total number of payments per entity, the type of payment (e.g., food and beverage, education, etc.), and the date of the specific payments.

For example, for the 2016 program year (reported in 2017), a dermatologist may have a report indicating that he received total payments of $4,545.00, with a total number of 43 payments, which comparatively states he also received $1,271.29 and 25 payments above the national mean, but below the specialty mean by $322.44 and above the specialty mean by nine payments. The user could also see how the totals compare to national and specialty medians. A user could dig deeper into the data to determine what kind of payments were made, and might see that the physician was paid these amounts solely for food and beverage, with most payments being small amounts paid by a wide range of pharmaceutical companies. By contrast, an oncologist might have much higher payments in a given year, falling above the national mean, but still well below the specialty mean, and the user might see that most of the money paid was for consulting fees, with a smattering of food and beverage payments, and travel and lodging payments, with almost all of the payments coming from a single pharmaceutical company.

Physicians are permitted to dispute payment information, but must do so in the calendar year in which the information is reported. Data is reported and published each year on June 30, and a second time as a “refresh publication” approximately six months later with updated data. Physicians are given 45 days to review and dispute records prior to initial publication, and an additional 15 days is provided for reporting entities to correct data. If a dispute is not resolved during the review and correction period, it will be published as a disputed payment at the time of initial publication. If a dispute is resolved between the June 30 publication date and the date of the refresh publication, it will be corrected in the database. Disputes that are resolved after the end of the calendar year may be published as corrected in the initial publication the following year. Disputes unresolved during the calendar year will remain as disputes in the subsequent calendar year’s initial publication, unless they are resolved prior to initial publication.

Although CMS provides a website through which physicians and reporting entities may initi-
ate and track disputes, CMS does not mediate disputes; disputes are handled outside of the Open Payments system. (For more information on how to initiate and navigate disputes, see CMS’ website, www.cms.gov/OpenPayments/Program-Participants/Physicians-and-Teaching-Hospitals/Review-and-Dispute.html.) Disputes may be resolved with changes, or without changes. For example, a physician might dispute two separate payments, with one being revised because it was incorrect, and the other payment remaining unchanged because the parties came to an agreement that the report was correct.

**Impact on physicians**
The actual impact of the Sunshine Act on physicians is debatable. While it is clear that educational payments by reporting entities for continuing medical education have plummeted, it is worth remembering that the Sunshine Act was passed in the midst of the financial crisis, at a time when companies may have already been inclined to tighten their belts; and physicians began to turn toward more “on demand” educational resources, such as CME webinars. However, the halcyon days of Big Pharma-sponsored Caribbean CME conferences are certainly long gone.

Beyond these impacts, however, it remains unclear just how much disinfecting the Sunshine Act has actually accomplished, or whether there was much to disinfect in the first place. The Sunshine Act does not penalize the underlying relationships between physicians and industry (although other laws such as Stark and the anti-kickback statute might impact payments received from industry), and only penalizes failure to report — with those penalties applying only to reporting entities. Moreover, the nature of the Open Payments website shifts responsibility to patients to review their physicians’ information, determine just how troubled they are by what they see, and whether to raise the matter with their physicians. Even an initial moment of “sticker shock” at discovering that your physician has received some $200,000 from industry might not result in much concern if, after examining the nature of the payments, it becomes clear that the physician has a license agreement with a manufacturer — suggesting that the physician may have licensed to the company a device he or she designed, and received payment for it. In other instances, all that patients may discover is a litany of $15-35 payments for food and beverages, which may not elicit much more than a yawn.

Within the dermatology specialty, a 2016 article published in *JAMA Dermatology* reported that in 2014, 8,333 dermatologists received 208,613 payments, for a total of $34 million (152(12):1307-1313). Of those receiving payments, 78% received less than $1,000, 63% received less than $500, and 25% received less than $100, with most individual payments being worth less than $50. Most payments received were made by pharmaceutical companies. The $34 million figure amounted to less than 1% of the $6.49 billion in industry payments to physicians during the same year. Payments took the form of speaking fees, consulting fees, research activities, food and beverage services, and royalty and licensing fees. Food and beverage services made up the greatest number of individual payments, while research, consulting, and royalty and licensing fees were the highest dollar payouts. Based on this information, it appears that dermatologists are relatively “small potatoes” in terms of specialties with strong ties to industry and that receive large payments. Thus, patients may not be particularly troubled by what they see on the Open Payments website about their dermatologist.

**Conclusion**
Ultimately, the Sunshine Act simply provides additional data by which a patient may evaluate whether their doctor is trustworthy. For that to happen, however, a patient has to be aware of the existence of the Open Payments website in the first place, then be curious enough to examine the information, understand the information presented, determine that the information they find warrants concern, and then speak to the physician about it. If you have never received a question from a patient about your ties to industry, then the Sunshine Act may be much ado about nothing. Dermatologists should monitor the data submitted about them for accuracy, and dispute incorrect data when they find it; but at the end of the day the Sunshine Act may be less important to your relationships with patients than a good bedside manner, courteous and helpful staff, and the patient’s own sense that you have their interests as your primary duty. *dw*
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Trialing it out
The nuts and bolts of adding a research component to your practice

BY VICTORIA HOUGHTON, ASSISTANT MANAGING EDITOR

Dermatology World talks with Craig Leonardi, MD, from Central Dermatology in St. Louis, about how to make a research practice successful.

Q DERMATOLOGY WORLD: Tell me about the research arm of your practice?
Dr. Leonardi: Central Dermatology is a private practice that’s about 20 years old. We’ve been doing clinical research here since the first day we opened the doors. Clinical research has always been a big component of my private practice here at Central Dermatology, but I’ve been doing clinical research for more than 30 years. Before I was in private practice, I did research at St. Louis University in Missouri and before that the University of Miami in Florida.

Q How many patients typically participate in your trials?
Dr. Leonardi: Usually we have 100 to 150 patients enrolled in a dozen active research trials. At any one time, we are actively enrolling three or four studies with these trials being the most intensive in terms of scheduling, procedures, and contact with the research staff. After this period, the number of visits decreases with time to a point where we might only see the subjects every three months.

Q What conditions are you primarily focused on with these trials?
Dr. Leonardi: The research I like doing is related to psoriasis. Also, there are similar drug development efforts now in atopic dermatitis. We’re hoping that the atopic dermatitis story will mirror what’s happened in psoriasis because both groups of patients have unmet medical needs.

Q Why did you decide to integrate clinical trials in your practice?
Dr. Leonardi: I created an integrated environment because it was a natural flow for many patients. For example, what happens at the end of the study? Do you dump these patients into the street and tell them you’ll call them later on? I’ve never felt comfortable with that model and try to find a soft landing for these patients. Remember, these are human beings and not lab rats on a wheel. You want to treat them with dignity and respect.

Q What methods do you utilize to recruit patients for these trials?
Dr. Leonardi: We find a lot of our study subjects by word of mouth. In addition, my colleagues in St. Louis have really supported us well over the years by sending their patients. We will also advertise on the radio and cable TV.

Q Your trials are sponsored by pharmaceutical companies. How do you go about finding and participating in these trials?
Dr. Leonardi: After all these years, the pharmaceutical companies know us well and decide that they want to include us. Apparently I have a reputation for performing high-quality clinical research. However, to get to that point, it took a lot of work. If you’re starting out, you need to contact the medical directors within the company and let them know that you’re interested in working with them and that you are committed to performing good-quality clinical research. The medical directors are usually receptive to that approach and
you're going to get put on a list. When they have a new project, they will work their way down that list. Eventually you'll get the call.

**Q.** Before signing a contract with one of these companies, what do you typically do to make sure that the contract lines up with your priorities and objectives?

**Dr. Leonardi:** I have a small team that reviews the contract and the budget. My lawyer deals with the legal document with an eye to protecting my interests. A second person negotiates the budget and prepares the regulatory documents. While both of these tasks are time consuming, it is more efficient to outsource these activities.

When evaluating a budget, we refer to the schedule of activities provided by the pharmaceutical company. From that schedule, we generate a budget and compare it to the one offered by the sponsor. It's important to look at that budget and make sure that the compensation makes sense for your cost structure.

**Q.** What are some red flags that the physician and/or their lawyer should look for in a contract?

**Dr. Leonardi:** On the legal side, the big issues involve intellectual property rights and reverse indemnification. In terms of intellectual property, sometimes the contract claims that the sponsor literally owns every thought in my head. Sorry but the reason I am usually included is because I am experienced in clinical research, trained as a dermatologist, and the sponsor wants to have my input on issues related to the study. You can't own my thoughts.

In terms of reverse indemnification, we don't accept any clauses which cause me to indemnify the sponsor. When you think about the relationship, it is very one sided. For example, the sponsor knows everything about the new drug. They choose to share some of that information with the investigators, who perform the work on a fee-for-service basis. If the project succeeds, the sponsor gets all of the reward and shares none. Under these circumstances, it really doesn't make much sense for us to indemnify the sponsor for issues related to the drug.

Now we're always willing to be responsible for issues that happen between us and the patient. Our malpractice insurance covers that possibility. However, that situation is very different from one where a patient is harmed by the sponsor's drug.

As you can tell, some of this can be contentious. Occasionally a sponsor will refuse to remove indemnification clauses. We thank them for their time and walk away.

**Q.** On average, how much time are you spending on the clinical research side of things?

**Dr. Leonardi:** It varies depending on the number, type, and stage of the studies that are active. On average I spend somewhere between 30 and 50% of my time on research activities.

**Q.** What do these trials entail with regard to physician time, staff time, capital, and resources?

**Dr. Leonardi:** You have to be staffed up. I have a registered nurse who is in charge of the research unit. She is also the IV infusion nurse for studies...
requiring that mode of drug delivery. I also have two medical assistants who see study subjects throughout the day.

You also need enough space to do this work properly. I have 5,000 square feet with ample room for my research team. You must also accommodate a small army of monitors that visit the site periodically. Even simple things like storage of research charts (large binders) consume a lot of space. You need to have a -20-degree freezer and a refrigerator (and sometimes more than one refrigerator). Once we had a dozen EKG machines on site, each for a different study. We called that room the EKG farm! If there are photographs in the trial, we need a room suitable for taking photos with a large blue background. Because you don’t want to tie up an exam room with phlebotomies, we have a separate room just for that activity. In summary, we try to make efficient use of our space.

Q  What do you need to do to ensure that you are abiding by regulatory requirements for clinical trials?
Dr. Leonardi: You should have a set of Standard Operating Procedures and you should also be aware of Good Clinical Practice Guidelines for performing human research [https://grants.nih.gov/policy/clinical-trials/good-clinical-training.htm]. Also, whenever the sponsor sends out auditors to review the charts, you need to carefully pay attention to their findings.

Q  Is there anything you need to do with your malpractice insurance when adding a research arm to your practice?
Dr. Leonardi: In my case, the only thing my medical malpractice carrier was interested in was whether I was performing any cosmetic procedures in my practice. They did not seem to be fazed about my research activities. However, don’t stick your head in the sand. Call up your malpractice provider and tell them you’re doing clinical research. Let them know exactly what it is so they can adjust your underwriting if need be. It’s a simple phone call and you will sleep better for having made it.

Q  What are the benefits of adding a research component to your practice?
Dr. Leonardi: It’s a stimulating and educational environment. You are contributing to our specialty and to the patients, of course. You get a new understanding of pharmacology and the mechanism of disease. Additionally, some patients have unmet medical needs that are poorly served by the current treatment options. So an experimental approach might be good for them. There are also financial rewards. A well-run research site should be profitable.

Q  What are any disadvantages of adding a research component to your practice?
Dr. Leonardi: Over the years, I’ve performed more than 200 research programs under my supervision. Every now and then one slips through our legal and contracting process that is a poor fit. Unfortunately you are still obligated to perform the work. For example, in one study my patients received placebo for the entire study. It was a little frustrating for the subjects and for us.

Q  What advice would you offer a physician looking to add this model to their practice?
Dr. Leonardi: One of the best things to do is find someone who is performing clinical research in their practice. Give them a call and let them know that you’re thinking about adding a research unit to your practice. Dermatology is a friendly and helpful specialty. It should be possible to visit one of the large research centers for a day or two. Then you can make a decision about whether to invest more developing this capability. dw
IMPOYZ™ (clobetasol propionate) Cream 0.025% is indicated for the treatment of moderate to severe plaque psoriasis in patients 18 years of age and older.

**IMPORTANT SAFETY INFORMATION**

**Warnings and Precautions**
Topical corticosteroids, including IMPOYZ Cream can cause reversible hypothalamic-pituitary-adrenal (HPA) axis suppression with the potential for glucocorticosteroid insufficiency. This may occur during treatment or after withdrawal of treatment. This may require that patients be evaluated periodically for evidence of HPA axis suppression. Factors that predispose to HPA axis suppression include, use of high-potency steroids, large treatment surface areas, prolonged use, use of occlusive dressings, altered skin barrier, liver failure, and young age. If HPA axis suppression occurs, gradually withdraw the drug, reduce frequency of application, or substitute with a less potent corticosteroid. If signs and symptoms of withdrawal occur, systemic corticosteroids may be required. Recovery of HPA axis function is generally prompt and complete upon discontinuation of topical corticosteroids. Although rare, systemic effects of topical corticosteroids may manifest as Cushing’s syndrome, hyperglycemia, and glucosuria. Pediatric patients may be more susceptible to systemic toxicity because of their larger skin surface to body mass ratios.

**Local Adverse Reactions with Topical Corticosteroids** - Local adverse reactions from topical corticosteroids may be more likely to occur with occlusion, prolonged use, or use of higher potency corticosteroids. Some local adverse reactions may be irreversible.

**Concomitant Skin Infections** - Use an appropriate antimicrobial agent if a skin infection is present or develops. If appropriate, discontinue use of IMPOYZ Cream.

**Allergic Contact Dermatitis** - Allergic contact dermatitis with corticosteroids is usually diagnosed by observing failure to heal rather than noting a clinical exacerbation.

**Adverse Events** - The adverse reaction that occurred in at least 1% of subjects treated with IMPOYZ Cream and at a higher incidence than in subjects treated with vehicle cream was application site discoloration (2% versus 1%). Less common local adverse events occurring in < 1% of subjects treated with IMPOYZ Cream were application site atrophy, telangiectasia and rash.

Please see Brief Summary of Prescribing Information on the following page.
IMPOYZ (clobetasol propionate) Cream, 0.025%, for topical use

INDICATIONS AND USAGE
IMPOYZ Cream 0.025% is indicated for the treatment of moderate to severe plaque psoriasis in patients 18 years of age and older.

DOSEAGE AND ADMINISTRATION
Apply a thin layer of IMPOYZ Cream to the affected skin areas twice daily and rub in gently and completely. Use IMPOYZ Cream for up to 2 consecutive weeks of treatment. Treatment beyond 2 consecutive weeks is not recommended, and the total dosage should not exceed 50 g per week because of the potential for the drug to suppress the hypothalamic-pituitary-adrenal (HPA) axis [see Warnings and Precautions (5.1)]. Discontinue IMPOYZ Cream when control is achieved. Do not use if atrophy is present at the treatment site. Do not bandage, cover, or wrap the treated skin area unless directed by a physician. Avoid use on the face, scalp, axilla, groin, or other intertriginous areas. IMPOYZ Cream is for topical use only. It is not for oral, ophthalmic, or intravaginal use. Wash hands after each application.

DOSE FORMS AND STRENGTHS
Cream, 0.025%: each gram contains 0.25 mg of clobetasol propionate in a white to off-white cream base.

CONTRAINDICATIONS
None

WARNINGS AND PRECAUTIONS
Effects on the Endocrine System: IMPOYZ Cream can cause reversible hypothalamic-pituitary-adrenal (HPA) axis suppression with the potential for glucocorticoid insufficiency. This may occur during treatment or after withdrawal of treatment. Because of the potential for systemic absorption, use of topical corticosteroids, including IMPOYZ Cream, may require that patients be evaluated periodically for evidence of HPA axis suppression. Factors that predispose a patient to HPA axis suppression include the use of high-potency steroids, large treatment surface areas, prolonged use, use of occlusive dressings, altered skin barrier, liver failure, and young age. Evaluation of ACTH stimulation test may be used in the diagnosis of HPA axis suppression. In a trial evaluating the effects of IMPOYZ Cream on the HPA axis, subjects with plaque psoriasis applied IMPOYZ Cream twice daily to at least 20% of involved Body Surface Area (BSA) for 15 days. Abnormal ACTH stimulation test suggestive of HPA axis suppression were seen in 3 of 24 (12.5%) subjects on IMPOYZ Cream [see Clinical Pharmacology (12.2)]. In another trial to evaluate the effects of IMPOYZ Cream on the HPA axis, subjects with moderate to severe plaque psoriasis applied IMPOYZ Cream twice daily to at least 25% of involved BSA for 28 consecutive days. Abnormal ACTH stimulation test suggestive of HPA axis suppression was seen in 8 of 26 (30.8%) of subjects on IMPOYZ Cream. If HPA axis suppression is documented, gradually withdraw the drug, reduce the frequency of administration, or substitute with a less potent corticosteroid. If signs and symptoms of steroid withdrawal occur, supplemental systemic corticosteroids may be required. Recovery of HPA axis function is generally prompt and complete upon discontinuation of topical corticosteroids. Systemic effects of topical corticosteroids may also manifest as Cushing’s syndrome, hyperglycemia, and glucosuria. These complications are rare and generally occur after prolonged exposure to larger than recommended doses, particularly with high-potency topical corticosteroids. Use of more than one corticosteroid-containing product at the same time may increase the total systemic exposure to topical corticosteroids. Minimize the unwanted risks from endocrine effects by mitigating risk factors favoring increased systemic bioavailability and by using the product as recommended [see Dosage and Administration (2)]. Pediatric patients may be more susceptible to systemic toxicity because of their larger skin surface to body mass ratios [see Use in Specific Populations (8.4)].

Local Adverse Reactions with Topical Corticosteroids
Local adverse reactions from topical corticosteroids may include atrophy, striae, telangiectasias, burning, itching, irritation, dryness, folliculitis, acneiform eruptions, hypopigmentation, perioral dermatitis, allergic contact dermatitis, secondary infection, and microbiota. These may be more likely to occur with occlusive use, prolonged use, or use of higher potency corticosteroids, including IMPOYZ Cream. Some local adverse reactions may be irreversible. Concomitant Skin Infections: Use an appropriate antimicrobial agent if a skin infection is present or develops. If a favorable response does not occur promptly, discontinue use of IMPOYZ Cream until the infection has been adequately treated. Allergic Contact Dermatitis: Allergic contact dermatitis with corticosteroids is usually observed by observing failure to heal rather than noting a clinical exacerbation. Such an observation should be corroborated with a specific diagnostic patch testing. If irritation develops, discontinue the topical corticosteroid and institute appropriate therapy.

ADVERSE REACTIONS
Clinical Trials Experience
Because clinical trials are conducted under widely varying conditions, adverse reaction rates observed in the clinical trials of a drug cannot be directly compared to rates in the clinical trials of another drug, and may not reflect the rates observed in practice. IMPOYZ Cream was evaluated in two randomized, multicenter, prospective, vehicle-controlled clinical trials in subjects with moderate to severe plaque psoriasis. Subjects applied IMPOYZ Cream or vehicle cream twice daily for 14 days. A total of 354 subjects applied IMPOYZ Cream and 178 subjects applied vehicle. The adverse reaction that occurred in at least 1% of subjects treated with IMPOYZ Cream and at a higher incidence than in subjects treated with vehicle cream was application site discoloration (2% versus 1%). Less common local adverse events occurring in <1% of subjects treated with IMPOYZ Cream were application site dryness, itching, and irritation.

Postmarketing Experience
The following adverse reactions have been identified during post-approval use of clobetasol propionate: striae, irritation, dryness, acneiform eruptions, hypopigmentation, perioral dermatitis, allergic contact dermatitis, secondary infection, hypertrichosis, and miliaria. Because these reactions are reported voluntarily from a population of uncertain size, it is not always possible to reliably estimate their frequency or establish a causal relationship to drug exposure.

USE IN SPECIFIC POPULATIONS
Pregnancy: Risk Summary
There are no available data on IMPOYZ Cream in pregnant women to inform a drug-associated risk for adverse developmental outcomes. Published data report a significantly increased risk of low birthweight with the use of greater than 300 grams of potent or very potent topical corticosteroid during pregnancy. Advise pregnant women of the potential risk to a fetus and to use IMPOYZ Cream on the smallest area of skin and for the shortest duration possible (see Data). In animal reproduction studies, increased malformations, such as cleft palate and skeletal abnormalities, were observed after subcutaneous administration of clobetasol propionate to pregnant mice and rabbits. No comparisons of animal exposure with human exposure are provided due to minimal systemic exposure noted after topical administration of IMPOYZ Cream [see Clinical Pharmacology (12.3)]. The estimated background risk of major birth defects and miscarriage for the indicated population is unknown. All pregnancies have a background risk of birth defect, loss, or other adverse outcomes. In the U.S. general population, the estimated background risk of major birth defects and miscarriage in clinically recognized pregnancies is 2% to 4% and 15% to 20%, respectively.

Data
Human Data
Multiple observational studies found no significant associations between maternal use of topical corticosteroids of any potency and congenital malformations, preterm delivery, or fetal mortality. However, when the dispensed amount of potent or very potent topical corticosteroids exceeded 300 g during the entire pregnancy, use was associated with an increase in low birth weight infants [adjusted RR, 7.74 (95% CI, 1.49–40.11)]. In addition, a small cohort study, in which 28 Sub-Saharan women using potent topical corticosteroids (27/28 used clobetasol propionate 0.05%) for skin lightening during pregnancy, noted a higher incidence of low birth weight infants in the exposed group. The majority of exposed subjects treated large areas of the body (a mean quantity of 60 g/month (range, 12–1700) over long periods of time.

Animal Data
In an embryo-fetal development study in mice, subcutaneous administration of clobetasol propionate resulted in fetotoxicity at the highest dose tested (1 mg/kg) and malformations at the lowest dose tested (0.03 mg/kg). Malformations seen included cleft palate and skeletal abnormalities. In an embryofetal development study in rabbits, subcutaneous administration of clobetasol propionate resulted in malformations at doses of 0.003 and 0.01 mg/kg. Malformations seen included cleft palate, cranioschisis, and other skeletal abnormalities.

Lactation: Risk Summary
There is no information regarding the presence of clobetasol propionate in breast milk or its effects on the breastfed infant or on milk production. Systemically administered corticosteroids appear in human milk and could suppress growth, interfere with endogenous corticosteroid production, or cause other untoward effects. It is not known whether topical administration of clobetasol propionate could result in sufficient systemic absorption to produce detectable quantities in human milk. The developmental and health benefits of breastfeeding should be considered along with the mother’s clinical need for IMPOYZ Cream and any potential adverse effects on the nursing infant.

Pediatric Use: The safety and effectiveness of IMPOYZ Cream in patients younger than 18 years of age have not been established: therefore, use in children younger than 18 years is not recommended. Because of a higher ratio of skin surface area to body mass, pediatric patients are at a greater risk than adults of systemic toxicity, including HPA axis suppression, when treated with topical drugs [see Warnings and Precautions (5.1)]. Rare systemic toxicities such as Cushing’s syndrome, linear growth retardation, delayed weight gain, and intracranial hypertension have been reported in pediatric patients, especially those with prolonged exposure to large doses of high potency topical corticosteroids. Local adverse reactions including striae and skin atrophy are also commonly observed with topical corticosteroids in pediatric patients. Avoid use of IMPOYZ Cream in the treatment of diaper dermatitis.

Geriatric Use: Clinical studies of IMPOYZ Cream did not include sufficient numbers of subjects aged 65 or older and over to determine whether they respond differently from younger subjects. Other reported clinical experience with topical corticosteroids has not identified differences in responses between the elderly and younger patients.

NONCLINICAL TOXICOLOGY
Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term animal studies have not been performed to evaluate the carcinogenic potential of clobetasol propionate cream. A 13-week repeat dose toxicity study in rats, topical administration of clobetasol propionate cream, 0.001, 0.005 and 0.025 % at corresponding doses of 0.004, 0.02 and 0.1 mg/kg/day resulted in corticosteroid class-related systemic effects such as reductions in body weight gain, reductions in total leukocytes and individual white cells, decrease in weight of adrenals, thymus, spleen, liver and lung. Histologically, there were decreased hematopoiesis in the bone marrow, thymic atrophy and mast cell infiltration of the mesenteric lymph nodes. All these effects were indicative of severe immune suppression consistent with long-term exposure to corticosteroids. A no observable adverse effect level (NOAEL) was determined to be clobetasol propionate cream, 0.001% (0.004 mg/kg/day) in male rats while a NOAEL could not be determined in females. The clinical relevance of the findings in animals to humans is not clear, but sustained glucocorticoid-related immune suppression may increase the risk of infection and possibly the risk of carcinogenesis. Clobetasol propionate was not mutagenic in three different test systems: the Ames test, the Saccharomyces cerevisiae gene conversion assay, and the E. coli B WP2 fluctuation test. Fertility studies conducted in the rat following subcutaneous administration of clobetasol propionate at dosage levels up to 0.05 mg/kg/day revealed that females exhibited an increase in the number of resorbed embryos and a decrease in the number of living fetuses at the highest dose.

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Strategies for caring for elderly patients
According to the U.S. Census, there were 47.8 million people over the age of 65 in the United States in 2015, and it’s expected that this figure will grow to 98.2 million by 2060. Many dermatologists are familiar with this Baby Boomer generation, as the 2017 Burden of Skin Disease Report indicates that 50% of Americans over the age of 65 have skin disease with an average of 2.2 skin diseases per person (J Am Acad Dermatol. 2017; May 76(5):958-72).

However, while dermatologists are uniquely qualified and well-versed in treating skin conditions and diseases among this particular patient population, Justin Endo, MD, MHPE, assistant professor at the University of Wisconsin’s dermatology department, contends that caring for elderly patients spans beyond dermatologists’ robust clinical acumen. “As dermatologists we play a big role in terms of improving the quality of life for this entire patient population and recognizing issues that other physicians might not think of.”

Dermatology World talks with experts about the following issues that dermatologists may encounter when caring for elderly patients:

- Treatment adherence
- Elder abuse and neglect
- Legal and ethical considerations

BY VICTORIA HOUGHTON, ASSISTANT MANAGING EDITOR
TREATMENT ADHERENCE

According to some estimates, up to 50% of patients with chronic conditions do not take their prescribed medications (Dtsch Med Wochenshr. 2011 Aug;136(31-32):1616-21). Moreover, “Across the United States, up to 21% of adverse drug events in ambulatory care was associated with nonadherence. It is estimated that $1 billion per year is wasted when patients are not taking their medications the right way,” said Dr. Endo. “That’s not specific to older adults or dermatology, but treatment non-adherence is a huge problem.” Although medication adherence is a challenge for patients of all ages, there are a number of factors that physicians may want to consider if treatment adherence is a challenge with their older patients.

COMMUNICATION

For Dr. Endo, communication with patients plays a major role in treatment adherence. “When we’re talking to older patients, we might not be using the best practices for communication.” Potential hearing loss and/or vision deterioration can interfere with communications about medicines. “Speaking in a lower tone can help patients with a hearing impairment,” Dr. Endo said. “Also, using a minimum of a 12-point font and 1.5 line spacing as well as high contrasts like black print on white paper [for printouts] can really improve people’s ability to understand,” Dr. Endo said.

Anne Lynn Chang, MD, associate professor of dermatology at Stanford University School of Medicine, tries to make her medication instructions as clear as possible, both for the older patients and their caregivers. “I will use a body map diagram and write in large font what medicine is applied where on the body. Same with prescription labels, I write down where on the body to apply a topical medication. I’m not just saying ‘Apply to the affected area,’ but ‘apply to arms’ or ‘apply to scalp.’” If adherence is a problem, Dr. Chang will also give patients a large-font printed diary with instructions to record their dates of use. “I ask them to bring their medication tubes and their diary to their next appointment so I can get an idea of how much of the medication they’re using and the frequency. Often drugs are ‘not working,’ according to the patient, but the lack of therapeutic effect is because they are not using their medication regularly and at appropriate amounts.”

CARE COORDINATION

In addition to patient communication, Dr. Endo contends that communication with other physicians is a critical component for ensuring treatment adherence, particularly with older patients who may be seeing multiple specialists in a number of care settings. “The more doctors or nurses that you have involved in transitions of care, the more opportunities there might be for medication reconciliation error. We need to make sure that we’re communicating to other providers — not just the patient and their families.”

This pearl applies to pharmacists as well where automatic refills are concerned. “While automatic refill reminders can be good for patients, we actually found at our institution that sometimes it can cause confusion. When a medicine is supposed to be stopped or adjusted, the pharmacy still has it in their system that there are more refills of the old prescription.” Dr. Endo says there are efforts afoot to improve communications with pharmacists so that when a physician discontinues a medication in their electronic medical records, it sends a ‘stop medication’ notification to the pharmacy. Until that happens, he said, physicians and pharmacists should be communicating about medication changes to avoid any confusion.

COMORBIDITIES

In addition to potential hearing loss or vision deterioration, other comorbidities can impede treatment adherence in older patients. “If you have really bad arthritis it might be hard for you to open up a really tiny tube with a little twist top,” Dr. Endo said. “Sometimes it takes some creativity and working with the pharmacist, or asking the patient to work with the pharmacist, to see if they can get their medications in easier-to-open containers.”

Similarly, patients with mobility issues may struggle with topical medications. Dr. Endo encourages physicians to get creative. “There are back-lotion applicators that you can find online that are helpful for all patients. Using assistive devices can make a huge difference.”
Polypharmacy
In addition to communication discrepancies and challenging comorbidities, another reason that older patients may not be adhering to their treatment plan is that they may be taking several medicines. “In general, older adults take more medicines compared to younger adults and children,” said Dr. Endo. According to Dr. Endo, taking multiple medications, also known as polypharmacy, can increase a patient’s likelihood of treatment non-adherence. “They have to keep track of more medications. It creates more opportunities for human error as regimens get more complicated.” Additionally, says Dr. Endo, older patients may see more specialists in various locations, and as such may have multiple care transitions. “There are all of these additional potential opportunities for medication confusion to occur.”

Recognizing these challenges, Dr. Chang will try not to give her patients too many medications if she can. “It’s easy to feel like we are addressing the patient’s problem when we give out more types of medications, but people get confused or simply don’t have the time to adhere to multiple topical medications. Multiple medications can also get expensive.” Additionally, Dr. Chang will follow up with the patient shortly after the initial appointment to check in on adherence. “Instead of seeing them in six months I’ll see them in maybe a month after the first visit. I need to see them to find out if the drug is working for them. That gives them a concrete endpoint and will hopefully motivate them to give a treatment a decent trial for efficacy. If they know it is efficacious, they may be more likely to stick to a treatment regimen long term,” said Dr. Chang.

Finances
The cost of drugs remains a critical hurdle for some patients with regard to adherence, says Dr. Endo. “The vast majority of people who are older are living on fixed incomes. Many of them are relying on government insurance.” However, the cost of health care in general may be keeping patients from not only taking medications, but following up with their physician. “The copays for people to visit their doctors can be really expensive, especially for the younger older people who may still be working and don’t have government assistance,” Dr. Endo said.

Dr. Chang agrees. “The cost of medications is definitely a concern. When patients mention that, I try to give them different options. There are some online pharmacies that people can ask a caregiver or family member to help them navigate online. Or they can call around different pharmacies before going to a particular pharmacy. They may find that prices can vary a lot. Then of course, I try to use generics but some generics can be pricey too now,” Dr. Chang said.

While prescription adherence is a key factor in caring for elderly patients, Dr. Chang adds that physicians should also be encouraging their patients to adhere to basic self-care practices. Dr. Chang will ask her patients to make their skin care regimen an extension of their other hygiene-related routines. “If they brush their teeth, they should put on their sunblock or moisturizer right afterwards. I also go over non-medical issues like keeping your shower short or not using very hot water while bathing,” Dr. Chang said. “Some of the treatment adherence isn’t just medicine, but also healthy skin habits such as dry skin care.”

“The key is: What’s unusual? We all hit our shins on the coffee table but if you see something in the middle of the back or hidden from sight that can be a red flag.”

Elder abuse and neglect
According to the National Council on Aging, one in 10 Americans older than 60 have experienced some form of elder abuse. Additionally, about five million elders are abused each year. For Dr. Chang, there is a unique role dermatologists can play in identifying elder abuse as many indications of mistreatment are cutaneous. “We look on the skin and do comprehensive skin checks so we often see things that other doctors don’t,” Dr. Chang said.

Monitoring
Elder abuse — from physical and sexual abuse to neglect — can manifest on the skin through bruising.
lacerations, burns, genital trauma, and malnutrition. When it comes to bruising and lacerations, Dr. Chang says that asymmetry may be a sign of abuse, as well as if the injury resembles an object such as a belt buckle. Similarly, burns that resemble an object, such as a cigarette, or have a stocking- or glove-type pattern indicating immersion could be red flags (J Am Acad Dermatol. 2015: Aug;73(2):285-93). “Certainly, the things that are typical to a rape victim with the area of penetration are quite similar here, such as skin breakdown and ulcers that are infected or getting worse,” said Julie Schoen, JD, deputy director of the National Center on Elder Abuse. Additionally, poor hygiene and photo-sensitive dermatitis, for example, could be suggestive of pellagra from a vitamin B3 deficiency (J Am Acad Dermatol. 2015: Aug;73(2):285-93).

If the physician notices any of these issues, Schoen recommends talking with the patient. “Often the caregiver will come in with the patient, but you’ll want that time alone with the patient to talk with them. Ask them — just like you would with any other patient — how is everything going?” While the patient is talking, keep an eye out for signs of fear and anxiety, or if they seem nervous in the presence of the caregiver, says Schoen. “The key is: What’s unusual? We all hit our shins on the coffee table but if you see something in the middle of the back or hidden from sight that can be a red flag.”

Documenting
If something looks unusual, Dr. Chang recommends documenting those suspicions carefully. “I would get their permission to document with photographs. If you see them once, it may be a one-time event where they fell by accident. However, if it’s a pattern and serious, then that may be something that you want to investigate further and potentially report if the story behind the injuries does not make sense.”

In addition to photos, Schoen says the more details a physician can add about their encounter with the patient, the better. For example, “Patient was able to tell me what day it was and knew who I was and seemed alert and oriented.” However, physicians should be careful about what they include in the records about the patient that can be used against the patient if a case were to go to prosecution, she warns. “Physicians should be cautious about how they write about the patient in their charts. Making judgment calls or loose statements about capacity, you have to be careful with that.”

Reporting
According to Todd Whatley, JD, president of the National Elder Law Foundation, physicians are required to report suspicion of elder abuse in almost every state. However, “statistically most physicians don’t because they are concerned about violations of physician-patient confidentiality and HIPAA-related issues.” Physicians can find out what’s required of them and how to report suspected elder abuse through their state’s adult protective services department. Additionally, if the physician suspects that the patient is receiving sub-optimal care at a nursing home, Whatley recommends speaking with the patient’s family and/or going to adult protective services. “I would start with the health care power of attorney and family member that is most involved and let them know that there’s a problem. Most family members can then go back to the nursing home and address that. If the situation is really bad, that’s abuse and the physician should be reporting to adult protective services.”

Overall, when it comes to elder abuse, Schoen encourages physicians to be proactive. “Just know that there are resources available and there are solutions. People think that there’s not much they can do about it, but there is a lot they can do.”

For state-by-state information and resources for identifying and reporting elder abuse visit the National Center on Elder Abuse at https://ncea.acl.gov/resources/state.html.

Legal and ethical considerations
In addition to spotting abuse and neglect among elderly patients, physicians should also be aware of potential mental capacity issues, says Whatley. “All
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of us have the responsibility to meet with the client or patient and talk to them and essentially determine if they are making good decisions.” How do you do that? “I think we can all tell if a person is ‘making sense,’” says Whatley. “Are they making reasonable decisions that a person looking out after their own self-interests would? You can tell if a person is simply not making well-reasoned, self-interest-protecting decisions. I think physicians are well trained in that and can see that fairly quickly.” Indeed, before a procedure, Dr. Chang will talk to the patient to make sure they understand the risks and benefits. “We try to document their assent and that to the best of the patient’s ability they understand the reason for what we’re doing, what the risks are, and what the possible benefits are.”

**Medical authority**

If the physician suspects that the patient no longer has the capabilities to make decisions about their health care, Whatley says the physician can then seek out others to help the patient make those decisions. “That’s where we hope that the patient has designated a health care power of attorney. This is a written document that is either witnessed and/or notarized that designates someone to make health care decisions when that person cannot, or to assist the patient in making those decisions.” According to Whatley, the form is often submitted to the patient’s primary care physician or hospital, so a specialist like a dermatologist will need to connect with them. “Typically, with health care powers of attorney, there is no triggering event. It is effective immediately and it is up to the physician to say, ‘I’m seeking someone else’s advice here because my client is not making good decisions.’”

If there is no health care power of attorney, Whatley says that the physician — usually the primary care — can work with the next of kin to determine next steps. “Typically, what most physicians will do is tell the family that they need to get a guardianship. I am very adamant that we should not do guardianships unless it’s absolutely the last resort because that is taking away the rights of the older person and allowing a judge to appoint someone.”

**Care goals**

However, many patients will be of sound mind, says Dr. Endo, and it’s important for physicians not to assume otherwise and base care decisions simply on age. “Avoid ageism. The aging process is so variable. When we’re kids, we go through developmental landmarks at roughly the same age. As we get older, we have different life experiences and health situations which is why geriatric care is not one-size-fits-all.”

Indeed, with this particular patient population, care priorities and goals will vary and may differ between what the patient wants and what the physician recommends. As a result, Dr. Chang suggests taking the time to come to an understanding about the patient’s care goals. “I try to assess what their most important priority is. I don’t want to just roll them into a blanket treatment plan, because I believe that every patient is different. Many older patients are very high-functioning and doctors shouldn’t assume that age alone precludes them from particular treatments, especially if they have few other medical problems. Taking the time to understand your patient’s goals might seem like it takes a lot of time, but in the long term it’s worth it as it helps you to guide the patient toward the best choices for the particular patient.”

Dr. Endo finds that often his patients will be candid about their care goals. “Some patients will say, ‘I just want to be around for my grandkids’ birthdays.’ Other people might be more concerned with quality of life. It goes back to patient-centered care and recognizing that there’s a lot of variability among older adults in terms of what they value, depending upon their psycho-social circumstances, their health, etc., and not just based upon their chronological age. What’s challenging but also rewarding about taking care of older adults is once we appreciate the big picture, we can optimize our treatment plans and not just focus on the skin.”

When it comes to treating elderly patients, Dr. Chang encourages all physicians to simply put themselves in the shoes of their patients. “The way I think about it is: How would all of us want to be treated when we’re not fully able to take care of ourselves? Hopefully, one day we’ll all be old enough to be in that situation. We should be doing what we can to help these patients age gracefully.”

*GOLDEN RULES for the GOLDEN YEARS*

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FIRST RESPONDERS

Exploring dermatology’s role in identifying and treating emerging public health trends
The world is a dangerous place. The health impact of natural disasters, man-made disasters, changes in climate, emergence of entirely new diseases, and the re-emergence of diseases thought long-since eliminated, loom not only in recent media reports — but also potentially in dermatologists’ own waiting rooms. Throughout medical history, dermatologists have been some of the first to identify major disease outbreaks — from the HIV epidemic, to the emergence of Lyme disease, to the 2001 anthrax attacks. The specialty continues to serve a crucial role in identifying and managing today’s public health concerns. “We can serve as part of a response team certainly, but also function as kind of a public health sensor — or pulse — based on what we’re seeing in our routine clinic patients. Hopefully we help catch an epidemic earlier than it otherwise would have been,” says Justin Bandino, MD, assistant professor of dermatology and dermatopathology at San Antonio Military Medical Center.

*Dermatology World* talks with physicians from across the specialty about how dermatologists fit into the unfolding public health concerns of today. This feature will explore the dermatologic consequences posed by ongoing public health threats such as climate change, natural disasters, dangerous water conditions, and emerging communicable diseases. It will also address the importance of recognizing when a single patient’s condition is a danger to the wider community, and how to appropriately report the threat.
Heating up
While pundits and politicians seem to spar over global climate change, scientists agree that “over the past few decades, our planet has entered a period of major changes in climate and weather patterns, almost certainly as a result of human activity” (*J Am Acad Dermatol*. 2016;76(1):140-147). Changes in global climate may create a variety of dermatologic consequences, including newly favorable habitats for disease vectors and reservoirs, longer and more intense transmission seasons for potential viral epidemics, and higher rates of skin cancers.

“Dermatologists in Puerto Rico can look to Hurricane Maria, those in Texas can look to Harvey, those in California can look to droughts, and all of us can look at the links between climate change, population migration, civil strife, war, and refugees,” says Misha Rosenbach, MD, associate professor of dermatology and internal medicine at the Perelman School of Medicine at the University of Pennsylvania and leader the of the AAD’s recently formed Expert Resource Group on Climate Change and Environmental Affairs. “It’s easy to come up with dozens, if not hundreds, of reasons why dermatologists should be paying attention — but it’s hard to not sound alarmist, and then be dismissed out of hand. There is a consensus on this in the scientific community, and it is a critical issue.”

Climate change can enable the spread of infectious diseases in particular, as the warming of the planet facilitates the expansion of the natural range of pathogens, hosts, reservoirs, and vectors that allow diseases to appear in immunologically naive hosts (*J Am Acad Dermatol*. 2016;76(1):140-147). Examples of this phenomenon include an uptick in incidence of Lyme disease, as the range of infected ticks expands as the habitat of their mammalian hosts also broadens. “The simplest link between dermatologic illness and climate change is to look at vector-borne diseases, where we are now seeing dengue, chikungunya, and Zika in the continental United States, while *Ixodes* tick territory has expanded far northwards — both due to global warming,” says Dr. Rosenbach. CDC data back up this observation. In May 2018, the *New York Times* reported that disease cases from mosquito, tick, and flea bites more than tripled in the U.S. from 2004 to 2016, as per a recent CDC report. “Warmer weather is an important cause of the surge, according to the lead author of a study published in the CDC’s Morbidity and Mortality Weekly Report,” notes the NYT story.

Beyond vector-borne disease, climate change has also been linked to increasing instances of deep fungal infections, such as coccidioidomycosis, due in part to longer dry seasons and more frequent wind storms that aerosolize the fungal spores throughout the southwest and western parts of the United States (*J Am Acad Dermatol*. 2016;76(1):140-147). “Droughts have dramatically expanded the typical places where one can acquire coccidioidomycosis. This list really goes on and on,” says Dr. Rosenbach. “Dermatologists are physicians — part of the house of medicine. It’s important to know what’s going on with the world at large, and for us to reflect on how we as the caretakers of the skin are involved in those changes.”

While the links between climate change and skin cancer are not yet clear, studies suggest that “ozone depletion by chlorofluorocarbons has resulted in an increased risk of skin cancer for the foreseeable future,” as elevated temperatures alone may result in greater ultraviolet damage from the same ultraviolet light dose (*J Am Acad Dermatol*. 2016;76(1):140-147). In addition, warmer weather may negatively influence sun exposure and ultraviolet-protective behaviors, as

“Dermatologists are physicians — part of the house of medicine. It’s important to know what’s going on with the world at large, and for us to reflect on how we as the caretakers of the skin are involved in those changes.”
patients may be inclined to spend more time outside without wearing sunscreen or protective clothing.

**Bad water**

“Although it is hard to definitively correlate stronger hurricanes with climate change, the Earth’s surface is steadily warming, and warmer temperatures lead to increased evapotranspiration, dramatic and unexpected changes in precipitation patterns, and therefore more frequent and intense flooding,” says Dr. Bandino. As much of the United States continues to urbanize, increasingly common natural disasters pose a wide range of health implications, many of which are dermatologic in nature. “Skin diseases are the most common medical issue” in the aftermath of flooding, says Dr. Rosenbach. The aftermath of major storms has historically led to a spike in reported skin infections (2017’s Hurricane Harvey being a recent example), as floodwaters contain a wide variety of contaminants and hazards that can result in bacterial, mycobacterial, and fungal infections, as well as increased arthropod bites, laceration injuries from debris, immersion foot, contact dermatitis, and more.

“I’m in San Antonio, Texas, and when Hurricane Harvey hit the state, its center of impact ended up shifting enough so that it grazed us but unfortunately ravaged nearby Corpus Christi and Houston. We definitely saw some of the sequelae,” says Dr. Bandino. Traumatic wounds are often the most immediate and pressing concern following a major instance of flooding. These can take the form of puncture wounds and lacerations, as well as electrical injuries due to downed power lines, and an increase in wild and domestic animal bites. Insects can have a particularly vicious impact as they compete for space with humans. “In the post-recovery period where there’s a lot of stagnant water, the breeding ground for mosquitoes or other arthropods increases. Malaria and many other arthropod-borne diseases may subsequently increase, but there are also simple noninfectious bug bites to contend with as well,” says Dr. Bandino. “In the aftermath of Hurricane Harvey there were literally floating fire ant colonies — one of those things you would never think about — but if you get enough fire ant stings on your body, especially if it’s a little kid, that can be serious — and potentially fatal.”

However, beyond more common skin and soft tissue infections that can develop after exposure to flood waters, it is the atypical pathogens found

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**Effect of climate change on skin disease**

What’s climate change got to with dermatology? Changes in global weather patterns can impact skin disease by:

- Expanding geographic areas of risk through the creation of favorable habitats that broaden the natural range of pathogens, hosts, reservoirs, and vectors that allow diseases to appear in immunologically naive populations
- Producing longer and more intense transmission seasons
- Indirectly affecting skin cancer rates due to changes in temperature and associated behaviors

within them that can often pose the greatest cause for concern. “The nature of a flooding disaster — whether it’s a hurricane or a tsunami — is that it stirs up the soil, unearthing pathogens that we aren’t normally exposed to,” explains Dr. Bandino. “If you have even a superficial cut from being thrown into a disaster scenario, particularly if you are nutritionally deprived or immunosuppressed, those infectious organisms are much more likely to establish a potentially dangerous infection.”

Beyond flooding, overall increases in water temperature and decreased ocean pH may also have dermatologic consequences. Invasions of non-native species due to changes in habitat can have skin-related consequences for unsuspecting swimmers. Growing jellyfish populations have posed a particular problem worldwide; large aggregations of the often painful and sometimes fatal Portuguese man-of-war have begun appearing along the southeastern U.S. coastline. Meanwhile, the Great Lakes region is expected to see a substantially higher uptick in waterborne disease (J Am Acad Dermatol. 2016;76(1):140-147).

While at first glance, post-hurricane relief may seem to be outside the responsibilities of the average dermatologist, Dr. Bandino says the specialty’s skill for quick and accurate assessment of the skin can be a boon in disaster situations. “It really boils down to the quick, simple morphological assessment with our eyes that we can provide that really no one else has the training to do. Being able to point to something and say, ‘that’s Vibrio vulnificus infection, because of x, y, and z,’ is something that few other physicians can do as readily,” he explains. “In a disaster scenario, certainly emergency personnel are most important in the immediate aftermath to save life and limb. But where dermatologists start to contribute is in the days or weeks after, being able to lend our eyes to someone’s skin and put puzzle pieces together to make diagnoses or at least narrow differentials without having to get cultures or do expensive lab tests — which are often impossible to do in a disaster scenario. You can’t sit there and say, ‘I’m going to culture this,’ because the lab itself may be underwater and you need answers now.”

Mother Nature is not to blame for all water-related skin crises, however. Flint, Michigan dermatologist Walter Barkey, MD, can relate first-hand the devastating effects that man-made meddling can have on a community’s health. In 2016, Dr. Barkey spearheaded a collaboration between local Flint-area dermatologists and the CDC to explore a potential connection between Flint’s contaminated water and a surge of reported skin rashes among its residents. (To read more about the project, read Dermatology World’s August 2016.

When it’s time to call it in

Your patient may have plague. What do you do next? While all U.S. states have a reportable disease list, many of these conditions must also be reported at the national level to the Centers for Disease Control and Prevention (CDC). The clinician’s job is to report suspicious cases to the state or local health departments, who in turn will notify the federal agencies.

For the full list of 2018 National Notifiable Conditions, visit: www.cdc.gov/nndss/conditions/notifiable/2018/

Dermatologists should visit their state’s department of health website for a full list of communicable diseases and other notifiable conditions required by that state, as well as guidelines on:

- How to report
- Who is required to report
- What conditions must be immediately reported by telephone
feature, “On the front lines in Flint.”) While the study ultimately concluded that approximately 20% of the rashes among the local residents surveyed were unrelated to Flint’s water condition, it deduced that the remaining 80% may have been related. The most common type of rash observed in the latter group was eczema — known to have a variety of aggravating factors including irritation, dryness, and stress.

Dr. Barkey was compelled to get involved with the wider investigation being conducted by federal officials after hearing that primary care providers were going to be brought in to diagnose the reported rashes. “That’s awful, I thought. They can’t do it. Somebody had to step in and help them with diagnoses,” he says. “I figured it would be maybe a dozen people, a couple afternoons.” While Dr. Barkey’s full involvement ended up involving screening several hundred patients, recruiting and organizing other local dermatologists to help, and coordinating with the CDC, EPA, and other national health organizations over a period of several months, the experience was worth it, he says. “It was such a learning experience, not just participating but also navigating all the politics that went on. It was a real hot potato issue as far as the press was concerned, and the CDC was very concerned about how the findings were going to be spun.”

While Flint’s recovery is still ongoing, Dr. Barkey cites his involvement with the aftermath of the water crisis as an example of dermatology’s potential to be key collaborators in public health. “What we did with the study was at least steer people straight. I had great cooperation from both my local and national colleagues in dermatology. We’re the only ones that can really diagnose skin conditions with any accuracy — and everything starts with getting a diagnosis,” he says. “It’s not natural for us in our outpatient world to have contact with other groups, other specialties, and this really made me come into contact with members of the health care community I never would have otherwise. Now we are colleagues, and they have a lot of respect for dermatologists. They always thought we were pretty bright, but very focused on what we do. Now I think that perception has changed in Flint for our medical community.”

Get involved

Did you know dermatologists can join the Medical Reserve Corps? The MRC is made up of a network of volunteers comprised of professionals from across the medical and public health community — including physicians, nurses, pharmacists, dentists, veterinarians, epidemiologists, and more.

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Visit https://mrc.hhs.gov/HomePage for more information about the program.

They’re back

Beyond active disaster zones, dermatologists have historically been some of the first physicians to observe major disease outbreaks — a role they likely will reassume at the re-emergence of major infectious diseases. “Dermatologists have been critical in identifying public health threats in the recent past,” says Dr. Rosenbach. “The country is facing a resurgence in syphilis — our field used to be dermatology, venereology, and syphilology — and some dermatologists have been critical in getting the word out.”

As noted by Academy Vice President Ted Rosen, MD, at the 2018 AAD Annual Meeting, “Virtually every continent is experiencing increased instances of syphilis with the exception of Europe and Antarctica. Keep syphilis in mind when seeing patients.” According to CDC, despite record lows in incidence between 2000 and 2001, the syphilis rate has increased almost every year since then. Between 2015 and 2016, the national syphilis rate increased by 17.6% to 8.7 cases per 100,000 population — the highest reported rate in the United States since 1993.

Due to increased global travel and the formation of concentrated groups of unvaccinated communities, outbreaks of measles have begun to reappear.
throughout the United States. As per the CDC, while there were only 63 reported cases of measles in the United States in 2010, by 2014 the number of reported cases surged to 667. Dermatologists should be aware of the possibility of encountering measles in their clinics, despite the once-rare likelihood of a confirmed diagnosis. “Most of our diagnoses are clinical, and we do things to confirm them — but first you have to suspect what it might be to even do a test to see if it’s measles,” says Dr. Barkey. “An old guy like me — I’ve seen measles. When you know the full differential, it’s a skill, and it’s very nice to be able to apply that.”

What can you do?
While the average dermatologist may not see themselves as a gatekeeper of public health, their specialized knowledge of the skin — where the first and most visible signs of illness often appear — makes them an essential part of the broader health community. Although climate change, natural disasters, and emerging infections may not immediately seem to be the purview of dermatology, why then should dermatologists stay engaged and up-to-date with these issues? “To me, that’s the important question in a nutshell,” says Scott Norton, MD, MPH, MSc, chief of dermatology at Children’s National Health System, in a 2017 episode of Dialogues in Dermatology. “Although dermatologists may not realize it, we have a front row seat in so many disease outbreaks in the United States and around the world. When we think about diseases like HIV infection or Lyme disease, dermatologists are the ones who see the index cases,” said Dr. Norton, who will lead a 1.5-day course on tropical dermatology Oct. 27-28 in New Orleans as part of the American Society of Tropical Medicine and Hygiene’s annual meeting. Even noninfectious diseases, like the outbreak of the gadolinium-induced fibrosis, are conditions that are seen by dermatologists first. We need to realize that when we recognize a novel presentation, that it may not just be a great case, but it may indeed be an index case and worthy of reporting to your local or state health authorities.”

Dr. Rosenbach agrees, citing dermatology’s eye for catching on to new disease patterns as being crucial to the management and prevention of public health outbreaks. “Dermatologists are expert diagnosticians and skilled in pattern recognition. It is essential that we actively participate in public health — both in identifying new and emerging threats, and helping address those that others have reported on,” he says.

For Dr. Barkey, stepping up to serve one’s community in times of crisis is simply part of being a good physician. “Take yourself out of the one-on-one, thinking that you’ll just see patients in your office, and stick your head out the window to see that there is a whole community of people out there,” he says. “You serve that community — you don’t just serve individuals in it. If you have a skill that’s needed, you have to be willing to step up if you’re called.”

Dermatologic consequences of flooding

- **Bacterial, mycobacterial, and fungal infections**
- **Increased insect, arthropod, and animal bites**
- **Laceration and puncture injuries from debris**
- **Immersion foot**
- **Contact dermatitis**
- **Psychodermatologic complications**

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Trump administration addresses health care policies in small bites
While the Trump administration has raced to eliminate the Affordable Care Act (ACA), it has put the brakes on other health care policy while contemplating how best to move forward. That pause may prove advantageous for dermatology...only time will tell.

**Affordable Care Act**

“Overall, the Trump administration has paused the Obama administration’s major health care initiatives and has been taking the time to dig deeply to see if the previous administration’s constructs work, given the current administration’s perspectives,” noted Leslie Stein Lloyd, JD, director of regulatory and payment policy for the American Academy of Dermatology Association. Within the first five months of Donald Trump taking office, the administration withdrew or delayed more than 850 proposed regulations, according to the Associated Press.>>
While pausing on some regulation, President Trump has forged ahead with his efforts to push Congress to dismantle the ACA. Most notable is the repeal of the individual mandate in December 2017 as part of the Tax Cuts and Jobs Act. That was followed in February by the repeal of the Independent Payment Advisory Board (IPAB), which was a provision under the ACA that created the potential to impose indiscriminate new payment cuts on physicians without congressional input.

Since then, the Trump administration continues to roll out new rules that further unravel the ACA. New rules proposed in January make it easier for small businesses and self-employed individuals to buy association health plans, which will no longer have to offer ACA-compliant health benefits. While association plans could charge consumers different prices based on their age, gender, and location, they can’t charge certain customers more based on their health status or refuse to cover people with conditions that are expensive to treat. The rules allow these plans to be sold across state lines.

All of these alternative plan options would further destabilize the ACA marketplace. They would create parallel insurance markets with varying and more limited consumer protections, but also lower premiums. These plans are targeting relatively healthier people who would leave the insurance risk pool of the ACA marketplace, raising the premiums for the sicker enrollees left behind.

“The Trump administration is trying to deconstruct the ACA any way it can,” said Michelle Mathy, the AADA’s assistant director of political and congressional affairs. “The individual mandate repeal, passed as part of the tax reform, was a big hit to the ACA.”

It’s too soon to tell what impact, if any, the repeal of the individual mandate will have on dermatologists, Mathy said, because the majority of Americans still get their insurance either from their employers or Medicare. It’s believed that the people who would stop buying insurance on the open market are young, healthy individuals who typically don’t access the health care system often. “If young, healthy people leave the insurance marketplace in droves and it crumbles that could impact dermatologists, depending on how many of their patients are covered,” she said. “It could have a ripple effect, but not a direct impact.”

The IPAB repeal has no direct impact on dermatology today, because it was never funded, Mathy added, but protects against future Medicare cuts. The IPAB was supposed to cut Medicare payments if a certain spending growth threshold was reached, but it never was. Repealing IPAB basically returns Medicare payment authority to Congress. While it’s helpful to have the IPAB repealed, said Bruce Brod, MD, vice chair of the AADA’s Council on Government Affairs and Health Policy, it’s important to remember that the 2% Medicare sequester payment reduction was extended another two years through 2027. That translates to approximately $40 billion, according to the Center on Budget and Policy Priorities.

All of the new proposed rules will likely result in more coverage options, but some of them may offer bare-bones coverage with exclusions of pre-existing conditions, noted Dr. Brod. “The current administration is certainly creating an environment that is moving away from one-size-fits-all type of plans. There may be advantages to that, but also disadvantages,” he said. “We will have to closely monitor that. The Academy always supports access to care for everybody.”

The proposed rule changes are vulnerable to court challenges and could get struck down or countered by state governments, Mathy said. Congressional Democrats are already raising questions about whether the Department of Labor has the authority to redefine the eligibility for association health plans proposed by the Trump administration.

Looking ahead, it’s unlikely that Congress will make additional changes to health care this year, she said, as many members will be in full campaign mode this fall. “A lot of the air has left the room,” Mathy noted. Depending on how open enrollment goes this fall and what the marketplace predictions are for next year, there may be last-minute attempts toward market stabilization, but they will have to be truly bipartisan efforts to get enough votes to pass. It also depends on what happens with the November elections and whether House Speaker Paul Ryan pushes for entitlement reform for health care before he leaves office. “If anything big will be done on the ACA, it would be done at the end of this year after the November elections,” she predicted.

**Drug approvals, compounding**

Access to new drugs took a positive turn in 2017 with the U.S. Food and Drug Administration (FDA)
approving 46 novel medicines, a 21-year record high. Within dermatology, two new drugs were approved to treat psoriasis and one was approved for treating atopic dermatitis. In 2018, two new drugs were approved to treat plaque psoriasis. Since his appointment, FDA Commissioner Scott Gottlieb, MD, has focused heavily on increasing competition in drug markets, said Josephine Nguyen, MD, chair of the AADA’s Regulatory Policy Committee. Jeremy Kahn, MA, trade press officer for the FDA’s Center for Drug Evaluation & Research (CDER), attributes the increased drug approvals to a variety of expedited review and approval tools. “From 2011 through 2017, about 60% of our novel drug approvals were approved using one or more expedited review tools,” he said.

Regarding FDA approval processes, the Academy believes that a primary driver of pharmaceutical costs is the reduced level of competition for a variety of generic and branded drugs and biologics, Dr. Nguyen said. To that end, the AADA has been supportive of legislative efforts that would provide the FDA with added authority and resources needed to expedite the review process and get additional drugs and biologics to market, which hopefully will lower the price.

In 2018, the FDA is expected to publish revised draft guidelines for Insanitary Conditions at Compounding Facilities for physicians who compound drugs in their offices. “The Academy has been working on its own and with the American Medical Association to maintain access to in-office compounding, which has been done safely for many years,” Dr. Brod said.

“The FDA is considering comments submitted by some providers who compound small quantities of drugs in their offices for patient use and as part of their routine clinical practice, including in the setting of dermatologic procedures,” Kahn noted. “The FDA plans to better define the circumstances under which we believe drugs are being mixed and applied in a manner that creates negligible patient risk, and therefore wouldn’t be subject to the same compliance policy under the agency’s risk-based approach to implementing these requirements.”

Dr. Brod added, “Commissioner Gottlieb has intimated that there may be exceptions for specialties, such as dermatology. We’re hoping for a favorable interpretation that will allow dermatologists to compound in their offices without too much burden, such as requiring hoods and gowns, because that’s not workable for a dermatology office.”

The Academy is also engaged with the U.S. Pharmacopeia, which is revising its chapter about compounded sterile preparations. A revised second draft is expected in late July. The goal is to have reasonable guidelines that promote safety without onerous requirements, said Dr. Brod.

**Public Health Issues**

In 2017, the FDA failed to finalize its proposed rule to restrict the use of tanning beds to individuals under the age of 18. Meanwhile, the House of Representatives’ Freedom Caucus flagged the under-18 ban for congressional review. “The Academy is cognizant of the current political climate of deregulation,” Dr. Brod said. “We pulled back on pushing for this regulation because we would risk Congress revoking the FDA’s authority to make this rule.” Once lost, regaining the FDA’s authority is a difficult process and could set this regulation back several years.

The proposed rule, however, remained in the Semiannual Regulatory Agenda published this spring. “The Trump administration has pulled other rules from other agencies, so the fact that the proposed rule has not been pulled is positive,” stated Natasha Pattanshetti, JD, MPH, the AADA’s manager of regulatory policy. There is no timeline for when a final rule would be published, but the Academy continues to advocate for that to happen, she added.

On the state and local levels, the AADA continues to advocate for under-18 indoor tanning bans. Pattanshetti said. At last count, 18 states and the District of Columbia have indoor tanning bans for minors who are 18 years of age and younger. To date, 45 states and the District of Columbia regulate the use of indoor tanning for minors. These restrictions include a ban on minors under a specified age or parental accompaniment or consent. The topic recently gained national attention when the wife of Surgeon General Jerome Adams, MD, MPH, was treated for metastatic melanoma. Dr. Adams highlighted her story to raise awareness about the risk factors for skin cancer as his wife was a frequent tanner.

Also in the Semiannual Regulatory Agenda is the FDA’s proposed rule to address the safety and effectiveness of 16 sunscreen ingredients and describe data gaps that the agency believes must be addressed to allow these ingredients to remain on the market without requiring new drug applications. The FDA also expects to address sunscreen dosage forms and maximum SPF values of current sunscreens on the market. This rule has an action date of August.

In April, the FDA requested quotes for absorption testing of current sunscreen formulations, according to Sabra Sullivan, MD, PhD, chair of the AADA’s Council on Government Affairs and Health Policy. She is optimistic that this action will speed up the sunscreen investigation. “I’ve been doing this for 25 years and I’ve never seen this issue go forward,” Dr. Sullivan

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**DERMATOLOGY WORLD // July 2018**

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PIECEMEAL POLICY

“Regardless of who won the election, we were coming to the point where we couldn’t move forward without slowing down and figuring out how to implement value-based payment without harming our patients. So the Trump administration is taking a step back to look at what we can realistically do.”

The FDA is not only concerned about new sunscreen ingredients, but also ingredients in formulations that are currently on the market, Pattanshetti noted. Many of the new ingredients are used in sunscreens marketed in Europe, but there they are regulated as a cosmetic. It seems unlikely that the FDA will lessen the safety standards finalized in its 2016 guidance for adding sunscreen ingredients to the over-the-counter sunscreen monograph, she said. However, the FDA has stated that it is willing to work with ingredient sponsors. During the Obama administration, the AAD’s Immediate Past President Henry Lim, MD, and AAD staff met with the FDA, which was very forthcoming with its safety requirements and willingness to work with stakeholders. “The FDA is asking for more data to prove that sunscreens are safe and not causing adverse effects for consumers,” Pattanshetti added.

The other issue is effectiveness, which addresses when sunscreen should be applied, how often it should be re-applied, and how much should be used. The FDA may be addressing this issue by ruling on its proposed SPF cap of 50+ in the fall, she noted. In 2011, the FDA proposed the limit unless the agency receives data demonstrating additional clinical benefit for SPF50+, Dr. Nguyen explained. The AADA also believes that manufacturers should be allowed to market 50+ SPF50s if there is research showing the effectiveness at these levels. Depending on how this proposed rule is finalized, she said, sunscreens with SPF50s above 50 may or may not be able to continue on the market. Fortunately, these data may be available in the nick of time. Results of a recent randomized, double-blind, split-face trial indicate that SPF 100+ sunscreen was more protective against sunburn from natural sunlight exposure than SPF 50 (J Am Acad Dermatol. May 2018; 78(5), 902–910). It remains to be seen whether these data or future studies will affect the tilt of the finalized rule.

Value-based payment

The question is not whether value-based based payment is moving forward, but how. “There is certainly bipartisan agreement in Congress to pursue policies of value-based care as evidenced by the Medicare Access and CHIP Reauthorization Act of 2015,” Dr. Brod said. Government payers are looking to link physician payment to improved care as are private insurers. The Trump administration, however, has paused to figure out the how. “The train isn’t stopping, it’s just slowing down and recalibrating at this time,” Dr. Brod said.

As an example, the Center for Medicare and Medicaid Innovation (CMMI) has put on hold all Advanced Alternative Payment Model (APM) development. This pause also gives the CMMI time to re-staff as it has lost some key leaders in the past year, Lloyd noted. “Now we’re seeing new medical directors at CMMI who have a fresh perspective and enthusiasm, which is fantastic.” Another tell-tale sign is the Centers for Medicare & Medicaid Services’ (CMS) announcement in February that participation in its Bundled Payments for Care Improvement-Advanced Model will be voluntary instead of mandatory. That shift will slow the progress, but that’s not a bad thing considering it’s such a large-scale shift in payment policy, Lloyd said. Dr. Brod noted that there aren’t any bundled episodes of care a dermatologist could participate in except perhaps cellulitis.

Even if there were, would they save money? Several studies published within the past year have
not shown a significant cost savings through APMs. These studies also highlighted the costs of, and barriers to, participating in APMs for physicians, including dermatologists, she added. The AADA has used this time-out as an opportunity to convey to the administration the difficulty for dermatologists in small and/or solo practices to meaningfully participate in APMs. “Fewer than 20% of physicians will be able to meet the definition for an Advanced APM qualifying participant, Dr. Brod said. “That is reflective of the fact that CMS was pretty aggressive in setting the metrics for engagement in Advanced APMs. This is a good time for there to be continued dialogue on how to make engagement in value-based payment more accessible to dermatologists,” he added.

The Academy’s Workgroup on Innovation in Payment and Delivery has spent five years trying to figure out how to create an APM that dermatologists can participate in, Dr. Sullivan said. “But the way the rules and regulations were constructed, it’s nearly impossible for any specialists to fit into an APM. Despite our best and brightest thinkers in the medical community, APM models are just not ready. Regardless of who won the election, we were coming to the point where we couldn’t move forward without slowing down and figuring out how to implement value-based payment without harming our patients. So the Trump administration is taking a step back to look at what we can realistically do. I think that it’s wise to step back and look.”

This pause also means that it’s unlikely that CMS will follow the Obama administration’s timeline to move 50% of Medicare provider payments from fee-for-service to APMs by 2018. Only 29% of total U.S. health care payments were tied to APMs in 2016, according to a report issued by the Health Care Payment Learning & Action Network — a public-private partnership launched in 2015 to drive adoption and alignment of APMs —while 43% were still tied to traditional fee-for-service or other payments not linked to quality. Even if someone else had won the election, APMs wouldn’t have met that timeline this year, Dr. Sullivan said, adding, “Congress makes the laws, but then they hand it to the federal agencies to interpret and enforce the laws.”

**Tax reform law**

On the tax front, the newly enacted tax reform law includes numerous provisions that may affect physicians. One such provision is a new tax deduction for “pass-through entities,” which include businesses set up as subchapter S corporations, partnerships, or businesses organized as LLCs at the state level that elect to file as partnerships for federal income tax purposes. Unlike C corporations, which are taxed at the entity level, the business income of such pass-through businesses is taxed on the personal tax returns of the individual owners or partners of the business. The 20% deduction is effective beginning in 2018 and is scheduled to expire after 2025.

The deduction, however, is limited by formula in the case of taxpayers with taxable incomes over certain threshold amounts, Mathy explained. For 2018, those amounts are set at $157,500 for single filers and $315,000 for joint returns; these thresholds are indexed for inflation in future years. For taxpayers with taxable incomes greater than $207,500 for single filers and $415,000 for joint returns in 2018, the deduction is phased out entirely and the taxpayer’s business income is instead taxed at the applicable ordinary income rate.

While many dermatology practices are set up as pass-through entities, especially small and solo practices, whether a practice qualifies for the deduction will depend on the owners’ or partners’ personal facts and circumstances, Mathy said. The Academy recommends that dermatologists talk to their accountant and/or tax attorney to determine whether they may claim this deduction in 2018 and beyond. Initially, there wasn’t going to be any tax break, Dr. Sullivan said. The 20% deduction was a modification, and she expects there will be more changes to the provision.

Practices that are set up as corporations may benefit from the tax reform bill that cut the corporate tax rate to 25%, Mathy stated. “If you were paying 40% in taxes and that goes down to 25%, that’s a big deal,” Dr. Sullivan said.

The tax reform law has the potential to impact certain corporate structures both positively and negatively, Dr. Brod added. “The best advice is since this was a sweeping tax bill that was passed, it’s very important for dermatologists to discuss potential opportunities and pitfalls with their financial consultant.

“In the current political climate, as in all political climates, there are opportunities and hazards,” Dr. Brod concluded. “The key is that the AADA remains very engaged on all fronts.” Dr. Sullivan is cautiously optimistic. “I’m beginning to see bipartisanship on issues,” she said. “I’m seeing things moving forward in ways that I never thought they would.” Part of that is due to physicians reaching out to their congressional representatives to discuss issues of importance to the medical community. “Each year, physician voices are getting louder,” Dr. Sullivan said. “It’s a different time and we are impacting what’s going on in our world in health care, and we need to keep doing it for the patients and physicians.”

* dw
Sometimes the news makes me cringe, especially reports about a physician or their non-physician providers making questionable treatment decisions. Even though the stories are usually about outlier behavior, it is worthwhile for all of us to regularly and consistently look at our own treatment choices and confirm that we are providing the highest quality of care for our patients. Fortunately, your Academy has developed a number of resources that can help inform your care decisions.

The Academy joined the American Board of Internal Medicine (ABIM) Foundation’s Choosing Wisely® campaign in 2013 to advance a national dialogue on the necessity of medical tests, procedures, and treatments, and, in some instances, their potential to cause harm. As part of the campaign, the Academy’s Choosing Wisely Work Group developed 10 evidence-based recommendations that physicians and patients should consider prior to making decisions about their individual course of care. These include ‘Don’t prescribe oral antifungal therapy for suspected nail fungus without confirmation of fungal infection,’ and ‘Don’t perform sentinel lymph node biopsy, or other diagnostic tests for the evaluation of early, thin melanoma because they do not improve survival.’ The recommendations were reviewed and approved by the Academy’s Council on Science and Research and the Academy’s Board of Directors, and each is backed by strong research. The Academy re-examines the recommendations and the evidence supporting them on an annual basis to ensure their continued accuracy. I encourage everyone to review the recommendations at www.aad.org/choosing-wisely.

In addition to participating in Choosing Wisely, the Academy has developed evidence-based guidelines of care for dermatologic conditions, such as nonmelanoma skin cancer, acne, psoriasis, melanoma, and atopic dermatitis, as well as guidelines on office-based surgery. Check out these guidelines at www.aad.org/guidelines. The Academy has also developed appropriate use criteria for Mohs surgery at www.aad.org/practicecenter/quality/appropriate-use-criteria. There is truly no shortage of resources to help guide you in making the best clinical decisions for your patients.

I am proud to be a part of this specialty because I know that as dermatologists we are committed to caring for our patients with integrity and professionalism. We are well-trained and uniquely qualified to provide high-quality care to patients with complex conditions. However, the resources and tools that your Academy has developed can help ensure that we are consistently making the best care decisions per the latest evidence-based research. dw
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Academy seeks nominations for 2019 AAD election

The American Academy of Dermatology Nominating Committee seeks nominees for the offices of president-elect, vice president-elect, Board of Directors, and Nominating Committee member representatives (NCMR) in the East Region. The current Administrative Regulation on Nomination and Election Procedures requires that nominees submit all the required materials to the Nominating Committee no later than Oct. 1, for the election that will take place in March 2019.

Successful officer and director candidates will take office in March 2020, at the close of the 78th Annual Meeting in Denver, and the successful NCMR will take office immediately. Nominees for the offices of president-elect and vice president-elect must have served on the Academy Board of Directors for at least one year prior to assuming office. President-elect nominees incur a four-year commitment — a one-year commitment prior to president-elect, one as president-elect, one as president, and one as immediate past president. Vice president-elect nominees assume a three-year commitment — a one-year commitment prior to vice president-elect, one as vice president-elect, and one as vice president.

The Nominating Committee screens and evaluates all nominees and selects a definitive slate of candidates based on professional, scholarly and administrative skills, and geographic representation. Remember, make your nomination(s) early to ensure that nominees have the necessary time to complete and submit all the required materials no later than Oct. 1.

2019 Nominating Committee:
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Submit nominations and all letters of support to www.aad.org/aadnominations or by mail to:
American Academy of Dermatology
Attn: Chair, Nominating Committee
P.O. Box 1968, Des Plaines, IL 60017-1968

For more information, contact the AAD Executive Office at callfornominations@aad.org or (847) 240-1046.

- JOAN TENUT

**Unauthorized Member Activities**

No member of the American Academy of Dermatology shall directly contact any member of the Nominating Committee regarding nominees under consideration. Any lobbying of committee members may eliminate the nominee from consideration by the Nominating Committee.

No nominee, slated nor write-in candidate(s), may engage in any campaign activities or events prior to the official announcement of the slate of candidates on Feb. 5, 2019. Both slated and write-in candidates should discourage others from campaigning on their behalf prior to the slate announcement. Violation of this rule may result in disqualification of the candidate.

For more information, contact the AAD Executive Office at callfornominations@aad.org or (847) 240-1046. 

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**President-Elect Candidates Must Agree to Abide by the Following Excerpt from the Administrative Regulation on Code for Interactions with Companies**

1.4. No Key Society Leader, defined for purposes of this Code as the Presidential-level of a Society’s membership organization (e.g., the President, President-Elect, and Immediate Past President as applicable),... may have Direct Financial Relationships with Companies during his or her term of service.

**Direct Financial Relationship:** A Direct Financial Relationship is a relationship held by an individual that results in wages, consulting fees, honoraria, or other compensation (in cash, in stock options, or in kind), whether paid to the individual or to another entity at the direction of the individual, for the individual’s services or expertise. As used in this Code, the term Direct Financial Relationship does not mean stock ownership or intellectual property licensing arrangements.

*Definition:* A Direct Financial Relationship is a compensated relationship held by an individual that should generate an IRS Form W-2, 1099 or equivalent income report. Key Society Leaders (including the President, President-Elect, Immediate Past President, the Secretary-Treasurer, Assistant Secretary-Treasurer, the chief executive officer of a Society’s membership organization, and the Editor(s)-in-Chief of Society Journal(s)) may provide uncompensated service to for-profit health care products companies (“Companies”) and accept reasonable travel reimbursement in connection with those services. Key Society Leaders may accept research support as long as grant money is paid to the institution (e.g., academic medical center) or practice where the research is conducted, not to the individual. Exception may be made in certain circumstances for provision of consultant or investigator expertise related to protocol development and/or safety monitoring or any other consulting work related to one’s own past, current or potential research studies as long as the activities are not related to marketing or promotional efforts. In this event, the Secretary-Treasurer must be provided with background information and approval must be provided in advance for an exception to the policy. In these circumstances, compensation to the individual may not exceed $10,000/company/year. Verifying 1099 forms must be submitted to the Secretary-Treasurer when received. This exception may not be applied to the President, who shall remain free from any and all direct financial relationships during his/her term of office.
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In order to encourage dermatologists to take leadership roles in their specialty going forward, the Academy is seeking applicants for three leadership programs in 2019.

Leadership Forum
The 2019 Leadership Forum will bring together aspiring leaders in dermatology with experienced mentors to enhance their communication and leadership skills. The event will take place May 30-June 2 at the Eaglewood Resort near Chicago. Aspiring leaders will engage in an interactive program with colleagues and Academy leadership, and will learn critical competencies for physician leaders, including self-assessment and leveraging innate skills. It is open to dermatologists in both private-sector practice and academic settings. The Academy will provide travel and lodging expenses, as well as on-site meals for the Leadership Forum. Applications will be open June 15 through Oct. 1, 2018. For more information on the 2019 Leadership Forum, visit www.aad.org/LeadershipForum.

Academic Dermatology Leadership Program
The Academic Dermatology Leadership Program is facilitated by the Academy to provide physicians in academic settings the resources to meet the unique challenges of life in academia. A total of 18 Academy members will be chosen to participate in this highly selective program, which includes informative sessions at both the annual and summer AAD meetings, participation in the 2019 Leadership Forum, and opportunities to connect with an experienced mentor. This program requires a year-long commitment of between five and eight hours per month in addition to the on-site sessions. Applications will be open from June 15 through Oct. 1, 2018. For more information on the Academic Dermatology Leadership Program, visit www.aad.org/ADLP.

Advanced Leadership Forum
The Academy also offers an Advanced Leadership Forum designed for mid-career level dermatologists. The event will take place May 30 – June 2 at the Eaglewood Resort near Chicago, in conjunction with the Leadership Forum. Applications are open to all dermatologists, especially those with a particular interest in developing leadership skills that are transferrable to both practice and advocacy settings. Eligibility requirements include the member being 10 years out of residency training or six years past Leadership Forum attendance. Applications will be open from June 15 through Oct. 1, 2018. For more information on the Advanced Leadership Forum visit www.aad.org/AdvancedLF.

Leadership Programs
For more information applying for Academy leadership programs, visit www.aad.org/LeadershipForum
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Dermatology practice staff by the numbers

BY EMILY MARGOSIAN, CONTENT SPECIALIST

Nurses, aestheticians, billers — who’s most likely to be spotted working in the average dermatology practice? Aside from dermatologists, medical assistants and practice administrators are the most widely employed across all practice settings, according the 2017 AAD Practice Profile Survey. Both staff types are employed in roughly a 3:1 ratio with dermatologists, while nurses are employed in close to half of practices, and physician assistants in just over a third.

Given that nearly half (47%) of dermatology practices employ a PA or NP, how does the workload of non-physician clinicians compare to that of dermatologists? Dermatologists are still bearing the brunt, data says. According to survey results, dermatologists see an average of 121 patients per week, while non-physician clinicians see 80-87 patients per week. For more on dermatology staff distribution across all practice types, see the chart below. dw

### Staff distribution across all practice types

<table>
<thead>
<tr>
<th>Staff Type</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical assistants</td>
<td>82%</td>
</tr>
<tr>
<td>Aestheticians</td>
<td>30%</td>
</tr>
<tr>
<td>Admin/Billing</td>
<td>82%</td>
</tr>
<tr>
<td>Nurse practitioners</td>
<td>20%</td>
</tr>
<tr>
<td>Practice managers</td>
<td>64%</td>
</tr>
<tr>
<td>Dermpath histotechs</td>
<td>12%</td>
</tr>
<tr>
<td>Nurses</td>
<td>47%</td>
</tr>
<tr>
<td>Medical scribes</td>
<td>11%</td>
</tr>
<tr>
<td>Physician assistants</td>
<td>37%</td>
</tr>
<tr>
<td>Lab technicians</td>
<td>9%</td>
</tr>
<tr>
<td>Mohs histotechs</td>
<td>33%</td>
</tr>
</tbody>
</table>
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