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I just finished reading the book Good to Great.

I’d recommend that you consider reading it if you have a free minute. It talks about what it takes to move a company from a good one to one that is universally admired. It is timely reading for me as I try to craft where I’d like my new department to go. Jim Collins points out that this transformation is rarely due to luck or external factors. Nor does it depend on where one is starting. Rather he points out that it requires a dedicated leader who confronts the facts on the ground, makes hard decisions, then takes steps both big and small to move the company where it needs to go. Focus and mission are inherent parts of this vision. Think Churchill...his focus on the evils of Nazism was unwavering in the face of a world tired of war and willing to keep trying to placate Hitler. This book stresses that leadership is critical at all times, not just times of trouble.

As physicians we are each leaders of our “individual ships” for our patients and staff. We learned in our training...the notion that the responsibility for a patient’s care stops with us. Who amongst us has not felt the weight of a treatment recommendation and its possible associated risks? Or the procedure that we worry about long after we leave the office for the day? Our leadership is also reflected in the tone of our offices. It reflects our beliefs and values as our staff takes its cues from us.

Our article on the metabolic syndrome brought me right back to one of Jim Collins’ points. He writes about the willingness of the best leaders to look at facts and make unpopular decisions because they are right. We’ve learned in the past several years about the role of systemic inflammation in some of our cutaneous diseases. It is nothing short of revolutionary. No longer can we be telling our patients, “Don’t worry, it is just a rash, it won’t kill you.” We went into dermatology because we loved it. I’m reminded of that daily as I listen to the medical students who’d like to follow in our wake. If we are great leaders today, then the new approaches that offer promise.

How about dermatology? Read our piece on body sculpting to find out. Freezing it, ultrasound sounding it, acoustic waving it, moving it…the approaches are multiplying under our very eyes. No longer should we simply tell patients to live with their weight; we are figuring out how to address our patient’s concerns. We are moving from simple weight reduction to these new approaches that offer promise.

We went into dermatology because we loved it. I’m reminded of that daily as I listen to the medical students who’d like to follow in our wake. If we are great leaders today, then the “company of dermatology” will remain great for tomorrow’s group.

Enjoy your reading.

Abby S. Van Voorhees, MD
Physician Editor

The Hill 90D Dermatology Chair offers an impressive list of features compared to other models and with quality you’d expect from a fourth generation company. Electric height, power lift-back, manual adjustable foot section, adjustable headrest and up to 600 lb. lift capacity are all standard. Add options like electric tilt and foot sections, removable armrests, contour cushions, matching stool—and new features like six-position programming and a rotating base to make the 90D the perfect solution for your practice.

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FACTS AT YOUR FINGERTIPS
Find out where the body contouring options you offer rank in a recent rundown of procedures performed nationwide.

FROM THE EDITOR
Physician Editor Abby Van Voorhees, MD, previews this month’s issue.

WHAT’S HOT?
Members of DW’s Editorial Advisory Workgroup share exciting news from across the specialty.

CRACKING THE CODE
Columnist Alex Miller, MD, goes local and addresses what local coverage determinations mean for your coding.

ROUNDS
Dealing with narrow networks in your state? The AADA is on the case.

ACTA ERUDITORUM
Which topicals work best for scalp psoriasis? Physician Editor Abby Van Voorhees, MD, asked the author of a recent Cochrane review.

LEGALLY SPEAKING
Can you waive copays for patients?

ANSWERS IN PRACTICE
Step one in staying out of trouble with regulators is having an effective compliance process.

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

Psoriatic disease has been linked with a higher risk of developing heart disease, including sudden MI, especially in younger individuals with severe disease. Providing additional evidence of this link, a recent article in *Arteriosclerosis, Thrombosis and Vascular Biology* (doi: 10.1161/ATVBHA.116.307469) describes the link between psoriasis and abdominal aortic aneurysms. Using data from Danish nationwide registries between 1997 and 2011, the authors examined information from 59,423 adult patients with mild psoriasis and 11,566 patients with severe disease. The rates for AAA in the general population were 3.72/10,000 per person years. For patients with mild psoriasis, the rate increased to 7.30, and jumped to 9.87 for those with severe disease. The lead author noted that this placed psoriasis patients at a 67 percent greater risk of developing an AAA. The correlation between psoriasis and AAAs may be related to their common immunopathology: AAAs are associated with increased inflammation involving T-helper 17 cell-mediated pathways, as is psoriasis. More research is needed to further investigate this association, however this certainly gives us greater impetus to encourage psoriasis patients to treat their disease with systemic agents and engage in healthy lifestyles that limit heart disease risk.

Can your dermatopathologist diagnose pemphigus and pemphigoid without the use of immunofluorescence?
Recent studies have shown that the use of immunoperoxidase staining on formalin fixed tissue with C3d can detect complement staining in cases of pemphigoid. A current study from France, “Application of C4d Immunohistochemistry on Routinely Processed Tissue Sections for the Diagnosis of Autoimmune Bullous Dermatoses,” showed that C4d immunoperoxidase staining of skin that has been formalin fixed and paraffin embedded was successful in diagnosing pemphigus and pemphigoid (*Am J Dermatopathol* 2016;38:186-188). The study included 29 cases of pemphigoid and 22 cases of pemphigus. The sensitivity for pemphigoid was 86 percent and the sensitivity for pemphigus was 77 percent. For both entities, the specificity was 98 percent. While the data in the literature for using both C3d and C4d immunohistochemistry in the diagnosis of pemphigoid and pemphigus is still limited, this potentially gives dermatopathologists another mechanism for diagnosing autoimmune blistering diseases if immunofluorescence testing is not available or if the patient cannot have an additional biopsy. Larger studies are needed to confirm this finding. However, in the interim, detecting the presence of C3d or C4d by immunohistochemistry can be “highly suggestive” of an autoimmune blistering disorder and perhaps can hasten treatment in patients with severe disease.

Wrong-site surgery for cutaneous lesions is an important patient safety issue and is one of the major causative factors of adverse events in cutaneous surgery. A recent review highlighted best practices for avoiding medical errors in cutaneous site identification (*Dermatol Surg* 2016;42:477-484). Preoperative photography with clearly labeled photographs remains the gold standard. Best practices for standardizing these photographs are discussed as well as the procedure of taking two photographs. One photograph is taken of the lesion itself and a second to delineate the lesion in relation to anatomic landmarks. As preoperative photography has challenges especially in the setting of electronic medical records that are not compatible, other options, including cell phone pictures taken by the patient, are an option. Having the patient-owned pictures on the patient’s own device helps avoid issues regarding privacy concerns. Ultraviolet tattoos marking the biopsy site are another technique that can be utilized to aid in later site identification. Finally, if there is no definitive documentation of the location frozen section rebiopsy of the suspected site can be performed.
Most clinicians performing patch testing are aware of the extremely useful member benefit that the American Contact Dermatitis Society has developed called CAMP (Contact Allergen Management Program). This program allows clinicians to enter the allergens identified through patch testing into the database and a list of products free of the known allergens is produced. Providing patients with this list helps them comply with avoidance by simplifying the selection of products they can use. The database separates the products into categories. The lists can be very long depending on the number of allergens the patient reacts to. The ACDS announced at its annual meeting in March that the CAMP database now has an app (ACDS CAMP) that simplifies this process ever further. By providing the patient with the code to their specific product list, the patient can have all of the products easily accessible at their fingertips through their smartphone, eliminating the need to carry with them the long lists provided to them by their physicians. When using the app with their specific code, patients can very easily navigate through specific categories to find products safe for their use. This app will hopefully enhance and simplify patients’ ability to comply with avoidance of known allergens.

Since gaining FDA approval in 1982, isotretinoin has proven to be a powerful tool for treating moderate to severe acne, especially acne refractory to other treatments. While the actual risk of depression and suicidal ideation due to isotretinoin is not completely understood, most dermatologists would agree that screening for this behavior is an important part of an isotretinoin visit. However, there are currently no guidelines about how to adequately screen for depression in patients taking isotretinoin. Schrom, et al, in their commentary in press with JAAD, “Depression screening using health questionnaires in patients receiving oral isotretinoin for acne vulgaris,” discuss the use of a two- or nine-question validated depression screening tool (http://dx.doi.org/10.1016/j.jaad.2016.02.1148). These tools provide a 74 percent and 89.5 percent sensitivity, respectively, and a 75 percent and 77.5 percent specificity, respectively, for the presence of depression in adolescents. The questions are brief and score from zero to three, making them very suitable for a printed questionnaire or EHR template. Using one or both of these standardized and validated tools can help protect our patients against the potential risks of this highly effective medication.

The University of Missouri’s Dermatology Department is taking an innovative approach to telemedicine. Using the Project ECHO (Extension for Community Healthcare Outcomes) model, Karen Edison, MD, has pioneered a large-scale telemedicine program that engages Missouri’s primary care clinicians and empowers them in their dermatologic care. Project ECHO was originally developed at the University of New Mexico by Sanjeev Arora, MD. In 2003, Dr. Arora was one of two hepatitis C specialists in the state and he was concerned that thousands of New Mexicans with hepatitis C could not get the treatment they needed because there were no specialists in their hometown areas. To address this issue, he created the Project ECHO model in which rural clinicians collaborate with specialists at academic medical centers through weekly virtual clinics to discuss specific patient care issues. Following the patient discussions, the specialist holds a short CME session to further educate the rural practitioners to better care for their patients in their hometowns. This program has resulted in improved care, avoidance of excessive travel for patients, and created a stronger primary care workforce. Dr. Edison is leading the first largescale Project ECHO Dermatology program in the U.S. and is transforming our dermatology access-to-care model.
Living with LCDs

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.

Medicare Administrative Contractor (MAC) Local Coverage Determinations (LCDs) exist for the purpose of defining coverage, billing, and documentation criteria for a variety of defined diagnoses or procedures. You most likely know that they exist, and you try to adhere to their directives. But do you really? If you receive a chart audit request focused upon specific services that you provided will you be able to justify what you did based upon fulfillment of LCD criteria, including documentation and signature?

The most prevalent LCDs affecting dermatologic care are for removal of benign lesions, actinic keratoses (AKs), and Mohs surgery. You may extract listings of LCDs pertinent to your practice from your MAC’s website. What if your MAC has no LCDs touching upon what you do? That does not mean that no policies regarding benign lesions, AK treatments, and Mohs surgery exist. In such instances the MAC simply does not feel a need to codify policies in an LCD. For example, despite a lack of LCDs for benign lesions, AKs, and Mohs surgery in the National Government Services (NGS) jurisdiction, which covers New York and all states north, you are expected to adhere to general coverage and documentation requirements, and to specific Mohs documentation criteria as delineated by the Centers for Medicare and Medicaid Services (CMS). (See www.aad.org/dw/monthly/2013/september/documenting-mohs-surgery). The LCD mandates the following minimum documentation requirements: the method of destruction/removal should be listed; the number and location of the AKs should be described. The LCD goes on to state the following: “When the documentation does not meet the criteria for the service rendered or the documentation does not establish the medical necessity for the services, such services will be denied as not reasonable and necessary.” The practical corollary of this statement is that if your patient record lacks the minimum documentation criteria for treated AKs your claim will be denied if audited.

Documentation for Mohs surgery must follow LCD edicts, particularly since lapses in documentation may result in post-payment claim rejections and demands for refunds. If faced with an audit of Mohs surgery chart material you should ensure that present and future documentation adheres to the criteria set forth in the LCDs. For example, both the First Coast (FCSO) (Florida and Puerto Rico) and Novitas (Texas and surrounding states and New Jersey and adjoining states except for New York) Mohs

ICD-9 to ICD-10

In order to promote a comfortable transition from ICD-9 to ICD-10 coding the AAD offers a concise ICD-9-CM to ICD-10-CM Crosswalk for Dermatology, available for purchase through the AAD website at www.aad.org/store/product/default.aspx?id=8649. This fold-out manual lists the most commonly used dermatologic codes in their ICD-9 format alongside the appropriate ICD-10 codes.

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The most prevalent LCDs affecting dermatologic care are for removal of benign lesions, actinic keratoses (AKs), and Mohs surgery. You may extract listings of LCDs pertinent to your practice from your MAC’s website. What if your MAC has no LCDs touching upon what you do? That does not mean that no policies regarding benign lesions, AK treatments, and Mohs surgery exist. In such instances the MAC simply does not feel a need to codify policies in an LCD. For example, despite a lack of LCDs for benign lesions, AKs, and Mohs surgery in the National Government Services (NGS) jurisdiction, which covers New York and all states north, you are expected to adhere to general coverage and documentation requirements, and to specific Mohs documentation criteria as delineated by the Centers for Medicare and Medicaid Services (CMS). (See www.aad.org/dw/monthly/2013/september/documenting-mohs-surgery). Furthermore, you should carefully observe Medicare guidelines on non-covered services. Specifically, the Medicare Benefit Processing Manual, Chapter 16, Sec. 120 states: “Cosmetic surgery or expenses incurred in connection with such surgery is not covered. Cosmetic surgery includes any surgical

procedure directed at improving appearance, except when required for the prompt (i.e., as soon as medically feasible) repair of accidental injury or for the improvement of the functioning of a malformed body member.”

The treatment of AKs is covered nationally by Medicare under national coverage determination 250.4. However, that does not allow for imprecise documentation. Noridian Healthcare Solutions (NHS), the MAC which administers Medicare claims processing for the western United States including Alaska and the Pacific Islands, has an LCD for AKs. The LCD mandates the following minimum documentation requirements: the method of destruction/removal should be listed; the number and location of the AKs should be described. The LCD goes on to state the following: “When the documentation does not meet the criteria for the service rendered or the documentation does not establish the medical necessity for the services, such services will be denied as not reasonable and necessary.” The practical corollary of this statement is that if your patient record lacks the minimum documentation criteria for treated AKs your claim will be denied if audited.

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LCDs list extensive documentation requirements. Among these are: a description of why a lesion was not managed with non-Mohs surgical techniques such as excision or destruction; why Mohs is an appropriate choice; why a complex flap or graft is done. A discussion of treatment options must be documented. The chart must also specify that the Mohs physician is both a surgeon and pathologist. Upon audit, charts lacking the details called for in the documentation requirements section will likely lead to a demand for a refund even if an otherwise perfectly legitimate Mohs surgery was done.

The Novitas Mohs surgery and Benign Skin Lesion LCDs contain the following ominous declaration: “Compliance with the provisions in this policy may be monitored and addressed through post payment data analysis and subsequent medical review audits.” What does this mean? Being a statistical outlier may get you audited.

**Example 1**

Your California Medicare patient implores you to remove multiple seborrheic keratoses because they are “ugly,” catch on clothing, and are a nuisance. You freeze 11 keratoses and bill Medicare CPT 17110, destruction of up to 14 benign lesions, and ICD-10 L82.0, inflamed seborrheic keratosis.

**Answer: Incorrect.** Ugly, catching on clothing, and nuisance do not fulfill the Jurisdiction E and F Noridian MAC Benign Skin Lesion LCD criteria. In order to be covered, a seborrheic keratosis would have to exhibit one or more of the following: bleeding, intense itching, pain, inflammation (purulence, oozing, edema, erythema), obstruction of an orifice or restricting vision, or be subject to recurrent physical trauma. Any of the qualifying criteria would need to be clearly documented in the patient record. A chart review by the MAC or other designated reviewer could lead to unpleasant consequences for the physician if a pattern of inappropriate billing were uncovered. However, if the chart record were to specify that the seborrheic keratoses that caught on clothing were painful, inflamed, or bleeding, then they would meet coverage criteria.

**Example 2**

A Medicare patient with a recently excised perinasal basal cell carcinoma complains of a reduction of air flow through the right naris and a traction deformity of the ala. You correct the deformity and open the naris with a V-Y release surgical procedure. As the surgery is related to the previous basal cell carcinoma, you bill Medicare CPT 14040 for the V-Y adjacent tissue rearrangement.
Answer: Correct. The surgery was done as a consequence of a previous treatment for a medically necessary service to treat the malignancy, and as such constituted an extension of the malignancy’s treatment. Furthermore, the procedure was done to improve the function of a deformity. The surgery therefore constituted a covered service. The Medicare Benefit Processing Manual allows for coverage when a surgery done for therapeutic purposes “also serves some cosmetic purpose.”

Example 3

You freeze nine actinic keratoses on a Medicare patient’s face and bill your Noridian contractor CPT 17000 and 17003x8 for your efforts. Your chart record specifies that the AKs were on the face and that they were destroyed with liquid nitrogen cryotherapy.

Answer: Incorrect. The Noridian Actinic Keratosis LCD (L34188) requires a description of the number and locations of the lesions. The description may be in the form of a photograph or drawing. In this particular case the chart did not accurately list the locations of the lesions beyond that they were located on the face. This imprecision may be used by an auditor as grounds for rejecting the claim.

Example 4

You receive a request for submission of several Mohs surgical chart files for review by your MAC. You are confident that you have satisfied all of the documentation requirements for the surgeries and ask your staff to submit the chart materials for audit. To your major surprise you receive a demand for a refund of all of the payments for the Mohs surgeries. How could that be? You were sure that your record keeping adhered perfectly to the LCD requirements.

Answer: You most likely neglected to submit one universally required detail: your legible signature. Lack of signature attestation is the number-one reason for rejection of reviewed claims. Medicare requires that a signature be appended to the chart entry and that the signature be legible. An electronic health record must appropriately attest to the authenticated signature. Otherwise, you may submit a signature attestation statement, downloadable from the MAC website, for each chart. Alternately, if the signature is not legible, attach a signature log listing the date, name, signature, initials, and degree of the treating physician or health professional.

(See www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM6698.pdf.)
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Network adequacy legislation picking up speed in 2016

STATE NEWS ROUNDUP

BY VICTORIA PASKO, SENIOR SPECIALIST, STATE POLICY

Maintaining accurate directories

In a JAMA Dermatology study examining the accuracy of provider directories in Medicare Advantage plans in 12 U.S. metropolitan areas, almost 50 percent of the physicians were listed inaccurately, whether by location, willingness to accept the plan, or ability to accept new patients (2014; 150(12):1290-1297). A similar set of studies conducted by the California Department of Managed Healthcare evaluated the accuracy of directories for marketplace plans offered by Blue Shield of California and Anthem Blue Cross. These studies found that the provider directories listed physicians with inaccurate locations in 12.5 percent of Anthem Blue Cross listings and 18.2 percent of Blue Shield of California listings. Further, 12.8 percent and 8.8 percent respectively of physicians listed were not willing to accept members enrolled in the Covered California products, despite being listed as willing to accept. As a result, several states have taken on this issue.

In Georgia, legislation is on the governor’s desk that would require insurers to maintain accurate provider directories that are accessible to the public via electronic and printed directories, and require certain information — such as contact information and specialty — to be listed in the directories, which the legislation would require to be updated every 30 days.

Similarly, legislation in Rhode Island would require insurers to maintain accurate provider directories and ensure their access to the public. The bill requires any insurer seeking to market a health plan to the state to submit a provider directory to the Insurance Commissioner for approval. In order to obtain approval, the directory must include: the physician’s name and contact information; specialty or subspecialty; hours that the physician is available to treat patients, and the names and locations of the hospital(s) where the physician has medical staff privileges and whether those hospitals are part of the provider network. The bill also states that a violation of the law would constitute an unfair and deceptive act or practice. The bill was held for further study in the House Health, Education and Welfare committee.

Comprehensive network adequacy

The Maryland House and Senate passed network adequacy bills that require carriers to ensure that all enrollees have access to providers and covered services without unreasonable travel or delay. Changes to networks must be reported to the commissioner within 15 days after the change occurs, and the Commissioner may consider how telemedicine, telehealth, or other technology may be used to meet the network adequacy standards for a carrier’s access plan. The bill also requires accurate and frequently updated network directories to be available on the internet to prospective enrollees. Among many other provisions, the bill authorizes the commissioner to create a “multi-carrier common online provider directory information system” so providers can update their network directory information with carriers. The bills will be sent to the governor for signature.

The Louisiana Senate may consider a bill that would require insurers to maintain a network of providers that is sufficient in numbers and appropriate types of providers. The Insurance Commissioner may approve a network’s sufficiency by using criteria including provider-covered person ratios by specialty,

Medicare Advantage Plans

To read more about the JAMA Dermatology study examining the accuracy of provider directories in Medicare Advantage plans, visit http://archderm.jamanetwork.com/article.aspx?articleid=1919439
Pending legislation

The Network Adequacy and Patient Fairness Act was introduced in the Senate but language for the bill has not been released. The AADA has made a number of recommendations for the bill language to ensure patient access to physicians.

Legislation was introduced that would require insurers to maintain accurate provider directories that are accessible to the public.

Legislation was introduced that requires insurers to maintain adequate networks of physicians as determined by the Insurance Commissioner. The legislation also requires numerous provisions that would protect providers and patients from narrowed networks.

Both chambers passed bills that require carriers to ensure that all enrollees have access to providers and covered services without unreasonable travel or delay.

Legislation is waiting to be signed into law that would require insurers to maintain accurate provider directories that are accessible to the public via electronic and printed directories and are updated every 30 days.

geographic accessibility of providers, wait times, hours of operation, and potentially even the availability of telemedicine capabilities. The bill also establishes a process for covered individuals to obtain their benefits when the provider needed isn’t covered by the plan for a multitude of reasons, and contains a brief provision requiring current and accurate directories. Only new plans need to have an access plan submitted for review, though the plan is exempted if it has National Committee for Quality Assurance (NCQA) accreditation, leases a network from a plan with NCQA accreditation, or has less than 750 covered lives. The bill has been referred to the Senate Committee on Insurance.

A shell bill known as the Network Adequacy and Patient Fairness Act has been introduced in the Illinois Senate. Language has not yet been released. The AADA sent the Illinois State Medical Society a redlined version of the National Association of Insurance Commissioners (NAIC) model network adequacy act as they consider bill language. The AADA’s recommendations include adding definitions of “material change” and “subspecialty,” requiring a sufficient number of specialists and subspecialists, requiring an insurer or regulator to calculate the Full-Time Equivalent (FTE) of available physicians when determining the provider-to-covered-person’s ratio, and considering practice hours of operation when determining network adequacy to ensure covered beneficiaries have access to specialists and subspecialists.

Legislation introduced in Connecticut mostly contains the NAIC model bill language, requiring insurers to maintain adequate networks of physicians — the sufficiency of which is to be determined by the Insurance Commissioner via a list of criteria — and requiring numerous provisions intended to protect providers and patients from the practice of narrowing networks. The bill does not presently include the section of the NAIC model bill dealing with “surprise” or out-of-network billing. The AADA opposes the inclusion of a section addressing surprise billing, noting that if a health plan offers adequate networks and aligns participating hospital-based physicians with in-network hospitals, the section becomes unnecessary. The bill passed committee and awaits a vote in the Senate. dw
Which topicals work for scalp psoriasis?

BY ABBY S. VAN VOORHEES, MD

In this month’s Acta Eruditorum column, Physician Editor Abby S. Van Voorhees, MD, talks with Justin Gabriel Schlager, MD, about his recent Cochrane Database of Systemic Reviews article, “Topical treatments for scalp psoriasis.” Cochrane conducts systematic reviews of primary research on health care and health policy topics to facilitate evidence-based decision-making by health care providers, patients, and policymakers.

Dr. Van Voorhees: What was the purpose of performing this review?

Dr. Schlager: Our goal was to summarize the current evidence on how well topical treatments for scalp psoriasis are tolerated and which works best. We graded the quality of the evidence for preparations that are often used, such as topical corticosteroids (e.g. betamethasone dipropionate), vitamin D (e.g. calcipotriol) and the two-compound combination of a corticosteroid and vitamin D (e.g. betamethasone dipropionate plus calcipotriol).

Dr. Van Voorhees: There have been many studies which have explored the benefits of topical medications in the treatment of scalp psoriasis. How many studies did you look at for this review?

Dr. Schlager: Indeed, during our systematic literature search, we found numerous references. This was due to our wide focus: we aimed to include any kind of topical treatment that has been explored by a randomized controlled trial (RCT). At the end, we included 59 RCTs from 1972 until 2015.

Dr. Van Voorhees: How good was the data? Was the quality of the data something that limited this review?

Dr. Schlager: Most studies that were published during the last decade focused on topical corticosteroids, vitamin D derivatives, or on the two-compound combination. Most were well designed, well conducted, and had a large number of participants. For this reason, we could gather good and reliable data for these therapies. Unfortunately, this was not the case for most other treatment options such as for tar preparations, dithranol, salicylic acid, or vehicle-comparisons. For these treatments, evidence was poor and we could not draw final conclusions.

Furthermore, almost all our findings are limited to short-term therapies, since most studies were conducted for less than six months.

Dr. Van Voorhees: What did you find? What approach was the most efficacious?

Dr. Schlager: Our metaanalyses showed that the two-compound combination as well as
corticosteroids of high and very high potency worked better than vitamin D. The two-compound combination was statistically more effective than the corticosteroid as monotherapy, but the benefit was small and probably not relevant.

**Dr. Van Voorhees:** Did certain medications have more risk of side effects from their use compared with the others?

**Dr. Schlager:** Compared to the two-compound combination and corticosteroids more patients who applied a vitamin D derivative stopped treatment because of side effects. In addition, more patients with vitamin D had at least one adverse event, such as local irritation, folliculitis, or skin pain. The two-compound combination and the corticosteroid as monotherapy did not differ in the risk of causing side effects or withdrawal from treatment. At this point, however, we must highlight that all three treatments were well tolerated and the risk of side effects was low.

**Dr. Schlager** is in the division of evidence based medicine, department of dermatology, venerology and allergology, at Charité – Universitätsmedizin in Berlin. His article appeared in Cochrane Database of Systematic Reviews 2016(2): CD009687. DOI: 10.1002/14651858.CD009687.pub2.

**Dr. Van Voorhees:** Were you able to demonstrate that use of a topical agent impacted the patient’s quality of life (QOL)?

**Dr. Schlager:** Unfortunately, we could only find two well-conducted studies with reliable data on QOL. One study found that clobetasol propionate improved QOL better than the vehicle (placebo) alone. The other trial showed that the two-compound combination of betamethasone dipropionate and calcipotriol was preferable to calcipotriol monotherapy. However, we could not grade the quality of evidence because statistical data were poorly reported.

**Dr. Van Voorhees:** What are the take-home messages for practicing dermatologists?

**Dr. Schlager:** In light of the only slim benefit and comparable safety profile of the two-compound combination compared to the corticosteroid alone, generic topical corticosteroid of high or very high potency may be fully acceptable for short-term therapy. dw
Waiver of copayments and deductibles

BY CLIFFORD WARREN LOBER, MD, JD

Every month, Dermatology World covers legal issues in “Legally Speaking.” Clifford Warren Lober, MD, JD, presents legal dilemmas in dermatology every other month. He is a dermatologist in practice in Florida and a partner in the law firm Lober, Brown, and Lober.

Brenda: Bryan, I would like to waive the copayments for my Medicare patients. Is this legal?

Bryan: Absolutely not! Routinely waiving Medicare deductibles or copayments is a violation of federal law. When you submit a claim to Medicare or any other federal program the amount you bill should be your usual, customary, and reasonable fee. If you routinely do not collect the portion due from the patient, the amount you bill Medicare is not actually your fee since you really have no intention of collecting that amount.

Brenda: What do you mean?

Bryan: If you bill Medicare $120 for your services, for example, and Medicare allows $100, the patient is responsible for 20 percent of that amount after they have met their annual deductible. Assuming their deductible was met, Medicare would pay you $80 and you would collect $20 from the patient. If you accept $80 as payment in full, the actual charge was $80—not the $120 you billed Medicare. Routinely waiving copayments and deductibles is construed as an inducement for Medicare patients to seek more services. Writing off the patient’s obligation may be considered a “kickback” to the patient and violates the federal anti-kickback statute. You could be excluded from Medicare and other federal programs as well as face significant fines.

Brenda: What if the patient is indigent?

Bryan: In cases where the patient is truly indigent, you can waive their deductible and copayments. You should have reasonable, clearly articulated, predetermined criteria for determining hardship and document, if possible, that the patient meets these criteria. The criteria should be uniformly applied to all patients. Waiving deductibles and copayments, however, should be a relatively uncommon event in most practices.

Brenda: Can I waive deductibles and copayments for patients covered by private insurance?

Bryan: I would encourage you not to do so for several reasons. Billing a private insurance company for an amount you do not actually intend to collect or habitually waiving deductibles and copayments leaves you vulnerable to being charged under our state anti-kickback and false billing statutes. It may also be a violation of the terms of your contract since the company’s payment is made with your express agreement and contractual obligation to collect deductibles and copayments from the patients. Not doing so is construed as encouraging overutilization and undue expense to the insurance company. Furthermore, private insurance companies frequently have “most favored nation” clauses in their contracts that require you to charge them the lowest rate you charge any other entity. By writing off deductibles and copayments, you may have violated your obligation to give the in-
insurance company the lowest fee you actually accept. Other contracts contain provisions which expressly prohibit your discounting or waiving deductibles and/or copayments.

**Brenda:** What about professional courtesy? Can I treat my medical colleagues without charging them?

**Bryan:** If you intend to discount or waive fees, be certain to do so for all physicians in the community or on the medical staff of your hospital, not just those who refer or who are typically or customarily in a position to refer patients to you, such as family physicians or internists. Under federal law and the laws of many states, the key consideration is whether the professional courtesy discount can be construed as an inducement or reward for referring patients to you. If you waive or discount your fees to physicians, in addition to the concerns I previously mentioned, be aware that you should not offer part of your services for free and bill only for those portions of the visit or services covered by insurance. Any discount should be on the total amount of the patient’s financial obligation and indicated on the patient’s bill to avoid the possible appearance or accusation of improper or fraudulent billing.

**Brenda:** Wow! I will certainly take your advice. *dw*

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**Key points**

1. Routinely waiving deductibles or copayments for Medicare or other federal programs is a violation of federal law. It is considered a “kickback” to the patient and an inducement for them to seek more services. You may face exclusion from federal programs and/or significant fines.

2. You can waive deductibles and copayments for truly indigent patients, but you should have reasonable, clearly articulated, predetermined, uniformly applied criteria for determining hardship and document, if possible, that patients receiving waivers meet these criteria.

3. Billing a private insurance company for an amount you do not intend to collect may result in charges of false or fraudulent billing, violate your contractual obligations to the insurance company to bill the patient for deductibles and copayments, or violate the “most favored nation” clause or other express provisions in your contract prohibiting discounting.

4. If you discount or waive fees to physicians, do not do so only to those who refer or who are typically in a position to refer patients to you, such as family physicians and internists, so that this professional courtesy is not construed as an inducement or reward for referring patients.

5. States have laws on billing and claim submission which may place other restrictions on discounting professional fees.
Setting up a compliance process

BY RACHNA CHAUDHARI, MANAGER, PRACTICE MANAGEMENT

Each month Dermatology World tackles issues “in practice” for dermatologists. This month Rachna Chaudhari, the Academy’s practice management manager, offers tips on an area she commonly receives questions about from members.

Whether or not your practice has faced ongoing issues with HIPAA, CLIA, OSHA, or other regulatory risks amongst the alphabet soup of compliance programs, the first step in addressing any of these challenges is setting up a compliance plan and a process to manage and update it. The Office of the Inspector General (OIG), which oversees the protection of programs in the Department of Health and Human Services, recommends seven fundamental elements of an effective compliance program:

1. Designating a compliance officer and compliance committee
2. Implementing written policies, procedures, and standards of conduct
3. Conducting effective training and education
4. Developing effective lines of communication
5. Conducting internal monitoring and auditing
6. Enforcing standards through well-publicized disciplinary guidelines
7. Responding promptly to detected offenses and undertaking corrective action

These seven fundamental elements should be utilized with all of your practice’s compliance programs to mitigate risk and ensure you do not face future penalties.

Designating a compliance officer
As most dermatology practices consist of either solo or small groups, you will want to assign one staff member to be the designated compliance officer for all regulatory programs. Most practices assign this task to the office manager or practice administrator. Create a job description for this position so the duties are well documented. The job description should establish how the dermatologist should be involved in overseeing the compliance duties as well as training requirements for the position and how much flexibility the compliance officer has in fixing deficiencies.

Implement written policies, procedures, and standards of conduct
Each facet of a compliance program should have clearly written policies and procedures that have been reviewed by the dermatologist owner and compliance officer. Your practice should keep these separate according to the compliance program they are referring to, i.e. a policy and procedure document for HIPAA compliance, a policy and procedure document for CLIA compliance, etc. The policies and procedures should take into account each staff person’s individual responsibilities and how they relate to that specific compliance issue as well as case studies which could be analyzed by staff.

Training and education
Not only should the compliance officer have documented compliance training ongoing throughout the year, but all staff members as well as physicians should be expected to maintain compliance education. This education should be a requirement for each employee’s yearly job performance rating. Practices can also
make this a regularly scheduled in-service training whereby the compliance officer leads the education for all staff. Free training resources are available at http://oig.hhs.gov/compliance/provider-compliance-training/index.asp#materials. Additionally, the compliance officer should keep documentation of all employees’ training and subscribe to relevant compliance listservs and educational resources.

Communication
It is key that the practice has open lines of communication about ongoing compliance concerns to ensure that all issues are addressed and risks mitigated. The compliance officer should stress to all employees that the practice has an open-door policy to address complaints along with an anonymous tip line for employees to report compliance issues. The dermatologist owner should also be heavily involved in reviewing this communication on an ongoing basis so deficiencies are not ignored.

Internal monitoring and auditing
In addition to keeping open lines of communication to discover common compliance concerns, the compliance officer should formulate a plan to routinely audit risk areas. For example, for purposes of HIPAA compliance, the compliance officer should review how often staff are using encrypted email to share protected health information (PHI). If a staff member is found to be using non-encrypted email, they would be identified and re-educated on the proper steps to take when communicating PHI. The compliance officer would also be expected to document where the risks were found and what steps were taken to mitigate each issue. Formulate actual benchmarks and goals that can be measured throughout the year to maintain compliance.

Enforcing standards
The key to enforcing all of the standards you have developed in your compliance process is to maintain consistency and create standard disciplinary action when those standards are violated. All staff should be educated on what the ramifications are if the compliance standards are not met. The compliance officer should also keep a documented log of these instances as well as how the practice reacted to address the situation. Enforcement shouldn’t take place only when the appropriate regulatory body learns of a violation but on an ongoing basis from the practice itself.

Taking corrective action
Even after accounting for all possible compliance issues through effective policies and procedures, the practice may still be faced with an actual deficiency and how the practice chooses to react should be expressed through an appropriate response. The compliance officer should document the deficiency along with what type of corrective action was taken and ensure the appropriate agencies were contacted. It is a common occurrence for practices to have compliance problems arise; however, how you choose to manage the situation will most likely determine whether the practice may face any legal and/or financial risk. dw
BODY CONTOURING CARVES OUT ITS NICHE

A look at what’s shaping up in cosmetic dermatology
When diet and exercise aren’t enough, a dermatologist might not be the first thought for patients looking to shed stubborn fat. However as minimally invasive technologies continue to open doors for patients looking for alternatives to traditional fat-reduction methods, dermatologists may find themselves treating more patients looking to smooth, fill, or compress their shape. As national spending on cosmetic procedures continues to rise, hitting an unprecedented $13.5 billion in the United States in 2015 according to the American Society for Aesthetic Plastic Surgery, new therapies continue to emerge to meet demand. (For more details on this rise in spending, see the Facts at Your Fingertips column, p. 56.)

Evolving patient expectations for minimal downtime and decreased costs have helped fuel a growing market for non-invasive devices focused on skin tightening and smoothing as opposed to more aggressive re-volumizing procedures. The convenience and steadily shrinking size of these devices have also enabled patients to contour parts of the body outside traditional areas such as the stomach and thighs, allowing the neck, chest, legs, chin, and hands to emerge as potential canvases for cosmetic work. >>
New fat reduction techniques

New devices that freeze fat or blast it with sound waves have given dermatologists new options for offering patients targeted fat reduction.

One of the hottest emerging treatments in body contouring, fat freezing has gained rapid popularity with patients and physicians due to its high efficacy. Operating on the premise that fat freezes at a higher temperature than skin, fat freezing devices cool sections of the body, causing the permanent death of targeted fat cells without damaging surrounding tissue. “Once you lose your fat cells, they’re gone forever. We’re born with a certain number of fat cells and we die with the same number of fat cells,” explains Rancho Mirage, California, dermatologist Timothy Jochen, MD. “With CoolSculpting, you’re losing 20-25 percent of fat cells.” Applauding cryolipolysis as “the current gold standard for fat reduction,” Lisa Donofrio, MD, associate clinical professor of dermatology at Yale University School of Medicine, estimates that depending “on the amount of fat one is trying to reduce, each session can give about a 25-40 percent reduction.”

Currently the only fat freezing device on the market, Zeltiq’s CoolSculpting received expanded FDA clearance in September 2015 for use of smaller applicator heads to treat smaller areas of the body, such as under the chin. An early critique of fat freezing was that the procedure was initially only suited for broad expanses of the body due to technical constraints posed by the size of the device. However, the expanded clearance has allowed for “multiple device heads with different shapes for the thighs, abdomen, flanks, and submental fat,” according to Dr. Donofrio. Described by Dr. Jochen as “outrageously popular” with patients due to its non-invasive nature, he cautions that fat freezing is not necessarily one-size-fits-all in terms of patient candidacy. Best results are visible in patients who are not obese, but rather have distinct pockets of fat, and also in those with skin that hasn’t been overly stretched by age or pregnancy. “The people who really aren’t good candidates are those who have lost elasticity in their skin, where it isn’t going to retract,” Dr. Jochen recommends.

Beyond common side effects such as initial swelling and mild discomfort during the procedure, in isolated cases cryolipolysis can lead to long-term, protracted pain, or even, very rarely, a reverse effect of increased fat accumulation in the target area (JAMA Dermatol. 2014 Mar; 150(3): 317–319). Outside of this, most patients require roughly two sessions per treated area with virtually no reported downtime, and most can expect to see results after a minimum of three weeks, with final results manifesting around three months post-procedure. “I’ve never seen anything like it in my practice. People love this treatment,” Dr. Jochen said. “We’ve been looking for a non-invasive treatment for fat for years, and this is the first that actually is showing dramatic fat reduction.”

Like fat freezing, ultrasound therapy is intended to reduce targeted areas of fat through the destruction of cells. However unlike fat freezing, instead of extreme temperature, ultrasound therapy uses high-intensity sound waves to permeate fat cells. Side effects can include mild pain and bruising, and visible results are best achieved through this method within the relatively narrow parameters of FDA-approved uses. “The ultrasound devices were only studied and approved for circumferential waist reduction, although they are commonly used off-label in other areas such as the thighs,” explains Dr. Donofrio.

“In terms of what it was approved for, it appears these devices can reduce abdomen circumference by a few centimeters.”

Of the two FDA-approved devices for ultrasound therapy currently on the market, UltraShape and Liposonix, Dr. Donofrio describes the choice between the two as a trade-off of side effects. “The devices use ultrasound differently. One hurts more than the other, and has more bruising. The high-intensity Liposonix tends to cause more pain,” she said. (For more about these two devices, see the “Contouring at the waistline” section.)

Although sometimes touted as helping to eliminate unwanted fat deposits, acoustic wave therapy generally shows greater efficacy in firming the skin and smoothing cellulite-related bumps. The procedure involves the vibration of skin and tissue via device-administered acoustic pulses. “This does not actually sculpt in the sense that it removes fat, but rather tightens up tissue,” explains Dr. Donofrio. “Acoustic wave therapy is not used for fat reduction, but as an ancillary means to rapidly heat up the tissue after CoolSculpting to improve the efficacy.” Like fat freezing, the process is non-invasive and requires no post-procedure downtime. - EMILY MARGOSIAN
Treatments for double chins

Two treatments for double chins have made a splash in dermatology: injectable deoxycholic acid (Kybella) and cryolipolysis (CoolSculpting). The Food and Drug Administration (FDA) approved Kybella in April of 2015. CoolSculpting had already been on the market for body contouring when the FDA cleared it for treating double chins in September 2015. Because both treatments kill fat cells, their results are permanent.

Deoxycholic acid

The deoxycholic acid in Kybella is similar to the bile acid of the same name normally produced in the body. It’s delivered to submental fat via fine needle.

“It’s the same type of substance that digests fries and burgers when we eat them,” said David Balle, MD, of Grosse Pointe Dermatology in Grosse Pointe, Michigan. “The method of injection is not that different from Botox, where you target certain key points to obtain the desired results.”

Some patients are better suited for these injections than others, Dr. Balle said. “It tends to work best on a person who has a moderate amount of submental fullness, with good skin quality and minimal skin laxity. If someone has excessive skin laxity, I would proceed with caution.”

Dr. Balle noted that the injections are not intended for fat outside the submental area. “It’s not for patients with a significant amount of fat that goes from one side of the jaw to the other. Fat outside the midline is not in the safety zone.”

Most people require two treatments of up to 30 injections each, spaced six to eight weeks apart, Dr. Balle said. “The main side effect is swelling, which resolves in about a week. But there may also be some firmness in the treated area afterwards, and it’s best that this resolves completely before the second treatment.”

Dr. Balle noted that he usually assesses a patient’s healing at one month and based on his evaluation sets the second treatment two weeks to one month after that.

Discomfort can be alleviated with both topical and injectable anesthetics as well as ice, Dr. Balle added. “I usually do all three so there is no pain or discomfort at all during the injections.”

Dr. Balle noted that if a patient has prominent platysmal bands, those may become yet more prominent as the fat goes away. “You can treat them later with Botox to improve their appearance either before or after treatment with Kybella, but I don’t recommend doing both treatments at the same time.”

Cryolipolysis

The CoolSculpting cryolipolysis works on submental fat the same way it works on subcutaneous abdominal and thigh fat, by freezing fat cells to death.

“The new clearance is just for the new applicator, which is much smaller and fits under the chin,” said Suzanne L. Kilmer, MD, of the Laser and Skin Surgery Center of Northern California in Sacramento. “It takes about an hour, and then the fat slowly dies over the next two to four months.”

Dr. Kilmer added that potential side effects include some temporary numbness under the chin, but noted that there is no hypopigmentation and as with using cryolipolysis elsewhere on the body, the skin and other tissue in the area is not frozen.

Patients may feel some discomfort, but it’s short-lived, Dr. Kilmer said. “The fat becomes frozen like a stick of butter. Massage the area and it becomes soft again, with some redness that goes away.”

The ideal candidate is one who has enough fat to fit into the chin cup, Dr. Kilmer said. “You can also use two chin cups, one on either side of the neck if the patient has a larger double chin. If there’s too little fat, that’s when you go to Kybella.”

Dr. Balle noted that using both treatments can produce more exact results. “You could debulk with CoolSculpting and then fine-tune focal areas later with Kybella.” - TERRI D’ARRIGO
Contouring at the waistline

Dermatologists who wish to offer aesthetic treatment of abdominal subcutaneous fat can offer their patients an increasing number of noninvasive or minimally invasive procedures. These options — cryolipolysis, ultrasound, and laser lipolysis — have shorter recovery times with less pain than surgery and liposuction.

Thanks to direct-to-consumer advertising, more and more patients are approaching dermatologists about these procedures, if only in a general sense, said Kimberly Butterwick, MD, of Cosmetic Laser Dermatology: Goldman, Butterwick, Groff, Fabi & Wu in San Diego. “Most patients don’t know exactly what they want, but they know there are noninvasive treatments out there and they are starting to ask.”

Patients are also concerned about the risks of surgery, said Arisa Ortiz, MD, director of laser and cosmetic dermatology and assistant clinical professor in the department of dermatology at the University of California, San Diego. “They prefer these treatments because they are noninvasive, and would rather get a few treatments than one big one with liposuction because they are aware of the risks.”

CoolSculpting is a popular option, Dr. Ortiz said. “The device has improved over time. It used to take an hour per site, but now there are applicators that require only 35 minutes.”

Dr. Butterwick notes that combining cryolipolysis with other techniques can yield better results than cryolipolysis alone. “Most technologies remove about 25 percent of the extra fat [in the treated area], but if you use an acoustic wave device after the [cryolipolysis] applicator comes off, one treatment could get closer to 30 or 35 percent. It’s more noticeable.”

Ultrasound devices like Liposonix also kill fat cells, but through heat, not cold, and usually only require one hour of treatment in one session. As with cryolipolysis, the body then rids itself of the fat and dead fat cells. There is an ouch factor, however, Dr. Ortiz said. “Liposonix is high-intensity and can cause some pain, so you might have to use distraction techniques like massage or a spray bottle.”

Yet other ultrasound devices such as UltraShape destroy fat cells through cavitation: They cause vapor cavities in the fat cells that stress the cell walls and the cells rupture and die. “This kind of ultrasound is appealing to those who want no pain at all, but it takes a few treatments, usually two or three,” Dr. Butterwick said.

Vanquish and TruSculpt use radiofrequency to heat fat cells enough to induce cell death. Vanquish does not come in contact with the skin; the device hovers over the patient and can treat the entire abdominal region at once. TruSculpt makes direct contact with a 40 cm² area. This large spot size allows it to penetrate up to 3 cm deep.

“Treatments that use either heat or cooling may help tighten the skin a little bit, but for those who have loose skin, you might want to choose radiofrequency,” Dr. Butterwick said. These devices heat the surface temperature up to 45°C and can help to tighten the skin as well. Alternatively, one could use a combination of cryolipolysis for fat loss followed by a tightening treatment to the surface with radiofrequency or microfocused ultrasound.

Lipid hydrolysis with low level diode lasers or salmeterol xinafoate can also provide results, but with a caveat, Dr. Butterwick said. “These treatments work by causing cells to release their fat, but they don’t actually kill the cells. That means the...
cells can re-accumulate fat, so results are not necessarily permanent."

Trials by Neothetics of an injectable formulation of salmeterol xinafoate for localized fat reduction and body contouring, which the company has labeled LIPO-202, were discontinued in Phase 3 last December. Results in Phase 2 trials had been promising. The company has since reformulated the product and will begin a new Phase 2 abdominal fat reduction trial this year, with results anticipated early in 2017. (The company is also testing using the same formulation for submental fat; Phase 2 results are expected by the end of this year.)

Preparing for results
Success in treating subcutaneous abdominal fat starts with knowing which patients are good candidates for the procedures and setting realistic expectations with them, Dr. Ortiz said.

"Results are better with people who are fit, but who have a problem area that doesn’t respond to diet and exercise. Patients need to understand that the results don’t approach liposuction," Dr. Ortiz said. “These procedures are more about contouring. The patient’s pants will be a little looser, their belly will be a little flatter.”

Dr. Butterwick agrees. "For noninvasive treatment, it’s good to have patients who are at their ideal weight or only slightly overweight with smaller bulges of fat. There’s really not much that can be done if someone is quite overweight. These aren’t weight loss procedures."

Dr. Butterwick notes that patients appreciate options. “They’ll be very happy you offer them choices with different devices. For soft bulges, cryolipolysis is my treatment of choice. For bound-down fat, radiofrequency or ultrasound is best. Combinations in different parts of the body often give optimal results.” - TERRI D’ARRIGO

Body dysmorphic disorder: when not to treat

Body dysmorphic disorder (BDD) generally manifests as an excessive fixation on a particular body part or perceived anomaly. Although it may be challenging to initially distinguish BDD from typical cosmetic concerns, there are four key indicators that can be used to make a diagnosis:

- Pre-occupation with an imagined defect, or excessive concern with a minor flaw
- Repetitive behaviors
- Impairment in the patient’s social or professional life
- Body dysmorphism behaviors compounded with another psychiatric disorder

Neelam Vashi, MD, assistant professor of dermatology at Boston University School of Medicine, advises that body dysmorphic disorder (BDD) patients seeking body contouring treatments are more prone to showing signs of accompanying eating disorders in particular. "That’s a little bit more important with body contouring, because you want to make sure the patient isn’t showing evidence of anorexia or bulimia. There may actually be a slight anomaly that the physician can pick up on, and it can be difficult for us to decide as physicians whether their distress is proportionate or not.” She estimates that although patients with BDD only account for about 1-2 percent of the general population, they are closer to 9-14 percent within dermatology patient populations, particularly among those seeking cosmetic treatments.

After positively identifying a patient as body dysmorphic, Dr. Vashi recommends that the physician refrain from administering treatment or discontinue any treatment that has been previously ongoing. "There have been a lot of studies on the effects of aesthetic treatments on BDD, and over 90 percent will have no change or worsening in their symptoms. Although there is a percentage that will find improvement in the part of the body that was treated, often their concern will go to another body part because their overall disease has experienced no change.” She suggests that physicians can instead help these patients by extending empathy in a way that does not directly comment on the perceived flaw. "These patients feel misunderstood. Sometimes they’re ashamed. As hard as it is, we recommend not saying things like ‘you look fine,’ or ‘it’s not that bad.’ These statements are often not helpful because the patient just won’t believe them to be true. Some helpful statements could be ‘sorry for your suffering,’ or ‘I understand you’re experiencing anxiety, and I think there’s a way for you to feel better.’” Dr. Vashi also recommends checking in with BDD patients about any potential suicidal thoughts due to the disorder’s high rates of suicidal ideation and completion.

Although there have been no documented cases of legal action against a dermatologist administering cosmetic treatment to a known BDD patient, beyond the ethical implications there may be safety-related deterrents as well. "Unfortunately a lot of patients with body dysmorphic disorder are delusional. These patients are generally unhappy with their results," she said, regardless of the outcome. “A lot of physicians just don’t know because it’s so hard to diagnose.”

For the safety of both patient and physician, once a diagnosis of body dysmorphia has been made dermatologists should refer these patients to a mental health expert familiar with the disorder. “This is a psychiatric disease so the main treatments are selective serotonin reuptake inhibitors and cognitive behavioral therapy that need to be done with a therapist,” Dr. Vashi recommends.

- EMILY MARGOSIAN
Fat transfer in HIV patients: how dermatologists address lipoatrophy

While high, rounded cheeks may be in vogue with certain socialite sets, the need for facial re-volumization carries greater significance among patients suffering from HIV-related lipoatrophy. Often the only visual indication that an otherwise healthy looking individual is unwell, loss of facial symmetry can be particularly distressing for HIV patients due to fears of stigmatization for carrying the disease. As a means of combating this effect, synthetic fillers and autologous fat transfer are the two most common methods to address the loss of subcutaneous fat in these patients, each with their own benefits and downsides.

While considered controversial in the past, autologous fat transfer (AFT) has been steadily growing in popularity due to its relative durability and longevity. The practice of fat grafting can be traced back to 19th century surgeon Gustav Adolf Neuber, and is generally lauded as having a decreased rate of rejection in comparison to fillers due to being sourced directly from the patient’s own body. Although considered a more invasive procedure due to the need for multiple sites of surgery (to withdraw the donor fat and then deposit it in the desired location), patients report satisfaction overall with AFT’s immediately visible results. “The upside of fat is that you see the results right away,” says Omar Torres, MD, a dermatologist in New York. He notes, however, that “the transfer is not 100 percent permanent despite what some studies claim, so you typically need to overcorrect initially for the best long-term results.”

Despite the low rate of complications, potential side effects can include fat necrosis, infection, and vascular occlusion. Particularly in HIV patients, other conflicts can arise if patients do not have fat deposits elsewhere on their body to donate, although Dr. Torres says he observes this problem infrequently. “Some patients have severe lipodystrophy, in which case you wouldn’t have much fat to harvest. However, the good thing about fat transfer is that you usually do have an unlimited source.” Another potential downside is that if the pathologic process causing the HIV-induced fat loss is ongoing, the results of the fat transfer can be quickly lost. Additionally, the abnormal fat distribution seen in HIV patients (sometimes manifesting in dorsocervical humps on their backs and upper shoulders) can complicate the procedure if the fat graft is taken from these accumulation sites, leading to abnormal behavior at the graft site resulting in disfigurement or cosmetic imperfections.

A more commonly used method to treat HIV-related lipoatrophy, popular fillers include Poly-L-lactic acid, hyaluronic acid, and calcium hydroxyapatite. “You have Sculptr and Radiesse which are FDA approved, but there are also permanent off-label fillers like silicone,” Dr. Torres said. Fillers are noted for being more convenient and less-invasive than fat transfer, and result in less post-procedure bruising and swelling. They can also be ideal for HIV patients who lack significant fat reserves elsewhere on their body to transfer to the face.

While fillers produce some swelling at the site of injection, more significant downsides include delayed visible results. “With Radiesse you do see better results right away, but with Scultra you need to wait to see results,” Dr. Torres said. Fillers also typically require more follow-up procedures than AFT, with recommended follow-ups once every four weeks to maintain the effects. These repeated follow-ups and the relatively higher cost of fillers can create financial hurdles for patients. “Price can be an issue because depending on the grade or the stage of lipoatrophy, you will need several syringes. Radiesse comes in a pre-filled syringe of 1.5 cc’s. I can transfer at least 10 cc’s of fat into a cheek. That would be almost seven syringes of Radiesse. So cost-wise, it would be very hard to compare. When you do need a big volume, fat is less expensive,” Dr. Torres said.

Despite their differences, both methods are considered highly effective ways of treating HIV-related lipodystrophy, although emerging hybridized treatments may potentially offer dermatologists a compromise between the two. Most visibly, Biologica has begun marketing filler-esque Allofill, an injectable treatment made of donated human fat, in an attempt to tap into AFT’s longer-lasting results without requiring patients to endure the additional procedure of harvesting their own fat for transfer. - EMILY MARGOSIAN
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Experts profile the link between metabolic syndrome and dermatologic disease
When it comes to metabolic syndrome, dermatologists are not traditionally the go-to specialist for patients. While not technically a disease, metabolic syndrome represents a group of five risk factors for developing heart disease, diabetes, or stroke. Specifically, these factors include: a large waistline, high triglyceride levels, low HDL cholesterol levels, high blood pressure, and high fasting blood sugar (see sidebar for more details). As a result, patients with these risk factors, or subsequent conditions, are often seen by primary care physicians, cardiologists, or endocrinologists.

However, researchers are beginning to see a clear link between patients with certain skin diseases and metabolic syndrome. As a result, dermatology has the potential to serve as a key player in the clinical care of these patients. “It’s a major public health problem,” said Joel Gelfand, MD, MSCE, associate professor of dermatology and associate professor of epidemiology at the University of Pennsylvania. “So we, as dermatologists, can play a role here.” Yet, the question remains for dermatology: What is the association between metabolic syndrome and skin disease? Dermatologists are investigating that link with the following conditions:

- Psoriasis
- Atopic dermatitis
- Hidradenitis suppurativa
- Polycystic ovarian syndrome (acne, hirsutism)
For several years, physicians have been keenly aware of the comorbidities associated with psoriasis—from cancer, to psoriatic arthritis, to anxiety and depression. However, cardiovascular disease, obesity, and diabetes are also prevalent among psoriasis patients, prompting researchers to delve deeper into the association between psoriasis and metabolic syndrome. “There have been scores of research studies published, all pointing to two central conclusions. One: psoriasis is clearly associated with metabolic syndrome,” Dr. Gelfand said. “Two: as psoriasis gets worse in severity, the odds of having metabolic syndrome increase.” According to Dr. Gelfand, these studies show a direct link to psoriasis and several key metabolic syndrome factors such as hyperglycemia, hypertriglyceridemia, obesity, and impairments in HDL function—all of which contribute to the development of diabetes and heart disease.

So, what’s behind this relationship between the two conditions? “We generally think that it’s inflammation that links psoriasis to diabetes and insulin resistance, but we don’t know that for certain. There may be some shared genetics between the two,” Dr. Gelfand said. One theory proposes that psoriasis and metabolic syndrome may have overlapping inflammatory pathways and that some of the cytokines—like tumor necrosis factor (TNF) alpha—are dysregulated and therefore prompt Th-1 and Th-17 inflammatory responses. “They [cytokines] tend to promote insulin resistance and may affect how well insulin signals.” Additionally, “We’ve recently learned that several psoriasis susceptibility loci—such as defects in the IL-23 pathway—seem to make people more prone to developing diabetes. There’s another locus called CDKAL1 that may also make one susceptible to both psoriasis and diabetes.” And when it comes to low levels of “good” cholesterol, it also appears that the chronic inflammation associated with psoriasis has the capacity to decrease the function of HDL. “The reason why that’s called good cholesterol is because the HDL molecule removes cholesterol from lipid-laden cells,” Dr. Gelfand says. “We’ve published some data on this and we’re learning that HDL doesn’t function very well in people with psoriasis.”

“Those are a few of the theories as to how the two disorders are linked but it’s probably more complicated than that.” In fact, according to Dr. Gelfand, the development of metabolic syndrome can potentially be exacerbated by some treatments for psoriasis. “We know that there’s some observational data that people may actually gain weight with TNF inhibitors and some treatments may lead to lipid abnormalities, such as acitretin.” However, Dr. Gelfand argues that metabolic syndrome in psoriasis patients can also result from a lack of physical and emotional well-being—causing patients to eat poorly or avoid exercise.

Yet, the specific causality between metabolic disease and psoriasis is hard to pinpoint. What came first: the metabolic syndrome or the psoriasis? “The arrow could go both directions,” Dr. Gelfand said. “There are certainly reasons to believe that having psoriasis could promote metabolic complications and we know that metabolic issues can make you more prone to psoriasis.” Several studies indicate that roughly 30 percent of new cases of psoriasis can be attributed to obesity (J Invest Dermatol. 2005 Jul; 125(1):61-7; Arch Intern Med. 2007 Aug; 167(15):1670-5). “Then there are other studies that show children with established psoriasis develop metabolic syndrome. You think: why would a 12-year-old have metabolic syndrome? But, there is a fairly significant prevalence of metabolic syndrome in kids with psoriasis.”

Nevertheless, Dr. Gelfand says that dermatology has a role to play in the management of metabolic syndrome in psoriasis patients. “In terms of screening for cardiovascular risk factors and educating patients, we’re probably not doing very well. That is something we need to get better at,” Dr. Gelfand said. “I think that educating patients about the association of psoriasis, its severity, cardiovascular risk factors, and cardiovascular outcomes is an important part of taking care of our patients. Instituting a screening ourselves or referring patients to their primary care doctors is another way we can provide good medical care for our psoriasis patients.”

To hear more from Dr. Gelfand about the metabolic syndrome and psoriasis, check out this month’s issue of Dialogues in Dermatology.
While there are obvious shared pathways for metabolic syndrome and some skin conditions, the connection between metabolic syndrome and atopic dermatitis (AD) is not clear yet. “This research is still in its infancy,” said Jonathan Silverberg, MD, PhD, MPH, assistant professor of dermatology at the Feinberg School of Medicine at Northwestern University. Regardless, dermatologists are starting to see a common thread among their AD patients — particularly obesity/high waist circumference and high blood pressure.

Dr. Silverberg has been connecting the dots between obesity and AD since 2009. His team conducted a retrospective, practice-based, case-control study of 414 randomly selected children and adolescents with AD, and 828 healthy controls and found that early onset and sustained obesity in childhood was a risk factor for developing AD (J Allergy Clin Immunol. 2011;127(5):1180–6.e1). “In that study we knew that the obesity preceded the atopic dermatitis and was associated not only with higher rates of atopic dermatitis but more severe disease,” Dr. Silverberg said. “To seal the deal, we performed a meta-analysis of the entire literature that has looked at different connections with obesity.” He found that among 30 different studies, there was a consistent link between AD in children and adults and significantly higher rates of obesity (J Am Acad Dermatol. 2015;72(4):906–16.e4). “That confirmed that there’s at least a subset of atopic dermatitis patients that clearly have higher rates of obesity.”

Additionally, Dr. Silverberg has found that while there were significantly higher rates of AD patients with high waist circumferences, AD patients also had higher blood pressure (JAMA Dermatol. 2015;151(2):144–152). “Patients with atopic dermatitis were more likely to have systolic blood pressure greater than 90th percentile — which would be hypertension in the pediatric range — and also fewer patients were in the less than 25th percentile range.” Interestingly, Dr. Silverberg found no link between the weight and blood pressure problems in AD. “In the non-atopic dermatitis children, there was a direct connection between obesity and high blood pressure, but in the children with atopic dermatitis, that connection was gone. Their high blood pressure appeared to be independent of their weight, their BMI, their waist circumference, and their weight-to-height ratio. This suggests there are different factors that are driving obesity and high blood pressure in atopic dermatitis.”

So what could be driving the high blood pressure? “It really raises some intriguing questions about whether this could be the effects of chronic inflammation.” Some theories speculate that there may be a role for cytokine IL-1 in that when an AD patient scratches, it causes inflammation that releases IL-1 into the circulation system and damages arteries and other organs (J Allergy Clin Immunol. 2015;136(3):823–4). “It’s certainly a possibility. I think there are many other inflammatory pathways involved. There’s some interesting work done by some groups that have shown that there may be a role for IL-17, 22, and 23 in atopic dermatitis.”

However, for Dr. Silverberg, the link between obesity and AD may simply be behavioral. Dr. Silverberg looked at multiple population-based studies and found that adults with atopic dermatitis have higher rates of smoking and alcohol consumption, and are more likely to be sedentary (J Allergy Clin Immunol. 2015;134(3):721–8). “The lack of physical activity is a real problem with our atopic patients. When patients are flaring and are really itchy, they will do everything they can to avoid aggravating the itch, like getting sweaty during exercise.” With regard to alcohol consumption and smoking rates, Dr. Silverberg argues that the harmful effects of AD may be driving patients toward these poor health behaviors. “Of course it could go the other way, in that smoking might aggravate the eczema, but overall, if they smoke more, drink more, and they’re not moving as much, they’re going to be at a higher cardiovascular risk.”

Regardless of these unknowns, Dr. Silverberg stresses that by focusing on controlling AD for the long term, dermatologists can help alleviate the metabolic syndrome. “If you can control the disease better, you can reverse the inflammation but you will also probably improve those health behaviors considerably.” Additionally, Dr. Silverberg says that while dermatologists don’t need to manage their patients’ weight and cholesterol first hand, they can play a role in shepherding patients to the appropriate help. “We should recognize that oftentimes we are the gatekeepers for recognizing systemic disease. We can at least refer them to a primary care physician or a cardiologist so they can get better control of those cardiovascular risk factors, and to prevent a catastrophic event from occurring.”
Hidradenitis suppurativa (HS) — a disease characterized by painful boils that develop and often rupture in sensitive areas of the body such as the underarm and genital areas — may affect as much as 1 to 4 percent of the population. However, in addition to the pain, depression, and in some cases suicidal ideation that sometimes accompany HS, these patients are also more likely to show metabolic syndrome characteristics.

According to a 2014 paper in JAAD, the prevalence of metabolic syndrome in HS patients is more than 50 percent (2014; 70(4): 699-703). “We’re more likely to see HS patients with higher cholesterol, obesity, and hyperglycemia,” said Iltefat Hamzavi, MD, senior staff physician at the Henry Ford Health System’s department of dermatology and president of the Hidradenitis Suppurativa Foundation. “It’s been documented in several different areas. At the Henry Ford Hospital, we have a very large database of about 1,100 HS patients and we’re seeing this link.” According to Dr. Hamzavi, European research has also found a similar relationship. Researchers conducted a hospital-based study in Berlin with 80 HS patients and 100 controls and found that the prevalence for metabolic syndrome in HS patients was 40 percent, and only 13 percent in the controls. Additionally, HS patients were almost six times more likely to have central obesity (a large waist circumference), more than four times more likely to have hyperglycemia and low HDL cholesterol, and more than two times more likely to have hypertriglyceridemia (PLOs. ONE: doi: 10.1371/journal.pone.0031810). “So you have several different studies showing that metabolic syndrome is clearly associated with HS,” Dr. Hamzavi said.

However, observational evidence shows that the type of HS that a patient has is key in determining the risk of developing metabolic syndrome. Several years ago, researchers conducted a latent class analysis and identified three subtypes of HS (J Invest Dermatol. 2013; 133(6): 1506-11). “You have the typical HS under your arms, below the breast, and in the groin; or you have the acne-associated HS; or you have a third type in the buttocks and the groin,” Dr. Hamzavi said. “Some patients have severe gluteal and inguinal involvement but they don’t have much metabolic issue. But the majority of people who have the typical type of HS — where they get it in their underarms and below the breast — tend to have high body mass index and high glycemic load that suggest metabolic syndrome.” According to Dr. Hamzavi, several studies are currently looking at the different subtypes of HS and the link to body mass index. “Hopefully, we’ll soon have a better understanding of which patients are more likely to have metabolic syndrome, where we’ll be able to walk into a room and figure out who’s going to have metabolic syndrome and who’s not just by looking at the patient.”

In addition to identifying the subset of HS patients who are more likely to develop metabolic syndrome, researchers are trying to pinpoint the pathogenesis of HS that causes these effects. “The short answer is, unfortunately, we don’t know yet,” Dr. Hamzavi said. “The long answer is that having constant inflammation can pre-dispose you toward metabolic syndrome.” But like with many other painful and uncomfortable conditions, Dr. Hamzavi says that much of the relationship between these metabolic syndrome factors and HS are behavioral in nature. “HS has the lowest quality of life score of almost any dermatologic disease. You’re in pain. You have pus flowing out of your legs every time you stand up. It doesn’t make for a good workout,” Dr. Hamzavi said. “Also, when HS patients walk and exercise they tend to have more problems with their lesions. So you have a disease that’s already uncomfortable, and when you do exercise you’re even more uncomfortable, so that could be the link.”

What are the clinical implications of this association with metabolic syndrome for dermatologists caring for HS patients? “Every patient that comes in gets their blood pressure and BMI checked. If they have a high BMI, they automatically get counseled about the risks.” Dr. Hamzavi will also counsel patients to follow a high-protein, low-carbohydrate diet — much like that of patients with diabetes. “We don’t suggest that diet will affect HS. Maybe it does. Maybe it doesn’t. But we do know that it will affect your metabolic syndrome.” Dr. Hamzavi also argues that employing the help of other physicians is a must in caring for these patients. “We almost become the primary coordinator of their care and working with a primary care doctor is critical — an internist who knows preventative medicine.” Dr. Hamzavi also suggests incorporating a dietician and endocrinologist with the patients’ care regimen. “You can’t manage HS without a multidisciplinary team.”
Metabolic syndrome: Key factors

Metabolic syndrome, while not a technically a disease, is defined by the presence of at least one of five risk factors. Patients with these factors are more likely to develop coronary heart disease, diabetes, or stroke and the more factors a patient presents, the more likely they are to develop one of these diseases.

According to the American Heart Association, metabolic syndrome risk factors include:

- High triglyceride levels (150+ milligrams per deciliter (mg/dL) of blood)
- Low HDL ("good") cholesterol level (less than 40 mg/dL in men; 50 mg/dL in women)
- High blood pressure (130/85+)
- High fasting blood sugar (100+ mg/dL)
- A large waistline (40+ inches for men; 35+ inches for women)

Generally speaking, metabolic syndrome and diet go together like peas and carrots. However, given the close link between several skin conditions and metabolic syndrome, researchers are also investigating whether there are relationships to diet and dermatologic disease. "The first thing that many patients think of when it comes to disease prevention/management is diet because there are dietary recommendations for so many prevalent medical conditions (high blood pressure, diabetes, coronary artery disease, obesity, etc.)," said Tara Bronsnick, MD, from the dermatology department at the Robert Wood Johnson Medical School at Rutgers University. "While I caution all patients that diet is certainly not a silver bullet, there are some cases in which I feel that diet modification is helpful."

Melanoma

Dr. Bronsnick has published several papers on diet and skin disease. She reviewed the literature on dietary factors that can be used to manage melanoma and found that overall, there is conflicting evidence that decreased alcohol consumption, and supplementation with omega-3 fatty acids, vitamin D, selenium, green tea, resveratrol, and lycopene can reduce melanoma risk. However, in the paper Dr. Bronsnick et al contend that melanoma patients should be counseled about the overall health and immune-system benefits of reduced alcohol consumption. Additionally, although there is no firm evidence that green tea, resveratrol, and lycopene can help manage melanoma, they are generally considered to be safe so if patients wanted to increase their intake of these supplements they could (J Am Acad Dermatol. 2015; 73(2): 353.e1-16).

Chronic urticaria

With regard to chronic urticaria — a condition that affects 2 percent of the adult population — Dr. Bronsnick’s literature review indicates that some studies have shown that chronic urticaria patients have significantly lower vitamin D levels, and therefore supplementation of vitamin D has helped improve the patient’s condition. However, before prescribing vitamin D, more trials will be needed to determine the appropriate dosing and duration for these patients. Also, because chronic urticaria can develop from celiac disease, some patients may be helped by the introduction of a gluten-free diet. However, similar to the use of vitamin D, more studies will be needed to determine if a gluten-free diet will help patients with chronic urticaria who do not have celiac disease.

Dr. Bronsnick’s review also finds that artificial preservatives and dyes may be a trigger for inducing or aggravating chronic urticaria in some patients. However, "I think it is difficult to recommend broad avoidance/elimination diets to patients with any skin disease, including chronic urticaria, given the risk of nutritional deficiencies as a result of these diets," Dr. Bronsnick said. "I would advocate for elimination diets based only on open oral food challenges, which are the gold standard for proof of food allergy/adverse reaction."

Psoriasis

According to the JAAD paper, a gluten-free diet for psoriasis patients may be helpful, but there is limited evidence to support this claim. In the same vein, there is conflicting evidence that supports supplementation of vitamin D, antioxidants, omega-3 fatty acids, and folic acid.

However, overall weight loss and decreased alcohol consumption may improve patients’ quality of life and PASI scores, and may improve the efficacy of certain psoriasis medications such as biologics and cyclosporine. "There have been very nice, elegant research studies that show if you’re on a treatment for psoriasis and you’re given a diet to help you lose weight, your skin will respond better to that treatment,” said Joel Gelfand, MD, MSCE, associate professor of dermatology and associate professor of epidemiology at the University of Pennsylvania. "I think there are a lot of diet fads out there but I think there’s not a lot of rigorous science behind it. But we know that weight loss in general would appear to modulate psoriasis and make it less severe and less active. You would probably also respond better to your treatment.” Dr. Bronsnick agrees and counsels that weight loss, reduced alcohol intake, and healthy eating are advisable for improving general health. However, overall, "recommendations for patients with skin disease are condition-specific."
According to the Office of Women’s Health (OWH) within the U.S. Department of Health and Human Services, polycystic ovarian syndrome (PCOS) — a condition characterized by missed or irregular menses, androgen excess and ovarian cysts — affects as many as five million women in the U.S. While PCOS is not typically a condition in dermatologists’ wheelhouse, it may be on their radar as skin conditions such as acne and hirsutism are often cutaneous manifestations of PCOS. “About 30 percent of women with PCOS will have acne,” said Rachel Reynolds, MD, assistant professor of dermatology at Harvard Medical School and physician at Beth Israel Deaconess Medical Center. “It tends to be what we call a hormonal acne pattern — along the jaw line, the face, the neck, and sometimes on the trunk. It often gets worse before menses.” Additionally, up to 60 percent of women with PCOS have hirsutism (J Am Acad Dermatol. 2014; 71(5): 847.e1-10).

While these dermatologic manifestations are not necessarily linked to metabolic syndrome, researchers believe PCOS is. According to Dr. Reynolds, it became clear to physicians who were seeing PCOS patients that there was a link to metabolic syndrome around the turn of the century. “In 2003, there was a consensus statement on the diagnostic criteria for PCOS known as the Rotterdam criteria.” In that consensus statement, researchers stated: “Insulin resistance and elevated serum LH levels are also common features in PCOS. PCOS is associated with an increased risk of type 2 diabetes and cardiovascular events” (Fert Steril. 2004; 81(1): 19-25). Indeed, according to the OWH, women with PCOS have an elevated risk of high blood pressure and low levels of HDL. As a result, more than 50 percent of women with PCOS will develop diabetes or pre-diabetes before the age of 40. Additionally, women with PCOS are four to seven times more likely to suffer a heart attack, although studies conflict on whether PCOS is an independent risk factor for cardiovascular events. “There’s such a strong clinical association, that it’s recommended that women with PCOS get their lipids evaluated, are monitored for hypertension, and have appropriate screening and risk management with regard to cardiovascular disease,” Dr. Reynolds said.

While PCOS is often considered a genetic condition, the metabolic syndrome aspect is thought to stem from androgen excess (hyperandrogenemia) caused by overproduction of the luteinizing hormone. “Constitutively, women with PCOS have higher amounts of GnRH which is a hormone released from the hypothalamus that stimulates the pituitary to release luteinizing hormone,” Dr. Reynolds said. “This excess luteinizing hormone binds to the ovarian theca cells, stimulating production of androstenedione which gets converted into testosterone, leading to hyperandrogenemia.” Meanwhile, “Insulin also binds to the ovarian theca cells to stimulate androgen production. Since these women also have high insulin levels at baseline, we see a synergistic effect in women with PCOS that really exacerbates the hyperandrogenemia induced by excess LH.” At the same time, according to Dr. Reynolds, high androgen levels lead to greater visceral fat which causes greater insulin resistance — resulting in high blood pressure and the dysregulation of HDL, and subsequently diabetes, obesity, or cardiovascular events. “So it’s really a vicious cycle of the androgen excess exacerbating the insulin resistance and high insulin levels exacerbating androgen excess.”

In terms of a treatment strategy, Dr. Reynolds recommends weight loss and the use of androgen-blocking and hormone-regulation medications. “If needed, the use of metformin in women who have insulin resistance, glucose intolerance, and diabetes, or who are trying to conceive, can help.” However, for Dr. Reynolds, while dermatologists don’t necessarily need to know the specific pathogenesis of PCOS and metabolic syndrome and how to treat these patients, they can help by paying close attention to their patients. “Dermatologists should have their radar up when they’re seeing women with acne or hirsutism. They can help direct these patients to an appropriate workup to help improve early diagnosis and get them appropriate counseling and treatment. I think in general PCOS is still underdiagnosed and just improving our ability to diagnose women would be an important goal for dermatologists to embrace.” dw
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Tackling patient access through many angles

As dermatologists, when we investigate various treatment options for our patients, our quest often requires a multifaceted process — trying out various approaches, treatments, doses, etc. The Academy also applies this multi-pronged approach when advocating against policies that negatively affect our patients. Indeed, our patients have been up against a number of policies that hinder their access to our services and their medications. Rest assured, your Academy is working to correct these policies at various policy levels and we’re seeing results.

We’ve all been there. You prescribe a medication for your patient and their insurer promptly denies coverage — requiring the patient to try and fail a cheaper drug before taking a more expensive, yet often more treatment- and cost-effective drug. This is called step therapy — a policy instituted by insurers to cut down on medication costs. As a result, physicians and their staff often spend hours on the phone fighting for our patients through pre-authorizations. Fortunately, we’ve made some progress on this issue at the state level.

Just this March, Indiana and West Virginia passed legislation that allows providers to expeditiously over-ride step-therapy requirements for their patients when medically necessary. This year, the Academy has its eye on Illinois, Massachusetts, Missouri, New York, North Carolina, Ohio, Virginia, and Florida — states that are all considering similar legislation. Visit the Academy’s website to see what your state is doing at www.aad.org/advocacy/state-policy/step-therapy-legislation and consider joining the effort.

Similar to step therapy, insurers are also attempting to cut down on costs by instituting coinsurance policies — a payment scheme that requires patients to pay for a percentage of a drug’s price rather than a fixed copayment. As a result, patients are either paying more out of pocket, or forgoing treatment altogether. Working at the federal level, the Academy is supporting the Patients’ Access to Treatment Act, which would limit the co-insurance percentages that patients are required to pay when they need a drug that falls into the specialty drug tier that requires coinsurance. I encourage all members to log on to the Dermatology Advocacy Network at www.aad-dan.com/actionalerts.aspx and send a letter of support to Capitol Hill advocating for this bill.

Patients are also struggling to find a dermatologist because of narrowed or inadequate networks. The Academy championed the effort to counteract these policies — under the leadership of past Academy President Brett Coldiron, MD — and we continue to see progress at many levels. Just this January, CMS put new regulations into place that fine payers up to $25,000 per beneficiary for errors in Medicare Advantage (MA) plan directories and up to $100 per beneficiary for errors in federal plans on the Affordable Care Act (ACA) health insurance exchanges. Additionally, CMS is proposing new network adequacy standards for ACA plans in 2017 that would require payers to provide 30 days’ notice to enrollees if their physician is being removed out of network. This would not have happened without your support.

The Academy is also tackling this issue on Capitol Hill by supporting the Medicare Advantage Bill of Rights Act which would prohibit plans from removing providers mid-year and ensure that continuity of care requirements are met when a provider is terminated from a plan. Again, I encourage you to send a letter to Congress supporting this bill through www.aad-dan.com/actionalerts.aspx. In addition to the Academy’s efforts at the federal level, we have also targeted private payers directly. As a result, America’s Health Insurance Plans just announced its plans to launch a pilot program in California, Florida, and Indiana that will attempt to help patients find providers in their insurance networks by ensuring that provider networks are accurate.

We have clearly moved the needle on these access issues at many levels. However, we have to keep our momentum going. There is no question this imposes on your time that could be spent doing what you love to do, which includes taking care of our patients. Yet, the time spent on this will preserve your ability to choose how you want to spend your time in the future. Please join your Academy in advocating at the state, federal, and private payer levels to remove these detrimental policies. Our patients are relying on us to show policymakers how these rigid step-therapy policies, unmanageable co-insurance schemes, and increasingly inadequate networks are forcing them to forgo the care they need. dw
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Dermatology's depth and breadth

This month’s special focus issue on fat shows the depth and breadth of the treatments dermatologists offer their patients. The story on the metabolic syndrome shows the field's relevance to a wide range of medical issues — and how dermatologists can be at the forefront of providing important care to very sick patients in collaboration with colleagues across medicine. If you haven’t read it, do; you may see treating your patients with psoriasis, atopic dermatitis, and hidradenitis suppurativa in a new light.

In the story about body contouring, we see how dermatologists can improve quality of life for HIV patients by addressing their lipoatrophy — and also how patients who want a tighter chin or a flatter stomach can find what they seek from a dermatologist. These latter treatments demonstrate that there are always a new range of issues that consumers will want addressed and that dermatologists will find ways to deliver.

One important role of your Academy is ensuring that patients and policymakers understand why those treatments should be provided by well-trained professionals. It’s tempting for patients to think that anyone can give them an injection of Botox, or of Kybella, the new chin fat treatment discussed in this issue. But knowing where to put the needle is no small matter. And knowing what to do if things should go awry — that is vital.

That’s why we support restricting the provision of these procedures to appropriately trained physicians or their appropriately supervised non-physician clinicians — and vigorously oppose efforts in some states to expand non-physician scope of practice where it would endanger patient safety. That’s why we provide world-class education, which in recent years has grown to include more in-person demonstrations and hands-on sessions. That’s why we spread the word about the value of seeking your care. Because whether the care they seek is medical, surgical, or cosmetic, patients need to know that their skin is safest in the hands of a dermatologist.

2017 committee appointment application now open

The American Academy of Dermatology and AAD Association is one of the most influential medical organizations in the world because its members are willing to offer their time and energy to activities to further advance the Academy’s strategic framework.

Each year, hundreds of dermatologists serve the Academy through its organizational governance structure and through other service opportunities. The Appointment Selection Committee, chaired by Henry W. Lim, MD, has begun accepting applications to fill 2017 open appointments.

The 2017 online appointment application is available at www.aad.org/forms/AppointmentApplication/Default.aspx.

Applications must be submitted by June 30, 2016. Members who are selected to serve will be contacted in the winter. Letters of recommendation are highly suggested, however not required.
OBITUARIES

BY JERRY GRAFF, MD

The Academy recently learned with sorrow of the passing of the following members of the dermatologic community.

MELVIN P. COOLIDGE, MD, of Palm Beach Gardens, Fla., Nov. 27, 2015, at age 78; while serving in U.S. Army, did preliminary training in dermatology at Walter Reed and was assigned as chief of dermatology at Ft. Knox, Ky.; completed dermatology residency at Yale, then opened his 35-year private practice in Fairfield, Conn.; remained on faculty at Yale and was chief of dermatology at Bridgeport Hospital; was on board of directors of “Drugs in Dermatology;” volunteered care to indigents and organized many skin cancer screenings within his community; avid tennis player and golfer who won several local golf tournaments.

EDMOND K. EDELSON, MD, of Boca Raton, Fla., June 2, 2015, at age 101; after graduating from University of N.C. Phi Beta Kappa and then medical school, he did a rotating internship with Michael DeBakey as his chief resident; assigned to a military hospital in Mississippi during WWII as head of dermatology even before starting his dermatology residency which led to his choosing to pursue a dermatology residency at NYU; practiced in Essex County, New Jersey for 50 years and was an innovator in dermatologic surgery and research in dermatopharmaceuticals on which he lectured at the AAD Annual Meeting; was attending dermatologist at both NYU and Columbia and was so enthusiastic about dermatology that his son, Richard L. Edelson, MD, now chairman at Yale, chose to follow him in the field; was married for 75 years to wife, Merylin.

JAMES A. EHA, MD, of Boca Grande, Fla., Jan. 30, 2016, at age 80; trained at University of Cincinnati and practiced dermatology for 30 years near Cincinnati in Anderson Township, Ohio.

KENNETH W. FIELDS, MD, of Naples, Fla., March 14, 2016, at age 57; trained in internal medicine and dermatology at the University of Miami; board certified in both specialties; practiced dermatology for 23 years in Naples.

GEORGE GAETHE, MD, of Slidell, La., Oct. 6, 2015, at age 96; residency at Louisiana State University Medical Center and practiced dermatology in Slidell for 50 years; known as a prankster, he loved driving his vintage Rolls Royce dressed in chauffeur’s livery and enjoyed startling family, friends, and patients in his gorilla costume.

DENIS R.S. HOWELL, MD, of Halifax, Nova Scotia, April 15, 2007, at age 95; after medical school and residency at the University of London, he joined the Royal Navy as a medical officer on convoy duty, then joined Mountbatten as a commando in India, Burma, Africa, and Madagascar winning the Distinguished Service Cross; took dermatology residency at the University of Toronto, then opened practice in Halifax and joined faculty of Dalhousie Medical School; dermatology section of Dalhousie medical library named for him; former president of Canadian Derm. Society; “But he was never a museum of himself — he was always too busy getting on with things.”

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FREDERICK A. J. KINGERY, MD, of Portland, Ore., Feb. 13, 2016, at age 88; a native of Portland, he was educated in the east and did his dermatology residency at University of Michigan; opened private practice in Portland in 1959 which became the Portland Dermatology Clinic with Paul Russell and Walt Larsen; served as president of the AAD and the ADA, and clinical professor at the OHSU dermatology department; held the presidency of several other medical and community organizations; loved opera and played the banjo; traveled widely; “Ted was an old school gentleman: a scholar, sportsman, aspiring cattleman and raconteur.”

ALLEN D. LEWIS, MD, of Chattanooga, Tenn., Nov. 15, 2015, at age 76; trained at University of Louisville and practiced in Chattanooga from 1972.

MANUEL R. MORMAN, MD, PhD, of North Caldwell, N.J., Nov. 25, 2015, at age 69; PhD in biochemistry from University of Kentucky and trained in dermatology at Penn State University followed by a fellowship in Mohs and dermatologic surgery at the Cleveland Clinic; practiced general dermatology and Mohs surgery for 34 years in Rutherford, N.J.; former president of N.J. Dermatological Society; known for his kindness to indigent patients — seeing them in his office, their homes, and even at his home; avid reader and theater aficionado.

ROBERT H. PRESTON, MD, of Cincinnati, Nov. 15, 2014, at age 93; trained in dermatology at University of Cincinnati and served in the dermatology department; practiced in Cincinnati and retired in 1989; traveled extensively and loved fishing and taxidermy.

BARTHOLOMEW D. RAGUCCI, MD, of Key Largo, Fla., March 1, 2016, at age 86; dermatology residency at University Hospitals Case Medical Center after practicing general medicine for seven years; opened dermatology practice in Parma, Ohio; was president of Ohio State Medical Association Section on Dermatology; was a founder and inspiration to the Ohio Dermatological Association as well as president of the Cleveland Dermatological Society; had a passion for training students and residents in dermatology.

THOMAS H. REA, MD, of La Canada, Calif., Feb. 7, 2016, at age 87; a native of Michigan, he trained in dermatology at the University of Michigan; began work at NYU and became interested in leprosy; moved to USC in Los Angeles, ultimately chaired the dermatology division at USC for 15 years; his studies of leprosy patients led to discoveries of treatments that freed those patients from social stigma and isolation; “He’d come straight in and shake their hands, no gloves on, and it would empower them to realize that they could get better.” Hansen’s Disease Clinic at LA County-USC Medical Center renamed for him; loved books and “could recall everything he’d learned in school, even the lineage of the British royal family.” Collected figurines of armadillos, because of their link to leprosy, classical music on vinyl, and Japanese art.

DONALD SCHETMAN, MD, of Glen Mills, Pa., Feb. 21, 2015, at age 83; trained at University of Pennsylvania and practiced many years in Wilmington, Delaware; was chief of dermatology for many years at Wilmington Medical Center; a student of history, he taught courses on the Spanish Civil War; loved tennis, watercolors, and the beach.

MORTON D. SCRIBNER, MD, of Arcadia, Calif., Sept. 19, 2015, at age 85; trained in dermatology at University of Cincinnati then moved to Arcadia to practice dermatology where he often made follow-up patient calls into the night to inquire about their conditions; enjoyed a love of food, wine, art, and music; supported the arts and collected New Yorker cartoons.

ROBERT R. SPROWELL, MD, of Fort Collins, Colo., Dec. 12, 2015, at age 89; grew up in Wyoming and trained in dermatology at the University of Iowa Hospitals and Clinics; was a member of the McFarland Clinic in Ames for 35 years; a sports enthusiast and musician, he played guitar and harmonica; loved animals.

Obituaries are published in Dermatology World after information is submitted to the AAD. Information on member obituaries should be submitted in writing to Member Resource Center, AAD Member Services Dept., P.O. Box 4014, Schaumburg, IL, 60168-4014, via fax at (847) 330-1090, or via email at mrc@aad.org. Jerry Graff, MD, assembles additional information for each obituary on behalf of DW.
Applicants sought for Academy leadership programs

In order to encourage dermatologists to take leadership roles in their specialty going forward, the Academy is seeking applicants for three leadership programs in 2017.

Leadership Forum
The 2017 Leadership Forum will bring together aspiring leaders in dermatology with experienced mentors to enhance their communication and leadership skills. The event will take place March 31 through April 2 in the Chicagoland area. 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 from July 1 through Sept. 1, 2016. For more information on the 2017 Leadership Forum, visit www.aad.org/LeadershipForum.

Academic Dermatology Leadership Program
The Academic Dermatology Leadership Program is administered by the Academy to provide physicians in academic settings the resources to meet the unique challenges of life in academia. A total of 15 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 2017 Leadership Forum, and opportunities to connect with an experienced mentor. This program requires a yearlong commitment of between five and eight hours per month in addition to the on-site sessions. Applications will be open from July 1 through Sept. 1, 2016. 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 March 31 through April 2 in the Chicagoland area 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 July 1 through Sept. 1, 2016. For more information on the Advanced Leadership Forum visit www.aad.org/AdvancedLF.

Leadership Institute programs are made possible in part thanks to the generous philanthropic support of Academy members and other individuals. You can help train tomorrow’s leaders in dermatology by supporting the Leadership Institute. Visit donate.aad.org/leadership-institute to make your donation online, or call (847) 240-1409.

Registration, housing for the 2016 AAD Summer Meeting now open

Registration and housing for the 2016 AAD Summer Meeting, July 28-31 in Boston at the Hynes Convention Center, is available online at www.aad.org. Housing reservations at the Sheraton Boston Hotel and the Mandarin Oriental Boston Hotel must be made online in conjunction with registration for the meeting to receive the discounted housing rate. See registration website for hotel deadlines, cancellation and change policies. More information about the 2016 AAD Summer Meeting is available at www.aad.org/meetings/summer-meeting, and in the Advance Program Announcement which was mailed to all members in April.

Make an impact
When you register for the 2016 AAD Summer Meeting, you can also make a donation and join in helping us change lives through two vital AAD programs.

SPOT Skin Cancer™ seeks to encourage sun-safe behavior by integrating public awareness and education, providing access to screenings and shade structures, advocating for increased legislation, and supporting research.

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To see a listing of all webinars scheduled in 2016 visit aad.org/webinars.

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Cosmetic spending sets new records

BY EMILY MARGOSIAN, CONTENT SPECIALIST

Americans spent approximately $13.5 billion on aesthetic procedures in 2015, according to the American Society for Aesthetic Plastic Surgery (ASAPS). This all-time record was the result of a hefty $1.5 billion increase in cosmetic spending since 2014. Despite accounting for less than half of the total cosmetic procedures performed for the year, non-surgical work still generated an unprecedented $5 billion in spending.

ASAPS’s data reveals some other trends beyond increases in consumer spending. Fat transfer to the face was ranked 9th among the top 10 most popular surgical procedures, notable given that 2015 was the first year the ASAPS tracked its frequency. Non-surgical skin tightening rose in popularity, jumping ahead to the 7th most popular non-surgical procedure overall, and the 5th most popular cosmetic procedure among men. 2015’s most injected cosmetic agents were botulinum toxin and hyaluronic acid. Although botulinum toxin has maintained its title as the most popular non-surgical procedure since 2000, in 2015 it passed the 4 million mark for number of procedures performed. See the chart below for a comparison of total procedures performed and cumulative national cost of treatment for the top five non-surgical cosmetic procedures of 2015.

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### Cosmetic Procedures in 2015

1. **Botulinum toxin**
   - 4,267,038 procedures
   - $1,354,742,009 total expenditures

2. **Hyaluronic Acid**
   - 2,148,326 procedures
   - $1,269,510,549 total expenditures

3. **Hair removal (laser or pulsed light)**
   - 1,136,834 procedures
   - $289,006,022 total expenditures

4. **Chemical peel**
   - 603,305 procedures
   - $379,050,763 total expenditures

5. **Microdermabrasion**
   - 557,690 procedures
   - $71,696,600 total expenditures
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