(Un)Equal care for all?

As physician bias creates care disparities, what can dermatologists do to balance the scales?
SAVE THE DATE!

2019 AAD Annual Meeting
Washington, DC • March 1-5, 2019
WALTER E. WASHINGTON CONVENTION CENTER

Learn the latest in dermatology at over 375 educational sessions, meet with other dermatologists from around the world, discover new products and services from over 400 exhibitors, and bring new information back to your practice. Plus, when you're not in session, explore the monuments and museums; and experience the art, culture and history of Washington, DC.

REGISTRATION AND HOUSING OPENS:

NOVEMBER 14, 2018
at 12 p.m. noon (CT)
Physician members, life members, honorary members, and applicants for membership

NOVEMBER 20, 2018
at 12 p.m. noon (CT)
Residents, medical fellows, AAD graduate members, and medical students

NOVEMBER 28, 2018
at 12 p.m. noon (CT)
Adjunct members, physician assistants, nurse practitioners, DermCare Team enrollees, dermatology practice staff, and all other non-member categories

Purchase 2019 Annual Meeting On-Demand Recordings with registration and SAVE!

AAD.ORG/AM19
November is a perfect month to give thanks.

It’s also a good time for personal reflection. As physicians, we have many privileges and, hopefully, much to be thankful for. With this privilege comes the responsibility of ensuring that we provide the best and most equitable care we can give. In October’s DW, we began a very important conversation about the impact implicit bias may have on your hiring practices. This month, we broaden the discussion by looking at how our implicit biases may impact our patient care. Most of us entered this profession with very altruistic goals and, if asked, likely believe we provide completely unbiased care. Most of us would never intentionally allow patient qualities such as sex, age, or race to influence our care. But what if your patient is homeless? Has no health insurance? Has emotional issues? Have you ever caught yourself making assumptions about a patient based largely on these qualities, rather than taking the time or effort to truly understand the individual? I know I have. Implicit bias is, as our article explains, both unconscious and automatic. Failure to recognize and acknowledge our implicit biases will almost certainly impact our care and, on a system-wide basis, may result in significant health care disparities within our health care system. Please take a few minutes to read our article and learn about a quick test that will help identify your own biases. You may be surprised by what you find. It may not fix all your biases immediately, but it’s a great place to start.

What else is in this issue? You may be familiar with the concept of biosimilars. They were a hot topic several years ago but have not been on the front pages lately. Read about the present status of biosimilars, and see why they remain something we should be aware of. We may yet see them on the market.

Cancers affecting the nail unit are rare, but you don’t want to miss one. Contributing writer Jan Bowers shares with us the wisdom of four of our nail experts to help us better recognize the clinical and dermoscopic features of nail cancers. Our experts offer advice on optimal biopsy techniques and identify some of the potential pitfalls in interpreting the histopathology of nail malignancies. This is a wonderful review, full of many great tips virtually guaranteed to improve the care of any dermatologist caring for nails! I am, unfortunately, one of those dermatologists who is not completely comfortable doing nail biopsies. Perhaps it is time for me to participate in one of the AAD hands-on courses that have been so well received!

We debut a new column this month, which we hope you will enjoy: Asked and Answered. The AAD frequently receives questions from members about a wide range of topics. We have created a forum in which we hope to answer these in a straightforward and informative format. We welcome your questions and encourage you to submit them directly to us at dweditor@aad.org. Feel free to ask all your burning questions! And remember, there is no such thing as a stupid question!

All the best to you and yours this Thanksgiving season!

KATHRYN SCHWARZENBERGER, MD, PHYSICIAN EDITOR
(UN)EQUAL CARE FOR ALL
As physician bias creates care disparities, what can dermatologists do to balance the scales?

ON THE SHELF
What is keeping biosimilars out of reach and when will they be available?

DEMystifying CANCER of THE NAIL
Unfamiliarity leads to missed diagnoses, reluctance to biopsy.

Don’t miss bonus online content at www.aad.org/dw!
I AM MODERNIZING DERMATOLOGY

WITH A SMARTER EHR

It’s so advanced, it actually learns from you. Modernizing Medicine’s all-in-one platform was designed by practicing dermatologists to streamline treatment and help improve workflow. From the moment you first log in, it begins learning how you practice, diagnose and treat patients, customizing itself to help give your practice greater efficiency.

So you can see more patients, while seeing more of your patients. It’s time to demand more from your EHR.

VIEW OUR 2-MINUTE DEMO MODMEDDERM.COM

TOGETHER, WE ARE MODERNIZING MEDICINE.
AWARDS

• 2018 Awards for Excellence
  - Feature Writing
  - Email Newsletter
  - Writing, Grand Award
• 2017 Awards for Excellence
  - Feature Writing
  - Magazines, Journals and Tabloids – Print – 32+ pages
  - Writing, Grand Award
• 2016 Awards for Excellence
  - Feature Writing
  - Editorial and Advocacy Writing
  - Magazines, Journals and Tabloids – Design and Layout
• 2015 Awards for Excellence
  - Writing – Feature Writing
  - Writing – Departments and Columns
  - Magazines, Journals and Tabloids – Print – 32+ pages

DEPTS

01 FROM THE EDITOR
Physician Editor Kathryn Schwarzenberger, MD, previews this month’s issue.

06 WATER COOLER
This column features the thoughts of readers like you! This month we asked, “How much sick leave do you give your staff?”

11 NEW! ASKED AND ANSWERED
You asked, we answered: What is ‘Question of the Week,’ and how do I sign up for it?

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

16 CRACKING THE CODE
Alex Miller, MD, outlines the new biopsy codes for 2019.

20 ADVOCACY NEWS
Tracking legislation and regulations at the state and federal levels.

28 ACTA ERUDITORUM
What common dermatologic diseases can be attributed to therapeutically and cosmetic cultural practices?

32 LEGALLY SPEAKING
Beneficiary inducements: What’s permissible?

34 ANSWERS IN PRACTICE
Earn a bonus for MIPS. Find out how DataDerm™ can help.

38 BALANCE IN PRACTICE
Dina Strachan, MD, talks about building connections online and in-office through literature.

62 FROM THE PRESIDENT
Academy President Suzanne Olbricht, MD, discusses the evolution of education and what the Academy is doing to keep up.

64 ACADEMY UPDATE
Secure your spot at the Academy’s 2019 Annual Meeting in Washington, D.C., March 1-5.

67 CLASSIFIEDS

68 FACTS AT YOUR FINGERTIPS
DataDerm™ participants were penalty-free in 2017! Flip to the back to find out how many of your colleagues were MIPS high performers.
How did you become involved as a judge for the Aspire Higher program?
I was approached by Ortho Dermatologics, and I thought it was a wonderful opportunity. I really liked that they were giving back to the community and that I could help people who want to further their education.

What is your favorite part about being a judge for Aspire Higher?
I really enjoy the whole experience, but two things come to mind: Seeing the impact the scholarships have on the lives of the people who win, and reading their stories.

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

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

Hear from 2017 winner Robby Ruffolo at aspirehigherscholarships.com
How much sick leave do you give your staff?

“Ten days in accrued increments of 3.08 hours per pay period.”

— Caryl Emmons, CDC, practice manager, Tarrant Dermatology Consultants, Fort Worth, Texas

“We give six days and pay our employees for any time left over!”

— Dana Kreuger, practice manager, Manhattan Beach, Calif.

“We used to give five days per year until one year when every employee took all of their sick leave even when not sick. Sometimes more than one called in on the same day. The solution was to add it to the vacation time. Now they get three weeks paid time off for the first three years, then four weeks PTO after three years.”

— Diana Parnell, MD, Kentfield, Calif.

“Six days.”

— Kelly Pape, director of operations, Symmetry Dermatology, Laser & Esthetics, Edmonton, Alberta

“Dr. Boote gives five sick days per year. If employees have used up vacation time, but haven’t taken any sick time, they can use that time for a day off. We do have a ‘use it or lose it’ policy — they don’t carry over to the next year. New employees do not accrue sick time until after their first work anniversary.”

— Candyce Underwood, office manager, St. Petersburg, Fla.

“Ten days.”

— Juan Pellerano, MD, Doral, Fla.
GETTING OTEZLA GETS EVEN EASIER

8 out of 10 commercially insured lives in the US have preferred access with no biologic step required for Otezla® (apremilast)¹

Your patients on commercial insurance can now access Otezla without any biologic step-edit requirements on:

- Aetna Prescription Drug Benefit
- Cigna Prescription Drug List
- CVS Caremark Basic and Standard Control Formularies
- Express Scripts National Preferred Formulary*
- OptumRx
- Prime Therapeutics
- UnitedHealthcare

*SafeGuardRxSM Program has 1 biologic step for patients on certain Otezla indications.

No DMARD or biologic step-edit required

Contact your Otezla representative or visit otezlapro.com for a complete list of plans

DMARD, disease-modifying antirheumatic drug.


Otezla® is a registered trademark of Celgene Corporation.
© 2018 Celgene Corporation 01/18 USII-APR170526
ESTEEM® Study Design

- Evaluated in 2 multicenter, double-blind, placebo-controlled trials of similar design. Patients with moderate to severe plaque psoriasis (N = 1257) were randomized 2:1 to Otezla 30 mg twice daily or placebo for 16 weeks after a 5-day titration.

- Selected inclusion criteria: age ≥18 years, BSA ≥10%, sPGA ≥3, PASI ≥12, candidates for phototherapy or systemic therapy.

INDICATIONS

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

Otezla is indicated for the treatment of adult patients with active psoriatic arthritis.

IMPORTANT SAFETY INFORMATION

Contraindications

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

Otezla® (apremilast) significantly increased PASI-75 response (n = 562) at week 16 (primary endpoint) vs placebo (n = 282) (33% vs 5%; P < 0.0001) in ESTEEM 1,2

RESULTS — the way THEY WANT THEM

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

Warnings and Precautions

- Diarrhea, Nausea and Vomiting: Cases of severe diarrhea, nausea, and vomiting have been reported with the use of Otezla. Most events occurred within the first few weeks of treatment. In some cases patients were hospitalized. Patients 65 years of age or older and patients taking medications that can lead to volume depletion or hypotension may be at a higher risk of complications from severe diarrhea, nausea, or vomiting. Monitor patients who are more susceptible to complications of diarrhea or vomiting; advise patients to contact their healthcare provider. Consider Otezla dose reduction or suspension if patients develop severe diarrhea, nausea, or vomiting.

- Depression: Treatment with Otezla is associated with an increase in depression. During clinical trials 1.3% (12/920) of patients reported depression, compared to 0.4% (2/506) on placebo. Suicidal behavior was observed in 0.1% (1/1308) of patients on Otezla, compared to 0.2% (1/506) on placebo. Carefully weigh the risks and benefits of treatment with Otezla for patients with a history of depression and/or suicidal thoughts/behavior, or in patients who develop such symptoms while on
START
your patients on Otezla today

Otezla. Patients, caregivers, and families should be advised of the need to be alert for the emergence or worsening of depression, suicidal thoughts or other mood changes, and they should contact their healthcare provider if such changes occur

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

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

Adverse Reactions

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

Use in Specific Populations

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

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

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

*Following a 5-day titration, the recommended maintenance dosage is 30 mg twice daily.
†  To receive a free bridge supply of Otezla, patients must have an on-label diagnosis and be denied or waiting for coverage. Patients in Massachusetts are not eligible to receive bridge.


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

Otezla® is a registered trademark of Celgene Corporation.
© 2018 Celgene Corporation 02/18 USII-APR180046
OTEZLA® (apremilast) tablets, for oral use

The following is a Brief Summary; refer to Full Prescribing Information for complete product information.

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

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

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

Depression: Treatment with OTEZLA is associated with an increase in adverse reactions of depression. Before using OTEZLA in patients with a history of depression and/or suicidal thoughts or behavior prescribers should carefully weigh the risks and benefits of treatment with OTEZLA in such patients. Patients, their caregivers, and families should be advised of the need to be alert for the emergence or worsening of depression, suicidal thoughts or other mood changes, and if such changes occur to contact their healthcare provider. Prescribers should carefully evaluate the risks and benefits of continuing treatment with OTEZLA if such events occur. During the 0 to 16 week placebo-controlled period of the 3 controlled clinical trials, 1.3% (12/920) of patients treated with OTEZLA reported depression compared to 0.4% (2/506) treated with placebo. During the clinical trials, 0.1% (1/1138) of patients treated with OTEZLA discontinued treatment due to depression compared with none in placebo-treated patients (0/506). Depression was reported as serious in 0.1% (1/1138) of patients exposed to OTEZLA, compared to none in placebo-treated patients (0/506). Instances of suicidal behavior have been observed in 0.1% (1/1138) of patients while receiving OTEZLA, compared to 0.2% (1/506) in placebo-treated patients. In the clinical trials, one patient treated with OTEZLA attempted suicide while one who received placebo committed suicide.

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

Drug Interactions: Co-administration of strong cytochrome P450 enzyme inducer, rifampin, resulted in a reduction in systemic exposure of apremilast, which may result in a loss of efficacy of OTEZLA. Therefore, the use of cytochrome P450 enzyme inducers (e.g., rifampin, phenobarbital, carbamazepine, phenytoin) with OTEZLA is not recommended [see Drug Interactions (7.1) and Clinical Pharmacology (12.3)].

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

Diarrhea, Nausea, and Vomiting:

Table: 3: Adverse Reactions Reported in ≥1% of Patients on OTEZLA and with Greater Frequency Than in Patients on Placebo; up to Day 112 (Week 16)

<table>
<thead>
<tr>
<th>Preferred Term</th>
<th>Placebo (N=506) n (%)</th>
<th>OTEZLA 30 mg BID (N=920) n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diarrhea</td>
<td>32 (6)</td>
<td>160 (17)</td>
</tr>
<tr>
<td>Nausea</td>
<td>35 (7)</td>
<td>155 (17)</td>
</tr>
<tr>
<td>Upper respiratory tract infection</td>
<td>31 (6)</td>
<td>84 (9)</td>
</tr>
<tr>
<td>Tension headache</td>
<td>21 (4)</td>
<td>75 (8)</td>
</tr>
<tr>
<td>Headache</td>
<td>19 (4)</td>
<td>55 (6)</td>
</tr>
<tr>
<td>Abdominal pain*</td>
<td>11 (2)</td>
<td>39 (4)</td>
</tr>
<tr>
<td>Vomiting</td>
<td>8 (2)</td>
<td>35 (4)</td>
</tr>
<tr>
<td>Fatigue</td>
<td>9 (2)</td>
<td>29 (3)</td>
</tr>
<tr>
<td>Decrease appetite</td>
<td>5 (1)</td>
<td>26 (3)</td>
</tr>
<tr>
<td>Insomnia</td>
<td>4 (1)</td>
<td>21 (2)</td>
</tr>
<tr>
<td>Back pain</td>
<td>4 (1)</td>
<td>20 (2)</td>
</tr>
<tr>
<td>Migraine</td>
<td>5 (1)</td>
<td>19 (2)</td>
</tr>
<tr>
<td>Frequent bowel movements</td>
<td>1 (0)</td>
<td>17 (2)</td>
</tr>
<tr>
<td>Depression</td>
<td>2 (0)</td>
<td>12 (1)</td>
</tr>
<tr>
<td>Bronchitis</td>
<td>2 (0)</td>
<td>12 (1)</td>
</tr>
<tr>
<td>Tooth abscess</td>
<td>0 (0)</td>
<td>10 (1)</td>
</tr>
<tr>
<td>Folliculitis</td>
<td>0 (0)</td>
<td>9 (1)</td>
</tr>
<tr>
<td>Sinus headache</td>
<td>0 (0)</td>
<td>9 (1)</td>
</tr>
</tbody>
</table>

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

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

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

USE IN SPECIFIC POPULATIONS
Pregnancy: Pregnancy Category C: OTEZLA should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus. Pregnancy Exposure Registry: There is a pregnancy exposure registry that monitors pregnancy outcomes in women exposed to OTEZLA during pregnancy. Information about the registry can be obtained by calling 1-877-311-8972. Nursing Mothers: It is not known whether OTEZLA or its metabolites are present in human milk. Because many drugs are present in human milk, caution should be exercised when OTEZLA is administered to a nursing woman. Pediatric Use: The safety and effectiveness of OTEZLA in pediatric patients less than 18 years of age have not been established. Geriatric Use: Of the 1257 patients who enrolled in two placebo-controlled psoriasis trials (PSOR 1 and PSOR 2), a total of 108 psoriasis patients were 65 years of age and older, including 9 patients who were 75 years of age and older. No overall differences were observed in the efficacy and safety in elderly patients ≥65 years of age and younger adult patients <65 years of age in the clinical trials. Renal Impairment: Apremilast pharmacokinetics were characterized in subjects with mild, moderate, and severe renal impairment as defined by a creatinine clearance of 60-89, 30-59, and less than 30 mL per minute, respectively, by the Cockcroft–Gault equation. While no dose adjustment is needed in patients with mild or moderate renal impairment, the dose of OTEZLA should be reduced to 30 mg once daily in patients with severe renal impairment [see Dosage and Administration (2.2) and Clinical Pharmacology (12.3)]. Hepatic Impairment: Apremilast pharmacokinetics were characterized in patients with moderate (Child Pugh B) and severe (Child Pugh C) hepatic impairment. No dose adjustment is necessary in these patients.

OVERDOSAGE
In case of overdose, patients should seek immediate medical help. Patients should be managed by symptomatic and supportive care should there be an overdose. Manufactured for: Celgene Corporation, Summit, NJ 07901 OTEZLA® is a registered trademark of Celgene Corporation. Pat. http://www.celgene.com/therapies ©2014-2017 Celgene Corporation, All Rights Reserved.
What is Question of the Week and how do I sign up for it?

Question of the Week is an opportunity to earn both CME and Self-Assessment credits, which can be used to fulfill Maintenance of Certification (MOC) requirements for AAD members who are enrolled in MOC through the American Board of Dermatology.

By completing a Question of the Week, members can earn 0.25 CME credit and 1 Self-Assessment credit. (Note that questions expire one year from the date of release.)

Join thousands of your colleagues and sign up to receive Question of the Week directly to your inbox. It’s easy —

1. Visit www.aad.org/account/communication
2. Select ‘Education’ under Dermatology World Academy Insider

Missed a question? Inbox too overwhelming to contemplate? Don’t worry — the full Question of the Week archives are also available at www.aad.org/olc.dw

Looking for more answers?

Send your burning questions to Dermatology World’s Asked & Answered column at dweditor@aad.org, and keep an eye out for the answer in an upcoming issue of Dermatology World!
What’s hot?

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

Atypical intraepidermal melanocytic proliferation (AIMP). Is that really a diagnosis? Getting this diagnosis on your pathology report is frustrating for most dermatologists. It is unclear if it is a benign or malignant diagnosis. In a busy practice, this descriptive diagnosis can be an inevitable event, especially if melanocytic lesions are biopsied at an early stage in their evolution. AIMP describes a proliferation of predominantly single melanocytes in the epidermis without clear development of either a nevus or melanoma in situ.

Dr. Etzkorn and his colleagues recently described their experience of Mohs micrographic surgery for atypical intraepidermal melanocytic proliferation in *JAAD* (doi:10.1016/j.jaad.2018.06.058). Their retrospective review included 223 such lesions of the head, neck, hand, foot, or pretibial region that were treated with Mohs surgery. Interestingly, 42 (18.8%) lesions upstaged to unequivocal melanoma in situ or invasive melanoma. Subclinical spread was present in approximately 24%. It is important for dermatologists to recognize that this diagnosis may be unavoidable even with the most experienced dermatopathologists. Re-excision of AIMP may be necessary in many cases to exclude malignant melanoma.

Are you familiar with “fish pedicures” and their risks? Fish pedicures are pedicures in which the feet are immersed in a tub filled with the fish *Garra rufa* — more commonly known as “doctor fish.” They nibble on human skin and have gained international popularity over the past 10 years due to claims they can make feet smoother, improve circulation, eat away bacteria and fungus, and combat skin diseases like psoriasis. However, a recent and highly publicized *JAMA* case report by Dr. Shari Lipner examines a patient who developed onychomadesis of her toenails after receiving a fish pedicure and reminds dermatologists of the inherent risks associated with these trendy foot treatments (*JAMA Dermatol.* 2018 July 3; [Epub ahead of print]).

First, the tubs cannot be cleaned between customers when the fish are present, and the fish cannot be disinfected or sanitized, posing the risk for spreading infection. In fact, pathogenic bacteria have been found in pedicure water and there have been reports of *S. aureus* and *Mycobacterium marinum* infections. Further, according to the CDC, Chinese *Chinchin* is a fish that is often mislabeled as *Garra rufa* and actually have teeth that can draw blood, increasing the risk of infection. Thus, when it comes to this foot fad, it is best to educate our patients to steer clear!

Dangers of the deep

Skin cancer screening by dermatologists is clearly effective at finding skin cancers. In the AAD’s national skin cancer screening program from 1986 to 2014, nearly 2 million screenings yielded clinical diagnoses of over 20,000 melanomas, over 30,000 squamous cell carcinomas, and nearly 130,000 basal cell carcinomas (JAAD, https://doi.org/10.1016/j.jaad.2018.05.1242).

But the point of cancer screening is not to find cancer. Rather, it’s to reduce morbidity and mortality. That’s something skin cancer screening has not been proven to do. Indeed, initial optimism over the SCREEN study, in which melanoma mortality fell nearly 50% after implementation of skin cancer screening in a German state in 2003-2004, has dissipated. Questions arose about attribution of causes of death in the study and about effects of the study’s public education component. Moreover, melanoma mortality reductions did not persist over time. Finally, melanoma mortality in Germany overall actually increased after nationwide rollout of skin cancer screening.

In 2016, the U.S. Preventive Services Task Force (USPSTF) reaffirmed its assessment that current evidence is insufficient to recommend skin cancer screening for asymptomatic adults who are not at high risk. USPSTF called for more research on skin cancer screening, recognizing the challenge of conducting a randomized clinical trial (RCT) given relatively low rates of melanoma mortality, even among those at high risk.

The feasibility of conducting an RCT continues to be hotly debated (BJD, 2018; 179:532-533; BJD 2018; Aug 13. doi: 10.1111/bjd.17089). In the meantime, the jury is still out on the effectiveness of skin cancer screening in the general population.
When should we initiate chemoprevention with topical therapies in our high-risk skin cancer patients? For most of us, it probably comes down to a simple question: Does treatment with these modalities actually decrease the future burden of skin cancer, and does the upfront cost justify any long-term savings that may be gained? While most dermatologists likely agree that these modalities decrease the incidence of AKs and NMSC, the long-term cost savings is likely less obvious. Yoon, et al, in their recent JAAD article “Impact of topical fluorouracil cream on costs of treating keratinocyte carcinoma (nonmelanoma skin cancer) and actinic keratosis” (Sept. 2018; 79(3):501-7) determined that for high-risk skin cancer patients in their VA population a single course of twice daily use of 5% 5-fluorouracil for up to 4 weeks as tolerated led to an overall cost reduction in AK/NMSC related treatment of $771 per patient over three years. When extrapolated to all VA patients they estimated that this intervention could save $69 million over 3 years. The comparator group in this study was a placebo cream, so the cost savings of topical therapy versus cryotherapy is not clear. However, a take-home point of this article is that high-risk patients — regardless of their current AK burden — will experience less need for AK/NMSC related treatment (thereby lowering costs) for at least 3 years with just a single course of 5% 5-fluorouracil.

What is the USP and how does it affect my ability to buffer lidocaine and reconstitute botulinum toxin? The United States Pharmacopeial Convention (USP) is an independent, standard-setting organization that is currently revising its chapter on compounded sterile preparations. This chapter consists of equipment and process requirements that individuals who are performing compounding must follow, should a relevant policymaker (e.g., state board of pharmacy) adopt and enforce this chapter.

USP considers ‘compounding’ as the “process of combining, admixing, diluting, pooling, reconstituting, repackaging, or otherwise altering a drug or bulk drug substance to create a sterile medication.” This definition categorizes low-risk medications that dermatologists prepare daily as ‘compounding.’ Specifically, (1) lidocaine with epinephrine buffered with sodium bicarbonate, and (2) botulinum toxins reconstituted with bacteriostatic saline, are considered compounded medications because they are not mixed according to manufacturers’ labeling. USP is proposing a one-hour exemption from the chapter’s requirements but that is not nearly long enough. This one-hour exemption would potentially disrupt surgical procedures and clinic flow as well as create medical waste.

If dermatologists are subject to this chapter (i.e., having to buffer lidocaine in a laminar airflow system), patient access would be adversely impacted, and dermatologists as well other specialties and health care providers would be subject to an unreasonable burden. For many practices, it is important to have buffered lidocaine syringes and reconstituted botulinum toxins ready ahead of patient visits. The AADA is advocating for increased time and preparation-specific exemptions. Now is the time to advocate for our specialty and our patients. Please join me in writing to USP by the Nov. 30 deadline to share the need for patient access by visiting www.aad.org/advocacy/drug-pricing-and-availability/access-to-compounded-medications.
Patients are paying more for healthcare. Dermatologists have more uncollected payments. We can help both of you.

When you accept the CareCredit healthcare credit card, it’s easier for patients to accept the care you recommend. And today, that’s more important than ever with patients being responsible for a larger share of out-of-pocket healthcare costs. 64% of providers say their biggest concern with billing is the length of time it takes to collect*. The CareCredit credit card, with promotional financing options, can be used for deductibles, copays, medical and aesthetic dermatology treatments, prescriptions and more**. And you get paid within two business days. It’s a healthy thing for everybody.

*CareCredit Payment Benchmark Study with Enrolled Providers, conducted by Chadwick Martin and Bailey, December, 2016
**Subject to credit approval.
DWAD2018CA
Biopsy coding in 2019: Part 1

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.

Dermatologists commonly biopsy skin lesions via a tangential shave technique, with a punch, or with a scalpel incision to extract an optimal tissue specimen for histologic evaluation. Have you ever wondered why these diverse techniques — requiring different supplies and procedures — are all commingled under one CPT® biopsy code, 11100? Wonder no more! The biopsy codes are changing for 2019. The long-established codes, 11100 and 11101, will be deleted and invalid as of Jan. 1, 2019. They will be replaced with procedure-specific codes based upon the biopsy technique: tangential, punch, and incisional. There will be no transitional grace period: Coding with CPT® 11100 and 11101 in 2019 will result in non-payment. So, it is imperative that the new codes are understood, activated within your billing system, and implemented on Jan. 1.

Unlike the existing integumentary biopsy codes, which include mucous membrane biopsies, the new codes are limited only to integumentary (skin) biopsy procedures. So, what happens if you biopsy a mucosal surface? Well, the existing site-specific biopsy codes, including those for mucosal surfaces such as lip vermilion, will be preserved unchanged and available for use.

The new, technique-specific biopsy codes will follow existing integumentary biopsy coding convention, specifying a primary code for the first biopsy and an add-on code for each additional biopsy. The table below defines the new codes as well as the codes to be deleted, for comparison.

<table>
<thead>
<tr>
<th>Primary CPT Code</th>
<th>Description</th>
<th>Add-on CPT Code</th>
<th>Description</th>
<th>Implementation Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>11102</td>
<td>Tangential biopsy of skin (e.g., shave, scoop, saucerize, curette); single lesion</td>
<td>+11103</td>
<td>Each separate/additional lesion (list separately in addition to code for primary procedure)</td>
<td>1/1/2019</td>
</tr>
<tr>
<td>11104</td>
<td>Punch biopsy of skin (including simple closure, when performed); single lesion</td>
<td>+11105</td>
<td>Each separate/additional lesion (list separately in addition to code for primary procedure)</td>
<td>1/1/2019</td>
</tr>
<tr>
<td>11106</td>
<td>Incisional biopsy of skin (e.g., wedge), (including simple closure, when performed); single lesion</td>
<td>+11107</td>
<td>Each separate/additional lesion (list separately in addition to code for primary procedure)</td>
<td>1/1/2019</td>
</tr>
<tr>
<td>11100</td>
<td>Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed; single lesion</td>
<td>+11101</td>
<td>Each separate/additional lesion (List separately in addition to code for primary procedure)</td>
<td>Deleted 1/1/2019</td>
</tr>
</tbody>
</table>
The 2019 CPT lists specific qualifying criteria for each of the new codes.

- **Intent:** Extract a sample of a lesion or lesions for diagnostic histopathologic examination.
- **Technique selection:** Technique selected based upon which would optimally present tissue for histopathologic evaluation.
- **Technique descriptions:** Listed in the following table.
- **Multiple biopsies done on the same day:** Same-day biopsies done on different lesions or different sites may be reported separately.
- **Exclusion criteria:** Stratum corneum sampling only — such as via a skin scraping or tape stripping — is not separately reportable, as this does not constitute a biopsy.

### CPT Code 2019

<table>
<thead>
<tr>
<th>CPT Code 2019</th>
<th>Code Description</th>
<th>Qualifying Criteria</th>
<th>Histopathologic Evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>11102, ++11103</td>
<td>Tangential biopsy</td>
<td>• Sharp instrument must be used for tissue removal&lt;br&gt;• Removed tissue depth: Partial thickness: includes epidermis with or without dermis, does penetrate into the subdermal space</td>
<td>Always done</td>
</tr>
<tr>
<td>11104, +11105</td>
<td>Punch biopsy</td>
<td>• Requires a punch tool&lt;br&gt;• Full-thickness tissue sample: through the dermis, into subcutaneous space&lt;br&gt;• Includes simple closure&lt;br&gt;• Undermining, excision of standing cones [Burow triangles] included</td>
<td>Always done</td>
</tr>
<tr>
<td>11106, +11107</td>
<td>Incisional biopsy</td>
<td>• Must use a sharp blade, not a punch tool&lt;br&gt;• Full-thickness tissue sample; through the dermis, into subcutaneous space&lt;br&gt;• May include subcutaneous fat along with skin&lt;br&gt;• Includes simple closure</td>
<td>Always done</td>
</tr>
</tbody>
</table>

### Coding for multiple biopsies

Just as with the soon to be deleted 11100 and 11101 codes, only one primary biopsy code may be reported. Additional biopsies are specified by their pertinent add-on codes. However, there are now three sets of primary and three sets of add-on codes. When doing multiple biopsies utilizing more than one technique, which primary code should you choose? There is a simple hierarchy to primary code selection:

**Incisional biopsy (11106) > Punch biopsy (11104) > Tangential biopsy (11102)**
When doing multiple biopsies utilizing the same technique, such as punch biopsies, for example, one would report one primary code, 11104 and multiples of the add-on code, 11105 x number of additional biopsies.

When doing multiple biopsies involving more than one biopsy technique, code selection will adhere to the above hierarchical guideline. Whenever an incisional biopsy is done, it is always reported with its primary code (11106) and all other biopsy modalities are reported with add-on codes (punch biopsy: +11105, tangential biopsy: +11103). When punch and tangential biopsies are done, the punch biopsy is reported with a primary code (11104) and any additional punch and tangential biopsies are reported with add-on codes (+11105, +11103).

The following illustrates six biopsy coding scenarios:

• **Three tangential biopsies coded as:**
  First: 11102
  Second: 11103
  Third: 11103

• **Two punch biopsies coded as:**
  First: 11104
  Second: 11105

• **One punch, two tangential biopsies coded as:**
  Punch: 11104
  Tangential 1: 11103
  Tangential 2: 11103

• **Three incisional biopsies coded as:**
  First: 11106
  Second: 11107
  Third: 11107

• **One incisional, two punch biopsies coded as:**
  Incisional: 11106
  Punch 1: 11105
  Punch 2: 11105

• **One incisional, one punch, two tangential biopsies coded as:**
  Incisional: 11106
  Punch: 11105
  Tangential 1: 11103
  Tangential 2: 11103

Okay, then, you have conceptualized and implemented the new skin biopsy codes. What if you are doing a biopsy of mucosal tissue? What is the code for that? Below is a table of all of the available site-specific biopsy codes. Their definitions remain unchanged. Site-specific biopsy codes are technique agnostic. Only the location, and not the biopsy technique, determines the appropriate code.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>11755</td>
<td>Biopsy of nail unit (plate, bed, matrix, hyponychium, proximal and lateral nail folds)</td>
</tr>
<tr>
<td>30100</td>
<td>Biopsy, intranasal</td>
</tr>
<tr>
<td>40490</td>
<td>Biopsy of lip mucosa</td>
</tr>
<tr>
<td>40808</td>
<td>Biopsy, vestibule of mouth</td>
</tr>
<tr>
<td>41100</td>
<td>Biopsy of tongue; anterior two-thirds</td>
</tr>
<tr>
<td>41105</td>
<td>Biopsy of tongue; posterior one-third</td>
</tr>
<tr>
<td>41108</td>
<td>Biopsy of floor of mouth</td>
</tr>
<tr>
<td>54100</td>
<td>Biopsy of penis</td>
</tr>
<tr>
<td>56605</td>
<td>Biopsy of vulva or perineum; 1 lesion</td>
</tr>
<tr>
<td>56606</td>
<td>Biopsy of vulva or perineum, each separate additional lesion</td>
</tr>
<tr>
<td>67810</td>
<td>Incisional biopsy of eyelid skin including lid margin</td>
</tr>
<tr>
<td>69100</td>
<td>Biopsy external ear</td>
</tr>
</tbody>
</table>

What next? Ensure that your electronic health records and office management programs will be updated to process the new codes appropriately, and that the old codes are rendered useless on Jan. 1, 2019. *dw*
Our Advantage SMART Practice™ suite of All-in-One Solutions use real-time data from your clinic to optimize efficiency, improve outcomes, and increase revenue.

DERMATOLOGY SPECIFIC
EHR & PM Leader for
33 YEARS

EHR | PM | RCM | INVENTORY
PATIENT ENGAGEMENT | ANALYTICS
TELEHEALTH | 2015 ONC CERTIFIED

REQUEST A DEMO TODAY

WWW.COMPULINKADVANTAGE.COM/DERMEHR | 800.456.4522
Most states have passed legislation that requires services delivered through telemedicine to be covered in the same way as in-person services. Obtaining payment parity for covered services is widely considered to be the next big hurdle in telehealth policy. The AADA strongly supports such policies and in 2018 tracked more than 60 bills pertaining to these issues and the utilization of telemedicine technology as a means of improving access to the expertise of board-certified dermatologists.

**Florida**
Bill #: SB 280
Overview: The bill defined terms such as telehealth, synchronous, telecommunications systems, and store-and-forward. It also would have established that the standard of care for telehealth providers is the same as the standard of care generally accepted for in-person health care services. It also would have authorized telehealth providers to use telehealth to perform patient evaluations. If a telehealth provider conducts a patient evaluation sufficient to diagnose and treat the patient, the telehealth provider would not be required to research the patient’s medical history or conduct a physical examination of the patient before using telehealth to provide services to the patient. Further, the bill stated that a nonphysician telehealth provider using telehealth and acting within their relevant scope of practice would not be deemed to be practicing medicine without a license.
Status: Passed Senate, died in the House

**Kansas**
Bill #: HB 2028
Overview: Defines telemedicine as the delivery of health care services or consultations while the patient is at an originating site and the health care provider is at a distant site — provided by means of real-time, two-way interactive audio, visual, or audio-visual communications. This includes the application of secure video conferencing or store-and-forward technology to facilitate the assessment, diagnosis, consultation, treatment, education, and care management of a patient’s health care. Telemedicine may be used to establish a valid provider-patient relationship, and the bill requires that the same standards of practice and conduct that apply to health care services delivered in-person also apply to those delivered via telemedicine. Payment or reimbursement of covered services delivered through telemedicine may be established by an insurance company in the same manner as payment or reimbursement for covered services that are delivered via in-person are established.
Status: Enacted

**Michigan**
Bill #: SB 1059
Overview: Defines telemedicine as the use of interactive audio-visual or other telecommunications technology by a health care professional to deliver health care services — including prescriptions — between a distant site and an originating site for diagnosis and treatment of a patient.
The bill defines telemedicine services as health care services provided through telemedicine, including services provided through a synchronous interaction or asynchronous store-and-forward action. An insurer shall not require face-to-face contact between a health care professional and a patient for services appropriately provided through telemedicine, and the provider must be licensed, registered, or otherwise authorized in Michigan.

**Status:** Referred to the Senate Committee on Insurance

### Nebraska

**Bill #:** LB 701

**Overview:** Defines telehealth as the use of medical information electronically exchanged from one site to another — whether synchronously or asynchronously — to aid a credential holder in the diagnosis or treatment of a patient. Telehealth includes services originating from a patient’s home or any other location where such patient is located; asynchronous services involving the acquisition and storage of medical information at one site that is then forwarded to, or retrieved by, a credential holder at another site for medical evaluation; and telemonitoring. A physician or physician assistant may establish a provider-patient relationship through telehealth and may prescribe a drug if authorized to prescribe.

**Status:** Enacted

### New Hampshire

**Bill #:** HB 1471

**Overview:** Defines ‘distant site’ and ‘originating site,’ and defines the application of telemedicine for covered services — provided within the scope of practice of a physician or other health care provider — as a method of delivery of medical care by which an individual at an originating site shall receive medical services which are clinically appropriate for delivery through telemedicine from a health care provider at a distant site without in-person contact with the provider. The bill also establishes a committee to study reimbursement for telehealth services.

**Status:** Enacted
New York
Bill #: A 1421
Overview: The bill would have required insurers, corporations, and health management organizations to reimburse a telehealth provider for covered services delivered via telehealth on the same basis and at the same rate that is established for the same service when not delivered via telehealth.
Status: Died in Assembly Insurance Committee

Ohio
Bill #: HB 546
Overview: States that a health plan shall provide coverage for telemedicine services on the same basis and extent that the plan provides coverage for the provision of in-person health care services. Plans shall not exclude coverage for a service solely because it is provided as a telemedicine service, and may not impose any annual or lifetime benefit maximum in relation to telemedicine services other than such a benefit maximum imposed on all benefits offered under the plan.
Status: Heard in the House Committee on Health

Pennsylvania
Bill #: SB 780
Overview: The bill would establish a statutory definition for telemedicine along with protections for patients, mandate that telemedicine services are reimbursed, and prohibit ‘audio-only’ services (video must be available if either the patient or physician requests it). A health care provider is required to hold a valid license and disciplinary actions may be set for violating the standards of care. The health care provider who provides telemedicine and does not have an established provider-patient relationship would disclose his or her medical specialty or applicable credentials.
Advocacy: The AADA sent a grassroots action alert to AAD members in the districts of the members of the House Professional Licensure Committee and helped the Pennsylvania Academy of Dermatology and Dermatologic Surgery submit a letter of support.
Status: Passed Senate, heard in the House Professional Licensure Committee

South Carolina
Bill #: S 4529
Overview: An advanced practice registered nurse (APRN) would have been allowed to perform delegated medical acts via telemedicine that are agreed to by both the Board of Nursing and the Board of Medical Examiners and performed pursuant to an approved written protocol between the nurse and the physician. An APRN who establishes a nurse-patient relationship solely by means of telemedicine would be required to adhere to the same standard of care as a licensee employing in-person medical care. An APRN may not perform services beyond the scope of what is currently authorized.
Status: Passed House, passed Senate committee, died in Senate upon adjournment

South Dakota
Bill #: SB 122
Overview: Health insurers would not be allowed to exclude a service for coverage solely because the service is provided through telemedicine. A health insurer would be required to reimburse the treating or consulting health care professional for the diagnosis, consultation, or treatment of the insured delivered through telemedicine-provided services on the same basis that the health insurer is responsible for coverage of the same service through in-person consultation or contact. Payment for telemedicine interactions would include reasonable compensation to the originating site for the cost incurred during the delivery of health care services.
Status: Died in the Senate Health and Human Services Committee
Improve patient engagement.

Share disease images and information with patients to build confidence and satisfaction.

VisualDx for you. VisualDx for your patient.

20% OFF
for AAD Members
visualdx.com/aad

Made by dermatologists for dermatologists.
AADA calls on CMS to withdraw harmful modifier 25 payment policy

FEDERAL NEWS ROUNDUP

BY VICTORIA HOUGHTON, MANAGING EDITOR

In this new column, Dermatology World breaks down the latest highlights of AADA advocacy activities at the federal legislative and regulatory level.

The advocacy arm of the Academy, the American Academy of Dermatology Association (AADA) provides a voice to dermatologists, ensuring that public policies address the ever-changing needs of practices and patient care. The AADA provides members with valuable resources and tools to adapt to the shifting health care landscape while contributing to policies that protect the quality of, and access to dermatologic care.

Not sure which topics are important to the specialty right now? Review the AADA’s top advocacy priorities at www.aad.org/advocacy/advocacy-priorities.

Medicare physician payment

Every year, the AADA dissects the proposed and final Medicare Physician Fee Schedule and offers comments and recommendations to CMS on policy changes.

Highlights from the AADA’s comment letter to CMS about the payment policies in the proposed 2019 Medicare Physician Fee Schedule include:

✓ A request for CMS to withdraw its harmful new modifier 25 payment policy for outpatient procedures, which would reduce payment on the lowest cost service by 50% when an E/M service and procedure occur on the same day.
✓ A recommendation that CMS work with the physician community to develop a better alternative to its proposed changes to the structure and payment of office-based E/M codes.


Administrative relief

The AADA continuously advocates for physician relief from regulations impacting the practice of medicine.

Recently, the AADA:

✓ Joined an AMA-led coalition letter thanking the Administration for its proposal to reduce E/M documentation requirements.
✓ Issued a statement for a U.S. House of Representatives’ Energy & Commerce Health Subcommittee oversight hearing that discussed challenges with EHR vendors and data blocking, and highlighted ways to reduce physician administrative burdens.

Want to learn more about these issues and more? Check out the AADA advocacy blog at www.aad.org/advocacy/news.
Better care doesn’t happen by chance – it happens by design. Design that takes into account not just the space, but the people working in it. At Midmark, we believe that who’s using our technology is every bit as important as how and why it’s being used. We know that with a few simple workflow considerations, functionality and patient and provider comfort at the point of care can be drastically improved. It’s this attention to our customers and design that has enabled us to transform the dermatology clinical care environment.

midmark.com/DWnov
Patient access to care and treatments

The AADA advocates against barriers that restrict patients’ access to care and treatments.

Recently the AADA:

- Submitted comments on the Trump Administration’s Blueprint to Lower Drug Prices and Reduce Out-of-Pocket Costs — advocating for transparency in how Pharmacy Benefit Managers operate in setting drug prices and lifting insurers’ “gag clauses” that restrict pharmacists from informing insured patients when a drug is cheaper if paid out-of-pocket.
- Supported legislation ensuring insurance coverage for children born with congenital anomalies, birth defects.

Skin cancer and indoor tanning

The AADA works to raise awareness among policymakers of the increased incidence of skin cancer. Additionally, the AADA is pursuing greater oversight of the indoor tanning industry.

Recently, the AADA:

- Submitted a comment letter to the FDA emphasizing the implications that recent proposals to ban the sale and distribution of sunscreens containing oxybenzone and octinoxate can have on the public, as access to a broad range of sunscreen ingredients may become further limited. Additionally, the AADA expressed its interest in facilitating discussion between the FDA and industry regarding unapproved sunscreen ingredients.
- Sent a letter to U.S. Sens. Rand Paul (R-Ky.) and Heidi Heitkamp (D-N.D.) opposing the Tanning Tax Repeal Act of 2018 (S. 2600).

Telemedicine

The AADA supports policies that protect patient safety while enabling dermatologists to appropriately use teledermatology services to meet the needs of communities and populations across the country.

Recently, the AADA has:

- Expressed its support for CMS’s proposal to increase access for Medicare beneficiaries to physicians’ services that are routinely furnished via communication technology.
Medical financing promotions

Debt consolidation promotion
3.89% for the first three years\(^1^2\)
- Pay off high interest rate business loans, and consolidate into one loan
- Flexible loan terms up to 15 years to improve cash flow of practice
- You’ll also get a competitive rate through maturity, and you’ll know the rate up front
- Debt consolidation applications beginning September 17, 2018 through November 30, 2018. Loan must close by December 31, 2018

Practice acquisition promotion
0% for the first six months\(^1^2\)
- Eligibility includes practice acquisition, partnership buy-ins, and second location purchases
- Flexible loan terms up to 15 years to improve cash flow of practice
- You’ll also get a competitive rate through maturity, and you’ll know the rate up front
- Practice acquisition applications beginning September 17, 2018 through November 30, 2018. Loan must close by December 31, 2018

Commercial real estate promotion
1.99% for the first six months\(^1^3^4\)
- Loans from $100,000 to $2,500,000
- We’ll pay your appraisal fee when you close a commercial real estate loan\(^1^4\)
- 1.99% interest rate for the first six months and then a competitive rate through maturity\(^4\)
- Applications beginning September 10, 2018 through October 31, 2018. Loan must close by January 31, 2019

Talk to a practice specialist today
Call 800.497.6076
Or visit bankofamerica.com/practicesolutions

\(^1\) All programs subject to credit approval and loan amounts are subject to creditworthiness. Some restrictions may apply. The term, amount, interest rate and repayment schedule for your loan, and any product features, including interest rate locks, may vary depending on your creditworthiness and on the type, amount and collateral for your loan.
\(^2\) Promotional rate only available with specific term payment agreement, see your Practice Solutions specialist for the required options. Not eligible with interest only in payment structure. Your rate after the promotional period ends will be fixed for the remaining term, up to 15 years. The application must be received between September 17, 2018 through November 30, 2018 and the loan must close by December 31, 2018 to be eligible.
\(^3\) Bank of America will pay the appraisal fee at the time the commercial real estate loan is closed. Loan must close by January 31, 2019 to be eligible.
\(^4\) For the limited time beginning with applications dated September 10, 2018, and ending with applications dated on or before October 31, 2018, take advantage of an introductory interest rate and appraisal fee waiver (if appraisal is ordered by Bank of America on approved Small Business commercial real estate secured loans (including Small Business SBA commercial real estate loans) closed by January 31, 2019 loan amounts must be a minimum of $100,000 and no more than $2,500,000 to qualify. Excludes Practice Solutions commercial real estate refinance of existing Bank of America loans, certain franchise lending program loans, Business Advantage products, construction loans, revolver to term loans, draw notes, leases, lines of credit, and any product that contains a variable rate. Subject to credit approval. The promotional rate supersedes other rate discounts during the promotional period. Other restrictions may apply.

Business Advantage Relationship Rewards (the program) is only available to Small Business, Merrill Lynch® Small Business, and U.S. Trust® Small Business clients. Other categories of clients, such as those commonly referred to as Business Banking, Global Commercial Banking, Global Corporate Investment Banking, or Institutional clients are not eligible to participate in the program. Subject to certain exceptions, eligible business checking accounts generally are any Small Business Checking account and the following Analyzed checking accounts: Full Analysis Business Checking or Analyzed Business Interest Checking. Clients in the eligible business categories may enroll in the program if you have an active, eligible Bank of America business checking account, and maintain a combined balance in your qualifying Bank of America® business deposit accounts and/or your qualifying U.S. Trust® or Merrill Lynch® business investment accounts of at least $25,000 for the Gold tier, $50,000 for the Platinum tier, or $100,000 for the Platinum Honors tier. The combined balance is calculated based on either (i) your average daily balance for a three calendar month period, or (ii) your current combined balance. If you enroll in the program, you open your first eligible business checking account and satisfy the balance requirement within thirty days of opening that account. U.S. Trust® Small Business clients are automatically enrolled in the program at the Platinum Honors tier as long as you maintain your U.S. Trust relationship. Certain benefits may be available without enrolling in the program if you satisfy balance and other requirements. Program benefits subject to change.

Practice Solutions business line of credit and term loan interest rate discounts are available to business applicants and co-applicants who are enrolled in the program at the time of line of credit or term loan application and receive customized pricing. Amount of discount (0.25% for Gold tier, 0.30% for Platinum tier, and 0.35% for Platinum Honors tier) is based on the business applicant’s or co-applicant’s eligible tier and status at the time of application. Benefits are non-transferable. The interest rate discount is an additional benefit and in certain instances may be combined with or superseeded by other promotional offers. This interest rate discount will be incorporated into final pricing upon loan approval, which is subject to credit approval. Standard underwriting guidelines and credit policies apply. Bank of America Practice Solutions may prohibit use of an account to pay off or pay down another Bank of America account.
What common dermatologic diseases can be attributed to therapeutic and cosmetic cultural practices?

BY KATHRYN SCHWARZENBERGER, MD

In this month’s Acta Eruditorum column, Physician Editor Kathryn Schwarzenberger, MD, talks with Nicole Patzelt, MD, and Neelam A. Vashi, MD, about their recent Journal of the American Academy of Dermatology article, “Dermatoses caused by cultural practices.”

Q Dr. Schwarzenberger: You and your colleagues wrote a very informative two-part article on skin conditions associated with cultural practices. What led you to write this and how did you learn about these practices?

Drs. Patzelt and Vashi: We have had the fortunate experience to have cared for patients from a variety of backgrounds and cultures. Because of our exposure, we are continuously learning about new home remedies or treatments. In terms of counseling and medical treatment for culturally related dermatoses, we found only sporadic case reports and a few limited reviews of dermatologic care and its association with cultural practices for reference. There was no single comprehensive review that highlighted the most common examples of these practices from a variety of cultures. Although by no means completely exhaustive, we aimed to compile a review that could be easily referenced in clinical practice regarding the most common as well as some lesser known cultural practices. In addition to performing our own extensive literature search for cultural practices that have been associated with dermatologic side effects, we referenced our own cultural backgrounds. Our team as well as other colleagues at Boston University’s dermatology department come from all corners of the globe and contributed information regarding practices they were aware of from either personal experience in a home country or from extended family practices.

Q Dr. Schwarzenberger: What cultural practices do you see most in your practice? Do you feel dermatologists are seeing more of these practices than in the past and, if so, is there a reason why?

Drs. Patzelt and Vashi: The rates of complementary and alternative medicine (CAM) use are increasing among the general U.S. population which certainly accounts for part of the increased recognition of these practices by dermatologists compared to years past. These rates are increasing as discussion in the popular media rises, with the wider availability of ‘ethnic’ stores and online vendors carrying alternative medicines, and due to more acceptance of these practices by a population that generally followed more Western medical guidelines before. We feel the more important aspect, though, is that dermatologists are recognizing these practices now more than ever. With increasing discussion in scientific texts and at national meetings, CAM is no longer considered a taboo subject. Rather, discussion and awareness is encouraged. This is because it has become well recognized that successful treatment of patients involves a clear understanding of all their therapies and habits. I (Dr. Vashi) am also the director of our Cosmetic and Laser Center and have an interest in disorders of hyperpigmentation. Therefore, on a personal level, we see dermatoses secondary to lightening agents most commonly in my practice.

Taking the waters

Read more about dermatologic spa treatments in the U.S. and abroad at www.aad.org/dw/monthly/2016/december/taking-the-waters.
Dr. Schwarzenberger: How might you encounter complementary and alternative medicine in a day-to-day practice? Are there particular clues in the history or physical exam that should make you ask more about this possibility? Are there particular populations in whom this is more likely to be practiced?

Drs. Patzelt and Vashi: It is difficult to pinpoint who ‘looks’ like they are or have used CAM unless presenting with a typical type of dermatitis. To ensure all relevant history is obtained, we often simply ask our patients about any alternative therapies that they are currently using. Although there are higher prevalence rates in different patient populations, as these practices become more streamlined, we see that everyone from visiting tourists to recent immigrants to the patient whose family has been living in the U.S. for generations may be using some form of CAM. In our practice, it is standard to not only ask about prior prescription or over-the-counter treatments but also any home remedies that may have been tried. Certainly on physical exam, there may be stigmata that would make one think more about specific practices that may not have been mentioned earlier in the history (cupping as the classic example comes to mind) and signal one to probe deeper into possible CAM use.

Dr. Schwarzenberger: How do you recommend addressing patients who wish to pursue CAM over the more traditional medical practices that we trust? Do you ever recommend CAM to any of your patients?

Q Dr. Schwarzenberger: How might you encounter complementary and alternative medicine in a day-to-day practice? Are there particular clues in the history or physical exam that should make you ask more about this possibility? Are there particular populations in whom this is more likely to be practiced?

Drs. Patzelt and Vashi: Failure to consider these practices could lead to failure to fully treat patients, inappropriate treatment of patients, or even inappropriate legal repercussions as discussed in the article regarding the confusion between child abuse stigmata and the cutaneous manifestations of cupping, spooning, and coining. Many of the practices we discuss in the two-part article result in contact dermatitis. Failing to recognize that alternative practices may be in use can easily result in prolonged steroid treatment as the offending agent is not removed. This would increase the risk of side effects and harm the trust the patient has in the physician’s ability as they continue to have scaling and pruritus of affected areas. Permanent harm can also occur. For example, treating hyperpigmentation in a patient who is, unbeknownst to the dermatologist, self-treating with a skin lightening cream from an online vendor containing hydroquinone could lead to irreversible ochronosis. This can be psychologically devastating to a patient.

Q Dr. Schwarzenberger: How do you recommend addressing patients who wish to pursue CAM over the more traditional medical practices that we trust? Do you ever recommend CAM to any of your patients?
Drs. Patzelt and Vashi: As with any medical therapy, we try to provide our patients with as much information as we can so that they can make informed decisions. As with much of CAM, there is unfortunately a significant lack of rigorous scientific data to support or refute its claims. For example, it was difficult to draw any definitive conclusions about much of the traditional Chinese medicine discussed in our article as the methods and measured outcomes of the reported studies were highly variable and the quality of much of the data was poor. This is not to say that there is no place for CAM in the treatment of our patients, but that, at this time, it is not our practice to make any specific recommendations regarding CAM as we do not have the scientific evidence to validate those recommendations. There is much need for rigorous research into these treatments. For now, our general recommendation to patients interested in using CAM is to try these treatments with caution. If they are not having any side effects and feel they are getting some relief with their use, we do not discourage our patients from branching outside of typical Western medical practices.

Q Dr. Schwarzenberger: I was struck by the fact that we who practice Western medicine consider practices that are outside of our traditional teaching to be ‘complementary and alternative.’ Are we possibly missing an opportunity to help our patients? Many CAM practices have historically had sparse data to support their use. In 1998, the National Institutes of Health formed a new institute, the National Center for Complementary and Integrative Health, whose mission is to define, through rigorous scientific investigation, the usefulness and safety of complementary and integrative health interventions and their roles in improving health and health care. To your knowledge, has this helped integrate dermatologic care?

Drs. Patzelt and Vashi: Unfortunately, the National Center for Complementary and Integrative Health also notes on their website that there have only been a few studies on CAM for skin conditions and that those generally have had serious methodological problems. Despite this, they do have some limited information regarding dermatologic care for two common conditions. For atopic dermatitis, there is some limited evidence that relaxation techniques may help improve symptoms especially in the pediatric population. For psoriasis, some evidence states that fish oil, Dead Sea climatotherapy, and the topical herbs Mahonia aquifolium and Indigo naturalis may be beneficial. Otherwise there is very limited data which is insufficient to support or refute use of CAM for the vast majority of dermatologic conditions. We believe that it is likely that useful treatments from CAM or at least treatments that can be developed from ingredients found in CAM remedies will prove to be beneficial for our patients. Our team sincerely hopes more research is put into this field of medicine to help develop new and effective therapies for our patients.

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 and matching stool to make the 90D the perfect solution for your practice.

Starts at $4295
The anti-kickback statute with its criminal and civil penalties, fines, and exclusion options is incredibly broad. It implicates a wide range of behavior among health care system participants and patients. It is applicable not just to Medicare and Medicaid, but to all federal health care programs. A long-standing prohibition under the statute has been against any person offering or giving remuneration to a patient that the giver knows or should know is likely to influence the patient to order or receive services from a particular provider. Virtually anything a physician might give to a patient could be seen as an inducement (42 CFR §1003.1000(a)). Fortunately, there are federal regulations and a Special Advisory Bulletin that address permissible inducements. Before there were regulations, there was a bulletin that indicated that a physician could offer patients inexpensive gifts of up to now $15 each with an annual limit of $75 per patient. That remains in effect even though there are more recent regulations that permit additional specific inducements.

Local transportation
There is a safe harbor regulation — under the anti-kickback statute — that allows a physician to offer local transportation to a patient to get medically necessary services. ‘Local’ means no more than 25 miles in urban areas and no more than 50 miles in rural areas (42 CFR § 1001.952(bb)). The practice may not advertise the availability of the service and may only offer it to established patients. A patient who has made an appointment with the practice but has not yet been seen is considered established. A caseworker or social worker making the appointment does not make the patient established! It is permissible to use vouchers with a third-party service or to reimburse the patient for travel expenses incurred based on a receipt. Signage on the transport, indicating who is sponsoring it, is permitted.

If local transportation will be made available, it must be pursuant to a formal policy which is applied uniformly and consistently setting forth the criteria for when the transport will be made available. Examples of factors that might be taken into account include:

- When it is unsafe for the patient to drive home after a procedure.
- When patients have a history of missed appointments.
- When it is based on financial need — the basis for determining such need must be stated.

The regulations also allow a shuttle service to be provided for free as well. The service is defined as “a vehicle that runs on a set route on a set schedule.” This can be made available to new patients, not just established patients, along with family members and visitors. The same prohibitions pertain to marketing its availability and to using it only locally.

Access to care
There is also an exception to the inducement prohibition for promoting access to care, where the inducement poses a low risk of harm to patients and to the federal programs (42 CFR §1003.110). Here, there is more interpretive analysis that should be applied and obtaining legal advice would be wise. The remuneration must increase the beneficiary’s ability to obtain care, which is defined as services or items payable by Medicare or a state health care program.
The factors that apply are that the items or services:

- Must support or help patients get access to care or make access more convenient.
- Eliminate socio-economic, educational, geographic, mobility, or other barriers to access to necessary care, which includes preventive care or following through on a treatment plan.

The form of remuneration does not matter as long as it is neither cash nor cash equivalents (like gift cards). So what types of things are they talking about? The regulators have offered examples which require some close scrutiny. The following are permitted:

- Providing free participation in smoking cessation, nutritional counseling, or disease-specific support groups.
- Providing free child care so a patient can attend an educational program.
- Providing a free blood pressure monitoring device or a purchase code for a smartphone app.
- Providing an item that dispenses medication at a predetermined time.
- Reimbursing parking expenses or providing free child care during office visits.

Free dinners or movie tickets, or offering a free debit card are not permitted.

**Other inducements**

In addition to the regulations which provide relief from the prior restrictive nominal value only policy, a number of OIG Advisory Opinions have approved various inducements that might be applicable by analogy to dermatology practices. These have included free educational videos to prospective patients, motivational incentives to reward patient achievement of goals at a substance abuse treatment center, free oral nutritional supplements from a dialysis facility for malnourished dialysis patients, and free hearing tests for prospective hearing aid patients.

There is yet another exception to the civil money penalties for inducement based on financial need and these are broader than what is permitted above (42 CFR § 1103.110 (a)(7)). The determination of need must be an individualized assessment made in good faith on a case-by-case basis, although no specific documentation is required. There should be a policy which is uniformly applied. Need must be established based on independent data and not merely the patient’s assertion of need. But allowable are car seats for infants, a health center offering items to incentivize preventive care — like a stroller or school supplies to patients who attend necessary preventive care appointments. Giving a diabetic compression stockings or offering a disease-management program are both legitimate as well.

**Conclusion**

What is permitted turns on context, but there is a fair degree of discretion for physician practices to curry favor with their patients. It is not hard to imagine what dermatology practices might offer — educational videos for treatment of various conditions, skin treatment accessories to enhance the application of prescribed drugs and lotions, providing sunscreen to pediatric patients. The point is that more is now allowed than has been before, but it would be important to obtain legal advice before initiating a program of beneficiary inducement. Any inducements should be the subject of a formal policy. In addition, how such inducements are made and who has authority to make such judgments should be included in the practice’s compliance program. dw

---

Take the pledge!

Are you an ethical dermatologist?

Let the world know.
Take the pledge and learn more at www.aad.org/form/ethicspledge.
Earning a high performance bonus for MIPS

Using DataDerm™ to report

BY VICTORIA HOUGHTON, MANAGING EDITOR

Dermatology World talks with Mary Barber, MD, and Scott Kelley, MBA, at the Skin Cancer Center of Central Florida about using DataDerm™ — the Academy’s clinical data registry — to report measures for the Merit-based Incentive Payment System (MIPS).

Stay tuned!

Curious about DataDerm? Keep an eye out for a full-length feature about the registry in the January issue of DW.

Q DERMATOLOGY WORLD: How long have you been using DataDerm?
Scott Kelley: We attested with DataDerm in 2016 and 2017. We picked it up in 2016 and it did quite a bit of the submissions for us for the Meaningful Use program. We reported through DataDerm for MIPS in 2017.

Q What was the process for getting your practice set up with DataDerm and how was your overall experience with MIPS reporting?
Kelley: I thought DataDerm did a great job. Getting set up was just a matter of getting a hold of FIGmd and having them set up the configurations and map out all of the fields. They did several mapping meetings with us where we would go back and look at the data for missing fields. All in all, the process was very good and they were very friendly and nice people to work with. They did a great job.

Q How much time did it take for you to get DataDerm integrated with your EHR system?
Kelley: It’s a work in progress because we’re still refining it. However, I think the initial setup only took a couple of meetings. We went through our workflow in our EMR, NexTech, and FIGmd identified which fields needed to be mapped to which metrics. From there, they went back out and they did all of the mapping and put it on a site where we could look at it. From there, we fine-tuned it in another meeting. I would say the initial process involved probably three or four phone calls. It went well.

Q How many MIPS measures did you report through DataDerm in 2017?
Dr. Barber: We already had a system that followed up on our biopsies and it worked very well through our EMR. We also already asked about smoking and alcohol since we are strictly a skin cancer practice and the answers are relevant to our practice.
NOW APPROVED
FOR MODERATE-TO-SEVERE PLAQUE PSORIASIS

ILUMYA™ (tildrakizumab-asrn) is an interleukin-23 antagonist indicated for the treatment of adults with moderate-to-severe plaque psoriasis who are candidates for systemic therapy or phototherapy.

IMPORTANT SAFETY INFORMATION

CONTRAINDICATIONS
ILUMYA is contraindicated in patients with a previous serious hypersensitivity reaction to tildrakizumab or to any of the excipients.

WARNINGS AND PRECAUTIONS

Hypersensitivity
Cases of angioedema and urticaria occurred in ILUMYA-treated subjects in clinical trials. If a serious allergic reaction occurs, discontinue ILUMYA immediately and initiate appropriate therapy.

Infections
ILUMYA may increase the risk of infection. Treatment with ILUMYA should not be initiated in patients with a clinically important active infection until the infection resolves or is adequately treated.

Consider the risks and benefits of treatment prior to prescribing ILUMYA in patients with a chronic infection or a history of recurrent infection. Instruct patients receiving ILUMYA to seek medical help if signs or symptoms of clinically important chronic or acute infection occur. If a patient develops a clinically important or serious infection, or is not responding to standard therapy, closely monitor and consider discontinuation of ILUMYA until the infection resolves.

Pretreatment Evaluation for Tuberculosis
Evaluate patients for tuberculosis (TB) infection prior to initiating treatment with ILUMYA. Do not administer ILUMYA to patients with active TB infection. Initiate treatment of latent TB prior to administering ILUMYA. Consider anti-TB therapy prior to initiation of ILUMYA in patients with a past history of latent or active TB in whom an adequate course of treatment cannot be confirmed. Patients receiving ILUMYA should be monitored closely for signs and symptoms of active TB during and after treatment.

Immunizations
Prior to initiating therapy with ILUMYA, consider completion of all age-appropriate immunizations according to current immunization guidelines. Patients treated with ILUMYA should not receive live vaccines.

Adverse Reactions
The most common (≥1%) adverse reactions associated with ILUMYA treatment that were more frequent than in the placebo group are upper respiratory infections, injection-site reactions, and diarrhea.

Please see brief summary of Full Prescribing Information on next page or visit ILUMYApro.com for Full Prescribing Information.

INDICATIONS AND USAGE
ILUMYA™ (tildrakizumab-asmn) is indicated for the treatment of adults with moderate- to-severe plaque psoriasis who are candidates for systemic therapy or phototherapy.

CONTRAINDICATIONS
ILUMYA is contraindicated in patients with a previous serious hypersensitivity reaction to tildrakizumab or to any of the excipients [see Warnings and Precautions].

WARNINGS AND PRECAUTIONS
Hypersensitivity: Cases of angioedema and urticaria occurred in ILUMYA treated subjects in clinical trials. If a serious hypersensitivity reaction occurs, discontinue ILUMYA immediately and initiate appropriate therapy [see Adverse Reactions].

Infections: ILUMYA may increase the risk of infection. Although infections were slightly more common in the ILUMYA group (23%), the difference in frequency of infections between the ILUMYA group and the placebo group was less than 1% during the placebo-controlled period. However, subjects with active infections or a history of recurrent infections were not included in clinical trials. Upper respiratory infections occurred more frequently in the ILUMYA group than in the placebo group [see Adverse Reactions]. The rates of serious infections for the ILUMYA group and the placebo group were ≤0.3%. Treatment with ILUMYA should not be initiated in patients with any clinically important active infection until the infection resolves or is adequately treated. In patients with a chronic infection or a history of recurrent infection, consider the risks and benefits prior to prescribing ILUMYA. Instruct patients to seek medical help if signs or symptoms of clinically important chronic or acute infection occur. If a patient develops a clinically important infection or an acute infection, consider stopping ILUMYA treatment and to reread the Medication Guide each time the prescription is renewed. Advise patients of the importance of communicating any history of infections to the health care provider.

Pretreatment Evaluation for Tuberculosis: Evaluate patients for tuberculosis (TB) infection prior to initiating treatment with ILUMYA. Initiate treatment with latent TB prior to administering ILUMYA. In clinical trials, of 55 subjects with latent TB who were concurrently treated with ILUMYA and appropriate TB prophylaxis, no subjects developed active TB (during the mean follow-up of 56.5 weeks). One other subject developed TB while receiving ILUMYA. Monitor patients for signs and symptoms of active TB during and after ILUMYA treatment. Consider anti-TB therapy prior to initiation of ILUMYA in patients with a past history of latent or active TB in whom an adequate course of treatment cannot be confirmed. Do not administer ILUMYA to patients with active TB infection.

Immunizations: Prior to initiating therapy with ILUMYA, consider completion of all age appropriate immunizations according to current immunization guidelines. Avoid the use of live vaccines in patients treated with ILUMYA. No data are available on the response to live or inactivated vaccines.

ADVERSE REACTIONS
The following serious adverse reactions are discussed elsewhere in the labeling:

Hypersensitivity Reactions [see Warnings and Precautions]

Infections [see Warnings and Precautions]

Clinical Trial Experience
Because clinical trials are conducted under widely varying conditions, adverse reaction rates observed in the clinical trials of a drug cannot be directly compared to rates in the clinical trials of another drug and may not reflect the rates observed in practice.

In clinical trials, a total of 994 subjects with plaque psoriasis were treated with ILUMYA, of which 1083 subjects were treated with ILUMYA 100 mg. Of these, 672 subjects were exposed for at least 12 months, 587 for 18 months, and 469 for 24 months.

Data from three placebo-controlled trials (Trials 1, 2, and 3) in 705 subjects (mean age 46 years, 71% males, 81% white) were pooled to evaluate the safety of ILUMYA 100 mg administered subcutaneously at Weeks 0 and 4, and followed by every 12 weeks (Q12W) [see Clinical Studies].

Placebo-Controlled Period (Weeks 0-16 of Trial 1 and Weeks 0-12 of Trials 2 and 3) In the placebo-controlled period of Trials 1, 2, and 3 in the 100 mg group, adverse events occurred in 48.2% of subjects in the ILUMYA group compared to 53.8% of subjects in the placebo group. The rates of serious adverse events were 1.4% in the ILUMYA group and 1.7% in the placebo group.

Table 1 summarizes the adverse reactions that occurred at a rate of at least 1% and at a higher rate in the ILUMYA group than in the placebo group.

Table 1: Adverse Reactions Occurring in ≥1% of Subjects in the ILUMYA Group and More Frequently than in the Placebo Group in the Plaque Psoriasis Trials 1, 2, and 3

<table>
<thead>
<tr>
<th>Adverse Reaction</th>
<th>ILUMYA 100 mg (N=705) N (%)</th>
<th>Placebo (N=355) N (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Upper respiratory infections*</td>
<td>98 (14)</td>
<td>41 (12)</td>
</tr>
<tr>
<td>Injection site reactions1</td>
<td>24 (3)</td>
<td>7 (2)</td>
</tr>
<tr>
<td>Diarrhea</td>
<td>13 (2)</td>
<td>5 (1)</td>
</tr>
</tbody>
</table>

* Upper respiratory infections include nasopharyngitis, upper respiratory tract infection, viral upper respiratory tract infection, and pharyngitis.
1 Injection site reactions include injection site urticaria, pruritus, pain, reaction, erythema, inflammation, edema, swelling, bruising, hematomata, and hemorrhage.

During the placebo-controlled period of Trials 1, 2, and 3, adverse reactions that occurred at a rate of at least 1% but greater than 0.1% in the ILUMYA group and at a higher rate than in the placebo group included dizziness and pain in extremity.

Specific Adverse Reactions

Hypersensitivity Reactions: Cases of angioedema and urticaria occurred in ILUMYA-treated subjects in clinical trials [see Warnings and Precautions].

Infections: Infections were slightly more common in the ILUMYA group. The difference in frequency of infections between the ILUMYA group (23%) and the placebo group was less than 1% during the placebo-controlled period. The most common (>1%) infections were upper respiratory infections. The rates of severe infections for the ILUMYA group and the placebo group were ≤0.3%.

Safely Through Week 52/64

Infections were slightly more common in the ILUMYA group. The difference in frequency of infections between the ILUMYA group (23%) and the placebo group was less than 1% during the placebo-controlled period. The most common (>1%) infections were upper respiratory infections. The rates of severe infections for the ILUMYA group and the placebo group were ≤0.3%.

Infections were slightly more common in the ILUMYA group. The difference in frequency of infections between the ILUMYA group (23%) and the placebo group was less than 1% during the placebo-controlled period. The most common (>1%) infections were upper respiratory infections. The rates of severe infections for the ILUMYA group and the placebo group were ≤0.3%.

Infections were slightly more common in the ILUMYA group. The difference in frequency of infections between the ILUMYA group (23%) and the placebo group was less than 1% during the placebo-controlled period. The most common (>1%) infections were upper respiratory infections. The rates of severe infections for the ILUMYA group and the placebo group were ≤0.3%.

Infections were slightly more common in the ILUMYA group. The difference in frequency of infections between the ILUMYA group (23%) and the placebo group was less than 1% during the placebo-controlled period. The most common (>1%) infections were upper respiratory infections. The rates of severe infections for the ILUMYA group and the placebo group were ≤0.3%.
Kelley: I think we reported a total of nine measures. For example, with the Promoting Interoperability category of MIPS, we did the ‘Electronic Prescribing’ measure. For the Quality category, for example, we did ‘Care Plan,’ ‘Preventive Care and Screening: Influenza Immunization,’ and ‘Pneumonia Vaccination Status for Older Adults.’ We also did ‘Biopsy Follow-Up’ because we are a Mohs center. We’re at 100% on biopsy follow up. We contact every single patient with positive or negative results.

Q  Can you walk me through the MIPS measure submission process?
Kelley: Using the DataDerm dashboard, when we get ready to submit, we go in and select the measures we want to submit on — the ones we did best on. Your data is pulled from the EHR so they have all of the metric data. Some of the measures you’re attesting manually, for example the ‘Security Risk Analysis’ measure. So you go through attestation screens on DataDerm. It’s a pretty simple process.

Q  How did your practice fare with MIPS in 2017?
Kelley: We maxed out. They gave us 100 points and this year we got a 2.1% bonus. We did pretty well and we’re striving to do better in 2018.

Q  Would you suggest that other practices adopt DataDerm?
Kelley: Oh, definitely. I don’t know what other registries there are out there that can actually pull the data from our specific electronic medical records. DataDerm spends the time to integrate their interface directly with our database. DataDerm puts the data in a nice graphical user-interface that makes it easy to follow and easy to deal with when the submission period comes around. I would highly recommend it.

Q  What do you like best about DataDerm?
Kelley: Anything that makes my job easier is favorable. The less paperwork that I have to do, the better. “dv

Mary Barber, MD, is a Mohs surgeon at her practice, the Skin Cancer Center of Central Florida.

Scott Kelley, MBA, serves as practice administrator.
Sometimes all it takes is a little serendipity in the spam folder. Dina Strachan, MD, a dermatologist in private practice in New York, attributes her recurring role on the literary web series *The Tea*, as part-chance, part whim when a casting call appeared in her inbox. “I’m in New York, where there are a lot of creative projects and industries going on,” she says. “I was like, well you know what, I could apply for this.” Looking to recreate the camaraderie she enjoyed as part of an informal book club during her medical school days, Dr. Strachan recalls being the only physician who showed up to casting. “There were initially a lot of actresses, a lot of English teachers, but they actually picked me as one of the cast members,” she says.

Since then, Dr. Strachan has been a part of *The Tea*’s monthly lineup for the past two years. “We try to focus on recent releases, and books that we think would generate good conversation. It’s a work in progress to get the balance of people right and keep the discussion organic.” Episodes span about 20 minutes and filming occurs once a month — covering several episodes-worth of material in a single session. According to Dr. Strachan, filming rarely interferes with her day job as a dermatologist. “The shooting doesn’t interfere — it’s reading the books! I love reading, but depending on what we pick and what I have going on — I just try to make it work.”

The series has built audiences on YouTube and Facebook, and Dr. Strachan has become no stranger to social media herself, embracing the moniker #TheBookDerm, which she says helps promote a more rounded view of physicians in the public eye. “Doctors are often seen as one-dimensional, but we can be very interesting people. We often talk about seeing patients as the whole person, and I think that goes for physicians as well.”

Far from being camera-shy, Dr. Strachan has brought a background in media work to her role on *The Tea*. “There’s always a little nervousness, but I’ve been on live television, been asked to speak at things. I actually built my business doing YouTube videos early on before the platform really took off, so I’m a little more practiced. I did have aspirations to be an actress when I was a child, and took theater classes all the time, so this has been a fun way to revisit that.”

Inside the clinic, the series has also helped Dr. Strachan bond with patients in new ways. “It’s a good way to connect with people. I often get good book recommendations from patients,” she says. In fact, Dr. Strachan discovered one of her favorite books based on a recommendation from a patient. “It’s called *The 48 Laws of Power*. It was written by two business school professors about the principles of power and human dynamics,” she says. “In New
York City a lot of people will sell books on the street, and around the year 2000, I'd see it out there a lot. I remember a patient came in and was reading it while I was treating his warts, and I was like, ‘I see everybody reading that. What’s the big deal?’ I ended up reading it, and thought it was really fascinating. My dermatology patient recommended one of my favorite books!”

Dr. Strachan on-set with her co-hosts of The Tea.
For your patients with primary axillary

Qbrexza™ Raises (glycopyrronium) cloth

INDICATION
QBREXZA™ (glycopyrronium) cloth is an anticholinergic indicated for topical treatment of primary axillary hyperhidrosis in adult and pediatric patients 9 years of age and older.

IMPORTANT SAFETY INFORMATION
CONTRAINDICATIONS
QBREXZA is contraindicated in patients with medical conditions that can be exacerbated by the anticholinergic effect of QBREXZA.

WARNINGS AND PRECAUTIONS
Worsening of Urinary Retention: Use with caution in patients with a history or presence of documented urinary retention.

Study design:
- Two randomized, vehicle-controlled multicenter trials, ATMOS-1 and ATMOS-2, enrolled a total of 697 patients 9 years of age or older with primary axillary hyperhidrosis. Patients were randomized to receive either QBREXZA or alcohol-based vehicle applied once daily to each axilla.
- The co-primary endpoints were the proportion of patients having at least a 4-point improvement from baseline in the weekly mean ASDD item 2 score at Week 4 and the absolute change from baseline in gravimetrically measured sweat production at Week 4.

References:
1. QBREXZA™ (glycopyrronium) cloth prescribing information, Dermira.
During the past 24 hours, how would you rate your underarm sweating at its worst? 
10 (worst possible sweating) to 0 (no sweating at all).1

- In ATMOS-1, 53% of patients reported a ≥4-point improvement with QBREXZA (n=229) vs 28% with alcohol-based vehicle (n=115) (P<0.001)1,2
- In ATMOS-2, 66% of patients reported a ≥4-point improvement with QBREXZA (n=234) vs 27% with alcohol-based vehicle (n=119) (P<0.001)1,2

60% of patients achieved significant improvements in patient-reported sweat severity vs 28% with alcohol-based vehicle2*

Control of Body Temperature: In the presence of high ambient temperature, heat illness (hyperpyrexia and heat stroke due to decreased sweating) can occur with the use of anticholinergic drugs such as QBREXZA.

Operating Machinery or an Automobile: Transient blurred vision may occur with use of QBREXZA. If blurred vision occurs, the patient should discontinue use until symptoms resolve. Patients should be warned not to engage in activities that require clear vision such as operating a motor vehicle or other machinery, or performing hazardous work until the symptoms have resolved.

ADVERSE REACTIONS
The most common adverse reactions seen in ≥2% of subjects treated with QBREXZA were dry mouth (24.2%), mydriasis (6.8%), oropharyngeal pain (5.7%), headache (5.0%), urinary hesitation (3.5%), vision blurred (3.5%), nasal dryness (2.6%), dry throat (2.6%), dry eye (2.4%), dry skin (2.2%) and constipation (2.0%). Local skin reactions, including erythema (17.0%), burning/stinging (14.1%) and pruritus (8.1%) were also common.

It is important for patients to understand how to correctly apply QBREXZA (see Patient Product Information). Instruct patients to wash their hands with soap and water immediately after discarding the used cloth.

Please see Brief Summary of Full Prescribing Information on adjacent page.
QBREXZA® (glycopyrronium) cloth, 2.4%, for topical use

The following is a Brief Summary; refer to Full Prescribing Information for complete product information.

1 Indications and Usage
QBREXZA® is indicated for topical treatment of primary axillary hyperhidrosis in adult and pediatric patients 9 years of age and older.

2 Dosage and Administration
For topical use only.

QBREXZA® is for topical use in the underarm area only and not for use in other body areas.

QBREXZA® is administered by a single-use pre-measured cloth packaged in individual pouches. QBREXZA® should be applied to clean dry skin on the underarm area only. QBREXZA® should not be used more frequently than once every 24 hours.

Four open the pouch and pull out the cloth, unfold the cloth, and wipe 6 to 12 cm (2 to 5 inches) from each other underarm. Using the same cloth, wipe the other underarm once. A single cloth should be used to apply QBREXZA® to both underarms.

Wash hands immediately with soap and water after applying and discarding the QBREXZA® cloth. QBREXZA® may cause temporary dilatation of the pupils and blurred vision if it comes in contact with the eyes. Avoid transfer of QBREXZA® to the periocular area (see Warnings and Precautions 3.12).

Do not apply QBREXZA® to broken skin. Avoid using QBREXZA® with occlusive dressings.

4 Contraindications
QBREXZA® is contraindicated in patients with medical conditions that can be exacerbated by the anticholinergic effect of QBREXZA® (e.g., glaucoma, paralytic ileus, unstable cardiovascular status in acute hemorrhage, severe ulcerative colitis, toxic megacolon complicating ulcerative colitis, myasthenia gravis, Sjogren’s syndrome).

5.1 Worsening of Urinary Retention
QBREXZA® should be used with caution in patients with a history or presence of documented urinary retention.

Prescribers and patients should be alert for signs and symptoms of urinary retention (e.g., difficulty passing urine, distended bladder), especially in patients with prostatic hyperplasia or bladder-neck obstruction. Instruct patients to discontinue use immediately and consult a physician should any of these signs or symptoms develop.

Patients with a history of urinary retention were not included in the clinical studies.

5.2 Control of Body Temperature
In the presence of high ambient temperature, heat illness (hyperpyrexia and heat stroke due to decreased sweating) can occur with the use of anticholinergic drugs such as QBREXZA®. Advise patients using QBREXZA® to watch for generalized lack of sweating in hot or very warm environmental temperatures and to avoid use if not sweating under these conditions.

5.3 Operating Machinery or an Automobile
Transient blurred vision may occur with use of QBREXZA®. If blurred vision occurs, the patient should discontinue use until symptoms resolve. Patients should be warned not to engage in activities that require clear vision such as operating a motor vehicle or other machinery, or performing hazardous work until the symptoms have resolved.

6 Adverse Reactions
The following adverse reactions are described in greater detail in other sections.

• Worsening of Urinary Retention (see Warnings and Precautions 3.11).

6.1 Clinical Trials Experience

Because clinical trials are conducted under widely varying conditions, adverse reaction rates observed in the clinical trials of a drug cannot be directly compared to rates in the clinical trials of another drug and may not reflect the rates observed in practice.

In two double-blind, vehicle-controlled clinical trials (Trial 1 [NCT02530281] and Trial 2 [NCT02530294]) of 459 subjects treated with QBREXZA® once daily and 232 treated with vehicle, subjects were 9 to 70 years of age, 47% male, and the percentages of White, Black (including African Americans), and Asian subjects were 82%, 12%, and 1%, respectively.

Table 1: Adverse Reactions Occurring in ≥2% of Subjects

<table>
<thead>
<tr>
<th>Adverse Reactions</th>
<th>QBREXZA® (N=459) n(%)</th>
<th>Vehicle (N=232) n(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dry mouth</td>
<td>111 (24.2%)</td>
<td>13 (5.6%)</td>
</tr>
<tr>
<td>Mydriasis</td>
<td>31 (6.8%)</td>
<td>0</td>
</tr>
<tr>
<td>Orthognathal pain</td>
<td>26 (5.7%)</td>
<td>3 (1.3%)</td>
</tr>
<tr>
<td>Headache</td>
<td>23 (5.0%)</td>
<td>5 (2.2%)</td>
</tr>
<tr>
<td>Urinary hesitiation</td>
<td>16 (3.5%)</td>
<td>0</td>
</tr>
<tr>
<td>Vision blurred</td>
<td>16 (3.5%)</td>
<td>0</td>
</tr>
<tr>
<td>Nasal dryness</td>
<td>12 (2.6%)</td>
<td>1 (0.4%)</td>
</tr>
<tr>
<td>Dry throat</td>
<td>12 (2.6%)</td>
<td>0</td>
</tr>
<tr>
<td>Dry eye</td>
<td>11 (2.4%)</td>
<td>1 (0.4%)</td>
</tr>
<tr>
<td>Dry skin</td>
<td>10 (2.2%)</td>
<td>0</td>
</tr>
<tr>
<td>Constipation</td>
<td>9 (2.0%)</td>
<td>0</td>
</tr>
</tbody>
</table>

Table 2 shows the most frequently reported local skin reactions, which were relatively common in both the QBREXZA® and vehicle groups.

Table 2: Local Skin Reactions

<table>
<thead>
<tr>
<th>Local Skin Reactions</th>
<th>QBREXZA® (N=454)* n(%)</th>
<th>Vehicle (N=233) n(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Erythema</td>
<td>77 (17.0%)</td>
<td>39 (16.9%)</td>
</tr>
<tr>
<td>Burning/stinging</td>
<td>64 (14.1%)</td>
<td>39 (16.9%)</td>
</tr>
<tr>
<td>Pruritus</td>
<td>37 (8.1%)</td>
<td>14 (6.1%)</td>
</tr>
</tbody>
</table>

*Patients with a post-baseline local skin reaction assessment

In an open-label safety trial (NCT02553798), 564 subjects were treated for up to an additional 44 weeks after completing Trial 1 or Trial 2. Adverse reactions occurring at a frequency ≥2% were: dry mouth (16.9%), vision blurred (6.7%), nasopharyngitis (5.8%), mydriasis (5.3%), urinary hesititation (4.7%), nasal dryness (4.6%), dry eye (2.9%), pharyngitis (2.9%), and application site reactions (pain [8.4%], dermatitis [3.8%], pruritus [3.8%], rash [3.8%], erythema [2.4%]).

7 Drug Interactions

7.1 Anticholinergics

Co-administration of QBREXZA® with anticholinergic medications may result in additive interaction leading to an increase in anticholinergic adverse effects (see Warnings and Precautions 5.1 and Adverse Reactions 6.3). Avoid co-administration of QBREXZA® with other anticholinergic-containing drugs.

8 Use in Specific Populations

8.1 Pregnancy

There are no data on the presence of glycopyrrolate or its metabolites in human milk, the effects on the breastfed infant, or the effects on milk production. The developmental and health benefits of breastfeeding should be considered along with the mother’s clinical need for QBREXZA® and any potential adverse effects on the breastfed infant from QBREXZA® or from the underlying maternal condition.

8.2 Lactation

There are no data on the presence of glycopyrrolate or its metabolites in human milk. 

8.3 Pediatric Use

The safety, effectiveness, and pharmacokinetics of QBREXZA® have been established in pediatric patients age 3 years and older for topical treatment of primary axillary hyperhidrosis. Use of QBREXZA® in this age group is supported by evidence from two multicenter, randomized, double-blind, parallel-group, vehicle-controlled 4-week trials which included 34 pediatric subjects 9 years and older (see Adverse Reactions 6.12). The safety and effectiveness of QBREXZA® have not been established in pediatric patients under 9 years of age.

8.4 Geriatric Use

Clinical trials of QBREXZA® did not include sufficient numbers of subjects age 65 years and older to determine whether they respond differently from younger subjects.

8.5 Renal Impairment

The elimination of glycopyrrolate is severely impaired in patients with renal failure.

10 OVERDOSAGE

Because glycopyrrolate is a quaternary amine which does not easily cross the blood-brain barrier, symptoms of glycopyrrolate overdose are generally more peripheral in nature rather than central compared to other anticholinergic agents. Associated signs and symptoms related to excessive anticholinergic activity include flushing, hyperthermia, tachycardia, ileus, urinary retention, loss of scoliosis accommodation and light sensitivity due to mydriasis.

In the case of overdose when symptoms are severe or life threatening, therapy may include:

• Managing of care of any acute conditions such as hyperthermia, coma, and/or seizures, as applicable, and managing any mydriasis or cholestatic liver movements which may lead to rhodanisulfone in some cases of anticholinergic overdose.

• Managing severe urinary retention with catheterization if not spontaneously reversed within several hours.

• Providing cardiovascular support and/or controlling arrhythmias.

• Maintaining an open airway, providing ventilation as necessary.

• Administering a quaternary ammonium anticholinesterase such as neostigmine to help alleviate severe and/or life threatening peripheral anticholinergic effects.

Topical overdosing of QBREXZA® could result in an increased incidence or severity of local skin reactions. Administration of QBREXZA® under occlusive conditions may result in an increase in anticholinergic effects, including dry mouth and urinary hesititation.

16.2 Storage and Handling

Store at room temperature 20° - 25°C (68° - 77°F); excursions permitted to 15° - 30°C (59° - 86°F).

[See USP Controlled Room Temperature].

QBREXZA® is flammable, keep away from heat or flame.

17 Patient Counseling Information

Advise the patient to read the FDA-approved patient labeling (Patient Information). Worsening of Urinary Retention

Instruct patients to be alert for signs and symptoms of urinary retention (e.g., difficulty passing urine, distended bladder). Instruct patients to discontinue use and consult a physician immediately should any of these signs or symptoms develop.

Control of Body Temperature (Risk of Overheating or Heat Illness)

In the presence of high ambient temperature, heat illness due to decreased sweating can occur with the use of anticholinergic drugs such as QBREXZA®. Advise patients using QBREXZA® to watch for generalized lack of sweating when in hot or very warm environmental temperatures and to avoid use if not sweating under these conditions.

Operating Machinery or an Automobile

Transient blurred vision may occur with QBREXZA®. If blurred vision occurs, instruct patients to contact their healthcare provider, discontinue use of QBREXZA® and avoid operating a motor vehicle or other machinery, or performing hazardous work until symptoms resolve.

Instruct patients to read the FDA-approved patient labeling (Patient Information).

It is important for patients to understand how to correctly apply QBREXZA® (see Patient Information).

Instruct patients to:

• Use one cloth to apply QBREXZA® to both axillae by wiping the cloth across one underarm, ONE TIME.

• Using the same cloth, apply the medication to the other underarm, ONE TIME.

• Instruct patients that QBREXZA® can cause temporary dilatation of the pupils and blurred vision if it comes in contact with the eyes.

• Instruct patients to wash their hands with soap and water immediately after discarding the used cloth.

• Instruct patients not to apply QBREXZA® to other body areas or to broken skin.

• Instruct patients to avoid using QBREXZA® with occlusive dressings.

• Instruct patients to wash their hands with soap and water immediately after discarding the used cloth.

Manufactured for:

Dermira, Inc.

Menlo Park, CA 94025

Version 3, June 2018

PM-US-QBR-0029
PRE-ORDER YOUR 2019 CODING RESOURCES

Your official source for the latest dermatology coding updates!

Get the most up-to-date ICD-10-CM, CPT®, HCPCS codes and guidelines to help you code confidently in 2019.

PACKS STARTING AT JUST $279.
Free shipping on select packs.

Visit aad.org/2019Coding to purchase your 2019 coding resources.

Use Promo Code CODEDW1019
(Un)Equal care for all?

As physician bias creates care disparities, what can dermatologists do to balance the scales?
“Of all forms of inequality, injustice in health care is the most shocking and inhuman,” remarked Martin Luther King, Jr., at the National Convention of the Medical Committee for Human Rights in 1966. More than 50 years later, the impact of implicit bias on patient care has become part of an ongoing national discussion about the pernicious effects of negative stereotyping in a diversifying United States. However, in contrast to deliberate racism, sexism, ageism, or other forms of discrimination, implicit bias is both unconscious and automatic. “These biases are deeply ingrained in our inner psyche, and it causes us to relate to people in different ways,” explains Amit Pandya, MD, past chair of the AAD’s Diversity Task Force. While physicians may view themselves as more impervious to bias than most due to the altruistic nature of their profession, research suggests that not only is bias in health care widespread, it is also having a significant impact on patient care. Dermatology World consults with physician experts both within and outside the specialty to discuss:

- Common sources of physician bias
- Care disparities created by unconscious bias
- Solutions for reducing bias within dermatology
How does bias manifest in patient care?
The effects of implicit bias can take many forms during the average physician-patient encounter, often favoring one’s own social group. “If you’re a man, for example, you may be less comfortable interacting with women; if you’re white, you might have a bias that favors white patients as opposed to those who are black, Hispanic, or Asian,” says Dr. Pandya. “I make a point to always stop myself when I’m making a diagnosis or treatment plan and ask: Would I do this for any patient, regardless of what type of person is in front of me?”

Due to the unconscious nature of implicit bias, physicians may be inclined to alter treatment recommendations or prescription habits based on what they perceive as a patient’s ability to comply. However, this perception may actually be derived from incorrect stereotypes about that patient’s age, gender, race, or socioeconomic group. “Implicit biases explain a potential dissociation between what a person explicitly believes and wants to do (e.g. treat everyone equally) and the hidden influence of negative implicit associations on her thoughts and action (e.g. perceiving a black patient is less competent and thus deciding not to prescribe the patient a medication),” explains a 2017 BMC Medical Ethics article (doi: 10.1186/s12910-017-0179-8).

Beyond differences in clinical decision-making, incorrect perceptions about patients can result in strained physician-patient communication, and ultimately result in disparities in quality of care. “From a health care standpoint, studies have shown over and over again that we treat patients differently based on the color of their skin, their weight, or their sexuality,” says René Salazar, MD, assistant dean for diversity and professor of internal medicine at Dell Medical School at the University of Texas at Austin. “We’ve spent more than two decades now pouring lots of money into health disparities research, but where we haven’t really moved the needle nearly as much as we should is motivating physicians to be more aware of this.”

While physicians are more likely to self-identify biases against patients with perceived low intelligence or those who are overweight (see sidebar for more on dermatology’s top biases), overall, race and socioeconomic status emerge as main predictors of worse health outcomes in the United States.

Race
“As far as implicit bias in health care, we all know that it exists and that it does negatively affect the care patients get,” says Valerie Callender, MD, medical director of Callender Dermatology and Cosmetic Center, and current member of the AAD Board of Directors. “Often the literature describes disparities in care between African-American and Caucasian patients, in which African-American patients receive poorer care as a result of stereotypes that they are either poor, can’t afford the medication, or can’t understand instructions.”

Additionally, a physician’s body language or non-verbal cues during an appointment with a patient of a different race may cause a communication breakdown that ultimately results in poor treatment outcomes. “For black patients, there is often a feeling of disrespect, or that they aren’t heard,” says Dr. Salazar. “If we’re interacting in a way that’s a little bit standoffish — I’m crossing my arms, or the way I’m interacting is less engaging — it can have a huge impact on the patient-physician relationship. How likely will it be that you’ll come back and see me? Or that you’re going to follow-through with the treatment I’ve prescribed you?”

Unconscious racial bias has also had a well-documented impact on physician prescription habits, particularly in regard to analgesics. A 2007 study found that physicians were twice as likely to underestimate pain in black patients compared to all other ethnicities combined (J Natl Med Assoc. 2007;99(5):532-538), and another more recent study investigating emergency room opioid prescriptions identified being of a non-white race as the number one predictor of provider mistrust (doi: 10.1171/journal.pone.0159224).

Assuming providers are acting unconsciously, where do these racial biases stem from? Subtle, everyday reinforcement from media, friends, family, and cultural and political institutions may be to blame. “We may consciously reject negative images and ideas associated with disadvantaged groups (and may belong to these groups ourselves), but we have all been immersed in cultures where these groups are constantly depicted in stereotyped and pejorative ways,” notes the BMC Medical Ethics piece (doi: 10.1186/s12910-017-0179-8). Dr. Salazar agrees that unconscious bias is often reinforced by an environmental feedback loop that physicians are not unaffected by. “I’ve been in rooms where you hear these messages on TV — black men depicted as thugs for wearing a hoodie, whereas a white boy who rapes a woman is in a suit and tie. It’s powerful how these images reinforce our stereotypes,” he says.

While long-term solutions for racial bias in health care are likely to be as complex as its cause, Dr. Pandya recommends dermatologists start by simply considering each patient in front of them as an individual. “You can’t make any assumptions about their likes, dislikes, dietary preferences, ability to speak English, ability to understand what you’re prescribing for them, or the products typically used in their culture.
— based on their ethnic background,” he says. “You can make some serious blunders, and that person may not come back and see you as a result.”

**Socioeconomic class**

While often linked to race and geographic location, a patient’s perceived socioeconomic class can also generate a range of biased reactions from the physicians they are seeking care from. “When I was at UCSF taking care of our Medi-Cal patients — which is the Medicaid equivalent in California — I would catch myself looking at the sticker, and as soon as I’d see Medi-Cal, my mind would start going a certain place, and I’d have to stop myself from going there,” says Dr. Salazar. “Absolutely socioeconomics, as well as language — and the assumptions made about them — can have a remarkable impact on how these biases play out in our interactions.”

Biased assumptions about what a patient’s insurance type dictates — inability to pay, non-compliance, or no-showing — can have implications beyond a visibly checked-out physician and a failed clinical encounter, with potential public health ramifications. A 2014 study found that an overwhelming 80% of patients with public insurance reported stigmatizing experiences in encounters with providers and the health care system, leaving them with unmet health needs and less likely to seek out care in the future (Milbank Q. 2014;92(2):289-318).

“A lot of times you may make assumptions based on someone’s speech, vocabulary, or appearance, and conclude that they’re very low on the socioeconomic scale and perhaps treat them a different way,” says Dr. Pandya. “I’ve personally volunteered at a free clinic for the past 16 years, and recommend that the average dermatologist who perhaps struggles with this may consider doing a mission trip or start volunteering at a free clinic one Saturday a month. That has helped me a lot in better understanding the people who are poor in our world.”

---

Where do dermatologists show bias?

According to a 2017 Medscape survey of dermatologists, the top biases among the specialty fall outside broader groupings such as gender or ethnicity. The top four self-reported biases among dermatologists according to the survey were:

- **Emotional problems**: 62% of MDs, 47% of MDs
- **Heavier weight**: 44% of MDs, 42% of MDs
- **Low intelligence**: 54% of MDs, 37% of MDs
- **Lack of insurance coverage**: 27% of MDs, 35% of MDs

While female dermatologists cited a stronger bias against patients with emotional problems and perceived low intelligence, male dermatologists were more likely to admit bias toward patients who lacked insurance coverage. Dermatologists 45 and younger expressed more bias than their older peers (with the exception of bias toward patients with heavier weight), although survey data suggested that dermatologists’ political leanings on social issues and personal faith had no relationship with their reported bias.

Recognizing and counteracting bias

Given the negative and well-documented effects of unconscious bias on patient care, what can dermatologists do to reduce its impact within the specialty? First steps include:

**Notice your assumptions.** Start by becoming aware of what accents, specific items of clothing, or hairstyles are potentially triggering an unfavorable assumption about a particular person. Not sure what they are? Take a test. While there are several Implicit Association Tests (IATs) available online, Dr. Pandya recommends Harvard’s free Project Implicit questionnaire: https://implicit.harvard.edu/implicit/education.html. “After taking it, I found out that I have some bias against a racial group that I was unaware of,” he says. “I went on to read some books that discuss what it’s like to grow up as a person from that background. Once I had a better understanding of what it’s like to live in this country as a member of that group, it gave me greater insight that reduced my discomfort, and hopefully reduced my implicit bias.”

Dermatologists may want to consider staff bias training as well, suggests Seemal R. Desai, MD, president of the Skin of Color Society and a member of the AAD Board of Directors. “All employees — from the nursing staff to the front office — need to have at least some awareness of different patient backgrounds to make them feel as comfortable as possible,” said Dr. Desai. “I think it’s especially important in dermatology, because so much of what we do involves a great deal of the patient’s privacy, for either a medical or even cosmetic skin exam.”

**Take steps to mitigate burnout.** Burnout among physicians is on the rise, and dermatology is no exception. In addition to negatively affecting physician health and well-being, research also suggests that physicians’ implicit bias can increase under conditions of stress. A 2016 study in *Academic Emergency Medicine* found evidence that cognitive stressors, such as increased patient load, can result in greater instances of implicit racial bias (2016;21(3):297-305).

**Foster diversity.** “As the U.S. population becomes more diverse, so must our specialty,” said Henry Lim, MD, former president of the AAD and chair emeritus of the Henry Ford Hospital department of dermatology, in his November 2017 DW From the President column. Indeed, as dermatology’s patient population keeps pace with the nation’s changing demographics, cultural representation — and competency — among the physician workforce will be increasingly crucial, suggests Dr. Desai. “By 2020, more than 50% of the population will be skin of color, and we really need to have a workforce that reflects the patients we’re treating,” he says. “If you know you have a practice that cares for patients of different backgrounds, see if you have staff who can relate to that background. Is there an employee on your team who speaks Spanish? I myself speak Hindi and other Indian dialects, which is helpful for patients. If a patient is comfortable, that’s when we often get the best history and avoid having a communication issue that could ultimately affect a treatment outcome.”

**Feeling burned out?** Check out Dermatology World’s feature story “Feeling the burn” at www.aad.org/dw/monthly/2017/september/feeling-the-burn to learn what you can do to avoid it — or recover.

**Be a mentor.** Find out how you can be a mentor through the AAD’s Diversity Mentorship Program for medical students interested in dermatology at www.aad.org/members/leadership-institute/mentoring/diversity-mentorship-program-information-for-mentors.

While Dr. Callender agrees that looking to the future is an important step, she also advocates for the value of bias awareness and education for those currently in practice. “I think this could be tackled on the state level by requiring some form of bias training that includes cultural competency in order to get your state license renewed,” she suggests. “As a specialty, I think we should have CME devoted to this topic to make sure that we are treating all patients equally.”

Overall, “I think it’s important that you take the opportunity to make sure patients understand that you’re really there caring for them,” said Dr. Desai. “It can be as simple as teaching your dermatology colleagues to be more aware of bias. Hopefully, in the next few years we’ll start to see more and more dermatologists and fellows more knowledgeable about this issue.”
Who Says Dermatologists Don’t Treat the Heart?

“I’ve been a dermatologist for over 40 years, and for the last 18 years or so, I’ve been steadfast in treating patients with hyperhidrosis and advocating for other dermatologists to treat them, too. The reason I spend so much time and effort on hyperhidrosis is because I know what extraordinary improvements in quality of life dermatologists can help these patients achieve. Great hyperhidrosis care truly transforms patients’ lives.”

Dr. David M. Pariser, 2009 President, American Academy of Dermatology; Secretary and Founding Member, International Hyperhidrosis Society; Professor, Department of Dermatology, Eastern Virginia Medical School.

Today, only 1 in 4 hyperhidrosis sufferers is diagnosed. The rest need you to help them break through the silence, stigma, and heartache caused by excessive sweating.

Why? Because hyperhidrosis:
• Is associated with much higher rates of anxiety & depression
• Has negative quality-of-life impacts equal to or greater than severe acne & psoriasis
• Triples the risk of skin infections
• Can be successfully treated by knowledgeable specialists, like you.

November is Hyperhidrosis Awareness Month. Will you ask about, diagnose & treat excessive sweating? It’s life changing when you do.

SweatHelp.org/Register

Special thanks to Dermira and the makers of Certain Dri for supporting Hyperhidrosis Awareness Month.
ON THE SHELF

What is keeping biosimilars out of reach and when will they be available?
Over the last few years, 12 biosimilars have been approved by the U.S. Food and Drug Administration (FDA), bringing the promise of potentially cheaper treatment options to patients throughout the country. However, after years of sitting idle on the shelf, are they even close to taking off in the United States? Jashin J. Wu, MD, Medical Board member of the National Psoriasis Foundation and a councilor for the International Psoriasis Council, spoke about biosimilars at a dermatology conference a few years ago. “In 2016 and 2017, biosimilars were a hot topic. But in 2018, the conference didn’t even include biosimilars since there’s nothing new happening. The majority of biosimilars that are approved are not available. Once they become commercially available, people will start talking about them again.”

According to a recent report by Avalere Health, the U.S. makes up only 2% of global biosimilar sales, with 87% of the sales taking place in Europe, where the first biosimilar was approved in 2006. Yet, the U.S. is responsible for 59% of reference biologic product sales globally. This suggests the U.S. market may be ripe for biosimilar sales if the conditions are right.

Biosimilars, however, are facing an uphill battle as they begin to enter the U.S. market. Although several biosimilars have been approved by the FDA, litigation, cost-savings considerations, and physician ease-of-use are simply a few of the obstacles that biosimilar manufacturers are encountering. >>
Status update: FDA approvals

The FDA has made strides in approving new biosimilar treatments: 12 since 2015 — eight of these approvals were gained in 2017 and 2018. According to the Alliance for Safe Biologic Medicines (ASBM), there are at least 240 more biosimilars in the development pipeline.

Six biosimilars have been approved for psoriasis:

- adalimumab-adbm (Cyltezo®) and adalimumab-atto (Amjevita®) for adalimumab (Humira®)
- infliximab-dyyb (Inflectra®), infliximab-abda (Renflexis®) and infliximab-qbtx (Ixifi®) for infliximab (Remicade®)
- etanercept-szaz (Erelzi®) for etanercept (Enbrel®)

As part of the 2010 Affordable Care Act, the Biologics Price Competition and Innovation Act (BPCIA) created a “biosimilar pathway” which outlined the criteria for the FDA to approve biosimilars of interchangeable biologics.

“The proposed biosimilar and reference product must have the same presumed mechanism of action, administration route, dosage, and potency to be considered for an abbreviated Biological License Application (BLA),” wrote Paul S. Yamauchi, MD, PhD, a clinical assistant professor at the David Geffen School of Medicine at UCLA, in “A Treatise from the Medical Board of the National Psoriasis Foundation.”

The biosimilar approval process has less emphasis on clinical trial outcomes, and greater attention to the pharmacology of the biosimilar — pharmacokinetics, pharmacodynamics, and immunogenicity, said Dr. Yamauchi. “For originator products, you have to do clinical trials for all approved indications, but for biosimilars, you could do a trial in a few diseases, and if the biologic is approved as a biosimilar, then the information can be extrapolated for other indications approved for the originator product.”

This expedited pathway was created in an attempt to expand patient access and lower health care costs by avoiding duplication of costly clinical trials. “I feel comfortable with extrapolation because it makes sense, as it’s basically the same molecule,” said Dr. Yamauchi. “If the pharmacology of the drug is similar to the reference, then I feel confident that it will perform for the other indications.”

Legal woes

While the FDA has been working to fulfill its promise to streamline biosimilar approvals, only a handful of biosimilars are actually available in the U.S. Infliximab-abda (Renflexis) and infliximab-dyyb (Inflectra) — biosimilars for infliximab (Remicade) — are the only biosimilars commercially available to treat psoriasis and psoriatic arthritis. Two other biosimilars which could be used to treat psoriasis have garnered FDA approval, but are stuck in what could likely become years-long patent disputes.

The first biosimilar to treat psoriasis, Amgen’s adalimumab-atto (Amjevita), a biosimilar for AbbVie’s adalimumab (Humira), was approved in September 2016, but still languishes in the no-man’s-land between FDA approval and commercial availability. Humira had more than 100 patents and shortly before Amgen’s biosimilar gained FDA approval, AbbVie filed a lawsuit for patent infringement. However, Amgen and other potential competitors have filed inter partes review (IPR) in which the Patent Trial and Appeal Board (PTAB) determines the validity of the challenged patents. Three of AbbVie’s patents were invalidated with several others being challenged. One such patent issued in 2014 covered methods of administering anti-TNFa antibodies to treat rheumatoid arthritis. The challenger, Coherus Biosciences Inc., claimed the patent was invalid because the dosage regimen covers “routine optimization of the therapy” that was known by researchers. In May 2017, the PTAB invalidated this patent.

This year, the drug companies reached an agreement that would allow adalimumab-atto to launch in the U.S. in Jan. 31, 2023, and in Europe in October 2018. Under terms of the settlement, all pending patent litigation will end and AbbVie will receive royalties from Amgen.

Similarly, in 2015 a Federal Circuit ruled that it was mandatory for biosimilar sponsors to provide 180-day (six months) notice of commercialization and the notice could only be provided after FDA approval had been granted. However, pharmaceutical
manufacturer, Sandoz, argued that the FDA-mandated six-month waiting period was tantamount to an additional six months of exclusivity.

The case made it to the U.S. Supreme Court and, in June 2017, the court unanimously reversed the 2015 decision: Biosimilar companies would not have to wait an additional six months after FDA approval before launching their biosimilar. This case was a win for biosimilar manufacturers as it meant their drugs could enter the market sooner. However, additional challenges remain.

View the AADA’s Position Statement on Generic Therapeutic and Biosimilar Substitution at www.aad.org/ps-biosimilarsub.

**Physician notification and pharmacy substitution**

For several decades, brand name and generic prescription drugs have been regulated at the state level. “The AADA started seeing the first legislation on biologic and biosimilar substitution in 2013,” said Lisa Albany, JD, the AADA’s director of state policy. “And now there are 46 states and Puerto Rico that have biosimilar substitution laws in place with the remaining states having filed bills.”

While legislation varies by state, the following are typical features and requirements included in the bills:

- A biosimilar must be designated as “interchangeable” by the FDA before it can be substituted. An interchangeable biosimilar must show that the product is expected to produce the same clinical result as the reference product in any given patient, and the risk in terms of safety or efficacy of switching between biological products must be no higher than using the reference product alone.

- The prescriber could prevent substitution by writing “dispense as written” or “brand medically necessary.”

- The prescriber must be notified of pharmacy substitutions, including a notation in an EHR or other pharmacy record accessible to the prescriber.

- Patients must be notified of the substitution or switch, and in some states, patient consent is required before a switch could be made.

- The pharmacist and physician must retain records of substituted biologics.

- Often, the drug’s cost must be explained and a handful of state laws require the biosimilar to have a lower cost if it is to be substituted.

According to the AADA’s Position Statement on Generic Therapeutic & Biosimilar Substitution, the Academy advocates that the pharmacist notify the prescriber by the time of dispensing (view the position statement at www.aad.org/ps-biosimilarsub).

Physician notification ranges from 24 hours to, in some states, 10 days. “What we’re seeing most often is three to five business days,” said Albany. “Earlier bills used language like a ‘reasonable amount of time,’ which the AADA did not support because the language was too vague.” While most state laws now specify a time frame for physician notification, the AADA still strongly advocates for physicians to be notified before or as patients receive the prescription, said Albany. “The closest we’ve come is with North Dakota’s legislation, which specifies 24-hour physician notification.”

**ROI DOA?**

Although the expedited pathway and removal of entry barriers have been helpful in bringing more biosimilars to market, biosimilars have not garnered as much savings as once anticipated. Generics revolutionized the way drugs were sold in the U.S., initially offering deep discounts to branded drugs — as much as 80% to 90%. A few years ago it was thought that biosimilars could do the same, potentially saving the U.S. up to $54 billion over 10 years, according to a RAND report. The savings have been nowhere near those of generics, though. Pfizer, for example, priced its biosimilar infliximab-dyyb (Inflectra) at only a 15% discount to the reference biologic infliximab, whereas in Europe it’s a 70% to 80% discount, said Dr. Wu.

Why? “Because manufacturing biosimilars is so costly, they will likely never achieve the savings of generics,” said Dr. Yamauchi. According to Gillian Woollett, PhD, senior vice president at Avalere Health, a generic drug costs about $1 to $5 million to move through the FDA approval process. A biosimilar, however, costs between $100–$500 million — which is in part the reason they won’t be discounted like generics. Dr. Yamauchi estimates that savings from biosimilars will not exceed 30% of the branded drug price.
Additionally, advances in disease treatment continue, and as a result the biosimilars of older generation treatments have to compete with newer biologic treatments. There’s a new generation of biologics that should be approved within the next year or two with promising safety and efficacy profiles, said Dr. Wu, noting risankizumab, a new drug that specifically targets IL-23 that will be approved in 2019.

**What's in a name?**

Even if biosimilars were on the market as significantly cheaper alternatives to biologics, there is still confusion about the FDA’s biologics naming system. In November 2017, the FDA adopted a new naming system for biologic products, including biosimilars, in which they added a random four-letter suffix to the end of biologics’ nonproprietary names. Previously, the suffixes were added only to the biosimilars’ nonproprietary names. This decision was not popular among many health care groups who wanted the FDA to attach meaningful suffixes for biosimilar names as was done for the first biosimilar approved in the U.S., filgrastim-sndz, whose suffix represents the manufacturer Sandoz.

“How can anyone remember these names? Obviously we can’t,” said Dr. Wu, who also preferred the suffix to represent the product manufacturer. He’s not alone. An ASBM survey of 400 physicians across multiple specialties showed that only 9% of physicians preferred a random suffix.

**Label clarification**

For physicians confused about biosimilar labels, the FDA recently released its final guidance on labeling biosimilar products indicating that it will treat biosimilars like generics in that the label will appear nearly identical to that of its reference product. Of note is the inclusion of a “Biosimilarity Statement,” which describes the biosimilar product’s relationship to its reference product.

Additionally, the biosimilar label can now indicate certain deviations from the reference product label — for example, that only some presentations are available and only a subset of indications is offered. Because a biosimilar may not be licensed for all indications of a reference product, the FDA guidance specifies that the biosimilar label should include only the information relevant to the approved indications.

The clinical trial information included in the label should come only from the reference product, not the comparative data used to establish biosimilarity. The FDA has taken this approach to avoid potential misinterpretation of the comparative data. “Basically, the package information for the biosimilar will be composed of the same information that is found in the reference product with regard to safety, efficacy, warnings, etc., and have no mention of clinical trial outcomes and any differences in pharmacokinetic, pharmacodynamics, or immunogenicity assays,” said Dr. Yamauchi.

The FDA did not provide guidance on the labeling of interchangeable products, but stated it plans to provide future guidance on this topic.

**Know your terms**

**Reference product or originator product:** A single biological product, already approved by FDA, against which a proposed biosimilar product is compared.

**Biosimilar:** A biologic product that is “highly similar” to a reference product that receives expedited approval based on comparing the biosimilar to the reference product. There are no clinically meaningful differences between the biologic and the reference products in terms of safety, purity, and potency.

**A biosimilar success story?**

In July 2018, the FDA released its “Biosimilars Action Plan,” an 11-step proposal that encourages competition in the pharmaceutical industry by streamlining the biosimilar approval process. While the first obstacle — FDA approval — doesn’t quite get a check mark, it’s on its way. “In order for biosimilars to be successful,
there needs to be a salesforce to educate health care providers about the availability and cost-saving potential,” said Dr. Yamauchi. “There needs to be easy access without step therapy or prior authorization requirements.”

In many ways, biosimilars must compete in the marketplace as if they are a branded drug. They need physicians and patients to know about them and understand their safety and efficacy. Cost savings will only be recognized if physicians prescribe the drug, said Dr. Yamauchi. He believes time may solve this problem as more data is accumulated in pharmacovigilance programs, easing physician reluctance and uncertainty about biosimilars.

“Dermatologists need to learn more about biosimilars to feel comfortable prescribing them; however, most aren’t even available to prescribe so they don’t feel like they need to learn about them yet,” said Dr. Wu.

The irony is that the U.S. is by far the most efficient market in the world for generics, said Dr. Woollett. She believes biosimilars can be made more efficiently, but the question remains as to how they can be incentivized so that the cheaper product gets the market share and can prosper. “The FDA can do its part to make it easier and cheaper to get more biosimilars available, but whether that’s enough, none of us know yet — but it’s a start.”

Wait, there’s more!
Want to learn more about biosimilars? Visit www.aad.org for a more in-depth look at biosimilars versus biologics.

**Biosimilar vs. biologic vs. generic**

Biological products are large, complex molecules. One expert said that if a traditional prescription drug is a tricycle, then a biologic is a spaceship. They can be produced through biotechnology in a living system, such as a microorganism, or plant or animal cell. Biologics, unlike the drugs to which generics are made, have intrinsic variations and are more complicated to manufacture because of their size and complexity. Biosimilars are “highly similar” versions of approved, branded biologics that have been shown to have no clinically meaningful differences from the reference product.

“Hypothetically, should the biosimilar demonstrate superior efficacy outside the specified margins over the reference product which might be interpreted as being favorable for the biosimilar, biosimilarity is not established because the two products are not equivalent since clinical meaningful differences are evident,” wrote Paul S. Yamauchi, MD, PhD, a clinical assistant professor at the David Geffen School of Medicine at UCLA, in “A Treatise from the Medical Board of the National Psoriasis Foundation.”

While generic drugs have active ingredients that are identical to those of the brand name drug, biologic medicines are much more complex than chemically synthesized drugs, making them more difficult to replicate. A truly “generic” biologic, or an identical copy, is virtually impossible to produce.

Learn more about the difference between biosimilars and biologics as well as the difference between biosimilars and interchangeable biosimilars online at www.aad.org.
Demystifying cancer of the nail

Unfamiliarity leads to missed diagnoses, reluctance to biopsy
“You can’t trust the nail,” remarked Richard K. Scher, MD, a dermatologist with nearly 50 years of experience in treating nail disorders. When it comes to detection and diagnosis of nail unit cancer, “you do the best you can, but it’s easy for errors to occur.” Dr. Scher, who is clinical professor of dermatology at Weill Cornell Medicine/Dermatology, noted that half the cases of nail unit, or subungual, melanoma are missed on the first examination. Even when telltale longitudinal melanonychia is spotted, he said, many physicians are hesitant to perform a biopsy for fear of permanently damaging the nail. Squamous cell carcinoma (SCC) of the nail unit can be equally elusive and can mimic several benign conditions, such as infections — sometimes causing patients to undergo months of ineffective treatment before cancer is suspected.

Because nail cancer is rare, many dermatologists have little or no first-hand experience in diagnosing and treating it. *Dermatology World* talks with four nail experts for insights into what to look for in a clinical exam, key dermoscopic features, when and how to biopsy, and current treatments.

---

*By Jan Bowers, Contributing Writer*
Demystifying cancer of the nail

**Subungual melanoma**

A subset of acral lentiginous melanoma, subungual melanoma is fortunately rare — comprising only 0.7 to 3.5% of all melanoma cases. Because diagnosis is often delayed, it has a poorer prognosis than cutaneous melanoma: the five-year survival rate ranges from 16 to 87%. It occurs most often on the thumb and big toe, and is more common in darker-skinned individuals than in Caucasians, Dr. Scher said. In children it’s extremely rare. “In teenagers and young adults it’s also rare but it happens, and as you get into adulthood, especially the elderly, it gets more common,” said Adam I. Rubin, MD, associate professor of dermatology at the Hospital of the University of Pennsylvania and a specialist at the Penn Medicine nail clinic.

**Causes elusive**

The causes of subungual melanoma are a topic of lively discussion, with no agreement on a single underlying cause. “Family history is definitely a factor and trauma is a factor. It’s sometimes associated with an infection,” said Dr. Scher. “The nail plate filters out UVB radiation completely and only a small portion of UVA penetrates so UVA light is thought to be a very small potential factor,” said Dana Stern, MD, assistant clinical professor of dermatology at the Mount Sinai Medical Center and a nail specialist. “We believe that nail melanoma occurs due to the complex interplay between genetics and trauma to the nail. There is some new data showing a possible causal relationship with UV, but more research needs to be done.”

Trauma to the nail has long been suspected as a potential cause of melanoma, but the relationship is something of a chicken-and-egg question. “At this point, the association is not clear,” said Dr. Rubin. “It’s a relatively common situation where someone will traumatize a nail, then they see something there that they show a dermatologist, and there may be a melanoma there. So we don’t know if the trauma just brings that nail to the attention of the patient, and they see that there’s been a change, or if there is some relationship between the nail being traumatized and the development of a cancer at that site. More information is needed about that.”

**Clinical examination, sans polish**

In a clinical examination, “a thorough examination of all 20 nails, oral mucosa, and relevant history is key,” said Dr. Stern. Dr. Scher insists that every physical exam should include the fingernails and toenails. In addition, “patients should be told in advance that they must remove their nail polish. I won’t accept patients who refuse to take their polish off.” Dr. Stern agrees that nail abnormalities can be easily camouflaged with nail cosmetics, contributing to a delay in potential diagnosis. “I saw a woman in her early 20s who had been covering a nail melanoma with an acrylic nail because she thought it was ugly.”

What are the key clues to detection of subungual melanoma? Dr. Stern cites the “ABC rule” from an article published by Levit, Kagen, and Scher, et al in the *Journal of the American Academy of Dermatology* (2000; 42:269-274):

- **A**ge, race: Range 20-90 years old, peak at 5th to 7th decades. Asian, African, Native American.
- **B**and (nail band): Brown or black pigment; breadth ≥ 3mm; border irregular or blurred.
- **C**hange: Rapid increase in size or growth rate of nail band; lack of change: failure of nail dystrophy to improve despite adequate treatment.
- **D**igit involved: Thumb — hallux — index finger; single digit — multiple digits; dominant hand.
- **E**xtension: Extension of pigment to involve proximal or lateral nail fold (Hutchinson’s sign) or free edge of nail plate.
- **F**amily or personal history of previous melanoma or dysplastic nevus syndrome.

Physicians should also look for signs of cuticle manipulation, or picking, which can lead to melanocytic activation, Dr. Stern added, and they should ask about drugs the patient may be taking (particularly tetracycline, HIV medications, anti-malarials and chemotherapy drugs) and whether the patient is pregnant.
The majority of patients with subungual melanoma present with longitudinal melanonychia (a dark streak in the nail), which dermatologists readily recognize as suspicious, Dr. Rubin said. “However, there is a relatively high percentage of amelanotic melanomas that can be very difficult to diagnose, and can mimic benign conditions — an ingrown nail, for example, or a pyogenic granuloma. It’s very tricky, so I think you have to have a high suspicion and a low threshold to biopsy the nail if it’s not responding to therapy, because these amelanotic melanomas will get worse if they’re ignored. When I think about the cases of amelanotic melanoma that I’ve seen, often it’s a surprise. They can have a very benign or nonspecific appearance.”

**Dermoscopy clues**
Although not a substitute for biopsy, dermoscopy can be extremely valuable in helping to distinguish melanoma from benign conditions, Dr. Scher noted. He described some dermoscopic features that serve as clues for identifying specific conditions: Melanocytic activation “produces regular gray/brown lines. Lentigo lines are regular, thinner, and usually brown. The nevus has brown lines with dots or globules, and — very importantly — nests of melanocytes. When it goes beyond that and becomes melanoma, you see irregular spacing, irregular thickness, and loss of parallelism. With dermoscopy, regularity is usually good and irregularity is definitely not good.”

For Dr. Stern, the key is to be able to recognize a micro-Hutchinson sign on dermoscopy at the periungual skin. “Any periungual pigment on dermoscopy will automatically equate to a need for biopsy,” she said. “When the bands are brown or grayish background with thin, regular gray lines — almost homogenous by the naked eye — they should be watched with serial dermoscopy every six months, and if stable, this follow-up schedule can be elongated. This pattern fits the majority of longitudinal melanonychias, which rarely if ever progress to melanoma. The melanonychias with darker regular lines within and pseudo-Hutchinson signs can be more challenging and require more frequent follow-up, and if there’s a change, biopsy.”

As a reference for dermoscopic features, Dr. Stern recommended an *International Journal of Dermatology* article titled “Proposed classification of longitudinal melanonychia based on clinical and dermoscopic criteria” (2014;53(5):581-585). The

**Expert guidance to mastering the nail biopsy**

Understanding how to do effective nail biopsies is critical for both the diagnosis and treatment of nail unit cancer, and it’s a skill any dermatologist can learn, said Christopher J. Miller, MD. “The nail unit anatomy is accessible and logical if we understand how the nail unit works,” he explained. “It allows us to diagnose the source of pathology for most nail unit diseases just by clinical examination. And if we know the source of pathology, we will be effective at biopsying the correct site. All dermatologists can perform high-quality nail unit biopsies if they understand the anatomy.”

Dr. Miller provides one of the few opportunities for dermatologists to get intensive instruction in diagnostic biopsy skills through his three-hour sessions at the AAD Annual Meeting and Summer Meeting. “The majority of our focus is on learning how to do diagnostic procedures,” he noted. “The course almost always includes instruction on the different components of the nail unit, how the nail plate grows, and how you can predict from the clinical exam where the pathology lies.” The format is usually a lecture followed by practical instruction in executing the procedure; for example, how to inject local anesthesia for a nerve block of the digit and nail unit, how to avulse all or part of the nail plate, how to do a punch biopsy, and how to do a matrix shave biopsy.

The course is designed to offer benefits to dermatologists at all levels of experience with nails, “but it’s particularly targeted to general dermatologists,” said Dr. Miller. “There are not many other places for dermatologists to get instruction in these techniques.”

Registration for the 2019 AAD Annual Meeting opens this month. Register at [www.aad.org/meetings/annual-meeting](http://www.aad.org/meetings/annual-meeting).
South Korean authors of a recent *JAMA Dermatology* article (2018;154(8):890-896) investigated the dermoscopic findings of 19 patients with biopsy-proven subungual melanoma in situ (SMIS) and 26 patients with benign longitudinal melanonychia and established a predictive scoring model for the diagnosis of SMIS in patients with adult-onset longitudinal melanonychia affecting a single digit.

**Biopsy challenges**

Because malignancies of the nail unit can mimic benign conditions, and vice versa, obtaining a biopsy is critical to making a definitive diagnosis of a clinically suspicious lesion, said Christopher J. Miller, MD, director of the Penn Dermatology Oncology Center. However, practitioners face a couple of barriers. “First, most people don’t have the benefit of doing a lot of nail procedures. They’re uncomfortable with the anatomy,” he explained. “Second, it’s hard to do a definitive diagnosis by doing a biopsy through the nail plate, because that’s not where the diagnosis lies in most cases. You need to biopsy the matrix for melanoma, and often, the nail bed for squamous cell carcinoma. The matrix extends about half the distance from the edge of the lumula to the joint, so if you have a dark, pigmented streak, usually to get to the right place you have to reflect the proximal nail fold back toward the joint so you can see. Your biopsy should sample where the pigment starts within the matrix.” The larger the portion of the matrix that’s removed, the higher the likelihood that the nail plate will grow back abnormally, Dr. Miller said. “And if you remove all of the matrix, it won’t grow back at all. However, your first priority has to be the biopsy.”

Another challenge to diagnosis, said Dr. Rubin, “is having a pathologist who is familiar with interpreting specimens from the nail. They are different and need different processing by the lab staff than pathology specimens from other parts of the skin. If you’re not sure if your pathologist has a good handle on how to interpret nail pathology, then you may be more reluctant to do the procedure.”

For typical longitudinal melanonychias that are located within the central nail plate, “a matrix shave biopsy has become the preferred technique among many nail specialists,” said Dr. Stern. “A 3mm punch biopsy of the matrix is also appropriate, but more ideal when the pigment is less than 3mm. A 3mm punch biopsy is the simplest and most efficient of the nail biopsy techniques for longitudinal melanonychia, and is a great technique for entry-level nail surgery.”

Most dermatologists don’t have access to nail specialists, but “you don’t need a nail specialist to do a great nail biopsy,” Dr. Rubin said. Dr. Miller, who offers instruction in biopsy techniques at AAD meetings (see sidebar) concurred, insisting that any dermatologist who understands nail anatomy can perform a high-quality nail unit biopsy.

**Treating in situ and invasive melanoma**

Years ago, “many patients underwent amputation, even for in situ melanoma. If you had asked the surgeon, he would have said you never know if you’ve gotten the whole thing out unless you amputate the digit,” said Dr. Scher. “Now we know that’s not necessary, and conservative surgery is more common.” Dr. Miller sees that shift as part of a broader trend, noting that “all of surgery has undergone a shift from the idea that more is better to the idea that precision is better.”

However, the shift from amputation to precision surgery for nail unit tumors has been slower, he believes, because “the nail unit anatomy is so specialized, and so few people are experts at it.” Dr. Rubin concurred that the standard of care is now functional surgery, where wide excision of the nail unit is performed but the remainder of the digit is left intact. “That allows the patient to continue to use the digit in the normal way, but they don’t have a nail.” The wound can be covered with a skin graft, he added, or left to heal by secondary intention.

The treatment decision is based on how far the melanoma has advanced, Dr. Rubin said. For melanoma in situ (the majority of subungual melanomas), removal of the nail unit is generally sufficient to prevent recurrence. Melanoma that has spread to the bone requires amputation. But for those in between? “The controversy lies with invasive melanomas that maybe are invasive but not extensive. That might be the most difficult area we’re dealing with at this time, because there are no specific guidelines about the depth at which a melanoma either requires amputation or can safely be treated with functional surgery.”
The extent of invasion is determined through the microscopic appearance of either a biopsy sample or an entire excised specimen, Dr. Miller said. He added another compelling reason that detection in the in situ phase is critical because there is very little soft tissue between the nail matrix and the bone of the distal phalanx. “If you have an invasive melanoma originating in the nail matrix, it may be difficult to get a clean margin of soft tissue superficial to the bone, and you may be forced to amputate just as a matter of safety because you can’t be sure that your deep margin is clear. If you have melanoma in situ, you should not need to amputate.” Mohs surgery is appropriate for some melanomas, he added.

Identifying nonmelanoma cancer of the nail

As with cutaneous cancers, both basal cell carcinoma (BCC) and squamous cell carcinoma (SCC) can occur in the nail unit. However, BCC in the nail is so rare that Dr. Miller said he has never treated one, and medical literature on the topic consists mostly of small case studies. SCC is also relatively rare (though more common than nail unit melanoma), with an estimated incidence ranging from three cases in 250,000 hospital admissions to 14 cases in 50,000 dermatological consultations, according to a recent review of the literature (J Hand Surg Am. 2018;43:374-379). This analysis of 74 international publications found that SCC of the nail unit affected more men than women (70% vs. 30%), and the mean age at presentation was 61 years (patient age ranged from 22 to 92). The study also demonstrated a strong correlation with human papillomavirus (HPV), a condition that Dr. Miller said he sees in the majority of his patients with SCC of the nail. Other predisposing factors identified in the study include skin contact with certain chemicals (including arsenic), exposure to UV light and ionizing radiation, trauma, immunosuppression, tobacco use, and congenital conditions such as xeroderma pigmentosa and epidermodysplasia verruciformis.

SCC of the nail can present in a number of different ways, “which can also make it confusing,” said Dr. Rubin. “One way would be an oozing area of space under the nail. Another could be a growth that looks like a wart but is not responding to therapy, or is extensive.” Most nail unit SCCs start on the skin folds around the nail and then grow under it, said Dr. Miller, “but you can get nail unit SCCs that start subungually. If you have a nail unit SCC that’s limited just to the subungual epithelium, under the nail plate, it usually presents as a red streak or spot. Or, the nail plate will separate from the nail bed (onycholysis).” Benign conditions such as trauma and fungal infection can result in onycholysis, so a biopsy may be necessary to determine the presence of SCC. Particularly in high-risk patients with HPV, any time a nail disorder looks suspicious and does not respond to therapy, a biopsy is needed, Dr. Rubin said. A punch or shave biopsy can easily be performed on the nail folds, he noted, but “in order to access the matrix you have to recline the proximal nail fold, and in order to get to the nail bed, you have to do some kind of avulsion. Those are tactically more difficult and time-consuming.” As with nail unit melanoma, interpretation of the biopsy specimen can be challenging to a pathologist who is unfamiliar with nail malignancies, Dr. Rubin noted, but “I would say that specimens for squamous cell do tend to be a little bit easier to interpret than the specimens sent for melanoma. However, still they can be very difficult.”

Treatment options

Once the diagnosis is made, the treatment for SCC of the nail unit is relatively straightforward, Dr. Rubin said, adding that “in general” the treatment is Mohs surgery, although amputation may be necessary if the malignancy has spread to the bone. The analysis published in the Journal of Hand Surgery revealed “bone involvement” in half the cases. The authors concluded that “a wide local surgical excision should be performed when there is no involvement of the distal phalangeal bone...when SCCNU does invade bone, amputation of the distal phalanx or disarticulation of the involved digit is indicated.” However, in Dr. Rubin’s view, “most of the time Mohs surgery can take care of the problem. Of course, these cases that are intermediate are probably more difficult,” he remarked. “The more extensive a tumor is, there’s not much give in that area of the body. There are not that many alternative maneuvers that can be done. It’s a small space.”

Infection inspection

Read more about diagnosing and treating onychomycosis at www.aad.org/dw/monthly/2017/august/infection-inspection.
The evolution of education

Notecards, notepads, pens, card catalogs, and textbooks. These are the objects I used in order to study in medical school and residency as I sat in classrooms and library carrels. No longer! Notepad and note card function is accomplished with iPads. The pen is now the thumb and forefinger. The card catalog is replaced with Google. Textbooks are online and often edited in real time and classrooms can be anywhere, any time. New technology has changed how and where we learn. It has also enabled us to share ideas and information and to test our knowledge and skills with a whole world of colleagues almost instantaneously.

Fortunately, your Academy has its finger on the pulse of the latest trends in education. The Academy’s Online Learning Center (OLC) houses a host of educational activities. Many of you are familiar with the Question of the Week (QOTW) — your weekly opportunity to quickly test your skills and earn both CME and Self-Assessment credits from the comfort of your smartphone. Similarly, the OLC offers a monthly Case Challenge for CME credit. Check out the sidebar to find out how you can receive QOTW and the Case Challenge in your inbox every Thursday.

Looking to interact with your peers? Join the Academy’s JAAD Journal Club on Facebook — an online forum for dermatologists to discuss the latest research published in JAAD. Visit www.facebook.com/groups/JAADJournalClub and join the discussion today.

My personal favorite way to keep up with new literature is the JAAD Twitter feed. JAAD pushes out a one-sentence description of an article and a link to the full reference, allowing me to know both the general scope of what is being published as well as a quick way to read the entire article. I can keep it in my “liked” file to reread or reference at a future date.

For our resident members, we also offer several board study tools, such as Race for the Case — an online clinical quiz published quarterly in Dermatology World Directions in Residency. Have some spare time waiting for the train or your morning coffee to brew? Check out Boards Fodder — comprehensive study charts now available online as downloadable PDFs — and Board Prep Plus — a new online study tool for dermatology residents. Check out more of these resources at www.aad.org/members/residents-and-fellows-resource-center/boards-study-tools.

Of course, we haven’t forgotten about the importance of hands-on, in-person learning. The Academy is implementing new hands-on courses throughout the year, such as this month’s Hands-On Cosmetics course in Illinois. Additionally, each year the AAD Annual and Summer Meetings offer several opportunities for physicians to get out of their chairs and participate in clinical demonstrations. Many new innovations are used to maximize onsite learning experiences. These are not your grandmother’s AAD meetings!

Registration for the 2019 AAD Annual Meeting in Washington, D.C. opens this month. Register at www.aad.org/meetings/annual-meeting.

This is just a taste of the educational resources that you have at your fingertips through the Academy. Check out www.aad.org/education to see more. I encourage all of you to take advantage of the numerous educational opportunities that the Academy has to offer. As physicians, it’s in our nature to seek out the latest medical information — we are life-long learners and want to provide up-to-date care to our patients. Thank you to our professional AAD Education staff for keeping us covered! dw
We Give You More Time to Focus on What Matters

Enjoy them knowing your website and practice are working for you.

It’s Black Friday all November long! New Clients receive $0 setup for a new website by calling before 11/30/18.

Call 877-870-1041
Visit DW.OfficiteBlackFriday.com
I’m proud to be able to report, in my final DW column as secretary-treasurer, that the Academy’s finances remain stable. The audited financials for 2017 are in (see p. 65) and show a healthy organization; our annual audits continue to turn up no flaws in our books.

This institutional strength allows the Academy to deliver all of the programs and activities you and your fellow members rely on — our Annual Meeting, the popular Question of the Week, the Practice Management Center, this and other important publications, numerous tools on our website, someone on the phone to answer your questions as needed, and advocacy with public and private payers and state and federal governments for the needs of dermatologists and our patients. But if my time in this role has taught me anything, it’s the following three things:

1. Just how many different programs and activities the Academy offers.
2. How vital our professional staff are to making them all happen.
3. How often members don’t realize the sheer scope of our undertakings.

Imagine putting on the Annual Meeting. For us, as members, it all just happens — we make our reservations, book a flight, and show up for the finest dermatologic education available. For our staff, and for the members of the committees they work with, the Annual Meeting represents the culmination point of dozens of different projects. Making sure the convention center and all of the city hotels are set up to host us is an enormous endeavor. So is planning out the best possible use of those spaces — ensuring that there’s something of interest to attendees with diverse educational needs throughout each day. So, too, is making sure members have the right information to find the places they want to be, whether by checking out a program book, an issue of DW Meeting News, or the AAD’s meeting app. And because the Annual Meeting is the year’s largest gathering of members, it’s also a time when many other activities are launched or planned, from new public relations efforts to practice management tools to advocacy efforts. Any of these things could easily go awry.

But year after year, our meeting, including all of the diverse elements that make it up, is a success.

But, you ask, wouldn’t it be nice if the Academy also did [insert your wished for activity here]? (And if you haven’t asked, trust that your colleagues have.) Often the answer is “Yes, it would be nice — but we have to review this suggestion with the appropriate committees to ensure it dovetails with our other efforts and have to ensure we have the funds and human resources to do it.”

I understand why that’s a frustrating answer to hear; indeed, it’s sometimes a frustrating answer to give. We all want to take a great idea and run with it. But the Academy’s tremendous institutional strength is due in large measure to a degree of prudence that may mean things take longer to get going — but also that they, and the Academy, endure.

I am confident that the Academy’s enduring success is in good hands. I hand the secretary-treasurer role to Marta Van Beek, MD, MPH, this coming March; she’s served as assistant secretary-treasurer the past three years and with her tremendous knowledge of the Academy and unique talents, is ready to take the helm. The recent selection of Daniel Bennett, MD, as your incoming assistant secretary-treasurer helps ensure new eyes and a fresh perspective along with the continuity vital to making the organization thrive over the long term. Most of all, I know that members will keep asking, “Wouldn’t it be nice?” — and that the Academy will keep finding ways to deliver. dw
Academy and Association audit report

The 2017 Audit was conducted by Plante & Moran, PLLC, certified public accountants. The firm rendered an unqualified opinion on the 2017 combined financial statements.

Members of the 2017 Audit Committee are: Hazle Smith Konerding, MD, chair, S. Wright Caughman, MD, Brian Berman, MD, PhD, Vinod Nambudiri, MD, Vincent A. DeLeo, MD, Elizabeth I. McBurney, MD, David D. Nelsen, MD, Barbara Mathes, MD, secretary-treasurer, and Marta J. Van Beek, MD, MPH, assistant secretary-treasurer.

The following exhibits are derived from the 2017 Audit Report. The full audit report is available on the Academy’s website, www.aad.org.

### AMERICAN ACADEMY OF DERMATOLOGY, INC. AND AMERICAN ACADEMY OF DERMATOLOGY ASSOCIATION, INC. COMBINED STATEMENT OF FINANCIAL POSITION

<table>
<thead>
<tr>
<th>ASSETS</th>
<th>$90,612,975</th>
</tr>
</thead>
<tbody>
<tr>
<td>LIABILITIES AND NET ASSETS</td>
<td></td>
</tr>
<tr>
<td>Liabilities</td>
<td>$31,254,413</td>
</tr>
<tr>
<td>Net Assets:</td>
<td></td>
</tr>
<tr>
<td>Unrestricted</td>
<td>$48,517,747</td>
</tr>
<tr>
<td>Temporarily Restricted</td>
<td>$8,497,700</td>
</tr>
<tr>
<td>Permanently Restricted</td>
<td>$2,343,115</td>
</tr>
<tr>
<td>Total Net Assets</td>
<td>$59,358,562</td>
</tr>
<tr>
<td>Total Liabilities and Net Assets</td>
<td>$90,612,975</td>
</tr>
</tbody>
</table>

### AMERICAN ACADEMY OF DERMATOLOGY, INC. AND AMERICAN ACADEMY OF DERMATOLOGY ASSOCIATION, INC. COMBINED STATEMENT OF ACTIVITIES

#### UNRESTRICTED NET ASSETS

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Revenues</td>
<td>$53,262,658</td>
</tr>
<tr>
<td>Expenses</td>
<td>$46,810,631</td>
</tr>
<tr>
<td>Change in unrestricted net assets - before loss on sale of fixed assets</td>
<td>$6,452,027</td>
</tr>
<tr>
<td>Loss on Sale of Fixed Assets</td>
<td>$(1,856,733)</td>
</tr>
<tr>
<td>Change in unrestricted net assets</td>
<td>$2,595,294</td>
</tr>
<tr>
<td>Unrestricted Net Assets @ Beginning of Year</td>
<td>$45,922,453</td>
</tr>
<tr>
<td>Unrestricted Net Assets @ End of Year</td>
<td>$48,517,747</td>
</tr>
</tbody>
</table>

#### TEMPORARILY RESTRICTED NET ASSETS

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Revenues</td>
<td>$5,708,544</td>
</tr>
<tr>
<td>Assets released from restrictions</td>
<td>$5,634,008</td>
</tr>
<tr>
<td>Change in temporarily restricted net assets</td>
<td>$74,536</td>
</tr>
<tr>
<td>Temporarily Restricted Net Assets @ Beginning of Year</td>
<td>$8,423,164</td>
</tr>
<tr>
<td>Temporarily Restricted Net Assets @ End of Year</td>
<td>$8,497,700</td>
</tr>
</tbody>
</table>

#### PERMANENTLY RESTRICTED NET ASSETS

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Revenues</td>
<td>$0</td>
</tr>
<tr>
<td>Assets released from restrictions</td>
<td>$0</td>
</tr>
<tr>
<td>Change in permanently restricted net assets</td>
<td>$0</td>
</tr>
<tr>
<td>Permanently Restricted Net Assets @ Beginning of Year</td>
<td>$2,343,115</td>
</tr>
<tr>
<td>Permanently Restricted Net Assets @ End of Year</td>
<td>$2,343,115</td>
</tr>
</tbody>
</table>
Academy seeks statements on proposed bylaws amendments

Statements due Dec. 1, 2018

The American Academy of Dermatology is seeking statements regarding the proposed bylaws amendments that will be presented to the membership for a vote on the spring 2019 election ballot. The amendments would create a new International Associate category of membership and re-align other international membership categories to address gaps and inconsistencies in the current application process and align international categories with U.S. categories.

Pursuant to the bylaws and administrative regulations for amendments, the ballot will be accompanied by up to three statements from members who express support of and up to three statements in opposition to the proposed bylaws amendments.

Any member who wishes to submit such a statement to the Secretary-Treasurer for consideration must submit it as follows:

- Statements may not exceed the length of two typewritten, double-spaced pages.
- A statement may be submitted by one or more members, but no more than three members can be designated as principal authors and identified with the statement.

Members can view the full bylaws amendments and submit their statements at www.aad.org/statements.

If you would prefer to receive a copy of the proposed bylaws amendments via email or fax, please email statements@aad.org or call (847) 240-1046.

2019 Annual Meeting registration and housing available online

Register online to attend the Academy’s 2019 Annual Meeting in Washington, D.C., March 1-5 at www.aad.org/AM19. Online registration and housing opens at 12 p.m. (CT) on Nov. 14 for physician members, including life and honorary members, and applicants for membership. Registration opens Nov. 20 for residents, medical fellows, AAD graduate members, and medical students, and Nov. 28 for all others.

Guest rooms are being held at several major hotels in Washington, D.C., at AAD discounted meeting rates. These rates are available only to those who book through the AAD. For a current listing of official AAD hotels, visit www.aad.org/AM19. Hotel reservations must be made online in conjunction with registration for the meeting. More information is available on the Academy website and in the 2019 AAD Annual Meeting Announcement, which is being mailed to members this month. Please note: The AAD website is the only place where registration and housing arrangements may be made for the 2019 Annual Meeting. When planning to register, ensure you are on the official Academy website.

You can help expand the scope of vital community outreach programs and services by adding a donation as you register for the Annual Meeting. Be part of the Academy’s efforts to create a world without skin cancer by contributing to SPOT Skin Cancer™. New this year, you can contribute to the AAD Graduate Member Resident Education Grant program. Help ensure that more than 1,300 dermatology residents are able to experience the meeting and build a bright future for the specialty. This program is applicable to AAD Graduate Members in AAD-approved U.S. and Canadian residency programs with a graduation year of 2019, 2020, and 2021.

– SUSAN JACKSON
PROFESSIONAL OPPORTUNITIES

WHITE PLAINS, MARYLAND

BOSTON, MASSACHUSETTS

GREENVILLE, MISSISSIPPI

RENO, NEVADA

CENTRAL NEW JERSEY

BOISE, IDAHO

FAIRFAX, VIRGINIA

WASHINGTON DC

PRACTICES FOR SALE

SONOMA, CALIFORNIA

YUMA, ARIZONA

LONE TREE, COLORADO

BRIDGEPORT, CONNECTICUT

MOHS SURGEON
Multiple Part Time Opportunities
Enfield, CT 2-3 days/mo
Groton, CT 1-2 days/mo
Sanford, NC 2-3 days/mo

MID- ATLANTIC & SOUTHERN STATES
Clinical Dermatologists needed in Major Metros. Full time or part time available; Medical Director or Senior Strategic roles available. Contact Mark Nolen at (214) 377-4990; mail CV to mnolen@fidelismp.com.

We gratefully acknowledge the following advertisers in this issue:

CareCredit Corporate ................................................... 15
Celgene Otezla ....................................................... 7-10
CompuLink EHR ............................................................ 19
Dermira Qbrexa ..................................................... 40-42
Eli Lilly Taltz .............................................................. 19D-G
Henry Schein Member Buying Program ...................... 1A
Mohl’s IBC ................................................................. 1B
Hill Laboratories Hill90D .................................................. 31
Int’l Hyperhidrosis Society Corporate ......................... 49
Midmark Corporate .................................................... 25
Modernizing Medicine EHR ........................................ 3
Nextech EHR ............................................................. 3- DC
Officite Corporate ..................................................... 63
Ortho Dermatologics Altrenad IFC .............................. 5
Sun Pharma Ilumya ..................................................... 35-36
Visual DX Corporate .................................................. 23

FOR DISPLAY ADVERTISING INFORMATION, CONTACT:
Ascend Integrated Media, Publisher’s Representatives
Bridget Blaney (Companies A-F)
Email: bblaney@ascendintegratedmedia.com
Phone: (773) 259-2825

Cathleen Gorby (Companies G-L)
Email: cgorby@ascendintegratedmedia.com
Phone: (913) 780-6923

Maureen Mauer (Companies M-R)
Email: mmauer@ascendintegratedmedia.com
Phone: (913) 780-6633

FOR CLASSIFIED ADVERTISING & REPRINT INFORMATION, CONTACT:
American Academy of Dermatology
Carrie Parratt
Email: cparratt@aad.org
Phone: (847) 240-1770

The Ad Index is provided as a courtesy to our advertisers. The publisher is not liable for omissions or spelling errors.
Since its debut in 2016, the AAD’s DataDerm™ registry has been making an impact within the specialty. As a CMS-approved Qualified Clinical Data Registry (QCDR) and Qualified Registry (QR), dermatologists enrolled in DataDerm can use the platform to report on MIPS measures in addition to dermatology-specific QCDR measures. To date, providers and practices have submitted data encompassing 17 million patient visits and 6.98 million unique patients.

Among those who participated, zero DataDerm users incurred a penalty for 2017 MIPS reporting, with the majority of users instead awarded a small bonus or noted as high performers. Not one of them? Visit [www.aad.org/dataderm](http://www.aad.org/dataderm) for more information. For a more precise breakdown of how DataDerm participants fared in 2017, see the chart below.

### DataDerm users’ MIPS 2017 results

#### Group Providers
- **Penalty incurred (<0 points)**: 0
- **Small bonus, penalty avoided (>3 to < 69 points)**: 475
- **High performers (>70+ points)**: 931

#### Individual
- **Penalty incurred (<0 points)**: 0
- **Small bonus, penalty avoided (>3 to < 69 points)**: 925
- **High performers (>70+ points)**: 394
Why choose *Henry Schein*?

Henry Schein offers a robust portfolio of dermatology products to perform Mohs micrographic surgery for effectively treating skin cancers including basal cell carcinomas (BCCs) and squamous cell carcinomas (SCCs), including:

- Dependable preparation and post-procedure supplies
- Precise, reliable surgical tools and sutures
- Fast, accurate pathology and specimen preparation products from industry-trusted brands

You can trust Henry Schein for your product needs throughout the Mohs surgical process, from removing the cancerous tissue to analyzing the lab specimens to closing or reconstructing the wound.

**LEARN MORE**

[www.HenrySchein.com/Mohs](http://www.HenrySchein.com/Mohs)

**QUESTIONS?** Contact your Henry Schein representative 1-800-P-Schein (1-800-772-4346)
Server-free EMR & PM
A Better Way to Run Your Practice

Discover a New Level of Freedom

Low Cost
- Eliminate expensive hardware and IT costs
- Packages available for any size practice
- Low monthly fee

Superior Performance
- Systems are hosted in an optimal environment
- Real-time automated software updates
- No maintenance necessary

Secure Data
- Run in the most protected and secure environment
- Never lose data with instant data replication
- World-class security practices

(800) 868-3694
Nextech.com/NexCloud