Message from the Chair
by Eva A. Hurst, M.D.

Hello everyone. As you approach the midpoint of your academic years, I hope everything is going well for you. However, I would be remiss to not acknowledge the difficulties some of our colleagues and friends are currently experiencing. While there is always a delay between writing of these columns and the mailing of Resident Roundup, I am writing this message in the wake of Hurricane Katrina. Recently, this 250-mile wide storm tore through the Southern United States, leaving billions of dollars in damage, thousands without homes, and approximately 1,200 people dead. Naturally, many dermatologists and dermatology residents in the area have been significantly affected by this disaster. Certainly, our thoughts are with you all as lives and homes are rebuilt.

To that end, the Academy has established a fund to help dermatologists and dermatology residents. Resident members can apply for a low-interest loan of up to $5,000 dollars to aid in their recovery process. In addition, a general relief fund has also been set up, with contributions to be sent to the Red Cross. Further information regarding all of these established aids, as well as other Hurricane Katrina information, can be found on the Academy’s Web site, www.aad.org.

Residency programs in the South and across the nation have also provided temporary training options for our colleagues affected by the hurricane. We have been happy to welcome two new friends from New Orleans to University of California at San Francisco for the coming months! I encourage other residents to network and help those affected by the storms.

Looking to the near future, I hope that many of you will be joining us in San Francisco for the Academy’s Annual Meeting, March 3-7. As usual, this will be a great time for people to exchange ideas and to share knowledge. The RFC invites you all to attend the Resident’s Colloquium. Look for more details in the next issue of Resident Roundup. See you in San Francisco!

Younger Dermatologists Can Lead the Way to Electronic Medical Record Adoption

In recent years electronic medical records have moved from being a vision for the future to a standard part of practicing in a large medical center. As such, while the ins and outs of EMR systems remain matters of confusion for older physicians, a younger cohort, having grown up using computers, appears primed to lead the way toward electronic medical record adoption, both in the general medical community and within dermatology.

Many factors make now the time to consider adopting an EMR system. For dermatologists starting their own practices, the decision is largely a forward-thinking financial one. With electronic records an inevitable part of medicine’s future, it is only a matter of time before any paper-based system will have to be replaced, with the old records transferred into a new system—a time-consuming process that can add to the expense of adoption. New practices, with no backlog of charts to transfer.

SEE ELECTRONIC MEDICAL RECORDS PAGE 4

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Plan to Attend!

American Academy of Dermatology
69th Annual Meeting
San Francisco, CA on March 3-7, 2005

Scheduled Events for Residents

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• PRACTICE MANAGEMENT SYMPOSIUM .................. 5
an essential element of our corporate responsibility is our commitment to the dermatology community. Connnetics and its employees take this commitment seriously, and work collaboratively with nonprofit organizations through a wide range of programs supporting education and research.

For more information about Connetics, please visit our website: www.connetics.com
2005 Annual AMA-RFS Meeting Addresses a Wide Range of Concerns
by Adam I. Rubin, M.D., AAD delegate to the AMA-RFS

The 2005 Annual American Medical Association, Resident and Fellow Section (AMA-RFS) assembly meeting took place June 17-18, 2005, in Chicago. Highlights of the approved resolutions follow:

**Specialty and Military Representation Count toward Quorum in the RFS Assembly**
The previous system of satisfying the quorum requirement to conduct business in the RFS Assembly did not include national medical specialty organizations, military or federal agencies. The previous quorum guidelines required 20% of representatives from at least 15 states to be in attendance to proceed with a business meeting of the RFS. However, some residents and fellows may only be represented by these aforementioned groups. In order to include these groups, this resolution calls for the official quorum requirement to include 20% of representatives from at least fifteen states and five national medical specialty organizations.

**Funding for Preventive Medicine Residencies**
Since Preventive Medicine residencies are not based in hospitals, in general they typically do not receive Medicare Graduate Medical Education funding. Because of this situation, support for faculty is not extensive, and there is not a stable source of funding for Preventive Medicine residents. Part of the Healthy Lifestyles and Prevention America Act (currently pending), would provide a federal grant to support preventive medicine residencies. This resolution calls for the AMA to work with the American College of Preventive Medicine, other preventive medicine specialty societies, and others, to formally support legislative efforts to fund Preventive Medicine residencies.

**Promoting the Utilization of Medicare Preventive Services Benefits**
Medicare beneficiaries are entitled to preventive services such as a “Welcome to Medicare Visit.” However, these preventative service benefits have not been well advertised. As a result, many patients and physicians are not aware that such services are covered. This resolution calls for the AMA to work with national medical specialty societies, state and county medical societies, relevant federal agencies, the American Health Quality Association, and the coalition Partnership for Prevention to promote the “Welcome to Medicare Visit” and other covered preventive services to the public and physicians. The resolution states that these efforts should particularly focus on underserved populations.

**Eliminating Health Disparities – Promoting Awareness and Education of Lesbian, Gay, Bisexual, and Transgender (LGBT) Health Issues in Medical Education**
The author of this resolution explains that the LGBT community has unique health care concerns. Recently, a medical school refused to allow a student group addressing LGBT issues to organize or host educational activities. This resolution calls for the AMA to support the right of medical students and residents to meet on-site to further their medical education and improve patient care without regard to their background. It further states that the AMA supports students and residents who wish to conduct on-site educational seminars and workshops on health issues in the LGBT community, and that the AMA encourage the Liaison Committee on Medical Education and the Accreditation Council of Graduate Medical Education to include LGBT health issues in the cultural competency curriculum for medical education.

**Appropriate Conditions for Breastfeeding by Residents and Fellows**
The authors of this resolution explain that the opportunity and facilities to express breast milk are not being provided to residents. The authors go on to state that this situation is not consistent with the goals of the AMA that promote breastfeeding. This resolution calls for the AMA to encourage all medical schools and Graduate Medical Education programs to support residents and medical students who provide breast milk for their infants by providing appropriate time and facilities to express and store breast milk.

**Reports**
Two reports were reviewed and adopted. The first report, Membership List Access, addresses the recent change in National Resident Match Program (NRMP) policy. Because of privacy concerns, the NRMP will only release match list information to the AMA, and not both the AMA and state medical societies. The AMA and state medical societies have used this match list data as a recruitment tool. If this information is not obtained by state medical societies in a timely manner, recruitment by these groups could be adversely affected. This report recommends that the AMA work closely with the NRMP to explore faster delivery of the match list. It also recommends that the AMA review its internal processing of the NRMP match list to improve delivery time to state societies.

The second report, Colleague Intimidation, calls for an identity protected survey to be conducted in order to study intimidation experienced during residency and fellowship training.
Residents & Fellows Symposium Schedule Announced

The 2006 Resident and Fellows Research Symposium will be held on Sunday, March 5, from 11:00 a.m. to 2:00 p.m. in Room 131 of the Convention Center, during the American Academy of Dermatology’s 64th Annual Meeting in San Francisco.

New knowledge about the pathophysiology and treatment of cutaneous diseases is crucial for the future of the dermatologist. In this session, talented young investigators who are actively working in a laboratory and/or clinic will present their latest research discoveries. Jeffrey B. Travers, M.D., Ph.D., will serve as director of the symposium. Judges will select the resident or fellow who presents the most outstanding paper at this symposium to receive the prestigious Everett C. Fox Award. The co-recipients of the 2005 Everett C. Fox Award were Amy E. Adams, M.D., Ph.D., and Shasha Hu, M.D.

For more details on this much anticipated event, see pages 172-173 of the AAD’s 64th Annual Meeting Program Book. The symposium is offered for 3 category 1 CME credits.

2006 RESIDENT AND FELLOWS SYMPOSIUM SCHEDULE

11:00 a.m. Factors that Influence a Career Towards Academic Dermatology
11:10 a.m. Simultaneous Quantification of Ten Cytokines in Allergic Contact Dermatitis to Chrome Using Luminex Technology (Cytokine Ten Plex Antibody Bead Kit)
11:20 a.m. An Unusual Presentation of Cutaneous Mycobacterium Avium Complex in an AIDS Patient
11:30 a.m. Chronic Varicella Zoster Infection in a Pediatric Patient after Bone Marrow Transplant
11:40 a.m. A Case of Eczema Herpeticum Suggesting the Importance of Sebaceous Follicles for Cutaneous Immunity Against Herpes Simplex Virus Type 1
11:50 a.m. Evaluation of Cats as the Source of Endemic Sporotrichosis in Peru
12:00 p.m. Tripe Palms and Arrested Hair Growth as a Paraneoplastic Syndrome
12:10 p.m. Outbreak of Unilateral Psoriasis
12:20 p.m. Transcriptional Events Modulated by Corticotropin Releasing Hormone (CRH) – Receptor Mediated Responses in Psoriasis
12:30 p.m. The Use of CoQ10 as a Potential Therapeutic Agent in Wound Healing
12:40 p.m. Wild-Type Blocking Polymerase Chain Reaction for Detection of Single Nucleotide Minority Mutations in Braf Using Real-Time PCR
12:50 p.m. Reflection Confocal Microscopy of Pigmented Basal Cell Carcinoma
1:00 p.m. Identification of the Clinical Features and the Molecular Basis of the Multiple Cutaneous and Uterine Leiomyomatosis and Renal Cancer Syndrome
1:10 p.m. Hay-Wells Syndrome in 4 Month Old Twin Boy and Girl
1:20 p.m. Immune Dysregulation, Polyendocrinopathy, Enteropathy, X-linked Syndrome (IPEX) associated with Pemphigoid nodularis
1:30 p.m. Alanyl-tRNA Antisynthetase Syndrome in a 58 Year-Old Woman
1:40 p.m. Granular Parakeratosis with Prominent Eosinophils
1:50 p.m. APACHE Syndrome: Acral Pseudolymphomatous Angiokeratoma

Electronic Medical Records from Page 1 can save themselves the cost of ever having to make a switch by starting out electronic. For technology-savvy younger dermatologists, many of whom have already been using electronic systems in residency, this choice may appear obvious. Indeed, a survey published in the January 2005 issue of Medical Economics, "Doctors and EHRs," showed that youth is a good predictor of electronic record adoption.

Also driving adoption are efforts by the federal government. In June, Health and Human Services Secretary Michael Leavitt announced the creation of a five-year joint public-private commission, the American Health Information Community, to oversee the development of viable and effective national health information technology strategy that includes digital and interoperable standards for electronic record systems that bridge needs and priorities of physicians, payers, vendors and patients. In addition to interoperability, AHIC will have oversight of modeling an integrated health information network architecture, setting and developing of EHR product standards certification process and a method of governance for ongoing implementation of health IT. Once the market has structure, patients, physicians and other medical professionals and vendors will innovate, create efficiencies and improve care. President Bush has also established a National Coordinator for Health Information Technology, a position filled by David J. Brailer, M.D., Ph.D.

Dr. Brailer has set out a series of goals, including universal adoption of electronic records, patient access to those records, the utilization of patient data to track disease epidemiology, and eventually interoperability between the electronic records systems of different institutions.

The American Academy of Dermatology Association is working with other physician groups to help develop recommendations regarding how these goals are met. The Academy joined the Physician Electronic Health Record Coalition (PEHRC) earlier this year, joining over 21 other physician groups whose joint aim is to take "practical steps to educate physicians about the value and best use of electronic health records," "to assist them in selection of systems," and "to help focus the market on high-quality and affordable products." The latter goal involves advising the Certification Commission for Health Information Technology as it establishes the guidelines it will use to certify electronic record products.

As these standards reach the market, both the government and private payers...
Latest Practice Management Gems to be Unveiled at 2006 Meeting

The Practice Management Symposium for Residents—Building a Foundation for Success, held in conjunction with the American Academy of Dermatology’s 64th Annual Meeting, will be offered Thursday, March 2, at the Hilton San Francisco. This one-day course provides an opportunity to expand residents’ knowledge through a variety of topics and formats and has preceded the Annual Meeting for the past 30 years. Upon completion of the Practice Management Symposium for Residents course, the learner will gain knowledge of the business aspects and strategies useful for starting a successful practice and/or career in dermatology. The symposium focuses on the future and how to manage the tough decisions ahead. It is not only for third-year residents, however; it is available to first- and second-year residents. Many residents attend it more than once. Others have said that they really wished they had received the information earlier in their residency. The session schedule is listed to the right.

For the first time registration for the Practice Management Symposium for Residents course will be available online! Registering online is fast, easy and convenient. Log onto www.aad.org, click on the Annual Meeting logo, click on “Residents,” and then the “Practice Management Symposium for Residents,” title bar. Traditional methods of registration will also be available via mail or fax. Please refer to the registration form for further information regarding this process. Advance Registration will begin on November 28, 2005, at 8:30 a.m. (CST).

For your convenience you may also download the registration form online at www.aad.org, following the aforementioned links.

The deadline for Advance Registration is Friday, February 3, 2006, at 5:00 p.m. (CST). Individuals who have not completed Advance Registration by February 3, 2006 at 5:00 p.m. (CST) may register for the course at the On-Site Registration desk. This course is supported by an unrestricted educational grant from Connetics Corporation.

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**PRACTICE MANAGEMENT SYMPOSIUM SCHEDULE, MARCH 2, 2006**

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
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<tbody>
<tr>
<td>6:00 a.m.</td>
<td>Registration</td>
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<td>6:00 a.m.</td>
<td>Continental Breakfast</td>
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<td>Concurrent Workshops</td>
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<td>W101 How to Become a Better Negotiator</td>
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<td>Scott M. Dinehart, M.D., Course Director</td>
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<td>Keith Borglum</td>
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<td>W102 Basic Coding</td>
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<td>Brett M. Coldiron, M.D.</td>
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<td>Vernell St. John</td>
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<tr>
<td>7:30 a.m.</td>
<td>Concurrent Workshops</td>
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<td>W201 Employee Incentives: The Dinehart/Borglum/Marks Rules</td>
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<td>Scott M. Dinehart, M.D., Course Director</td>
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<td>Victor I. Marks, M.D.</td>
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<td>Keith Borglum</td>
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<td>W202 A Career in Academics: Is it Right For You?</td>
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<td>Dee Anna Glaser, M.D.</td>
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<td>W203 Coding and Reimbursement Scenarios</td>
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<td>Brett M. Coldiron, M.D.</td>
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<td>Vernell St. John</td>
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<td>8:45 a.m.</td>
<td>General Session</td>
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<td>Welcome</td>
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<td>Scott M. Dinehart, M.D., Course Director</td>
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<td>9:00 a.m.</td>
<td>Practice Options</td>
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<td>Keith Borglum</td>
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<td>9:20 a.m.</td>
<td>Skills for Succeeding in a Partnership/Group Practice</td>
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<td>David M. Pariser, M.D.</td>
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<td>9:50 a.m.</td>
<td>Refreshment Break</td>
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<td>10:20 a.m.</td>
<td>Dermatology is a Service Business!</td>
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<td>Victor I. Marks, M.D.</td>
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<td>11:15 a.m.</td>
<td>Coding: 7 Things You Shouldn’t Do</td>
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<td>Brett M. Coldiron, M.D.</td>
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<td>11:45 a.m.</td>
<td>Thirty Tips in 30 Minutes</td>
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<td>Scott M. Dinehart, M.D., Course Director</td>
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<td>Brett M. Coldiron, M.D.</td>
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<td>Dee Anna Glaser, M.D.</td>
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<td>Bill Kalogridis, JD, CHBS, CFP</td>
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<td>Victor I. Marks, M.D.</td>
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<td>David M. Pariser, M.D.</td>
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<td>Darrell S. Rigel, M.D.</td>
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<td>12:15 p.m.</td>
<td>Lunch with Faculty General Session</td>
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<td>1:15 p.m.</td>
<td>Employment Contracts</td>
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<td>Vasili Kalogridis, JD, CHBC, CFP</td>
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<td>2:10 p.m.</td>
<td>Financial Mistakes that Young Dermatologists Make</td>
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<td>Darrell S. Rigel, M.D.</td>
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<td>2:50 p.m.</td>
<td>Refreshment Break</td>
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<tr>
<td>3:10 p.m.</td>
<td>Enhancing the Cosmetic Aspects of Your Practice</td>
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<td>Dee Anna Glaser, M.D.</td>
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<td>3:45 p.m.</td>
<td>Practice Management and Marketing</td>
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<td>Keith Borglum</td>
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<td>4:50 p.m.</td>
<td>Question and Answer Session</td>
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<td>5:00 p.m.</td>
<td>Adjourn</td>
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### Boards' Fodder:

**Syphilology Manifestations & Treatment of T. pallidum Infection**

Antoine Amado, M.D., and Sharon E. Jacob, M.D.

<table>
<thead>
<tr>
<th>STAGE</th>
<th>MANIFESTATIONS</th>
<th>TREATMENT</th>
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</table>
| **CONGENITAL (PRENATAL)** | **PLACENTA**
- Langhan's cell layer [*]
- Placenta:
  - acute chorioamnionitis
  - chronic villitis
  - hydrops placentalis
  - necrotizing funisitis | **FETUS**
- Hydrops fetalis
- Intrauterine growth retardation
- Premature delivery
- Stillbirth | **PRIMARY**
- **Aquadex**
- crystalline: PCN G
  - 100,000 – 150,000 
  - µg/kg/day, administered as
  - 50,000 µg/kg/dose
  - IV q12h x first 4 days then q8h x 7-21 days | **ALTERNATIVE**
- Procaine PCN G
  - 50,000 µg/kg/dose
  - qd IM x 10 days |
| **CONGENITAL (POSTNATAL)** | **EARLY**
- Choriorrhexis
- ('Salt & pepper' fundus)
- Dactylyitis
- Epiphysitis
- Hepatomegaly/Hepatitis | **LATE**
- Clutton's joints
- Frontal bossing
- Higoumenaki's sign
- Hutchinson's triad
- Interstitial keratitis
- 'Mulberry' molars
- Neurosyphilis
- Producendo meningeal
- Saber shins
- Saddle nose
- Short maxillae | **Primary, secondary or early latent (<1 year):**
- Benzathine
  - PCN G 2.4 mill U IM in a single dose
- Late latent (>1 year) or syphilis of indeterminate duration, late benign:
  - Benzathine PCN G
  - 2.4 mill U IM q wk x3 | **Doxycycline** 100 mg bid PO x14 days or
- **Tetracycline** 500 mg qd PO x14 days or
- Ceftriaxone 1gr
  - IM/IV daily x8-10 days |
| **LATENT** | **SECONDARY**
- Cutaneous findings: Biotte's colllarette, condyloma latum, 'corona veneris', corymbiferous, 'frambesiform syphilis', leucoderma colli (collar of Venus), lues maligna (ulceromembranous, 'la grand verole'), moist, moist red, alopecia, mucous patches (plaques fauchées en préaline). Ollendorf's sign, 'raw ham' papules, ringed (annular) plaques, 'rupial plaques, split papule | **TREATMENT**
- Primary, secondary or early latent (<1 year):
  - Benzathine
  - PCN G 2.4 mill U IM in a single dose
- Late latent (>1 year) or syphilis of indeterminate duration, late benign:
  - Benzathine PCN G
  - 2.4 mill U IM q wk x3 | **Doxycycline** 100 mg bid PO x28 days or
- **Tetracycline** 500 mg qd PO x28 days |
| **TERTIARY (LATE)** | **LATENT**
- Asymptomatic | **TREATMENT**
- Primary, secondary or early latent (<1 year):
  - Benzathine
  - PCN G 2.4 mill U IM in a single dose
- Late latent (>1 year) or syphilis of indeterminate duration, late benign:
  - Benzathine PCN G
  - 2.4 mill U IM q wk x3 | **Procare PCN G**
  - 2.4 mill U qd IM plus Probenecid
  - 500 mg qid PO, both x13-14 days |
| **TERTIARY (LATE)** | **TREATMENT**
- Cutaneous: Gummas, pseudochancre redux
  - Neurosyphilis: Asymptomatic, Gummas, Meningeal, Meningovascular, Parenchymatous (paresis, tabes dorsalis, Argyll-Robertson pupil), Rheuma: bilateral bursitis of Verneuil, Chancriform joints
  - Vascular: Aortic, aortic aneurysm, coronary aortitis stenosis | **Glossary of Terms**

- **Argyll Robertson pupil**
  - Pupil accommodates, but does not react to light.
- **Balanitis of Folllman**
  - Chancres may be atypical [multiple, painful, purulent, and destructive].
- **Biotte’s colllarette**
  - Thin, white ring of scales on the surface of the papules.
- **Chancre re’ dux**
  - (Mononucleic chancre) the reappearance of a chancre after partial healing as a result of insufficient treatment.
- **Charcot joints**
  - Enlarged, painless, uninflamed joints, with or without deformity, in the lower extremities and spine.
- **Clutton’s joints**
  - Synovitis with effusions of the knees and elbows.
- **Corona veneris**
  - Macules &/or papules along the hairline.
- **Corybbose (lump shell)**
  - A large central papule surrounded by satellite raised papules.
- **Condylooma latum**
  - Skin-colored or hypopigmented, moist, oozing papules located perianally and on the genitalia. They become flattened and macerated. These are tending with trichomoniasis, and thus are extremely infectious.
- **Dory flop sign**
  - When the foreskin is retracted, mucosal surface chancres flip briskly.
- **Frambesiform syphilis**
  - Condylomata latum in intertriginous areas may proliferate forming nodular lesions that resemble raspberries.
GLOSSARY OF TERMS (CONTINUED)

**Gummas**
Rubbery tumors with predilection for skin or long bones, may also develop in the eyes, mucous membranes, throat, liver, or stomach lining.

**Higoumenaki’s sign**
Unilateral, irregular enlargement of the clavicle at site of sternocleidomastoid attachment, secondary to perinostitis.

**Hutchinson’s teeth**
Centrally notched, widely spaced, peg-shaped upper incisors.

**Hutchinson’s triad**
Hutchinson’s teeth, CN 8 nerve deafness, and corneal opacities (2ndry to interstitial keratitis).

**Langhan’s cell layer [+]**
Layer of the cytotrophoblast of the placenta; a controversial protective placental barrier until 20 wk gestation. Recently it has been demonstrated that treponemes cross the placenta in early pregnancy.

**Leukoderma colla**
(Syphilitic leukoderma / collar of pearls / collar of Venus / venereal collar), round or oval, ill-defined, depigmented macules with occurring on the anterolateral neck and chest.

**Lues maligna**
Areas of ulcerated and necrotic tissue, occurs in secondary syphilis (more likely in patients with HIV).

**Mulberry molars**
(Moon’s or Fournier’s molar) sixth-year molars, is seen in the first lower molar.

**Mucous patch**
Painless, shallow, rounded gray macerated erosions, located on the oral, genital and anal mucosa. These are teeming with treponemes.

**Ollendorf’s sign**
Papules tender to palpation.

**Parrot’s pseudopenis**
Reduced movement of the lower 1/3 of the penis due to pain.

**Pneumonia alba**
Yellowish-white, heavy firm, and grossly enlarged lungs (pneumonitis).

**Psuesoancre rash**
A solitary gumma of the penis.

**Rhegades (Parrot’s lines)**
Perioral fissures.

**Ruptured lesion**
Ulcerative lesions with a heaped-up crust, oyster-shell like.

**Saber shins**
Anterior tibial bowing.

**Snuffles**
 Bloody or purulent mucinous naso-pharyngeal discharge.

**Split papule**
Lesions at the angle of the mouth or the corner of the nose which have a central linear erosion.

**Syphilis d’embrée**
Syphils occurring without an initial sore.

**Syphilitic pemphigus**
Vesiculoulcerous eruption.

**Winberger’s (cat-bite) sign**
A radiographic “saw tooth” appearance at the medial aspect of the proximal tibial metaphysis.

REFERENCES:

Sharon E. Jacob, M.D., is an Assistant Professor of Clinical Dermatology, Director of the Contact Dermatitis Clinic and Medical Student Education, Department of Dermatology and Cutaneous Surgery, University of Miami, School of Medicine, Miami, FL.

Tools for Every Dermatology Practice

The Practice Management Essentials Series provides dermatologists and their office staff with the business strategies and federal compliance information necessary to manage a well-run and successful dermatology practice.

Written specifically for the dermatology practice, each manual provides comprehensive information in an easy-to-understand format. New requirements, important concepts, and essential steps are highlighted throughout the text.

The PME Series includes 9 manuals:
- Starting and Marketing a Dermatology Practice
- Valuing a Dermatology Practice

To order, call (866) 503-SKIN (7546).
ELECTRONIC MEDICAL RECORDS FROM PAGE 4 will likely increase the pressure on physicians to adopt, particularly by implementing “pay for performance” components whose reporting standards for payments can be facilitated through the use of an electronic record system. Because the bonus payments proposed by Medicare for claims from physicians using electronic records are currently slated to come out of the same pool of funds as other reimbursement, they will amount to a penalty for non-adoption if they come to pass.

These factors, along with the many features new electronic systems include, have enticed some dermatologists into adopting already. Dermatologist Charles E. Crutchfield III, M.D., of Minnesota started his own practice in 2002, four years out of his residency, and implemented an electronic records system. The ability to quickly generate printed referral and consultation letters, print out prescriptions for patients, and click his way through note-taking allows Dr. Crutchfield to spend less time on paperwork and more time focused on his patients, he says.

Despite such success stories, the fact remains: the January 2005 *Medical Economics* survey also found that specialists and smaller practices have lower adoption rates than large groups or institutions and generalists. As the push toward electronic record adoption continues, the Academy will continue to advocate for standards that recognize the unique medical record needs of its members. *Dermatology World* will offer updates on the state of the electronic record industry and on government and payer efforts to drive adoption.

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