



NOAH WORCESTER DERMATOLOGICAL SOCIETY

**FIFTIETH ANNUAL MEETING
THE FAIRMONT SCOTTSDALE PRINCESS
SCOTTSDALE, ARIZONA
MARCH 30 - APRIL 5, 2008**

www.noahderm.org

This activity has been planned and implemented in accordance with the Essentials Areas and Policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint sponsorship of the Chicago Medical Society and the Noah Worcester Dermatological Society. The Chicago Medical Society is accredited by the ACCME to provide continuing medical education for physicians. The Chicago Medical Society designates this educational activity for a maximum of 20 category 1 credits towards the AMA Physician Recognition Award. Each physician should claim only those hours of credit that he/she actually spent in the educational activity.

SUNDAY, MARCH 30, 2008

Registration East Foyer H

12:30 – 4:30 pm

Board of Trustees Meeting Salon Princesa

1:00 – 4:00 pm

Unless otherwise stated, each speaker will declare whether he/she has any financial relationship with any of the pharmaceutical companies supporting these scientific sessions or with any company whose products are discussed in the presentation, according to American Academy of Dermatology Guidelines. The views expressed by each speaker are not to be construed as official policy of the Noah Worcester Dermatological Society.

MONDAY, MARCH 31, 2008

Registration East Foyer H

7:00 – 9:00 am

Members' Continental Breakfast North Foyer H & I

6:30 – 8:00 am

BREAKFAST ROUNDTABLES Salons Princesa, 9 & 10

7:00 – 8:00 am

Sponsored by Galderma Laboratories, L.P.

- 1) **Office Management and Therapy: Tips, Tricks and Pearls**
Alan M. Ruben, MD
- 2) **Fractional Lasers: An Update on the Facts and Controversies**
Ashish C. Bhatia, MD
- 3) **Great Cases from the University of Vermont**
Paul A. Krusinski, MD

FIRST SCIENTIFIC SESSION Salons H & I

8:15 – 12:00 pm

Sponsored by Intendis, Inc.

Announcements

Moderators: Daniel M. Siegel, MD and David A. Whiting, MD

Presidential Welcome: J. Robert West, MD

Harold O. Perry - The Man

Roger I. Ceilley, MD

- 1) **HAROLD O. PERRY LECTURE**
Challenging Cutaneous Malignancies - Marc Brown, MD
- 2) **Port Wine Stains: 2008 Therapeutic Update**
Elizabeth McBurney, MD
- 3) **Tolerability of Keloid Scars Post-shave Excision with Imiquimod 5% Cream: A Prospective, Double-blind, Placebo Controlled Pilot Study**
Brian Berman, MD
- 4) **Actinic Keratoses: Every Patient Deserves Consideration for Field Therapy**
Neil A. Fenske, MD

5) Radiation Therapy in Modern Dermatology

Adam B. Bodian, MD

Coffee Break

North Foyer H & I

Moderators: Alan Ruben and Sabra Sullivan

6) Hailey-Hailey Disease: Clinical Patterns and Response to Therapy

Kenneth J. Tomecki, MD

7) Calciphylaxis in the Setting of Diabetes, Renal Failure and Normal Serum Calcium Levels

Carla Bauman, MD

8) Dermatologic Phantasmagoria and its Effect on the Socio-Political Environment

Gary W. Cole, MD

9) The Use of Topical Alpha Adrenergic Agonists in the Treatment of Erythematotelangiectatic Rosacea

Stuart D. Shanler, MD

10) Update of Medical Vaccines in Dermatology

Neal Bhatia, MD

TUESDAY APRIL 1, 2008

Members' Continental Breakfast

6:30 – 8:00 am

North Foyer H & I

BREAKFAST ROUNDTABLES

7:00 – 8:00 am

Salons Princesa, 9 & 10

Sponsored by Graceway Pharmaceuticals, Inc.

1) Planning & Building a New Dermatology Office

James Zalla, MD

2) Dermatological Threats from Exotic Pets

Ted Rosen, MD

3) CSI: North American Contact Derm Group—Interesting and Instructive Cases

James Taylor, MD and Christine Mowad, MD

SECOND SCIENTIFIC SESSION

8:15 – 12:00 pm

Salons H & I

Announcements

Moderators: Gerald Weinstein and Kenneth J. Tomecki

1) Alfred L. Weiner – The Man

Anthony F. Fransway, MD

**The ALFRED L. WEINER LECTURE -
Cutaneous Manifestations of Agents of Bioterrorism**

Boris Lushniak, MD

2) Contact Allergens of the Year- a Review

Christen Mowad, MD

3) Generic Drugs in Medicine

Peter Halperin, MD

4) Chronic Idiopathic Urticaria – Diagnosis and Treatment

Diane R. Baker, MD

5) Contact Dermatitis – An Update

Christen Mowad, MD

Coffee Break

North Foyer H & I

Moderators: Peter Muelleman and David A. Whiting

- 6) Tidbits from Rx-derm**
Gail E. Drayton, MD
- 7) Report from the American Academy of Dermatology**
James Taylor, MD
- 8) Things Therapeutic, Novel, and Wonderful**
P. Haines Ely, MD

WEDNESDAY APRIL 2, 2008

- Combined Breakfast** Princess Plaza
6:30 – 9:00 am
- Annual Business Meeting (members only)** Salons H & I
3:00 – 5:00 pm

THURSDAY APRIL 3, 2008

- Members' Continental Breakfast** North Foyer H & I
6:30 – 8:00 am
- BREAKFAST ROUNDTABLES** Salons Princesa, 9 & 10
7:00 – 8:00 am
Sponsored by OrthoNeutrogena

- 1) Emergency Dermatology: Severe Drug Reactions**
Paul A. Krusinski, MD
- 2) Medicolegal Interactions: An Interactive Discussion**
Robert P. Feinstein, MD and Gilbert Goldman, MD, Atty-at-Law
- 3) What's New in Acne and Rosacea**
Guy Webster, MD

- THIRD SCIENTIFIC SESSION** Salons H & I
8:15 – 12:30 pm
Sponsored by Warner-Chilcot

Announcements

Moderators: Kenneth J. Tomecki and Sabra Sullivan

- 1) Surgical Complications**
Marc Brown, MD
- 2) Cutaneous Squamous Cell Carcinoma: A Comprehensive Classification**
Ronald J. Barr, MD, and David Cassarino, MD
- 3) Histopathology of Central Centrifugal Cicatricial Alopecia**
David A. Whiting, MD
- 4) Biofilm – The Devil in Implants**
Gary D. Monheit, MD
- 5) Office Headaches and Their Cures**
Michael Greenberg, MD
- 6) Adnexal Carcinoma Arising in a Nevus Sebaceum in an Eight-Year-Old Girl**
Paul A. Krusinski, MD

- Coffee Break** North Foyer H & I

Moderators: Daniel M. Siegel and Peter Muellman

- 7) The Etiology of Eyelid Dermatitis: A 10-year Retrospective Analysis**
Donald Belsito, MD
- 8) Melasma-like Facial Hyperpigmentation**
Allan S. Wirtzer, MD

9) The Microecology of the Skin

Guy Webster, MD

10) The Tri-wizards Tournament

Stuart M. Brown, MD, P. Haines Ely, MD, and Stephen P. Stone, MD

FRIDAY APRIL 4, 2008

Members' Continental Breakfast

6:30 – 8:00 am

North Foyer H & I

BREAKFAST ROUNDTABLES

7:00 – 8:00 am

Salons Princesa, 9 & 10

Sponsored by Stiefel Laboratories, Inc.

1) Documenting Acne and iPLEDGE For Profit and Protection

Joseph Bikowski, MD

2) Therapeutic Pearls

Stuart M. Brown, MD

3) The Therapy of Moderate to Severe Psoriasis with Photo and Systemic Drugs (our pre-2000 therapies) Exclusive of Biologics

Gerald Weinstein, MD

FOURTH SCIENTIFIC SESSION

8:15 – 12:45 pm

Salons H & I

Announcements

Moderators: Stuart M. Brown and Peter Muelleman

1) Pandemic Influenza – Planning and Preparation

Boris Lushniak, MD

2) Cosmetic Botulinum Toxin Type A Consultation – Do It Right!

Kevin C. Smith, MD

3) Creating Perfect Lips: A Morning at the Movies

Roberta Sengelmann, MD

4) Laser Hair Removal Consultation – Do It Right!

Kevin C. Smith, MD

5) Filler Complications

Allan S. Wirtzer, MD

6) Botulinum Toxin Type A for Hyperhidrosis Consultation – Do it right!

Kevin C. Smith, MD

Coffee Break

North Foyer H & I

Moderators: Daniel M. Siegel and Alan Ruben

7) Challenging Mohs Repairs and Pearls

Roberta Sengelmann, MD

8) Vascular Laser Consultation - Do It Right!

Kevin C. Smith, MD

9) Surgical Panel Discussion

Drs. Smith, Sengelmann, and Wirtzer

10) Noah: A Living History

Michael Greenberg, MD, et al

SCIENTIFIC PRESENTATION ABSTRACTS**Monday, March 31, 2008****BREAKFAST ROUNDTABLES**

7:00 - 8:00 am

1) Office Management and Therapy: Tips, Tricks and Pearls**Alan M. Ruben, MD**

This will be a presentation of many ideas concerning the fiscal management of a dermatology practice. Also to be presented will be a select group of therapeutic pearls gleaned from 30 years of private practice. Handouts will be distributed.

2) Fractional Lasers: An Update on the Facts and Controversies**Ashish C. Bhatia, MD**

Over the last few years, much of the buzz in dermatologic lasers has revolved around fractional laser technologies. With the numerous technologies currently available and under development, it may be difficult to understand this growing field. In this session, we will review the available technologies and take a critical look at the literature in this domain. The attendee will be able to discuss the indications, risks, benefits, and alternatives to the various fractional laser procedures after attending this session. We will also cut through the marketing hype with the assistance of an expert panel of fractional device users from the Noah membership.

3) Great Cases from The University of Vermont**Paul A. Krusinski, MD**

Come on consult rounds and attend Dermatology clinic at The University of Vermont. Cases will be presented in a CPC format as unknowns. The following disorders will be discussed: histiocytoid Sweet's syndrome, acrodermatitis chronica atrophicans, interstitial granulomatous dermatitis associated with tumor necrosis factor inhibitor, mucormycosis, pigmented purpuric dermatosis and mycosis fungoides with large cell transformation, nocardiosis, petal xanthoma associated with lymphedema and Noonan Syndrome, prurigo pigmentosa, Mohs micrographic surgery for recurrent basal cell carcinomas, and Kawasaki disease.

FIRST SCIENTIFIC SESSION

8:15 - 12:00 pm

1) HAROLD O. PERRY LECTURE – Challenging Cutaneous Malignancies**Marc Brown, MD**

Dermatologists are often challenged with unusual tumors. Some are very aggressive with a significant morbidity and/or mortality. Such tumors include Merkel cell cancer, angiosarcoma, atypical fibroxanthoma, microcystic adnexal carcinoma and dermatofibrosarcoma protuberans.

In addition, there are subsets of more common tumors that can be challenging to manage. These include high risk squamous cell cancers and certain melanoma subtypes, especially lentigo maligna. An overview of these tumors, as well as their management and treatment, will be discussed. The immunosuppressed patient and skin cancer risk will be highlighted.

2) Port Wine Stains: 2008 Therapeutic Update**Elizabeth McBurney, MD**

Port wine stains (PWSs) are a relatively rare type of capillary vascular malformation occurring in 0.3% of all newborns. In the past, treatments of PWSs have included radiation, excision with or without skin grafting, flesh colored tattooing, and a variety of lasers. For almost two decades the gold standard of PWS treatment has been the pulsed dye laser. Experience has demonstrated that lesions on the head and neck respond better than those of the extremities. Side effects are uncommon, but do include scarring, atrophy, hypo/hyperpigmentation. Several new advances in laser equipment such as cooling devices and different wavelengths have improved the results and allowed treatment

with higher fluences and longer pulse durations. Recent data shows that it is rare to achieve 100% lightening with laser therapy and more disturbing are the articles reporting reoccurrence of the PWSs a decade or more after completion of laser treatment. The untreated PWS matures with tissue hypertrophy and nodule formation and can also be a therapeutic challenge. Experience with using multiple wavelengths on the thickened PWS has demonstrated efficacy, but carries a higher rate of scarring than the pulsed dye laser.

3) Tolerability of Keloid Scars Post-shave Excision with Imiquimod 5% Cream: A Prospective, Double-blind, Placebo Controlled Pilot Study **Brian Berman, MD**

Background: Case series suggest the tolerability and efficacy of imiquimod 5% cream application to sites of tangentially shaved keloids. However, these observations have not been verified in double-blind, placebo-controlled studies. Objective: To determine the tolerability of the application of imiquimod 5% cream versus vehicle cream to tangentially shaved keloids. Methods: 20 subjects with tangentially shaved keloids of less than 2 cm in diameter at the base were randomized to be treated with either imiquimod 5% cream or vehicle cream every night for the first two weeks, beginning the same night as surgery, and then three times a week under occlusion with an over-the-counter, sterile, waterproof, clear, thin film dressing for one more month. Subjects were evaluated at baseline, 2 weeks, 6 weeks and 6 months for pain, tenderness, pruritus and keloid recurrence. Results: Tenderness and pain were significantly ($p=0.02$ and $p=0.02$, respectively) more at week 2 in those treated with imiquimod 5% cream than with vehicle cream, but not at week 6. 8/10 subjects treated with imiquimod 5% cream required temporary rest periods from the study treatment due to application-site adverse events (average total days off treatment = 8.75 days), but all were able to restart study treatment. Significantly fewer subjects in the control group (1/6) completing the treatment part of the study required a treatment rest period, $p=0.01$. There was no statistically significant difference in pruritus in the two groups. Conclusions: Imiquimod 5% cream was considered to be overall well-tolerated.

4) Actinic Keratoses: Every Patient Deserves Consideration for Field Therapy **Neil A. Fenske, MD**

Cryosurgery is clearly the ‘gold standard’ for treating actinic keratoses. Unfortunately, many patients are denied the opportunity to benefit from field therapy, an extremely useful adjunct for treating extensive disease as well as sub-clinical disease. Moreover, a secondary cosmetic benefit results many of these agents further supporting their use. A critical assessment of the data supporting the efficacy of cryosurgery will be presented along with data showing the efficacy of the many topical agents. Several off-label reports of novel treatment approaches will also be discussed.

5) Radiation Therapy in Modern Dermatology **Adam B. Bodian, MD**

“Use it or lose it!” X-ray therapy has been an important treatment option in dermatologists’ offices for almost 100 years. However, during the 1980s there was a dramatic decline of X-ray use in our field. This may have occurred as a result of the poor publicity of radiation or the decrease of teaching in resident training programs. Recently, there has been a revival of interest in both superficial radiation treatments and Grenz-ray therapy. The aim of the lecture is to briefly remind us of this therapeutic possibility and its continued role in modern dermatology

6) Hailey-Hailey Disease: Clinical Patterns and Response to Therapy **Kenneth J. Tomecki, MD**

Twenty-eight patients with Hailey-Hailey Disease (HHD) were evaluated at the same institution during a recent forty-year span. All patients were adults; most (20) were female and six were black. Twenty had similarly affected family members. All patients had typical skin disease—moist, macerated plaques in flexural and intertriginous areas. Most (24) experienced pain, burning, and/or itching. All patients had similar and characteristic histopathology—extensive acantholysis in suprabasilar bullae; ten had direct immunofluorescence, which was negative. Therapy, most often topical corticosteroids, antibiotics,

and/or anti-fungal agents, was uniformly unpredictable. Ten patients received dapsona with only negligible benefit. Eight patients had laser therapy, all with relatively good results. This review, perhaps the largest known series of patients, confirms that HDD is an uncommon entity with distinctive history, morphology, and histopathology. Therapy remains a challenge, but laser therapy is a promising approach for many patients.

7) Calciphylaxis in the Setting of Diabetes, Renal Failure and Normal Serum Calcium Levels

Carla Bauman, MD

A 59 year old woman with a history of diabetes, renal failure and a bowel bypass procedure for obesity was referred for evaluation of "chronic cellulitis unresponsive to antibiotics." Her history was significant for renal failure controlled with peritoneal dialysis and a recent hospitalization for peritonitis. She also had achieved through diet and surgery a greater than 50 pound weight loss. On exam, the patient had multiple, painful purple to livedo colored indurated plaques on both medial thighs and lower legs. Pathology of an incisional biopsy revealed foci of calcium in the fat lobules, rimming lipocytes and forming globular and crystalline aggregates. Calcium also was present focally in the walls of the blood vessels. Her immunofluorescence was negative. Pertinent laboratory serum tests revealed a normal calcium level, normal phosphate and an intact parathyroid level well within the normal range for a dialysis patient. Her sedimentation rate was 109. The patient was begun on aggressive wound care and ultimately managed with a parathyroidectomy and an empiric course of pamidronate, a bisphosphonate helpful in reducing osteoclast bone resorption. Prolonged infections and pain management issues have complicated her hospital course. The patient's condition is remarkable for having severe subcutaneous calciphylaxis in the setting of well-controlled serum calcium-phosphate product. We speculate that the patient's baseline nutritional status and possible impaired gastrointestinal absorption may have contributed to her medical condition.

8) Dermatologic Phantasmagoria and its Effect on the Socio-Political Environment

Gary W. Cole, MD

It has been estimated that there are about 1.8/100,000 dermatologists in the United States. Undoubtedly, smaller numbers of dermatologists are present in other countries. However, despite the scarcity these specialists, patients with dermatologic diseases play a disproportionate large role in current events. Anecdotal examples of this assertion will be presented from South America, Asia, Africa and the United States.

9) The Use of Topical Alpha Adrenergic Agonists in the Treatment of Erythematotelangiectatic Rosacea

Stuart D. Shanler, MD

Rosacea is a common chronic cutaneous disorder affecting over 40 million people worldwide. Type I, Erythematotelangiectatic rosacea (ETR), is the subtype of rosacea characterized by frequent episodes of transient facial erythema (flushing) and/or persistent erythema, and may be accompanied by facial edema, burning or stinging. ETR in general responds poorly to treatment and there are no effective topical therapies directed towards the erythema and telangiectasias. While rosacea remains a disorder of uncertain etiology and pathogenesis, the abnormal flushing and persistent erythema have usually been theorized to arise from a progressive dysregulation of the cutaneous vasomotor response resulting in an abnormal and persistent dilation of facial blood vessels. The mechanism of such dysregulation has never been elucidated. The regulation of the cutaneous circulation is extremely complex and activation of adrenoceptors (adrenoceptors) present on vascular smooth muscle may result in vasoactive changes that are difficult to predict. Recent studies, however, have demonstrated that the contraction of peripheral vascular smooth muscle is primarily mediated by $\alpha 1A$ and $\alpha 1D$ adrenoceptor subtypes, and certain experimental models indicate several $\alpha 2$ receptors may play a role as well. Early evidence that the erythema and flushing of ETR may be treated with topically applied oxymetazoline, a potent selective $\alpha 1A$ and partially selective $\alpha 2A$ adrenoceptor agonist - a potent vasoconstrictor, will be discussed, as will the concept that the erythema and flushing of ETR may be due to an abnormal expression, function, distribution, or responsiveness of a adrenoceptors, likely of an $\alpha 1$ subtype.

10) Update of Medical Vaccines in Dermatology

Neal Bhatia, MD

Medical vaccines are changing the approach to infectious diseases caused by viruses that affect the skin, such as HPV and VZV. Dermatologists need to be aware of the preventative benefits of these new interventions and make them part of their regular treatment regimens.

Monday, April 1, 2008

BREAKFAST ROUNDTABLES

7:00 - 8:00 am

1) Planning & Building a New Dermatology Office

James Zalla, MD

Thirty-five years of dermatology practice experience was applied to the process of planning and building a new 10,000 sq.ft. group dermatology space, including Mohs surgery, and dermatopathology lab within our 40,000 sq.ft. multi-office building. Tips on office layout, design, equipment, furnishings, lighting, phone and nurse call system, cost, negotiations, financing and more will be shared in this session. I will describe the complete process from concept to completion to 3 year follow-up, based on our group's recent experience.

Following this session, attendees will be able to:

1. Decide if they are suited for such a building project
2. Plan functional, efficient space and facilities
3. Recognize cost saving opportunities and negotiate better prices

2) Dermatological Threats from Exotic Pets

Ted Rosen, MD

The ever-expanding number and variety of "exotic" pets housed in American homes has led to both common and uncommon dermatological events. These range from dermatophytosis due to especially virulent fungi to severe cellulitis caused by unusual bacteria; allergic reactions may also be encountered, even when seemingly implausible. There is little readily available literature detailing the relatively new trend of disease acquired from exotic pets, putting the dermatologist at a severe disadvantage when confronted with this possibility. This session is designed to provide an efficient and pragmatic review of the subject for the interested practitioner.

Suggested reading: Rosen and Jablon: Infectious threats from exotic pets: Dermatological Implications. *Dermatol Clin* 2003;21:229-236.

3) CSI: North American Contact Derm Group – Interesting and Instructive Cases

James Taylor, MD and Christine Mowad, MD

Instructive and challenging cases of contact and other exogenous dermatitis from Cleveland Clinic and Geisinger Clinic will be presented in this special session utilizing our spongiotic and inflammatory detection techniques! A patch test clinic format will be used followed by discussion of clinical and diagnostic teaching points. Topics will include the value of testing standard patch test chemicals as well as the patient's personal products; cases of hand and foot eczema, latex allergy and contact urticaria; and putative reactions to implanted medical devices. Discussion will include newer allergens and older allergens that have resurfaced in this CSI Patch Test Clinic.

SECOND SCIENTIFIC SESSION

8:15 - 12:00 pm

1) ALFRED L. WEINER LECTURE – Cutaneous Manifestations of Agents of Bioterrorism

Boris Lushniak, MD

The U.S. public health system and healthcare providers must be prepared to address various biological agents, including pathogens that are rarely seen in the United States. High-priority agents (Category A) include organisms that pose a risk to national security because they can be easily disseminated or transmitted from person to person; result in high mortality rates and have the potential for major public health impact; might cause

public panic and social disruption; and require special action for public health preparedness. The Category A agents of bioterrorism (BT) include anthrax (*Bacillus anthracis*), smallpox (*variola major*), plague (*Yersinia pestis*), tularemia (*Francisella tularensis*), the viral hemorrhagic fevers (filoviruses and arenaviruses), and botulism (*Clostridium botulinum* toxin). All but the latter have cutaneous manifestations which may be the presenting features of a BT event. Anthrax and smallpox will be emphasized in this presentation. The lesions of anthrax and smallpox have important diagnostic features but can be confused with an extensive list of differential diagnoses. In addition, the adverse events associated with smallpox vaccination (vaccinia) have important cutaneous features which must be recognized by health care practitioners. The role of the health care practitioner in having a high level of suspicion and in accurately diagnosing and reporting these conditions is key.

2) Contact Allergens of the Year – A Review

Christen Mowad, MD

Each year, since 2000, an allergen is highlighted in the journal of the American Contact Dermatitis Society, *Dermatitis*. This allergen is selected by a group of experts within the field to represent allergens of new or emerging significance, increasing incidence, or other reasons of particular interest. We will review these allergens and discuss the significance of each including allergens such as blue disperse dyes, paraphenylenediamine, bacitracin and others.

3) Generic Drugs in Medicine

Peter Halperin, MD

The use and development of generic medication impinges on the worlds of pharmacology, economics, government and clinical medicine. Government enacts the laws that determine the availability of generics. Politicians and the media influence the public by claiming that generics are cheaper yet the same as branded forms. Pharmacists and health plan administrators echo the same principles. Health plans spend less money when their enrollees receive generic medicines. Less obvious is that pharmacists make more money when dispensing generics. But physicians and even patients realize that generics are sometimes less efficacious than original forms. Discussion of whether generic medicines must be identical to innovator compounds, appropriateness of generic substitution, and financial incentives to various parties will be examined. Whether topical generic medicines approximate branded topical medicines will also be discussed.

4) Chronic Idiopathic Urticaria – Diagnosis and Treatment

Diane R. Baker, MD

Chronic Urticaria is defined as the presence of recurrent transitory pruritic wheals occurring daily for at least six weeks, but in some cases lasting for years. Those cases that are not physical or vasculitic urticaria are called chronic idiopathic urticaria (CIU), and of those anywhere from 30 to 50% are autoimmune urticarias. The diagnosis of autoimmune urticaria can be confirmed by an in vivo positive autologous serum skin test (ASST) or a serum functional anti-Fc epsilon RI test. Autoimmune urticaria tends to be more severe and more resistant to standard therapy with antihistamines and may require systemic immunosuppressants to control. Methotrexate, cyclosporine and sulfasalazine have been used successfully in some patients. Clinical trials of omalizumab and rituximab are underway.

5) Contact Dermatitis – An Update

Christen Mowad, MD

Contact dermatitis is a common disease process that is comprised of allergic and irritant contact dermatitis. Allergic contact dermatitis affects patients of all types: surgical, laser, general dermatology, workman compensation, young, old, men and women. The gold standard for diagnosing allergic contact dermatitis is patch testing. In an ever-changing consumer market, new ingredients and new products are continuously being introduced. These chemicals have the potential to become new allergens. A physician's knowledge of these products, experience with patch testing, level of interest, access to allergens and stamina to provide through education to the patient, are all critical components that determine the reliability of the test and the benefits gained. This session will review these topics and highlight allergens of new and expanding significance.

6) Tidbits from Rx-derm
Gail E. Drayton, MD

The Internet has enabled dermatologists to communicate with many other dermatologists rapidly. Rx-derm, a dermatologist only site, is a source of information and place to exchange ideas. In this presentation I will share some of the interesting tidbits picked up from the list.

7) Report from the American Academy of Dermatology
James Taylor, MD

8) Things Therapeutic, Novel, and Wonderful
P. Haines Ely, MD

Each year Haines Ely reviews the therapeutic literature and picks out the good and bad. He also reveals some of his own therapies that prove useful. This year among these are bleomycin therapy of merkel cell carcinoma and griseofulvin therapy of bullous pemphigoid and epidermolysis bullosa. Therapies that work when you get home are emphasized.

THURSDAY, April 2, 2008

BREAKFAST ROUNDTABLES

7:00 - 8:00 am

1) Emergency Dermatology: Severe Drug Reactions
Paul A. Krusinski, MD

This case-based discussion will deal with life threatening drug reactions seen by the dermatologist. Included will be: Drug hypersensitivity syndromes (DRESS syndrome; Drug Reaction, Eosinophilia, and Systemic Symptoms), Toxic Epidermal Necrolysis, Anticoagulant necrosis to Coumadin and Heparin, and Minocycline hypersensitivity. Drugs implicated in these reactions are: allopurinol, azathioprine, carbamazepine, erythromycin, lamotrigine, nitrofurantoin, sulfonamides, trimethoprim, and minocycline.

2) Medicolegal Interactions: An Interactive Discussion
Robert P. Feinstein, MD and Gilbert Goldman, MD

Physicians deal with medicolegal matters on a daily basis. This interactive session will discuss interesting malpractice cases, as well as unusual medical/legal interactions, such as being an expert witness in a criminal or other civil trial, or involvement with national or international events. We will be presenting some of the most interesting events in our careers, with Dr. Feinstein discussing the clinical aspects and Dr. Goldman the legal interpretations of the cases. In addition, we hope to open the floor to anyone who has had a novel experience, and attempt to have the meeting become a round-robin discussion of some of the most unusual ways in which we as dermatologists have had the opportunity to be a part of and effect events inside and outside of our offices.

3) What's New in Acne and Rosacea
Guy Webster, MD

A leader in the field will present newer findings and thinking in acne and rosacea. Bench research and therapy will be presented and hopefully linked to the satisfaction of the participants.

THIRD SCIENTIFIC SESSION

8:15 - 12:30 pm

1) Surgical Complications
Marc Brown, MD

No matter how talented or experienced the surgeon, complications will occur. This talk will look in depth at the most common surgical complications: infection, bleeding, necrosis, and dehiscence. Discussion will include recognition, management and prevention of these complications. Specifically the use of perioperative antibiotics and

anticoagulants will be debated. Less common complications, such as hypergranulation tissue, contact dermatitis to topical preparations and unusual scars will be reviewed.

2) Cutaneous Squamous Cell Carcinoma: A Comprehensive Classification

Ronald J. Barr, MD, and David Cassarino, MD

Cutaneous squamous cell carcinoma (SCC) includes many subtypes with widely varying behaviors, ranging from indolent to aggressive tumors with metastatic potential. However, the tendency for pathologists and clinicians alike is to refer to all squamoid lesions as generic SCC. No definitive, comprehensive clinicopathological system dividing cutaneous SCCs into categories based upon their aggressiveness has yet been promulgated. Therefore, we have proposed the following based upon the malignant potential of SCC variants, separating them into categories of low(10%), and indeterminate behavior. Low-risk SCCs include SCC arising in AKs,HPV-associated SCC, tricholemmal carcinoma, and spindle cell SCC(unassociated with irradiation). Intermediate-risk lesions include adenoïd SCC, intraepidermal epithelioma with invasion, and lymphoepithelioma-like carcinoma. High-risk lesions include de novo SCC, SCC arising in association with irradiation, burn scars, and immunosuppression; invasive Bowen's disease, adenosquamous carcinoma, and malignant proliferating pilar tumors. The indeterminate category includes signet ring SCC, follicular SCC, papillary SCC, SCC arising in adnexal cysts, squamoid eccrine ductal ca., pigmented, and clear cell SCC. It is, therefore, recommended that histological subtype be reported with the diagnosis of SCC along with size, depth of invasion, degree of differentiation, perineural, and vascular invasion.

3) Histopathology of Central Centrifugal Cicatricial Alopecia

David A. Whiting, MD

Central centrifugal cicatricial alopecia (CCCA) is the current name for a condition previously known as hot comb alopecia or follicular degeneration syndrome. It has a characteristic clinical appearance, usually commencing centrally on the crown or vertex. It spreads slowly into a fairly symmetrical oval area resembling female pattern alopecia. It has an inflamed border with perifollicular scales, papules or pustules. Gradually, follicular ostia are lost and scarring becomes apparent. It affects mainly dark skinned patients of African descent (Blacks, African Americans) usually females, but occurs sometimes in whites and Asiatics. It has become increasingly common. In some clinics, it is the most common cause of cicatricial alopecia in a ratio of 3 females (average age 36 years): 1 male (average age 31 years). The condition is chronic and progressive but eventually burns out. A history of traction, heat, relaxers and permanent waves is common in female patients, but stopping these practices may not arrest disease progression. The clinical picture prompts diagnosis. Fungal and bacterial cultures may be indicated. 4mm punch biopsies of the scalp for horizontal and/or vertical sections, possibly with immunofluorescence should be taken from the active spreading margin of the balding area. Histopathological features include perifollicular inflammation of lower infundibulum and upper isthmus, premature desquamation of the inner root sheath in some cases and progressive thinning of external root sheath leading to distortions, rupture, hair granulomas, polytrichia and dense fibrosis. Analysis of 62 biopsies taken at BHRTC showed scalp hair reduction to 1 hair per mm² with 88% anagen and 12% telogen hairs and a terminal:vellus ratio of 3:1 with moderate to severe inflammation and fibrosis. CCCA accounted for 7.6% of the cases of cicatricial alopecia. Treatment includes topical corticosteroids and minoxidil, intralesional triamcinolone acetonide suspension (TAC) 5 to 10mg/ml, oral prednisone, hydroxychloroquine (eye exams), azathioprine and cyclosporine, and intramuscular TAC suspension 40 to 60mg. The avoidance of physical and chemical trauma is advised. Eventual hair restoration or a hairpiece may be needed. References: Sperling LC: *An Atlas of Hair Pathology with Clinical Correlations*. New York, Parthenon Publishing, 2003, p91

4) Biofilm - The Devil in Implants

Gary D. Monheit, MD

Biofilms are complex aggregations of microorganisms marked by the excretion of a protective and adhesive matrix. Biofilms can envelop any inanimate surface and can act as a complete unicellular organism with signaling systems. They can be disastrous when they involve permanent implants. Their etiology, basic science and management will be discussed.

5) Office Headaches and Their Cures

Michael Greenberg, MD

As much satisfaction as can be derived from the practice of dermatology, the everyday issues that we encounter in the running of our practices can create stress—office headaches. In this session, the root causes of these office headaches are uncovered and practical solutions to ease them are offered. Participants will be provided with a “black bag” of remedies that can “cure” even the most difficult of problems.

6) Adnexal Carcinoma Arising in a Nevus Sebaceum in an Eight-Year-Old Girl

Paul A. Krusinski, MD

An eight-year-old girl with a nevus sebaceum on her right cheek since birth returned to clinic because the papule had increased in size (diameter) and had become more raised over the preceding two months. Because of its changing course it was excised. The patient’s past medical history included seizures and pulmonic stenosis. Biopsy revealed a polypoid central portion containing evidence of an infiltrating carcinoma in keeping with the features of a microcystic adnexal carcinoma. This was contained within a nevus sebaceum. Special stains supported an eccrine or apocrine origin. Nevus Sebaceum (NS) is present at birth as yellow/orange sometimes linear papules or plaques that become thicker and/or verrucous at puberty and may later in life develop secondary neoplasms (10-30%). Such tumors may include basal cell carcinoma (1%), trichoblastoma (10%), Syringocystadenoma papilliferum (10-20%), squamous cell carcinoma, syringoma, apocrine cystadenoma, osteoma, keratoacanthoma, tricholemmoma, sebaceous adenoma, poroma, apocrine carcinoma, and adnexal carcinoma. Widespread or large NS have been linked to the epidermal (organoid) nevus syndrome and may be associated with other medical conditions which include: ocular tumors, mental retardation, seizures, intracranial vascular malformations, skeletal and cardiac abnormalities. This is a very unusual case since the lesion was exceptionally small to be a forme fruste of the organoid nevus syndrome with seizures and pulmonic stenosis. Likewise, onset of a secondary malignant tumor at this young age is previously unreported.

7) The Etiology Of Eyelid Dermatitis: A 10-year Retrospective Analysis

Donald Belsito, MD

Few studies have examined the etiology of eyelid dermatitis across broad demographics. The objectives of this study were (i) to compare the diagnoses of patients with isolated eyelid dermatitis to the diagnoses of patients with eyelid dermatitis and additional sites of involvement; and, (ii) to determine the relevant allergens among patients with allergic eyelid dermatitis. A retrospective analysis of 1215 patients, 105 of whom had eyelid dermatitis, who were patch tested over 10 years was conducted. Compared to patients without eyelid dermatitis, patients with this entity were more often female, but were no more likely to have an atopic diathesis. There were no racial or age differences between patients with or without eyelid dermatitis. Of the 105 patients with eyelid dermatitis, 43.8% had allergic contact dermatitis (ACD), 36.2% seborrheic dermatitis, 11.4% other dermatitis/dermatoses, 7.6% irritant contact dermatitis, 3.8% psoriasis, and 2.9% atopic eczema. When only the eyelid(s) was (were) involved, seborrheic dermatitis was the most frequent diagnosis (46.3%) followed by ACD (35.2%). Allergens commonly causing allergic eyelid dermatitis included fragrances, metals, neomycin, oleamidopropyl dimethylamine, tosylamide formaldehyde resin, benzalkonium chloride, and other preservatives. Of note, compared to patients without eyelid dermatitis, those with eyelid dermatitis were significantly more likely to be allergic to fragrances, oleamidopropyl dimethylamine, tosylamide formaldehyde resin and benzalkonium chloride. A majority of the causative allergens for eyelid dermatitis are not present on the Food and Drug Administration (FDA)-approved patch test panels available in the USA. Thus, practitioners evaluating patients for potentially allergic eyelid dermatitis must be prepared to patch test with non-FDA-approved allergens.

8) Melasma-like Facial Hyperpigmentation**Allan S. Wirtzer, MD**

A female presented with facial hyperpigmentation in a melasma-like rather common pattern on the cheeks. The condition was initially diagnosed as melasma, but failed to respond to UV avoidance and bleaching preparations. A biopsy was performed and an uncommon condition, mastocytosis/TMEP was diagnosed.

9) 11:10 The Microecology of the Skin**Guy Webster, MD**

The determinants of the skin microflora and its role in disease will be presented.

10) The Tri-wizards Tournament**Stuart M. Brown, MD, P. Haines Ely, MD, and Stephen P. Stone, MD**

A clinical pearls session with cases from the masters and questions from the audience, asked on site or sent in advance to noahsci@gmail.com. This is a follow-up by popular demand to the 2006 session "Wizard at Work" that was so popular at our previous meeting in Los Cabo.

FRIDAY, April 3, 2008**BREAKFAST ROUNDTABLES**

7:00 - 8:00 am

1) Documenting Acne and iPLEDGE for Profit and Protection**Joseph Bikowski, MD**

This presentation will discuss two topics. The first is a new acne grading system to be used in clinical trials and for improving the accuracy of chart documentation of acne severity in clinical practice for quality of care, medical-legal purposes and third-party reimbursement. The second is why and how the presenter implements the iPLEDGE program in the clinical practice of dermatology. Emphasizing how iPledge protects the prescriber and a method for having the female patient document in the medical record their understanding of and agreement to comply with the iPLEDGE program.

2) Therapeutic Pearls**Stuart M. Brown, MD**

A discussion format wherein attendees offer ideas that have been successful in their practices in managing a variety of disorders. The group will then be stimulated to get involved in the discussion to amplify the concepts. These pearls can be old, new, borrowed or blue.

3) The Therapy of Moderate to Severe Psoriasis with Photo and Systemic Drugs (our pre-2000 therapies) Exclusive of Biologics**Gerald Weinstein, MD**

In a straw poll that I obtained about the treatment of moderate to severe psoriasis, the use of phototherapy (BBUVB, NBUVB, and PUVA), methotrexate, acetretin, or cyclosporine was the first choice of about 80% of the doctors before using "Biologics". There were obvious patients that warranted a biologic. This talk will update the usage of these therapies at the present time since they are infrequently discussed now in lieu of biologics.

FOURTH SCIENTIFIC SESSION

8:15 - 12:45 pm

1) Pandemic Influenza – Planning and Preparation**Boris Lushniak, MD, MPH**

Previous outbreaks of pandemic influenza in the 20th Century have shown us that pandemics are unpredictable and inevitable. This lecture will emphasize the basics of influenza and the conditions necessary for a pandemic, specifically looking back in history at the features of the 1918-1919 pandemic, which resulted in over 40 million worldwide deaths. The world has changed since 1918 and pandemics in the 21st century may have

completely unique features and impact society in a different way, but to some extent basic public health approaches will still be utilized. Preparedness planning is being undertaken at the global (World Health Organization) and national levels. The cornerstones of pandemic preparedness include the development of vaccines, use of antiviral medications, and community public health measures (social distancing, hygiene practices, use of personal protective equipment). This approach is a difficult undertaking in that there are many unknowns associated with the next pandemic. Unanswered questions include – when will the pandemic occur, what will be its level of severity, which influenza viral subtype will be the cause and what will be its characteristics (e.g., levels of resistance to antivirals). The ultimate goal of all planning and preparedness is to protect the public's health in the event of a pandemic.

2) Cosmetic Botulinum Toxin Type A (BOTOX®) Consultation – Do it right! Kevin C. Smith, MD

Video of a typical consult will be shown, and a handout will be distributed deconstructing the consult into its essential elements:

- 0008 Brought in BOTOX® tray, ready to treat patient.
- 0012 Addressed patient by name
- 0020 Review previous Rx and ask about results
- 0030 Is there anything else I can do for you today?
- 0040 BOTOX® for DAO made my mouth feel funny
- 0045 Examine patient for dynamic facial lines
- 0055 Give patient Kleenex® before starting Rx
- 0105 Review treatment plan and post treatment instructions
- 0130 Take social history so treatment does not interfere with plans
- 0150 Explain REASONS for post-treatment instructions
- 0210 Enquire about ongoing medical issues, e.g., rosacea
- 0215 Advice re sun protection
- 0225 Discuss follow-up BOTOX® treatment
- 0325 Bill patient BEFORE you treat them, to prevent sticker shock
- 0335 Allergan patient retention program
- 0400 Crows feet Rx
- 0405 Static and dynamic exam of patient before treatment
- 0420 Enquire about patient comfort during Rx
- 0505 Wipe blood off after Tx, apply pressure on bleed points
- 0535 Frown lines
- 0610 Effective use of pre-treatment photos
- 0635 Add on frown line Rx

3) Creating Perfect Lips: A Morning at the Movies Roberta Sengelmann, MD

Lip augmentation is more than just about injecting the latest, greatest substance into the mouth for volume enhancement. In fact, doing so without consideration of the architectural detail of the mouth and what is needed to restore youthfulness, will lead to disastrous results. I will walk you through my approach to lip augmentation that has been successful for years. Video will be shown, as time permits.

4) Laser Hair Removal Consultation – Do It Right! Kevin C. Smith, MD

Video of a typical consult will be shown, and a handout will be distributed deconstructing the consult into its essential elements. Note the structure of the consult, the tone, the choice of words and turn of phrase.

5) Filler Complications Allan S. Wirtzer, MD

Many dermatologists utilize one or a variety of injectable filling agents to offset the loss of volume associated with aging. Most presentations emphasize their effectiveness and safety. However all filling agents can produce complications. This presentation will review the common and less common complications associated with fillers that all dermatologists should be aware of.

6) Botulinum Toxin Type A for Hyperhidrosis Consultation – Do It Right!
Kevin C. Smith, MD

Video of a typical consult will be shown, and a handout will be distributed deconstructing the consult into its essential elements. Note the structure of the consult, the tone, the choice of words and turn of phrase. Compare, contrast and critique the various types of consults.

7) Challenging Mohs Repairs and Pearls
Roberta Sengelmann, MD

With an aging population and skin cancer on the rise, it behooves all of us, not just fellowship trained Mohs surgeons, to be well versed in cutaneous reconstruction. I will share a compilation of challenging repairs from my practice and discuss my thought process in choosing a particular option as well as a bit of a “how to” for many of the repairs discussed. Even the experienced reconstructive surgeon should enjoy and learn a few pearls from my practice.

8) Vascular Laser Consultation – Do It Right!
Kevin C. Smith, MD

Video of a typical consult will be shown, and a handout will be distributed deconstructing the consult into its essential elements. Note the structure of the consult, the tone, the choice of words and turn of phrase. Compare, contrast and critique the various types of consults. Note how the aesthetic consult differs from a medical or surgical consult.

9) Surgical Panel Discussion
Drs. Smith, Sengelmann and Wirtzer

10) Noah: A Living History
Michael Greenberg, MD, et al

Join some of our Charter Members and “Grand Masters” as they reminisce and share not only stories, but also the legacy of excellence that makes Noah Worcester Dermatological Society not just another medical organization but a unique family whose members are the heart and soul of our specialty. This will be especially valuable for newer members who will gain an even deeper appreciation of the traditions as they create our future. Spouses are welcome to join this part of the scientific session. Our history is a continuum that includes you. Please bring your own stories to share with the group even if they happened as recently as today— but if sharing is not your thing, just come and enjoy listening to others.