foreFRONT CENTER AND

Q4 NEWSLETTER | October 2021 Edition

President's Message: Do Scary Things!

By: Betsy Wernli, MD, FAAD

The season of Fall has so much meaning, a turning over of another season, visible by both changes of colors and weather. Historically, fear has been a seasonal focus, with a touch of fun during the Halloween holiday. But doesn't it seem like fear has started to seep itself into daily life year-round? You cannot turn on the evening news without spiking some anxiety from local to international events. We are living in fear like never before. But, I do believe fear can be a good thing. Fear can fuel or freeze your personal growth.

In a world filled with fear, I have decided I will be fueled and do something that scares me daily, a mantra lived out by a legend, Eleanor Roosevelt. She was a rock star in her own right, ahead of her time as a champion for women's rights, civil rights, and focusing on the forgotten. And her bold actions led to reactions that scared her. For example, she was placed on the communist watch list by the head of the FBI, J. Edgar Hoover, for upending the status quo as a woman in America. Speaking out against her actions as a woman at that time was so outside of the traditionally thought woman-mold, she was considered to be working with the communists. Add on the bounty placed on her head by the Ku Klux Klan of $25,000 for her civil rights activism. She focused on medical care and on many humanitarian causes throughout her life. During World War I, she was the mother of six children and a passionate volunteer for the Red Cross and Navy hospitals. She went on post-White House to help draft the Universal Human Declaration of Rights for the United Nations. She died at age 78 with the triad of tuberculosis, heart failure, and aplastic anemia. Her legacy lives on, her work impactful long after her death. She said, "You gain strength, courage, and confidence by every experience in which you stop to look fear in the face. You can say to yourself, 'I have lived through this horror. I can take the next thing that comes along.' You must do the thing you think you cannot do."

Do something every day that scares you; we all should channel a piece of that courage in our day-to-day with the realization that fear is only unhealthy when you fail to attack it, face it head-on, and show it who's boss.

So this spooky season, let's do something scary together. Maybe you have always wanted to learn a new procedure or add a service, but the fear of failure has halted progress. I know I am guilty of this, so I am facing that fear by launching retail in my clinic like never before, complete with staff incentive programs, monthly specials and lunch and learns, and even a men's line! What service is lacking for your patients in your clinical realm? We have such an arsenal of experts to help you accomplish any goal at Forefront, from medical to surgical and cosmetics to retail!

And we cannot forget growth outside of the clinic because it leads to a more satisfying work-life. Personally, to keep up with the boys, I purchased a new two-stroke and have amped up my motocross, leaving the track exhausted after chasing the boys and attempting the tabletops; my scare for the day.

What will you do this spooky season to drive you, your family, your clinic to success? Please share your stories, your ideas on Workplace and inspire us all! Are you lacking inspiration in general? We have two new additions to ForeFront & Center: a cosmetics column and something special for food and wine lovers. And, of course, get inspired by patient excellence tips, pediatrics, and pathology, along with the latest literature. Grab a glass of wine or cup of hot cider, turn the pages of this quarter's newsletter, and take in the amazing culture and colleagues we are so blessed to share in the Forefront Family!

Sincerely,

Dr. Betsy Wernli

Table of Contents

Click to jump to a page.

The Board Report: Scope of Practice

By: Adam Asarch, MD, FAAD, FACMS

At Forefront Dermatology, we have truly separated ourselves as leaders in dermatology. We focus on physician leadership, autonomy, and support.

Our colleagues at the American Academy of Dermatology, academic institutions, and practices throughout the country have certainly noticed that we are a unique group that has grown without compromising professional standards, or physician leadership. Dr. Betsy Wernli and the physician board of directors always make decisions with these core principals in mind, and these guiding beliefs remain the key to our success.

Given the large size of our group, disagreements on scope of practice can certainly arise between our practitioners. Fortunately, debates on clinical practice will always be confined to our dermatologists, and clinical decisions will only be made by our physicians, PAs and NPs. Our support team, are the first to uphold this tenant of clinical autonomy. The central support that we (the practitioners) receive at Forefront is truly unparalleled, but decisions on scope practice and patient care will only be made by our physicians. Your physician board of directors constantly measures decisions made against our original values, in order to uphold the field of dermatology. These decisions are not always easy, or fun, but are always made to ensure the quality we profess at Forefront.

Many may have noticed the recent controversy surrounding the decision by the American Society of Mohs Surgeons' (ASMS) Board of Directors to allow non-board certified dermatologists such general surgeons, plastic surgeons, otolaryngologists, and ocoluplastic surgeons to train in Mohs and to join their society. At Forefront Dermatology, we have have Mohs surgeons from both the ASMS and the American College of Mohs Surgeons (ACMS). Both groups are outstanding and integral to our practice, but all are board certified dermatologists. We, on the physician board of directors, unanimously opposed this decision by the ASMS, and have worked



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>> Return to Table of Contents

feverishly to distance Forefront from this decision by the ASMS BOD, while encouraging the ASMS to amend their motion. We continue to strongly hope that the ASMS Board of Directors will reverse this decision.

Further, we agree with that position statement of the ACMS that "Micrographic Dermatologic Surgery is a complex, multifaceted field requiring specialized and rigorous training in surgery, pathology, laboratory medicine, cutaneous oncology, and reconstruction built on the foundation of skills and knowledge attained through residency training in dermatology. Expertise in Mohs surgery is best achieved through the high volume, closely supervised training." We also advocate for MDS Board Certification for our ASMS and ACMS Mohs surgeons, which is limited to board certified dermatologists.

"Micrographic Dermatologic Surgery is a complex, multifaceted field requiring specialized and rigorous training in surgery, pathology, laboratory medicine, cutaneous oncology, and reconstruction built on the foundation of skills and knowledge attained through residency training in dermatology."

As I have said many times, Forefront has focused on attracting and retaining outstanding board certified dermatologists and new partnerships. The physician board strongly believes in the talent of our outstanding dermatologists as well as our physician assistants and nurse practitioners. Regardless of our growth, we will always focus on maintaining professional standards, physician autonomy, and physician leadership.

Forefront Forum: Big Scary Goals!

By: Tori Negrete, MD, FAAD

Raise your hand if you've ever been scared by a big goal. If you're raising your hand, don't worry. You're not alone. If your goals scare you, that simply means that achieving them would have a dramatic impact on your life. Your goals should scare you enough that they change your behavior and get you thinking creatively but are still within the realm of possibility for you. To start achieving your goals, begin with the acronym SMART to set realistic goals that make them a little less scary to reach.

S M A R T

Specific
Set goals that are well-defined, clear, and unambiguous.

Measurable
Set goals with specific criteria that allow you to measure your progress toward the fulfillment of the goal.

Achievable
Make the goals attainable and not impossible to achieve.

Realistic
Make the goals within reach, realistic, and relevant to your life purpose.

Timely
Set goals with a clearly defined timeline, including a starting date and a target date. The purpose is to create urgency.

>> Return to Table of Contents

The Extra Mile: Don't be Spooked by the Upset Patient

By: Giacomo Maggiolino, MD, FAAD

We all get one sooner or later, that email titled "Patient Concern." It is hard not to take it personally as hard-working physicians, PAs, and NPs who have dedicated our lives to caring for others. Our first reaction may be to become defensive and upset. We can feel offended, hurt, and unappreciated. But, if we look at these complaints as an opportunity to impress the patient, we do not have to be afraid of them any longer.

Patient concerns can be opportunities for us to demonstrate outstanding service and reinforce to the patients that we care about them. Furthermore, use the patient concerns as an opportunity to utilize patient feedback to identify system failures, performance problems and implement quality improvement. Here are a few tips that I have found helpful in dealing with patient concerns.

01. Don't take it personally

Despite our best efforts to continually provide Service Excellence, we will all encounter conflicts, miscommunications, and upset patients. It is impossible to make everyone happy all the time, and complaints are bound to happen. A patient's experience is complicated by a myriad of external factors which we may have no control over. Calm yourself down before responding or reacting to these concerns.

02. Call the patient yourself

I cannot stress how important this is and what a difference it makes. It is easy to have your team lead call and manage these concerns. But many times, if we take the time to call the patient personally, they will be much more impressed because it shows them that we do indeed care. I have been much more successful at retaining patients by personally reaching out to them.

>> Return to Table of Contents

03. Listen and validate

Many times, patients just want to vent their frustrations to someone willing to listen. It is better to have them vent to you than for them to go online and find an alternative outlet. Place yourself in the patient's shoes, and let them know that you understand their frustrations. Offer a statement of empathy (e.g., "I am sorry that ...," or "I understand that ..."). Summarize what they have said so that they know that you were listening.

04. Don't become defensive

It is not about who is right. Do not argue, pass blame, or interrupt with explanations. Be sure to control your emotions. Remember that your goal is to retain this patient. You can do so without agreeing to guilt on your part or on behalf of the practice. You can extend understanding without necessarily finding agreement.

05. Salvage the relationship

Ask how you can make things right. Suggest solutions you can perform. Let the patient know that the complaint is being taken seriously. Explain that it will be reviewed and discussed with your team lead and management and that they can expect a response (e.g., "I will contact ... and ask her to get back to you"). Thank the patient for taking the time to notify you of the complaint. Stress that patient satisfaction is a critical component of quality patient care in your practice.

>> Return to Table of Contents

Diversity in Dermatology: iPLEDGE Change for Gender-Neutral Language

By: Sarah Taylor, MD, FAAD

October is a wonderful month, ushering in a change of season, crisper weather, and of course, Halloween. The change of seasons can often inspire us to get out of our comfort zones and explore areas for growth, both personally and professionally. Though getting out of our comfort zones can sometimes be uncomfortable and a bit scary, it can also be an opportunity for positive change.

One significant change that has recently occurred and is relevant to dermatology is the FDA's decision to make the iPLEDGE Program language more inclusive for transgender and gender-diverse patients. If you are not familiar with many transgender or gender-diverse patients, it can be intimidating to understand and connect with them. However, breaking out of one's comfort zone and learning about our transgender and gender-diverse patients can go a long way in making our offices a more welcoming environment.

Beginning this December, the language will change for registering iPLEDGE patients. Currently, there are three categories to register patients regarding gender: females of reproductive potential, females not of reproductive potential, and males. However, for our trans and gender-diverse patients, these categories can be limiting, confusing, and certainly not inclusive. I will never forget the first transgender patient I registered for iPLEDGE several years ago while still serving in the military. A military-

dependent born female, but knowing inside his true gender was male, he was undergoing hormone therapy with testosterone. Of course, this therapy exacerbates acne and often requires isotretinoin for optimal control. Once the acne became quite severe, he sought care in our clinic. It took him longer than the average patient to seek care due to understandable fear of how our office might approach him.

Transgender patients often experience angst and anxiety at doctors' offices, as offices may not always be gender-affirming in their practices. For instance, in our electronic medical system in the military, the patient showed as female. However, my patient presented as male and went by a different shortened name. This caused my secretary to come to me, questioning if this was the right patient, asking the patient multiple times for ID, etc. Once the patient was past the front desk, he was confronted with the current registration choices for iPLEDGE, which also presented options that didn't reflect his identity. The entire process can leave a patient feeling sad, frustrated, unseen, and unheard.

I welcome the changes iPLEDGE will make in December. The new categories simply ask the individual to identify as either a patient who can get pregnant or a patient who cannot get pregnant. This is more inclusive for patients who are transgender or gender-diverse and allows us as dermatologists to remain focused on the importance of pregnancy prevention. Many fellow dermatologists have lobbied long and hard for these changes, and I am pleased to see their efforts make a difference.

Though it may only be a small segment of our patient population, it's worth asking how we can be more welcoming and inclusive to our trans and gender-diverse patients. Do the intake forms only have boxes to check for males or females? This can feel limiting. Are bathrooms marked as male and female, or simply as restrooms? Does your staff know to refer to the patient with their chosen name and not just the name on their intake form or official ID? Some patients may not have had the chance to change their name legally but prefer to go by their chosen name rather than the one given at birth.

"Though it may be a small segment of our patient population, it's worth asking how we can be more welcoming and inclusive."

Although it can be challenging, be willing to get a bit uncomfortable, learn more, and meet patients where they are. If you feel uncomfortable with terminology, there are many good resources to educate yourself. Remember, too, that the trans and gender-diverse communities are not a monolith, so it's important not to make assumptions. It's ok to ask your patient questions; don't feel afraid to do so! But keep in mind, it is not their job to educate you.

Resource articles

The following resources aim to learn about ways to make sure your office is a welcoming and not an intimidating or scary place for trans and gender-diverse patients. Hopefully, October can be a month of breaking out of our comfort zones and experiencing positive change and growth for the benefit of ourselves, as well as for our trans and gender-diverse patients. Here's to embracing change and being open to learning about the many diverse segments of our patient population!

Explore the article links below to learn more:

- Creating a trans affirming medical office
- Creating a safe and welcoming clinic environment
- Transgender health in medical education

>> Return to Table of Contents

keeping up with the Kids

By: Sapna Vaghani, MD, FAAD

What could be scarier than coming home after a long day of clinic and finding THIS in your mailbox? The Pediatric Dermatology Journal.

Perhaps a waiting room full of screaming children; that would be even more terrifying, no?! Well, fear NOT! This quarter, I'm going to break down the most recent issue of Pediatric Dermatology for you so that you are armed and ready when these scary, little people walk, crawl, or roll into your clinic.

Toenails

What is more freaky than toddlers' toenails? They're often brittle, oddly shaped, and don't always grow normally. Moms always want answers! "Will my baby's toenails always look like this? Can we check some blood tests?" What do you do when the nails truly are abnormal, and you need to treat for onychomycosis? Do you check labs or not? A recent survey was conducted to 121 members of the Society for Pediatric Dermatology (SPD) and the Pediatric Dermatology Research Alliance (PeDRA). Of this group, 77% of respondents identified themselves as pediatric dermatologists, with 51% practicing in an academic setting. 88% always or almost always confirmed the diagnosis of onychomycosis before prescribing oral therapy. Regarding lab monitoring, 39% always or almost always routinely order baseline laboratory tests while 40% never or rarely do; similar percentages monitored labs during therapy. 91.5% have never discovered a significant reaction to terbinafine with routine monitoring.

What do I do? I almost always confirm the diagnosis via DPAS or fungal culture. I never order laboratory studies unless my patient has significant underlying medical issues or other medications that can impact hepatic function.

Nail Abnormalities

What about congenital nail abnormalities? A retrospective observational case series from the University of Massachusetts Medical School and Dartmouth was conducted on 12 patients with neonatal abstinence syndrome (NAS), which

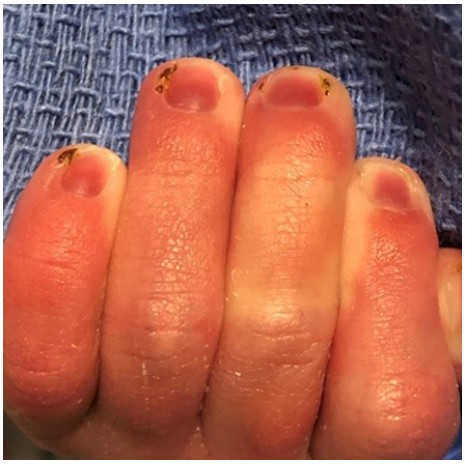

Figure 1: Left fingernails with dark yellow-brown crescent-shaped crusting, desquamation, and areas of sheared periungual skin hanging from the base (hangnails).

is rising due to increasing opioid use in pregnancy. Common nail findings included periungual erythema, yellow crusting, desquamation of the proximal or lateral nail folds, and sheared distal nail edges. 100% had severe NAS, failing standard-of-care, non-pharmacologic therapy. Multiple pathogenic mechanisms have been proposed, including trauma secondary to NAS-associated agitation, tremors, and myoclonic jerks, as well as the self-soothing mechanisms that can result from self-soothing behaviors. Poor feeding is also a sign of severe NAS, increasing the risk of poor weight gain and nutritional deficiency.

Headaches and Eczema

The adorable little ones that come to your clinic may give some of you headaches, and many of them have eczema. But is there a deeper connection between headaches and eczema? Dr. Jonathan Silvererg recently analyzed data from Northwestern from a longitudinal birth cohort study of nearly 5000 urban children born in 1998-2000. Atopic dermatitis was associated with headaches at age 5 and 15 years. Eczema at the age of 9 was associated with higher odds of subsequent headaches at age 15. Persistent atopic dermatitis in childhood was associated with headaches in adolescence. This review suggests that atopic dermatitis precedes the development of headaches in a subset of children and that headaches may be a symptom of more severe and uncontrolled atopic dermatitis. The mechanism linking the two is unknown. However, AD patients with headaches may have increased T-helper 2 inflammation; studies have demonstrated increased levels of the T-helper 2 cytokine IL-13 in children and adolescents with tension headaches and migraines.

Anogenital Warts

So which single diagnosis gives this pediatric dermatologist chills? Anogenital warts (AGW). The circumstances are often quite challenging to navigate, and the question is always this: to report or not report? A systematic review of studies published before 2018 was conducted with a goal to evaluate the association between AGW and sexual abuse in children 12 years of age or younger concerning wart location, age, and gender. 25 studies encompassing nearly 800 subjects were summarized, with 10 studies (200 subjects) included in the statistical analysis. Approximately 20% of all subjects with AGW were abused or probably abused, similar to other studies. Overlapping HPV types were found in abused and non-abused subjects. Perianal location and gender were not significant predictors of abuse. Of those with perianal warts only, the incidence of abuse was 17% compared to 35% in those with genital warts only. Both age and genital wart location (penis and vulva) did significantly predict sexual abuse. The odds ratio for sexual abuse was increased for children over 2 years; 7.45 for ages 3-4 years, 6.52 for ages 5-8, and 6.93 for ages 9-12 years. In all studies where a perpetrator was reported, it was a male family member or male family acquaintance.

Resources

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What room does a ghost not need?

A living room

>> Return to Table of Contents

HOT OFF THE PRESS

By: Katie Hunt, MD, FAAD

Your fast and furious bite-sized review of the latest literature

mRNA Vaccines

Skin reactions to mRNA vaccines: ~4% of patients reported cutaneous reactions after their 1st (1.9%) or 2nd (2.3%) dose of the mRNA vaccine.

- Rash and itch were most common.
- Of the patients who had a reaction to the 1st dose, 95% pursued a second dose; of those, 83% reported no recurrence the 2nd time.
- Cutaneous reactions are not a contraindication to vaccination and referral to dermatology or allergy is not indicated for these patients.
- *Reference: Robinson et al. JAMA Dermatology June 2021.*

Hidradenitis Suppurativa

Antibiotics for hidradenitis suppurativa: no significant efficacy difference between tetracyclines (majority doxycycline) and clindamycin/rifampin irrespective of disease severity.

- *Reference: Straalen K et al. JAAD August 2021.*

Oral Isotretinoin

Oral isotretinoin litigation.

- Pediatric patients received more favorable verdicts.
- Psychiatric cases more commonly ruled in favor of physician.
- Reproductive cases were mixed:
  - Before iPledge: four cases ruled against physicians who did not assess pregnancy.
  - No statistical difference in verdicts for patient when pre-iPledge and post-iPledge cases were compared.
- Adverse gastrointestinal effect cases awarded most wins to patients (against drug company and physicians combined) but most occurred before the label change in 2000.
  - There is currently, insufficient evidence to prove either an association or causal relationship between IBD and isotretinoin use (AAD 2016).
- *Reference: Martell et al. JAAD August 2021.*

Stage III Melanoma

Patients with resectable stage III melanoma may benefit from referral to medical oncology, in addition, to surg onc for neoadjuvant checkpoint inhibitor therapy.

- *Reference: Carlino et al. Lancet Sept 2021.*

Pemphigus Vulgaris

Rituximab was superior to mycophenolate mofetil in treatment of pemphigus vulgaris.

- *Reference: Werth et al. New England Journal of Medicine June 2021.*

Simultaneous PDT

"Simultaneous PDT" offers less pain and greater simplicity.

- A small (n = 23), split-face study of face and scalp PDT found less pain and no significant difference in % decrease of actinic keratoses when comparing simultaneous with traditional PDT.
  - Simultaneous PDT - aminolevulinic acid applied and then face or scalp immediately illuminated with blue light for 30, 45, or 60 minutes.
  - Traditional PDT—1 hour incubation before illumination for 1000 seconds.
- *Reference: Kaw U et al. JAAD April 2020.*

Exanthem

Exanthem, viral or drug? Viral etiologies most likely to display an enanthem than drug.

- This series of 21 COVID patients had an enanthem ~30% of the time.
- All enanthems were macular and/or petechial and located on the palate.
- No enanthems were vesicular.
- *Reference: JAMA Dermatology July 2020.*

>> Return to Table of Contents

Under the Scope: Merkel Cell Carcinoma (MCC)

By: Will Patino, MD

Merkel cell carcinoma (MCC) is an uncommon but highly aggressive primary cutaneous neuroendocrine carcinoma. The number of cases of MCC is increasing rapidly, having quadrupled in the past few decades to over 2,000 new cases per year in the United States.[1] While still relatively rare, more people are developing this skin cancer than ever before. Between 2000 and 2013, the number of MCCs diagnosed increased by 95%.[2] Because MCC is so aggressive, finding it early can be life-saving.

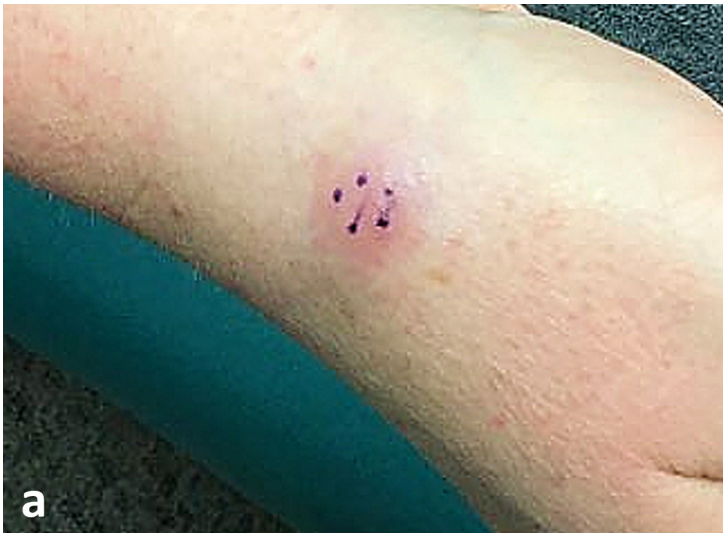
Clinical presentation

Some clinical characteristics that might help identify this type of skin cancer can be remembered with the acronym **AEIOU: A**symptomatic/ lack of tenderness; **E**xpands rapidly and it usually becomes noticeably bigger in a few weeks to months; **I**mmunosuppressed patients; **O**lder than age 50 (although most people are in their 70s or 80s); And **U**V exposed sites such as head and neck (50% of cases), and the extremities (40% of cases). The tumors usually present as a red or violaceous nodule that usually measures 2 cm or less in diameter.[3-5]

Pathogenesis and histological features

The precise histogenesis of MCC is uncertain. However, sun exposure, immunosuppression, and Merkel cell polyomavirus are the main risk factors associated with the development of this neoplasm.[3]

Diagnosis requires microscopic evaluation as the clinical appearance is nonspecific and can mimic a variety of benign and malignant skin lesions. Histologically, the tumor is commonly located in the dermis and often there is extension into the subcutaneous fat. However, in up to 10% of cases there is intraepidermal spread, including Pautrier-like microabscess formation, and therefore cutaneous T-cell lymphoma and superficial spreading melanoma enter the differential diagnosis. Histologic evaluation shows a nodular or diffusely infiltrative tumor composed of small round blue cells with high nuclear-cytoplasmic ratio, round nuclei, finely



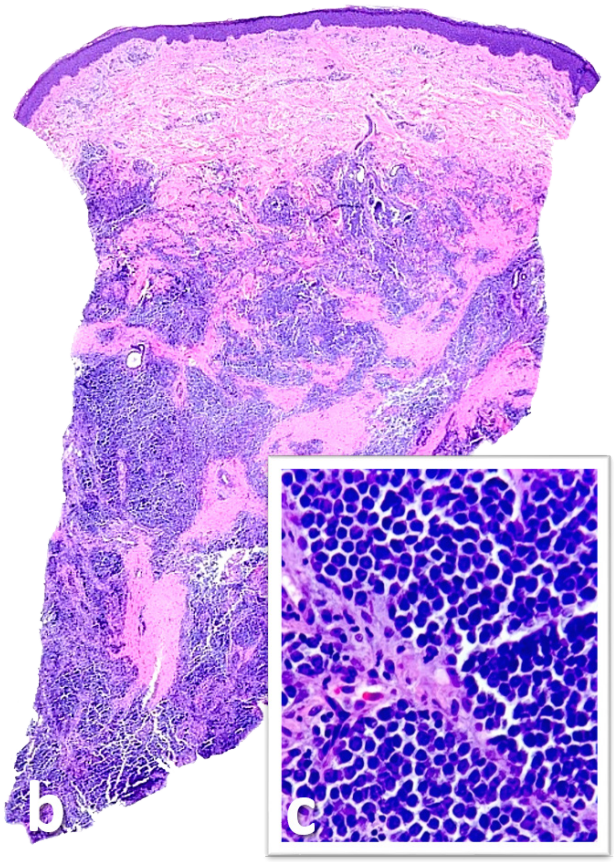


Figure 1. ***(a)*** *Clinical picture. This 52 year-old woman is a patient of Dr. Mark G. Cleveland and presented with the lesion shown in her right hand. A punch biopsy was performed and submitted to the Dermatopathology laboratory with a rule out of lymphocytoma cutis.* ***(b)*** *H&E-stained sections show a neoplasm that infiltrates the dermis and subcutaneous tissue.* ***(c)*** *The neoplasm is composed of irregular aggregates of atypical small round blue cells with pleomorphic nuclei and finely distributed chromatin.*

>> Return to Table of Contents

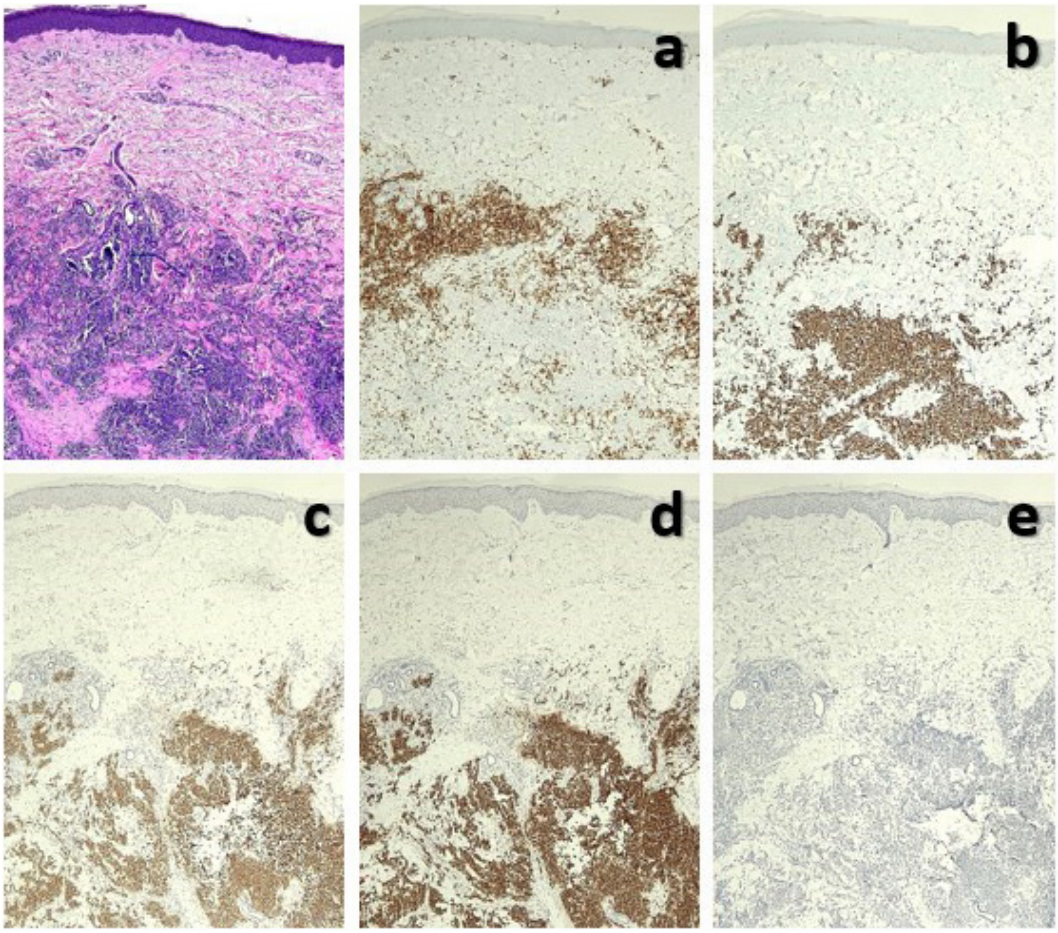


*Figure 2. **(a)** An immunostain for CD45 shows an inflammatory infiltrate comprised of small lymphocytes in the background. However, the neoplastic small round blue cells are positive for cytokeratin-20 **(b)**, synaptophysin **(c)**, and chromogranin **(d)**. TTF-1 immunostain was negative within the neoplastic cells **(e)**. The histologic findings and staining pattern are diagnostic of primary cutaneous neuroendocrine carcinoma (Merkel cell carcinoma).*

dispersed chromatin (salt and pepper chromatin), indistinct nucleoli and scant cytoplasm. Conspicuous mitoses and apoptotic bodies are present as well as variable nuclear molding and crush artifact. Histologic features indicative of adverse outcome include tumor size > 5 mm, tumor thickness > 5 mm, diffuse infiltrative growth pattern, invasion of subcutis and deeper structures, and lymphovascular invasion.[5] The differential diagnosis includes basal cell carcinoma, metastatic neuroendocrine carcinoma, lymphoma, small cell melanoma, and Ewing sarcoma. With immunohistochemistry, the tumor cells express epithelial antigens in addition to showing neuroendocrine features. Most characteristic of MCC is positive staining with low molecular weight keratin, and more specifically cytokeratin-20, in a classic dot-like paranuclear pattern. The neoplastic cells also show positive staining for different neuroendocrine markers such as chromogranin, synaptophysin, CD56, neuron specific enolase, and neurofilament. Distinction between MCC and metastatic neuroendocrine carcinoma in the skin is very important and requires immunohistochemical and clinico-pathologic correlation. In these cases negative staining for TTF-1 is very helpful to distinguish MCC from metastatic small cell lung carcinoma.

Treatment and prognosis

Treatment options include surgical removal, lymph node dissection, radiotherapy, and immunotherapy. Data derived from a comprehensive review of over 400 cases have shown survival rates of 88% at 1 year, 72% at 2 years, and 55% at 3 years. The recurrence rate of MCC is approximately 40%. Regional spread occurs in 55% of patients and distant metastases occur in 35% of patients and particularly affect the liver, bone, lung, and skin. In general, about 30% of all MCC patients will succumb to this disease. While recent advances are helping people with MCC live longer, those who are diagnosed in its earliest stage have the best outcomes.[1, 5]

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Coding Corner: Surviving a Payer Review

By: Molly Moye, MD, FAAD, FACMS and
Kayleen Moore, Lead Documentation & Coding Specialist

A year ago, there was much discussion regarding denials for Mohs surgery where tumor histology was not documented for the first stage, even when no tumor was visible. CMS revised their documentation requirements for the first stage of Mohs on October 27, 2020, and per the AAD, the primary carrier involved in the denials corrected the issue with their auditors. Our Billing Team is not needing to appeal as many denials now, but they continue to receive chart note requests from payers. This situation has placed the spotlight on documentation requirements for Mohs surgery. It has led many to wonder what is required to be in the operative note and how detailed the documentation needs to be.

A comprehensive list of documentation requirements can be found in the table. When a tumor is present in the first stage, describing the histology of the specimen is required. The description should include pathological pattern, cell morphology, depth of invasion, and if present, perineural invasion or presence of scar tissue.[1] If an identical tumor is present on subsequent stages, it is adequate to state as such; however, if a different tumor or tumor characteristics are present, the differences need to be described. EMA makes it very easy for staff to document all procedure details, so they are part of the formal operative note. If you include the tumor description on your Mohs map, then clinical staff can use it as a reference for entering the details in EMA. In EMA, you can also tailor exactly how you would like each tumor subtype to be described. This can be accomplished by editing the Histology Library in the Mohs plan of a test patient. For more information on editing the Histology Library, email the training team.

Mohs surgery with linear repair

Another hot topic has been the utilization of intermediate vs. complex linear repair codes with Mohs surgery. As a refresher, new requirements for coding complex repairs went into effect on January 1, 2020. The requirements include specific and much more restrictive criteria that must be met to support complex repair coding. This year, the ACMS had linear repair data as part of their Improving Wisely initiative, which raised many questions within the specialty. A recent email from the ACMS clarified that their evaluation of intermediate vs. complex repair utilization is meant more as an educational tool for members rather than to identify outliers. The email also made a great point that to code a complex linear repair, or any CPT code for that matter, the procedure must be medically necessary. In other words, if a wound can be repaired with minimal undermining, then there is no medical necessity to code as a complex repair. If you feel that you need a review of the requirements to code complex repairs, please reach out to the Documentation and Coding Team, and we can pass along some helpful resources!

Resources

1. CMS Medicare Learning Network. "Guidance to Reduce Mohs Surgery Reimbursement Issues," MLN Matters Number SE1318. October 27, 2020.
2. American Academy of Dermatology. "Principles of Documentation for Dermatology." 4th Edition, 2021.

Required Mohs Documentation[2]

- Diagnosis or type of lesion
- Medical necessity
- Why Mohs is the best treatment option and indication for Mohs surgery, e.g., aggressive histology, high risk patient or site
- Statement that physician acted as surgeon and pathologist
- Complexity of procedure, including:
  - Number of stages
  - Number of tissue blocks per stage
  - Mapping of specimens
  - Special or immunohistochemical stains used
- Description of specimen from stage one if tumor is present:
  - Pathological pattern and cell morphology
  - Depth of invasion
  - Perineural invasion or scar tissue, if present
- Subsequent stages, if tumor is still present:
  - If similar to that seen in stage one, may comment as such.
  - If differences from the description in stage one are seen, note the changes.

Other Mohs Documentation[2]

- Type and volume of anesthesia
- Type of hemostasis
- Estimated blood loss
- Presence/absence of surgical complications
- Follow up instructions
- Discussion of treatment and repair options with patient
- Comorbidities that might complicate care, e.g., smoking, diabetes

>> Return to Table of Contents

Beauty Blog: Offering Skincare Products

By: Betsy Wernli, MD, FAAD and
Tori Negrete, MD, FAAD

We talked about the evolution of dermatology clinics at the retreat. We have changed how we think about the consumer market; instead of visiting the hardware store, the grocer, and others, we use one click to order at midnight on the internet. This behavior shift of consumerism has also affected how our patients view our clinics. Patients are busier than ever, juggling kids, work, aging parents, and more, and want the most out of every visit. As dermatologists, we should strive to provide a comprehensive ecosystem to our patients by offering medical, surgical, and pathologic diagnosis and treatments along with cosmetic services and medical-grade skin care products. If we don't we risk a less satisfying patient experience, or worse, losing them to another more comprehensive clinic. So, we want to encourage all clinics to offer a retail line from prescription products to cosmeceuticals to ensure our patients get just what they want out of every experience with you! Here are the top ten tips for launching retail in a busy medical dermatology clinic:

01. **Involve your staff with incentive programs and monthly lunch and learns about products.**

02. **Talk to patients about you and your staff's use of products—during skin checks talk about products asking, "What are you doing to protect yourself from skin cancer and signs of aging?"**

03. **Use handy checklists in every clinic room to promote your favorite core products.**

04. **Grab your patients' attention by displaying products in your waiting room.**

05. **Create a year's worth of promos, based on holidays and themes (back to school, Mother's Day, etc.) Bonus if you can pair a cosmetic treatment with the product.**

06. **Do not duplicate work: use your colleague's monthly promo plans, staff incentive programs, and more!**

07. **Simple dermatologist routine: Sunscreen, moisturizer, antioxidants, and tretinoin.**

08. **Train your staff with monthly lunch and learns coordinated with your promo schedule and give them products to use—they will be walking billboards.**

09. **Know your patient base—determine a skincare line based on patient population.**

10. **Have a sample displayed in your patient rooms—patients love to touch and try products.**

>> Return to Table of Contents

Support Report: Great Resignation Have You Spooked?

By: Garth McMullen, Vice President, Talent

If today's job market was a Halloween costume, it might look like the classic Ava-Cato. It's simply hard to explain. We will, however, prevail leveraging our people, technology, and winning talent strategies.

I don't want to scare you, but the labor market is in a very tricky place right now. As I observe today's job market, I find that it's both trick and treat. While the state of the current job market may seem daunting, it's essential to understand the "treat" in this scenario. Those in the labor market who may have once felt biased now see a much more inclusive dynamic.

In my 30 years in Talent, I must state that these are strange days indeed. Organizations can no longer solely rely on a replacement recruitment model to compete for talent needs. With all organizations subject to shifting supply behaviors, successful organizations will need to build, enhance, and align total talent strategies to funnel quality talent into the right roles at the right time. We need to ask ourselves: What are the exact roles and responsibilities that we need to collectively fulfill our mission? What does quality look like? What are we willing to be flexible on (build vs. buy)? What is the right number of resources we need to deliver? How many assets (talent) do we have performing to our expectations? How many are ready to step up and step in? What gaps do we have that we can fill through our network? How many external resources (candidates) do we need to attract and screen? Who is responsible for communicating needs and expectations?

50%

The number of open jobs is 50% higher this year than last year.

3%

Of workers (that's the entire U.S. labor force) quit their jobs in August 2021.

87%

Of employees see gaining new skills as a priority in their employment.

30%

New hires should come from referrals.

35-40%

New hires are hired from within the organization.

30-35%

Of talent needs should be fulfilled by competitive talent acquisition strategies.

>> Return to Table of Contents

Long-term investment: Organizational planning and development drives business continuity and growth.

Our continued talent success will require focusing on priorities such as:

- Employer-of-choice brand recognition
- Competitive and proactive talent attraction
- Efficient talent acquisition and onboarding
- Learning and development programs, organizational planning, acquisitions and integrations, and workforce operations
- Promotions
- Transfers
- Growth plan (organic and in support of M&A)
- Applicant tracking (ATS)
- Talent analytics and intel

With Forefront's investment in our new best-in-class talent acquisition applicant and onboarding solution, iCIMS, our new integrated background screening vendor, HireRight; our recently created new career site; and a commitment from our clinician and functional leaders on creating a collaborative and supportive culture within our clinics and central support teams, we will build a brand and continue to position ourselves as an employer-of-choice into the future.

Since our launch of iCIMS, it takes our candidates 2.2 minutes to apply for an open position, which is best-in-class.

"Not all cheese plates need to be expensive. In fact, my smaller cheese plate cost $56 from Trader Joes!"

PERFECT *pairings*
WINES & CHEESES

By: Ashley Dietrich, MD, FAAD

If you happened to participate in our Fall Retreat Friday Wine Event, you may have heard a few of these tips & tricks for pairing wine with a delectable cheese plate. If you saw the Workplace app, you may have seen similar photos of my plate creations. Here, I delve into the details (with photos) to show off your skills at your next gathering and wow your guests! Ultimately, "I'm a fan of the following "rules" of cheese plate making which may change based upon the number of wines and guests present:

01. Find 2-5 great cheeses. Add accompaniments—meats, fresh fruit, dried fruit, jams, nuts, chocolate.

02. Fill the plate—when in doubt, try not to see the board in the background, this is the wow factor. Provide crackers, bread, and utensils such as knives, spoons, or napkins.

03. Try to pair with wine (but if the cheese tastes great— does it really matter?)

- A great pairing is what we look for in the wine (balance, flavor, texture, acid, etc)
- The lighter cheeses (Brie, goat cheese) pair well with the lighter wines (sparkling, most whites)
- The heavier cheeses (aged gouda, cheddar) pair well with the heavier wines (big reds)
- Funky cheeses (blue cheese, gorgonzola) pair well with the sweeter wines (moscato)
- If it grows together, it goes together such as an Italian Montepulciano and Parmesan

>> Return to Table of Contents

Our wines for the wine night included bubbles, chardonnay, and fleurie (a fun, light red Beaujolais). Here are some of my favorite cheeses to pair:

Triple Cream Brie

A classic soft-ripened cheese with a snow-white edible rind. It has all the subtle yet characteristic flavors of regular Brie but with a buttery core.

***Pairs well with* bubbles and chardonnay**

Chèvre

Has a unique, tart, earthy flavor that sets it apart from cow cheeses. This distinctive tang and aroma grow robust and bold as it ages.

***Pairs well with* fleurie**

Aged Gouda

Similar to parmesan in texture, developing crunchy cheese crystals and more crumbly texture. Aged gouda has a rich, nutty, caramelly taste, often reminiscent of butterscotch.

***Pairs well with* fleurie and bubbles**

Gruyère

Known for its rich, creamy, salty, and nutty flavor. Young Gruyère has pronounced creaminess and nuttiness, while older Gruyère has developed an earthiness that is a bit more complex.

***Pairs well with* fleurie and bubbles**

Want to learn more? Check out www.winefolly.com. If you have a wine, beverage, or food pairing topic for a future column, email me!

How to create an Instagram-worthy cheese and charcuterie plate

Step 1

Get your board and bowls out.

Step 2

Begin by arranging the cheeses.

Step 3

Add the bowls, fruit, and larger items. By the way, this plate was made for a gluten-free friend where all crackers were separate from the board.

Step 4

Fill the board with charcuterie, nuts, dried fruit, etc.

Step 5

Arrange with jams, honey, etc. Note: these accompaniments are also separated from the board due to an allergy.

Step 6

Finally, sit back and feast your eyes! These boards have a little something for everyone with a mix of textures, temperatures, salt, acidity, crunch, for that all inclusive great bite. The above is an example of a party-sized cheese plate, but my cheese plates for 1-2 always include cheese, a charcuterie, jam, fresh and dried fruit and nuts.

>> Return to Table of Contents

President & Editor
Betsy Wernli, MD, FAAD

Email

Betsy has a busy practice in Manitowoc, WI. She completed her undergraduate at the University of Oklahoma where she stayed for medical school and completed her residency at Iowa. She has three boys, four if you count her husband, and enjoys all things sports. She is obsessed with her Peloton®, and loves serving the Forefront physicians. Betsy is always available by cell or email.

Adam Asarch, MD, FAAD

Adam practices dermatology and Mohs surgery in Grand Rapids, MI. He is a fellowship-trained Mohs surgeon and serves on the physician board of directors at Forefront. His professional areas of interest include skin cancer detection and treatment with a strong focus on Mohs surgery. He is passionate about dermatology, Forefront, and in ensuring that our practitioners are supported in all areas of their practice.

Giacomo Maggiolino, MD, FAAD

Giacomo graduated from the University of Notre Dame, attended medical school at the University of Illinois in Chicago, and completed his residency at Cook County in Chicago. He now practices in Pleasant Prairie and Grafton, WI. He is kept busy at home with four young children but he also enjoys traveling and cooking—especially making homemade pasta and Italian dishes. Giacomo is Forefront's Public Relations Chairperson.

Sarah Taylor, MD, FAAD

Sarah is a dermatologist in Vienna, Virginia. She completed her medical schooling at Uniformed Services University of the Health Sciences and then went on to Dermatology Residency at Walter Reed Army Medical Center. She completed her time as an Active Duty Dermatologist in 2016 while stationed at Fort Gordon in Georgia. She is married to an Allergist/ Immunologist who is still Active Duty at Walter Reed National Military Medical Center. They have three children, 13,11 and 7. When not running kids around to soccer or other activities, Sarah enjoys running, reading, cooking and travel.

Sapna Vaghani, MD, FAAD

Sapna is a pediatric dermatologist working in the suburbs of Chicago. She completed her undergraduate work at Northwestern University, followed by medical school at MCP Hahnemann (now Drexel) in Philadelphia. She came back to Northwestern to complete her residencies in pediatrics, dermatology, and finally, a fellowship in pediatric dermatology. Sapna's free time is spent with her husband and two girls. They love to cook, eat, do arts and crafts, and travel!

Will Patino, MD

Will is board-certified in anatomic and clinicical pathology and dermatopathology. His areas of interest include melanocytic lesions, infectious diseases, cutaneous lymphomas, alopecia, and adnexal neoplasms.

Molly Moye, MD, FAAD, FACMS

Molly is a fellowship-trained Mohs surgeon who practices in Elizabethtown and Louisville, KY. Her professional areas of interest are skin cancer detection and treatment, Mohs surgery, and performing cosmetic treatments including, Botox®. Molly finds it very rewarding to follow patients over time and see improvements in their quality of life as their skin conditions are treated.

Tori Negrete, MD, FAAD

Tori practices in Carmel, IN, Neenah, WI and is also the medical director of Excelin Medical Spa in Appleton, WI. A Chicago native, she returned to complete her dermatology residency at Cook County Hospital after attending medical school at the University of Iowa. In her free time, she loves to travel the world with her husband George, drink wine, eat fabulous food, Peloton® (to burn off those calories), and love up her adorable French bulldogs, Bruster, Bernadette and, Claudette.

Katie Hunt, MD, FAAD

Katie started her career in business and engineering at the University of Alabama. She worked as a patient flow consultant for Stockamp & Associates and as a supply chain leader at GE Healthcare before discovering her desire to help others in the field of medicine. Katie completed her medical education and dermatology residency at the University of Alabama and served as chief resident during her final year. She enjoys hiking, camping, running, and strategic board games.

Ashley Dietrich, MD, FAAD

Ashley practices in Wauwatosa, WI, just outside Milwaukee. She traveled south to a warmer climate to complete residency at the University of North Carolina, Chapel Hill. She enjoys being back in Wisconsin with her husband, Peter. She enjoys golf, tennis, pickleball, Wisconsin sports, and wine tasting.

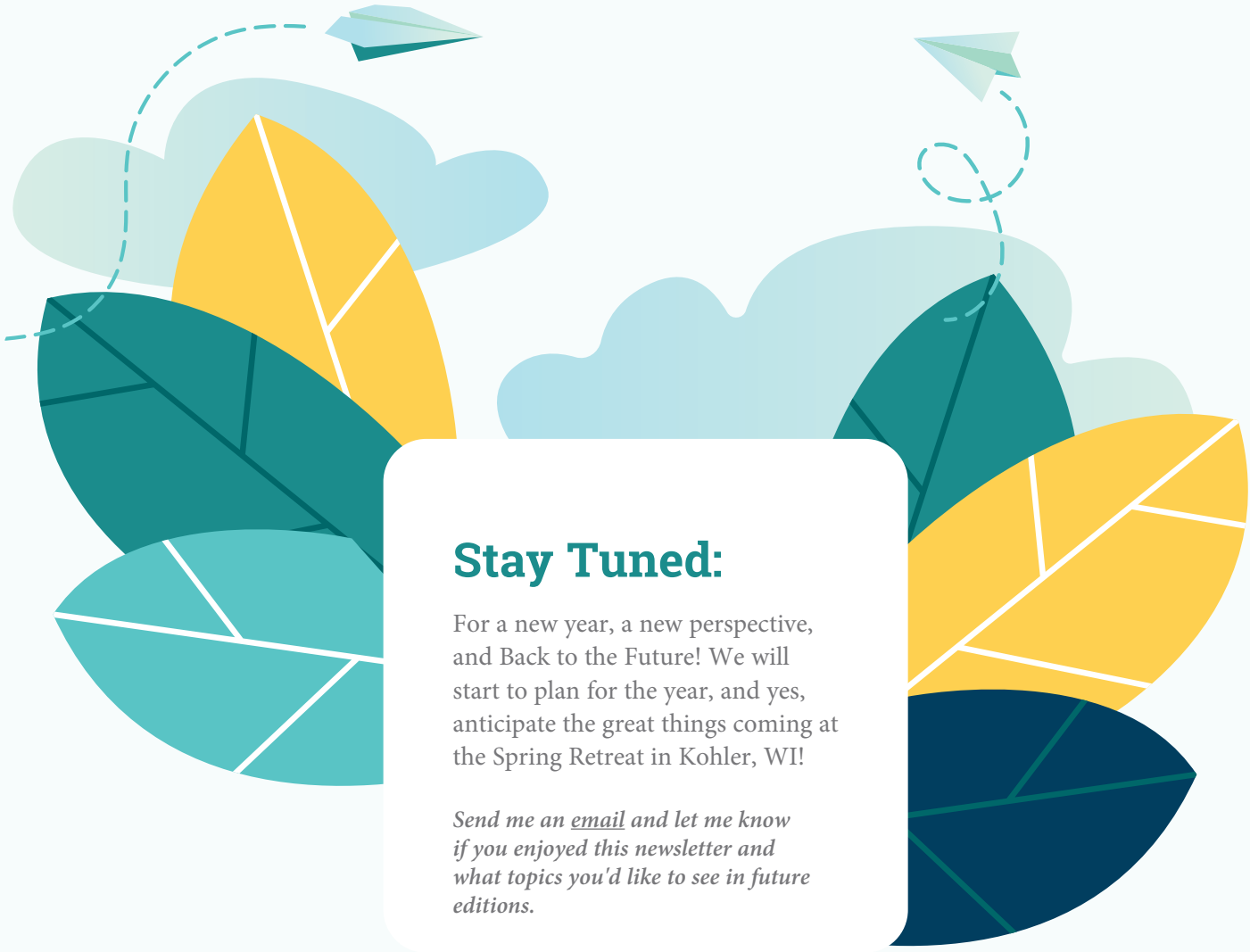
Kayleen Moore
Lead Documentation & Coding Specialist

Kayleen is our Lead Documentation and Coding Specialist and works in the Manitowoc support services offices. She enjoys working with fellow coders (Kari Wagner and Beth Westcott) on a team that is passionate about supporting Forefront's physicians, PAs, and NPs in the ever-changing world of coding and documentation. Kayleen loves traveling with her husband Ian and spoiling her two dogs, Lucky (a sweet and cuddly Poodle/ Dachshund mix) and Mabel (a sassy little Westie).

Garth McMullen
Vice President, Talent

Garth joined Forefront in August to lead Forefront's Talent Function. Garth's experience and accomplishments in Talent are extensive, spanning over 30 years in varying industry sectors and geographies. Garth enjoys spending time with his wife, Stephanie, his mother and father, who live a short five-minute drive away, and his four legged furry son, Sammy.

>> Return to Table of Contents



Stay Tuned:

For a new year, a new perspective, and Back to the Future! We will start to plan for the year, and yes, anticipate the great things coming at the Spring Retreat in Kohler, WI!

Send me an email and let me know if you enjoyed this newsletter and what topics you'd like to see in future editions.

>> Return to Table of Contents