foreFRONT AND CENTER

Q3 NEWSLETTER | July 2022 Special Edition

President's Message: Break out of routine

By: Betsy Wernli, MD, FAAD

Welcome to summer! As we grow weary of our "broad spectrum," "SPF 30 or more", and "mineral vs. chemical sunscreen" patient mantra 45+ times a day, we often get caught up in our "regular routine." And for me, the same old routine breeds nothing but anticipation for the weekend. I love the quote: "People wait all week for Friday, all year for summer, all life for happiness."

How do you optimize each and every day, break out of the same old routine, and appreciate every moment, both in and out of work? We face so many barriers and blockades to this; from technology to workplace challenges to busy home schedules. Optimizing your life during summer is key, but optimization of the clinic is vital, no matter what season it is.

So, wait for a routine rut-buster theme in the upcoming retreat in October, where we will look at how we can strategically approach some of the business aspects to impact our busyness in the clinic. In the meantime, during the longest days of the year, the summer warmth, the backyard BBQs, I will be trying to seek out the last days of summer on the motocross track, in the pool, and lazy nights reading to my kids without any forced homework or bedtime.

> "PEOPLE WAIT ALL WEEK FOR FRIDAY, ALL YEAR FOR SUMMER, ALL LIFE FOR HAPPINESS. — UNKNOWN

I hope you enjoy each day at work, not waiting for the weekend, love every day of this season, and find happiness with a strategic focus on improving our lives in and out of the clinic. I am hoping that this issue of ForeFRONT & CENTER gives you a fresh look at your life in and out of the clinic and sets your sights ahead for a killer retreat event in Atlanta. The retreat will focus on optimization to ensure we are breaking out of routine ruts and genuinely loving what we do every day, both at work and at home!

Here's to being present today, both in and out of the clinic, and optimizing life no matter where you may be this summer!

Sincerely,
Dr. Betsy Wernli

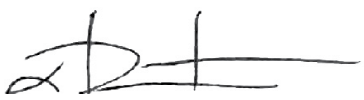

Table of Contents

Click to jump to a page.

Catch Up on Past Editions

- Q2 - 2022 Newsletter
- Q1 - 2022 Newsletter
- Q4 - 2021 Newsletter


The
Physician
Board

BOARD Report:
What makes Forefront what it is?

By: Peter Katz, MD, FAAD

At every Forefront Physician Board meeting, I am reminded of how blessed I am to be a part of this group of dynamic, highly intelligent, goal-oriented and driven doctors who get together at least four times yearly to ensure Forefront continues to be the shining star among U.S. Dermatology practices. Our last meeting was no exception.

Among many things that kept us in the board room late into the night (HR, real estate, compliance, etc.), we discussed what makes Forefront what it is – you, the doctors, NPs, and PAs that lead every day in your clinics. We talked at length about our physician-led culture, and how we can continue to grow that internal leadership with the expansion of our LeAD team. As we grow, we must continue refining our advisory committees to serve our clinics across the country best. Congratulations to all of our newly elected or re-elected LeADers and all who ran; you are a big part of what makes Forefront great!

Stemming from that, we came up with strategies to continue to boost employee morale and investment in our clinics' success. If you are looking for help on how to arrange something, please speak with your RCM; just a little thank you goes a long way. Keep it up for the many of you who already do a lot for your staff!

JUST A LITTLE THANK YOU, GOES A LONG WAY.

We spent the remainder of the night discussing what has made Forefront the nation's leading dermatology practice and how we can use those ideas to propel us into the future. These included reinvigorating our mentorship program, improving metrics reports to help us identify what we do well and how we can do better for our clinics and our patients, and many other exciting ideas yet to come.

It doesn't all happen overnight, but look how far we've come- from a small collection of dermatologists, NPs, and PAs just a handful of years ago… imagine where you, the clinicians who help lead the way, will take us in just a handful more!

Thanks to all of you who make Forefront great; see you all in the Fall Retreat!









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OUR Secret SAUCE

FOREFRONT CULTURE

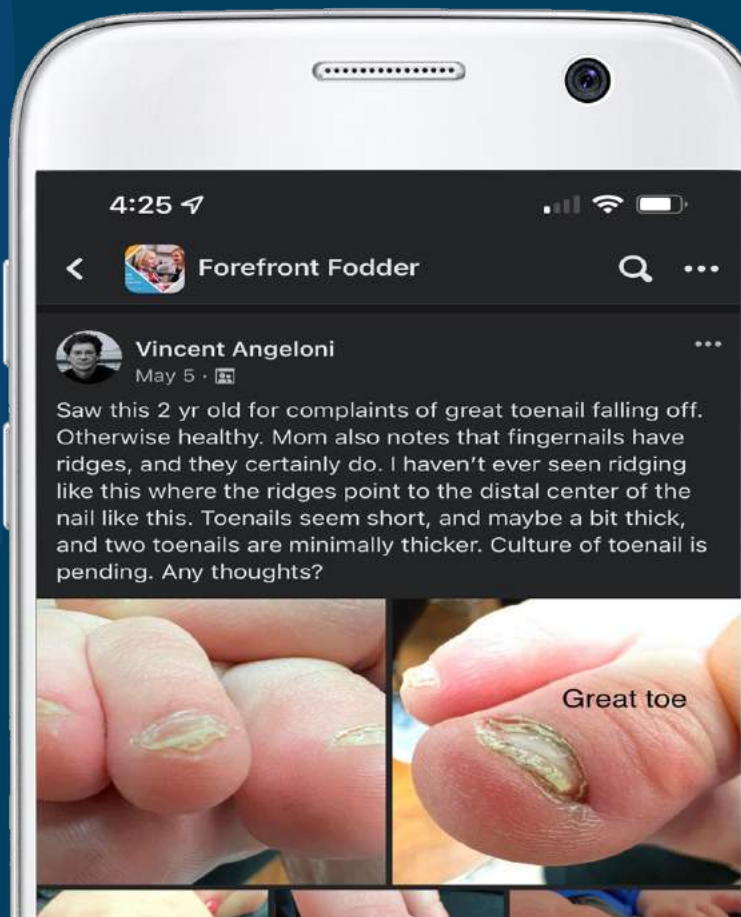
Our culture is unmatched, from our physician leadership extending from committee participation to serving on the Leadership Advisory Directors (LeAD), all the way up to the nine-person Physician Board of Directors. Forefront's culture is different from the rest. Physician leadership drives innovative ideas that resound with clinicians, ways to connect and collaborate, and opportunities to grow. There's no place like Forefront!

Workplace

Stay in the loop from anywhere

Use Facebook Workplace to enhance your day-to-day clinic life, resulting in better team and patient outcomes. Tough rash? Who else can consult over 400 talented physicians, PAs, and NPs who may have seen and successfully treated that same eruption that week? Stay-up-to-date and connected on events, podcasts, CME opportunities, and more!

Join the conversation!



CODING CORNER

Injections are a commonplace in dermatology.

By: Molly Moye, MD, FAAD, FACMS and

Injections are commonplace in dermatology, and correctly coding the service performed can be tricky. In this Coding Corner, we address some frequently encountered questions about the most common injections we perform in the office.

Please reach out to our coding team with any questions.

Question: Alopecia Areata

I injected a large patch of alopecia areata with triamcinolone. It took 25 sticks! Shouldn't I code 11901 for this service, given the large area and the number of sticks?

Answer

No. For a single skin lesion of any size, no matter how many sticks are required, 11900 is the correct code. If more than seven lesions are treated, 11901 is the correct code to use.

Question: Methotrexate

I am injecting methotrexate to destroy a squamous cell carcinoma. Because my intention is malignant destruction, can I code it as malignant destruction rather than coding as an injection?

Answer

No. The injection is not included in the list of treatment modalities for malignant destruction, so coding an injection in this way would not stand up to an audit. The correct code for intralesional chemotherapy administration is 96405 for up to and including seven lesions and 96406 for more than seven lesions.

Question: 5-Fluorouracil

I am injecting 5-fluorouracil for a keloid that is not responding to intralesional steroids. Should I consider this as intralesional chemotherapy administration even though I am not using it to treat cancer?

Answer

Yes! Initially, 96405 and 96406 were only reimbursed for malignant diagnoses; however, this has changed over time. Currently, many carriers will cover these codes for non-malignant diagnoses, such as when bleomycin is used to treat warts and fluorouracil for keloids. The best way to think through this is as follows: if you inject an anti-neoplastic agent, it is an intralesional chemotherapy administration, regardless of the diagnosis.

Question: Acne

A new patient came in for acne. We discussed the risks and benefits of oral and topical prescription options, and prescriptions were sent

in. In addition, a few larger inflamed acne cysts were injected with intralesional triamcinolone. For some reason, our EMR is only generating the injection code. Can I bill an evaluation and management code as well?

Answer

Yes! In this clinical scenario, a significant and separately identifiable service was provided in addition to the injection. The evaluation and management service is also billable with modifier 25 attached to it. Modifier 25 indicates that the same clinician provided an assessment and management service on the same date of service as a minor procedure. Unfortunately, EMRs are not great at determining that a separate service has been provided when there is only one diagnosis. In EMA, add the plan of "separate and identifiable documentation" to trigger the appropriate office visit code to generate.

Question: Inflamed Cyst

A patient came in for an inflamed cyst. I discussed the likely diagnosis and expected course of an inflamed cyst. After discussing treatment options, the patient opted for an injection of intralesional triamcinolone. For some reason, our EMR is only generating an injection code. Can I bill an evaluation and management code as well, given that I discussed the diagnosis and treatment with the patient in addition to performing an injection?

Answer

No. In this clinical scenario, no significant and separately identifiable service was provided over and above the injection. Discussing the diagnosis and treatment options is part of the service of performing the injection, so the evaluation and management are bundled within the reimbursement for the injection. In this scenario, adding an evaluation and management code with modifier 25 would be an inappropriate use of modifier 25.

Perhaps these questions have gotten you thinking about other injection-related scenarios for which you could use some clarification! Our team is always happy to provide coding and documentation guidance and education. Happy injecting!

Clinical Corner: Summer Photodermatosis

Presented By: Ashley Dietrich, MD, FAAD
Submitted By: Robert Korenberg, MD, FAAD & Brent R. Weed, MD, FAAD

A 50+ year old female presents with a 2-month history of blistering on her hands. This seems to occur with each dose of chemotherapy and then resolves. The patient receives treatment (IV carboplatin/paclitaxel) for synchronous primary breast cancer and high-grade ovarian cancer with a BRCA1 mutation. The oncologist wondered about herpetic whitlow as the patient has a history of cold sores. We are consulted to evaluate her blistering rash.

Diagnostic Considerations

In addition to common acute rashes on the hands, especially those related to chemotherapy, we must also consider primary blistering disorders as well as photodermatoses. This has implications for patients' cancer and chemotherapy treatment protocols.

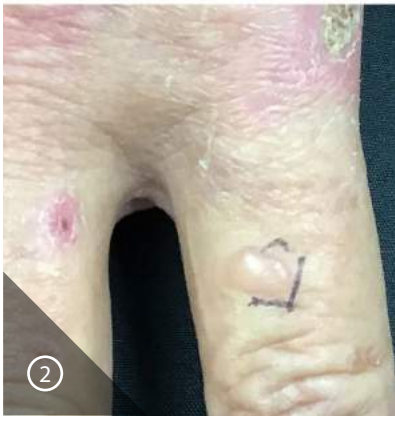


Figure 1: Non-inflamed tense bullae with crusting, erosions, and secondary inflammation, on dorsal right hand and fingers; Figure 2: Tense bulla on second right dorsal finger

Exam

The primary lesions are tense vesicles and small bullae on a non-inflamed base on the dorsal hands indicating a photosensitive rash. There is secondary inflammation and crusting. This spares the palms and feet. There did not appear to be a substantial change on the face or neck such as hyperpigmentation, hypertrichosis, milia, or sclerodermoid changes.

Differential Diagnosis

One may consider porphyria cutanea tarda, pseudo-porphyria cutanea tarda, epidermolysis bullosa simplex, epidermolysis bullosa acquisita, dyshidrotic eczema, PMLE, chemotherapeutic drug rash, and others.

Next Steps

A lesional biopsy for H&E was remarkable for a cell-poor subepidermal blister with focal

>> Return to Table of Contents

caterpillar bodies within the overlying epidermis. There is presence of festooning. In addition, labs show plasma with elevated levels of uroporphyrins, hexacarboxyl porphyrins, and heptacarboxyl porphyrins. A DIF was not obtained in this case.

Diagnosis

Porphyria Cutanea Tarda (PCT) was confirmed with a combination of clinical exams, H&E pathology, and labs.

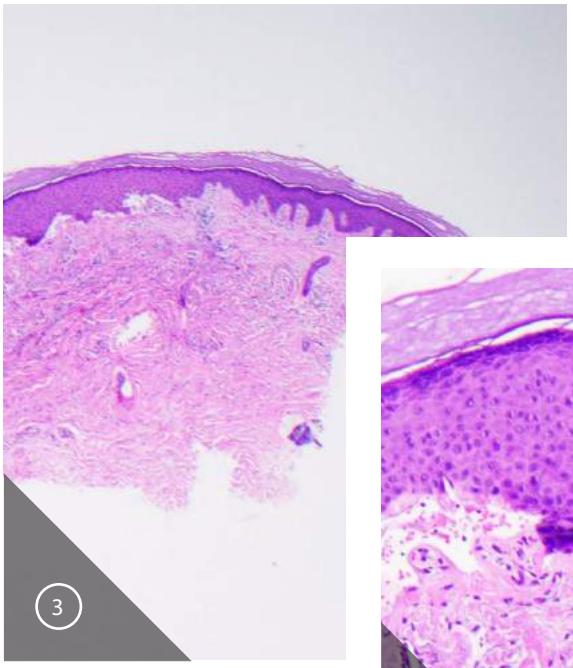
Treatment

Ultimately, treatment is focused on sun protection, avoidance of triggers, and decreasing iron and porphyrin levels (such as phlebotomy or medications such as low dose plaquenil, etc).

Discussion

Porphyria Cutanea Tarda (PCT) is the most common of the porphyrias, targeting only the skin. Porphyrias occur with a disruption of the heme synthesis chain of chemical reactions. PCT shows a deficiency of the enzyme uroporphyrinogen decarboxylase (UROD). It is typically an acquired disease with a genetic component in some patients. Development is usually in mid to late life, such as in this patient. Triggers include liver disease (with alcohol consumption, hepatitis B & C, iron overload from hemochromatosis, blood transfusions, or significant iron supplementation) and/or estrogens (including oral contraceptives, hormone replacement therapy, or prostate cancer therapy).

A similar yet important distinctive condition is Pseudo-PCT which is caused by renal dialysis or medications (most commonly NSAIDS and diuretics). It shows the clinical features of PCT, but blood and urinalysis do not demonstrate elevated porphyrin levels.



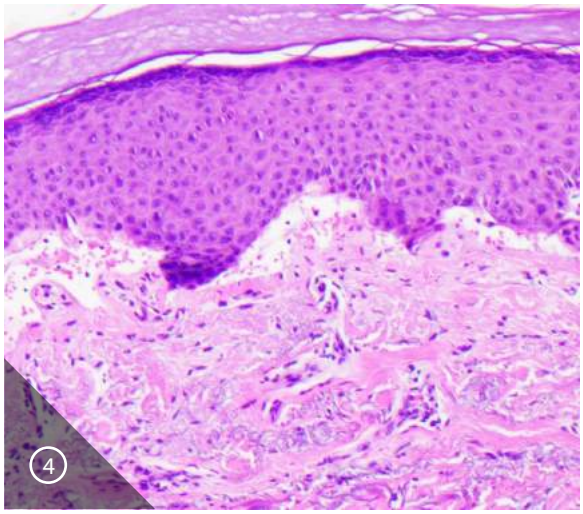


Figure 3 & 4: H&E stained slides show a cell-poor subepidermal blister

Clinical Note

Paclitaxel has been associated with photo-sensitivity and photosensitive rashes. This is the likely trigger for the patient's PCT given flares coinciding with chemotherapy treatments and this known association. We do not believe this is related to elevated estrogen levels or hepatic changes (as a major hepatic insult did not occur).

This patient was managed by her hematologist/oncologist, who was also managing her breast and ovarian carcinoma. At diagnosis, she was negative for Hep B and C, HIV, and her baseline ferritin was 616. Her oncologist elected to treat her with phlebotomy. Because of her breast and ovarian cancers with ongoing chemotherapy, a gentle approach to phlebotomy every few months kept the patient free from symptoms without regular phlebotomy follow-up. She has aimed for a ferritin level of 100, rather than the usual, more stringent 50. The patient was also advised to use sunscreen diligently and to avoid alcohol.

Resources

Bolognia, J., Jorizzo, J. and Schaffer, J., 2017. Dermatology. [Philadelphia]: Elsevier Saunders.

Cohen AD, Mermershtain W, Geffen DB, Schoenfeld N, Mamet R, Cagnano E, Cohen Y, Halevy S. Cutaneous photosensitivity induced by paclitaxel and trastuzumab therapy associated with aberrations in the biosynthesis of porphyrins. J Dermatolog Treat. 2005 Feb;16(1):19-21. doi: 10.1080/09546630510026724. PMID: 15897162.

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SCAN TO VIEW

DIVERSITY *in* DERMATOLOGY

By: Missy Mesfin, MD, FAAD, FACMS

Sunscreen use on skin of color

Summer is well underway, with it all the "accessories" of the season. As dermatologists and those in the dermatology field, that means sunscreen- and lots of it! As we all know, there are so many sunscreens on the market- from UVA, and UVB blockers, to chemical vs. physical blockers and, more recently, the addition of tinted sunscreens.

Currently, the American Academy of Dermatology (AAD) recommends sunscreens that have an SPF of 30 or higher and are water resistant and broad spectrum, as well as other sun-protective measures (sun-protective clothes, hats, and of course, shade). Sunscreens have historically been recommended for lighter skin types (Fitz 1-3), but more evidence has emerged regarding the importance of regular sunscreen use in darker skin types (Fitz 4-6).

In the past, the higher degree of melanin in skin of color (SOC) has been thought to be protective against the harmful effects of sun exposure. But as my 7-year-old daughter says- myth buster! There may be some protection, but it is not sufficient. Research has shown that melanin in SOC can filter 2 to 5 times more UV radiation than melanin in lower Fitz types. One study shows the intrinsic sun protective factor (SPF) in Fitz 5-6 is equivalent to about 13.4 vs. SPF 3.3 in light Fitz types. However, there is still UV damage that occurs on darker skin. While we know the usual risks of UV damage in lighter skin, in darker skin, photodamage more commonly presents with pigment issues, such as uneven skin tone, post-inflammatory hyperpigmentation (PIH), melasma, or a combination of these pigment disorders. These differences are thought to be due to some degree of protection from UVB in darker skin colors, while dyspigmentation is more likely due to UV-A1 and visible light (VL) effects. Certainly, photodamage risks lead to skin cancers and premature aging in SOC, but pigmentary disorders are more prominently seen.

While we have long known the damage that can occur from UV light, visible light has become an area of interest in photodamage, and we are learning more about its effects on the skin. In particular, it seems that visible light may particularly affect darker skin types. Studies are starting to show that at high doses, VL induces erythema and hyperpigmentation in SOC patients but not those with light Fitz types. The pigment darkening caused by VL may be longer lasting and intense than that induced by UV-A1. Therefore, VL is likely more of a concern for darker skin types. The good news is that tinted sunscreens help protect from VL. Tinted sunscreens containing iron oxide pigments reduce VL transmission by >90%. One study shows these sunscreens improve melasma and melasma relapses compared to UV-only sunscreen. Currently, tinted sunscreens are the only photoprotection we have that filters out VL. Therefore, these options would likely be the most beneficial photoprotection we can recommend

for our SOC patients.

So sunscreens to recommend- that can be a challenge for all of our patients, particularly our SOC patients. While it is personal for each individual, as a SOC patient myself, the last thing I want is the dreaded white/blue cast from sunscreen. And we want to ensure our patients will actually use the sunscreen and not put it aside because that ghost-look is definitely worse on darker skin, particularly with many mineral sunscreens.

So I have tested several sunscreens (both mineral and chemical) on my Fitz type 5 skin to give some guidance for recommendations to your SOC patients. Listed below are my observations:

	Chemical VS. Mineral	SPF	Comments
Elta MD UV Clear (Tinted and Untinted)	Mineral and Chemical (no oxybenzone)	**46**	▪ Great for acne-prone skin, has niacinamide ▪ Regular: Takes a bit of rubbing to blend *Tinted: Rubs in easily, looks very natural
Excelin/Topix Antioxidant Moisturizing Sunscreen	Mineral and chemical (oxybenzone is present)	**50**	▪ Not formally tinted, but has tint from green tea extract ▪ Rubs in easily, looks natural *Only product listed that still has oxybenzone
Neutrogena Invisible Daily Defense (Tinted)	Chemical (no oxybenzone)	**30** **60**	▪ Rubs in and blends in extremely well, invisible ▪ Disclaimer: I have been using this product this summer and absolutely love it
Supergoop Unseen Sunscreen	Chemical (no oxybenzone)	**40**	▪ Clear, mostly used for face ▪ Can be used as make-up primer ▪ Rubs right in, matte-finish, Most invisible option I have used ▪ Supergoop Play sunscreen is also great for the body
LaRoche-Posay Anthelios Melt-in Milk Sunscreen	Chemical (no oxybenzone)	**60** **100**	▪ Includes antioxidants ▪ Rubs in and blends in well
CeraVe Hydrating Sunscreen (Tinted)	Mineral	**50**	▪ Includes ceramides ▪ Facial moisturizer/sunscreen ▪ Rubs in fairly well with no hue
LaRoche-Posay Anthelios Mineral Sunscreen (3 types: Tinted, non-tinted and one with hyaluronic acid)	Mineral	**50** (30 for HA)	▪ Face version: Tinted - Rubs in better than non-tinted ▪ Include antioxidants ▪ HA option does rub in, but can leave a bluish cast
Cetaphil Sheer Mineral Face Liquid Sunscreen	Mineral	**50**	▪ Formulated for sensitive skin ▪ Eventually rubs in, but takes some effort
Neutrogena SheerZinc sunscreen	Mineral	**50**	▪ Does not rub in easily and can leave a bluish cast

Special mentions that I have not tried but were developed specifically for darker skin tones:

Black Girl Sunscreen: Chemical blocker with SPF 30, has a creamy, lotion-like feel

Kinlò: Tinted mineral blocker with SPF 50, non-comedogenic, developed with Naomi Osaka

Regular sunscreen use should be recommended in all our patients, including our SOC patients. A 2020 study reported that 12 months of daily photoprotection with a sunscreen of SPF 30 improved photoaging and pigmentary concerns in patients of Fitz type 4-6. So there are multiple reasons to recommend daily sun protective measures for darker skin types. Growing data shows the benefit of tinted sunscreens in SOC due to their VL protection. Finding sunscreens we recommend to our patients is essential and should be tailored to our patient's particular needs.

Resources

1. Rigel, et al.Photoprotection for skin of all color: Consensus and clinical guidance from an expert panel. JAAD: March 2022. 86(3). S1-8.
2. Taylor, et al. Misconceptions of photoprotection in skin of color. JAAD: March 2022. 86(3). S9-17.
3. Rigel, et al. Photoprotection for all: Current gaps and opportunities. JAAD: March 2022. 86(3). S18-26.

>> Return to Table of Contents

keeping up with the Kids

By: Sapna Vaghani, MD, FAAD

Get your guide for talking to young patients about sun protection.

Summer is in full swing, but kids will be back in school before you know it! Teaching our youngest patients the importance of and how to practice diligent sun protection, even when their parents are not around to guide them, is critical to long-term skin health. It is a conversation I have with every single family, but the reality is that we do not have a finite amount of time to spend with each patient. If you do not already, I encourage you to hand out printed instructions with sun protection tips to your patients.

A handout that also gives specific recommendations for children (feel free to copy any or all of my text) and include your favorite specific sunscreens. It will save you so much time when patients ask at the end of an appointment what they should be using. Below are the talking points I focus on, which I can cover in about 2 minutes, usually while examining a patient but sometimes at the end of the visit. It is essential to be mindful of each child's maturity and anxiety level. Sometimes telling a child that their freckles are an indicator of sun damage (a concept that is quite surprising to many parents), which increases their risk for skin cancer (the dreaded "C" word!), can be over the top; sometimes it's exactly what they need to hear. I also gauge where the parents stand on the importance of sun protection; that sometimes dictates how frank I am in my discussion. The children whose parents say, "Dr. Vaghani, can you please explain to them how important sunscreen is" get the complete and detailed talk!

> Teaching our youngest patients the importance of and how to practice diligent sun protection, is critical to long-term skin health.

Sun protection is about more than just sunscreen; it's also about:

- Being in the shade when possible
- Wearing hats
- Wearing sunglasses
- Covering exposed skin with clothing when the weather (and fashion!) permit.

Especially if you're going to be outside for a long time, consider t-shirts instead of tank tops, crew necks instead of v-necks, capris instead of short shorts, etc.

Hats are a great way to protect your scalp and face when outdoors, but not all hats are created equally! Baseball hats do not protect the ears or neck (which are constantly exposed if you

have short hair) and don't protect the entire face. Bucket hats and hats with a wider brim are best. If you get overheated easily in hats, consider wide-brimmed visors and hats that are vented/made of more breathable material. For younger children, a hat with an adjustable strap is helpful (they are very easy to find on Amazon). Keep an extra hat in the car. Keep a hat in your backpack and wear it at recess, also to and from school if you walk. Did you know that children in Australia are not allowed to go to recess without a wide-brimmed hat?!

Hair part: If you part your hair, move it around over the course of the summer so that in the event you aren't wearing a hat, you do not get chronic sun on one focal part of the scalp. Applying sunscreen to your part can sometimes matte the hair down and make your scalp more visible.

Sunscreen is for every day, not just for the pool and the beach. You brush your teeth every morning to prevent cavities; apply a face lotion with sunscreen on your face every morning to prevent damage and skin cancer. M**ake it part of your morning routine every single day**; do not think about the forecast or what you are doing that day. Keep your sunscreen next to your toothpaste, so you don't forget to use it.

Reapply sunscreen throughout the day; it lasts only 2 hours, and no sunscreen is actually "waterproof". Consider keeping a small tube of sunscreen in your lunch box so you can reapply it before recess.

Avoid spray sunscreens; they do not work as well as lotions; most are made of chemical sunscreens, and they also contain propellants and other chemicals that are not good for you to inhale as you spray it on.

Use only physical blockers, and sunscreens with an active ingredient of zinc oxide and/or titanium dioxide because they are inert and long-term may be safer. Some active ingredients used in chemical blockers can be absorbed through the skin in high enough quantities that they can be measured in the bloodstream. Chemical blockers are used in sunscreens with higher SPFs, but **you do not need an SPF higher than 50.**

Favorite body physical blockers (SPF 50-60): Coppertone Pure & Simple (more liquidy and easier to spread than others), Banana Boat for Kids, Vanicream (the most hypoallergenic, great for people who react to additives in skin products). All of these are good options for sensitive skin.

Favorite face physical blockers (SPF 50-60): Cetaphil Sheer Mineral Face (yellow top, rubs relatively well even on darker skin), Neutrogena Sensitive Skin Mineral Sunscreen, Skinceuticals Physical Fusion (tinted).

Sun protective clothing with built-in sun protection is a great way to provide added protection when outdoors for an extended period, especially in the pool. Wear a long-sleeved rash guard and long-sleeved bathing suits when possible (they have become more main-streamed in the last few years, and the styles are much cuter!). Not all brands are created equally; only some brands, like Coolibar & UVSkinz, claim their materials can withstand the damage caused by chlorine and salt water. Wash them in cold water and air-dry them; do not put these materials in the dryer.

Freckles are a sign of sun damage. There is nothing wrong with what they look like, but they are your skin's way of telling you that your skin has already been damaged in this area. If you are getting more freckles over time, it means you need to STEP UP your sun protection.

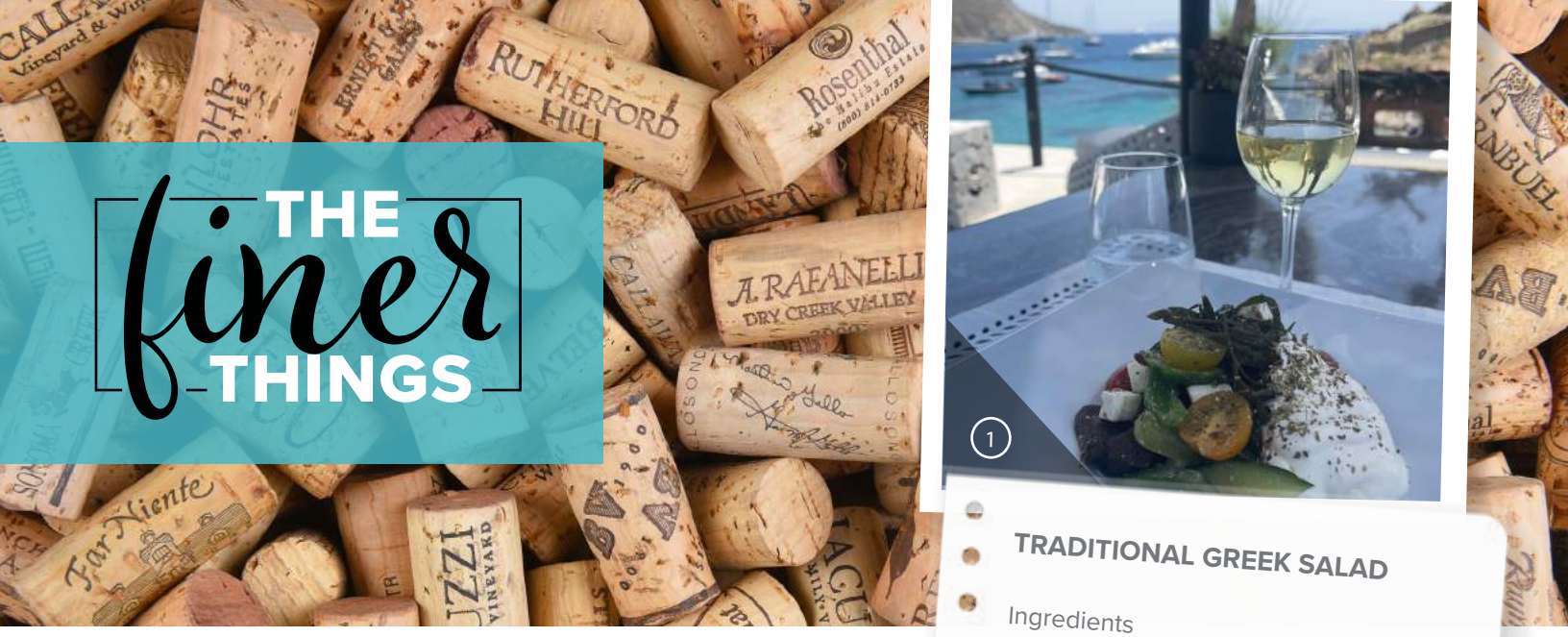
Last, the most important and take-home point I make to my pediatric patients is, "Your skin is your largest organ, and it's up to you if you want to take care of it. Most of the sun damage we get occurs before age 18 and can never be erased; it will come back to bite you when you are older. It's what ages your skin and causes skin cancer. Your parents should not have to remind you to wear hats and apply sunscreen constantly. You should be playing outside, sports, swimming, etc., but you must ensure you are doing it safely. The rule in my house is that if you aren't wearing a hat and sunscreen, you go back inside. Yup. Just imagine what it's like for the kids that live in my house!"

Remember, it takes just 2-3 minutes to cover ALL OF THIS with your pediatric patients while freezing a wart and examining their acne. Regardless of what they are in your office for, I would argue that sun protection will almost always be the most important thing you can discuss with minors and their parents.

If you are interested in Sunhero, click here.

>> Return to Table of Contents

THE finer THINGS



By: Ashley Dietrich, MD, FAAD

Who doesn't love a refreshing beverage paired with a delicious summer greek salad with the summer heat? Check out Dr. Tori Negrete's recipe that she adapted from their adventure in Greece this summer.

For an added twist on this traditional greek salad, swap out the feta cheese for burrata cheese, like Dr. Negrete had at her favorite restaurant in Mykonos!

This would pair well with a chilled Matthiasson Napa White (a greek version of this wine is in Tori's glass in this picture in Figure 1). The acidity of this blend of Sauvignon blanc, Ribolla gialla, Semillon, and Tocai friulano should help to balance the variable flavors in the salad.

When in doubt, a chilled sparkling rose or champagne typically pairs well with just about any summer dish. Recently, Pete and I were introduced to Charles Heidsieck Champagne at our Friday night Retreat tasting dinner at the Immigrant Room in Kohler. We have found it is a great champagne you can find at a reasonable price!

TRADITIONAL GREEK SALAD

Ingredients

- Roma or Vine-Ripe Tomatoes
- Cucumbers - Firm, smooth-skinned
- Red Onion
- Greek Kalamata Olives
- Green Bell Peppers
- Creamy Feta Cheese

Directions

Chop all vegetables into large chunks. Cut feta into chunks (never crumble), and add to bed of lettuce. Season with a dash of salt and dried oregano. Dress with an excellent extra virgin olive oil and a splash of red wine vinegar.

Serve immediately and enjoy!

If you are worried about finishing a bottle of sparkling, this is my favorite Champagne Stopper that can keep those bubbles fresh for another day or 2. It comes in three colors (silver, rose, and black) and is reusable.

If you are interested in learning more about wine, this user-friendly guide, "Wine Folly: The Essential Guide to Wine," is amazing to help with varietals (just reading the names is like learning dermatology all over again!), pairings, and tasting notes.

Wondering what to pair with the 2017 Alexander Valley Silver Oak Cabernet Sauvignon from the SKNV webinar? Try a dry-aged steak (like this tomahawk steak from your local butcher) served family style with your favorite roasted veggies and dipping sauce. This Cab I would consider a "big red." It's a classic Napa Cab with rich dark fruit flavors, tannins, and high alcohol. If steak isn't your thing, a cheese plate with Wisconsin-aged cheddar will pair well too!

Want to share? Do you have a wine, beverage, or food pairing topic for a future column.

>> Return to Table of Contents

FOREFRONT FIVE PODCAST

5 TAKEAWAYS

Are you looking for another way to immerse yourself in Forefront culture? Check out the Forefront Five podcast on your favorite platform. **Looking to beef up your business sense? Tune in to our next episode, focusing on running a practice, where we discuss everything from real estate to perfecting a P&L.**

Stay tuned this summer for more helpful episodes!

Listen on Apple Podcasts

LISTEN ON Spotify

Email betsywernlimd@forefrontderm.com *for ideas on content!*

FOREFRONT DERMATOLOGY® GRAND ROUNDS

A Grand Rounds Approach to Culture and Values

Did you know that your pathology lab sponsors CME every single month? Participate via webinar anywhere in the country to learn about exciting topics that will enhance your practice of dermatology, and earn you one hour of CME! Not available at the time of the live Grand Rounds? No problem! Listen on your own time through Zencast and earn CME hours when it's convenient for you!

Next Session:

Skin Cancer Management

Join Dr. Gaurav Singh as he discusses skin cancer mangement. During this session, treatment guidelines and management pearls for basal cell and squamous cell carcinoma will be discussed. Evidence for cure rates between surgical techniques will be explored. Participate via webinar anywhere in the country. This activity has been approved for *AMA PRA Category 1 Credit™.*

Session Airs On:

08.23

@5PM CST

Under the Scope: Dermatitis Herpetiformis

Article By: Kelli Hutchens, MD, MBA, FCAP
Pathology By: Ling Xia, MD, FCAP
Patient Of: Hannah Miller, PA-C

This 66-year-old male presented with an itchy, red, blotchy, and blistering rash that began five to six months ago. The patient states that a 12-day prednisone taper was prescribed by his Primary Care Physician and did not help. Clinical examination shows widespread urticarial papules and plaques, rare dry erosion, and a tense vesicle on the lower leg (Figures 1 and 2). Two punch biopsies were performed for H&E and Direct Immunofluorescence. The clinical differential diagnosis included bullous pemphigoid versus other blistering diseases.

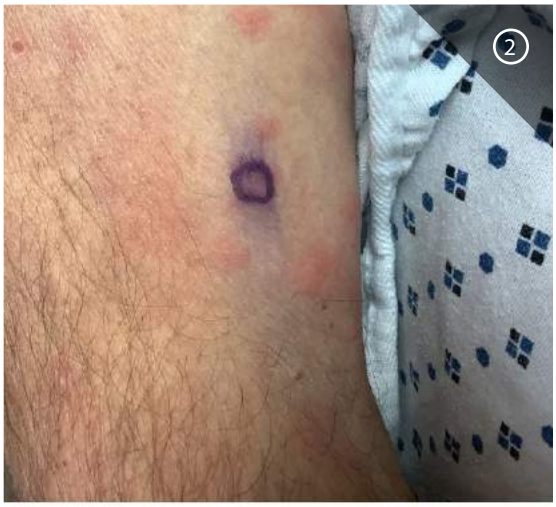
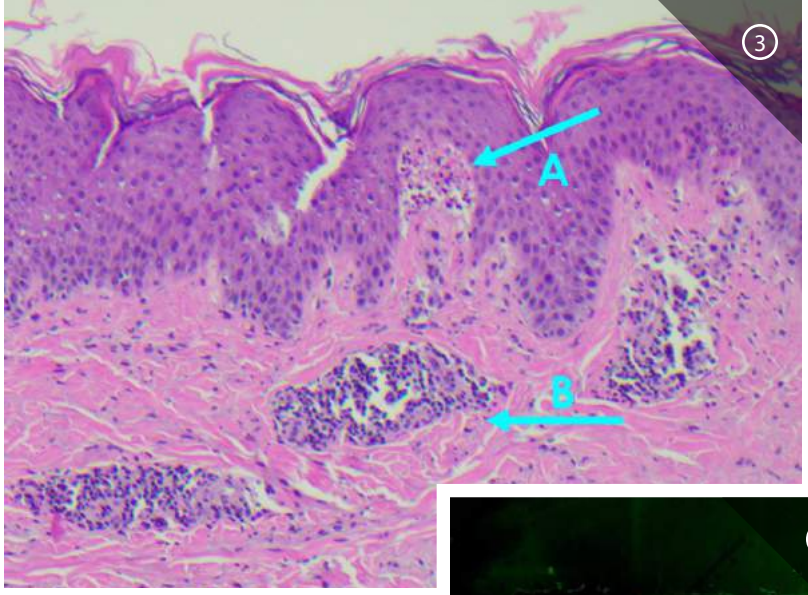


Figure 1: Landmark – Right anterior distal upper arm – Punch Biopsy performed for H&E.; Figure 2: Close-up – Right anterior distal upper arm – Punch Biopsy for H&E.

Pathology

H&E sections show a punch of skin to the deep reticular dermis with orthokeratosis and underlying superficial and deep perivascular and interstitial infiltrate of neutrophils. There is some neutrophilic infiltrate along the dermal-epidermal junction. Neutrophils are forming loose collections (abscesses) in the papillary dermis (Figure 3). There is a focal subtle vacuolar change of basal keratinocytes. There is dermal edema.



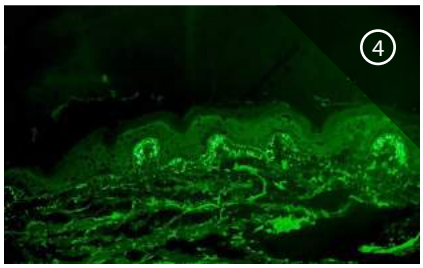


Figure 3: Classic DH histology: Collections of inflammatory cells, including neutrophils in the dermal papillae (A) as well as the perivascular and interstitial mixed inflammatory infiltrate (B).
Figure 4: Direct Immunofluorescence Studies showing granular deposition of IgA in the dermal papillae.

Direct Immunofluorescence Studies show granular deposition of IgA and IgG along the dermal-epidermal junction solidifying the diagnosis of Dermatitis Herpetiformis. Dermatitis Herpetiformis (DH) is a specific cutaneous manifestation of celiac disease (CD) due to gluten sensitivity and autoantibody generation. Tissue transglutaminase (tTG) catalyzes the deamidation of gliadin, creating epitopes that increase gluten-peptide binding affinity to HLA-DQ2 and DQ8 expressed on the surface of antigen-presenting cells. In a subset of individuals with HLA haplotypes DQ2 and DQ8, this binding leads to an adaptive immune reaction against gliadin, tTG, and sometimes eTG (epidermal transglutaminase). Due to the genetic inheritance required to express DQ2 and DQ8, 5-10%

of patients have a first-degree relative with DH or CD. Nearly all patients with cutaneous DH have typical CD alteration in a GI biopsy (villous atrophy, intraepithelial lymphocytes) and circulating autoantibodies against tissue transglutaminase (tTG).
All patients with DH have autoantibodies to eTG and tTG, while CD patients without DH only have anti-tTG.

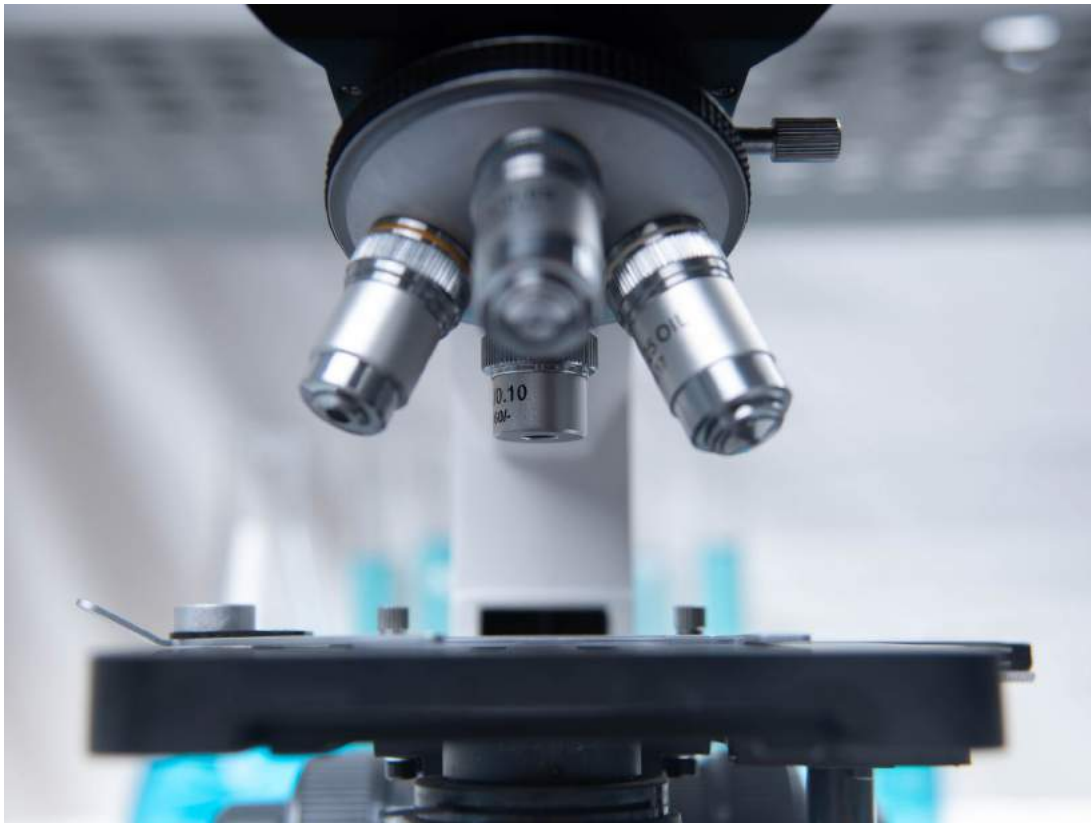
The creation of anti-eTG is likely due to epitope spread. This is supported by the high homology between these two enzymes and the presence of autoimmunity against neuronal TG in CD and DH patients. There is a lower prevalence of anti-eTG in pediatric patients and early-diagnosed CD patients, suggesting increased exposure to anti-tTG results in increased chances of forming anti-eTG. The specific role of anti-eTG in the formation of cutaneous symptoms is also still under investigation. The most accepted current theory is that this is a form of koebnerization (eTG released from the epidermis secondary to damage). Alternate theories include circulating IgA and eTG complexes that aggregate in vessels of the skin and kidney, creating cutaneous manifestations.

DH affects 11.2-75.3 per 100,000 people in Northern Europe. At the same time, it is rare in African and Asian populations due to extremely low to absent HLA DQ2 and DQ8 and low wheat consumption in these geographic regions. Interestingly, the association of DH with CD is weaker in Asian populations, and several reports exist of DH without concurrent CD. Overall, DH has decreased over the last ten years while CD is increasing. This is likely due to earlier identification and screening for CD patients. Like CD, DH is associated with autoimmune disorders, including type I diabetes mellitus, thyroid disease, connective tissue disease, and bullous pemphigoid. DH patients have a 22-fold increase in BP compared to the general population.

DH's most common clinical presentations include a pruritic, multiform skin eruption with erythema, papules, bullae, pustules, and classical grouped vesicles in typical areas (extensor aspects of the limbs and the sacral regions). It is typically symmetrical and rarely involves mucosa. Pruritus is the leading symptom and is nearly universally present. However, more often in pediatric patients, atypical presentations have been reported. Atypical presentations include asymptomatic palmoplantar petechiae, diffuse petechial rashes, palmoplantar keratosis, chronic urticaria, and prurigo pigmentosa-like lesions.

We all think of the classical microscopic findings for DH as neutrophilic papillitis with subepidermal splitting. However, up to 40% of patients may have nonspecific histologic findings with features of dermal hypersensitivity (perivascular infiltrate with rare eosinophils or neutrophils) or features of early eczematous dermatitis. The high percentage of nonspecific findings emphasizes the importance of performing Direct Immunofluorescence for the identification of the diagnostic presence of granular IgA in the deposition in the papillary dermis (Fig. 4). We recommend a punch biopsy of perilesional skin for Direct Immunofluorescence as well as a punch biopsy from an area of lesional, although not excoriated, skin for a standard histologic exam. Serologic labs for IgA tissue transglutaminase antibody (tTG), IgA epidermal transglutaminase antibodies (eTG, when available), and Total IgA Level are recommended. A positive test for anti-tTG generally should be referred to GI for biopsy. Additional screening considerations may include complete blood count, liver function tests, and serum calcium; iron, zinc, vitamin B12, and folate; and thyroid function tests even for patients with the skin-only disease.

Patients nearly universally respond to long term (life-long) gluten-free diet and Dapsone in the interim.



beauty BLOG

By: Tori Negrete, MD, FAAD & Ashley Dietrich, MD, FAAD

I am sure many of you, like me, came out of the retreat jazzed about Social Media after hearing our very own Dr. Sandra Lee's story on how DPP came to be. Maybe you already set up a Facebook page or Instagram account and have made a few posts! Perhaps you want to do more but are not sure where to start? Read on to learn more!

Let's start with building your brand for social media. As you define how you want to showcase your presence on social media: how do you want to be seen in your office and community? It is important to build brand consistency in your community.

For a more comprehensive workbook, please click HERE.

To start building out their branding, dermatologists should consider the following elements across their platforms:

- **Consistent logo** or icon image, color palette, and handle
- **Key terms** that help set the tone of your posts
- **Target audience** or followers

First, pick a platform you feel comfortable with, keeping your audience in mind. Many dermatologists start on Instagram because IG lends itself well to photos and short videos. However, Facebook likely has a more substantial target audience and the ability to build your brand. The platform you ultimately choose will also define your content and your target audience.

Note that Instagram and TikTok are highly visual, using photos or short videos, and are more popular among Gen Z and Millennial patients. Facebook, which uses pictures and text-based content, is more commonly used to connect to Gen X and Boomer generations.

The Forefront Dermatology Marketing Team is here to help you!

Helpful Social Media Hints

Dr. Ashley Dietrich, MD, FAAD

Social Media can help with brand awareness within your community. Here are some hints to help you build your social brand:

- Have a home page with links to your clinic page, so patients can book appointments and become more engaged in your practice.
- Post content that makes sense to you, so if you don't want to share a bunch of personal content then don't - keep it all about the clinic.
- If sharing any patient photos, get a social media consent form signed.
- Follow other accounts with a similar vibe, follow other Forefront dermatology colleagues, and share/ tag back and forth to show collaboration and increase reach.

Check out our Instagram:
Carmel, IN
Dr. Ashley Dietrich

>> Return to Table of Contents

summer HIGHTLIGHTS

FROM OUR FAMILY OF DOCTORS & PA/NPs

1

As Dr. Wernli mentioned in her President's Message, it's vital to get out and enjoy each day and not wait for the weekend or the right time! Take a look at a few of the submissions of summer fun from our Forefront Family.

1

1

1 Dr. Victoria Negrete and Dr. George Negrete enjoyed an absolutely fabulous vacation in Greece this summer.

2

2 Dr. Ashley Dietrich made her first hole-in-one on a 97-yard par 3 with her pitching wedge at her home course Chenequa Country Club. Witnessed by her husband, Pete. What a memorable 4th of July!

3

3 Dr. Betsy Wernli with her boys enjoying all the summer activities at their family compound, including a new motocross track! Of course, she will wave as she smokes her boys across the finish line!

4

4 Dr. Wernli represented Forefront with a tasty cocktail on the dock. Everyone needs some R&R after a busy clinic week!

6 Dr. Libby Jacobson and her family visited the Galapagos Islands 500 miles off the coast of Ecuador for her 20th wedding anniversary!

7 Dr. Ashley Dietrich and her husband, Dr. Peter Dietrich, enjoyed a golf weekend at Wisconsin's Sand Valley Resort.

8 Dr. Ashley Dietrich celebrated Pete's last graduation! Dr. Peter Dietrich is Milwaukee's newest Andrologist (male infertility specialist).

9 Dr. Maggie Maxi and her family loved the pool and outdoor activities this summer in Wisconsin!

10 Dr. Dietrich's 10-month-old puppy Riesling enjoyed their pool at their new house on his favorite dermatologist-approved floatie- the covered golf cart.

We hope you are getting out and enjoying your summer! Have a submission you'd like to share in our next newsletter? Submit **Here.**

FOREFRONT Forum

By: Tori Negrete, MD, FAAD & Ashley Dietrich, MD, FAAD

Forefront Dermatology is flourishing! We are excited to be heading to Georgia Peach state for our Fall Retreat!

(For additional details click on the bolded text to take you to the website)

Want to be a tourist in Atlanta? We are so excited to (finally!) be heading to the Georgia Peach state for Forefront's Fall Retreat! Since we all will have a little free time, here are some ideas for you to explore this great city!

Top Attractions

World of Coca-Cola: the one and only place you can explore the story of the world's most popular beverage brand. Take a guided tour for the VIP treatment!

Lenox Square: Great shopping just head to Buckhead, for all your luxury shopping needs (Nieman Marcus, Louis Vuitton, Prada, Gucci, Cartier, and more)!

National Center for Civil and Human Rights: an engaging cultural attraction that connects The American Civil Rights Movement to today's Global Human Rights Movements. Immersive and thought provoking exhibit spaces, including a MLK collection.

Chic-fil-A College Football Hall of Fame: a great place to check out for our college football fanatics! Check out the 760 piece helmet wall, interactive exhibits, and more!

Ponce City Market: a 2.1 million square feet attraction, and is home to big retailers, local boutiques, gyms, and more than 20 varied restaurants and food stalls (including multiple James Beard Award-winning chefs), plus an amusement park on the roof. Also, a great access point to the walking trails of the Atlanta BeltLine.

Atlanta BeltLine: repurposes the historic 22-mile railway loop around the downtown area into a multi-use paved path lined with native plants and art installations.

Krog Street Market: "one of the world's best food halls".

>> Return to Table of Contents

Check out the Alantan Resturants & Bars!

Restaurants By Hotel

Ray's in the City
$$$$
American Seafood and Steakhouse

By George
$$-$$$
American by James Beard award-winning chef Hugh Acheson

Top Restaurants Midtown

Steamhouse Lounge
$$-$$$
Seafood Bar

South City Kitchen Midtown
$$-$$$
Southern food

Empire State South
$$$$
Reservations required

Top Bars

Atlantucky – lofty brewery owned by Grammy-nominated Nappy Roots

12 Cocktail Bar – elevated cocktail experience on the Roof at Ponce City

Jojo's Beloved – 70s' and 80s' retro cocktail lounge

Bar Margot – for a sophisticated date night at the Four Seasons

Do's & Don'ts: Managing Angry Patients

By: Scott Goss, Chief Operating Officer, Regional & Practice Operations

Short fuses can exist in people at any time. Add in a time of great uncertainty in the world, and the result is that everyday annoyances that might have provoked mild irritation in the past can make someone explode today. Now makes a great time to reflect on how we can best manage angry patients. Knowing how to de-escalate tense situations is a valuable skill requiring the presence of mind, tact, and compassion.

DO	DON'T
Listen to the person's grievance. Don't be too quick to jump in with defense, to correct a misunderstanding, or even offer a fix. Just hear them out. Really listen and sincerely identify with the expressed irritation. Let the person know you personally get it: "I wouldn't like having to wait either. Your time is valuable, and this does seem to be a really long wait."	Fault the patient for experiencing the emotion. When anger arises, keep in mind that people feel this emotion for a legitimate reason. You may not like how people express their anger, but it is important to remember that the situation you are in likely wasn't the first thing to fuel their anger of the day, but just the tipping point of a collective bad day.
To the extent possible, you want to give the aggrieved person some sense of control over the situation. This can be as simple as offering an explanation: "We are extremely short-staffed today, and it is resulting in a delayed clinic." If you don't know why things are the way they are, promise to find out. People feel more in control when they have information. When possible, provide options such as offering to reschedule or to text patients, in a HIPAA compliant way, when it's their turn, so they have the freedom to leave and come back.	Do anything that intensifies or magnifies those feelings, such as assuming a confrontational or condescending air, threatening punishment, scolding, or otherwise ignoring or dismissing the angry person. Saying things like, "You need to calm down," or "I can't help you," or "You're disrupting others" is like pouring gasoline on an open flame.
Speak calmly with genuine curiosity and concern. Remaining polite and matching your nonverbal communication (expressions and posture) to your words can sometimes be enough to turn things around and help bring the patient to a calmer, more understanding state. Human beings are inherently social, and we have an almost irresistible urge to mimic one another and be more like those around us.	Ignore your body language. You can talk calmly all you want, but if your face clearly states you are irritated and annoyed with this patient, the situation will never reverse itself.

Adapted from: Kate Murphy. "The Best Ways to Deal with Angry Customers" *The Wall Street Journal* (May 29, 2022)

401k Corner: How to Handle Volatility

By: Chad D. Gruett, your Financial Advisor at Morgan Stanley

Big market declines can be unnerving for investors, often triggering emotions of fear and concern, mainly if they occur unexpectedly or in a very brief period of time. However, such declines are historically not unusual. Market volatility fluctuates based on where we are in the business cycle and due to external events that heighten risk and threaten growth. It is a standard feature of markets that investors should expect. When markets sell-off, investment returns will head lower in ways that can leave investors with material losses.

Does that mean you should try to sell when the market's "high" or sell if it starts to fall in order to reduce the potential for that kind of unpleasantness? Not necessarily. Here's why:

> Market volatility fluctuates based on where we are in the business cycle and due to external events **that heighten risk and threaten growth.**

Common Investing Mistakes

It's extremely difficult to predict the timing of a market downturn with the accuracy needed to profit from such a prediction. In other words, getting such a prediction wrong is easy and can be costly. While we do tilt our portfolios more aggressively or more conservatively based on our market outlook, the data shows that individual investors who radically reposition out of stocks in an attempt to catch the tip of a market top reliably miss out on gains more than they prevent losses and generate excessive transactions and tax costs along the way.

While "buy low, sell high" may sound like time-honored advice, the challenge of getting it right means it rarely is a good way to make decisions in practice. Indeed, individual investors who "sell high" and go to cash waiting

for a market downturn to come and go, often lose patience as stocks continue to increase. This results in their missing out on gains rather than preventing losses. That costly mistake is the reciprocal of another, wherein panicking investors sell their holdings during a market selloff, potentially locking in losses as stocks rebound while they remain on the sidelines. The prevalence of these value-destroying behaviors helps explain why individual investors tend to dramatically underperform market benchmarks.

There is a caveat to the generally superior buy-and-hold approach, which is that seeing a paper loss in your portfolio doesn't feel good. Some investors would rather take less risk, which may mean giving up some long-term returns, to reduce the time they may need to wait out losses, making for smoother sailing.

Consider Your Goals

Another factor to consider is how you're doing relative to your financial goals. A Financial Advisor can help by discussing goals and priorities and reassessing your portfolio based on where you stand. For instance, if you are saving toward a goal and have made good progress, it may make sense to take on less risk, regardless of the market outlook. This is for two reasons. First, it intuitively makes sense to take less risk when you have more to lose than to gain. Second, for additional peace of mind that your progress won't be jeopardized, you may desire less uncertainty from a more conservative blend of stocks, bonds, and cash.

If, like many of us, you have more progress to make and more roads to travel towards achieving your goals, riding out the market's jitters can be the best advice. Our research shows that markets are most predictable when you have a seven- to 10-year time horizon (due to how well current yields and valuations predict returns over those horizons). Our forecasts continue to suggest that stocks will outperform bonds and cash over that time horizon.

Bottom line: Working with your Financial Advisor can help you avoid short-term thinking and remember that investing is a long-term proposition. Keeping your eye on the horizon is your best strategy as an investor.

A Financial Advisor can help by talking through goals and priorities and reassessing your portfolio based on where you stand.

Risk Consideration

Equity securities may fluctuate in response to news on companies, industries, market conditions, and the general economic environment. Asset allocation and diversification do not assure a profit or protect against loss in declining financial markets.

Rebalancing does not protect against a loss in declining financial markets. There may be a potential tax implication with a rebalancing strategy. Investors should consult with their tax advisor before implementing such a strategy.

Yields are subject to change with economic conditions. Yield is only one factor that should be considered when making an investment decision.

Specific securities referred to in this material may not have been registered under the U.S. Securities Act of 1933, as amended, and, if not, may not be offered or sold absent an exemption therefrom. Recipients must comply with any legal or contractual restrictions on their purchase, holding, and sale, the exercise of rights, or performance of obligations under any securities/instruments transaction.

Discolsures

Article by Morgan Stanley and provided courtesy of Morgan Stanley Financial Advisor Chad D. Gruett. Chad D. Gruett is a Financial Advisor and Corporate Retirement Director in the Brookfield office of Morgan Stanley
Smith Barney LLC ("Morgan Stanley"). He can be reached by email at Chad.Gruett@MorganStanley.com or by telephone at (262) 523-8361. Chad D. Gruett may only transact business, follow-up with individualized responses, or render personalized investment advice for compensation, in states where he is registered or excluded or
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President & Editor
Betsy Wernli, MD, FAAD

Email

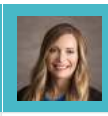
Betsy has a busy practice in Manitowoc, WI. She completed her undergraduate at the University of Oklahoma where she stayed for medical school and completed her residency at Iowa. She has three boys, four if you count her husband, and enjoys all things sports. She is obsessed with her Peloton®, and loves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

Kelli Hutchens, MD, MBA, FCAP

Kelli practices dermatopathology in Manitowoc, WI. Kelli has a special interest in healthcare quality management practices and serves as the Medical Director for our pathology lab. She is passionate about the lab, providing support to all of the Forefront physicians and PAs/NPs and their patients. Kelli and her husband have three busy children, and she spends her free time at sporting events or traveling to Irish Dance competitions.

Tori Negrete, MD, FAAD

Tori practices in Carmel, IN, 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, and Bernadette.



Ashley Dietrich, MD, FAAD

Ashley practices in the greater Milwaukee area in Menomonee Falls and Wauwatosa, WI. She completed undergrad at Marquette University and then medical school just down the road at Medical College of Wisconsin with her husband, Peter. She traveled south to a warmer climate to complete her residency at the University of North Carolina – Chapel Hill. She enjoys summer at their new house with Riesling, their 1-year-old golden retriever. While not being busy with her medical, procedural, and cosmetic practice, she enjoys golf, Wisconsin sports, and wine tasting.

Ling Xia, MD, FCAP

Ling completed his resident training at Brown University and fellowship at Cornell University. He is a dermatopathologist in our downtown Manitowoc pathology lab since 2009. When not reading slides, he spends his free time traveling. He and his wife Diana have two beautiful daughters, Kim, and Kate.

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!

Missy Mesfin, MD, FAAD, FACMS

Missy is a Mohs surgeon in Vienna, VA. She is a fellow of the American Academy of Dermatology, American College of Mohs Surgery and the American Society of Dermatologic Surgery. She attended the University of Michigan for both undergraduate and medical school. She also completed her dermatology residency and Mohs fellowship at U of M. Missy's interests include treating skin cancer, performing cosmetic procedures, and enjoying time with her two children.

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.

Robert Korenberg, MD, FAAD

Robert is in practice in Missoula, Montana, where he has been since 1994. He attended Albany Medical College, follow by University of Miami residency program. He and his wife enjoy the great outdoors, under the Big Sky. They especially like hiking and water activities on Flathead Lake.

Peter Katz, MD, FAAD

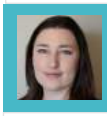
Peter practices general dermatology in Appleton, WI. He completed his MD at the Medical College of Wisconsin after graduating from UW-Whitewater, where he played football for four years and finished his residency training at the University of Iowa. He has two high school sons and a daughter in middle school, where he has coached football for several years and serves as the middle school football and wrestling programs director. He is also a pheasant farm owner and enjoys spending time with his family, traveling, and hunting when not attending one of his boys' football games, wrestling/track meets, or daughter's dance competitions.

Brent Weed, MD, FAAD

Brent practices dermatology and dermatopathology in Appleton, WI. He completed his dermatology residency and dermatopathology fellowship at Mayo Clinic in Rochester, MN. Brent and his wife have 6 children, 4 boys and 2 girls, and spend much of their time trying to keep up with them. He enjoys taking on odd jobs around the house, reading, and spending time in the great outdoors.

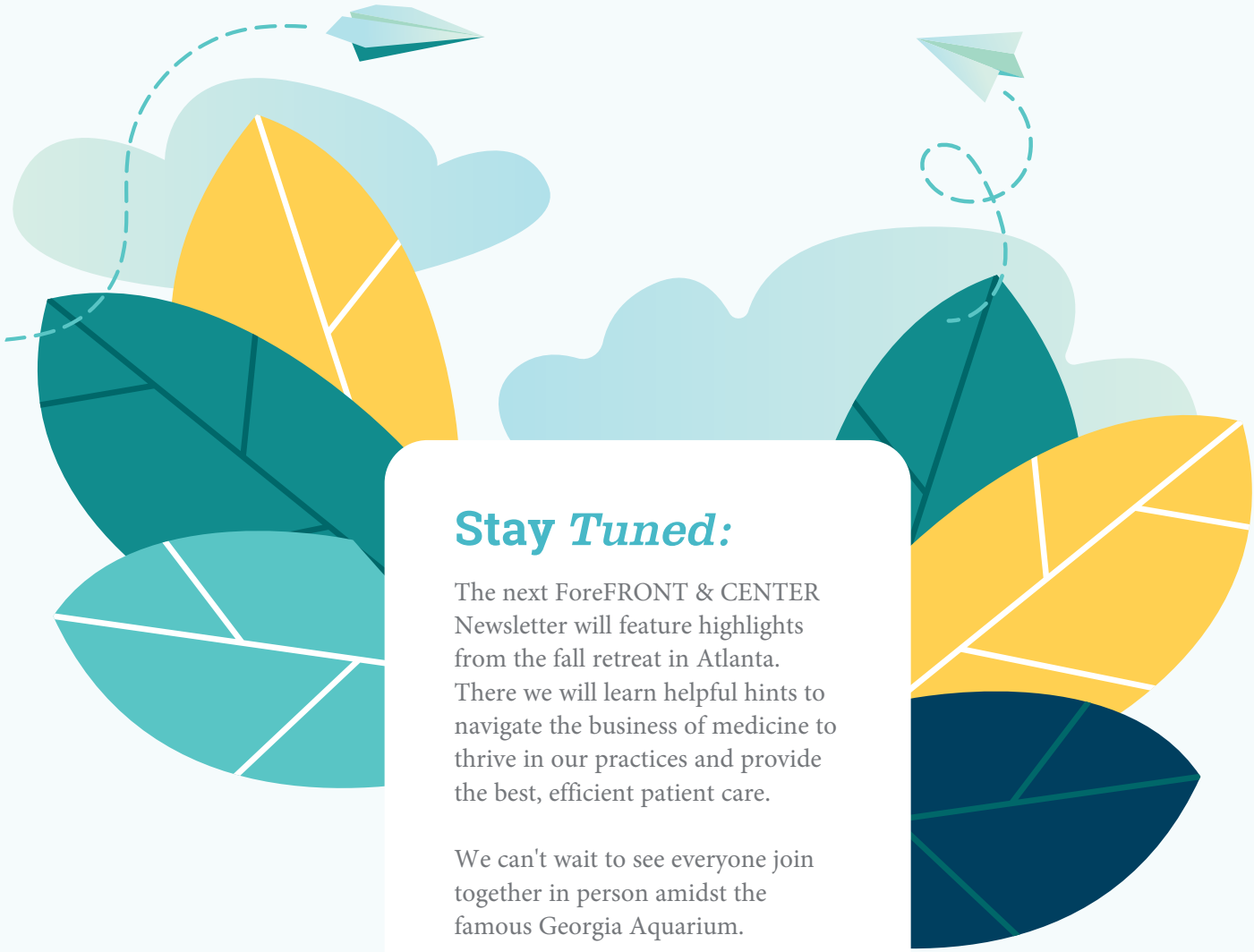
Scott Goss
Chief Operating Officer

Scott is the Chief Operating Officer and has direct leadership responsibility for clinic operations, marketing, patient access, credentialing, human resources, and clinical recruiting. He has been at Forefront for the past six+ years and has held leadership positions within healthcare services, device, and technology companies for 20+ years. He has been married to his wife, Janet, for over 20 years, and they have two boys, Nate (18) and Ben (16).



Kayleen Moore
Lead Documentation & Coding Specialist

Kayleen is our Lead Documentation and Coding Specialist. 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).



Stay *Tuned:*

The next ForeFRONT & CENTER Newsletter will feature highlights from the fall retreat in Atlanta. There we will learn helpful hints to navigate the business of medicine to thrive in our practices and provide the best, efficient patient care.

We can't wait to see everyone join together in person amidst the famous Georgia Aquarium.

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