foreFRONT AND CENTER

Q4 NEWSLETTER | October 2022 Special Edition

President's Message: How can we practice gratitude?

By: Betsy Wernli, MD, FAAD

Fall has hit, and our retreat is in the books. During the retreat, we focused on the business of medicine, everything from expanding access and engaging patients to how our coding turns into bills. While reflecting on the retreat, it struck me how much is involved in a single patient visit and how many people are behind the scenes ensuring our train stays on the tracks; I am genuinely grateful for our entire Forefront Family!

> "Feeling gratitude and not expressing it is like wrapping a present and not giving it.
>
> —WILLIAM ARTHUR WARD

As the holiday season approaches, what better time to say thanks? Practicing gratitude for not only our staff in the clinic and coworkers we work with daily, but also for someone we don't always see, someone who made our day better or allowed us to do what we do best, provide exceptional patient care.

Gratitude is an instrumental piece of the puzzle for all of us at Forefront. Psychology research shows that gratitude is associated with happier people, better health, and stronger relationships.

Being grateful does fit with the business of medicine and aligns with Forefront's values. I know we all feel thankful for the coworker who chips in and appreciate the steps others took before we enter the patient journey, but sometimes we forget to be grateful.

Remember, "Feeling gratitude and not expressing it is like wrapping a present and not giving it."—William Arthur Ward. Let's start practicing gratitude together; join me in thanking everyone from clinic staff to the teams in Central Services who help make the magic happen. Send a note to those who deserve it and enjoy this edition of foreFRONT & Center!

Because gratitude is never risky business, I want to thank each and every one of you for all you do!

THE

OCTOBER ISSUE

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Scan the QR code to catch up on past issues.

THE EXTRA MILE

By: Giacomo Maggiolino, MD, FAAD

Perhaps you may feel that Service Excellence is "nice to have," but doesn't affect your success as a physician or your profitability.

Well, I'm here to tell you that the opposite is true:

If you create a truly excellent patient experience and wow every patient you interact with, you are much more likely to grow your practice and see a significant improvement in your profits.

Impressed patients are more likely to share their experiences with others, creating a referral base to fuel your practice growth. They will tell their friends, family members, and even their primary care physicians, who will start and continue to refer patients to you! It is said that customer referrals are a critical factor for any business. In fact, it has been shown that existing customers can be your best source for advertising. Not to mention that referrals don't cost you what advertising does!

> "If you create a truly excellent patient experience and wow every patient you interact with, you are much more likely to grow your practice and see a significant improvement in your profits.

At the spring retreat, we discussed creating a vision to make every patient interaction a wow experience. We do this by trying to exceed expectations. We try to create greater value, better experience, and higher satisfaction than the competition.

There are many examples of successful companies that have used Service Excellence to fuel their growth. Consider Nordstrom or Chick-fil-A, which has revolutionized the fast food industry and is more than five times as profitable per location as its competitors, mainly due to extraordinary customer service. Within the medical field, the classic example is the Mayo Clinic, which has promoted its primary value of "the needs of the patient come first" and is recognized as a world leader in healthcare.

Don't miss the business opportunity that Service Excellence provides. Focus your energy on exceeding your patients' expectations, and your practice and profits will grow!

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Staying Ahead in the Dermatology Market

Listen to Download on Drugs + Devices, monthly, to stay ahead of the latest developments in dermatology and learn from your peers as they share essential information from their areas of expertise.

UPCOMING SESSIONS

11.10.22 @6PM CST
DISCOVER SOTYKTU (DEUCRAVACITINIB) FOR PSORIASIS

12.08.22 @6PM CST
CLEAR CELLULAR BENIGN SKIN LESIONS

01.12.23 @6PM CST
SELLING ORTHO-DERMATOLOGIC PRODUCTS IN THE CLINIC

Q&A

CODING CORNER

Unpacking Global Surgical Packages: What's Included and What's Not

By: Molly Moye, MD, FAAD, FACMS

For many dermatologists, global periods are a source of great confusion, and for good reason! What is included can seem arbitrary, and the difference between 10-day and 90-day global periods can be tricky. In this coding corner, we hope to demystify the global surgical package and answer some common questions our fantastic coding team fielded.

Q: What are global surgical packages?

The global surgical package includes all necessary services typically furnished by a surgeon before, during, and after a procedure. Routine post-operative care may include suture removal, bandage changes, wound checks, post-operative visits, and post-operative complications that do not require a return to the operating room, including management of post-operative bleeding.

Q: What procedures in dermatology have a global surgical package?

Many common dermatologic procedures have a 10-day global period, including destruction of benign, premalignant, and malignant lesions, intermediate and complex repairs, skin tag removal, and most nail procedures. Flaps, grafts, and soft tissue excisions carry a 90-day global period.

Q: When does the global period start? When does it end?

For 10-day global periods, the day of the procedure is Day 0 when it comes to determining when the global period begins and ends, so it's really 11 days. For 90-day global periods, the day before surgery, the day of surgery, and 90 days afterward are included in the global period, so it's really 92 days.

Q: I spent a long time talking with a patient about their likely squamous cell carcinoma, including potential treatment options, before performing a skin biopsy. Shouldn't I be able to code an office visit for all of this talking?

While this topic is not directly related to global periods, our coding team fields this question too frequently to miss this opportunity for education! The decision to perform a minor procedure (e.g., one with a 0-day or 10-day global period) on the day of the procedure is bundled into the reimbursement for the procedure. Coding a separate office visit code is inappropriate unless a separately identifiable service was also provided on the same day, which typically means other concerns were evaluated. The decision to perform a major procedure may be billed separately using a -57 modifier.

Q: I saw a patient on Monday and did a biopsy which came back Thursday as an invasive melanoma. I have an open excision spot on my schedule tomorrow. Is it okay to have the patient return within the global period for the excision? Is there any special modifier I need to use?

Our coding team gets this question all the time! Biopsies have a 0-day global period. Patients may return for an excision at any point after a biopsy, and no modifier is required.

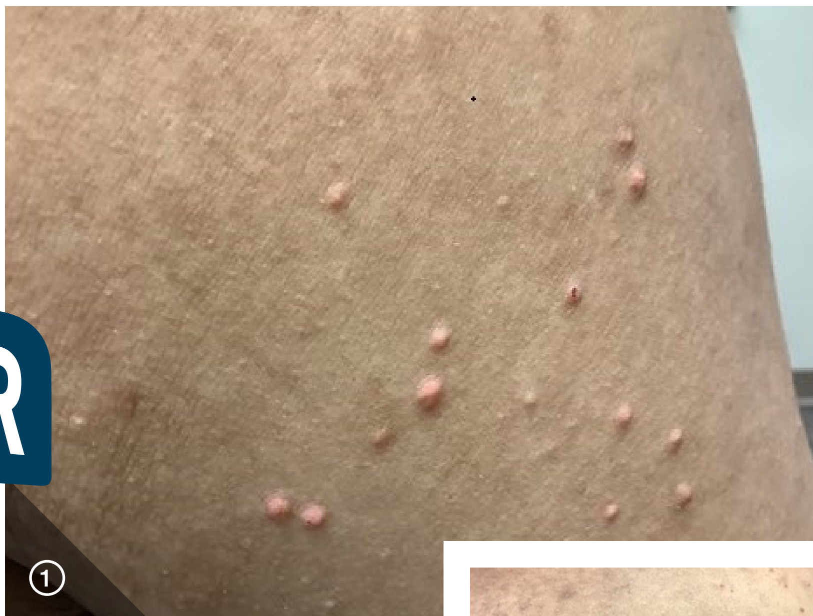
Q: My colleague did an excision with an intermediate repair, but was not in the office when the patient returned for suture removal seven days later, so I saw him instead. I counseled the patient on what to expect during the healing process and removed their sutures. Since I did not perform the procedure, can't I charge for this visit?

Global surgical packages include routine post-operative services, whether provided by the physician who performed the procedure or by another physician of the same specialty within the same group practice. 99024 should be coded for this visit. It would be incorrect to code an office visit.

Q: Why don't they do away with global periods? They are a pain…

You are not alone in thinking this! Payers would like to do away with them. Over the years, there have been many threats to eliminate global periods; this is an ongoing battle that our specialty societies fight on our behalf. The elimination of global periods would cause an instant 50-60% reduction in reimbursement for many of our common procedures because, for some procedures, over half of what we are being paid is for the anticipated post-operative visit. So, while you may feel you miss out on being compensated now and then for seeing a colleague's post-op patient, you benefit from global periods every day.

CLINICAL CORNER



By: Hannah Miller, PA-C

A 21-year-old male presents as a referral for keratosis pilaris. He reports a bumpy, asymptomatic rash involving his arms, legs, and trunk. Rash has been present for one month, developing abruptly. Ammonium lactate and over-the-counter hydrocortisone have been used without improvement. He has a family history of hyperlipidemia and diabetes and does not follow up with PCP for annual wellness exams.

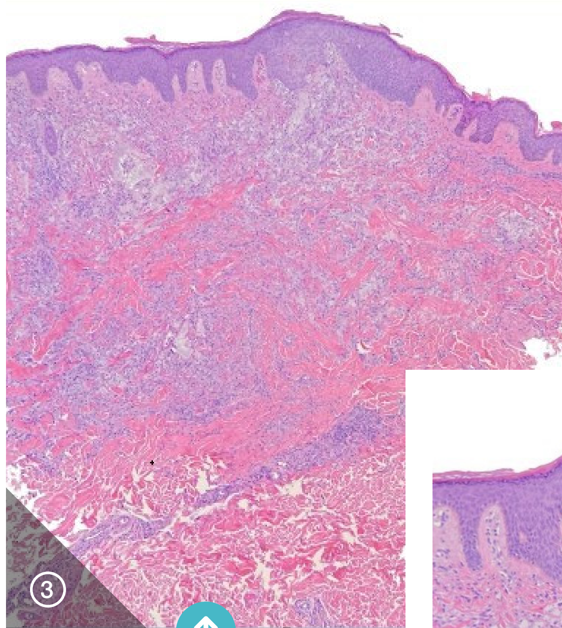
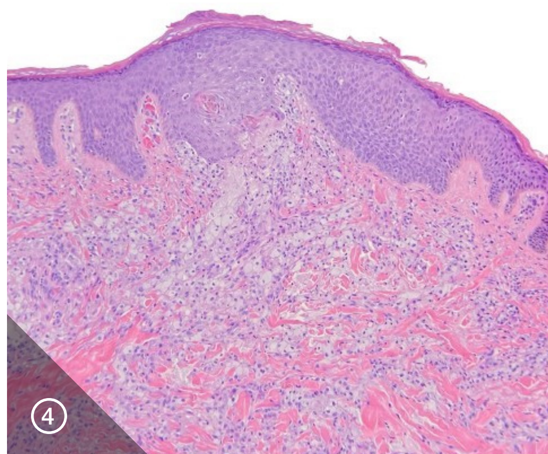


Figure 3 & 4: Collections of foamy histiocytes within the dermis.



Diagnostic Considerations

Cutaneous presentations of systemic disease are encountered regularly by dermatology providers. Abnormalities in lipid process and/or amount lead to the development of xanthomas, most commonly seen on the skin, tendon, and eyes. Identifying and correcting a lipid disorder can significantly benefit a patient's quality of life and reduce cardiovascular risk.

Exam

Remarkable for 2-5mm firm, dome-shaped, pink-yellow papules on the ears, dorsal arms, back, and anterior legs. The papules are too numerous to count.

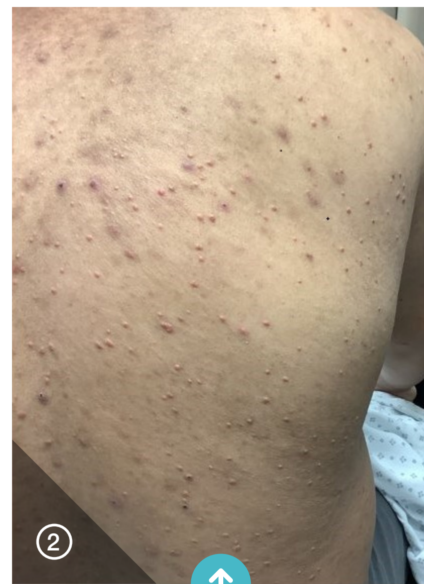


Figure 1: Eruptive Xanthoma—Right Upper Arm; Figure 2: Eruptive Xanthoma—Back.

Differential Diagnosis

The following would be considered: granuloma annulare, xanthoma disseminatum, folliculitis, sarcoidosis, leukemia cutis, Langerhans cell histiocytosis, lichen amyloidosis, erythema elevatum diutinum.

Next Steps

A punch biopsy of a lesion on the upper arm was obtained for H&E and was consistent with xanthoma. The patient was fasting, and the following

labs were drawn in the office: lipid panel, TSH, BMP, hemoglobin A1C, and hepatic function panel.

Triglycerides were elevated at 6,126, and total cholesterol was 613. In addition, he had a hemoglobin A1C of 13.0. TSH was within normal limits.

Diagnosis

Eruptive xanthoma—confirmed by pathology and severe hypertriglyceridemia. Histopathology findings include foamy histiocytes or lipidized macrophages within the dermis.

Treatment

The patient was urgently referred to primary care for the management of severe hypertriglyceridemia and diabetes with a recommendation for referral to cardiology. He was instructed to avoid all alcohol until the condition was managed.

Discussion

Eruptive xanthoma is a manifestation of systemic disease and ultimately the consequence of chylomicronemia and hypertriglyceridemia, with triglycerides often presenting in the thousands. In this condition, xanthomas favor the extensor surfaces and buttocks. Koebnerization has been reported, and pruritus may be present. The papules are made up of accumulated lipid-filled macrophages, described as foamy histiocytes by histopathology. The skin lesions often resolve within six months with the correction of hypertriglyceridemia.

It's important to determine if the cause of the lipid disorder is primary or secondary. Secondary causes guide lab work-up and include hypothyroidism, nephrotic syndrome, diabetes mellitus, excessive alcohol use, and medications. For medications, systemic retinoids, estrogens, protease inhibitors, cyclosporine, and prednisone commonly cause hypertriglyceridemia. If a secondary cause is not determined by work-up, the patient should be referred to cardiology for a familial lipid disorder evaluation.

Triglyceride lowering in cases of eruptive xanthoma is best achieved with medication, specifically fibrates and niacin. Triglyceride levels may be worsened with the use of bile acid sequestrants, and they should be avoided.

Patients with severe hypertriglyceridemia are at risk for acute pancreatitis. Triglycerides above 1000 mg/dL have been reported to cause pancreatitis. Symptoms of nausea, vomiting, and severe epigastric pain radiating to the back are concerning for acute pancreatitis.

SHOUT OUT!

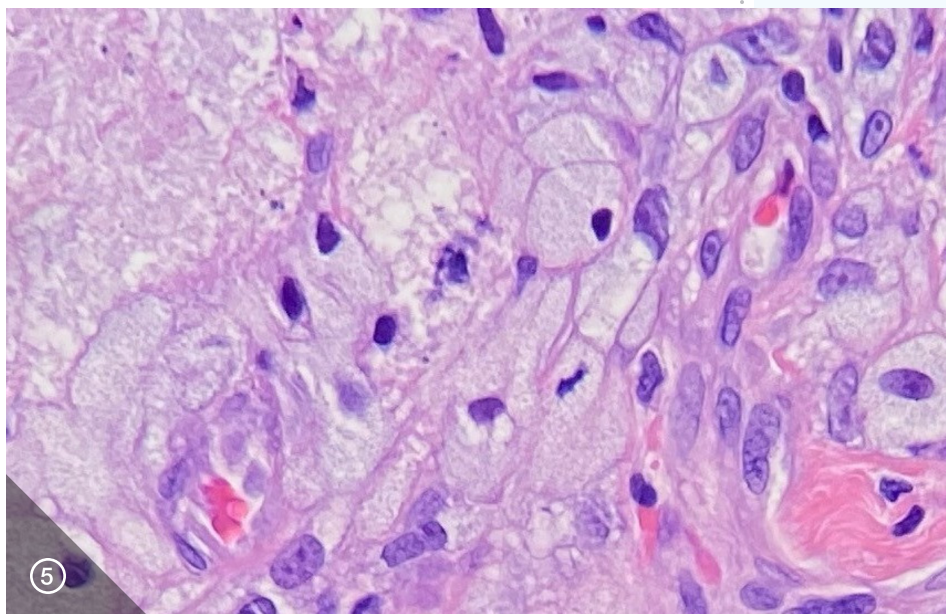
A big thanks to Drs. Semyon Zarkhin and Ashley Dietrich for their guidance with this case report and their continued support.

Dr. Semyon Zarkhin

Bellevue, WI
Green Bay, WI
Shawano, WI

Dr. Ashley Dietrich

Wauwatosa, WI
Menomonee Falls, WI



Clinical Note

It's important to note for individuals with skin of color, papules may appear tan to dark brown as the pink and yellow colors may not be easily appreciated.

While most lesions resolve within six months with appropriate therapy, some will persist. Surgery, laser, and cryotherapy have been used with success in lesions persisting in patients with normalized lipid levels. Patients should be cautioned about the potential for hypopigmentation with cryotherapy.

Resources

1. Danesh MD, Tan MD, Burgin MD, Eruptive Xanthoma. In: Goldsmith LA, ed. VisualDx. Rochester, NY: VisualDx; 2022.
2. Wanat K, Noe M. Cutaneous Xanthomas. In: UpToDate, Post TW (Ed), UpToDate, Waltham, MA. (Accessed on September 01, 2022.)

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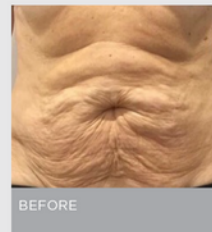

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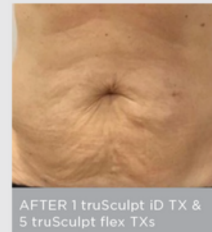

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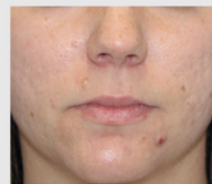

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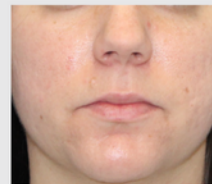

AFTER 1 TX

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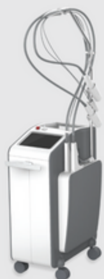

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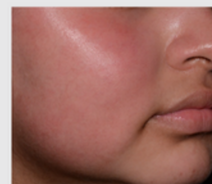

BEFORE

AFTER 2 TXs

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DISCOVER THE FUTURE OF DERMATOLOGY AND AESTHETICS AT CUTERA.COM

SCAN TO VIEW

DIVERSITY *in* DERMATOLOGY

By: Missy Mesfin, MD, FAAD, FACMS

The importance of diversity in the workforce

Diversity in the workforce has been an issue in the last decade brought to the forefront of many industries. In healthcare, diversifying the workforce is important in reducing healthcare disparity and improving patient outcomes. Inclusion is also another word that is also used with diversity, particularly as it relates to the workplace. What do those terms really mean? A diversity advocate named Verna Myers puts it like this: "Diversity is being invited to the party; inclusion is being asked to dance." While very simplistic, this description helps us understand how we address these issues in our medical workforce.

So, is there actual value of diversity in the workplace? Data collected in the 1990s-2000s, primarily in the corporate world, would support that. The data found that there were benefits of incorporating diversity and inclusion in both strategy and culture of businesses—not just for building relationships. Studies showed that diverse teams exhibited improved problem-solving ability, employee retention, and engagement. They found that more diverse executive boards actually generated improved profitability and overall business success. We in healthcare have another critical value that diversity improves—improved patient outcomes.

Various factors play a role in representation, acceptance, and progress in healthcare, including race/ethnicity, gender, sexual orientation, socioeconomic level, and physical disability status. These factors should all be represented to reflect our communities to allow us to give the best possible care to our patient populations that represent all various factors. In 2009, the American Medical Association (AMA) and Association of American Medical Colleges (AAMC) developed two diversity accreditation standards to ensure allopathic medical schools engage in systemic efforts to attract and retain students from diverse backgrounds and developed programs to broaden diversity amongst qualified applicants. These efforts have helped to ensure that a more diverse group is "invited to the party" in medicine.

As far as "being asked to dance," studies have also been done to evaluate how to be inclusive. The Harvard Business Review published an article on why inclusive leaders are good for organizations and how to become one. They found that inclusive leaders create an environment where all team members feel they are treated respectfully and fairly, are valued, and have a sense of belonging. To be an inclusive leader, one must have personal and institutional commitment.

WE MUST ALL DO OUR PART TO ENSURE THAT DIVERSITY AND INCLUSION ARE APPRECIATED IN ALL OF OUR PRACTICES.

6 Traits to distinguish inclusive leaders:

1 Visible Commitment

- Authentic
- Challenges status quo
- Accepts accountability

2 Humility

- Admits mistakes
- Creates Space for participation

3 Awareness of Bias

- Works to build awareness of personal blind spots

4 Curiosity About Others

- Has an open mindset and listens without judgment

5 Cultural Intelligence

- Attentive
- Adapts as required

6 Effective Collaboration

- Empowers others
- Provides psychological safety

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Many hospital systems have implemented various measures to achieve a more diverse and inclusive environment to incorporate these values. The Triple Aim has been established to align healthcare equality and equity: improve the patient experience in care, improve the health of patient populations, and reduce the per capita cost of health care. Below are some lessons learned from various hospital systems.

CHRISTUS Health

A not-for-profit health system in Texas, Louisiana, New Mexico

- "Increasing diversity and inclusion cannot be accomplished by one department. It must be embedded in a system-wide manner so that all leaders are held accountable for driving and sustaining it."
- "A reliable infrastructure must be in place to successfully collect and analyze race, ethnicity, and language data."

Main Line Health

Not-for-profit health system in Philadelphia and its western suburbs

- "Even at the most senior level of leadership in healthcare, mistakes will be made during the sensitive discussion of diversity. Therefore, it is imperative that the workplace environment encourages transparent discussions and empowers staff to hold each other accountable"
- "Leaders set the tone for promoting diversity and cultural competence within the organization by modeling respectful behavior and recruiting a diverse team."
- "It is critical to invest in the development and management of diverse talent, increasing the likelihood of retaining diverse employees."

Rush University Medical Center

Academic medical center in Chicago

- "Creating a culture of diversity should be consistent and deliberate, integrating patient care, education, research, and community partnerships:"
- "It is important to understand and meet the needs of underserved patients and employees, including those who are LGBT."

As healthcare providers, we must always strive to improve the quality of care we deliver to our patients. Understanding diversity and inclusion as it relates to the healthcare workforce is essential in achieving optimal patient care and other documented benefits. It is not just a matter of a "hot topic" as there is significant data to support the efforts to increase diversity and improve inclusion. Dr. Martin Luther King, Jr. stated, "Of all forms of inequality, injustice in healthcare is the most shocking and inhumane." We must all do our part to ensure that diversity and inclusion are appreciated in all of our practices.

Resources

1. Health Research & Educational Trust. (2015, July). "Diversity in Health Care: Examples from the Field." Chicago, IL: Health Research & Educational Trust. www.hpoe.org
2. Rosenkranz, KM, Termuhlen PM, et al. "Diversity, Equity and Inclusion in Medicine: Why It Matters and How do We Achieve It?" J of Surgical Education. July/Aug 2021; 78(4): 1058-65.
3. Standford, FC. "The Importance of Diversity and Inclusion in the Healthcare Workforce." J National Med Assoc. June 2020; (112(3): 247-249.

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401K CORNER: RETIREMENT PORTFOLIO

By: Chad Gruett, your Financial Advisor at Morgan Stanley

Economic uncertainty has fueled market volatility that we haven't seen since the 1930s, and as a result (I think), I've seen a significant increase in the number of individuals interested in reviewing their Forefront retirement account(s) in the context of their overall financial portfolio and goals. To that end, I wanted to highlight a couple specific tools/services that your peers have found useful, both of which are available to you at no cost by virtue of Forefront's relationship with Morgan Stanley:

Portfolio Risk Tool

Helps us to help you understand the risk embedded in your portfolio, hypothetically stress test your portfolio, and consider portfolio changes that seek more attractive opportunities.

Goals Planning System

Allows us to help you articulate/ formalize your goals and assess whether or not you're "on track" to achieve them.

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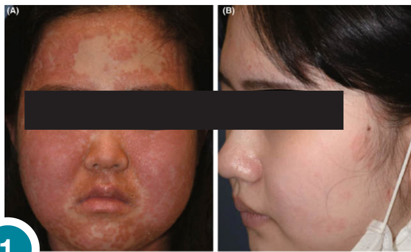
keeping up with the Kids

By: Sapna Vaghani, MD, FAAD

With the kids back in school, it's time we also exercise our brains! Take a break from the business side of medicine to test your knowledge as it relates to the most recent issue of Pediatric Dermatology (July/Aug 2022, Vol 39) and some of my clinic patients from last week!

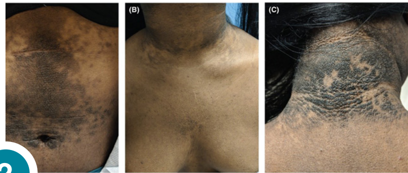


1

Facial involvement in psoriasis is associated with:

A. Increased disease severity with increase BSA and PASI
B. A younger age of onset
C. A higher average BMI
D. All of the above

D. While the above associations have been published about psoriasis in the adult population, a recent retrospective review of 175 pediatric psoriasis patients in South Korea found the associations hold true in the pediatric population as well. Given that up to 60% of pediatric patients with psoriasis report feeling stigmatized and bullied, it is important to consider facial involvement in pediatric psoriasis as a risk factor for a more difficult disease course, both medically and psycho-socially.

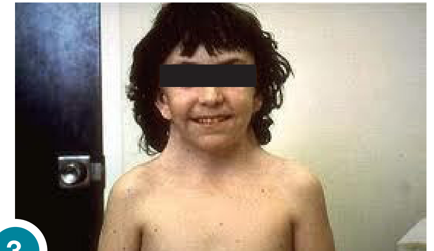


2

This patient is more likely than the average teenager to have:

A. Developmental delay
B. Hypothyroidism
C. Polycystic ovarian syndrome (PCOS)
D. Growth delay

C. This is confluent and reticulated papillomatosis (CARP). High rates of obesity (up to 84%) and comorbidities of insulin resistance, such as acanthosis nigricans and other endocrine disorders (primarily PCOS and type II diabetes), have previously been reported in a review of about 60 pediatric cases. More recently, a retrospective review of 111 pediatric patients of CARP at UT Southwestern from September 2013 to 2021 confirmed these findings with high rates of severe obesity (70%), acanthosis nigricans (65%), hyperlipidemia (22%), hypertension (10%), and PCOS (9%).

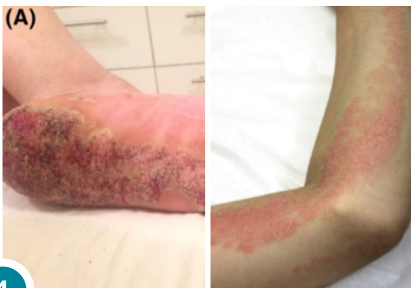


3

This patient is at great risk than average for:

A. Dysplastic nevi
B. Melanoma
C. Pilomatricomas
D. Vision loss

C. This patient has Turner syndrome (TS), or gonadal dysgenesis. Patients with TS have various cutaneous abnormalities, especially hair-bearing skin. Multiple pilomatricomas, including giant lesions, have been reported. Although patients with TS have increased numbers of melanocytic nevi, they are not at increased risk for dysplastic nevi or melanoma. Patients are more likely to develop hypertrophic scars and keloids. Other cutaneous findings include cystic hygroma, lymphedema of the distal extremities (sometimes with resultant onychodystrophy), and hair abnormalities (asynchronous scalp hair growth, absent axillary hair, or hypertrichosis).

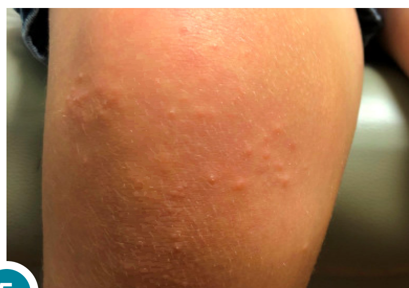


4

This lesion:

A. Is more common in males
B. Has a diversity of genetic causes
C. Typically develops at puberty
D. Classically has acanatholysis on histology

B. This is inflammatory linear verrucous epidermal nevus (ILVEN). It is more common in females and usually presents at birth or within the first year of life. It typically extends in a blaschkoid pattern over time and stabilizes in early childhood. Classic histologic findings in ILVEN are psoriasiform acanthosis with overlying alternating parakeratosis and orthokeratosis and corresponding hypo- and hypergranulosis underneath. A superficial perivascular lymphocytic infiltrate is seen within the dermis; however, the findings are not always characteristic, and rare histologic subtypes have been described. A recent study of five patients diagnosed with ILVEN based on clinical and histological findings revealed three different germline mutations (CARD14, PMVK, NSDHL), indicating ILVEN is a heterogeneous group of blaschko-linear inflammatory conditions as opposed to a well-defined monogenic mosaic disorder with some genetic findings more suggest child nevus and linear porokeratosis.



5

A 6-year-old boy presents with pruritic papules on the knees and elbows. The best initial step in management is:

A. To start topical steroids twice daily
B. To apply cantharidin
C. Observation, it will self-resolve
D. To refer to GI for a work up

A. This is frictional lichenoid dermatitis, a recurring condition that classically affects boys between 4 and 12 years of age. It is characterized by plaques of discrete lichenoid papules, primarily on the elbows, knees, and dorsal hands. Pruritus may be absent or severe. It is more common in the spring and summer, with many cases associated with outdoor play on grass and sandboxes. Interestingly, about half of the affected children also have asthma, atopic dermatitis, or allergic rhinitis. Treatment focuses on emollients, topical steroids, and avoiding frictional trauma in these areas.

Resources

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2. Jung JM, Jung CJ, Yang HJ, Lee WJ, Won CH, Lee MW, Chang SE. *Clinical implications of facial psoriasis in children and adolescents.* Pediatr Dermatol. 2022 Jul;39(4):528-534. doi: 10.1111/pde.14986. Epub 2022 Mar 28. PMID: 35347761.
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THE Secret SAUCE

FOREFRONT CULTURE

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

A FULL SUITE OF DEVICES FOR:

- LASER SKIN REVITALIZATION
- RF MICRONEEDLING
- VASCULAR CONDITIONS
- PIGMENTATION
- FAT REDUCTION
- MUSCLE SCULPTING
- ACNE TREATMENT

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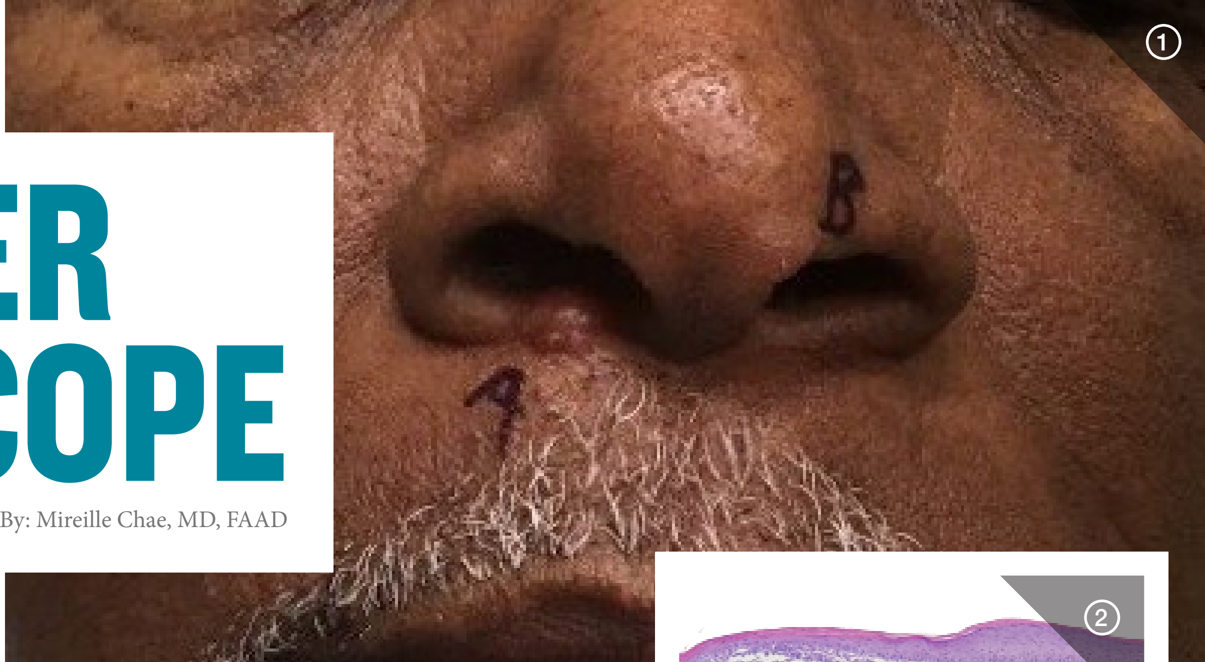
UNDER *the* SCOPE

By: Mireille Chae, MD, FAAD

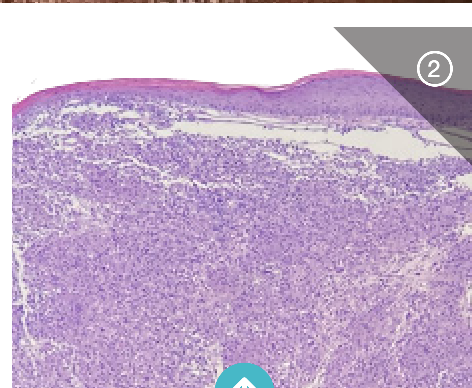


Patient 1: History

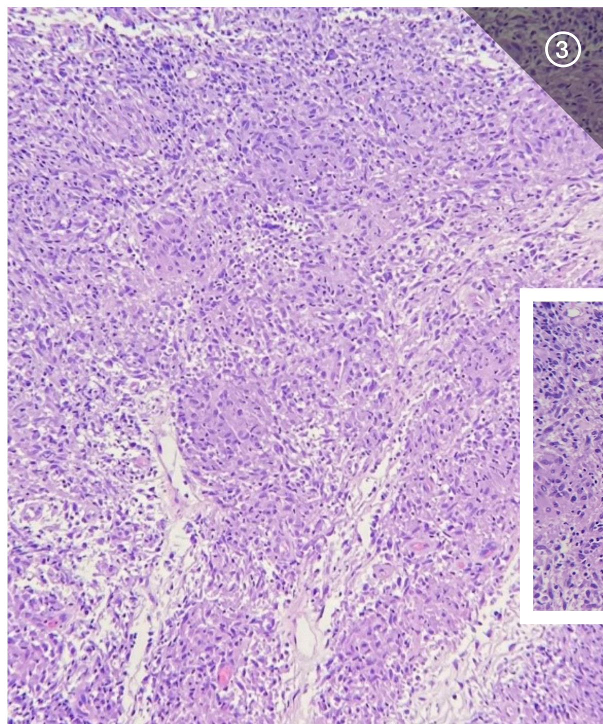
A 69 year-old male (patient of Frank Ferritto, PA-C) has been picking at irritated, tender pearly telangiectatic papules, present for several years, on the upper cutaneous lip and columella. The patient has no history of skin cancer and has been treating the lesions for two to three years with clobetasol cream from a prior derm office. Two shave biopsies were performed with a clinical differential diagnosis of basal cell carcinoma.

Patient 1: Pathology

Microscopic examination reveals a prominent dermal granulomatous inflammatory infiltrate with collections of epithelioid histiocytes and some lymphocytes. PAS-D and Fite stains are negative for organisms. These features are consistent with granulomatous dermatitis, with the differential diagnosis of sarcoidosis or infection. Correlation with clinical photographs and impressions favors sarcoidosis.

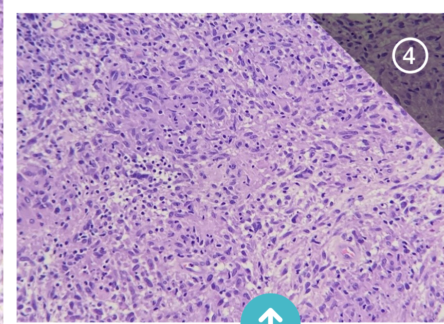


Patient 1; Figure 1: Clinical photo; right upper cutaneous lip (A) and columella (B). Figure 2: Histology low power.



Patient 1: Follow-up

Chest X-ray and CT scan were recommended to rule out sarcoidosis.



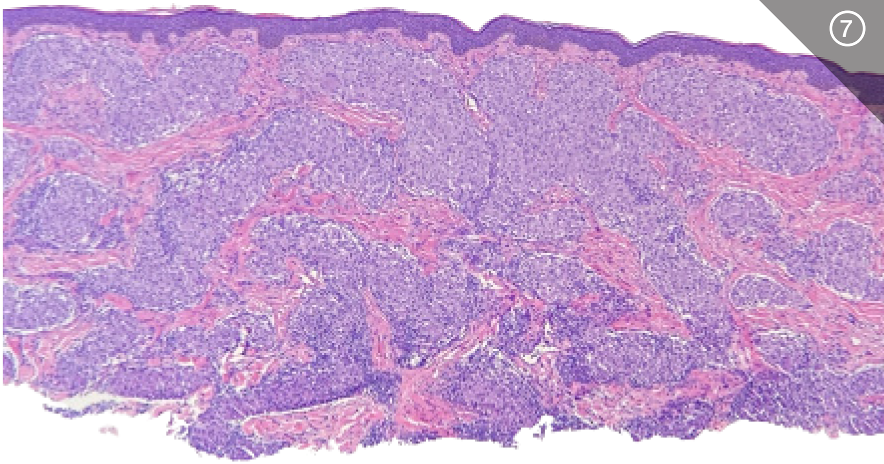
Patient 1; Figure 3: Histology medium power. Figure 4: Histology high power.

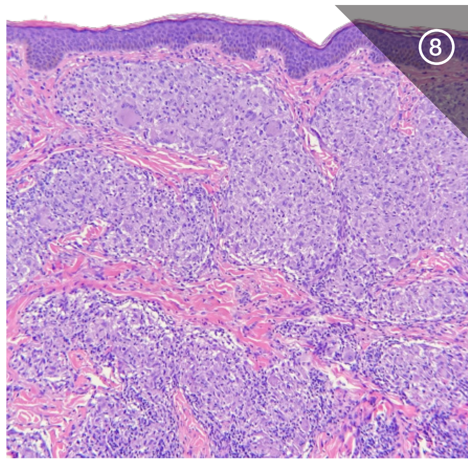
Patient 2: History

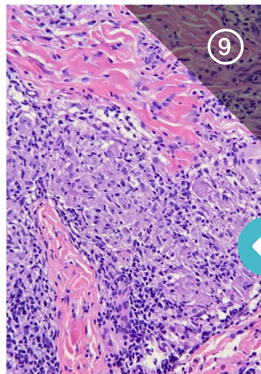
A 53 year-old female (patient of Mona Olive, CRNP) presents with untreated bumpy rash located on arms, shoulders, and upper back for six months. A shave biopsy was performed with clinical differential diagnosis, including granuloma annulare vs. sarcoidosis vs. guttate psoriasis. Clobetasol cream was prescribed.

Patient 2: Pathology

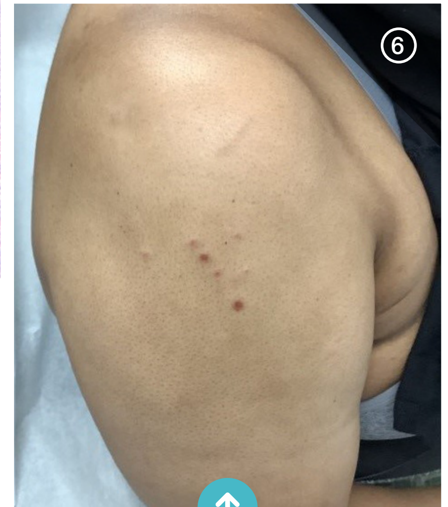
Histologic sections show a prominent dermal granulomatous inflammatory infiltrate with collections of epithelioid histiocytes. Minimal lymphocytes are present. No polarizable foreign body material is seen. PAS-D and Fite's stains are negative for organisms. These features are those of a granulomatous infiltrate compatible with the clinical impression of sarcoidosis.







Patient 2; Figure 7: Low power. Figure 8: Medium power. Figure 9: High power.



Patient 2; Figure 5: Upper back. Figure 6: Right arm.

Patient 2: Follow-up

None available.

Patient 2: Diagnosis

Granulomatous dermatitis, consistent with **sarcoidosis.**

Patient 2: Discussion

Sarcoidosis is a multisystem disease characterized by granulomas in various organs, including lungs, skin, eyes, liver, heart, nervous, and musculoskeletal systems. It occurs worldwide. African Americans and Scandinavians have a higher incidence of the disease. Sarcoidosis mainly affects people between 30-50 years of age and is more prevalent in women, non-smokers, and rural communities. Its incidence is estimated to be between 2.3 and 11 per 100,000 individuals/year. No single cause has been identified. Many researchers have hypothesized the role of genetics, environmental factors, and autoimmunity in the development of sarcoidosis. Cutaneous sarcoidosis can be the presenting sign of systemic sarcoidosis, and a work-up is indicated in all patients with cutaneous manifestations.

Lupus pernio is one of the more common forms of cutaneous sarcoidosis. Lupus pernio presents as bluish-red or violaceous nodules and plaques over the nose, cheeks, and ears.

A little history: The name is derived from the Latin name for 'wolf' (lupus) and 'chilblain' (pernio). It was incorrectly thought to be related to cutaneous tuberculosis and lupus vulgaris.

The prognosis may be worse when there is nasal mucosal involvement, and ENT intervention would be indicated. Nasal mucosal involvement can include cartilaginous destruction, nasal collapse leading to saddle nose deformity, and severe rhinitis with crusting and bleeding.

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Are you looking for another way to immerse yourself in Forefront culture? The Forefront Five is medically minded and lifestyle focused, a perfect blend of useful information and unique conversation! From famous guests to Forefront Dermatologists, we cover a full range of topics. Take your mind off the daily grind and tune in; you will find yourself lost in an entertaining conversation!

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!

UPCOMING SESSION

11.09.22
@4:30PM CST

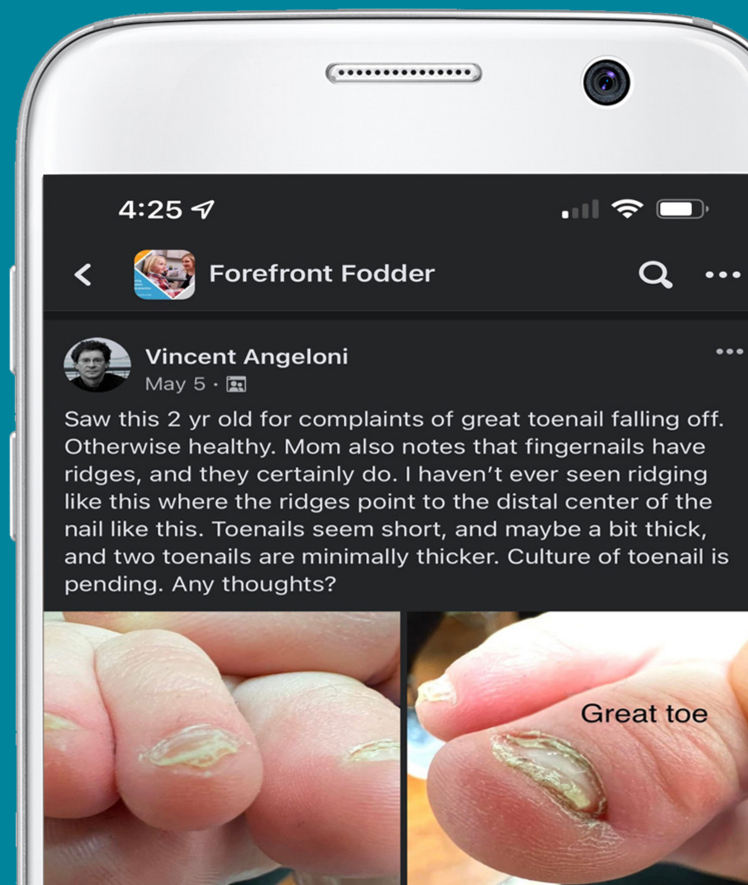
CODING & DOCUMENTATION FOR SURGICAL SERVICES

Join Dr. Molly Moye, MD, FAAD and Kayleen Moore, LPN, CDC as they discuss procedural coding and documentation for surgical services including: complex and intermediate repairs, mohs surgery, measuring flaps, PDT, global periods, and more!.

Stay in the loop from anywhere

You've probably heard of Facebook's platform Workplace, but are you familiar with how it works? 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 on the go!

Join the conversation!



HOT OFF THE PRESS

By: Katie Hunt, MD, FAAD

MOLLUSCUM CONTAGIOSUM

New topical for molluscum contagiosum: berdazimer gel (nitric oxide-releaser) demonstrated a 32.4% complete clearance count vs 19.7% in vehicle. Most common side effect was mild to moderate erythema.

RESOURCES
JAMA Dermatol, August 2022.

HIDRADENITIS SUPPURATIVA SURGERY

Patients report high satisfaction with clinic-based hidradenitis suppurativa surgery. Post-op healing reported to be less painful than flares. Types of procedures: sequential tunnel probing and deroofing of overlying tissue and excision with 5-10 mm margins with layered closure.

RESOURCES
JAMA Dermatol, February 2022.

KELOIDS

Keloids treated with combination shave removal and contact cryosurgery exhibited major reduction in scar volume in one cohort study.

RESOURCES
JAMA Dermatol, August 2022.

SKIN PICKING DISORDER

N-acetylcysteine yields 61.5% positive response rate among patients with skin picking disorder. Minimum 600 mg twice daily for 3 months.

RESOURCES
JAAD, July 2022.

MELANOMA

Melanoma overdiagnosis: an observational study of a primary care skin cancer screening initiative showed increased detection of thin melanomas. (Matsumoto M et al.) One side says this points to overdiagnosis, defined as "diagnosis of a disease that would not cause symptoms or death in a patient's lifetime." (Swerlick RA.) The other side notes that physicians have an obligation to individual patients to do no harm, optimize outcomes for patients and society, and advance technology. (Kulkarni RP et al.)

RESOURCES
JAMA Dermatol, April 2022.

ACTINIC KERATOSIS

Dermatoscopic findings that support squamous cell carcinoma arising in actinic keratosis: dotted/glomerular vessels, hairpin vessels, and white structureless areas.

RESOURCES
JAMA Dermatol, August 2022.

SQUAMOUS CELL CARCINOMA

4-year cumulative risk for invasive squamous cell carcinoma after field treatment was: 2.2% after fluorouracil, 3% after ingenol mebutate, 3.6% after MAL-PDT, and 5.8% after imiquimod in one secondary analysis of an RTC out of the Netherlands.

RESOURCES
JAMA Dermatol, June 2022.

PSORIASIS & ECZEMA

Psoriasis or eczema on palms and soles? One study in Korean patients found that palmoplantar pustulosis (PPP) patients were more likely to have typical comorbidities of psoriasis (inflammatory arthritis, type 2 diabetes, Crohn's disease) than patients with pompholyx eczema. PPP patients had higher risk of ankylosing spondylitis and Graves' disease and lower risk of the following than patients with psoriasis vulgaris (psoriatic arthritis, systemic lupus, Sjogren syndrome, systemic sclerosis, vitiligo, or alopecia areata.)

RESOURCES
JAMA Dermatol, April 2022.

ISOTRETINOIN MONITORING

Less tests needed for isotretinoin monitoring: international Delphi consensus study recommends ALT and triglycerides at baseline and again at 2 months only (peak dose).

RESOURCES
JAMA Dermatol, August 2022.

the Support Report

Putting Your Trust in Vendor Claims

By: Tori, Negrete, MD, FAAD, Joel Dalinka, General Counsel, and Ryan Cauley, Assistant General Counsel

We all know most sales reps will say just about anything to close a sale. Nevertheless, we tend to rely on what we are told without confirmation. Sales reps may even show you support for their claims from an "independent" third-party such as a think tank or a consultant. However, you should be skeptical of many third-party opinions because they are often paid or influenced in some way to hold that opinion.

Forefront clinics are also frequently approached by vendors seeking to sell products that are not FDA-approved. While Forefront places a great emphasis on clinical autonomy, it is important to understand the risks before making such a purchase. For instance, clinics should be cautious when using products vendors claim do not require FDA approval. Some such products, such as certain microneedling devices, may or may not be regulated by the FDA, and physicians should not rely solely on the vendor's claim. Similarly, there are ethical considerations that clinics should weigh when selling dietary supplements and other products to patients. The AMA warns us that physicians' sale of health-related products presents a financial conflict of interest. Physicians "should not sell any health-related products whose claims of benefit lack scientific validity." Therefore, if clinics decide to sell supplements or other products, they should only sell such items for which there is appropriate scientific evidence supporting the claims of benefit (e.g., double-blind studies as opposed to anecdotal evidence).

> When it comes to vendor claims, it may be prudent to trust, but verify!

If your clinic is considering entering into a relationship with a vendor and the sales rep makes a claim that sounds too good to be true or that you think might be untrue, you should independently validate the claim. Unless the information comes from a truly independent third-party, such as a government agency or a reputable non-profit, the opinion is likely not of much value. Evidence prepared by or on behalf of the vendor should be highly discounted. Feel free to contact Forefront's Legal Department to assist you in verifying a vendor's claims. When it comes to vendor claims, it may be prudent to trust, but verify!

Get Your Free Melanoma Box Today

Your patient has just been diagnosed with Melanoma; now what? While receiving all of the information and feeling prepared for what's next is important, it can still feel overwhelming. That's why we created our melanoma box—partnering with L'Oreal to give patients something to take home besides a pathology report—a box of skincare products, information, and sun protection advice.

MEET OUR **CONTRIBUTORS**

Betsy Wernli, MD, FAAD

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.

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.

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.

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.

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.

Mireille Chae, MD, FAAD

Dr. Chae has found her dream job in Dermatology and Dermatopathology here at Forefront Dermatology. She worked in private practice for some time in Washington state after medical school, but the Midwest drew her back (along with her husband's job). She loves a mystery, mystery being her favorite literary genre, and dermatology and dermatopathology give her the opportunity to be a medical detective. When she is not busy with mysteries, she practices ballroom dancing, hoping one day to dance on the floor of the famous Blackpool Empress Ballroom.

Hannah Miller, PA-C

Hannah practices medical dermatology in Green Bay, WI. She completed her PA program at Marquette University. Her journey with Forefront started in her childhood when her mother was diagnosed with melanoma. Hannah's free time is spent with her husband and Scottish Terrier, Norman, traveling and enjoying the outdoors.

Joel Dalinka

General Counsel

Joel is the General Counsel responsible for all legal and regulatory issues affecting Forefront. He also oversees Forefront's risk management and insurance programs. He has been with Forefront for the past 6+ years. Joel has been married to his wife, Andrea, for 20+ years, and they have three teenage children. When not dealing with all of the above, Joel also plays saxophone in various bands and spent 15+ years in an old-fashioned big band playing music from the 1920s and beyond.

Ryan Cauley

Assistant General Counsel

Ryan recently joined our team as Assistant General Counsel and has broad healthcare law experience, having previously practiced both in-house and private practice. Ryan completed his undergraduate studies at the University of Southern California and attended law school at the University of Iowa College of Law. He received a master's in healthcare law from the Georgetown University Law Center. Ryan, his wife, Jacky, and his son, Jack, reside in the Chicagoland area. Ryan enjoys playing golf and exercising in his spare time.

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As we continue to evolve as a specialty to meet the needs of our patients, our newsletter is also evolving to better meet the needs of our clinicians and staff. You can look forward to new changes, more faces, and reader-friendly content as 2023 rolls around. Please let me know if you have any ideas for topics to cover or would like to contribute!

Don't keep all your great ideas to yourself! Email me if you enjoyed this newsletter and what topics you'd like to see in future issues.

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