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DERM Perspectives
Practical Advice for the Dermatology Physician Assistant

About Face: Strategies for Topical Management of Facial Dermatoses

Know how to choose the best treatments for quick and effective clearance of various conditions that can affect the face.

By Gerard W. Stroup, PA-C and Coyle S. Connolly, DO

With no attempt at facetiousness, one can argue that facial dermatoses truly represent the "face" of a dermatology practice. Numerous diseases can affect facial skin, requiring diagnostic precision and an informed approach to treatment. Whether treating verruca, pigmentation loss, acne, scarring, or another condition, pinpointing the diagnosis and fine-tuning therapy are essential to success.

Importantly, recognizing how we differentiate between facial skin diseases and what kind of protocols we employ when treating a given condition is important for understanding diagnosis and treatment. Determining the severity of the condition and learning more about how the patient reacts to its progression or resolution will help to guide ongoing therapy.

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Treatment Tips

What Patients Should Know About Sunscreens

In response to repeated urging from inside and outside of the dermatology specialty, many patients may be using sunscreen on a more consistent basis. In many cases, however, simply applying sunscreen each morning is not sufficient to yield protection from photoaging, skin cancer, and pigmentary alterations. As the variety of available sunscreens continues to grow, patients must become savvy label readers. You can help by suggesting that patients look for specific label wording and ingredients.

For maximum benefit, every patient should select a broad-spectrum sunscreen with an SPF 15 or higher. Take a moment to explain to patients that, despite some persistent popular thinking, a product with an SPF 30 does not offer twice the protection of a product rated SPF 15. Furthermore, many patients fail to recognize that SPF is a measure of protection from burning only (UVB rays); it does not indicate protection, if any, from UVA rays, which

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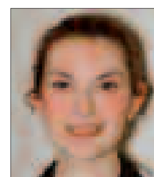

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Professional Opinions

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Letter From The Editor

Dear Physician Assistant:

Next year, the Society of Dermatology Physician Assistants (SDPA) celebrates its 15 anniversary. While PAs' service to the dermatology specialty extends well beyond two-and-a-half decades, this milestone reflects a more formal and unified presence for dermatology physician assistants in recent history. And it offers a good excuse to contemplate the future of PAs in the specialty.

As reported on p. 5, Physician Assistants in general can anticipate a growing presence in medical care, as observers predict continuing demand for services, accompanied by growth in income. Specifically within dermatology, PAs should face continued demand, as more and more physicians recognize that PAs can play an important role in enhancing patient care and improving the function of a thriving practice.

As Dermatology PAs continue to grow in prominence, discussions of scope of practice will remain front-and-center. Particularly among physicians who have not yet worked with a PA, the nuances of scope of practice can be confusing. Beyond having an impeccable knowledge of what falls within his/her own scope of practice, each PA can benefit both physicians and his/her PA peers by understanding scope of practice more generally and being prepared to accurately convey that knowledge. This is a good way o highlight PAs' collaborative approach to patient care, working side-by-side with supervising dermatologists.

Best wishes,
Coyle Connolly, DO
Medical Editor

Are You Acting Within Your Scope of Practice?

Think you know the scope of practice for PAs in your state? Unless you've personally checked the right sources, you could be wrong.

By Abby Jacobson, PA-C

Discussions about the role of Physician Assistants in dermatology almost always center on "scope of practice." Your scope of practice is what you can (or can't) do. Without doubt, "scope of practice" guidelines established by each state's medical board or governing body are at the heart of every PA's actions within the state. Yet it seems that few practitioners actually review these guidelines on a regular basis. Furthermore, each individual PA's scope of practice is further affected by physician supervision.

Getting Started

Simply put, in order to comply with scope of practice for your state, you must read and understand the practice guidelines put forth by your state medical board or governing body. The American Academy of Physician Assistants (AAPA) provides a link to the medical board/governing body for each of the 50 states at www.aapa.org/gandp/statereg.html. Obviously PAs who practice in more than one state must be intimately familiar with the regulations for each state in which he or she practices. In some states there are different regulations for working with a MD vs. a DO. Each PA must read these guidelines his/herself and seek clarification on any points that are unclear. A single read-through, however, is not sufficient. You must revisit guidelines on a regular basis—at least every six months—in order to maintain familiarity with regulations and identify any changes.

Do not rely on your supervising physician, the office manager, or PA colleagues to tell you what the scope of practice for your state is. Certainly these individuals—particularly the supervising physician—must also be familiar with regulations. But it is ultimately your responsibility to know the facts yourself. The temptation to rely on the knowledge of peers, especially those with significant experience and who tend to be knowledgeable about issues affecting practice, can be strong. Don't give in. I recall a conversation I had with a fellow PA who informed me that her state did not permit her to perform injections of Botox. When I asked her to show me where this restriction appeared within the scope of practice guidance, she found that it did not exist. She had been misinformed.

Unfortunately, jargon occasionally obfuscates the meaning of particular passages. If you are confused about anything in the scope of practice guidance, turn to the state medical board for clarification. Usually staff will be willing to explain any points of uncertainty to you. You may also contact your state PA society, the AAPA (aapa.org), or the Society of Dermatology Physician Assistants (SDPA, dermpa.org) for clarification.

Supervision: Another Ingredient

State guidelines are like an umbrella, providing guidance for a broad range of PA practice settings. Supervision may be likened to a raincoat, for inherent in all regulation is that the PA's specific activity will be directed by the practice of the supervising physician. Supervision is not simply a legal/oversight issue; it is part of our practice philosophy as PAs and essential to our approach to patient care. There are two primary considerations regarding supervision as it relates to scope of practice.

Each state will define "supervision" as it relates to the PA. Specifics vary, but each state will set forth the requirements for direct and indirect supervision as well as outline when and if each is appropriate. Laser use is one area of practice for which states may dictate specific requirements for direct supervision. Obviously any PA who practices outside of these requirements would be acting outside his/her scope of practice. Acting outside your scope of practice is grounds for revocation of your license.

The second component of supervision may not always be consciously recognized: The PA's scope of practice is very much determined by the scope of practice of the supervising physician. The PA should only be providing care consistent with the care provided by the physician with whom he or she works. Consider, for example, that by nature of my training and experience, I am prepared to deliver a baby. And scope of practice for my state permits PAs to provide obstetric services, including delivery. However, since I practice under a dermatologist, and obstetrics is not an element of dermatologic practice, I would be acting outside my scope of practice if I began delivering babies ("good Samaritan" care in an emergent situation is a matter for other discussions). In addition, most states require you to write up a practice agreement that states which duties you'll perform, where you will see patients, and how you'll be supervised. Obviously delivering babies is not included in my practice agreement that we submitted to the state board of medicine for approval.

Recognition of this fact effectively refutes a common argument set forth by some detractors who suggest that PAs working with dermatologists can eventually use their skill and experience to "do dermatology" for internal medicine or family practices. Beyond the fact that PAs in dermatology have worked hard to establish strong ties with the specialty and that most seem to enjoy the challenges and opportunities (as well as higher income) that service to a bona fide dermatology practice provides, the reality is that few PAs would agree to "do derm" in a non-dermatology

practice because such practice would be outside the PA's scope of practice. Certainly a PA in family practice or internal medicine would be expected to treat all the common dermatoses that these practices see on a regular basis. However, the PA would also be expected to provide referral to a dermatologist when the patient's needs exceed the scope of internal medicine or family practice.

Some PAs who primarily practice dermatology may moonlight in other fields. Emergency medicine is popular. In this setting, the PA may occasionally apply her/his dermatology knowledge to assist in diagnosis or management of a cutaneous presentation (a porphyria, perhaps). This is certainly acceptable, so long as the PA does not misrepresent his/her role as a dermatology "expert," and that the patient receives appropriate referrals to a dermatologist for follow-up care.

Special Considerations

From the initial interview/contracting stage through each day of practice, the PA and physician should work together to address any issues related to scope of practice. Whether the PA wishes to take on new duties within the practice or the physician wants to delegate additional responsibilities, compliance with scope of practice is usually clear-cut. If for any reason you are uncomfortable providing a particular service, whether due to a scope of practice concern or any other reason, simply inform your supervising physician of your discomfort. Most physicians are wise enough to accept this statement at face value. No PA should ever provide a service he or she does not feel comfortable providing. However, if and when confusion regarding scope of practice is at the heart of the PA's concerns, he or she should be willing to work with the physician to clarify the issue and engage in conversation with the physician to determine how similar instances will be handled in the future.

Thankfully it is extraordinarily rare for a physician to ask a PA to do something that is unethical or illegal, but news headlines and anecdotal reports confirm that such situations can arise. Should you ever feel pressured to do anything inappropriate, simply refuse and maintain your position. We could address proper handling of such scenarios in a full article of its own. Suffice it to say that the PA has a responsibility to act ethically and within his/her scope of practice and to report any action by supervisors or peers that is clearly illegal. At a minimum, a PA pressured by a supervisor to act inappropriately would do well to consider alternative employment opportunities.

> You must revisit guidelines on a regular basis—at least every six months—in order to maintain familiarity with regulations and identify any changes.
> Do not rely on your supervising physician, the office manager, or PA colleagues to tell you what the scope of practice for your state is.

Finally, avoid the temptation to comply with patient requests that may exceed your scope of practice. Perhaps, for example, an affable, elderly patient with no nefarious intent asks you to provide a refill for her hypertension medication, "so I won't have to get my son to drive me to the doctor's again tomorrow." She may even argue that she "sees you more than Dr. Smith, anyway." You may be knowledgeable about and even have experience with the use of these agents and could make rational arguments that you are ensuring the patient's overall health by promoting compliance with her medication. However, since hypertension management does not fall within the practice of dermatology, you would be acting outside your scope of practice.

Patient Advocates

Scope of practice generally is not a nebulous concept. State regulations delineate what PAs may do and the requisite level of supervision. Each PA's scope of practice is further defined by the scope of practice of the supervising physician. It is incumbent upon PAs to be familiar with scope of practice guidance for the sate in which they practice and to revisit those guidelines on a regular basis. PAs must also pay attention to scope of practice issues that may arise and become involved in issues if needed. National and state PA societies along with the SDPA can help PAs understand state regulations and issues regarding scope of practice.

As patient advocates and subscribers to the Hippocratic oath, we as PAs strive to provide the best care to our patients. Failure to comply with scope of practice—even inadvertently—puts our licensure and subsequently our ability to care for patients at risk. In addition to ensuring that we provide services with the utmost skill and in compliance with current standards or care, it also means that we work within our scope of practice to ensure the safety of patients and maintain our patient's rights to access the PA-Physician team. ■

PA Practice Insight

In a Shaky Economy, PAs Enjoy Job Security

Whether or not the US economy currently or soon will meet the definition of a "recession," there's no denying a present "slump," with markets flat or down and employment figures disheartening. It turns out, though, whatever the nation's economic future holds, physician assistants can be confident about their future. PAs have one of the best careers for a recession. According to a CNNMoney.com article recently reported by the AAPA (aapa.org), PAs have a projected job growth rate of 27 percent over the next decade and a median salary of $84,000.

The CNN report was based on a review of a US Bureau of Labor Statistics list of 30 occupations expected to grow most quickly over the next 10 years. PAs ranked high in that listing. Additionally, independent salary analysts predict continued income growth for PAs. ■

Facial Dermatoses

Continued from p. 1

Facing the Conditions

Some of the conditions that may affect the face are actually core conditions that clinicians are used to seeing, but when they occur on the face, these presentations may pose unique challenges. Consider this example: one of the most common facial problems presenting to general dermatology clinics is acne. While many clinicians can diagnose acne rather simply, other elements may either complicate acne or prevent the selected treatment from reaching its optimal potential. For example, patients may present with acne, but what's really concerning them is the discoloration and scarring. This is where the art of medicine comes in: It's easy to treat the acne, but not necessarily as easy to treat the side effects. What bothers the patient and what you see clinically may be very different, which is why it's important to be on the same page.

Given these considerations, there is a fair amount of subtlety in matters of the face. Sometimes patients have one or two or three conditions at a time, some of which depend on each other or are caused by another condition. Patient understanding of the process, patient compliance, managing the side effects, and knowing what OTC products the patient is using directly affect success and treatment outcomes.

Another common condition we see in our offices would be irritant/allergic contact dermatitis. Identifying the causative agent is crucial and often challenging. Initial triggers can come from anywhere, ranging from occupational chemical exposure to application of apparently harmless creams and lotions to the face. Hand sanitizers, fingernail polish, makeup, perfume, and fragrances are all potential causes.

Facial verruca is not as common as irritant dermatitis or acne, but you have to ask yourself many of the same questions about patient history, age, and lifestyle. For example, treatment of verruca on a child's face may require a topical retinoid to start, while an adult may tolerate light cryosurgery at the first visit.

These complexities coupled with insurance issues and a patient's financial status may often affect treatment scenarios, and clinicians must consider these factors when deciding on a treatment. Prior authorization for specific medication can delay treatment, and some medications are not covered by insurance.

The following discussion will cover a variety of facial dermatoses with an emphasis on understanding the most useful components of effective protocols for diagnosis and treatment. Sometimes the best regimen is something that the patient can afford and will actually use rather than the textbook approach.

Pop Quiz

Post-inflammatory hyperpigmentation: When determining the appropriate treatment, it's important to assess the patient's skin type on the Fitzpatrick scale. The standard of care for post-inflammatory hyperpigmentation (PIH), in most cases, is a hydroquinone-containing formulation, which is generally successful across the board for various types of PIH. There are a number of prescription-strength medications that are beneficial for some types of PIH—from EpiQuin Micro (SkinMedica), to TriLuma (Galderma), and Lustra (Taro)—all containing 4% hydroquinone, that can be applied once or twice a day with a recommended sunscreen for optimal efficacy.

The glaring downside to hydroquinone is that it's not covered by insurance in most cases and may be needed for two or three months of therapy. Whether hydroquinone is a fit often depends, therefore, on the patient's financial situation/insurance. If prescription-strength hydroquinone is not a suitable option, then consider an over-the-counter preparation containing lower concentrations of the agent. Another topical drug to consider is azelaic acid (Finacea), which may help darkly complected individuals with post-inflammatory hyperpigmentation. In our practice, we find ourselves scrambling to give samples of hydroquinone or azelaic acid for patients who can't afford the agents or lack insurance coverage.

> A trial of topical retinoids can also aid diagnosis of AKs, as areas of persistent scaliness or redness following several weeks of retinoid therapy could confirm the presence of profound actinic damage.

It's helpful to consult a staff aesthetician, if available, to determine if any cosmetic interventions could be useful. Chemical peels and microdermabrasion can be useful adjuncts or first-line interventions, depending the degree of PIH and the patient's skin tone. Again, though, the downside is that aesthetic intervention is not covered by most insurance plans.

Consider ancillary costs associated with therapy, as well. For example, a patient using a hydroquinone must also use a sunscreen at all hours of the day because reduction of sun exposure is key to treatment and prevention of pigmentary alterations. Explain to patients that sunscreens with SPF 15 or greater in winter or with minimum sun exposure are acceptable. In cases of significant sun exposure and in the summer, they should be using a sunscreen with SPF 30 or greater. Also, it's important to use sunscreens offering UVA and UVB protection. We favor products such as over-the-counter Neutrogena with Helioplex and Anthelios (LaRoche-Posay), which is readily accessible and affordable for the patient. If the patient does not use the appropriate sunscreen, treatment will likely be compromised. Vigilance is essential, because even a little bit of sun, (depending on the patient) can potentially worsen the condition.

Finally, identify and treat any underlying process, such as acne or eczema, that may be contributing to PIH and treat it accordingly.

Melasma: Similar to PIH in that it represents a disorder of pigmentation, melasma is a relatively easy diagnosis. Patients tend to be female, have been exposed to excessive sun, or have fair skin. Oral contraceptives and pregnancy are also common causes of melasma. TriLuma is a solid therapy with a good track record and a substantial amount of data supporting it. Moreover, it's relatively affordable, (between $84-120, which is reasonable for a prescription medication). One of the benefits of TriLuma is that it contains tretinoin and the corticosteroid fluocinolone acetonide in addition to hydroquinone, which is helpful when irritation and/or redness are present. Over-the-counter formulations containing hydroquinone are occasionally helpful, though efficacy and speed of improvement will be much lower compared to a prescription-strength formulation.

Actinic Keratoses: The standard of care for AKs is cryosurgery. The downside is that it often results in hypopigmentation and is typically painful to endure. Nonetheless, it is highly effective. Topical therapies offer an alternative to cryosurgery, and include topical 5-fluorouracil (such as Carac, Dermik or Efudex, Valeant), which are proven treatments that do not typically leave hypopigmentation. Topical imiquimod (Aldara, Graceway) is also effective but can be expensive.

Some physicians have had success with diflocenac sodium (Solaraze, Doak) which is the lowest potency agent used to treat AKs. It creates minimal irritation, but treatment courses may proceed from several weeks to months. It may be beneficial for providing a field effect in patients with multiple pre-cancerous lesions or those with very thin or sensitive skin, though we don't use it often in our practice due to lack of patient compliance associated with the length of therapy.

Topical retinoids are now widely employed in management of AKs. It can be helpful to start a patient on a lower-dose retinoid—preferably provided as a sample—and then work them up to a higher concentration retinoid, fluorouracil or imiquimod, or cryosurgery, when indicated. A trial of topical retinoids can also aid diagnosis, as areas of persistent scaliness or redness following several

Sunscreen Selection

Continued from p. 1

have been directly implicated in increasing an individual's risk for melanoma.

Increasing evidence suggests that physical sunscreens provide more durable protection than traditional chemical sunscreen ingredients. Zinc oxide and titanium dioxide are physical sunscreens, and they naturally confer protection against both UVA and UVB rays. Some early formulations featuring these agents were not cosmetically elegant, producing a white haze on the skin once applied. But newer products formulated with micronized zinc or titanium dioxide are acceptable to most patients.

Until recently Avobenzone or Parsol 1789 was the primary chemical UVA sunscreen used in the US. However, this molecule itself is not photostable. Therefore, its ability to protect the individual's skin degrades with time in the sun. Special chemical compounds, such as Helioplex, have been developed to work synergistically with avobenzone to improve its durability. A newer chemical sunscreen ingredient, Mexoryl does not degrade with UV exposure. It was approved in the US relatively recently but has been used in Europe for many years.

Even though physical sunscreens and newer chemical sunscreens provide more durable protection against damaging UV rays, instruct patients to re-apply sunscreens as frequently as product directions indicate, especially after swimming or sweating extensively.

To aid sunscreen selection, the AAD has unveiled a new "Seal of Approval" that patients can begin to look for as they brows the pharmacy shelves. Manufacturers voluntarily submit their sunscreen products for consideration by an AAD panel. In order to receive approval, a sunscreen formulations must have an SPF rating of 15 or higher and must confer broad-spectrum UV protection. ■

weeks of retinoid therapy could confirm the presence of profound actinic damage.

However, in most cases retinoids alone are not sufficient for patients with multiple precancerous lesions or photodamage absent of AKs. Combination treatments may include a retinoid, antioxidant preparation, and photoanalysis at baseline to monitor progress. (Digital photographs can be helpful for monitoring.) Any retinoid preparation is not a bad consideration for minor involvement or limited involvement—face and neck—before more aggressive therapy is initiated. Any retinoid would be appropriate, including cream or gel.

Verucca: First-line therapy for a facial verruca in children is a retinoid. In adults, the decisions is between a retinoid vs. cryosurgery. Keep in mind that strength of retinoid depends on patient's age. The condition can be seen in children aged between 18 months and three years and older patients. Facial verruca mostly appears on the inside of the nose or rims of nose and in perioral regions in children. In older patients verruca plana or flat verruca (spread by shaving) is most common. Abrupt onset of verruca may indicate an underlying pathological condition that may require further evaluation.

If the patient is a child, we first consider a retinoid or blistering agent before cryosurgery. Scarring potential is always possible with cryosurgery, and given that the procedure is painful, it may be better to try a higher strength retinoid first. With older adults, a light freeze may be well-tolerated and efficacious. Also, retinoids may be helpful because they provide exfoliation to prepare areas for other treatment.

Although it's indicated for genital warts, Aldara is often effective for verruca in older patients. Some clinicians have found Aldara to be effective for treatment of verruca of the face. However, use caution, since this is an off-label use.

Steroid Acne. When presented with "steroid acne," either from oral or topical sources, consider how the inflammatory rash developed. It is important to know what was being treated with the topical steroid: Was it seborrheic dermatitis, irritant contact dermatitis, etc? Is the patient taking oral prednisone or did a pediatrician prescribe a steroid cream for a rash?

The first step to clearance is to eliminate the high potency steroid, because that's the precipitating factor. Step down therapy, but proceed cautiously. Abrupt withdrawal of the steroid can yield worsening of symptoms. But some patients reject the notion of steroid withdrawal and wish to maintain it. Tapering down to lower-strength corticosteroids—again relying on samples—helps. We use mid-potency Cloderm cream (clocortolone pivalate 0.1%, Coria Laboratories) for one to two weeks as a taper.

An option to consider for the management of steroid acne is Elidel. It is not a steroid, but it is good for itchy skin. It's also important throughout treatment to introduce appropriate facial cleansers and moisturizers. In many cases, an oral antibiotic typically used for acne, like doxycycline or minocycline, can quickly calm inflammation. Combination therapy with a topical antimicrobial, such as sodium sulfacetamide/sulfur lotion, is also helpful.

Patient education is key. The condition is going to get worse before it gets better, because the body has depended on the steroid. Tapering off of the steroid is paramount for patient compliance. Also, be sure to emphasize side effects of steroid use, such as skin thinning, scarring, skin atrophy, and cataracts.

Looking at the Face

As clinicians, getting control of a skin disease often requires looking beyond the data and theoretical knowledge and focusing instead on the case right in front of you. Asking questions is never a bad thing, and one's approach to treatment should reflect that inquiry. Ask about the history of the current complaint, previous bouts of the condition, successful and failed therapies from the past, inciting factors, etc.

Although it's important to fine-tune the specific treatment plan based on patient responses to these questions, the practice should have a general protocol for each condition/dermatitis. This helps ensure consistency in patient care and can promote more efficient management. ■

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