

# What's in Your Dermatology Toolbox?

Take time now to assemble the tools you need to work more efficiently. Your patients and your practice will benefit.

By Terry Arnold, MA, PA-C

**I** come from a long line of construction men. My dad was a general contractor, his brother was a home builder, and my grandfather was also in construction. After spending a few summers working with my dad's crews in the hot Oklahoma sun, I knew it wasn't for me. But I learned some really valuable lessons that continue to serve me well in the practice of medicine.

My dad taught me early on that you must have the right tool to do a job correctly and efficiently. He had an amazing array of tools and equipment at his disposal and knew how to get the most from them. He also knew it was important to respect the tools, inventory them regularly, treat them with care, and maintain them diligently. This is equally important when it comes to obtaining and maintaining the items in your dermatology toolbox.

## Take an Inventory

The first step in building and maintaining your dermatology toolbox is to know what you already

► 6



## Improve Topical AK Therapy

**Treatment  
Tips**

For any clinician working in dermatology, actinic keratoses are a common sight. Numerous treatment options exist, the most popular of which are generally liquid nitrogen cryotherapy or topical 5-fluorouracil, depending on the number and location of lesions.

When applying 5-FU broadly to the face to treat AKs, many patients develop marked inflammation of the nasolabial folds and eyebrows. This condition has come to be known as 5-FU allergy, but it may actually be a result of

active seborrheic dermatitis, suggests dermatologist Robert T. Brodell, MD.

He explains: Topical 5-FU targets rapidly proliferating keratinocytes, and therefore, preferentially destroys the atypical keratinocytes within actinic keratosis. Treating the face broadly with this agent will selectively destroy many actinic keratoses while sparing normal skin and ultimately reduce the risk of developing basal and squamous cell carcinoma.

► 4



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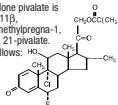
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**Chemically, clocortolone pivalate is** 9-chloro-6 $\alpha$ -fluoro-11 $\beta$ , 21-dihydroxy-16 $\alpha$ -methylpregna-1, 4-diene-3, 20-dione 21-pivalate. Its structure is as follows:



### CLINICAL PHARMACOLOGY:

Topical corticosteroids share anti-inflammatory, antipruritic, and vasoconstrictive actions.

The mechanism of anti-inflammatory activity of the topical corticosteroids is unclear. Various laboratory methods, including vasoconstrictor assays, are used to compare and predict potencies and/or clinical efficacies of the topical corticosteroids. There is some evidence to suggest that a recognizable correlation exists between vasoconstrictor potency and therapeutic efficacy in man.

**Pharmacokinetics:** The extent of percutaneous absorption of topical corticosteroids is determined by many factors including the vehicle, the integrity of the epidermal barrier, and the use of occlusive dressings.

Topical corticosteroids can be absorbed from normal intact skin. Inflammation and/or other disease processes in the skin increase percutaneous absorption. Occlusive dressings substantially increase the percutaneous absorption of topical corticosteroids. Thus, occlusive dressings may be a valuable therapeutic adjunct for treatment of resistant dermatoses. (See **DOSE AND ADMINISTRATION**).

Once absorbed through the skin, topical corticosteroids are handled through pharmacokinetic pathways similar to systemically administered corticosteroids. Corticosteroids are bound to plasma proteins in varying degrees. Corticosteroids are metabolized primarily in the liver and are then excreted by the kidneys. Some of the topical corticosteroids and their metabolites are also excreted into the bile.

### INDICATIONS AND USAGE:

Topical corticosteroids are indicated for the relief of the inflammatory and pruritic manifestations of corticosteroid-responsive dermatoses.

### CONTRAINDICATIONS:

Topical corticosteroids are contraindicated in those patients with a history of hypersensitivity to any of the components of the preparation.

### PRECAUTIONS:

**General:** Systemic absorption of topical corticosteroids has produced reversible hypothalamic-pituitary-adrenal (HPA) axis suppression, manifestations of Cushing's syndrome, hyperglycemia, and glucosuria in some patients. Conditions which augment systemic absorption include the application of the more potent steroids, use over large surface areas, prolonged use, and the addition of occlusive dressings. Therefore, patients receiving a large dose of a potent topical steroid applied to a large surface area or under an occlusive dressing should be evaluated periodically for evidence of

HPA axis suppression by using the urinary free cortisol and ACTH stimulation tests. If HPA axis suppression is noted, an attempt should be made to withdraw the drug, to reduce the frequency of application, or to substitute a less potent steroid.

Recovery of HPA axis function is generally prompt and complete upon discontinuation of the drug. Infrequently, signs and symptoms of steroid withdrawal may occur, requiring supplemental systemic corticosteroids.

Children may absorb proportionally larger amounts of topical corticosteroids and thus be more susceptible to systemic toxicity. (See **PRECAUTIONS: Pediatric Use**).

If irritation develops, topical corticosteroids should be discontinued and appropriate therapy instituted.

In the presence of dermatological infections, the use of an appropriate antifungal or antibacterial agent should be instituted. If a favorable response does not occur promptly, the corticosteroid should be discontinued until the infection has been adequately controlled.

**Information for the Patient:** Patients using topical corticosteroids should receive the following information and instructions:

1. This medication is to be used as directed by the physician. It is for external use only. Avoid contact with the eyes.
2. Patients should be advised not to use this medication for any disorder other than for which it was prescribed.
3. The treated skin area should not be bandaged or otherwise covered or wrapped as to be occlusive unless directed by the physician.
4. Patients should report any signs of local adverse reactions especially under occlusive dressing.
5. Parents of pediatric patients should be advised not to use tight-fitting diapers or plastic pants on a child being treated in the diaper area, as these garments may constitute occlusive dressings.

**Laboratory Tests:** The following tests may be helpful in evaluating the HPA axis suppression: Free cortisol test  
ACTH stimulation test

**Carcinogenesis, Mutagenesis, and Impairment of Fertility:** Long-term animal studies have not been performed to evaluate the carcinogenic potential or the effect on fertility of topical corticosteroids. Studies to determine mutagenicity with prednisolone and hydrocortisone have revealed negative results.

**Pregnancy Category C:** Corticosteroids are generally teratogenic in laboratory animals when administered systemically at relatively low dosage levels. The more potent corticosteroids have been shown to be teratogenic after dermal application in laboratory animals. There are no adequate and well-controlled studies in pregnant women on teratogenic effects from topically applied corticosteroids. Therefore, topical corticosteroids should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus. Drugs of this class should not be used extensively on pregnant patients, in large amounts, or for prolonged periods of time.

**Nursing Mothers:** It is not known whether topical administration of corticosteroids could result in sufficient systemic absorption to produce detectable quantities in breast milk. Systemically administered corticosteroids are secreted into breast milk in quantities not likely to have deleterious effect on the infant. Nevertheless, caution should be exercised when topical corticosteroids are administered to a nursing woman.

**Pediatric Use:** Pediatric patients may demonstrate greater susceptibility to topical corticosteroid-induced HPA axis suppression and Cushing's syndrome than mature patients because of a larger skin surface area/body weight ratio.

Hypothalamic-pituitary-adrenal (HPA) axis suppression, Cushing's syndrome, and intracranial hypertension have been reported in children receiving topical corticosteroids. Manifestations of adrenal suppression in children include linear growth retardation, delayed weight gain, low plasma cortisol levels, and absence of response to ACTH stimulation. Manifestations of intracranial hypertension include bulging fontanelles, headaches, and bilateral papilloedema.

Administration of topical corticosteroids to children should be limited to the least amount compatible with an effective therapeutic regimen. Chronic corticosteroid therapy may interfere with the growth and development of children.

### ADVERSE REACTIONS:

The following local adverse reactions are reported infrequently with topical corticosteroids, but may occur more frequently with the use of occlusive dressings. These reactions are listed in an approximate decreasing order of occurrence:

- Burning
- Itching
- Irritation
- Dryness
- Folliculitis
- Hypertrichosis
- Acneiform eruptions
- Hypopigmentation
- Perioral dermatitis
- Allergic contact dermatitis
- Maceration of the skin
- Secondary infection
- Skin atrophy
- Striae
- Miliaria

### OVERDOSAGE:

Topically applied corticosteroids can be absorbed in sufficient amounts to produce systemic effects (see **PRECAUTIONS**).

### DOSE AND ADMINISTRATION:

Apply Cloderm (clocortolone pivalate) Cream 0.1% sparingly to the affected areas three times a day and rub in gently.

Occlusive dressings may be used for the management of psoriasis or recalcitrant conditions. If an infection develops, the use of occlusive dressings should be discontinued and appropriate anti-microbial therapy instituted.

### HOW SUPPLIED:

Cloderm (clocortolone pivalate) Cream 0.1%, is supplied in 15 gram, 45 gram and 90 gram tubes.  
Store Cloderm Cream between 15° and 30° C (59° and 86° F). Avoid freezing.

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Professional  
Opinions

### Dear Physician Assistant:

As promised, **DermPerspectives** continues to cover the patient care and professional development issues important to PAs in dermatology. In this edition, we'll take a step back from the controversy over biologics to identify straightforward, effective topical regimens that will benefit the significant proportion of psoriasis patients affected by mild to moderate disease.

Managing a chronic skin condition like psoriasis obviously brings challenges, but with sensitivity to patients' needs and an emphasis on effective therapies, control and improvement are possible. Of course, numerous other challenges face dermatology care providers on a regular basis. With that fact in mind, Terry Arnold, PA-C offers practical tips that will help any clinician be prepared to manage diagnostic and therapeutic challenges.

Once again, support from Coria Laboratories makes it possible to provide **DermPerspectives** free of charge. I commend them for their service to dermatology PAs and thank them for their support.

I hope you find this edition helpful in your practice, and I wish you continued success in your endeavors.

Best wishes,  
Coyle S. Connolly, DO  
Medical Editor

Letter From  
The Editor

# Topical Psoriasis Therapy: Strategies that *Really* Work

The majority of psoriasis patients are actually candidates for topical therapy. Here's how to build a regimen that will yield rapid control.

By Coyle S. Connolly, DO

**T**here's no denying that psoriasis can be a challenging presentation for affected patients as well as for the dermatologists who treat them. The condition can be itchy, irritating, and painful, not to mention unsightly and emotionally bothersome. It can be recalcitrant, capricious, or recurrent. Numerous studies document the potential impact of the disease on a patient's quality of life and functioning. The extent to which any of these factors affect a particular individual varies tremendously and is not strictly correlated to the extent of involvement.

For all of these reasons, it is important for clinicians to implement treatments that will efficiently and meaningfully improve both the symptoms and the appearance of psoriasis. As is the case in most of the conditions we treat, approaching treatment of mild to moderate psoriasis based on the specific needs of the individual patient is critical to success.

## Assessment

Emphasis on hard-to-treat or severe cases of psoriasis and the newest treatment options for these may overshadow the fact that a majority of patients affected by psoriasis have mild to moderate involvement and are ideal candidates for topical therapy, which can be both efficient and cost-effective when properly selected. Patients with more "severe" disease are also often candidates for non-systemic therapy, particularly if co-morbidities, concurrent drug therapies, or other factors limit the utility of systemic agents.

Several proposed methods attempt to assess the severity of psoriasis and its impact on patients, ranging from patient questionnaires to measurements of surface area involvement. While these offer some general guidance in helping clinicians think about psoriasis, it's important to approach each case individually.

Patients can respond very differently to psoriasis. Listen attentively to the individual's concerns and treatment goals. A woman with rather extensive body area involvement may seek itch relief and not mind the appearance of



her skin as much as a man with limited involvement in a high visibility area who seeks rapid clearance of erythema and scale. Ask the patient how the disease affects his or her personal, professional, and social interactions. Get a sense for the patient's lifestyle. Do they work? What are their hours? Do they travel? Are they in school? These factors may influence regimen design and formulation selection, as discussed below.

Also note the characteristics of the individual's disease. Are they very scaly? Erythematous? Can you identify trauma from scratching and picking? Is koebnerization evident? Is there active infection? Do they have a variant, such as guttate psoriasis? Again, such considerations will influence treatment.

## An Old Standard

A well-known and long-used regimen for psoriasis remains the first-line option in topical management: calcipotriene ointment or cream (Dovonex, Warner-Chilcott) in conjunction with a topical corticosteroid ointment, cream, or lotion.

Prescribe the highest-potency corticosteroid appropriate for the given presentation and area of involvement. While we should all maintain a healthy respect for the potency and possible risks associated with topical corticosteroids, some clinicians tend to take an overly cautious approach to the use of these important agents. For many inflammatory dermatoses, including

psoriasis, using the highest appropriate potency yields more rapid control of symptoms and cutaneous clearance. In many cases, this actually necessitates a shorter duration of exposure and possibly lower cumulative dose of topical corticosteroid compared to a longer course of therapy with a lower-potency agent.

Choice of vehicle is key. Moisturizing ointments are ideal, but patients may be reluctant to use these, especially prior to dressing for work, school, or public functions. Switch to moisturizing creams for such patients. Creams or lotions are also better for larger surface areas as they spread more easily, simplifying application. Obviously, corticosteroid shampoos and/or foam and oil vehicles aid management of scalp involvement and can be useful for other body sites.

Despite my general admonition to always keep regimens as simple as possible, it may be necessary to provide patients with a prescription for two different corticosteroid and/or Dovonex formulations—a cream for daytime use and an ointment for "at-home" or evening use.

For all but very mild cases (which may warrant less frequent application) patients should apply the corticosteroid with Dovonex twice daily. Morning and evening is common, but alternate application schedules may be considered. A patient who applies medications upon returning home from work and then just before bed (six to seven hours later), will benefit more than one who applies the regimen once daily.

## Treatment Tips

### Topical AK Therapy, continued from p. 1

The keratinocytes in skin affected by seborrheic dermatitis, however, are also rapidly proliferating. Therefore, 5-FU can inflame the skin in the eyebrows, and nasolabial fold to the same marked degree inflammation is induced in actinic keratoses.

To avoid 5-FU allergy, look for signs of seborrheic dermatitis and treat accordingly for seven to 14 days prior to initiating 5-FU therapy.

—*Practical Dermatology*, 2(10):33



Photo courtesy of 3M

Have patients return for follow-up about two to four weeks later. If they are not clearing sufficiently, consider switching to a higher potency corticosteroid or (preferably) incorporating occlusion. Have patients occlude the treatment area every other or every third night in order to boost the efficacy of the corticosteroid in a controlled manner.

When meaningful clearance is evident, taper the corticosteroid to perhaps once a day. Eventually, the goal is to implement a control phase regimen of Dovonex use on weekdays and corticosteroid use on weekends.

When patients seem reluctant to use certain formulations or types of formulations, offer samples. Simply ask the patient to give the formulation a trial and then report back to you. Ideally, this will result in the patient “converting” to a formulation they would have otherwise avoided but you think is best for them. At the least, it prevents them from wasting money on a prescription they won't use.

To ensure compliance and proper application, prescribe a sufficient quantity of topical corticosteroid, but use discretion with regard to refills to prevent possible steroid misuse.

### Other Prescription Agents

Moisturizers are a critical element of skin care for the psoriasis patient. Encourage frequent use of the non-sensitizing, fragrance-free moisturizing lotion of the patient's choice. For a number of patients with keratotic plaques, I prescribe Saalex lotion (salicylic acid 6%, Coria Laboratories). Used once daily (usually in the morning), Saalex helps to diminish scale while offering moisturizing benefits. Because Saalex can deactivate Dovonex, advise patients not to apply the two agents together. Long-term maintenance for many of my patients involves daily use of a non-medicated moisturizer coupled with regular application of Saalex, as needed.

Also useful for hyperkeratotic plaques are topical retinoids, such as tazarotene (Tazorac, Allergan). However, these can also be irritating, so it's wise to implement them slowly. At about the third week of treatment with Dovonex/corticosteroid, I will have select patients begin to use the retinoid once daily.

Very itchy patients and those who admit to or show signs of scratching are at risk for Koebner phenomenon and possible infection. To help alleviate itch, consider a non-sedating antihistamine, such as Zyrtec (cetirizine,

	<b>Intervention Phase</b>	<b>Control Phase</b>	<b>Maintenance Phase</b>
<b>Treatment</b>	<ul style="list-style-type: none"> <li>• Dovonex plus topical corticosteroid BID</li> <li>• Frequent moisturizer use</li> </ul>	<ul style="list-style-type: none"> <li>• Dovonex weekdays</li> <li>• Topical corticosteroid weekends</li> <li>• Frequent moisturizer use</li> </ul>	<ul style="list-style-type: none"> <li>• Frequent moisturizer use</li> <li>• Saalex regularly, as directed</li> </ul>
<b>Also Consider</b>	<ul style="list-style-type: none"> <li>• Saalex for keratotic plaques (not combined with Dovonex)</li> <li>• Tar scalp preparations or tar baths</li> <li>• Zyrtec, Benadryl, or Atarax for severe itch</li> <li>• Sunlight</li> </ul>	<ul style="list-style-type: none"> <li>• Slowly add-on Tazorac to daily application for keratotic plaques or maintain Saalex (not combined with Dovonex)</li> <li>• Tar scalp preparations or tar baths</li> <li>• Sunlight</li> </ul>	<ul style="list-style-type: none"> <li>• Tar scalp preparations or tar baths</li> <li>• Sunlight</li> </ul>

Pfizer). Benadryl (Diphenhydramine Hydrochloride, Warner Lambert) is an inexpensive alternative that may have sedating effects. Atarax (Hydroxyzine, Pfizer) is less commonly used. It is strongly sedating, which may benefit patients whose sleep cycle is interrupted by itch.

Be vigilant for signs of infection. Gutatte psoriasis, a variant that is tied to Staph infections requires special consideration. Antibiotic therapy is often indicated.

### Non-prescription Adjuvants

Coal tar is a well-known anti-psoriatic agent that has been effectively used since antiquity. Tar baths may be worth considering for a variety of patients. Some patients have previous experience with tar baths and will ask if they are permissible. Others may be willing to try baths as a method of conferring rapid but often short-term symptom relief. Some patients simply will refuse coal-tar baths, as they can be messy. Several options are available. One brand I often recommend is Cutar 7.5% coal tar solution (Summers Labs).

For patients with scalp psoriasis I also recommend regular use of a coal tar shampoo. Tarsum Gel/Shampoo (Summers Labs) incorporates 10% coal tar solution, which the company says is equivalent to 2% coal tar, and salicylic acid. Patients should apply Tarsum solution up to one hour before bathing then lather with water and shampoo the hair, as usual.

### Small Steps

It's important to recognize that many psoriasis patients have previously sought treatment, often with limited success. The media attention regarding newer systemic therapies may drive patients back to the office—a good thing even if they aren't truly candidates for these interventions. Take the time to listen carefully to each patient's concerns and convince them that control of psoriasis is possible. Especially if they've failed treatment in the past, get them to commit to one month of fully compliant treatment. As they begin to see results they will trust your expertise and be willing to adhere to your recommendations through each step of treatment. ■

## Some Thoughts on the Sun

UV phototherapy is highly effective for psoriasis, but patients don't need to depend on a lightbox in a physician's office in order to reap benefits. Psoriasis patients can benefit from natural sun exposure. Given the long-term risks associated with excessive sun exposure, it's critical to preach moderation to patients. Daily sun exposure of up to about 15 minutes a day can provide benefit for the psoriasis patient without conferring significant risk. Advise patients to cover-up areas of the body unaffected by psoriasis.

Patients must understand the need for regular sunscreen use. Anytime they anticipate spending more than 15-20 min-

utes outdoors they should apply sunscreen to all exposed skin including active psoriasis lesions before going out. Since sunscreens do not block 100 percent of UV radiation, the cumulative exposure even with sunscreen will influence psoriasis. Physical sunscreen ingredients, such as zinc oxide, are preferred.

If the patient is an ideal candidate for standard lightbox phototherapy but it is not readily available, tanning beds can be helpful. Again, offer patients specific advice regarding frequency and duration of exposure and monitor them closely.

## Dermatology Toolbox

Continued from p. 1

possess. Think of your tools in two broad categories: the tangible and the intangible. Obviously, a more experienced practitioner will have acquired a wider array of tools. But even new PAs have life experiences beyond medicine from which they can assemble some very beneficial implements.

Your tools will definitely include tangible items, such as medical equipment and supplies—cryoguns, hyfercators, surgical instruments, lasers, etc. These are all critical to performing daily tasks. However, the intangible “tools” sometimes separate good clinicians from exceptional care providers. In this two-part series of articles we’ll first look at some of the tangible items you need in your dermatology toolbox.

### Supplies and Equipment

The first things that come to mind when you talk about a toolbox are its contents: the hammer, screwdriver, tape measure, and other practical items. A good box contains all the items that are frequently used and a few specialty items that are utilized in unique situations. The same goes for your dermatology toolbox.

It’s important to have a well organized, clean, and attractive set of exam rooms. You should be able to find and use any item in the room without having to think about where you last put it. It’s also beneficial to set up all your rooms in the same fashion, making it easier to find things when you need them, regardless of where you are.

My medical assistants inventory and restock the rooms every morning and again before seeing afternoon patients.  
T h e y

g r o u p  
equipment  
and supplies  
according to  
their frequency of  
use and function. For  
example, the syringes,  
needles, anesthetics, alcohol  
pads, razor blades, and band-  
aids are grouped on the same  
shelf, making it very easy to find the  
necessary items for shave biopsies. The  
same goes for punch biopsies, excisions,  
wound care, acne surgery, etc.

I typically carry a few supplies and some equipment items in my lab coat, because I reach for them all the time. My pockets contain a pen light for checking the oral cavity, scalp, and other dark places. I have a small 10x hand lens for evaluating small and pigmented lesions. The 10x lens from a standard microscope fits the bill quite nicely and is

inexpensive, but I’ve also seen inexpensive 20x jewelers loupes for greater magnification. I also have a small handheld dermatoscope when I want to see greater detail of a potentially malignant lesion. Newer models from companies like 3Gen don’t require oil and utilize a very bright white LED light source with cross-polarization filters to limit reflection. Everyone who borrows mine immediately seems to buy one of their own.

I also have a small digital camera that I use countless times during the day. Our practice sees a tremendous volume of non-melanoma skin cancer, and it can be very cumbersome to plot every biopsied tumor on a lesion map. It can also become very difficult to identify biopsy sites once they have healed, which makes a Mohs’ surgeon crazy! Photographic documentation proves invaluable. My camera is very small, has a 3.2MP lens, and allows me to take macro photos with ease. It also “boots-up” very quickly, which minimizes waiting.

I have a ruler for measuring most lesions, and a measuring tape for measuring greater lengths or along curved surfaces like the

lems or preparing lectures/articles. For quicker reviews I usually reach for *Fitzpatrick’s Color Atlas and Synopsis of Clinical Dermatology* or the old standby *Andrews’ Diseases of the Skin*.

My current surgery references include *Surgery of the Skin*. It covers all areas of dermatologic surgery in a highly readable style, with an accompanying DVD that demonstrates many of the surgical principles.

My favorite prescribing reference is *Medications Used in Dermatology*. This small paperback contains an incredible amount of practical information for prescribing dermatologic medications and recommending OTC cosmeceuticals. I can honestly say I’ve used it daily for the entire time I’ve been in dermatology. For more comprehensive study, *Comprehensive Dermatologic Drug Therapy* just can’t be beat.

Other references I seem to utilize regularly include *Litt’s Drug Eruption Reference Manual*, *Fisher’s Contact Dermatitis*, and *Advanced Dermatologic Therapy II*. See the box (below, right) for more information on these titles.

**It’s also beneficial to set up all your rooms in the same fashion, making it easier to find things when you need them.**

### Personal Digital Assistants

Another constant companion in my lab coat or on my desktop is my PDA. I have an older model Palm OS device in which I keep everything! It has all the addresses and phone numbers for family, friends, colleagues, referral sources, and drug reps.

I also have the indispensable ePocrates program that I can’t imagine practicing medicine without. The basic version of the program is still a free download and allows you to quickly find information on drug doses, adverse reactions, contraindications, interactions, pricing, and mechanism of action. You can even input the formularies for your local health insurance carriers to minimize call-backs from the pharmacy and the patient. My patients absolutely love knowing how much prescriptions will cost before they even leave the office and whether their newly prescribed meds will interact with their old ones.

Another very useful reference that I’ve tried is the downloadable PDA version of *Treatment of Skin Disease* by Mark Lebwohl, MD. This is a very nice version of the text by the same name that covers many common

scalp. My ruler also doubles as a prescribing reference, as it has many of the common topical steroids listed on the reverse side. These rulers are readily available from your pharmaceutical reps.

I carry a lighter and a small bottle of KOH and chlorazol black for performing quick KOH preps, as these materials frequently go missing from our lab area.

The final item I carry is a small piece of thin plastic in which I’ve drilled holes of varying diameter. I use this all day for cryosurgery in order to minimize cryo injury to surrounding tissues. Many dermatologists use disposable ear speculums for the same purpose.

### Textbooks and References

I seem to collect textbooks and medical references the same way my wife collects shoes—we both have a lot! I have books on general dermatology of varying sizes and detail. My current favorite is the two-volume *Dermatology* text. It is an extremely comprehensive text with excellent summaries, photos, tables, and medical drawings. It is invaluable for doing research on uncommon prob-



## Build Your Presence on the Practice Website

More and more dermatology practices have websites that at a minimum provide basic information about the practice and its services, including hours, insurance participation, and directions. Better sites also include patient resources and information about care providers. If your practice has a website, be sure information provided will help patients understand your qualifications and your role within the practice. Consider including:

- **A good quality photo.** Since photos for Internet use must be digital but not necessarily high resolution, many people are tempted to snap a digital photo for posting. However, to accompany a biography on a website that may be viewed thousands of times, consider sitting for a professional photo.

If you opt for do-it-yourself photos, consider a shot that demonstrates some action, rather than simply standing in front of a white curtain. (*Photographer's hint:* Photos taken under incandescent bulbs provide better color tones than those taken under fluorescent lights.) Obviously, you should not include patients in the shot unless you obtain written consent.

- **An accurate introduction to PAs.** Increasing numbers of patients are familiar with PAs and the services they provide, but there are still some patients who are unfamiliar with physician assistants and their qualifications. A brief statement describing PA training, scope of practice, oversight, and related issues may improve patients' understanding of your role.

- **Your current bio.** Writing the first-draft biography is rarely a challenge. The trick is to keep your information current. Have you been published? Obtained an additional certification? Trained on a new cosmetic procedure? If so, update your biography accordingly.

- **An FAQ section.** Frequently-asked questions used to be the rage on websites, though they seem less popular now. Nonetheless, consider providing a list of common patient questions about PAs along with accurate responses. This may avoid confusion and/or calls to the office.

- **A focus on education.** PAs are well known for patient-focused care that includes an emphasis on education and communication. Consider providing your own disease-specific educational hand-outs and care guidelines (such as biopsy site post-op instructions) that patients can download. For obvious reasons, giving specific therapeutic advice is dicey; ask for legal advice if in doubt.

Also consider links to reliable dermatology websites.

- **Contact information.**

Include the office address and phone number for scheduling on every page so that patients can find it quickly when they need to contact the office.



and uncommon dermatoses, along with evidence-based strategies for treatment. The photos look great on a color PDA screen.

### Care and Maintenance

Simply having these items handy doesn't

necessarily ensure success, unless you keep your tools in good working order and your technology and references up-to-date. It's not hard to do.

Take a moment to thoughtfully consider which items you will include in your

toolbox. Identify which tools you are missing, then build up your inventory. Not only will your patient care improve, but you will find yourself working more efficiently with less frustration and wasted time. ■

## References Worth Having

*There are numerous valuable texts available, but, as noted, these are the ones I find most helpful in day-to-day practice:*

<p><b>Advanced Dermatologic Therapy</b> Walter Shelley, Dorinda Shelley (W.B. Saunders Co., 1987)</p>	<p><b>Dermatology (2 Volume Set)</b> Jean L. Bolognia, Joseph Jorizzo, Ronald Rapini (C.V. Mosby, 2003)</p>	<p><b>Litt's Drug Eruption Reference Manual</b> <i>Incl. Drug Interactions with CD-ROM</i> Jerome Z. Litt (Taylor &amp; Francis, 11th ed. 2005)</p>
<p><b>Andrews' Diseases of the Skin</b> William D. James, Timothy G. Berger, Dirk M. Elston (W.B. Saunders Co., 10th ed. 2005)</p>	<p><b>Fisher's Contact Dermatitis</b> Robert L. Rietschel, Joseph F. Fowler (Williams &amp; Wilkins, 4th ed. 1995)</p>	<p><b>Medications Used in Dermatology</b> Andrew J. Scheman, David L. Severson (Lippincott Williams &amp; Wilkins, 2003)</p>
<p><b>Comprehensive Dermatologic Drug Therapy</b> Stephen E. Wolverton, Editor (W.B. Saunders Co., 2001)</p>	<p><b>Fitzpatrick's Color Atlas &amp; Synopsis of Clinical Dermatology</b> Klauss Wolff, Richard A. Johnson, Richard Suurmond (McGraw-Hill Professional, 5th ed. 2005)</p>	<p><b>Surgery of the Skin: Textbook with DVD</b> June K. Robinson, William C. Hanke, Roberta Sengelmann, Daniel Siegel (C.V. Mosby, 2005)</p>

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