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 have in your office.

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

Improve Topical AK Therapy

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.
Safety that’s reassuring for everyone

For children and adults, Cloderm® is the mid-potency topical steroid with proven safety in extensive clinical trials.

- Uniquely formulated to be selectively absorbed where it’s needed
- Designed to minimize the likelihood of local and systemic side effects
- Proven efficacy as early as Day 4
- The most common adverse events with Cloderm include dryness, irritation, folliculitis, acneiform eruptions, and burning. Cloderm is contraindicated in patients who are hypersensitive to any of the ingredients of this product. As with all topical corticosteroids, systemic absorption can produce reversible HPA-axis suppression. Please see full prescribing information on reverse side of page.

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For Topical Use Only

INDICATIONS: Clocortolone pivalate is a specially formulated water-washable emollient topical corticosteroid, clocortolone pivalate, in a base of petrolatum, mineral oil, stearyl alcohol, polyethylene glycol, and purified water. Clocortolone pivalate is indicated for the management of cutaneous manifestations of steroid-responsive dermatoses. It is intended for use in children and adults.

CONTRAINDICATIONS: Clocortolone pivalate is contraindicated in those patients with a history of sensitivity to any of the components of the preparation.

PRECAUTIONS: Systemic absorption of topical corticosteroids has produced adrenal suppression and the loss of normal hypothalamic-pituitary-adrenal (HPA) axis feedback (see CLINICAL PHARMACOLOGY). Indication for treatment must be constantly reviewed and dosage adjusted accordingly. The use of individual topical corticosteroids and their combinations should be confined to the sites and periods of time necessary for control of inflammatory skin conditions, since treatment of more than 2 weeks duration and use in extensive areas, may lead to adrenal suppression (see CLINICAL PHARMACOLOGY).

Overdosage: In the event of an overdose, appropriate supportive treatment is indicated.

ADVERSE REACTIONS:

Dermatological reactions, which may occur more frequently with the use of occlusive dressings. These reactions are listed in an approximate decreasing order of occurrence:

- Miliaria
- Striae
- Secondary infection
- Perioral dermatitis
- Hypopigmentation
- Acneform eruptions
- Hypertrichosis
- Folliculitis
- Burning

Systemic effects and manifestations of Cushing’s syndrome, hyperglycemia, and glucosuria in some patients.

Symptoms: Signs of Cushing’s syndrome may be manifested in children as growth retardation, delayed weight gain, low blood pressure, and secondary amenorrhea.

Serm: In women, these may include reduced sex drive, menstrual irregularities, and hirsutism.

Preparations: There have been reports of systemic manifestations (such as hyperglycemia, hypertension, edema, and Cushing’s syndrome) associated with the use of topical corticosteroids in children. However, some of these reports are unsubstantiated, and others can be attributed to the underlying disease process.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Carcinogenesis, mutagenesis, or impairment of fertility have not been studied with topical corticosteroids.

OVERDOSAGE: Systemic corticosteroids can be adsorbed in sufficient amounts to produce systemic effects (see PRECAUTIONS).

Tell Us What You Think

Dear Physician Assistant:

As promised, DermPerspectives continues to cover the patient care and professional development issues important to FAs 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 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 Derm Perspectives free of charge. I commend them for their support of dermatology FAs 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
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 presenta-
tion for affected patients as well as for the dermatologists who
treat them. The condition can be itchy, irritating, and painful, not to mention unseemly 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 cli-
dent to implement treatments that will effi-
ciently 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 indi-
vidual 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, par-
ticularly if co-morbidities, concurrent drug
therapies, or other factors limit the utility of sys-
temic 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 psio-

rasis. Listen attentively to the individual’s con-
cerns 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 involve-
ment in a high visibility area who seeks rapid
clearance of erythema and scale. Ask the patient
how the disease affects his or her personal, pro-
fessional, 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 individ-
ual’s disease. Are they very scalp? 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 psori-

asis remains the first-line option in topical man-
agement: 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 actual-
ly 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 oint-
ments are ideal, but patients may be reluctant to
use these, especially prior to dressing for work,
school, or public functions. Switch to moisturiz-
ing 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 involve-
ment 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 war-
rant less frequent application) patients should
apply the corticosteroid with Dovonex twice
daily. Morning and evening is common, but
alternate application schedules may be consid-
ered. 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.
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 Salex lotion (salicylic acid 6%, Coria Laboratories). Used once daily (usually in the morning), Salex helps to diminish scale while offering moisturizing benefits. Because Salex 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 Salex, 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, 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. Guttate 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 minutes 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, hypercators, 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. They group 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 dermatoscope 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 2.1MP lens, and allows me to take macro photos with ease. It also “boosts-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 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 prep. I use it all day for cryosurgery in order to minimize cryo injury to surrounding tissues. Many dermatologists use disposable ear speculums for the same purpose.

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 or to drain abscesses from our lab area.

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-

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 eBocrates 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 callbacks 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
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:

**Advanced Dermatologic Therapy**
Walter Shelley, Dorinda Shelley (W.B. Saunders Co., 1987)

**Dermatology** (2 Volume Set)

**Litt’s Drug Eruption Reference Manual**
Incl. Drug Interactions with CD-ROM
Jerome Z. Litt (Taylor & Francis, 11th ed. 2005)

**Andrews’ Diseases of the Skin**

**Fisher’s Contact Dermatitis**
Robert L. Rietschel, Joseph F. Fowler (Williams & Wilkins, 4th ed. 1995)

**Medications Used in Dermatology**
Andrew J. Scher, David L. Severson (Lippincott Williams & Wilkins, 2003)

**Comprehensive Dermatologic Drug Therapy**
Stephen E. Wolverton, Editor (W.B. Saunders Co., 2001)

**Fitzpatrick’s Color Atlas & Synopsis of Clinical Dermatology**

**Surgery of the Skin: Textbook with DVD**
June K. Robinson, William C. Hanke, Roberta Sengelmann, Daniel Siegel (C.V. Mosby, 2005)
As a dermatologist, you face a new challenge with each patient.

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