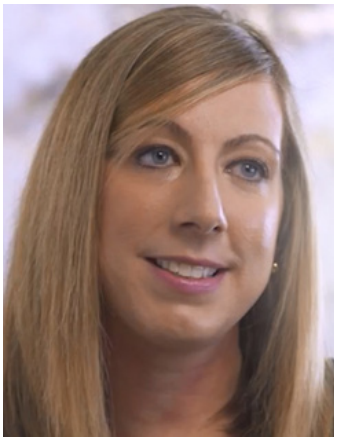
foreFRONT AND CENTER

Q2 NEWSLETTER | May 2023 Special Edition

Dr. Wernli and Amber Preston, MA deliver another cancer-free skin check to a Forefront melanoma survivor.

"YOU'RE NEVER TOO YOUNG AND NEVER TOO OLD TO GET AN ANNUAL SKIN EXAM. TEN MINUTES COULD SAVE YOU.

—Laura



Melanoma Survivor

President's MESSAGE:

BY: BETSY WERNLI, MD, FAAD

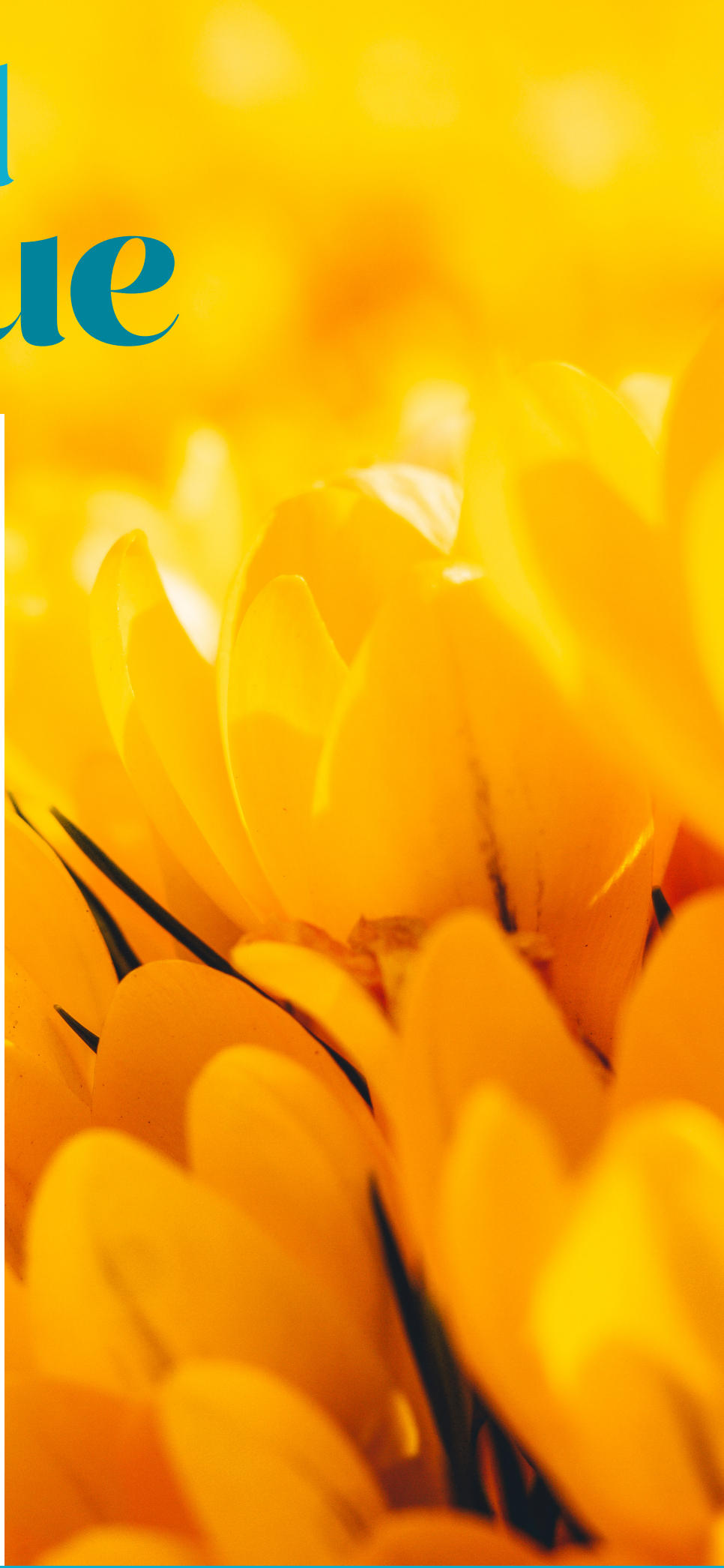
May is Melanoma Awareness Month, a mission everyone at Forefront is very aware of and connected to daily. But sometimes, connecting to this mission during your day-to-day tasks of rooming patients, answering phones, processing paper, troubleshooting tech, and more becomes difficult. Connecting to a mission is not only critical, but difficult for most companies in today's world. In healthcare, it becomes easier when we drill down into the individual contributors of said mission.

"WE ARE MAKING A DIFFERENCE. WE ARE SAVING LIVES. WE HAVE A POWERFUL, LIVING, BREATHING MISSION THIS MAY.

Forefront's mission is to be the dermatology practice of choice, treating all skin conditions in every community we serve. That mission is deliberately broad, but much like a puzzle, comprised of many powerful, individual stories spread across 27 states.

This month, we focus on those stories of cancer survival to connect you to what makes Forefront and your own mission powerful. Because our field of dermatology has a dramatic impact on the quality and longevity of human life, connecting to this purpose day in and day out should be one of the easiest parts of our job! I hope you listen to many of the stories shared this month; listen to boost your day, end a stressful week, and connect you to the "why" behind it all. Thank you for being a vital part of the puzzle!

the April issue



FEATURES

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.

Kurt Grelck, DO, FAAD

Kurt practices general dermatology in Stevens Point, Waupaca, and Wisconsin Rapids. Originally from Chicago, he did a combined internal medicine/dermatology residency in Palm Beach, Florida, after attending medical school at the Chicago College of Osteopathic Medicine. Kurt usually spends his free time at his cabin on Chamber's Island in Green Bay, fishing for whatever bites and rebuilding his two boys' legos. He has also served as the head of the physician advocate/mentorship program.

Doug Hansen, MD

Dermatopathologist

Doug completed his residency and immunohistochemistry fellowship at the University of Washington and his dermatopathology fellowship at the AFIP. His favorite thing is when the histopathology fits exactly with the clinical presentation. He also really likes skiing, hole-in-the-wall restaurants, and unexpected first-class upgrades. He is married with 3 teenagers and an attention-demanding Cavapoo puppy.

Kari Hutchins, RN, CDC

Documentation & Coding Specialist

Kari Hutchins is a Registered Nurse and certified dermatology coding and documentation specialist based near Louisville, KY. She has been a nurse for over 17 years. Kari inhabited several roles before moving to the coding and documentation department, where she found her true passion. Kari enjoys spending her free time writing fiction novels and making crafts alongside her wife, Ashley. They also enjoy traveling, hiking, fishing, and spending time with their three kids and animals.

Alisha Junk

Senior Graphic Designer

Alisha is a Senior Graphic Designer in the Marketing Department. She has been with Forefront for six years. Her favorite thing about being a graphic designer is that every day is different. Each day brings new challenges, problems to solve and projects to get creative with. Alisha enjoys spending her free time with her husband, Casey, and two children, Leah and Waylon. She enjoys being outdoors, running, and hiking. When she's not being active, she can be found scoping out new breweries with her husband or watching her favorite TV shows and movies.

Maria Kohlmeier

Marketing Manager

Maria has been a part of Forefront Dermatology's Marketing Team since 2016. She is passionate about maintaining a direct line of open communication between clinics and marketing, supporting all needs that arise. Outside of work, you will find Maria spending time with her son on their hobby farm outside of Manitowoc, Wisconsin.

THE *Physician* BOARD

Lead the *Way*

Click here to learn more about all of the exciting leadership opportunities we have to offer!

PRESS RELEASE

FOREFRONT *Update*

Forefront Dermatology is pleased to welcome Matt Mellott! We are thrilled to have you join us as our new CEO. We are confident that with your leadership and vision, we can take Forefront to its next level of growth. Be on the lookout for more communications from us as we embark on this exciting journey together.

MATT OFFERS A UNIQUE BLEND OF ENTERPRISE LEADERSHIP, ENTREPRENEURIAL MINDSET, HEALTHCARE KNOWLEDGE, FINANCIAL SKILLS, AND FOCUS ON DOCTOR, CLINICIAN, PATIENT, AND EMPLOYEE EXPERIENCES— MAKING HIM THE PERFECT PERSON TO TAKE FOREFRONT TO ITS NEXT LEVEL OF GROWTH.

Manitowoc, Wisconsin, April 13, 2023 – Forefront Dermatology, the nation's largest single-specialty dermatology group practice, today announces the appointment of Matt Mellott as CEO beginning May 2, 2023.

Mellott is an accomplished senior operational and financial leader with over 30 years of progressive experience in the healthcare industry. He comes to Forefront from Brightree, where he has served as CEO since 2016. Brightree, a subsidiary of ResMed, provides software and services solutions to HME and home infusion providers. Under Mellott's leadership, the Brightree team built a foundation and strategy that supported significant growth and strengthened the company's position as the industry leader.

Prior to Brightree, Mellott was co-founder and president of MedBridge Healthcare, a sleep disorder diagnostic testing and respiratory therapy provider. He also served as the CFO for American Healthcare Services as well as a variety of senior financial roles for two of the largest national post-acute providers. Earlier in his career, Mellott spent several years in public accounting at KPMG in its Healthcare Audit Practice. He was recently awarded MedTech Breakthrough's 2022 MedTech Company CEO of the Year.

"Forefront has an impeccable reputation in the medical dermatology space and an impressive track record of growth. I look forward to joining this talented team to expand its world-class offerings to new geographies," Mellott said.

Forefront's current CEO, Scott Bremen, will join the Forefront Board as an independent Operating Director.

SO YOU WANT TO BE A BOARD MEMBER?

Below are some key points from fifteen of our physician colleagues on why they would like to serve on the Physician Board of Directors. Stay tuned for more information about the candidates in the upcoming weeks and at the Shareholders' meeting.

Lisa Campbell, MD, FAAD, FACMS
Board-Certified Dermatologist
Fellowship-Trained Mohs Surgeon

My focus as a board member will be elevating the importance and visibility of workplace culture at Forefront for employees, PAs, NPs, and physicians within the expanding framework of this great company. Growth is more than numbers, and a great company's magic is in its people's growth.

Jenny Sobera, MD, FAAD
Village Dermatology
Board-Certified Dermatologist

I would like to help improve financial data and reporting. I believe that readily available and easily interpreted data makes a tremendous difference in promoting profitability that fits within our boundaries of excellent patient care and employee satisfaction.

Victoria Negrete, MD, FAAD
Board-Certified Dermatologist

While I bring the medical aesthetic growth perspective to the board of directors, I have also been privileged to be welcomed by so many of our doctors, nurse practitioners, and physician assistants in their offices for training which has allowed me to develop not only professional, collegial relationships but also have first-hand experience on issues pressing the clinics on a local level where we can make big impacts.

Board REPORT

DON'T FORGET TO *Vote!*

BY: TORI NEGRETE, MD, FAAD

A fundamental tenet of Forefront Dermatology is being led by board-certified dermatologists, working hand-in-hand with our incredible support team. Our physician leaders' dedication at Forefront truly sets us apart from other large dermatology practices, and one of the most important leadership positions in our practice is to serve on the Physician Board of Directors.

Being physician-led at Forefront Dermatology isn't simply lip service. As a physician leader for the last ten years, I can easily say this is one of the most rewarding (and sometimes challenging) parts of my job. For years I have been proud to serve on the board and look out for the best interests of the physicians, nurse practitioners, physician assistants, and our shareholders, often making difficult decisions, even if not necessarily the best decision for the individual board members.

LOOKING BACK AT THE LAST TWO YEARS

Partnered with several plastic surgery and dermatology practices; opened several de novo clinics and recruited some of the country's best dermatologists, PAs, and NPs.

Oversaw the transaction and partnership with Partners Group, confirming Forefront as the world's largest and most valuable dermatology group.

Refined our leadership structure by developing the Physician Leadership Advisory Director (LEAD) role.

Expanded medical aesthetics, switched to self-funded health insurance, and so much more!

Doug Gervais, MD, FACS

Minneapolis Plastic Surgery
Board-Certified Plastic Surgeon

Board-certified plastic surgeon with nearly 30 years of experience managing, growing, and expanding medical and surgical aesthetics and previous experience serving on executive boards. Desire and commitment to excellence via ethical and financial responsibility.

Mary Hurley, MD, FAAD

North Dallas Dermatology
Board-Certified Dermatologist

My goals include maintaining the autonomy of each individual practice, ensuring that the mechanisms are in place for each doctor/provider to be heard, and securing the support they need to perform and grow optimally. In addition to ascertaining that patient care remains a top priority, I also strive to help each practice improve its efficiency and optimize its operations.

Shari Sperling, DO, FAAD

Sperling Dermatology
Board-Certified Dermatologist

As one of the top cosmetic practices in the country, I have had the unique opportunity to utilize and learn about many of the most cutting-edge treatments in the cosmetic space, and I would love to continue to ensure Forefront remains at the "Forefront" of both the medical dermatology world, as well as the cosmetic dermatology world by keeping pace with the ever-changing cosmetic landscape in our industry.

Jeff Rebish, MD, FAAD

Skin Physicians & Surgeons
Board-Certified Dermatologist

I think it is critical for newly partnered practices to feel their transition was a very positive experience, as they will be the ones being asked about this period by prospective partners... I want to be the Board's voice representing newly joined practices.

John Soderberg, MD, FAAD

Board-Certified Dermatologist

I would love to continue to serve this organization through a position on the Board of Directors; to help to facilitate continued measured growth of our group; to support initiatives to attract top candidates to join us, and through measures to ensure the continued success of our all of our members.

Adam Asarch, MD, FACMS

Board-Certified Dermatologist
Fellowship-Trained Mohs Surgeon

It has been an honor to serve on the physician board for the past four years, and if re-elected, I will continue to focus on representing our many practice types while always ensuring that we maintain physician autonomy and our high level of centralized support and responsiveness for our physicians, PAs, and NPs.

the extra MILE

BY: GIACOMO MAGGIOLINO, MD, FAAD

Ensuring your patients are well-informed and well-supported when communicating a melanoma diagnosis are two criteria that the Melanoma Research Foundation (MRF) believes are essential for living as long and as well as possible.

MRF MELANOMA PATIENT GUIDE

Scan or tap the QR code to download your copy.

4

TIPS WHEN COMMUNICATING A MELANOMA DIAGNOSIS

Dr. Tim Turnham, former executive director of the MRF, provided some informal guidelines that can help dermatologists. Below are some excerpts taken from Dr. Turnham's article in *The Dermatologist*:

1 GIVE THE PATIENT THEIR DIAGNOSIS IN PERSON, IF POSSIBLE

The emotional and psychological blow can be lessened if the news is provided in a safe, controlled environment, such as a doctor's office.

2 BE UPFRONT AND HONEST, BUT CHOOSE YOUR WORDS CAREFULLY

Doctors should address at the very beginning the severity of the cancer. Being honest, upfront, and positive can make the rest of the important information you impart easier to receive.

3 BE VERY, VERY CLEAR

When we are under stress our ability to receive and process information is limited. Avoid technical terms and jargon that people don't understand.

4 PROVIDE INFORMATION IN WRITING

A number of good resources exist, including a free brochure from the MRF entitled *Just Diagnosed—Now What?* Consider opening the booklet to that page, circling the appropriate stage for the patient, and explaining, "We need to do a few more tests to be absolutely sure it isn't more serious than we think it is." The personal touch of your writing or drawing, even on printed materials, makes a huge difference in the patient's ability to receive and retain information.

Resource: T Turnham. *Tips for Communicating a Melanoma Diagnosis.* The Dermatologist. April 2014

Coding CORNER

BY: MOLLY MOYE, MD, FAAD, FACMS AND
KARI HUTCHINS, RN, CDC, DOCUMENTATION & CODING SPECIALIST

When performing an excision on a biopsy-proven dysplastic nevus, the most appropriate ICD-10 code is D48.5 – Neoplasm of Uncertain Behavior. Many clinicians may find this confusing as they have already biopsied the lesion and received a pathology result of "atypical or dysplastic nevus." So why go back and use D48.5 again?

Unfortunately, there are no ICD-10 codes that specifically represent atypical or dysplastic nevi. One could consider using the code set of D22.X – melanocytic nevus, but these codes are broadly recognized as representing benign nevi. The D22.X code set would not convey to the payer that the excision was performed for a nevus that can potentially become malignant. If we use the D22.X code set, the payer will receive a claim for a benign excision with a benign diagnosis. They may question whether or not the procedure was medically necessary. Medical necessity can sometimes be demonstrated by adding associated diagnosis codes, such as R52 – pain or L53.8 – erythema, etc.; however, there's no associated diagnosis code that speaks to the potential of a condition to become malignant. By looking at the documentation, we would know there's a medical necessity for the excision, but payers typically only see documentation if they request it. The claim form is the payer's first line of communication from us, and we don't have a way to communicate the medical necessity for excising atypical or dysplastic nevi on the claim if D22.X is the primary diagnosis.

Therefore, the most appropriate ICD-10 code is D48.5 – Neoplasm of Uncertain Behavior. D48.5 will portray that the condition cannot definitively be called benign or malignant based on histopathologic examination. Remember that this code is different than D49.2, Neoplasm of Unspecified Behavior. With atypical/dysplastic nevi, we are excising because of the uncertain behavior of the lesion and its potential to become malignant if not excised.

Please share this information with your clinical assistants. The clinical staff often choose the diagnosis of "dysplastic nevus" or "atypical nevus" in EMA while documenting because that is what the patient is having excised. The description of the diagnosis in the visit note will read as atypical or dysplastic nevus, but the ICD-10 code that pulls through is D22.X, representing a benign nevus.

UPCOMING SESSION

Grand ROUNDS

Did you know that your pathology lab sponsors CME every month? Participate via webinar from anywhere to learn about exciting topics that will enhance your practice of dermatology, and earn you one hour of CME!

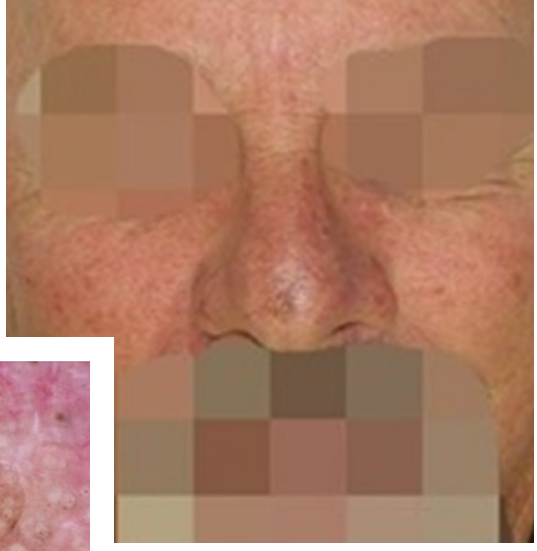
06.07.23
@6:00PM CST

Hidradenitis Suppurativa

Join Dr. Ashley Dietrich as she discusses hidradenitis suppurativa, focusing on the quality of life to be successful in the care and management of this difficult disease. This activity has been approved for AMA PRA Category 1 Credit™.

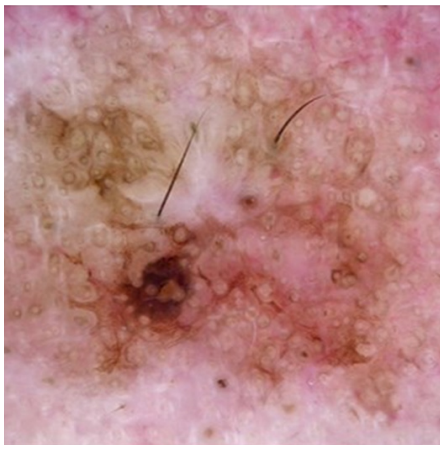
Clinical CORNER

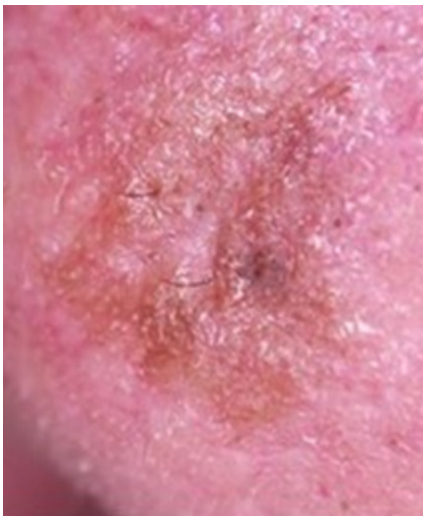
BY: KURT GRELCK, DO, FAAD



A 69-year-old man presents with an asymptomatic lesion on his nose. Based on the dermoscopic appearance, how many of the four facial melanoma-specific criteria are present on this lesion?

- A. One facial melanoma-specific criteria
- B. Two facial melanoma-specific criteria
- C. Three facial melanoma-specific criteria
- D. Four facial melanoma-specific criteria
- E. None; it's a lichen planus-like keratosis

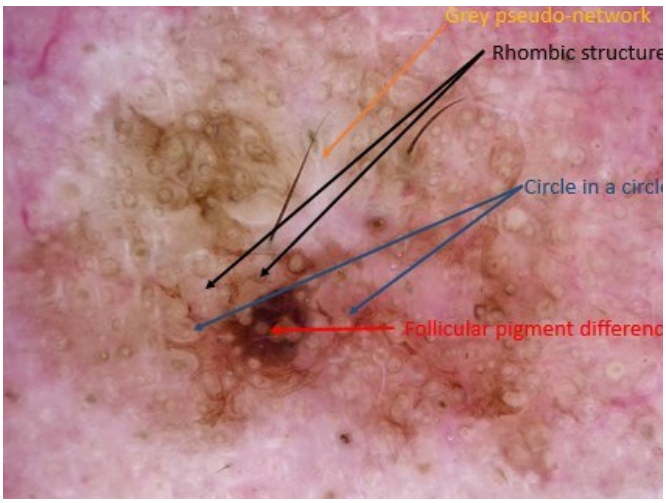




ANSWER D: All four facial mm-specific criteria are present. This lesion represents the prototypical lentigo maligna melanoma on sun-exposed facial skin. Generally, an isolated pigmented lesion in an area of heavy sun damage needs dermatoscopic evaluation.

There are many ways of interpreting dermoscopy, but this model has four criteria:

- Annular granular structures
- Asymmetrically pigmented follicles
- Rhomboidal structures
- Gray pseudo-network



As a melanoma evolves from a lentigo, one can imagine the ablation of the normal structures by cancerous cell invasion.

ANNULAR GRANULAR STRUCTURES

Annular-granular structures are multiple brown or blue-gray dots surrounding the follicular ostia with an annular-granular appearance.

ASYMMETRIC FOLLICULAR PIGMENTATION

Asymmetrically pigmented follicles are gray circles/rings of pigmentation distributed asymmetrically around follicular ostia. Sometimes, the gray circles may contain an inner gray dot or circle.

RHOMBOIDAL STRUCTURES

Rhomboid structures are thickened areas of pigmentation surrounding the follicular ostia with a rhomboidal appearance (a rhomboid is a parallelogram with unequal angles and sides).

GRAY PSEUDO-NETWORK

Gray pseudo-network describes gray pigmentation surrounding the follicular ostia formed by the confluence of annular-granular structures.

Consider the crossover between what you see dermoscopically, such as perifollicular invasion, and what would be seen pathologically with follicular involvement.

ASYMMETRIC FOLLICULAR PIGMENTATION

Annular-granular structures are present in this lesion (Figure 1) (arrows). Do not confuse the ostia of the appendages with the milia-like cysts of seborrheic keratosis. Now check the ostia carefully. Some are totally and partially ringed by layers of pigmentation. The dermoscopic diagnosis of asymmetrically pigmented follicles is made when the rim of pigmentation does not surround the entire ostium. True rhomboidal structures are not formed yet. The vessels should not be confused with those seen in basal cell carcinomas. They correspond to the dermal plexus shining through the thinned epidermis.

We can observe dark and short lines (Figure 3) (short arrow) associated with irregular perifollicular pigmentation (long arrow) and slate-gray dots and globules (asterisk) in this LM.

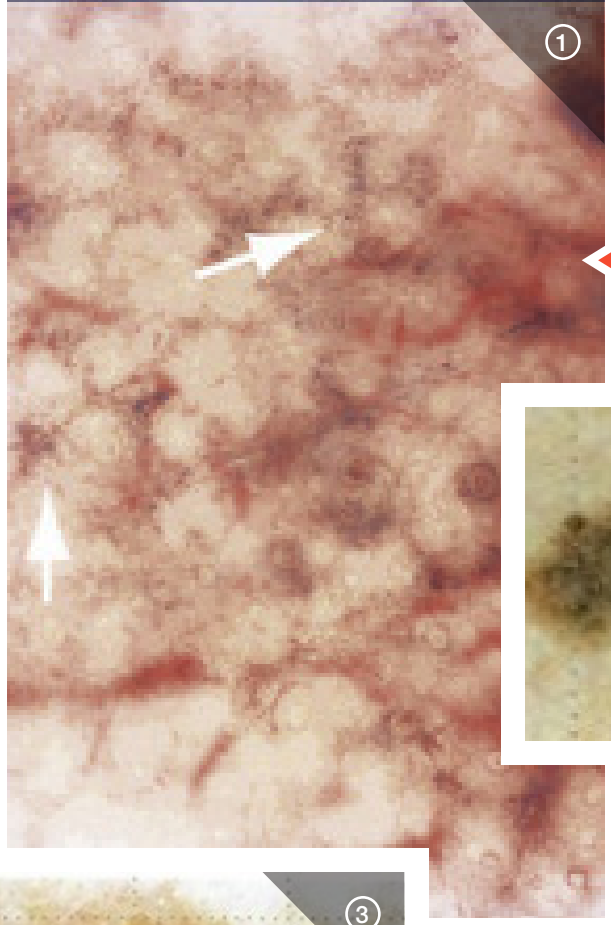
RHOMBOIDAL STRUCTURES

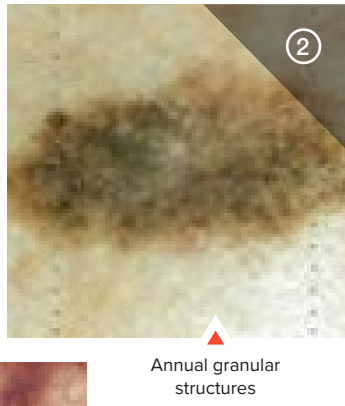
In this LM melanoma on the scalp (Figure 4), we can observe the development of rhomboidal structures (long arrow) associated with the presence of asymmetric perifollicular pigmentation (short arrow) and slate-gray dots and globules (asterisk).

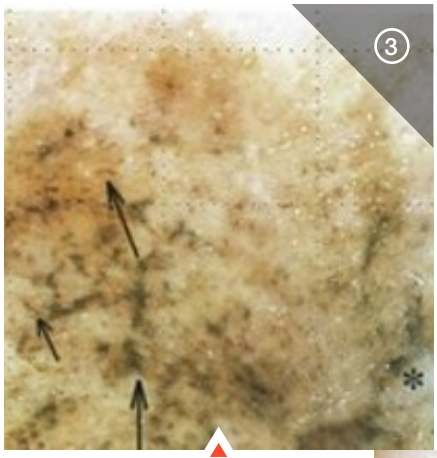
GRAY PSEUDO-NETWORK

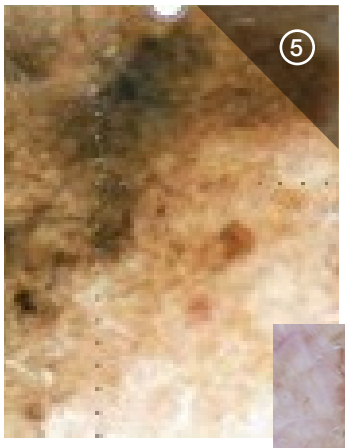
The default differential diagnosis of lentigo maligna (melanoma in situ on severely sun-damaged skin) clinically, dermoscopically, and sometimes histopathologically is actinic (solar) lentigo. This diagnostic uncertainty is underlined by unstable lentigo, an actinic lentigo on the way to a lentigo maligna. Interestingly, this concept has not been widely adopted, maybe because we are used to accepting a benign/malignant dichotomy. The lesion depicted here (Figure 6) is a lentigo maligna characterized by a few rhomboidal structures.

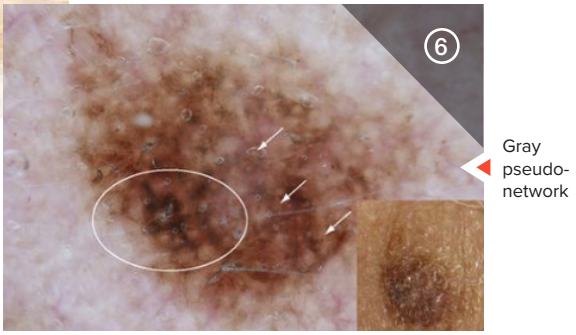
The challenge of LM on sun-exposed skin is finding it early; stage 0 can be challenging and requires a significantly lower biopsy threshold. However, in a later stage melanoma, most of these criteria become much more apparent.



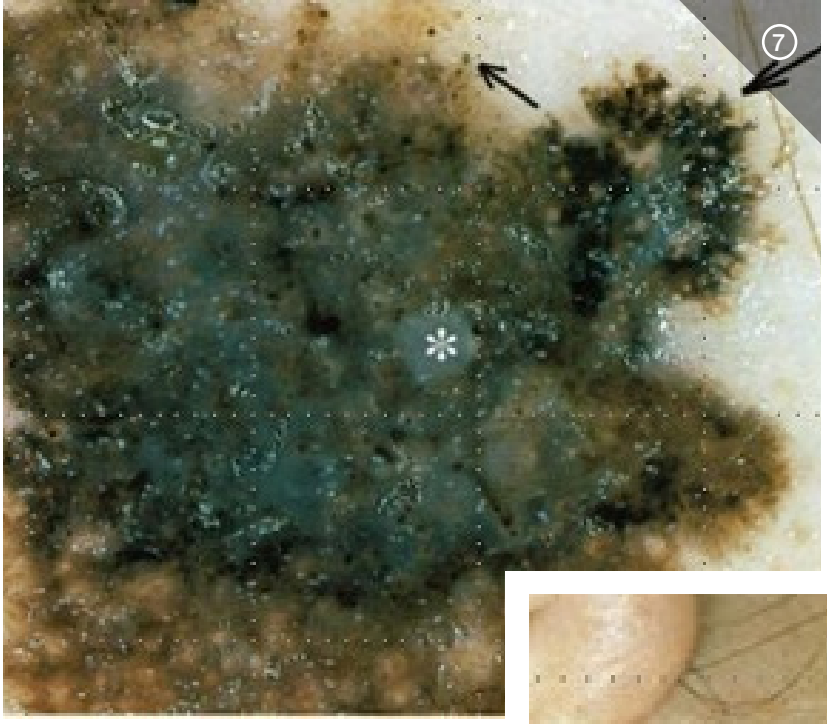


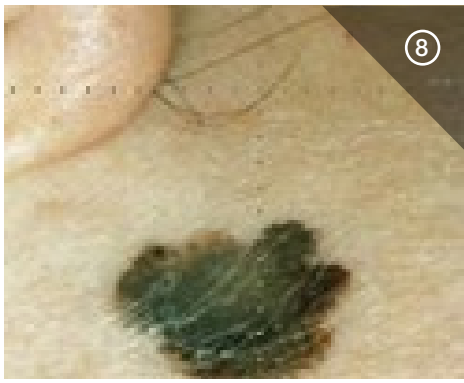






In this superficial spreading malignant melanoma (Figure 7) (Clark III, Breslow 0,9) on the face, asymmetry presences of multiple colors (black, blue-gray, light and dark brown), pigmented pseudo-network that in some places show the occlusion of the follicular opening by the invasion of the tumor, irregularly distributed pseudopods (long arrow), multiple brown dots (short arrow) and blue-whitish veil homogeneous areas (black asterisk) can be observed.





Resources

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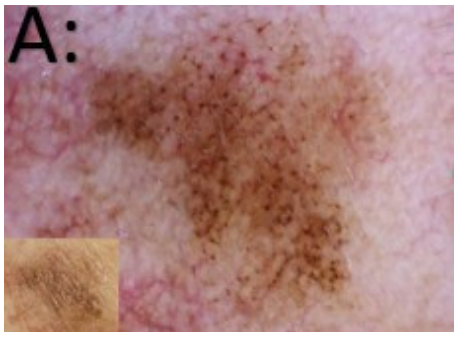
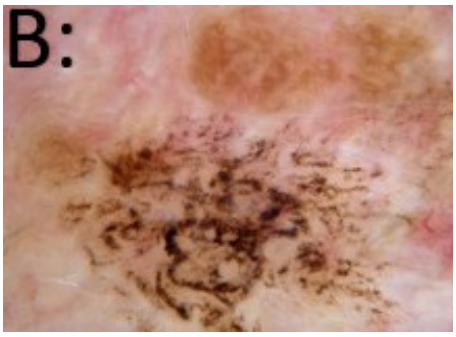
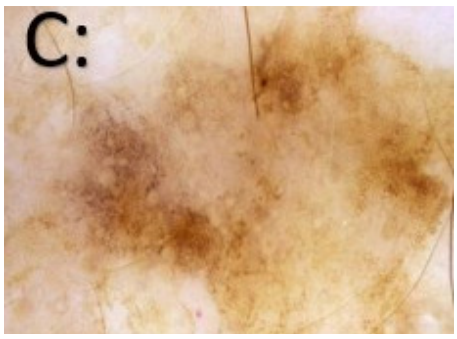
2. Marghoob, A. A., Malvehy, J., & Braun, R. P. (2012). *Atlas of dermoscopy.* Boca Raton: CRC Press.
3. Argenziano, G., Zalaudek, I., & Giacomel, J. (2013). *Dermoscopy.* Philadelphia: Elsevier.
4. Argenziano G, Fabbrocini G, Carli P, et al. *Epiluminescence Microscopy for the Diagnosis of Doubtful Melanocytic Skin Lesions: Comparison of the ABCD rule of Dermatoscopy and a New 7-Point Checklist Based on Pattern Analysis.* Archives of Dermatology. 1998;134(12):1563–1570.
5. Kopf et al. *Dermoscopy: Advanced Principles.* American Academy of Dermatology. 8/1/2009.
6. Schiffner R et al. J Am Acad Dermatol. 2000; 42:25-32

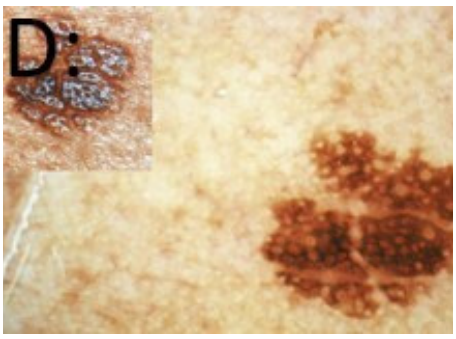
pop QUIZ

Now that you have the background knowledge, hopefully, you can identify which image is lentigo maligna (LM). If you really want to show off, identify all the images. Hint: Only one is an LM.





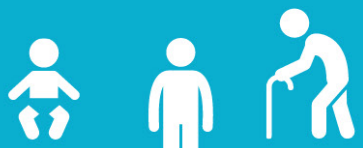




ANSWER KEY: A: LM (all four criteria are present); **B:** Lichen Planus-Like Keratosis; **C:** Lichen Planus-Like Keratosis; **D:** Seborrheic Keratosis

2022
Forefront Path Lab
Melanoma Stats

Melanoma by age



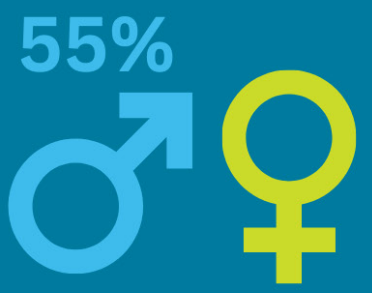
12yo
Youngest

0.1%
Pediatric

66yo
Average

105yo
Oldest

Melanoma by sex



55%

45%

Melanoma by Stage

T0: 59%
T1: 33%
T2: 5%
T3: 2%
T4: 1%

92% early!

Melanoma by State

17.1% Wisconsin

10.2% Alabama

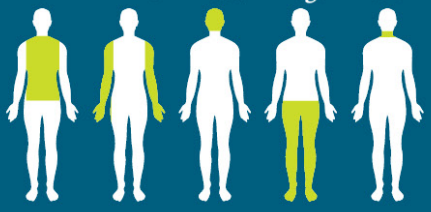
9.4% Indiana

8.8% Florida

6.5% Illinois

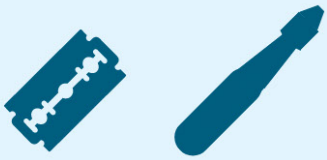
6.5% Montana

Melanoma by anatomic site



32% Trunk
27% Arms
21% Head
13% Legs
6% Neck

Melanoma by Method



95% Shave

5% Punch

Melanoma by Type

in situ/Lentigo Maligna: 59%

Invasive: 41%

Metastatic: <1%

2022 Melanoma Stats
From your Forefront Path Lab

FOREFRONT DERMATOLOGY®

Q&A

DIVERSITY IN DERMATOLOGY *meets* BEAUTY BLOG

BY: TORI NEGRETE, MD, FAAD &
MISSALE MESFIN, MD, FAAD

February's Grand Rounds Discussion of Dermatologic Diagnoses was among our best-attended! Drs. Mesfin, O'Bryan, and Taylor had some great recommendations for products for Skin of Color (SOC) patients. Here we will highlight sun protection and products to help lighten post-inflammatory hyperpigmentation.

Q WHAT UNIQUE FACTORS MUST YOU CONSIDER WHEN CHOOSING SUNSCREENS FOR PEOPLE WITH SOC?

Firstly, you must realize that you may be the first person to tell them they must wear sunscreen. Many SOC patients have never been informed that protecting their skin from the sun is important, even if they don't get sunburns easily. You may need to educate them that the sun can cause damage even without burns and can cause pigmentation problems- more so in darker skin. When selecting sunscreens, the most important factor is finding a sunscreen that does not create a white cast/blue hue that will dissuade use. Most mineral sunscreens cause that unpleasant look and/or are very difficult to rub in on darker skin. I have pictures from a trip to Cancun where part of my face is blue from the sunscreen running in the water, and it is not a good look!

Q WHAT ARE YOUR SUNSCREEN RECOMMENDATIONS FOR PEOPLE WITH SOC? ONES THAT OFFER EXCELLENT PROTECTION AND RUB IN WELL?

Tinted mineral sunscreens have the advantage of blocking visible light, which can worsen hyperpigmentation. Therefore, the optimal sunscreen for those with pigmentation problems would be a tinted mineral sunscreen that rubs in well. Listed below are a few options that fit the bill. Of note, the top two are of a higher price point, and the bottom two options are more affordable for those to whom it makes a difference.

Q WHAT ARE YOUR FAVORITE POST-INFLAMMATORY HYPERPIGMENTATION (PIH) INGREDIENTS?

The great thing is that there are many options to try, and you can use multiple agents simultaneously. Below is a list of ingredients I have found to work well.

- Retinoid
- Tranexamic acid (TXA)
- Kojic acid
- Niacinamide
- Azelaic acid
- Alpha arbutin

This sounds like a lot of products, but the great thing is that most of these ingredients are available in combinations. For example, you will often find TXA combined with kojic acid. Niacinamide is often combined with all these products. So, you really only have to use 2-3 products other than the retinoid. And also, the price points of these products are very good, with most of them varying between $10-30, and they last several months.

ASK THE *Experts*

Everything you need to know about sunscreen products for SOC patients.

DR. TORI NEGRETE

DR. MISSY MESFIN

Tap any product to learn more!

Best SUNSCREENS FOR DARK SKIN TONES

ELTA® MD UV CLEAR, TINTED SPF 40

Serious UV protection and superior hydration join forces in this sheer facial sunscreen.

LA ROCHE-POSAY® ANTHELIOS TINTED MINERAL SPF 50

This lightweight 100% mineral tinted face sunscreen with titanium dioxide was developed for sensitive skin.

CERAVE® TINTED MINERAL HYDRATING SUNSCREEN SPF 30

Helps maintain moisture—while leaving a sheer, natural finish that blends seamlessly with your skin.

KINLÒ™ GOLD RAYS SUNSCREEN SPF 50

A mineral sunscreen for major UVA/UVB defense without the white cast.

Q WHAT ARE YOUR MUST-HAVE OTC AND PHYSICIAN-DISPENSED PRODUCTS FOR PIH?

Starting with the topical retinoid of your choice is important. Many of us offer these in our offices, and if you don't, Forefront has negotiated great prices to allow us to provide them to our patients. SkinCeuticals® and SkinMedica® offer tolerable retinols, and SKNV™ has excellent tretinoins combined with niacinamide and hyaluronic acid.

IN-OFFICE OPTIONS:

Skinceuticals® Discoloration Defense and Dermamade® Melafade are good serums with TXA and kojic acid. Both can be dispensed in your office or purchased online.

OTC OPTIONS:

I like two cosmeceutical companies that offer products for PIH; The Ordinary and Naturium. The Ordinary contains a product with alpha-arbutin and niacinamide, and azelaic acid.

Resources

1. www.cancer.org/melanoma-skin-cancer/about/key-statistics.html#reference
2. Mahendrajaj, K et al. *Malignant melanoma in African Americans—A population-based clinical outcomes study involving 1106 African American patients from the Surveillance, Epidemiology, and End-Result (SEER) database 1988-2011).* Medicine. April 2017; 96(15): e6258.
3. Perez, Maritza. *Skin Cancer in Hispanics in the United States.* Journal of Drugs in Dermatology. March 2019; 18(3): s117-20.
4. Yiyuan, JZ et al. *Poor melanoma outcomes and survival in Asian American and Pacific Islander patients.* JAAD. June 2021; 84(6): 1725-27.

BY *the* NUMBERS

The American Cancer Society estimates that in 2023 in the United States, there will be:

- ~97,610 new melanoma diagnoses
- ~ 7,990 expected deaths from melanoma
- Lifetime risk is 1 in 38 for white patients

In our SOC patients, melanoma statistics vary to some degree.

Melanoma in African American patients:

- Lifetime risk is 1 in 1000
- Over ½ of melanomas occur on the lower extremity, and most in non-sun-exposed areas

Melanoma in Hispanic patients:

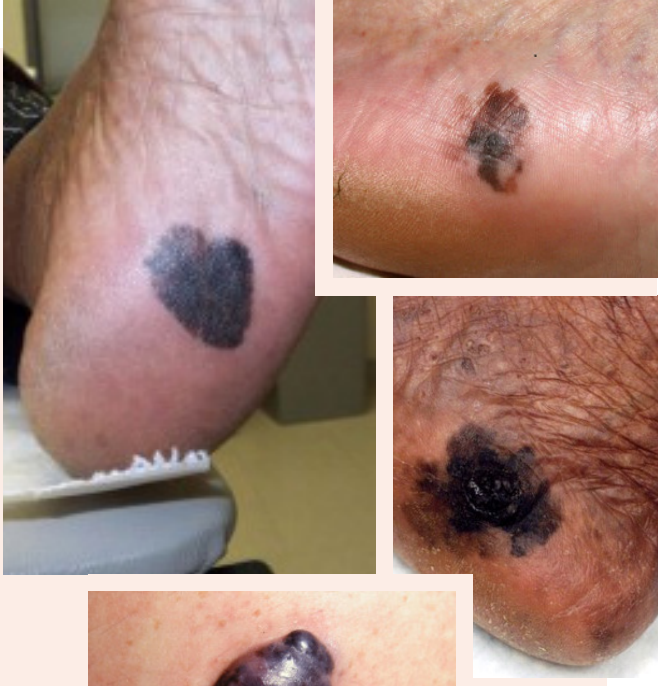
- Lifetime risk is 1 in 167
- Incidence has increased by 20% in the last two decades

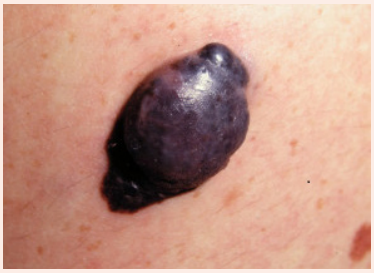
Melanoma in Asian American and Pacific Islander patients:

- 27% increased risk of mortality
- Lymph node positivity at diagnosis is higher than in white patients

What differences do we see among all SOC patients with melanoma?

- The acral lentiginous type is more common
- Melanomas are diagnosed later and at more advanced stages
- Melanoma-specific 5-year survival is significantly lower





Reasons for variation in statistics among different racial groups

- Less understanding that sun protection is necessary for all skin types
- Less public health efforts for darker skin types
- Less discussion of sun protection in SOC patients

What can we do to improve this variability in outcomes?

- Ensure we are discussing the importance of sun protection for all our patients
- Check non-sun-exposed areas during skin exams (especially lower extremities/feet)
- Teach patients how to identify abnormal lesions

Tap any product to learn more!

NEUTROGENA® PURESCREEN+™ MINERAL UV TINT SUNSCREEN

This tinted broad spectrum SPF 30 sunscreen improves the look of skin, blurring visible imperfections and revealing a radiant-looking glow.

NEUTROGENA® INVISIBLE DAILY DEFENSE SPF 30

Serious UV protection and superior hydration join forces in this sheer facial sunscreen.

EXCELIN/TOPIX ANTIOXIDANT MOISTURIZING SUNSCREEN SPF 50

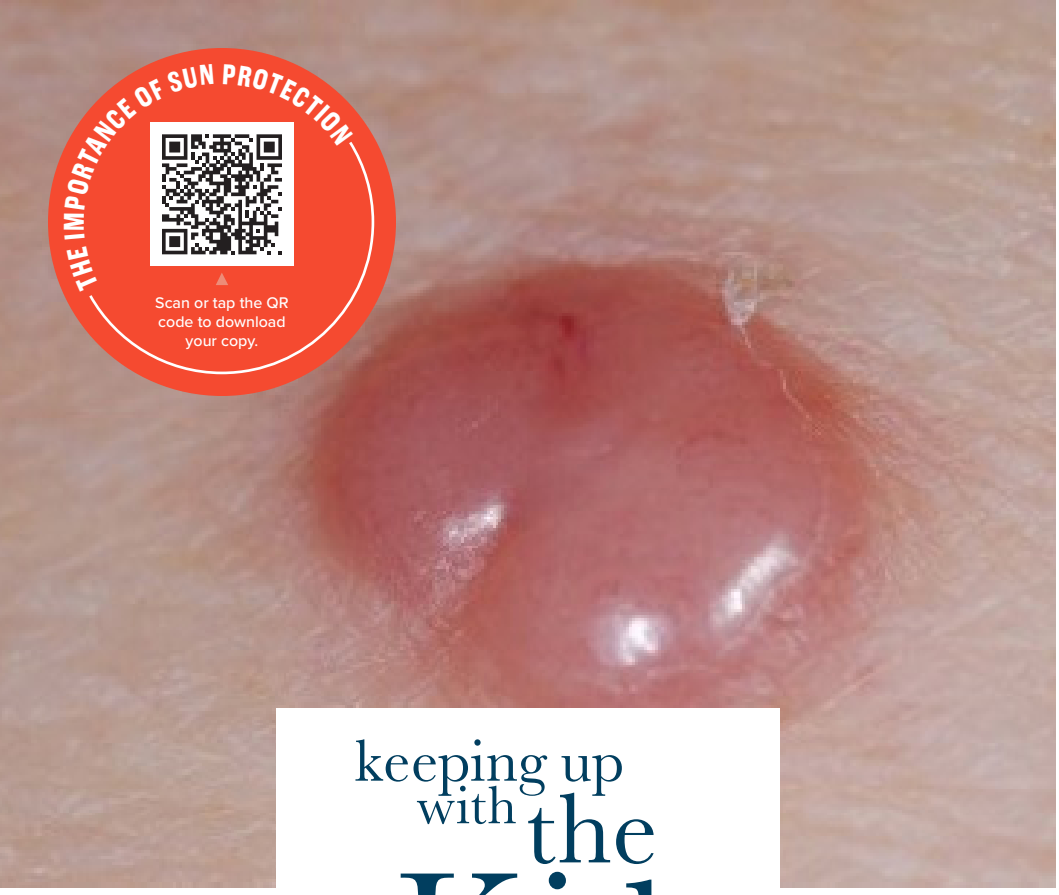
Formulated with finely milled micronized zinc oxide and a powerful antioxidant blend providing the highest level of UVA/UVB protection.

LA ROCHE-POSAY® ANTHELIOS MELT-IN MILK SPF 60

Multi-award winning sunscreen with advanced protection in a fast-absorbing, velvety texture that leaves skin hydrated and smooth.

SUPERGOOP!® UNSEEN SUNSCREEN SPF 40

A weightless, colorless, scentless, oil-free formula for face that leaves behind a velvety soft finish.



keeping up with the Kids

About 300 children in the U.S. are diagnosed with melanoma each year. Among children and teenagers, melanoma often looks different and may grow faster than it does in adults—here are a few questions to test your pediatric melanoma knowledge.

BY: SAPNA VAGHANI, MD, FAAD

1 A healthy 9-year-old presents with a lesion, present for six months but changing slightly in shape. The family has many questions about melanoma. You tell them which of the following?

- **A** It is normal for moles to develop and change during growth and puberty.
- **B** Pediatric melanoma comprises 3-4% of childhood malignancies.
- **C** Pediatric melanoma patients are more likely to present with positive sentinel lymph nodes and increased Breslow depth than their adult counterparts.
- **D** Recent studies indicate similar survival rates of melanoma in adults and children ages ten and older.
- **E** All of the above.

2 A review of pediatric melanoma reported from 1988-2015 in the Colorado Central Cancer Registry was published in 2019. 256 cases of patients diagnosed at 19 years of age or younger were identified. Which of the following was noted?

- **A** Melanoma was more prominent in males.
- **B** Most cases were diagnosed before the age of 5.
- **C** Girls were significantly more likely to present with lesions on a lower extremity compared to boys.
- **D** The majority of cases were in prepubertal children.
- **E** The trunk was the most common site for boys only.

3 You are seeing a six-year-old for an annual skin check. Which of the following are you most concerned about?

- **A** A growing brown macule on the leg.
- **B** Her mother was diagnosed with stage III melanoma at the age of 22.
- **C** A uniform pink papule on the shoulder.
- **D** A 9mm brown macule, darker centrally, on the trunk.
- **E** A 2mm congenital melanocytic nevus (CMN) over the mid spine.

4 A multi-center, retrospective review of pediatric melanoma patients with fatal outcomes (1994-2017) was performed on patients diagnosed at 20 years of age or younger. Thirty-eight cases were identified. Which of the following was noted?

- **A** The majority of patients were female.
- **B** The majority of patients were Caucasian.
- **C** About 25% of cases arose from a CMN.
- **D** Adolescent melanoma had a more aggressive disease course.
- **E** All of the above.

5 A review of 70 patients diagnosed with melanoma before the age of 20 over a twenty-five-year period was performed at UCSF. Which of the following was noted?

- **A** The majority had a first-degree relative with a history of melanoma.
- **B** Prepubertal patients were more likely to have an amelanotic melanoma.
- **C** Time from lesion detection to time of diagnosis was usually < 2 mos.
- **D** Conventional criteria for melanoma (ABCDEs) were present in most cases.
- **E** Most lesions were flat.

ANSWER E

Answer E: The family should be informed that it is normal for moles to develop and change during growth and puberty, pediatric melanoma comprises 3-4% of childhood malignancies, pediatric melanoma patients are more likely to present with positive sentinel lymph nodes and increased Breslow depth than their adult counterparts, and recent studies indicate similar survival rates of melanoma in adults and children ages ten and older.

ANSWER C

Answer C: 160 cases (62.5%) were reported in girls. There was a significant predominance of female cases in the adolescent (P= 0.048) and teenage (P= 0.047) groups. The majority of diagnoses were made during teenage years (ages 15-19), with 136/160 (85%) of girls and 72/96 (75%) of boys diagnosed after 15 years of age; the mean age at diagnosis in both sexes was age 16 with zero cases before the age of 5. The trunk was the most common site of melanoma in both sexes, with 36% of cases in this location. Girls were significantly more likely to present with lower extremity lesions than boys (27.5% vs. 12.5%, p= 0.0049). In concordance with other large studies, a trend toward a higher incidence of lesions of the scalp and neck among boys compared to girls (12.5% vs. 5.63%, p= 0.052) was noted.

ANSWER C

Answer C: A uniform pink papule on the shoulder is concerning because it could be a sign of a worrisome skin condition, such as an early melanoma or a precancerous lesion. A careful examination of the papule should be done to rule out any potential skin cancers.

ANSWER E

Answer E: A review of the cases noted that 2% were male and 58% were female patients. 57% of patients were white, and 19% were Hispanic. Among the 10 cases associated with congenital nevi, half were diagnosed in adolescence (13-19 years of age) and half in childhood (6 years and under).

ANSWER B

Answer B: Only 27% of patients had a 1st or 2nd-degree relative with melanoma, and only <6% had a 1st-degree relative. 77% of lesions in the prepubertal group were amelanotic, compared to 23% in older patients. 40% of patients had numerous or a "severe" number of nevi noted. The time from lesion detection to time of diagnosis was 6 months or more in 82% of cases and >12 months in 62% of cases. Conventional criteria for melanoma (ABCDEs) were lacking in 40% of the post-pubertal group and 60% of the prepubertal group, which had more features of amelanosis, bleeding, papulonodular lesions, and denovo development. All lesions in the prepubertal group were papulnodules, and the majority were one color. The increased size was noted in nearly all cases.

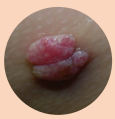
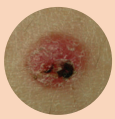
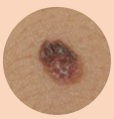
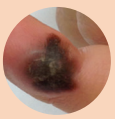
Resources

1. Neale H, Plumptre I, Belazarian L, Wiss K, Hawryluk EB. *Central nervous system magnetic resonance imaging abnormalities and neurologic outcomes in pediatric patients with congenital nevi: A 10-year multi-institutional retrospective study.* J Am Acad Dermatol. 2022 Nov;87(5):1060-1068.
2. Kalani N, Guidry JA, Farahi JM, Stewart SB, Dellavalle RP, Dunnick CA. *Pediatric melanoma: Characterizing 256 cases from the Colorado Central Cancer Registry.* Pediatr Dermatol. 2019 Mar;36(2):219-222.
3. Roberts M, Moxham JP, Gregory A, Armstrong L, Terry J, Courtemanche D, Harvey M, Rehmus W. *Ulcerated amelanotic melanoma of the ear in an 11 year old with Fitzpatrick VI skin type: A case report.* Pediatr Dermatol. 2021 Nov;38 Suppl 2:106-109.
4. Campbell L, Kreicher K, Gittleman H, Strodtbeck K, Barnholtz-SloanJ, Bordeaux J. *Melanoma incidence in children and adolescents: decreasing trends in the United States.* J Pediatr. 2015;166(6):1505-1513.
5. Cordoro K, Gupta D, Frieden I, McCalmont T, Kashani-Sabet M. *Pediatric melanoma: results of a large cohort study and proposal for modified ABCD detection criteria for children.* J Am Acad Dermatol. 2013;68(6):913-925.
6. Hawryluk E, Kao P, London W, Huang J, Marghoob A. *A retrospective multicenter study of fatal pediatric melanoma.* J Am Acad Dermatol. 2020;83(6):AB99.
7. Bartenstein DW, Kelleher CM, Friedmann AM, Duncan LM, Tsao H, Sober AJ, Hawryluk EB. *Contrasting features of childhood and adolescent melanomas.* Pediatr Dermatol. 2018 May;35(3):354-360.
8. Carrera C, Scope A, Dusza SW, Argenziano G, Nazzaro G, Phan A, Tromme I, Rubegni P, Malvehy J, Puig S, Marghoob AA. *Clinical and dermoscopic characterization of pediatric and adolescent melanomas: Multicenter study of 52 cases.* J Am Acad Dermatol. 2018 Feb;78(2):278-288.

PEDIATRIC MELANOMA

ABCDE

Remember the conventional "ABCDE" criteria is not as helpful in the diagnosis of pediatric melanoma, a modified ABCDE approach is best:

A	B	C	D	E
				
Amelanosis	Bleeding/ Bumps	Uniform Color	Any Diameter/ Denovo	Evolution

Forefront FORUM

May is Melanoma Awareness Month, giving us an opportunity to give back to our communities. Let's use this chance to show and expand our support beyond just one month.

BY: TORI NEGRETE, MD, FAAD

BECOME A SUN HERO

The Sun Hero program was founded by our very own, Dr. Amy Brodsky of The Derm with a mission to raise awareness of the importance of sun safety in childhood, increase the adoption of sun safety habits, and motivate change that will reduce the amount of skin cancer.

Are you ready to motivate change? Once you become a Sun Hero, you'll receive an educator kit complete with branded Sun Hero items, a full curriculum guide, and fun educational materials to use in the classroom. You'll also get kits for each student filled with sun-protection swag and SPF products for the kids to take home. The best part is you can get started right now. Identify a school or program in your area.

→ Want to learn more about Sun Hero? Head to **BEASUNHERO.COM**

TOOLS TO HELP YOU GET *Started*

▲ SPOT SKIN CANCER PROGRAM GUIDELINES

▲ CAMP DISCOVERY CAMPER REFERRAL FORM

HOST AN AAD SPOT SKIN CANER SCREENING

Hosting an AAD SPOT Skin Cancer™ screening is a great way to demonstrate your commitment and passion for the community and the specialty. The screening program is the Academy's longest-standing public health program. Since its inception in 1985, dermatologists have conducted more than 2.8 million free SPOT Skin Cancer™ screenings and detected more than 291,000 suspicious lesions, including more than 33,000 suspected melanoma.

→ Want to learn more about SPOT Skin Cancer Screenings? Head to **AAD.ORG/MEMBER/CAREER/VOLUNTEER/SPOT**

SUPPORT AND FUNDRAISE

One way to support the fight against skin cancer is by donating to a skin cancer foundation, such as the AIM at Melanoma Foundation or the Melanoma Research Foundation. Fund public education and early detection programs, medical seminars, and groundbreaking research. Choose something you love to do. Organize an office dress-down day, auction off goods and services, throw a bake sale, participate in a Step Against Melanoma or Miles for Melanoma run/walk, and more! The ways you can fundraise are endless.

→ Want to find more ways to help? Head to **MELANOMA.ORG/HOW-TO-HELP** or **AIMATMELANOMA.ORG**

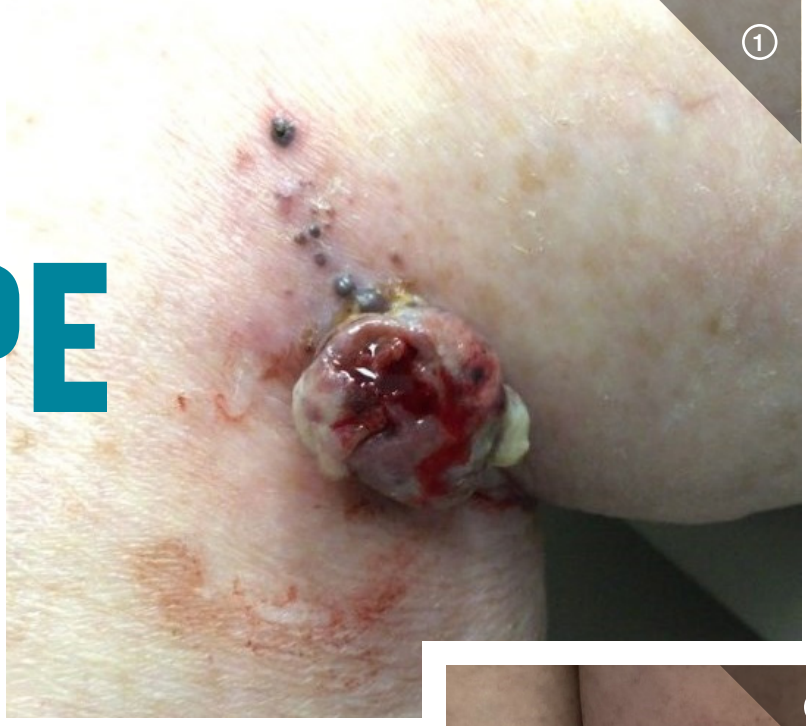
VOLUNTEER FOR CAMP DISCOVERY

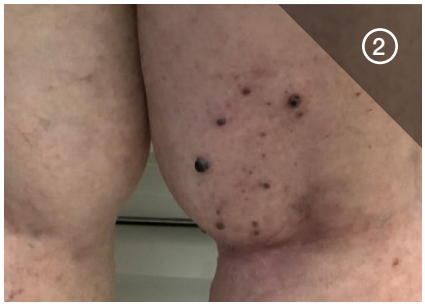
Camp Discovery offers children living with chronic skin conditions a one-of-a-kind camp experience. Provided at no cost to the families, Camp Discovery is one week of fun for kids with conditions ranging from eczema and psoriasis to vitiligo and alopecia to epidermolysis bullosa and ichthyosis.

→ Want to learn more about Camp Discovery? Head to **AAD.ORG/PUBLIC/PUBLIC-HEALTH/CAMP-DISCOVERY**

UNDER *the* SCOPE

BY: DOUG HANSEN, MD





CLINICAL

This 81-year-old female presented to Dr. Jody Hanson with a 1.3 cm multi-colored, ulcerated nodule on the right medial knee. Small brown-black papules were noted near the tumor, depicted in the clinical images (Figure 1). His clinical diagnosis was melanoma, and a biopsy was performed.

PATHOLOGY

The low-power image (Figure 4) demonstrates ulceration with associated fibrin and erythrocytes. There is a nodular growth pattern of atypical cells, which is often a feature of thick melanomas. The higher power photomicrograph (Figure 3) shows highly atypical, enlarged epithelioid cells with increased mitotic activity and obvious brown melanin cytoplasmic pigmentation, diagnostic of melanoma.

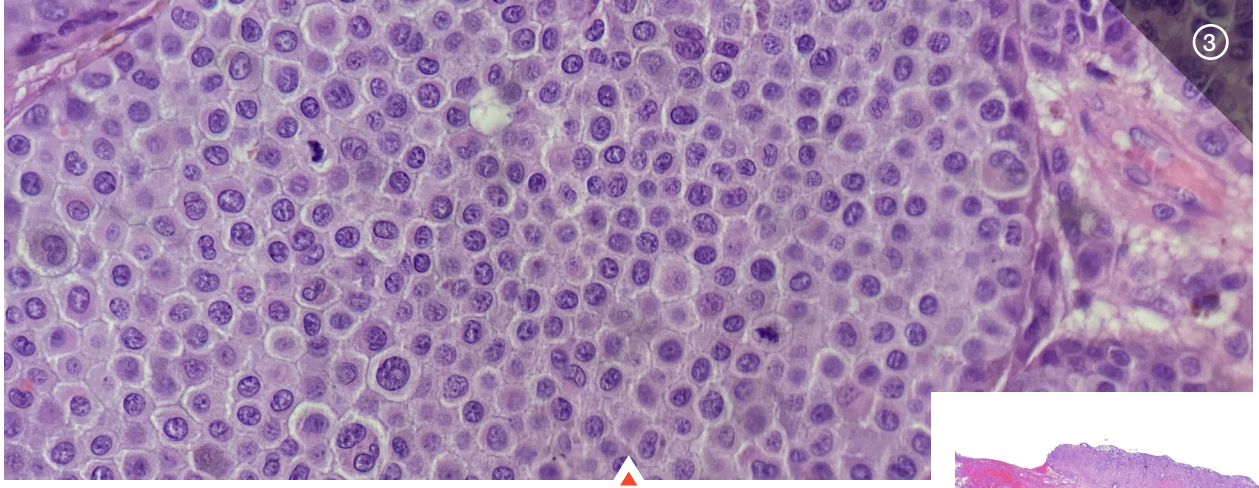
The tumor is at least 8 mm thick (extending to the base). The small brown papules are indubitably foci of cutaneous metastatic melanoma. One of the clinical images (Figure 2) demonstrates a somewhat linear arrangement of the metastases, likely delineating the course of one of the nearby lymphatics draining toward the inguinal lymph nodes.

REPORTING

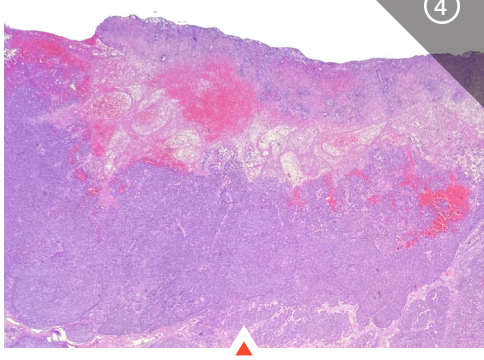
There are a number of essential elements contained in a pathology report which are critical for staging, prognosis, and treatment. Accurate reporting of tumor thickness and the presence of ulceration are amongst the most critical elements and largely define the pathologic stage of the primary tumor.

The importance of accurate measurement of tumor thickness

T Category	Thickness	Ulceration Status
Tis (melanoma *in situ*)	Not applicable	Not applicable
T1	≤ 1.0 mm	Unknown or unspecified
T1a	< 0.8 mm	Without ulceration
T1b	< 0.8 mm	With ulceration
	0.8-1.0 mm	With or without ulceration
T2	> 1.0-2.0 mm	Unknown or unspecified
T2a	> 1.0-2.0 mm	Without ulceration
T2b	> 1.0-2.0 mm	With ulceration
T3	> 2.0-4.0 mm	Unknown or unspecified
T3a	> 2.0-4.0 mm	Without ulceration
T3b	> 2.0-4.0 mm	With ulceration
T4	> 4.0 mm	Unknown or unspecified



High Power: Atypical Cells & Mitoses



Low Power: Ulceration

cannot be overstated; very thin melanomas have a 5-year survival rate that approaches 100%, whereas pT4b melanomas (very thick with ulceration) have a 5-year survival rate of around 50%. Mitotic rate is another essential element of the pathology report, being the second most powerful independent predictor (within the primary tumor) of survival after tumor thickness. Other important elements of melanoma reporting include:

- Histologic type (superficial spreading, lentigo maligna, acral lentiginous, etc.).
- Margin status (peripheral and deep)
- Angiolymphatic invasion
- Perineural invasion
- Tumor regression
- Anatomic level (papillary dermal, dermal, subcutaneous)
- Growth phase (radial or vertical)
- Presence of cutaneous metastasis
- Presence of lymph node metastasis
- Ancillary testing results (IHC, FISH, Gene expression profiling)

This patient demonstrated localized metastatic disease. Two cutaneous metastases were biopsied at Vanderbilt University, confirming the clinical impression. She additionally underwent a sentinel lymph node biopsy, with 2 of 2 inguinal lymph nodes positive for macrometastatic disease. Localized metastasis decreases the 5-year survival to around 33%. She, fortunately, did not have clinical evidence of distant (visceral) metastatic disease, a finding which can decrease the 5-year survival to 10-25%, depending on the organ involved and extent of involvement. She is being treated with Braftovi + Mektovi, kinase inhibitors, a newer therapy demonstrating significant improvement in median survival in a subset of patients (BRAF V600 mutated) with metastatic melanoma.

UPCOMING SESSIONS

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Staying AHEAD

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.

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SkinMedica®

Learn about the SkinMedica Method as Dr. Lycia Thornburg presents an in-depth look at the science and technology behind the skincare line.

401K CORNER

BY: CHAD GRUETT, FINANCIAL ADVISOR AT MORGAN STANLEY

For many of us, estate planning is something we know we should do but often manage to postpone until some indefinite time in the future. But, putting off this part of your financial life could mean passing over an opportunity to preserve the lifestyle you've worked so hard to create and to dictate your legacy on your terms.

WHY YOU NEED AN ESTATE PLAN

The primary purpose of estate planning is to ensure that you control how your assets are distributed. Estate planning is also about planning for unexpected events, such as physical and mental impairment, which may place a financial strain on your family.

A well-crafted estate plan is likely to have multiple goals:

- To protect your lifestyle
- To provide for your family and others, including charitable organizations that are meaningful to you
- To control the distribution of your assets
- To minimize estate taxes

YOUR ESTATE PLANNING CHECKLIST

Depending on your goals, you may need to consider different tools, resources, and strategies to help you develop an estate plan that reflects your priorities. Here are some important documents and services you may need to help protect you and your family in the event of disability:

- A living will is a legal document containing your wishes regarding medical measures that might be taken to prolong your life in case of serious illness or injury.
- A durable power of attorney for health care, also known as a health care proxy, appoints someone you trust to make health care decisions on your behalf if you are unable to do so.
- A durable power of attorney for financial matters gives someone legal authority to make financial decisions if you are unable to do so.
- An inventory of important information includes information about your property, bank accounts, insurance policies, employee benefit plans, mortgages, and debts. It also includes your estate planning documents and beneficiary designation forms.
- Disability insurance can help replace a portion of lost income if illness or injury prevents you from working.
- Long-term care insurance can help to pay for the costs associated with disabilities caused by age and infirmity, such as nursing home care.

Other important documents and services help to protect your family and your legacy in the event of your death:

- Life insurance can provide financial benefits for your named beneficiaries if you pass away. Used strategically, life insurance can also help address other estate planning objectives, such as reducing the impact of estate taxes or charitable giving.
- A will is a state-specific legal document that sets forth your wishes regarding the distribution of your property and the care of any minor children.
- Trusts may be beneficial for a variety of life events and situations, including tax law changes, marriage, college savings, a child with special needs, serious illness, inheritance, and retirement planning.

The most challenging part of estate planning is getting started. Once you begin, you will find estate planning is a positive and constructive way to put yourself in control of your legacy.

support report

BY: MARIA KOHLMEIER, MARKETING MANAGER

Patients with melanoma often face physical, emotional, and mental challenges throughout their journey, which can be overwhelming and isolating. Providing our patients with supportive materials upon melanoma diagnosis can play a small but critical role in helping them cope with these challenges and improve their overall quality of life.

> "HEARING A MELANOMA DIAGNOSIS CAN BE OVERWHELMING. GIVING INFO AND PRODUCTS TO REVIEW HELPS PROVIDE A REFERENCE OUTSIDE THE OFFICE.

SINCE ITS LAUNCH, WE HAVE DISTRIBUTED OVER

1,600

MELANOMA KITS

In 2020, we collaborated with L'Oreal to develop a small kit designed for our patients diagnosed with melanoma. The kit includes a short letter from Forefront Dermatology, a pamphlet on skin cancer prevention, product coupons, and sample products from CeraVe® and La Roche-Posay®. This supportive gesture from our team to our patients helps educate them on steps they can take to prevent future melanomas.

Request YOUR FREE MELANOMA BOX

If you are interested in ordering melanoma kits for your clinic, please email us and include the destination address and the number of kits you would like (maximum of 10 per order). Packages are shipped weekly.

HOT OFF THE PRESS

BY: KATIE HUNT, MD, FAAD

ISOTRETINOIN

Isotretinoin did not confer an increased risk of suicide attempts in a retrospective population-based cohort study.

RESOURCE: JAAD, FEBRUARY 2023.

SEROLOGIC SCREENING

US Preventative Services Task Force reaffirms its recommendation against serologic screening for genital herpes.

RESOURCE: JAMA DERMATOLOGY, MARCH 2023.

TELEMEDICINE

Psoriasis patients report high satisfaction with telemedicine follow-up appointments.

RESOURCE: JAAD, FEBRUARY 2023

SYSTEMIC LUPUS

Risk factors for discoid lupus patients to progress to systemic lupus:

- Age of diagnosis under 25 years
- Phototypes V and VI
- ANA titer 1:320

RESOURCE: JAAD, MARCH 2023

PEDIATRIC MELANOMA

Risk factors for worse prognosis in childhood and adolescent melanoma:

- Head or neck location
- Ulceration
- Breslow thickness >4 mm
- Survival rates were very high, overall

RESOURCE: JAAD, MARCH 2023

ORAL MINOXIDIL

A small (n=34), prospective study of men treated with low-dose (5 mg) oral minoxidil showed only subclinical hypotension and a 3.3% incidence of tachycardia as measured with Holter monitors:

- Other common side effects: headache (21%), vertigo (3%), edema (3%)

JAAD, FEB 2023

pastISSUES

Q1 - 2023 Newsletter

Q4 - 2022 Newsletter

Q3 - 2022 Newsletter

FOREFRONT DERMATOLOGY®

Forefront is a physician group led and operated by dermatologists for the benefit of dermatologists. We provide general, surgical, and aesthetic dermatology services along with related laboratory services through a network of dermatologists, physician assistants, and nurse practitioners.

To learn more visit:

forefrontdermatology.com