

Skin Deep



Autumn 2013 – News and information from the Department of Dermatology

CALENDAR

HARTFORD PSORIASIS NETWORK MEETINGS

November 1 and December 6 at 7 pm
First Church of Christ,
12 S. Main St., West Hartford
Hartford Psoriasis Network
1-877-546-5558 x209
hartford@support.psoriasis.org

UConn DERMATOLOGY GRAND ROUNDS, 8 AM, WEDNESDAYS

November 6 and December 4
Dermatology Waiting Room
21 South Rd., 2nd Floor,
Farmington

UConn DERMATOLOGY JOURNAL CLUB, 12:15 PM,

November 22 and 27 and December 11 and 18
Dermatology Conference Room
21 South Rd., 2nd Floor,
Farmington

WE UPDATE OUR CALENDAR AND EVENTS ON A REGULAR BASIS. TO SUBMIT AN EVENT OR FOR MORE INFORMATION, FEEL FREE TO CONTACT OUR MAIN LINE AT 860-679-4600.

Letter from our Chairman

*M*edicine, and specifically Dermatology, is under siege!

I am a member of a legislative group in Washington, D.C., which is representing the American Academy of Dermatology in its struggle to protect the rights of our patients. I would rather be seeing patients or teaching but have chosen to come to Washington with other dermatologists because medicine is under assault by our government.

The specific issues that we are addressing with our Connecticut congressmen and senators include the rising incidence of skin cancer and the role of indoor tanning establishments. We are urging our congressman to join the Congressional Skin Cancer Caucus and our Senators to create a Skin Cancer Caucus or workgroup in the upper chamber. Additionally, sequestration has resulted in egregious cuts in medical research. The research that is no longer receiving funding has previously been the source of hope to us and our patients in the struggle to find cures and treatments for many debilitating and life threatening skin diseases. Under sequestration, the NIH was cut by \$1.7 billion and funding for research is scheduled to face additional cuts in 2014 and beyond. These cuts have negatively impacted funding for the CDC's Skin Cancer Prevention Program as well as other compelling initiatives. Therefore, we are asking our CT representatives in the House to cosponsor HR 460 which will enable patients to access treatments and control health care costs. We are asking our senators to become more familiar with the extant barriers to patients obtaining needed medications and to join the Senate sponsor of the Patient's Access to Treatments Act. Finally the flawed sustainable growth rate (SGR) formula needs to be replaced with meaningful reform. If not repealed the SGR will negatively impact our ability to care for and effectively treat patients on Medicare.

As you may or may not be aware, last year the reimbursement for processing and evaluating skin biopsies was reduced by 33% and this year phototherapy is scheduled for a reduction of 50%. These reimbursement reductions have taken place despite the reality of increasing overhead costs for the vast majority of practitioners. Furthermore, these cuts will ultimately result in the financial failure of dermatopathology laboratories and the closure of phototherapy units with attendant negative repercussions for patient care. Other major cuts in reimbursement are looming on the regulatory horizon which worries me, not only as a physician trying to deliver the best care to my patients, but also as a potential future patient. The future of medical care as outlined by our legislators will create a medical landscape characterized by reduced access to specialists, panels rather than our doctors deciding what constitutes medically necessary care, and curtailed or absent research and development in critical areas.

Obviously, some change is needed and may be long overdue. Coverage of young adult children under their parents' policies if needed and retaining health care despite a pre-existing condition are arguably noble achievements. However, lack of access to specialists, curtailed research and inappropriate cuts to reimbursement that will make some treatments unavailable, and the absence of tort reform, are almost certainly egregious developments! Patients need to join their physicians in letting our legislators know that we are concerned about the future of medicine. Please help us in our effort to help you!



- Jane Grant-Kels, MD



Skin: the athlete's largest organ. How to protect it for optimal performance and long-term health

- Logan D'Souza, MD, Chief Resident

(recently published in the NCAA Sport Science newsletter)

Most sports involve some sort of protective gear to guard against injury; soccer has shin guards, baseball has helmets, football has shoulder pads, and the list continues. An often-overlooked part of the body that withstands daily damage if not properly protected is the body's largest organ – skin. Data shows that more than 90% of outdoor NCAA do not use sunscreen.

Practice and competition schedules commonly take place in the mid-day sun, a major risk factor for all skin cancers. Outdoor athletes are at a particularly higher risk compared to the general population for multiple reasons, including sweating that both increases the skin's photosensitivity and washes off sunscreen. Additionally, UV radiation is amplified by reflecting off most training grounds, including water, sand, concrete, light-colored surfaces, and snow. Alpine and winter athletes are even more susceptible to sun damage given that harmful UV rays are less absorbed by the atmosphere at higher altitudes. Notably, intense athletic training can also temporarily weaken the skin's immune system and increase the risk of some types of skin cancer.

Knowing these risks is vital, as skin cancer is on the rise. More than 3.5 million skin cancers in more than 2 million people are diagnosed in the United States annually, including about 137,990 new cases of melanoma, the most serious form of skin cancer. Current estimates are that one in five Americans will eventually develop skin cancer, including a projected one in 50 Americans will develop



melanoma during their lifetime. Moreover, the risk is not just for the elderly. A recent study found that basal cell carcinoma and squamous cell carcinoma are increasing in men and women under 40. As for melanoma, it is the most common form of cancer for young adults 25-29 years old and the second most common form of cancer for adolescents and young adults 15-29 years old.

Because exposure to ultraviolet light is the most preventable risk factor for all skin cancers, the American Academy of Dermatology encourages everyone to protect their skin. Examples of safe skin practices include: applying a broad-spectrum, water-resistant sunscreen with a Sun Protection Factors (SPF) of 30 or more and reapply every 2 hours; seeking shade and avoiding training and competing when the sun's rays are strongest between 10am and 2pm; using extra caution near water, snow, and sand that can augment the damaging rays of the sun; and avoiding tanning beds that can cause skin cancer and wrinkling. Additionally, be on the lookout for warning signs of melanoma, including changes in size, shape, or color of a mole or other skin lesion, or the appearance of a new growth on the skin.

The importance of early detection is paramount, as most skin cancers can be easily treated with high cure rates when found promptly. It is essential to know your risk factors that should prompt regular evaluation by a dermatologist, which include: a high amount of intermittent sun exposure; exposure to tanning beds; having more than 50 moles, atypical moles, light skin, freckles, or a personal or family history of melanoma. Individuals with a history of melanoma should have a full-body exam by a board-certified dermatologist at least annually and perform regular self-exams for new and changing moles. Know your spots and be aware of your skin, and if you see a spot that is changing, see a dermatologist – it could save your life!

Clinical Trials



We have several active clinical trials here in the Department of Dermatology. Presently these are all for moderate to severe plaque Psoriasis and are sponsored by pharmaceutical companies. If you have any questions about clinical research here, please contact Gloria Borders at 860-679-3475 or e-mail gloriaborders@adp.uchc.edu.

A clinical trial, also known as clinical research or a research trial, is a research study in human volunteers in order to answer specific health questions. Clinical trials can take place in a variety of locations, including hospitals, universities, doctors' offices, freestanding research centers or community health clinics. All clinical trials are conducted according to strict scientific and ethical principles. Every clinical trial must have a protocol, or action plan that describes what will be done in the study, how it will be conducted, and why each part of the study is necessary. The protocol will have guidelines about who can participate in the research study. These guidelines are based on such factors as age, type of disease, medical history, and current medical condition. Some research studies seek volunteers with illnesses or conditions to be studied, while other trials need healthy volunteers.

Clinical trials are sponsored by government agencies, private organizations, and individual researchers who are seeking ways to improve the health of people who may be living with diseases. Sponsors include:

- government agencies such as the National Institutes of Health (NIH), the Department of Defense (DOD), and the Department of Veteran's Affairs (VA)
- pharmaceutical, biotechnology and medical device companies
- individual researchers

- health care institutions such as academic medical centers and health maintenance organizations (HMOs)

Clinical trials are conducted in a series of steps, called phases - each phase is designed to answer a separate research question.

- Phase I: Researchers test a new drug or treatment in a small group of people for the first time to evaluate its safety, determine a safe dosage range, and identify side effects.
- Phase II: The drug or treatment is given to a larger group of people to see if it is effective and to further evaluate its safety.
- Phase III: The drug or treatment is given to large groups of people to confirm its effectiveness, monitor side effects, compare it to commonly used treatments, and collect information that will allow the drug or treatment to be used safely.
- Phase IV: Studies are done after the drug or treatment has been marketed to gather information on the drug's effect in various populations and any side effects associated with long-term use.

Your participation in any clinical trial is voluntary. Before you volunteer to participate, you will receive an informed consent document that explains the details of the study, including the potential risks and benefits, as well as your rights and responsibilities. A member of the research team will discuss the study with you and answer your questions so you can make an informed decision about whether or not to participate. In addition, you have the right to ask questions throughout the course of the study and may withdraw consent (stop) at any time. This would not affect your regular care at the clinic or with your doctor. Since the decision to volunteer for a clinical trial is a personal one, you should decide by consulting with your health care provider, family members, and friends.



CTCL - Katalin Ferenczi, MD

Cutaneous lymphomas are a distinct subset of non-Hodgkin's lymphomas that involve the skin. They are cancers of white blood cells (lymphocytes) that primarily affect the skin but can also involve the blood, lymph nodes and/or internal organs in patients with advanced disease. The disease affects men more often than women and usually occurs in people in their 50s and 60s. Rarely, younger people can also be affected.

Cutaneous T-cell lymphomas (CTCL) represent the majority of cutaneous lymphomas. The two main subtypes of CTCL are mycosis fungoides and Sézary syndrome. Mycosis fungoides is the most common type of CTCL. It is a very indolent, slow-growing form of lymphoma and usually only affects the skin. Symptoms include flat, scaly patches, raised plaques, or, rarely, tumor nodules. Skin lesions are often itchy and frequently mistaken for eczema or psoriasis. Sézary syndrome is the leukemic variant of CTCL, characterized by enlarged lymph nodes and the presence of lymphoma cells in the blood. In Sézary syndrome the rash is more extensive and usually covers over 80 percent of the body. These patients may also experience changes in the nails, hair, or eyelids, severe itching and are at increased risk for infections.

How CTCL is diagnosed - Mycosis fungoides is difficult to diagnose in its early stages because the symptoms and skin biopsy findings can mimic eczema or other skin conditions. A medical history, physical exam, and skin biopsy are essential for diagnosis. The diagnosis is made by removing a small piece of affected skin (skin biopsy) and examining it under a microscope for abnormal cells. If the biopsy is consistent with CTCL, the doctor will examine your lymph nodes and order blood

tests to check if there are any abnormal lymphocytes present. Scans are usually not needed for those with the earliest stages of the disease. However, patients with advanced disease or Sézary syndrome need imaging tests, such as CT (computerized tomography) scan to check if the cancer has spread to the lymph nodes or other organs.

CTCL stage and disease course - The stage of CTCL describes how much of the skin is affected and whether it has spread to the lymph nodes and/or blood. In most cases, only skin symptoms are present and the disease has an indolent clinical course. Patients diagnosed with the earliest stages of the disease have a normal life expectancy. Progression from limited skin involvement is variable and some patients with early-stage CTCL might not progress to later stages at all. Over time, in a small number of people, the disease may spread to the lymph nodes, blood, and internal organs and serious complications can develop.

How CTCL is treated - Treatment selection depends on a number of factors, including stage of the disease, patient's age and general health. Treatment choices for cutaneous lymphomas are directed at either the skin (topical) or the entire body (systemic). In early stages of CTCL, since malignant T-cells are present in the skin only, the so-called skin-directed therapies, such as corticosteroid or retinoid creams, topical chemotherapy, ultraviolet light (phototherapy) or local radiation can often achieve long-lasting remissions.

Treatment for patients with advanced CTCL or Sézary syndrome generally requires systemic approaches, including biologic or immune therapies, extracorporeal photopheresis, chemotherapeutic agents or stem cell transplantation.

MELAFIND optics by Carl Zeiss

This information can also be obtained from the MelaFind brochure that is distributed to our patients.

MELANOMA is the most dangerous form of skin cancer. Skin cancer occurs when cells grow abnormally and uncontrollably. One way to identify melanoma is to look for moles with irregular growth patterns. **MelaFind** is a brand new medical technology that is used during a skin exam or mole check to help dermatologists see under the skin's surface. MelaFind can help your dermatologist determine how irregular the growth pattern of your mole is under the skin.

How does MelaFind work? MelaFind collects information from 2.5mm deep into the skin, using computer vision technology. MelaFind then analyzes that information and gives feedback on how irregular or peculiar your mole is under the skin.

Does MelaFind use x-ray light? No. MelaFind uses light of 10 different wavelengths, from blue (430nm) to near infrared (950nm), to illuminate the mole for data capture; neither ultraviolet light nor X-rays are employed.

Is MelaFind a body scanner? No. A scan means that MelaFind would be used on all of your moles. MelaFind should only be used on irregular-looking or peculiar moles that your dermatologist wants more information about.

Is MelaFind painful? No. MelaFind is placed lightly on top of the skin and is painless. Minor irritation may result from the application of alcohol.

Does MelaFind cause scarring? No. MelaFind is non-invasive, therefore, it leaves no scars. If your dermatologist chooses to biopsy an irregular mole, a scar may develop at the biopsy site.

What is the cost? The cost of MelaFind is an out of pocket expense. The cost per picture is \$25.

How can I obtain more information about MelaFind? For more information on MelaFind, please call our office at 860-679-4600.

What's new...

Our department would like to welcome our three new dermatology residents:

Dr. Nikita Lakdawala, MD

Dr. Syril Keena Que, MD

Dr. Breton Yates, MD

We wish you much success during your three years here at UConn!!

You can make a difference. Your gift to the George H. Grant Department of Dermatology Melanoma Research Fund will help the UConn Health Center make advances in the diagnosis, treatment and prevention of melanoma.

Every contribution toward the UConn Health Center benefits our patients and their loved ones. Gifts of any size are deeply appreciated. Donors who make annual gifts totaling \$1,000 to \$25,000 are honored in the UConn Foundation's Leadership Giving Society.

Make your donation at: giving.uchc.edu.

Thank you for your generous support!

Have a question? Please contact Dina Plapler, Vice President for Development, at 860/679/8077 or dplapler@foundation.uconn.edu.



For more information or to schedule an appointment, please contact:

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Farmington, CT 06030-6231

Main Line: 860-679-4600

Web: dermatology.uchc.edu

Katalin Ferenczi, MD



Dr. Ferenczi is a board certified dermatologist and dermatopathologist who has been working at UConn since 2010. She graduated from Semmelweis University of Medicine in Hungary and went on to complete her dermatology residency at Case Western Reserve University. She then completed her fellowship in dermatopathology at University of Pennsylvania School of Medicine. She has also conducted research on the immunology of cutaneous lymphomas at Harvard University in Boston. Dr. Ferenczi's interests include clinical dermatology and dermatopathology with a particular interest in cutaneous lymphomas.

William Holmes, MD - PGY 5



Dr. Holmes is our first fellow in our Procedural Dermatology fellowship program. He graduated from the Medical College of Wisconsin and completed his transitional year of residency at Wheaton Franciscan Healthcare in Wisconsin. Dr. Holmes completed his dermatology residency here at the UConn School of Medicine. He recently passed his dermatology board exam and is now a board certified dermatologist. His professional focus is cutaneous oncology and Mohs micrographic surgery.

Christina Iwanik, BA Administrative Program Coordinator



Christina has been with the department since 2006 and is the coordinator to the Dermatology Residency and Procedural Dermatology Fellowship programs. Beyond the programs she also coordinates and schedules all rotating medical students and residents within and outside of UConn who come to our department for their 4 week rotations. She also meets with pharmaceutical representatives, schedules call for the attendings, is one of the editors for 'Skin Deep', and coordinates all administrative aspects for the department's Continuing Medical Education with regards to Grand Rounds and Journal Club.