BY ALAN ROCKOFF, M.D.

Under My Skin

Peeves

Life always brings annoyances, major or otherwise. I'm no more peevish than usual; it's just that I've saved up a few smallish peeves, none weighty enough for a column of its own.

High-Tech Lists

It's an old story that lists are the bane of a dermatologist's life. I refer of course to the fellow who pulls out a used envelope or a slip of paper on which he's listed every spot he or his wife are concerned with or every skin-related question he's ever thought of but never had the chance to ask until, "Now that I've got you. …"

When the list is on a paper, you can gauge about how long it is and answer accordingly. You can also tell about how much farther you have to go.

Not so with people who whip out a handheld device, scroll to their list, and start to read. My heart sinks when I see that, because I have no idea how much longer this is going to go on, and when, or whether, I'll need to sue for mercy.

I suppose I could make up a waiting room sign that says, "Please Present All Question Lists to the Clerk for Encryption," but that might just encourage more people to make lists.

Warts Are Female, Skin Tags Are Male

That warts are female is clear; the original one is always called the mother wart. Skin tags (and seborrheic keratoses), however, are always male; every time and without exception, you will hear them called "little guys," as in, "Can't you get rid of these little guys?"

As a male, I find this disturbing. Females rightly complained when hurricanes were given only girls' names, which implied that women are windy, unpredictable, and sometimes destructive. Why then should men stand idly by while our gender is compared with things that just hang around being annoying, irritating, and redundant? Maybe Maureen Dowd of the New York Times can address this issue in the second edition of "Are Men Necessary?"

I Am Not a Dermo!

Internet correspondents have a habit of referring to members of our esteemed profession as "dermos" (as in, "I checked it out with my dermo").

We dermatologists are among the medical specialists favored with undignified monikers, like the ones that compare some physicians with creepy-crawlies ("orthopods"), gnarly mammals ("gynos"), or voodoo savants ("shrinks").

Not all specialists are so honored. Would you visit your interno? Consult your ophthalmo? Get a cysto from your uro?

Likewise, it's hard to imagine other professionals referred to in this way. Would anyone make a will with their attorno? Confess to their clergy guy? Prepare taxes with their bean counter? (There is, of course, "politico," but that's deserved.)

A variant of dermo is "derm." Even our professional publications sometimes call us that, running headlines like "Derms Tout Combo Tx," which makes it sound as though we're pushing a betting option at the dog track.

Clinical Research

From time to time, I'm asked to take part in drug evaluations. These may take the form of round-table discussions over dinner, in which I, a "thought leader," would be given the chance to air my leading thoughts about rosacea or eczema. Another option is to take part in clinical research, following a dozen or so patients to record how they fare with a particular product. Whether such "research" contributes to human knowledge or just advances brand-name recognition is another matter. In any case, I always decline these offers, though I'm tempted to accept just so I can add a financial disclaimer to my byline.

Then my eye falls on those ads on the inside front cover of prestigious periodicals like the New England Journal of Medicine, the ones for drugs that promise new hope for erectile dysfunction. Their copy includes footnoted claims like "high intercourse success," and "high patient satisfaction."

Now *there's* a research area of interest. The claims these adverstisements make raise important questions (methodologic, of course). For instance, how do they develop and validate questionnaires to assess "success" or "satisfaction?" And when, exactly, do they administer these questionnaires? These are matters in which I'm sure I could make a real—ad-writers would say aff**irm**ative—contribution. So how come no one ever asks me to?

RBRVS, CMS, OSHA, CLIA, HIPAA, HMO, PPO, PRO, ICD, CPT, iPLEDGE, ETC., ETC., ETC.

No elaboration needed. ■

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Clarification

The method for skin grafting surgical defects of the nasal alar region known as the drumhead graft was invented and developed by Dr. J. Michael Wentzell of Billings, Mont. ('Drumhead' Technique May Spare Alar Graft Depressions, Skin & Allergy News, January 2007, p. 32). Dr. Bradley K. Draper of Billings presented Dr. Wentzell's technique at the annual meeting of the American Society for Dermatologic Surgery.

Point/Counterpoint

Should PAs be able to screen for melanoma to offset long wait times to see dermatologists?

Training will improve PAs' diagnostic accuracy.

GABRIEL F. SCIALLIS, M.D.

The delay of treatment of melanoma could be deadly. If we reduce the number of patient providers by restricting the public to see only dermatologists, it would be logical to assume that this would delay patient appointments and therefore increase risk in that patient who has a melanoma.

We educate patients to perform skin self-examination routinely using American Academy of Dermatology–provided resources. Obviously, patients have not been trained to the extent that dermatologic physician assistants (PAs) have. Therefore, it's logical to allow PAs to screen patients for melanoma, since we already ask patients, parents, and other caregivers to screen for these malignancies.

Based on experiences we have had with PAs here at Mayo in the last 3-4 years, we have found that with good training, their judgments have equaled those of our staff and residents who are screening for skin cancers. The PA must be supervised according to state regulations. If there is a concern about a lesion, the PA calls the dermatologist in to evaluate the lesion and they discuss it together.

If we did not allow dermatologically trained PAs to screen patients for melanoma, we would have to expand the number of dermatology residents whom we train. Otherwise it would be impossible to adequately screen patients. There would be reduced survival in patients who had melanoma and couldn't get in to see physicians for 3-5 months. ■

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Lack of acumen will lead to misdiagnoses.

NAOMI LAWRENCE, M.D.

The issue of how to address melanoma diagnosis should be one of quality of care. That is, we ought to be thinking about how to provide patients with the best care, not to take an assembly-line approach with PAs, who are not as intensively trained as dermatologists.

During a skin exam, dermatologists are relying on years of training and clinical acumen—the way something looks and the levels of suspicion that arise.

The medical literature has supported the notion that dermatologists are better at diagnosing skin conditions than are nondermatologists. One review article found that dermatologists were 93% correct in making skin diagnoses, compared with 52% among primary care physicians (Arch. Fam. Med. 1999;8:170-2) . If primary care physicians get the diagnosis wrong half the time, how often will a PA get it right?

And what would keep patients from being biopsied inappropriately? For example, let's say someone who is not well trained mistakes a benign, large, dark seborrheic keratosis for melanoma and decides to excise it. A terrible scar will be created in somebody who didn't need a biopsy.

Alternatively, if a PA dismisses a suspicious lesion that turns out to actually be melanoma, the physician is ultimately responsible for a misdiagnosed patient's outcome. ■

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