

UNDER MY SKIN

The Way We Were

A jammed sharps container doesn't sound like the kind of thing to trigger a nostalgic reverie, but the other day one of them did just that.

Back in 1981, after my first day in my current office building, my secretary called me at home to say that the janitor was furious: He'd been stuck by a needle that came loose in one of the garbage bags.

We used to put capped needles in the trash!

Yes, there were needle breakers, little red plastic boxes that snipped off needles at the hub, but we didn't always use them; instead, we just screwed the needles into their plastic hubs before discarding them.

Then came AIDS and the Occupational Safety and Health Administration and sharps containers, but even those evolved. The first ones were crude affairs that let you poke inside to retrieve something and possibly get jabbed. Newer models eliminated that chance with one-way-valve

openings. Change is troublesome but inevitable. We look for some of it, some we have thrust upon us, and the rest just sneaks in somehow.

Because most change is slow and incremental, it's hard to remember what things were like even a few years ago. We're always brought up short when we see a snapshot, an old TV sitcom, a movie like "Back to the Future." "Hey look, 'Bonanza!' " "I haven't seen a hand lawn mower since I was a kid." "How about those bell-bottoms?" "Look, Windows 98!" (That's for the younger set.)



BY ALAN
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My office past came blasting through recently in this exchange:

"Your skin cancer will need surgery, Mr. Mortimer. What hospital is your PCP with? I have to choose a specialist from the right referral circle."

"I have Blue Humdinger Supreme, Doctor. I can go anywhere."

"What?"

"I can go anywhere."

"You can go anywhere ...?"

(I am running in slow motion through a green meadow filled with crimson wildflowers. Smiling models from nonsedating antihistamine ads are sitting at picnic tables, joyfully inhaling pollen. I can send my patients anywhere I want! It's a dream!)

Actually, it is. But once upon a time I could. Anybody could see me without referrals, and I didn't need an army of referral clerks. I could schedule a follow-up visit just because I wanted to. ... I could write a prescription for any drug I felt like. ...

We fixed typos with Wite-Out correction fluid. There was no voice mail or e-mail. Faxes had not been thought of. There wasn't any health insurance, and patients paid in chickens, if they paid at all.

You win some, you lose some.

We can't hide from change, but it may be best not to be the first kid on the block to adopt it, either. Let other people work out the bugs, and wait for the higher prices of early adoption to come down.

It's also a good idea to ignore the predators who are always ready to cash in on our fear of instability. They're the ones who send out those screaming flyers, "Give Us Lots of Money and We'll Protect You From the Latest Government Threat!" Better to wait for soberer voices, like those

of our professional associations, to assess the situation and give guidance. The sky won't fall in the meantime.

Sometimes, change is so sensible it makes you wonder why it took so long to happen.

Back when I started, I sent pathology specimens to a lab at the dermatology department of my alma mater. They supplied me with little white cylinders containing a formalin bottle and path slip. Printed on the cylinder were the lab's address and a notice, "No postage necessary if mailed in the United States."

We sent specimens ... by regular mail! (Online tracking was not available.)

"Dr. Rockoff, do I have melanoma or not?"

"Hello, lab, do you have the biopsy on Mr. Mortimer? ... What do you mean, 'Who is Mr. Mortimer?'"

Yes, things like that really happened. Sometimes the missing cylinder eventually showed up, many palpitations later.

At some point in the early 1980s, some labs started offering courier service. Soon, all the rest followed suit.

See? At least in some respects, these are the good old days. ■

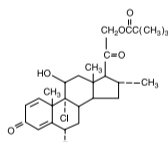
DR. ROCKOFF practices dermatology in Brookline, Mass. To respond to this column, write Dr. Rockoff at our editorial offices or e-mail him at sknews@elsevier.com.

Cloderm[®] (clocortolone pivalate) Cream, 0.1%

For Topical Use Only

DESCRIPTION: Cloderm Cream 0.1% contains the medium potency topical corticosteroid, clocortolone pivalate, in a specially formulated water-washable emollient cream base consisting of purified water, white petrolatum, mineral oil, stearyl alcohol, polyoxyl 40 stearate, carbomer 934P, edetate disodium, sodium hydroxide, with methylparaben and propylparaben as preservatives.

Chemically, clocortolone pivalate is 9-chloro-6 α -fluoro-11 β , 21-dihydroxy-16 α -methylpregna-1, 4-diene-3, 20-dione 21-pivalate. Its structure is as follows:



CLINICAL PHARMACOLOGY:

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

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

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

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

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

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

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

PRECAUTIONS

General: Systemic absorption of topical corticosteroids has produced reversible hypothalamic-pituitary-adrenal (HPA) axis suppression, manifestations of Cushing's syndrome, hyperglycemia, and glucosuria in some patients.

Conditions which augment systemic absorption include the application of the more potent steroids, use over large surface areas, prolonged use, and the addition of occlusive dressings.

Therefore, patients receiving a large dose of a potent topical steroid applied to a large surface area or under an occlusive dressing should be evaluated periodically for evidence of HPA axis suppression by using the urinary free cortisol and ACTH stimulation tests. If HPA axis suppression is noted, an attempt should be made to withdraw the drug, to reduce the frequency of application, or to substitute a less potent steroid.

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

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

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

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

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

- This medication is to be used as directed by the physician. It is for external use only. Avoid contact with the eyes.
- Patients should be advised not to use this medication for any disorder other than for which it was prescribed.
- The treated skin area should not be bandaged or otherwise covered or wrapped as to be occlusive unless directed by the physician.
- Patients should report any signs of local adverse reactions especially under occlusive dressing.

5. Parents of pediatric patients should be advised not to use tight-fitting diapers or plastic pants on a child being treated in the diaper area, as these garments may constitute occlusive dressings.

Laboratory Tests: The following tests may be helpful in evaluating the HPA axis suppression:

Urinary free cortisol test

ACTH stimulation test

Carcinogenesis, Mutagenesis, and Impairment of Fertility: Long-term animal studies have not been performed to evaluate the carcinogenic potential or the effect on fertility of topical corticosteroids.

Studies to determine mutagenicity with prednisolone and hydrocortisone have revealed negative results.

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

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

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

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

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

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

Burning

Itching

Irritation

Dryness

Folliculitis

Hypertrichosis

Acneiform eruptions

Hypopigmentation

Perforal dermatitis

Allergic contact dermatitis

Maceration of the skin

Secondary infection

Skin atrophy

Striae

Miliaria

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

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

Occlusive dressings may be used for the management of psoriasis or recalcitrant conditions.

If an infection develops, the use of occlusive dressings should be discontinued and appropriate anti-microbial therapy instituted.

HOW SUPPLIED: Cloderm (clocortolone pivalate) Cream 0.1% is supplied in 15 gram, 45 gram and 90 gram tubes.

Store Cloderm Cream between 15° and 30° C (59° and 86° F). Avoid freezing.

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LETTERS

We're Not Just 'Dentists'

The ruckus about restrictions on dermatologists' ability to perform outpatient procedures largely concerns cosmetic surgery and is propagated primarily by competing specialties ("State Battles Intensify Over Outpatient Derm Surgery," November 2004, p. 1).

Given the fact that dermatologists perfected tumescent liposuction and pioneered laser and chemical resurfacing, it is difficult to imagine that someone would protest their ability to perform these procedures, regardless of the location.

I am a board-certified oral and maxillofacial surgeon and my practice is limited to cosmetic facial surgery. The article cited legislation in California and Colorado that allows "dentists" to perform cosmetic facial surgery. This is inaccurate. The legislation is limited to board-certified oral and maxillofacial surgeons. No state that I am aware of allows general dentists to perform cosmetic facial surgery.

After dental school, oral and maxillofacial surgeons must perform a 4- to 6-year residency that includes medicine, cardiology, surgery, neurosurgery, medical ER, surgical ER, pathology, plastic surgery, and anesthesia. Despite this excellent training, the same competing specialties mentioned in the article attempt to prevent my specialty from performing cosmetic facial procedures. They claim that we are only "dentists" and only have a "dental education."

My specialty has successfully supported legislation passed in 15 states to amend the

state laws, allowing qualified oral and maxillofacial surgeons to perform cosmetic facial surgical procedures above the clavicle. Despite the thinly veiled, self-serving arguments about patient safety presented by competing specialties, there is no evidence that any specialty has a better safety record when performing cosmetic surgery.

No one specialty owns the body, and one's ability to perform a procedure should be based on experience, training, and outcomes. It is extremely misleading for any specialty to preach to the public that only its specialty is qualified to perform cosmetic procedures. Requiring hospital privileges as a prerequisite for office-based cosmetic procedures is a simple means to eliminate competition, if the procedure is fairly monitored, but the specialists who promote hospital privileges are the same ones who control the hospital board rooms and use their clout to keep "outsiders" out.

When legislators have examined our training and experience as oral and maxillofacial surgeons, we have been victorious more often than not. Dermatologists must follow the same path or be maligned as nonsurgeons. They must establish a relationship with local legislators before the battle begins. Justice usually prevails, but politics sometimes overrules reason and common sense. Be proactive, tell your story, and legislate for your right to perform these procedures.

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