Highlights of this Issue:

4th Annual Medical Esthetic Conference
August 27, 2007
Moscone South – San Francisco, CA

• What’s New in the Medicine Chest?
• Hair Stimulation Following Laser and Intense Pulsed Light Photo-Epilation
• Combination Regimens for Treatment of Acne Vulgaris
• Can Sun Protection Knowledge Change Behavior?

SAVE THE DATE
6th Annual Society of Dermatology SkinCare Specialists Meeting
February 4-7, 2008
El Tropicano Riverwalk - San Antonio, TX
The 4th Annual Medical Esthetic Conference
Monday, August 27 (additional fee)
Moscone South
San Francisco
Register before August 1 and receive rates as low as $275.
Prices to increase after August 1.

9–9:15 AM
Welcome from Austine Mah, managing editor of PCI Journal

9:15–11 AM
The Art of Consultative Selling: Taking Your Practice to the Next Level—There is a difference between hard sell and “heart” sell. Strengthen the connections you make with every patient. Do you know how to present a consult emotionally while appealing to patients emotionally? Do you know what you are selling? Here it’s not treatments or surgery! Let us show you the five steps on presenting the benefits of treatment and new self-image to patients.

11–11:15 AM
Morning Break

11:15 AM–12 NOON
Working with Skin of Color—Broaden your perspectives for working with skin of color. Take away key lessons and gain new knowledge critical for pre- and post-operative considerations in skin of color.
Austine Mah, PCI Journal

12 NOON–1 PM
Lunch on Your Own/Visit the Expo Floor

1:15–1:30 PM
Medical Spa Startup—Are You Ready?—The presentation will take you through the business end of setting up and running a medical spa, including staffing, technology acquisition and pricing, competition, budgeting and more.
Greg Worthington, Patient Unlimited Marketing Consultants

1:30–3 PM
Afternoon Break

3:15–4:45 PM
What’s New in Combination Therapies?—This lecture will address how combining treatment modalities will maximize outcomes in the treatment of photoaging and wrinkles. Topics will include Botox, soft tissue fillers and noninvasive lasers.
Tomi L. Wall, MD, FAAD

4:45–5 PM
Evaluation and Closing Remarks

For more information on these conference programs or to register, visit www.SkinInc.com
Class size is limited and is available on a first-come, first-served basis. Separate registration fees required.
Table of Contents

Scientific Abstracts
What’s New In the Medicine Chest? ..........................6
New Options Improve Treatment Outcomes .....................6
Pneumatic Skin Flattening (PSF): A Novel Technology for Marked Pain Reduction in Hair Removal with High Energy Density Lasers and IPLs ........................................7
Adapalene 0.1% Gel in Combination with Microdermabrasion Treat Acne ........................................8
Scarring Occurs at a Critical Depth of Skin Injury: Precise Measurement in a Graduated Dermal Scratch in Human Volunteers .....................10
Null Mutations in the Filaggrin Gene (FLG) Determine Major Susceptibility to Early-Onset Atopic Dermatitis That Persists into Adulthood .....................11
Use of Complementary and Alternative Medicine for Weight Control in the United States .....................12
Hair Stimulation Following Laser and Intense Pulsed Light Photo-Epilation: Review of 543 Cases and Ways to Manage It .................................13
Clobetasol Proprionate Shampoo 0.05% in the Treatment of Seborrhoeic Dermatitis of the Scalp: Results of a Pilot Study .....................15
Primary Focal Hyperhidrosis: Scope of the Problem ..................16
Allergy to Tea Tree Oil: Retrospective Review of 41 Cases with Positive Patch Tests Over 4.5 Years .....................17
A Horse Chestnut Extract, Which Induces Contraction Forces in Fibroblasts, is a Potent Anti-Aging Ingredient .....................18
A Comparative Review of the Efficacy and Tolerance of Retinoid-Containing Combination Regimes for Treatment of Acne Vulgaris .....................18
Can Sun Protection Knowledge Change Behavior in a Resistant Population? .....................20

Legal Issues Q & A
Esthetician Licensing in a Medical Practice .....................22

Skin 101
Rosacea ...........................................30

Practice Marketing
Publicizable Treatments .......................................32

Practice Management
Leaving the Right Impression with Business Card Etiquette .....................35

PROGRAM

4th Annual Medical Esthetic Conference .....................2
Monday, August 27th, 2008
Moscone South, San Francisco, CA.

Meetings Calendar .....................38

Editorial Board

Interested in being on the Editorial Board of the PCI Journal™?
We are accepting inquiries from physicians, estheticians, and medical professionals who are interested in serving on our Editorial Board. To be considered you must have access to medical journals and follow our Editorial Board Guidelines found on www.pcijournal.com

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Mission Statement

The mission of the PCI Journal™, The Medical Journal for Skin Care Professionals, is to provide its readers with the latest technological, scientific, and economic developments in the areas of dermatology, plastic surgery, cosmetic chemistry, and complementary therapies. With the formation of the Society of Dermatology SkinCare Specialists (SDSS), additional educational opportunities, specific to dermatology, will be an added benefit for those who join the SDSS.

The Green Journal (as it is now known), started as a 4-page newsletter to the consulting clients of Paramedical Consultants, Inc. Through numerous letters it became evident that the emerging field of skin care professionals working in a medical facility or medical spa were in need of an educational journal.

The abstracts published in the PCI Journal are derived from peer-reviewed medical journals that we review each month.

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What’s New In the Medicine Chest? New Options Improve Treatment Outcomes
By James Z. Dell Russo, D.O., F.A.C.O.S.C.D.
Published in Skin & Aging 2007, 15;1:s3–s9

This article’s author asked what the most current tools and practices were in treating skin disorders. Fortunately, there were new ingredients and also more effective ways to use current options to positively improve treatment outcomes.

The Impact of Skin Care in Response to Medications
For many dermatologic disorders, skin care products significantly impact the results of treatment regardless of what medications are prescribed. One study investigated the impact of skin care products and evaluated the use of Dove® (Unilever, London, UK), a synthetic detergent soap, versus a soap bar. The study tested Dove’s influence on symptomatology in patients using Differin® (Galderma Laboratories, Ft. Worth, TX) and Benzamycin® (Dermik Laboratories, Berwyn, PA). Patients using bar cleansers and experiencing irritation switched to Dove. With the switch, there was a marked reduction in symptom severity, indicating that by changing the cleanser, the degree of acne irritation is decreased.

A similar study determined that as skin care product use is specified and controlled in clinical trials, specific skin care regimens contributed to the efficacy and tolerability results of medications. It was the skin care use along with the medication, which equalled the final outcome, especially with disorders such as acne, rosacea or atopic dermatitis. A third study evaluated the symptoms of patients using a physician suggested regimen versus those using a patient preferred regimen. The group using the recommended regimen saw a greater reduction in symptomatology. This study emphasized how vital it is to educate patients on the details of product use, especially as it relates to improved therapeutic outcome and decreased potential medication-related irritation.

Value of Moisturization
Patients with atopic dermatitis typically had a reduction in skin barrier integrity and an increased ability to permeate and permeable to external irritants and allergens. For example, this article found that the skin was compromised by “cracks in the cement” (fissures and exudation) of the brick wall analogy of the skin. As a result, there was an open invitation for staphylococci infections. The skin of the patient with atopic dermatitis was in great need of hydration to maintain and maintain the skin's natural barrier. A new foam version was approved in September 2006 and was tested in terms of penetration against creams and ointments versions. Results were favorable due to maximum penetration as well as quickness and ease of penetration. In a phase II study, one of those with atopic dermatitis, after 4 weeks of twice daily application, 58% of the participants rated clear or almost clear compared to 21% of those treated with another vehicle. Additionally, itching was resolved or very minimal after 4 weeks with 67% of patients treated with desonide 0.05% foam, versus 26% of the vehicle-treated patients. Finally, because of the petrolatum, reactions such as stinging were less than 3%.

High-Potency Topical Corticosteroids and Delivery Systems
Previously to achieve maximal effect with topical corticosteroids, one needed to prescribe an ointment. However, in this impact case study because of the new super-potent topical corticosteroid Vanos® (Medicis, Palo Alto, CA) (fluticasone 1%). Twice as potent as Lides, fluticasone 0.05% was approved for use on psoriasis and atopic dermatitis. Another conventional notion was that lotions are weaker in potency. On the contrary, Clobox Lotion® (Galderma Laboratories, Ft. Worth, TX) was found to be a super-potent topical corticosteroid. Studies and experience supported the efficacy of this formulation especially in cases of severe eczema.

Spray formulations were also showing impressive efficacy in results. In clinical trials of Clobox Spray® (Galderma Laboratories, Ft. Worth, TX), after two and four weeks respectively, 55% and 78% of patients with plaque psoriasis were clear or almost clear. Four weeks after discontinuation of therapy, 44% of patients remained clear or almost clear and another 28% exhibited minimal involvement. At the close of the four-week study, an impressive 72% of patients using the spray exhibited only mild disease or better, with close to half remaining completely clear.

Combination Therapy Approaches with Topical Corticosteroids
While corticosteroids clearly were central to psoriasis and atopic dermatitis treatment management, there were new combination therapies showing promise, including Dovonex® (Galderma Laboratories, Ft. Worth, TX) (fluocinonide 1%). Twice as potent as Lidex, fluocinonide 0.05% was approved for use on psoriasis and atopic dermatitis. Previously to achieve maximal effect with topical corticosteroids, one needed to prescribe an ointment. However, in this impact case study because of the new super-potent topical corticosteroid Vanos® (Medicis, Palo Alto, CA) (fluocinonide 0.05%) were divided into 3 groups: Group A used only Lidex, Group B used the MVE cleanser, while Group C used the cleanser and the cream. Using both products in conjunction with Lidex, Group C exhibited the greatest clinical and symptomatic improvement. Clearly this study stressed the importance of appropriate skin care as a vital component in the overall skin care management plan.

Delivery Systems
Product delivery systems varied and influenced product usage, application technique and patient compliance. The pump, a new delivery system for benzyl alcohol and Retin-A Micro 0.04% (Ortho-Neutrogena, a division of Ortho-McNeil Pharmaceuticals, Inc. Skillman, NJ) offered users a clear meter for usage. The manufacturer stated that two pumps were enough for the entire face. With 400 pumps per container, 2 pumps applied twice daily, the product should last 6 to 8 months. Approximately 90% of users saw the ability to quantitatively use as easy and as taking the guesswork out of application.

Foam Vehicle Formulation
Until recently VersaFoam® (Stiefel Laboratories, Coral gables, FL), a hydroethanol foam (HF), was the only foam delivery system available. Although there was a number of advantages to using HF including rapid skin penetration of active ingredients and easy spreadability, it had high ethanol content, causing stinging in eczema patients. However, an ethanol-free foam, incorporating desonide 0.05% did become available. This petrolatum-based emission was FDA approved to treat atopic dermatitis in patients as young as 3 months. While both products were easy to use and have great skin penetration, it was determined that the later contains petrolatum and light mineral oil and was better for eczema and dermatitis. Additionally, 70% of patients found it to be moisturizing better than the marketed version and the later product over other vehicles they had used previously.

The Resurrection of Desonide
Desonide was the low potency topical corticosteroid most prescribed by dermatologists. A new foam version was approved in September 2006 and was tested in terms of penetration against creams and ointments. Another new option in treating seborrheic dermatitis was Lipothece® (Medicis, Palo Alto, CA) and Nizoral® (Johnson & Johnson, New Brunswick, NJ) reduced the growth of yeast, the organism thought to trigger seborrheic dermatitis inflammation. Another option was Salex® Shampoo (Healthpoint Dermatology, Ft. Worth, TX) a 6% salicylic acid shampoo, which was approved for use in scalp psoriasis. Because there were a number of studies reporting the separation of corneocytes due to desmolytic activity, the cellular clumping that lead to flaking and scaling in seborrheic dermatitis diminished. In addition, Salex® Shampoo created a significant lather and had many humectants and conditioners that maintained hair texture. Finally studies showed no adverse effects on dry hair, and very low potential for eye irritation.

Hair Growth Formulations
In pre-clinical testing minoxidil 5% (Rogaine® Pfizer US Pharmaceuticals, New York, NY) with VersaFoam® technology, showed two to three times the follicular penetration as other vehicles without adverse side effects. Male patients were assessed on hair count, detailed questionnaires, photographs. At the end of the study, clinical patients who used minoxidil foam 5% had at least 20 new hairs in the target area while those who used the vehicle had up to 5 new hairs. The corresponding photographs were impressive and patients reported a high degree of preference and satisfaction with the minoxidil 5% foam.

Optimizing Treatments
New products and vehicles along with improvements in current options provide therapeutic improvements in dermatology. They provide better ways to treat patients safely and efficiently.

Reprint requests to: Skin & Aging, HMP Communications, LLC, 83 General Warren Boulevard, Malvern, PA 19355.

Abstracts

Pneumatic Skin Flattening (PSF): A Novel Technology For Marked Pain Reduction in Hair Removal with High Energy Density Lasers and IPLs
By G. Lask, M.D., D. Friedman, M.D., M. Elman, M.D., N. Fournier, M.D., R. Shantl, M.D., & M. Slatkine M.D.
Published in J Cosmet Laser Therapy 2006, 8;2:76–81

Background and Objectives
Aesthetic laser treatments are often painful, thus resulting in the need to use topical analgesics creams or the application of less effective energies. Exploring new technology to afford the ability to treat without the necessity of topical analgesics has been examined with the use of pneumatic skin flattening (PSF). Additionally, the reduction of post treatment erythema

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www.pcijournal.com Volume 15 • Number 3 • 2007
The most effective topical agent for treating acne was adapalene 0.1% gel with the rapid onset of action within one-week. With regard to the tolerability factor, patients may experience erythema, dryness, burning and itching. Avoiding the sun and using moisturizers helped reduce some of these side effects. One effective treatment for acne was adapalene 0.1% gel (Differin®; Galderma Laboratories, Forth Worth, TX), with a low potential for skin irritation. Microdermabrasion has been very effective for improving the appearance of hyperpigmentation, photo aging, stretch marks on the face.

Method
Fourteen participants with moderate to severe acne were invited to participate in a 14-week study with Fitzpatrick skin types I, II, III and VI. All participants were younger than 18 years. For daily cleansing, participants were given Cetaphil® gentle skin cleanser and Cetaphil moisturizing cream to use as needed. Adapalene 0.1% gel was initiated once nightly as described in the package insert for 14 days prior to microdermabrasion. Microdermabrasion treatments were initiated at week two after starting the skin care regime. Microdermabrasion treatments were given every other week through week 12 and adapalene 0.1% gel continued nightly for the 14-week study. Participants were seen at two-week intervals. There was a baseline of acne lesions taken initially and at each two-week visit. At each two-week visit, interval ratings of tolerability were taken, as well as an evaluation for erythema, scaling, dryness, stinging, and burning before microdermabrasion treatment.

Materials and Methods
Laser hair removal and treatment of lentigines with high energy pulsed lasers or IPLs were studied. A vacuum chamber with a transparent window that pulled and compressed the skin against the window was used. This study compared the pain and efficacy of laser hair removal and IPL treatment of lentigines on 70 sites with and without PSF.

Results
Pain reduction with the use of the PSF and 30% higher energy levels were applied. Erythema and edema were reduced due to the blood expulsion from the laser beam or IPL pathway, which resulted in increased efficacy in most cases.

Discussion
This study found the use of the PSF resulted in gating effect of pain nerves in the dorsal horn by the compression of the pain receptors in the skin.

Conclusion
The use of the PSF reduced the pain associated with laser hair removal and removal of lentigines with IPL, which eliminated the use of analgesic creams, enabled increased energy densities and reduced post treatment erythema. PSF was a repeatable process and adaptable to most lasers and IPLs.

Adapalene 0.1% Gel in Combination with Microdermabrasion Treat Acne

By C. Virtue, LA & J. Campbell, JR M.D., MS
Published in Cosmet Dermatol 2007, 20;4:248–254

Introduction
Teenagers have suffered the most from the dermatologic disease acne vulgaris. Acne vulgaris affects the individuals self-esteem causing threatening anxiety, depression and suicide. Treatment of this condition is important and can be very effective for self-confidence and body image. Adapalene, tazarotene and tretinoin are US Food and Drug Administration (FDA) approved drugs for the treatment of acne. When using retinoids there were side effects in the early stages, such as peeling, erythema, dryness, burning and itching. Avoiding the sun and using moisturizers helped reduce some of these side effects. One effective treatment for acne was adapalene 0.1% gel (Differin®; Galderma Laboratories, Forth Worth, TX), with a low potential for skin irritation. Microdermabrasion has been very effective for improving the appearance of hyperpigmentation, photo aging, stretch marks on the face.

Microdermabrasion is a cosmetic procedure that incorporates aluminum oxide crystals to resurface the face. This procedure can be provided by an esthetician in a dermatologist’s office and does not require an anesthetic. Microdermabrasion can increase the skin’s sensitivity to topical therapies such as retinoids.

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Mobility – It is NCEA’s goal to have all state regulatory boards “recognize NCEA Certified Professionals in their state.” Standardization of educational requirements provided within the NCEA Certification Program support mobility of the skin care professional State-to-State and Internationally. NCEA has the commitment of several state boards to review the NCEA Certification Program, and as each state announces their participation, NCEA Certified Professionals will have increased mobility.

Standardization – It is NCEA’s goal to further define and convey standards of practice by raising the educational requirements of a skin care professional to a standardized 1200 hours across the country.

International Recognition – The additional need for International recognition of theoretical and practical knowledge of a licensed skin care professional moving outside of the United States also requires validation. NCEA is exploring International recognition for the NCEA Certified Professional.

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For more information visit www.ncea.tv the Official Website for National Certification

Abstracts (continued)
Abstracts (continued)

tended to be very compliant. Micromembranabrosis was used in combination with adipose dermabrosis 0.1% to treat acne because of its mild nature. Other retinoids have greater skin irritation and may not be suitable to be used with micromembranabrosis.

Micromembranabrosis can address abnormalities such as, fine lines, wrinkles, acne scarring and photodamaged skin. This study showed the results of adipose dermabrosis every 2-5 weeks. Participants only experienced mild redness or stinging. All participants reported progressive improvements in skin texture and appearance throughout the 14-week study. This treatment protocol proved to be very effective for the treatment of acne.

Reprint requests to: Cosmetic Dermatology, Quadrant HealthCom Inc., 7 Century Drive, Suite 302, Parsippany, NJ 07054-4603.

Scarring Occurs at a Critical Depth of Skin Injury: Precise Measurement in a Graduated Dermal Scratch in Human Volunteers

By C. S. J. Dunkin, MRCS, J. M. Platt, MRCs, P. H. Gillespie, FRCS, M. P. H. Tyler, FRCS, A. H. N. Roberts, FRCS, & D. A. McCrother, FRCS, MSc.

Published in Plast Reconstr Surg 2007, 119;6:1722–32

Introduction

This study’s authors tested the hypothesis of a threshold depth of skin injury for scarring. They questioned whether a wound meeting a certain depth or below, would cause scarring while a shallower wound would not. The testing involved 113 volunteers with the same dermal wound at the same site to determine the scarring response to dermal injury at different depths and to define the threshold depth for scarring.

Patients and Methods

Gillespie, one of the study’s authors, produced a surgical instrument consisting of a blade block to secure a number 11 blade, and a wedge-shaped base block with a central slot to accommodate the blade. This jig produced an elongated teardrop shape dermal wound, extending deep into the deep dermis on one end, and into the superficial dermis on the other. A group of 113, male and female, healthy volunteers were assembled for the study. There were a number of exclusions including non-whites, those with circulatory or inflammatory disease as well as others, including skin disorders. Each volunteer was marked with the jig on the lateral aspect of the hip along lines of relaxed skin tension, mid-way between the anterior superior spine and the greater trochanter. EMLA cream (Aphaxis Pharmacmedicinal Products, Chicago, IL) was applied to the area, the wound sites were created under aseptic conditions and the wound was hygienically dressed throughout the study.

The hip markings were reviewed immediately post-operatively, every week for first month, then at 6, 10, 18, 24 and 36 weeks. Assessment of scarring was done with digital photography (surface area, length and width) and high frequency ultrasound (depth) scanning. Finally, measurements of skin thickness were taken at the deep end, two probe widths from the deep end, and at the superficial end. To ensure reproducibility of results, all the measurements were done by both the author and an independent observer.

Results

As wound healing progressed, a fibrous scar developed at the deep end, whereas the superficial end resolved without visible scarring. This scar was quantified as a reduction in the length, shape, surface area, and depth of the wound obtained from various digital images and high frequency ultrasound.

Immediately after injury the wound length was 51.3(±) 6 mm. There was no significant decrease until week 3 when the wound length was 46.3/4 mm. The greatest reduction was seen between weeks 3 and 6. Afterwards there was no significant reduction in wound length. By week 36, the mean length of the scar was 34.9/1.0 mm. Approximately 68% of the wound length healed with a scar and the remaining 32% had none.

The changing shape of the wound as healing progressed was quantified by measuring width at four standardized points along the length of the wound. There was a significant difference between the width of the wound at different depths of dermal injury, with the widest part of the wound at the deep end and the narrowest part at the superficial end.

Discussion

The ability to heal cutaneous wounds was fundamental to the survival of higher vertebrate animals. The body’s ability to heal after wounding involved an inflammatory phase and triggered a cytokine cascade. However, there was massive redundancy in the inflammatory response so that the regenerative capacity of the dermis was overrun, resulting in a fibrotic scar.

Specialists in burns and reconstructive surgery have long recognized the association of the degree of scarring and the depth of dermal injury. However, the threshold depth of injury required to produce scarring had not been demonstrated previously and the relationship between the depth of injury and scarring remained poorly understood.

Three factors, resistance of subject’s skin to the blade, depth of penetration due to downward pressure on jig, and lateral tension placed on skin contributed to the variability in the length of the wound and depth of dermal penetration. To minimize effort, all of the wounds were produced by two investigators: one applying consistent downward pressure and the other applying lateral tension.

Additionally tension across the wound may have influenced healing. To reduce this effect, wound depth was limited to the dermis. However analysis of digital images and high frequency ultrasound suggested that tension across the wound was not a factor in the scarring response in this study.

The depth of dermal injury was calculated because the initial depth of dermal injury could not be measured directly. Image analysis was performed using modified standard software. Finally, the results for the use of high-frequency ultrasound were consistent with other studies in which it was used to measure skin thickness.

These methods of scar monitoring were noninvasive, reproducible, and relatively easy to use. However they were insufficently sensitive to monitor disruption of the dermal structure at the superficial end of the scar. Further study with more sensitive monitoring devices would demonstrate changes in the superficial wound.

There was a depth of dermal injury that resulted in a fibrotic scar, however, if this depth was not met, the wound healed with regeneration rather than fibrosis, and there was no scarring. Different depths of dermal injury may result in different inflammatory responses and cytokine profiles, which in turn provide the environment for different fibrotic responses. This response was less so with a superficial injury. Further study was in the works to determine differences in blood flow at different depths of dermal injury and the cellular and molecular basis of these differences.

Conclusion

In sum, the dermal scratch provided a well tolerated, standardized, and reproducible wound model that promoted the study of healing response of dermal injury of different scars. Scarring appeared to occur when injury reached a critical depth of wounding, which can be quantified. The study authors concluded that further study at other body sites was necessary.

Reprint requests to: Williams & Wilkins, Author Reprints Department, 351 W. Camden Street, Baltimore, MD 21201.

 Null Mutations in the Filaggrin Gene (FLG) Determine Major Susceptibility to Early-Onset Atopic Dermatitis That Persists Into Adulthood


Published in J Invest Dermatol 2007, 127;3:564-567

Introduction

Filaggrin is the main protein component of the keratin filaments in the epidermis. Upon further differentiation the filaggrin breaks down to filaggrin, which aggregates the keratin filaments, brings about squame formation and is essential for skin barrier formation. It was recently shown that one of two loss of function (null) mutations occur in about 10% of people of European origin and that these cause a complete absence of filaggrin pre-cising in the epidermis.

Additional filaggrin mutations have been linked to severe ichthyosis vulgaris in the homoyzogous or compound heterozygous state and have been shown to be a major predisposing factor for atopic dermatitis (AD).

The purpose of this study was to determine role of filaggrin genes in the development and persistence of AD.

Results and Discussion

Adults with childhood onset and persistent AD had a 6-fold elevated frequency of over representation of the null alleles of the filaggrin genes in the development and persistence of AD.

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Results and Discussion

Adults with childhood onset and persistent AD had a 6-fold elevated frequency of over representation of the filaggrin genes in the development and persistence of AD.
Of the 11,211 respondents, 372 respondents had used CAM for weight control in the past 12 months. Yoga, Results in areas where fine or coarse hair was present prior to the onset of treatments. Frequency of hair growth occurred in more age groups of the patients that developed terminal hair were 10-21 years, 44 patients, 30-40 years, 8 patients, 5 patients. The increase in terminal hair growth occurred mostly with the Nd:Yag, 85% were performed with the alexandrite laser, 10% received the Nd:Yag. Parameters used were within the manufacturers suggested guidelines for each Fitzpatrick skin type.

Introduction

The purpose of this study was to assess the prevalence and correlation of complementary and alternative medicine (CAM) use for weight control in the United States. Recent findings revealed that 36% of adults in the United States have used CAM in the previous year. When the use of prayer specifically religious reasons was added to the definition of CAM, CAM use increased to 62%.

In the general population, CAM use is highest among women, whites, persons of higher educational attainment and income and persons who are widowed or divorced, middle-aged, have poorer perceived health, or live in the western United States. Overall, however, little is known about the prevalence and correlation of CAM use for weight loss and weight control. Given the obesity epidemic in the United States, CAM use for weight control has significant public health implications.

Materials and Methods

The National Physical Activity and Weight Loss Survey (NPAWLS) was a nationwide telephone survey conducted between September 2002 and December 2002. Survey questions included items pertaining to overall health status and quality of life, weight-control measures, and participation in physical activity. The overall objective of the study was to obtain data on individual physical activity and nutrition risk behaviors.

The sample of respondents was drawn from the total non-institutionalized US adult population residing in telephone-equipped households in the United States generated by preparing a list of all current operating telephone exchanges within each area code. The study design was a list-assisted, random-digit-dialed sample of telephone-equipped households in the United States by P. A. Sharpe, PhD, Prevention Research Center Arnold School of Public Health, University of South Carolina, 730 Devine Street, Columbia, SC 29208.

Results

Of the 11,211 respondents, 372 respondents had used CAM for weight control in the past 12 months. Yoga, including breathing techniques, was named by the largest proportion of respondents as their most used therapy in the last 12 months, followed by meditation, massage, acupuncture, and Eastern martial arts. Other therapies included hypnosis, subliminal messages, prayer, Pilates, guided imagery/visualilation/affirmation, chiropractic, light therapy, colon cleansing and energy healing.

The mean estimated number of days respondents had used the primary CAM method in the previous 12 months was 146, with a range of 1-265 days and a median of 93 days.

Discussion

This report provided new information about CAM use for weight control in a very large sample of US adults. These results showed that people who had engaged in other weight control behaviors were more likely to have used CAM in the previous 12 months, a finding that suggested that people may be using physical activity, lower carbohydrate/higher protein diets, and nonprescription weight loss products in conjunction with other CAM methods for weight control, or trying them one after the other. This pattern may indicate persistent unsuccessful attempts to lose weight by multiple methods.

Only 3% (weighted) of the total respondents had used CAM for weight control in the previous 12 months. 5% (weighted) of respondents who were trying to lose weight at the time of the interview had done so. These results indicated that the use of CAM therapies for weight loss, other than nonprescription supplements, was relatively low. The method of choice by far was yoga, trailed by medication, massage, acupuncture and Eastern martial arts as the top five.

Neither the potential direct effects of these methods of weight control, nor the potential indirect effects have been adequately investigated. Thus, the effectiveness of these methods for weight control and weight loss remains unknown.

Reprint requests to: Patricia A. Sharpe, PhD, Prevention Research Center Arnold School of Public Health, University of South Carolina, 730 Devine Street, Columbia, SC 29208.
could be minimized in some patients by applying cold packs to the surrounding tissue and by double passing with each treatment. This stimulation suggested that sub-therapeutic fluences at the edge of the treated areas induced terminal differentiation of hair growth rather than miniaturization and reversal of the follicle with a subsequent prolonged telogen phase, follicles were shifted towards terminal anagen hair growth.

Local abnormal hypertrichosis can be acquired in various settings of dermal injury, including terminal growth at the periphery of a burn, transient limb hypertrichosis associated with casting, peri-incisional hair growth following knee surgery or fracture sites, distal hair growth following lymphadenectomy, terminal hair growth at the site of bug bites and verruca vulgaris, localized reaction to lesions, smallpox, scratching and biting associated different clinical conditions. Follicle studies of these widely varied clinical presentations was the hypothesis that local inflammation may lead to localized terminal hair growth.

Considering this idea, in addition to the complex orchestrated events of follicular cycling that lead to the transformation of the follicle proper, the surrounding follicular epithelium, associated with dermal components and follicular vascular supply, spectacular morphogenesis with each cycle of hair growth. During anagen, a pronounced increase in follicular vascularization occurs that is also accompanied by the upregulation of vascular endothelial growth factor in the outer root sheath keratinocytes. Catagen is followed with a rapid regression in perifollicular vessels. Growing follicles have much higher perfusion requirements than catagen follicles. These accounts taken together with our observations raise the compelling possibility that sub-therapeutic injury to the follicular vasculature may affect follicular cycling in such a way to induce terminal hair growth rather than miniaturization. Another hypotheses included the possible effect that sub-therapeutic injury to the follicle may result in the release of factors that alter follicular anagen and influence hair cycling. Ultrastructural and light microscopic studies demonstrated the uniform induction of perifollicular inflammation associated with photoepilation that persisted for up to 2 weeks. When this occurred local inflammatory responses may have also affected follicular cycling in such a way to induce terminal hair growth. While this may be feasible, this does not explain why some follicles react in this way and others do not, since inflammation is not selective and thus may not be limited to less thermally injured areas.

Key Factors
These key factors are associated with failure to epilate and risk of hair stimulation

1. Thickness of treated hair. Thicker hair was easier to heat since the follicle reached a high enough temperature to destroy the cell critical for follicular cycling. Thinner hair absorbed less light energy due to less chromophore. This may explain the failure to epilate fine vellus hair that occurs on various parts of the body.

2. Color of hair. The chromophore absorption of hair treated with photo-epilation was dependent upon the melanin of the follicular matrix and shaft, thus dark hair is more efficiently heated and induce longer, thicker hairs as a consequence of accelerating the transition from vellus to terminal hair.

3. Hair depth. Penetration of light may not be deep enough to adequately photo-epilate deeply anagen hair in some areas. This hypothesis does not have real time sequences of laser reaching target cells. Possibly hair in telogen or late anagen are located in the dermis and are more susceptible to hair growth stimulation. Due to these observations, current photo-epilation protocols include the use of ice packs for all patients with vellus hair on facial and body areas. Additionally, we have observed in side by side studies that two passes with a long pulsed 755 nm alexandrite laser using 18 mm spot size is more effective than a single pass. The current technique is to use 12-14 J/cm² followed one minute later with 8-10 J/cm² on a second pass. The amount of energy delivered is important in destruction of the cells responsible for normal follicular cycles. Less optimal results were seen in some areas and failed to epilate fine vellus hair that occurs on various parts of the body. Thinner hair adsorbed less light energy due to less chromophore. This may explain the failure to epilate fine vellus hair that occurs on various parts of the body.

Prior descriptions of hair stimulations have occurred with the use of various devices including 694 nm ruby, 755 nm alexandrite, 810 nm diode, and IPL sources. It was unclear if the 1064 NM Nd:Yag laser was less inclined to cause hair stimulation or if it was simply used less as it was in our practice. The occurrences of hair stimulation on the lower facial areas in females were observed in this study more consistently, however; reports of back hair in men have been described. Females with vellus hair on the facial “beard area” should be anticipated as needing multiple, on going treatment sessions for year.

Most women in this study did not have a history of hormonal abnormalities, the true hormonal status can not be certain from this data. Hormonal abnormalities may have been directly related to the hair growth stimulation. Regardless, hirsute individuals may be at an increased risk regardless of hormonal status. Observation of the amount of vellus hair may change with different hormonal cycles or may be induced by photo epilation during different treatment sessions. The authors experiences showed photo-epilation should be performed more frequently and with higher energies to optimize efficacy in these patients.

Prior reports of paradoxical hair growth associated with laser-IPL photo-epilation suggested the incidence was uncommon. Additionally, since the majority of the cases reported occurred in patients of Fitzpatrick skin types III-V it has been felt that these patients are at greater risk. Additional observations suggested that hair growth stimulation after laser-IPL may be more common than previously recognized and that individuals of the Fitzpatrick skin type II are susceptible.

Reprint requests to: Andrea Willey, Oregon Health & Science University, 3181 S.W. Sam Jackson Park Road, Portland, OR 97229
Other evaluations included itching, assessed at each visit by the subject on a 100-mm analog scale and global improvement assessed by the investigator on a 7-point scale.

**Conclusion**

Results showed that an application of clobetasol propionate for 5 and 10 minutes provided a similar mean percentage decrease of TSS, and the mean percentage decrease of TSS for all active groups.

Reprint requests to: Cutis, c/o Quadrant HealthCom Inc., 7 Century Drive, Suite 302, Parsippany, NJ 07054.

**Primary Focal Hyperhidrosis: Scope of the Problem**

By D. A. Glaser, M.D., A. A. Hebert, M.D., D. M. Pariser, M.D. and N. Solish, M.D.

Published in Cutis 2007, 79:5-8-17

Focal hyperhidrosis (HH) is an over activity of the eccrine sweat glands resulting in excessive, bilateral, relatively symmetric sweating beyond the amount necessary to maintain a body temperature within normal limits. Patients suffering from HH found that it was generally idiopathic (primary) and most commonly occurred in the axillae, palms, soles and face. It was reported that between 0.6% and 2.8% of the US population suffered from HH, greatly impacting the quality of life (QOL) both physically and emotionally. Treatments for HH reviewed in this article included topical agents, oral agents, tap water iontophoresis (TWI), and surgical therapies along with new data supporting the use of botulinum toxin (BTX) therapy for focal HH. This article presented the clinical experiences of Glaser et al. and developed a best practice recommendation for what dilution of BTX to use, injection sites and number of injections.

**Treatment Options**

A variety of options were available for patients who suffered from HH, however their impact on QOL for patients may not be much greater than the HH itself. These treatments may be inconvenient or have side effects that impact the patients.

**Topical Treatment**

OTC antiperspirants and AIIC3 were the two most common topical treatment options for HH. Patient concerns included skin irritation, messiness of the product, staining of clothing, inconvenient application and cosmetic concerns (mainly with facial HH).

**Oral Agents**

No oral agents had been approved by the FDA for treatment of HH, however; oral anticholinergic agents had been used. Common side effects included dry mouth, blurred vision, urinary retention, and constipation. Botulinum Toxins-BTX-A received FDA approval for treating axillary HH and was proven safe and effective. Oral use for treating the palms, soles, and face for HH has shown positive results. The only reported side effects were slight temporary muscle weakness or decrease in muscle tone. Adequate anesthesia was required.

**Surgical Treatments**

Endoscopic transthoracic sympathectomy (ETS) should be considered only when all other treatment options have failed. This surgery interrupts the sympathetic innervation to the sweat glands, ultimately causing permanent cessation of sweating by those glands. Patient satisfaction ratings were low for this treatment option, and it also included the general risks of undergoing surgery.

**Best Practice Techniques for Treating Palmar and Plantar HH with Botulinum Toxin**

Glaser et al. recommended using 4-mL dilution of BTX-A, drawn up in four 1 cc syringes, which provided 2.5 U per 0.1 mL of injection. Insulin syringes were recommended with a 31 or 32 gauge needle for reduced patient pain, though the final selection was based on physician’s preference.

Injection depth is the deep dermis, at or near the subcutaneous tissue, which is where the sweat glands are located. Care must be taken to not inject too deeply, or the patient may experience muscle weakness. Depending on the size of the patient’s hand or foot, there will be approximately 45 to 50 injection sites, spread approximately 1 to 1.5 cm apart. Injection site volume should remain between 0.05 and 0.1 mL.

**Final Thoughts**

The chief concern for facial HH was the cosmetic look of the injections, though they were generally temporary. BTX-A should be diluted with 2.5 mL of 0.9% non-preserved saline, which is the standard for cosmetic use. The drug should be drawn into five 0.5 cc syringes, enabling 2 or 4 U BTX-A to be injected in volumes of 0.05 or 0.1 mL, respectively. Recommended needle gauge is the same as for palmar or plantar injections.

The injections should be intradermal, where the sweat glands are located. Depending on the pattern of sweating, the average total dose is 40 U BTX-A for the forehead alone, but may range from 33 to 100 U, with a series of 20 to 30 injections. The entire affected area should be treated with 2 to 3 U BTX-A per site, with sites spaced approximately 2 cm apart.

**Conclusion**

Choosing the appropriate treatment for focal hyperhidrosis can greatly improve a patient’s quality of life. Older treatments have provided results, but the side effects often made the patient more uncomfortable than the HH. Botulinum Toxin treatments provided a safe and effective treatment for HH when used within the best practice recommendations for treatment.

Reprint requests to: Cutis, c/o Quadrant HealthCom Inc., 7 Century Drive, Suite 302, Parsippany, NJ 07054-4603.

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### Allergy to Tea Tree Oil: Retrospective Review of 41 Cases with Positive Patch Tests Over 4.5 Years

By T. Rutherford, MB BS, R. Dixon, FACD, M. T. Tam, FACD & B. Tate, FACD

Published in Australasian J Dermatol 2007, 48:2:83-87

Tea tree oil is derived from the tea tree, native to Australia. Currently being used and marketed for its “natural” antimicrobial and anti-inflammatory properties, the increased use and development of tea tree products have come more reports of tea tree oil skin reactions including allergic contact dermatitis (ACD).

**Introduction**

Tea tree oil is the essential oil derived from the tea tree, native to Australia. Currently being used and marketed for its “natural” antimicrobial and anti-inflammatory properties, the increased use and development of tea tree oil skin reactions including allergic contact dermatitis (ACD).

**Methods**

Patients with positive patch test results between January 2000 and June 2004 to tea tree oil at 5% or 10% concentrations were included in the study. Patients were included in the study if a recognized contact allergen test was negative for the tea tree oil. The study was conducted at the Dermatology Research and Education Centre, P.O. Box 132, Carlton South, Victoria, Australia.

**Results**

Reprint requests to: Dr. Rosemary Dixon, Occupational Dermatitis and Research Centre, P.O. Box 132, Carlton South, Victoria, Australia.

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### Abstracts (continued)

#### Iontophoresis

TWI delivered a direct current to the area of skin affected by HH using large, shallow pans of tap water and an electrode device. TWI required 6 to 10 treatments to achieve results with maintenance treatments every 1 to 4 weeks. This treatment was only logistically possible for treatment of palmar and plantar HH. Patients may have experienced discomfort during treatment and irrigation could occur.

**Oral Agents**

No oral agents had been approved by the FDA for treatment of HH, however; oral anticholinergic agents had been used. Common side effects included dry mouth, blurred vision, urinary retention, and constipation. Botulinum Toxins-BTX-A received FDA approval for treating axillary HH and was proven safe and effective. Oral use for treating the palms, soles, and face for HH has shown positive results. The only reported side effects were slight temporary muscle weakness or decrease in muscle tone. Adequate anesthesia was required.

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Injection depth is the deep dermis, at or near the subcutaneous tissue, which is where the sweat glands are located. Care must be taken to not inject too deeply, or the patient may experience muscle weakness. Depending on the size of the patient’s hand or foot, there will be approximately 45 to 50 injection sites, spread approximately 1 to 1.5 cm apart. Injection site volume should remain between 0.05 and 0.1 mL. In total, 41 of 2320 (1.8%) patients presented with positive reactions to tea tree oil. At least 13 components of tea tree oil have been identified as potential sensitizers. Factors that affect the composition of tea tree oil include the distillation process and oxygen. The sensitizing factors of tea tree oil are strengthened by oxidation such that oxidized tea tree oil has a sensitizing capacity three times stronger than fresh oil. The tea tree oil produced for commercial products has been intermittently exposed to light, moisture, heat and air, so the products used by consumers may actually be even more allergenic than those preparations used in patch testing.

**Discussion**

The prevalence of a positive reaction (1.8%) was higher than had been reported by previous studies performed outside of Australia. Reports of increasing incidence of tea tree oil ACD have been partly attributed to an overall increase in usage of tea tree oil but also to the more widespread availability of neat tea tree oil. At least 13 components of tea tree oil have been identified as potential sensitizers. Factors that affect the composition of tea tree oil include the distillation process and oxygen. The sensitizing factors of tea tree oil are strengthened by oxidation such that oxidized tea tree oil has a sensitizing capacity three times stronger than fresh oil. The tea tree oil produced for commercial products has been intermittently exposed to light, moisture, heat and air, so the products used by consumers may actually be even more allergenic than those preparations used in patch testing.

**Results**

Given the findings of a tea tree allergy of 1.8% in a patch test population, tea tree oil allergy should be added to all standard patch-test series in Australia. It was recommended that the testing occur with 10% tea tree oil as it appears to increase the sensitivity of the patch test compared with testing at 5% concentration. The application of more concentrated solutions of tea tree oil, particularly on eczematous or broken skin, was strongly discouraged; moreover, manufacturers are suggested to include appropriate warnings on their products.
A Horse Chestnut Extract Which Induces Contraction Forces in Fibroblasts, is a Potent Anti-Aging Ingredient

By T. Fujimura, M.D., K. Tsuhara, M.D., S. Morisaki, M. Hotta, M.D., & T. Kitahara, M.D.
Published in J Cosmet Sci 2006, 57;5:369–76

Introduction
In a recent search among various plant extracts, with a model that such ingredients generate cell contraction using fibroblast to determine cell structure, vasocostriction, and /or wound healing; the extract of horse chestnut (Aesculus hippocastanum) was able to generate the desired result.

Materials and Methods
Clinical tests of the extract were performed using photo scales as the visual scoring base. The testing was started with 40 female volunteers applying a 0.3% gel formulation, of the extract, to the eye area three times daily for 9 weeks.

Conclusion
After a 6-week evaluation, considerable decreases in the wrinkles were observed compared with the control group. After 9 weeks the same results were apparent.

The papillary layer sits just under the epidermis. It connects the dermis to the epidermis and is the vascular layer of the skin. The reticular dermis is under the papillary layer. It is best known for its role as a supportive layer where the collagen and elastin fibers provide the support, strength and flexibility to the skin. It is in the dermis that you will find fibroblast cells, mast cells and phagocytic cells. The fibroblast cells create the skin’s support structure where the collagen and elastin are produced.

The conclusion of the study suggested that an extract of horse chestnuts can generate contraction forces in fibroblasts and can be a potent anti-aging ingredient.

Reprint requests to: Blackwell Publishing, 9600 Garsington Road, Oxford OX4 2DQ, United Kingdom.

A Comparative Review of the Efficacy and Tolerability of Retinoid-Containing Combination Regimes for Treatments of Acne Vulgaris

By James L. Campbell Jr., M.D., MS
Published in J Drugs Dermatol 2007, 6;6:633–629

Introduction
This article presented a review of several studies comparing the efficacy of combination treatments for acne vulgaris. Acne vulgaris, a chronic skin disorder, affects 70-87% of prepubescent teens. The condition is characterized by abnormalities in follicular epithelial desquamation, sebum production, bacterial proliferation, and inflammation. Many topical retinoids have been approved by the Food and Drug Administration to treat acne vulgaris. Most commonly used are: adapalene, tazarotene, and tretinoin.

Retinoids are effective because they target the primary lesion of acne, the microcomedone, and have therefore played an important role in treatments. This article reviewed studies of combination therapies, which included a topical retinoid as well as an oral antibiotic. These therapies have proved more effective than monotherapy.

The studies presented all displayed similar levels of efficacy, however they differed in reports of patient tolerability, safety and satisfaction. Therefore, the comparison of these studies can be used to determine the best combination therapy for individual patients.

Retinoids and Oral Antibiotics

Study #1
The first study looked at the combination of adapalene gel 0.1% and doxycycline. In a 12-week study, 467 patients with severe acne were randomly administered a 100 mg capsule of doxycycline daily, and either adapalene gel 0.1% or adapalene gel vehicle. While both groups experienced reductions in lesions, the success rate was significantly higher with the adapalene gel 0.1%. Both groups experienced positive local cutaneous tolerability.

Erythema, dryness, scaling and burning/stinging were mild in severity. Greater adverse effects were reported in the group who used the vehicle and doxycycline as opposed to the adapalene 0.1% gel and doxycycline. Overall, patients in this group reported great satisfaction with the combination therapy and the results. A follow-up study supported that 75% of subjects that showed at least moderate improvement in the treatment phase, maintained the results during the maintenance period.

Study #2
A second study examined the results of combination treatment with minocycline and tazarotene gel 0.1%. 189 patients with severe acne were treated with a 100 mg capsule of minocycline plus tazarotene gel 0.1% once daily for 12 weeks. After 12 weeks, patients with 75% and higher rates of global improvement were randomized to 12 weeks of maintenance with tazarotene gel 0.1% and placebo capsules, vehicle gel and minocycline or tazarotene gel 0.1% and doxycycline.

The combination therapy proved most effective in reduction of lesions and overall global improvement. However, all regimens were well tolerated with the most common adverse effects to treatment being burning (3%), peeling (3%) and erythema (2%).

Retinoids and Topical Antibacterials

Study #3
A third study compared the effects of once-a-day application of combination tretinoin 0.025%/clindamycin 1% hydrogel, clindamycin 1% hydrogel alone, tretinoin hydrogel 0.025%, or vehicle hydrogel on 1,156 patients with facial acne for 12 weeks. The study had an attrition rate of 87%. By the end of the treatment the patients in the combination treatment group showed the greatest reduction in lesions. The three active treatments were well tolerated, with a 36% report of adverse events and less than 11% discontinuation based on these events.

Study #4
A fourth study compared 105 patients who used applied adapalene gel 0.1%, benzoyl peroxide (BPO) 5%, or a combination of the two each evening. Patients were evaluated after 6 months. All three regimens proved effective in treating both inflammatory and noninflammatory lesions. There were no statistical differences between the effectiveness of the three groups. Further, there were no statistically significant differences between the regimens in erythema, dryness and burning. However, 2 patients in each the adapalene gel 0.1% group and the adapalene gel plus benzoyl peroxide lotion group discontinued therapy due to acne contact dermatitis.

Retinoid and Topical BPO/AB Combination Therapy

Another combination therapy study was conducted to measure the efficacy of retinoids used with topical BPO/AB. The MORE trial viewed the results of adapalene gel 0.1% combined with topical BPO/AB. In a 12-week study, 1,720 patients found high levels of improvement in non-inflammatory and inflammatory lesions. Further, there were high percentages in tolerability, most patients having none or mild peeling/scaling or dryness. Patients commonly reported being very satisfied with the combination therapy.

Tazarotene cream 1% was also used in combination with topical BPO/AB gel. In this study, 121 patients were treated over 12 weeks with the tazarotene cream in the evening, and some were treated with either a BPO/AB gel or a vehicle gel. The improvements in the combination group therapy were numerically, but not significantly higher. However, the patients using the combination therapy reported milder grades of peeling.

Discussion
The data reviewed indicated the advantage of including topical retinoids in the treatment of acne vulgaris. Based on patient satisfaction and low occurrence of adverse events, adapalene gel 0.1% offered better tolerability in comparison to tazarotene or tretinoin in combination regimens. Further, the lower irritation potential and inflammatory properties of adapalene resulted in patient preference. The data showed the importance of seeking out treatments for acne vulgaris that do not require long-term antibiotic use. Due to the increase of antibiotic-resistant microbes, it is important to look at combination therapies to treat acne vulgaris. Emphasis was made on the importance finding appropriate treatments that can be effectively maintained. More research is required to determine the most effective therapies that can be successfully maintained. This review focused on comparing topical retinoids as a part of combination therapy. Topical retinoids were shown to be an integral part of treatment strategies to control acne vulgaris. Therefore, this review is useful in identifying the most appropriate treatment for acne vulgaris.
Habit Reversal Training for the Itch-Scratch Cycle Associated with Pruritic Skin Conditions

By M. Grillo, RN, MNG, R. Long, BMBS, FRANZCP, & D. Long, BMBS
Published in Dermatol Nursing 2007, 19:3:243-248

Clinical Brief
Habit reversal therapy has been found to be an effective treatment to help patients with eczema and other skin conditions deal with the urge to scratch. This therapy was recommended for patients to improve their quality of life and allow the skin to heal.

While managing chronic itching caused by disease requires medical intervention, the authors noted that scratching calls for a psychological approach. In the habit reversal method, patients were first educated about the itch-scratch cycle and then taught alternative behaviors to scratching such as exercising their hands.

The authors said their clinical experience shows it was possible to diminish the scratch habit with reversal therapy, but said follow-up may be necessary to evaluate effectiveness long-term. This is where an interested professional comes in, they say, as motivation and guidance are keys to success.

Reprint requests: to: Dermatology Nursing, East Holly Avenue Box 56, Pitman, NJ 08071-0056.

The good news is that for 80% of the survey respondents they had experienced embarrassment, 65% reported feelings of frustration and 41% experienced anxiety over their condition. 35% said they had felt helpless; 25% suffered depression; and 18% felt isolated.

Here’s how to do it:
- Generously apply sunscreen to all exposed skin using a Sun Protection Factor (SPF) of at least 15 that provides broad-spectrum protection from both ultraviolet A (UVA) and ultraviolet B (UVB) rays. Re-apply every two hours, even on cloudy days, and after swimming or sweating. Look for the AAD Seal of Recognition ™ on products that meet these criteria.
- Wear protective clothing, such as a long-sleeved shirt, pants, a wide-brimmed hat and sunglasses, where possible.
- Seek shade when appropriate, remembering that the sun’s rays are strongest between 10 a.m. and 4 p.m.
- Use extra caution near water, snow and sand as they reflect the damaging rays of the sun which can increase your chance of sunburn.
- Protect children from sun exposure by applying sunscreen.
- Get vitamin D safely through a healthy diet that includes vitamin D-rich foods like fatty fish, eggs or fortified milk.
- Avoid tanning beds. Ultraviolet light from the sun and tanning beds can cause skin cancer and wrinkling. If you want to look like you’ve been in the sun, consider using a sunless self-tanning product, but continue to use sunscreen with it.
- Check your birthday suit on your birthday. If you notice anything changing, growing, or bleeding on your skin, see a dermatologist. Skin cancer is very treatable when caught early. By applying a broad-spectrum sunscreen with an SPF of 15 or higher, wearing protective clothing and seeking shade whenever possible.

No reprints available.

From the American Academy of Dermatology

Academy of Dermatology Warns that Skin Cancer is Leaving Its Mark on Athletes

The dangerous effects from the sun can disrupt athletes and their game. It is especially important to practice proper sun protection while outdoors. Since sun exposure is the most preventable risk factor for skin cancer, the American Academy of Dermatology recommends athletes and weekend sports enthusiasts be Be Sun Smart™.

Sun exposure is the most preventable risk factor for skin cancer. You can have fun in the sun and be Be Sun Smart™.

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- Seek shade when appropriate, remembering that the sun’s rays are strongest between 10 a.m. and 4 p.m.
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- Check your birthday suit on your birthday. If you notice anything changing, growing, or bleeding on your skin, see a dermatologist. Skin cancer is very treatable when caught early. By applying a broad-spectrum sunscreen with an SPF of 15 or higher, wearing protective clothing and seeking shade whenever possible.

This year, more than 1 million new cases of skin cancer will be diagnosed in the United States, making it the most common form of cancer. Even more alarming is the fact that an estimated 10,800 people will die of skin cancer this year.

No reprints available.

From the National Rosacea Society

New Survey Maps Emotional Toll Of Rosacea As Severity Increases

Rosacea has been shown to inflict significant damage to quality of life and emotional well-being in direct proportion to its physical effects. It is a disorder that affects an estimated 14 million Americans and is becoming increasingly widespread as the populous baby boom generation enters the most susceptible ages.

This survey was conducted on 603 patients, 76% said rosacea’s effect on their personal appearance had lowered their self-confidence and self-esteem, and nearly half said it had diminished their outlook on life. Moreover, for those who described their condition as severe, 94% said it had damaged their self-confidence and 77% said their rosacea had negatively affected their outlook.

More than 60% of the total survey respondents said they had experienced embarrassment, 65% reported feelings of frustration and 41% experienced anxiety over their condition. 35% said they had felt helpless; 25% suffered depression; and 18% felt isolated.

The respondents with severe symptoms, nearly 61% said they avoided face-to-face contact during flare-ups, and 38% said they even canceled meetings or social engagements because of rosacea’s effect on their appearance.

With greater public awareness, it has been determined that more people are seeking medical attention before their rosacea becomes increasingly severe. Therefore the impact of rosacea has been managed before the emotional consequences become even more intrusive on daily lives.

The good news is that for 80% of the survey respondents, the results of effective medical therapy have improved or somewhat improved their emotional well-being.

Many rosacea patients said they had learned to successfully cope with their condition and that openly discussing their disorder with others helps dispel any embarrassment or social stigma. Nearly 56% of the respondents said they have explained their medical condition to others during a flare-up, and 56% said they carried on their lives as usual.

The signs and symptoms of rosacea can be effectively controlled with medical treatment and lifestyle changes.

No reprints available.
Question:
I am an esthetician and I would like to work in a physician’s office. I have seen and heard many times that an aesthetician license is “not recognized in a physician office. What does this mean?

Answer:
There are several states that will not recognize an esthetician license in a physician’s facility. State regulatory boards that govern your license must be able to provide protection for consumers. They do so by periodical-ly inspecting licensed facilities where the licensee works. If a consumer files a complaint, the board has the right and responsibility to inspect that licensee within the facility where they are performing the services. Physicians (by their licenses) are permitted to designate or delegate the performance of many (but not all) services to subordinates or employees. They are permitted this discretion pursuant to their licensure. State regulatory boards that govern your license may not be able to provide the same or similar protections in a physician’s facility. State regulatory boards have the broad responsibility to inspect that licensee within the facility where they are performing the services. Physicians (by their licenses) are permitted to designate or delegate the performance of many (but not all) services to subordinates or employees. They are permitted this discretion pursuant to their licensure. According to PCI Journal’s most recent study conducted of state regulatory boards (that govern cosmetologists and estheticians), there are over 28 boards that have chosen NOT to govern these facilities. Most boards are required by law to investigate a claim regardless of how apparent it may be, that it is motivated by illegitimate reasons. Many of these situations that I have encountered have been as a result of one esthetician reporting to a board that another esthetician is engaging in improper conduct. If you are choosing to work in a physician’s office, please remember to comply with state licensure require-ments to maintain your license and/or facility licenses, if required. If there are continuing education requirements, be sure to comply with them even though you are working in a physician’s office.

My final commentary on this issue is that if you are choosing to work for a physician, choose one that is already performing services similar to what you will be offering. It would be better to work with a “core” physician that is practicing cosmetic or aesthetic medicine. The “core” physicians are dermatologists and plastic surgeons. They are the physicians that by training and experience are practicing cosmetic and aesthetic medicine.

(Continued on Page 25)
in utero

- In a dermal application study using TRI-LUMA Cream in pregnant rabbits, there was an increase in the number of treatment only after having had a negative pregnancy test, and used effective birth control measures during therapy. Results showed that 6 resulted in healthy babies, 6 outcomes still unknown, 2 were reported as miscarriages, and 1 case was lost to follow-up.

- In clinical trials used to support the use of TRI-LUMA Cream in the treatment of melasma, patients were instructed to avoid pregnancy or breastfeeding. The data are not available with topical hydroquinone. Corticosteroids have been shown to be teratogenic in laboratory animals. In the controlled clinical trials, adverse events were monitored in the 161 patients who used TRI-LUMA Cream once daily during an 8-week treatment period. There were 102 (63%) patients who experienced at least one event, indicating that these events were related to the study drug. 42 (26%) patients experienced two or more events. Patients who were pregnant at the end of the study had a similar pattern of adverse events as in the 8-week studies. In an open-label long-term safety study, patients who have had cumulative treatment of melasma with TRI-LUMA Cream for 6 months showed a similar pattern of adverse events as in the 8-week studies.

- In a dermal application study in pregnant rats treated with TRI-LUMA Cream during organogenesis there was evidence of embryo-fetal death, altered fetal growth, congenital anomalies, and embryonic mortality. The safety and efficacy of TRI-LUMA Cream cannot be extrapolated to human pregnancy. The safety and efficacy of TRI-LUMA Cream cannot be extrapolated to human pregnancy. The safety and efficacy of TRI-LUMA Cream cannot be extrapolated to human pregnancy. The safety and efficacy of TRI-LUMA Cream cannot be extrapolated to human pregnancy.

- In vitro studies in mammalian cells, and in the FLAWLESS FINISH APPLICATION SITE TABLE, the overall prevalence of sulfite sensitivity in the general population is unknown and probably low. Sulfite sensitivity is seen more frequently in asthmatics and in individuals with atopic dermatitis. Symptoms include flushing of the skin, sneezing, rhinorrhea, tearing of the eyes, and tightness or choking of the throat. Severe systemic reactions have included anaphylactic symptoms and life-threatening asthmatic episodes in susceptible people. The overall prevalence of sulfite sensitivity in the general population is unknown and probably low. Sulfite sensitivity is seen more frequently in asthmatics and in individuals with atopic dermatitis. Symptoms include flushing of the skin, sneezing, rhinorrhea, tearing of the eyes, and tightness or choking of the throat. Severe systemic reactions have included anaphylactic symptoms and life-threatening asthmatic episodes in susceptible people. The overall prevalence of sulfite sensitivity in the general population is unknown and probably low. Sulfite sensitivity is seen more frequently in asthmatics and in individuals with atopic dermatitis. Symptoms include flushing of the skin, sneezing, rhinorrhea, tearing of the eyes, and tightness or choking of the throat. Severe systemic reactions have included anaphylactic symptoms and life-threatening asthmatic episodes in susceptible people.

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The Medical Spa Society is a not-for-profit professional organization designed to provide educational and networking forums for the medical and spa communities and promote excellence of care for patients. It will create national awareness for the new "medical spa" entity and develop standards of care for these facilities.

The board of directors and medical board include leaders in the spa consulting, editorial, medical and conference fields as well as directors of some of the best-known spas in the country.

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info@medicalspasociety.com
MEMBERSHIP APPLICATION

BENEFITS: *Check website www.sdss.tv for additional benefits as they become available...

- Subscription to the PCI Journal™ Official Journal of the SDSS.
- Subscription Discounts to Skin Inc. magazine, Cosmetic Surgery Times, Dermatology Times.
- Membership Certificate.
- Discounted rates to educational conferences, meetings and products.
- Membership Roster to network with other skin care professionals.

Preferred Address for SDSS Mailings:

Name:

Physician Name: (If applicable)________________________

Practice/Company Name: (If applicable)________________________

Address:

City: ___________________ State: ___________________ Zip + 4

Tel: Day: (_____)_____________________ Home Fax: (_____)_____________________

Fax: (_____)_____________________

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*Monthly SDSS eNewsletter sent via email

Optional Information

Tel: Home: (_____)_____________________ Home Fax: (_____)_____________________

Home E-Mail: ______________________________________________________________________

Type of Membership:

___ SkinCare Specialist (Works with BC/BE dermatologist) Are you a licensed esthetician ______ Cosmetologist ______ Nurse ______

___ Associate Membership (Do not work with BC/BE dermatologist) Are you a licensed esthetician ______ Cosmetologist ______ Nurse ______

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Amex/Visa/MC: ___________________ Exp. Date: ______ / ______ / ______

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Signature: ___________________ Member Renewal Lt

Society of Dermatology SkinCare Specialists, (SDSS)• 484 Spring Avenue • Ridgewood, NJ • 07450-4624
Tel: 201.670.4100 • Fax: 201.670-4265 • Email: sdssorg@aol.com • Web: www.sdss.tv
Onset
Rosacea is a chronic and potentially life-disruptive disorder primarily of the facial skin, often characterized by flare-ups and remissions.

Location
Often found on the cheeks, nose, chin or forehead, the redness and flare-ups tend to come and go. In some cases it may also occur on the neck, chest, scalp or ears.

History
Left untreated, bumps and pimples often develop, and in severe cases the nose can become swollen and bumpy from excess tissue. This condition, rhinophyma, can appear as a bulbous nose.

Description
Four subtypes of rosacea have been defined as common patterns or groupings of signs and symptoms.

Subtype 1 (erythematotelangiectatic rosacea), characterized by flushing and persistent redness, and may also include visible blood vessels.

Subtype 2 (papulopustular rosacea), characterized by persistent redness with transient bumps and pimples.

Subtype 3 (phymatous rosacea), characterized by skin thickening, often resulting in an enlargement of the nose from excess tissue.

Subtype 4 (ocular rosacea), characterized by ocular manifestations such as dry eye, tearing and burning, swollen eyelids, recurrent styes and potential vision loss from corneal damage.

General Characteristics
Typically beginning after age 30 as a redness. Fair skin individuals who tend to flush or blush easily are believed to be at greatest risk. The disease is more frequently diagnosed in women, but more severe symptoms tend to be seen in men.

Etiology
Persistent redness is the most common individual sign of rosacea, and may resemble a blush or sunburn that does not go away.

Treatment
Oral and topical medications may be prescribed to treat the bumps, pimples and redness. Physicians usually prescribe initial treatment with oral antibiotics and topical therapy to bring the condition under immediate control, followed by long-term use of the topical therapy alone to maintain remission.

Laser treatments, intense pulsed light sources or other medical and surgical devices may be used to remove visible blood vessels, reduce extensive redness or correct disfigurement of the nose. Ocular rosacea may be treated with oral antibiotics and other therapy.

Follow-up
For additional information:
National Rosacea Society
800 S. Northwest Hwy, Suite 200
Barrington, IL 60010
Tel: (888) NO-BLUSH
Gifting a Story

Gift certificates in general are a good publicity hook. Creating certificates for specific treatments will help garner press for that item. You can start by promoting your holiday gift certificate program. For instance, for everyone who buys a gift certificate or a holiday present in the spa, the spa gives them a special holiday gift. Again, that gift may be a sample of some of your other products that are sold in the spa retail store.

Editors appreciate knowing about unusual holiday gifts. Contact the newspaper’s business editor and tell him about your corporate gift certificates for company employees and their best customers.

A Picture’s Worth a Thousand Words

Think about interesting visuals for your treatment. When Gwyneth Paltrow was photographed with circular burn marks on her back, spas offering an ancient therapeutic treatment called “cupping” saw a surge in requests for people looking to have cups of flaming alcohol pressed to their skin.

What’s in a Name?

Generally speaking, Americans are obsessed with celebrities’ lives. If there aren’t celebrities in your area dropping by, try luring women into your spa in packs with a “Desperate Housewives” package of day long pampering for four.

Adopting a trendy treatment isn’t going to bring in new customers unless you generate that buzz. Public relations is critical to circulating your message to reach a large number of people through media that are most read, watched and listened to by your target audience.

Nancy Trent is the owner and founder of Trent & Company, Inc., a New York City-based public relations firm that specializes in publicity for the healthcare, fitness and spa industries. She can be reached at (212) 966-0024 or through e-mail at nancy@trentandcompany.com. You may also visit www.trentandcompany.com.
Leaving the Right Impression with Business Card Etiquette
By Dr. Kathleen D. Pagana, R.N.

Recently, while attending a conference, a lot of interesting people met at a dinner banquet. At the end of the meal, several wanted to exchange business cards. Two people were embarrassed to admit that they did not have cards, but said they planned to get them. Are you wondering if it is time to get a business card? Do you need an update on business card etiquette? If either or both of your answers are “yes,” this article will enhance your professional image. Let’s discuss five common questions related to business cards.

Why do you need a business card?
Business cards are a great way to capture essential information in a quick and user-friendly manner. Every professional needs a business card to network. Recently, a colleague at a luncheon was asked if she wanted to run in a 5K race to support breast cancer research. When asked for race details, the website was written on the back of a business card. Isn’t that better than writing on a table napkin?

Most people love to get a business card. It gives them a sense of being an important part of a team and having access to key personnel. Business cards can be clipped to a report, a note, or anything you are sending to someone. This lets the person know that you are the sender and gives your contact information.

What information should be on a business card?
This will depend on the purpose of the card. Some basics include your name, degrees, position, and contact information – address, phone, email, and fax. If your full name is ambiguous (such as, “Pat”), add a title (for example, “Mr.” Pat Sweeney or “Ms.” Pat Sweeney). If you are trying to promote something, like a consulting business, make sure you have consultant on the card and include a web address if you have one.

Can I make my own business card?
Yes, if this is the only way that you will get a card. This will give you an opportunity to test out what you have written on the card. Usually these homemade cards are readily detected by the perforations around the edges. As soon as you can afford something better, get the cards printed professionally. The business card is one of the first graphic statements we make about ourselves. Consider asking your employer to provide a card so you can network more effectively. This will improve your image and the image of your facility. Make sure the card is in good condition. Don’t use a card if it is soiled, bent, or ripped because the card will not reflect a positive impression or memory of you. It is better to give no card than to give one in a bad condition. The business card is sometimes described as “the handshake you leave behind.” Men should not remove a warm and mushy card from their back pocket and present it to someone.

What are some common mistakes people make with business cards?
Here are five mistakes with some suggestions.

Passing out your cards like you are dealing a deck of cards. (It is better to have a person ask for your card. One way to do this is to ask for his or her card.)
Not presenting the card.
(Business cards should be presented with the content face up and readable to the receiver. The receiver should look at the card and make a comment. For example, “I see you are a Computer Specialist.”)

Writing on the card without asking permission.
(In some parts of the world, such as Japan, you deface the card if you write on it without asking permission.)

Not having your business cards with you at all times.
(Keep some cards in your wallet or purse at all times. You never know when someone will ask you for one. A business card holder will keep your cards looking professional.)

Not having a card and asking for someone else’s card to write on the back.
(This is rude. You should jot your information on a piece of paper. Then, make sure this doesn’t happen again.)

Does business card etiquette differ around the world?
Yes, it does. So, if you are traveling for business to a foreign country, check into this before you travel. Some countries (for example, Germany) are impressed by education and like to see all degrees and titles above the bachelor’s degree. Other countries have a particular way to present the card. For example, in China, the card is held in both hands when it is presented. In Saudi Arabia, the card should be printed in English on one side and Arabic on the other side. When traveling to Poland, bring plenty of cards and give one to everyone you meet. For more tips on business etiquette for international travel, see www.executiveplanet.com.

These questions and answers clearly show the need and importance of having a business card. If you don’t have a business card, when are you going to get one?

Dr. Kathleen D. Pagana, RN, is a teacher and speaker, specializing in Momentum Leadership techniques for individuals and companies that want to reposition themselves to maximize their leadership potential. She draws on her experience of more than 25 years in healthcare, college teaching, administration, clinical practice, and business management. Among the 18 books Dr. Pagana has written, she has co-authored the bestselling book on healthcare diagnostic and laboratory testing. She began her professional career in the Army Nurse Corps and received her PhD from the University of Pennsylvania in Nursing Research. For more information, please visit www.kathleenpagana.com.
## Meetings Calendar

### 2007

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<th>Date</th>
<th>Event</th>
<th>Location</th>
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<tbody>
<tr>
<td>Aug. 1-5</td>
<td>American Academy of Dermatology</td>
<td>New York, NY</td>
<td>(866) 503-SKIN or <a href="http://www.aad.org">www.aad.org</a></td>
</tr>
<tr>
<td>Aug. 4-5</td>
<td>Dermatology Nurses’ Association</td>
<td>New York, NY</td>
<td>(856) 256-2320 or <a href="http://www.dnanurse.org">www.dnanurse.org</a></td>
</tr>
<tr>
<td>Aug. 25-27</td>
<td>Face &amp; Body Healthy Aging</td>
<td>San Francisco, CA</td>
<td>(630) 633-2155 or <a href="http://www.faceandbody.com">www.faceandbody.com</a></td>
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### 2008

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<tr>
<td>Nov. 12-15</td>
<td>ISPA Conference &amp; Expo</td>
<td>Kissimee, FL</td>
<td>(888) 651-ISPA or <a href="http://www.experienceispa.com">www.experienceispa.com</a></td>
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<tr>
<td>Jan. 28-29</td>
<td>National Coalition of Estheticians, Manufacturers/Distributors &amp; Associations (NCEA) Meeting</td>
<td>New Orleans, LA</td>
<td>(203) 670-4100 or <a href="http://www.ncea.tv">www.ncea.tv</a></td>
</tr>
<tr>
<td>Feb. 1-5</td>
<td>American Academy of Dermatology Annual Meeting</td>
<td>San Antonio, TX</td>
<td>(866) 503-SKIN or <a href="http://www.aad.org">www.aad.org</a></td>
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<tr>
<td>Feb. 4-7</td>
<td>6th Annual Society of Dermatology SkinCare Specialists Meeting</td>
<td>San Antonio, TX</td>
<td>(203) 670-4100 or <a href="http://www.sdsd.tv">www.sdsd.tv</a></td>
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<tr>
<td>Feb. 23-25</td>
<td>Medical Spa Expo &amp; Conference Spa and Resort Expo &amp; Conference</td>
<td>Los Angeles, CA</td>
<td>(800) 363-3631 or <a href="http://www.spaandresortexpo.com">www.spaandresortexpo.com</a></td>
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<tr>
<td>Apr. 2-6</td>
<td>American Society for Laser Medicine and Surgery Annual Conference</td>
<td>New York, NY</td>
<td>(800) 363-3631 or <a href="http://www.aslms.org">www.aslms.org</a></td>
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<tr>
<td>Apr. 13-14</td>
<td>International Congress of Esthetics &amp; Spa</td>
<td>Dallas, TX</td>
<td>(800) 471-0229 or <a href="http://www.iecsc.com">www.iecsc.com</a></td>
</tr>
<tr>
<td>May 17-19</td>
<td>International Congress of Esthetics &amp; Spa</td>
<td>South Beach, FL</td>
<td>(800) 471-0229 or <a href="http://www.iecsc.com">www.iecsc.com</a></td>
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### August 27th, 2007

4th Annual Medical Esthetic Conference
Sponsored by PCI Journal
Moscone South - San Francisco, CA

### September

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<tr>
<td>Sept. 9</td>
<td>National Coalition of Estheticians, Manufacturers/Distributors &amp; Associations (NCEA) Continuing Education</td>
<td>New York, NY</td>
<td>(800) 363-3631 or <a href="http://www.spaandresortexpo.com">www.spaandresortexpo.com</a></td>
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<tr>
<td>Sept. 8-10</td>
<td>Medical Spa Expo &amp; Conference Spa and Resort Expo &amp; Conference</td>
<td>New York, NY</td>
<td>(800) 363-3631 or <a href="http://www.spaandresortexpo.com">www.spaandresortexpo.com</a></td>
</tr>
<tr>
<td>Sept. 29-Oct. 1</td>
<td>International Esthetics, Cosmetics &amp; Spa Conference,</td>
<td>Orlando, FL</td>
<td>(800) 624-3248 or <a href="http://www.iecsc.com">www.iecsc.com</a></td>
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### October

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## Some sunscreens weren’t meant to be put on the face...

Many popular sunscreens are loaded with greasy UV-absorbing chemicals, whitening pigments and hydrophilic polymers that leave a shiny, sticky, smelly film on the face. OK for the beach, not pretty for daily facial photoprotection.

Introducing MelaShade, a combination of micronized Titanium and Zinc oxides, fortified with the powerful anti-oxidant Molanin, an anhydrous silicone elastomer vehicle. With a silky rub-in and matte finish, MelaShade leaves no shine, no stickiness and no odor on the skin.

With such cosmetic elegance, your patients will look forward to applying their sunscreen every morning. And the inert, fragrance-free, preservative-free vehicle is ideal for patients with sensitive skin or post-treatments that leave skin dry or irritated. So leave the white faces to the life-guards... and introduce your patients to a new look in facial photoprotection!

![MelaShade](image)

MelaShade is a distinguishable sunscreen marketed by daily use for sensitive skin. Not to be used on mucous membranes. Wears as a transparent oil-free foundation. SPF 30. Water resistant. Some users may experience some redness and irritation.

Youth-enhancing, lightweight, sheer formula. Does not contain parabens, PABA, or alcohol. Easy to use and apply. In stock and ready to deliver. For more info, call (800) 766-4955 or visit www.plasticsurgery.org.
Did You Know That Your Eyelashes Age?

Age Intervention®
Eyelash Conditioner
A stunning new eyelash technology from Jan Marini Skin Research gives you the lashes of your dreams. Fuller, thicker, and noticeably lusher-looking lashes. Lashes like never before from the company that delivers amazing looking skin. Now get amazing eyelashes.

Did You Know That Your Hair Ages?

Age Intervention®
Hair Revitalizing Conditioner
Introducing a stunning new technology that targets thinning, aging, or chemically and environmentally challenged hair. Get ready for lusher, fuller and younger-looking hair. Hair with body, bounce and vitality. The hair of your dreams from . . . Jan Marini Skin Research.

Remarkable Products . . . Amazing Results

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Tel (800) 347-2223  www.janmarini.com  Fax (408) 362-0140

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