STATE BOARD OF OPTOMETRY
2450 DEL PASO ROAD, SUITE 105, SACRAMENTO, CA 95834
P (916) 575-7170 F (916) 575-7292 www.optometry .ca.gov

Continuing Education Course Approval Checklist

Title: Benign Eyelid Lesions

Provider Name: Dr. Jeong-Ah Kim

☑Completed Application
Open to all Optometrists? ☑Yes ☐No
Maintain Record Agreement? ☑Yes ☐No

☑Correct Application Fee

☑Detailed Course Summary

☑Detailed Course Outline

☑PowerPoint and/or other Presentation Materials

☐Advertising (optional)

☑CV for EACH Course Instructor

☑License Verification for Each Course Instructor
Disciplinary History? ☐Yes ☑No

1-2877/3815685/890747/100 -

BUSINESS, CONSUMER SERVICES, AND HOUSING AGENCY — GOVERNOR EDMUND G. BROWN JR.

CALIFORNIA STATE BOARD OF OPTOMETRY

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CONTINUING EDUCATION COURSE APPROVAL APPLICATION

$50 Mandatory Fee

Pursuant to California Code of Regulations (CCR) § 1536, the Board will approve continuing education (CE) courses after receiving the applicable fee, the requested information below and it has been determined that the course meets criteria specified in CCR § 1536(g).

In addition to the information requested below, please attach a copy of the course schedule, a detailed course outline and presentation materials (e.g., PowerPoint presentation). Applications must be submitted 45 days prior to the course presentation date.

Please type or print clearly.

Course Title	**Course Presentation Date**
BENIGN EYELID LESIONS	03/14/2017

Course Provider Contact Information

Provider Name

JEONG-AH (First) KIM (Last) JENNIFER (Middle)

Provider Mailing Address

27107 TOURNEY ROAD
Street **City** SANTA CLARITA **State** CA **Zip** 91355

Provider Email Address jenniferkim100@hotmail.com

Will the proposed course be open to all California licensed optometrists?	☒ YES ☐ NO
Do you agree to maintain and furnish to the Board and/or attending licensee such records of course content and attendance as the Board requires, for a period of at least three years from the date of course presentation?	☒ YES ☐ NO

Course Instructor Information

Please provide the information below and attach the curriculum vitae for each instructor or lecturer involved in the course. If there are more instructors in the course, please provide the requested information on a separate sheet of paper.

Instructor Name

GARY (First) GROESBECK (Last) (Middle)

License Number G52329	**License Type** MD
Phone Number (760) 599-2409	**Email Address** gary.d.groesbeck@gmail.com

I declare under penalty of perjury under the laws of the State of California that all the information submitted on this form and on any accompanying attachments submitted is true and correct.

Signature of Course Provider — ***Date*** 2-9-17

27107 Tourney Road

Santa Clarita, CA 91355

February 9, 2017

CALIFORNIA BOARD OF OPTOMETRY
2450 Del Paso Road, Suite 105

Sacramento, CA 95834

To whom it may concern:

I am submitting a request for continuing education approval for the Kaiser Permanente Mammoth Ocular Symposium (3/12/17-3/14/17) less than the required 45 days because we have had a last minute cancellation from one of our speakers. Thus, Drs. Howard Cohen and Gary Groesbeck have volunteered to give lectures to replace the speaker who had to cancel.

Thank you so much for your understanding and my apologies for this unforeseeable change in our speakers.

If you need to contact me, please email me at jenniferkim100@hotmail.com or call me at 323-574-8957.

Sincerely,

Jeong-Ah Jennifer Kim, OD
CA Lic 11674TLG

27107 Tourney Road
Santa Clarita, CA 91355
March 4, 2017

State Board of Optometry
2450 Del Paso Road, Suite 105
Sacramento, CA 95834

To whom it may concern:

Thank you for your attention to the Kaiser Permanente Mammoth Ocular Symposium 2017 continuing education approval submission. In anticipation of receiving deficiency notifications for the other lectures, I have included a summary of each of the lectures and the respective powerpoint presentations.

There will be 7 lectures from 3/12/17-3/14/17:

The Retinal and Choroidal Dystrophies lecture is relevant to diagnosing and providing proper care as optometrists perform retinal exams on a regular basis. As optometrists continue to go toward medical aspects of eye care, this lecture will keep us well informed regarding various retinal conditions.

The Update on Cataract Surgery is relevant to optometrists because this is one of the most common referrals we make. It is important for optometrists to remain informed about advancements and changes to cataract surgeries so that we can properly educate our patients.

The Retinal White Dot Syndromes lecture is relevant in providing proper optometric care with respect to retinal diseases. Such retinal conditions may lead to discovering the underlying systemic condition giving rise to the specific white dot syndrome.

The Corneal Ectasias and Cross-Linking lecture provides information for conditions such as keratoconus and its treatment with cross-linking. Optometrists are often the first to diagnose keratoconus thus it's important that we know about various medical treatments, in addition to contact lenses and glasses.

The IOL Materials and Design lecture provides information regarding the details of lens implants for cataract patients. IOL materials and designs are topics that are commonly discussed between optometrists and their patients.

The Sports Injuries lecture is relevant as patients come into our clinics with various sports injuries sustained at school, sporting teams/clubs, and times of recreation. It is

important to anticipate and know what injuries can be sustained as optometrists provide a wide range of eye care.

The Benign Eyelid Lesions lecture provides information and visuals regarding eyelid lesions that optometrists observe daily. This will help to properly diagnose benign lesions and contrast those with lesions that need further work ups and/or referrals.

I apologize for submitting the lectures less than the 45 day request. I was waiting for all the presentations so that the lectures can be submitted together. The Benign Eyelid Lesions and Sports Injuries lectures were submitted less than the 45 request because there was a last minute cancellation of one of the original speakers, thus Drs. Groesbeck and Cohen prepared the presentations thereafter. In the future, an earlier deadline will be proposed so that the submissions will be on time.

I am attaching 2 checks that have already been deposited, one for $250 and the other for $100. All the files could not be sent in one email because the files were too large so there are 3 emails total which contain the required documents.

Thank you very much for your attention.

Sincerely,

Jeong-Ah Jennifer Kim, OD
CA Lic 11674TLG

Benign Eyelid Lesions: (Lecture will include clinical slides of each type of lesion and discussion of the clinical findings and implications of each)

Gary Groesbeck, MD
March, 2017

I. Introduction
   a. Characteristics of malignant lesions
      i. Irregular border
      ii. Induration
      iii. Ulceration
      iv. Telangiectasia
      v. Alteration of surface anatomy
   b. Characteristics of Benign lesions
      i. Stability over time
      ii. Regular margins
      iii. Soft fleshy texture
      iv. Intact surface epidermis
      v. Absence of telangiectasia
      vi. Preservation of surrounding anatomy

II. Epithelial Hyperplasias
   a. Seborrheic Keratosis
   b. Verruca vulgaris
   c. Cutaneous horn

III. Benign Epithelial Cysts
   a. Epidermal inclusion cysts
   b. Milia
   c. Pilar or Trichilemmal Cysts
   d. Molluscum contagiousum

IV. Benign Adnexal Lesions
   a. Chalazia
   b. Hordeola
   c. Sebaceous hyperplasia
   d. Sebaceous adenoma
   e. Xanthelasma

V. Tumors of Eccrine Gland origin
   a. Syringoma
   b. Eccrine hidrocystoma

VI. Tumors of Apocrine Gland origin
   a. Apocrine hidrocystoma

VII. Tumors of Melanocytic Origin
   a. Nevi
   b. Lentigo Simplex
   c. Solar Lentigo
   d. Blue Nevus
   e. Dermal Melanocytosis

VIII. Premalignant Epidermal Lesions
   a. Actinic Keratosis
   b. Bowen's Disease
   c. Keratoacanthoma

IX. Premalignant Melanocytic Lesions
   a. Lentigo Maligna

Benign Eyelid Lesions

Benign Eyelid Lesions

Kaiser Ocular Symposium XXIV

Gary Groesbeck, MD

March 2017

Financial Disclosure

I have no financial or non-financial relationships to disclose as to any devices or products mentioned in this presentation.

Eyelid lesion

- localized change in the eyelid skin
- Most arise from epidermis, but can also originate in the dermis or adnexal elements
- 80-85% are benign

Characteristics of Benign Lesions

- Regular Borders
- Soft, fleshy surface
- Intact surface epidermis
- Absence of telangiectasia
- preservation of surrounding anatomy
- stability over time

Characteristics of Malignant Lesions

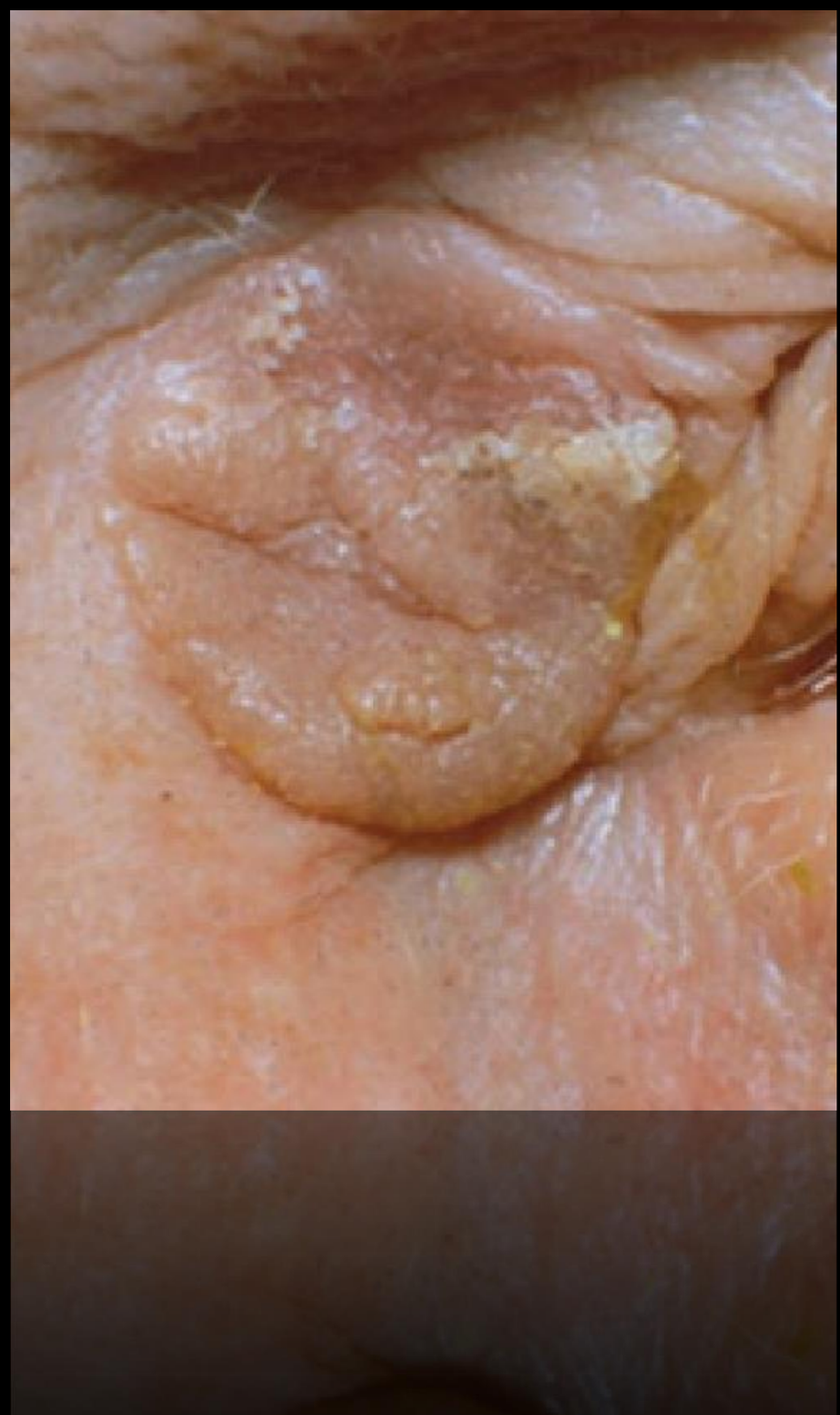
- Irregular border
- Induration
- Ulceration
- Telangiectasia
- Alteration/Disruption of surface anatomy

Skin tag

- Fibroepithelial polyps
  - skin tags
    - squamous papillomas
    - acrochordons
- removed by shave excision at the dermal epidermal junction

Seborrheic keratosis

- very common
- sessile or pedunculated
- +/- pigment
- +/- hyperkeratosis
- flat, “greasy,” “stuck-on”
- lobulated
- shave or excise

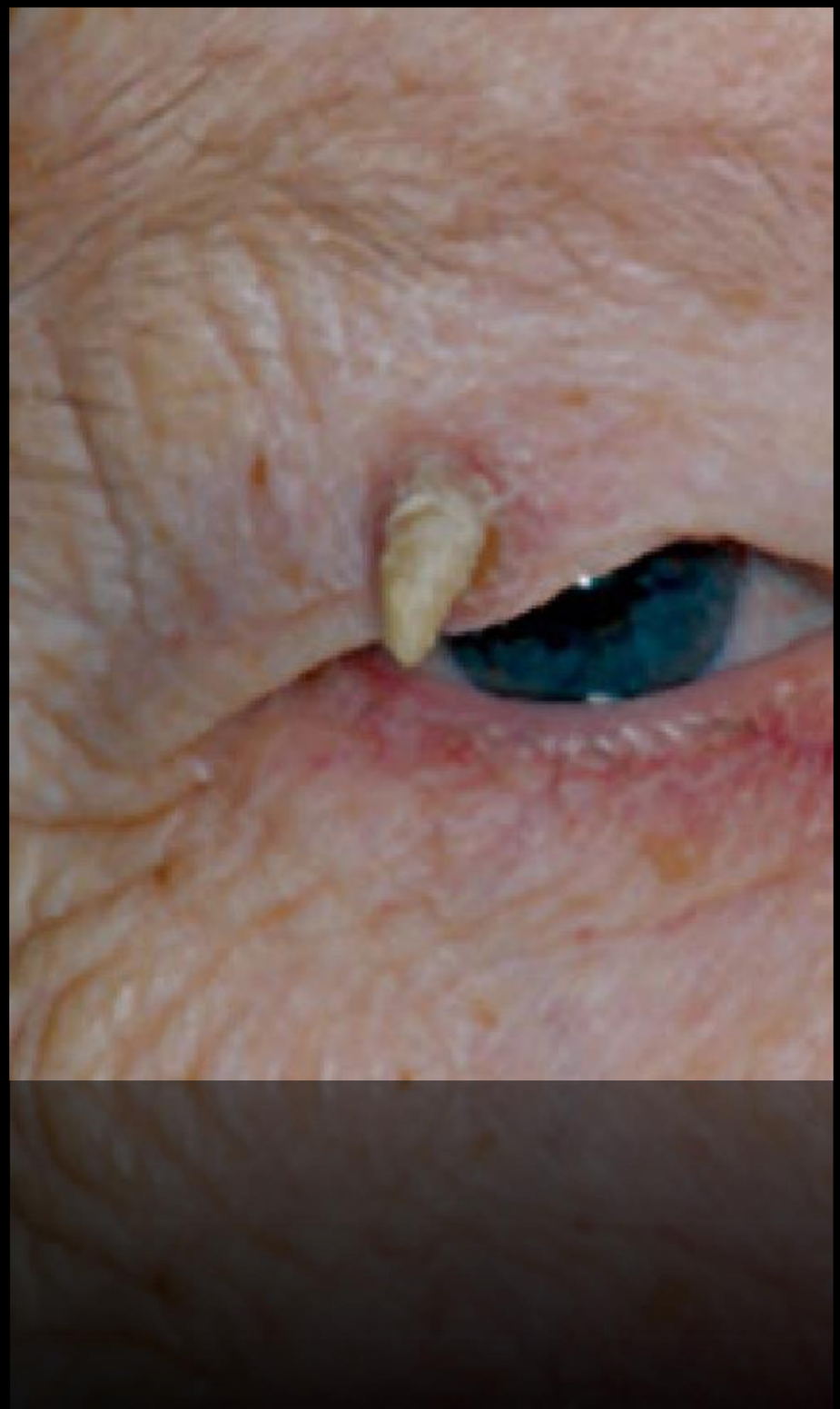


Verruca Vulgaris

- caused by virus
- human papilloma virus VI or XI
- often along lid margin
- excise or cryo

Cutaneous horn

- exuberant hyperkeratosis
- may grow rapidly (or not)
- arise from seb keratosis, verruca vulgaris, BCC, and squamous cell
- need pathology of base for definitive diagnosis

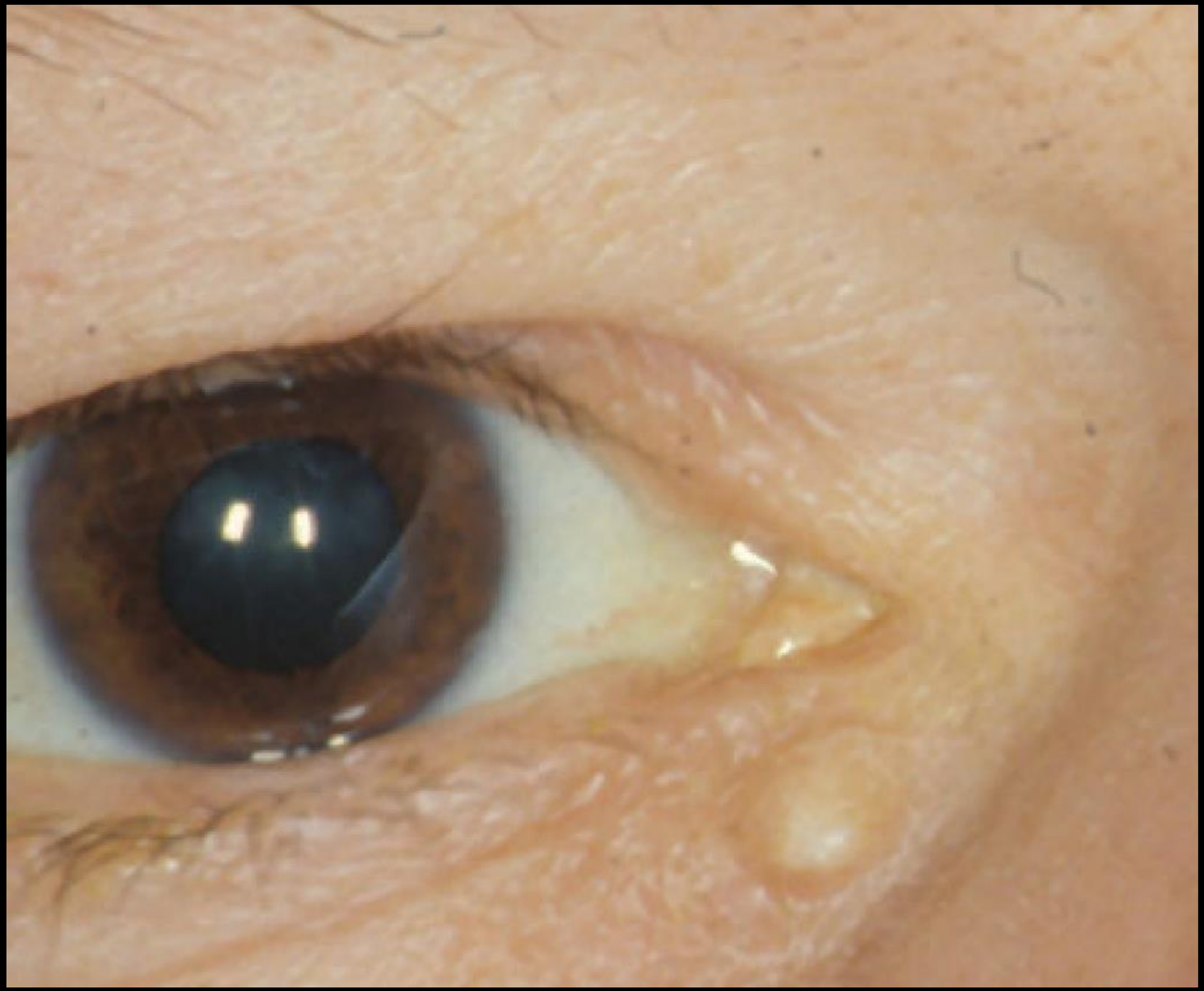


Epithelial Hyperplasias

- Skin tag (acrochordon, fibroepithelial polyp, etc)
- Seborrheic keratosis
- Verucca vulgaris
- Cutaneous horn

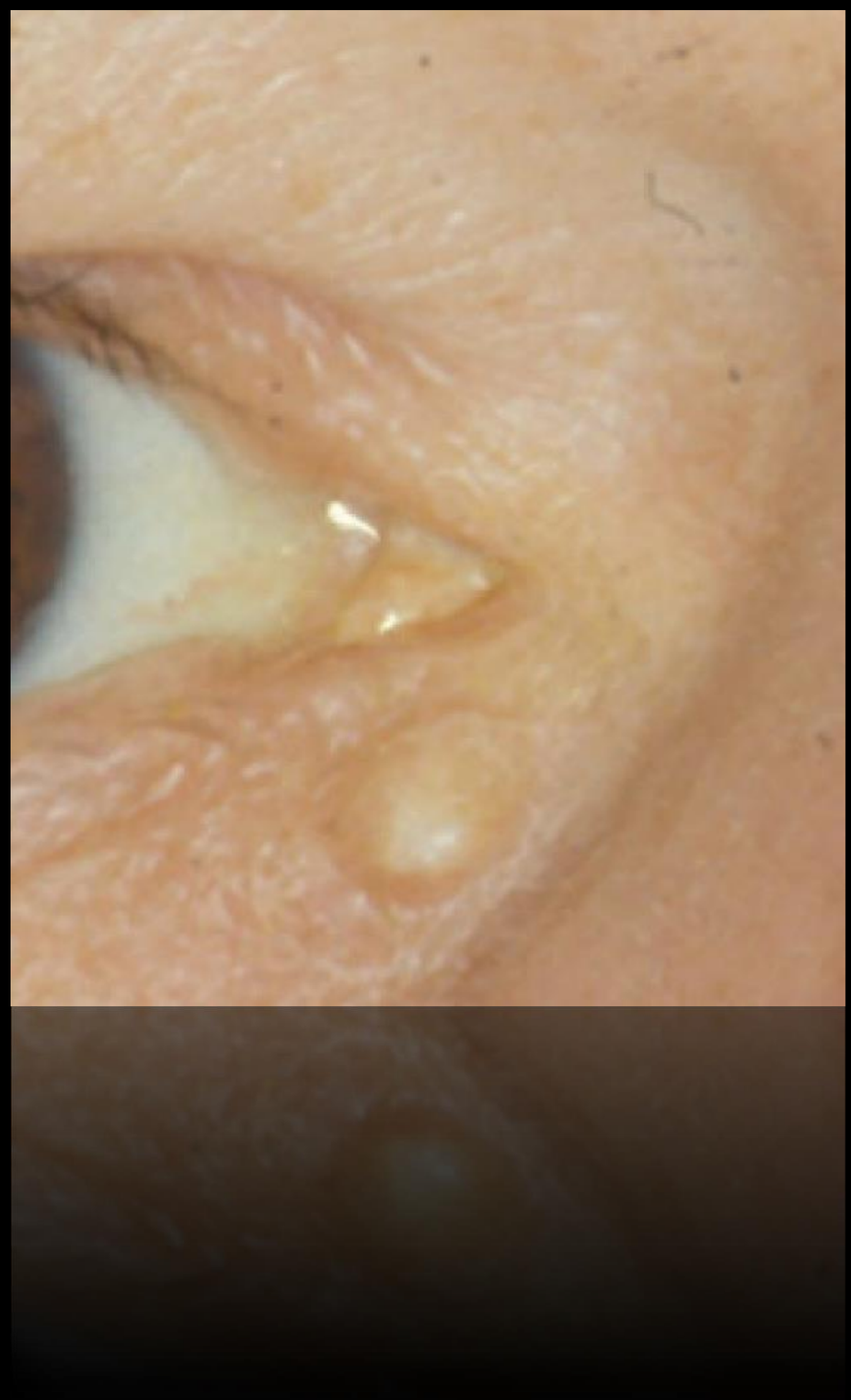
Epithelial Cysts

- Second most common benign eyelid lesion after epithelial hyperplasias



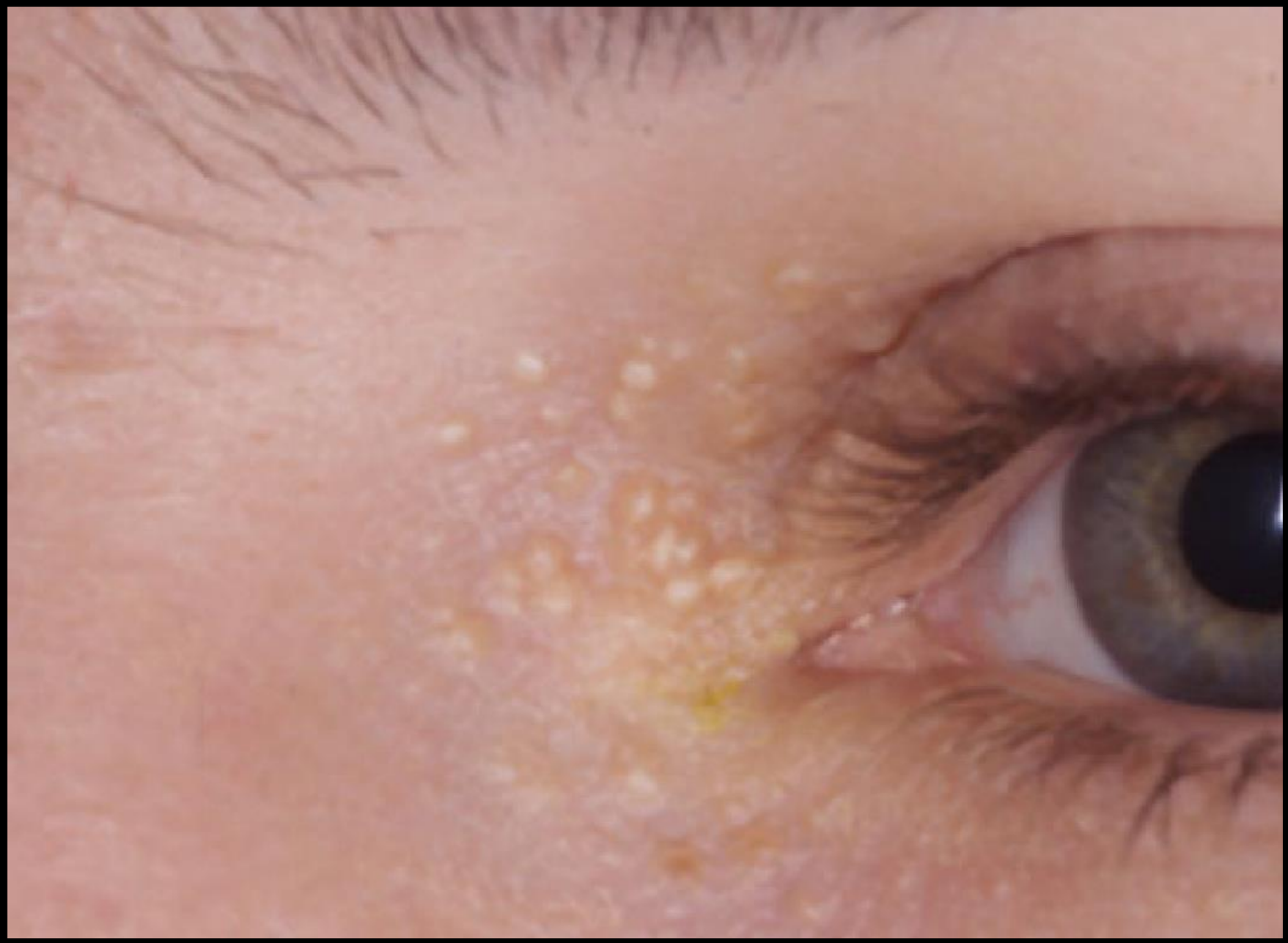
Epidermal inclusion cyst

- epidermal cells trapped within a hair follicle
- desquamated epithelial keratin accumulates inside.
- smooth, round, +/- central pore
- not “sebaceous cysts”, since they have keratin, not oil/sebum inside



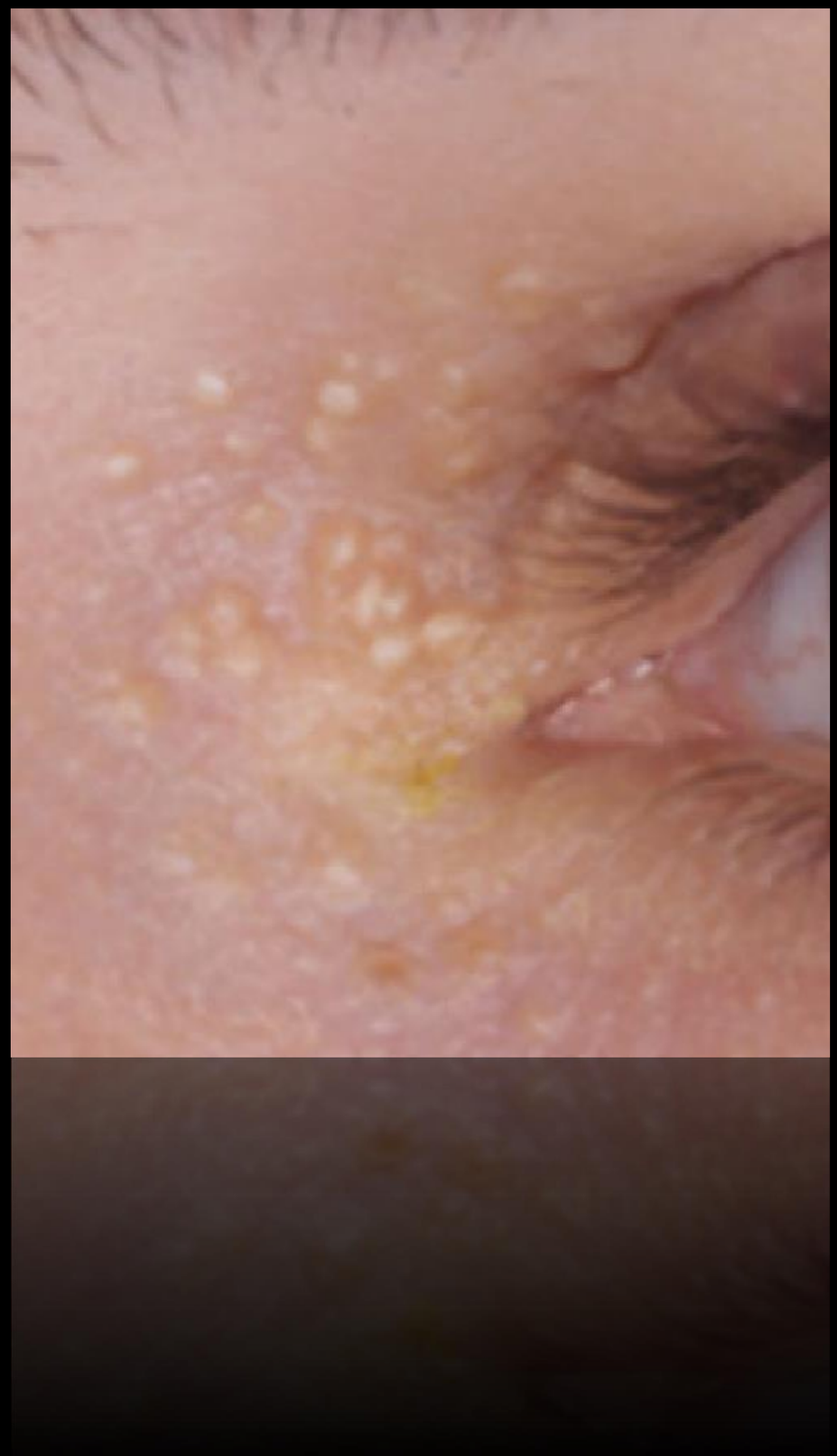
Epidermal Inclusion Cyst

- excise completely
- smaller ones can be marsupialized and the base cauterized



Milia

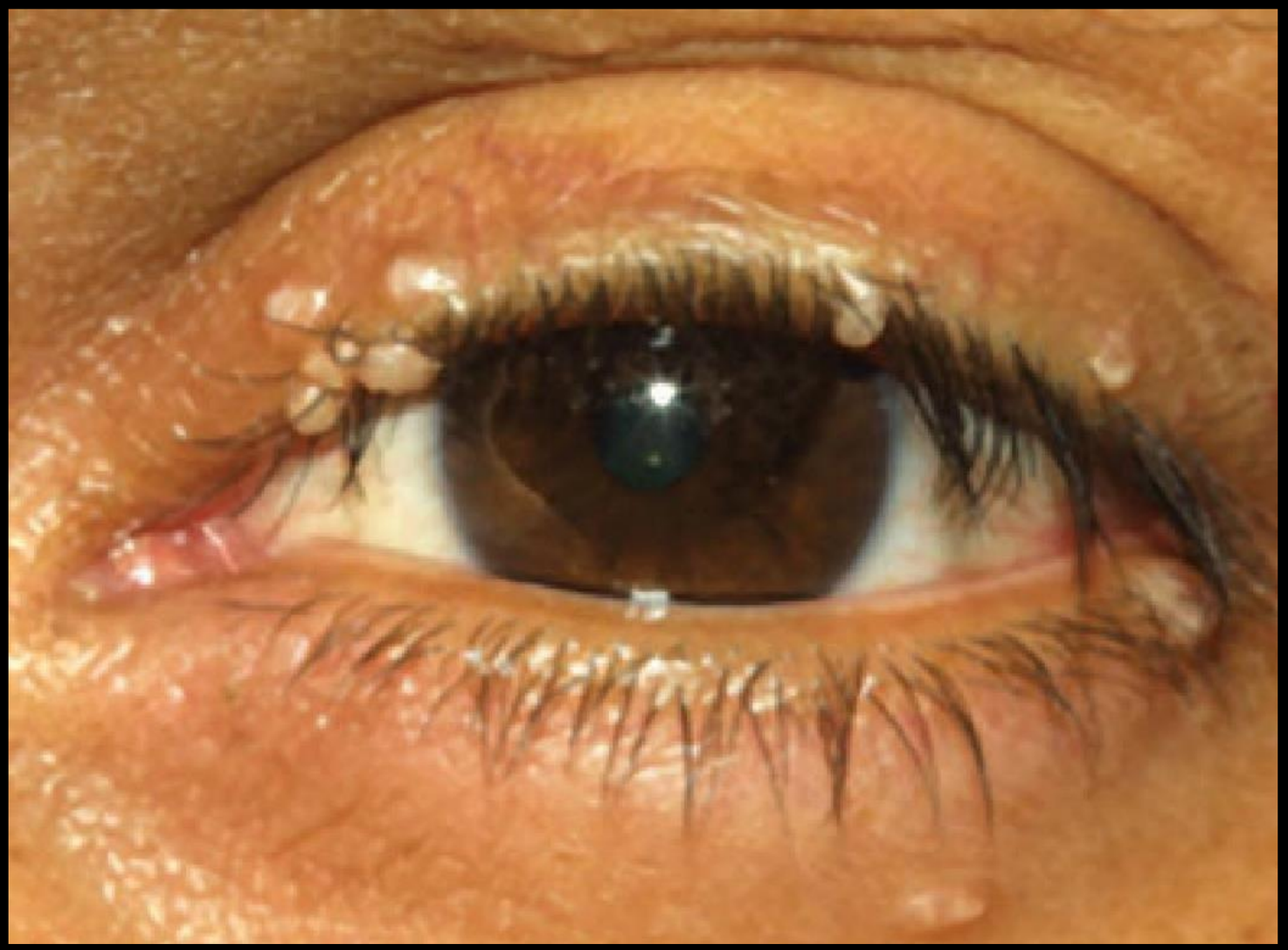
•Tiny clusters of cysts
• may be from trauma or irritation or random
• common in neonates, but go away.
• can be marsupialized
• can use topical retinoic acid.



Pilar or Trichilemmal cysts

- arise from skin with high density of hair (lashes or eyebrows)
- keratin-containing cysts
- 25% contain calcium

Molluscum Contagiosum



- waxy, nodular
- central umbilication
- viral
- chronic follicular conjunctivitis
- kids, lids
- excise, curettage, cryo if needed
- grow larger in AIDS

Benign Epithelial Cysts

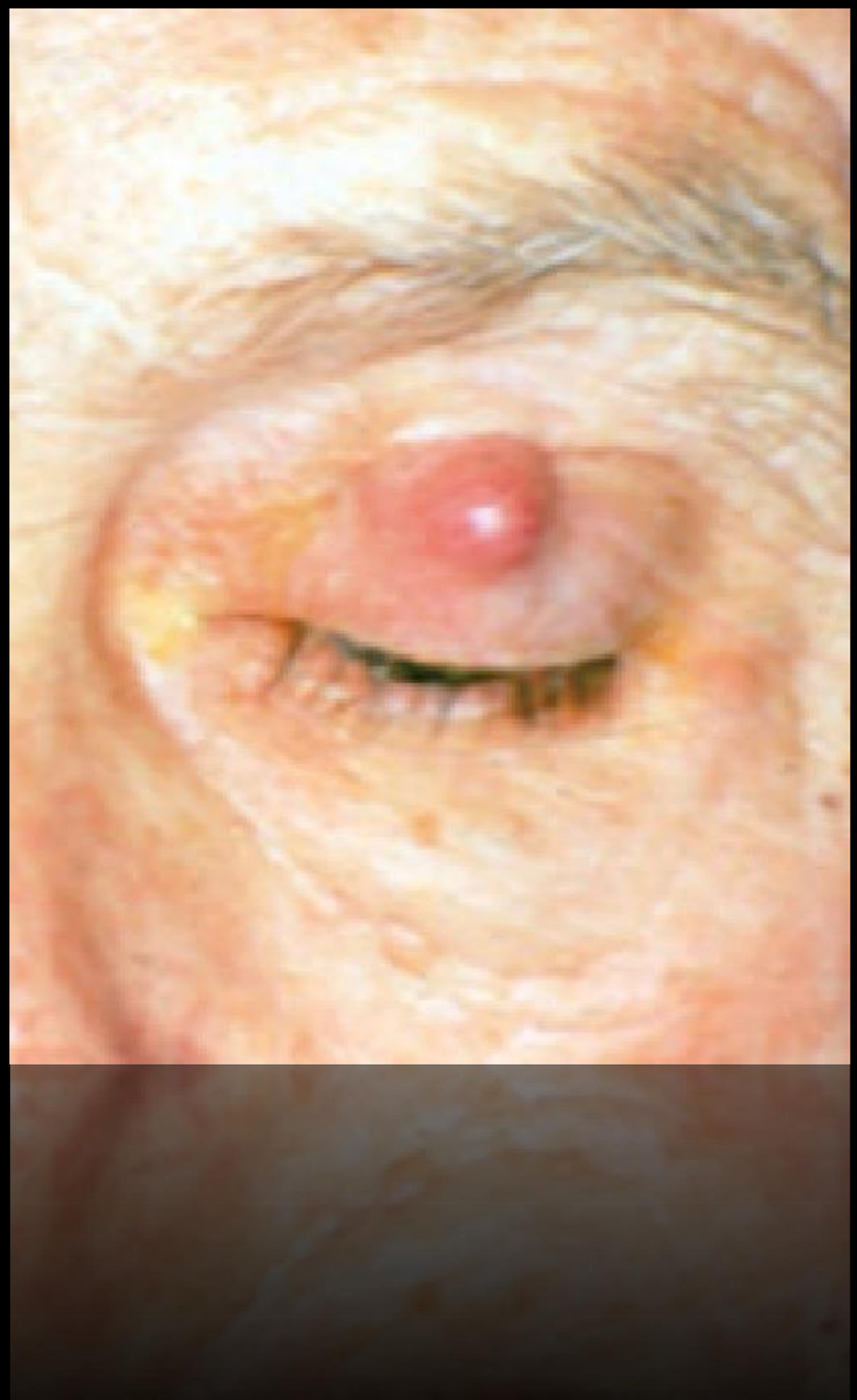
- Most common eyelid lesion after the epithelial hyperplasias
- Epidermal inclusion cysts
- Milia
- Pilar or Trichilemmal cysts
- Molluscum contagiousum

Benign Adnexal Lesions

- Chalazia and Hordeola
- If chronic and non-inflamed, can be confused w malignancies

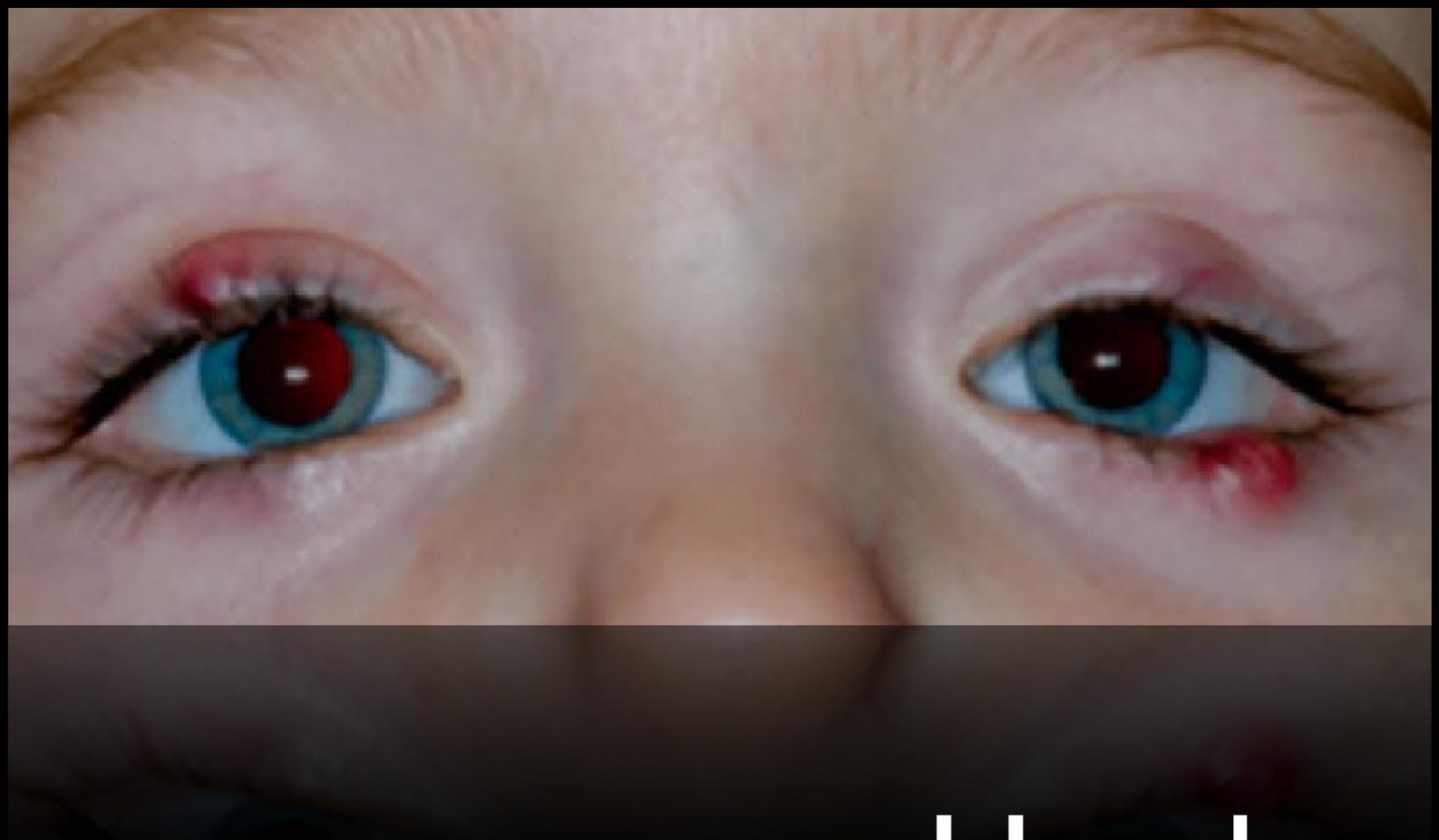
Chalazion

- obstructed meibomian glands
- meibum in tarsal tissues
- chronic inflammatory rxn
- blepharitis,rosacea, particulates
- WC/LS/antibx
- doxycycline or TCN x 2-3 mo
- I&D
- Kenalog injection



Steroids and Chalazia

- Intralesional steroid is alternative to excision
  - only after hot packs
  - risk of depigmentation in non-whites
  - risk of retinal artery occlusion



Hordeolum

- bacterial infx in glands of Zeis
- appears to be lash follicle
- WC topical antibiotic
- po antibiotics if large or cellulitis

Sebaceous hyperplasia

- multiple small yellow papules
- often w central umbilication
- usually over 40 yrs old
- similar to BCC
- Yellow color
- Not indurated

Sebaceous adenoma

yellowish papule on face, scalp, or trunk
rare, may look like BCC
Excise completely, ablate w CO2

Xanthelasma

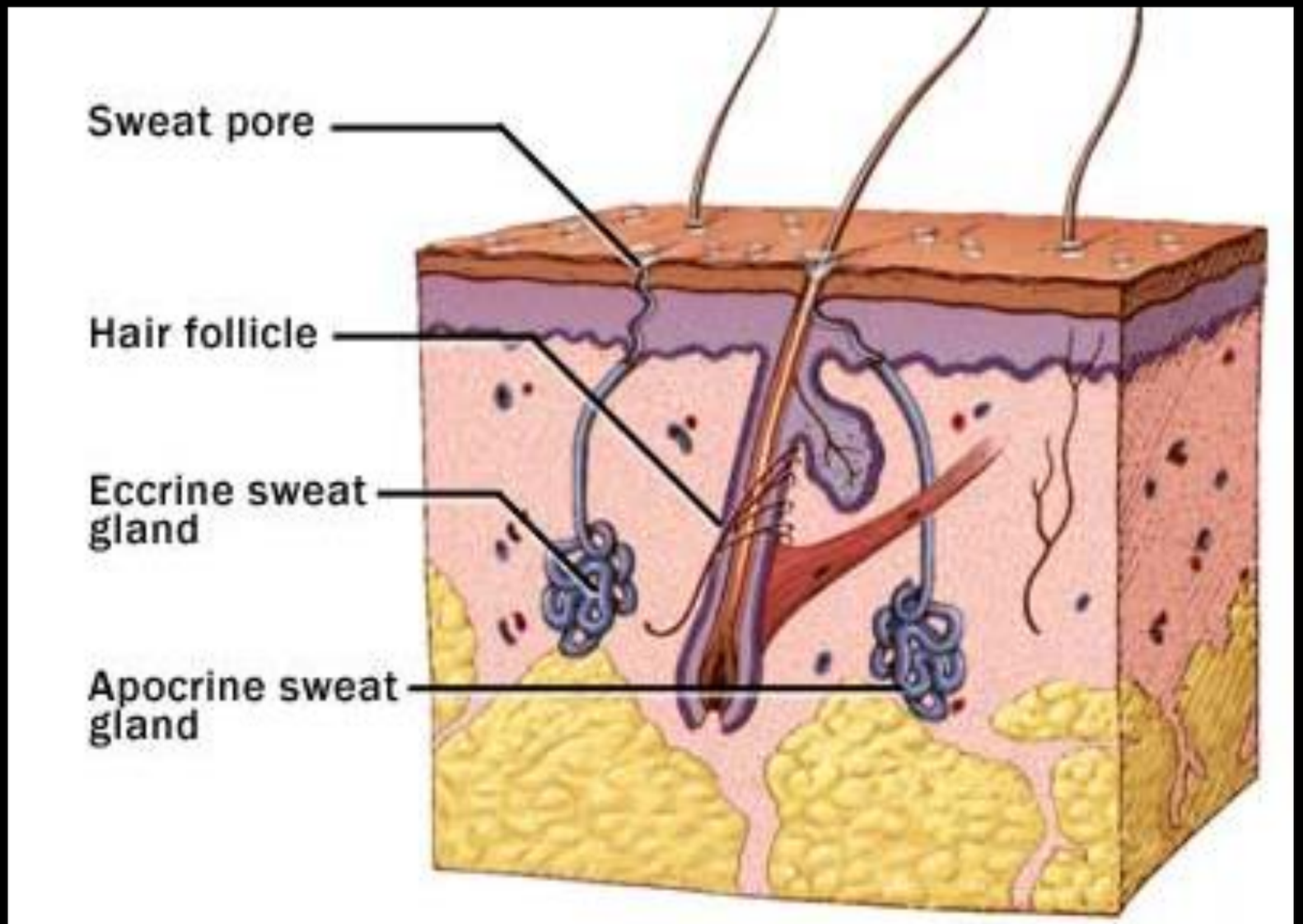
yellowish plaques
lipid-laden macrophages
superficial dermis into orbic
occasionally asst'd lipid disorders
excision, laser, or topical TCA
recur

Benign Adnexal cysts

- Chalazia
- Hordeola
- Sebaceous hyperplasia
- Sebaceous adenoma
- Xanthelasma

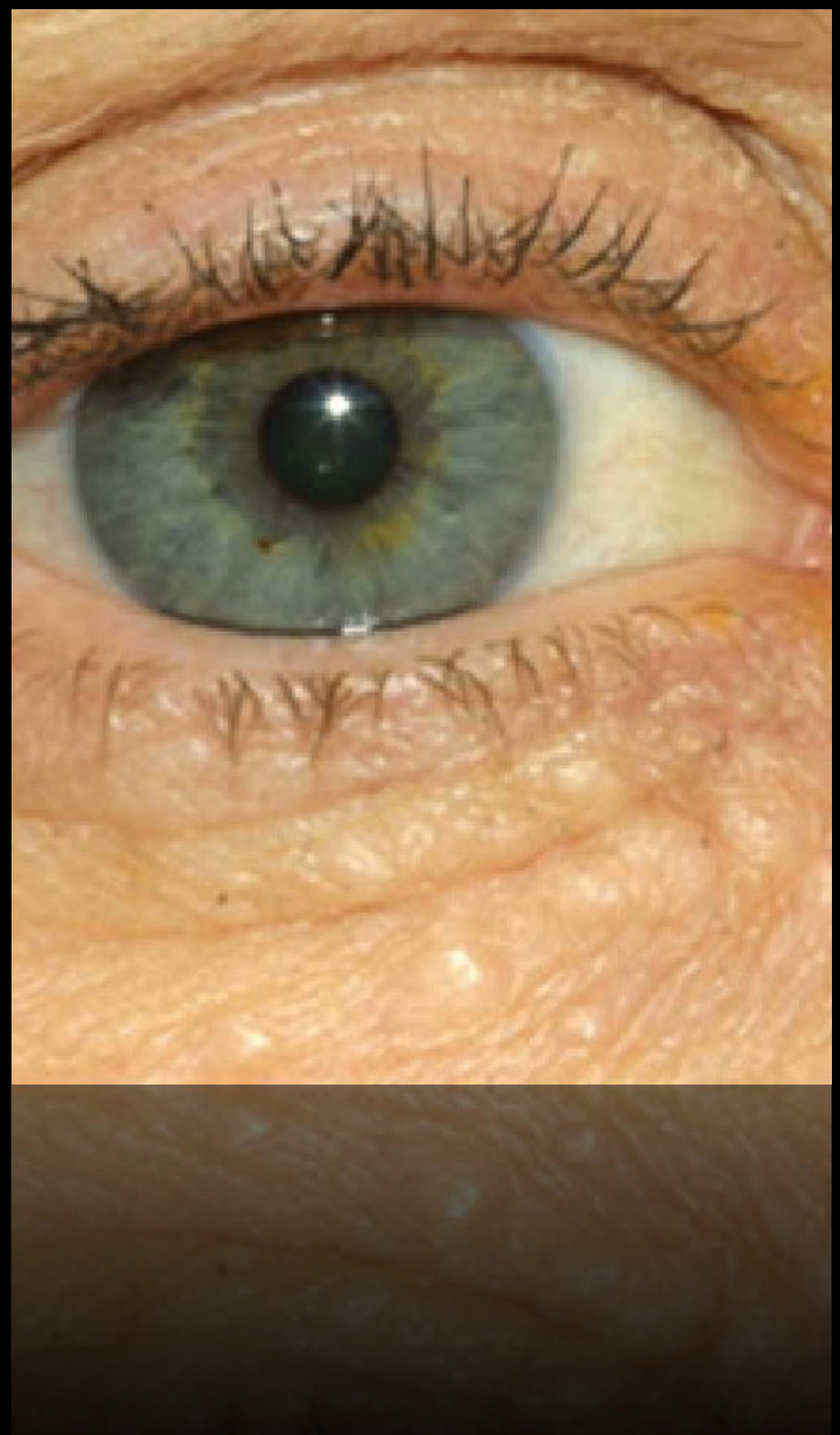
Tumors of Eccrine Gland origin

- Syringoma
- Eccrine hidrocystoma



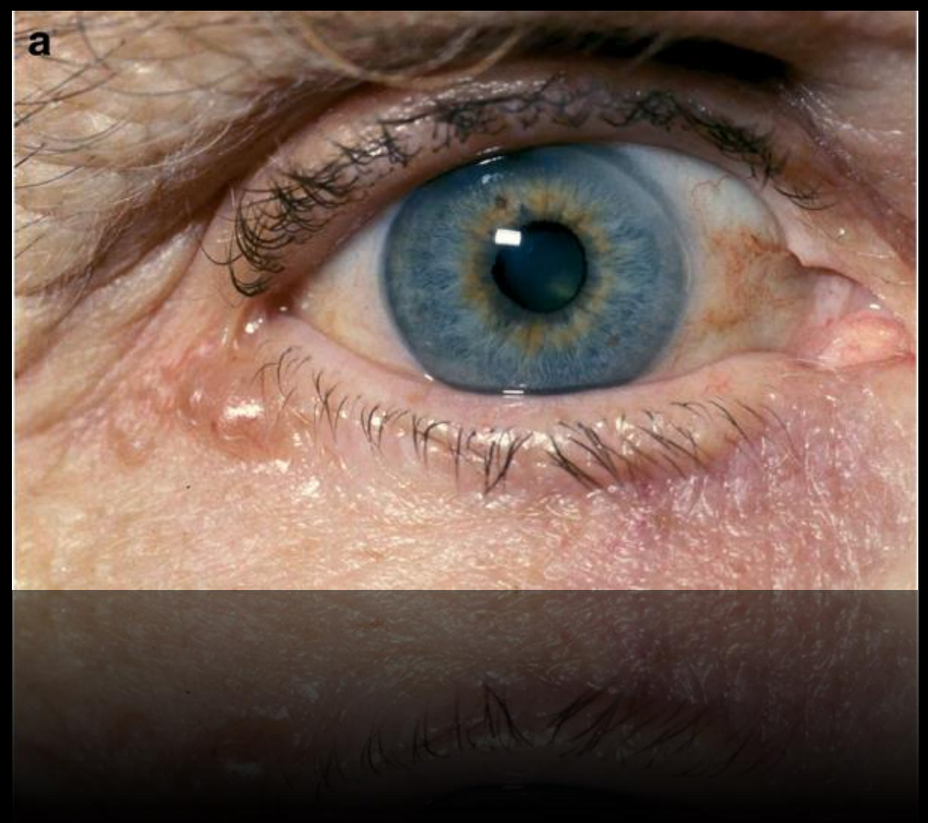
Syringoma

sweat gland tumor
multiple small pale yellow waxy
1-2 mm lower lids
females at puberty
beneath dermis
complete excision



Eccrine hidrocystoma

- translucent 1-5 mm cysts or clusters of cysts on lids or face
- retention cysts from excess temp or humidity
- excise or marsupialize

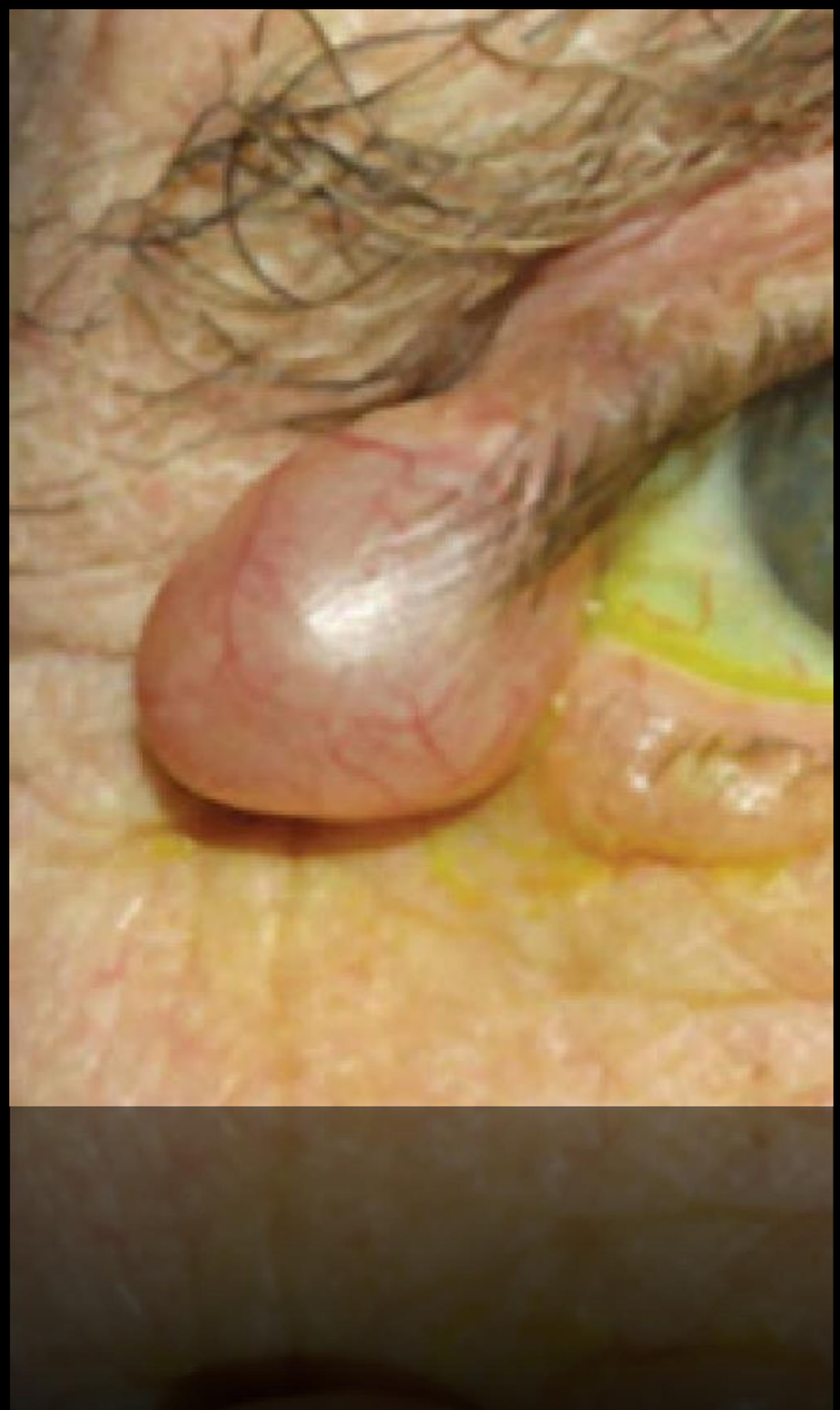


Tumors of Apocrine Gland origin

- Apocrine hidrocystoma

Apocrine hidrocystoma

- cystadenomas, sudoriferous cyst
- translucent, bluish smooth cyst
- adenoma of glands of Moll
- not retention cysts
- deep into dermis
- often near canthus
- excise completely or marsupialize

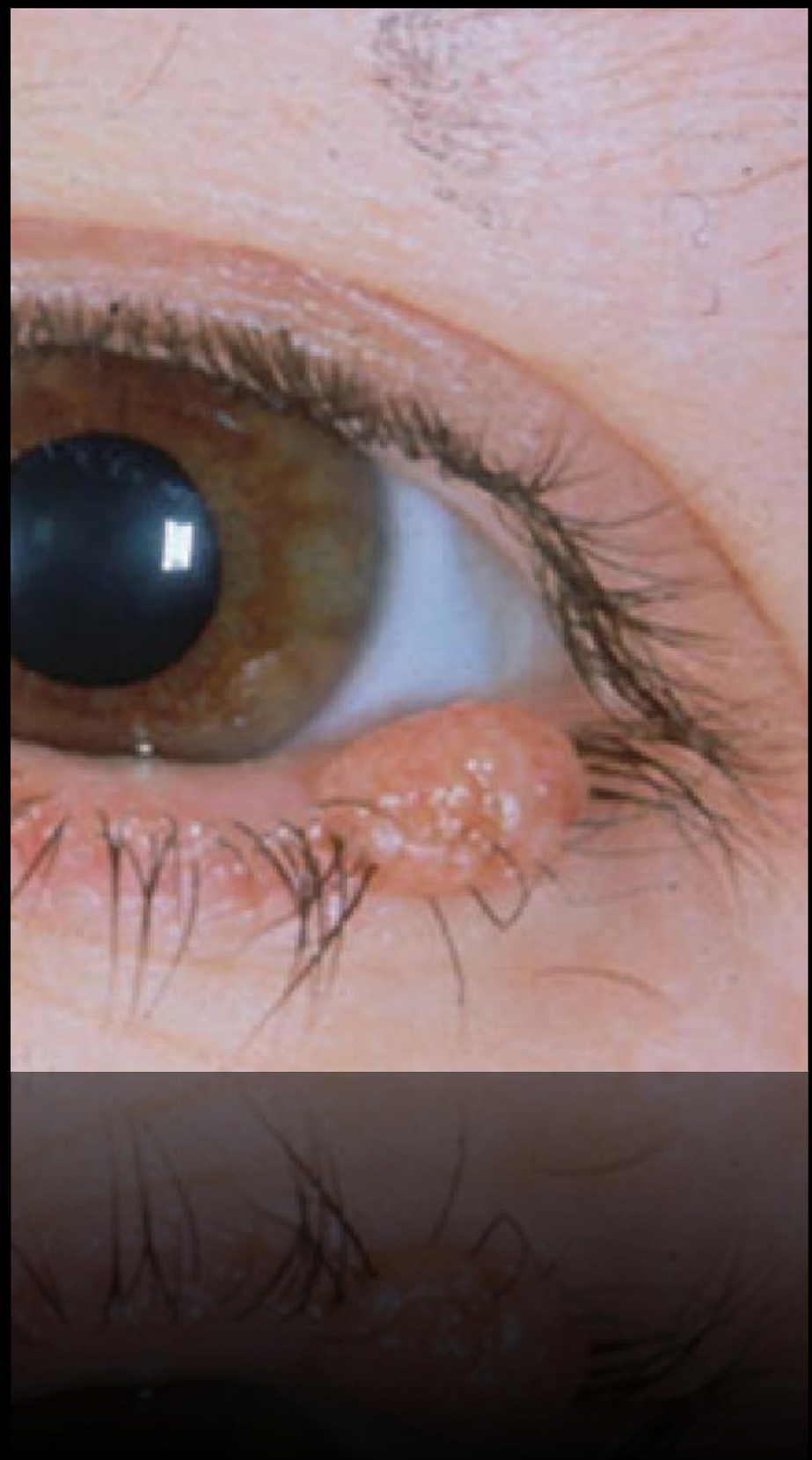


Benign lesions of melanocytic origin

- from nevus, epi- and dermal melanocytes
- any benign or malignant lid lesion may be pigmented, regardless of origin (eg. seb keratoses, BCC)
- nevus cells are in clusters
- melasma or chloasma - diffuse hyperpigmentation

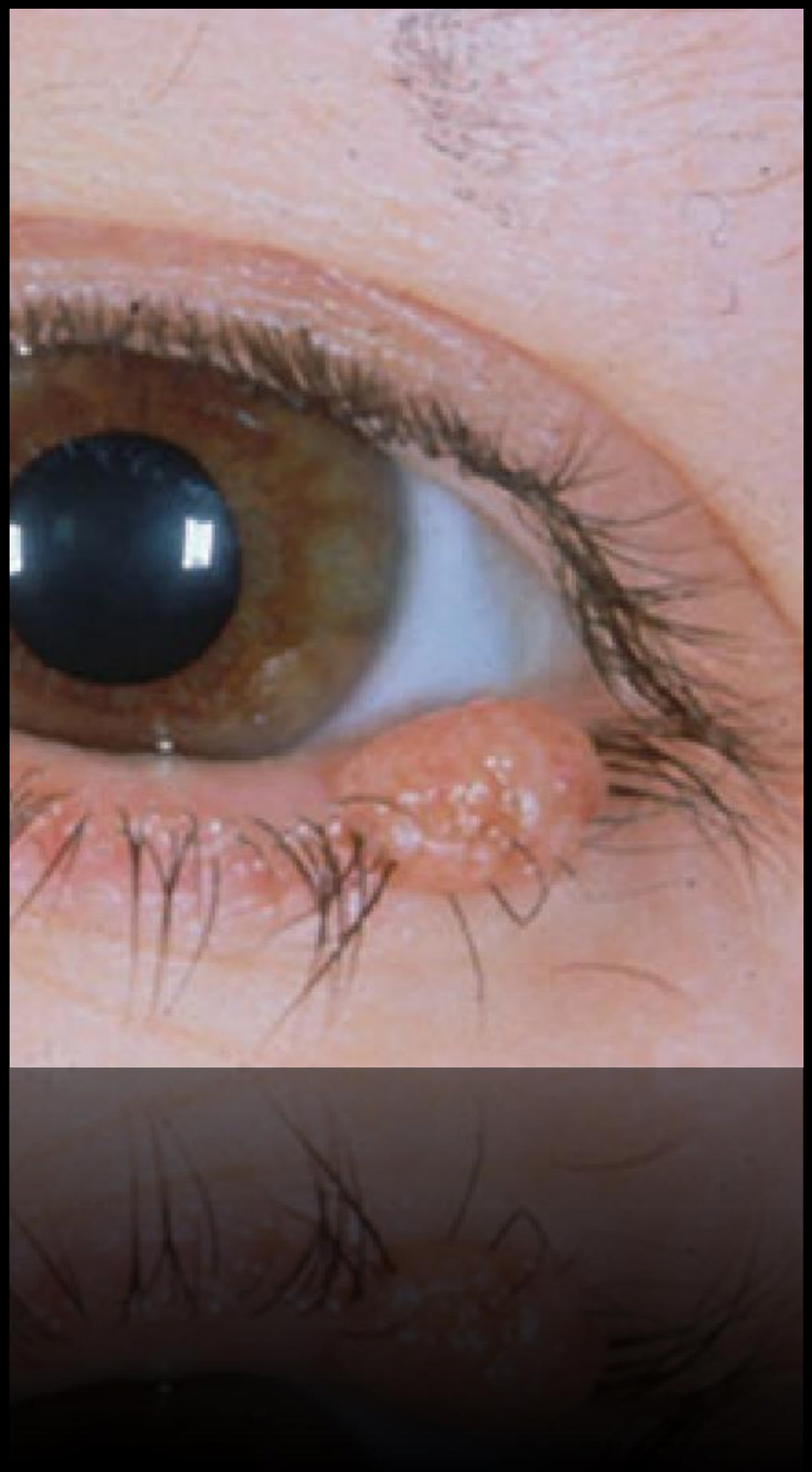
Nevus

- 3rd most common benign lesion
- from incompletely developed melanocytes
- clusters in epi-, dermis, or junctional zone
- Not visible at birth
- appear during puberty
- stage 1 - junctional - basal epi
- stage 2 - compound - into epi
- stage 3 - intradermal - involution of epidermis, loss of pigment



Nevus

- by age 70, most have lost pigmentation
- common on lid margin
- molded to eye surface
- malignant transformation rare
- excise at dermal junction
- rarely recur after excision




© dermaimaging

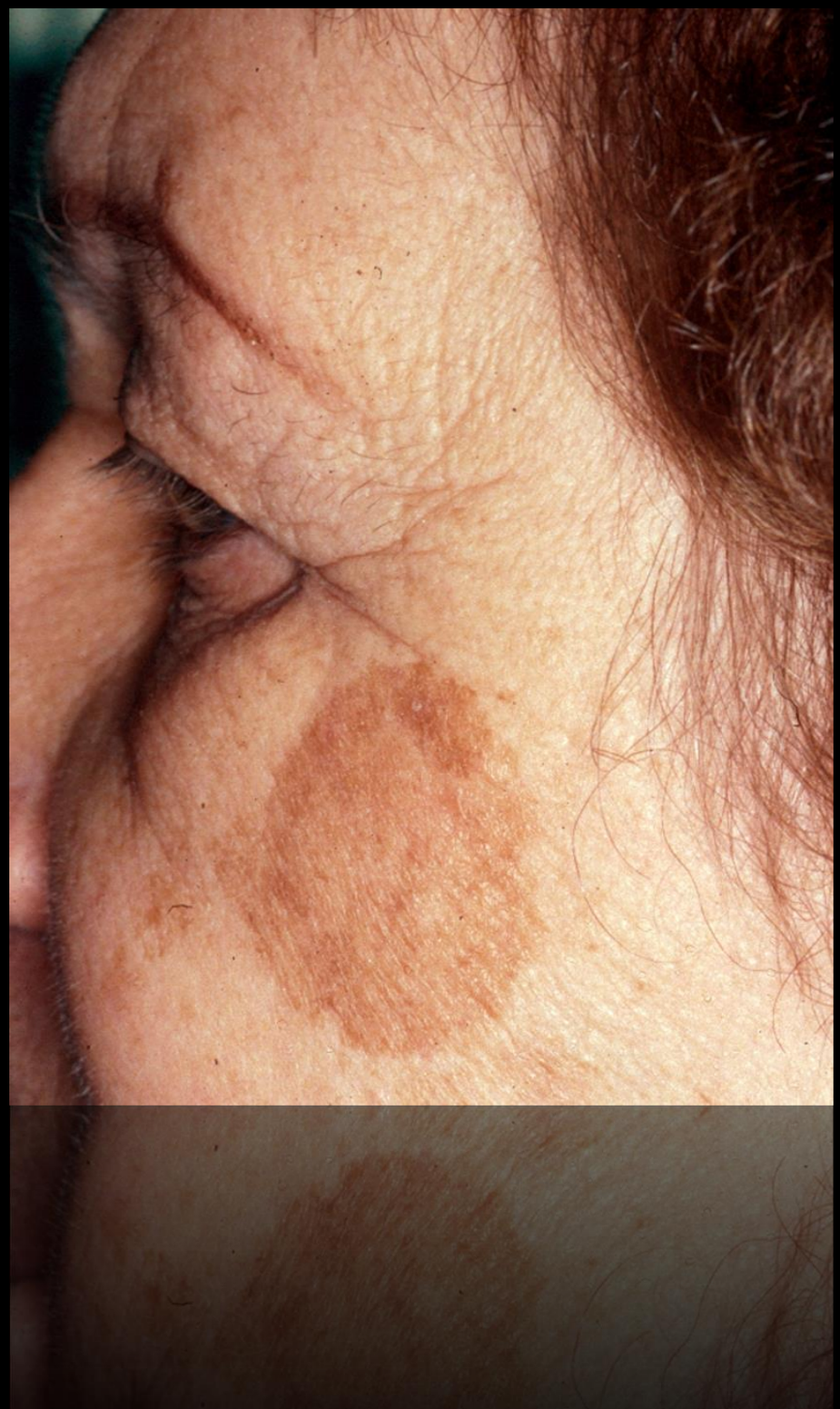
Lentigo Simplex

- flat, evenly-pigmented macules
- slightly larger than a freckle
- normal texture and
- can be bleached

Solar Lentigo

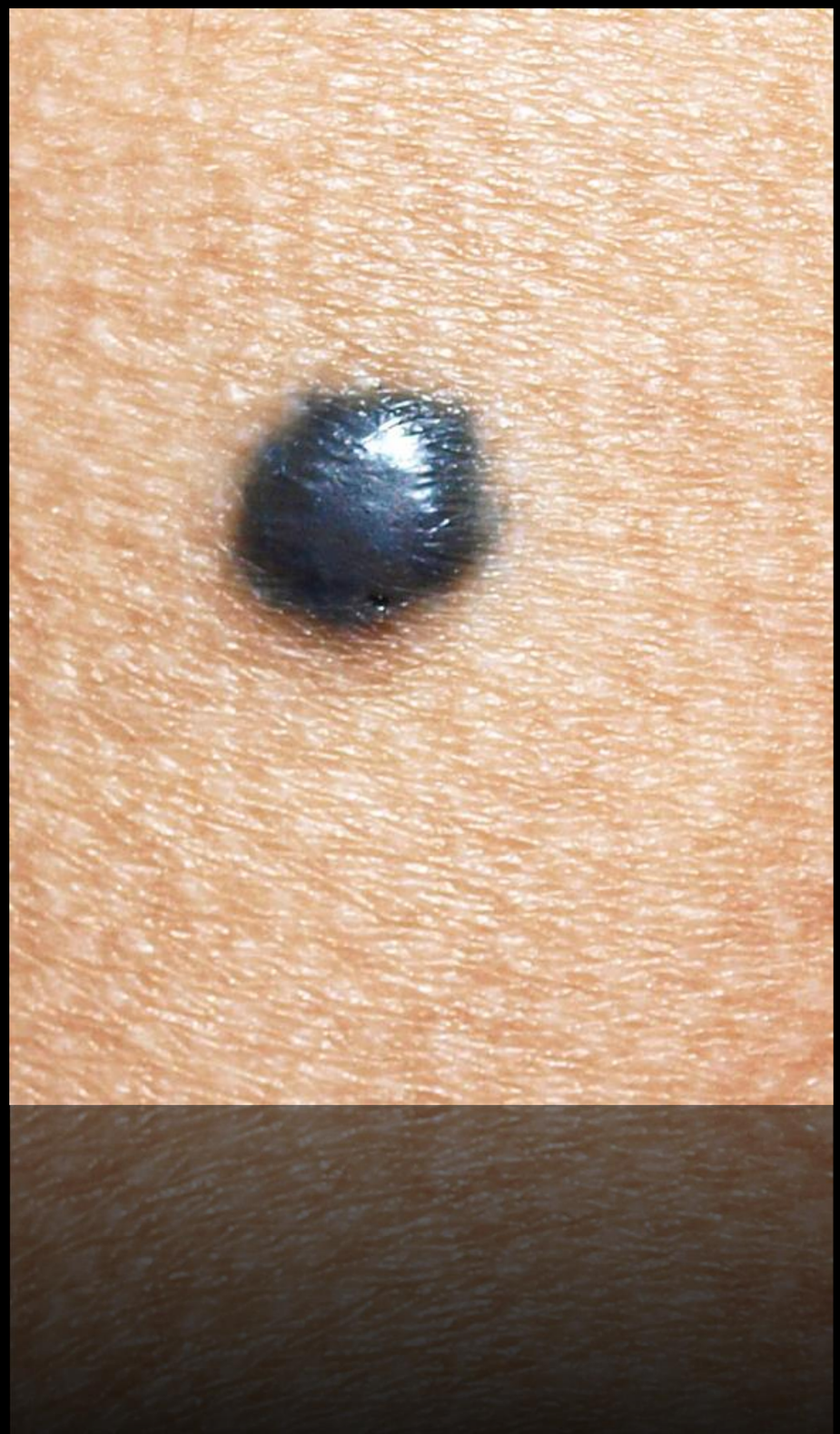
- “liver spots”
- flat, brown, sometimes irregular borders
- texture of normal skin
- increased melanocytes
- associated w chronic sun exposure
- may be bleached if desired

- May be bleached if desired.



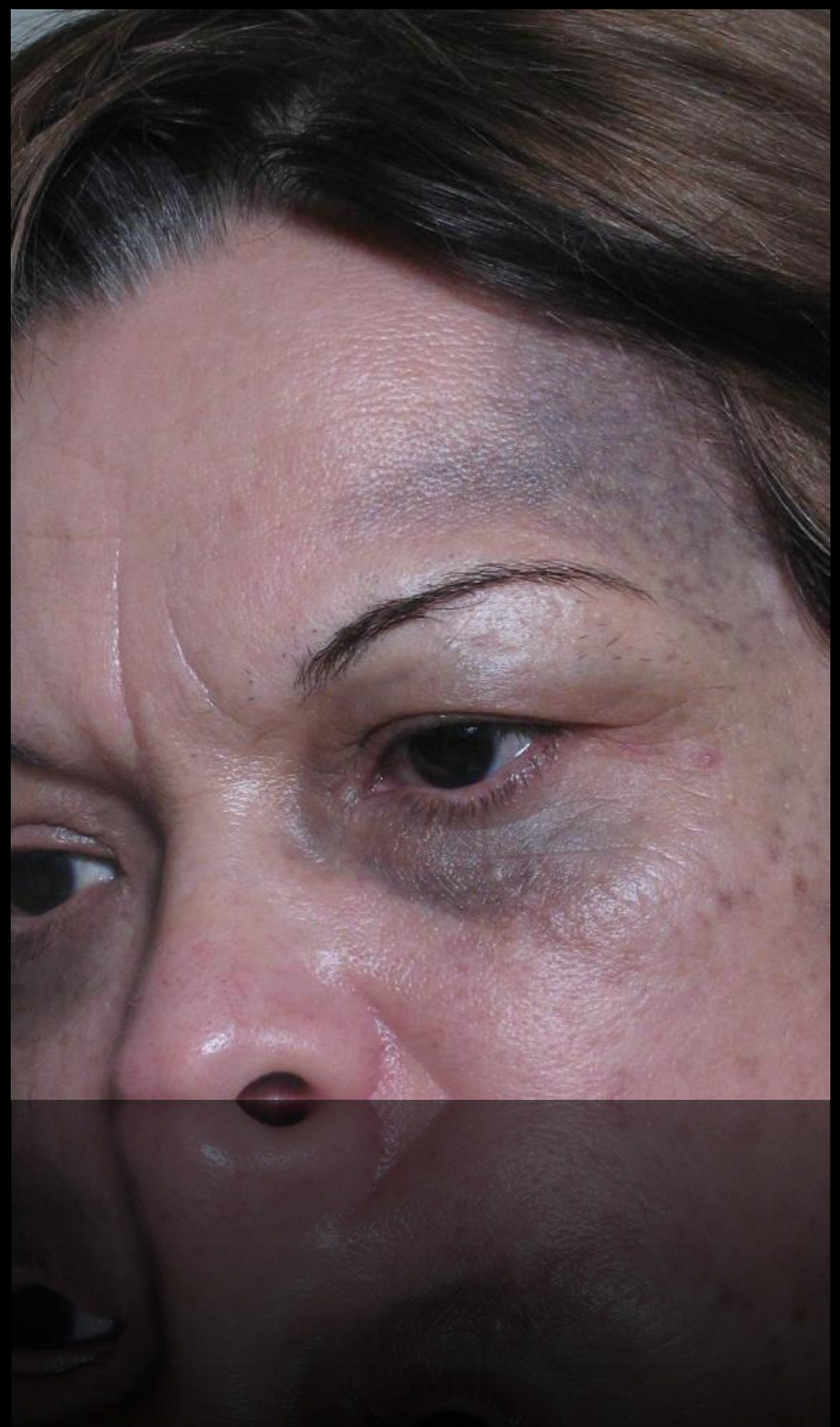
Blue Nevus

- dark bluish-gray,
- dome shaped
- congenital or in childhood
- less than 10 mm
- low malignant potential



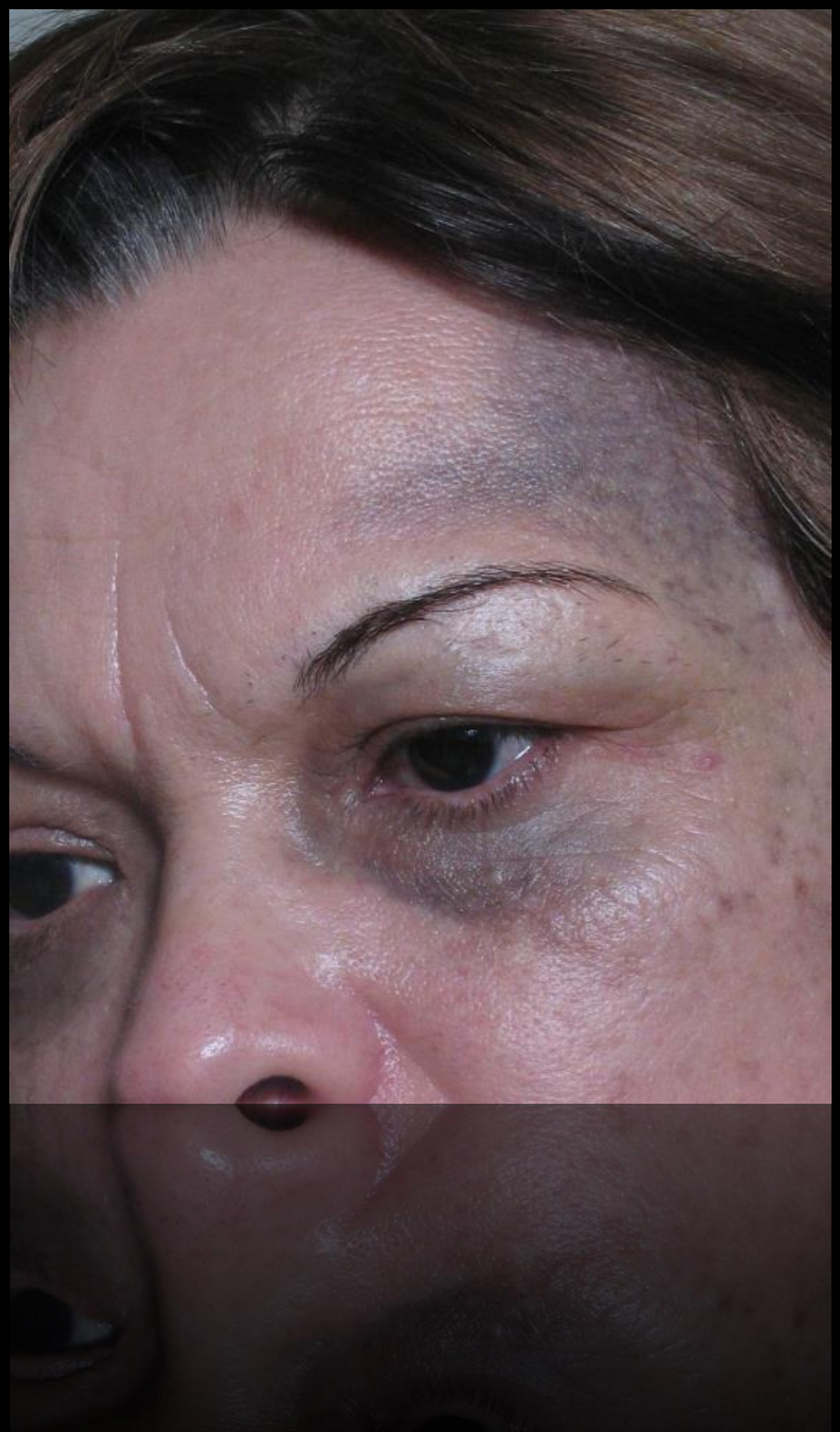
Dermal melanocytosis

- “nevus of Ota”
- incr melanocytes in V1 and V2
- diffuse, blue periocular congenital blue nevus
- more common in females 5:1
- Asian, also African & Hispanic
- 0.2-0.6% in Japanese



Oculodermal melanocytosis

- when associated w slate gray pigment of episclera and uvea
- 1 in 400 develop uveal melanoma (more likely in whites)
- no prevention
- annual screening from childhood if eye & skin pigment



Benign Tumors of Melanocytic Origin

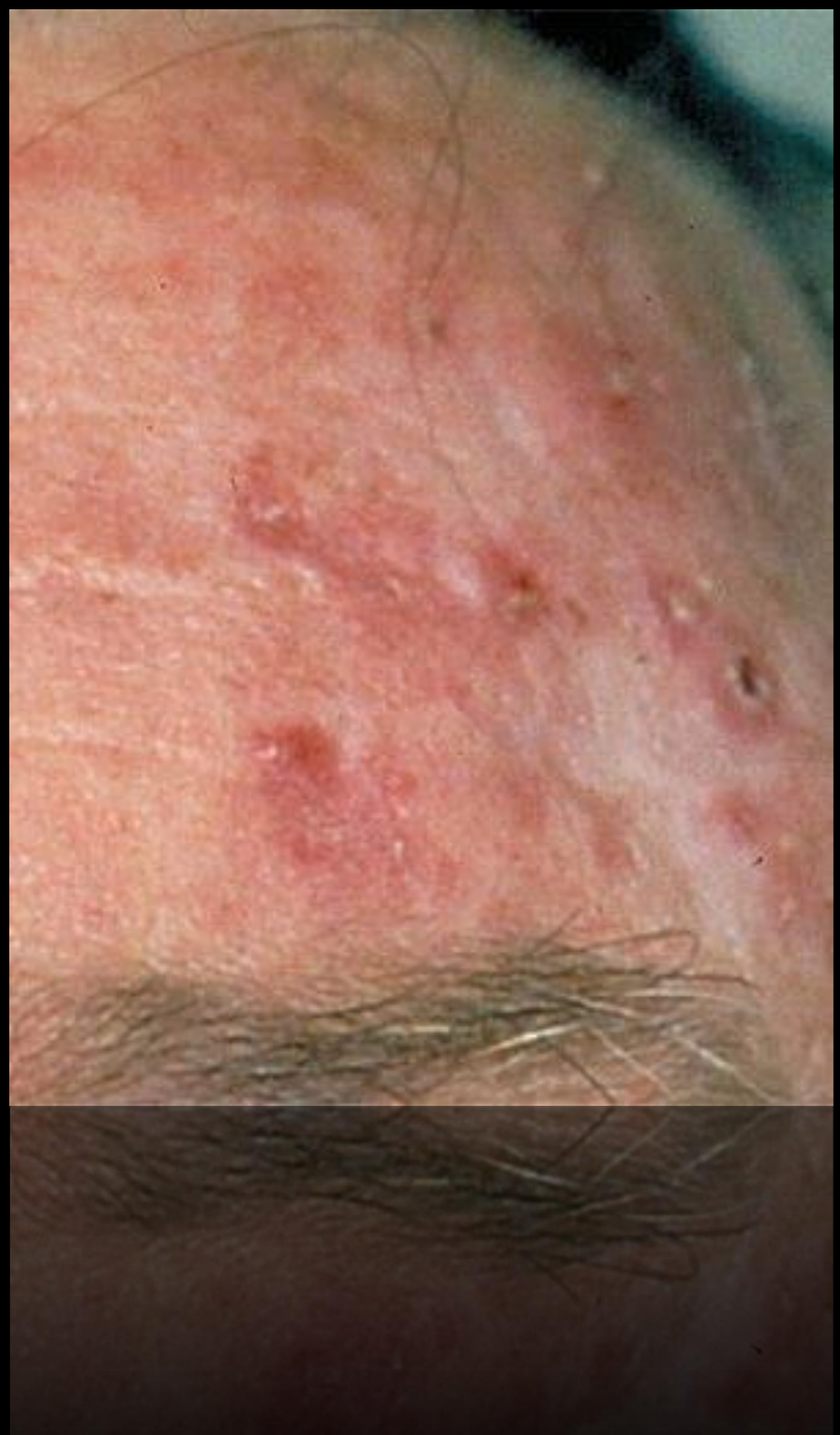
- Nevi
- Lentigo simplex
- Solar Lentigo
- Blue Nevus
- Dermal Melanocytosis

Premalignant Epidermal and Melanocytic Lesions


dermaimaging

Actinic Keratosis

- irregular, scaly, keratotic plaque
- sun exposure
- rough, scaly to palpation
- change and evolve
- 25% resolve
- 0.24% malignant transformation
- 12-16% personal risk if multiple
- cryo or excision
- topical 5-FU



Bowen's Disease

- squamous cell in situ
- elevated, erythematous
- non-healing
- scaling, crusting, keratotic
- 5% progress to invasive
- complete excision

Keratoacanthoma

- traditionally benign
- low grade squamous cell
- flesh-colored papule becomes an elevated crater
- middle-aged or older
- resolve in 3-6 mo
- excise

Keratoacanthoma

- Observe or biopsy
- Some observe for spontaneous regression for 1-2 months - others biopsy directly

Pre-Malignant Epidermal Lesions

- Actinic Keratosis
- Bowen’s Disease
- Keratoacanthoma

Lentigo Maligna

- flat, irregular, slowly enlarging
- unevenly pigmented
- differentiating features:
  - irreg pigment, irreg borders, and radial growth
- radial intraepithelial growth of melanocytes
- 10-30% risk of transformation
- may take 20 yrs or more

Premalignant Melanocytic Lesions

- Lentigo Maligna

To Path or not to Path..

- 2-5% of “benign” lesions may be malignant
- Send all, or just non-obvious specimens
  - squamous papilloma or seborrheic keratosis
  - Patients always cautioned to return if any change or growth occurs

Excise and document

- Photograph lesion if possible before excision
- If margins are +, then have to decide what next - observe or re-excise
- patient to return for possible recurrence

Mohs surgery for Benign Lesions?

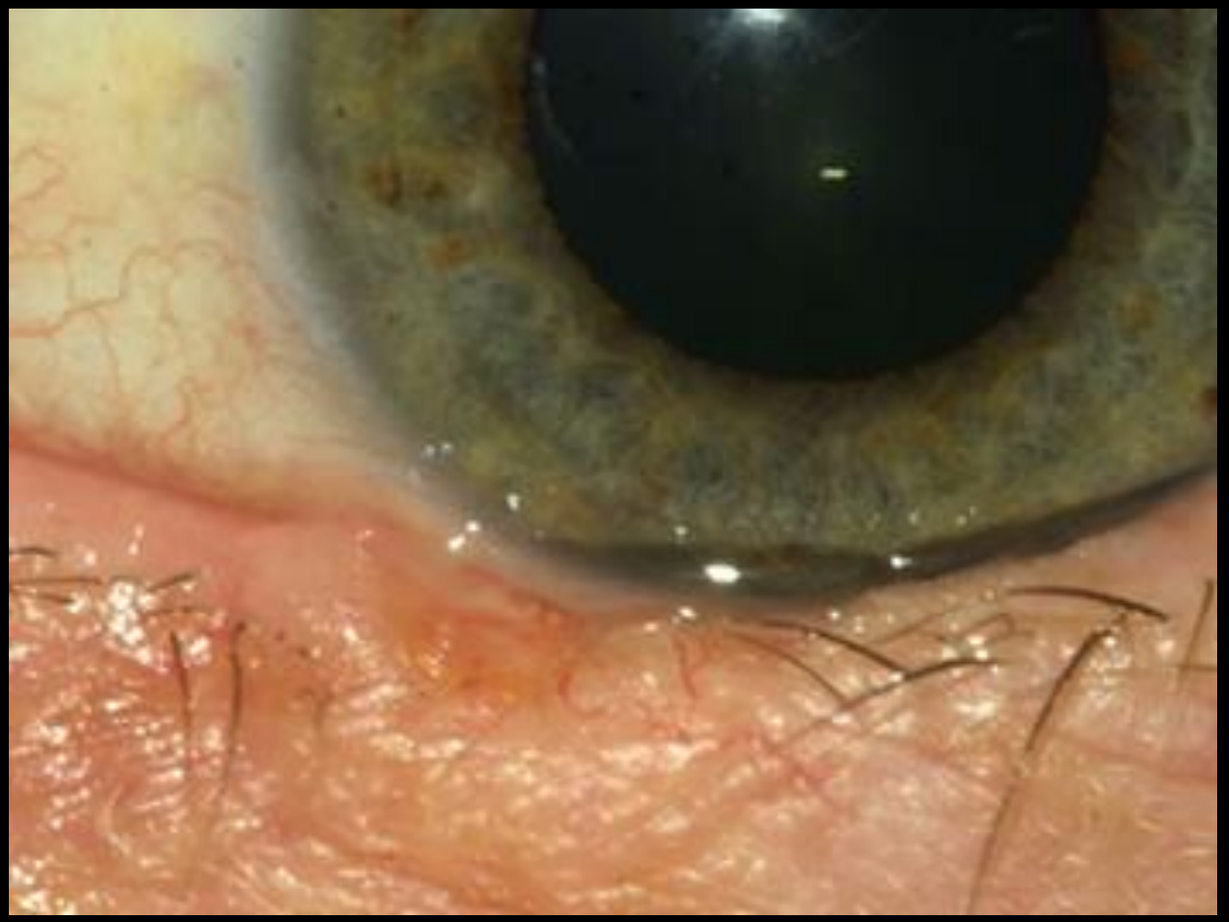
- only reimbursable lesions are:
  - atypical fibrous xanthoma
  - keratoacanthoma

Benign vs Malignant

- Regular Borders
- Soft, fleshy surface
- Intact surface epidermis
- Absence of telangiectasia
- preservation of surrounding anatomy
- stability over time
- Irregular border
- Induration
- Ulceration
- Telangiectasia
- Alteration/Disruption of surface anatomy
- progressive spread

Red flags...

- nodularity
- hypervascularity
- ulceration w and wo bleeding
- loss of lashes or surface hair follicles
- loss of normal anatomic structure



The End

CURRICULUM VITAE

Personal data: Gary Groesbeck, M.D.

Address: 4955 Concannon Court
San Diego, California 92130

Contact information: 760-599-2409 (office)
Gary.d.groesbeck@gmail.com

Spouse: Diane Groesbeck

Professional Activities:

Full-time clinical comprehensive ophthalmology practice, Southern California Permanente Medical Group:
- ~12,000 cataract surgeries performed since 1985
- Chief of Ophthalmology Dept, San Diego area (22 MD's) 2005-2011
- Lead ophthalmologist, Vista Eye Center, 1992-present
- Kaiser-Bellflower, 1986-1988, San Diego, 1988-present

Clinical Instructor, UCSD Dept. of Ophthalmology, 1992-2006
Fellow, American Academy of Ophthalmology 1988-present
Board-certified, American Board of Ophthalmology, 1988

Education:

Pasadena High School, Pasadena, California

Brigham Young University, Provo, Utah
- B. S., Zoology, 1978 summa cum laude
- Phi Kappa Phi
- Varsity Water Polo team

University of California, San Diego, School of Medicine
- M.D., 1982
- Research:
  "Current Concepts on Endophthalmitis" (senior thesis)
- Ranking: No rankings, honors, or honor societies were permitted during the years of my attendance at UCSD School of Medicine

L.D.S. Hospital, Salt Lake City, Utah
- Rotating internship, 1982-1983

University of California, San Diego, Dept. of Ophthalmology
- Ophthalmology residency, 1983-1986
- OKAP Scores: 1984: 83% 1985: 79% 1986: 85%

Community Activities:
Church youth leader

References:

Peter Custis, M.D.	Chief of Ophthalmology, San Diego Kaiser	619-516-7100
Barry Weinstein, M.D.	Colleague, Ophthalmology, San Diego	619-516-7100
Robert Weinreb, M.D.	Chairman, UCSD Ophthalmology Dept.	619-534-8823

Gary Groesbeck, MD
Corneal Ectasias and Corneal Crosslinking

1. Corneal Stucture
    A. Anatomy
    B. Biomechanics
    C. Testing of Corneal Structure
    D. Clinical applications for Evaluation and Treatment of Corneal disease

2. Corneal Ectasias
    A. Keratoconus
    B. Pellucid Marginal Degeneration
    C. Terrien's Marginal Degeneration
    D. Post-refractive surgery Ectasias

3. Corneal Collagen Crosslinking - Patient Selection
    A. Indications
    B. Contraindications
    C. Safety Factors

4. General Surgical Principles
    A. Riboflavin Loading
    B. UVA light application
    C. Postop Care

5. Complications
    A. Short term changes
    B. Long term effects

5. Outcomes:
    A. Germany Study
    B. Italina Study
    C. Australian Study
    D. US FDA Phase III Trials

6. Variations in Surgical Technique
    A. Epithelium-Off
    B. Epithelium-On
    C. Variable Duration treatments
    D. Adaptive techniques for Thin Corneas
    D. Corneal Crosslinking + Intacs

7. Clinical Application
    A. Current Status of Corneal CXL in SCPMG/Kaiser Permanente
    B. Future Trends