AAD
DermWorld
directions in residency
A Publication of the American Academy of Dermatology | Association
Winter 2025

Financial planning in residency: Frequently asked questions — Part 1

By Emily Margosian, Senior Editor

David B. Mandell, JD, MBA, answers frequently asked questions about financial planning during medical residency.

Directions in Residency: Is there a difference between a financial advisor and a financial planner? What are their qualifications?

MANDELL: Unfortunately, in the financial world nomenclature is intentionally confusing. If I see a board-certified dermatologist, I know for certain what training they've received. If I see a financial advisor, their experience could range from someone who graduated high school and passed a securities exam to a PhD in finance. There can be a lot of variation. As far as the difference between a planner and advisor, the answer is there is none, based on just title alone. The key is the training, certification, and experience of the professional.

Should physicians talk to a financial advisor during residency?

MANDELL: Even in residency and fellowship, you should start doing some research. It's unfortunate that most medical training programs don't spend any time on finance. Obviously clinical education should be the number one priority, but my personal input — having three physicians in the family and working with thousands across the country for 30 years — is that the medical establishment could spend more time preparing young physicians on these issues.

If you're a resident or fellow and you're thinking, 'I'm kind of overwhelmed with student debt, and I don't have wealth to manage right now,' look at the net present value of your future income stream

see **FINANCIAL** on p. 3

David B. Mandell, JD, MBA, is an attorney and author of more than a dozen books for physicians. He is a partner in the wealth management firm OJM Group. Check out his podcast, *Wealth Planning for the Modern Physician* at **www.ojmgroup.com/wealth-planning-for-the-modern-physician-podcast** or wherever you get your podcasts.

CASTLE BIOSCIENCES

RISK IDENTIFIED

Every skin cancer carries a different risk. Clearly identify it.

Gene expression profile testing can provide individualized risk information to help guide clinical decision making.

DecisionDx ▸Melanoma

Delivers personalized risk-assessment for recurrence and metastasis, including the likelihood of sentinel lymph node positivity, for patients with cutaneous melanoma

DecisionDx ▸SCC

Identifies the risk of metastasis for patients with high-risk squamous cell carcinoma and predicts which patients are most likely to benefit from adjuvant radiation therapy

MyPath ▸Melanoma

Aids in diagnosis and management decisions for patients with ambiguous melanocytic lesions, dysplastic nevi, as well as in cases when melanoma cannot be ruled out

Learn how to incorporate testing into your practice

FINANCIAL from p. 1

— you're millionaires. It can be hard to wrap your brain around that, but it is true even with student debt. That doesn't mean run up credit cards and live beyond your means, but it does mean that even at this stage of your career you should dedicate some time to research what's out there. Meet with some financial planners and see whether there's a fit, even if you don't have investments to manage yet. Young doctors often have a lot of questions as they begin to make some money: 'Should I pay down debt? Should I save? Should I buy a house and put that money into a down payment? Should I invest?' Financial advisors can help you think about those questions and make decisions that are right for you.

What planning can physicians realistically do right now paycheck-to-paycheck on a resident salary?

MANDELL: Often at the start of your career, you may be feeling anxious about your finances. People have a lot of emotions when it comes to money. Simply developing a relationship with an advisor is a great place to start. They likely will not charge you much. When we work with young doctors, we may not charge anything and instead have a couple of conversations with them and let them know that they can grow with us over time. It may be helpful for a resident to speak with a financial advisor to relieve some of that worry about the future.

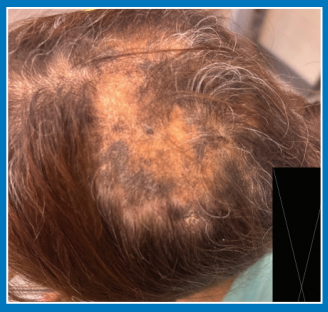
While you may be living paycheck-to-paycheck now, an advisor can help you chart a path forward so when you get to point B — that may be your first post-residency job or some other benchmark — you're prepared for the decisions you're going to have to make, because you will start to make more money than you spend each month and will have to decide what to do with that excess. Right now, as a resident, it's all in front of you. I'd advise residents to spend a little bit of time — which is of course not something you have a lot of right now — to at least look at the resources that are out there. Some are even free: podcasts, AAD resources, and books we provide. Start to get educated so when the dollars start to come, it's not the first time you've thought about your financial future, and you may even have a network of people and resources established. DR

Haowei Han, DO, is a PGY-4 dermatology resident at St. John's Episcopal Hospital, in Far Rockaway, New York.

Aysham Chaudry, DO, is a research fellow at the Center for Clinical and Cosmetic Research, in Aventura, Florida.

Race for the Case

By Haowei Han, DO, and Aysham Chaudry, DO



A 64-year-old woman presented to the dermatology clinic with a two-year history of a widespread rash involving the scalp and left ear. She reported associated joint pain but denied fevers, fatigue, weight loss, oral ulcers, photosensitivity, or Raynaud phenomenon. Social history is notable for cigarette smoking and lack of regular sunscreen use.

On physical examination, there were bilateral preauricular hyperpigmented, atrophic plaques. The parietal scalp demonstrated violaceous to hyperpigmented, atrophic plaques accompanied by alopecia.

Laboratory evaluation revealed a positive antinuclear antibody (ANA) with a speckled pattern at a titer of 1:160 and an elevated Sjögren's syndrome-related antigen A (SS-A/Ro) antibody level of 3.6 (reference range: 0.0–0.9). Anti-double-stranded DNA (anti-dsDNA) and anti-Smith antibodies were negative. Complete blood count (CBC), comprehensive metabolic panel (CMP), and urinalysis (UA) were all within normal limits.

A 4-millimeter (4 mm) punch biopsy of the scalp revealed follicular plugging, perifollicular fibrosis, periadnexal lymphocytic inflammation, increased dermal mucin deposition, and pigment incontinence. Vacuolar interface changes were noted, along with increased thickness of the basement membrane zone.

1. **Based on the clinical, histopathologic, and laboratory findings, what is the most likely diagnosis?**
2. **What is the likelihood that this condition will progress to systemic lupus erythematosus (SLE)?**
3. **Which stain can be used to highlight the thickened basement membrane zone seen in this condition?**
4. **What stain can be used to highlight the increase in mucin deposition?**
5. **Infants born to mothers with positive SS-A (Ro) antibodies are at increased risk for which condition characterized by congenital heart block, annular lesions, and thrombocytopenia?**

Respond with the correct answers at **www.aad.org/RaceForTheCase** for the opportunity to win a Amazon gift card!

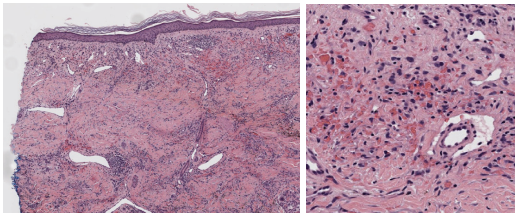
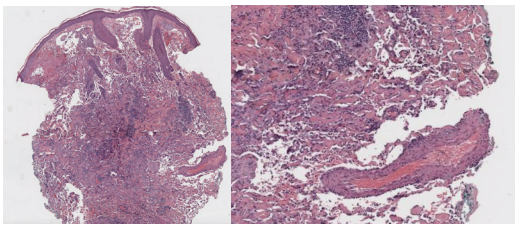
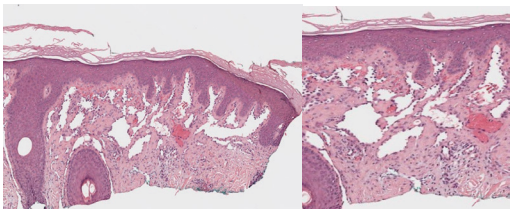
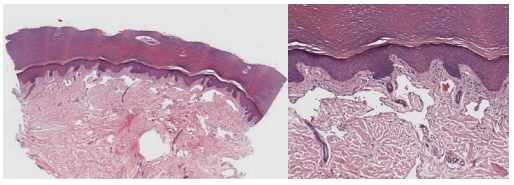
Race for the Case winner (Fall 2025)

The winner of the fall 2025 Race for the Case is Haowei Han, DO, a PGY-4 at St. John's Episcopal Hospital. Dr. Han correctly identified syringocystadenoma papilliferum in our latest Race for the Case and provided the most accurate responses in the quickest time. Congrats to Dr. Han!

You can read more about this case online at **www.aad.org/race-case-answers**. If you can solve the case above, there may be a $100 Amazon gift card in your future, and you will be invited to contribute your very own Race for the Case. Visit **www.aad.org/RaceForTheCase**.

Promontory sign microscopic differential diagnosis

By Alexandra Stroia, DO, and Stephen Olsen, MD

Diagnosis	Histopathologic features	Stains	Histology image
Kaposi sarcoma	• Busy dermis with diffuse infiltration of **spindled cells and small channels** • Ectatic **lymphatic-like vessels** • Extravasated **red blood cells** • Plasma cells common	CD31+, CD34+, Factor VIII+ (weakly positive), ERG+ **HHV8+ (nuclear). Latency-associated nuclear antigen (LANA-1) is the specific HHV8 marker**	
Angiosarcoma	• **Crack-like spaces** between collagen bundles • Spaces lined by **hyperchromatic endothelial cells** • Nodular areas commonly epithelioid with more pronounced **atypia**	CD31+, CD34+, Factor VIII+, ERG+ D2-40+ **MYC+ (post-radiation)**	
Hobnail hemangioma	• Central superficial dilated vessels with **hobnail nuclei** • Peripheral proliferation of small vessels • **Angulated look to the blood vessels** • Hemosiderin deposition	CD31+, CD34+, Factor VIII+, ERG+ D2-40- GLUT1-	
Acquired progressive lymphangioma (lymphangioendothelioma)	• Proliferation of well-circumscribed, anastomosing, **thin-walled irregular staghorn vessels** • **Arise post trauma, surgery, chronic lymphedema, or radiation** • Usually single or localized plaque or nodule • Limited to the dermis	CD31+, CD34+, Factor VIII+, ERG+ **D2-40+** **LYVE-1+** **PROX1+**	

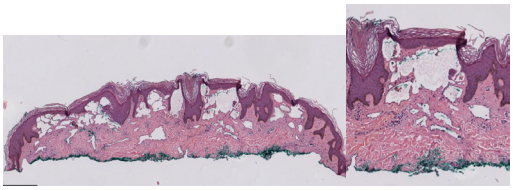
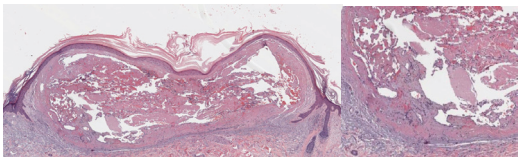
Alexandra Stroia, DO, is a PGY-3 at Trinity Health Livingston in Howell, Michigan.

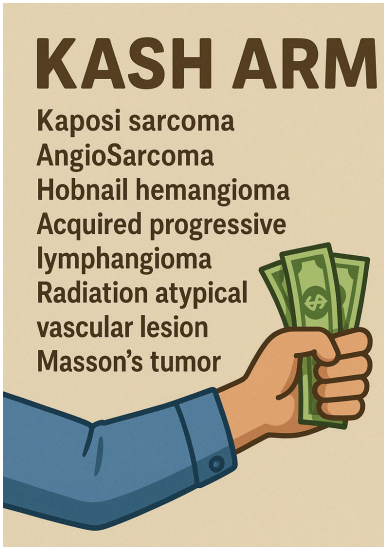
Stephen Olsen, MD, is a board-certified dermatopathologist at Trinity Health Livingston in Howell, Michigan.

Histology slides courtesy of Stephen Olsen, MD.

Promontory sign microscopic differential diagnosis

By Alexandra Stroia, DO, and Stephen Olsen, MD

Diagnosis	Histopathologic features	Stains	Histology image
Post-radiation atypical vascular lesion	• Well-circumscribed vessels, with minimal anastomosis, and **single layer of non-atypical appearing endothelial cells** • **Arise post-radiation** • Often multiple small papules or plaques within irradiated skin	CD31+, D2-40+ MYC-	
Intravascular papillary endothelial hyperplasia (Masson's tumor)	• Recanalized thrombus within vascular space • **Fibrin in thrombus** within papillary projections • Papillary projections with **hyalinized cores**	CD31+, CD34+, Factor VIII+	



Promontory sign: *New vessels surrounding adnexal structures or pre-existing vessels*
DDx: KASH ARM

References:

1. Bolognia JL, Callen JP, Jorizzo JL, Schaffer JV. *Dermatology*. 5th ed. Elsevier; 2024.
2. Elston DM and Ferringer T. *Dermatopathology*. 3rd ed. Elsevier; 2018.
3. Alikhan A and Hocker TLH. *Review of Dermatology*. 2nd ed. Edinburgh: Elsevier; 2023.
4. Fernandez-Flores A and Rodríguez R. Promontory Sign in a Reactive Benign Vascular Proliferation. *Am J Dermatopathol*. 2010;32(7):700-703.
5. Lazova R, McNiff JM, Glusac E, Godic A. Promontory Sign-Present in Patch and Plaque Stage of Angiosarcoma. *Am J Dermatopathol*. 2009;31(2):132-136. DR

More study charts online!

There are more Boards Fodder charts online! In addition to the chart in this issue, you can view the **UV radiation and sunscreen** chart by Benjamin Cooper, DO, Taha Rasul, MD, and Anthony Concilla, DO, and the **Flap update 2025: Part 2 lifting flaps** chart by Vixey Silva, DO, Mohammad Fardos, DO, and Kent Krach, MD, FAAD.

These and many more charts can be found at **www.aad.org/boardsfodder**.

Nanette Silverberg, MD, FAAD, is chief of pediatric dermatology for the Mount Sinai Health System and site director of pediatric and adolescent dermatology at Mount Sinai West and Mount Sinai Beth Israel. Dr. Silverberg is also clinical professor of pediatrics and dermatology at the Icahn School of Medicine at Mount Sinai.

Clinical Pearls

Clinical Pearls help prepare residents for the future by providing them with insights about what they should know about a specific subject area by the time they complete their residency.

Molluscum contagiosum

By Nanette Silverberg, MD, FAAD

Pearl #1: Pediatric molluscum has become exceedingly common and we can all expect to see many cases and experience it in our families. With a prevalence between 5.1–11.5% in children aged 0–16 years, molluscum contagiosum (MC) is the third most common viral skin infection in children and one of the five most prevalent skin diseases worldwide. Skin lesions present as firm rounded papules, pink or skin-colored, with a shiny and umbilicated surface.

Pearl #2: Educating parents is the first aspect of shared decision-making. Three key elements to education include natural history, preventing spread, and therapeutic options. We really must look at each patient individually. It's a patient-centered outcome that we're looking for because molluscum does eventually go away. We want to make sure it's not scarring. We want to make sure that they're not uncomfortable and then support them in their decisions. If they really feel they want to be clear, and they're upset with their appearance, we should support those patients and offer them judicious treatment.

Pearl #3: Parents should know these facts: More than half of molluscum cases last over a year and some will go two years. For our individuals who have molluscum, we expect them to have disease naturally for one to two years. About 50% of people will clear around the one-year mark, 70% by a year and a half, and about 90% by two years out. We start to see intense clearance in the second year, but not so much in the first year.

Pearl #4: Good skin care in molluscum includes not sharing bath and bath equipment, avoiding rubbing and scrubbing, and treating dermatitis to improve quality of life and reduce spread. We want to make sure any associated eczema is under control first. We use a lot of topical steroids largely because things like topical calcineurin inhibitors may promote spread of molluscum. About half of kids with molluscum live in households that support co-bathing. It's certainly something we see in early childhood, particularly with early childhood activities.

Pearl #5: Therapeutic options include our two FDA-approved agents, berdazimer and cantharidin, as well as myriads of in-office destructive therapies like lidocaine/prilocaine and curettage. Choose therapies with more than 50% clearance for patient satisfaction. Parental choice and the child's choice are important in shared decision-making. Not every child needs to be treated. As much as we want to offer people immediate clearance, sometimes it's okay to do things more slowly to avoid trauma in children. We sometimes respond to parents' anxiety and stress, and they may be encouraging us to be very aggressive — and we may want to be a little less aggressive, depending on the situation.

Cantharidin 0.7%, which is applied through an applicator device, was approved by the FDA in July 2023. Despite its status as a newly approved treatment for molluscum, the compounded form has been used for decades. We've always known cantharidin creates blisters, but now we have better control over the product. Berdazimer is interesting because it has some antiviral properties. We really have only had compounded cidofovir in the past that has antiviral properties, which we reserve for very severe cases or for people who are treatment resistant. Berdazimer offers an alternative mechanism of action, with the option for combination with other agents.

If there is a lesion that is extremely bothersome to a child, we may want to do curettage to try to get the lesion off as quickly as possible. Cryotherapy has proven successful for patients with molluscum, with adults being more tolerant of it. However, cryotherapy can cause pigmentation issues in skin of color patients. DR

AAD annual MEETING

MARCH 27–31, 2026
DENVER, COLORADO

Level Up Your Learning at the AAD Annual Meeting!

Head to Denver for the can't miss educational meeting of the year. With 1,000+ expert speakers and 275+ sessions, this year's program offers fresh opportunities for every stage of your career, including **resident-focused sessions:**

- Gross & Microscopic Symposium
- Residents & Fellows Symposium
- Beyond the Boards
- Boards Blitz
- Resident Jeopardy
- Conquer the Boards

AAD Career Insights & Employment Fair

Thursday, March 26 | 2:00 p.m. – 5:30 p.m.

Discover unparalleled opportunities, insightful learning sessions, and connections with employers from across the nation. Join us for Career Insight Sessions 2:00 p.m. – 3:30 p.m. followed by the Employment Fair from 3:30 p.m. – 5:30 p.m. held at the Colorado Convention Center.

Resident Social

Thursday, March 26 | 6:30 p.m. – 9:30 p.m.

Exclusively for AAD Residents, food, drinks, games, and great connections — join us at Punch Bowl Social for a casual night of fun and the opportunity to connect with Young Physician mentors.

Returning in 2026

- **Opening Ceremony** to kick things off on Friday.
- **Member Welcome Reception** Friday evening.
- On-site **childcare** offered.

Learn more at **aad.org/AM6**

Don't wait, register now before prices increase February 25 at noon CT!

Inside this Issue

Chirag Vasavda, MD, PhD, is a PGY-3 at Harvard Combined Dermatology Residency.

Treating versus caring

When I walked into the clinic room, I could tell something was wrong. Worsening dyspigmentation, new atrophic plaques, progressive alopecia. His labs confirmed what I feared: persistent proteinuria and a rising creatinine. I reviewed his medications, wondering if the mycophenolate dose was too low or if it was time to escalate to belimumab. Before adjusting anything, I asked how he felt about his lupus. He paused, eyes downcast, "It's not the medicine, doc. It's the apartment."

This was not the response I was expecting. He explained that he had to move into a cheaper building, one with mold, pests, and poor ventilation. Since then, he felt like his lupus had spiraled.

He wasn't wrong. A growing body of evidence links air pollution and environmental toxins to lupus. No amount of immunosuppression could shield him from toxins at home.

Over the last few weeks, I've found myself thinking about patients like him often. Many of our patients have lost SNAP benefits, been furloughed, or worked without pay. Housing is unstable. Affordable Care Act subsidies are set to expire at the end of 2025, and health insurance premiums are higher across the board. For many of our patients, it's not the medicine — it's everything else.

When caring for a patient falls outside the comfortable confines of a prescription, I can quickly feel out of my depth. However, as dermatologists, we are uniquely equipped to help. The skin bridges the visible to the invisible, telling stories not only of autoimmunity and malignancy, but also of deprivation and discrimination. More recently however, I've reminded myself not to lean so much on my exam. Sometimes morphology can and should trump an incongruent history, but history often matters more. Take a moment to ask patients about food, employment, stress, and safety. Document barriers clearly so insurers and assistance programs recognize how they shape care. Finally, when possible, I've found it's worth calling or messaging social work directly rather than delegating the task to a patient who is already overburdened.

Being a good physician is more than just accurately diagnosing and treating — it's also about caring. In times like these, our patients may need us to care for them in ways we never have before. DR

American Academy of Dermatology | Association
9500 W Bryn Mawr Avenue, Suite 500
Rosemont, IL 60018-5216

DermWorld
directions in residency

Winter 2025

***DermWorld* Resident Advisor:** Chirag Vasavda, MD, PhD

Senior VP, Marketing and Communications: Melanie Hall

Senior Director, Communications: Katie Domanowski

Associate Director, Member Communications: Richard Nelson, MS

Senior Manager, Publications: Victoria Houghton, MPA

Senior Editor: Emily Margosian, MA

Senior Manager, Creative: Nicole Torling

Senior Designer: Theresa Oloier