DERMATOLOGY WORLD

DIRECTIONS *in* RESIDENCY

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Spring 2018

The power of service

Service can take a multitude of forms. Luckily, the Academy has many excellent opportunities for residents to provide service and get some unique education as well. The Academy knows that the key factor in providing service is time; however, some studies show that dermatologists are most likely to volunteer and provide service *during* residency.

DW Directions talked to three dermatologists who exemplify the impact of service through their work with the AAD. Although their accomplishments have been extraordinary, these dermatologists would like you to know that they felt their service was an honor and a duty to fulfill within their busy lives.

Accordingly, *DW-DIR* simply asked them: what, how, and why?

What were your first experiences in AAD service?

Casey Carlos, MD, PhD: I first became involved with the AAD as a resident when our program director encouraged us to apply to be part of a committee. I have served on the Volunteerism Committee and the Education and Volunteers Abroad Committee, which both work toward goals that are near and dear to my heart. They represent some of the best things the AAD does for our community. Through my work with the AAD, I can advocate for issues important to me, such as our continued support of health care for the underserved, volunteer work, and medical education. I've really enjoyed learning what the AADA (which encompasses the Academy's advocacy efforts) does by going to the House and Senate to advocate for our patients. Internationally, there are volunteer opportunities for teaching or clinical work through the AAD Resident International Grant or the AAD's partner program for volunteering with Health Volunteers Overseas. You can also continue your volunteer work locally with underserved clinics in your area or through the AAD's program with the Indian National Health System — known as the Native American Health Service Resident Rotation.

Kari Wanat, MD: I initially became involved with the AAD when I was a resident and my program director, William James, MD, introduced me to what the Academy can do for the dermatology community and the public. There were several service projects offered in conjunction with the AAD, including overseas volunteering through the Resident International Grant, volunteering through the SkinCare in Developing Countries Grant, and the chance to be on several committees. I have met so many amazing dermatologists and been part of teams that have done great work, in addition to fostering mentorship, and developing long-lasting friendships.

Gail Goldstein, MD: Initially, I volunteered for one-to-three week periods of international work. After several of these medical brigades, my physician husband and I decided that we wanted to work together as a family with our three daughters. We embarked upon a 10-month volunteer trip — a family gap year — in South America and Southeast Asia. We worked with eight different non-profit organizations, including HVO in Hue, Vietnam.

How can residents work service into their busy schedules?

Dr. Carlos: The time commitment to service with the AAD can be fairly minimal throughout the year. The

see **SERVICE** on p. 3

Casey Carlos, MD, PhD is assistant clinical professor of internal medicine, division of dermatology, at University of Washington School of Medicine, and practices at Dermatology Arts, Bellevue, Washington.

Kari Wanat, MD, is an assistant professor of dermatology at the University of Iowa.

Gail Goldstein, MD, is a dermatologist with the Annapolis Dermatology Center, Annapolis, Maryland.

What we do

1. "Dermatology in Action" during the AAD Annual Meeting in 2012. Dermatologists helped paint St. Vincent De Paul Village (a facility for housing the homeless) in the East Village of downtown San Diego. Left to right: Casey Carlos, MD, PhD; Ron Bernardin, MD; William James, MD; Campbell Stewart, MD; and Kari Wanat, MD. **2.** Dr. Carlos and Dr. James.

3. Kari Wanat, MD (in green) with local Tanzanian doctors Jesse Kitundu, MD, (far left) and Omar Juma, MD (center), plus University of Iowa medical student Brady Campbell, MD (second from left), and University of Iowa dermatologist Kanya Ferguson, MD (far right). Last year they all worked together at a local clinic in Zinga, Tanzania to help develop a collaborative relationship using teledermatology.

4. Gail Goldstein, MD, with a patient in Chonta Punta, Ecuador in 2016 where she volunteered her dermatologic services with Timmy Global Health in the Amazon region. **5.** Dr. Goldstein at a dermatology clinic in Sapa, Vietnam with Children of Peace International (COPI) nonprofit.

SERVICE from p. 1

AADA also offers opportunities to learn more about advocacy in dermatology for residents.

Dr. Wanat: Service is easy to incorporate through the AAD. There are many ways to get involved with service projects, committees, task forces, and local societies. Depending on your passions, there is always a way to get involved.

Dr. Goldstein: The AAD/HVO partnership in Hue, Vietnam (and other countries) is available for dermatologists who can serve for a minimum of two weeks. I know that every dermatologist can spend two weeks trying out volunteer service. You'll return refreshed, inspired, and with a new appreciation for the generous service you can provide with your specialized skills and knowledge.

Why do residents need to make time for service?

Dr. Carlos: The Academy is there to work with us throughout our careers. It will only be as good as we make it! It is important for all of our voices to be heard and the best way to do that is to actively participate.

I found it helpful to become involved as a resident so I could start to understand how the committees and councils worked. It was also helpful to be able to meet some of the more experienced AAD members and understand how they incorporated their AAD service into their careers. I think the AAD finds the residents' voices to be very helpful. We have a different and important perspective on some of the issues the AAD is facing.

Dr. Wanat: Giving back to the community and our organization is easy and fun through the AAD! Because we can shape our future and make a difference for others, I think it is so important. We as dermatologists often get a bad rap from other specialties, so helping others is one way to avoid this — plus have fun!

Dr. Goldstein: Volunteerism in dermatology not only helps the underserved patient, but also serves the dermatologist in so many ways. We are lucky to have jobs that consistently challenge us to learn more and improve our skills. Sometimes, however, we long for experiences that are different from our day-to-day jobs. When was the last time you brushed up on tropical dermatology? Do you remember what it feels like to rely only on your diagnostic skills, without the benefit of laboratory or pathology confirmation? Volunteering in underserved areas, particularly through the AAD-HVO (Health Volunteers Overseas) program, will challenge and reward you in the most unexpected ways.

See ways to get involved on page 7. **DR**

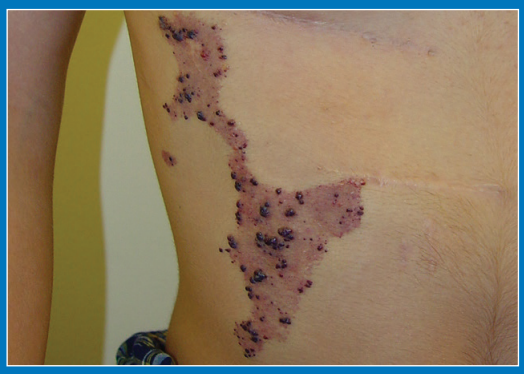
Join the Camp Discovery Residents Challenge

Residents can engage with fellow dermatology residents, and give kids with chronic skin conditions the chance to laugh and play at AAD's Camp Discovery. Featured at right (and on our cover) is happy camper Adrian Morales at Camp Discovery in Connecticut. Keep him smiling by signing up now at **www.aad.org/residentschallenge**. **DR**

Paul Gruber, MD, is a PGY-4 dermatology resident at Saint Louis University department of dermatology, St. Louis, Missouri.

Race for the Case

By Paul Gruber, MD



A 15-year-old Caucasian male presents with a focal irregular lesion on the right abdomen since birth. The lesion has grown progressively in proportion to the patient. It is asymptomatic in nature, but becomes intermittently irritated due to friction from overlying clothing. The patient is otherwise healthy with no other cutaneous lesions.

1. **What dermoscopic findings would you expect?**
2. **Which three genetic disorders can this condition be seen in?**
3. **Where on the body are these lesions most commonly found?**
4. **What are the most common management options?**

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

Race for the Case: Winner (Winter 2017)

Congratulations to Pooja Virmani, MD, PGY-2 for submitting the correct responses in the quickest amount of time! Dr. Virmani is a dermatology resident at Rutgers Robert Wood Johnson Medical School in New Jersey.

For the last Race for the Case, go to: **www.aad.org/RaceForTheCase**.

Vaccines in dermatology

By Caroline A. Nelson, MD

LIVE	INACTIVATED/KILLED	TOXOID	SUBUNIT/ CONJUGATE
Adenovirus Cholera (oral) **Influenza (intranasal)** **Measles, mumps, rubella** Polio (oral) Rotavirus **Smallpox** **Tuberculosis** Typhoid (oral) **Varicella zoster virus** Yellow fever **Zoster (Zostavax)**	Hepatitis A virus **Influenza (injection)** Japanese encephalitis Polio (injection) Rabies	**Diphtheria, tetanus, and pertussis**	Anthrax Haemophilus influenzae **Hepatitis B virus** **Human papillomavirus** **Influenza (injection)** **Meningococcus** **Pneumococcus** Typhoid (injection) **Zoster (Shingrix)**

VACCINE	ROUTINE INDICATIONS	SKIN REACTIONS/ COMPLICATIONS*	NOTES†
		Viral Infections	
Hepatitis B virus (HBV)	Infants at 0-, 2-, and 6-months of age and at-risk adults	Anetoderma, **granuloma annulare, lichen planus**, lichen nitidus, lichen striatus, **papular acrodermatitis of childhood (Gianotti-Crosti syndrome), polyarteritis nodosa**, and pseudolymphoma	**Patients without evidence of disease or immunity on serologic testing and with risk factors should be offered vaccination prior to immunosuppression**
Human papillomavirus (HPV)	**Gardasil and Gardasil-9: Patients 9-26 years of age** with a second dose after 6-12 months (patients 15-26 years of age should receive a second dose after 1-2 months and a third dose after 6 months) Cervarix is no longer available in the United States (US)	Localized lipoatrophy	Vaccines contain **L1 capsid protein** of specific HPV types: Cervarix has 16 and 18; **Gardasil has 6, 11, 16, and 18**; and Gardasil-9 has 6, 11, 16, 18, 31, 33, 45, 52, and 58 Can be administered regardless of history of abnormal PAP smear
Influenza	Patients ≥ 6-months of age each flu season (children 6 months-8 years of age may need two doses) **The intranasal vaccine is contraindicated in immunosuppressed patients**	**Lichen planus, linear IgA**, papular acrodermatitis of childhood, **serum sickness like reaction, and Sweet syndrome**	
Measles, mumps, rubella (MMR)	Children at 12-15 months and 4-6 years of age The vaccine is contraindicated in immunosuppressed patients	Faint morbilliform exanthem, morphea, papular acrodermatitis of childhood, and transient localized hypertrichosis **Most common cause of type I hypersensitivity** **Modified measles:** reduced severity disease after exposure to natural measles with less confluent exanthem, inconsistent presence of Koplik spots, and shorter course	Patients without evidence of disease or immunity on serologic testing should be vaccinated prior to immunosuppression
Smallpox (Vaccinia)	Patients at high risk of exposure **(not contraindicated in children)** The vaccine is contraindicated in immunosuppressed patients	**Auto-inoculation, contact transmission, eczema vaccinatum, erythema multiforme/Stevens Johnson syndrome, generalized vaccinia**, hypersensitivity reactions (exanthematous > urticarial > erythema multiforme-like), papular acrodermatitis of childhood, post-vaccination follicular eruption, **"robust take"** (plaque of erythema and induration > 10 cm at the injection site), superinfection, and vaccinia necrosum/ gangrenosum also known as **"progressive vaccinia"**	"High risk" includes military personnel and health care workers **Formation of a vesiculo-ulcer with 4 cm of erythema at the injection site is required to ensure adequate immunity** Bandage the injection site to prevent auto-inoculation and contact transmission Eczema vaccinatum can also occur in Darier's disease, Netherton syndrome, and other disorders of cornification Ocular implants, generalized vaccinia in the immunodeficient patient, eczema vaccinatum, and progressive vaccinia are indications for vaccinia immune globulin Vaccine also decreases severity of **Monkeypox**
Varicella zoster virus (VZV)	Children at 12-15 months and 4-6 years of age The vaccine is contraindicated in immunosuppressed patients	Zoster, pseudolymphoma, and **varicella-like eruption** **Modified varicella-like syndrome:** reduced severity disease after exposure to natural varicella with more macules and papules than vesicles, shorter course, and fewer lesions	Even **protects individuals who have never had seroconversion or whose antibody levels were undetectable from severe VZV disease** Patients without evidence of disease or immunity on serologic testing should be offered vaccination prior to immunosuppression Varicella-like eruption in leukemic children on chemotherapy may require acyclovir
Zoster	**Shingrix: Adults ≥ 50 years of age** with a second dose after 2-6 months Zostavax was recommended for adults ≥ 60 years of age (contraindicated in immunosuppressed patients); however, Shingrix is now recommended including for those who previously received Zostavax		**Shingrix is a subunit vaccine (HZ/su) containing recombinant VZV glycoprotein E and the $AS01_B$ adjuvant system that decreases risk of disease and post-herpetic neuralgia by >90%** 24 hours before until 14 days after you administer Zotstavax, antivirals should be stopped.

Caroline A. Nelson, MD, PGY-4 is a dermatology resident at the University of Pennsylvania.

Vaccines in dermatology *(continued)*

By Caroline A. Nelson, MD

VACCINE	ROUTINE INDICATIONS	SKIN REACTIONS/ COMPLICATIONS*	NOTES†
		Bacterial Infections	
Diphtheria, tetanus, and pertussis	DTaP: Children at 2-, 4-, 6-, 15–18 months and 4-6 years of age Tdap: Patients 11-64 years of age (once) Td: Patients every 10 years and after a severe and dirty burn or wound **(cat bite, dog bite, human bite, frostbite, myiasis, centipede bite, or brown recluse spider bite)**	Localized lipoatrophy, morphea, panniculitis, and papular acrodermatitis of childhood	Vaccination against diphtheria does not necessarily prevent cutaneous disease Td vaccination should be offered prior to immunosuppression
Meningococcus	Monovalent (MenB): Patients ≥ 10 years of age at increased risk of exposure and patients at 16-23 years of age to provide short-term protection with a second dose ≥ 1 month after Quadrivalent (MenACWY and MPSV4): Children at 11-12 and 16 years of age and patients at increased risk of exposure		"Increased risk" includes **asplenia, persistent complement component deficiency, and eculizumab therapy**, and, for the quadrivalent vaccine, **college freshmen living in dormitories and military recruits**
Pneumococcus	PCV13 ("Prevnar"): Children 2-, 4-, 6-, and 12-15 months of age, patients 2-64 years of age with certain health conditions, and adults ≥ 65 years of age PPSV23 ("Pneumovax"): Patients 2-64 years of age with certain health conditions, adults 19-64 years of age who smoke cigarettes or have asthma, and adults ≥ 65 years of age		**Patients should be vaccinated with PPSV23 prior to immunosuppression** **Immunosuppressed patients should be vaccinated with PCV13 followed by PPSV23 if not given previously**
Tuberculosis (Bacillus of Calmette and Guérin [BCG] strain of *Mycobacterium bovis*)	BCG is not routinely administered in the US but is recommended for infants and children at high risk of exposure and exposed health care workers in high-risk settings The vaccine is contraindicated in immunosuppressed patients	**"BCGitis"** (enlarging granulomatous plaque at the injection site), dermatomyositis, **disseminated disease, granuloma annulare**, lichen striatus, **lupus vulgaris**, pityriasis rosea-like eruption, **regional lymphadenitis, scrofuloderma**, Sweet syndrome, transient localized hypertrichosis, and the tuberculids: **erythema induratum, lichen scrofulosorum, and papular and papulonecrotic tuberculid**	**May result in false positive tuberculin skin test (TST)** **Chronic granulomatous disease patients are at particularly high risk of disseminated disease** BCG can also be used as **post-exposure prophylaxis for household contacts of leprosy patients** <12 years of age
		Melanoma	
Traditional tumor-associated antigen-based vaccines (e.g. **gp100 peptide**) and personalized neoantigen-based vaccines	Clinical trials	Trial data showing improved survival of melanoma patients	Vaccines stimulate the antitumor response, which consists of a **priming phase** (tumor antigens released by dying tumor cells captured by dendritic cells and presented to T lymphocytes) followed by an **effector phase** (immune response)

*All vaccines may cause injection site reactions and type I hypersensitivity (urticaria, angioedema, and anaphylaxis). **Nicolau syndrome may occur after intramuscular vaccinations. Aluminum-containing vaccines may cause nodules and foreign body reactions. Thimerosal-containing vaccines (a mercury-based preservative) may cause allergic contact dermatitis or eosinophilic cellulitis (Wells syndrome).**

†**Live vaccines are contraindicated in immunosuppressed patients** including those on high dose prednisone (equivalent to ≥20 mg/day of prednisone or ≥2 mg/kg/day in children weighing <10 kg), biologic agents such as tumor necrosis factor (TNF) inhibitors, interleukin (IL)-12, -23 inhibitors, IL-17 inhibitors, dupilumab, IL-1 inhibitors, rituximab, omalizumab, and Janus kinase (JAK) inhibitors.

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Boards Fodders online!

In addition to this issue's Boards Fodder, you can download the new online Boards Fodder at **www.aad.org/Directions.**

Go online for a very special Boards Fodder exclusive, Melanoma and Mycosis Fungoides by Parin Pearl Rimtepathip, MD, and Janna Mieko Vassantachart, MD.

To view, download, or print every Boards Fodder ever published, check out the archives at **www.aad.org/boardsfodder.**

Mallory Abate, MD, is an assistant professor at Saint Louis University in Missouri. Dr. Abate also recently completed her term as physician advisor for *DW Directions*. We are very grateful for her service!

Job Searching

Check out the Academy's online job board for help with job searching: **www.aadcareercompass.org**

Career Case Study

Career Case Study is a quarterly feature to help residents with choosing a subspecialty.

Next issue: Dermatopathology

Career case study

The academic dermatology career path

Mallory Abate, MD, interviewed by *DW Directions*

Why did you choose to pursue a specialty in academics?

I really like working with the residents and I like to teach. My niche is in inpatient dermatology. So, as the dedicated inpatient dermatologist at Saint Louis University (SLU), I get to see a lot of interesting hospital consults which I love. I have resident clinics, too, so academics provides a nice mix. In academics, you get to see a broad patient population, a lot of difficult cases and rare diseases, and teach residents at the same time, so every day is fun and challenging.

What personality traits are most desirable and helpful in this type of work? Is it more social or solitary; do you need good "people" skills?

Yes, it is definitely more social. For example, there are four other attendings plus residents at my workstation, so we are always interacting. However, you don't have to be a social butterfly by any means. We all have different personalities, which is what makes it work. You do need to be able to work well in a group setting and be able to teach. I would also say that curiosity is a trait that we all share — even as attendings, we still like to learn. There are weekly grand rounds, journal clubs, lectures, etc., so you have to enjoy this "academic" part of dermatology in order to thrive in this environment.

Describe a typical day. What are the various tasks? How much time are you spending with patients, office work, etc.?

My morning clinics start at 8 a.m. The resident sees the patient first and then we go in together. In the afternoons, I see GvHD patients in a bone marrow transplant clinic and then hospital consults after that, all with the consult resident. The vast majority of my day is spent seeing patients, reviewing results and signing charts, and teaching. I do spend a fair amount of time at night working on papers, and presentations, or reading on challenging cases.

Does the work vary at different times of the year?

Not much — I will say that clinics are slower in July because the new residents are just starting so everything is new to them. Then toward the end of the year, those clinics move much faster.

Is travel a factor in this profession?

This is very individual to the academic institution — at SLU, I do work at various locations, which requires frequent travel; however, a lot of this is by choice. But, in residency, all of our sites were connected or in close proximity.

What areas of your residency training and education are being put to use the most?

This is easy — all of them! Basic medical knowledge, teaching, time efficiency, etc. I am really glad that I trained at a VA. That has been essential in my education.

How does a career path in academics differ from other practice models?

As far as how the practice model compares to private practice, a major plus of academics is that you don't have any of the business stressors of private practice, so you are able to come to work each day and focus on medicine. On the flip side, the salary is going to be less and you aren't your own boss, so you can't, for example, take off on a last-minute vacation or choose which EHR you use. So, there are pros and cons, but more pros in my opinion.

In terms of need, workforce, and opportunities, how does it compare? Is it more difficult to land an academic dermatology position than another subspecialty?

There is probably a much broader selection of academic positions in general dermatology as compared to a subspecialty like dermpath or Mohs. This is because you need a larger ratio of general derms to subspecialists in order to support their caseload.

Are the networking opportunities any greater or different in an academic environment?

Definitely greater. Academics provides so many easy avenues for networking, both within the field of dermatology and beyond. This is because you are constantly surrounded by other physicians whom you can make natural, unforced connections with. Then you make connections through your new connections. You have the opportunity to give lectures to other departments and collaborate on mutual patients. Your colleagues are able to introduce you to dermatologists in other parts of the country — so yes, the opportunities are truly endless.

Is there something specific to academic dermatology that is personally rewarding to you? Why will residents feel satisfied in this choice?

I think a lot of people don't go into academics (vs. private practice) because of the salary, but job satisfaction is paramount and a life in academics is *incredibly* rewarding. If more people knew that, I don't think salary would factor in as much. I get satisfaction from being challenged, seeing cool cases, and from teaching residents. I have fun at work each day, and that is priceless in my opinion. DR

Act now! Service opportunities for residents

AAD Volunteerism: The Academy offers numerous opportunities for dermatologists to give back to underserved communities through public outreach at local, national, and international levels. **www.aad.org/members/volunteer**

Skin Cancer Screening: Residents are needed to help with hosting local free skin cancer screening events. **www.aad.org/communityprograms**

AAD Resident International Grant: The Academy offers funding for 15 residents to participate in a four- to six-week elective in Botswana to provide dermatologic HIV care for children and adults. **www.aad.org/members/volunteer/resident-international-grant**

Camp Discovery: Join other dedicated dermatologists who volunteer their medical services to kids living with chronic skin conditions at this weeklong summer camp experience. **www.aad.org/public/kids/camp-discovery**

State Societies: Membership in your state society keeps you engaged in local society activities and priorities. The AAD can help residents coordinate involvement with their local state societies. Contact Sandra Ring for more information at **sring@aad.org**. Or visit **www.aad.org/advocacy/state-societies**

American Medical Association: Membership in the AMA helps ensure that dermatology's voice is heard in the house of medicine. The Resident and Fellow Section (RFS) of the AMA offers opportunities to network and attend RFS meetings where RFS members influence policy on key resident and fellow issues, hear from nationally recognized leaders and attend education sessions. **www.ama-assn.org/membership** DR

Time saving tip: the art of pairing

By Afton Chavez, MD

My life-balance study tip? Pairing. And I'm not talking about food and wine.

Pairing is a step beyond multitasking. It's not just listening to Derm In-Review audio files while you're doing laundry, or memorizing Rapini on your iPad while you crush it on the stationary bike. For me, pairing is building positive associations with studying by combining it with activities that I love and make me feel good. This way, when I hit the books, it feels like a pleasant experience, and my mind is more open and willing to take in new information.

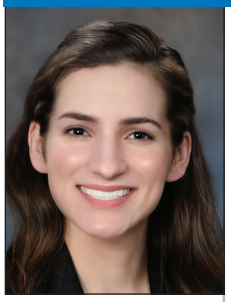
Paired associations create positive meaning (comfort, friends, fun, adventure), so you can recreate that pleasant feeling the next time you're studying, even if you're just sitting at your desk or in the library (what a treat! I get to memorize the genodermatoses!). DR

Afton B. Chavez, MD, is a dermatology resident at Brown University in Providence, Rhode Island. You can follow her on Instagram **@thatdermlife**.

How do you handle resident life?

Send your photos and pearls of wisdom to Dean Monti at **dmonti@aad.org**.

Inside this Issue



Tara Oetken, MD, is a PGY-2 dermatology resident at the University of Arkansas for Medical Sciences (UAMS), in Little Rock, Arkansas.

I am so honored and excited to be taking over as the next physician reviewer and columnist for *Dermatology World Directions in Residency*. Over the past two years, Mallory Shiver Abate, MD, has certainly set the bar high. I know we have all benefited from her hard work, and I promise to do my best to fill her shoes! I am currently finishing my PGY-2 year at the University of Arkansas for Medical Sciences (UAMS). This year, I have learned so much about the various aspects of dermatology. My goal in this column is to highlight high-yield topics for residents and learn with you along the way.

This issue discusses the idea of volunteering — a word that, at times, has a tenuous relationship to its meaning. It's no secret that sometimes volunteering feels more mandatory than not. So, after finally making it past all the hoops and hurdles, and into dermatology residency, am I seriously suggesting that volunteering is worth it? The answer is... yes!

To begin with, volunteering has tons of benefits, including being linked with higher levels of happiness, lower levels of depression, blood pressure, and even a longer lifespan. In one Harvard survey of weekly volunteers, 16% reported feeling very happy compared to the baseline — an increase which researchers said was comparable to a monetary raise of $55,000-80,000. So the next time anyone asks you why you volunteer, just tell him or her you do it for the money (sort of). In addition to making you happier, healthier, and "richer," volunteering can be a great way to become more involved in the dermatology community and network with peers. Of course, the biggest benefit (in my opinion) is always the people. Nothing makes our job cooler than the feeling we get from helping someone. As Michael Scott from *The Office* once said, it is a "win, win, win."

Okay, I've convinced you volunteering is great, now if you only had the time, right? Some ways I have recently tried to work around limited time include: writing my state and national elected officials regarding legislation, talking with my neighbor's English class students about what a career in medicine looks like, and attending dermatology interest groups for medical students. None of these things have been time intensive and that's okay! There is no right or wrong way to volunteer; there is, as they say, enough to go around. The most important thing is to get started, and I want to encourage each of you to dip your toe in the water. If you are unsure where to start, check out a list of Academy volunteer opportunities at **aad.org/members/volunteer**. No matter your interests or abilities, there is an opportunity waiting for you, all you have to do is take it!

I would love to hear from you on this topic — are there any special volunteer projects you or your residency programs are involved in? What ways do you think AAD could facilitate greater resident involvement? Email me at **taoetken@uams.edu** with any thoughts, questions, or other topics you'd like to see covered in future columns! **DR**

AMERICAN ACADEMY of DERMATOLOGY | ASSOCIATION
9500 W Bryn Mawr Avenue, Suite 500, Rosemont, IL 60018-5216

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