

Fall 2022



Should I stay or should I go? Choosing a career path after residency

By Tanya Greywal, MD, FAAD

While choosing a career path after residency can often feel daunting and overwhelming, it can also be an exciting and rewarding process. For most, the many years of training it took to become a dermatologist required following a set pathway. After residency, for the first time in a long time, one has the freedom to decide the next step. For those who want to remain at an academic institution, or for those who simply aren't sure about their next step, a position at the same institution in which they trained may be a good transition into clinical practice.

I recently surveyed several physicians who took their first job after residency at the same institution in which they trained, and I found many similarities in their experiences.

Why should I stay?

The transition into clinical practice after residency training is commonly described as having a steep learning curve. The first several years will push you to take more complete ownership of your patients, expand your clinical knowledge, and manage staff at a level you haven't experienced before. However, when staying at the same institution in which you trained, much of this transition becomes easier. You are already familiar with the system and personnel. You know how to use the medical record system, place orders, refer patients to other specialties, and navigate through clinic visits more smoothly. In addition, you will be able to seek help and advice from administrators or other dermatologists, who are now your colleagues.

see **RESIDENCY** on p. 3



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RESIDENCY from p. 1

When you are familiar with a particular division or department, you can more easily find your niche and role, since you are familiar with the needs of the institution and any open clinical, research, and teaching opportunities. In fact, having a close connection with your former co-residents, especially in the first few years as an attending, can provide you with more direct opportunities for resident education and research endeavors. You also have the ability to continue research projects that you may have started as a resident and enlist the help of other residents or medical students.

Attending where you trained

Training at a particular institution for several years can provide you with insight into areas that may need improvement. If so, you should ask yourself if these deficiencies are something that you can live with, especially since change is often slow or not possible.

When surveying those who graduated from residency and accepted an attending position at the same institution in which they trained, some reported that, to some extent, they were still being viewed as a resident, and sometimes even had attendings continue to refer to them as a resident and treat them as such. In addition, administrators and staff may not acknowledge and respect a recent graduate as much as they do other attendings. Many felt that this was specific to the familiarity attendings and staff had with one's role as a resident for several years, since other recent graduates who trained at a different institution were treated differently. For example, many reported being asked or assigned to less desirable clinics, call schedules, and other tasks that were not asked of equally junior attendings who trained at a different institution.

Don't forget to negotiate!

While physicians may feel that they cannot negotiate many terms of an employment contract when working at a training institution, this is particularly true for those residents seeking a position as an attending physician within the same institution. It is sometimes more difficult to ask for a higher salary when you are "negotiating" with mentors who supported you for so many years. In some cases, many accept less than what they deserve or are afraid to ask for more, as they do not want to seem ungrateful or affect their relationship with mentors or leadership. In addition, some institutions may take advantage of this power play and may even "low-ball" their residents with salaries and benefits that are not commensurate with what they offer other recent graduates who trained elsewhere. The best way to counter this is to educate yourself about what other institutions may be offering, so that you can better advocate for yourself when the time comes.

Weigh all options

Searching for your first job after residency should be an exciting process to find the best fit for your life and goals. While you will certainly hear a lot of opinions from those around you during this process, you should ask for what is important to you. Keep in mind that nothing is permanent; you always have the ability to change your position or work setting.

While there may be advantages and comforts if you continue to work in the same environment where you trained, you also owe it to yourself to weigh all your career options to find the best fit when you leave residency. But whatever you choose, establish your role as an attending early on. You've definitely earned it. DR



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Race for the Case



A 50-year-old female presented to the dermatology clinic with a 3-week history of two growing "bumps" on the midchest. She has no similar lesions elsewhere and no prior treatments attempted. No personal or family history of autoimmune disorders. A review of symptoms was negative, specifically for vulvar pruritus and dyspareunia. However, she did note that her gynecologist recommended starting hydrocortisone for an asymptomatic rash in her groin. Physical examination revealed two circinate atrophic ivory-colored papules with an erythematous rim and follicular plugging. Punch biopsy for H&E confirmed the suspected diagnosis.

- 1. What is your diagnosis and name the most common locations affected in this disease?
- 2. Name the antibody associated with this disease and the genodermatoses that share a genetic mutation in the same protein?
- 3. What are the characteristic findings on H&E?
- 4. Name several conditions that can be associated with this disorder?
- 5. What is the first-line treatment for active localized disease? Mention two other treatment modalities?

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

Race for the Case winner (Summer 2022)

Congrats go out to Pallavi Basu, MD, MPH, a PGY-3 at Stanford Dermatology who gave the most comprehensive answers in the quickest time. She is also featured in this issue's Resident Life section on page 7. If you win the latest case, there may be a Starbucks gift card in your future, **plus an invitation to contribute to our Resident Life section on page 7**! The race begins!

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Antiseptics and sterilization methods

By Stephanie Saridakis, DO, and Morgan Amigo, MD

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Morgan Amigo, MD, is a PGY-2 dermatology resident at OhioHealth Riverside Methodist Hospital.

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Agent	Mechanism	Onset	Advantages	Disadvantages	Residual activity	Comments
Alcohol (isopropyl and ethanol) 70%=optimal strength	Denatures pro- teins (bacterial cell walls)	Fastest (Skin must remain wet for 2 min for max effect)	Broad antimicro- bial coverage: G(+), G(-), mycobacteria, fungi, and many viruses	Inactive against spores and some nonenveloped virus- es. Not effective for soiled hands.	None, dissi- pates upon evaporation	• Inexpensive, but flammable!
Chlorhexidine (2-4%)	Disrupts cell membranes	Fast	Broad antimicro- bial coverage: G(+), G(-), mycobacteria, fungi, and viruses. Blood/sputum do not inactivate.	Inactive against spores; Risk of oto- toxicity and keratitis/ conjunctivitis. Risk of contact urti- caria, ICD, and ACD. Anaphylaxis rare.	#1 overall (>6 h, even when wiped from field; binds to stratum cor- neum)	• Longest acting
Chlorhexidine- isopropyl alcohol combination (Typically, 2% CHG and 70% isopropyl alcohol)	Denatures cell walls, disrupts cell membranes	Fast	Improved broad spectrum coverage: G(+), G(-), myco- bacteria, fungi, and viruses	Inactive against spores; ototoxic and ocular toxicity risk (CHG). Supplied as single-use applicator.	48 h	 Provides both short- and long- term effects More effective than povidone- iodine
Chloroxylenol (PCMX)	Deactivates enzymes, alters cell walls	Intermediate	Fairly broad-spec- trum: G(+) > G(-), mycobacteria, and viruses	Decreased efficacy in presence of organic materials.	Several hours; still not as long- lasting as CHG	• Ineffective against <i>Pseudomonas</i> unless combined with chelating agent like EDTA
Hexachlorophene	Inactivates enzymes	Slow	Strong effect against G(+) cocci	Ineffective against G(-), fungi and myco- bacteria. Neurotoxic in infants; teratogen.	Modest	 No longer in use High skin absorption
lodine and lodophors (e.g., Povidone-iodine)	Oxidation leads to disruption of protein syn- thesis and cell membranes	Fast (Must wait for it to dry to be effective)	Very broad cover- age: G(+), G(-), bacterial spores, mycobacteria, fungi, and viruses	Skin irritation and discoloration. Inactivated by blood and sputum. ACD/ ICD risk. Chronic maternal use → risk of neonatal hypothy- roidism	Minimal, especially if wiped from skin	 May cross-react with iodine in radiocontrast media and iodides in medi- cations Stains fabrics
Quaternary ammonium com- pounds (e.g., Benzalkonium)	Induces leaks in cytoplasmic membranes	Slow	G (+) and lipophilic viruses	Ineffective against G(-), mycobacteria and fungi; inactivated by organic materials and cotton gauze. ACD risk > ICD	Good	• Also found in cosmetics and ophthalmic solutions
Triclosan	Alters cytoplas- mic membrane and synthesis of RNA, fatty acids, and pro- teins	Fast	Broad coverage: G (+), mycobacte- ria, and candida; not inactivated by organic material	Ineffective against G(-) and filamentous fungi	Good	• FDA banned use in certain OTC antiseptic products for use in health care setting
Soap and water	Detergent; removes dirt, organic substanc- es; disinfects.	Very rapid	Highly effective against <i>C. Difficile</i> and Norwalk virus	Skin irritation	None	• Most appropri- ate for soiled hands

Antiseptics

Additional Considerations:

- Antiseptic solutions may become contaminated and support bacterial growth (e.g., Serratia colonizing chlorhexidine bottles) leading to infection

Do not shave prior to procedures, it is best to use clippers and/or chemical depilatories right before procedure. However, lowest risk of infection when hair is left intact within the surgical field.

- Hand hygiene: alcohol or alcohol plus chlorhexidine reduces bacterial counts the most.

Abbreviations:					
ACD = Allergic contact dermatitis	h = Hours	CHG = Chlorhexidine gluconate	ICD = Irritant contact dermatitis		
G (+) = Gram positive	OTC = Over-the-counter	G (-) = Gram negative	PCMX = Parachlorometaxylenol		

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Antiseptics and sterilization methods

By Stephanie Saridakis, DO, and Morgan Amigo, MD

Sterilization methods:					
Method	Advantages	Disadvantages	Settings		
Steam autoclave	Most popular in office settingEasiest/safest	 Corrosive → may dull sharp instruments 	 Specific settings required (20-30 min at 2atm pressure & 121°C) 		
Chemiclave	 Lower humidity than steam, therefore less damage to sharp instruments 	 PPE & ventilation, cannot be used in small spaces 	 Special chemical required (mix- ture of formaldehyde, methyl ethyl ketone, acetone, and alcohols) 		
Dry heat (oven)	InexpensiveNo risk to instruments	Cannot use cloth, paper, or plastic	 High temperature, longer dura- tion (1h at 171 °C; 6h at 121 °C) 		
Gas sterilization	 Mostly used in hospitals since better for large volumes Effective for heat and moisture-sensitive instruments 	Expensive equipmentToxic and mutagenic gas	 Longer durations (1 day for paper, 7 days for polyvinyl chlo- ride) 		
Cold sterilization (glutaraldehyde or ortho-phthalal- dehyde solutions)	 Simple and inexpensive Used for heat-sensitive equipment 	 ACD risk due to glutaraldehyde Not recommended as only method; instruments must be used immediately, cannot be wrapped Not always effective against bacterial spores (ortho-phthalaldehyde has greater sporicidal activity) or hepatitis B virus 			

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Got Boards?

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AAD welcomes new Boards Fodder chart ideas.

View the Boards Fodder guidelines for submission at www.aad.org/member/publications/more/dir.

Contact DermWorld Directions Editor Dean Monti at dmonti@aad.org.

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More boards!



There's more new charts online! We recently posted an extended chart on **Mohs micrographic** surgery by Michael

J. Visconti, DO, Emily R. Davis, DO, Brayden J. Healey, DO, and Kent J. Krach, MD, FAAD; plus a new chart on cutaneous

squamous cell carcinoma staging, risk classification, and management by

Hope Barone, DO. Check out the full archives at **www.aad.** org/boardsfodder.



H. William Higgins II, MD, MBE, FAAD, is assistant professor of dermatology at Perelman School of Medicine at the University of Pennsylvania in Philadelphia.

Clinical Pearls

Clinical Pearls help prepare residents for the future by providing them with top tips from experts about what they should know about specific, key subject areas by the time they complete their residency.

Scar revision pearls

By H. William Higgins II, MD, MBE, FAAD

1) Z-plasty is a scar revision staple!

Z-plasty is an invaluable tool for scar revision that can be utilized to correct free margin distortion (ectropion, eclabium), address webbing of areas such as the medial canthus, and to revise prior straight-line closures with a more camouflaged geometric design. They can be single or multiple depending on the desired degree of movement. A z-plasty restores free margin contour by effectively lengthening a scar. For correct design, the "belly" or middle line of the z-plasty should be oriented parallel to the desired direction of lengthening. The angles on the associated limbs can be adjusted accordingly to add length (i.e., 30-degree angles lead to 25% increase in length; 60-degree angles lead to a 75% increase in length).

2) Don't botch the alar notch.

There are various options for correction of alar notching, including z-plasty, turnover flap with overlying full-thickness skin graft¹, and a "stair step flap."² The choice will depend on the degree of notching and location, medial or lateral, along the alar rim.

3) Don't forget the Y-V advancement flap.

The Y to V advancement flap is a useful alternative to a z-plasty for repairing medial canthal webbing. It should be designed so the forked aspect of the Y is pointing laterally. A Y-shaped incision is made, and the flap is advanced medially to create a V-shaped closure. This allows for recreation of a natural and more symmetric contour of the medial canthus.

4) Don't forget the V-Y advancement flap.

V-Y advancement flap is an excellent revisionary option for cicatricial eclabium of the upper or lower lip. It can be used alone or combined with z-plasty(s) to enhance movement. A V-shaped flap is designed with the V opening toward the direction of desired movement. The V-shaped lines are incised, and great care must be made to undermine/release any pre-existing scar tissue at the area as this will otherwise limit movement of the flap. The flap is then advanced to create a Y-shape closure, with closure of the secondary defect creating the stem of the Y.

5) Camouflage with broken lines.

Geometric broken line repairs can be utilized to revise conspicuous linear scars on the head and neck. The idea being the geometric lines are less conspicuous to the naked eye than a depressed linear closure. Great care must be taken when suturing these repairs to provide good approximation and eversion of the merged skin edges.

6) Master the lateral tarsal strip. The lateral

tarsal strip is a more advanced technique that can be utilized during large repairs (i.e., cervicofacial flap near the lower lid, to reinforce correct position of the lower lid, or months after the initial reconstruction to repair cicatricial ectropion). The surgeon must first release the lower crus of the lateral canthal tendon, strip the anterior lamella off the tarsal plate, trim the lateral aspect of the tarsal plate, and suture the tarsal plate in a superolateral position at Whitnall's tubercle, a small bony prominence within the lateral aspect of the orbital rim.

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Dr. Higgins would like to thank the speakers who contributed to the Derm Labs: Scar Revision session at the AAD 2022 Innovation Academy: Dr. Ally-Khan Somani, MD, PhD; Travis Blalock, MD, FAAD; Jerry Brewer, MD, MS, FAAD; Dan Eisen, MD, FAAD; and Thomas Jennings, MD, PhD.

More Clinical Pearls online!

The AAD has compiled its Clinical Pearls archives from the pages of *DermWorld Directions in Residency*.

The popular feature provides residents with useful tips from experts in dermatology.

Learn more by visiting the archives at www.aad.org/member/publications/more/dir/clinical-pearls.

Resident Life Mentorship matters

By Pallavi Basu, MD, MPH

"Hi Dr. O, are you in Maine next weekend? My partner and I will be visiting Acadia - would love to stop by and say hello." I quickly jot down these words in an email to my former dermatology research mentor, Suzanne Olbricht, MD, FAAD, while planning an excursion to Acadia National Park in Maine. It is fall of 2020, and I am savoring the thought of escaping the perceptible claustrophobia the pandemic has created. And like so many others, I am finding that the burden of physical isolation seems to pale in comparison to the emotional distance from family, friends, and colleagues. So, it is with delight that I read Dr. Olbricht's response just a few minutes later — "Yes, please come spend some time with us in our backyard! I'll get some of my favorite lobster rolls."



Mentor Suzanne Olbricht, MD, FAAD (left) with mentee Pallavi Basu, MD, MPH (right) at Dr. Olbricht's home in Maine.

Needless to say, they are phenomenal lobster rolls. As a lover of seafood, they are almost as memorable to me as the gorgeous hikes in Acadia during the fall season. But more importantly, the conversations I have with Dr. Olbricht feel incredibly grounding after the universally rocky transition from medical student to COVID-era hospital intern. Hearing about Dr. O's current personal projects, professional pursuits, and most of all, practice reflections serve as a much-needed reminder of what lies beyond the upcoming months of critical care medicine rotations.

Dr. Olbricht, as many know, has carried a staggering number of professional roles: former president of the American Academy of Dermatology and chair of dermatology at Beth Israel Lahey Medical Center, among many other leadership positions. Yet what renders her such a wonderful mentor is her down-to-earth personality and wide range of interests, not only professionally but also personally. Whether it is inviting me to Turkish classical music concerts or taking me out for Indian food in Boston with her family, the sense of self she cultivates alongside her professional ambitions have informed my own lofty hopes for work-life balance.

Why is this kind of mentorship so important? It is no secret that medical training is pervaded by social disparities, a "hidden" curriculum, and often unrealistic or demanding work expectations. As a woman in medicine, an immigrant, and first doctor in my family, having strong female mentorship in Dr. Olbricht and many others in medical school was and continues to be integral to my personal and professional well-being. As Carla Harris, vice chairwoman of Morgan Stanley, explains in her book *Expect to Win*, it is only when we participate in the informal and more personal conversations with our professional supervisors that we start to realize how important those conversations are in shaping our next steps.

As a resident, I am constantly discovering that the clinical knowledge curve is steep and can overshadow the expansive abyss that is our post-training career. Taking advantage of opportunities to connect with my faculty at Stanford has already yielded invaluable insight into potential career trajectories and barriers that may arise along the way of each one. It has become a standing goal to continue to explore those paths this academic year, to participate in the informal conversations whenever possible, and to then foster such opportunities for more junior trainees. And as Dr. Olbricht reminded me at the 2022 AAD Meeting, when we celebrated her upcoming retirement, she is always available should I need her input along the way. DR

Pallavi Basu, MD, MPH, is a PGY-3 dermatology resident at Stanford Dermatology.

Inside this Issue



Naomi Briones, MD, is a PGY-4 dermatology resident at University of Michigan in Ann Arbor, and a member of the AAD Resident and Fellows Committee.

After the proverbial drinking from a fire hose that characterized my medical school experience, I found dermatology training to be just as information dense. Learning the fundamentals as a medical student was a new language in and of itself and dermatology has certainly been no different. This fall, with first years orienting themselves to this new language and senior residents studying for core exams or applying for jobs, days fill up quickly with studying, clinic responsibilities, research projects, and applications. As we settle into the new academic year and consider these many priorities, I encourage you to keep wellness top of mind. I am not just referring to yoga and mindfulness (although both have value).

Our dermatology department at University of Michigan has worked on a longitudinal wellness initiative the past several years, and, along with one of my peers, I am helping lead our residency efforts for 2022. When we drew up our mission and goals, we agreed our priorities should be to address multiple dimensions of wellness in creating a well-rounded curriculum. This included adding events to deepen a sense of belonging and camaraderie: departmental ice cream outings, tailgating, faculty-hosted dinners, and a variety of resident socials, just to name a few. However, we also sought to address other facets of wellness, such as physical and financial health through funding for group sports (shout out to the 'Derminators' softball team) and invited speakers on contract negotiation and retirement planning. Based on feedback from residents, we will also allocate funding to improve resident spaces, including adding workstations, updating décor, and supplying snacks at our various clinic sites.

Entering a more formal role with wellness initiatives has encouraged me to be more thoughtful about my own wellbeing. As many of my loved ones are spread out across the country, I am committed to approaching my relationships with more intention. Now that COVID waves have slowed in some areas, I hope to allow myself more time to travel and reconnect in person. And with the wealth of wonderful friends and mentors close by, I am saying 'yes' to an increasing number of informal local gatherings. So, as we approach the winter months, especially for those of us in northern latitudes, please continue to take great care of patients and each other, but please also keep wellness in mind and take care of yourself.

What are you or your residency programs doing to enhance wellness in your department? I'd love to hear from you! You can send feedback to **nbriones@med.umich.edu**. **D**R

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