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

A structured approach to dermatology residency learning: A year-by-year guide

By Morgan Murphrey, MD, MS, FAAD

Learning and understanding the wide field of dermatology requires a blend of broad foundational knowledge, image-based recognition, and clinical reasoning. Success hinges on clinical experience, a structured approach to learning dermatology, and adequate preparation for in-training and board examinations. This article provides a year-by-year guide to studying and learning during dermatology residency, highlighting strategies, resources, and milestones along the way.

Year 1: Building your bookcase

The first year of dermatology residency is dedicated to laying the groundwork for your career as a dermatologist. Early in the year, familiarize yourself with your program's didactic schedule and establish your own personal schedule in tandem. Continue the strong study habits you honed in medical school to ensure you get through the wealth of material that this specialty covers.

Textbooks remain the backbone of dermatologic education. Among the most widely used are *Dermatology* by Bolognia and Fitzpatrick's *Dermatology*. For dermatopathology, Elston's *Dermatopathology* is frequently recommended. There are many options out there, so pick one and stick with it to avoid redundancy and information overload. Review texts, such as those by Jain and Alikhan, can serve as supplementary resources.

The focus during first year should be breadth, rather than depth. During this first year, you are building a mental bookshelf, recognizing clinical patterns and categorizing diseases, with a focus on developing your expertise in morphology. Building your foundation is the first step before later mastering and memorizing the esoteric details.

In March, residents take the Basic Exam, which is primarily a self-assessment tool. Instead of focused preparation for the exam, or last-minute review, use this test as an internal control. It should serve as a benchmark of progress over your first 10 months of residency and highlight weak points for future focus.

Year 2: Putting the books on your bookshelf

In this second year of residency, you will begin to organize the books for your bookshelf. This year also introduces the series of CORE exams, which are critical milestones in your residency training, and must be successfully completed prior to taking your boards upon graduation. There are four unique assessments: medical dermatology, pediatric dermatology, dermatologic surgery, and dermatopathology.

The CORE exams are offered four times across residency (February, July, November, and the following February). Residents may take 1-4 examinations per

see **LEARNING** on p. 3

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RISK IDENTIFIED

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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 into your practice

LEARNING from p. 1

session. While some choose to spread the exams out, most opt to "double up" at least once, completing the series in three sittings.

Preparation for your CORE exams will likely include multiple resources. High-yield review books such as Alikhan and Jain remain popular. Question-based platforms, including DermQBank, AAD Board Prep Plus (**www.aad.org/member/education/residents/board-prep**), and Derm-In-Review, provide opportunities for active recall and application. *Self-Assessment in Dermatology* is another commonly utilized text. Additionally, Dr. Mariwalla's *Boards University* video series is highly regarded for its concise, board-oriented review of key topics, interactive sessions, and guest lecturers.

Most residents take their first one or two CORE exams in February of their second year. Establishing a structured study schedule and progressively integrating question-based learning will optimize performance and retention, setting you up well for your board examination.

Year 3: Using (and enjoying!) your bookshelf

Congratulations on making it to your third year of dermatology residency; this is an exciting accomplishment! By your third and final year, preparing for your BASIC and CORE examinations, in addition to your clinical practice, have helped you establish a strong foundation. Now, focus on putting this newly mastered information to good use. You should work to integrate your knowledge, and ultimately, prepare for the American Board of Dermatology (ABD) Applied Examination.

During this senior year, residents typically complete their remaining two or three CORE exams. It is critical to keep up your momentum. At this stage, your studying should evolve beyond fact recall, and into a deeper understanding of disease mechanisms, diagnostic pathways, and therapeutic decision-making. When you see patients, think through the case and commit to a decision. Imagine what you would do if you were on your own, without an attending guiding your plan.

When it comes to studying for boards, an important component of exam preparation is reviewing Kodachromes, image-based slides that form the backbone of dermatology board testing. When you review these images, go beyond identification and test yourself on associations, next steps in management, and appropriate therapeutic interventions. This approach mirrors the style of questioning in the Applied Examination, which emphasizes clinical reasoning in addition to recognition.

The examination timeline for senior residents is demanding. Many will sit for CORE examinations in July and November, with a final opportunity in February if needed. Shortly thereafter, attention turns fully to the Applied Examination, typically administered in July.

Final thoughts

Dermatology residency requires a thoughtful, staged approach to learning. You will progress from broad foundational knowledge in the first year, to detail-oriented mastery during CORE preparation, to integrative reasoning and board readiness.

Key strategies across all years include:

- Establishing consistent study habits
- Selecting a manageable set of core resources
- Progressively incorporating active learning tools such as question banks and image review

The Basic Exam provides an early opportunity for self-assessment, the COREs allow for dedicated focus on subspecialty knowledge, and the Applied Examination ultimately synthesizes your three years of learning.

Approach residency learning with a deliberate plan, and don't forget to collaborate with co-residents and friends along the way. You've got this! DR

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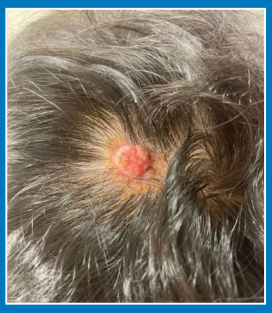
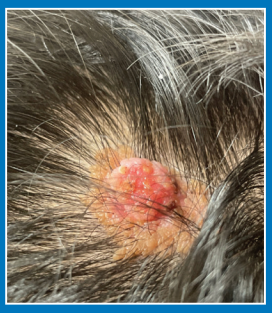
Race for the Case

By Madeleine Medvedev, MD, and Alejando Barrera-Godínez, MD, IFAAD





A 22-year-old male patient with no significant past medical history presents to clinic with a "spot on the scalp." It was present since birth, though over the past few years has been growing and bleeding. Initially, it was not bothersome though more recently can be tender on palpation. The patient denies a personal or family history of skin cancer.

1. **Biopsy showed a typical "fjords and fronds" appearance. What other cell type would be present (usually within the cores of the fronds)?**
2. **Based on the diagnosis, within what primary lesion did this occur?**
3. **What is the most common secondary neoplasm that can occur within this patient's primary lesion?**
4. **What is the main histologic differential diagnosis of this lesion? On histology it would show a maze-like configuration and usually occurs on the vulva/perineum.**
5. **If this lesion was not removed via biopsy for this patient, is there a high likelihood of malignant transformation?**

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

Race for the Case winner (Summer 2025)

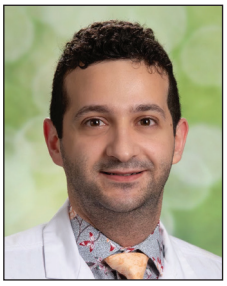
The winner of the summer 2025 Race for the Case is Cynthia Chan, MD, a PGY-5 dermatology/dermatopathology fellow at Montefiore Medical Center. Dr. Chan correctly identified VEXAS syndrome in our latest Race for the Case and provided the most accurate responses in the quickest time. Congrats to Dr. Chan!

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**.

Flap update 2025: Part 1 sliding flaps

By Vixey Silva, DO, Mohammad Fardos, DO, and Cynthia Bartus, MD, FAAD

Vixey Silva, DO, is a PGY-4 at HCA Healthcare/USF Morsani College of Medicine GME: HCA Florida Largo Hospital, in Largo, Florida.



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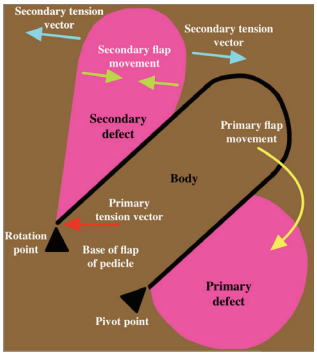
Terminology

Body: Portion of skin that is advanced, transposed, rotated, or interpolated into the primary defect site.
Pedicle: Vascular base of the flap that remains intact to preserve blood supply to the flap body.
Primary defect: Area devoid of skin that receives tissue from the flap.
Secondary defect: Donor site from which tissue is mobilized to create the flap; results in a new defect.
Primary flap movement: Initial motion of the flap required to close the primary defect.
Secondary flap movement: Additional tissue movement needed to close the secondary defect created by the flap's mobilization.
Primary tension vector: Direction of force resisting the movement of the flap into the primary defect.
Secondary tension vector: Direction of force generated during closure of the secondary (donor site) defect.
Flap tip: Distal portion of the flap farthest from the pedicle and blood supply; area most vulnerable to ischemia and necrosis.

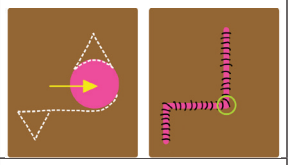
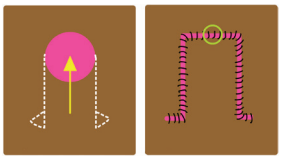
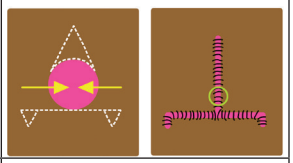
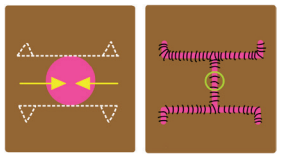
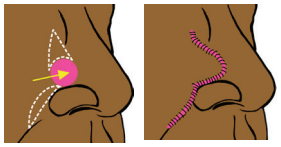
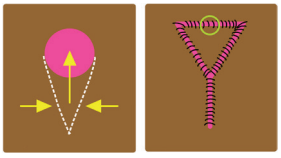


Pivot point: Fixed point at the base of a flap around which the flap moves. Adequate undermining is necessary for optimal mobility.
Key stitch: First suture placed to secure and accurately position the flap into the primary defect; ensures proper alignment and distribution of tension.

Note: The grouping of advancement and rotation flaps in this section (Part 1) reflects their shared primary movement of sliding tissue into the defect.
*__Key stitch__ locations are marked with a **green circle** where applicable on the flaps described below

Advancement flaps

- **Primary movement:** Slides tissue unidirectionally or bidirectionally; results in a series of straight lines upon closure.
- **Tension vector:** Tension remains in the direction of flap movement without alteration of wound's original tension vector.
- **Considerations:** (1) Moves tissue directly forward in a linear direction to close a defect while displacing Burow's triangles away from free margins to minimize distortion of critical anatomical structures. (2) Random pattern flaps relying on the subcutaneous and dermal vascular plexus for survival. (3) Designed with tangents (a line that touches a curve/curved surface at a single point without crossing into the curve's interior) in mind to ensure smooth closure and optimal tension distribution.

Type	Description	Image
Unilateral advancement flap (O to L)	**Design:** Utilizes two asymmetric Burow's triangles to advance tissue into the defect. Takes advantage of tissue laxity on one side, creating "L-shaped" closure. **Locations:** Forehead and nose, particularly for nasal tip or sidewall defects. **Considerations:** Often referred to as the "east-to-west" flap when used on the nasal tip.	
Unilateral double tangent advancement flap (O to U)	**Design:** Utilizes two parallel tangents and Burow's triangles to advance tissue into the defect, creating a "U-shaped" closure. **Locations:** Helical rim and suprabrow region. **Considerations:** Due to its small pedicle, this flap is prone to ischemia.	
Bilateral single tangent advancement flap (O to T)	**Design:** Advances tissue from opposite sides of the defect along a single tangent, creating a "T-shaped" closure. **Locations:** Forehead, suprabrow, and chin. **Considerations:** Height of the flap should be twice the diameter of the defect.	
Bilateral double tangent advancement flap (O to H, H-plasty)	**Design:** Advances tissue from both sides along two parallel tangents, creating a "H-shaped" closure. **Locations:** Used for defects on the mid-forehead, suprabrow, and glabella. **Considerations:** Can result in forehead numbness due to long horizontal incision lines.	
Crescentic advancement	**Design:** Excision of a crescent-shaped area of skin adjacent to the defect enables tissue advancement and linear closure. Primary movement is unilateral (lateral to medial). **Locations:** Medium-to-large defects of the medial cheek, nasofacial sulcus, and lateral nose. **Considerations:** Some view it as a variation of a linear closure, while others consider it a modified version of an O to L flap.	
Island pedicle (V-Y advancement flap)	**Design:** A triangular flap completely separated from adjacent lateral skin retaining an underlying vascular pedicle attached to the subcutis. **Locations:** Small to medium wounds on the upper cutaneous lip, nasal ala, lateral brow, nasal dorsum, cheek, and forehead. **Considerations:** (1) 40-50% of the pedicle should remain intact to enhance flap survival. (2) Length should be 3-4 times the width of the surgical defect.	

Flap update 2025: Part 1 sliding flaps

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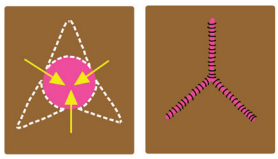
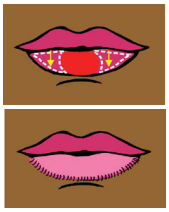
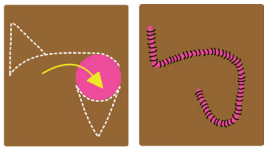
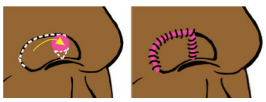
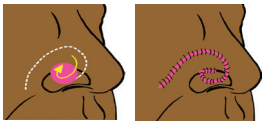
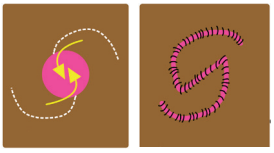
Type	Description	Image
Mercedes flap (Triple advancement flap)	**Design:** Three advancing triangular flaps arranged around a central defect. These flaps are designed to advance into the defect area with minimal tension. **Locations:** Scalp, trunk, temples **Considerations:** Simultaneous excision of Burrow's triangles can be an effective technique for full-thickness skin transplantation in cases of large defects or defects in challenging areas. **Disadvantages:** (1) Star-like appearance may be undesirable in highly visible areas (e.g., cheeks, forehead). (2) Risk of dog-ear formation or excessive tension if not carefully designed.	
Mucosal advancement flap	**Design:** Involves advancing mucosal tissue to restore the vermilion of the lip. **Locations:** Lip **Considerations:** (1) Undermine deep to the minor salivary glands and superficial to the orbicularis oris muscle. (2) Temporary loss of sensation in the reconstructed area may occur. **Disadvantages:** May result in increased vermilion show; alternatively, this may be an advantage for some patients.	
Rotation flaps • Primary movement: Rotational movement around a pivot point; requires extensive undermining at areas of pivotal restrain. • Tension vector: Redirects primary tension vectors away from free margins; ideal for defects near arcing junctions of cosmetic subunits or curved relaxed skin tension lines. • Considerations: (1) Flap arc length must be significantly longer than the primary defect's width. (2) Flap height must exceed the defect's height to compensate for functional loss when rotated. (3) Use of back-cuts or Burow's triangles can increase flap mobility and reduce tension.		
Single curvilinear tangent advancement (Standard rotation flap, Mustardé flap)	**Design:** Utilizes a single curved incision line to rotate tissue into the defect. The Mustardé flap uses cheek and temple skin to close lower eyelid or infraorbital defects. The flap's primary motion supports the lower eyelid. **Locations:** Cheek, chin, mental crease, and scalp.	
Dorsal nasal flap (Rieger flap)	**Design:** Displaces the Burow's triangle from the nasal tip to the glabella and follows an arc that extends from the inferior aspect of the defect to the nasofacial sulcus and onto the glabella. **Locations:** Moderately sized distal nasal defects. **Considerations:** (1) The angular artery is the major source of blood supply for this flap. (2) The body of the flap must be dissected just above the perichondrium. (3) The medial canthal tendon acts as the pivotal restraint. **Disadvantages:** (1) Potential for transposition of thick glabellar skin onto the medial canthus. (2) Potential "pig-nose" deformity due to inadequate undermining and unwanted secondary tension vectors.	
Alar rotation	**Design:** Utilizes a crescent-shaped incision along the alar groove to rotate tissue into the defect. **Locations:** Small defects on the nasal ala. **Disadvantages:** Contraction may result in alar notching.	
Spiral rotation	**Design:** Utilizes a curved incision to follow the natural contours of the nasal ala and sidewall; elevated tissue rotates into the defect in a spiral pattern. **Locations:** Larger defects of the nasal ala and lower nasal sidewall.	
O to Z (double rotation flap)	**Design:** Utilizes two rotation flaps starting at opposite ends of the defect with both incisions taking off in the same direction (either clockwise or counterclockwise). **Locations:** Large defects on the scalp. **Considerations:** Prominent incision lines.	

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More study charts online!

There are a lot more Boards Fodder charts online! In addition to the flaps chart in this issue, you can view our new **FDA-approved systemic therapies for atopic dermatitis** chart by Layan Al-Sukhni, MD, Hannah R. Johns, MD, and Tejesh Patel, MD, FAAD.

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

Jenny Murase, MD, FAAD, is associate clinical professor in the department of dermatology at the University of California, San Francisco. She is also the director of the pruritus and dermatitis specialty clinic at the Palo Alto Foundation Medical Group.

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.

Management of dermatitis and pruritus

By Jenny Murase, MD, FAAD

Pearl #1: Ask staff to conduct a numeric rating scale (NRS) at every intake for your patients presenting with itch and/or rash. Also consider having staff ask about sleep disturbance and distraction from activities during the day due to itch. The pruritus NRS is phrased, "In the past 24 hours, what is the worst itch you have experienced on a scale of zero to ten." Itch is invisible but has a dramatic impact on quality of life. You will approach your patient completely differently if they have an NRS of nine versus an NRS of one. All too often, our most miserable and undertreated patients have little to see on the skin, but their degree of pruritus is life-altering and goes unnoticed by those caring for them.

Pearl #2: If you have a younger patient with severe pruritus who has little to see on the skin, be afraid. Use the diagnostic testing that we have available to screen for malignancy and metabolic conditions (see doi: 10.1016/j.jaad.2025.03.047 for a guide). Obtain a chest X-ray to rule out Hodgkin's Lymphoma. Screen for hepatic, renal, thyroid, celiac, and parathyroid diseases; diabetes; and blood dyscrasias. We have powerful therapeutics now available to control pruritus — wield them responsibly by doing the appropriate testing for your patient prior to initiating treatment.

Pearl #3: Understand that there is a difference between a reasonable therapy that fails the patient and the physician who fails the patient due to inappropriate or insufficient diagnostic testing. In performing nearly 7,000 consultations for dermatologists and allergists in the Bay Area, I have repeatedly cleared patients labeled as "dupilumab failures" with "topical steroid withdrawal" using topical steroids and dupilumab in otherwise purportedly recalcitrant cases (see reference 3 for a case of a woman who was bedbound and unable to work for years). By uncovering the underlying allergic contact dermatitis with patch testing or identifying a causative organism with bacterial culture followed by decolonization of their home environment, you will find that our relatively safer systemic therapeutics work much more effectively when underlying concomitant conditions are identified and treated.

Pearl #4: Master the Yin-Yang. Use a graphic when describing the impact of skin disease and therapeutics during patient care to improve patient understanding and compliance with proposed therapy. Explain the difference between therapeutics impacting cell-mediated immunity that suppress the "soldiers" of the immune system (the Th1/Th17 component) that require monitoring of blood counts versus those that solely affect the Th2 arm. Explain how both immunologic eruptions of aging ("itchy red bump disease" in the elderly) and pregnancy can shift patients to become more Th2-dominant.

Pearl #5: Understand how the balance between the Th1, Th2, and Th17 arms of the immune system is affected by therapeutics and how they result in paradoxical reactions. Th2 blockade with agents such as dupilumab, tralokinumab, and lebrikizumab will reduce Th2 immunty and increase Th17 signaling, resulting in psoriasiform reactions in our patients with eczematous dermatitides. IL-17 or 12-23 blockade will blunt Th17 activity and increase Th2 signaling, resulting in eczematous dermatitis in our psoriasis patients. Suppression of Th1 axes can result in "psoriasiform spongiotic dermatitis" that clinically mixes both psoriasis (from the Th17 relative increase) and eczema (from the Th2 relative increase). DR

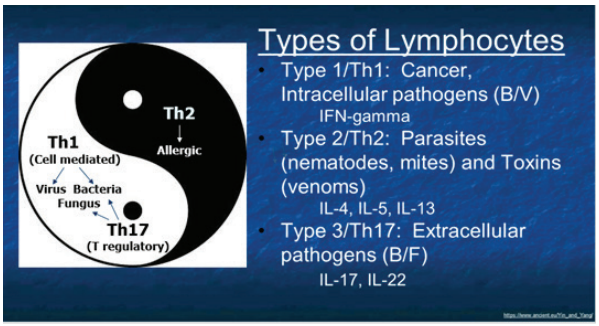

Figure 1: A graphic depiction of the Yin-Yang Balance of Th1, Th2, and Th17 pathways that can be used in patient care. Th1 cell-mediated immunity affects intracellular pathogens such as intracellular bacteria and viruses and cancer. Th17 affects extracellular pathogens such as extracellular bacteria and fungus. Th2 is the allergic arm of the immune system and in the past played a role fighting parasitic infection and toxins.

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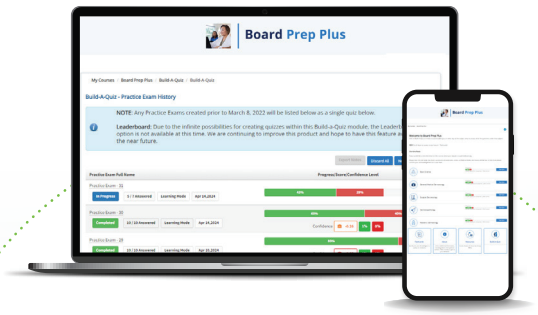

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25-590-MKT

Inside this Issue

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

Keeping pace

As dermatology residents, we are training in an era where the pace of scientific discovery is faster than ever, with an increasingly nuanced understanding of the molecular pathways that drive dermatologic disease. This knowledge offers us the opportunity to practice more rigorous evidence-based medicine than at any other point in our field's history. Amid this progress, however, the ability to deliver thoughtful, patient-centered care hinges on our grasp of the underlying data: how it is collected, what it means, and how it is applied. To take the best care of our patients, we need to know what therapies exist for a disease, but also which ones may work best for the individual in front of us.

Consider the major endpoints that define research and trials in dermatology: IGA 0/1, NRS, PASI, EASI, CDASI, and HiSCR. Each of these serves as a proxy for disease severity or improvement, but capture different dimensions. A therapy that achieves PASI90 might fail to control itch as measured by NRS. A drug that meets HiSCR criteria in hidradenitis suppurativa might not address a patient's pain or quality of life. If we don't understand how these endpoints are defined, who was included or excluded in pivotal trials, differences in efficacy, or side-effect profiles, we risk misapplying treatments and misguiding patients.

This deeper knowledge isn't just academic. It builds trust. When we can articulate the nuances of a treatment — its mechanism, trial population, limitations, and where it fits in the broader therapeutic landscape — patients recognize that we are not simply putting blind faith into dogma. They can see that we've taken the time to be thoughtful partners in their care. Crucially, patients are less likely to lose confidence in us if a particular treatment fails because we've demonstrated that our recommendations are informed, individualized, and rooted in expertise. They know we're not guessing and that we're invested in finding the right answer for them, even if it takes time.

This mindset also strengthens our ability to collaborate across specialties. Our insights into inflammatory pathways, therapeutics, and diagnostics can support our colleagues in rheumatology, infectious disease, oncology, and beyond. These shared patients benefit most when we bring our full depth of knowledge to the table. It also challenges us to develop the heuristics that shape how we make decisions. We need to become both lumpers and splitters, knowing when to group clinical presentations and when to dig deeper.

This month's issue reflects that level of thoughtfulness. Jenny Murase, MD, FAAD, highlights the difference between a reasonable therapy that fails the patient, and a clinician who fails the patient by not performing appropriate or sufficient diagnostic testing. Vixey et al offer a practical guide to flap selection in surgical cases, rooted in careful data analysis. Morgan Murphrey, MD, FAAD, provides a framework to integrate these complex skills throughout residency training. Al-Sukhni et al also review the landscape of systemic therapies for atopic dermatitis. With so many choices, it serves as a reminder some drugs excel at controlling inflammation while others are better at relieving itch; our task is to discern which matters most for our patients.

By digging into data and thinking critically about how we use it, we can shape ourselves into the physicians our patients need: discerning, rigorous, compassionate, and deeply engaged with their care. DR

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Fall 2025

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