DERMATOLOGY WORLD

DIRECTIONS *in* RESIDENCY

A Publication of the American Academy of Dermatology | Association

Summer 2020

Top five financial strategies for dermatology residents

by David B. Mandell, JD, MBA

As a dermatology resident, you are in a challenging position that includes extreme time demands in training. Nonetheless, it's important that dermatologists spend time preparing for the financial side of their careers, as well. In this article, I will discuss five actions residents and young dermatologists can take while in training — often without a huge time commitment.

1. Proactively manage student loan debt

Student loan debt is likely to be top-of-mind for most residents and fellows. Fortunately, a large time commitment is not required to proactively manage these obligations.

Capitalization is one area of student loan debt that can be managed annually with some budgeting and foresight. Capitalization is the addition of unpaid interest to the principal balance of the loan, thus increasing the loan balance when payments are postponed during periods of deferment or forbearance.

It is sometimes difficult to avoid capitalization during residency due to high cost of living. However, if possible, paying some or all of the interest during training will allow residents to significantly slow runaway capitalization of their debt burden.

Income-driven repayment plans have recently become a solution for allowing repayment of student loan interest during residency with much more tolerable monthly payments. One such example is the Revised Pay As You Earn (REPAYE) program offered through the Department of Education. With REPAYE, the federal government covers 50% of all interest above the monthly payment amount during repayment. More information about REPAYE (and information about COVID-related debt) can be found at studentaid.gov.

2. Protect your greatest asset: Present value of future income

A crucial factor for building a solid financial foundation for the long term is to protect what you have already built. Many young doctors with little savings and often large student loan debts, may ask: "What have I built? I am in severe debt!" But you may have actually built a significant asset that needs protecting — the present value of your future income.

For example, let's assume that you are offered a starting salary of $300,000, including benefits. Assuming you plan on practicing for 30 years (and 3.5% inflation), the present value of this annual income is $5,517,613, even if you never make more than the original $300,000 per year, including inflation — a very

see **FINANCIAL** on p. 3

David Mandell, JD, MBA, is an attorney and author of more than a dozen books for doctors, including *Wealth Planning for the Modern Physician* and *Wealth Protection Planning for Dermatologists*. He is a partner in the wealth management firm OJM Group (**www.ojmgroup.com**), and can be reached at 877-656-4362 or **mandell@ojmgroup.com**.

To receive free print copies or ebook downloads of these books, text **DERMWORLD** to 555-888, or visit **www.ojmbookstore.com** and enter promotional code **DERMWORLD** at checkout.


THE MOST UN-SUNSCREENY SUNSCREEN EVER.
💧Water-light feel & invisible finish.
💧Instantly quenches dry skin with hydration.
💧Powerful UVA/UVB protection you'll 💙 to wear.
Neutrogena®
Hydro Boost
water gel lotion
sunscreen
BROAD SPECTRUM SPF 30
30
helioplex®
broad spectrum uva•uvb
#1 DERMATOLOGIST RECOMMENDED SUNCARE
©J&JCI 2020

FINANCIAL from p. 1

conservative assumption. Most people would think an asset this valuable is worth protecting.

How can you protect this asset? It depends on why you are protecting it — for just you as a physician, or for others dependent on you. If you have no dependents, then the focus should be on disability insurance, which will cover the risk of becoming disabled and not being able to work. If you have financial dependents as well, then life insurance is an essential addition. While an analysis of the success factors surrounding these types of policies is beyond the scope of this article, a financial professional (see #5) can save time on this endeavor and lead to better outcomes than doing it on your own.

3. Get comfortable with financial modeling

Financial modeling, in the finance world, is the process of creating a summary of expenses and earnings in the form of a spreadsheet that can be used to calculate the impact of a future event or decision. Obviously, this can be fundamental to the decision-making process when you are evaluating job opportunities. As such, it becomes increasingly important as you approach your last year of training. Online learning can be helpful here, as can outsourcing to a financially savvy friend or professional.

4. Become more financially literate

This strategy is certainly more general and potentially more time consuming than the rest — as it has no specific objective. On the other hand, between podcasts, webinars on demand, and books which can be read on smartphones and tablets, residents and fellows can listen/read and learn on virtually every subject in finance and access much of the material at no cost.

5. Understand the different types of financial professionals

The overwhelming majority of dermatologists will use the services of a financial professional for all or part of their careers. In working with a professional investment advisor, understanding the distinction between a fiduciary and suitability standard is crucial — yet it is one that even many experienced dermatologists do not comprehend. You will do yourself a significant service by becoming educated on the differences from the outset.

Quite simply, one set of investment advisors operates under a professional standard that requires them to make suitable recommendations to their clients. Instead of having to place their interests below those of their clients, these financial advisors' suitability standard requires only that the advisor reasonably believe that any recommendations made are suitable for their clients. A key distinction in terms of loyalty is also important, in that this type of advisor's duty is to the firm he or she works for, not necessarily to the client served.

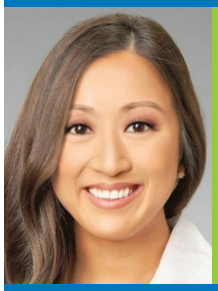
In contrast, another set of investment advisors operates under the fiduciary standard, meaning they have a fiduciary duty to their clients — i.e., they have a fundamental obligation to provide suitable investment advice and always act in the clients' best interests.

I strongly encourage residents to closely examine the qualifications of any prospective financial advisor. What licenses does the advisor hold? Does he or she have professional certifications? And, perhaps most importantly, does the advisor owe the client a fiduciary duty to act in their best interests or are they subject only to the suitability standard?

Understanding how advisors make money and to whom they owe their duty (their clients or their firms) is a paramount first step in finding the right professional to guide you throughout your career.

Remember, every journey begins with a single step.

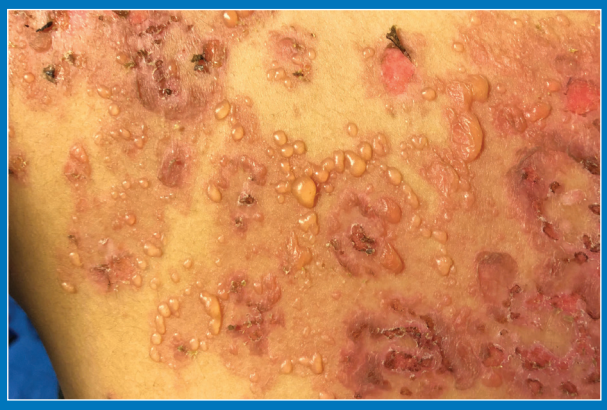
While the financial side of a dermatology career may seem just as daunting as the medical side to some, there is no better time than the present to begin. **DR**



Angelia Stepien, DO, is a PGY-2 dermatology resident at Orange Park Medical Center in Orange Park, Florida.

Race for the Case

By Angelia Stepien, DO



A 20-year-old female with no significant past medical history presented to the hospital with a one-week history of a diffuse blistering rash. One week prior to onset, the patient reports she took a pain reliever for headache relief. She denied any fever, arthralgias, edema, eye pain, throat pain, urinary issues, or abdominal discomfort. During her hospital stay, she had no laboratory abnormalities and her vital signs were within normal limits. On physical exam, no lymphadenopathy, peripheral edema, or joint tenderness was noted. Over her back, shoulders, arms, legs, chest, and face there were several erythematous annular plaques with surrounding tense vesicles in a "crown of jewels" arrangement and bullae with associated erosions and crust. No involvement of the palms, soles, or mucous membranes were noted. Biopsy showed a subepidermal blister with neutrophils and a perivascular infiltrate. Direct immunofluorescence demonstrated IgA (immunoglobulin A) and C3 (complement component 3) in a linear pattern along the basement membrane zone.

1. **What is the diagnosis?**
2. **In drug-induced cases, what is the most common culprit?**
3. **What is the treatment of choice and what laboratory study must be ordered prior to initiation?**
4. **What are the two antibody targets in this condition?**
5. **What is on the differential diagnosis?**

Respond with the correct answers at **www.aad.org/RaceForTheCase** for the opportunity to win a $25 Starbucks gift card!

Race for the Case winner (Spring 2020)

Congrats to **Ashley Reader, DO**, chief dermatology resident PGY-4, at St. Joseph Mercy in Ann Arbor, Michigan. She correctly identified pretibial myxedema and provided the most accurate responses to our last Race for the Case questions.
She has been sent a Starbucks gift card with our compliments.

Grafts

by Matthew Helm, MD, and Paul Wirth, MD

Full thickness skin graft (FTSG)
Most common form of graft used in dermatologic surgery
Composed of full thickness epidermis and dermis
Classic donor sites include pre/post auricular skin, lateral neck, supraclavicular area • Burow's Graft: specialized FTSG utilizing skin adjacent to wound defect taken as Burow's triangles that would have otherwise been discarded
Defatting required to help allow nutrition to flow from wound bed into graft
Bolster utilized for first week in order to stabilize graft and keep in contact with wound bed

Stages of FTSG	Timing	Characteristics
Imbibition	Day 1-2	Ischemic period; graft sustained by passive diffusion from wound bed
Inosculation	Day 2-10	Dermal blood vessels of graft link with vessels of wound bed
Neovascularization	Starts day 7	New blood vessels and lymphatics grow in to graft from wound bed
Reinnervation/ Maturation	Starts at 2 months	Slow process, ongoing for years; graft blends in to surrounding skin and sensation returns

Split thickness skin graft (STSG)
Composed of full thickness epidermis + variable amounts of dermis
Classified by thickness • Thin: 0.13-0.30 mm • Medium: 0.30-0.46 mm • Thick: 0.46-0.76 mm
Can be harvested using a multitude of tools • Small to medium grafts: Free hand techniques using surgical scissors, scalpel blades, double-edged razors, Dermablade or a Weck blade • Large grafts: Electric dermatomes such as a Zimmer
Fenestrating the graft can increase the size of the graft if needed and allows for serosanguinous drainage, however, can decrease overall cosmesis

Composite graft
Contains more than two types of tissue • Skin + Cartilage or Perichondrium ○ Used to restore structure, commonly employed for full thickness defect repairs of the nasal ala and helical rim • Skin + Fat
Four stages after placement 1. Initial complete blanching of tissue 2. 6 hours: graft becomes pale pink indicating anastomosis of graft vessels with wound bed 3. 12 hours: graft becomes blue indicating venous congestion 4. 3-7 days: graft becomes light pink indicating survival

Matthew Helm, MD, is a PGY-4 dermatology resident at Penn State Health, Milton S. Hershey Medical Center.

Paul Wirth, MD, is a PGY-3 dermatology resident at Penn State Health, Milton S. Hershey Medical Center.

Grafts

by Matthew Helm, MD, and Paul Wirth, MD

Free Cartilage Graft
Used to restore architecture after significant cartilage loss to maintain structure of free margins
Donor sites include the auricular helix, antihelix, nasal septum, conchal bowl and ribs

Graft comparison	FTSG	STSG	Composite	Free cartilage
Match to surrounding tissue	Best	Worst	Moderate	N/A
Nutrition requirements	High	Low	Highest	Moderate
Vascularity of wound bed	High	Low	Highest	High
Risk of infection	Low	Low	Moderate	Moderate
Amount of contraction	Low	High	Low	N/A
Durability	Excellent	Moderate	Moderate	Good
Adnexal function	Excellent	Poor	Good	N/A
Uses	Coverage of defects of almost any site, best overall tissue match	Coverage of large areas, sites with limited vascular supply or those at high risk for recurrence	Repair of full thickness or deep alar defects	Repair of helical rim, partial/full thickness lower eyelid or alar rims defects

References

1. Adams DC, Ramsey ML. Grafts in Dermatologic Surgery: Review and Update on Full- and Split-Thickness Skin Grafts, Free Cartilage Grafts, and Composite Grafts. Dermatologic Surgery. 2006;31:1055-1067.
2. Alikhan A, Hocker TLH, Chavan R. Review of Dermatology. Edinburgh: Elsevier; 2017.
3. Bolognia JL, Callen JP, Jorizzo JL, Schaffer JV. Dermatology. 4th ed. Elsevier; 2018.
4. Glogau RG, Stegman SJ, Tromovitch TA. Refinements in Split-Thickness Skin Grafting Technique. The Journal of Dermatologic Surgery and Oncology. 1987;13(8):853-859.
5. Johnson T, Zide MF. Freehand full-thickness grafting for facial defects: a review of methods. The Journal of Oral Maxillofacial Surgery. 1997;55:1050-1056.
6. Snow SN, Stiff M, Lambert D. Freehand technique to harvest partial-thickness skin to repair superficial facial defects. Dermatologic Surgery. 1995;21:153-157.

More Boards Fodder online!

In addition to this issue's Boards Fodder, you can download **two new** online Boards Fodder at **www.aad.org/Directions**. **Neutrophilic dermatoses** by Alvaro J. Ramos, MD, FACP, and Marely Santiago-Vázquez, MD, is now available to download.

We've also added a new **Mastocytosis review** chart by Mohammed Shanshal, MD.

The AAD now has more than 100 Boards Fodder study charts! Check out the archives at **www.aad.org/boardsfodder**.

Got Boards?

Directions in Residency is currently accepting submissions for new Boards Fodder charts for 2020-2021. Get published, impress your friends, and help out your fellow residents. Contact Dean Monti, **dmonti@aad.org** with your chart ideas.

Henry W. Lim, MD, is a renowned expert in photomedicine who is past chair of the department of dermatology at Henry Ford Health System in Detroit and the former president of both the American Academy of Dermatology and American Board of Dermatology.

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.

Pearls for phototherapy

Henry W. Lim, MD

Is there a role for phototherapy in my practice?

Currently, the most widely used forms of phototherapy in the U.S. are narrowband (NB)-UVB and targeted phototherapy (excimer laser, excimer light, and a relative newcomer, home UVB-LED light). Phototherapy is a long standing, versatile treatment modality not only for psoriasis, but also many other dermatoses. It has an excellent safety profile, and can be use in pregnant women, nursing mothers, and in children. As dermatologists, we are uniquely qualified among all physicians to properly administer it for our patients. Along with other treatment modalities that have been developed in our specialty, such as biologics, small molecule inhibitors, and JAK inhibitors, the availability of phototherapy in your office would enable you to offer the full range of treatment options to your patients.

References:

1. Torres AEE, Lyons AB, Hamzavi IH, Lim HW. Role of phototherapy in he era of biologics. J Am Acad Dermatol. 2020 Apr 24. doi: 10.1016/j.jaad.2020.04.09

What instructions should I give patients receiving phototherapy during the COVID-19 crisis?

Similar to patients seen in a general dermatology office, all patients should be screened for COVID-19 following the recommendation of your local health care authority. Social distancing should be practiced. Therefore, the patient should attend the phototherapy appointment alone; if the patient is a minor, one guardian would be allowed to accompany the patient. Face covering should be worn (except when patient is in the phototherapy booth), and hand sanitizer should be used upon entering and leaving the unit. For patients requiring treatment of the face, individual goggles should be provided; goggles should be cleaned by the patient upon completion of the treatment, stored in a bag, and kept in the unit to be used solely by the same patient. Consider providing a plastic bag for patients to store their clothes when they disrobe; the bag should be discarded at the end of treatment.

References:

1. Lim HW, Feldman SR, Van Voorhees AS, Gelfand JM. Recommendations for phototherapy during the COVID-19 pandemic. J Am Acad Dermatol. 2020 Apr 24. doi: 10.1016/j.jaad.2020.04.091.

What instructions should I give my phototherapy staff during the COVID-19 crisis?

To minimize traffic in the phototherapy unit, consider scheduling patients not more than every 30 minutes. Waiting time in the waiting room should be minimized, and seats should be spaced 6 feet apart. Staff should wear masks, and hand sanitizer should be used before and after each patient encounter. Avoid turning on the fan of the phototherapy unit; if need be, treatment can be fractionated to avoid excessive heat build-up in the unit. High-touch surfaces in the changing area and in the phototherapy equipment should be disinfected after each patient.

References:

1. Lim HW, Feldman SR, Van Voorhees AS, Gelfand JM. Recommendations for phototherapy during the COVID-19 pandemic. J Am Acad Dermatol. 2020 Apr 24. doi: 10.1016/j.jaad.2020.04.091.

Should I continue to offer targeted phototherapy in the office?

Based on Medicare phototherapy billing codes, targeted phototherapy is the fastest growing segment of phototherapy in the U.S. In the era of COVID-19, for the protection of the staff, treatment of facial lesions should be minimized or, if possible, avoided.

References:

1. Lim HW, Feldman SR, Van Voorhees AS, Gelfand JM. Recommendations for phototherapy during the COVID-19 pandemic. J Am Acad Dermatol. 2020 Apr 24. doi: 10.1016/j.jaad.2020.04.091.
2. Tan SY, Buzney E, Mostaghimi A. Trends in phototherapy utilization among Medicare beneficiaries in the United States, 2000 to 2015. J Am Acad Dermatol. 2018 Oct;79(4):672-679. doi: 10.1016/j.jaad.2018.03.018. DR

If you have suggestions for topics or content for Clinical Pearls, contact Dean Monti at **dmonti@aad.org**

Career Case Studies online

Not sure what specialty to pursue? Or do you want to know more about the one you've chosen? We've got you covered. The AAD has recently compiled its Career Case Study archives from the pages of *Directions in Residency*. The feature provides residents with information to help them choose a subspecialty, with tips from experts in that specialty.

Choose from:

- Mohs
- Academic
- Cosmetic
- Dermatopathology
- Pediatric
- Hospital
- Medical
- Surgery

Learn more by clicking on the Career Case Study archives icon at **www.aad.org/member/publications/more/dir**.

A global pandemic – a global response

Pandemic impact in New York City

By Ann Lin, DO, MS, resident at St. John's Episcopal Hospital Dermatology

In mid-March, as New York City became the epicenter of the COVID-19 pandemic, dermatology clinics were temporarily closed and transitioned into teledermatology in compliance with city policy. St. John's Episcopal Hospital dermatology residents, recognizing that we are physicians first, felt the call of duty to help patients and support our fellow medical practitioners. In addition to stepping into the frontlines where we served in the emergency medicine department, palliative care, and inpatient medicine wards, we reached out to donors to request meals to sustain hospital workers through their lengthy and hectic shifts. Furthermore, we acquired, assembled, and distributed skin care packages for residents at our hospital along with educational pamphlets on hygiene and skin care, with tips to alleviate damage caused by the prolonged use of harsh personal protective equipment and handwashing. We successfully delivered over 100 skin care packages along with thank you notes and warm meals to our fellow in-house residents, physicians, and health care workers in various departments. DR

Left to right: Gerard Danosos, DO, Stefanie Cubelli, DO, Ann Lin, DO, and Paloma Reiter, DO.

Unmasked! Dr. Danosos, Dr. Lin, Dr. Reiter, Dr. Cubelli, and Angela Kim, DO.

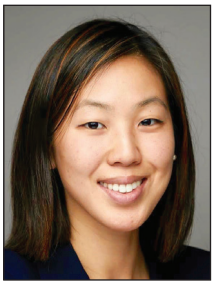
Residents on the front lines in Málaga

by Pedro J. Navarro-Guillamon, MD

In Málaga (southern Spain), residents have been helping in the emergency department and also at the COVID hospitalization unit at Hospital Universitario Virgen de la Victoria de Malaga. In this photo from April, we were in the midst of working 17 or 24-hour shifts at the ED, managing many suspected COVID patients.

By mid-May Spain had around 224,000 confirmed cases, 26,600 confirmed deaths, and 136,000 recoveries. In my state, Andalucia, we've had 15,400 cases and 1,320 deaths so far, while in Malaga (my city) there are 3760 confirmed cases and 271 deaths. In Málaga, a group of scientists and doctors have developed a ventilator that can be produced within two hours. My fellow physicians and I have been on lockdown for five weeks so far. We can only go home, to the grocery store, and to essential jobs like these.

Dr. Navarro-Guillamon, MD, with oncology resident Mora Guardamagna, MD, during a shift in the respiratory area of the emergency department.



Ann Lin, MD, DO, MS, is a PGY-4 dermatology resident at St. John's Episcopal Hospital in Far Rockaway, New York.

Pedro J. Navarro-Guillamon, MD, is a second-year dermatology resident at Hospital Universitario Virgen de la Victoria de Malaga in southern Spain.

What's happening in your residency program?

Send your photos and accomplishments to Dean Monti at **dmonti@aad.org**.

Inside this Issue

Rachel Wheatley, MD, is incoming PGY-4 chief resident at Harbor-UCLA Medical Center in Torrance, California..

Janice E. Ma, MD is a PGY-3 dermatology resident, at Harbor-UCLA Medical Center in Torrance, California.

With this latest issue we welcome two new resident advisors to the DW Directions in Residency *team!*

***Rachel Wheatley, MD**, is incoming PGY-4 chief resident at Harbor-UCLA Medical Center in Torrance, California. She completed medical school at the University of Central Florida and undergrad at the University of Florida, majoring in Food Science and Human Nutrition.*

***Janice E. Ma, MD** is a PGY-3 dermatology resident, also at Harbor-UCLA Medical Center. She completed medical school at Mayo Medical School and undergrad at University of California, Los Angeles. She majored in Biology.*

We are excited to have both of these talented residents assist with the Directions in Residency *content.*

In this issue, we have a feature with tips on financial strategies for residents. Financial planning is an important factor in looking toward the future, but residents don't have a lot of time to think about it. I know that for me, it's something that I have been placing in the "I'll think about this later" compartment of my brain for years. Recently, working primarily from home in light of COVID-19, I've had some time to think about my financial strategy and retirement plan for the coming decades. Simple online retirement contribution calculators make it very clear that beginning earlier can maximize the impact of compound interest. Though I initially planned on preparing for retirement after residency, I'm glad to be starting now. Taking control of my financial future has allowed for some steadiness during these uncertain times.

We hope that this issue finds our dermatology colleagues and their loved ones well. To those of us who have been called to the front lines to care for COVID-19 patients, I know that I speak for the entire dermatology community when I say that you have our utmost respect and admiration. We stand with you, and all of the health care workers facing this pandemic, in solidarity. **- Rachel Wheatley, MD** DR

Residents registered for AAD VMX can access sessions to help prepare for the boards, including "*Conquer the Boards: An Experiential Review.*"

Go to **www.aad.org/member/meetings-education/aadvmx** to learn more.

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

DIRECTIONS *in* RESIDENCY

Summer 2020