DERMATOLOGY WORLD

DIRECTIONS *in* RESIDENCY

A Publication of the American Academy of Dermatology Association

Spring 2017

Avoid these mistakes for a blemish-free resume

By Angela Rose

There are many challenges you'll face on the journey to a career in dermatology. From passing the MCAT and securing your place in medical school, to completing an internship and residency, you've nearly aced them all. But you're not in the clear quite yet. You still have to land your first dermatology job, and your resume is the most valuable tool you have for doing so. It's usually the basis of any potential employer's first impression, so you'll want to avoid these mistakes in order to keep it blemish-free.

1. Avoid cluttered formatting

On average, employers spend mere minutes reviewing your resume before deciding whether to reject you or dig deeper (nearly half spend less than two minutes according to one survey). On this first pass, they're generally scanning for important details rather than reading every word, so make it easy for them to absorb what's important. Avoid cluttered formatting and large paragraphs of unbroken text by judiciously using white space, bold headlines, and bulleted lists. Stick with a standard, easily readable front — such as Times New Roman or Arial — throughout the document as well.

2. Cookie-cutter copy won't cut it

That said, you don't want your resume to read like every other dermatology resident's resume, either. Make it stand out and you'll quickly capture your potential employer's attention while coming across as an individual rather than a mindless automaton. There are many ways to do this, though one of the simplest ways is to avoid copying text from the many dermatology resume templates you can find online and using your own words instead. Additionally, consider including some personal information in your skills statement — such as why you got into health care, your volunteer work, or a killer quote from a faculty member about your performance.

3. Don't fib — keep it real!

The survey mentioned earlier found that more than half of employers have caught a lie on a candidate's resume. The most common fibs include skill set embellishment, responsibility exaggeration, dates of employment, job titles, and academic degrees. While it can be tempting to exaggerate a bit to impress a hiring manager, even a small misrepresentation — when caught, and you can bet it will be — is enough to get your resume thrown in the reject pile and yourself blacklisted from that practice, clinic, or hospital.

4. Focus on accomplishments

Endless lists of "duties included" and "responsible for" statements quickly put potential employers to sleep

see RESUME on p. 6

Angela Rose
is a writer for **AADCareerCompass.org**.

For more information, visit **www.AADCareerCompass.org**.

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The life of a Mohs specialist

Why did you choose to pursue a Mohs specialty?
It stemmed from my academic interest in the management of dermatology issues in organ transplant patients. I started a dermatology multidisciplinary clinic for organ transplant patients at my institution, and quickly realized I needed to become proficient in Mohs and dermatologic surgery so I could best provide comprehensive care for these patients. It is well known that organ transplant patients are often afflicted with aggressive skin cancer which contributes to tremendous morbidity in their transplant life. An understanding of complex histology, tumor behavior, and tumor extirpation were skills I learned during my Mohs fellowship. These therapeutic skills proved vital to the care of these complex patients.

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?)
An empathic, caring personality is important in any aspect of patient care, but more so when taking care of a patient who is worried about skin cancer. A Mohs surgeon who can relate and identify with the patient will help to alleviate the patient's fears about the Mohs procedure. The Mohs surgeon should patiently listen to the patient's fears and concerns. Post-operative care is extremely important for good patient outcomes, so the Mohs surgeon should be attentive to the patient's questions and be available for questions in the post-operative period. Excellent surgical technique requires attention to detail but histological confirmation of tumor extirpation requires being meticulous and focused when assessing tissue sections.

What's a typical day in a Mohs clinic?

- **What you are doing in the morning, afternoon and into the evening, etc.**
  A typical Mohs surgery day starts with patient evaluation, consent for the Mohs procedure, clarification of histology as provided by dermatopathology, and correct site identification. Patients are staggered during the day depending on tumor type and location. Despite the surgeon's best efforts, one can never really predict how a typical Mohs day will go. Ongoing communication with the patient and coordination with staff is critical, especially if the patient's Mohs procedure takes longer than expected (i.e. the tumor requires more than the expected number of stages to clear). After my Mohs patients are taken care of and post-operative instructions are given, I usually see patients who require skin cancer screening examinations. These patients are typically seen in the later afternoon after the Mohs day is over.
- **What are the various tasks (how much time are you spending with patients, office work, other?)**
  I would estimate that 90 percent of my time is spent with patient care and 10 percent with administrative activities.
- **Does the work vary at different times of the year?**
  The summer time tends to attract patients who request skin cancer screenings and pigmented lesion evaluations.

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

How does a career path in Mohs differ from other subspecialties?
Mohs is a referral type subspecialty, therefore networking in the community and providing excellent care of patients is important. I like to maintain my general dermatology skills so I continue to take care of patients who do not require surgery, but have other medical dermatology concerns.

In terms of need, workforce, and opportunities, how does it compare? (Is it more difficult to land a Mohs position than another subspecialty?)
There is still a great need for general dermatologists around the country, but there remains a great need for Mohs surgeons outside of the metro areas.

If residents are considering a Mohs subspecialty, what else should they be considering? Any special training or ways to increase their proficiency beyond their residency?
The ability to perform Mohs surgery and reconstruction is a life-long lesson. If a resident is considering becoming a Mohs surgeon, I would certainly recommend applying for a fellowship in Mohs surgery with the ACMS. It's also always a good idea to have colleagues at hand with whom you can discuss some of the more challenging cases.

Is there something specific to Mohs that is personally rewarding? Why will residents feel satisfied with this choice?
Mohs surgery is a wonderful profession, but it can be challenging. Surgery is tiring and our patients are understandably worried because they have skin cancer. Personally, one of the aspects I enjoy about being a Mohs surgeon is my patient comes into my clinic with a skin cancer and to the best of my ability leaves without it. Also, because I perform all my reconstructions and my patients are generally awake, I have a wonderful opportunity to spend time with my patients, learn more about their lives, and try to relate to them in some way so that their experience with me is a pleasant one. That is a true privilege. DR

Fiona Zwald, MD, MRCPI, has specialized as a Mohs surgeon and dermatologist for more than 10 years and currently practices at Dermatology Consultants in Atlanta, Georgia.

Find out more

To find out more about Fiona Zwald's practice, visit **www.dermatologyconsultants.org**

Career Case Study

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

Next issue: Cosmetics

Photosensitivity Disorders

By Diana C. Valentín Colón, MD, Nicole M. Rochet, MD, MSc, and Sheila M. Valentín Nogueras, MD

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Nicole M. Rochet, MD, MSc, is a PGY-3 dermatology resident at the University of Puerto Rico, Medical Sciences Campus

Sheila M. Valentín Nogueras, MD, is an assistant professor and Director of Mohs Surgery in the department of dermatology at the University of Puerto Rico, Medical Sciences Campus.

Photosensitivity Disorders

Inherited photosensitivity disorders

Disease	Inheritance/ Mutation	Clinical features	Buzzwords/ Comments
Bloom Syndrome	AR BLM gene RecQL3 (DNA helicase) (RecQL2 by some sources)	- Skin: early-onset photo-induced erythema and telangiectasias in face, hands and forearms (photo-distributed poikiloderma), CALM's, dyspigmentation, hypertrichosis, cheilitis - Failure to thrive ("proportionate dwarfism"), distinct facies (small and narrow) with oversized ears, long limbs; immunodeficiency, increased risk of malignancy and type 2 DM	- Ashkenazi Jews - Associated malignancies: leukemia (most common before 20 y/o), lymphoma, GI adenocarcinoma, sarcomas (avoid treatment with alkylating agents and radiation) - Reduced serum IgM and IgA; early death from pneumonia - Quadriradial configuration in chromosomes is pathognomonic
Rothmund Thompson Syndrome (Poikiloderma congenitale)	AR RecQL4 gene defect (DNA helicase)	- Skin: early, acute PS results in poikiloderma of the face and extensor extremities; alopecia, nail dystrophy, premalignant acral keratosis, increased cutaneous malignancies: BCC, SCC, melanoma - Juvenile subscapular bilateral cataracts, radiologic bony abnormalities, osteoporosis, hypogonadism, cryptorchidism	- Hypoplastic thumbs, radii and ulna - Osteosarcoma (most common malignancy) may be multicentric and resistant to radiation. Recommended screening: baseline radiologic survey and by age 3 (and yearly if abnormal).
Xeroderma Pigmentosum (XP)	-All AR, (except XPB: AD) Multiple gene disorder- 7 nucleotide excision repair (NER) deficient complementation groups: -XPA -XPB/ERCC3 -XPC -XPD/ERCC2 -XPE/DDB2 -XPF/ERCC4 -XPG/ERCC5	-XPA: Most severe variant. PS, severe neurologic impairment, deafness, growth delay -XPB: PS, pigmentary retinopathy, basal ganglia calcification -XPC: At greatest risk for skin cancer (melanoma); rare neurological involvement -XPD: Poikiloderma, early onset skin cancer, decreased intelligence, ocular damage, neurologic impairment -XPE: Mildest skin/ocular PS; rare neurologic involvement -XPF: Mild PS, freckling, rare neurologic/ocular involvement -XPG: Mild skin changes, rare skin cancer, rare neurologic/ocular, except when XP/CS overlap - General skin findings: dry, atrophic, parchment-like texture with freckling, dyspigmentation/poikiloderma	- Groups A, B and C are most common: XPC in US/ Europe vs. XPA in Japan - Group A: AKA DeSanctis-Cacchione syndrome – severe neurologic abnormalities - XPV (variant): defective DNA polymerase (pol η) leads to increased risk of skin cancer; no neurologic abnormalities - PS is the most common presenting sign in all groups; excessive in groups: A, B, D, F, G, except C and E. - Up to 10,000x increase in risk of malignancies in anterior 2/3 of the tongue (SCC, angiosarcoma) XPC, XPD, XPA: associated with increased risk of cutaneous melanoma
Cockayne Syndrome (CS)	AR CSA/ERCC8 and CSB/ ERCC6 Defective transcription coupled repair subpathway of NER Unable to repair cyclobutene pyrimidine dimers	- Skin: PS, dry hair and skin, anhidrosis, acral cyanotic livedo, edema - Microcephaly, stunted growth, progressive neurological dysfunction due to leukodystrophy, mental retardation, basal ganglia calcifications, cataracts, dental caries	- Cachectic dwarfism: lipoatrophy of the face, sunken eye appearance, "bird headed facies, "Mickey mouse ears" -Salt and pepper retinal pigmentation - No increased incidence of skin cancer or sun induced pigmentation - Mutations in XPF may also cause CS and CS/XP/ Fanconi anemia phenotype. - XP/CS overlap syndrome with mutations in XPB, XPD and XPG have more neurologic, than cutaneous involvement typical for XP.
Cerebro-oculo-facio-skeletal (COFS) syndrome	AR Mutations in CBS, ERCC1, XPD, XPG	- Typical features of CS with hypotonia, impaired reflexes, poor vision and distinctive facial characteristics (small eyes +/- congenital cataracts, low set ears, small jaw)	- Arthrogryposis (congenital joint contractures) and microphthalmia differentiate from severe CS
Ultraviolet-sensitive syndrome (UVS)	AR Defective transcription coupled repair with mutations in 3 complementation groups (CSA, CSB and UVSSA)	- Skin: acute PS/ sunburn, dryness, freckling, photodistributed dyspigmentation, telangiectasia	- No increased incidence of skin cancer (normal global genomic repair)
Trichothiodystrophy aka "Tay syndrome," (PIBIDS)	AR Defective complementation groups in global and transcription-coupled NER subpathways (PS in XPD/ERCC2, XPB/ERCC3 and TTDA gene mutations)	- BIDS, IBIDS, PBIDS, PIBIDS: photosensitivity, ichthyosis, brittle hair (sulfur deficient trichoschisis), intellectual impairment, decreased fertility (+/- hypogonadism), short stature - Microcephaly, cataracts, hearing loss, recurrent infections/ hypogammaglobulinemia, osteoporosis, dental caries, nail abnormalities	- May present as collodion baby - Tiger-tail-like pattern of hair under polarized light. Also trichorrhexis nodosa, ribboning - Overlap with XPB, XPD
Kindler syndrome	AR KIND1 (AKA FERMT1) gene (encodes the focal adhesion protein fermitin family homolog-1)	- Skin: Congenital and neonatal blistering/ transient early-onset PS, progressive poikiloderma with marked cutaneous atrophy (cigarette paper-like atrophy), dental caries, nail dystrophy, palmoplantar hyperkeratosis - Ectropion, colitis, phimoses, pseudoainhum, digital webbing	Subtype of epidermolysis bullosa

Photosensitivity Disorders *(continued)*

By Diana C. Valentín Colón, MD, Nicole M. Rochet, MD, MSc, and Sheila M. Valentín Nogueras, MD

Photosensitivity Disorders

Acquired Disease/ Immunologically mediated

Disease	Epidemiology	Clinical features	Pathophysiology	Action Spectrum	Pathology	Treatment	Comments
PMLE	Women > Men 2nd and 3rd decades	Repeated outbreaks of lesions on sun-exposed skin during spring and summer Non-scarring, pruritic, erythematous papules, papulo-vesicles, vesicles or plaques Most common locations: upper chest, upper arms, back of the hands, the side of the face Onset minutes to hours from sun exposure and lasts for a few days	Delayed cellular hypersensitivity reaction to an undefined photo-induced antigen	UVB, UVA; rarely visible light	Epidermal spongiosis Superficial and deep, perivascular and periadnexal, lymphohistiocytic dermal infiltrate; may have eosinophils and neutrophils Significant papillary dermal edema	Mild disease: photoprotection Severe disease: hardening with NB-UVB phototherapy (initial dose 50-70% of MED) or PUVA Oral prednisone (<0.5mg/kg for 5-7 days during vacation Very severe disease: azathioprine or cyclosporine	Juvenile spring eruption is considered a clinical variant of PMLE in boys. Helices of the ear are the most common affected area. PMLE may be lifelong
Actinic prurigo (Hutchinson's summer prurigo)	Common in Native Americans (familial form), but can occur in all races Childhood onset (earlier than PMLE), most common in girls, often resolution by adolescence (may persist)	Erythematous papules or nodules, sometimes with hemorrhagic crust; marked pruritus May heal with fine linear or pitted scars Most common locations: face (including the nose) and distal limbs May have exudative cheilitis favoring lower lip or conjunctivitis	UVR exposure is the provocative factor Altered delayed immune response	UVB, UVA	Epidermal spongiosis, acanthosis, and dermal mononuclear cell infiltrate (occasional eosinophils) Papillary edema in early lesions	Photo-protection Mild disease: topical corticosteroids and topical tacrolimus Phototherapy with NB-UVB and PUVA (hardening) Resistant disease: oral thalidomide Other oral treatments: corticosteroids, azathioprine and cyclosporine	Association with HLA-DR4 (DRB1*0401) and subtype DRB1*0407
Hydroa vacciniforme (Hydroa = vesicles Vacciniforme = scarring)	Predilection for lightly pigmented individuals Childhood onset (boys>girls); resolves by adolescence	Symmetrical, clustered, pruritic or stinging erythematous macules Lesions can increase in size, become vesicular, umbilicate and progress with extensive crusting Healing over weeks: leaves varioliform scars Photo-distribution: face and dorsal aspect of hands Can be associated with general malaise (fever and headaches) May have ocular symptoms: photophobia, lacrimation, conjunctivitis or corneal lesions	Nature of the reaction is unknown. Summer sunlight generally provokes the eruption Epstein-Barr viral infection has been detected in a number of patients	UVA	Early: epidermal spongiosis with perivascular lymphohistiocytic infiltrate Prominent reticular keratinocyte degeneration; intra-epidermal vesicles with fibrin and acute inflammatory cells; confluent epidermal and focal upper dermal necrosis	Photoprotection Almost always refractory to treatment. Anecdotal treatments: BB-UVB, NB-UVB, PUVA, β -carotenes, antimalarials, azathioprine, cyclosporine, and thalidomide	Rare: finger, nose or ear disfiguration In Hydroa vacciniforme-like eruptions associated with systemic EBV-related disease (including lymphoma); the skin lesions are more severe and more widespread. Can also have facial swelling, ulcerated nodular lesions, high-grade fever, and hepatosplenomegaly.
Solar urticaria	Women > men 4th and 5th decade	Wheals limited to sun-exposed areas that appear a few minutes after exposure. Lesions resolve after 1 – 2 hours Anaphylactic shock may occur May last several years	IgE -mediated response against photo-induced, endogenous, cutaneous antigens	UVA, UVB, UVC, visible light	Mild dermal edema with perivascular mixed neutrophilic and eosinophilic infiltrate	Photoprotection Oral antihistamines Hardening with UVA or PUVA Refractory disease: plasmapheresis, omalizumab or IVIg	Fixed solar urticaria is limited to one area (mast cell alteration at that site)
Chronic actinic dermatitis	Most common in men over 50 years of age	Persistent, pruritic eczematous dermatitis with infiltrated papules and plaques located in sun-exposed areas (may extend to covered areas) Often spares: furrows, upper eyelids, finger webs, Nasolabial folds or post-auricular areas Patients can develop erythroderma Chronic lesions become lichenified Other findings: palmoplantar eczematous changes, loss of eyebrows or scalp hair from scratching	Delayed type hypersensitivity response (unknown endogenous, photo-induced, cutaneous antigen) Often patients have an existing allergic or photo-allergic dermatitis to exogenous sensitizer (plants or fragrances)	UVB, UVA, visible light	Epidermal spongiosis and acanthosis; lymphocytic exocytosis Superficial and deep dense dermal lymphohistiocytic infiltrate (may have eosinophils and plasma cells)	Strict photo-protection (including car window filters) Avoidance of relevant contact allergens Topical or oral corticosteroids, topical tacrolimus Refractory disease: low dose PUVA with initial high-dose steroids, azathioprine, cyclosporine, and mycophenolate mofetil	Lymphocytic infiltrate can mimic cutaneous T-cell lymphoma Chronic actinic dermatitis infiltrates are predominantly CD8+ cells

Abbreviations:

- PS: Photosensitivity
- CALMs: cafe au lait macules

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Double the Boards Fodders online!

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

The latest online Boards Fodder is Hyperplasias and Benign Neoplasms of Adnexal Origin by Kristy Charles, MD, and Emily Smith, MD. To view, download, or print every Boards Fodder ever published, check out the archives at **www.aad.org/boardsfodder.**

Jordan Heskett, MD, is a PGY-3 Resident Physician at Indiana University School of Medicine.

Race for the Case

By Jordan Heskett, MD

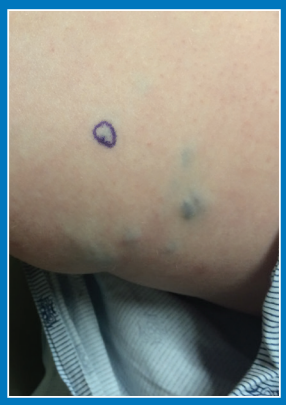


Figure 1 Right medial thigh

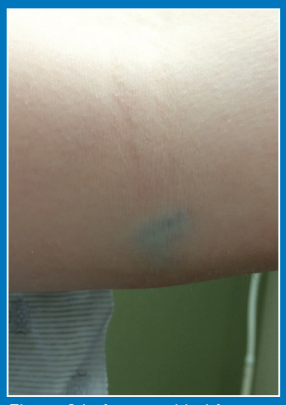


Figure 2 Left antecubital fossa

A 12-year-old female presented to a pediatric dermatology clinic with a two-year history of intermittently painful lesions on her extremities. The patient had no significant past medical or family history and an otherwise negative review of systems. On exam, she had multiple painful, slightly compressible, soft blue nodules on the right medial thigh and left antecubital fossa.

1. **What are the differential diagnoses for these lesions?**
2. **What would be expected on histological examination?**
3. **In familial cases, what is the mode of inheritance and gene mutation?**

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 2016)

Congrats to Klint Peebles, MD, PGY-4, a resident physician at the University of Wisconsin-Madison department of dermatology. Enjoy your Starbucks gift card!

To view the answers for the last Race for the Case, go to **www.aad.org/RaceForTheCase**.

RESUME from p. 1

— doing nothing to help your cause. They're much less interested in your past chores than they are in your quantifiable accomplishments. Spend some time thinking about ways to describe your internship and residency successes using concrete numbers. This could include an increase in the number of patients you were able to see per day, for example, or any cost-saving measures you had a hand in implementing.

5. Consider the keywords

Whether you're posting your resume online or submitting it directly to potential employers, keywords are essential. Many large health care organizations use applicant tracking software — or ATS — to scan and rank the relevance of the resumes they receive. Recruiters who search online databases for potential applicants also use keywords to identify the best matches. Leave pertinent keywords out of your resume and it's unlikely to ever be seen.

For best results when using keywords, customize them to the health care position for which you're applying. Read the job posting carefully to identify the best options. They're most often nouns and generally relate to the skills and experience required for the position. Certifications and degrees are also often keywords, as are any software programs mentioned in the posting. You should consider the job title and the city in which the position is located as keywords as well. **DR**

Resume Must-Haves

- ☑ Full name, complete address, phone number, and email
- ☑ Bold headlines and bulleted lists
- ☑ Quantified accomplishments
- ☑ Soft skills as well as hard skills
- ☑ Credentials including degree, licenses, certifications and areas of specialized training
- ☑ Other keywords culled from the job posting

Time Saving Tip

By Cherise M. Levi, DO

There is no better way to store facts in your long-term memory than by having a fellow resident quiz you, then recalling that information, and discussing the topic in a group. It is also tremendously helpful to create funny and sometimes inappropriate pneumonics to aid in recollection — particularly with the porphyrias! This is especially beneficial when studying for the in-service or board exam, as the amount of material can seem endless. Pneumonics will not only help you to more quickly remember topics, but will also allow more time to conquer a wider range of material while giving you a confidence booster from how much you actually ARE retaining! Efficient studying and time management are crucial for avoiding burnout and ensuring adequate sleep throughout residency. Being well-rested while reading and employing techniques of repetition and group studying will save time by enabling you to remember and recall what is learned, rather than having to reread material which is not retained.

Cherise M. Levi, DO, is a board certified dermatologist at the Tribeca Skin Center at New York Presbyterian - Columbia University Medical Center, New York. ***www.tribecaskincenter.com.***

What practice model is right for you?

By Mark Kaufmann, MD

Where do you see yourself after your residency and/or fellowship? By the beginning of the third year of residency, most residents should start thinking about their ideal practice model.

It's not uncommon for this decision to fluctuate as residency advances, and residents may change their mind as they are exposed to other practice models. It may be beneficial to observe and/or spend some time in the kind of practice you are considering. If you have the opportunity and are allowed to work in your desired environment while in your residency, take advantage of it.

Others find it helpful to have a mentor to help them decide if they want to pursue a private or academic career.

Here are some of the main factors residents should be considering when choosing academic, solo, or group practice:

- Career goals
- Personal and financial considerations
- Compensation
- Location
- Need/opportunities for employment
- Time commitment
- Your personality (although you will find all personality types in all practice models)

All of these factors are critical to consider, and all contribute to one's ultimate decision. While respecting any restrictions from the criteria, residents should seek out mentors. Find someone you respect, and decide if that's how you want to practice. Then sit down and calculate the pros and cons of following that path. Also, you should assume that government regulations are only going to become increasingly challenging, so consider how much you will ultimately want to put up with, and where you can (relatively) shelter yourself from having to deal with all of the regulations.

Success is very dependent on the individual. To some, success is publishing a certain number of articles, to others it is making a certain amount of money. In my experience, true satisfaction is finding the right balance between work, personal/family life, and hobbies. If you can do that, then you have truly succeeded.

Mark D. Kaufmann, MD, is an associate clinical professor in the department of dermatology at Icahn School of Medicine at Mount Sinai, New York. He recently presented a talk on this topic at Life After Residency: A Toolkit for Success, during the 2017 AAD Annual Meeting. DR

Join the Camp Discovery Residents Challenge!

Have a fun and friendly competition with your fellow residents, and help send a child to Camp Discovery! The residency program/team that raises the most funds will be recognized by AAD and will win various prizes. Hurry, the challenge ends April 30, 2017!

For more information and to sign up, visit **events.aad.org/residents.** DR

Join the club... the Virtual *JAAD* Journal Club!

Join the Virtual *JAAD* Journal Club to engage directly with authors about their research. Ask questions, post comments, and discuss the latest studies in the field. Sign up for a Mendeley account at **www.mendeley.com**, and join the group here. Once you sign into Mendeley, search for "*JAAD* Journal Club" and sign up! DR

Journal reading fatigue?

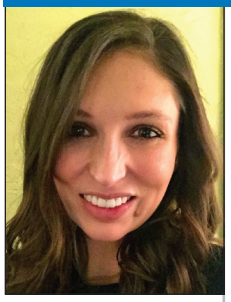
"Take the time to investigate technological aids and establish a plan." – Justin Bandino, MD

Read more tricks of the trade in "Keeping up with the journals" in the March issue of *Dermatology World*, **www.aad.org/dw**. DR

Virtual *JAAD* Journal Club

to join the Virtual *JAAD* Journal Club, sign up for a Mendeley account at **www.mendeley.com**.

Inside this Issue



Mallory Shiver, MD, is a PGY-4 at the University of Arkansas for Medical Sciences in Little Rock, Arkansas.

Welcome learners!

I'm excited to be the physician reviewer and columnist for the new *Dermatology World Directions in Residency*, and I promise to try to make these columns worth your read, and include topics for residents without all the fluff. As physician reviewer, I will talk about the content of the issue and other related matters of study and interest to residents.

This issue reinforces the fact that resident life is complex, from career decisions to the trials of boards studying. There are some relevant topics that aren't covered in residency. For example, here is something that we have talked about recently in our resident didactics that isn't really covered in our books — do you know the difference between retinoic acid vs. retinaldehyde vs. retinol vs. retinyl palmitate? Are you able to explain to your patients and friends which one of their anti-aging products is superior to the other based on the above ingredients? It's actually fairly simple! Vitamin A exists in three interconvertible forms: retinol, retinaldehyde, and retinoic acid. Retinoic acids are our prescription strength retinoids — i.e. tretinoin and tazarotene. Remember this simplified explanation: in order for our skin to use any form of vitamin A, it must first convert it to retinoic acid (i.e. tretinoin — that's easy to remember!), and it goes in a series of conversion steps through oxidation: retinol → retinaldehyde → retinoic acid. Thus, retinoic acid is the strongest and retinol is the weakest.

Retinoic acids have the fastest onset of action because no conversion steps are required. Retinaldehyde should be stronger than retinol (the naturally occurring form of vitamin A) because it has one less step to go through to be converted to retinoic acid (think: retin**al**dehyde is **al**most there). So what is retinyl palmitate? A retinyl ester and "anti-aging" ingredient of OTC moisturizing creams, retinyl palmitate has to first be converted to retinol to become active (one more step!), so it is unclear how much benefit there is (although it may have some antioxidant effect). Keep in mind that as potency increases, so does irritancy! Now, when your friends and patients ask you how good their anti-aging retinoid is, you have the answer, and you can explain it in easy terms: retinyl palmitate < retinol < retinaldehyde < retinoic acid. Hope this was helpful!

Have an idea for one of my columns that would be of interest to residents? Please email me at **mbshiver@uams.edu**. DR

DIRECTIONS *in* RESIDENCY

Spring 2017

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