



“Thank you for your submission...” — passing the hurdles of journal publication

By Dean Monti, MFA, Managing Editor, *DW Directions*

As both an editor and published author, I've been on both sides of the fence when it comes submitting a work for publication. I know from experience that it takes a combination of hard work, talent, persistence, and the willingness to be open to criticism to get published. And sometimes luck. When you submit a scientific paper to a journal for publication, however, it's far less about luck and more about presenting interesting, innovative, and well-researched work. And no matter what you write, spelling and grammar count for a lot. Directions asked Brett Sloan, MD, Editor-in-Chief, JAAD Case Reports, and Milan J. Anadkat, MD, deputy editor of JAAD Case Reports, questions that many aspiring journal authors face, and they provided superb insights. Read on and submit well!

DIR: When you look at a submission, what's the first thing that catches your attention? Is it an interesting topic, or something else?

Dr. Sloan: I look at the title and the cover letter. The cover letter or introduction should be brief and highlight the importance and novelty of the case report.

Dr. Anadkat: The first thing I notice is the title. It is what draws any reader to an article of potential interest. This is an often-overlooked aspect of scientific writing.

DIR: What are some common mistakes people make when submitting?

Dr. Sloan: 1) Failure to proofread and, for foreign authors, failure to have the manuscript proofed by a native English speaker. 2) Failure to maintain focus. Often, discussions will become tangential and take away from the main point of the paper. 3) Too much information in the introduction. The introduction should simply introduce the reader to the content of the manuscript and stress why it is unique. It should be no more than five sentences. 4) Failure to include pertinent negatives from the physical examination and lab results.

Dr. Anadkat: Submitting an article involves many considerations, above the scientific journey that is being reported. Will someone want to read my article (title)? Will they be able to find my article if necessary (key words)? Is this the right article for the target audience of

see **JOURNAL** on p. 3



Brett Sloan, MD, is editor, *JAAD Case Reports*, and associate professor of dermatology at the University of Connecticut.



Milan J. Anadkat, MD, is deputy editor, *JAAD Case Reports*, and director of the residency program, and associate professor, division of dermatology at Washington University School of Medicine

Residents excel at Annual Meeting in D.C.!

Resident and Fellows Research Symposium

Recipients of this year's Everett C. Fox Memorial Award presented the most outstanding papers in basic science and clinical research March 3 during the "Resident and Fellows Research Symposium" (S024) in D.C. The top papers were chosen by faculty judges led by Cory Dunnick, MD.

Resident and Fellows symposium winners:

Clinical:

1. Akaike Tomoko, MD
2. Raj Chovatiya, MD, PhD
3. Maggie Chow, MD, PhD

Basic Science

1. Roxana Daneshjou, MD, PhD
2. Phillippe Lafrancois, MD, PhD
3. Yuanshen Huang MD, PhD **DR**



Resident Jeopardy

A team from University of Minnesota won the Resident Jeopardy competition March 2 at the 2019 AAD Annual Meeting in D.C. The exultant winners were Seth Lofgreen, MD (left) and Addison Demer, MD.

A banner for the 2019 AAD Summer Meeting. The left side features a cityscape of New York City with the Empire State Building prominent. A blue box over the city says "REGISTRATION OPENS IN MAY!". The right side is a green background with white text: "SAVE THE DATE!", "2019 AAD Summer Meeting", "New York, New York", "July 25-28, 2019", "NEW YORK HILTON", and "aad.org/summer19". The AAD logo is in the bottom right corner.

REGISTRATION OPENS IN MAY!

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aad.org/summer19

JOURNAL from p. 1

this journal? Attention to basics such as spelling and grammar are also an easy-to-avoid error.

DIR: Is there anything that can cause you to reject a work before you even read it?

Dr. Sloan: Honestly — no! I read every manuscript completely before I reject it. Poor quality pictures and bad grammar are poor prognostic signs though.

Dr. Anadkat: I don't reject anything before reading it. I know a lot of work goes into developing a submission, so feel I owe the submitting authors an honest look.

DIR: Do you have a sense early on if something is promising? What qualities do those submissions have?

Dr. Sloan: Yes. Some authors are very good at immediately capturing my attention by stressing the novelty in the title, in the introduction, or in the cover letter. Very good high-quality pictures also catch my attention.

Dr. Anadkat: An article with promise tells a clear story: a novel finding, unique challenge, or some twist on what was already assumed to be known.

DIR: How important are an author's qualifications? What do you need to do to show you have expertise in an area?

Dr. Sloan: One of the great things about case reports is that you do not have to be an expert to report on a unique observation or treatment. Having a board certified dermatologist involved in the manuscript is strongly encouraged as it can only strengthen the quality of the paper.

Dr. Anadkat: The content speaks for itself in terms of expertise. I respect the reputation and qualifications of many, but judge each article on its individual content.

DIR: Do you provide feedback on all submissions, or only submissions that could be further developed?

Dr. Sloan: I try to provide constructive criticism on all submissions. I recognize that authors take considerable time and effort to submit a manuscript and feel they deserve to know why it was rejected. That being said, due to the volume of submissions we receive, it is something we strive to do better. All manuscripts sent back for revision have detailed concerns that should be addressed.

Dr. Anadkat: Yes, I try to provide feedback on most submissions, including some (but not all) that are rejected.

DIR: What about re-submissions? Are these encouraged?

Dr. Sloan: If there are substantial changes and/or new information I encourage resubmissions

Dr. Anadkat: Absolutely. Scientific writing is a process, and everyone wants to see information published that can move the field forward. Whether for our journal or another, taking feedback, improving the product, and resubmitting is an essential part of the process.

DIR: Do you respond to ideas or do you need a full-formed submission?

Dr. Sloan: I prefer full-formed submissions, as it is definitely easier to make a decision, but do respond to ideas to potential authors who may have concerns.

Dr. Anadkat: Dr. Sloan, the editorial staff, and Elsevier have been open to ideas that could benefit the journal for its readership. That being said, the best feedback can be given for full submissions. **DR**

For information and guidelines for submission to *JAAD Case Reports* go to: www.jaadcasereports.org/content/authorinfo



Kavita Darji, MD, is clinical research fellow in the department of dermatology at Saint Louis University.

Race for the Case

By Kavita Darji, MD



A 78-year-old male presented to dermatology clinic with a 5-year history of an eruption that is pruritic and painful. He denied fevers, chills, night sweats, and weight loss. His past medical history is otherwise non-contributory. Prior skin biopsies showed psoriasiform dermatitis. He had been previously treated with methotrexate, oral prednisone, and various topical steroids with minimal improvement.

On skin exam, he had ill-defined, pink, scaly patches on his chest, legs, and buttocks, several well-demarcated pink to violaceous patches and plaques on his arms and back, and tender nodules on bilateral arms. No lymphadenopathy was appreciated. Skin biopsy from the arm showed epidermotropic atypical lymphocytes in the epidermis along with a superficial and deep lymphocytic infiltrate in the dermis. CD3 highlighted the majority of the infiltrate, with a CD4:CD8 ratio of 6:1. PET/CT showed mild increased FDG activity in cutaneous lesions, but was otherwise unremarkable.

1. What is the diagnosis?
2. What does a comprehensive work-up of this condition typically consist of?
3. What is the typical immunophenotype?
4. What are the treatment options?



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

Race for the Case: Winner (Winter 2018)

Congrats go out to Sophia Akhiyat, MD, who provided the most accurate responses in the shortest amount of time. To view the last case and answer the latest Race for the Case, visit:

www.aad.org/RaceForTheCase.

Surgical Instruments

by Atieh Jibbe, MD

SCISSORS

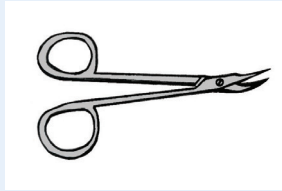
Iris

Contains short handle and sharp tip that is used for sharp dissection and cutting on the face.



Gradle

Curved and tapered; used in periorbital region.



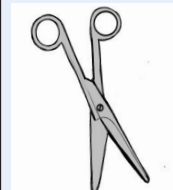
Westcott

Used for cutting around the eye.



Mayo

Used for coarse dissection; contains a 1:1 handle to blade ratio.



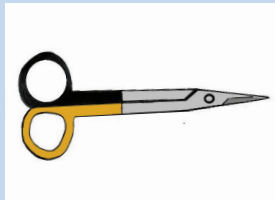
Metzenbaum

Used for blunt dissection. Helpful in areas that require long reach.



Supercut

One blade has razor edge denoted with black handle.



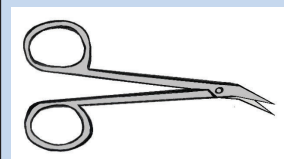
Spencer

Notched end for cutting sutures.



O'Brien

Used for cutting sutures in delicate areas.



FORCEPS

Adson

Used for trunk and extremities.



Bishop Harmon

Delicate tissues (Mnemonic: HOLEY bishop).



Jewelers

Distinguished by pointed tips; Used for suture removal.



SCALPEL HANDLES

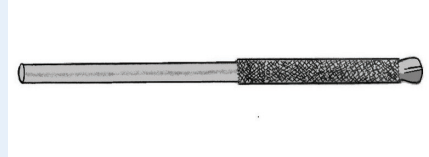
Bard-Parker

Flat handle; Most common blade handle used in dermatologic surgery.



Beaver

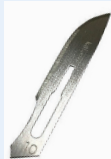
Round or hexagonal handle; Used for delicate areas ie. around the eyes.



SCALPEL BLADES

#10

Used for cutting thick skin ie. Back; Mnemonic: blade looks like a 0 from number 10.



#11

Used for I&D or cutting sharp angles; Mnemonic: two lines like the two "ones" in number 11 forming a point.



#15

Most commonly used in dermatologic surgery.

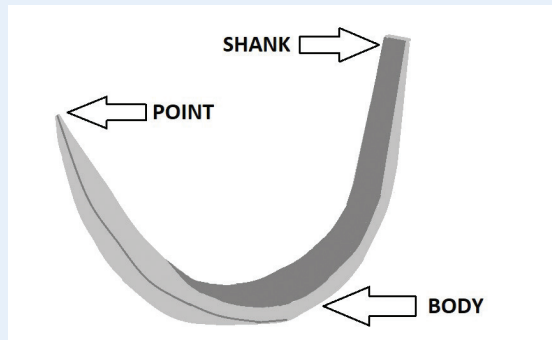


Atieh Jibbe, MD, is PGY-3 at University of Kansas department of dermatology.

Surgical Instruments (continued)

by Atieh Jibbe, MD

SURGICAL NEEDLE



Parts of a Needle

Shank aka Swage: weakest portion of needle

Body: strongest portion of needle; various curvatures with most common being 3/8th

Tip: option of round vs cutting

-Round: used for soft tissues and muscle

-Cutting: mc in derm, easily passes through tissues

Reverse cutting with sharp edge on outer portion of needle is **less likely** for sutures to tear through wound edge than Conventional cutting with sharp edge on the inner portion.

NEEDLE DRIVERS

Smooth Jaws (Smaller)

For smaller needles;
Decreases risk of tearing small sutures and less damaging to small fine needles, but increases risk of needle twisting.



Serrated jaws (larger)

For larger needles and work on the trunk;
Holds needles more securely, but damages delicate needles and shreds small sutures.



MISCELLANEOUS

Hemostat

Used to grasp bleeding vessels before ligation.



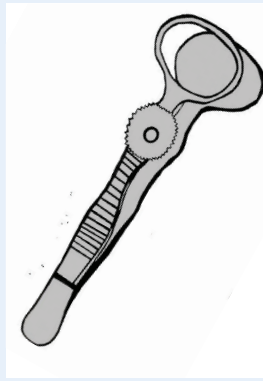
Periosteal Elevator

Used to separate nail plate from nail bed or remove periosteum.



Chalazion Clamp

Used for eyelid or lip surgery.



Skin Hook

Least traumatic tool for handling tissue.



Information References

1. Hocker, Thomas L. H., and Ali Alikhan. Review of Dermatology. Elsevier - Health Sciences Div, 2016.
2. Mariwalla, Kavita, and David J. Leffell. Primer in Dermatologic Surgery: a Study Companion. American Society for Dermatologic Surgery, 2011.

ALL PHOTOS TAKEN OR DRAWN BY AUTHOR

Boards Fodders online!



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

Go online for a new Boards Fodder web exclusive, **CPT Billing Codes of Common Procedures**, by Janna Mieko Vasantachart, MD, and Parin Pearl Rimtepathip, MD.

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

Ready to pay it forward?



Ready to pay it forward? You can help future residents by helping the AAD ensure access to resident education. It's important.

See why at www.aad.org/ResidentEducationGrant



Jenny Murase, MD, is an associate clinical professor in the department of dermatology at the University of California, San Francisco. She is also director of patch testing at the Palo Alto Foundation Medical Group and is on the board of the American Contact Dermatitis Society.



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

Clinical Pearls

Clinical Pearls will help prepare residents for the future by providing them with five top pearls about what they should know about a specific subject area by the time they complete their residency.

Contact dermatitis

By Jenny Murase, MD

Pearl #1. Don't forget to patch test your chronic adult atopic dermatitis (AD) patients! AD patients have immunologic predisposition to develop allergic contact dermatitis (ACD) and have also been exposed to more moisturizers over the years, as well as topical corticosteroids and antibiotic ointments, compared to others, so their risk of developing ACD is increased. Adult AD patients need to be thoroughly screened for topical medication, fragrance, emulsifier, surfactant, and preservative allergy.

Pearl #2. If your AD patients on dupilumab continue to have persistent dermatitis on their face, neck, and hands but their body has substantially cleared, you need to consider patch testing them. In the past we used “sledgehammers” for the immune system that shut down all inflammatory mediators, utilizing medications like prednisone, azathioprine, cyclosporine, and mycophenolate mofetil in our AD patients, that shut down both Th1 (cell mediated immunity) and Th2 (the allergic arm of our immune system). So the clinician treating the adult eczematous dermatitis did not have to distinguish between AD and ACD. Now that we have a biologic designer drug like dupilumab which focused on the Th2 component, allergic contact dermatitis (largely Th1) will not be suppressed as effectively, and patients will not clear sufficiently on dupilumab if you do not detect their ACD. Now **effective management requires you to perform the appropriate diagnostic testing for your patients.**

Pearl #3. If you plan to do patch testing in your practice, it is important to get familiar with series available to your patients above and beyond the True Test [40 allergens] and the NACDG (North American Contact Dermatitis Group) [70-80 allergens]. With a True Test only one third of patients are fully evaluated for their contact allergens, and one third of ACD diagnoses are missed without supplemental allergens to the NACDG. Supplemental trays such as the fragrance, emulsifier/external agents, cosmetic, sunscreen, corticosteroid, and others can increase diagnostic yield.

Pearl #4. One mistake I tend to see out of residency is that ACD is not entertained as much as it should be. **Consider ACD in all patients with recalcitrant eczematous dermatitis.** Although there are certain patterns of dermatitis that suggest ACD (for example, the hands, eyelids, face, neck, lips, and perianal area),

even if it is more diffuse there could be an allergic component to the recalcitrant rash.

Pearl #5. There are challenges to dermatologists interested in performing patch testing in academic practices and large group practices that are hospital based. The technical fee for patch testing does not have a professional component (wRVU = work Relative Value Unit) so the dermatology department does not receive revenue. Only revenue for the evaluation and management services are paid to the physician group. Alternative business models used throughout the United States are detailed in this reference. You can use this article to approach a future employe if you are interested developing this subspecialty out of residency and building a lucrative and thriving patch test practice for the academic center or medical group.

*Reference for Pearl 1: A Pragmatic Approach to Patch Testing Atopic Dermatitis Patients: Clinical Recommendations Based on Expert Consensus Opinion. *Dermatitis*. 2018; 27(4).*

*Reference for Pearl 2: Suresh R, Murase JE. The Role of Expanded Series Patch Testing in Identifying Causality of Residual Facial Dermatitis Following Initiation of Dupilumab Therapy. *Journal of the American Academy of Dermatology Case Reports*. 2018;4(9):899-904. <https://doi.org/10.1016/j.jidcr.2018.08.027>.*

*Reference for Pearl 3: Zhu TH, Suresh R, Warshaw E, Scheinman P, Mowad C, Botto N, Brod B, Taylor JS, Atwater AR, Watsky K, Schalock PC, Machler BC, Helms S, Jacob SE, Murase JE. A Review of the Medical Necessity of Comprehensive Patch Testing. *Dermatitis*. 2018;29(3).*

*Reference for Pearl 4: A Pragmatic Approach to Patch Testing Atopic Dermatitis Patients: Clinical Recommendations Based on Expert Consensus Opinion. *Dermatitis*. 2018;27(4).*

*Reference for Pearl 5: Zhu TH, Suresh R, Farahnik B, Jeon C, Warshaw E, Scheinman P, Mowad C, Botto N, Brod B, Taylor JS, Atwater AR, Watsky K, Schalock PC, Machler BC, Helms S, Jacob SE, Murase JE. Survey of Patch Test Business Models in the United States by the American Contact Dermatitis Society. *Dermatitis*. 2018;29(2), 85-88. DR*

JAAD Cases Reports submission Wish List: What the editors would like to see, or see more of.



The field is broad – take advantage.

The value of an educational case or case series has always been viewed as valuable in dermatology, and the journal's growth in both readership and citations exemplifies that this opinion remains. We receive broad submissions on multiple topics, which has been wonderful.



Think beyond the interest of the case itself.

Would an accompanying video be useful? Are emerging techniques worthy of a spotlight to educate the specialty? What distinguishes the current submission from what is already in the literature?



Think globally.

We would like to continue encouraging submissions coming from across the globe. While the journal is a product of the AAD, we have benefited from the valuable observations and contributions from authors both at home and abroad. We would also like to see more tropical diseases and interesting cases involving the hair and nails. **DR**

Resident Life Hack: Like minds

By Nikolajs Perdue, MD

It's hard to believe that a process as random as Match Day could bring four people together in such a perfect way to thrive, learn, and grow. We all ended up in the same residency program at Indiana University, finished residency this past June, and passed our dermatology board exam in July. Being surrounded by like-minded people with similar interests allows maximum success. Find people who you can just as easily quiz on the plane flying down for boards with as you can plan which Airbnb to stay at on Clearwater Beach after the test. Find others who you can just as comfortably discuss your first Thanksgiving call with as you can plan your residency Friendsgiving party with. Find someone who you can just as easily ask to cover your clinic in an emergency as you can ask to help cover your boat after a chief retreat weekend on the lake. I would not have made it through residency as easily without my colleagues turned friends turned best friends, and I wish that for all the residents out there. Whether it is asking for advice on a complicated patient that we see in clinic or planning a reunion at the AAD Annual Meeting, this is a bond that will last a lifetime. This photo was taken at a graduation party in June 2018 at the home of one of our volunteer faculty, Dr. Ingrid Ozols. **DR**



Nikolajs Perdue, MD, was chief resident, Indiana University School of Medicine Dermatology, residency class of 2018, and is now a board-certified dermatologist at Eagle Creek Dermatology in Indianapolis, Indiana.

You can follow him on Instagram: **@doctor.dermatology**

How do you manage resident life?



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

Inside this Issue



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

As a dermatology resident, you likely have some experience in publishing papers or case reports. Even with familiarity and experience, however, it can still be a stressful process. Here are some things with which I have personally struggled, as well as things I wish I would have done differently for publishing and research:

1 Knowing if a case is worthy of being written up.

I remember my first year of residency I had no clue what was unique and what was run of the mill. Now I try to keep a running list of cases that I find interesting, and when I have time I will do a quick PubMed search and see if the topic has already been extensively covered. If the topic isn't new, maybe the case is a great presentation of a classic finding or would make a great Race for the Case!

2 Get your consents up front.

Nothing is more frustrating than having an awesome case, great pictures, and no patient consent to use it! Working in a safety net hospital, especially in a rural state like Arkansas, we often have difficulty with getting patients to come all the way to clinic just to sign a release form. I try to have any patient that may be an interesting case sign a release form when I first see them. Worst case scenario I don't end up using the case and it took up a few minutes of my time.

3 Know your journals.

There are so many publications it can seem overwhelming. I am working to really familiarize myself with the format of 3-4 journals and target audience. It is easier to write up a paper for a specific journal than write up something generic and then adapt it to everyone's particular format.

4 Practice makes perfect!

Everyone has articles or cases that are rejected. Do your best to see it as a learning opportunity. Even if your paper was not accepted you are sure to learn tons about the topic while doing your research.

In this issue you will find expert advice from our *JAAD Case Reports* editors about submitting your work to journals. I also encourage you to contribute to *Directions!* Like the *JAAD* editors, we are always looking for new, interesting and relevant content for our Boards Fodder charts and Race for the Case submissions. And, take it from me, being published is always a nice extra feather in a resident's cap. **DR**

Ready to launch?

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