DERMATOLOGY WORLD

DIRECTIONS *in* RESIDENCY

A Publication of the American Academy of Dermatology | Association

Fall 2018

Disability insurance 101

By Stephanie Pearson, MD, FACOG

Why is disability insurance important? Why does anyone buy insurance? Because life happens.

When I was kicked in the shoulder during a routine delivery and developed a torn labrum -- which developed into frozen shoulder -- I was deemed unfit to continue working as an OB/GYN. If you, like me, ever became unable to practice the profession you were educated and trained for, disability insurance would help you to meet your expenses. It would allow you and your family to continue your standard of living.

How do I determine which policy is best for me?

It's all about the riders; they are the building blocks of your policy. They lay out the benefits you stand to receive, and can be tailored to your individual needs as a dermatologist. You will want and need several riders:

- **Own occupation:** this rider guarantees that you will receive your benefit if you are no longer able to practice as a dermatologist, even if you take on a new career post-disability.
- **Residual disability:** this covers you in the event you are rendered unable to work full time. Conditions such as multiple sclerosis (MS), post-concussive states, and other autoimmune diseases may not preclude you from working altogether, but they may render you unable to work long shifts. This rider closes the gap in your earnings.
- **Cost of living adjustment:** this rider protects against rises in inflation and recalibrates your benefit once it kicks in.
- **Benefit update/GPI/FIO:** this gives you opportunities to increase your benefit without additional medical underwriting, which will save you money in the long run.
- **Catastrophic disability benefit:** this rider offers extra protection, in addition to the monthly benefit, from the financial impact of a more serious injury or illness.

Another key consideration is the wide-ranging variability among carriers in their underwriting of mental health issues and substance abuse. If either of these is a part of your medical history, be sure to address it early on with your broker so they can be sure to target the carriers who are not as punitive toward these conditions.

What's the difference between a group policy and an individual policy?

A group benefit can be employer- or employee-paid. It covers a percentage of your income, often to a capped maximum amount, for as long as you remain employed by that specific employer. If your employer pays for your policy, the benefit is taxable; however, if you pay, the benefit is not taxed (see chart on p. 7).

see DISABILITY on p. 3

Stephanie Pearson, MD, FACOG, is an obstetrician and gynecologist; she is also a physician disability insurance broker and advocate. www.pearsonravitz.com

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DISABILITY from p. 1

If I have a group policy through my workplace, do I need an individual one?
There are several nuances you need to be aware of when you're evaluating the utility of your group long-term insurance policy, such as:

- Does it cover own occupation or any occupation?
- How long is the benefit period of the policy?
- Are work-related injuries covered?
- How is "salary" defined?

The answers to these questions reveal how much — or how little — your employer's group long-term insurance plan covers you.

What are some common roadblocks?
There are several issues I see with incredible regularity, and for the most part, they are easily preventable. The first is timing: **don't wait until you've finished residency/fellowship to get your policy!** I often hear two common rationales for waiting: "I am waiting until I make more money," or "I can't afford it during training." Unfortunately, waiting until you make more money will potentially cost you in the long run. You may not qualify for the same benefit rates as an attending that you would have qualified for as a resident or fellow (note: at the time of writing, one carrier is an exception to this rule). In fact, I was that attending! I got my first disability policy after completing residency. I didn't know better. Not only did I qualify for less money, but it was more expensive. Once you finish with training, carriers take both your income and group benefits (the latter of which, as I shared earlier, may or may not cover you fully) into account when determining your benefit.

Secondly, please don't have your colleagues write your scripts! I know that it may not seem like a big deal to ask a friend or colleague to write you a quick script or to get a hallway consult for a problem. I know, you're busy. But the problem arises during underwriting; you have to answer a series of medical questions and list medications. There is a script check, usually going back five years. Depending on answers to the questions and the results of the prescription check, carriers can request medical records. When there are no records to support medications or treatments, it creates a big problem. Some of the red flag drugs are antidepressants, anxiolytics, sleep agents, weight-loss drugs, and steroids. If these drugs pop up, there needs to be a paper trail. You do not want to look like you're hiding anything. Exclusions can be very difficult to argue. Please do not do this!

Third: ladies, please get coverage before your first pregnancy! Many carriers are quick to exclude coverage for "abnormal outcomes of pregnancy." As an Ob/Gyn, I know just how many things can happen during pregnancy and while trying to get pregnant. I have been shocked at what qualifies as an "abnormal outcome." Infertility workups, recurrent miscarriages, cesarean sections...these are all reasons that carriers have excluded future pregnancy coverage.

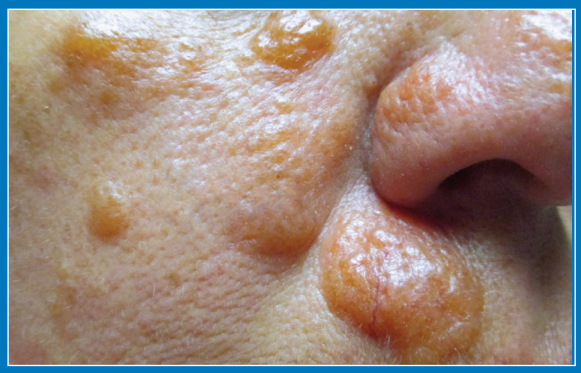
Finally, another common sticking point is not prioritizing your own health. Many of us are uncomfortable discussing weight and BMI with our patients, let alone with the mirror. It is important to understand that height/weight ratios play an important role in determining policy cost. We all know that with increasing BMI, there is an increase in medical morbidity. Be aware that your premium will go up if you are overweight. Worse, you can "weigh out" of insurance. If you are over a certain weight, you may be uninsurable by the regular carriers. Please stay healthy!

Areas specific for dermatologists
As a resident, before you have specified your specialty in dermatology, you can qualify for lower rates. As a resident, you are placed in a lower risk class, meaning your premium will be lower. This is especially strategic if you plan to become an invasive dermatologist and routinely perform procedures such as Mohs. For non-invasive dermatologists, the delta in premium is not as wide, but still considerable. **DR**

Parin Pearl Rimtepathip, MD, is a PGY-3 dermatology resident at Loma Linda University department of dermatology, Loma Linda, California.

Race for the Case

Parin Pearl Rimtepathip, MD



A 48-year-old white, Latin female presented to the dermatology clinic with a chief complaint of painful growing lesions on her face over the last year. A biopsy of one of the lesions showed steatocystoma. Per the patient's request, she had received no treatment. She endorsed there was no similar affliction in the family or any recent travel; however, the patient had recently moved from Mexico a couple years prior. Her past medical history was unremarkable and review of systems was negative.

On physical examination, she was found to have multiple yellow-pink, firm nodules and plaques distributed in the central face with overlying telangiectasia. Lymph node examination was normal. Biopsy results of one the plaques revealed a nodular deposit of a homogenous eosinophilic material with an associated lymphocytic and plasma cell infiltrate in the dermis.

1. **What are four histologic stains that could be used to highlight the homogenous eosinophilic material seen on H&E?**
2. **What is the protein component in the lesion?**
3. **Name two studies that should be ordered next to evaluate for systemic involvement.**

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 (Summer 2018)

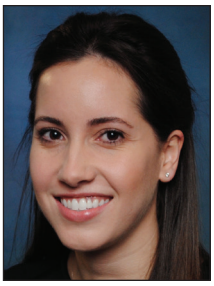
Congratulations to Sarmad Abdulrahman Sulaiman, MD, for being the first person to submit the correct responses for the summer 2018 edition of Race for the Case. Dr. Sulaiman is a dermatology specialist at the Erbil Dermatology Teaching Center in Erbil, Iraq.

See your name in the next issue of *Directions* by correctly answering the new Race for the Case questions at **www.aad.org/RaceForTheCase**.

Infectious diseases of genitalia

by Christina Kraus, MD, Sama Kassira Carley, MD, and Lance Chapman, MD, MBA

INFECTIOUS GENITAL CONDITIONS	ORGANISM	CLINICAL	DIAGNOSIS	MANAGEMENT	COMMENTS
Bacteria					
Gonorrhea	*Neisseria gonorrhoeae*	Men: dysuria, purulent discharge; +/- testicular pain and swelling. Women: purulent discharge, dysuria; +/- edema, tenderness of Bartholin's glands; +/- abdominal pain, and fever (PID). Disseminated: acute asymmetric arthritis, fevers, hemorrhagic pustules in distal extremities.	Path: Epidermal necrosis sometimes with pustules, neutrophilic inflammatory reaction, extravasated RBCs. Micro: Gram negative diplococci on gram stain; culture (gold standard), molecular test (PCR).	Ceftriaxone 250mg single dose IM + azithromycin 1 gm PO x1.	10% of men and 50% of women infected with gonorrhea are asymptomatic. Commonly co-infected with chlamydia.
Syphilis/condyloma lata	*Treponema pallidium*	Primary stage: Weeks to months after infection. Non-tender ulceration (chancre) with LAD. Secondary stage: 6 months, malaise, fever, lymphadenopathy, and disseminated rash +/- palmoplantar. Tertiary stage: Months to years, spread to skin, bones, CNS, ocular, and CV system. Development of gummas (eroded plaques).	Path: Dense Th1 immune response with treponemes, +plasma cells. Secondary stage +/- granulomatous. Tuberculoid granulomas in tertiary. Non-treponemal tests: VDRL, RPR. Become negative with treatment. Treponemal tests: TTPA, FTA-ABS, FTA-ABS-19S-IgM (higher specificity), SPHA.	Primary: Benzathine penicillin 2.4 million units single dose; procaine penicillin 1.2 million units daily for 10 days. Alternatives: Doxycyline, tetracycline, ceftriaxone, azithromycin. Latent: Benzathine penicillin 2.4 million units weekly for 3 doses; procaine penicillin 1.2 million units daily for 20 days. Alternatives: Doxycycline, tetracycline. Neurosyphilis or ocular syphilis: Aqueous IV penicillin 3-4 million units q4h for 10-14 days. Alternatives: Ceftriaxone or desensitization.	FTA-ABS is the first test to become positive and stays positive for life.
Chancroid	*Haemophilus ducreyi*	Papule -> pustule -> tender genital ulcer with tender LAD. Multiple or giant variants. Men: shaft of penis or prepuce. Women: introital area.	Path: 1st zone: necrotic debris with neutrophils; 2nd zone: granulation tissue; 3rd zone: infiltrate of plasma cells and lymphocytes. Micro: Gram stain with "school of fish" or railroad track small gram-negative bacilli; culture.	Azithromycin 1 g single dose.	Chancroids are an important risk factor for acquiring HIV. Co-infection with syphilis or HSV is common.
Lymphogranuloma venereum	*Chlamydia trachomatis serovars L1-3*	Primary: Herpetiform lesion at exposure site which heals spontaneously on coronal sulcus in men and posterior vaginal wall in women. Mild dysuria or tenderness, +/- LAD. Secondary: Unilateral, red, tender LAD (bubo) with rupture with drainage. Late: ano-genito-rectal syndrome with anogenital fistulas and LAD.	Path: Ulceration with mixed infiltrate with multinucleated giant cells, +/- abscesses. Stellate abscessed in lymph nodes. Giemsta stain showing Gamma-Favre bodies. Micro: Chlamydia-specific PCR, more sensitive than culture.	Doxycycline 100mg BID or erythromycin 500mg QID for 3 weeks.	Exclude other causes of genital ulcers during workup.
Granuloma inguinale (donovanosis)	*Klebsiella granulomatis*	Small nodule that progresses to a large 'beefy' ulcer, tendency to bleed, malodorous. Most commonly on penis or vulva.	Path: Ulceration with granulation tissue, PEH at edges, neutrophilic abscesses. Giemsa, Wright, or leishman stain for Donovan bodies Micro: Smears from tissue showing Donovan bodies.	Azithromycin 1 g PO once weekly for at least 3 weeks or until all lesions heal.	Extra-genital lesions affecting skin, bones, abdominal cavity, and oral cavity have been reported.
Perianal streptococcal dermatitis	Group A beta-hemolytic *Streptococcus* (can also be caused by Group B strep and *staphylococcus aureus*)	Perianal bright red well-demarcated patches, associated with pruritus. +/- painful defecation, fissures, exudate, erosions.	Bacterial culture of skin to confirm microbe.	Oral penicillin (unless *S. aureus* is identified) or oral cefuroxime (+ test of cure) for 2-3 weeks. Can add topical mupirocin ointment.	Most often seen in pediatric patients.
Erythrasma	*Corynebacterium minutissimum*	Clinically, may mimic tinea cruris. Well-demarcated pink to brown plaques with fine scale in crural creases. Common in warm climates.	Path: Perivascular infiltrate of lymphocytes. Gram stain will reveal gram-positive rods in cornified layer. Wood's lamp: Fluoresces coral-red.	Erythromycin 500 mg BID for 7-14 days. Alternatives: topical erythromycin, topical clindamycin, topical fusidic acid.	Coral-red fluorescence under wood's lamp due to coproporphyrin III.
Bullous impetigo	*Staphylococcus aureus*	Flaccid blisters or pustules (sometimes only collarette noted) which can involve genital area and proximal thighs.	Bacterial culture of skin confirming *S. aureus*. Subcorneal split (desmoglein 1).	Limited disease - mupirocin cream or ointment. Otherwise antistaphylococcal antibiotic such as doxycycline or clindamycin.	*S. aureus* can be cultured at site of lesion (unlike in staphylococcal scalded skin syndrome). Usually caused by *S. aureus*, phage II, type 71.
Reactive arthritis (previously called Reiter syndrome)	Immune response often precipitated by one of the following infectious agents: *yersinia enterocoliticia, neisseria gonorrhoeae, chlamycia trachomatis, shigella flexneri, ureaplasma urealyticum, campylobacter fetus.*	Red plaques with pustules, scale, crusts on hands, feet, genitalia (keratoderma blenorrhagicum affects palms/soles). Small ulcers on shaft or glans penis. Associated with arthritis, conjunctivities, urethritis or cervicitis.	Should be tested for HIV and chlamydia and stool cultures performed if diarrhea.	If infection present, treatment should ensue. Mild disease - NSAIDs at anti-inflammatory doses or topical CS (circinate balanitis usually improves with low-potency topical CS). Moderate to severe disease - oral methotrexate or cyclosporine or biologics.	HLA-B27 positivity is common.



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Infectious diseases of genitalia *(continued)*

by Christina Kraus, MD, Sama Kassira Carley, MD, and Lance Chapman, MD, MBA

INFECTIOUS GENITAL CONDITIONS	ORGANISM	CLINICAL	DIAGNOSIS	MANAGEMENT	COMMENTS
Viruses					
Genital herpes	Herpes simplex virus 2 > 1	Painful grouped vesicles on an erythematous base. May progress to ulceration with crusting. May lead to extra-genital lesions, urinary retention, aspetic meningitis.	Path: Enlarged gray keratinocytes that progress to multinucleated giant cells, ballooning degeneration, Cowdry A inclusions, dense mixed infiltrate, may have extensive epidermal necrosis. Micro: Viral culture, DFA, Tzanck smear.	Acyclovir 400mg TID 7-10 days; valacyclovir 500mg QD 3 days; famciclovir 1g x1. May be used in HIV+ patients as well. If 6 or more outbreaks per year or seronegative partner, chronic suppressive therapy. Acyclovir resistant: foscarnet, cidofovir.	Genital lesions are frequently asymptomatic.
Condyloma acuminatum	Human papillomavirus	Variety of clinical presentations. May be solitary or clustered, can be warty or flat or papular. May be white, pink, skin-colored, pigmented.	Acetic acid can be applied to whiten lesions. Path: epidermal acanthosis, koilocytes. PCR to identify type.	Cryotherapy, TCA, electrocautery, podophyllotoxin, imiquimod, surgical excision, laser surgery, sinecatechins.	High-risk genotypes: 16, 18, 31, 33, and 35. Low-risk: 6 and 11.
EBV or CMV-associated ulcers	Epstein-barr virus or Cytomegalovirus	Aphthous-appearing ulcers in immunocompetent patients. The ulcers are usually deeper, larger and more friable in immunocompromised patients.	Viral culture or PCR revealing virus or IgM antibodies, respectively.	EBV: Usually supportive. CMV: ganciclovir or valganciclovir. Foscarnet and cidofovir are second-line agents.	Both are types of human herpesviruses. EBV is HHV4. CMV is HHV5.
Molluscum contagiosum	Molluscum contagiosum virus (a DNA poxvirus)	White to skin-colored dome shaped papules and nodules, some with central dell.	Path: Henderson-Patterson inclusion bodies.	No treatment vs topical treatment. Curretage. Cryotherapy, cantharidin, imiquimod.	Immunocompromised patients are at increased risk of infection and when affected, have more diffuse involvement.
Kaposi sarcoma	Human herpesvirus type 8	Red, brown, or purple papules or patches or nodules.	Path: promontory sign, slit-like vascular spaces.	Topical retinoids, excision, cryotherapy (2 freeze cycles), radiation, intralesional vincristine or bleomycin, initation of ART if patient with AIDS.	Genital lesions occasionally occur and can involve penile shaft or suprapubic area. Few reports of involvement of female genitalia.
Fungi					
Cutaneous candidiasis	*Candida albicans*	Red plaques, often with satellite papules, pustules, collarettes. Involes crural creases, vulva, scrotum. Glans penis is frequently involved in uncircumsized men.	Microscopic exam demonstrating pseudohyphae or yeast is diagnostic. Path: hyphae and pseudohyphae in stratum corneum, neutrophilic inflammation and subcorneal pustules.	Topical azoles such as clotrimazole, miconazole, ketoconazole, econazole BID. If concern for vaginal yeast, treat with oral fluconazole 150 mg x1.	
Tinea cruris	Dermatophytes (most commonly *trichophyton rubrum)*	Erythematous annular plaques often with central clearing and raised scaly border.	KOH prep demonstrating hyphae. Path: parakeratosis, neutrophilic inflammation, hyphae in stratum corneum. PAS or GMS highlight hyphae.	Topical azoles such as clotrimazole, miconazole, ketoconazole, econazole BID. Can use topical terbinafine, ciclopirox. Oral therapy for majocchi granuloma or extensive disease includes terbinafine 250 mg QD, fluconazole 150-300 mg QD, itraconazole 200mg QD. Griseofulvin for severe cases. Oral treatment for many weeks (4-12).	Scrotum rarely involved.
White piedra	*Trichosporon* species, *Trichosporon inkin* is the most common organism affecting pubic hair.	White or brown concretions along hair shaft, may be tubular and easily separated from hair shaft. May cause hair breakage. Usually asymptomatic.	KOH prep: revealing hyphae, arthroconidia, blastoconidia. Culture: Creamy yellow-white colonies on Sabouraud's dextrose agar.	Shaving the hair is first-line but oral and topical antifungals can be used. Consider topical imidazoles, ketoconazole shampoo, or oral fluconazole.	
Ectoparasites					
Pediculosis pubis (pubic lice)	*Phthirus pubis*	Adult lice can be seen with the naked eye. Erythematous macules or papules at feeding sites. +/- Inguinal LAD. Maculae ceruleae (blue-gray macules) seen in chronic infestations. Significant pruritus.	Clinical, enhanced by dermoscopy.	Launder all clothes (at least 130 degrees F). Permethrin 1% cream is the safest and most effective. Topical lindane or oral ivermectin may be used as alternatives.	The crab louse resembles a miniature crab with wider, shorter bodies than head lice.
Scabies	*Sarcoptes scabiei var. hominis*	Small red papules, often with excoriations, commonly involves penis and scrotum or vulva. Intense pruritus, usually worse at night. May see burrows. Dermoscopy: delta wing sign. Crusted scabies presents with thick, crusted plaques.	Mineral oil scraping: identify mite or scybala. Path: mites, ova, scybala in stratum corneum. Inflammatory infiltrate of eosinophils and lymphocytes.	Permethrin cream 5% overnight and repeat in one week or ivermectin 200 ug/kg repeated in two weeks. Second line: lindane lotion or sulfur ointment. Do not use oral ivermectin in children <5 years of age due to CNS side effects.	Crusted scabies is seen in the immunocompromised.

Abbreviations:

PID - pelvic inflammatory disease. LAD - lymphadenopathy. CNS - central nervous system. VDRL - Venereal Disease research Labaratory Test. RPR - Rapid Plasma Reagin. TTPA - T.palladium particle agglutination test. FTA-ABS - Fluorescent treponemal antibody test. SPHA - solid phase hemabsorption test. PEH - pseudoepitheliomatous hyperplasia. DFA - direct fluorescent antibody assay. BID - twice a day. QD - once a day. KOH = Potassium hydroxide. PAS - Periodic acid–Schiff. GMS - Grocott-Gomori's methenamine silver stain. TCA - Trichloroacetic acid. ART - antiretroviral therapy. AIDS - acquired immunodeficiency syndrome. q4h - every four hours. CV - cardiovascular. CS - corticosteroids. NSAIDs - non-steroidal anti-inflammatory drugs.

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2. Edwards L, Lynch PJ. Genital Dermatology Atlas. 2nd ed. Lippincott Williams & Wilkins; 2012.

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

Want more on genitals? Go online for a special Boards Fodder extended chart by this issue's authors: Genital (non-venereal) conditions.

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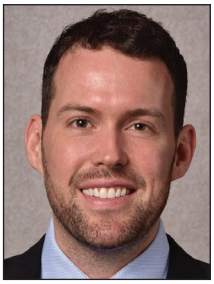


David R. Carr, MD, is an assistant professor in the division of dermatology at The Ohio State University, director of the OSU micrographic surgery and dermatologic oncology fellowship, and a current MPH in epidemiology candidate at Harvard University.

Job Searching

www

Check out the Academy's Career Compass for help with job searching: **www.healthecareers.org/aad.**

Career Case Study

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

Next issue: Hospital Dermatology

Career case study

Pursuing a career path in surgery

David Carr, MD, interviewed by *DW Directions*

Why did you pursue a specialty in surgery?

One of the best aspects of dermatology is the breadth of options available within the field. I gravitated to dermatologic surgery because the surgeries were extremely interesting, it has a very favorable patient-contact-to-administrative-burden ratio, and I am very interested in cutaneous oncology.

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?)

Dermatologic surgeons are often working on very sensitive areas; therefore, having good social skills and being able to gain patients' confidence quickly is key.

Describe a typical day. What are the various tasks? How much time are you spending with patients, office work, other?

On a typical day, we start around 7 a.m. The morning is comprised of approximately eight Mohs surgeries of varying complexity. The morning is a busy time composed of meeting patients, taking layers, reading under the microscope, and performing repairs. As I am in an academic setting, I nearly always have a fellow with me, and residents are intermittently in clinics as well. The teaching happens on the fly, discussing cases at the microscope and repair options while viewing the defect photos. Generally, most Mohs cases are finished by the afternoon unless we have a particularly complex case. In the afternoon, we see wound checks and perform several simple dermatologic procedures (for example, cyst removal). The great majority of the day is direct patient care, which is one of the highlights of the job. I do approximately 90 minutes of charting a day.

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

The knowledge base with regard to clinical diagnosis, surgical skills, and management are put to use every day. More importantly though, the ability to be flexible with my thought process, how to deal with difficult patients, and being a lifelong learner are skills I was introduced to in my training that have been the most impactful.

How does a career path in surgery differ from other subspecialties?

By definition, it is a very procedural career. Most dermatologic surgeons will be performing surgery on a daily basis.

In terms of need, workforce, and opportunities, how does it compare? (Is it more difficult to land a surgical derm position than another subspecialty?)

As in many areas of dermatology, there are always positions for dermatologic surgeons available. However, if an individual has a specific geographic location in mind, finding a position may be more difficult. Also, many dermatologic surgeons will initially find positions that are a combination of dermatologic surgery and general dermatology.

If residents are considering a surgical subspecialty, what else should they be considering? Any special training or ways to increase their proficiency beyond their residency?

If a resident is considering a micrographic surgery and dermatologic oncology fellowship, they should consider spending an increased amount of time with the dermatologic surgeons at their institution. This will allow the resident to discover the facets of the job and help with the decision of whether this is their preferred career path. Becoming involved in the ACMS and helping with surgery-specific projects are other ways to explore the field and improve their applications for fellowship.

Is there something specific to dermatologic surgery that is personally rewarding to you?

When patients hear the word cancer, many become extremely concerned. As ACMS fellowship-trained surgeons, we have invested the time to train in cutaneous oncology and the Mohs technique that will best take care of many of these cancers. In many cases, I am able to effectively treat patient's tumors within one visit. Being able to offer such a great technique has been personally very rewarding. DR

Group vs. individual: what you need to know

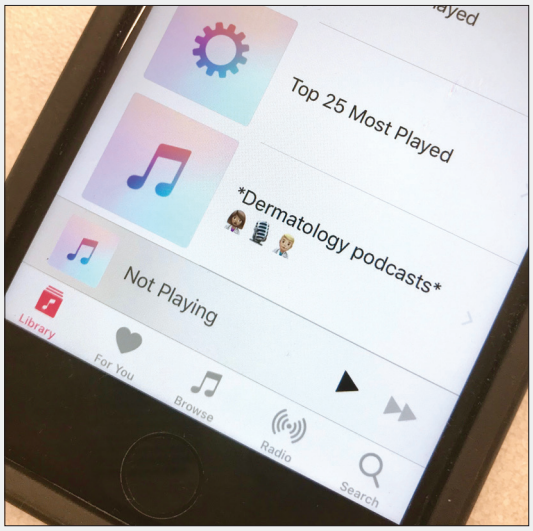
The main points of consideration between group and individual policies are differences in taxation, their portability, and the language and definitions they include. Below is a summary.

Group disability policies		Individual disability policies
If your employer pays for your group policy, the benefit is taxable.	TAX	Because you pay for the policy with post-tax dollars, the benefit is not taxed.
Usually employer-owned and therefore not portable, should you change workplaces.	PORTABILITY POLICIES	These will remain active and in force no matter where you work.
Tend to have inferior language (e.g. nebulous definitions, toothless riders) because workplaces are often required to offer them to all employees.	DEFINITIONS	As long as you do your homework, you will be able to find a policy that meets your needs.

Driving and didactics: making the most of travel time

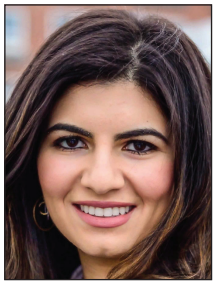
By Cindy Wassef, MD

Like most residents, I find myself doing a great deal of commuting. Whether it's commuting between clinical sites, visiting family on the weekends, or going to conferences, I have found more and more of my time spent in cars, trains, and planes. With the total commuting time sometimes spanning hours, losing this precious study time is really not an option.



In the current era, we are all very lucky to have smartphones and cars equipped with impressive sound systems. Using podcasts is a great and easy way to learn. My personal go-tos are the AAD *Dialogues in Dermatology* and *Dermatology in Review* podcasts. If I am using public transportation, headphones turn my cell phone into my own classroom. For auditory learners, this is great reinforcement for those especially dry topics that require a lot of perseverance and repetition.

I offer a few tips to enhance your audio learning experience. Invest in a car charger or portable charger — podcasts do drain your phone battery. If you are driving an older car and do not have a great sound system, putting your phone in the cup holder can help amplify the sound. Download your podcasts before leaving home to minimize data usage. And always keep your eyes on the road! Safety is key but if you are able to integrate this auditory learning into your commute, I think you will find it's a great way to get some learning in during downtime. DR



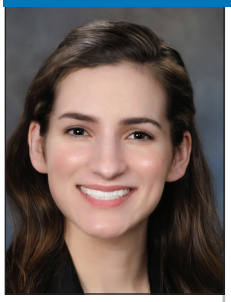
Cindy Wassef, MD, is an assistant professor of dermatology at Rutgers Robert Wood Johnson Medical School in Somerset, New Jersey.

You can follow Dr. Wassef on instagram **@girlmeetsderm**.

How do you manage resident life?

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

Inside this Issue



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Greetings residents! I hope you enjoy the content in this issue. A lot of residents have been asking about disability insurance and I hope the primer is helpful for you. It's information that a lot of us don't receive during our residency.

And speaking of what residents need to know, I thought it might be helpful to share some of my personal tips for new residents, based on what my experience has been.

1. **Get in a rhythm:** as the joke goes, "you have to eat a cow one bite at a time," and the same can be said for dermatology. There is no way to learn everything in your first few months. Accept there will be things you don't know, but make yourself a schedule and stick to it. If your program has a set didactic schedule, give yourself time to complete the reading before the lecture so hearing it again can reinforce key points. If your program doesn't include a reading schedule, take a few minutes to sit down and make one for yourself. Try to learn at least one new thing every day. When I find it hard to sit and focus, I like to set a timer on my phone and know that until it goes off, all I will do is read. Start at five minutes and work your way up.

2. **Find a review book:** by far the two most common review textbooks are *Dermatology: Illustrated Study Guide and Comprehensive Board Review* by Sima Jain, MD, and *Review of Dermatology* by Alikhan and Hocker. They are both fantastic resources for the quick and essential high-yield aspects.

3. **Apps I use in clinic:** if provided by your institution, take advantage of the UpToDate app. It is a great resource for fast information on drug formulations, standard dosages, and other information. I also really enjoy the VisualDx app; if you have a VA email, you are able to get the app for free. If using EPIC, I highly recommend installing the EPIC Haiku app onto your smartphone and using the camera function to document lesions. It is so fast and easy and the images are stored directly into the EMR, avoiding issues with keeping patient photos on a clinic camera.

4. **Get in "optical mileage":** our old path fellow loved to talk about optical mileage! The best way to learn path is to keep putting in your mileage. For me, path is definitely what I struggle with the most, but it is getting easier the more I force myself to do it. One resource I recently discovered is pathpresenter.net, which is a free digital slide library. The slides are labeled with the key findings for each diagnosis. Dr. Gardner and Dr. Singh have also uploaded a YouTube video, which covers 100 of the classic dermpath cases and is excellent for anyone getting ready to study for boards.

What study habits/books have you found helpful during residency? As always, you can reach me at **taoetken@uams.edu**. DR

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DIRECTIONS *in* RESIDENCY
A Publication of the American Academy of Dermatology

Fall 2018

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