DERMATOLOGY
Resident ROUNDUP

MARCH/APRIL 2002

Official publication of the Resident & Fellows Committee, American Academy of Dermatology Association

Supported by an educational grant from Berlex Laboratories, Inc.

Get involved with the Academy

Have you completed your residency within the last five years? Are you under 40 years of age and want to serve on a committee of the American Academy of Dermatology, or AAD Association, the organization that will represent you throughout your career in dermatology? Your knowledge and experience can be put to good use by becoming a member of the AADA Young Physicians Committee (YPC). Young Physicians are dermatologists who are under the age of 40 or within five years of completion of residency training.

Being a member of the Young Physicians Committee means you will help foster leadership of young physicians and prepare them for future roles in organized medicine. You will also have a role in presenting young physician issues to the American Academy of Dermatology (AAD) and AAD Association Boards of Directors, and foster participation in the Academy.

There are three representatives appointed to each of four regions for the YPC, and three at-large positions. The Committee is composed of 15 members. To find out if you are eligible for your region of the Young Physicians Committee, write a letter to the president of the Academy and express your interest. Your commitment to the profession will benefit you and your colleagues alike. RR

Fred F. Castrow II, M.D.
President

On the heels of another informative Residents/Fellows Symposium, held Feb. 24 at the AAD Annual Meeting in New Orleans, the 2002 Everett C. Fox Award went to Eli Sprecher, M.D., Ph.D, Rambam Medical Center, Haifa, Israel, for "Hypotrichosis with juvenile macular dystrophy is caused by a mutation in the CDH3 gene encoding P. cadherin."

Message from the outgoing chair

By Jack Resnick, M.D.

Upon the publication of this issue of *Dermatology Resident Roundup*, the AADA Residents and Fellows Committee (RFC) will be under the leadership of a newly-nominated chair, so I will be brief in my final update.

Since our last publication, continuing efforts to ease the burdens of medical school debt have led to another significant bit of progress.

Your Committee worked with trainees from other specialty societies and the AMA to support S. 1762, a bill which locks in the current federal student loan rate (the lowest rate in the program's history) until 2006. The lowest rates apply to new educational borrowing (which will affect future students), but the bill also addresses federal loan consolidations (which will affect some current trainees). I am pleased to report that the Senate approved this bill by unanimous consent in December, the House passed the bill in January, and President George W. Bush signed it into law on Feb. 8. Only three House Members voted against the bill: Jeff Flake (R-AZ), Jerry Moran (R-KS), and Ron Paul (R-TX).

In closing, I want to take a moment to thank a number of groups who have helped our Committee to function so well this year. First, credit goes to the Regional Representatives and all of the trainees who have provided input and worked for progress on resident and fellow issues. Second, I want to acknowledge the Board of Directors and other Academy leadership for their continuing support of an active role for trainees in the organization. Finally, I want to thank the Academy staff in general, and Sandra Peters, AAD Staff Liaison to the RFC, for their support and energetic efforts on behalf of trainees.

In the year ahead, I encourage each of you to communicate with your Regional Representatives and other members of the committee. Their names and e-mail addresses can be found on the resident section of the AAD Web site, *www.aad.org*. The RFC is here to help work on issues facing dermatology trainees, and I urge you to continue bringing suggestions and ideas to the attention of the committee. Chairing the RFC has been a wonderful opportunity and a great learning experience for me. Stay involved! I think you will find it both rewarding and personally fulfilling. RR

INSIDE THIS ISSUE...

Levulan® Kerastick®

(aminolevulinic acid HCl) for Topical Solution, 20%

For Topical Use Only • Not for Ophthalmic Use

Please see full Prescribing Information.

The term "ALA HCl" refers to unformulated active ingredient, "LEVULAN KERASTICK for Topical Solution" refers to the drug product in its unmixed state, "LEVULAN KERASTICK Topical Solution" refers to the mixed drug product (in the applicator tube or after application), and "LEVULAN KERASTICK" refers to the applicator only.

INDICATIONS AND USAGE

The LEVULAN KERASTICK for Topical Solution plus blue light illumination using the BLU-U®Blue Light Photodynamic Therapy Illuminator is indicated for the treatment of non-hyperkeratotic actinic keratoses of the face or scalp.

CONTRAINDICATIONS

The LEVULAN KERASTICK for Topical Solution plus blue light illumination using the BLU-U Blue Light Photodynamic Therapy Illuminator is contraindicated in patients with cutaneous photosensitivity at wavelengths of 400-450 nm, porphyria or known allergies to porphyrins, and in patients with known sensitivity to any of the components of the LEVULAN KERASTICK for Topical Solution.

WARNINGS

The LEVULAN KERASTICK for Topical Solution contains alcohol and is intended for topical use only. Do not apply to the eyes or to mucous membranes.

PRECAUTIONS

General: During the time period between the application of LEVULAN KERASTICK Topical Solution and exposure to activating light from the BLU-U Blue Light Photodynamic Therapy Illuminator, the treatment site will become photosensitive. After LEVULAN KERASTICK Topical Solution application, patients should avoid exposure of the photosensitive treatment sites to sunlight or bright indoor light (e.g., examination lamps, operating room lamps, tanning beds, or lights at close proximity) during the period prior to blue light treatment. Exposure may result in a stinging and/or burning sensation and may cause erythema and/or edema of the lesions. Before exposure to sunlight, patients should, therefore, protect treated lesions from the sun by wearing a wide-brimmed hat or similar head covering of light-opaque material. Sunscreens will not protect against photosensitivity reactions caused by visible light. It has not been determined if perspiration can spread the LEVULAN KERASTICK Topical Solution outside the treatment site to eye or surrounding skin.

Application of LEVULAN KERASTICK Topical Solution to perilesional areas of photodamaged skin of the face or scalp may result in photosensitization. Upon exposure to activating light from the BLU-U Blue Light Photodynamic Therapy Illuminator, such photosensitized skin may produce a stinging and/or burning sensation and may become erythematous and/or edematous in a manner similar to that of actinic keratoses treated with LEVULAN photodynamic therapy (PDT). Because of the potential for skin to become photosensitized, the LEVULAN KERASTICK for Topical Solution should be used by a qualified health professional to apply drug only to actinic keratoses and not perilesional skin.

The LEVULAN KERASTICK for Topical Solution has not been tested on patients with inherited or acquired coagulation defects.

Drug Interactions: There have been no formal studies of the interaction of LEVULAN KERASTICK for Topical Solution with any other drugs, and no drug-specific interactions were noted during any of the controlled clinical trials. It is, however, possible that concomitant use of other known photosensitizing agents such as griseofulvin, thiazide diuretics, sulfonylureas, phenothiazines, sulfonamides and tetracyclines might increase the photosensitivity reaction of actinic keratoses treated with the LEVULAN KERASTICK for Topical Solution.

Carcinogenesis, Mutagenesis, Impairment to Fertility: No carcinogenicity testing has been carried out using ALA. No evidence of mutagenic effects was seen in four studies conducted with ALA to evaluate this potential. In the *Salmonella-Escherichia coli*/mammalian microsome reverse mutation assay (Ames mutagenicity assay), no increases in the number of revertants were observed with any of the tester strains. In the *Salmonella-Escherichia coli*/mammalian microsome reverse mutation assay in the presence of solar light radiation (Ames mutagenicity assay with light), ALA did not cause an increase in the number of revertants per plate of any of the tester strains in the presence or absence of simulated solar light. In the L5178Y $TK^{\pm}$ mouse lymphoma forward mutation assay, ALA was evaluated as negative with and without metabolic activation under the study conditions. PpIX formation was not demonstrated in any of these *in vitro* studies. In the *in vivo* mouse micronucleus assay, ALA was considered negative under the study exposure conditions. In contrast, at least one report in the literature has noted genotoxic effects in cultured rat hepatocytes after ALA exposure with PpIX formation. Other studies have documented oxidative DNA damage *in vivo* and *in vitro* as a result of ALA exposure.

No assessment of effects of ALA HCl on fertility has been performed in laboratory animals. It is unknown what effects systemic exposure to ALA HCl might have on fertility or reproductive function.

Pregnancy Category C: Animal reproduction studies have not been conducted with ALA HCl. It is also not known whether LEVULAN KERASTICK Topical Solution can cause fetal harm when administered to a pregnant woman or can affect reproductive capacity. LEVULAN KERASTICK Topical Solution should be given to a pregnant woman only if clearly needed.

Nursing Mothers: The levels of ALA or its metabolites in the milk of subjects treated with LEVULAN KERASTICK Topical Solution have not been measured. Because many drugs are excreted in human milk, caution should be exercised when LEVULAN KERASTICK Topical Solution is administered to a nursing woman.

ADVERSE REACTIONS

In Phase 3 studies, no non-cutaneous adverse events were found to be consistently associated with LEVULAN KERASTICK Topical Solution application followed by blue light exposure.

Photodynamic Therapy Response: The constellation of transient local symptoms of stinging and/or burning, itching, erythema and edema as a result of LEVULAN KERASTICK Topical Solution plus BLU-U treatment was observed in all clinical studies of LEVULAN KERASTICK for Topical Solution Photodynamic Therapy for actinic keratoses treatment. Stinging and/or burning subsided between 1 minute and 24 hours after the BLU-U Blue Light Photodynamic Therapy Illuminator was turned off, and appeared qualitatively similar to that perceived by patients with erythropoietic protoporphyria upon exposure to sunlight. There was no clear drug dose or light dose dependent change in the incidence or severity of stinging and/or burning.

In two Phase 3 trials, the sensation of stinging and/or burning appeared to reach a plateau at 6 minutes into the treatment. Severe stinging and/or burning at one or more lesions being treated was reported by at least 50% of the patients at some time during treatment. The majority of patients reported that all lesions treated exhibited at least slight stinging and/or burning. Less than 3% of patients discontinued light treatment due to stinging and/or burning.

The most common changes in lesion appearance after LEVULAN KERASTICK for Topical Solution Photodynamic Therapy were erythema and edema. In 99% of active treatment patients, some or all lesions were erythematous shortly after treatment, while in 79% of vehicle treatment patients, some or all lesions were erythematous. In 35% of active treatment patients, some or all lesions were edematous, while no vehicle-treated patients had edematous lesions. Both erythema and edema resolved to baseline or improved by 4 weeks after therapy. LEVULAN KERASTICK Topical Solution application to photodamaged perilesional skin resulted in photosensitization of photodamaged skin and in a photodynamic response. (see **Precautions**).

Other Localized Cutaneous Adverse Experiences: Table 1 depicts the incidence and severity of cutaneous adverse events, stratified by anatomic site treated.

TABLE 1 Post-PDT Cutaneous Adverse Events - ALA-018/ALA-019

	FACE				SCALP			
	LEVULAN (n=139)		Vehicle (n=41)		LEVULAN (n=42)		Vehicle (n=21)	
Degree of Severity	Mild/ Moderate	Severe	Mild/ Moderate	Severe	Mild/ Moderate	Severe	Mild/ Moderate	Severe
Scaling/ Crusting	71%	1%	12%	0%	64%	2%	19%	0%
Pain	1%	0%	0%	0%	0%	0%	0%	0%
Tenderness	1%	0%	0%	0%	2%	0%	0%	0%
Itching	25%	1%	7%	0%	14%	7%	19%	0%
Edema	1%	0%	0%	0%	0%	0%	0%	0%
Ulceration	4%	0%	0%	0%	2%	0%	0%	0%
Bleeding/ Hemorrhage	4%	0%	0%	0%	2%	0%	0%	0%
Hypo/hyper-pigmentation	22%		20%		36%		33%	
Vesiculation	4%	0%	0%	0%	5%	0%	0%	0%
Pustules	4%	0%	0%	0%	0%	0%	0%	0%
Oozing	1%	0%	0%	0%	0%	0%	0%	0%
Dysesthesia	2%	0%	0%	0%	0%	0%	0%	0%
Scabbing	2%	1%	0%	0%	0%	0%	0%	0%
Erosion	14%	1%	0%	0%	2%	0%	0%	0%
Excoriation	1%	0%	0%	0%	0%	0%	0%	0%
Wheal/Flare	7%	1%	0%	0%	2%	0%	0%	0%
Skin disorder NOS	5%	0%	0%	0%	12%	0%	5%	0%

Adverse Experiences Reported by Body System: In the Phase 3 studies, 7 patients experienced a serious adverse event. All were deemed remotely or not related to treatment. No clinically significant patterns of clinical laboratory changes were observed for standard serum chemical or hematologic parameters in any of the controlled clinical trials.

OVERDOSAGE

LEVULAN KERASTICK Topical Solution Overdose: LEVULAN KERASTICK Topical Solution overdoses have not been reported. In the unlikely event that the drug is ingested, monitoring and supportive care are recommended. The patient should be advised to avoid incidental exposure to intense light sources for at least 40 hours. The consequences of exceeding the recommended topical dosage are unknown.

BLU-U Light Overdose: There is no information on overdose of blue light from the BLU-U Blue Light Photodynamic Therapy Illuminator following LEVULAN KERASTICK Topical Solution application.

LEVULAN KERASTICK for Topical Solution is not intended for use with any device other than the BLU-U Blue Light Photodynamic Therapy Illuminator. Use of LEVULAN KERASTICK for Topical Solution without subsequent BLU-U illumination is not recommended.

HOW SUPPLIED

The LEVULAN KERASTICK for Topical Solution, 20%, is a single-unit dosage form, supplied in packs of 6. Each LEVULAN KERASTICK for Topical Solution applicator consists of a plastic tube containing two sealed glass ampules and an applicator tip. One ampule contains 1.5 mL of solution vehicle. The other ampule contains 354 mg of aminolevulinic acid HCl. The applicator is covered with a protective cardboard sleeve and cap.

Product Package	**NDC number**
Individual LEVULAN KERASTICK for Topical Solution, 20%	50419-810-01
Carton of 6 LEVULAN KERASTICKS for Topical Solution, 20%	50419-810-06

Storage Conditions: Store at 25°C (77°F); excursions permitted to 15° – 30°C (59° – 86°F). The LEVULAN KERASTICK for Topical Solution should be used immediately following preparation (dissolution). Solution application must be completed within 2 hours of preparation. An applicator that has been prepared must be discarded 2 hours after mixing (dissolving) and a new LEVULAN KERASTICK for Topical Solution used, if needed.

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Playing the match game: advice for dermatology applicants

By Jashin J. Wu, B.A.

For Match Day 2001, there were over 850 applicants for 266 residency spots. This comes out to an unmatch rate of over 70 percent. According to polls conducted on the Dermatology Residency Board Forum *(http://pub50.ezboard.com/bdermatology)*, the USMLE Step 1 scores of the Class of 2001 and the Class of 2002 indicate that the majority of dermatology applicants are above the 90th percentile, and 25 percent are at the 99th percentile. In addition, half of all dermatology applicants are AOA (medical honor society for the top 16-20 percent of each class), another indication of the strength of this applicant pool.

Because most dermatology programs receive more than 300 applications each year, compounded by the recent use of the Electronic Residency Application Service (ERAS), which greatly facilitates applying to multiple programs, Step 1 cutoffs are set in the initial screening process. Some programs use scores in the 220-230 range as their cutoff so that the small number of faculty members can have a more manageable number of applications to review. Some top dermatology programs use AOA status together with a high Step 1 score as screening tools.

However, gaining a dermatology residency is not entirely a numbers game, and program directors look for dedication to the field as evidenced by significant research projects and strong letters of recommendation from highly regarded dermatologists. There are anecdotes of dermatology matchers who do not complete their residency due to family considerations or a lack of dedication to the field. "Non-defectors" and "known-commodities" are more likely to be accepted into a program if they are more well known to the faculty due either through attending that home institution, completing a research fellowship at that institution, or receiving a letter of recommendation from a "name" dermatologist who can correctly assess the aptitude and dedication to dermatology.

Warren Heymann, M.D., dermatology chairman at the University of Medicine and Dentistry of New Jersey at Camden, recently wrote an article in *Archives of Dermatology* outlining his personal preferences in a dermatology applicant. He admitted that it is very difficult to decide which superstar to interview for the one spot in his program. He recommended writing a unique personal statement rather than the conservative essay explaining how and why you came to the field of dermatology. An applicant should write about himself or herself candidly so that the reviewer would want to meet the applicant.

For the interview itself, he recommended that you relax, enjoy the day, have a sense of humor, and be yourself. Be honest about your answers rather than giving answers that the interview would want to hear. Ask stimulating questions to show sincere interest and knowledge of the particular program. After the interview, write a note detailing an honest appraisal of the program. Overall, he is looking for an enthusiastic, compassionate, inquisitive, honest resident who will bring joy for the next three years and who will become a trusted colleague for life.

Although it is extremely difficult for foreign medical graduates (FMG) to enter dermatology through the traditional match, there are three "back door" ways to attain dermatology training, but they require hard work and dedication to the field. The first way is to complete residency at the FMG's homeland, and upon completion, apply for a position in the United States. For instance, one resident at Northwestern University completed his training in Switzerland before being accepted at Northwestern. The drawback is that dermatology training in the FMG's homeland may be just as difficult to attain as it is in America.

If the applicant has true interest in laboratory-based research, he could attempt to find a position in the lab of a well-known dermatologist/researcher. Gaining the trust of a faculty member can result in a strong letter of recommendation, and numerous publications. On the Dermatology Forum, one person said that there were FMGs who gained residency positions at Harvard University, John Hopkins, and the Mayo Clinic in Rochester after several years of hard work in a laboratory. However, this route would require solid English speaking and writing skills in order to carry out the scholarly activities, which could be inherently difficult, depending on the FMG's homeland.

The final way may be the most reasonable. As pathology is a comparatively easier field to enter and routinely does not fill its positions, FMGs can realistically aspire to a position in that field. During their residency, they can start networking in the dermatology community and publishing dermatology papers. After completing residency, they can apply for a dermatopathology fellowship and have a reasonable chance at matching, as most positions eventually go to pathology residents rather than dermatology residents.

Matchers speak out

All applicants are not created equal, although their records may indicate so. What do some matchers do that separates them from non-matchers? Below are edited quotes of tips for applicants found on the forum. One advice sharer was in the 99th percentile for both Step 1 and 2, received honors in all of her clinical rotations, and believed that she was a pretty good candidate. She matched only in her 12th choice out of 16, prompting her to leave many pearls to future applicants.

"Apply to many programs, as many as 60-80. The money you invest is well worth a spot in dermatology anywhere! Besides, if you get 20-30 invitations out of that, consider yourself very lucky, because you can choose the ones you

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want to attend and pick interviews with dates that do not overlap."

"I interviewed at as many as I humanly could manage (16). Yet, as you will hear from this board and other applicants who have had the misfortune of not matching now or in the past, you could interview at three places and be lucky to match, or interview at 16 and not match. There were some of us who did not get our top 10 choices, so when someone tells you that you will be fine with 8-9 interviews (as I was told time and again), I would not be secure in that sentiment. You should be very strategic and interview at those places that offer 4-7 spots and not just accept those with 1-2 spots. I passed up places with four seats and six seats because of undesirable locations. But if you want dermatology bad enough, a less than perfect location for 3-4 years is not a bad exchange. And, don't be afraid to ask the program director how many people they are asking to interview and for how many seats to get an idea of your chance at that program."

"Interview at the 'good programs,' but don't forget about the 'not so good' programs. I feel that the reason I may have ended up so low down on my rank list is because the programs I chose to attend were also the ones everyone else wanted to attend. These programs are the ones that typically get their first few choices of applicants, so this will not help you if you are at the middle or bottom of their rank list."

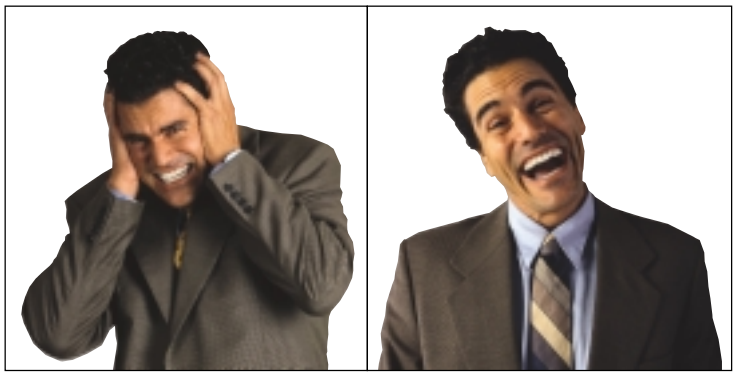
"Keeping one person from their own medical school doesn't seem out of the ordinary, but when they select four out of five it certainly catches your eye. This is useful to know when deciding where to apply and which places to accept interviews. One place in particular made me feel like they were really interested in me, and after the Match I was surprised to see they kept almost all of their own folks. More than a third (36 percent) of the people who matched did so at either their home school or the school where they did a research fellowship." RR

Jashin (Jay) Wu, B.A., a fourth-year medical student at Northwestern University, is moderating the Dermatology Residency Forum for 2002. The forum is located at *http://pub50.ezboard.com/bdermatology*. Every Sunday from 6 to 9 p.m. Eastern time, there are online chats between dermatology applicants, matchers, and residents. If you have any questions about participating in the forum and chats, please contact Jay at *jjwu@northwestern.edu*.

The morale of dermatology residents

By Jashin J. Wu, B.A.

What factors correlate with the level of satisfaction among dermatology residents at various programs? A study by the University of Alabama at Birmingham reported the perspective of 248 residents regarding the didactic, clinical, and surgical aspects of U.S. dermatology residency training in the United States. The study indicated that residents with more didactic faculty involvement, consultations and research, and surgical procedures were more satisfied with their training. This suggests that resident satisfaction is strongly correlated with a more challenging and varied training curriculum and greater faculty involvement. However, 17 percent of residents believed that they were not being trained adequately. A study of an internal medicine training program showed that resident satisfaction can be accurately measured with surveys and that residents respond positively to program modifications based on resident feedback. The University of Alabama modified its resident curriculum to include broader surgical training and a more diverse conference schedule based on the survey results.



Major changes in residency training programs may affect the quality of training and morale of residents. Murad Alam, M.D., from Columbia University described the process of converting a single program at Columbia University into two separate but strong programs. In short, intensive communication among all parties and a proactive attitude enabled the formation of two programs with minimal disruption of resident life.

Anecdotally, dermatology residents have remarked how happy they are compared to their peers in other specialties, especially internal medicine and general surgery. A controllable lifestyle and a manageable workload are undoubtedly strong factors in general satisfaction of dermatology residents. Further, there are always stories of medicine or surgery residents who decide to switch into dermatology, whereas dermatology residents who have already started dermatology training very rarely switch into other fields. My father, an internist, once told me after I decided upon a career in dermatology, "In this day and age, especially with managed care, dermatology is easily one of the best fields of medicine today!" RR

DermatoEpidemiology curriculum instituted at CWRU

By David Barzilai, M.D.-Ph.D. student

The Epidemiology Committee of the AAD has worked for years to develop a curriculum to address topics in epidemiology related to dermatology. Many areas of dermatology clinical practice depend on quality research in epidemiology and related fields. This includes research on the burden, natural history and cause of skin disease in populations, health services research, and clinical decision making with an emphasis on evidence-based medicine. The committee approved and released their curriculum about three years ago, which was then published on the AAD and International DermatoEpidemiology Association (IDEA) Web sites (see *http://www.aad.org/* in the "Member's Only" section or the publicly available version at *http://www.nottingham.ac.uk/~muzidea/aadcurric.htm*). Last year, Case Western Reserve University (CWRU) Department of Dermatology integrated this curriculum into a dermatology residency program for the first time.

In their consensus statement, the AAD Epidemiology Committee pointed out that while epidemiological principles and research are valuable in understanding patients' diseases, epidemiological training in residency is not uniformly available in residency programs. Since 1999, when the curriculum was originally released, the importance and influence of clinical epidemiology in dermatology has significantly grown.

We live now in an era of clinical practice guidelines, evidence based medicine, the Cochrane Collaboration, and increasingly rapid developments in population based research and clinical trials. To keep up with and critically evaluate these accelerating clinical advances while providing the best and most contemporary care for patients, a basic understanding of clinical epidemiology is becoming more of a necessity than a luxury for practicing dermatologists. Even today, the benefits of many therapies in dermatology have been poorly evaluated, and measuring patient outcomes such as quality of life a measure of morbidity particularly important for patients with cutaneous disease are still in the early phases of our understanding. Finally, in the current cost-conscious and outcomes-driven medical environment, there is a compelling and urgent need to promote epidemiological and health services research, establishing dermatologists as providers of the highest quality, most cost-effective care. Dermatologists early in their careers need to become well-informed active participants in the research and policy debate surrounding the health services they provide, lest they be subsequently excluded.

"...a basic understanding of clinical epidemiology is becoming more of a necessity than a luxury for practicing dermatologists."

My role in helping bring the curriculum to CWRU came out of an AAD epidemiology curriculum meeting last March, where the most recent chairman, Eliot Mostow, M.D., described the guidelines. As an M.D.-PhD. student in Epidemiology/Health Services Research interested in academic dermatology, I was particularly excited about making population based clinical research concepts more accessible. I offered to volunteer my time to coordinate with faculty to bring this curriculum to CWRU residents, and to write and administer lectures complementary to the AAD curriculum. The faculty at CWRU were receptive to the idea. CWRU Dermatology Chairman, Kevin Cooper, M.D., and residency director Bryan Davis, M.D., were particularly helpful, supporting the goals of developing interest and training related to dermatoepidemiology. Radha Mikkilineni, a first-year resident with an M.S. in epidemiology also volunteered her time to help implement the curriculum and lead a portion of the lectures and discussions.

The experiment at CWRU has received positive feedback from the residents and faculty as clinically relevant, thought provoking, and fun. The primary goals have been to foster familiarity with basic vocabulary, issues, methods, analysis, and design of epidemiological studies/biostatistics; cultivate critical evaluation skills for reading the dermatological literature; and keep the material conceptually oriented and relevant to board examinations and clinical practice.

CWRU has had a long history of support for epidemiology dating back to Mary-Margaret Chren, M.D., (now at UCSF) who developed Skindex, the popular quality of life instrument for patients with skin disease. However, the Epidemiology Curriculum is not meant solely for programs with epidemiological expertise. Rather, it was designed as a list of didactic and clinical articles for a journal club format that can be adapted by any program, regardless of the human resources available. Any program with some interest can integrate part of the curriculum, simply by bringing recommended papers into an already established journal club.

Residents or faculty interested in bringing this curriculum to your program, can e-mail me at *dxb69@po.cwru.edu* and I'd be happy to discuss the many options. I have also created a Web link resource for residents, attending clinicians, and researchers interested in learning more about the growing field of dermatoepidemiology: *http://home.cwru.edu/~dxb69/dermatoepidemiology.htm.* RR

NEWS FROM THE AMA

President signs affordable student loan bills

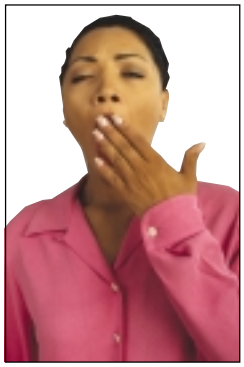
On Feb. 8, President George W. Bush signed into law S.1762, ensuring the availability of affordable student loans. This bill, which was approved by the Senate on Dec. 14 and the House of Representatives on Jan. 24, extends the current interest rate calculation

for student loans under the Federal Stafford Loan Program. The interest rates currently provided are the lowest in the Stafford Loan Program's history. The existing standard would have expired on July 1, 2003, which could have potentially raised the costs of making loans to the point that lenders could have been forced to drop out of the program. The new law extends the use of the current formula until July 1, 2006, at which time the rate will covert to a fixed rate of 6.8 percent. If financial conditions force lenders to charge a higher rate, the federal government will make up the difference.

JAMA addresses resident work hours

The January 16th issue of *JAMA* includes an article addressing recent events in the ongoing resident work hours debate, highlighting the recent Symposium, "Sleep, Fatigue, and Medical Training," cosponsored by the AMA and the American Academy of Sleep Medicine, held this past October in Washington, DC.

The article also outlines plans for a nationwide prospective study to be conducted by Charles Czeisler, Ph.D., M.D., director of the Division of Sleep Medicine at Brigham and Women's Hospital in Boston, and a multidisciplinary team of colleagues at Harvard Medical School. The study will test the hypothesis that long hours with little sleep jeopardizes both clinicians' health and the safety of their patients. It aims to survey all U.S. physicians and dentists in the class of 2002 monthly through their first postgraduate year.



A second study conducted concurrently, will examine the impact of a schedule designed to minimize extended sleep deprivation in interns in their 3-week rotation in a medical intensive care unit or a coronary care unit at Brigham and Women's Hospital. Both studies are being funded through the National Institute for Occupational Safety and Health (NIOSH) and the Agency for Healthcare Research and Quality (AHRQ).

To participate in the national resident survey or for more information, please email *workhours@rics.bwh.harvard.edu.*

IRS issues memo regarding FICA refunds for residents

In July 1998, the 8th Circuit U.S. Court of Appeals ruled that the University of Minnesota did not have to pay FICA (Federal Insurance Contribution Act) taxes for their residents because they were considered students rather than employees. In response to this court ruling, the Internal Revenue Service issued a memo in 2000 establishing rules by which institutions may file a claim to recoup FICA taxes on behalf of their residents.

However, on Nov. 9, 2001 the IRS issued a second memo in which it states that it views the primary purpose of a teaching hospital to be patient care, not education. Under this analysis, if a hospital is found to be the common law employer of a resident (i.e., in tax parlance "has the right to direct and control" the resident), the residents who trained at that hospital will not qualify for a FICA refund. For more information, or to view a copy of the IRS memo, please visit the RFS Web site at *www.ama-assn.org/ama/pub/category/7095.html#Fica* or contact Nicole Dube, RFS Policy Analyst, at *nicole_dube@ama-assn.org.*

New publication helps residents make transition

The AMA Young Physicians Section has just released its newest publication, "Making the Right Choice-Assessing Practice Opportunities, Including the Practice Environment." This interactive online publication identifies questions to consider when exploring new practice opportunities, presents considerations in choosing a practice setting, compensation issues, and identifies some available resources for information specific to any community one may be considering. Included in the latter are life-style and community resources, healthcare demographic resources, state and county information, and specialty society resources. The publication also includes links to other helpful information, including Online Job Opportunities.

This free publication is available online only, and is only accessible to AMA member physicians at *www.ama-assn.org/ama/priv/category/6739.html*. For additional resources for residents transitioning into practice, visit the RFS Web site at *www.ama-assn.org/ama/pub/category/194.html*.

NIH OFFERS LOAN REPAYMENT PROGRAMS

The National Institutes of Health (NIH) has established a number of Extramural Loan Repayment Programs. These programs are designed to recruit and retain highly qualified health professionals as clinical investigators by offering partial repayment of student loan debt.

The NIH has extramural programs in five areas: Clinical Research Loan Repayment Program, Clinical Research LRP for Individuals from Disadvantaged Backgrounds, Contraception and Infertility Research Loan Repayment Program, and Health Disparities Loan Repayment Program. Visit *www.lrp.nih.gov/* for complete information. RR

RFC announces new regional representatives

The Resident Fellows Committee added six new regional representatives this year.

Brad R. Johnson. M.D., attended medical school at UAMS and was an undergraduate at Hendrix College in Conway, Ark. He currently lives in Little Rock with his wife Sandra Marchese Johnson, M.D., and their one-year-old son, Mark. Dr. Johnson is a first year dermatology resident at the University of Arkansas for Medical Sciences (UAMS).

J. Matthew Knight, M.D., attended college at Indiana University, Bloomington and later attended medical school at the Indiana University School of Medicine. He received his MD degree in 2000. He did his internship at University of Hawaii Transitional Residency Program, Honolulu and graduated in 2001. He is currently a dermatology resident at Kansas University Medical Center, Kansas City, KS.

Alice Lee, M.D., attended Yale University, and graduated in 1993 with a B.S. in Chemistry, cum laude. After performing 18 months of voluntary church missionary work, she entered Washington University School of Medicine in St. Louis, Mo, and graduated in 1999. Part of her medical education included a rotation in Durban, South Africa, in the internal medicine and dermatology departments of the University of Natal Medical School. Dr. Lee completed a preliminary year internal medicine internship at the University of Utah. She is currently a second-year dermatology resident at the University of Chicago.

Isaac M. Neuhaus, M.D., attended Princeton University as an undergraduate. Subsequently, he went to the University of Florida for his medical school training and graduated in 2000. He completed his internship in internal medicine at Brigham and Women's Hospital. Dr. Neuhaus is currently a first year dermatology resident at the University of California, San Francisco.

Samir B. Patel, M.D., attended Northwestern University, Evanston, Ill., and later medical school at University of Cincinnati College of Medicine. He did his internship at University of Cincinnati, University Hospital, and is currently a dermatology resident there. Dr. Patel plans to pursue a career in dermatopathology.

Benjamin Solky, M.D., was born in Rochester, N.Y. He attended Haverford College as a Robert C. Byrd Senatorial Scholarship winner. In 1995, he graduated Phi Beta Kappa and with honors in Molecular Biology. He subsequently graduated from the University of Pennsylvania School of Medicine in 2000 as a member of the Alpha Omega Alpha honor society and the winner of the Nathan and Pauline Pincus Prize for outstanding achievement as a clinician. Dr. Solky completed an internship in Internal Medicine at Pennsylvania Hospital in 2001. He is currently a first-year resident at the Harvard Medical School Department of Dermatology. RR

WHAT'S ON YOUR MIND?

We are always on the lookout for interesting stories, news, ideas and issues of interest to residents. We'd also like to see more stories written *by* dermatology residents regarding topics of interest to all dermatology residents. If you have news or ideas for stories, please contact Dean Monti at the American Academy of Dermatology, *dmonti@aad.org*.

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