Message from the chair
By Samir B. Patel, M.D.

It is a privilege to serve as the Chair of the Resident and Fellows Committee (RFC) of the American Academy of Dermatology Association (AAD). In recent years, the RFC has been instrumental in promoting several important issues. The committee worked diligently to change the date of the American Board of Dermatology (ABD) Certifying Examination to August of each year. The change will take effect this year. The RFC also worked with the American Medical Association (AMA) to support bill S.1762 which locked in the federal student loan rate at an all time low until 2006. President George W. Bush signed the measure into law on Feb. 8, 2002. The RFC's AMA representatives also attended AMA meetings and supported an AMA approved policy limiting resident work hours and mandating improved work conditions.

The committee has also put significant effort into publication of the AAD's Dermatology Resident Roundup newsletter, which has provided an important informational resource for trainees in dermatology. Benjamin Solky, M.D., has created the Dermatology Boards' Fodder section of the publication, which has proved to be an extremely popular learning resource for residents (see page 6). In addition, J. Matthew Knight, M.D., coordinated the Resident Colloquium at this year's AAD Annual Meeting in San Francisco. The forum provided an excellent setting for leading dermatologists to discuss dermatology related career options with residents (see page 4).

As a new year begins, our committee is eager to address topics that are important to residents and fellows. We are working very closely with the American Board of Dermatology (ABD) to enact changes which will improve the computerized format and test content of the yearly In-Training Examination (Mock Boards). The Board has been very receptive to RFC input concerning the examination.

As chair of the RFC, I report to the AADA's Council on Health Policy and Practice during monthly conference calls where we discuss issues ranging from HIPAA and Medicare reimbursement to workforce shortage matters. As part of this Council, I will travel to the 2003 AADA Washington Conference in September to meet with members of Congress to discuss issues important to physicians. I am also participating in quarterly AAD Board of Directors meetings where we are fortunate to have an RFC presence. Our AMA delegate, Adam Rubin, M.D., will be attending AMA meetings to represent dermatology residents and to advocate trainee concerns (see page 5). We will continue our efforts to provide useful information in the Dermatology Resident Roundup, as well.

I would like to take this special opportunity to thank Edgar Ben Smith, M.D., for his extremely important role as a consultant to the RFC over the last several years and to congratulate him as the 2003 recipient of the AAD's Gold Medal.

The American Academy of Dermatology is constantly and actively involved in promoting our profession's ideals and goals. The RFC provides a place within the Academy where residents and fellows can be heard. If you would like to become involved or have any ideas to discuss, please do not hesitate to contact me by e-mail at patelsb2001@yahoo.com. I appreciate the opportunity to serve on this committee, and I look forward to another great year!
3M Pharmaceuticals, makers of Aldara (imiquimod) Cream, 5% would like to thank the Dermatology Community for their support.
Aldara® SR (imiquimod) 5% cream is indicated in the treatment of external genital and perianal warts (vulvar and anal) occurring in individuals 12 years old and above.

**INDICATIONS AND USAGE**

Aldara cream has not been evaluated for the treatment of genital, intra-epithelial, cervical, rectal, or intra-anal human papillomavirus-related disease and is not recommended for these conditions.

**PRECAUTIONS**

**Information for Patients**

Patients using Aldara 5% cream should receive the following information and instructions: The effect of Aldara 5% cream on the transmission of genital human papillomavirus (HPV) is unknown. Aldara 5% cream is an occlusive dressing and may cause hyperhidrosis (increased sweating). Therefore, concurrent use is not recommended.

- Use of the product is to be used as directed by a physician. Individuals with external genital warts may need different treatments from those with internal genital warts.
- The treatment area should not be bathed or otherwise covered or wrapped to be occlusive.
- Benzoyl peroxide, a soap, or wash should be avoided with the cream on it for 4 to 6 hours prior to applying the cream.
- It is recommended that 4 to 6 hours before Aldara 5% cream application the treatment area be washed with mild soap and water. Treatment with Aldara cream can be removed after the skin reaction has subsided. There is no clinical experience with Aldara cream therapy immediately following the treatment of genitapillary warts with other cream-based applied drugs; therefore, Aldara cream administration is not recommended until genital/papillary lesions is healed from any previous drug or surgical treatment. Aldara has the potential to exacerbate inflammatory conditions of the skin.

**WARNINGS**

Aldara cream has not been evaluated for the treatment of vulvar or anal skin reactions associated with individuals 12 years old and above.

**CONTRAINDICATIONS**

There are no known contraindications to the use of Aldara 5% cream.

**ADVERSE REACTIONS**

Up to 25% of patients treated with Aldara™ cream experienced skin reactions. Most of these reactions were mild and consisted of erythema. In the treatment area, the skin may become red, tender, and itchy. A reaction may occur when the cream is applied to the skin. The reaction will typically subside within 72 hours. Typically, the reaction clears in 3 to 4 days. The reaction may be reduced by applying less cream or applying the cream less often. The reaction may occur after one application or after multiple applications. The reaction may be treated with an oral antihistamine. If the reaction persists or worsens, the cream should be stopped and the treatment area should be washed with soap and water.

**REMAINING MATERIALS**

- **Further information:**
  - For further information, contact your health care provider.
  - To report suspected adverse reactions, contact your health care provider or the manufacturer.

**DOSAGE AND ADMINISTRATION**

Aldara cream is to be applied 3 times per week, prior to normal sleeping hours, and left on the skin for 4 to 6 hours. Following the bedtime application, the cream should be washed off with soap and water. The patient should wash their hands after treatment with Aldara cream. If a patient develops a severe skin reaction or develops a new rash or lesion while using Aldara cream, the patient should consult their physician. If a patient develops a severe skin reaction, the cream should be discontinued and a physician should be consulted. If a patient develops a new rash or lesion while using Aldara cream, the patient should consult their physician. If a patient develops a severe skin reaction, the cream should be discontinued and a physician should be consulted. If a patient develops a new rash or lesion while using Aldara cream, the patient should consult their physician. If a patient develops a severe skin reaction, the cream should be discontinued and a physician should be consulted. If a patient develops a new rash or lesion while using Aldara cream, the patient should consult their physician. If a patient develops a severe skin reaction, the cream should be discontinued and a physician should be consulted.

**HOW SUPPLIED**

Aldara cream is available in 5%, is supplied in single-use packets which contain 250 mg of the cream. Available as a box of 12 packets NDC 03094-00142. Store below 25°C (77°F). Avoid freezing.

**Important:** For dosage recommendations, directions for use, and precautions, see the prescription information, read accompanying insert. Store below 25°C (77°F). Avoid freezing.

**Rx only**

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RFC meets by the bay

The Resident/Fellows Committee met in San Francisco March 22, coinciding with the 2003 AAD Annual Meeting. Joel Gelfand, M.D., outgoing chair of the RFC, led the meeting, which focused on strategies to inform residents and medical students about dermatology in general and medical dermatology in particular.

New officers for the 2003-2004 term are:
- Samir B. Patel, M.D., chair
- Benjamin Solky, M.D., vice chair
- Issac Neuhaus, M.D., secretary

Residents Colloquium presents diversity in dermatology

The 2003 Residents Colloquium was held March 22, during the American Academy of Dermatology’s 2003 Annual Meeting in San Francisco. This event, sponsored by the AAD Residents/Fellows Committee, is regarded by attendees as vital and informative to dermatology trainees, providing them with a clearer understanding of the various fields in dermatology and helping to guide the aspiring sub-specialist/academician.

J. Matthew Knight, M.D., led the event and presented the speakers, who were: Antoinette F. Hood, M.D., Eastern Virginia University (dermatopathology); William D. James, M.D., University of Pennsylvania (academic dermatology); Neil Prose, M.D., Duke University (pediatric dermatology); Dee Anna Glaser, M.D., Saint Louis University (cosmetic dermatology); and Roy C. Grekin, M.D., Univ. of California-San Francisco (Mohs micrographic surgery/dermatological surgery).

Medical liability top concern for final-year residents

Final-year residents say medical liability tops their list of concerns, according to a recent survey conducted by the national physician search firm of Merritt, Hawkins and Associates (MHA). The survey results, which sampled 325 respondents from 34 states, reveals that 62 percent of the residents are concerned about medical liability — a 59 percent increase over 1995 figures.

AMA Resident and Fellows Section Governing Council Chair-Elect Maurice Sholas, M.D., said the results are very telling. “This goes beyond preparing to practice. It speaks to being adequately trained in the process as well. Medicine is a series of tutelages. If everyone who is supposed to be teaching us is leaving, then there is no one left behind to show us the way.”

To view the resident survey in its entirety online, go to http://unity.ama-assn.org/UM/TA.asp?A40.442.56.2.80424.
By Adam Rubin, M.D.
Dermatology Resident & Fellows Committee Delegate to the AMA-RFS

The Resident and Fellow Section (RFS) of the American Medical Association held its 27th Annual Business Meeting from June 12-14, 2003, in Chicago. A brief summary of the highlighted issues follows:

**RESIDENT WORK HOURS**

The Accreditation Council on Graduate Medical Education (ACGME) approved new standards for resident work hours in June 2002. These standards included a limit of 80 work hours per week, with a possibility of increasing the limit by 10 percent. One day (defined as 24 hours) out of seven was to be free of patient care activity. Call was to be limited to no more than every third night. Each of these parameters could be taken as an average over four weeks. A 10-hour minimum rest period was required between work periods. Continuous on-duty time was to be limited to 24 hours, with an additional 6 hours permissible for patient transfers and educational activities. These changes were scheduled to go into effect July 2003.

However, in February 2003, the ACGME modified these requirements by giving training institutions more leeway. The requirement for a 10-hour rest period between work periods was removed, and instead it was stated that resident’s “should” have this rest period. The activities permissible during the 6-hour time period after a 24-hour shift was expanded by allowing the definition of these activities to be set by a resident’s specialty program requirements. The definition of a “new” patient was also changed to be under the discretion of a resident's specialty program requirements.

The American Academy of Sleep Medicine designed a task force called S.A.F.E.R. (Sleep, Alertness, and Fatigue Education in Residency) in which the AMA-RFS participated. This task force met to develop an educational program about sleep deprivation that will be distributed to residents, program directors, and others involved in resident training in July 2003.

In March 2003, Congressman John Conyers Jr. (D-MI) reintroduced his bill “The Patient and Physician Safety and Protection act of 2003” which addresses resident work hours. Key components of this bill include civil penalties for work hour violations, public disclosure of violations, and whistleblower protections. Senator John S. Corzine (D-NJ) has recently introduced a similar bill.

**EMPLOYMENT OF NON-CERTIFIED FOREIGN MEDICAL GRADUATES**

A California law was passed last year that allowed the creation of a pilot program to allow Mexican physicians not certified by the Educational Commission for Foreign Medical Graduates (ECFMG) to practice in underserved areas of California. This program was opposed by the RFS, with emphasis on ensuring the same standard of care for all United States populations. To fill the void of physicians in underserved areas, the RFS suggested expanding incentive programs such as the National Health Service Corps or visa waiver programs.

**PRIVACY PROTECTION AND THE FEDERATION CREDENTIALS VERIFICATION SERVICE (FCVS)**

The RFS supported a resolution to limit the authority of the FCVS when gathering and verifying information. The current “Affidavit and Release” form allows wide latitude in obtaining information about a licensure applicant and denies any recourse if any negative outcome occurs from the mishandling of this information.

**CONSOLIDATION OF THE LCME SECRETARIAT OFFICE**

The Liaison Committee on Medical Education (LCME) is currently housed in both the AMA and the Association of American Medical Colleges (AAMC) headquarters and has two Secretary positions. The AMA and AAMC have agreed to consolidate these two positions into a single position housed in the AAMC offices. The RFC opposed this action, as it may result in diminished effectiveness in the AMA’s role in medical education.

**MEDICAL ERRORS**

The RFS supported a resolution to re-emphasize to patients and the public current efforts to improve quality and reduce errors in medical practice. The obligation of physicians to report impaired, incompetent, or unethical colleagues was also emphasized. The RFC also supported a reaffirmation of the AMA’s commitment to uphold the highest ethical standards in clinical practice, research, and administration by physicians.

**“JUNIOR AMA”**

In an effort to increase long-term membership, and increase awareness of the AMA, the RFS supported a resolution to work with the Medical Student Section to develop an outreach program to premedical students. The specifics of the program will be developed and reported at the December 2003 interim AMA meeting.

**TOBACCO**

Two resolutions concerning tobacco were supported by the RFS. The first resolution was to oppose the securitization of future tobacco settlement payments. The AMA already supports a policy that all monies derived from the Master Settlement Agreement of 1998 be applied to research, education, and prevention of nicotine addiction as well as to treatment of tobacco related diseases. At least 13 states have all or part of the future tobacco settlement as a smaller up-front payment. Several of these states have used the revenues to balance their budget, and not towards the intended goal. The RFS also passed a second resolution to support the Framework Convention on Tobacco Control Treaty.

**HOSPITAL SAFETY**

The RFS supported a resolution to encourage the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and the Occupational Safety and Health Agency (OSHA) to investigate the protection of physicians from violence in the workplace.
**Boards’ Fodder: Histologic Bodies**

Benjamin A. Solky, M.D., Jennifer L. Jones, M.D., and Clare Pipkin, M.D.

This is the fourth installment in an ongoing series designed to bring to light “askable factoids” for the dermatology boards and mock boards. This installment focuses on important (or frequently asked) histologic bodies. Again, by no means is the list exhaustive, but...enjoy!

<table>
<thead>
<tr>
<th>BODY</th>
<th>DESCRIPTION</th>
<th>ENTITY OR ENTITIES</th>
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<tr>
<td>Antoni A tissue</td>
<td>Cellular areas with Verocay bodies</td>
<td>Schwannoma</td>
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<tr>
<td>Antoni B tissue</td>
<td>Loose stromal area with relative paucity of cells</td>
<td>Schwannoma</td>
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<td>Arao-Perkins Bodies</td>
<td>Elastic bodies seen within “streamers”</td>
<td>Androgenic alopecia</td>
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<td>Stellate collections of eosinophilic spicules and giant cells</td>
<td>Sarcoïdosis, Botryomycosis, Sporotrichosis, Actinomycosis, other</td>
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<td>Banana Bodies</td>
<td>1) Found in Schwann Cells on EM</td>
<td>1) Farber’s Disease</td>
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<td>2) Crescent Banana-shaped pigmented bodies in the upper dermis</td>
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<td>Birbeck Granules</td>
<td>Racquet-shaped bodies seen on EM</td>
<td>Langerhans Cells</td>
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<td>Caterpillar Bodies</td>
<td>Eosinophilic wavy collection in basal layer of epidermis, found on roof of blister</td>
<td>Porphyria Cutanea Tarda, pseudoporphyria, and erythropoetic protoporphyosis</td>
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<td>Cholesterol Clefts</td>
<td>Needle-like crystals in fat cells</td>
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<tr>
<td>Cigar Bodies</td>
<td>Budding cigar-shaped PAS + yeast (rarely seen)</td>
<td>Sporotrichosis</td>
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<td>Civatte/Colloid Bodies</td>
<td>Apoptotic keratinocytes which may be found in epidermis or extruded into papillary dermis</td>
<td>Interface Dermatitis</td>
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<td>Comma-shaped Bodies</td>
<td>Cytoplasmic bodies seen on EM</td>
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<td>Dyskeratotic keratinocytes with elongated nuclei seen in the granular zone</td>
<td>Darier’s, Grover’s, Warty Dyskeratoma, (Hailey-Hailey)</td>
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<tr>
<td>Corps Ronds</td>
<td>Dyskeratotic keratinocytes with perinuclear halo and surrounding basophilic dyskeratotic material</td>
<td>Darier’s, Grover’s, Warty Dyskeratoma, (Hailey-Hailey)</td>
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<td>Cowdry Type A &amp; B Inclusion Bodies</td>
<td>Type A: intranuclear eosinophilic, amorphous bodies surrounded by a clear halo Type B: in neuronal cells</td>
<td>A-HSV, CMV, and VZVB- Polio</td>
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<td>Donovan Bodies</td>
<td>Intrahistiocyte inclusions comprised of organisms which stain positively with Warthin-Starry stain or Giemsa</td>
<td>Granuloma Inguinale</td>
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<td>Dutcher Bodies</td>
<td>Intranuclear inclusions of immunoglobulins</td>
<td>Plasmacytoid Proliferations (e.g. Multiple Myeloma)</td>
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<td>Farber Bodies</td>
<td>Curvilinear bodies seen in the cytoplasm of fibroblasts and endothelial cells on EM</td>
<td>Farber’s Disease</td>
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<td>Flame Figures</td>
<td>Dermal eosinophils and eosinophilic granules surrounding central masses of brightly pink amorphous collagen</td>
<td>Well’s syndrome, Arthropod bites, other</td>
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<td>Floret Cells</td>
<td>Multinucleated giant cells with radially arranged nuclei</td>
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<td>Flower Bodies/Cells</td>
<td>Atypical CD4 + T-cells</td>
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<td>Giant Liposomes in Neutrophils</td>
<td>Large liposomal granules</td>
<td>Chédiak-Higashi</td>
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<td>Globi</td>
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<td>Lepromatous Leprosy</td>
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<td>Henderson-Patterson Bodies</td>
<td>Cytoplasmic eosinophilic inclusions in keratinocytes</td>
<td>Molluscum Contagiosum</td>
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<td>Kamino Bodies</td>
<td>Eosinophilic bodies composed of BMZ material</td>
<td>Spitz Nevus</td>
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<td>Lamellar/Odland Bodies</td>
<td>Free fatty acid, ceramide, and cholesterol containing vacuoles released from the golgi in the stratum granulosum seen on EM</td>
<td>Normal Skin, absent in Harlequin Fetus</td>
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<td>Lipofuscin Granules</td>
<td>Yellow-brown granules in macrophages</td>
<td>Amidarone hyperpigmentation</td>
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<tr>
<td>Macromelanosomes</td>
<td>Large melanosomes</td>
<td>Café au lait macules, Neurofibromatosis (in CALs), Chédiak-Higashi</td>
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<tr>
<td>MaxJoseph Space</td>
<td>Artificial separation between dermis and epidermis</td>
<td>Interface dermatitis, especially LP</td>
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SEE BOARDS’ FODDER PAGE 7
Student launches evidence-based dermatology Web site

Dr. David Barzilai, who is five years into the Case Western Reserve University School (CWRU) of Medicine’s M.D./Ph.D. in health services research program, has founded http://ebderm.org, an evidence-based dermatology Web site to help dermatology residents, physicians and other health professionals to locate and evaluate the best and most current published research and learn how to practice evidence-based medicine. The information even can be used to brush up on epidemiology, or applied clinically, immediately before and during patient encounters.

Dr. Barzilai originally established the site in 2002 as part of an effort to incorporate epidemiologic topics into the curriculum for those in dermatology residencies at CWRU-affiliated hospitals, complementing a goal of the American Academy of Dermatology (AAD). In addition to the Web site, he developed a lecture series based on recommendations of the AAD Epidemiology Resource Group. “I wanted to make epidemiology and health services research exciting and accessible to dermatology residents,” he said. “I wanted them to appreciate how, for example, when they see a patient, knowing the prevalence of the disease in the population and understanding the characteristics of the diagnostic test are pertinent to clinical decision making. An understanding of epidemiological principals not only permits critical evaluation of new research findings, but also complements the reasoning behind sound patient management.”

The site, which has proven popular among Web surfers visiting dermatology sites, was recently certified by the nonprofit Health on the Net Foundation as meeting its eight principles for ethical, confidential and trustworthy health-related information on the Web. Because peer review is a critical component of evidence-based medicine, Dr. Barzilai had the site reviewed by respected members of the dermatology community, including Eliot Mostow, M.D., M.P.H., assistant clinical professor of dermatology at CWRU and chairman of dermatology at Northeastern Ohio Universities College of Medicine, who serves as co-chief editor of the stewriter Dr. Barzilai. With support from Kevin Cooper, M.D., chairman of the department of dermatology at CWRU and University Hospitals of Cleveland, Drs. Barzilai and Mostow have established an editorial board comprised of Martin Weinstein, M.D., Ph.D., an expert in dermato-epidemiology and melanoma; Michael Bigby, M.D., of Harvard Medical School, an editor of Archives of Dermatology and originator of its quarterly evidence-based dermatology section; Meg Chren, M.D., a health services researcher in dermatology at the University of California, San Francisco, and creator of Skindex, a quality-of-life measure for skin diseases; and Hywel Williams, Ph.D., co-author of the widely used textbook The Challenge of Dermato-Epidemiology and leader of the Cochrane Skin Group, an international consortium based in the United Kingdom. Ashish Bhatia, M.D., a pioneer in dermatology educational software development (http://derm.md), serves as chief technological officer for the Web site, and will be overseeing enhancements for the “next generation” implementation of the Web page. Those interested in contributing can contact Dr. Barzilai at dxb69@cwru.edu. He has visions of a virtual community with scientific research exchange, continuing medical education, and site content that can be downloaded to personal data assistant devices (PDAs). Dr. Barzilai received his Ph.D. in May and ultimately, after completing his M.D. in 2005, hopes to become a leader in academic dermatology research and education.
AAD resident, fellows mentor program available

The American Academy of Dermatology’s Resident and Fellows Committee (RFC) has formed a mentorship program that is intended to serve as a resource for residents, young physicians, and all AAD members who have career or clinical questions in dermatology.

The Mentorship Program has been designed informally. Specific details, including the scope of the mentorship, are to be worked out on an individual basis. This program is aimed at all residents, fellows and young physicians.

Mentors include:

Michael J. Bernhardt, M.D., Jacksonville, FL
Alina C. Bridges, M.D., Rochester, MN*
Richard Clark, M.D., Stony Brook, NY
Fran E. Cook-Bolden, M.D., New York, NY
Ray Cornelison, M.D., Oklahoma City, OK
Jaime Ferrer-Bernat, M.D., MEXICO
Philip Fleckman, M.D., Seattle, WA
Carlos Guillen, M.D., Valencia, SPAIN
Thomas J. Hogarty, M.D., Big Horn, WY
Sandy Johnson, M.D., Little Rock, AK
Jason Lockridge, M.D., Gainesville, FL
Markham C. Luke, M.D., Rockville, MD
Laertes Manuelidis, M.D., Charleston, SC
Ricardo Mejia, M.D., Heathrow, FL
George Murakawa, M.D., Detroit, MI*
Alessandra B. Alio Saenz, M.D., VENEZUELA
Linda Spencer, M.D., Crawfordsville, IN
Virginia P. Sybert, M.D., Seattle, WA
Birgit K. Toome, M.D., Voorhees, NJ*
LaKimerly Woods-Coates, M.D., Freeport, IL

* new since last issue

Members who would like to participate as a mentor may fill out the questionnaire online at the AAD’s Web site, www.aad.org. Mentors will be posted on the resident section of the AAD Web site. For more information about the program, contact RFC Staff Liaison Steve Currier by phone at (847) 240-1798, or e-mail scurrier@aad.org.

Save the date!
AAD ANNUAL MEETING
FEB. 6-11, 2004  WASHINGTON, D.C.