DERMATOLOGY
Resident ROUNDUP

FALL 2004

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

Supported through an unrestricted educational grant from 3M Pharmaceuticals

Message from the chair

By Brian Lester, M.D.


BRIAN LESTER, M.D.

As Chair of the Residents and Fellows Committee (RFC), I want to share with you some significant progress that has been made regarding the In-Service Examination ("Mock Boards") as well as invite your input regarding important proposed changes to the Certifying Examination ("Real Boards").

Many months ago, I began a dialogue with the American Board of Dermatology (ABD) leadership regarding how best to improve the annual In-Service Examination. Several resident concerns were raised, regarding both the exam itself as well as the manner in which exam scores were reported. The ABD leadership has promised to take action to address these concerns. First, they have committed to providing higher quality images for next year's test. Second, they have promised to report scores to individual residents at the same time that scores are released to programs. Additionally, the ABD has agreed that a more specific breakdown of scores will be helpful in providing residents with a detailed account of their strengths and weaknesses. This will be particularly helpful to senior residents as they begin to prepare for the Certifying Examination.

We will also soon be seeing substantial changes to the Certifying Examination. Beginning in 2007, the ABD will be changing the examination from a two-day paper and pencil test to a one-day computer based exam. The main obstacle in this conversion stems from the fact that the glass slide portion of the test cannot be administered at commercial testing centers. Therefore, the ABD has proposed several options for how best to conduct the exam. One option involves splitting the test into two parts: a microscopic section (to be administered either sometime during the third year of residency or sometime after the final year) and a computerized multiple choice section. A second proposed option would be to administer the entire examination at one time in August at the American Board of Pathology Testing Center in Tampa.

The ABD has not yet decided which option to pursue. I recently sent a letter out to all chief residents explaining in more detail these choices and asking for your feedback. I urge all residents (and especially those in their first year of training who will be most affected!) to take a moment to review with your chief resident my letter as well as the enclosed, corresponding memo and survey from Toni Hood, M.D., executive director of the ABD. The ABD cares what residents think, and I hope you will take a moment to voice your opinion. Please feel free to contact me with any thoughts or concerns at Brian_Lester@brown.edu. RR

Practice Made Perfect!

Advice on starting a practice: Life after Residency

By Richard L. Averitte, Jr., M.D.

I know what you're thinking — residency will be over in less than a year and what am I going to do? Those of you who have decided to stay in academics will practice similarly to the way you practiced in training. Although you will have more responsibility and be unsupervised, you will have a good support system.

The decisions — for those of you who will be entering some form of private practice during the summer or fall — are many and complex. But first you must assess who you are as a person and as a practitioner. Simply put, your personal needs and lifestyle will influence your decisions as a practitioner. Many physicians are unsure about starting a new private practice of their own. It can be a very challenging endeavor but the rewards are many. This is an option that should be considered by all. However, being an owner is not for everybody. Contemplating ownership should be considered by every graduate as an exercise in self-evaluation. Many graduates consider joining an existing practice

SEE PRACTICE MADE PERFECT PAGE 5

INSIDE THIS ISSUE...

NOW APPROVED

FOR ACTINIC KERATOSIS AND SUPERFICIAL BASAL CELL CARCINOMA

3M Pharmaceuticals

 Printed in U.S.A. 9/04 AL-9300

3M

Spotlight on Fellowship

The MOHS Micrographic Surgery Fellowship at the University of Louisville

By Jeannine Koay Hoang, M.D.,
University of Louisville, Kentucky

"A substantial caseload of complex and interesting surgeries, extensive experience with numerous cosmetic procedures, excellent training in the medical and surgical evaluation and treatment of skin cancers, and a wonderful mentor"—these characteristics are the strengths of the dermatologic surgery/MOHS micrographic surgery fellowship at the University of Louisville, according to the current fellow, Maralyn Seavolt, M.D.

The MOHS fellowship at the University of Louisville is an intense one-year program established by Michael McCall, M.D., in 1989, during which the fellow receives extensive instruction on all aspects of MOHS micrographic surgery, including its indications and applications, the techniques involved in removing tissue, mapping, and processing frozen tissue specimens, the histopathologic evaluation of frozen sections, and the various methods of repairing surgical defects. The fellow spends five days a week in the MOHS surgery area, where he/she aids in the evaluation and consultation of new patients and acts as assistant (or as primary surgeon after gaining experience) during the surgical procedures. The fellow also participates in follow-up evaluation of patients, thereby acquiring important knowledge regarding the healing process and potential surgical complications.

In describing part of his philosophy of teaching, Dr. McCall related, "I allow my fellows quite a bit of autonomy, but I never leave them to fend for themselves. A lot of the learning is simply by doing the surgeries. However, I think that a significant degree of supervision is imperative for learning correct surgical technique, good principles of managing skin cancers, and the different approaches to reconstructing a surgical defect."

Dr. McCall, who trained under Frederic Mohs, M.D., performs around 1,200 MOHS cases a year, reconstructing 90-95% of his own cases. The fellow is also able to spend time with Timothy Brown, M.D., another MOHS surgery attending in the practice, who is currently applying for co-directorship status of the fellowship program. Dr. Brown performs approximately 1,000-1,100 cases a year. With this considerable volume of patients, fellows are exposed to a wide array of intermediate and complex closures, far surpassing the minimum requirements of the American College of Mohs Micrographic Surgeons and Cutaneous Oncologists.

Dr. McCall is also part of a busy cosmetic dermatology practice. In addition to MOHS procedures, fellows are also able to observe, assist, and perform a variety of cosmetic procedures, including but not limited to, botulinum toxin treatment, fillers, tumescent liposuction, fat transfer, laser therapy, thermage, dermabrasion, sclerotherapy, and intense pulsed light (IPL).

As part of their training, fellows are encouraged to participate in clinical research projects and are required to help in the supervision and teaching of medical students and residents through staffing clinics, participating in hospital consultations, presenting lectures at noon conferences, and moderating surgery journal club.

"In the few months that I've trained under Dr. McCall, I've already learned so much," said Dr. Seavolt. "I feel very lucky to be here because we not only perform high volumes of MOHS procedures, but we also do a substantial amount of cosmetics. This fellowship provides great opportunities to acquire expertise in all realms of surgical and cosmetic dermatology."

For more information about the Mohs fellowship at the University of Louisville, please contact Paul Eakins (surgical coordinator), via phone (502) 625-2210, or fax (502) 583-3028. RR

JEANNINE KOAY HOANG, M.D.

Estate Planning Documents – What Every Physician Must Have

by Lawrence B. Keller, CLU, ChFC & Doris L. Martin, Esq.

All physicians need to have certain legal documents as part of their estate plan. Even if you are young, have little or no assets, and are not married, it is important to execute the proper legal documents to ensure that your wishes regarding medical treatment and property distribution are respected and honored. Generally, four documents form the foundation of every estate plan — a last will and testament, a durable power of attorney, a healthcare representative appointment, and a living will.

Last Will and Testament

A **will** is the cornerstone of an estate plan. If your will is drafted properly and conforms to the law in your state, it will ensure that wishes regarding property distribution are recognized and legally enforceable. If you do not have a will when you die, you will be considered as having died "intestate." This means that the laws of your state will determine how your property will pass to your closest living relatives. Unfortunately, many times the state's formula and rules for distributing assets to those people would not be what you would have wanted if you had done some planning.

In addition, a will can allow you to:

- Appoint a guardian for a minor child.
- Name an executor to collect and manage the estate assets, distribute them to beneficiaries, and pay any taxes, debts, and estate expenses.
- Establish domicile (permanent legal residence) in a particular state, for tax or other reasons.
- Provide that property is held in trust for your spouse or children under the terms that you choose until the age that you determine.
- Create a trust for a disabled beneficiary to maximize eligibility for government assistance.
- Avoid the increased legal costs and delay of administering an estate without a will.
- Protect your children's inheritance if they are not children of your current spouse.
- Prevent or ameliorate family tension by expressing your wishes.

Durable Power of Attorney

It is expected that during the course of our lives we may become incapacitated and unable to act either because of a physical infirmity or mental incapacity. A **durable power of attorney** is a document that allows a person, referred to as an "attorney-in-fact," to act in all matters of a financial and/or legal nature when you are not in a position to act for yourself. Without one, it is necessary for someone to go to court to be appointed as your representative, which is both an expensive and cumbersome proceeding, and one that can take months to complete.

Healthcare Representative Appointment

A document appointing a **healthcare agent** empowers another person to act as your "agent" to make decisions regarding your healthcare if you become incapacitated and unable to make them yourself. This document is called a health care proxy, a medical power of attorney, or the designation of a surrogate, depending on the state in which you live. It allows your agent to make, as you have instructed, all types of medical decisions, including changing medications, choosing courses of treatments, selecting physicians, transferring you to medical facilities, and withholding artificial nutrition, hydration, and ventilation. Not surprisingly, doctors, like the proverbial cobbler's child, often have never appointed a health care representative for themselves. Without one, your medical care could be determined by lawyers and the courts.

Living Will

A **living will** (sometimes called a "medical directive" or "advanced directive") is a statement of your wishes as to what medical treatment should be provided or withheld, if you become incapacitated and unable to communicate them yourself. States accord this expression of your wishes varying degrees of enforceability, but it can at least provide a guide.

Beyond The Basics

Many married couples in the United States have a tragic financial blunder hidden in their estate plans. In order to understand why, you must be familiar with two fundamental rules of the estate tax system.

The Unified Credit

The unified credit (commonly called the "estate tax exemption") allows an individual to leave assets worth up to a certain amount ($1,500,000 in 2004) at his or her death to anyone, without any Federal estate tax being levied. However, if it is not used, it is lost forever.

The Unlimited Marital Deduction

A married person may leave an unlimited amount of assets to his or her spouse (provided both spouses are U.S. citizens) free of estate taxes and without using up any of the estate tax exemption. Unfortunately, when thinking about their estate plan, too many married couples see the unlimited marital deduction as their solution. Unfortunately, this strategy can cost one's children or other beneficiaries hundreds of thousands of dollars in estate taxes if the surviving spouse's estate is worth more than the estate tax exemption. Meanwhile, the first spouse's estate tax exemption was not used and, in effect, wasted.

Bypass or Credit Shelter Trust

The "bypass trust" was created to solve this problem. This trust is used to allow both spouses to take advantage of the estate tax exemption — once at the death of the first spouse, and then again at the death of the second spouse. It permits a couple to pass up to $3,000,000 (in 2004) free of Federal estate tax to children or other beneficiaries.

Irrevocable Life Insurance Trust (ILIT)

The majority of physicians either own or plan to purchase a significant amount of life insurance to protect their families. You are probably already aware that life insurance death benefits are paid on an income

SEE ESTATE PLANNING PAGE 5

ESTATE PLANNING FROM PAGE 4

tax-free basis to named beneficiaries. However, those same death benefits are subject to Federal estate taxes. Understanding the threat of estate taxes on your life insurance proceeds is the first step in protecting these funds from unnecessary taxation.

The **irrevocable life insurance trust** (ILIT) ensures that your life insurance will not be subject to estate taxes, which can exceed 50 percent, depending on your state of residence. On a $1,000,000 policy, this tool may save your beneficiaries approximately $500,000. If structured properly, the ILIT, like a Will, can protect the funds for the use of children, and not their disgruntled spouses or creditors. The funds can be used to cover estate taxes, to provide an income stream, to pay off liabilities, and to keep other valuable assets intact for the family for years to come.

Summary

Every estate plan is built around four legal documents — a last will and testament, a durable power of attorney, a healthcare representative appointment, and a living will. By working with an attorney who specializes in estate planning, you can ensure that your wishes regarding medical treatment and property distribution are respected and honored. In addition to drafting the above documents, your attorney might also incorporate other legal instruments and/or strategies to take advantage of further estate tax savings opportunities and/or protect your assets from the claims of creditors.

Lawrence B. Keller, CLU, ChFC is the founder of Physician Financial Services, a New York-based firm specializing in income protection and wealth accumulation strategies for physicians. He can be reached for comments or questions at (516) 677-6211, or by e-mail to lkeller@physicianfinancialservices.com

Doris L. Martin, Esq. is a partner in Garfunkel, Wild, & Travis, P.C., a New York and New Jersey- based law firm designed to serve the unique business and legal needs of members of the medical profession . She is also the Chair of both the Tax and Personal Counseling & Estate Planning Practice Groups. She can be reached for comments or questions at (516) 393-2205. RR

PRACTICE MADE PERFECT FROM PAGE 1

temporarily to understand the region in which they intend to be an owner. This can be perilous, which is why I recommend evaluating one's need to be an owner. If ownership is a goal, a timetable should be established. Answering these questions will provide the insight needed to make key employment decisions prior to ownership.

Most of you will consider joining an existing practice in some capacity, such as becoming an associate, working locum tenens, or as an employee on a partnership track. All of these are viable options, but you must make decisions that allow you the flexibility to change as you grow personally and professionally with limited risk. The risk may be financial, and, in the worst circumstances, professional. For example, I recently consulted with a gentleman who is practicing in a different state while he is undergoing legal separation from his former group. He will do so until his partnership interests are legally severed. He feels this will protect his right to return to this area in the future. Prior to starting practice in his new state, he was out of work for approximately four and a half months. This is a perfect illustration of personal as well as financial hardship. The moral of the story — maintain flexibility until you are sure.

Accordingly, you should enter every professional agreement with an exit strategy. This is the major tenet I've used as a consultant. We work with our clients to understand them personally, as well as professionally, urging them to analyze their needs objectively. This approach eases the anxiety associated with addressing issues of compensation, restrictive covenants and contracts structured with complicated buy-in provisions.

Compensation should be fair for the market you are entering. Never enter into an agreement feeling that you are being inadequately compensated, hoping that over time your compensation will improve. Many recent residency graduates underestimate their worth in the workplace. Additionally, they neglect to realize that they are entering a market where demand far outweighs supply. For instance, how many practices can actually see a patient within the same day, week or month that they call for an appointment? Many practices are scheduling patients four to twelve weeks in advance. Understanding lead times is just one example of evaluating your worth to a practice. Thus, providing points for negotiating compensation.

Although the next several months can serve as great source of confusion and anxiety, don't let them. Realize that your opportunities are endless in virtually any region of the country. Dermatology provides a unique set of options which are unparalleled by any other specialty of medicine. This is a position that should be seized upon by graduates. The points for consideration I have highlighted here should provide graduates with an extreme sense of security. Remember — pursue all options with the highest degree of flexibility and keep in mind that compensation should be fair and reasonable.

Richard L. Averitte, Jr., M.D., is the founder and principal dermatologist of a private practice in Scottsdale, Ariz. He is also the founder of CLEA Concepts, LLC, a medical consulting firm specializing in issues regarding the practice of dermatology. RR

Familial Cancer Syndromes With Dermatologic Manifestations

Antoine Amado, M.D. & Sharon E. Jacob, M.D.

DISORDER	INHERITANCE	GENE DEFECT	CLINICAL MANIFESTATIONS	NEOPLASMS
Bazex Syndrome	AD	BZX	Follicular atrophoderma, hypohidrosis, hypotrichosis	BCC
Birt-Hogg-Dube Syndrome	AD	BHD, FLCL	Fibrofolliculomas, trichodiscomas, acrochordons, lipomas, intestinal polyposis	Renal cell carcinoma, medullary carcinoma of the thyroid
Brooke-Fordyce Syndrome (Epithelioma Adenoides Cystica)	AD	CYLD1	Epitheliomas, cylindromas of Poncet-Spiegler, surface telangiectasias	Breast carcinoma, Cervical carcinoma
Carney Complex (NAME & LAMB Syndromes)	AD	PRKAR 1A, CNC	Blue nevi, atrial/cutaneous/breast myxomas, ephelids, lentigines, pigmented nodular adrenocortical disease	Teticular tumors (Sertoli, Leydig tumors), pituitary growth hormone secreting- tumors
Cowden Disease (Multiple Hamartoma Syndrome)	AD	PTEN/MMAC1	Acral keratoses, trichilemmomas, oral papillomas, sclerotic fibromas, intestinal polyposis	Breast cancer, follicular thyroid carcinoma, colon hamartomas
Dyskeratosis Congenita (Zinsser-Engman-Cole Syndrome)	AD XLR	TR, TERC, SCX_ DKC1	Atrophy & reticular pigmentation of skin, nail dystrophy, leukoplakia, aplastic anemia	SCC of the oral mucosa & rectum Cervical cancer
Gardner Syndrome	AD	APC	Epidermal inclusion cysts (EIC), fibromas, GI polyps, pilomatricomas, desmoids, CHRPE	Colorectal carcinoma
Gorlin Syndrome (Nevoid BCC Syndrome)	AD	PTC	Nevi achrochordon-like, palmar & plantar pits, jaw cysts, bifid ribs, calcification of falx cerebri	BCC, ovarian fibromas medulloblastomas, fibrosarcomas
HLRCC Syndrome	AD	LRCC, FH	Cutaneous & uterine leiomyomas	Leiomyosarcoma, papillary RCC
Howel Evans Syndrome (Tylosis)	AD	TOC, TEC, (_envoplakin)	Palmoplantar keratoderma (PPK)	Esophageal carcinoma
Huriez Syndrome	AD	TYZ, HRZ	Scleroatrophy, keratoderma of palms & soles, nail hypoplasia	Cutaneous SCC
KID Syndrome (Congenital Ichthyosiform Syndrome)	AD	CX26 (GJB2)	Ichthyosis, vascularized keratitis, stippled PPK, deafness	Malignant fibrous histiocytoma (MFH)
Maffucci Syndrome (Multiple enchondromatosis)	AD	PTHR 1	Hemangiomas, subcutaneous calcifications, dyschondrodysplasia, enchondromas, Olliers syndrome	Chondrosarcoma, angiosarcoma
MEN I Syndrome (Wermer Syndrome)	AD	MEN I (menin)	Facial angiofibromas, collagenomas, migratory necrolytic erythema (glucagonoma), lipomas, CALM, parathyroid & pituitary adenomas, pancreatic islet-cell tumor	Renal carcinoma, papillary thyroid carcinoma, adrenal cortical adenomas/ hyperplasia, rhabdomyosarcoma, carcinoid gastrinomas
MEN IIa Syndrome (Sipple Syndrome)	AD	RET	Cutaneous macular or lichen amyloidosis	Medullar thyroid carcinoma, parathyroid hyperplasia, pheochromocytoma
MEN IIb/III (Wagenman-Froebose Syndrome)	AD	RET	CALM, marfanoid habitus, mucosal neuromas, GI ganglioneuromatosis (megacolon)	Medullar thyroid carcinoma, pheochromocytoma
Muir-Torre Syndrome	AD	hMSH2	Sebaceous adenomas, keratoacanthomas	Colorectal carcinoma, sebaceous carcinoma, GU cancer (transitional cell)
Neurofibromatosis I (Von	AD	NF1	CALM, axillary freckling, sphenoid wing dysplasia, plexiform fibromas, hamartomas (Lisch nodules),	Neurofibrosarcoma, astrocytomas, carcinoid pheochromocytoma, rhabdomyosarcoma, NF + JXG assoc w/CML
Neurofibromatosis II	AD	NF2 (merlin)	CALM, peripheral schwannomas, neurofibromas, posterior subcapsular lenticular opacity/cataracts	Meningiomas, spinal schwannomas, multiple gliomas
Peutz-Jeghers Syndrome	AD	STK11/ LKB1	Lentigos, melanoplakia, GI polyps, risk intussuseption	Small bowel carcinomas> colon>stomach; ovarian, breast, lung carcinomas

DISORDER	INHERITANCE	GENE DEFECT	CLINICAL MANIFESTATIONS	NEOPLASMS
Tuberous Sclerosis	AD	TSC1 (hamartin), TSC2 (tuberin)	Poliosis, adenoma sebaceum, shagreen patch, periungual fibromas (Koenen tumors), "ash-leaf" spots, confetti macules, Shagreen patches, seizures, retinal phakomas, enamel pits	Renal carcinoma, cardiac rhabdomyomas, molluscum fibrosum pendulum, pulmonary lymphangiomyoma (PLAM), angiomyolipomas, renal cysts and RCC
Acrodermatitis Enteropathica	AR	SCL3qA4, ZIP4	Paronychia, photophobia, periorificial eczema	Sarcomas
Ataxia Telangiectasia (Louis-Barr Disease)	AR	ATM	Cerebellar ataxia, telangiectasia, CALM, sinopulmonary infections, progeroid, athymia	Leukemias, Lymphomas
Bloom Syndrome	AR	BLM, RECQ2 SCX_	Facial telangiectasia, CALM, photosensitivity, short stature, infertility	Non-Hodgkin lymphoma, carcinoma of the colon> esophagus
Chediak-Higashi Syndrome	AR	LYST, CHS1	Incomplete albinism, oral ulcers, staphylococcal infections, silver hair	Lymphoma-like acceleration phase
Cockayne Syndrome	AR	CSA ERCC8, CSB ERCC6, SCX_	hotodermatitis, optic atrophy, mental retardation, "salt & pepper" retinitis pigmentosa, cachectic dwarfism	Skin cancer only with XP-CS complex
Fanconi Anemia	AR	FA-A - FA-H SCX_	Hyper/hypopigmentation, CALM, hypoplastic anemia, mental retardation,	Myelomonocytic leukemia, SCC of the skin, Breast cancer (FA-D1=BRCA2)
Rothmund-Thompson Syndrome (Poikiloderma Congenitale)	AR	RECQL4	Poikiloderma, keratoses, nail dystrophy, cataracts, photosensitivity, EPS	Osteosarcomas, nonmelanoma skin cancer
Werner Syndrome (Adult Progeria)	AR	WRN, RECQ3	Premature aging, scleroderma-like skin, hyperkeratosis, telangiectasia, atherosclerosis, cataracts, high pitched voice	Thyroid carcinoma, fibrosarcoma, osteosarcomas, meningioma, melanoma
Xeroderma Pigmentosum	AR	XP-A - XP-G (excision repair)	Dermatoheliosis, lentigines, AKs, keratoacanthomas, photosensitivity, MR	BCC, SCC, melanomas, leukemia, 10-20X rish of internal malignancy: sarcoma, GI/lung CA
Familial Melanoma (Dysplastic Nevus)	Polygenic	CDK2A	Atypical moles, GI tumors	Pancreatic carcinoma, melanoma
Schimmelpenning Syndrome (Epidermal Syndrome)	Sporadic AD	Unknown	CALM, sebaceous epithelioma, cutaneous hemangioma, coloboma, CNS abnormalities, conjunctival lipodermoids	Wilms tumor, nephroblastoma, rhabdomyosarcoma, astrocytoma
Wiskott-Aldrich Syndrome	XLR	WASP CD43 sialophorin	Atopy (eczema), thrombocytopenia (purpura), and recurrent pyogenic infections (impetigo, cellulitis, abscesses).	Lymphoma, leukemia

Abbreviations:

APC: adenomatous polyposis coli
CHRPE: congenital hypertrophied retinal pigmented epithelium
FH: fumarate hydratase
GU: genitourinary
LYST: lysosomal trafficking regulator
MEN: multiple Endocrine Neoplasia
SCC: squamous cell carcinoma
XP-CS: Xeroderma pigmentosum-Cockayne syndrome
BCC: basal cell carcinoma
CX26: conexin 26
EPS: elastosis perforans serpiginosa
FLCL: folliculin
GJB2: gap junction protein B2
PTC: patched gene
SCX_: sister chromatid exchange
ZIP4: zinc transporter
CALM: café au lait macules
ERCC: excision-repair cross-complementing
DKC1: dyskerin
GI: gastrointestinal
HLRCC: Hereditary Leiomyomatosis & renal cell cancer
PTHR 1: parathyroid hormone-related protein
TERC: telomerase RNA component

References:

Hensin, Tsao. Familial cancer syndromes and skin. J Am Acad Dermatology June 2000, Vol 42, 6
Cohen, Philip. Genodermatoses with malignant potential. Derm Clin. January 1995

University of Miami, Department of Dermatology and Cutaneous Surgery

Note: In the course of creating this chart, the authors have used reliable, up-to-date sources. Readers are encouraged to confirm the information periodically, however, as some variables evolve over time.

NEXT ISSUE: PORPHYRIA!

RR

Register now for 2005 practice management symposium for residents

The American Academy of Dermatology's Practice Management Symposium for Residents for 2005, "Building A Foundation for Success," will be held Thursday, Feb. 17, 2005, at the New Orleans Marriott in New Orleans. The registration deadline is **Jan. 27, 2005**.

Designed for 1st, 2nd, and 3rd year residents, the Practice Management Symposium for Residents provides a balanced overview of the "business side of dermatology." This one-day course provides an opportunity to expand residents' knowledge through a variety of topics and formats and has preceded the Annual Meeting for the past 29 years. The symposium will help you gain knowledge of the business aspects of dermatology and strategies useful for starting a successful practice and/or career in dermatology. The symposium will include concurrent workshops and lectures with time allotted for Q & A.

Registration will provide you with attendance to all sessions; continental breakfast, lunch, and refreshment breaks and a comprehensive course syllabus that supports and augments information provided in the educational sessions. The syllabus is designed to be a valuable take-home reference tool.

American Academy of Dermatology
Practice Management Symposium for Residents

BUILDING *a* FOUNDATION *for* SUCCESS

Thursday, February 17, 2005
New Orleans Marriott
New Orleans, Louisiana

To register for the Practice Management Symposium please download the brochure and Registration Form online at the Academy Web site at and mail or fax back to the Academy.

If you need further information, contact Susan Carlson in the Education Department at the American Academy of Dermatology at (847)330-0230 or scarlson@aad.org. RR

Grants Available to Overseas Volunteers

The American Academy of Dermatology is offering grants to dermatologists who are interested in volunteering to teach dermatology in the developing world.

A grant of $10,000 will be awarded to one applicant or $5,000 each for two applicants who are planning a volunteer trip abroad.

For additional information on the grants or to request a copy of the guidelines and application form, contact Barbara Paez, member services coordinator, by e-mail at bpaez@aad.org

Resident DERMATOLOGY ROUNDUP

American Academy of Dermatology Association
P.O. Box 4014
Schaumburg, IL 60168-4014

FALL: 2004 VOL. 8, NO. 3

MISSION STATEMENT:

Dermatology Resident Roundup is published by the American Academy of Dermatology Association to provide a forum for information concerning resident dermatology physicians, and providing news, views and actions of the Academy, the Residents & Fellows Committee, and the American Board of Dermatology. It is supported through an unrestricted educational grant from *3M Pharmaceuticals.*