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 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.

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**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.
NOW APPROVED

FOR ACTinic KERATOSIS
AND SUPERFICIAL
BASAL CELL CARCINOMA
“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.
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.

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

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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.

PRACTICE MADE PERFECT FROM PAGE 1

temporary 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 example, 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 of compensation, restrictive covenants and contracts structured with complicated buy-in provisions. He can be reached for comments or questions at (516) 393-2205.

Save the date

63rd ANNUAL MEETING
American Academy of Dermatology
February 9-12, 2005 • New Orleans, Louisiana
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<td>Brooke-Fordyce Syndrome (Epithelioma Adenoides Cystica)</td>
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<td>Carney Complex (NAME &amp; LAMB Syndromes)</td>
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<td>Terticular tumors (Sertoli, Leydig tumors), pituitary growth hormone secreting-tumors</td>
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<td>Dyskeratosis Congenita (Zinsser-Engman-Cole Syndrome)</td>
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<td>Gardner Syndrome</td>
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<td>Epidermal inclusion cysts (EIC), fibromas, GI polyps, pliomatricomas, desmoids, CHRPE</td>
<td>Colorectal carcinoma</td>
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<td>Gorlin Syndrome (Nevoid BCC Syndrome)</td>
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<td>PTC</td>
<td>Nevi acrochordon-like, palmar &amp; plantar pits, jaw cysts, bifid ribs, calcification of faix cerebi</td>
<td>BCC, ovarian fibromas medulloblastomas, fibrosarcomas</td>
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<td>HLRCC Syndrome</td>
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<td>LRCC, FH</td>
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<td>Howel Evans Syndrome (Tylosis)</td>
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<td>TOC, TEC, (_envoplakin)</td>
<td>Palmoplantar keratoderma (PPK)</td>
<td>Esophageal carcinoma</td>
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<td>Huriez Syndrome</td>
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<td>TYZ, HRZ</td>
<td>Scleratrophic, keratoderma of palms &amp; soles, nail hypoplasia</td>
<td>Cutaneous SCC</td>
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<td>Kid Syndrome (Congenital Ichthyosiform Syndrome)</td>
<td>AD</td>
<td>CX26 (GJB2)</td>
<td>Ichthyosis, vascularized keratosis, stippled PPK, deafness</td>
<td>Malignant fibrous histiocytoma (MFH)</td>
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<td>Maffucci Syndrome (Multiple enchondromatosis)</td>
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<td>PTHR 1</td>
<td>Hemangiomas, subcutaneous calcifications, dyschondroplasia, enchondromas, Olliers syndrome</td>
<td>Chondrosarcoma, angiosarcoma</td>
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<td>MEN I Syndrome (Wermer Syndrome)</td>
<td>AD</td>
<td>MEN I (menin)</td>
<td>Facial angiofibromas, collagenomas, migratory necrolytic erythema (glucagonoma), lipomas, CALM, parathyroid &amp; pituitary adenomas, pancreatic islet-cell tumor</td>
<td>Renal carcinoma, papillary thyroid carcinoma, adrenal cortical adenomas/ hyperplasia, rhabdomyosarcoma, carcinoind gastrinomas</td>
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<td>MEN IIa Syndrome (Sipple Syndrome)</td>
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<td>RET</td>
<td>Cutaneous macular or lichen amyloidosis</td>
<td>Medullary thyroid carcinoma, parathyroid hyperplasia, pheochromocytoma</td>
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<td>MEN IIb/ III (Wagenman-Froebose Syndrome)</td>
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<td>RET</td>
<td>CALM, marfanoid habitus, mucosal neuromas, GI ganglineuromatosis (megacolon)</td>
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<td>hMSH2</td>
<td>Sebaceous adenoma, keratoacanthomas</td>
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<td>Neurofibromatosis I (Von Recklinghausen)</td>
<td>AD</td>
<td>NF1</td>
<td>CALM, axillary freckling, sphenoid wing dysplasia, plexiform fibromas, hamartomas (Lisch nodules)</td>
<td>Neurofibrosarcoma, astrocytomas, carcinoid pheochromocytoma, rhabdomyosarcoma, NF + XG assoc w/ CML</td>
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<td>Neurofibromatosis II</td>
<td>AD</td>
<td>NF2 (merlin)</td>
<td>CALM, peripheral schwannomas, neurofibromas, posterior subcapsular lenticular opacity/ cataracts</td>
<td>Meningiomas, spinal schwannomas, multiple gliomas</td>
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<td>Peutz-Jeghers Syndrome</td>
<td>AD</td>
<td>STK11/ LKB1</td>
<td>Lentigos, melanoplakia, GI polyps, risk intussusception</td>
<td>Small bowel carcinomas&gt; colon&gt; stomach; ovarian, breast, lung carcinomas</td>
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<td>Tuberous Sclerosis</td>
<td>AD</td>
<td>TSC1 (hamartin), TSC2 (tuberin)</td>
<td>Poliosis, adenoma sebaceum, shagreen patch, periungual fibromas (Koenen tumors), &quot;ash-leaf&quot; spots, confetti macules, Shagreen patches, seizures, retinal phakomas, enamel pits</td>
<td>Renal carcinoma, cardiac rhabdomyomas, molluscum fibrosum pendulum, pulmonary lymphangiomyoma (PLAM), angiomyelolipomas, renal cysts and RCC</td>
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<tr>
<td>Acrodermatitis Enteropathica</td>
<td>AR</td>
<td>SCL3qA4, ZIP4</td>
<td>Paronychia, photophobia, peri-orificial eczema</td>
<td>Sarcomas</td>
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<td>Ataxia Telangiectasia (Louis-Barr Disease)</td>
<td>AR</td>
<td>ATM</td>
<td>Cerebellar ataxia, telangiectasia, CALM, sinopulmonary infections, progeroid, athymia</td>
<td>Leukemias, Lymphomas</td>
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<tr>
<td>Bloom Syndrome</td>
<td>AR</td>
<td>BLM, RECQ2 SCX_</td>
<td>Facial telangiectasia, CALM, photosensitivity, short stature, infertility</td>
<td>Non-Hodgkin lymphoma, carcinoma of the colon, esophagus</td>
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<td>Chediak-Higashi Syndrome</td>
<td>AR</td>
<td>LYST, CHS1</td>
<td>Incomplete albinism, oral ulcers, staphylococcal infections, silvery hair</td>
<td>Lymphoma-like acceleration phase</td>
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<tr>
<td>Cockayne Syndrome</td>
<td>AR</td>
<td>CSA ERCC8, CSB ERCC6, SCX_</td>
<td>Photo dermatitis, optic atrophy, mental retardation, &quot;salt &amp; pepper&quot; retinitis pigmentosa, cachectic dwarfism</td>
<td>Skin cancer only with XP-CS complex</td>
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<td>Fanconi Anemia</td>
<td>AR</td>
<td>FA-A - FA-H SCX_</td>
<td>Hyper/hypopigmentation, CALM, hypoplastic anemia, mental retardation</td>
<td>Myelomocytic leukemia, SCC of the skin, Breast cancer (FA-D1=BRCA2)</td>
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<td>Rothmund-Thompson Syndrome (Poikiloderma Congenitale)</td>
<td>AR</td>
<td>RECQL4</td>
<td>Poikiderma, keratoses, nail dystrophy, cataracts, photosensitivity, EPS</td>
<td>Osteosarcomas, nonmelanoma skin cancer</td>
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<td>Werner Syndrome (Adult Progeria)</td>
<td>AR</td>
<td>WRN, RECQ3</td>
<td>Premature aging, scleroderma-like skin, hyperkeratosis, telangiectasia, atherosclerosis, cataracts, high pitched voice</td>
<td>Thyroid carcinoma, fibrosarcoma, osteosarcomas, meningioma, melanoma</td>
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<tr>
<td>Xeroderma Pigmentosum</td>
<td>AR</td>
<td>XP-A - XP-G (excision repair)</td>
<td>Dermatoheliosis, lentigines, AKs, keratoacanthomas, photosensitivity, MR</td>
<td>BCC, SCC, melanomas, leukemia, 10-20X risk of internal malignancy: sarcoma, GI/lung CA</td>
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<tr>
<td>Familial Melanoma (Dysplastic Nevus)</td>
<td>Polygenic</td>
<td>CDK2A</td>
<td>Atypical moles, GI tumors</td>
<td>Pancreatic carcinoma, melanoma</td>
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<td>Schimmelpenning Syndrome (Epidermal Syndrome)</td>
<td>Sporadic AD</td>
<td>Unknown</td>
<td>CALM, sebaceous epitheloma, cutaneous hemangioma, coloboma, CNS abnormalities, conjunctival lipodermoids</td>
<td>Wilms tumor, nephroblastoma, rhabdomyoscarcoma, astrocytoma</td>
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<tr>
<td>Wiskott-Aldrich Syndrome</td>
<td>XLR</td>
<td>WASP, CD43 sialaphorin</td>
<td>Atopy (eczema), thrombocytopenia (purpura), and recurrent pyogenic infections (impetigo, cellulitis, abscesses)</td>
<td>Lymphoma, leukemia</td>
</tr>
</tbody>
</table>

**Abbreviations:**

APC: adenomatous polyposis coli  
CHRF: 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  
CKX26: conomex 26  
EPS: elastosis perfrons serpignosa  
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: dykerin  
GI: gastrointestinal  
HLRRC: Hereditary Leiomyomatosis & renal cell cancer  
PTHR 1: parathyroid hormone-related protein  
TERC: telomerase RNA component

**References:**

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!

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.

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.