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Directions in Residency

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What's on your CV?

Whether you are applying for a position in academia, trying to get into a residency or fellowship program, or going into private practice, your curriculum vitae (CV) is a document that can provide a first impression about who you are, what you've done and, moreover, suggest what you might be capable of doing in the future. Directions in Residency *contacted dermatology program directors from across the nation to get their thoughts on what they look for in a CV.*

Does size matter?

"A thick CV does not always equal an impressive one," said William D. James, M.D., president-elect of the American Academy of Dermatology. Dr. James, the Paul Gross professor of dermatology, residency program director, and acting chair of the dermatology department at University of Pennsylvania Health System, said it is the quality of the work that is paramount.

"Certainly some build their CV with space and verbiage out of proportion to the commitment," Dr. James said, adding that he's encountered some applicants that will pad out their CVs with a volunteer effort that lasted only a few hours for one day (a lament echoed by other program directors, as well). A resume should reflect a story that is consistent, otherwise, "it is more likely to be perceived that the effort is more about adding items to the CV than revealing a true interest and quality effort."

Amy McMichael, M.D., associate professor of dermatology in the department of dermatology at Wake Forest University School of Medicine, Winston-Salem, agreed. "Residency CVs should be brief, since most applicants only have 4 to 8 years of reasonable experience."

However, while there may be such a thing as a resume that's too long (a university student in China reportedly had a CV in excess of 100 pages), you can also err on the side of brevity.

"While a long CV isn't a guarantee, a short one without any accomplishments cannot be interpreted as anything but inadequate," said Dr. James.

Quality, commitment valued

The insight a CV provides to the person behind it is just as important as the content. If an applicant has done overseas volunteer work, it shows me something about the potential for long standing commitment that is going to be followed up on in the future," said Dr. James.

"Open times unaccounted for on a CV is a problem," Dr. James said, "as in not finishing something begun without a good explanation; someone with many publications in progress, but none published; lots of talks and research projects listed but no publications."

"At our institution, we look at the whole package and not just their list of publications," said Karen Wiss, M.D., director, pediatric dermatology and director, dermatology residency program, and professor

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Resident Perspective

Andrew C. Krakowski, M.D.

Me, myself, and my CV or...

my life on two pieces of paper, by Andrew Krakowski, M.D.

When I first decided to relocate from Baltimore to San Diego, I spent an entire week planning how many trucks it was going to take to move all of my stuff. When it came time to actually move, however, I was painfully forced to admit to myself, to those who helped me move, and to the no-refunds-allowed pod company that all my worldly possessions fit easily into a single 12 x 12-foot glorified box. Apparently, I had not acquired quite as much as I had led myself to believe. The entire experience was, in a word, humbling.

Discovering that the sum total of one's life's work should and could fit onto a couple of pieces of 8.5 x 11-inch paper can be similarly demoralizing. In my mind, I had convinced myself that the first draft of my CV looked great. Why would someone not want to work with a harmonica-playing, yo-yo'ing, pediatrics-trained dermatologist?

See ***PERSPECTIVE*** on p. 7

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of medicine (dermatology) and pediatrics at University of Massachusetts Medical School. "We try to look for those who will be team players, easy to work with, highly motivated, and unlikely to burn out. A well- rounded person."

Dr. McMichael concurred. "I would question CVs that show no outside interests, no work experience or outside club work."

Preferences, poor choices, and peccadilloes

All of the program directors agreed: there's no excuse for a sloppy resume. Many cited "spelling errors and poor grammar," as particularly annoying. Christopher R. Shea, M.D., professor of medicine (dermatology), chief, section of dermatology, at University of Chicago, even reported seeing a CV with the applicant's own name misspelled. Dr. Shea added that he's averse to "cuteness, such as poetry, and weird fonts."

"Layout should avoid excessive white space and fonts should be legible," advised Dr. Shea. Information should be stated once only." Another red flag, he said, is "lack of clarity regarding whether the scholarly work cited is a paper/abstract/chapter/article, and whether the work has been printed/accepted /submitted."

"The most appealing CVs have no paragraphs and no long descriptions of research months," said Dr. McMichael.

References vital

Most department chairs indicated that while a solid CV is desirable, what really helps is the reference to back it up. "To me a personal reference is better than a CV," said Al Lane, M.D., professor and chair, department of dermatology, Stanford University School of Medicine, Redwood City, Ca. "Often a great CV matches great personal references."

"We pay the most attention to strong letters of recommendation from those we know," said Dr. Wiss. "We try to recognize what we have to offer and find those who will thrive in our setting."

"The most important parts are the CV and the recommendations from dermatology faculty," Dr. McMichael said." If they do not walk on water to the people with whom the student rotated, there is not real interest for me.

The person behind the paper

You've wowed a department head with a CV and reference, but ultimately, a personal interview – once you've snagged one – will remain the deciding factor.

"A good CV without a solid recommendation from a mentor and a poor interview goes nowhere," said Dr. James. "Likewise a good interview is necessary but insufficient if there is a lack of accomplishment over the years of study and research. They need to go as a package, one is not more important than another."

"By the time the candidate gets to the interview stage, it helps to merely weed out those with issues that may be problematic during three years of training," Dr. McMichael reported. "We had one candidate with an outstanding CV and recommendations, but he came on the wrong day for his interview. He had such a wonderful and different skill set that the interview date issue was overlooked. This resident was constantly making similar date and time errors for the entire three years as a resident and required intervention to improve and overcome this behavior enough to complete the residency. So now, subtle hints in the half-day of interviews are closely observed."

"The interview can really bring someone who looks good on paper up to the top or can make them fall short," said Dr. James. DR

Disorders of Hyperpigmentation

by Sarah Brooks, M.D.

GENETIC			
	Gene	**Pathophysiology**	**Clinical Features**
Dyskeratosis congenita	XLR: DKC1 gene AD: hTR, hTERT	Mutation in dyskerin protein which interacts with telomerase, or mutation in telomerase subunits	Lacy reticulated hyperpigmentation on the neck, upper arms, upper chest. Pterygium, leukoplakia, pancytopenia, mucosal squamous cell carcinoma, leukemia
Naegeli–Franceschetti–Jadassohn	AD: KRT14	Mutation in non-helical head domain of keratin 14 leading to early termination of translation	Periocular, perioral, abdominal gray-brown reticulate hyperpigmentation. Fades after puberty. Decreased sweat glands w/ heat intolerance, dental anomalies, absent dermatoglyphics.
Dermatopathia pigmentosa reticularis	(possible) AD: KRT14	Mutation in non-helical head domain of keratin 14.	Triad: reticulate hyperpigmentation of trunk and proximal extremities, non-scarring alopecia, and onychodystrophy. Does not fade after puberty.
X-Linked Reticulate pigmentary disorder	X-Linked	Unknown	Male: generalized hyperpigmentation, onset 4 mo to 5 yrs. Severe systemic manifestations (recurrent pneumonia, COPD , early death). Blonde unruly hair with a frontal upsweep, +/- low intelligence. Female: skin-limited manifestations with lacy or reticulated hyperpigmentation w/in lines of Blaschko.
Dowling-Degos disease (DDD)	AD: KRT5	Loss of function mutation (possible role of keratin 5 in melanosome uptake & organelle transport)	Reticulate hyperpigmentation, beginning in axillae and groin and spreading to other body folds. Comedone-like lesions on the back or neck, pitted perioral or facial scars.
Galli-Galli Disease	AD	Acantholytic variant of DDD.	Same as DDD
Reticulate acropigmentation of kitamura	AD, possibly KRT5	May be on a spectrum with DDD.	Atrophic lentigo-like reticulated hyperpigmented macules on the dorsal aspect hands and feet. Aggravated by sunlight. Palmoplantar pits, breaks in dermatoglyphics. Majority Japanese.
Haber's syndrome	AD		Reticulate hyperpigmentation on the trunk and proximal extremities, axillae. Facial rosacea-like eruption starting in childhood. Predominantly truncal keratotic papules, representing SK's.
Dyschromatosis Symmetrica Hereditaria	AD, DSRAD mutations	Encodes an adenosine deaminase. Unknown why mutation causes pigmentary problems.	Dorsal distal extremities with small, irregular, hypo- and hyperpigmented macules.
Dyschromatosis universalis hereditaria	Unclear	Unknown	Hyper- and hypopigmented macules on the head, neck, trunk and extremities. Isolated cases with systemic abnormalities. Majority Japanese.

DRUG-INDUCED/INGESTION		
	Drug Use	**Clinical Features/Pathology**
Bleomycin	Lymphoma and testicular carcinoma	Hyperpigmentation overlying pressure points, linear flagellate bands in areas of prior minor trauma, transverse melanonychia, sclerodermoid changes. Increased epidermal melanin, minimal dermal pigment incontinence.
5-Fluorouracil	Breast and gastrointestinal carcinomas	Hyperpigmentation of sun-exposed skin; transverse or diffuse melanonychia; lunular pigmentation.
Dactinomycin (actinomycin-D)	Wilms tumor, gestational trophoblastic neoplasia, rhabodomyosarcoma	Generalized hyperpigmentation, most prominent on the face, fades after discontinuation
Daunorubicin	Leukemia	Hyperpigmentation of sun exposed areas, transverse brown–black melanonychia
Doxorubicin	Breast cancer, sarcomas, lymphoma, ovarian cancer	Hyperpigmentation overlying the small joints of the hand and involving the palmar creases, palms, soles and oral mucosa (buccal, tongue). Increased epidermal melanin, and number or melanocytes
Arsenic	Not used medically, found in contaminated well-water	Areas of bronze hyperpigmentation ± superimposed raindrops of lightly pigmented skin which may appear up to 20 years following exposure, keratoses on the palms and soles, which may evolve into SCC. Dermal and epidermal deposition of arsenic, increased epidermal melanin synthesis
Gold	Rarely used for rheumatoid arthritis, pemphigus vulgaris	Permanent blue–gray discoloration, most prominent in sun-exposed areas, especially around the eyes. Gold particles within lysosomes in dermal macrophages, especially in perivascular and perieccrine areas
Silver	Occupational exposure, topical use of silver sulfadiazine, alternative medicine	Generalized slate-gray discoloration. Nail and sclera can also be involved. Silver granules in the basement membrane eccrine glands
Amiodarone	Cardiac arrhythmias	Slate-gray to violaceous discoloration in sun-exposed areas. Fades very gradually. Yellow–brown granules within peri-vascular dermal macrophages.
AZT (zidovudine)	HIV treatment	Hyperpigmentation of the mucous membranes and nails in up to 10% of treated patients, blue lunulae. Increased melanin within epidermal basal layer and dermal macrophages.

Sara Brooks, M.D., is a medicine-dermatology resident at Washington Hospital Center and Georgetown University Hospital.

DRUG-INDUCED/INGESTION (cont.)		
	Drug Use	**Clinical Features/Pathology**
Clofazimine	Mycobacterial infections	Violet–brown to blue–gray discoloration; diffuse reddish discoloration of the skin and conjunctivae. Dermal collections of foamy macrophages that contain diffusely distributed brownish granular pigment.
Diltiazem	Hypertension	Slate-gray to gray–brown discoloration of sun-exposed skin in patients of dark skin phenotypes; may be perifollicular or reticulate in nature. Sparse lichenoid infiltrate and numerous dermal melanophages.
Minocycline	Acne, inflammatory conditions, infectious processes	Type I: blue–black discoloration in sites of inflammation and existing scars. Intra- and extracellular iron-containing pigment within the dermis. Type II: blue–gray macules and patches that appear within previously normal skin, most commonly on the anterior legs. Melanin- and iron-containing pigment granules in the dermis and subcutis. Type III: diffuse muddy brown discoloration most prominent in sun-exposed areas. Increased melanin in the basal layer of the epidermis and in dermal macrophages without the presence of iron.
Hydroquinone	Post-inflammatory hyperpigmentation	Hyperpigmentation in areas of application due to irritant contact dermatitis or exogenous ochronosis. Yellow–brown banana-shaped fibers in papillary dermis.
Flagellate mushroom dermatitis	Those who eat or cultivate raw shiitake mushrooms	Long, flagellate streaks with petechiae or papules that are often seen on the trunk and extremities. Thermo-labile toxin is responsible for manifestations. Spongiosis and necrotic keratinocytes within the epidermis, lymphocytic dermal infiltrate.
Chlorpromazine	Psychotropic medication	Slate-gray discoloration in sun-exposed areas. Golden-brown granules in the upper dermis, electron-dense inclusion bodies.

BLASCHKOID HYPERPIGMENTATION		
	Pathogenesis	**Clinical Features**
Linear and whorled nevoid hypermelanosis	Unknown, but likely related to somatic mosaicism and melanoblast migration	Blaschkoid streaks of hyperpigmentation developing within the first year of life that persist indefinitely. Systemic abnormalities rare.
Incontinentia pigmenti, Stage III	X-linked dominant disorder, NEMO gene mutation	Gray–brown streaks and whorls along the lines of Blaschko developing within 1st year of life. Fade later in life secondary to cellular apoptosis. Systemic manifestations include conical teeth, dystrophic nails, skull abnormalities, seizures, and eye abnormalities.

OTHER DISORDERS		
	Epidemiology	**Pathogenesis/Clinical Features**
Melasma	Young females of darker skin phototypes	Hypothesized that hyperfunctional melanocytes are exposed to UVR and produce increased melanin compared to surrounding skin. Symmetric light to dark brown irregularly bordered patches in either centrofacial, malar, or mandibular distribution.
Erythema dyschromica perstans	Latin America, 2nd to 3rd decade of life, M=F	Pathogenesis unknown, but postulated to be immunologic in origin, HLADR4 found in to be associated in Mexican patients. Symmetric, circular to irregularly shaped blue-gray ('ashy' appearing) patches with erythematous borders on the trunk>extremities>face.
Post-inflammatory hyperpigmentation	No gender or age preference. Darker skin types are particularly affected.	Epidermal form is from increased production of melanin and transfer to keratinocytes in areas of inflammation. Dermal form is from damage to basement membrane, which allows pigment to seep into the dermis and become engulfed by melanophages. Dermal form appears darker secondary to Tyndall effect. Asymptomatic dark brown to gray-blue-brown macules and patches, color depends on location of melanin, with dark brown being epidermal and gray-brown dermal.

Type of Melasma	**Woods lamp**	**Response to topical treatment**
Epidermal	Accentuated	Possibly
Dermal	Blend with surrounding skin	Not Usually

References: Bolognia, J., Jorrizo, J. (2008) *Dermatology* (2nd Edition). Spain: Elsevier Limited.

Online Mendelian Inheritance in Man, OMIM (TM). McKusick-Nathans Institute of Genetic Medicine, Johns Hopkins University (Baltimore, MD) and National Center for Biotechnology Information, National Library of Medicine (Bethesda, MD), August 2008. World Wide Web URL: http://www.ncbi.nlm.nih.gov/omim/

68th ANNUAL MEETING

Miami, FL • March 5-9, 2010

Take advantage of advanced registration for the AAD's 68th Annual Meeting, March 5 -9 in Miami beginning Tuesday, Nov. 24. There are many sessions designed with residents in mind.

Watch the AAD Web site, www.aad.org, for more information as it becomes available.

Plan ahead for Miami 2010

The Resident Track for the American Academy of Dermatology's 68th Annual Meeting in Miami includes these includes these session listings (available at press time):

Basic Self-Assessment of Dermatopathology	Friday, March 5	7:00am-5:00pm
High Yield "Power Hour" for Residents	Friday, March 5	7:15am-8:45am
Resident Jeopardy	Saturday, March 6	9:00am-11:00am
Resident Transitions	Saturday, March 6	3:00pm-5:00pm
Careers in Academic Dermatology: Beer & Wine	Saturday, March 6	3:00pm-5:00pm
Residents & Fellows Symposium	Sunday, March 7	11:00am-2:00pm
An Approach to Cultural Diversity in Dermatology	Monday, March 8	12:15pm-1:45pm

Check your program book (or online at www.add.org) in November to view the full listing of Resident Track courses (including course numbers and CME credits) available when you register for the meeting. **Don't forget to make room on your 2010 Annual Meeting schedule for the Resident Reception, scheduled for Friday, March 5, fron 5 to 6 p.m.** DR

New high yield session added for residents in 2010

In addition to the returning sessions, the "High Yield 'Power Hour' for Residents" session is being added in 2010. The session, led by Harley A. Haynes, M.D., is designed for dermatology residents who seek to achieve a comfort level with four high-yield topics encountered during training. Image-based learning will focus on mechanisms of action and side effects of systemic dermatologic therapies; basic concepts of laser and surgical dermatology; allergens associated with contact dermatitis; and genetic and autoimmune disorders of the epidermal basement membrane. Multiple choice questions will highlight take-home pearls. Lectures will be based on the newest available literature on novel therapies, new contact allergens, innovative laser and procedural dermatology, and recent findings relevant to the basement membrane zone. DR

www.aaddevelopment.org

The American Academy of Dermatology is proud to announce a new Web site showcasing the charitable activities of the organization — **aaddevelopment.org**. This new site features detailed information about the many philanthropic opportunities available through the Academy.

At **aaddevelopment.org** you can learn more about:

- Becoming a Sustaining Member
- Donating to AAD Camp Discovery
- Honoring a colleague or mentor with a Tribute donation

Visit **aaddevelopment.org** today and don't forget to sign up for our e-newsletter while there!

Thank you for Furthering Excellence in Dermatology… Today and Tomorrow

PERSPECTIVE from p.1

Oh, right … because that person sounds totally annoying and borderline creepy.

I've been told that a CV should look and feel like a representation of yourself, but you'd better also show you've got the chops for what you are seeking. If you are a beach-bum looking to hang ten in the surf all day then, by all means, go ahead and mail in that wrinkled-up CV with the spelling errors and awkward stain in the upper right-hand corner. If, however, you are looking to score the ultimate Mohs gig, then your CV better show surgical precision. Start by choosing the perfect font (God bless you, 11-point Garamond!), and use Microsoft Word's table feature to space everything down to the last obsessive-compulsive pixel. And don't forget to spell ~~Czech~~… spell check.

Fill the pages with "action words" to convey the perfect combination of leadership, initiative, and determination. At the same time, however, there's no point in self-deception. No one will want to work with a weenie who does not finish what he/she started, so you had better be able to demonstrate that you are a team-player with tried and true stick-to-it-iveness. And, yes, community service counts, especially when it is clear that you are doing it because you feel the duties are important and not just something else to throw on your CV.

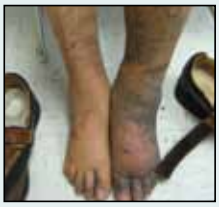
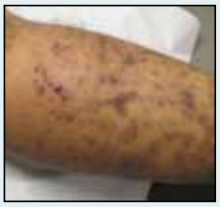
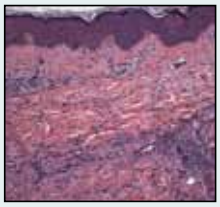
But most importantly, be prepared to explain and/or demonstrate anything you put down on paper. Perhaps this is a way-too-revealing side-note, but I was once asked by UPenn's chairperson, John R. Stanley, M.D., to teach him a yo-yo trick during a derm residency interview. It had been mentioned to Dr. Stanley that I was competent with a yo-yo, but I had not thought to bring one to our first interview. The following year, however, we "walked the dog" up and down the hallowed halls of the nation's first school of medicine. The lesson here is clear: Be prepared to back up any skills you are purported to possess.

Pique enough interest about yourself so that the person reading your CV will want to ask you to interview just so you can fill in the details of your life. The CV should be your professional calling card. Like the Dos Equis "Most Interesting Man in the World," you want the person reading your CV to immediately recognize your potential and, most importantly, want to hear more from you. If you fill the CV with too much detail you run the risk that no one will ever get through it and then no one will ever get to know the real you. The only caveat here may be if you are a director, vice-chair, or chair of a derm program; then, you are apparently allowed as much space/detail as you want (you may have noticed that this rule also seems to apply in Grand Rounds discussions). Everyone else should keep it short and sweet.

That said, I have already tripled the requested word limit for this article. In summary, have fun with your CV. Do not lie or misrepresent yourself, and always put your best foot forward. Your words and experiences will ring true if they come from the heart. And, remember, like anything else, putting your CV out there has its ups and downs. Yes, like a yo-yo. DR

Race for the Case *by Andrew Krakowski, M.D.*

What's your diagnosis?

This 62 year old Hispanic man has a personal history of hypertension, hyperlipidemia, and end-stage renal disease secondary to poorly controlled diabetes mellitus. He had a successful renal transplant, in 2004. He takes cyclosporine, mycophenolate and prednisone for his kidney transplant and lisinopril, clonidine, atenolol, and lasix for his hypertension. He is referred to you by nephrology for a 4-month history of non-pruritic, non-tender, purple papules and plaques involving bilaterally edematous lower extremities (left lower extremity much more involved than the right). On physical exam, you notice similar lesions on his left upper extremity and a palpable thrill in his left anterior forearm. A punch biopsy is performed on the left lower extremity. HHV-8 is negative. Additionally, CD-34 and Latency Associated Nuclear Antigen (LANA) tissue stains are negative. Your diagnosis is...?

Submit the diagnosis to to dmonti@aad.org. The answer will be revealed in the next issue along with the name of the first person to nail the diagnosis! The winner will also receive a $10 starbucks gift card, so ... don't delay! DR

Skin Deep

"Here we go. This should cure your insomnia in no time!"

message from the chair

Jennifer Lucas, M.D.

Another academic year is underway and I would like to welcome the first year dermatology residents who may be receiving *Directions in Residency* for the first time. This is the official publication of the American Academy of Dermatology's Residents and Fellows Committee (RFC). The purpose of the publication is to keep residents updated on activities that impact them. *Directions in Residency* will be mailed to you quarterly and is now also available online. You can view this issue online and access any of the Web addresses instantly for more information.

One of the goals of the RFC is to represent the educational needs of residents beyond the residency curriculum to the Academy. There are exciting updates to the 2010 Annual Meeting in Miami. A listing of some of the essential sessions and events that will be of interest to residents can be found on page 6 of this publication.

As you begin a new year in your graduate education, I want to encourage you to get involved with the Academy. There are opportunities to do skin cancer screenings, apply for grants at www.aad.org/international/scholarships.html, or present at the Annual and Summer Academy Meetings. If you are politically inclined, consider joining DAN the Dermatology Advocacy Network. Your membership in DAN will keep you up to date on important legislative and regulatory issues that affect our specialty. They are always looking for support and participation. Join the Grassroots campaign, write your congressperson, but above all else get involved!

Directions in Residency is your publication! If you have suggestions for articles or if you would like to submit an article on a topic you are interested in, send an e-mail to me at residents@aad.org, or to Dean Monti, senior associate editor at dmonti@aad.org. The RFC wants to hear from you. Have a great year! DR

Flash! New technology for Directions on the Web

Starting this year, we will be posting issues of *Directions in Residency* on the Web, using a new Flash PDF technology. This new technology allows you to virtually turn the pages of the newsletter, and also make use of hyperlinks and e-mail addresses within each issue. Check it out on the Residents/Fellows section of the Academy's Web site, www.aad.org. If you have other ideas for interactive content or just want to let us know what you think, contact Dean Monti, Senior Editor at dmonti@aad.org. DR


Directions in Residency

Now is the time for networking

2009 Fox Award

Laboratory, clinical breakthroughs honored

Questions or Comments?
Contact the AAD Member Resource Center (MRC) toll-free at (866) 503-SKIN (7546) or mrc@aad.org.

Mission Statement
Directions in Residency 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.

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