“Walk in beauty”: A Navajo dermatology experience

By Campbell Stewart, MD

Since 2010, the Academy has had a formal partnership with the Indian Health Services (IHS) on the Navajo Nation. Each year, the AAD selects four dermatology residents to receive the Native American Health Services Resident Rotation Grant, which supports travel, room, and board for one to two weeks in Chinle, Ariz. While on the Navajo Nation, residents work closely with IHS primary care providers and see dermatology patients at the main facility in Chinle as well as smaller clinics in the communities of Pinon and Tsaiie.

My experience on the reservation in Chinle was an inspiring, challenging, and eye-opening one. On my first night I felt like I had traveled to another country. So much about the reservation was foreign and I felt like an ignorant outsider. One of the tenets of the Navajo Nation that could be seen on signs in the town was to “walk in beauty.” The landscape and the people themselves certainly had that beauty, but it was tarnished by much of the Western influence. The lack of educational and employment opportunities on the reservation has lead to extreme poverty, and I was concerned that the health and health care of this population would be similarly poor.

While the health of the population met my expectations, the health care was the opposite. Upon entering the hospital on my first day, I was impressed by the facilities and the resources. Most impressive were the providers at the Chinle, Pinon, and Tsaiie clinics. Many of them had worked on the reservation for numerous years and had developed close relationships with their patients and the local staff. The lack of means, food, and education about health and diet has widespread implications, making the providers’ task even more challenging than usual. A large percentage of the population is diabetic and/or obese and the morbidity of these issues is apparent. The providers showed an unwavering dedication to the health of the Navajo.

The most rewarding moments came when I understood the Diné, or Navajo people, more clearly. The Diné are incredibly good-natured and have warm spirits; they love humor and laughter is very important to them. I most enjoyed taking care of the “grandmas” and “grandpas,” as the locals called the elders. These elders speak minimal English and instead speak in their beautiful native tongue. While we would need a translator to help with the details, we connected and laughed together without spoken language. We could communicate — and building that connection without words was a heart-warming experience.

The cultural barriers were still difficult to hurdle at times. Managing expectations of a person with a different cultural perspective was a particular challenge. The dermatologic conditions there were not significantly different from those I see in Philadelphia and included many cases of seborrheic keratoses, skin tags, and acne. There was a significant amount of actinic prurigo and photodermatitis — even more than I had been told to expect. While many patients had already diagnosed themselves with a photosensitivity disorder and were practicing photoprotection, others were harder to convince. Education regarding post-inflammatory pigment change was mostly well received, but not everyone trusts an outside physician the first time they meet one.

I struggled most with patients who had waited for months to see a dermatologist and whom I could not cure. For example, there were several patients with large congenital nevi in challenging locations that I could not remove. They had firmly believed that after such a long wait, a dermatologist could fix them. Comforting these patients was a privilege, but the disappointment is still palpable.

The rotation truly reinforced the need to be flexible in all situations, and limitations of supplies taught me to be innovative. The formulary was very well stocked and I did not struggle with prescribing patients the medications they needed. However, sometimes there were no blades to perform shave biopsies in delicate areas. We developed a system whereby we opened disposable razors used for shaving surgical sites and snapped the blades in two. This system worked well, and I was able to show the providers in clinic the advantages of this method so they could use it in the future.

One of the most important educational experiences of this rotation was developing independent decision-making skills. As residents, we often rely on the attendings with whom we work. On the reservation, although there is a primary care doctor supervising and assisting, yours is the final word on der-
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*Amgen is a proud sponsor of the American Academy of Dermatology’s Directions in Residency.*
NAJAVO from p. 1

matologic issues. Practicing in that environment forced me to grow as a clinician and become more confident in my diagnostic and therapeutic skills.

I would highly recommend this rotation to any dermatology resident. I am very grateful to the American Academy of Dermatology for providing this opportunity, to the staff of the clinics in Chinle, and the outreach sites for allowing me to work closely with them, and finally to the Diné for welcoming me into their hearts and lives for a brief moment.

Electronic applications for the grant are available on the Academy website each spring for travel to Chinle during the following calendar year. Grant applicants must be U.S. dermatology residents who will be in their second or third year of training during their time in Chinle. For more information, please visit www.aad.org/NativeAmerican or contact the Native American Health Services Resident Rotation Program director, Camille Introcaso, MD, at camille.introcaso@gmail.com.

In 2012, Dr. Campbell Stewart received the AAD’s Native American Health Services Grant and traveled to Chinle, Ariz. during his time as chief dermatology resident at the Hospital of the University of Pennsylvania. Dr. Stewart completed his residency in June 2013 and is now in dermatopathology fellowship training at University of Pennsylvania.

The Navajo Nation, or Diné ("the People"), is the second largest federally recognized tribe in the United States. There are about 298,000 Navajo nationwide, with over 234,606 people living on the 27,000-square-mile Navajo reservation.

The main clinic in Chinle, Ariz. “The providers showed an unwavering dedication to the health of the Navajo.”

45 Boards’ Fodder charts at the ready!

Earlier this year we rolled out our new Directions Web page, www.aad.org/DIR, including unsealing the Boards’ Fodder archives and adding new and exclusive Web content. Our Boards’ Fodder feature has consistently been chosen as one of the top resident study tools in dermatology, with its popularity growing larger each year.

Now, the Academy is providing you with every Boards’ Fodder ever published, along with something extra:
• Each chart is in its own PDF, available for you to save or print,
• Broad range of study topics chosen and written by your fellow residents-in-training.

And — in addition to our regular quarterly Boards’ Fodder feature (see p. 4-5) we added a Web-only quarterly Boards’ Fodder. This newest chart, covering cysts, by Alison Galatian Fischer, MD, and Stacie Rougas, MD, is online now at www.aad.org/DIR. Want to contribute your own Boards’ Fodder? Contact Dean Monti, dmonti@aad.org.

Join the movement.
Get involved.

Find out about volunteer and mentor opportunities at www.aad.org/volunteerandmentor
## Neonatal Dermatoses

**Israel D. Andrews, MD, and John A. Mouzakis, MD**

<table>
<thead>
<tr>
<th>Disease</th>
<th>Timing of Onset</th>
<th>Morphology/Location</th>
<th>Work-Up</th>
<th>Hints</th>
</tr>
</thead>
<tbody>
<tr>
<td>Erythema Toxicum Neutorum</td>
<td>Birth - 2 weeks to average 24-48 hours</td>
<td>Macules, papules, or pustules on a “splochty” erythematous base, can present anywhere, but spares palms and soles</td>
<td>Sterile smear w/ Wright Stain will show EOSINOPHILS, No treatment necessary</td>
<td>Full Term Infants</td>
</tr>
<tr>
<td>Transient Neonatal Pustular Melanosis</td>
<td>Birth</td>
<td>Fragile vesicles and pustules, rupture leads to hyperpigmented macules with collarettes of scale with progressing to hyperpigmented macules, rarely involves scalp, palms, and soles</td>
<td>Sterile smear w/ Wright Stain will show NEUTROPHILS, No treatment necessary</td>
<td>More common in dark skin</td>
</tr>
<tr>
<td>Milia</td>
<td>Birth</td>
<td>1-2mm pearly white papules, few to numerous but can be grouped.</td>
<td>Disappear spontaneously in 1st month, no treatment necessary</td>
<td>Persistence or widespread distribution may be associated with Dystrophic Epidermolysis Bullosa, Bazex, Rombo, or hereditary trichodysplasia (Marie-Unna Hypotrichosis)</td>
</tr>
<tr>
<td>Miliaria</td>
<td>Crystallina Birth - first week</td>
<td>Crystallina - “dew drop” vesicles w/o erythema, can present anywhere</td>
<td>Often caused by excessive warming/swaddling leading to the blockage of eccrine ducts. Resolves with cooling and removal of occlusion</td>
<td>Findings are due to a relative immaturity of eccrine ducts, patients may have a recent history of fever</td>
</tr>
<tr>
<td></td>
<td>Rubra - After first week</td>
<td>Rubra - erythematous papules, sometimes pustules, favoring intertriginous areas</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acne Neonatorum</td>
<td>Within first 30 days</td>
<td>Eruption and distribution similar to adolescent acne, erythematous papules, pustules on the face, NO COMEDONES typically</td>
<td>Giemsa Stain reveals neutrophils and yeast. Usually no treatment necessary, soap and water, mild keratolytics and topical antibiotics for persistent lesions</td>
<td>Neonatal Cephalic Pustulosis = Acne Neonatorum, associated with Malassezia species, treat w/ topical antifungals if desired. In recalcitrant cases of Acne neonatorum, consider a work-up for Androgen Excess</td>
</tr>
<tr>
<td>Seborrheic Dermatitis</td>
<td>1 week after birth, average 3rd-4th week of life</td>
<td>Greasy, scaly, erythematous, patches and plaques +/- occasional weeping, primarily on scalp (Cradle Cap), groin, face, ears and trunk, “Seborrheic distribution”</td>
<td>Scalp: Mild “No Tears” Shampoo/Selenium Sulfide, for thick scale mineral/baby oil Body: Topical Ketocnazole 2%, or Class VI/VII Steroid cream/ointment</td>
<td>Severe and recalcitrant Seb Derm should prompt search for alternative diagnoses. Seb Derm + exfoliation + failure to thrive and diarrhea = Leiner Disease, a phenotype associated with complement deficiency, SCID, Bruton’s Hypogammaglobulinemia and Job Syndrome</td>
</tr>
<tr>
<td>Eosinophilic Pustular Folliculitis</td>
<td>Birth - first few weeks</td>
<td>Follicular pustules most commonly on scalp and extremities</td>
<td>Bx: eosinophilic follicular inflammatory infiltrate Tx: Topical Steroids and antihistamines, resolution is typically by 3 years of age</td>
<td>Lesions resemble the adult variant but do not occur in annular crops, may occasionally be the presenting sign of Hyper IgE syndrome</td>
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</tbody>
</table>
### Neonatal Dermatoses (continued)

**Israel D. Andrews, MD, and John A. Mouzakis, MD**

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<tbody>
<tr>
<td>Langerhans Cell Histiocytosis</td>
<td>Birth</td>
<td>Yellowish to red-brown papules, +/- erosive or purpuric features, involving “Seborrheic Areas” - groin, axillae, and retroauricular scalp, palms and soles may be involved</td>
<td>Skin biopsy with stains for Langerhans cells is diagnostic (CD1a, S100, Langerin ), Lymphadenopathy is common, and multi-organ system must be ruled out</td>
<td>Consider in infants with recalcitrant seborrhea OR diaper dermatitis. A self-healing variant with involvement limited to the skin is called Hashimoto-Pritzker Disease</td>
</tr>
<tr>
<td>Impetigo Neonatorum</td>
<td>2nd day - 2nd week</td>
<td>Vesicular, pustular or bullous lesions on an erythematous base, denudation leaves a red moist base w/o crust, usually found in moist folds of the body (groin, axillae, neck)</td>
<td>Topical Antibiotics</td>
<td>Neonatal pustulosis due to <em>Staph aureus</em> leads to the development of fragile pustules on an erythematous base, neonates do not usually develop systemic symptoms</td>
</tr>
<tr>
<td>Scabies</td>
<td>Birth - all ages</td>
<td>Erythematous papules, nodules, burrows and vesiculopustules +/- crust distributed in the diaper area, palms, soles, axillae head or scalp</td>
<td>Mineral Oil Exam identifying mites, eggs, or scybala is diagnostic</td>
<td>Like adults, infection is intensely pruritic. Signs include irritability, poor sleep and eating habits. Crusted scabies maybe a sign of immunodeficiency</td>
</tr>
<tr>
<td>Neonatal Varicella</td>
<td>Birth – 2 weeks</td>
<td>Vesicles on erythematous base, generalized; lesions may be in different stages – papules, vesicles, crusts</td>
<td>Tzanck preparation, DFA, viral culture, serology</td>
<td>Primary maternal infection: 1 week before to 2 days after birth</td>
</tr>
<tr>
<td>Neontal Herpes Simplex Virus</td>
<td>Birth - 2 weeks of age, often &gt;5 days</td>
<td>Vesicles, bullae, erosions can favor scalp/trunk or be disseminated</td>
<td>Tzanck preparation, DFA, PCR, viral culture, serology</td>
<td>Congenital: erosions + scarring, maternal acquisition 1st, 2nd trimester, low birth weight, ocular abnormalities, limb anomalies, cortical atrophy</td>
</tr>
<tr>
<td>Neonatal Candidiasis</td>
<td>1 - 2 weeks of age</td>
<td>Scaly red patches, satellite papules/pustules in intertriginous areas, face</td>
<td>KOH showing budding yeast and pseudohyphae, fungal culture</td>
<td>Higher risk if mother acquires genital HSV near delivery, mother may be asymptomatic, low risk for recurrent infection, can involve CNS, eye, and internal organs</td>
</tr>
</tbody>
</table>

**References**

Race for the Case
By Razieh Soltani, MD

A 40-year-old female presents with progressive, woody sclerosis of the skin and reduced range of motion of mouth and fingers. On exam she had multiple waxy, 2–4 mm, dome-shaped papules on face, ears, dorsal hands, and extensor forearms.

1. What is the diagnosis?
2. What is the most common systemic organ involvement?
3. What would a skin biopsy show?
4. What is the characteristic hematologic finding on serum protein electrophoresis?

Respond today with the correct diagnosis to Allison Evans, staff editor, at aevans@aad.org, and you will be part of our drawing for a Starbucks gift card and your photo in Directions!

Answers to Fall 2013 Race for the Case

A 62-year-old Caucasian female presents with one-week history of intensely pruritic erythematous serpiginous rash on left dorsal foot. The rash has been resistant to over the counter topical steroids. She does not have rashes anywhere else on her body. She is otherwise healthy and does not report any systemic symptoms. She had a trip to Mexico and spent some time on the beach a month ago. She recalls a pruritic rash on left second toe web several days after her trip which resolved after a few days.

1) What is the name of this condition?
   Cutaneous Larva Migrans
2) Name three most common causes of this eruption.
   Larva of animal hookworms, mainly Ancylostoma caninum, A. braziliense and Uncinaria stenocephala
3) What is the natural course?
   The lesions migrate 1-2 cm per day and are ultimately self-limited.
4) Name three treatment modalities for this condition.
   Freezing the leading edge of the skin track (cryotherapy), oral ivermectin, oral albendazole, oral thiabendazole.

Congratulations to Navid Ezra, MD, for winning the fall 2013 Race for the Case! Navid is a PGY3 at Indiana University Department of Dermatology. He moved to Indianapolis from a suburb of Los Angeles, which was quite a transition to make! His hobbies include staying warm in the winter — while he awaits spring.
Reflections

Colleagues for medical school, partners for life

By Jane Grant-Kels, MD

Two weeks after graduating medical school together, my husband and I were married. Because I was accepted to complete my internship in lieu of my fourth year of medical school, the only day I could arrange time off resulted in our getting married on Father’s Day. After surviving this reality, which displeased my future in-laws, and returning from a few days in Bermuda, I was on call for the weekend. This was 1974 — long before the Libby Zion law suit created reasonable on-call schedules and work days. I awoke that Saturday morning at 6 a.m., showered, dressed in my hospital-supplied white skirt, white shirt, and white jacket and reported for rounds at 7 a.m. Being on call meant living and working in the hospital for the next three days.

I returned home to my new husband in our tiny New York City apartment across the street from New York Hospital on Monday night around 7 p.m., not having slept, showered, or eaten a decent meal since my departure early Saturday morning. I was exhausted, my ankles were swollen, and I was famished. Since my husband’s internship did not start until July 1, he had been home the entire weekend. I slipped my key into our apartment door fantasizing about a loving reception from my new husband, a warm shower followed by a home cooked meal, and then slipping into bed with clean sheets beside my new husband. The door swung open to a dark apartment with only a flickering light coming from the bedroom. I walked down the short hall to the bedroom and found my husband in sweats, lying on our unmade bed, watching television. He looked up and asked me what was for dinner?

A sense of despair overwhelmed me and I sat on our bed and cried, thinking to myself that marriage was not going to be what I had hoped for. My husband quickly realized my state of mind, took me in his arms, and I fell asleep with my clothes still on — unshowered and unfed. The next morning he awoke early and brought me coffee and breakfast in bed before I showered and dressed for the next day.

Fast forward almost 40 years, and I am still married to the same man and could not be happier. He has been my perfect best friend and life partner. We survived our internships, residencies, and even more challenging, the raising of our children. That night had taught us both not to have unrealistic expectations and to be more sensitive to the other. Lessons well learned and learned early in our life together!

Annual Meeting in Denver is just a few months away!

Many opportunities await residents at the AAD’s 72nd Annual Meeting in Denver. Don’t forget to plan on these special events as you create your schedule:

**Residents’ Reception**
Friday, March 21, 2014
5-6 p.m.
Centennial ABC, Hyatt Regency

**Boards and Beyond**
Sunday, March 23, 2014
1-3 p.m.
Colorado Convention Center — Room 301/302

Visit www.aad.org/AM14 for more information.

Jane M. Grant-Kels, MD, is the assistant dean of clinical affairs; founding chair of the department of dermatology; professor of dermatology, pathology, and pediatrics; dermatology residency director; director of dermatopathology; and director of the cutaneous oncology and melanoma program at University of Connecticut Health Center.

Barry D. Kels, MD, JD, is executive director of risk management and associate professor of surgery at University of Connecticut Health Center.

www.aad.org/DIR
Greetings from Louisville!

On the cover of this issue, we are pleased to feature Campbell Stewart, MD, who offers a firsthand perspective from the comprehensive dermatologic care clinic in Chinle, Ariz. Thanks too, to Camille Introcaso, MD, who helped with some details of our cover story.

The Academy-sponsored Native American Health Service Resident Rotation Program provides a meaningful experience for dermatology residents. Whether you are interested in assisting patients on the Navajo Nation, attending a meeting of an international society, participating in a rotating mentorship, or striving to create innovative research, the AAD is the premiere sponsor of resident scholarship opportunities. See www.aad.org/residentsandfellows for details.

As we approach the end of 2013, I would be remiss without mentioning a New Year’s resolution: championing cost-conscious medical care. Recently, the AAD submitted five evidence-based statements to Choosing Wisely, an American Board of Internal Medicine-sponsored campaign aimed at promoting high value, low cost medical care.

1) Don’t prescribe oral antifungal therapy for suspected nail fungus without confirmation of fungal infection.

2) Don’t perform sentinel lymph node biopsy or other diagnostic tests for the evaluation of early, thin melanoma because they do not improve survival.

3) Don’t treat uncomplicated, non-melanoma skin cancer less than one centimeter in size on the trunk and extremities with Mohs micrographic surgery.

4) Don’t use oral antibiotics for treatment of atopic dermatitis unless there is clinical evidence of infection.

5) Don’t routinely use topical antibiotics on a surgical wound.

There is a difficult dilemma looming on the horizon with regard to cost-conscious medical care. It is currently estimated that upwards of 30 percent of clinical care delivered in the U.S. is unnecessary. “Toxic cost” is a real side-effect of dermatologic prescriptions that impinge upon therapeutic access. Several generic topical steroids have ballooned to an egregious price of $250 or more for a 30g tube, threatening the existence of the infamous $4 drug list. The purported reasons behind inflated generic drug prices are multifactorial, dynamic, and complex. Nevertheless, in a busy university clinic, physician-patient communication regarding a therapy, more specifically as it relates to insurance coverage, drug price, and out-of-pocket costs, could lead to improved adherence rates and clinical outcomes.

A recent article in the New England Journal of Medicine (NEJM) underscores a dire need for cost transparency to prevent undue financial strain. It is imperative that we improve our stewardship of health care resources in dermatology. The Choosing Wisely campaign (www.aad.org/education/choosing-wisely) and future legislation in price transparency may be helpful adjuncts to avoid treatment-induced financial burden. As we venture into a world of high deductible medical care and narrowing physician networks, we should be aware that a ‘mouse-click’ in our friendly EMR may yield an indirect blow to the ethical adage, primum non nocere.

References
