As dermatology residents, navigating training while planning a professional course can be challenging. There is a multitude of information to absorb, questions to answer, and decisions to make. In the midst of this, another question will loom — if and how to interact with industry when approached. Since residency programs often limit interactions between residents and physicians, it is important to understand potential conflicts of interest as well as the benefits industry provide the specialty of dermatology.

Open book, Open Payments

Recently, physician-industry relations have endured much scrutiny with the Physician Payments Sunshine Act in effect, part of the 2010 Patient Protection and Affordable Care Act (ACA). The act requires manufacturers of drugs, medical devices, and biologicals to report payments and items of value given to physicians and teaching hospitals to the Centers for Medicare and Medicaid Services (CMS). The first disclosures are expected in September 2014 and will cover the period of August to December 2013. The AAD recommends that physicians also keep track of all of their own payments from industry to verify accurate reporting. For more information about the Sunshine Act, visit www.aad.org/SunshineAct.

Currently, the Sunshine Act does not apply to physicians in training and non-physician clinicians. Moving ahead in one’s career, however, greater transparency between practitioners and industry will make it easier to identify potential conflicts of interest. One potential conflict of interest may involve a physician that conducts clinical research trials for a drug company while also accepting payment for speaking or consulting on behalf of the same company. Critics believe that doctors who conduct clinical trials while accepting personal payments from the company can feel beholden to the pharmaceutical company, said Ornstein and Growchowski in a ProPublica article. While this does not automatically make the interaction unethical, the relationship needs to be monitored to ensure potential conflicts of interest don’t hinder scientific findings and clinical recommendations.

Industry matters

Despite the negative shadow, or at least thick veil of skepticism, that’s been cast over physician-industry involvement, industry is a necessity in health care. According to the Pharmaceutical Research and Manufacturers of America (PhRMA), ethical relationships with health care professionals are critical to developing and marketing new medicines. Although clinicians that market and promote for industry are highly criticized, as they can be perceived as transforming themselves
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Industries can provide rewarding career options for dermatologists beginning their journey, said Jeannette Jakus, MD, MBA, inaugural recipient of the AAD’s Translational Biotechnology Fellowship at Galderma. “As companies are looking for the new generation of doctors to lead them into the future, young physicians are the perfect candidates to bring fresh, new ideas and skills to the table. There is a strong need for new physician leaders in the pharmaceutical world, and companies are looking and willing to support these careers,” she said.

Without industry, innovation would be significantly diminished, said Mary Maloney, MD, chief of the division of dermatology at the University of Massachusetts and deputy chair of the Academy’s Professionalism & Ethics Committee. She points out that industry may or may not share physicians’ motivations. Industry must show profit to stay in business and provide a return on investment. However, “approval of new medications and devices require clinical trials and involvement of practicing physicians. So yes, we must partner with industry. The question is how to do this professionally?”

In addition to marketing and promotion, which can offer its share of financial gain, there are other ways dermatologists can get involved with industry that may leave less room for ethical qualms, said Seemal Desai, MD, clinical assistant professor of dermatology at the University of Texas Southwestern Medical Center. “Clinical research trials are one way physicians may feel more comfortable getting involved because they deal primarily in research and development as opposed to sales,” he said.

Dr. Desai, president and medical director at Innovative Dermatology in Plano, Texas, suggested that physicians look into investigator-initiated trials (IIT). These clinical trials are proposed by the clinical sponsor-investigator, without industry taking the role as sponsor. And while a pharmaceutical company may not sponsor an IIT, they can provide support to the sponsor-investigator in the form of test articles, grants, services, and advice, said clinical research scientist Surabhi Sharma, MD, in “Working with Pharmaceutical Companies on Investigator-Initiated Clinical Trials” in the Journal of Clinical Research Best Practices. “We must participate in clinical trials and well-designed studies,” said Dr. Maloney. “We have the expertise to run such studies and deliver the results on cutting-edge therapies. But these studies must be based in real science. Some companies have “pseudo” trials that pay physicians to try their therapy. As this arrangement lacks true scientific investigation, this is not an ethical practice.”

Through her fellowship, Dr. Jakus was introduced to the extensive research and development activities at Galderma. “As a newly graduated resident, with no previous exposure to the pharmaceutical industry, I was surprised by the complexities involved in the process of bringing a drug to market. I have been impressed by the high quality of research taking place and was excited to hear that many of the pathways and targets that I read about in my weekly journal club in residency were being experimented on right here behind these doors. Galderma, like other pharmaceutical companies, is truly interested in the needs of patients and is working hard to bring innovative and novel treatments to our field, beginning with the most basic and fundamental research of identifying new targets.”

“This process is very much dependent on physicians, and dermatologists in particular, to help define the clinical needs of our patients and to advocate for our specialty,” said Dr. Jakus. “The relationship between physicians and industry is one that should not be overlooked, as who better knows the needs of our patients than we do?”

**Make the relationship count**

So how should a physician sort through all the confusion when it comes to deciding how to interact with industry? “My one mantra has been to always keep in mind that what you’re doing should be for the betterment of the patient,” Dr. Desai said. “It’s important that by the time a resident graduates and becomes a young physician, he or she is able to differentiate between what is a valuable industry interaction and what is not a valuable interaction,” he said.

“Going to dinner to talk about a medicine for five minutes while having a five hundred dollar meal is not really meaningful. But going to a CME-accredited talk sponsored by an unrestricted educational grant to the organization that’s presenting is valuable because you’re learning about new technology and how patients can be treated. Yes, you learn about a new drug — but that drug is what we’re interested in because at the end of the day we need drugs to treat patients.”

“We need to partner with industry for the benefit of science and the care of our patients, Dr. Maloney said. “We need to be compensated for work when we cannot bill for services. We do not need dinner or gifts. Let us separate science from gifts; let us pay for our own entertainment and rely on industry to develop new treatments that add to our fight for the health and well-being of our patients.”

See **LOOKING GLASS** on p. 7
## Pregnancy Dermatoses

**Kelly K. Park, MD, MSL & Monika Kanizewska, MD, MS**

<table>
<thead>
<tr>
<th>Dermatosis</th>
<th>Description</th>
<th>Timing</th>
<th>Location</th>
<th>Risk Factors</th>
<th>Treatment</th>
<th>Pathology</th>
<th>Fetal Involvement</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pemphigoid gestationis</strong></td>
<td>Pruritic vesiculobullous eruption</td>
<td>Classically late pregnancy, may occur in any trimester, or immediately postpartum</td>
<td>Abdomen, umbilicus, can generalize Spares mucous membranes</td>
<td>HLA-DR3, HLA-DR4</td>
<td>Self-limited; topical and systemic corticosteroids, antihistamines</td>
<td>Subepidermal vesicle mixed infiltrate with eosinophils</td>
<td>↑ risk of prematurity, small-for-gestational age neonates, neonatal pemphigoid gestationis</td>
</tr>
<tr>
<td><em>Herpes gestationis</em></td>
<td>Spontaneously remits weeks to months after delivery</td>
<td>Commonly recurs in subsequent pregnancies</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Polymorphic eruption of pregnancy (PEP)</strong></td>
<td>Pruritic erythematous papules and plaques that may become vesicular, targetoid, eczematous</td>
<td>End of third trimester, immediately postpartum</td>
<td>Within abdominal striae, can generalize Spares umbilicus, face, palms, soles</td>
<td></td>
<td>Self-limited; resolves within 4 weeks, topical corticosteroids, antihistamines</td>
<td>Non-specific, negative IF and ELISA</td>
<td>None</td>
</tr>
<tr>
<td><strong>Atopic eruption of pregnancy (AEP)</strong></td>
<td>Flare or new onset eczematous or papular eruption in atopics May have serum IgE elevation</td>
<td>Commonly prior to third trimester Commonly recurs in subsequent pregnancies</td>
<td>Can be in a flexural distribution</td>
<td>Atopic diathesis</td>
<td>Topical corticosteroids, ultraviolet B (UVB) phototherapy</td>
<td>Variable, but commonly spongiosis, acanthosis, lymphocytic and eosinophilic infiltrate</td>
<td>None</td>
</tr>
<tr>
<td><strong>Pruritic folliculitis of pregnancy†</strong></td>
<td>Follicular-based papules and pustules</td>
<td>After first trimester May recur in subsequent pregnancies</td>
<td>Trunk &gt; extremities</td>
<td>Atopy has been suggested May be a variant of Atopic Eruption of Pregnancy</td>
<td>Post-partum resolution Sterile folliculitis</td>
<td>Variates</td>
<td>None</td>
</tr>
<tr>
<td><strong>Prurigo of pregnancy†</strong></td>
<td>Prurigo nodules May have serum IgE elevation</td>
<td>After first trimester May recur in subsequent pregnancies</td>
<td>Extremities &gt; abdomen</td>
<td>Atopy has been suggested May be a variant of Atopic Eruption of Pregnancy</td>
<td>Resolves post-partum</td>
<td>Varies</td>
<td>None</td>
</tr>
</tbody>
</table>

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*Kelly K. Park, MD, MSL, is a PGY-3 dermatology resident at Loyola University Medical Center in Maywood, Illinois.*

*Monika Kaniszewska, MD, MS, is a PGY-4 dermatology resident at Loyola University Medical Center in Maywood, Illinois.*
Physiologic cutaneous changes in pregnancy

First Trimester
Mucosal: Chadwick’s sign (blue-to-violaceous discoloration of mucous membranes of cervix, vagina, vulva)
Vascular: gingival hyperemia and edema, palmar erythema, spider angiomas
Glandular: hypertrophy of Montgomery tubercles, ↑ sweating

Second Trimester
Pigmentary changes
Pruritus (late)

Third Trimester
Pruritus (early)
Hair and nail changes
Connective tissue changes
Vascular: edema, purpura, petechiae

References
Race for the Case
By Julia Curtis, MD

A 34-year-old previously healthy male with history of atopic dermatitis presents to emergency department with three-day history of eruptive painful vesicular rash. Patient reports that he has burning pain all over his head. He has no other associated symptoms.

The rash has now spread to his eyelids.
1. What is the name of this condition?
2. What immediate consult would you request?
3. What additional tests would you perform?
4. What is the treatment for this condition?

A 27-year-old previously healthy male presents with 10-day history of fevers, photophobia, bilateral lower extremity edema, and arthralgias so severe he has difficulty ambulating. Five days into this illness he develops painful subcutaneous nodules on his bilateral lower legs and upper extremities. He has just been released from jail and denies any sick contacts or recent illnesses.

1. What imaging would you do? CXR to look for hilar lymphadenopathy
2. What is the name of this condition, and which connective tissue disease is this associated with? Lofgren’s syndrome and sarcoidosis
3. What is the natural course? Usually resolves in two years with no sequelae
4. What is the treatment for this acute case? Mostly supportive; however, steroids can be indicated if symptoms severe enough

Answers to Summer 2014 Race for the Case

So You Think You Can Race?
Why not submit your own Race for the Case feature? Our guidelines are designed for busy residents (are there any other kind?) who wish to share their knowledge, show their competitive nature, and have their work published in an AAD publication (and wouldn’t that look good on your CV?). All you need is an interesting case, a few questions and answers, and a few images that you have permission to use for publication. While the wheels are still turning inside your head, submit your Race for the Case query to Dean Monti at dmonti@aad.org.

Directions
Residency
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Summer 2014 Race for the Case winner

Julia Curtis, MD, is a PGY-3 dermatology resident at University of Utah Health Care in Salt Lake City.

Katherine Moritz, MD

Congratulations to Katherine Moritz, MD, a 3rd-year dermatology resident at Washington University in St. Louis. When she’s not living the crazy busy life of a dermatology, Dr. Moritz loves spending time with her husband and 1-year-old daughter as well as cooking and drawing. She received a certificate for a cup of coffee from us, and her mug is pictured above.
IOM seeks reform of GME

In July, Politico.com reported that The Institute of Medicine (IOM) recommended a complete overhaul of government financing to train new doctors, rejecting calls for increased funding of graduate medical education to address workforce shortfalls.

A report released by IOM in July rejected the position of some physician and hospital groups that more GME funding is needed to boost physician ranks in areas like primary care. The evidence, the report says, "suggests that producing more doctors is not dependent on additional federal funding."

According to an analysis of the report Politico.com said the IOM recommended that funding "remain flat for now but that it be separated into two streams — one making payments for traditional residency training programs and another to transform the GME system into one that pays based on the performance of hospitals in contributing to health care workforce needs."

"Funding for GME reached $15 billion in 2012. Urban hospitals and academic medical centers receive an outsized share of that money, which has triggered complaints about the geographic distribution of the funding. Despite years of pressure to produce more primary care providers, the system is failing to create a higher proportion of generalists, the report states. Moreover, the hospital-based focus of training is antiquated as more and more care is delivered on an outpatient basis, the report notes."

Politico.com also cited the conclusion in the report, "Under the current terms of GME financing, there is a striking absence of transparency and accountability for producing the types of physicians that today's health care system requires."


Looking Glass from p. 3

Know the facts

Dr. Desai recommends that residents and young physicians familiarize themselves with the Academy’s position statement on Physician-Industry Relations.

Academy policies urge dermatologists to help maintain the “highest level of professionalism, ethics, and transparency by minimizing any actual and perceived conflicts of interest.” The Academy’s position statement notes that “there should be substantive, appropriate, and well-managed interactions between industry and physicians, including residents and fellows. ... Appropriate interactions with industry would help to ensure that physicians and residents avail themselves of the latest scientific developments and innovations impacting patient care.” Read the entire position statement at www.aad.org/positionstatements.

Dr. Desai also suggests looking at the big companies in dermatology — the players in the game. Know which ones specialize in research and development and which ones do not. "Is the company only out there to sell a product? Or are there companies that are really dedicated to our specialty?"

With the Sunshine Act in effect, the majority of physician interactions with industry will be visible in a publicly accessible database. "Your reputation is everything. It’s important to be selective in your pharma interactions so that your involvement continues to support what your treatment goals are for your patient and what your career goals are for your specialty," Dr. Desai said.

Submit to new JAAD case reports journal

JAAD Case Reports is an open access journal dedicated to publishing case reports related to diseases of the skin, hair, and nails. Manuscripts must be authentic, understandable, educational, and of interest to an international audience of dermatologists, residents, fellows, and researchers in all dermatology subspecialties, as well as clinicians in related fields. All submissions are peer reviewed. If accepted for publication, authors are requested to pay an article processing fee per article. Following payment of this fee, the article will be made available at jaadcasereports.com and www.sciencedirect.com. Visit www.jaadcasereports.com for more information.

Research symposium: correction!

In our last issue we inadvertently switched the order of two of the winners of the AAD’s Resident and Fellows Research Symposium in Denver. The correct results for clinical-based research were:

1st Place: Mary Therese Padilla Evangelista, MD
2nd Place: Shivani Tripathi, MD
3rd Place: Young H. Lee, MD

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Message from the Chair

Greetings from San Francisco! It has certainly been an exciting time of transitions. In this fall message, I would like to redirect your attention to the excellent cover story by Allison Evans.

At present, residents/fellows are rightly excluded from the Sunshine Act. It is safe to surmise that dermatology training programs, for better or worse, lack exposure to ‘real world’ interaction with industry. In 2011, the ACGME updated a 2002 version titled, “Relationship of GME to Industry and Other Funding Sources,” to reaffirm professional standards in a competency-based format. Ironically, a 2001 JAMA-published survey of Canadian IM residents revealed that restricting access to pharmaceutical representatives effectively translated to negative attitude towards industry post-graduation.

A series of questions are posed to encourage reflection: Are dermatology programs enhancing resident education by restricting access to industry? Are residents effectively taught [behind closed doors] key professional behaviors requisite to an ethical relationship? Is experiential learning a better way for residents to adopt professional and ethical behaviors? If residents do not learn these skills in training, are they more vulnerable to negative influences from industry later in practice?

For many, a dermatology clinic without visits from pharmaceutical representatives might only be a reality either on an island or a cruise ship. If we do not have industry relationships, certain therapies that help patients with skin disease are marginalized. Moreover, practicing dermatologists are requisite for future evidence-based clinical trials. Perhaps this particular type of career affiliation with industry should be clearly visible to residents early in training. It is perhaps time for the pendulum to swing toward neutral ground; to empower all of us to reach a goal of improved patient care.

Fall 2014 Residents / Fellows Committee
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Lindsey Hunter-Ellul, MD, physician reviewer
Lacey Lea Kruse, MD, physician reviewer
Kathryn Belezray, MD
Nancy Habib, MD
Mark Tye Haeberle, MD
Nathanial R. Miletta, MD
Jenna L. O’Neill, MD
Nishit Sharadchandra Patel, MD, MS
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