’Tis (always) the season – to be networking

By Brian Hinds, MD, chair, Resident/Fellows Committee

Whether you’re talking about workplace holiday parties, family get-togethers, or planned events among colleagues, peers or friends, the holiday season increases the occurrences of social interaction. And social interaction creates more opportunities for networking. I’m not suggesting you hinge your dermatology future on talking to your Uncle Fred over an egg nog, but don’t miss those opportunities to talk about what you’d like to do with your future and consider those who might help it along. In any case, as one year draws to a close and another begins, it’s a good time to talk about networking and how you might plan for networking in 2015.

Networking encompasses a broad, at times intangible definition that may be uniquely applied to professional peer-to-peer interaction. It is helpful to first define networking and then qualify what it means to you. The strict definition is the following: network, verb; to interact with other people to exchange information and develop contacts, especially to further one’s career [Merriam-Webster]. Could it really be more than using Twitter or Facebook?

In my opinion, networking in dermatology, or really medicine as a whole, is the most concrete form of continuing education. It builds a foundation for personal development and professional practice. Networking is more than social connectivity; it is a form of learning with exposure to new ideas, perspectives, and processes. For resident physicians, networking is ubiquitous and a permanent by-product of training. Perhaps best recognized early in training, it is helpful to realize the potential impact of our daily interactions. The relationships that you build with your own training program are solidified in time, e.g. forever. When you establish positive relationships in training, it yields a functional, happy family that provides personal and professional support, which is invaluable to your career.

So once you embrace a definition of networking, how do you apply it to your busy to-do list? The easiest step, perhaps more challenging for introverts, is to step out of your comfort zone. At the next AAD meeting, try to approach residents or faculty from other programs or community dermatologists and make a point of meeting two to three new individuals between lectures. If this is not your style, then seek out lectures that you are most interested in and stay afterwards for Q/A sessions. Experts in our field are extremely approachable and willing to teach and mentor residents or young physicians. You do not have to travel a long distance: Grand Rounds, state society meetings, or regional conferences, are all prime settings for exploring the personalities and ideas present around you.

Above all, it is important to avoid the common misperception that networking is a form of schmoozing. If you consider networking in this way, you will truncate any substantive networking relationship. As you contemplate an action plan, remember that networking transcends well beyond the professional arena. We all are capable of being successful networkers, so with that in my mind, a healthy peer network will transform your career and indirectly provide sustenance for our specialty.

New Board Prep for Residents course – get right on it now!

There’s a lot of buzz, and deservedly so, about the Board Prep for Residents session that has been slated for the AAD’s 73rd Annual Meeting in San Francisco. New for 2015, the AAD will offer the full-day course on Friday, March 21 from 9 am to 5 pm. The session will be directed by Jennifer Lucas, MD, who participated in the wildly popular Boards Blitz session at the Academy’s last Annual Meeting in Denver.

Invited speakers include Anthony Fernandez, MD, Natasha Atanaskova Mesinkovska, MD, PhD, and Michelle B. Tarbox, MD.

Attendees will be able to practice their timing, increase their comfort with the exam format, and identify areas of weakness in their knowledge base. The morning session will consist of two sections: dermatopathologic glass slides and a multiple choice section which will encompass digital images and written questions. In the afternoon, expert faculty will review the exam results, providing high yield information for the certification exam. Residents attending this course should walk away with a better understanding of the pace and structure of the exam.

The Board Prep Course is unique among other board study sessions in that it will mimic the structure of the ABD’s initial certification exam. During the morning, residents will take a “mock exam” reviewing histopathologic slides on microscopes and answering a series of multiple choice questions. In the afternoon, expert faculty will review the mock exam. Residents attending this course should walk away with a better understanding of the pace and structure of the exam.

Because this is a ticketed event ($120 for residents), with limited space, we encourage residents to GROIN (Get Right On It Now!)

See BOARD PREP on p. 6

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6 Race for the Case
7 JID Connector: New Journal study materials
8 Message from the Chair
Transforming the language of life into vital medicines

At Amgen, we believe that the answers to medicine’s most pressing questions are written in the language of our DNA. As pioneers in biotechnology, we use our deep understanding of that language to create vital medicines that address the unmet needs of patients fighting serious illness — to dramatically improve their lives.

For more information about Amgen, our pioneering science and our vital medicines, visit www.amgen.com.

*Amgen is a proud sponsor of the American Academy of Dermatology's Directions in Residency*
Two views from the hill

Two residents who attended the 2014 Legislative Conference in September talked to Directions in Residency about the conference’s importance to dermatology as well as its personal impact.

Erika Reid, MD, is a third-year resident in the department of dermatology at the University of Pennsylvania.

Most days, it’s hard for me to feel like I understand, let alone have any influence over, the complicated policy decisions that determine how I practice dermatology. Usually, I only notice the policies when they don’t work well — when my patient’s insurance company suddenly changes their network providers, and she can’t see me anymore, or when the prescription plan won’t cover an expensive medication that I think my patient needs. The rest of the time, I don’t think about policy that much. But the legislation that governs our practice is informed by and impels what it means to be a physician every day and all the time — our level of responsibility, the tools we have, the shape of the system we work within to care for patients.

The day I spent on Capitol Hill, I felt and saw how physicians, and dermatologists in particular, can influence the way these policies are formed. As someone who spends her days surrounded by dermatologists, it’s easy to forget that not all physicians understand the issues that are so familiar to us in dermatology. It’s easy to lose track of what others might know or think about dermatologists. For instance, it’s not common knowledge that we are trained and tested in pediatric dermatology, surgery, and pathology. Dermatologists are hugely outnumbered by other specialists and primary care physicians, and it’s alarming to think that unless we show up to the discussions about health care policy, no one at the table will be able to fight for us, because no one will know what we are doing or what we need to do it. We have to show up. Even if you know nothing about health care policy, it’s important to be active in your local, state, and national medical and dermatology organizations to make our issues and voices heard.

Residency is a great time to get involved, because it takes a while to get a feel for how the system works. The world of health care policy can seem like a dizzying whirl of lingo and committees and political crossfire. The Schoolhouse Rock “How a Bill Becomes a Law” is recommended review material. If you stand back and watch the scene for a while, you start to see the patterns and pick up on the language and process. And you start to realize that, for the most part, policy makers are there because they want to make life better for their constituents. (That’s you and your patients!) They want to know what matters to you and your patients. No matter the issue, lawmakers need to hear about it to know about it — whether it’s an orphan disease that needs research funding, or public health issues like tanning bed restrictions, or ironing out the legislation on reimbursement for certain procedures, or advocating for policies that would allow patients greater access to care and medications. Speak up, because other specialties are talking, as are the insurance companies, and the pharmaceutical companies too.

The AAD’s Legislative Conference is a fantastic opportunity to learn about the process of influencing health care policy, and the current issues that directly affect dermatology. But even if you can’t attend next year, I’d urge you to join your professional medical and dermatology organizations and advocate for the issues that matter to you. There are not a lot of dermatologists in America to begin with, and only very few of these are involved in advocacy work. We need more voices and, I think, younger voices, to participate in the conversation.

Daniel Y. Sugai, MD, is a second-year dermatology resident at Harvard Medical School/Massachusetts General Hospital.

“How else can I help my patients?” That is the question we as physicians should always be asking ourselves. I have found the answer to this question through the 2014 AADA Legislative Conference. As a dermatology resident, I find much joy in treating and caring for patients in clinic and in the hospital setting. By leaving my comfort zone and trying my hand at advocating on Capitol Hill, I have now discovered a new way to help my patients.

This conference was extremely fulfilling for me on many levels. I was able to interface with fellow dermatology residents, faculty members from other academic institutions, private practice dermatologists, and patient advocates from various organizations. The conference gave updates on previous successful changes the AADA took part in including tightening regulations on tanning booth use.

I had only heard of a case or two of providers being cut from networks in Massachusetts before this conference. During my time in Washington D.C., the issue of limiting networks was apparently a serious issue affecting providers across the country. Through a series of lectures within the first two days of the conference, I had become knowledgeable about issues regarding access to care (H.R. 4998/S. 2552) and treatment (H.R. 460) and gained the confidence to give a concise presentation of asks to our Members of Congress. The third day of the conference culminated in multiple meetings with US Representatives and Senators, and their staff members on Capitol Hill.

My day on Capitol Hill was a rush. The hustle and bustle of throngs
Drug Eruptions

Ranjan Bronfenbrenner, MD, and Courtney Esslin, MD

**Drug Eruption**

<table>
<thead>
<tr>
<th>Common medications</th>
<th>Time course</th>
<th>Clinical features</th>
<th>Laboratory values</th>
<th>Pathology</th>
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<th>Notes</th>
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</table>
| **Fixed Drug Eruption**

<table>
<thead>
<tr>
<th>Sulphonamides</th>
<th>NSAIDs</th>
<th>Tetra cyclics</th>
<th>Pseudoephedrine, Barbiturates</th>
<th>Carbamazepine</th>
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<tbody>
<tr>
<td>Begins 1-2 weeks after first exposure; &lt;48 hours after re-exposure</td>
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<td>One or few round, sharply demarcated, erythematous to violet-brown plaques, and deep red center in diameter; often edematous with a bulla, or central erosion and peripheral hyperpigmentation or erythema; predilection for oral and genital mucosa, face, hands, feet; as lesions heal, they leave behind a post-inflammatory brown pigmentation</td>
<td>None</td>
<td></td>
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</tbody>
</table>
| **Urticaria**

<table>
<thead>
<tr>
<th>NSAIDs</th>
<th>Monoclonal antibodies</th>
<th>Contrast media</th>
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<tr>
<td>Develops within minutes to hours and resolves within 24 hours</td>
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<tr>
<td>Transient erythematous and edematous papules and plaques with central necrosis; has associated pruritus; lesions can appear anywhere on the body, and vary in size and number; may have associated angioedema; respiratory compromise and hypoxia can be fatal in severe reactions</td>
<td>None</td>
<td></td>
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</tbody>
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Ranjan Bronfenbrenner, MD, is a 2nd year dermat resident or PGY-3 at SUNY - Stony Brook

Courtney Esslin, MD, is a MS-4 at SUNY - Stony Brook University Medical School

**Acute Generalized Exanthematous Pustulosis (AGEP)**

| Antibiotics, anti-infectives, calcium channel blockers, macrolides, antimalarials | Sudden onset; within an average of 10 days of medication and lasts for 1-2 weeks | High fever; diffuse edematous erythema studded with numerous non-follicular minute, sterile bullae; lesions begin on the face or intertriginous areas and then disseminate; may have pruritus and/or burning; resolves with widespread superficial desquamation; may have + Nikolsky sign | Marked leukocytosis with neutrophilia; mild to moderate eosinophilia; transient renal dysfunction; hypocalcemia | Inflammation of neutrophils and pustules; edema of the papillary dermis; eosinophilic mixed infiltrate of neutrophils and some eosinophils | Discontinue offending agent; supportive treatment with antihistamines, and topical corticosteroids. | May patch test for suspected medication; mortality rate of 1-5% main differential is pustular psoriasis, elucidated by history and other evidence of psoriasis; AGEP can also be caused by radiointerstitial material and mercury |

**Drug reaction with eosinophilia and systemic symptoms (DRESS)**

| Anticonvulsants, sulfonamides, Allopurinol, Minocycline, dipirona, nevirapine, abacavir | Relatively late-onset; begins >3 weeks after drug initiation; long-lasting; lasts >2 weeks after drug discontinuation | Fever; lymphadenopathy; multiform eruption that becomes edematous with follicular acantholysis; facial edema; often involves vesi,cus, tense bullae, pustules, erythroderma and purpura; may have associated arthralgias and arthritis; internal organ involvement (most commonly hepatitis, but also myocarditis, intestinal pneumonitis, interstitial nephritis, thyroiditis and eosinophilic men ingitis or eosinophilia) | Marked leukocytosis with neutrophilia; mild to moderate eosinophilia; transient renal dysfunction; hypocalcemia | Superficial epidermal spongiosis and pustules; edema of the papillary dermis; eosinophilic mixed infiltrate of neutrophils and some eosinophils | Discontinue offending agent; topical and/or systemic steroids; antihistamines; antipyretics. | |
### Drug Eruptions (cont.)

**Roman Bronfenbrenner, MD, and Courtney Esslin, MD**

<table>
<thead>
<tr>
<th>Drug Eruption</th>
<th>Common medications</th>
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</tr>
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<tbody>
<tr>
<td>Serum Sickness Like Reaction (SSLR)</td>
<td>Cefadroxil, penicillins, sulfonamides, minocycline, NSAIDs, bupropion, phenytoin</td>
<td>Occurs 1-3 weeks after drug exposure</td>
<td>Fever, arthralgia, urticarial or morbilliform rash and lymphadenopathy. Urticarial plaques favoring Wallace’s lines are seen in TRUE serum sickness, not SSLR</td>
<td>Absence of hydropsymmetry, vasculitis and renal disease (in comparison to true serum sickness)</td>
<td>No vasculitis; superficial and deep dermal, intravascular and/or perivasculary lympho-histiocytic infiltrate; dermal edema may be seen</td>
<td>Withdrawal of causative agent; antihistamines or oral steroids to speed resolution</td>
<td>More common in children; not due to immune complex deposition as in Serum Sickness</td>
</tr>
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</table>

**Acneiform reactions**
- Corticosteroids, androgens, hydantoins, lithium, oral contraceptives, iodides/bromides, EGFR inhibitors
- Varies depending on offending agent
- Monomorphic papules and/or pustules on the face and upper trunk; no comedones
- None
- Folliculitis neutrophilic pustules
- Withdrawal of causative agent; topical acne medications and oral antibiotics

**Vasculitic reactions**
- Penicillins, NSAIDs, sulfonamides, cephalosporins
- Occurs 7-21 days after drug initiation and less than 3 days following rash exposure
- Palpable purpura on the lower extremities; may also involve papules, ulcers, blisters, urticarial-like lesions, and digital necrosis; internal involvement includes GI bleeding, arthritis, nephritis, peripheral neuropathy; systemic symptoms are rare
- Must rule out cutaneous involvement of a systemic vasculitis; consider CBC, CMP, UA, Complement, ANA, ANCA, cryoglobulins, RF as directed by history
- Transmural infiltraion vessels walls by leukocytes (early stage: neutrophils, late stage: mononuclear cells) with leukocyto- clasia, fibrinoid necrosis of the damaged vessel walls, resulting in extravasation of erythrocytes; direct immune fluorescence (DIF) reveals deposition of C3, IgM, IgG and/or IgA within the vessel walls in a granular pattern
- Discontinue medication; supportive care; oral corticosteroids may benefit those with systemic symptoms
- ANCA-positive vasculitis has been associated with pro-pylthiouracil, hydralazine, and minocycline; polyarteritis nodosa has been observed following hepatitis B vaccination; drugs are the cause of 10-15% of cutaneous small-vessel vasculitides

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<tr>
<td>Lichenoid reactions</td>
<td>ACE inhibitors, beta-blockers, calcium channel blockers, antimalarials, diuretics, NSAIDs, gold salts</td>
<td>Occurs several months to years after drug introduction and takes months to resolve</td>
<td>Photodistributed or generalized plaques, small papules, or exfoliative erythema; +/- Wickham’s striae</td>
<td>None</td>
<td>Lichenoid inflammation along the dermoeipidermal junction, necrosis of keratinocytes, and a dermal lymphocytic infiltrate (very similar to idiopathic lichen planus)</td>
<td>Photophobia and oral involvement is uncommon; may affect nails</td>
<td>Withdrawal of the suspected drug; symptomatic treatment with antipruritics; topical or intralesional steroids; systemic retinoids, narrowband UVB, PUVA, topical calcineurin inhibitors, and antimalarials may be helpful</td>
</tr>
<tr>
<td>Photoallergic</td>
<td>Triazolo diuretics, sulfonamide antibiotics, sulfonamides, phenothiazines, sunscreens</td>
<td>Sensitization on first exposure; upon re-exposure, cutaneous eruption occurs quickly; course may be chronic (months to years)</td>
<td>Pruritus; eczematous or lichenoid lesions; limited to sun-exposed areas</td>
<td>None</td>
<td>Epidermal spongiosis, dermal lymphohistiocytic infiltrate</td>
<td>Withdrawal of offending agent; photoprotection; topical steroids</td>
<td>Cell-mediated hypersensitivity reaction to an allergen produced by the effect of UV light on a drug; phototesting may be useful; when phototests in patients with light exposure persists for months to years it is known as chronic actinic retinopathy</td>
</tr>
<tr>
<td>Phototoxic</td>
<td>Tetracyclines, NSAIDs, fluoroquinolones, aminodarone, procainamide, phenothiazine</td>
<td>Onset within hours to days of exposure</td>
<td>Erythema, vesicles and bullae limited to sun-exposed sites; appears similar to an exaggerated sunburn; heals with desquamation and residual hyperpigmentation; photo-ochotolysis</td>
<td>Normal plasma porphyrin (in pseudoporphyrin)</td>
<td>Necrotic keratinocytes, edema; mild dermal lymphohistiocytic infiltrate, vasculitis</td>
<td>Dose reduction or withdrawal of offending agent; photoprotection</td>
<td>Can occur in anyone who reaches the clinical threshold for phototoxicity and has sufficient UV light exposure, resulting in reactive oxygen species damage to the skin; studies show decreased reactivity in higher Fitzpatrick skin type</td>
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### References
Race for the Case
By Robyn Marszalek, MD

A 48-year-old male presents urgently to the outpatient clinic after a business trip to the Caribbean with an extremely pruritic, expanding eruption on the sole of the right foot. On examination, a slightly serpigenous curvilinear, pink, blanchable slightly palpable plaque is noted, which is more well defined medially and less circumscribed laterally. The patient is otherwise well without systemic complaints.

1) What is the name of this condition? Eczema Herpeticum
2) What additional consult would you order immediately? Ophthalmology with eyelid involvement
3) What additional tests would you perform? Viral culture of vesicles for HSV/VZV PCR or DFA
4) What is the treatment for this condition? Valacyclovir 1 gram TID for 7 days, gabapentin 300 mg TID for neuropathic pain, Vaseline ointment for lesions

Visit the Residents and Fellows Resource Center Online at www.aad.org/members/residents-fellows-resource-center

Robyn Marszalek, MD, is a PGY-4 dermatology resident at Boston University Medical Center.

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.

Answers to Fall 2014 Race for the Case
A 34-year old previously healthy male with history of atopic dermatitis presents to the 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? Eczema Herpeticum
2) What additional consult would you order immediately? Ophthalmology with eyelid involvement
3) What additional tests would you perform? Viral culture of vesicles for HSV/VZV PCR or DFA
4) What is the treatment for this condition? Valacyclovir 1 gram TID for 7 days, gabapentin 300 mg TID for neuropathic pain, Vaseline ointment for lesions

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Fall 2014 Race for the Case winner
Our October 2014 Race for the Case winner is Nahid Vidal, MD, a PGY-3(R2) at University of Iowa Hospital & Clinics, department of dermatology. In addition to acing our case, she enjoys hip hop dance; playing with her golden retriever Hudson (cuddled in our winner’s arms, above); obsessing over the latest episode of The Voice; two-hand touch football or pick-up basketball (or any sport); and trying out new foods. She also somehow manages to excel in her residency and also beat out the competition in Race for the Case. We suspect the kind of person who would not turn down a well-deserved gift certificate for coffee. Congrats!

Visit the Residents and Fellows Resource Center Online at www.aad.org/members/residents-fellows-resource-center

Nahid Vidal, MD

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New journal study materials available online

The Journal of Investigative Dermatology hosts a website, the JID Connector, that is designed to help residents share ideas and gain knowledge of research techniques and diagnostic methods. The website provides educational self-study and didactic materials relating to skin biology and basic science including image quizzes, articles on research techniques, social media links, a monthly newsletter, and other resources. Each contains clinically relevant images of skin conditions and applies basic science knowledge to clinical disease.

The JID Connector currently offers a free digital Resident Welcome Package that can be downloaded from their website. https://www.dropbox.com/sh/rhrha-jsi97/wrks5AACBpMve9DYwDAeRsGfmOh6ma/Resident-Welcome-Packet.pdf.

JID Connector articles can help residents enhance their diagnostic skills with the VisualDx and Cells to Surgery quizzes. These monthly quizzes present an image along with questions asking the diagnosis and highlighting new information about the disease from a recent JID article.

Other important research techniques and topics in skin biology included on the JID Connector:

- Research Techniques Made Simple (RTMS) articles review a research technique, its purpose, benefits, limitations, and interpretation of the results. They are ideal for journal clubs or didactics. CME credit is available (1 hour per article).
- The Skin Biology Lecture Series comprises eleven PowerPoint presentations covering the basic science of the skin and related clinical skin diseases. Filled with basic science “trivia” and more detailed explanations, as well as a kodachrome image and other quiz questions to test your knowledge and help you prepare for the board exam, these presentations can be used for study or in your didactic program.
- SkinPod, the dermatology podcast from the JID, features captivating interviews in which leading scientists discuss the latest in clinical and basic science.
- The JID Jottings Blog, moderated by Lowell A. Goldsmith, MD, covers a variety of timely and creative topics from members of the dermatologic community.

Connect with the dermatology community.

- Meet the Investigator is a Facebook feature that provides a biography of a junior co-author of a recent JID article and provides insight into his or her motivation and journey.
- JID regularly posts current events, conference notices, and news from the dermatology community.
- Join our growing community by liking us on Facebook (https://www.facebook.com/JournalOfInvestigativeDermatology) and following us on Twitter (https://twitter.com/JIDJournal). JID Connector features are all available free at (http://www.nature.com/jid/jid-connector). To receive their monthly e-alert newsletter, you can sign up on the Connector website.

Present your ground-breaking research at the Annual Meeting

The Academy invites all members to submit their abstract presentations for review and selection for the Late-Breaking Research in Dermatology Forums at the 73rd Annual Meeting, March 20-21, 2015, in San Francisco. These forums highlight the latest ground-breaking results in clinical, therapeutics, surgical, pediatric, dermatopathologic, and basic research areas of dermatology.

The authors of the selected studies will be invited to briefly discuss their findings during one of five themed forums. New therapies will be given top priority, particularly data from pivotal trials of unapproved drugs or unapproved indications. Abstracts are limited to 200 words and should clearly identify the background, approach, results, innovation, and relevance of research to dermatology.

Learn more about how to apply at www.aad.org/Symposium/LBAM2015/. The deadline to submit applications is Jan. 30, 2015 at 5 p.m. (CT). For more information, contact Molyka Rath at 847-240-1679 or mrath@aad.org.

Views From The Hill from p. 3

of people dressed in suits briskly walking through the monumental neoclassical buildings of Capitol Hill reminded me of the chaos one would see in the hospital. I felt surprisingly comfortable and excited to be entering a whole new world representing the patients of Massachusetts. I was part of the Massachusetts delegation which consisted of attending dermatologists, Drs. Shadi Kourosh, Eileen Deignan and Lynn Drake — all of whom were able to provide valuable and personal insight regarding these access to care and access to treatment issues.

I am most grateful to the Harvard Combined Residency Training Program for allowing me to go to this conference which has supplemented my dermatology training immensely. I also would like to thank the AADA for giving the residents this opportunity to be introduced to advocacy while in training. Moreover, this opportunity is not always available to other resident physicians training in other specialties. Shortly after returning back to Boston, I gave the Harvard dermatology residents an oral presentation on the issues we discussed with the Members of Congress and introduced them to the relevant bills which affect our patients. By incorporating advocacy into my medical career, I feel much more fulfilled as a physician. In addition to asking “How else can I help my patients?” I can now focus on how much I can help patients individually and by the masses through political advocacy.
Message from the Chair

Season’s Greetings from San Francisco! As 2014 draws to a close and we prepare to ring in 2015, I would like to personally thank our phenomenal Directions editorial staff (including Dean Monti, Allison Evans, and graphic designer Theresa Oloier) for another successful year!

Overall, we have welcomed many new RFC members in 2014 who have picked up the torch and continue to volunteer, always advocating for you. To this end, the AAD has provided an abundance of brand new resources to residents and fellows in the past year. The Resident-Fellows webpage at AAD.org has experienced a robust revamp that includes a user-friendly interface with links to top-rated content. Check it out! A few of my favorite features are:

- Answer Race for the Case questions for a chance to win a $25 Starbucks gift card, or contribute your own RFTC.
- Boards Fodder charts (also seeking new contributors)
- Browse for jobs using the AAD Career Compass and other practice management resources.
- Test your skills at the microscope with a 45 question Dermatopathology Self-Assessment.
- View the latest issue of Directions in Residency and read articles online in the article library.
- Link up with the Dermatology Advocacy Network to stay up-to-date with key legislative issues.

Also very exciting, the AAD has officially kicked off a brand new online forum to link up all residents/fellows nationwide. This is quite a victory for trainees! The Member to Member Communities page for residents and fellows debuted in November (see sidebar on page 7). For the first time in the history of dermatology, physicians in-training are able to circumvent geographical limitations/time zones and openly discuss important issues. Please check this out today at the Resident and Fellows Resource page at aad.org and contribute your thoughts/opinions or pose burning questions to the entire grid of residents/fellows.

To round out 2014, the AAD secured sponsorship for a new Board Review Course, which debuts at the Annual Meeting in San Francisco next year (see page 1 for details). I look forward to seeing a large number of participants from the Class of 2015, and I project that the AAD will quickly become the #1 dermatology board study resource!