Sitting here, post-graduation, sipping my first (and very necessary) cup of coffee for the day, I’m reflecting upon the past three years. What often felt like an intangible goal — becoming a dermatologist — has become my reality. We’ve all experienced the countless hurdles that take us by surprise along this journey. I recall feeling as though I had already made it through the most difficult challenge by being accepted into medical school, and all that remained was choosing a field to later train in. Except, as each of us now know, the tireless dedication and hard work required to merely match into a dermatology residency is almost a specialty of its own! I will never forget the day I matched, feeling overwhelmingly relieved knowing that yet another seemingly remote goal had been accomplished. But then I became a first-year resident, and the next 1,095 days marked the final stretch of a vigorous, yet incredibly rewarding marathon.

FIRST YEAR OF RESIDENCY

The first few days of dermatology residency are particularly exciting. The anxiety-ridden application process is finally over, and you have tremendous feelings of pride and triumph. First-year dermatology residents walk into the hospital with wide eyes, freshly-ironed lab coats, and biopsy bags in hand. However, it doesn’t take long to feel that you are once again at the bottom of the totem pole, surrounded by brilliant and experienced colleagues who — despite what you may or may not want to admit — actually do know a lot more than you. It’s a very humbling experience. The first-year resident must adjust from being at the top of their class (and the most stellar intern at morning report), to being the least experienced physician among the dermatology consult service. Many first-years don’t have an easy time taking orders from senior residents (especially when you were so convinced that matching into residency made you an automatic equal!), but it is a necessary rite of passage in the training process.

Surviving your first year of residency can be easier if you remember a few key things. The first is that being humble, open-minded, and self-aware of the fact that becoming an excellent dermatologist truly requires three years of training will position you for success. The second is that, despite all of the pimping, scut work, assigned manuscripts, research projects, grand rounds presentations, and…well, no need to belabor that point…the purpose is the same: to teach you and to prepare you for a bright future of helping and caring for patients while practicing in the field you love. Residency is the only time in your career when your colleagues will make a daily effort to ensure that you are accurately taught dermatology, so absorb as much of it as possible. Stay in the process. Never lose sight of your goal, and never lose sight of who you are inside.

See RESIDENT JOURNAL on p. 3
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
FINDING WORK-LIFE BALANCE
In my experience, success at work is integrally tied to success outside of work. Residency can be a rollercoaster of emotions — from receiving accolades after giving a remarkable lecture on the basics of hemidesmosomes, to being chastised for arriving late to grand rounds, and drawing a blank when the attending asks you (in front of everyone) to provide a differential. It is imperative to focus on the positive experiences and not to let the challenging ones get the best of you. Residents should find fun and physical activities outside of work that serve as an outlet for stressors. As a resident in New York City, I spent my free time (admittedly minimal) jogging through Central Park, doing yoga in the Village, or visiting art museums around town. Anything that keeps you grounded and recharges your energy enough to face the next day with a rejuvenated and clear mind is invaluable. By the time you develop a routine that balances challenging workdays with some much-needed enjoyable personal time, you’ll realize that first-year of residency is likely almost over.

SECOND YEAR OF RESIDENCY
The second year of residency typically begins with additional feelings of accomplishment — and rightfully so. You are now in a position where new first-year residents are going to look to you for guidance, direction and teaching, and you have a newfound responsibility to set an example for them. One of the more difficult facets of my second-year was financial hardship. Living alone in an expensive urban area can be extremely challenging. As residents, we are no longer eligible for student loans, have little to no free time to get a part-time job, and many of us live in a state far from home and familial support, thus leaving us with limited options. When I reached out to a graduate of my program, I was desperate for advice on how to cope with these financial difficulties. She told me to open a credit card and “don’t worry about it because in two years you’ll be an attending.” When dealing with meticulous, dermatologist type-A personalities, expecting us to just do something and not worry about it isn’t easy, or likely. But I took her advice, and I must say that after a 14-hour work day and endless hospital consults, being able to enjoy a fresh, healthy sushi dinner certainly beats having ramen noodles! And when that small glimpse of delight motivates you to come home and read the next assigned chapter in Bologna, it’s worth it. Bottom line — finances will always be a challenge. Seek whatever support you can to ease your anxieties.

THIRD YEAR, BOARDS & GRADUATION
The beginning of third year is about being a leader, especially if you are chief resident. It requires organizing the academic curriculum and scheduling for clinic coverage for the year. There is a lot of coordination involved as a third-year/chief resident because you have to make sure all of the various clinics and offices are staffed with residents. For many, the second half of third-year is also about deciding where you want to work, sending out your CV, and going on job interviews. Ideally, the contracts should be signed before your third-year ends, and then at the very end of third-year (see sidebar for more information).

EMPLOYMENT CONTRACTS
Once presented with your (possibly first-ever) employment contract, it is imperative that you hire a lawyer to sift through each contract with a fine-toothed comb. An ideal lawyer is one who has experience with medical contracts and offers a fair rate — or even better, a residency discount. The process of making what feels like a permanent and lifelong career decision can be overwhelming. While negotiating contracts, it’s important to remain true to your long-term goals. Successful contract negotiation involves deciding what is most important to your career AND your personal life, and what you’re willing to give up (versus those things that you can’t conceivably forfeit). It’s a new type of anxiety and pressure that most of us are not familiar with. But remembering how hard you’ve worked for nearly half your life to achieve this milestone helps keep things in perspective. Also, when it comes to contract negotiating, put everything that you want in writing, because if it’s not in writing, it never happened!

— Cherise Mizrahi-Levi, DO

As the journey of residency comes to a close, and the next phase of life brews with anticipation, every dermatology resident must pull out their myriad notes and textbooks, and study for one last and final board exam. Boards study was most intense at the very end of my third year. The home stretch is certainly not an easy feat, and studying for boards requires roughly two months of committed, dedicated and unfaltering perseverance. The best advice I can offer is to make board prep exam your number one priority. Have all of your senior year presentations, manuscripts and paperwork completed, with your job lined up. Take some time off (if scheduling permits) to focus on studying. Non-urgent personal life matters that can be delayed until after the exam absolutely should be. For example, I don’t recommend having your wedding immediately after the exam ends, and then at the very end of third-year (see sidebar for more information).

See RESIDENT JOURNAL on p. 7
# Vascular Malformations

**By Jennifer Eyler, MD and Patricia Todd, MD**

## Capillary Malformations

Present at birth as well-demarcated pink to dark red macular stain. Can be isolated lesion or associated with a syndrome. Proportional growth with child and may darken and become nodular over time.

<table>
<thead>
<tr>
<th>NEVUS SIMPLEX (Salmon Patch)</th>
<th>GENETICS</th>
<th>VASCULAR FEATURES</th>
<th>ADDITIONAL CLINICAL FEATURES</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Somatic mutations in GNAQ</td>
<td>Facial CM (variably V1, increased risk if bilateral V1 or V1 + V2 and V3)</td>
<td>Ipsilateral leptomeningeal angiomatosis, calcifications, and cerebral atrophy; ipsilateral ocular abnormalities. Neurologic symptoms include seizures, cognitive and developmental delay, emotional or behavior problems, and attention deficit. Endocrine complications include growth hormone deficiency and central hypothyroidism.</td>
</tr>
</tbody>
</table>

## Associated Syndromes

By Jennifer Eyler, MD and Patricia Todd, MD

### Phakomatosis Pigmentovascularis

<table>
<thead>
<tr>
<th>Twin spotting</th>
<th>Types I-IV (CM)</th>
<th>I – CM + epidermal nevus</th>
</tr>
</thead>
<tbody>
<tr>
<td>Types I-IV (CM)</td>
<td>Type V (CMTC)</td>
<td>II – CM + dermal melanocytosis</td>
</tr>
<tr>
<td>May be associated with Sturge-Webber or Klippel-Trenaunay</td>
<td>III – CM + nevus spilus</td>
<td></td>
</tr>
<tr>
<td>IV – CM + dermal melanocytosis + nevus spilus ± anemicus</td>
<td>V – CMTC + dermal melanocytosis</td>
<td></td>
</tr>
</tbody>
</table>

### Cutis Marmorata Telangiectatica Congenita

Localized or generalized reticulated violaceous vascular network with focal atrophy; network persists with rewarming.

### Macrocephaly-CM

<table>
<thead>
<tr>
<th>Pik3ca, Akt3, Pik3r2</th>
<th>CM, often central facial (platinum and glabella) or persistent nevus simplex</th>
</tr>
</thead>
</table>

### Ataxia-Telangiectasia

Autosomal Recessive, ATM.

### ANGIKERATOMAS

Ectasias of dermal capillaries associated with hyperkeratotic and acanthotic epidermis. Subtypes:
- Solitary or multiple angiokeratomas – lower extremities of young adults
- Angiokeratoma of Fordyce – scrotum or vulva in adults
- Angiokeratoma circumscriptum – plaque composed of multiple red-purple papules on extremity (present since birth or early childhood)
- Angiokeratoma of Mibelli – digits or interdigital spaces during childhood or adolescence, autosomal dominant
- Angiokeratoma corporis diffusum – widespread lesions in bathing trunk distribution (associated with Fabry disease and α-fucosidase deficiency)

### VENOUS MALFORMATIONS

Soft, compressible, blue nodules that expand in dependent position. Can affect face, including lips or oral mucosa (cesophageal VMs), as well as trunk and limbs. Commonly penetrate deep into muscles, joints, and bones. Monitor for thrombosis and coagulopathy.

<table>
<thead>
<tr>
<th>GENETICS</th>
<th>VASCULAR FEATURES</th>
<th>ADDITIONAL CLINICAL FEATURES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Familial Cutaneous and Mucosal VM</td>
<td>TEK, TIE2</td>
<td>Small, superficial cutaneous and mucosal VMs</td>
</tr>
<tr>
<td>Blue Rubber Bleb Nevus Syndrome</td>
<td>GATA2</td>
<td>Small black-blue papules and skin-colored nodules involving palms and soles</td>
</tr>
<tr>
<td>Glomuvenous Malformation</td>
<td>Glomulin</td>
<td>Painful, partially compressible, cobblestoned plaques on trunk and limbs</td>
</tr>
<tr>
<td>Maffucci Syndrome</td>
<td>Somatic mutations in IDH1 and IDH2</td>
<td>VM-like lesions with spindle cell hemangioendothelioma on biopsy, phleboliths</td>
</tr>
<tr>
<td>Cerebral Cavernous Malformation (CCM, Cerebral Capillary Malformation)</td>
<td>Autosomal dominant, KRIT1 (CCM1), MGC4637 (CCM2), PDCD10 (CCM3)</td>
<td>Hyperkeratotic dark red to purple congenital plaque located on extremities</td>
</tr>
</tbody>
</table>
**Vascular Malformations**

*By Jennifer Eyler, MD and Patricia Todd, MD*

**LYMPHATIC MALFORMATIONS**

**PRIMARY LYMPHEDEMA**
- Abnormalities of lymphatic vessels and nodes leading to inadequate clearance of lymph. Affects extremities. Increased risk of bacterial infection.
- **Subtypes:**
  - Generalized – associated with intestinal or pulmonary lymphangiectasias, exudative enteropathy, and pleural effusions
  - Milroy Disease – AD mutation in FL74, congenital lymphedema of lower extremities
  - Lymphedema-Distichiasis Syndrome – AD mutation in FOXC2, peri-pubertal onset of lymphedema, congenital distichiasis and venous varicosities

**SOLITARY LM**
- Consist of irregular, ectatic lymphatic channels. Classified as macrocystic, microcystic, or combined based on the size of cystic spaces present.
- Macrocytic LM (cystic hygroma): large, soft, skin-colored, subcutaneous mass, detectable by ultrasound, CT, or MRI. Seen in Turner Syndrome (45 XO), Noonan Syndrome (PTPN11), and Down Syndrome (trisomy 21).
- Microcystic LM (lymphangioma circumscriptum): most common type of LM occurring on proximal limbs, trunk, and mouth.
- Plaques with overlying clear or hemorrhagic vesicles. Swelling follows injury or infection around the lesion.

**COMPLICATIONS OF LM**
- Cerebrofacial – bony involvement common. Leads to mandibular overgrowth and prognathism
- Intracranal – bleeding in setting of dental or upper respiratory infection, leads to growth of LM
- Oropharyngeal – airway compromise
- Orbital – chemosis, amblyopia, strabismus, proptosis, vision loss
- Multifocal truncal lesions – may have associated visceral lymphangiomatosis
- Gorham-Stout Disease – LM with bony involvement leading to massive osteolysis causing pathologic fractures and deformity

**ANGIOVENOUS MALFORMATIONS**
- Fast-flow vascular malformations with direct communication between arteries and veins. 40% visible at birth; head and neck are most frequent locations. May worsen with puberty, pregnancy, and trauma.
- Classified into 4 stages:
  - Quiescent/dormant – muscular or slightly infiltrated, red, and warm lesions that mimic CMs
  - Expansion – warm masses with throbbing and thrills over dilated draining veins
  - Destruction – necrosis, hemorrhage, ulceration, lytic bone lesions
  - Cardiac decompensation

**ASSOCIATED SYNDROMES**

<table>
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<th>ADDITIONAL CLINICAL FEATURES</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cobb</strong></td>
<td>Dermatomal CM or AVM overlying spinal cord +/- associated hyperkeratosis</td>
<td>Intramedullary spinal AVMs, vertebral vascular anomaly of same segment cause neurologic symptoms as lesions expand or bleed, including back pain, radiculalgia, rectal/bladder dysfunction, paraplegia.</td>
</tr>
<tr>
<td><strong>Bonnet-Dechaume-Blanc</strong></td>
<td>Facial AVM</td>
<td>AVM extends to the orbit and brain, may be asymptomatic, may cause seizures or hemiplegia/paresis.</td>
</tr>
<tr>
<td><strong>CM-AVM</strong></td>
<td>Autosomal dominant; RASA1</td>
<td>Multiple small CMs, cutaneous AVMs in 11%, typically underlying largest CM</td>
</tr>
</tbody>
</table>

**OVERGROWTH SYNDROMES ASSOCIATED WITH VASCULAR MALFORMATIONS**

<table>
<thead>
<tr>
<th>GENETICS</th>
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| **PTEN hamartoma**
  **tumor (includes**
  **Bannayan-Riley-Ruvalcaba)** | PTEN AVMs (intramuscular), CMs, and venous varicosities | Genital lentigines and lipomas. Macrocephaly, segmental excess of hypervascularized fat, cerebral venous anomalies. Increased risk of thyroid or breast malignancy. |
| **Parkes Weber** | RASA1 Unilateral diffuse red CM, underlying AV fistula, lymphatic anomaly | Limb overgrowth, excess fat, lytic bone lesions and heart failure. Poor prognosis after puberty. |
| **CLOVES** | Somatic mutations in PKDCA CM, CLVM, less commonly AVM | Congenital Lipomatous Overgrowth, Vascular anomalies, Epidermal Nevus, Scoliosis and other Skeletal abnormalities. |
| **Klippel-Trenaunay** | Somatic mutations in PKDCA | Capillary stain, venous varicosities usually involving lower limb, thrombophlebitis | Soft tissue/bony hypertrophy, coagulopathy, congestive heart failure, pulmonary embolism, stasis dermatitis, cutaneous ulcerations, and bleeding. Sharply demarcated “geographic” stains with increased risk of massive limb overgrowth, lymphatic involvement, and cellulitis. |
| **Proteus** | AKT1 CM, VM, LM, CLVM | Epidermal nevi, cerebroformative connective tissue nevi of palms and soles, café au lait spots, lipomas. Learning disabilities. Disproportionate overgrowth leading to deformity and disabling orthopedic consequences. |

**Abbreviations:**

**References:**
A 55-year-old female was admitted for pneumonia complicated by sepsis. On hospital day three, she was noted to have six asymptomatic, non-tender, edematous papules and plaques scattered on her neck, upper arms, and left hand. Her medical history including a hematologic malignancy, for which she received her first course of chemotherapy two weeks prior. On biopsy, the inflammatory infiltrate is centered on sweat ducts.

1. What is the name of the disorder?
2. This was first characterized in association with what malignancy?
3. What is the most common chemotherapy association?
4. Classic finding on pathology?
5. What is another name for this disorder?
6. What is the name for the disorder that shares similar pathology findings, but is found on children’s soles?

A: Hallopeau type often has a more benign course, requiring lower doses of systemic corticosteroids and usually associated with prolonged remission. Neumann type has a course similar to pemphigus vulgaris, requiring higher doses of systemic corticosteroids with more frequent relapses and remissions.

Respond online with the correct answers at www.aad.org/ RaceForTheCase for the opportunity to win a Starbucks gift card! If you win, we will also publish your mug (face), and if you have an interesting story to tell residents, we might share it (see our current winner profile on the right). Good luck!

Answers to Fall 2015 Race for the Case

A 75-year-old Turkish female who recently immigrated to the United States presents with a several month history of ulcerative and vegetative plaques involving primarily her cheeks, anterior neck fold and perioral region. Patient was noted to have erosions in her mouth as well. Her past medical history is unremarkable.

1. What are the two subtypes of this condition? How are they different?
   A: Hallopeau type often has a more benign course, requiring lower doses of systemic corticosteroids and usually associated with prolonged remission. Neumann type has a course similar to pemphigus vulgaris, requiring higher doses of systemic corticosteroids with more frequent relapses and remissions.
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3. What type of changes would you expect to see in the mouth?
   A: Cerebriform tongue
4. What other areas of the body (that are not shown in this photo) are commonly involved in this condition?
   A: Intertriginous areas (groin, axilla, neck)

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By Travis Morrell, MD, MPH

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before the exam. Be “Boardzilla” first, then bridezilla later! Once the boards are over, the world is your oyster. Travel, spend time with family, redecorate your home, train for a triathlon, or merely relish in the fact that you survived residency!

If you are on track and have your three years completed and all paperwork is finalized, the national board will approve you to sit for the exam. Your three years of residency may represent the most demanding workload you have experienced up to that point. But, although three years seems like an eternity at first, the time truly does fly by. In these short years, it’s imperative to absorb as much medical knowledge and work experience as possible, because after graduation, those skills will shape the kind of dermatologist you become.

LAST BUT NOT LEAST...
As residency comes to a close, and we begin the transition from resident into attending, we are forced to make monumental decisions that will have a long-term impact. Each graduating resident has to decide what the next step will be, and for the first time since taking the MCATs, this choice is entirely up to you. Those who do not continue training in a subspecialty fellowship have to decide whether to work in academia or in private practice, and in which part of the country (or the world). The graduate is faced with enormous opportunities, but options must be carefully weighed and evaluated. Deciding which geographic region, as well as which type of hospital, practice, or academic setting to work in is entirely a personal decision—based on what you seek to accomplish and find most fulfilling.

“The graduate is faced with enormous opportunities, but options must be carefully weighed and evaluated.”

Factors to consider include the desire to see private office patients or work in a hospital clinic and teach residents; the option to practice in a rural versus urban environment; the choice to join a large multi-specialty group (where the volume is there but personal attention may not be); or the option to work in a small intimate office where the reverse may be true. Other crucial aspects to evaluate are salaried positions compared to a percentage-based income; the inclusion of benefits such as malpractice coverage; 401K; health insurance; and other required obligations (in addition to seeing patients), such as volunteer skin cancer screenings.

Also consider the devoted attendings that spend their careers teaching and inspiring residents, and how rewarding it can be to give back to the field by lecturing at conferences, precepting resident clinics, mentoring research fellows, volunteering, or even being a sounding board of support and advice for your peers. Paying it forward is not in the curriculum, but should always be part of your life’s plan.

RESIDENT JOURNAL from p. 3

Do you have a story to tell about residency or an item of interest? Study tips, work life balance, interesting images, iconoclastic views? We’re accepting submissions for 2016! Email dmontt@aad.org to submit your story or get more information.

Cochrane Award
The Cochrane Award is extending their deadline to Jan. 31, 2016 (previously Oct 31) and is open to all U.S./Canadian members and graduating residents. The award will offer individuals a $3,000 grant to travel to Seoul, South Korea from Oct. 21-25, 2016.

Registration is now open!
Be sure to check out all the great courses and events geared towards residents!
Discounted registration ends January 27, 2016 at 12 p.m. CT
Advanced Registration ends February 24, 2016 at 12 p.m. CT
Learn more at www.aad.org/AM16Residents
Message from the Chair

With the academic year well under way and the holidays approaching, I hope this message finds you and yours well.

I would like to use this brief note to focus on the importance of mentorship in professional development. Personally, the perspective, experience, and friendship of mentors proved to be an invaluable resource throughout my residency. You may choose to engage with a mentor within your program, local community or the Academy. Whichever path(s) you choose, I would first recommend reviewing the “Mentee Job Description” as outlined by the AAD Leadership Institute (www.aad.org/mentoring). Understanding your responsibilities as a mentee is crucial to establishing a rewarding relationship with your selected mentor.

The AAD has a wealth of experienced and enthusiastic leaders ready to advise you. In addition to networking at the Annual Meeting, the AAD Leadership Institute offers the opportunity to search nationally for resident mentors by location, practice type, subspecialty, and core values. Upon completion of residency, this search tool can also be used to identify mentors to ease your transition to staff physician and leader (www.aad.org/mentorsearch). I recommend keeping your search parameters broad and reviewing the curriculum vitae and personal statements of the staff listed. Once you have found a potential match, reach out to the individual through the provided contact information. Whether you utilize the AAD Leadership Institute or direct networking, establishing a mentorship relationship offers the opportunity to learn from someone that has excelled in your field.

I would encourage you to take the opportunity at the 2016 Annual Meeting to engage with potential mentors and learn about the various transitions in your career. In particular, on March 6 from 1 to 4 p.m., the Masters of Dermatology Symposium will have a dais of terrific speakers that are recognized as leaders within dermatology. The speakers are tailoring their talks to the young physician audience and will highlight pivotal lessons from their careers. Furthermore, the Boards and Beyond Forum from 10 a.m. to 12 p.m. on Saturday, March 5 will offer the opportunity to learn more about the board exam, maintenance of certification, and dermatology career options from subject matter experts and leaders within our field. (Look for more information on sessions in the next issue of Directions!)

Finally, the RFC has the privilege of advocating for issues important to residents and fellows. Please do not hesitate to contact us if there is anything we can do to help support you!

Nathanial Miletta, MD

Amgen proudly supports the American Academy of Dermatology and the Directions in Residency newsletter.