Learning how to learn

By Dean Monti

Sharon Jacob, MD, has been a contributor and long-time supporter of the Boards’ Fodder study charts from Directions in Residency. Last year, she and a team of residents updated more than a decade of archived charts, in addition to creating an entirely new chart on contact dermatitis. Recently, she created an educational hub for consumers and dermatologists-in-training as part of a public health outreach campaign on the current epidemic of contact dermatitis in the U.S. She also has a keen interest in how residents learn and how this translates to teaching aptitude. Directions talked with her about how she learned to study, how that knowledge helped create learning programs for others, and how her passion fueled the creation of a new dermatology website.

Where did you do your residency?
My residency was at the University of Miami. I was in residency there from 2001 to 2004 and then stayed on as teaching faculty until 2007. I chose UM because of the strength of the faculty, the opportunities to learn in the inpatient dermatology program, and the wide range of infectious disease cases.

What do you think makes for a strong faculty?
Multiple factors. Focusing on fundamental concepts like learner-centered development and passion for the many aspects of dermatology. Our program was built on this model. Our chairman, Bill Eaglstein, MD, would have every resident self-assign themselves to be an expert in a given area not covered by a faculty member. That person would then be the go-to person for the latest evidence-based literature. I relate with those, as I also make charts, and have been doing so since the sixth grade when I realized I could easily memorize facts that were systematically grouped and classified. This skill proved quite useful in medical school and in residency when I needed to categorize large amounts of information into succinct, easy review sheets.

How do you relate this to dermatology study?
I found that dermatology lent itself particularly well to charting. It seems like I charted daily between 2001 and 2004, digesting chapters, journals, and archived slides. Around that time, I offered my charts to the AAD’s Resident Round-Up (now Directions in Residency) and had several published. I figured others probably learned by charting as well, and could potentially save precious time if they utilized and built upon the time-less information in those charts. In 2014 (a decade later), I realized the same charts (a.k.a. Boards’ Fodders) were still being used by residents, so we set out in teams of resident peer-reviewers to take on the colossal task of updating the archived charts and creating some much needed new ones. The feedback from residents on how useful the Boards’ Fodders have been is quite interesting, not only on the organization of the material, but how they’re being utilized for study.

What have you discovered about the way people study?
Certainly, having an established knowledge base is fundamental, but there is also an inherent preference for learning modality.

See LEARNING HOW TO LEARN on p. 3
"Embracing Change is the Key to Skincare Success"

The past decade has seen unprecedented changes in professional skincare. Increasing demand. Better results. And distribution that left the control of the physician.

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Enhanced Revenue
Better Results
Patient Loyalty

The ZO® Difference

Created the Science
original Obagi
Conceived the
2006
Key to Skincare Success”

And distribution that left the control of the physician.
Increasing demand. Better results.

The past decade has seen unprecedented changes in
health, Inc.

ZO Medical Director
and protocols
medical products
Developed new

® . We have advanced skincare

Recommends ZO ®
2006
Ended relationship 
with OMP

Another aspect I have found to be
educational method and one to be
out sessions. It is clearly a useful
discussions and faculty-led break-
options for the University of Miami Dermatology course uti-
lized on information retention across all
with Psoriasis” — an independent

film by Fred Finklestein — followed
with a lecture.

The video had a profound effect
information retention across all three years. Currently, the University
of Miami Dermatology course uti-
lizes this well-received reversal
method, allowing students to first
learn the material according to their
learning preferences (readings, vi-
de-lectures) followed by interactive
discussions and faculty-led break-
out sessions. It is clearly a useful
educational method and one to be
emulated.

When and why did you decide to create an original contact
dermatitis Boards’ Fodder?

In the last five years of teaching
workshops on contact dermatitis to
different practitioners (dermatolo-
gists, allergists, nurses, physician
assistants, residents-in-training),
I became very aware of the learning
gap that existed on this topic. About
a year ago, we looked at the original
contact dermatitis Boards’ Fodder
(created more than a decade ago),
and realized it was outdated. This
prompted me to create a much more
in-depth review based on my own
chart that I’d been creating for the
last 10 years to help organize the
difficult-to-digest information. I love
the new contact dermatitis Boards’
Fodder that I worked on with Elise M.
Herro, MD, and Alina Goldenberg,
MD, MAS. They are both phenom-
enal to work with and are really
knowledgeable about learning styles
different from my own. These differ-
es allowed us to optimize the chart
so that the vast amount of
difficult information could be eas-
ily accessible in one spot through
the Directions in Residency Boards’
Fodder archives at www.aad.
.org/boardsfodder.

I understand you’ve also
created additional study tools
for residents on your new
website?

Yes. Building on what we learned
from utilizing videos, we have cre-
ated a dedicated webinar series
on contact dermatitis from brilliant
thought leaders that are free to any-
one who wants to learn about con-
tact dermatitis. To fully engage our
learners and complement the AAD’s
Directions in Residency Boards’
Fodder charts, we are also launch-

ing a free Board review series. We
have lectures geared on everything
from contact dermatitis to dermato-
logic surgery (including flaps), and
more. Residents can learn about the
new series at http://dermatitis
academy.com/boards.

Do you have a
story to tell about
residency or a spe-
cific item of inter-
est? Study tips,
work life balance,
unique images,
icnocastric views?
We’re now accept-
ing submissions
for 2016! Email
dmonti@aad.org to
submit your story
or get more info.

Download the new DERMATOLOGY ROADMAP pdf!
Charting the Route to Your Best Career

Whether you’re a resident in search of your first dermatology job or a vet-
eran in the field contemplating a change, you’ll find a variety of practice
types from which to choose. Answer the questions in the quiz in the pdf
and then tally up the number of times you receive each letter to narrow in
on the type of practice that will best suit your needs and preferences. Some
answers will result in more than one letter – include them all in your tally!

https://www.aad.org/careeremap
Flaps

by Lance Chapman, MD, MBA, Dorota Korta, MD, PhD, and Patrick Lee, MD

Table 1: Nomenclature

<table>
<thead>
<tr>
<th>Flap</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Defect</td>
<td>Initial or original wound to be closed (yellow circumscribed area in drawings below)</td>
</tr>
<tr>
<td>Secondary Defect</td>
<td>Wound created by elevation/mobilization of flap from adjacent tissue</td>
</tr>
<tr>
<td>Primary Motion</td>
<td>Movement of flap toward the primary defect to close it, creating stress or tension on flap</td>
</tr>
<tr>
<td>Secondary Motion</td>
<td>Movement of the tissue surrounding the secondary defect to close it, with resultant stress or tension placed on this tissue</td>
</tr>
<tr>
<td>Random Flap</td>
<td>Flaps with abundant collateral circulation with no named blood supply</td>
</tr>
<tr>
<td>Axial Flap</td>
<td>Flaps supplied by a named artery and vein</td>
</tr>
</tbody>
</table>

Table 2: Advancement flap: Movement of adjacent tissue along unidirectional vector

<table>
<thead>
<tr>
<th>Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>U-plasty</td>
<td>Simplest advancement flap. Parallel incisions tangentially made on defect with subsequent advancement of flap.</td>
</tr>
<tr>
<td>(unilateral advancement flap)</td>
<td>Forehead in horizontal direction so incision lines can run parallel to relaxed skin tension lines (RSTLs). Not commonly used.</td>
</tr>
<tr>
<td>H-plasty</td>
<td>Essentially a “bilateral” U-plasty. Two sets of parallel incisions made in symmetric distribution on BOTH edges of defect.</td>
</tr>
<tr>
<td>(bilateral advancement flap)</td>
<td>Forehead and upper lip (in order to hide incision lines along RSTL and cosmetic unit junctions).</td>
</tr>
<tr>
<td>T-plasty</td>
<td>Standing cone removed from one end of defect (converting the “O” into an “A”) with subsequent single incisions extending beyond BOTH sides of base of defect.</td>
</tr>
<tr>
<td>(O-to-T or A-to-T plasty)</td>
<td>Ideal for locations with broad base along free margin or cosmetic unit junction.</td>
</tr>
<tr>
<td>L-plasty</td>
<td>Incision at base of defect made only on ONE end and extends outwards (1/2 of T-plasty).</td>
</tr>
<tr>
<td>(O-to-L plasty)</td>
<td>Ideal for locations where limb of flap hidden in RSTL.</td>
</tr>
<tr>
<td>Island pedicle</td>
<td>Unique advancement flap in that advancement of tissue is perpendicular to the skin and vascular supply comes from SubQ pedicle, which is attached to the central portion of the flap – DEEP vascular blood supply rather than horizontal.</td>
</tr>
<tr>
<td>(V-to-Y advancement flap)</td>
<td>Ideal for locations with elastic and “spongy” SubQ tissue with rich vascular supply.</td>
</tr>
<tr>
<td>Crescentic advancement</td>
<td>Removal of a crescent of tissue along advancement flap to better hide scar line or increase length of incision.</td>
</tr>
<tr>
<td></td>
<td>Upper lip and peri-alar region.</td>
</tr>
</tbody>
</table>

Table 3: Rotation flap: Movement of adjacent tissue around a single pivot point along a radiating arc

<table>
<thead>
<tr>
<th>Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>O-to-Z flap</td>
<td>Circular defect turned into Z-shaped incision, then tissue is rotated into defect from two opposite sides.</td>
</tr>
<tr>
<td>(bilateral advancement rotational flap)</td>
<td>Large defects on scalp and lower lip.</td>
</tr>
<tr>
<td>Dorsal nasal rotation flap</td>
<td>Curvilinear incision that involves entire rotation of dorsum of nose (undermining at perichondrium).</td>
</tr>
<tr>
<td>(Rieger flap)</td>
<td>Distal dorsum or tip of nose.</td>
</tr>
</tbody>
</table>
Flaps (cont.)
by Lance Chapman, MD, MBA, Dorota Korta, MD, PhD, and Patrick Lee, MD

Table 4: Transposition flap: Movement of flap by lifting and “transposing” tissue over intervening skin

<table>
<thead>
<tr>
<th>Type</th>
<th>Description</th>
<th>Ideal Locations</th>
<th>Drawing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Z-plasty</td>
<td>Used in scars that cross RSTLs to elongate scars or rotate scar tension lines.</td>
<td>Locations with contracted surgical scars and/or scars distorting a free margin (i.e. lower eyelid margin).</td>
<td></td>
</tr>
<tr>
<td>Nasolabial transposition flap</td>
<td>Alar wound defect in which flap from medial cheek adjacent to melolabial fold transposed to defect (flap taken from sebaceous skin in medial cheek).</td>
<td>Lateral nasal sidewall and central alar wounds.</td>
<td></td>
</tr>
<tr>
<td>Rhombic flap</td>
<td>Defect converted into four-sided parallelogram with angles 60 and 120. Incisions extended from one of 120 degree angle tips (length of incision equal to one of sides of rhombus, see line a-b). Then from free end of extended line, a second line is incised with angle of 60 degrees (line b-c).</td>
<td>Medial canthus, upper nose, lower eyelid, temple, peripheral cheek.</td>
<td></td>
</tr>
<tr>
<td>Bilobed transposition flap</td>
<td>Two transposition flaps performed in succession. Primary defect filled with adjacent primary lobe and secondary defect filled with secondary lobe, leaving a triangular tertiary defect to be closed primarily.</td>
<td>Distal lower one-third of nose.</td>
<td></td>
</tr>
</tbody>
</table>

Table 5: Interpolation (importation) flap: Two-stage tissue flap in which the base of the flap is not immediately adjacent to recipient site (often axial flap)

<table>
<thead>
<tr>
<th>Type</th>
<th>Description</th>
<th>Ideal Locations</th>
<th>Drawing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paramedian forehead flap</td>
<td>Axial flap based on the supratrochlear artery. Tissue is mobilized from forehead and transposed to a large distal nasal defect. Requires pedicle division often at three weeks.</td>
<td>Subtotal and total nasal defects, particularly nasal tip and ala.</td>
<td></td>
</tr>
<tr>
<td>Nasolabial (melolabial) interpolation flap</td>
<td>Random pattern pedicle flap. Tissue is mobilized from the cheek and transposed to a defect in the nasal alar rim. Requires pedicle division at three weeks.</td>
<td>Medium to large defects involving the nasal alar rim. The disadvantage is the mild blunting of the alar crease.</td>
<td></td>
</tr>
<tr>
<td>Reverse nasolabial pedicle flap (Spear’s flap)</td>
<td>Tissue is mobilized from the cheek to a defect in the nasal alar rim; flap is folded upon itself to recreate the alar rim and internal and external nasal surface.</td>
<td>Full-thickness defects of the ala that involve the alar groove (attachment point of the lateral ala to the cheek).</td>
<td></td>
</tr>
<tr>
<td>Retroauricular flap</td>
<td>Random pattern flap. Tissue is mobilized from the retroauricular skin to a defect in the helical rim. Requires pedicle division at three weeks. The donor site can either be closed with a skin graft or left to heal by second intention.</td>
<td>Large defects of the helical rim that involves loss of cartilaginous support.</td>
<td></td>
</tr>
<tr>
<td>Abbe flap</td>
<td>Tissue is mobilized from normal lip and turned 180 degrees to fill the defect on the opposite lip. Requires pedicle division at three weeks.</td>
<td>Medially based defects of the upper lip most frequently.</td>
<td></td>
</tr>
</tbody>
</table>

Double the Boards’ Fodders online!
In addition to this issue’s Boards’ Fodder, you can download two new Boards’ Fodder online exclusives from www.aad.org/Directions.
The latest online Boards’ Fodders are Advanced & Immuno-therapies by Helena Pasieka, MD and Wound Healing by Aileen Santos, MD. To view, download, or print every Boards’ Fodder ever published, check out the archives at www.aad.org/boardsfodder.

Race for the Case: Summer 2016

By Aman Sandhu, MD

A 70-year-old Caucasian man with a history of melanoma presented for his scheduled skin monitoring evaluation. On physical exam, he was noted to have a diffused gray-blue discoloration of his skin and nails. He has been otherwise healthy and does not take medications, with the exception of a natural immune boosting supplement.

1. Which over the counter supplement is the patient likely taking?
2. Which topical medication can also cause this finding?
3. What is the classic histopathologic finding?
4. What type of microscopy can further support diagnosis?
5. What other heavy metal can cause a similar presentation if administered parenterally?

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 to the right). Good luck!

Answers to spring 2016 Race for the Case

Spring 2016 RFTC was submitted by Emily de Golian, MD — a resident physician at Loma Linda University Dermatology.

A 69-year-old Caucasian male presented for treatment evaluation for a 4.3 x 3.7 cm left hip plaque, which was present for 10 years prior to recent biopsy by an outside physician. Firm palpable nodules were present within this asymptomatic, growing lesion. His medical history is otherwise non-contributory.

1. Which translocation is most likely present within this lesion? t(17;22), which leads to a collagen type I alpha 1 (COL1A1) and PDGF-beta chain (PDGFB) fusion protein.
2. What are the histopathologic findings? Cellular proliferation of spindle-shaped cells in a storiform pattern infiltrating the subcutaneous fat, mild to moderate cytologic atypia with few mitoses.
3. Identify the immunohistochemical pattern classic to this diagnosis. CD34 positive, Factor XIIIa negative.
4. What is the recommended standard treatment option with the highest cure rate without recurrence? Mohs micrographic surgery has a lower recurrence rate than wide local excision.
5. What treatment is recommended for patients with recurrent or metastatic lesions? Imatinib mesylate (a PDGF receptor inhibitor).
Residents are encouraged to register for the 2016 AADA Legislative Conference that will take place in Washington, D.C. from September 11-13. The conference is a unique opportunity to receive advocacy training sessions taught by health policy experts, discuss dermatology issues with colleagues, and spend time meeting with U.S. Senators, Representatives, and their staff. Participants will also learn about issues and legislation that could affect the specialty’s future, and will help advance the AADA’s legislative priorities by meeting directly with members of Congress to voice dermatology-related concerns.

Residents do not need to be experts on health policy, the legislative process, or the legislators themselves in order to attend; they only need to be experts in the field of dermatology and patient care. At the conference, the AADA will provide you with any necessary background materials on your legislators, as well as a copy of the AADA legislative priorities, briefing materials on legislation, and training on how to advocate for the specialty. The AADA will schedule all Capitol Hill meetings for residents by using their home and office addresses to determine who their members of Congress are.

Moreover, the AADA also awards several scholarships for residents to attend the conference and commit to a year-long involvement in AADA advocacy issues. The scholarship gives recipients an all-expense paid trip to Washington, D.C., but space is limited, so those who are interested must apply early. For more information, please visit www.aad.org/members/resident-scholarship-to-legislative-conference. The final deadline to apply for this scholarship is July 15, 2016.

Registration for the 2016 Legislative Conference is now open. To register, or to obtain additional information on the conference, please visit: www.aad.org/meetings/legislative-conference.

Camp Discovery Residents Challenge

Congratulations to everyone who participated in the inaugural Camp Discovery Residents Challenge, which took place March 1 - April 30. Over $12,000 was raised, which is enough to send six kids to Camp Discovery! Special thank you to the top fundraising teams listed below:

1. SUNY Downstate Dermatology
   Georgina M. Ferzli, MD, Team Captain
   Tony Adar, MD
   Natilia Fiadorchanka, MD
   Juliya Fisher, MD
   Stephanie Gallitano, MD
   Amanda A. Hassler, MD
   Gelareh Homayounfar, MD
   Raman Madan, MD
   Celine Mestel, MD
   Devorah R. Shagalov, MD
   Rex U. Ugorji, MD

2. University of California, Davis
   Faranak Kamangar, MD, Team Captain
   Whitney Fisk, MD, MS
   Farzam Gorouhi, MD
   Yong He, MD
   Baran Ho, MD
   Sandy Kuo, MD, MS
   Jillian W. Millsop, MD
   Jonathan Okman, MD
   Kory Parsi, DO
   Forum Patel, MD
   Tatyana Pezukhova, MD, MS
   Neha Prakash, MD
   Vivian Shi, MD
   Danielle Tartar, MD, PhD
   Davina Wu, MD, PhD

3. University of California, San Francisco
   Lucinda L. Kohn, MD, Team Captain
   Yiyin Chen, MD, PhD
   Melissa A. Kinnebrew, MD
   Ethan C. Levin, MD
   Alison M. Small, MD
   Rabina K. Walsh, MD
   Bree Zimmerman, MD

4. Mayo Clinic Rochester
   Meredith A. Olson, MD, Team Captain

5. Medical University of South Carolina Dermatology
   Jessica Connett, MD, Team Captain
   Christina Clarke, MD
   James Lagrew, MD

Watch for an article on challenge winners from SUNY Downstate Dermatology in an upcoming issue of AAD’s Aspire publication.
In my first message as chair, I would like to thank you for the opportunity to serve our residents and fellows in this upcoming year. I would also like to thank our outgoing chair, Nathanial Miletta, MD, for his mentorship and exemplary job. With this in mind, I would like to discuss the topics of leadership and mentorship.

I am certain we can all recall leaders and mentors who have helped shape who we are today. At this point in our careers, it is important to embark on our own journey to develop our personal leadership style and focus. This April, I had the opportunity to attend the AAD Leadership forum. The focus of this forum was to develop insight into leadership, effective conversation, managing conflicts, as well as workshops on communicating with confidence and building effective teams.

One major theme of this conference was that leadership is not always an inherent trait; it is one that is learned and requires practice. These skills are absolutely vital, and if practice makes perfect…the earlier we start, the better. What can we do as residents to hone our leadership skills? There is a plethora of opportunities to not only give back to our field but also practice these crucial skills. To name a few: AAD committees and task forces, resident scholarships to attend the AADA Legislative Conference, American Society for Dermatologic Society, and the Women’s Dermatologic Society.

Mentorship has been a crucial part in our success thus far. As a resident and in the early years of one’s career, it is vital to continue meaningful relationships with mentors who can aid in this journey of personal development. The December 2015 edition of JAAD contains an article titled, “Mentorship in Dermatology” which includes a nice list of mentorship opportunities for residents.1 Whether mentorship is obtained at one’s own institution or from an outside source, it is vital to have clear goals set early in the process between the mentor and mentee. A “mentorship contract” can be a useful tool as a starting point for the partnership.

Volunteering and fundraising for Camp Discovery is another great way to take charge and become involved. I would like to thank all of the residents who dedicated their time and effort in the Camp Discovery Residents’ Challenge fundraiser this year. With all of your help, we achieved our resident goal in raising funds to help our pediatric patients attend this life changing experience!

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