Practices adapt to new demographic and racial shifts

Population trends across North America continue to evolve in a manner where people with skin of color increasingly comprise a larger proportion of the demographic. Current North American immigration statistics demonstrate a large number of immigrants of Asian origin. Recent figures show that the Asian, Hispanic, African-American, and Native American population have risen by 36, 22, 15 and 8 percent respectively [1]. The increase in the Caucasian population, by comparison, is 1.5 percent [1].

If present trends continue, it has been posited that approximately 48 percent of the U.S. population will be non-Caucasian by the year 2050 [1]. In Canada, similar trends exist where projections suggest that approximately one third of Canada’s population will be a visible minority by 2031 [2]. In Toronto and Vancouver the proportion of visible minorities are expected to become the majority by 2031 where visible minorities will consist of 63 percent of the population in Toronto and 59 percent in Vancouver [2].

Given shifting demographics occurring within the North American population, not only is it important for the dermatologist to become skilled in diagnosing and managing disease in skin of color, it is important for the dermatologist to understand cultural practices performed by different ethnicities and their potential for dermatologic sequelae.

Ethical Considerations

The dermatologist/pharmaceutical industry interface, part 1

By Karen Scully, M.D.

This is the second in a continuing series of articles devoted to ethics for dermatology residents. For this edition, we present the first of a two-part article about the pharmaceutical industry and its impact on dermatologists.

The New York Times recently ran an article titled, “Debate over Industry Role in Educating Doctors.” The article reported that the University of Michigan Medical School will no longer accept any funding from pharmaceutical or device companies for continuing medical education so that CME will be free of commercial bias. The pharmaceutical industry presently supports medical research and medical education to a significant degree and there is growing concern that this is biased and not in patients’ best interests.

Pharmaceutical companies engage physicians in a number of ways, including having their representatives visit physicians offices marketing their products, paying physicians to speak to other groups of physicians, having physicians sit on company advisory boards, and so on. Physicians’ financial ties to industry place them in a conflict in which professional judgment concerning a primary interest (care of the patient) may be unduly influenced by a secondary interest, in this case, financial gain.

Significant ethical issues revolve around the relationship between dermatologists and the pharmaceutical industry, the cosmetic industry, and device makers. Although this relationship may result in positive and important advances in medicine, it also tests the integrity of the dermatologist and medicine as a profession. Patients need to be able to trust that their physicians are making decisions with the patients’ best interests at heart. Can the dermatologist be trusted?
Merz Pharmaceuticals, LLC proudly supports the American Academy of Dermatology and the *Directions In Residency* newsletter.
Coining

Cultural practices performed by people from Southeast Asia include coining and cupping. Coining, also known as “cao gio,” is practiced by many people of Cambodian and Vietnamese origin and is believed to treat many symptoms by releasing excess “wind” or energy that is perceived to be responsible for illness [3]. Coining is performed by applying mentholated oil to various parts of the body such as the temples, forehead, chest, back and shoulders followed by vigorously rubbing a coin on the skin potentially leading to the formation of the following skin lesions in a linear distribution: petechiae, eechymosis and skin bums [4]. In some cases, the cutaneous lesions produced by coining have resulted in a mistaken diagnosis of child abuse, therefore a judicious history is particularly important during consultation [5, 4].

Cupping

Cupping is a form of traditional Chinese medicine used to treat a variety of ailments whereby a localized vacuum applied against the skin breaks the superficial blood vessels in the papillary dermis creating distinctive, circular, cutaneous lesions. A number of theories have been proposed to explain the benefits of this intervention including improved circulation leading to the elimination of toxins as well as placebo effect[5]. In order to perform cupping, an alcohol soaked cotton ball is ignited and placed into a cup where it is inverted and placed onto the skin. When the flame extinguishes a vacuum is created causing the involved skin to be pulled into the jar. Modern techniques employ the use of a hand help pump to manually create suction. In addition to circular, eechymotic or purpuric macules, cupping has resulted in bullae and skin bums [5, 6].

Traditional dress may cause lesions

Cultural practices of South Asians may also lead to dermatologic manifestations. Traditional clothing such as the sari and salwaar kameez are garments worn by South Asian women which have the potential for inducing or precipitating cutaneous lesions. The sari and its accompanying petticoat are tied around the waist of women by a drawstring with overlapping layers of the sari resting between the skin and petticoat. The salwaar kameez consists of loose pajama-like trousers tied around the waist by a drawstring called the “salwaar” and a long shirt or tunic called the “kameez”. Both the sari and salwaar kameez elicit similar cutaneous effects. Frictional forces exerted on the waist by both garments can lead to hyper and hypopigmentation, a hyperkeratotic groove of skin as well as koebnerization of vitiligo and lichen planus [7]. Rarely, “sari cancer”, a form of squamous cell carcinoma presumably induced by friction of the sari and petticoat has been reported to occur [7]. Wearing of a sari or salwaar kameez, especially by obese women with diabetes, can also promote superficial cutaneous infections by contributing to an occlusive and humid environment at the waistline and by providing a potential source of entry for organisms via the trauma induced by constant pressure [7].

Tattoos and body art

Henna tattoo is a form of body art enjoyed by many South Asians with potential dermatologic repercussion, as well. Henna is derived from the shrub Lawsonia inermis with its active ingredient being lawson. Women of South Asian decent frequently apply henna or “mehndi” during cultural events. Henna use appears to have increasing popularity in the Western world as it is often advertised as “temporary” or “harmless” form of body art, despite a number of described cases of allergic contact dermatitis (ACD). In its pure form, henna rarely induces ACD. However, black henna often contains additives, such as paraphenylenediamine (PPD). In addition to intensifying color, accelerating the tattooing process and increasing the duration of tattooing, PPD is a potent skin sensitizer that can cause ACD [8]. Post inflammatory hyperpigmentation can result after ACD resolves and a case of keloidal scarring has also been reported following an episode of contact dermatitis at the tattoo site [8, 9]. Patients found to have ACD to PPD should be informed of other products containing this substance as well as products that may cross react with PPD in order to prevent further reactions.

Given current population trends, recognizing and managing dermatosis in diverse populations are of increasing importance. Residents, therefore, should be encouraged to spend elective time in cosmopolitan cities, centers that focus on skin of color, or by obtaining international experience. Upon graduation these skills will be quickly utilized as the face of the North American population continues to diversify.

References

## Boards Fodder: Nail Disease

**Amy Reinstadler, MD and Nazanin Saedi, MD**

<table>
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<td>Proximal matrix</td>
<td>Transverse indented furrow from growth arrest of nail matrix</td>
<td>Mechanical trauma, dermatologic disease of proximal nail fold, systemic disease/stressful event</td>
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<td>Blue lunula</td>
<td>Distal matrix</td>
<td>Short nails (width &gt; length) Racquet thumbs</td>
<td>Congenital: Rubenstein-Taybi, trisomy 21 Acquired: nailing biting, hyperparathyroidism, psoriasis</td>
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<td>Brachyonychia</td>
<td>Nail plate</td>
<td>Greater than 180-degree angle between proximal nail fold and nail plate</td>
<td>Hypertrophic pulmonary osteoarthropathy, thyroid disease (acropachy)</td>
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<tr>
<td>Clubbing</td>
<td>Proximal and distal matrix</td>
<td>Greater than 180-degree angle between proximal nail fold and nail plate</td>
<td>Hypertrophic pulmonary osteoarthropathy, thyroid disease (acropachy)</td>
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<td>Distal notching</td>
<td>Nail bed</td>
<td>Darier, lichen planus</td>
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<td>Dolichonychia</td>
<td>Nail plate</td>
<td>Long nails (Length/width &gt; 1)</td>
<td>Ehler’s Danlos Syndrome, Marfans, hypopituitary</td>
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<td>Habit tic</td>
<td>Cuticle and nail plate</td>
<td>Horizontal parallel ridges; absent cuticle</td>
<td>Trauma to the cuticle</td>
<td><img src="https://via.placeholder.com/150" alt="Image" /></td>
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<td>Heller median canaliiform dystrophy</td>
<td>Nail plate</td>
<td>Longitudinal fissures with oblique lines, “Christmas tree pattern”</td>
<td>Idiopathic</td>
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<tr>
<td>Koilonychia “spoon nails”</td>
<td>Proximal and distal matrix</td>
<td>Thinned concave nails</td>
<td>LEOPARD, ectodermal dysplasia, nail-patella, trichothiodystrophy, Plummer-Vinson, Iron deficiency, hemochromatosis, physiologic in children</td>
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<td>Apparent leukonychia</td>
<td>Nail bed</td>
<td>White discoloration that fades with pressure</td>
<td>Hypoalbuminemia, chemotherapy</td>
<td><img src="https://via.placeholder.com/150" alt="Image" /></td>
</tr>
<tr>
<td>True leukonychia</td>
<td>Distal matrix</td>
<td>Punctate: small opaque white spots Striate: multiple transverse white parallel lines Diffuse: completely or almost completely white</td>
<td>Trauma, hereditary, infection, anemia, low calcium, heart/renal disease, drugs</td>
<td><img src="https://via.placeholder.com/150" alt="Image" /></td>
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<tr>
<td>Lindsey’s nails (half and half)</td>
<td>Nail bed</td>
<td>Distal nail is normal, proximal nail is white</td>
<td>Chronic renal failure</td>
<td><img src="https://via.placeholder.com/150" alt="Image" /></td>
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<td>Longitudinal melanonychia (melanonychia striata)</td>
<td>Proximal or distal matrix</td>
<td>Longitudinal pigmented bands extending from the proximal nail fold to the distal margin.</td>
<td>Nevus/melanoma of matrix, Laugier-Hunziker, Peutz-Jegher, AZT, AIDS, normal variant in dark skinned individuals, trauma</td>
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<tr>
<td>Macronychia</td>
<td>Nail plate</td>
<td>Neurofibromatosis 1, Tuberous sclerosis, Proteus syndrome</td>
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<td>Mee’s lines</td>
<td>Proximal matrix</td>
<td>Transverse white lines that affect all nails</td>
<td>Arsenic poisoning, rheumatic fever, congenital heart failure, leprosy</td>
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<tr>
<td>Muehroek’s lines</td>
<td>Nail bed</td>
<td>Double white transverse lines from abnormal vascular bed Disappear with squeezing of the nail</td>
<td>Nephrilic syndrome, low albumin, liver disease, malnutrition</td>
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<td>Oil spots</td>
<td>Nail bed</td>
<td>Brownish macules beneath the nail plate</td>
<td>Psoriasis</td>
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<td>Onychogryphosis</td>
<td>Nail plate</td>
<td>Ram’s nail; long, curving</td>
<td>Neglect, trauma</td>
<td><img src="https://via.placeholder.com/150" alt="Image" /></td>
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Boards Fodder: Nail Disease (continued)

Amy Reinstadler, MD and Nazanin Saedi, MD

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Onycholyis</td>
<td>Nail bed</td>
<td>Distal separation. Appears white because of the presence of air in the subungual space</td>
<td>Psoriasis, trauma, drugs, contact dermatitis</td>
<td><img src="image1.png" alt="Image" /></td>
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<td>Onychomadesis</td>
<td>Proximal and distal matrix</td>
<td>Detachment of the nail plate from the proximal nail fold</td>
<td>PCN, TEN, SJS, syphilis, pemphigus, radiation</td>
<td><img src="image2.png" alt="Image" /></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Medications: carbamazepine, lithium, doxycycline (photo-onychomadesis)</td>
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<tr>
<td>Onychorrhexis</td>
<td>Proximal matrix</td>
<td>Longitudinal ridging and fissuring of the nail plate</td>
<td>Lichen planus, impaired vascular supply, trauma</td>
<td><img src="image3.png" alt="Image" /></td>
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<td>Onychoschizia</td>
<td>Nail plate</td>
<td>Brittle nails, fragility</td>
<td>Dehydration of the nail plate as a result of environmental factors such as frequent handwashing</td>
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<td>Pachyonychia</td>
<td>Nail bed</td>
<td>Thickened nails with an increased transverse curvature due to severe nail bed hyperkeratosis</td>
<td>Pachyonychia congenital</td>
<td><img src="image5.png" alt="Image" /></td>
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<td>Pitting</td>
<td>Proximal nail matrix</td>
<td>Punctate depressions of the nail plate surface</td>
<td>Psoriasis, alopecia areata, eczema, paronychia</td>
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<tr>
<td>Pincer nails</td>
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<td>Transverse excessive curvature from widened base of terminal phalanx</td>
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<td>Dorsal pterygium</td>
<td>Proximal nail fold</td>
<td>Scarring of the proximal nail fold</td>
<td>Lichen planus, acrosclerosis, Lesch-Nyhan syndrome, chronic GVHD, SJS/TEN, cicatricial pemphigoid</td>
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<td>Ventral pterygium</td>
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<td>Adherence of the ventral surface of the distal nail plate to the hypochium</td>
<td>Systemic sclerosis, congenital</td>
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<tr>
<td>Red lunula</td>
<td>Distal matrix</td>
<td>Adherence of the ventral surface of the distal nail plate to the hypochium</td>
<td>Alopecia areata, psoriasis, carbon monoxide poisoning, cardiac failure, SLE, rheumatoid arthritis, COPD, cirrhosis;</td>
<td><img src="image10.png" alt="Image" /></td>
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<tr>
<td>Red spotted lunula</td>
<td>Distal matrix</td>
<td>Adherence of the ventral surface of the distal nail plate to the hypochium</td>
<td>Alopecia areata, psoriasis, lichen planus, rheumatoid arthritis, SLE</td>
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<tr>
<td>Splinter hemorrhage</td>
<td>Nail bed</td>
<td>Dark red thin longitudinal lines</td>
<td>Endocarditis, vasculitis, trauma, psoriasis, trichinosis</td>
<td><img src="image12.png" alt="Image" /></td>
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<td>Terry’s nails</td>
<td>Nail bed</td>
<td>Nails are evenly white, except for the distal 2mm</td>
<td>Cirrhosis, congenital heart failure, diabetes</td>
<td><img src="image13.png" alt="Image" /></td>
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<tr>
<td>Trachyonychia (20 nail dystrophy, “sandpaper nails”)</td>
<td>Proximal matrix</td>
<td>Excessive longitudinal ridging producing nail roughness</td>
<td>Alopecia areata, lichen planus, psoriasis</td>
<td><img src="image14.png" alt="Image" /></td>
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<td>Triangular lunulae</td>
<td>Distal matrix</td>
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<td>Slow growth, absent cuticle/ lunulae, transverse ridging</td>
<td>Pulmonary disorders; Medications: D-penicillamine, bucillamine</td>
<td><img src="image16.png" alt="Image" /></td>
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References:


The American Board of Dermatology (ABD) has produced a content outline to help dermatology residents understand the scope of information covered in the ABD certifying examination. “This list is not exhaustive and content for examination questions will also come from new and evolving concepts,” according to the ABD. The pdf can be accessed at www.abderm.org/docs/pdf/content_outline.pdf.
ETHICS from p. 1

matologist advocate for his/her patient and, at the same time be a paid consultant for a pharmaceutical company?

Can influence be objectively judged?

Let’s look at physicians’ interactions with pharmaceutical representatives. Studies show that the more frequent the contacts between physicians and pharmaceutical representatives, the greater the likelihood that the physician will prescribe that company’s product preferentially. Not only will physicians deny this influence but they are also poor judges of the extent of that influence on their prescription writing. Even small gifts can influence the behavior of the recipient in ways the recipient does not always realize, according to social science studies. One study looked at prescriptions of two drugs, before and after the pharmaceutical company’s funded conference at a resort. There was a significant increase in prescriptions written for both drugs by the attendees at that conference, which was statistically significantly different from the national usage pattern. These authors concluded that physicians’ relationships with the pharmaceutical industry conflict with their duty to act in the best interests of their patients. Another conclusion could be that the attendees became more familiar with these particular drugs and felt more comfortable prescribing them.

The ethical issue here is not only whether physicians’ prescribing habits are influenced by these contacts (as they certainly are), but whether the relationship is beneficial or harmful to patients.

In the next issue, part two of the dermatologist/pharmaceutical industry interface will address beneficence, sampling and transparency.

References

Race for the case by Andrew Krakowski, M.D.

We’re upping the ante, because you readers are breezing through these cases with impressive accuracy. This one is a ‘three-parter,’ so read carefully. A young boy presents with a generalized eruption consisting of sharply demarcated, somewhat shiny, flat-topped, pinpoint-to-pinhead-sized, polygonal-to-round, flesh-colored papules. The dorsal hands, extensor arms, and lateral face are most affected. His nails are normal and there are no oral lesions present.
1) What is your diagnosis?
2) What are the dermpath “boards buzzwords” that would clue you into this diagnosis?
3) In addition to lymphocytes and the occasional giant cell, what other cells typically constitute the inflammatory infiltrate seen stereotypically on histopath?

Send your answers to Dean Monti, senior associate editor at the AAD, dmonti@aad.org. The answer and winner will be revealed in the next issue of Directions. The winner will also receive a Starbucks gift card, so … don’t delay!

First place in last race

Betsy J. Wernli, M.D. is in her final year of residency at University of Iowa, and recently signed in Wisconsin to practice general dermatology. In addition to her wonderful family life in Iowa with her husband and one-year-old son, Dr. Wernli she said she also loves camping, candy corn, and running marathons. Apparently her race experience and case experience (and perhaps even her sugar high) paid off in the last Race for the Case, as she correctly identified chloracne caused by Agent Orange, crossing the finish line well ahead of the pack.
Plan ahead for New Orleans 2011

There are hundreds of sessions available to choose from at the 2011 Annual Meeting. Here are a few of special interest to residents:

Friday, February 4, 2011
- F005 Boards Blitz 9 – 11 a.m.
- F013 EHR Implementation, Maintenance and Lessons Learned 12 – 2 p.m.
- F017 Resident Jeopardy 3 – 5 p.m.
- S003 Hot Topics 9 a.m. – 12 p.m.
- S010 Surviving Healthcare Reform 2 – 5 p.m.

Saturday, February 5, 2011
- F031 Food Allergy and Dermatology 9 – 11 a.m.
- F040 Resident Transitions 3 – 5 p.m.
- F044 Dermatology Teaching & Education Group 3 – 5 p.m.
- S007 Gross & Microscopic Dermatology 9 a.m. – 5 p.m.
- S018 Late-breaking Research 9 a.m. – 12 p.m.

Sunday, February 6, 2011
- P151 Plenary 8 a.m. – 12 p.m.
- S024 Residents & Fellows Symposium 11 a.m. – 2 p.m.
- S030 Electronic Health Record (EHR) Physician Demonstration Symposium 2 – 5 p.m.

Monday February 7, 2011
- F061 Medical Dermatology Challenge: Complex cases from the collection of Dr. Samuel Moschella 9 – 11 a.m.

Monday & Tuesday February 7 & 8, 2011
- C029 Dermatology Review 9 a.m. – 5 p.m.

Don’t stress those boards, blitz ‘em!

Studying for the American Board of Dermatology certification or recertification exam can be overwhelming! Boards Blitz, on Friday Feb. 4, from 9 – 11 a.m., is an interactive session that will provide key points and tips for identifying and making diagnoses for the digital image portion of the certification or recertification exam. Attendees will have the opportunity to view numerous digital images in rapid fire. High yield study material will also be covered as the images are reviewed. This session will benefit any dermatologist preparing for the ABD certification, recertification or mock board exams. Led by the dynamic Jennifer Lucas, M.D., this is a session residents will not want to miss!

Sharpen your psoriasis savvy

The Academy is offering a new forum (FRM F023), “Psoriasis Guidelines: Implementing them in Your Practice” on Feb. 4, from 3 - 5 p.m. This forum, led by Alan Menter, M.D., chairman, of the AAD’s Psoriasis Guidelines Committee, will be helpful in expanding physician knowledge base and improving clinical confidence. It will also address a wide range of clinical presentations including psoriatic arthritis. See page 103 of the 2011 Annual Meeting Program Book for more information.

Skin Deep by Krakowski/Monti

Could you give me all dimes? My dermatologist said I have a nickel allergy.
Greetings from Cleveland! The Academy’s 69th Annual Meeting in New Orleans is just around the corner! Page 7 of this issue includes a list of sessions and events of interest to residents. In particular, I would like to recommend “Boards Blitz.” This is a brand new session at the Annual Meeting, directed by Jennifer Lucas, M.D. Boards Blitz is designed to simulate the kodachrome section of the board certification exam. This will be a great opportunity to test your knowledge for the exam. Be sure to add Resident Jeopardy to your schedule to root for your favorites and find out who this year’s champion will be. Also, I would like to encourage you to attend this year’s Resident Transitions Symposium on Saturday, Feb. 5, from 3 to 5 p.m. You will gain valuable insight on how to make the transition from dermatology resident to dermatology fellow to practicing dermatologist. A representative from the American Board of Dermatology will present information on the board certification exam and the session will conclude with a panel discussion led by dermatologists that have recently taken the exam.

This has been a busy year for the Residents/Fellows Committee (RFC). The RFC has made progress on several initiatives:

- **Resident Website:** The Academy is in the process of updating the AAD website and is working with the RFC to ensure the resident page has the resources residents want.
- **Mentoring:** This year, the RFC launched a mentor program for committee members. We have learned a great deal about the value of having a mentor relationship and hope to offer this program to all residents in the future.
- **Leadership curriculum:** In conjunction with the Academy’s leadership development efforts, the RFC is working to develop an outline for a resident leadership curriculum.

Your committee has been very busy working to identify and address your needs. I would like to personally thank all of this year’s committee members for their enthusiasm and hard work to date. The RFC would love to hear from you! If you have questions or you’re looking for ways to get involved, send us an email at residents@aad.org. Have a great winter, and I’m looking forward to seeing all of you in New Orleans.

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**GALDA expands its outreach**

This year is the 30th Anniversary of the Gay and Lesbian Dermatology Association (GALDA). The group was founded in 1980, and to mark the milestone, they are planning a networking meeting on Friday evening, Feb. 4, while the AAD is in New Orleans for its 69th Annual Meeting.

The association is actively expanding its outreach for the 21st century. Information about the organization, its history, as well as news and events associated with GALDA (including the networking meeting in New Orleans) can be found at the association’s website, www.GLDerm.org.

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