VA Derm Rotation Student Orientation

Keep bags and hang out in student / microscope room (not resident office)
OK to wear scrubs every day except Thursdays
Be at work at 9:00 every day except Thursdays (8:00 am)
Be back from lunch and ready to start at 12:45 pm (12:30 pm on Thursdays if no Thursday activities; 1:30 pm on Fridays)

I. When you get to clinic in am:
Split up into rooms to see patients. Leave 3 rooms open in the front for residents (don't use 520 - PA room). Get logged on to computers. Go to front desk and bring back patient to see.

II. In Afternoon:
Split up into rooms to see pts. You can usually use surgery rooms in the back in the afternoon, but check with chief to make sure that's ok first. Log on to computers. Bring back patient to see.

III. CPRS:
Open patient - First letter of last name and last 4 SSN
Look at last derm note (or last 2 or last surgery note)
Last notes could be under Derm Clinic Note, Derm Consult, or Derm Surgery
Create new note:
- click 'new note'
- select 'Derm Clinic Note' - unless a consult is pending at bottom (usually on Wednesdays) - select 'Derm Consult,' and then highlight consult at bottom.
Select attending from list on wall or what is written on white board in hall

IV. History:
The history from the patient should be very brief and guided by their previous visits (only talk to patient for a couple minutes)
If h/o skin cancer → any new areas of concern
If other problems → responding to therapy
If patient has other concerns, just find out how long they've been there, if they are symptomatic, and what they have tried on them
If returning after a biopsy, see what the biopsy showed - click labs tab, then select 'anatomic path', 'surg path', and make sure you select date when biopsy was performed

V. Exam:
If h/o non-melanoma skin cancer, check from waist up (UBSE - upper body skin exam)
If history of melanoma, need to check entire body (FBSE - full body skin exam)
If rash in groin, check feet and toenails
Have patient undressed and sitting up on exam table with shoes off if necessary before coming to check out

VI. Check Out:
- very concise
- does patient have h/o cancer?
- or have we seen him for something else?
- meds working? or not?
- here for skin check?
'58 yo WM with h/o BCC treated with regular excision in 2007 here for skin check and has a new growth on R ear.'

VII. Biopsy:
- set up according to handout / shave or punch biopsy
- consent the patient:
  i. click tools, iMed consent
  ii. make sure dermatology – consents – basic is selected
  iii. select skin – shave biopsy or skin – punch biopsy
  iv. check that patient has decision making capacity and click next
  v. in text appearing on consent for box, write type of biopsy and location without using abbreviations – ‘shave biopsy left ear’
  vi. don’t type anything under comments
  vii. select resident as practitioner obtaining consent
  viii. select attending as supervising practitioner
  ix. don’t select anyone for supervising practitioner
  x. click finish, then click ok
  xi. leave on screen, when resident returns to room, click ‘sign’ on right side of screen, have resident sign, have patient sign, then you sign as witness.
- this is a good time to have the resident sign the path form also

VIII. Stickers:
- ALWAYS ALWAYS ALWAYS put a sticker in the book for all biopsies, surgeries, labs and cultures performed
- fill out stickers exactly as shown on sticker sheet
IX. Note:
-very concise; the shorter your note is the better; don’t spend too long on note, it will be changed, anyway
-soap note format
-only list things that we specifically addressed; no need to put angiomas, SK’s or lentigines, unless we treated them or that is what we were consulted for.

SAMPLE NOTE: (This note is much longer than usual to show plan for various conditions)

RFC – ‘cut and paste from consult tab and put in quotes’
[only if it is a consult – usually on Wednesdays]

S: 71 yo WM with h/o SCC R ear s/p Mohs 2004, BCC L temple s/p regular 2009 here for skin check. Also c/o “scaling” on face for the last 3 months and yellow discoloration of toenails.

O: WDWN in NAD, UBSE done, [well developed well nourished in no acute distress]
[don’t ever use words like ‘lesion’ in this section. Describe using handout terms. Don’t stress too much about description, we may change it anyway.]
1. well-healed scar on R ear, L temple
2. erythematous scaly papules on arms, head
3. 3 mm pearly papule on L nasal tip
4. 5 mm crusted hyperkeratotic papule on L upper back
5. greasy scale on central face and eyebrows
6. thick yellow toenails with subungual debris

A/P:
[make sure numbers from exam correspond to the numbers in the A/P section]
1. H/O NMSC – ner [NMSC – non-melanoma skin cancer; ner – no evidence of recurrence]
2. AK – LN2 x 7 after RBECO [AK – actinic keratosis; RBECO – risks benefits explained, consent obtained]
3. Likely BCC – shave biopsy done after RBECO. Timeout done prior to procedure to identify patient and proper site and to obtain consent. Mohs if positive.
[you have to write that line after every biopsy; then follow with plan: regular if positive. Mohs if positive, general surgery if positive, ENT if positive, or C&D done] [C&D – curettage and desiccation]
4. BCC v. SCC - shave biopsy done after RBECO. Timeout done prior to procedure to identify patient and proper site and to obtain consent. C&D done.
5. Seb Derm – ketoconazole cream daily, HC cream PRN redness, irritation [seb derm – seborrheic dermatitis; HC – hydrocortisone]
6. Onychomycosis – check CBC, LFT today. If WNL, start terbinafine 250 mg daily. RTC in 7 weeks with preclinic CBC, LFT.

RTC 7 weeks [RTC – return to clinic – ask resident when to RTC]
Derm Med Reconciliation Done [always write this line]
Med Student Name & Year [write your name and year at the end of the note]

→change author to the resident that you checked out to
I. Stickers

*ALWAYS put sticker in path book for biopsies, labs, cultures, etc.

PATH BOOK

Last Name, First Name (Last 4 SSN)                     Date
Location - Differential Dx → Plan                   Resident
Phone Number/Alternative Number                    Initials

Wolf, John (1234)                  8/2
A) Nasal Tip → BCC → Mohs if +
B) Antihelix → AK r/o SCC → Reg if +
C) Paramedian Back → BCC v. SCC → C & D done
(713) 791-1414

*Put Sticker on biopsy bottle(s)

Last name, First Name                     Date
Full SSN                  Res. Init.
Location (exact location on path form)

Wolf, John                  8/2
123-12-1234
A) Left Nasal Tip
BIOPSIES

- Turn on Hyfrecator
- Set on 20

Hyfrecator Tip
Hyfrecator Cover

Specimen (Biopsy) Jar
- 1 Specimen Jar For Each Site (labeled)

Gauze
Band Aid & ABx ointment
Gilette Blade
Alcohol Wipe

Blue Chuck
Curette if we are doing C&D

SHAVE BIOPSY

PUNCH BIOPSY

SUTURE [usually 4-0 Ethilon]
- But Ask Resident

Scissors
Needle Driver

Open Laceration Tray and set out:
PATHOLOGICAL REPORT

MEDICAL RECORD

TISSUE EXAMINATION

DATE OBTAINED

SPECIMEN SUBMITTED BY

Derm

SHAVE Biopsy Right Arm

BRIEF CLINICAL HISTORY (Include duration of lesion and rapidity of growth, if a neoplasms)

very brief if at all

PREOPERATIVE DIAGNOSIS

BCC v. SCC v. other → ask resident for differential (will usually be same as note)

OPERATIVE FINDINGS

POSTOPERATIVE DIAGNOSIS

→ Have Resident Sign Here

NAME OF SIGNER: Sean Doherty

TITLE OF SIGNER: M.D.

PATHOLOGICAL REPORT

GROSS DESCRIPTION, HISTOLOGIC EXAMINATION AND DIAGNOSES

SIGNATURE OF PATHOLOGIST

NAME OF PATHOLOGIST

DATE

HOSPITAL OR MEDICAL FACILITY

RECORDS MAINTAINED AT

DEPARTMENT: SERVICE OF PATIENT

RELATION TO SPONSOR

SPONSOR'S NAME (first, first, middle)

SPONSOR'S ID NUMBER (SSN or other)

PATIENT'S IDENTIFICATION: (For typw or written entries, give Name last, first, middle; ID no.

(If other: Sex, Date of Birth, Rank, Grade)

REGISTER NO.

WARD NO.

TISSUE EXAMINATION

Medical Record

Last Name, First Name

XXX-XX-XXXX → Full SSN

Signature: [Signature]

Printed Name: [Printed Name]
BASIC MORPHOLOGIES

Most skin lesions can be described using these eight basic terms. Also describe color (say erythematous, not red or pink) and size in mm or cm.

Macule
A small, flat, non-palpable lesion, less than 10 mm in size.

Patch
A flat, non-palpable lesion 10 mm in diameter or larger (a large macule). Some clinicians accept a slight amount of scale as still acceptable in a patch, as in early mycosis fungoides (otherwise, most large patches would be plaques).

Papule
A small, superficial, circumscribed, palpable lesion elevated above the skin surface, less than 10 mm in diameter.

Plaque
A palpable lesion elevated above the skin surface, 10 mm or greater in diameter.

Nodule
A firm (indurated) lesion that is thicker or deeper than the average papule or plaque. The term comes from the Latin word ‘nodulus’, meaning ‘knot’. A nodule that is subcutaneous might not elevate the skin surface.

Vesicle
An elevated lesion that contains clear fluid, a small blister less than 10 mm in diameter

Bulla (plural bullae)
An elevated lesion that contains clear fluid, a large blister 10 mm or greater in diameter

Pustule
A superficial elevated lesion that contains yellow fluid (pus) within or beneath the epidermis, generally protein-rich and containing neutrophils

OTHER TERMS

Erosion
Defect of only the epidermis, not involving the dermis

Ulcer
Defect extends into the dermis or deeper
<table>
<thead>
<tr>
<th>DESCRIPTION (IN EXAM SECTION)</th>
<th>DIAGNOSIS (IN A/P SECTION)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stuck-on brown verrucous papule or plaque</td>
<td>Seborrheic keratosis (SK)</td>
</tr>
<tr>
<td>Erythema with greasy yellow scale on central face</td>
<td>Seborrheic dermatitis (seb derm)</td>
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<tr>
<td>Thick yellow toenails with subungual debris</td>
<td>Onychomycosis (nail fungus)</td>
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<tr>
<td>Rough scaling hyperkeratotic papules</td>
<td>Actinic keratoses (AK's)</td>
</tr>
<tr>
<td>Well-demarcated red plaque with silvery scale</td>
<td>Psoriasis</td>
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<tr>
<td>Shirky or translucent pink papule with rolled border</td>
<td>Basal cell carcinoma (BCC)</td>
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<tr>
<td>Indurated scaling crusted hyperkeratotic papule</td>
<td>Squamous cell carcinoma (SCC)</td>
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<tr>
<td>Irregular brown/black macule, papule, or nodule with irregular borders</td>
<td>Melanoma</td>
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<tr>
<td>Regular appearing brown macule or papule with smooth borders</td>
<td>Melanocytic nevus (common mole)</td>
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<tr>
<td>Pruritic scaling erythematous patch</td>
<td>Eczema</td>
</tr>
<tr>
<td>Annular scaling erythematous patch with central clearing</td>
<td>Tinea (fungus or “ringworm”)</td>
</tr>
<tr>
<td>Beefy erythema involving body folds (usually) with satellite (surrounding) papules and pustules</td>
<td>Candida (yeast)</td>
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