

hospitalization, suggesting that many of these patients developed the disease in the hospital (Table II). Although not statistically significant, the longer hospital stays in IgA vasculitis are likely explained by the later consultation and, thus, diagnosis and intervention. The limitations of this study include the retrospective design, small sample size, high dropout rates, and different time courses—namely, that nonspecific immunodeposition might have been the result of later biopsies and IgA degradation. Prospective validation is needed to confirm these results.

Kalyn P. Hoffman, MD,<sup>a</sup> Catherine Chung, MD,<sup>b,c</sup>  
Samir Parikh, MD,<sup>d</sup> Shawn G. Kwatra, MD,<sup>e</sup>  
John Trinidad, MD,<sup>b</sup> and Benjamin H.  
Kaffenberger, MD<sup>b</sup>

From The Ohio State University College of Medicine, Columbus, Ohio,<sup>a</sup> The Ohio State University Wexner Medical Center Division of Dermatology,<sup>b</sup> The Ohio State University, Wexner Medical Center, Department of Pathology, Columbus, Ohio,<sup>c</sup> The Ohio State University, Wexner Medical Center, Division of Nephrology, Columbus, Ohio,<sup>d</sup> and Johns Hopkins University Department of Dermatology, Baltimore, Maryland<sup>e</sup>

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Correspondence to: Benjamin H. Kaffenberger, MD,  
Ohio State University Medical Center Dermatology,  
2012 Kenny Road, 2nd Floor, Columbus, OH,  
43212

E-mail: Benjamin.Kaffenberger@osumc.edu

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## Gender and racial underrepresentation in academic dermatology positions in the United States: A retrospective, cross-sectional study from 2007 to 2018

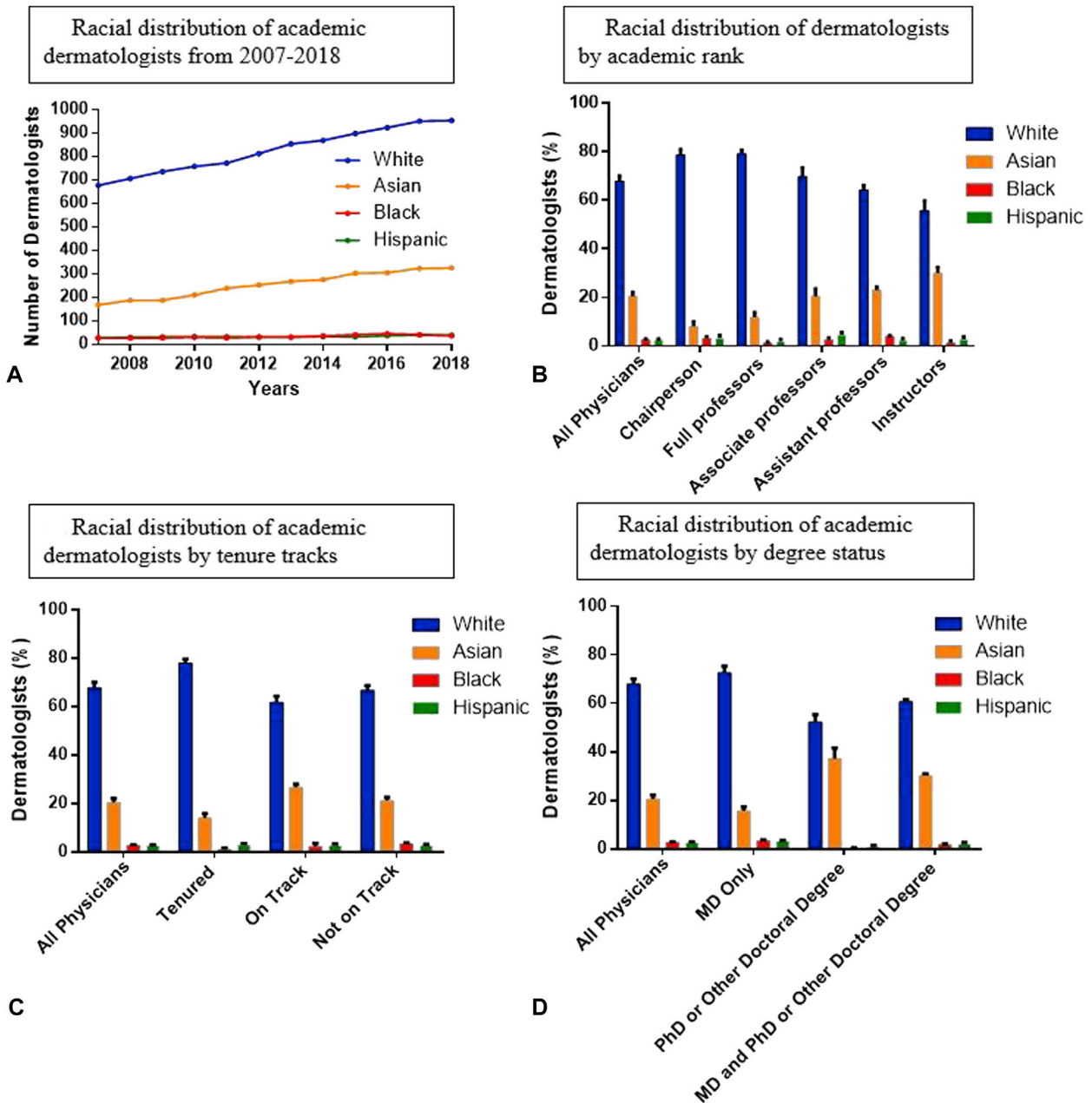


*To the Editor:* According to the US Census Bureau, by the year 2044, more than half of the US population is projected to belong to racial and ethnic minority groups.<sup>1</sup> As minority populations continue to increase, diversification of the health care workplace is crucial for providing high-quality patient care.

Patients of minority groups are more satisfied from race-concordant visits and experience longer and more engaged visits from their physicians.<sup>2</sup> Physicians of underrepresented minority (URM) groups are more likely to practice in underserved areas and treat patients with limited access to health care.<sup>2</sup> Furthermore, increased diversity in the learning environment prepares trainees to serve diverse populations.<sup>2</sup> This is very significant in dermatology; despite the lower incidence of skin cancer, Black patients present with more advanced melanomas, resulting in worse prognosis and higher mortality.<sup>3</sup>

Using the annual reports from the American Association of Medical Colleges, we conducted a retrospective cross-sectional study to investigate the trends in gender and racial representation in academic dermatology positions across the United States from 2007 to 2018. During this 12-year period, the total number of academic dermatology appointments increased by 53.0%, but White dermatologists made up the majority (67.9%) and were overrepresented in higher academic ranks such as chairs (78.7%) and full professors (79.2%). As the ranks decreased in hierarchy, other races increased in representation, particularly Asian individuals. Black and Hispanic individuals made up only 2.7% of academic dermatologists, respectively, with negligible increases in representation over the past 12 years (Fig 1).

A recent review indicates that the number of Black and Hispanic applicants for medical schools remains low and that only 6% to 8% of matriculated medical students are Black or Hispanic.<sup>4</sup> Consequently, there is a bottleneck in the recruitment process at medical schools, and diversity should continue to be prioritized as an explicit goal in the medical school selection process. Emphasis on test scores and grades systematically disadvantages individuals of URMs, who often lack financial resources and opportunities.<sup>5</sup> In addition, dermatology is one of the most competitive specialties, with higher Step 1 test scores, more publications, and higher medical



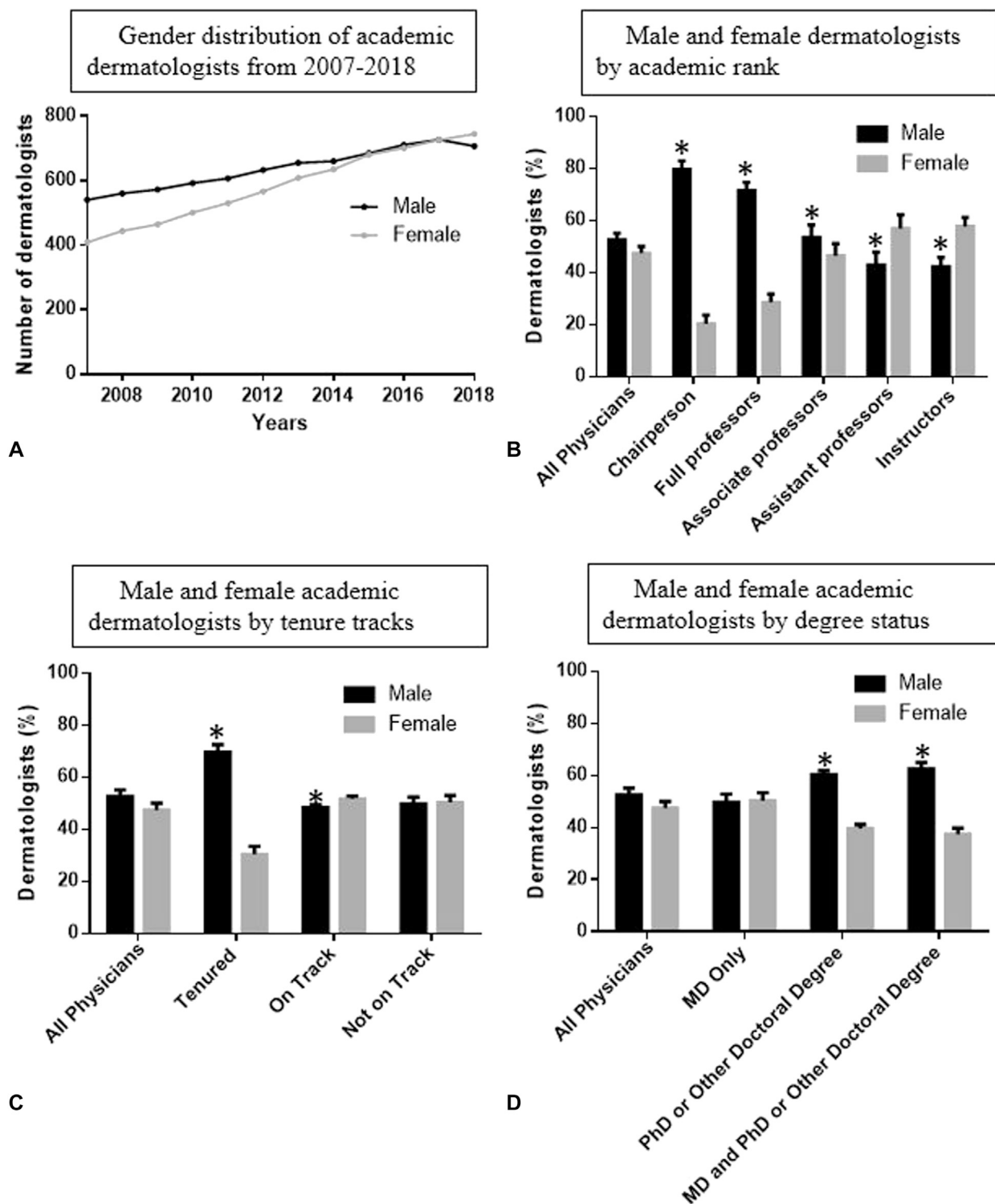
**Fig 1.** Racial distribution of academic dermatology positions from 2007 to 2018 with respect to academic rank, tenure track, and degree status. Statistically significant ( $P < .001$ ) between every race except between Black and Hispanic dermatologists.

school research ranking predicting dermatology match success.<sup>5</sup> With the recent change of the Step 1 test to pass/fail, establishing a more holistic review of applicants and increasing URM exposure and mentorship should be prioritized to advance diversity in dermatology.

We found that men overrepresented higher ranks, including chair positions (79.6%), full professors (71.5%), and associate professors (53.6%), whereas women overrepresented lower positions such as assistant professors (56.9%) and instructors (57.7%)

(Fig 2). Barriers to academic promotion persist for women in medicine, and changes need to be made in academic dermatology positions such as promotion and support for women in senior roles, increasing mentorship opportunities from women in leadership positions, and creating more family-friendly career tracks with flexible or part-time commitments.

As the number of minority populations continue to increase in the United States, efforts at all levels are needed to foster and support the careers of minority



**Fig 2.** Gender distribution of academic dermatology positions from 2007 to 2018 with respect to academic rank, tenure track, and degree status. \*Statistically significant between men and women ( $P < .001$ ).

and female faculty to ensure their equitable representation in all levels of academic dermatology. This will ensure diversification and improve health care delivery to all populations in the United States.

Justin D. Lu, MSc,<sup>a</sup> Sabeen Tiwana, DMD, BDS,<sup>b</sup> Priya Das, PhD,<sup>c</sup> Javed Siddiqi, MD, DPhil (Oxon),<sup>d</sup> and Faisal Khosa, MD, MBA, FRCPC<sup>e</sup>

Michael G. DeGroot School of Medicine, McMaster University, Hamilton, Ontario, Canada<sup>a</sup>; Department of Dentistry at University of British Columbia, Vancouver, British Columbia, Canada<sup>b</sup>; Education and Proficiency Center, King Hamad University Hospital, Al Sayb, Bahrain<sup>c</sup>; Arrowhead Neurosurgical Medical Group, Colton, California<sup>d</sup>; Department of Radiology, Vancouver General Hospital, Vancouver, British Columbia, Canada.<sup>e</sup>

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Correspondence to: Faisal Khosa, MD, MBA, FRCPC, Department of Radiology, Vancouver General Hospital, 899 12th Avenue W, Vancouver, British Columbia, Canada, V5Z 1M9

E-mail: [fbkxosa@hotmail.com](mailto:fbkxosa@hotmail.com)

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## Dermatologic disorders in transgender patients: A retrospective cohort of 442 patients



*To the Editor:* Although the number of patients identifying as transgender has increased in recent decades,<sup>1</sup> there remains a practice gap regarding optimal dermatologic care for transgender patients.<sup>2-4</sup> A retrospective chart review of all transgender patients evaluated at the Mayo Clinic in Rochester, Minnesota, from March 15, 1986, through June 21, 2018, was performed using billing codes for gender dysphoria, gender identity disorder, and transsexualism to identify patients of all ages for potential inclusion. Medical records were reviewed to ensure patients selected for inclusion met gender dysphoria

**Table I.** Demographics and characteristics of transgender patients who presented with dermatologic concerns

Patient characteristics (N = 214)	Results
Age at GD diagnosis, y	
Mean	28.8
Median	25
Range	11-75
Age at dermatologic diagnosis, y	
Mean	31.7
Median	25
Range	11-77
Sex assigned at birth, n (%)	
AFAB	80 (37.4)
AMAB	134 (62.6)
Gender identity, n (%)	
Man/male	79 (36.9)
Woman/female	129 (60.3)
Nonbinary or other	6 (2.8)
GD-related medical intervention received	
Masculinizing HT	67 (31.3)
Feminizing HT	130 (60.8)
Puberty suppression (leuprolide)	10 (4.7)
Gender-affirming surgery, n (%)	93 (43.5)
Masculinizing chest surgery	31 (14.5)
Phalloplasty	1 (0.5)
Vaginoplasty	41 (19.2)
Orchiectomy	48 (22.4)
Breast augmentation	23 (10.8)
Facial surgery	18 (8.4)
Race, n (%)	
White	187 (87.4)
Black	2 (0.9)
Hispanic or Latino	7 (3.3)
Asian	3 (1.4)
Mixed race/other	12 (5.6)
American Indian or Alaska Native	3 (1.4)

AFAB, Assigned female at birth; AMAB, assigned male at birth; GD, gender dysphoria; HT, hormone therapy.