During my almost 40 years of practice, the clinical problems I found most challenging involved pediatric patients with skin rashes. I found distinguishing the common benign origins of a maculopapular, pustular, or vesicular rash from more serious etiologies difficult.

In this issue of Pediatric Annals, Drs. Miriam Weinstein and Deepak Kamat and their team of authors present a series of practical articles about common clinical pediatric dermatologic problems that clinicians face on almost a daily basis. As I read each article, I learned new and important information about atopic dermatitis, contact dermatitis, “moles,” and vascular lesions.

**GENDER IDENTITY: THE PEDIATRICIAN’S ROLE**

In my role as the Director of Pediatric Resident Research at Comer Children’s Hospital, University of Chicago for the past 5 years and in other editing duties, it has become evident that the discussion of the diagnosis and management of gender variant or transgender children has been seen with much greater frequency. What made me decide to discuss this topic in this month’s editorial is the recent horrific mass shooting in Orlando, FL, in which 49 people were killed at a club that catered to the lesbian, gay, bisexual, transgender, and queer community.¹

Dr. Ilana Sherer, the Primary Care Director of the Gender Center Clinic at the University of California, San Francisco, gave a recent grand rounds presentation at the University of Chicago about the best-practices approach to working with and providing adequate care to pediatric patients who are gender fluid. Dr. Sherer explained that a child is assigned a sex at birth based on anatomy,² and that gender identity is determined by how people identify internally (how they think of themselves). Gender expression is how a person presents themselves to the world, and can represent a spectrum between male and female. Dr. Sherer indicated that gender variant youth represent between 2% and 38% of the US population, and that 6% to 20% of these children will become transgender, whereas 80% will be cisgendered adults.² During the presentation, she displayed a chart that illustrated how clinicians can create positive, supportive environments for gender expansive youth.²

One recommendation was to use the child’s “preferred pronoun” when meeting with them. I encourage professionals in the pediatric field to become knowledgeable about how to provide the best care to every patient regardless of gender identity. Some practical articles to peruse for additional information include Merens³ and Olson and Garofalo.⁴

We could also spend a few hundred pages discussing gun control and violence, but Shulman⁵ addressed this issue as it relates to us as pediatricians in an earlier editorial.

**REFERENCES**