Coming to America: The international dermatology resident experience

Residents from around the globe — recipients of the Academy’s Visiting Residents Scholarship — did a one-month rotation in the United States in 2008. Directions in Residency interviewed three of these residents to find out what the experience was like and how dermatologic education, practice and treatment differed between America and their home countries.

Ana-Maria Forsea, M.D. (Romania)
While visiting the AAD booth during World Congress of Dermatology 2007, I learned about scholarship opportunities. When I discovered I was eligible, I asked the consent of the director of my desired host program — Memorial Sloan-Kettering Cancer Centre, Dermatology Service — and then I applied to the Academy. I was very happy to be selected.

Since skin cancer (and melanoma in particular) are my main area of interest, from my PhD research to the clinical activity, I chose this program to experience a comprehensive skin cancer center. I was able to observe the management of skin cancer patients in all its aspects, from diagnosis procedures and treatment strategies, to referral logistics and interdisciplinary approach. I learned about early melanoma diagnosis techniques and melanoma prevention studies, and it was illuminating to see skin cancers at such an early phase. I could see that prevention and patient education are working wonders in the US. We have such a long way to go, in this regard, back home.

In Romania, hospital-based dermatology practice and teaching takes place mainly in in-patient clinics. Hospital dermatology departments usually have between 25 and 45 in-patient beds. The residents thus have the opportunity to follow more closely the evolution of dermatological patients and to take the responsibility and the decision for the management of complicated cases, requiring a multidisciplinary approach.

Primary care network and ambulatory dermatology practices as well as preventive care in Romania are significantly less developed than in the US, so many dermatological patients are treated first in hospital dermatology departments. This often means that in Romania we are seeing complicated cases, often in advanced stages of skin diseases, including many advanced skin cancers.

In Romania residency lasts 5 years (2 years general med-

See INTERNATIONAL on p. 3

Flash! New technology for Directions on the Web
Starting this year, we will be posting issues of Directions in Residency on the Web, using a new Flash PDF technology. This new technology allows you to virtually turn the pages of the newsletter, and also make use of hyperlinks and e-mail addresses within each issue. Check it out on the Residents/Fellows section of the Academy’s Web site, www.aad.org. If you have other ideas for interactive content or just want to let us know what you think, contact Dean Monti, Senior Editor at dmonti@aad.org.
Upcoming ABD exam dates, information available online

The ABD publishes a resident newsletter that provides information about upcoming examination dates, including vital information about the sessions, content and scope of the information covered in the ABD certifying examination. Access the newsletter online at www.abderm.org/home/resident_newsletter.htm.

- In-training examination for dermatology residents: Administered online at dermatology residency training centers in the United States and Canada on March 25, 2010. The deadline for receipt of applications is Jan. 15, 2010.
- Certifying examination: American Board of Pathology in Tampa, Fla. and the American Board of Radiology in Tucson, Ariz. the week of Aug. 3-7, 2009 and Aug. 2-6, 2010. The annual deadline for receipt of applications is March 1.
- Subspecialty certification in dermatopathology examination: Administered at the testing center of the American Board of Pathology in Tampa, Fla. on Sept. 16, 2009 and Sept. 1, 2010. The deadline for receipt of applications is May 1. Dermatologists must submit applications to the American Board of Dermatology office and pathologists to the American Board of Pathology office.
- Subspecialty certification in pediatric dermatology examination: Administered at Prometric testing centers around the country on Oct. 18, 2010. The deadline for receipt of applications is April 1, 2010.

For further information about these examinations, check the ABD Web site at www.abderm.org.

How long will you take?
Study Plans for ABD Certifying Exam
(according to a recent AAD survey of dermatology residents)

<table>
<thead>
<tr>
<th>Timeframe to Begin Studying</th>
<th>Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Six months prior to taking exam</td>
<td>50.6%</td>
</tr>
<tr>
<td>One year prior to taking exam</td>
<td>19.3%</td>
</tr>
<tr>
<td>Over one year before taking the exam</td>
<td>28.4%</td>
</tr>
<tr>
<td>No reply</td>
<td>1.7%</td>
</tr>
<tr>
<td>Total</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

New physician editor takes the helm

Directions in Residency welcomes Andrew C. Krakowski, M.D. as new physician editor for this publication. Dr. Krakowski is currently a resident in the division of dermatology at the University of California, San Diego (UCSD). He earned his medical degree from the University of Pennsylvania and completed a pediatrics residency at the Johns Hopkins Medical Institute, followed by a two-year clinical research fellowship in pediatric dermatology at the Rady Children’s Hospital, San Diego.

Dr. Krakowski has a special interest in inflammatory pediatric skin conditions, laser surgery, and wilderness and travel medicine. He serves as a resident liaison to the Association of Professors of Dermatology (APD) and is the Web site editor for Rady Children’s Eczema Center (www.EczemaCenter.org). You can also hear him on his radio show on XM/Sirius Channel 160 or at www.ReachMD.com.

Readers are encouraged to contact Dr. Krakowski at akrakowski@rchsd.org and AAD senior editor Dean Monti dmonti@aad.org with ideas for features, submissions, Boards Fodder, or issues of interest to dermatology residents.
icne and 3 years dermatology). However, in Romania only the 11 university centers of the country are certified to train residents, which leads to a greater number of residents concentrated in several major hospitals throughout the country. Accordingly, residents in the US have a much looser schedule than we do in Romania, with significantly less workload.

There are fewer fundamental research opportunities for dermatologists in Romania. In Romania 90 percent of universities are public, medical training is free, and university and teaching hospitals are supported through public funds, in a system based on state-universal health-care insurance.

I was impressed by the organization of the residents — their assertiveness in organizing teaching events and actively seeking training opportunities and expert guidance. They take an active part in shaping their curricula and in claiming their rights to quality training. They also collaborate more all through their residency than my Romanian colleagues, and participate more actively in sharing knowledge. They perform more cohesively as working groups, despite high competitiveness. But this may also derive partly from the smaller number of US residents in each program, which makes these groups possible.

Chandanmal Suthar, M.D. (India)
The division of dermatology at Boston Medical Center (BMC) supported my application and allowed me to observe at their excellent clinical facility. Thomas Ruenger, M.D., graciously afforded special time and effort in making sure that my experience at BMC was of superior quality and included all activities carried out at the dermatology department. My schedule also included exposure to inpatient consulting service, which allowed me to understand the principles of dermatological evaluation of patients admitted with other medical conditions.

Thomas Ruenger, M.D., and Chandanmal Suthar, M.D.

One of the initial interesting challenges I faced had to do with the color and type of skin of the patients. I had difficulty at first recognizing lesions, because everything was so pink. My eyes have been trained for Indian skin, but after this opportunity, I have a broader understanding of skin types. In the hair clinic at BMC, I had a chance to learn about hair problems, including those prevalent in the African-American patients, something I was never exposed to in India. I attended dermato-surgery clinic and I had opportunity to observe basal cell carcinoma excision by Mohs microsurgery technique. I had never seen Mohs microsurgery before, as the infrastructure required to perform this is not available in India.

I was also exposed to a different type of work environment, where electronic medical records make it easy and helpful to retrieve records at the time of follow up. I also learned about the impact of health insurance on health care in the US, something that has not developed as rapidly in India.

The prevalence of skin cancer in the US is remarkably high compared to what we see in India; and I saw the benefits provided by skin cancer screening — patients whose lesions were detected in pre-cancerous states and treated before there was any malignant transformation. It reemphasized why we, as dermatologists, must screen every patient for skin cancer.

Before I began my residency in dermatology, I was trained first as a pediatrician. That experience instilled in me a healthy respect for the principle of “therapeutic abstinence” or “active nonintervention” — in other words, knowing when to stop yourself from doing something you or your patient might later regret. When parents bring their children in to see you with specific therapies in mind — curettage of molluscum lesions in a frightened toddler or propranolol for an uncomplicated spontaneously involuting infantile hemangioma — it is important to evaluate the necessity of these. While the parents may express a wish to quickly rid their child of a particular condition, you must consider whether the condition will spontaneously resolve or remain benign. If you take the time to explain the natural history and the potential risks of treatment, both the parents and child may be reassured and prefer therapeutic abstinence over active treatment despite their original intentions when they made their appointment to see you. There is a reason that physicians are taught the precept: primum non nocere.

Early in my career as a pediatric dermatologist, I was asked to consult on a newborn infant who had presented with a congenital “bleeding hemangioma” on the palm. The patient had been started on systemic steroid treatment, which had initially shrunk the lesion, but had begun to enlarge despite ongoing therapy. While the clinical appearance of the lesion resembled other ulcerated hemangiomas I had seen, its congenital presentation and exuberant ulceration were unusual. Despite the working diagnosis, I could not escape a nagging feeling that this was something else — I just didn’t know what it was at the time. So, I asked for help from those with more experience. I consulted colleagues at institutions across the country who responded promptly, and pursued several diagnostic leads. Ultimately, the child was diagnosed with a malignant fibrosarcoma and the child received appropriate treatment and survived.

Trust your gut if something doesn’t feel right, and don’t be afraid to ask for help. You work in a welcoming and supportive community of colleagues.
## Histiocytosis

*by* Adam Friedman, M.D.

<table>
<thead>
<tr>
<th>Syndrome</th>
<th>Presentation</th>
<th>Systemic Manifestations</th>
<th>Key Histological Findings</th>
<th>Board Relevant Miscellanea</th>
</tr>
</thead>
<tbody>
<tr>
<td>Langerhan cell Histiocytosis</td>
<td>Acute; children less than two years old. Skin colored to pink 1-2 mm papules, pustules, and vesicles in scalp, flexural areas of neck, axillae, and perineum, trunk.</td>
<td>Lung, liver, bone, lymph nodes Thromocytopenia and anemia</td>
<td>Langerhan cells in dermis with retiform nuclei CD1a, S-100, ATPase, peanut lectin and alpha-D-mannosidase + Birbeck granules on EM</td>
<td>Associated malignancies: Retinoblastoma and acute lymphoblastic leukemia</td>
</tr>
<tr>
<td>Letter-Siwe disease</td>
<td>2-6 years of age; Early lesions look like Letter-Siwe but older lesions are xanthomatized Premature loss of teeth</td>
<td>Diabetes insipidus: Infiltration of posterior pituitary by LCH cells Bone lesions Exophthalmos</td>
<td>Chronic otitis media</td>
<td></td>
</tr>
<tr>
<td>Hand-Schuller-Christian disease</td>
<td>First sign of disease may be spontaneous fracture or oitis media</td>
<td>Solitary bone lesions (cranium most frequently affected)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eosinophilic granuloma</td>
<td>Develop at birth or first few days as eruption of widespread red to brown nodules involute after several weeks</td>
<td>None</td>
<td>Sheets of cells with eosinophilic cytoplasm as well as a ground glass cytoplasm</td>
<td></td>
</tr>
</tbody>
</table>

### Non-Langerhan cell Histiocytosis

<table>
<thead>
<tr>
<th>Syndrome</th>
<th>Presentation</th>
<th>Systemic Manifestations</th>
<th>Key Histological Findings</th>
<th>Board Relevant Miscellanea</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benign cephalic histiocytosis</td>
<td>Rare, children Red to brown 2-5 mm papules develop on face and then on neck and ears (rarely on extremities and trunk) Spontaneously resolves after months to years</td>
<td>Ultrastructural studies with cytoplasmic comma-shaped bodies and worm-like particles CD11b, CD14b, CD68, HAM56, factor XIIa +</td>
<td>Touton cells absent Foamy cells rare or absent</td>
<td></td>
</tr>
<tr>
<td>Generalized eruptive histiocytoma</td>
<td>Recurrent crops of hundreds of firm small red to brown papules Affects adults more commonly than children No internal involvement</td>
<td>No xanthomatized cells or giant cells</td>
<td>More serious forms of non-LCH (i.e., xanthoma disseminatum) may develop within these patients</td>
<td></td>
</tr>
<tr>
<td>Indeterminate cell histiocytosis</td>
<td>Generalized and a solitary form</td>
<td>Monomorphous infiltrate of vacuolated and xanthomatized histiocytes throughout entire dermis</td>
<td>Immunophenotypically expresses both LCH and non-LCH markers Ultrastructural features similar to those seen in Langerhans cells except NO Birbeck granules are found</td>
<td></td>
</tr>
<tr>
<td>Juvenile xanthogranuloma</td>
<td>Most common: head and neck micronodular lesions</td>
<td>Extracutaneous sites: 1. eyes 2. lungs</td>
<td>HAM56, CD68, factor XIa Touton giant cells (characteristic histologic finding)</td>
<td>NF-1 JOML</td>
</tr>
<tr>
<td>Necrobiotic xanthogranuloma</td>
<td>#1 site periorbital Asymptomatic indurated papule, nodule, or plaque with yellow ‘xanthomatized’ hue</td>
<td>Orbital masses: Ectropion Ptosis Increased risk of plasma cell dyscrasias and lymphoproliferative disorders</td>
<td>Mid dermis with a palisading xanthogranuloma extending into fat Touton giant cells and large bizarre foreign body giant cells both present Lysozyme, CD-68, Mac387, and CD-11b positive</td>
<td>IgG monoclonal gammopathy is seen in at least 80% of patients Avoid surgical removal</td>
</tr>
</tbody>
</table>
Syndrome | Presentation | Systemic Manifestations | Key Histological Findings | Board Relevant Miscellanea
--- | --- | --- | --- | ---
Multicentric Reticulohistiocytosis | Single to multiple Cutaneous and mucous membrane Reticulohistiocytomas Severe arthropathy Acrally distributed coral bead lesions along periungual region May lead to facial disfigurement and leonine facies | Systemic vasculitis Hypercholesterolemia Hyperlipidemia | Mononuclear and multinuclear cells with eosinophilic, homogenous and finely granular cytoplasm (‘ground glass’ effect) | Progression to arthritis mutilans +PPD Associated malignancy: bronchial, breast, stomach, cervical CA
Rosai-Dorfman disease | Massive, painless, bilateral cervical lymphadenopathy Non-specific cutaneous lesions | Fever, elevated ESR, and an IgG polyclonal hypergammaglobulinemia | Emperipolysis: Engulfment of intact lymphocytes and plasma cells by histiocytes S100, CD68, CD14, CD11c, lysozyme, and Laminin 5 | HHV-6 Non-Hodgkin’s lymphoma and immune disorders
Xanthoma disseminatum | Eruption of hundreds of yellow, red, or brown papules Papules symmetrically arranged and distributed on face and in flexural and intertriginous areas of the trunk and proximal extremities Mucosal lesions in 40-60% of patients | CNS lesions may be found in hypothalamus or pituitary (diabetes insipidus) or other sites (seizures) | Many foam cells, Touton giant cells, lymphocytes, plasma cells, and PMN’s May also see accumulation of hemosiderin Stains for lysozyme, alpha-1-antitrypsin, CD68, CD11b, CD14, CD11c, and factor XIII | Normolipemic

When you post your résumé/CV on AADCareerCompass.org, you have access to careers in dermatology located in some of the nation’s most desirable places!

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- Search over 300 job openings, including practices for sale
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- Sign up for e-mails alerting you to available positions that meet your criteria
- Review articles and other resources relevant to your field

Sign up today at www.aadcareercompass.org, new positions are posted daily!

Increase your profitability with upcoming 2009 Webinars!

AAD Practice Management Essentials Webinars – available for viewing in your office via the Web – refresh your knowledge of coding, practice management, payer regulations, and updates through the use of dermatology-specific examples and definitions. Perfect for in-service training for physicians and staff.

- Managed Care Contracting – July 16
- Making the Most of Modifiers – Sept. 17
- Mastering CCI Edits – Oct. 22
- 2010 Coding Updates – Nov. 19

Visit www.aad.org/webinars to register today!
Resident International Grant in Botswana

In keeping with its dedication to international educational opportunities, the American Academy of Dermatology is providing funding in 2010 for six U.S. or Canadian senior dermatology residents to participate in a four to six-week elective in a developing nation where the Education and Volunteers Abroad Committee (EVAC) has established dermatology support programs and teledermatology consulting services. The primary site is Gaborone, Botswana, where participants rotate between the Princess Marina Hospital, in conjunction with the Botswana-U Penn Partnership, and the Baylor International Pediatric AIDS Initiative (BIPAI). Residents take part in dermatologic HIV care for both children and adults, and can visit outreach sites in Francistown and Southern Botswana.

Residents will also have the option of completing their rotation at other BIPAI sites in Maseru, Lesotho; Mbabane, Swaziland; or Lilongwe, Malawi. The grant allows residents an opportunity to learn about the care of tropical and HIV-related dermatologic conditions, as well as how to practice routine dermatology with finite resources. Residents are expected to prepare lectures and presentations, develop a database of photos, submit teledermatology consults, as well as present a report of activities to the Academy and their home programs.

Applicants must provide a letter of support from their program director or department chair, a short application essay, and detailed curriculum vitae. Grant recipients will be given a stipend for accommodation, lodging, and insurance. Airfare to Botswana will be covered by the Academy. Incoming second and third-year residents are encouraged to apply during Summer 2009 for a rotation that will be completed between January and December 2010.

Applications are due Aug. 31, 2009. If interested, please submit your application online through the Academy’s website: http://www.aad.org/members/international/scholarships.html.

Applications are reviewed and decisions made by the Education and Volunteers Abroad Committee in September 2009. Individuals are notified in October 2009 about the status of their applications. Please visit www.aad.org for more information.
Lidiane P. Marques, M.D. (Brazil)

I found out about the US residency scholarship through the Academy’s Web site and looked on the Internet for good universities with dermatology residency programs. I decided to apply to the University of California, San Francisco. It was a great experience. It’s always enriching to be in a different country, but it was especially interesting to be able to observe dermatology practiced in another country. The director of the residency program, Timothy G. Berger, M.D., gave me the opportunity of being in different clinics of the dermatology department. I was impressed with the organization, and with its many specific clinics filled with very dedicated and skilled professionals.

I didn’t experience a qualitative difference between dermatology education in Brazil and in the United States. The biggest difference I noticed was that we see lots of tropical diseases in Brazil (such as leprosy, South American blastomycosis, and leishmania) that you don’t usually see in America, and I think it would be enlightening for American students to get some experience and exposure to these diseases.

In general, however, our methods of dermatology diagnosis and treatment are more similar than they are different, with some exceptions with regards to some expensive things we have less access to in Brazil. In the follow up of bullous diseases, in some Brazilian universities (but not in private care), we have difficulty in obtaining direct and indirect immunofluorescence and some biologic agents for treatment.

In Brazil, we hear so much about the doctor-patient relationship in America — so many issues about suing doctors — that I was really surprised to see that, at least at University of California, patients were very satisfied with the medical staff’s attention and care.

Living alone in the United States for a month was good, but not without its difficulties. I learned firsthand in my hotel room about bedbugs (which are rare in Brazil). The irony of going to the US for a dermatology scholarship and developing a skin condition was not lost on me. Fortunately, it was not enough to overshadow the great time I had during this one month. The residents helped me a lot, making my stay really enjoyable. It was valuable — on both sides, I think — to exchange experiences about dermatology.

Lidiane P. Marques, M.D.

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Pay it Forward

We all have influential people in our lives who shape our careers and help us to become the people we are today. Now is the time to pay tribute to those who have helped further your career in dermatology. As you take the next step in your journey to become a board-certified dermatologist, take a moment to reflect on those who have helped you get to this point.

Who inspired your pursuit of a career in dermatology? Has someone influenced your training or assisted you along the way?

The Academy’s Tribute Program is a sincere way to show gratitude to those who have encouraged you. Tribute donations of any dollar amount ($25 suggested minimum) are very much appreciated and will support important Academy programs such as AAD Camp Discovery, Skin Cancer Prevention and Public Awareness.

When you make your Tribute contribution, a letter will be sent to the person, family or organization (excluding donation amount) letting them know of the donation given in their name. You will receive a copy of the letter along with an acknowledgement of your gift for tax purposes. The American Academy of Dermatology is a 501(c)(3) charitable organization; your gift is tax deductible to the fullest extent of law.

If you would like more information or would like to make a contribution by phone, contact Valerie Thompson, Development Manager, at 847-240-1427 or vthompson@aad.org. You may also make your Tribute donation online by visiting the Academy’s Web site at www.aad.org and clicking on the Support the Academy graphic on the left side.

What Web site communities are you using?

(from a recent AAD survey of dermatology residents)

<table>
<thead>
<tr>
<th>Community</th>
<th>Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facebook</td>
<td>53.4%</td>
</tr>
<tr>
<td>Sermo</td>
<td>12.5%</td>
</tr>
<tr>
<td>LinkedIn</td>
<td>7.4%</td>
</tr>
<tr>
<td>MySpace</td>
<td>5.1%</td>
</tr>
<tr>
<td>Dermrounds</td>
<td>1.1%</td>
</tr>
<tr>
<td>Other</td>
<td>0.6%</td>
</tr>
<tr>
<td>No Reply</td>
<td>39.8%</td>
</tr>
</tbody>
</table>
Greetings! For those of you completing your residency, congratulations and good luck on your upcoming Boards. For those still in training, savor every moment as it certainly goes fast!

As always, your Resident and Fellows Committee is continuing to work hard for you. The Resident/Fellows Committee (RFC) presented proposals to the Scientific Assemble Committee (SAC) to add additional seats for the Basic Self-Assessment of Dermatopathology course at the Annual Meeting and to address resident concerns regarding the meeting registration process for residents. SAC and the Board of Directors approved both proposals! Our Academy leadership is working to address the needs and concerns of all residents. The RFC is currently forming work groups to address our needs including: leadership training, the Indoor Tanning is Out public awareness campaign, social networking opportunities, and a career Web site with valuable resources. You do not need to be a member of the RFC to join a workgroup, if you are interested in one of the workgroups, send an e-mail to residents@aad.org. Your involvement can make a difference!

If you are interested in Academy advocacy efforts, consider joining SkinPAC, the Academy’s political action committee. SkinPAC raises money from AAD members to support the campaigns of congressional candidates and members of Congress. By raising this money, SkinPAC is supporting the AAD’s advocacy efforts to keep dermatology’s concerns at the legislative forefront and assures us that members of Congress are keenly aware of what our positions are. These concerns range from Medicare reimbursement, to electronic health record implementation costs, to getting money for skin cancer research funding. I have pledged to give $10 a month to SkinPAC — that’s only the cost of two lattes. I’d encourage everyone else to do the same for the good of our profession. For more information contact Sam Hewitt, at shewitt@aad.org.

I also encourage you to join DAN the AADA’s grassroots advocacy network. As residents, it is very important to be up to date on important legislative and regulatory issues at a federal, state, and local level and as a member of DAN you will be invited to participate in a monthly briefing teleconference. No prior experience in advocacy is required. Check out the AAD Web site at www.aad.org/gov/index.html for more information on joining DAN and the Academy’s advocacy efforts.

Questions or Comments?
Contact the AAD Member Resource Center (MRC) toll-free at (866) 503-SKIN (7546) or mrc@aad.org.

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Mission Statement
Directions in Residency is published by the American Academy of Dermatology Association to provide a forum for information concerning resident dermatology physicians, and providing news, views and actions of the Academy, the Residents / Fellows Committee, and the American Board of Dermatology.

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