



DermWorld

directions in residency

A Publication of the American Academy of Dermatology | Association

Winter 2020



The journey goes on — staying involved after residency

By Dean Monti, MFA

Residency is part of a complex and thrilling continuum. What you are doing now is already laying the groundwork for where you will be in the next decade. The AAD provides many ways for residents and graduates to keep involved with the AAD after residency. Directions asked recent grads, young physicians, and other high achievers to talk about the many options ahead and what they afford.

Preparing to lead

As you advance through residency, you are becoming an increasingly trusted leader in dermatology. And when *Directions* asked young physicians about next steps after residency, the AAD Leadership Institute (LI) was front and center. LI is an Academy initiative that provides training, mentoring, and networking opportunities to help dermatologists develop leadership skills to make them successful in their careers and in life. Many have cultivated skills that helped them rise through the ranks in the AAD via the AAD's Leadership Forum, available to those who have completed at least one year post dermatology residency/fellowship training.

After residency, Travis Blalock, MD, became chair of the AAD Young Physicians Committee (YPC) after attending the AAD Leadership Forum. "The

forum allowed me to cultivate and realize essential personal and professional skills," he said. Beyond that, Dr. Blalock said he "realized the importance of the diverse voices required for the AAD to be successful." He said that the YPC, LI, and becoming involved in the annual AADA Legislative Conference made him "appreciate how my voice was one of the many that shapes the trajectory of the AAD."

A seamless transition

Steven Chen, MD, assistant professor of dermatology at Harvard Medical School/Massachusetts General Hospital and also a member of the YPC, said it felt natural for him to stay involved in the AAD after residency as he was already a part of committees and task forces that allowed him to contribute to the organization in a meaningful way. "It was also eye opening to realize how much support the AAD provides for its members, especially the young physicians," Dr. Chen said. He added that LI helped pair him with an amazing mentor for the year and has given him a lot of new skills. The AAD also helped him with conference attendance via travel grants. "Ultimately, I stay involved for the community



Apply to serve on an AAD council, committee, or task force in April 2021:
www.aad.org/member/membership/cctf

July 2021:
Applications open for AAD Leadership Program and Leadership Institute:
www.aad.org/member/career/li

see **JOURNEY** on p. 3



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of dermatologists who want to improve the specialty for our patients and for our peers,” Dr. Chen said. “I hope I have the chance to give back to the organization and to my colleagues in the future if given the opportunity!”

Anisha B. Patel, MD, currently an associate professor of dermatology at UT MD Anderson Cancer Center and at UT McGovern Medical School, reported that “staying involved with the AAD after residency was a given for me. She said she “gains as much as she gives” by participating in committees and initiatives within the AAD. “It has been eye opening to see the thoughtfulness of our leaders and staff, the infrastructure required to keep our society running smoothly, and the numerous ways that derms can be involved.” She added that “Serving on the SAC this year is a window into the massive effort involved in putting together our annual and summer meetings. It is a privilege to be included in these discussions with dermatology leaders and to see the growing body of expertise of our members.” Dr. Patel, who is also on the AAD’s YPC as well as being a liaison to the AAD Scientific Assembly Committee, emphasized that post-graduates have the opportunity to be involved at all levels of the AAD in variety of different areas. “Through the YPC I have seen how passion projects can become reality and how influential young voices can be in the AAD,” she said. “Bringing that energy to the AAD and helping make our specialty better for all of us is why I stay involved. It is inspiring to meet and work with dermatologists who are interested in doing the same.”

Staying connected

Directions also heard from those who found much gratification working in AAD committees.

Samantha Schneider, MD, who graduated from fellowship in June 2020 and is now an attending physician at Skin Cancer and Dermatology Institute in Carson City, Nevada, is currently benefiting from her involvement in the AAD Resident and Fellows Committee (RFC). “It is so fulfilling to be involved in the AAD,” Dr. Schneider said. “Applying to be on a committee or a workgroup where you can connect with colleagues, share your expertise, and help affect change in dermatology — these are all great ways to stay involved. I joined the RFC because residents and fellows are the future of our specialty. It is imperative that we consider issues affecting residents and fellows and their training so that we can continue to train exceptional physicians.”

“I have continued to stay involved in the AAD after residency since it is not only a great resource to help me navigate my needs for a new practice, but it is an amazing networking opportunity,” said Dhvani Mehta, MD. “I continue to stay connected to many colleagues and have also found mentors through the committees I have participated in.” As a resident, Dr. Mehta was on the Council on Government Affairs and Health Policy as the resident member. Later she joined the YPC and then acquired a position on the AAD Corporate Relations Committee. In the YPC, she is chair of the Transition from Resident to YP Workgroup. “Being a part of various committees has also shown me that the AAD is an advocate for physicians, whether I am just starting off or have been in practice for many years,” Dr. Mehta said.

Consider your future

Serving the AAD involves a serious commitment, but one that all agree is worthwhile, productive, and potentially life changing. Opportunities to apply for positions for AAD councils, committees, and task forces open in April. The time to start considering how you will make a difference in 2021 is now.

Review your opportunities at www.aad.org/member/membership/cctf, and see more opportunities to get involved on p. 7. **DR**



Julia Escandon Brehm, MD, PhD, is a resident at the department of dermatology, University of Miami/ Jackson Memorial Hospital in Florida.

Race for the Case

Julia Escandon Brehm, MD, PhD



Photo credit: Karishma Desai.

Thanks to Karishma Desai for her input with photos and review of medication literature.

A 23-year-old woman with a history of ulcerative colitis (UC) presented with a 3-week history of a pustular rash on the palms and soles that is intermittently pruritic but not painful. The patient had been on infliximab for her UC for 7 months when the rash appeared. Infliximab was stopped due to concern for a paradoxical drug-related reaction. Histopathological evaluation of a lesion on the left palm demonstrated a subcorneal bulla with neutrophils, and Periodic-acid Schiff stain was negative for fungal organisms. She was started on topical steroids and cyclosporine 100mg twice daily. After one month on this treatment regimen, the rash improved significantly but did not completely resolve. The patient has recently been started on ustekinumab to manage her UC.

1. What is the diagnosis?
2. What factors support this diagnosis over a diagnosis of palmoplantar psoriasis?
3. What factor(s) in this patient’s history likely contributed to the development of this condition?
4. What information is important to elicit from this patient’s social history that is associated with the development of this condition?
5. Name some potential treatment options.
6. How is the pustular rash expected to evolve with the addition of an anti-IL-12/23 agent (ustekinumab)?



Respond with the correct answers at www.aad.org/RaceForTheCase for the opportunity to win a \$25 Starbucks gift card!

Race for the Case winner (Fall 2020)

Congrats to **Emily Yin, MD**, a PGY-3 dermatology resident at NYU Langone Health. She correctly identified leprosy in our last photo feature and provided the most comprehensive answers to the accompanying questions. She has been sent a Starbucks gift card with our compliments!

Soft tissue fillers, part 1: biodegradable

by Stefanie Altmann, DO, and Natalie M. Curcio, MD, MPH

Hyaluronic Acid (HA) Fillers

Derived from bacterial (*Streptococcus*) fermentation
Crosslinked by BDDE (1,4-bis(2,2,2-trichloroethyl) ether)
Premixed with 0.3% Lidocaine, except for Belotero Balance®
No skin test required

Trade Name	Total HA concentration	Needle	FDA-approved indication	Notes
Belotero Balance®	22.5 mg/mL	30 G	Moderate to severe facial wrinkles and folds	<ul style="list-style-type: none"> • CPM® • Crosslinking rate variable • No lidocaine
Juvéderm® Ultra XC	24 mg/mL	30 G	Moderate to severe facial wrinkles and folds; Lip augmentation	<ul style="list-style-type: none"> • HYLACROSS™ • Crosslinking rate ~6%
Juvéderm® Ultra Plus XC	24 mg/mL	30 G	Moderate to severe facial wrinkles and folds	<ul style="list-style-type: none"> • HYLACROSS™ • Crosslinking rate ~8%
Juvéderm® Vobella XC	15 mg/mL	32 G	Lip augmentation; Correction of perioral rhytids	<ul style="list-style-type: none"> • VYCROSS™
Juvéderm® Vollure XC	17.5 mg/mL	30 G	Moderate to severe facial wrinkles and folds	<ul style="list-style-type: none"> • VYCROSS™
Juvéderm® Voluma XC	20 mg/mL	27 G	Midface volume loss	<ul style="list-style-type: none"> • VYCROSS™ • Deep injection (subcutaneous/ supraperiosteal) for cheek augmentation; not for intradermal or in lip injection
Restylane®/ Restylane®-L	20 mg/mL	30 G	Moderate to severe facial wrinkles and folds; Lip augmentation	<ul style="list-style-type: none"> • NASHA™ • Particle size range: 330-430 m
Restylane® Lyft	20 mg/mL	27 G or 29 G	Moderate to severe facial folds and wrinkles; Midface volume loss; Dorsal hand volume loss	<ul style="list-style-type: none"> • NASHA™ • Particle size range: 750-1000 m
Restylane® Silk	20 mg/mL	30 G	Lip augmentation; correction of perioral rhytids	<ul style="list-style-type: none"> • NASHA™ • Particle size range: 50-220 m
Restylane® Defyne	20 mg/mL	27 G	Moderate to severe facial wrinkles and folds; Lip augmentation	<ul style="list-style-type: none"> • XpresHAn™ • First approved in Europe under the brand name Emverl
Restylane® Refyne	20 mg/mL	30 G	Moderate to severe facial wrinkles and folds; Lip augmentation	<ul style="list-style-type: none"> • XpresHAn™ • First approved in Europe as brand name Emverl • Less crosslinked vs. Restylane® Defyne
Restylane® Kysse	20 mg/mL	30 G	Lip augmentation; correction of perioral rhytids	<ul style="list-style-type: none"> • XpresHAn™
Revanesse® Versa™	25 mg/mL	30 G	Moderate to severe facial wrinkles and folds	<ul style="list-style-type: none"> • Thiofix® Technology



Stefanie Altmann, DO, is a PGY-3 dermatology resident at Orange Park Medical Center in Florida.



Natalie Curcio, MD, MPH, is a Board-certified dermatologist, fellowship-trained Mohs surgeon (FACMS), and a Fellowship-trained cosmetic and laser surgeon. She is also president and founder of Curcio Dermatology, PC, in Nashville.

Soft tissue fillers, part 1: biodegradable

by Stefanie Altmann, DO, and Natalie M. Curcio, MD, MPH

Hyaluronic Acid (HA) Fillers

Derived from bacterial (*Streptococcus*) fermentation
Crosslinked by BDDE (1,4-bis(2-diol) diglycidyl ether)
Premixed with 0.3% Lidocaine, except for Belotero Balance®
No skin test required

Trade Name	Total HA concentration	Needle	FDA-approved indication	Notes
RHA® 2 (resilient HA)	23 mg/mL	30 G	Dynamic moderate to severe facial wrinkles and folds	<ul style="list-style-type: none"> Preserved Network® technology (PNT) Mid to deep dermis Less cross-linked Teosyal RHA fillers in Europe
RHA® 3	23 mg/mL	27 G	Dynamic moderate to severe facial wrinkles and folds	<ul style="list-style-type: none"> Preserved Network® technology (PNT) Mid to deep dermis
RHA® 4	23 mg/mL	27 G	Dynamic moderate to severe facial wrinkles and folds	<ul style="list-style-type: none"> Preserved Network® technology (PNT) Deep dermis to superficial subcut More cross-linked

CPM® (Cohesive Polydensified Matrix): proprietary crosslinking process using low and high molecular weight HA to produce a smooth, flexible gel

PNT (Preserved Network® Technology): Utilizes longer HA chains that are less cross-linked leading to a dynamic structure with natural viscoelastic properties

NASHA™ (nonanimal stabilized hyaluronic acid): firmer gels, used to create projection and definition.

XpresHAN™ Technology/OBT™ (Optimal Balance Technology): Uses a range of HA cross-linking and gel calibration (particle size), designed to increase softness and flexibility.

HYLACROSS™ Technology: Utilizes crosslinked high molecular weight HA

VYCROSS™ Technology: Utilizes primarily crosslinked low molecular weight HA (90%) and high molecular weight HA (10%); designed to last longer vs. earlier generation HA fillers with less swelling.

Thiofix® Technology: provides a higher rate of homogenous cross-linking using shear rate mixing and proprietary wet-milling process to produce spherical particles

Micheels, P, et al. Rheological Properties of Several Hyaluronic Acid-Based Gels: A Comparative Study. *J Drugs Dermatol.* 2018 Sep 1;17(9):948-954.

Micheels, P, et al. Effect of Different Crosslinking Technologies on Hyaluronic Acid Behavior: A Visual and Microscopic Study of Seven Hyaluronic Acid Gels. *J Drugs Dermatol.* 2016 May 1;15(5):600-6.

References:

1. Bologna J, Jorizzo J, Schaffer I. *Dermatology*. Philadelphia: Elsevier; 2017.
2. Alikhan A, Hocker TL. *Review of Dermatology*. Elsevier; 2017.

Some information in this chart has been acquired from these product websites:

- Belotero (Merz)
- Juvéderm (Allergan)
- Restylane (Galderma)
- Revanesse
- RHA Collection
- Radiesse (Merz)
- Sculptra (Galderma)
- LAVIV

See online chart for more information.

The complete updated chart has been posted online at aad.org and includes **biostimulatory fillers** and **autologous fillers**. A complementary new chart on **HA gel technology** by Dr. Curcio has also recently been posted.

Bonus Boards!



This chart is an update of **Soft tissue fillers, Part 1: biodegradable**, by Natalie M. Curcio, MD, MPH, originally published in 2011.

You can find the expanded version of this Boards Fodder, as well as **Soft tissue fillers part 2 non-biodegradable** by Stefanie Altmann, DO, and Natalie M. Curcio, MD, MPH, and also **HA gel technology** by Dr. Curcio, all available to download at www.aad.org/Directions.

The AAD now has more than 100 Boards Fodder study charts!

Check out the archives at www.aad.org/boardsfodder.

Got Boards?



Directions in Residency is looking for new Boards Fodder charts for 2021. We would particularly like to see new charts with **graphic elements!** Contact Dean Monti, dmonti@aad.org with your chart ideas.



Andrew F. Alexis, MD, MPH, is professor and chair in the department of dermatology at Mount Sinai West and Mount Sinai Morningside in New York. He is also director at the Skin of Color Center in New York.

Clinical Pearls

Clinical Pearls help prepare residents for the future by providing them with top tips from experts about what they should know about specific, key subject areas by the time they complete their residency.

Eczematous diseases

Andrew F. Alexis, MD, MPH

1. Broaden your color palette when assessing eczema in richly pigmented skin types (skin of color).

Looking for shades of red in the background of richly pigmented skin can result in under-diagnosis or under-appreciation of the severity of eczematous disorders in skin of color. In this population, the “erythema” may look purple/violet, reddish-brown, or gray-brown.

References:

1. Kaufman BP, Guttman-Yassky E, Alexis AF. Atopic dermatitis in diverse racial and ethnic groups-Variations in epidemiology, genetics, clinical presentation and treatment. *Exp Dermatol*. 2018 Apr;27(4):340-357.

2. Calibrate your eyes when assessing erythema in higher skin phototypes.

To better assess the severity of erythema in skin of color (particularly in Fitzpatrick skin phototypes V and VI), I recommend “calibrating” your eyes by first assessing non-lesional skin and then comparing it to lesional skin. Taking a “delta” of the color differences helps to better appreciate the severity of erythema or hyperchromia in clinically active areas.

References:

1. Kaufman BP, Guttman-Yassky E, Alexis AF. Atopic dermatitis in diverse racial and ethnic groups-Variations in epidemiology, genetics, clinical presentation and treatment. *Exp Dermatol*. 2018 Apr;27(4):340-357.

3. When treating seborrheic dermatitis in women of African ancestry (whose natural hair is Afro-textured) be sure to design a regimen that is compatible with the patient’s hair care practices.

Due to structural differences in the hair shaft as well as practical considerations pertaining to the length of time involved in hair washing and subsequent styling, hair washing frequency among black women tends to be less than in individuals with naturally straight hair (e.g. once weekly or once every two weeks on average). More frequent hair washing is not only time consuming and often impractical, but can also lead to hair dryness and fragility — especially with medicated shampoos typically prescribed for seborrheic dermatitis. Therefore, in my experience, recommending a medicated shampoo once weekly and then asking the patient if that frequency works well for them is a culturally sensitive way to approach this. Then,

prescribing a “leave on” topical corticosteroid in a vehicle that the patient finds acceptable is important for treatment as needed throughout the week.

References:

1. Elgash M, Dlova N, Ogunleye T, Taylor SC. Seborrheic Dermatitis in Skin of Color: Clinical Considerations. *J Drugs Dermatol*. 2019 Jan 1;18(1):24-27.

4. Seborrheic dermatitis in skin of color can present with hypopigmented patches without visible scale.

Recognizing this sometimes subtle presentation is important. I like to differentiate it from vitiligo with a Wood’s light during the initial examination. Looking for hypopigmentation in the typical seborrheic areas of the face including the palpebral area and medial cheeks is helpful when presented with a patient who complains of dry or sensitive skin on the face (including those that may report flaring after using topical retinoids or benzoyl peroxide agents for acne). The scale may be masked by moisturizers or simply not present at the time of clinical presentation, and erythema may not be seen. Treatment with topical calcineurin inhibitors or the topical PDE4 inhibitor crisaborole for 8-12 weeks typically results in resolution of the pigment change. Topical antifungal creams can be used as an alternative if the above are not covered.

References:

1. Elgash M, Dlova N, Ogunleye T, Taylor SC. Seborrheic Dermatitis in Skin of Color: Clinical Considerations. *J Drugs Dermatol*. 2019 Jan 1;18(1):24-27.

5. Sensitivities to specific contact allergens can vary in frequency by race or ethnicity.

This is likely due to differences in culturally determined exposure patterns rather than genetic differences. In a study from the North American Contact Dermatitis Group, positive patch tests to p-phenylenediamine occurred in 7.0% of blacks vs 4.4% in whites ($P < 0.001$), whereas positive patch tests to fragrances occurred in 12.12% of whites vs 6.77% of blacks ($P < 0.0001$). Other significant differences were found between groups.

References:

1. Deleo VA, Alexis A, Warshaw EM, Sasseville D, Maibach HI, DeKoven J, Zug KA, Belsito DV, Fowler JF Jr, Marks JG, Mathias CG, Pratt MD, Rietschel RL, Storrs FJ, Taylor JS, Zirwas M. The Association of Race/Ethnicity and Patch Test Results: North American Contact Dermatitis Group, 1998-2006. *Dermatitis*. 2016 Sep-Oct;27(5):288-92. **DR**



If you have suggestions for topics or content for Clinical Pearls, contact Dean Monti at dmonti@aad.org

Advocacy, legislative opportunities for residents

The AAD encourages residents get involved in their state or local dermatology society as a way to connect and network with fellow dermatologists in their area. Beth Laws, director of advocacy and policy operations for the AADA, reminds residents that all state and local dermatology societies have an AAD/A Advisory Board representative. *“Currently there are 66 members from all over the country serving as Advisory Board representatives,”* she said. *“It’s a great way for residents get involved in the Academy with a tie to boots on the ground in their local areas.”*

The AADA Legislative Conference typically takes place annually in Washington, D.C. Due to the COVID-19 public health emergency, the 2020 conference was held virtually. All U.S.-based AADA members are welcome to participate, even if they haven’t participated in the conference previously. In 2020, the AAD had 60 residents participate in its virtual Legislative Conference — its highest attendance ever.

One of the 2020 Legislative Conference attendees was Greg Bourgeois, MD, a Birmingham, Alabama dermatologist and member of the AAD Young Physicians Committee. *“I highly encourage attending the Legislative Conference where you will see your Academy at work for dermatology,”* Dr. Bourgeois said. *“Besides getting a chance to meet and reconnect with colleagues in dermatology, you see how our specialty unites as one as we speak on behalf of our patients to the federal government.”* Dr. Bourgeois said he particularly enjoyed seeing how engaged AADA legislative staff is in Washington, D.C. *“They bring you into their process of advocacy to promote not only dermatology but all of medicine to our legislators,”* he said. *“The AADA Legislative Conference is a great way to become more involved as their work continues even beyond the conference itself — and they need us to help continue this work.”* DR

AADA Legislative Conference information



[www.aad.org/
member/advocacy/
leg-conference](http://www.aad.org/member/advocacy/leg-conference)

Resident Life

Speaking didactics

Jordan Parker, MD (PGY-2, SIU Dermatology)

It is easy, especially during this time of restricted social interaction, to stagnate in the doldrums of didactics. Learning becomes “just another thing” on the already mountainous pile of things, a hurdle to overcome even when our minds are sluggish and tired from the marathon of day-to-day life. At SIU Dermatology, however, variety is the centerpiece of medical dermatology curriculum.

Didactic learning is reserved for Wednesday and Friday afternoons at SIU Dermatology, but it never looks the same from week-to-week. There is always some form of “Visual Recognition Conference,” also called “digies” or “kodachromes,” in which residents develop differential diagnoses from dermatologic photos, and reading review, in which we discuss assigned chapters from *Dermatology* by Bologna, Schaffer, and Cerroni. These lectures vary, however, in their location (we love being outside!), presenter, and, overall format based upon who is leading the discussion that week. Once a month we have Grand Rounds, where we discuss challenging patient cases with local dermatologists, and Melanoma Multidisciplinary Conference, where we discuss complex melanoma patients with our oncology, plastic surgery, and ENT colleagues. Twice monthly we review new and innovative literature from both dermatology and non-dermatology journals in our divisional Journal Club. Peppered throughout the month, we have unique and varied lectures and white-board discussions led by faculty on medical dermatology, dermatologic



Can didactics can make the great outdoors even greater? Just ask these residents studying at SIU Dermatology!

surgery, and interactive dermatopathology sessions. We particularly enjoy our strong, structured dermatopathology and dermatologic surgery curriculum. Most recently, we have added a monthly alternating dermatoehtics curriculum, where we discuss ethical issues facing the contemporary dermatologist, and HEAL (Health, Equity, and Antiracism Learning), a curriculum designed by our program director to create culturally competent and empathetic residents and dermatologists.

As a whole, the varied curriculum at SIU Dermatology not only helps break up the predictable routine of didactic learning, but it appeals to a wide range of learning styles to ensure that residents obtain a strong education in dermatology. DR



Dr. Parker thanks Brittany Blaise, MD (PGY-4, SIU Dermatology) for her input on this Resident Life piece.

What’s happening in your residency program?



Send your recent accomplishments to Dean Monti at dmonti@aad.org.

Inside this Issue



Rachel Wheatley, MD,

is incoming PGY-4
chief resident at
Harbor-UCLA Medical
Center in Torrance,
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**Janice E. Ma,
MD**

is a PGY-3
dermatology resident,
at Harbor-UCLA
Medical Center in
Torrance, California.

As dermatology trainees we get to work daily with our co-residents, and if you're as lucky as me, you also get to call them your friends. In fact, throughout our entire educational journey, we have had social, emotional, and professional support systems built into our lives via our peers. As I finish my last month of being on consults, I have noticed a sudden sense of nostalgia walking through the hospital and seeing familiar faces that have shaped me into the physician that I am today. This year will be the last year that I have a "built in" community of co-residents to lean on to query about a challenging patient or vent to after a tough day. Though I feel excited to start practicing independently, I feel sad that my residency buddies won't be on the other side of the office divider. In this issue, we discuss strategies to stay involved in the AAD after graduation. Fortunately, we are living in an era that — despite a global pandemic — we are able to connect, stay involved, and lean on colleagues across the nation, near and far. Personally, I do not want to be the type of physician who becomes stagnant following training, once beyond the daily educational opportunities that residency provides. Luckily, the AAD provides opportunities for mentorship, education, and outreach both during and after graduation, discussed in this issue's story "The journey goes on — staying involved after residency." Let's all challenge ourselves to think of residency graduation not as the end, but as the beginning of a lifelong expedition of learning, service, and community involvement.

- Rachel Wheatley, MD DR

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DermWorld
directions in residency

Winter 2020

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