RESIDENT DREAM

Dermatology Residents Education And Motivation Bulletin

Dec 2015, Vol.2, No.3 *A newsletter for IADVL Residents*

In Retrospect…

The end always shows us a new beginning

It has been 2 years since the conception of Resi-DREAM, the brain-child of Dr. Rashmi Sarkar. Today, as we look back at the fond memories, we thank residents from all over the country for their invaluable suggestions, constructive criticisms, well-written articles and enthusiastic reviews – all of which have immensely helped in the evolution of Resi-DREAM. The primary aim of this newsletter was to provide a platform for the residents to showcase their academic writing skills, express their opinions, share views and also, interact with the stalwarts of dermatology. The feedback we received on various exam-related topics and candid interviews over the past five issues has been truly heart-warming. As we bring to you the sixth and final issue of Resi-DREAM under the secretaryship of Dr. Rashmi Sarkar, we hope that its journey continues and a fresh bunch of eager residents will come forward to take its responsibility.

In this issue, we have interesting case reports by Dr. Monali Pattnaik and Dr. Aseem Sharma. Dr. Ramya Nagraj shares with us a well-drafted quiz. A few of the brightest residents of India to have received scholarships for international conferences guide us on how to apply for them. We thank Dr. Amita Sharma, Dr. Sneha Gandhi and Dr. Teena Ramesh for sharing their experiences. Dr. M. Ramam, the current editor-in-chief of IJDVL, spills the secrets of how to write a research paper and get it published, in an elaborate interview with Dr. Ishad Aggarwal. Like in our previous issues, we have included an exam-oriented topic 'Approach to a case of leg ulcer' and we thank Dr. Sumit Sen and his student Dr. Pranshu Mishra for the same. Dr. Deepak Parikh and Dr. Rashmi Sarkar share their experiences of the past 2 years with us. We also have a fun write-up by Dr. Venkataram Mysore, where he helps us break the monotony of academics.

Finally, we invite all of you to be a part of Residents' session at Dermacon 2016, Coimbatore on 24th Jan at 1130 hrs, where we shall try to facilitate an interaction between you and eminent faculty members.

Signing off,
Dr. Anupam Das
Dr. Jimish Bagadia

CONTENTS

An Interview with PROFESSOR RAMAM

How To Write A Research Paper?

Professor, Dermatology, AIIMS, New Delhi
Editor, IJDVL

Sir, residency is the time when most of us are initiated into writing a research paper, as a novice what are the basic constructs of writing a good research paper?

Choose a topic that is likely to be of interest to other dermatologists. Collect enough evidence for the statements you make. It is important to recognise that the level of proof required for publication is higher than that necessary for routine clinical practice. Take good pictures.

The most tedious task in writing a research paper is the literature search, what are tenets one should follow while searching the vast sea of medical literature?

This task has become easier with the availability of electronic databases such as PubMed. Pick those articles that are relevant to your study and make sure that you report the results of previous work accurately. A hurdle may be that an article that is directly related to your manuscript is only available on payment. In such cases, you can seek the help of people who may have access to the article. Acad-IADVL is a good forum for such requests. Sometimes, writing to the corresponding author helps.

We feel totally out of our depths when it comes to statistics, a lot of papers that we read are full of jargons and terms we can barely comprehend, so where do we start learning them?

Most papers that are written well have clear and simple messages that can be easily understood. If you are reading a paper in a subject you know something about but are unable to comprehend the author's point, the fault is very likely to lie with the paper and not with you. For most statistical terms, simple definitions and explanations are available on the internet and one can consult these sources if there is particular difficulty in following a paper.

As an editor, what qualities do you look for in a paper before accepting it for publications?

We are looking for novelty and originality, something that will provide our readers information that they don't already have or cannot easily access. Since our specialty is such a visual one, we expect articles to have good images that illustrate the point being made. We also want the article to be written well so that the message is clear and easily understood.

How do we select a journal to submit our manuscript to?

Send your article to a journal where you have read other articles of the same kind. This ensures that your article will be of interest to both the editorial team and the readers of the journal. When there are many journals which fit the bill, it is usual to start with the more prestigious journals and work one's way down till the manuscript is accepted. Sometimes, the audience you are hoping to reach may be a consideration in choosing a journal. Publishing in a journal that allows free, full text access increases the visibility of your work. It is nice to be able to publish in a journal that does not have any author fees. Avoid journals that promise rapid review and publication for a fee; they are almost certainly not academically sound publications.

How important is the abstract and what are the essential things one should bear in mind while writing an abstract?

Usually, every journal provides fairly detailed instructions on how to write an abstract. It is a good idea to follow the instructions to the letter. One common error in writing abstracts is to provide a long introduction of the subject followed by a sentence or two stating what the manuscript will be about. In fact, the abstract should be a brief summary of the content of the manuscript with a short introductory and closing sentence.

Sir how can young dermatologists become part of IJDVL? Are there any Resident's activities by IJDVL?

Let the editorial team know that you would like to do journal work. When an opportunity arises, they will contact you.

What inspired you to be a thorough academician and publish?

My seniors and teachers encouraged me to write papers and helped me with my early attempts. Getting published was gratifying and made me want to publish more. One of my teachers told me that one should write when one has something to say that is of value, not merely to have a publication and this is an important lesson to keep in mind. However, don't wait till you have the perfect case or the perfect study before publishing. Get started on something and keep at it. Be prepared for questions, comments, criticisms, delays and rejections. These are a part of every medical writer's life.

Which section of research paper should be written first? Should one go by an order?

It is best to start with the sections that one knows the most about: materials and methods and results. These sections are relatively easy to write. Younger authors may need guidance with the discussion section where the results have to be put in the context of already existing information and its significance explained. Introduction should be brief and rarely exceed one or two paragraphs. It should indicate why the study was conducted or why a case is being reported. Writing a thesis is very different from writing a paper and this is something that new authors should keep in mind. Only relevant analyses and tables and graphs should be included in a paper.

What are common mistakes people make while writing a paper?

Copying sentences and paragraphs from other articles. Going on and on about how the case is the first or third or fifteenth report in the world, or India or a geographical region or subdivision. Believing that co-existence of two conditions amounts to an association. Believing that if one thing happens after another, the first thing is the cause of the second. Not taking into consideration other likely explanations for a change that has been noticed whether this is improvement in a disease or an event following exposure to a drug or disease. Making broad and sweeping generalizations from an insufficient base of data or cases. Using suboptimal pictures. Exaggerating positive results and downplaying negative findings.

Interviewed by - Ishad Aggarwal, Senior Resident, Dermatology, IPGMER and SSKM Hospital, Kolkata

APPROACH TO A CASE OF CHRONIC LEG ULCER

Dr. Pranshu Mishra, PG-3, Dermatology, IPGMER and SSKM Hospital, Kolkata

Dr. Sumit Sen, Professor, Dermatology, IPGMER and SSKM Hospital, Kolkata

Chronic leg ulcer (CLU) is defined as defect in the skin below the level of knee that shows no tendency to heal after 3 months of appropriate treatment or are still not fully healed at 12 months.Venous ulcers are the most common type of leg ulcers, accounting for approximately 70% of cases. Arterial disease accounts for another 5% to 10% of leg ulcers; most of the others are due to either neuropathy (usually diabetic) or a combination of those diseases.

STEP 1: HISTORY

(1) History of ulcer development

Mode of onset :-

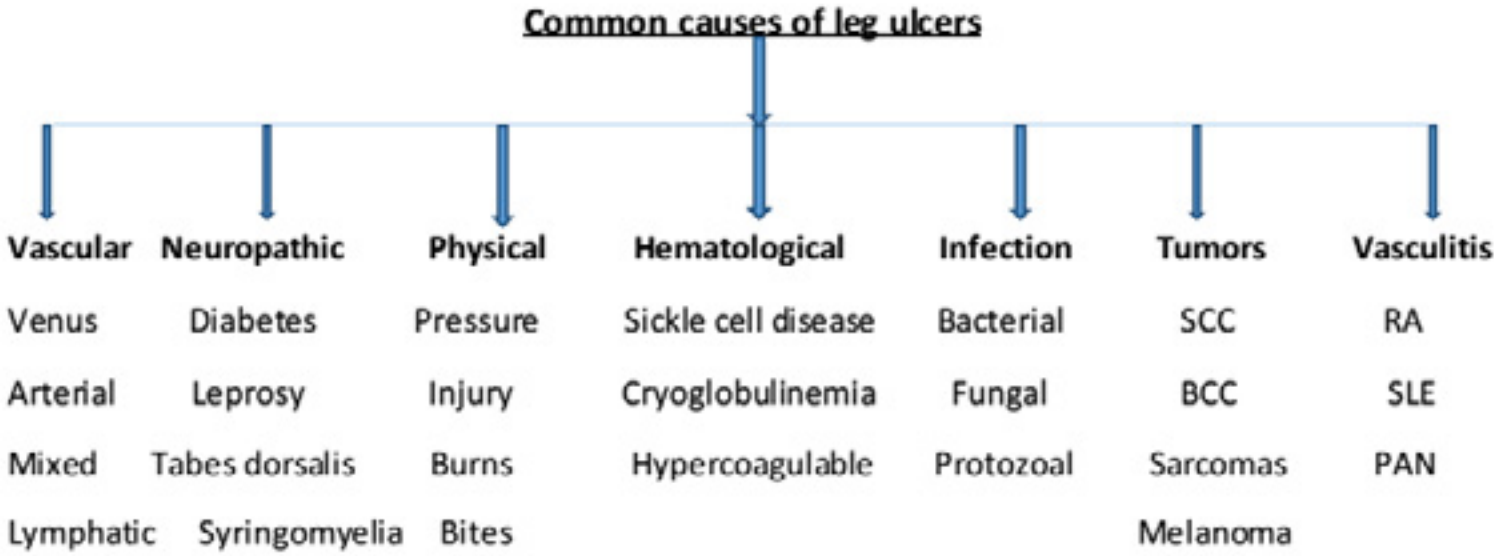
H/o trauma, burn ,bite – points towards physical causes of ulcer

H/o origin of ulcer in exuberant,moist,malodorus callus (mal perforans) in diabetic ulcers.

Duration :- Malignant ulcers run a chronic course.

Recurrence :- May be seen in vascular and neuropathic ulcers.

Pain :- Very important clue to diagnosis as venous, neuropathic and neoplastic ulcers are usually painless unless invading underlying structures. While Arterial ulcers and inflammatory ulcers due to vasculitis, pyoderma gangrenosum etc. are



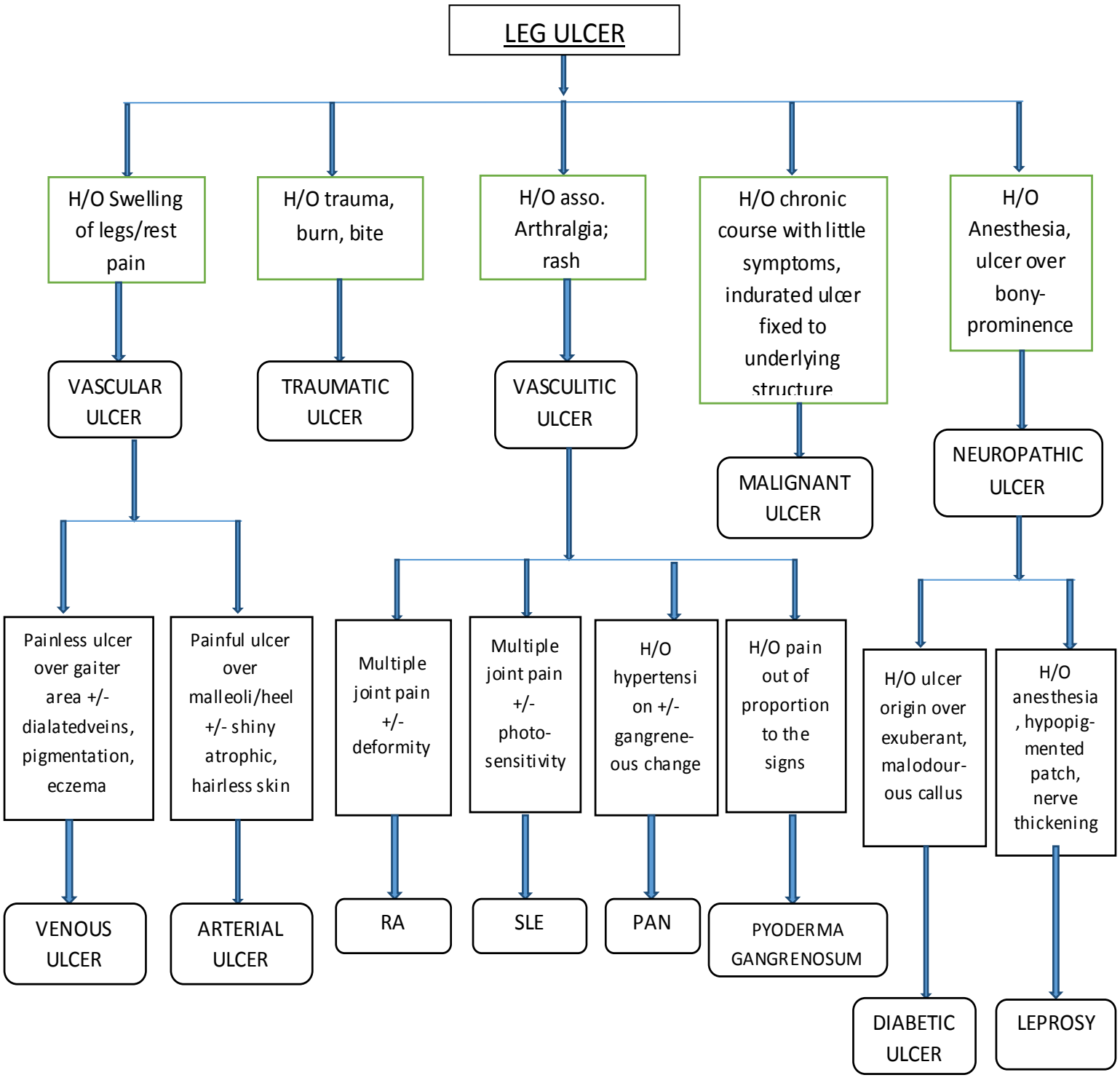
painful.

H/o anesthesia or paresthesia- If present neuropathic causes of ulcer must be excluded.

H/o foul smell and discharge of grains :- Points to infective etiology mostly deep fungal and bacterial infection.

Aggravating and relieving factors :- H/o swelling and aching of legs worsened by dependency but improving on limb elevation or walking is very typical of venous ulcers. While leg pain induced by ambulation and relieved by resting (intermittent claudication) is the earliest and most common presenting symptom of arterial ulcers. However in later stage patient may complain of pain even at rest.

H/o Previous interventions/Treatment :- Helps in establishing diagnosis and formulating the line of treatment.



(2) History of Past and current medical problems :- as they play a very crucial role in not only the etiology of ulcer but also its prognosis and treatment response. Special emphasis should be given to diseases like diabetes mellitus, hypertension, peripheral arterial disease, leprosy, connetive tissue diease and tuberculosis.

Personal history:-

Occupation – those in jobs requiring prolonged standing are specially prone to develop venous ulcers. Farmers are those who work bare-footed are more prone to trauma and deep fungal infections.

H/O recurrent/spontaneous abortions - gives clue to hypercoagulable state specially Antiphospholipid antibody syndrome.

H/o Addiction- like smoking , i.v. drug abuse, alcoholism must be taken. Smoking is an important factor in precipitating peripheral arterial diseases specially Buerger's disease.

STEP 2 : CLINICAL EXAMINATION

(1)GENERAL ASSESSMENT OF PATIENT- Obese, old , malnourished patients with poor hygiene do not respond well to treatment. So these factors must be identified and managed.

GENERAL SURVEY

Pallor, icterus, clubbing-if present cause must be identified and treated

Edema– Pitting or non- pitting if present gives clue to diagnosis.

Lymph nodes- Suspected tuberculosis and malignancy.

Blood pressure (both brachial and ankle)- Must be measured as it not only gives clue to diagnosis but is also crucial while deciding the treatment modalities like compression therapy.

(2) EXAMINATION OF LIMBS–

Temperature :- Cold extremities point towards arterial disease while raised temperature usually seen in infective and venous ulcers.

Tenderness :- An acutely inflamed ulcer is exquisitely tender. Chronic ulcers are slightly tender. Neoplastic ulcers are never tender

Signs of venous hypertension- varicose veins, hemosiderin pigmentation, eczema , atrophie blanche and lipodermatosclerosis as they indicate venous congestion. But cold pale limb with shiny, atrophic, hairless skin or presence of gangrene indicate arterial disease.

Examine Peripheral pulses:- In every case of leg ulcer, presence of pulse in four peripheral arteries i.e Femoral, Popliteal , Posterior tibial and Arteria dorsalis pedis must be seen to rule out peripheral vascular disease.

Test for sensation :- Anesthesia , paresthesia - neuropathic cause of leg ulcers to be investigated.

Vasculitic lesions: - Ulcer with associated lesions like petechiae, purpure indicate ulcer due to vasculitis so underlying etiology

Table 1: Examination of an Ulcer

FEATURES	VENOUS	ARTERIAL	NEURO-TROPHIC	TRAUMAT-IC	MALIG-NANT
SITE	Gaiter area 70%, lateral 20%, circumferen-tial 5%	Malleoli, heel, meta-tarsal heads, 5TH MT base	Pressure areas & bony promi-nences- Metatar-sal head, great toe & heels	Site of trau-ma	Variable
SIZE/ SHAPE	Large shallow ver-tically oval	Small, deep round	Variable	Variable	Variable
MARGIN	Irregular	Regular	Regular	Variable	Variable
EDGE	Sloping	Punched out or Sharply demarcated	Punched out	Sloping	Everted/ rolled
FLOOR	Granulation	Slough/ ne-crotic	Slough	Variable Usually dirty, yellowish slough	Black mass
BASE	No indura-tion	No induration	No induration	No indura-tion	Indurated
DEPTH	Shallow	Deep	Deep up to bone	variable	Shallow/ variable
TENDER-NESS	Painless	Painful	Painless	Painful	Painless
SUR-ROUND-ING SKIN	Edema,ecze-ma, pigmen-tation, atro-phie blanche and varicose vein	Thin skin, decreased hair growth brittle nails	Callus; loss of sensation	Cellulitis	Fixed to underlying structure
LYMPH NODE	Absent	Absent	Absent	Absent	Usually present

must be looked accordingly.

Deformity: - Certain deformities may give some clue for diagnosis like-

Hallux valgus - Rheumatoid arthritis

Foot drop- leprosy

Hammer toes, claw toes, high or flattened arch (Charcot foot) – Diabetes mellitus

Restriction of movement: - If present due to any cause can lead to pressure ulcers, so must be excluded.

STEP 3 : INVESTIGATIONS

1. Blood investigations - such as complete

Table 2: TIME SCORE- Wound assessment (2003)

WOUND SCORE	0	1	2	3
T- presence of necrotic tissue	0%	30%	60%	90%
I-presence if inflammation/ infection	Absent	Contamination	Colonisation	Infection
M- presence of maceration	Absent	Little exudate	Much exudate	Smelly exudate
E- absence of epidermis re-construction	0%	30%	60%	90%

Table 3: General Condition of the patient

General condition	0	1
Mental state	Good	Poor
Self- sufficiency	Adequate	Very poor
Nutrition	Good	Poor
Age in years	<70	>70
Predisposing disease	Absent	Present

TIME Score + General Condition Score = *TIME-H SCORE (Healing score 2007)*

Table 4: Time H-Score Interpretation

TIME-H SCORE	OUTCOME
0-6	Certain healing
7-12	Uncertain healing
13-17	Difficult healing

blood count, coagulation profile , erythrocyte sedimentation rate, blood sugar, lipid profile, renal function tests, and liver function tests

2. Plain radiography of the foot along with CT and MRI to exclude osteomyelitis and malignancy.

3. Special tests– like urine analysis, antinuclear antibodies, rheumatoid factor, complement C4, circulating immune complexes if connective disease or vasculitis is suspected.

4. Tests for vascular assessment-

a) Doppler measurement of ankle/brachial pressure index :- If less than 0.8, indicates arterial insufficiency.

b) Color flow Doppler imaging:- Assessment of venous system of lower limb.

5. Biopsy:- Atypical ulcer or those not responding to active treatment even after 12 weeks

6. Bacteriological evaluation:- If clinical evidence of infection present OR if there is rapid deterioration of ulcer, pyrexia and foul odor.

7. Gene variant analysis :- rarely required

STEP 4 : TREATMENT

1. Cleaning, debridement and dressing
2. Topical antimicrobials and antiseptics
3. Systemic antibiotics
4. Compression therapy – Multilayered high compression system with adequate padding
5. Supportive therapy – Analgesics, Pentoxifylline 1200-2400 mg along with compression, GM-CSF topical & perilesional injections, calf muscle exercises, Proper

nutrition & psychological support

6. Surgery:- Surgical ablation of incompetent superficial veins

7. Sclerotherapy: - Done for superficial varicosities and incompetent perforators.

Newer modalities:-

1. Endovascular laser therapy
2. Antimicrobial photodyanamic therapy
3. Platelet rich plasma
4. Spray formulation of allogeneic neonatal keratinocytes and fibroblasts
5. Vegetal biomembrane dressing extracted from Hevea brasiliensis
6. Becaplermin :- PDGF for neuropathic ulcers.
7. Composite graft - Apligraf

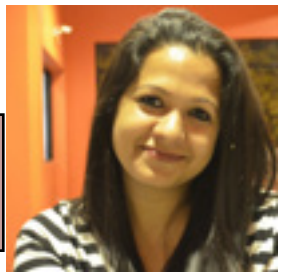
Prevention of ulcer recurrence:-

By proper patient education regarding skin care , elevation of limb when immobile, compliance of compression therapy and exercise. Along with this proper management of associated diseases and comorbidities like obesity should be done to achieve faster cure.

DERMATOLOGY SCHOLARSHIPS: MY EXPERIENCE

International Summer Academy, Munich

Amita Sharma, PG-3 Burdwan Medical College, West Bengal



ISA Munich happened to me as one of the most beautiful experiences of my life. My first international trip- from travel to conference and back! For this, all I had to do were two things, which were both interesting and fun! First, was to keep a good and helpful attitude towards my colleagues and second, was to keep surfing the internet!

The first information regarding ISA was given to me by my very good friend and co-PG Surajit. Everything else was very easily available on the internet and any doubts regarding the scholarship process could be cleared via emails to the IDs provided on their website. I had to apply with my CV and a one page write up on the reasons for my interest in the conference.

The results came out a few months later and the selected candidates were awarded scholarships that included free registration and 400 euros in cash. Along with that a chance to submit abstracts was also given. Luckily my abstract was selected too, which gave me one of the biggest opportunities I have ever got!

Giving my presentation in front of a foreign audience and being addressed as “Amita Sharma from India” was both an exciting and a proud moment. Apart from Munich, I also travelled to a few more places and collected awesome memories, experience, a feeling of self confidence and the beautiful sense of being independent. But with that, I realized the importance of my family, friends and Indian food!

If one asks me what was the best moment in this whole trip? l would say, when the announcement was made that “your flight has landed at the Mumbai Chhatrapati Shivaji International Terminal”, because east or west, my India is the best!!

IADVL Academy of Dermatology Scholarship-SARCD 2015

Sneha Gandhi, PG-2 J.J.M. Medical College, Davangere, Karnataka

I was awarded the IADVL scholarship for my original study on vitiligo at SARCD 2015. A few weeks before the conference I received a mail that informed me of this golden opportunity- A chance to win the scholarship offered by the IADVL academy of dermatology.

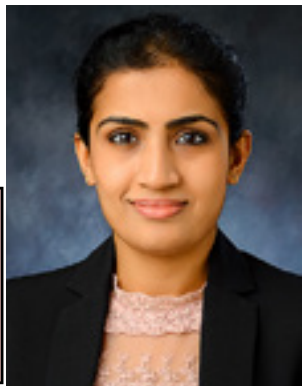
All that was required of me was to send a mail that contained a brief abstract of my work, CV and a bonafide certificate from the head of my department. A simple and easy mail from my end was all that was needed and a few weeks later I received a confirmatory mail congratulating me and 35 other post graduates on winning the scholarship.

Scholarships instill a sense of achievement at any stage but when we post graduates receive such a prestigious scholarship at this stage, when we are just beginning our journey reaffirms our beliefs and re-strengthens our dedication and the efforts we make to achieve our aspirations.

I humbly thank IADVL for this initiative of providing a platform of showcasing our work that is within everyone's reach.

IADVL World Congress of Dermatology Scholarship - 2015

Dr. Teena Ramesh Mathanda, Consultant Dermatologist, Dr. Shetty's Aesthetics, Bangalore, Karnataka.



I had the golden opportunity to attend the 23rd World Congress of Dermatology at Vancouver, Canada and this was facilitated with the help of the IADVL-WCD scholarship. Two of my abstracts were chosen for presentation and it was received well. I hope this summary of my experience will help residents through the process of applying for scholarships to attend international conferences.

It was, as a matter of fact a combination of the right set of circumstances that paved the way for my travel and my magic formula included a great mentor like Dr. Ramesh Bhat, who guided me through the process, my interest in publication, presentation and research work, love for travel, some very good luck and of course, support from my parents.

Most conferences have some scholarship funds allotted for residents and young doctors from developing countries and they have the prerequisites listed in the website and it's always worth applying. The chances of securing it improve with a good letter of intent and acceptance of abstracts for presentation. Scholarships and grants are also given by IADVL, and presentations in the state and national conferences certainly improve the odds of receiving the scholarship.

Vancouver is a beautiful seaport surrounded by mountains, and it felt like I was living inside a landscape postcard. A number of outdoor activities, museums and art galleries, and great seafood made my visit worthwhile. But, what really inspired me was the politeness of people of Vancouver, any conversation with them felt like a musical and also their importance to fitness and outdoor pursuits.

Conferences not only keep one updated about the recent advances in dermatology, but it also gives an opportunity to travel and explore new places. And the experience can only be sweetened with an added scholarship grant.

The 24th World Congress of Dermatology is going to be held at Milan, Italy and that should certainly inspire residents to start working on their papers and applications.

A RARE CASE OF MONILETHRIX ASSOCIATED WITH KERATOSIS PILARIS

Authors: Dr Aseem Sharma[a], Surg Capt Rahul Ray,VSM[b],Dr Aditi Bhagat[a], Surg Cdr Ramesh Rao[c]

a-Resident, Department of Dermatology; *b*-Consultant & HOD Dermatology, Venereology and Leprosy; *c*-Classified Specialist Pathology, INHS Asvini

Dr. Aseem Sharma

ABSTRACT

Monilethrix is a rare hair shaft disorder with structural defect resulting in increased fragility of hair with beading and patchy, dystrophic alopecia. It is usually transmitted in an autosomal dominant pattern.[1] Affected individuals usually have normal appearing hair at birth, which is soon replaced by short, fragile and brittle hair. Perifollicular erythema and follicular hyperkeratosis are commonly observed. Trichoscopy shows elliptical nodes of normal thickness separated by abnormal constrictions resulting from defective cortical cell keratinisation.[2] Despite advances in the field of hair shaft disorders, this condition shows poor response to treatment.We report a young boy who presented to our outpatient department.

CASE REPORT

21 year old male, borne out of a non-consangineous marriage, with no known comorbidities, hailing from Maharashtra, presented with a history of rough, dry, brown and brittle hair of more than 15 years duration. He gave history of rough sand-paper like eruptions over the back of his neck, armpits and extensor aspects of his elbows and knees of 10 years duration. He further gave historic evidence of patchy baldness predominantly over the back of

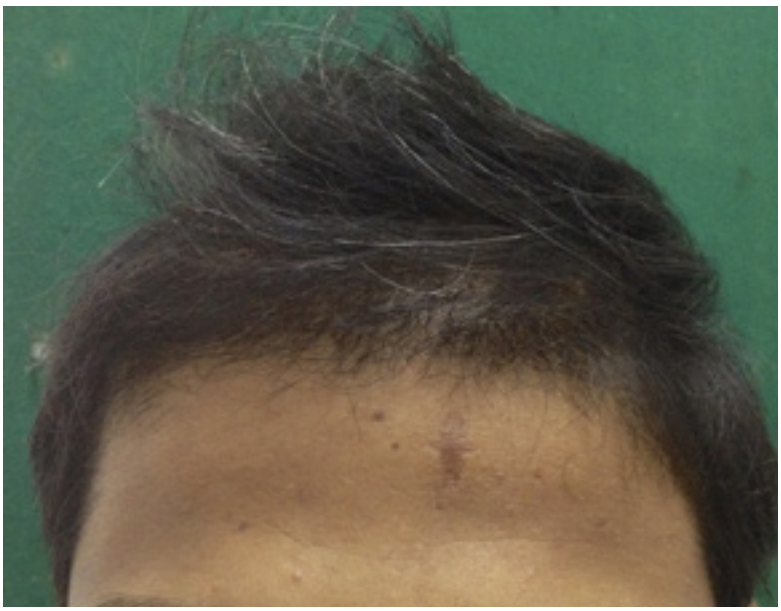


Figure-1 Depigmented, wispy hair shafts.

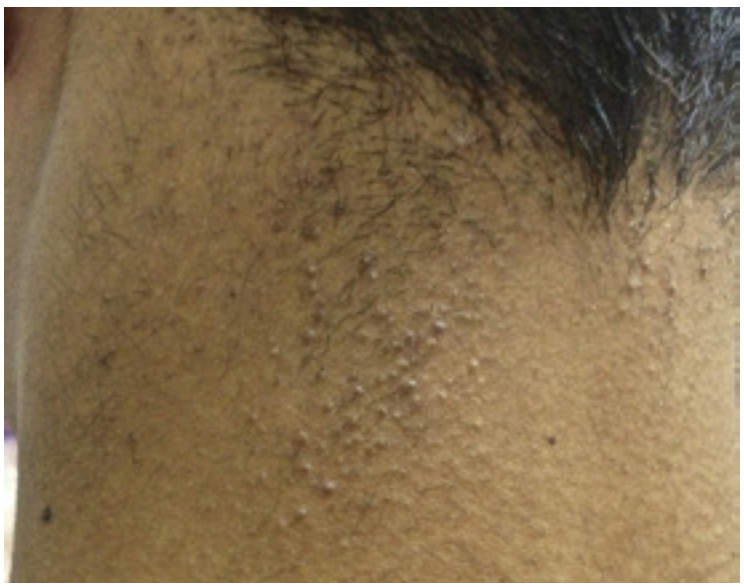


Figure-2 Follicular accentuation with peri-follicular thickening; Keratosis pilaris

his head of 5 years duration, progressing to involve entire scalp over the past few months.

He denied history suggestive of nail changes, diminution of vision, supernumerary digits, tooth defects or generalized rashes. He further denied contact with chemicals, topical medicaments or recent trauma. There was no past or family history suggestive of an atopic diathesis. There was no historic evidence of a similar occurrence in his extended family upto two generations.

General and systemic examinations were essentially within normal limits. Cutaneous examination revealed depigmented, dry, wispy and fragile hair shafts (Figure-1). There was clinical evidence of diffuse alopecia over the scalp. Similar hair characteristics were noted over bilateral axillae and the pubic region. Palpation revealed rough, gritty texture over scalp, accentuated over the occiput. Follicular keratosis was noted over occiput, nape of neck, extensor aspect of bilateral elbows and knees (Figure-2). There was no clinical evidence of syndactyly, leukonychia or onychorrhexis. Ophthalmology and dental consultations were within normal limits.

Trichoscopy revealed multiple vellus hairs. Average length of 70% hair per field was found to be less than 2 cms. Fusiform, spindle-shaped hair with periodic bulges and nodes were visualised, repeated at every 1 mm of hair shafts with few shafts fractured at the internodes (Figure–3,4). There was no evidence of bamboo hair shafts, indentations or twisting of hair. Peripilar sign was negative. Also noted were nodose hair shafts over bilateral axillae and pubic region.

All hematological, biochemical and serological investigations were normal. Scalp biopsy from an alopecic lesion over occiput revealed non-specific changes.

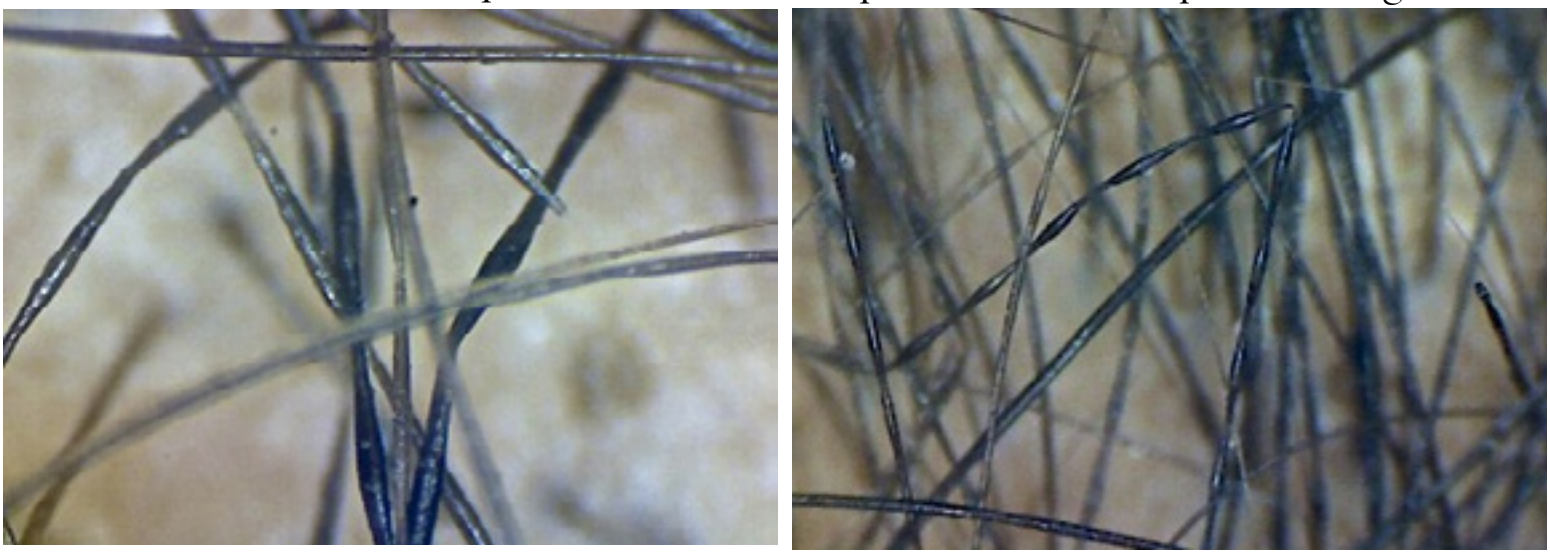


Figure-3,4 Fusiform hair with periodic bulging at every 01 mm viz nodes and internodes, with few fractured shafts.

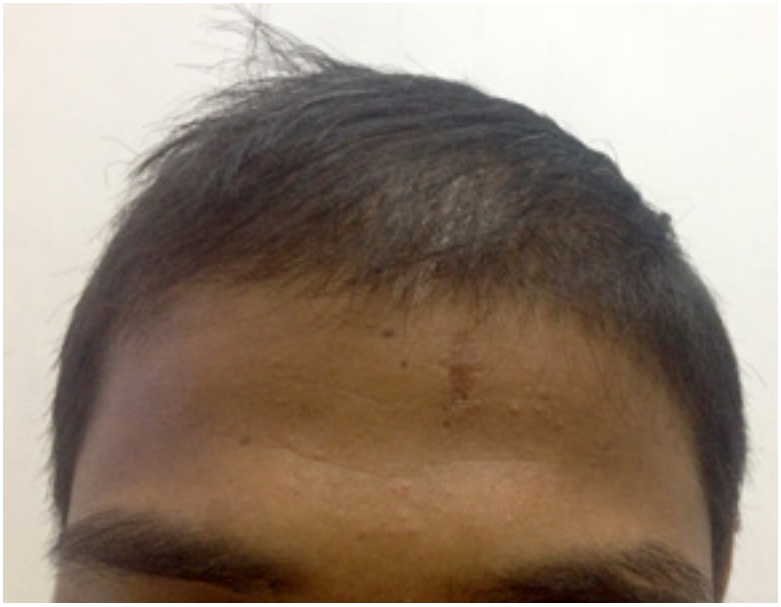


Figure-5 Review at 12 weeks showed significant improvement in texture

A diagnosis of monilethrix was made and he was started on topical 5% Minoxidil lotion twice daily and topical 0.04% tretinoin at night. Review at 12 weeks revealed a decrease in vellus hair (Figure-5) and a slight improvement in keratosis pilaris (Figure-6). The patient is being worked up for oral retinoids.

DISCUSSION

Monilethrix (Latin: Monilis = necklace, thrix = hair) synonymous with Spindlehäar or Pili Moniliformes, is a rare genodermatosis, first described by WJ Smith in 1879 as a 'nodose condition involving the hair shafts'.[3]

Monilethrix is a rare hereditary condition with variable expressivity[5,6] characterised by the presence of beaded or spindle shaped shafts of the scalp hair. Hair shaft shows beaded appearance due to

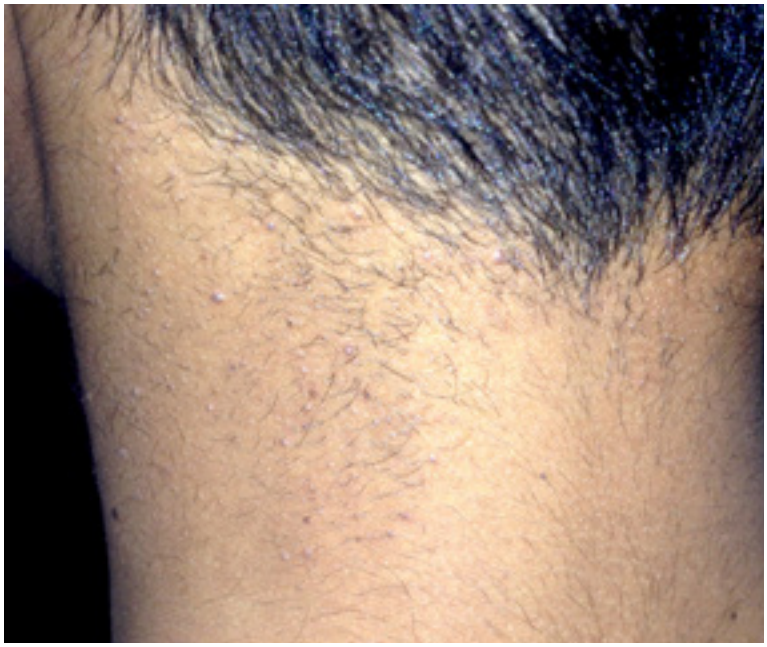


Figure-6 Flattening of keratosis pilaris

alternate zones of spindle like thickening and thinning placed about 0.7 to 1 mm apart. Swelling represents normal part of the hair, whereas the narrow part is abnormal.[4] It is usually inherited as an autosomal dominant trait and rarely can be autosomal recessive.[5]

Mutations in the human hair basic keratins hHb1 and hHb6 have been described with this disorder.[5-7] Mutations have also been documented in desmoglein protein DSG-4.[5] It shows considerable variation in age of onset, severity and course. Hair is usually normal at birth and progressively replaced by abnormal hair during the first few months of life. Hair loss is due to hair fragility and break occurs at internodal junction. Follicular papules may be seen all over the scalp, mostly on occiput and nape of the neck, where broken hair stumps are seen. In some patients, eyebrows, eye lashes, pubic hair, axillary hair and general body hair may be affected. This condition

may improve in adulthood but usually persists with little change throughout life. It is rarely associated with mental retardation, metabolic disorders, tooth and nail defects, cataract, ichthyosis, and iron-deficiency. Spontaneous remissions, post-puberty, can occur.[8]

The diagnosis is estabilished clinically; by trichoscopy and polar microscopy.[9] Other investigations to rule out associations should be done.

Treatment modalities include topical vasodilators like minoxidil[10], oral and topical retinoids[11], nutritional supplementation and avoidance of trauma, sun exposure, chemicals like dyes and bleaches, procedures like waving and curling.[12] Hair prostheses like wigs may also be used.

CONCLUSION

The aim of this article was to report a rare case of monilethrix with keratosis pilaris, and bring forth, the investigative modalities, treatment options, and response to the same.

REFERENCES

1. Vikramkumar AG, Kuruvila S, Ganguly S. Monilethrix: A rare hereditary condition. Indian J Dermatol 2013;58:243
2. Qazi MA, Iffat H, Shah P. Monilethrix. Indian J Dermatol2002;132:574-5.
3. Smith WG. A rare nodose condition of the hair. BMJ 1879; 11: 291–6.
4. Dawber RPR, Ebling FJG, Wojnarowska FT. Disorders of Hair. In : Textbook of Dermatology vol 4, 5th Ed. Edited by Champion RH, Burton JL, Ebling FJG, Blackwell Scientific Publication, Oxford, p.2607
5. Zlotogorski A, MarekD,Horev L, Abu A, Ben-Amitai D, Gerad L, et al. An autosomal recessive form of monilethrix is caused by mutations in DSG4: clinical overlap with localized autosomal recessive hypotrichosis. J Invest Dermatol. Jun 2006;126(6):1292-6.
6. Muramatsu S, Kimura T, Ueki R, Tsuboi R, Ikeda S, Ogawa H. Recurrent E413K mutation of hHb6 in a Japanese family with monilethrix. Dermatology. 2003;206(4):338-40.
7. Winter H, Vabres P, Larregue M, Rogers MA, Schweizer J. A novel missense mutation, A118E, in the helix initiation motif of the type II hair cortex keratin hHb6, causing monilethrix. Hum Hered. Sep-Oct 2000;50(5):322-4.
8. Monilethrix. Indian J Dermatol Venereol Leprol 1998;64:247-8
9. Liu CI, Hsu CH. Rapid diagnosis of monilethrix using dermoscopy. Br J Dermatol. Sep 2008;159(3):741-3
10. Rossi A, Iorio A, Scali E, et al. Monilethrix treated with Minoxidil. Int J Immunopathol Pharmacol. Jan-Mar 2011;24(1):239-42
11. Tamayo L. Monilethrix treated with the oral retinoid Ro 10–9359 (Tigason). Clin Exp Dermatol 1983; 8: 3936.
12. Genetic and Rare Diseases Information Center (2008-09-09). “Monilethrix”. NIH Office of Rare Diseases Research. Retrieved 2011-01-15.

QUIZ: FACIAL HYPERPIGMENTATION

Dr. Ramya Nagraj,
PG-3, Dermatology, Kempegowda Institute of Medical sciences, Bangalore, Karnataka

A 59 year old male presented with progressive darkening of skin on both the cheeks since 7 – 8 years, which gradually darkened and thickened over time. History of prolonged sun exposure, vigorous scrubbing using herbal leaves and use of topical agents consisting of various skin lightening agents was present. There was no other significant history.

On examination, the patient belonged to Fitzpatrick skin type 4, having bilaterally symmetrical well defined bluish-grey hyper-pigmented macules and papules coalescing to form plaques over the malar areas extending laterally up to the eyebrows and temple and medially onto the root of the nose. Lichenification was present on the upper part of the plaques along with other signs of photo aging (Fig 1 & 2).

Systemic examination was within normal limits. Skin biopsy showed sharply defined yellow-brown curvilinear shaped deposits within homogenized elastotic fibers with surrounding degeneration of elastic fibers in the superficial dermis (Fig 3 & 4). Subsequent Urine analysis and Blood investigations were within normal limits.

What is your diagnosis?

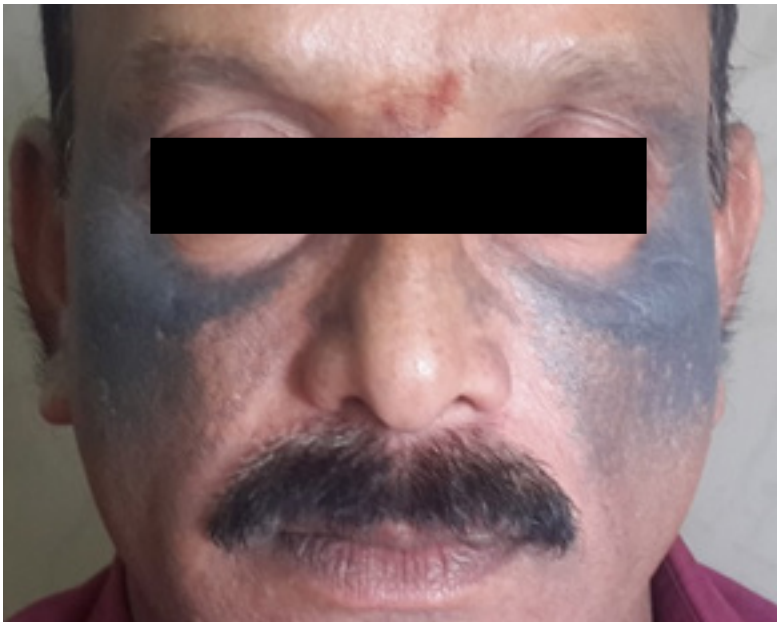


Figure-1

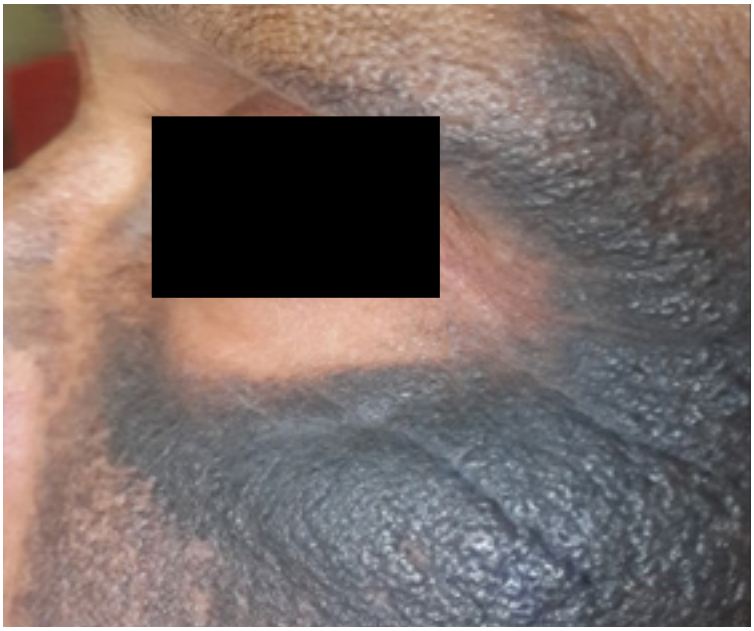


Figure-2

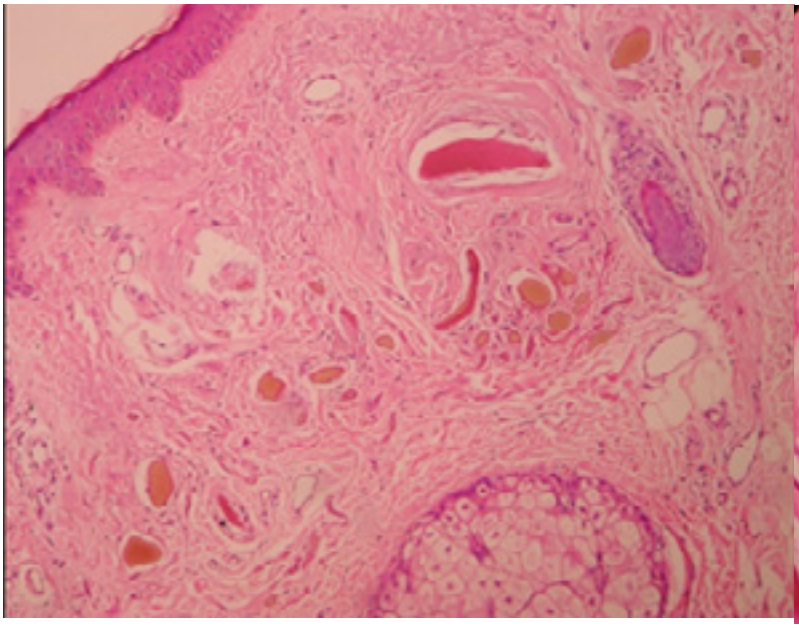


Figure-3

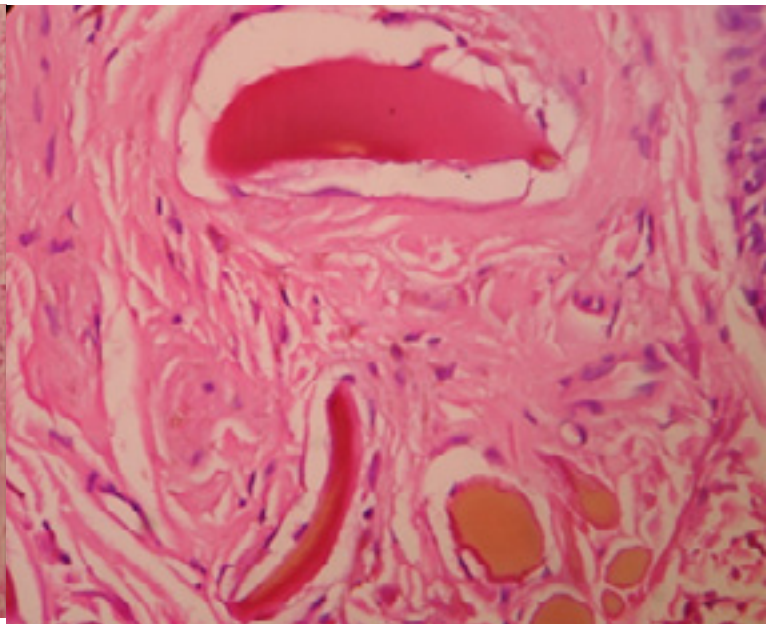


Figure-4

A: Exogenous Ochronosis

DISCUSSION

Ochronosis is a rare disease characterized histologically by banana-shaped ochre-colored deposits in the dermis.[1] It can present itself in either exogenous or endogenous form. Endogenous ochronosis or alkaptonuria is an autosomal recessive disease caused by a deficiency of homogentisic acid oxidase, which results in the accumulation of homogentisic acid, a hydroquinone metabolite of tyrosine. Homogentisic acid binds irreversibly to dermal fibrillar collagen which is said to be responsible for skin pigmentation and/or arthropathy.[2]

Exogenous ochronosis is a localized paradoxical hyperpigmentation of the skin due to prolonged use of bleaching agents containing hydroquinone and phenolic compounds. This entity was first described by Findlay et al.[3] The condition, unlike endogenous ochronosis, does not exhibit systemic involvement. Several theories were formulated in an attempt to describe the exact pathogenesis of exogenous ochronosis. The most accepted theory is Penneys', which proposes that hydroquinone inhibits the local activity of the homogentisic acid oxidase enzyme, resulting in accumulation of homogentisic acid, that is polymerized, forming the ochronotic pigment and being deposited in the dermis.[4] The ochronotic coloration most commonly results from the prolonged use of certain topical agents like hydroquinones, but it also occurs with the use of antimalarials and products containing resorcinol, phenol, mercury and picric acid.[5] The duration of use is directly proportional to the risk of developing ochronotic changes with most cases occurring after years of use. Volatile excipients, occlusive vehicles, and keratolytic agents enhance penetration of hydroquinone.

Dogliotti and Leibowitz described a staging system based on the presumed evolution of the lesions.[6]

Stage I is characterized by erythema and mild hyperpigmentation. Stage II is described as hyperpigmentation, black colloid milium and atrophy. Stage III has the addition of a papulonodular element. Stage III is further divided into inflammatory and a well circumscribed, elevated, non-inflammatory subtype.

Histology of exogenous ochronosis characteristically reveals yellow-to-brown banana-shaped fibers in the papillary dermis. Homogenization and swelling of the collagen bundles are noted and a moderate histiocytic infiltrate may be present.[4]

In addition to the presence of this ochronotic material, stage I and II lesions were also described as hyperkeratotic with thinning of the epidermis, depletion of the melanocyte population, follicular plugging and liquefaction of the basal layer. Additionally, stage III lesions showed development of sarcoid-like granulomas in focal distributions. However, the source of the sarcoidal granulomas is a topic of debate.[6]

Dermoscopy reveals brown-gray, globular, irregular-to-arciform structures with a granular appearance.[7] RCM (Reflectance Confocal Microscopy) examination describes a normal epidermis and dermoepidermal junction; however, in the dermis, diffuse, hyporefractile, oval and "banana-shaped" spaces were observed near the inferior portion of the hair follicles.[8]

When evaluating a patient with hyperpigmented lesions, there is a broad differential diagnosis to be considered, and often the diagnosis of exogenous ochronosis may only be elicited with a proper history for topical medications. In fact, many of the hyperpigmented lesions such as melasma or post-inflammatory hyperpigmentation are the inciting event for patients to begin using topical lightening agents. Histopathology is the key to differentiate between the two conditions, when in doubt.

Treatment of this condition is very difficult. The causal agent must be avoided and improvement occurs slowly. Q-switched 755 nm alexandrite laser, Q-switched ruby laser, CO2 laser, cryotherapy, trichloroacetic acid, tretinoin gel, dermabrasion have all been used for treatment with varying results.[9]

Hence, its prevention is of paramount importance, which may be possible by the usage of lower concentrations of hydroquinone, good sun protection, early diagnosis of irritation and discontinuation within 6 months even if there is no clinical

improvement. Counselling of patient and explaining the consequences of prolonged self-medication of hydroquinone should be done prior to start of therapy. There is no substitute for adequate patient education and a meticulous dermatological follow-up.

REFERENCES

1.Zawar VP, Mhaskar ST. Exogenous ochronosis following hydroquinone for melasma. J Cosmet Dermatol. 2004;3:234–6.

2.Glodsmith LA. Cutaneous changes in errors of amino acid metabolism: Alkaptonuria. In: Fitzpatrick TB, Eisen AZ, editors. Dermatology in general medicine. 6th ed. New York: McGraw- Hill; 1993. pp. 1841–5.

3.Findlay GH, Morrison JGL, Simson IW. Exogenous ochronosis and pigmented colloid milium from hydroquinone bleaching creams. Br J Dermatol. 1975;93:613–22.

4.Penneys ND. Ochronosis like pigmentation from hydroquinone bleaching creams. Arch Dermatol.1985;121:1239.

5.Engasser PG, Maibach HI. Ochronosis caused by bleaching creams. J Am Acad Dermatol.1984;10:1072–3.

6.Dogliotte M, Leibowitz M. Granulomatous ochronosis - a cosmetic-induced skin disorder in blacks. S Afr Med J. 1979;56:757-60.

7.Sunil N. Mishra, Rachita S. Dhurat, Deepal J. Deshpande, Chitra S. Nayak. Diagnostic utility of dermatoscopy in hydroquinone-induced exogenous ochronosis. Int J Dermatol. Apr 2013; 52(4): 413-417.

8.Gil I, Segura S, Martínez-Escala E, Lloreta J, Puig S, Vélez M, et al. Dermoscopic and reflectance confocal microscopic features of exogenous ochronosis. Arch Dermatol 2010;146:1021-5.

9.Levin CY, Maibach H. Exogenous ochronosis: An update on clinical features, causative agents and treatment options. Am J Clin Dermatol. 2001;2:213–7.

Recounting the last two years...

The Resi-DREAM project is the brainchild of our mentor Dr. Rashmi Sarkar and has proved to be a valuable tool in engaging the youngest members of our fraternity. Personally, the quest has been very rewarding. It opened horizons for us and we could connect to residents from across the country. I have gained many lifelong friends in our team. I hope we have done justice to the newsletter. As our guiding light, Dr. Sarkar has instilled in us a spirit of leadership, networking and looking out for each other as we initiate our baby-steps in the world of Dermatology.

- Sumit Gupta

Residream has given me a lot of things to be thankful for: a great mentor in Rashmi ma'am, invaluable friendships, indispensable advice, priceless guidance, fun moments, fame and honor and above all it has reinstated my belief in myself. On the other hand, if you ask me what have I given Residream, my answer will be - Nothing much!! (Now that's exactly the kind of relationship I love to have 😀) On a more serious note, the end still looks quite far for Residream, it has many more miles to go and brilliant young minds to tap into. I wish my successors get all the above and much more from Residream…

- Jimish Bagadia

"Fare thee well, my good friend!"

Time flies but so do ideas..that's what ResiDREAM has been all about. Ideas flying left, right and centre. What topics would be relevant for our Newsletter? What do our readers seek from us? How can we make this different from anything they have ever read? How is this issue relevant to Dermatology in India? That's how whatsapp conversations went. With each one of us pitching in from different parts of the country. And amidst all these we made time for having meaningful as well as silly conversations. Each one of us was always just a message or call away. And all this blossomed under the ever watchful guidance of Rashmi Sarkar Ma'am. She mentored us and gently nudged us along in the direction that would help us become who we are today. Each one us Residreamite has been instrumental in making ResiDREAM a success.

A big thank you to Drs Sumit Gupta, Jimish Bagadia, Sahil Mrigpuri, Indrashis Podder, Saloni Katoch, Aayushi Mehta, Gillian Britto, Anupam Das, Anuj Tenani, Zubin Mandlewala and Ishad Aggarwal. And as always - Team work makes Resi-DREAM work!

- Samujjala Deb

We are born in our families, and yet over the course of life we come across people who become close to us and thus families are formed beyond blood and flesh. Residream is one such family.

Our ever so benevolent Dr. Rashmi Sarkar mam brought us all together and wove a fine fabric of ethics, diligence, dedication and humility which binds us all together. "Terrific Twelve" as we are lovingly called by her , we are all very different , we have different outlooks , we come from geographic regions spread widely apart , yet we have worked together as one unit to bring out the "Resident- DREAM".

We have imbibed so much from one another that we are forever transformed and have a treasure box of memories and everlasting friendships. With this spirit, we hope to serve Dermatology and our nation and its people.

This isn't farewell, this is a new beginning.

- Ishad Aggarwal

"Resi-DREAM" – the terminology symbolizes exactly what it states, a dream that each and every Resident ought to have – scaling the ladder of name, fame and most importantly – academic growth. Our mentor, Dr. Rashmi Sarkar ma'am is the epitome of the aforementioned virtues, and it was her dream to instill the core values in not just us, the "Dream Team", but to each resident in every nook and corner of the country.

Through this endearing journey, we, the Residents, achieved a means to channelize our thought and ideas into action, as a team. The Newsletter was the voice of a confident, dedicated and enthusiastic team, as it was meticulously navigated and propelled through turbulent winds, by our ever-so affectionate Ma'am.

Although our professional goal is to progress towards the "church spire," we shall never forget that, we, the evolving "keratinocytes" our deeply endowed to our basal(e) roots.

-Zubin Mandlewala

"Sometimes it's the journey that teaches you a lot about your destination". Our journey began as a team of Post graduates being led and guided by a visionary who believed that we as residents could make a difference; hence commenced this beautiful journey of the Resident DREAM. A DREAM nurtured by Dr. Rashmi Sarkar comprising of the residents, by the residents and for the residents.

As I look back, I see two years of hard work, dedication, creativity, deadlines, team effort and learning. What started as a professional endeavor, gave me memories and friends for life. We as a team have done our best to bring six issues of this newsletter to our resident fraternity and I hope this venture continues to benefit post graduates in the future academically and professionally.

I have grown as an individual, imbibing from the team and our mentor. I have learnt that the courage to pursue your dreams fearlessly is what sails you through the roughest of tides. The lessons I have learnt and the values I have gained, will stay with me for the years to come. I would like to thank Dr. Rashmi Sarkar and my team mates for always inspiring and encouraging me to be my best professionally and as a human being.

"There is no greater reward than working from your heart and making a difference".

I hope that we have touched lives of many residents with this sincere and dedicated effort of ours and have somewhere played a role in molding them as individuals and professionals. "Coming together is a beginning; keeping together is progress; Working together is success". I hope that this journey that we embarked on as residents will inspire and motivate thousands more like us to follow their dreams with passion and to join in unison for the development and advancement of residents at the national and international level. Thank you,

Saloni Katoch

'Resident Dream' provides ample opportunities for residents to network, learn through other's experiences, build confidence by sharing thoughts and ideas. This was possible when a group of residents were guided by an able mentor, someone who believes knowledge and opportunities to progress must not remain static and cloistered, but must be spread all around and freely.

A true altruist, Dr. Rashmi Sarkar, conceptualized 'Resident Dream' and trusted us to make it a success. It has in turn taught us how to work as a team with co-ordination and dedication, to channel our energies towards a greater goal, to search for answers without giving up, and to give of oneself without holding back, all for the benefit of others. It has been a truly enriching experience to learn from Ma'am and to have met and interacted with the team. They say all good things must come to an end, but the bonds created during your term will last for a life time.

-Gillian Britto


1st
Pigmentarycon
2013
PIGMENTARY DISORDERS SOCIETY
JULY 27 - 28, 2013
A-11
ORLD CONGRESS
ERMATOLOGY

It gives me huge pleasure and honour to be able to express my immense joy at the completion of five issues of Resident Dream Newsletter. It has been a wonderful journey, which we undertook under the guidance of Rashmi Sarkar mam. She had a vision, and she gave us the opportunity to fulfil her dreams. We all tried our best; learning many new things on our way and most importantly gaining a wonderful "family" to fall back upon.
I fall short of words to thank mam, without whom all this would have remained a distant dream. So, even in this moment of profound happiness; somewhere, we all strike a chord of melancholy, as this is going to be Mam's last issue. But we all pledge to carry forward Mam's dream with our utmost sincerity and take our newsletter to greater heights in the coming days…

- Indrashis Podder

Time flies but memories last forever!!

I still remember the day I met Rashmi mam during Pigmentarycon 2013 in Goa. I didn't have any idea that something like Resi-DREAM would grow up and reach this height as it is today. The second time I met her was in International Congress of Dermatology in Delhi, 2013. At that time, I heard of this newsletter and many residents, including myself volunteered to be a part of the same. The leadership of Ishad da was phenomenal; who by virtue of his strong decision making qualities played the role of a perfect senior. Thereafter, I was introduced to Saloni and Jimish, the nicest persons I have ever come across. Right now, three of us are the bestest friends and share a relationship, to be cherished forever. Samujjala, Anuj, Gillian, Sumit, Zubin and Sahil became an indispensable part of our dream team. And yes, how can I forget Indrashis, my favourite colleague in my alma mater; without whom this journey would have been impossible. Aayushi, our tech savvy member deserves a special mention, who does the most tedious job of designing and formatting but always with a smiling face. We wrote, debated, discussed, argued but we grew up as a family under the mentorship of Rashmi mam. Doing whatsapp day and night and pulling each other's legs is definitely one of the most memorable parts of this journey. Parikh Sir and Venkat Sir were always ready to guide us, inspite of their hectic schedules. Two years have passed, and right now, with a heavy heart, I am writing that this is going to be the last issue under the secretaryship of Mam. I hope this journey continues further.

Long live Resi-DREAM

- Anupam Das

A Poem For ResiDREAM

When I first heard about this newsletter called “Residream”
I decided to join this team (purely on a whim)

Little did I know, it would be such an entertaining ride,
As much as we learnt, working together side by side

We started with Dermatology, but ended up getting lessons in life
We dealt with much more than just deadlines and the occasional strife

With Rashmi ma’am, our beloved friend, mentor and guide by our side;
We learnt how to take leaps and bounds in our professional lives

We made so many memories, beautiful stories to tell the world
We tried our best to help our friends navigate through this “residency blur”

We learnt what it means, to be a part of a team,
We also learnt how we can shine a light on all our dreams

Presentations, research, publications, passing exams
Quizzes, thesis submission, vivas, and professor rounds

All became easier, accessible, memorable, achievable;
As in each issue of Residream we told a different parable

Now as this journey is at its end, we look back with laughter -
At all the crazy stories, we can tell our friends for years after!

It was a precious experience which for nothing we would trade,
And this is the start of a new ‘dream’ which we hope is here to stay!

- Aayushi Mehta

Malignant degenerations in long standing cutaneous dermatoses: two case reports

Authors: 1. Dr Monali Pattnaik, PG-3[a] 2. Prof. Dr. Prasenjeet Mohanty[a] 3. Asso Prof Dr. Monalisha Nanda[a]
a-SCB Medical College & Hospital, Cuttack

Dr. Monali Pattnaik

Abstract

Development of malignancy over preexisting long standing dermatosis is a rare occurrence. Common dermatological diseases in this group are lichen planus, trophic ulcers, discoid lupus erythematosus, porokeratosis etc. Chronic inflammatory change and continuing reparative processes are the contributing factors. Such patients should be regularly followed up for early detection of malignant changes. Here we report two such cases. One is a case of long standing hypertrophic lichen planus and the other one is a case of trophic ulcer; both developing squamous cell carcinoma over time.

Introduction

Lichen planus is a chronic inflammatory condition. Its hypertrophic variant usually occurs on the extremities as thickened elevated violaceous or reddish brown plaques or nodules which are extremely pruritic. It often persists for a long duration and heals with scar formation and hypo or hyperpigmentation.

Trophic ulcers are chronic, mostly painless ulcers occurring over pressure points in patients with neurological deficits. Treatment involves giving adequate rest to the area and avoiding friction and pressure.

Malignancy is a potentially serious complication that can occur in either of these two conditions, affecting 1-2% of long-standing cases.[1-7]

Case Report

Case 1

A 40 year old house wife presented with ulcerated lesion over her left lower leg associated with mild pain and pruritus of 3 months duration. On examination, it was a single ulcero-proliferative growth measuring 3x3x2.5cm and associated with necrosis and foul-smelling purulent discharge. There were a few violaceous, flat-topped plaques nodules underneath it and in the surrounding areas which were associated with severe pruritus. No lymphadenopathy or organomegaly could be discerned. The general & systemic evalution was within normal limits. Findings from routine investigations including blood

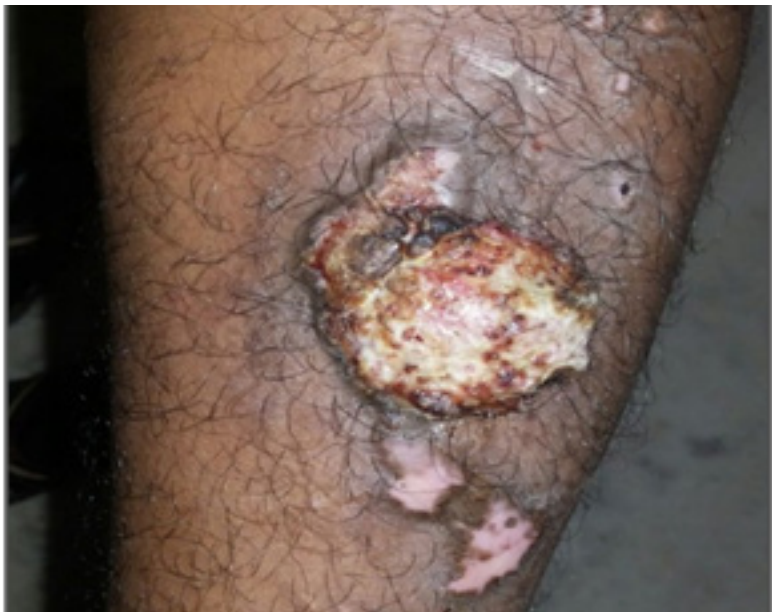


Figure-1a Single ulcero-proliferative growth with areas of necrosis and foul smelling purulent discharge; few violaceous-to-depigmented flat-topped plaques & nodules in the surrounding area

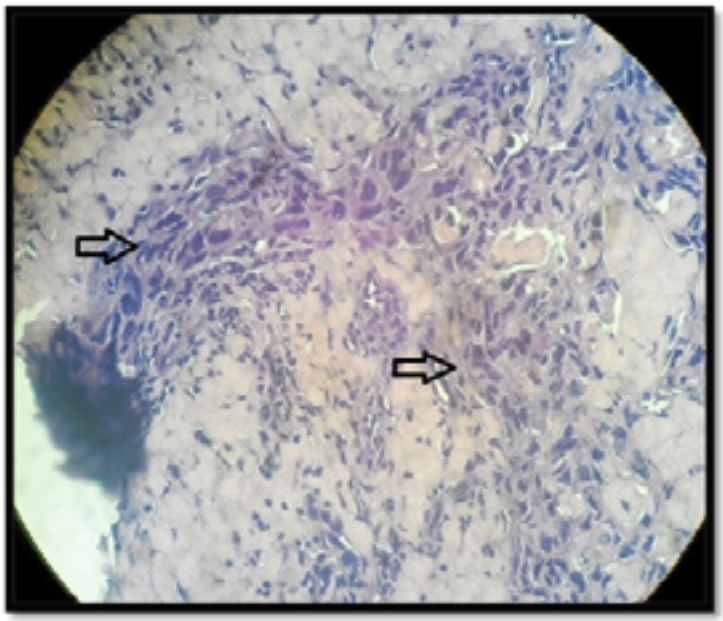


Figure-1b Biopsy from the ulcerated growth shows sheets of dysplastic squamous cells in the epidermis and dermis, suggestive of squamous cell carcinoma

counts, liver and renal function tests were all within normal limits. Results for human immunodeficiency virus (HIV) and hepatitis viruses were negative. Patient was a known case of lichen planus hypertrophicus since 8 years, biopsy-proven and had received multiple doses of intralesional triamnicolone and oral cyclosporine in the past. However she had been irregular in taking treatment for last one year. A biopsy was done from the ulcerated growth which showed sheets of dysplastic squamous cells in epidermis and dermis, suggesting it to be a squamous cell carcinoma. She underwent wide surgical excision with 2cm margins.

Case 2

A 58 year old male patient, farmer by occupation, presented with a growth over plantar aspect of his left foot since 2 months. There was a single, yellowish-white, firm to hard circumscribed lesion measuring 6 by 5.6 by 4 cm with multiple haemorrhagic and necrotic areas, present over the non-healing ulcer. There were no palpable lymph nodes and general and systemic examination was within normal limits. He had taken treatment for Hansen's disease ten years ago. The initial injury/ insult to the area causing the trophic ulcer had occurred 9 months back. A wedge biopsy was done which revealed it to be a case of well differentiated squamous cell carcinoma with dysplastic squamous cells and multiple keratin pearls. He underwent wide surgical excision with partial amputation of foot followed by radiotherapy.

Discussion

Lichen planus (LP) is a common inflammatory skin disorder. The incidence of squamous cell carcinoma (SCC)

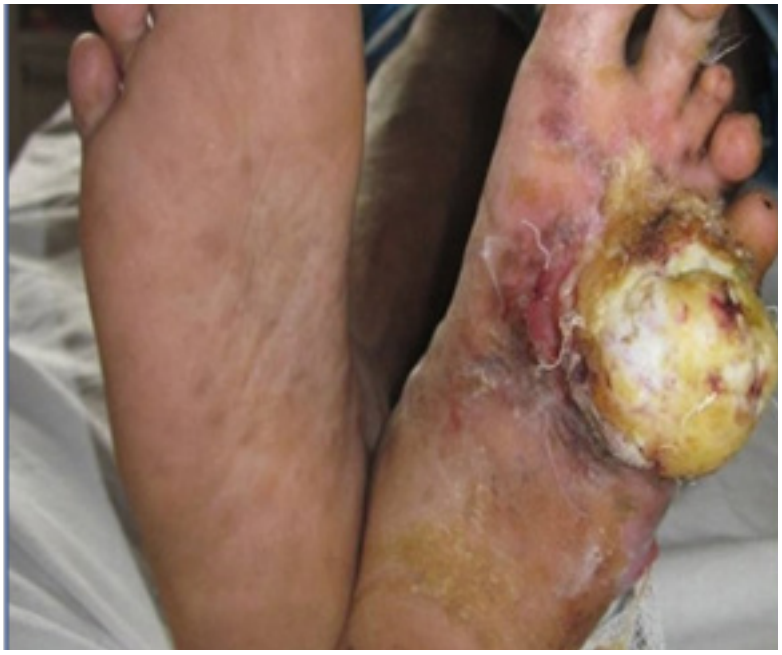


Figure-2a Single yellowish-white firm to hard circumscribed lesion with multiple haemorrhagic and necrotic areas overlying the growth and the adjacent skin

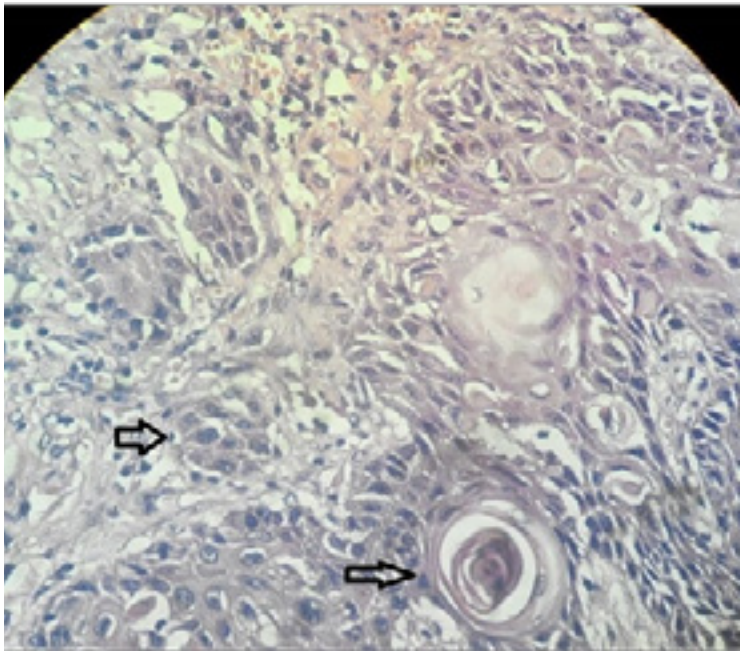


Figure-2b Histopathology showing well differentiated squamous cell carcinoma with dysplastic squamous cells and multiple keratin pearls

complicating cutaneous lichen planus is 0.4% and most of the reported cases are of hypertrophic type.[1] Other variants of lichen planus which carry the risk of developing malignancy include ulcerative, erosive, atrophic and oral lichen planus . To the best of our knowledge, less than 50 such cases of SCC developing in hypertrophic LP have been reported. Both chronic inflammation and accelerated cellular turnover in LP provides a fertile environment for development of carcinoma.[2] Longstanding, non-healing, severely itchy hypertrophic lichen planus lesions of the lower limbs are prone to develop malignancy as seen in our case.[1-5]

Ulcus Marjolini or Marjolin's ulcer was first described by Jean Nicholas Marjolin in 1828. It is the malignant transformation of any chronic wound, not just restricted to burns, and presents as an aggressive, ulcerating SCC in areas of trauma, chronic inflammation and scarring.[6] Incidence of SCC in trophic ulcers is found to vary between 1.2 – 2%.6 Very aggressive in nature, Marjolin's ulcers are thought to be caused by long-term, continuous mitotic activity as the epidermal cell's attempt to resurface the open defect. The time taken for malignant transformation in Marjolin's ulcers averages 32.5 years, ranging between 25 and 40 years.[7,8] In other studies, the mean latent period between original injury and development of Marjolin's ulcer was 11.34 ± 6.14 years (ranges from five months to 48 years).[9] Two distinct types of marjolin ulcers have been described in literature: Acute marjolin ulcers occurring with a lag phase of less than one year, and chronic marjolin ulcers with a lag phase of longer than a year. The former is quite rare, seen more often following burn injuries in

the older age groups.[6-10] In our case, the gap between the development of the ulcer and the growth was very less (around seven months) suggesting it to be a case of acute marjolin ulcer.

Chronic irritation or repeated trauma causes cellular atypia and a continuous mitotic activity of regeneration and repair leads to a malignant change in the long run.These patients need to be examined at regular intervals for a prolonged period, which may be years to decades. Any changes suspicious of malignancy, such as ulceration, sudden growth, necrosis or haemorrhage over the preexisting dermatosis should alert the physician and a biopsy should be performed immediately. This will enable early detection and help to reduce morbidity and mortality in these patients.

References

1. Singh SK, Saikia UN, Ajith C, Kumar B. Squamous cell carcinoma arising from hypertrophic lichen planus. J Eur Acad Dermatol Venereol 2006;20:745-7

2. Sigurgeirsson B ,Lindelof B : Lichen Planus & malignancy : An epidemiological study of 2071 patients) and a review of the literature . Arch Dermatol 1991;127:1684-6

3. Manz B , Paasch U , Sticherling M . Squamous cell carcinoma as a complication of long standing hypertrophic lichen planus . Int J Dermatol 2005 ; 44 (9): 773-4

4. Bandyopadhyay D , Panda S. Basal cell carcinoma occurring in a lesion of lichen planus : Coincidence or causation ? Indian J Dermatol Venerol Leprol. :2008; 74:662-664

5. Kolios AG , Marques Maggio E , Gubler C , Cozzio A , Dummer R , French LE , et al . Oral , esophageal and cutaneous lichen ruber planus controlled with alitretinoin : a case report and review of literature . Dermatology 2013 ; 226(4):302-10

6. Opara KO, IC Otene . Marjolin's Ulcers: A Review. The Nigerian Health J. 2011:11(4): 107-12

7. Sabin SR, Goldstein G, Rosenthal HG, Haynes KK. Aggressive squamous cell carcinoma originating as a Marjolin's ulcer. Dermatol Surg. 2004;30:229-230.

8. Hill BB, Sloan DA. Marjolin's ulcer of the foot caused by nonburn trauma. South Med J. 1996;89:707-710.

9. Shahla A: An overview of heel Marjolin's ulcers in the orthopedic department of Urmia University of Medical Sciences. Arch Iranian Med. 2009;12(4):405–408.

10. Chalya et al.: Marjolin's ulcers at a university teaching hospital in Northwestern Tanzania: a retrospective review of 56 cases. World Journal of Surgical Oncology 2012 10:38.

The Fellowship Conundrum [Residents' forum, Cuticon Maharashtra 2015 Dec, Nashik]

Panelists: Dr. Deepak Parikh (Former IADVL president), Dr. M. Ramam (present IJDVL editor-in-chief), Dr. Robert Schwartz (Professor & Head of dermatology at New Jersey Medical School), Dr. Toby Maurer (conducts HIV fellowships at UCSF Lakeshore Family Medicine Center, USA) and Dr. Pravit Asawanonda (Bumrungrad International Hospital, Thailand)

Session co-ordinators: Dr. Rupinder Kaur, Dr. Vijay Zawar (Maharashtra State IADVL President)

Eager residents listened with rapt attention as expert panelists spoke about the fellowship opportunities available in India and abroad. Here's a short summary of what transpired during the session:

Dr. Deepak Parikh emphasized on the need to get MCI and DNB boards to approve IADVL fellowships and the steps taken by the IADVL committee for the same. He said there was a lot of untapped potential in the mentorship program within our country with excellent teachers available and not being utilized to the fullest. He also re-iterated the need for residents to train under Indian mentors before going abroad. This point was agreed upon by both Dr. Schwartz and Dr. Maurer who said that with the tightening of already stringent VISA conditions in USA and the limited exposure to patients mandated by their country guidelines (only observerships available in most cases), it would be more prudent for Indian doctors to first have a basic training in the sub-speciality of their interest at a local level. Dr. Maurer said another good alternative was going for research fellowships in countries like USA and UK as that would enable Indian doctors to have a more free interaction with patients abroad. Dr. Pravit said Thailand was very welcoming for foreign students and his university offers a wide range of courses and fellowships in Lasers, Phototherapy and dermato-surgery. Also, there was an option of combining two or more of these fellowships in certain cases.

The panelists suggested that before applying for fellowships/observerships to a particular institute, it was important that students try and establish some form of informal interaction with the faculty, either at various conferences or through known references. This would enable the mentors to know the international students beforehand, thereby increasing their chances of selection as well as improving the student-teacher communication during the training period.

Dr. Parikh said IADVL will continue to periodically announce fellowships/observerships through website, e-mails, journals and newsletters so that students are not deprived of further learning in their fields of interests.

(Report compiled by Dr. Jimish Bagadia)

BYE BYE RESIDENT DREAM!

Dear IADVL Members,

All good things come to an end! It seemed just another day that I was working as the Scientific Chair at a conference in 2013, when I was introduced to some bright postgraduates in dermatology who were applying for free and award papers.

Communications helped and I was happy to find wonderful residents who were ready to volunteer to work on my proposal as Secretary General IADVL , which was to bring out the Resi-DREAM, an IADVL Resident's Bulletin by the residents, for the residents, of the residents; as a part of the IADVL Residents' Welfare Committee. I must thank our Past President, Dr Deepak Parikh Sir to have the faith in my vision and my current President, Dr Venkat for his unquestioning continued support.

I was fortunate to have Dr Ishad Agarwal with good leadership skills to take up as the Chief Editor of our Bulletin and we brought together Drs Anupam Das, Indrashis Podder, Zubin Mandlewala, Jimish Bagadia, Aayushi Mehta, Samujjala Deb, Saloni Katoch, Gillian Britto, Sahil Mrigpuri, Sumit Gupta, Anuj Tenani from all parts of India as the "Industrious Twelve"! We talked, we discussed…in my times of low as Secretary General, they became family. Young in age but sharp in mind, they have made me always realize-"If today is bad, tomorrow is another day" as we discussed careers, PLM issues, marriage, magic, movies, food. It was like family. I have given them mind assignments and challenges. They have delivered.

I am sure in years to come you will see them as sound academic leaders, hopefully with their heart in the right places. I just got to know them two and a half years back (the only person I knew was Samujjala) but I have lived through their PG, exams, Post PG period, marriage, children-I have seen several life events in this little period. We have brought out 6 wonderful issues.

This is my last issue as Secretary General , IADVL although my work for IADVL will continue. I will leave happy that the future of Dermatology is in secure hands----Resi-Dream should continue to flower and blossom! The journey continues amidst others but a new change is born-Residents are now in the fold of IADVL!

Long live IADVL and Resident DREAM!

Dr Rashmi Sarkar
Secretary General IADVL (2014-15)
Advisor Editorial Board ResiDREAM

Dear Residents,

Wish you all a very happy and prosperous 2016!

The year gone by has seen progress – there have been multiple programs for residents- in Delhi by IADVL and in every state. There have been scholarships, workshops, research grants and fellowships in greater numbers than before. Residents have greater opportunity than ever before – and I hope they will continue to make use of them.

And I hope they will prosper- prosper in every sense of the term- prosper not just academically, but as doctors, community activists, researchers, family members, and teachers- a doctor needs to do all of these.

And to do these, I hope they will get the skills needed. Medical course is an all consuming course- there is so much to learn and for such a long time-and it limits our skills in other fields.

But in today's world, with emphasis on skills for communication and entrepreneurship, an all round development is what is needed.

And the best way to do this is to read- not just medical reading which we do and we have to do any way- but non-medical reading too.

Discover the joy of reading- joy of reading for reading's sake-whether from a book or from Kindle-

Reading books should be like breathing- one should not have to put in effort.

Read Quantum by Manjit Kumar if you want to understand the progression of physics leading to atom bombs and lasers

Read Origin of Species to understand the grandeur of biology

Read The Emperor of Maladies to understand disease and mortality

Read Atul Gawande's Complications to understand dilemmas of practice

Read A Brief History of Time to wonder and marvel at the creation

Read Schrodinger's cat to get perplexed

Read Andre Agassi's autobiography to understand focus and determination

Read PG Wode house to have fun

Read My Experiments With The Truth to marvel at honesty of a Mahatma.

But read!!

Wish you best of luck in future.

- Dr. Venkataram Mysore,

President, IADVL 2015

Looking Back...

Dear Friends,

How time flies by!

Two years are over of "Resident-DREAM"!

It feels as if I was discussing this with Rashmi just yesterday. This whole idea was the brain child of Rashmi. Five issues in last two years have covered varied topics of interest to residents. I must congratulate past and present editorial team for excellent work done. I am sure some day, one of them will lead IJDVL as editor.

I am sure future IADVL presidents will fully support this initiative of "Young Minds"

With best wishes,

Dr. Deepak Parikh

Immediate-Past President IADVL

FEEDBACK

We hope you liked the 6th issue of our ResiDREAM newsletter, and the final one under the mentorship of our beloved Dr. Rashmi Sarkar. The ResiDREAM newsletter is of the residents, by the residents, and for the residents. If you have any comments, queries, suggestions or contributions, please write to us at: *residreamiadvl@gmail.com*. We are eagerly waiting to hear from you!

Until next time,

Team ResiDREAM!

CALENDER OF EVENTS 2016

1. Dermacon, Coimbatore — 21st – 24th January 2016
   (http://dermacon2016.com)
2. IMCAS World Congress, Paris, — 28th – 31st January 2016
3. 1st conference of Association of Clinical Dermatologists of India, ACDI, Gauhati, — 19th - 21st February 2016
4. 74th Annual meeting of American Academy of Dermatology, Washington D.C., — 4th – 8th March 2016
5. Pigmentarycon 2016, New Delhi — 1st - 3rd April 2016
   (http://www.pigmentarycon2016.com)
6. 5th Continental Congress of Dermatology, Dubai, — 12th – 14th April 2016
7. ACSICON, Mahabaleshwar, — 21st – 23rd April 2016
8. 13th EADV Spring symposium, Athens, Greece, — 19th – 22nd May 2016
9. DAAS summit, New Delhi, — 1st – 3rd July 2016
10. Summer Academy Meeting of American Academy of Dermatology, Boston, — 28th – 31st July 2016
11. IMCAS Asia, Taiwan, — 29th – 31st July 2016
12. Mid-Dermacon 2016, Bhubaneswar, — 13th – 14th August 2016
13. ISPD Annual conference, Hyderabad, — 26th – 28th August 2016
14. 25th EADV Congress, Vienna, Austria, — 28th Sep – 2nd Oct 2016
15. DASIL 5th Annual Congress, Dubai, — 19th -23rd October 2016