RESIDENT DREAM

Dermatology Residents Education And Motivation Bulletin

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June/July 2017
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A newsletter for IADVL Residents

June/July - 2017

EDITORIAL

"Individually we are one drop, but together we are an ocean"

The Resident-DREAM moves into another year of inspiring and motivating young residents to achieve and embark on this journey of Dermatology, Venereology and Leprosy with a hint of difference. We bring to you a newsletter by the residents, from the residents and for the residents. With an assemblage coming from authors all over the country, we hope to throw light upon a wide variety of topics both academic and some out of the box. A word of gratitude to residents and teachers from all over the country for appreciating and contributing to this novel endeavor which now has its expanse all over the country.

In this next edition, we bring to you 'Pearls from the pioneers', with leaders from four different corners of the nation, sharing their experiences & enlightening us with their wisdom & advice. Being tech-savvy nowadays is the way to be, guiding us through the usage of the IADVL website is our next article, 'The ultimate guide to the IADVL website'. 'Candid with Dr. Seemal Desai' takes us through the journey of our International faculty through his post graduate & residency days with an overview of training programmes, mentorships & fellowships overseas. From the archives of the history of Venereology comes one of the most dreaded & controversial human experiments, read about the Tuskegee Syphilis experiments in 'Out of the box I'. Debating a very common topic of discussion 'Are fellowships the need of the hour' are two of our talented residents in the Arena segment.

'The best part of one's story is when it changes'. All of us have been through the doubtful and confusing phase of what to do next post residency, our next article 'Metamorphosis: My journey from a resident to a consultant' focusses on this transitory period

in our professional lives. Giving our readers important exam oriented notes is our next section 'Dermatology notes' with notes on HLA in Dermatology and Rituximab. The next article will take our residents to the exciting and fulfilling world of publications, clearing all your doubts and guiding you through this very rewarding field of research and publication is 'Road to publishing articles'. From the supernatural world of vampires and werewolves comes a deep-rooted connection to dermatology, throwing light upon these myths and legends is 'Out of the box II'. Stimulating your neurons is our next school styled Quiz segment 'Back to school' with a nerve wracking collection of Ecto-match, Pantheon spell bee and Criss-cross.

Sure to tickle your funny bone is our wisely crafted Show stopper 'To be or not to be an independent private practitioner', the author takes us on a light hearted journey of the Do's and Don'ts of plunging into private practice post residency. Last but not the least is the answer key to the quiz and important announcements from the National executive.

We hope you like our honest efforts as we bring to you this next edition of the Resident Dream. Together we hope to create an ocean of learning with a dash of innovation and creativity. My heartfelt gratitude to the National executive, the editorial team and all the authors for their contribution and participation as we continue this novel journey of learning and educating each other.

Have a good read!
Best wishes,

Dr. Saloni Katoch
(Editor-In-Chief)

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We have a huge back-log of PLM due to become LM because of inertia from your side. There isa provision to discontinue membership of provisional life members if they don't convert to life members within stipulated time limit.We are going to implement the same.

FROM THE DESK OF DR. YOGESH S MARFATIA, NATIONAL PRESIDENT IADVL 2017

Teaching is learning twice. As a Teacher, I get a lot of opportunities to learn, re-learn and un-learn regularly from my PG's. Every teacher is indebted to their PG's. I am thankful for this chance to interact with you all through RESIDREAM.

Let me share the recent IADVL initiatives to encourage PGs :

1. PG Thesis Grant- Twenty grants of Rs.50,000/- each shall be given. Look for the announcement and come forward to apply.
2. PG thesis based Award paper session during MID-DERMACON and DERMACON.Prizes and certificates will be given to the PG's and their teachers as well.This is in addition to the Best Thesis Award already being given for the last many years.
3. IADVL PG Education Task force is formed with an objective to revise teaching, evaluation and exam pattern taking into account the current needs.

Many ongoing PG support activities like Scholarships for National and International conferences, Post-PG observershipsare already there. Come forward to take advantage.

What is expected from you?

Let all the PG's join IADVL as PLM.

Do convert your PLMship into Life membership after obtaining your degree.

We have a huge back-log of PLM due to become LM because of inertia from your side.There isa provision to discontinue membership of provisional life members if they don't convert to life members within stipulated time limit.We are going to implement the same.

As per the MCI, there are 3 P's for every PG: Paper presentation, Poster Presentation and Publication. Don't miss the opportunity to do it before you leave your institute.It is necessary to enter into SR/ teaching positions. It is observed that there is dearth of interest in data collection, research and publication. This cannot be accomplished without input from Post-Graduates. I think the need of the hour is whole-hearted participation ofall PG's in Research activities. Do attend atleast one Research Methodology workshop.

I am happy that RESIDREAM provides a platform to interact , disseminate useful information and cultivate a habit of writing.

Best wishes and festive greetings.

Dr. Yogesh S Marfatia
National President, IADVL

FROM THE DESK OF HONORARY SECRETARY GENERAL

I sincerely hope that this newsletter will continue to resonate with fresh ideas and concepts under the new Editorial team and carve its niche in the life of each and every Dermatology Resident across the country.

It is a matter of joy that the Resident DREAM (Dermatology Resident Education & Motivation) newsletter has stepped into its fourth year. As the mouthpiece of the residents, by the residents, and for the residents, this newsletter attempts to address their concerns and provides a platform for exchange of ideas to prepare them for life after residency.

This year, we have a fresh editorial team of enthusiastic and capable residents from all over the country. The team is led by the bright and talented Dr. SaloniKatoch as the Chief Editor. Dr. Anupam Das, the Immediate Past Chief Editor, continues as an advisor this year to guide and encourage the new team. I offer my congratulations and best wishes to the new editorial team.

I sincerely hope that this newsletter will continue to resonate with fresh ideas and concepts under the new Editorial team and carve its niche in the life of each and every Dermatology Resident across the country. In the long run, it is expected that several of the residents will look back to their association with this newsletter as the stepping stone for greater responsibilities in the speciality and the association.

To conclude, I wish all residents the very best for a bright future ahead.

Dr. Shyamanta Barua

Hon. Secretary General, IADVL

PEARLS FROM THE PIONEERS

DR. KN BARUA

DR KN BARUA, with over 46 years of experience is a much-loved teacher, academician & the father of clinical dermatology in India. On the administrative front, sir has been the former principal of Guwahati Medical College & the HOD of Dept. of Dermatology, GMCH. He is presently the Director & Chief Consultant of the Dr. KN Barua Institute of Dermatological Sciences, Guwahati.

Journey as a resident : I was never a man of Biology, I was always a man of Mathematics, never scored anything other than first division in maths. But it was my elder brother's wish to see me as a doctor, so I took up the challenge and jumped into the medical field. After completing M.B.B.S, I did my housestaffship (Medicine and Dermatology) at Safdarjung Hospital, Delhi. Luckily,I was one of the 4 housestaffs out of the 84, who had procured a grade 1, which at that time was equivalent to 5% at Delhi University.

My then Dermatology Boss or as we knew him as Mehta sir told me "Beta tum Dermatology meinjao" but the dilemma was that Dermatology then was not recognised by the Delhi University. I wanted to study at AIIMS, Delhi but that seat was reserved for the armed forces.Then with all the guidance from Mehta sir I was selected for a degree in Dermatology from Amritsar, Punjab. On hearing that I was going to Amritsar that too to study Dermatology, my classmates had only one thing to say "bandarhai tum, jo Delhi and Medicine chorkejaarahahai". And that is how my journey as a Dermatology resident began.

Interesting experiences : During my residency in Amritsar everyone heard that a so and so resident has joined and he is from Assam. On hearing that, all my colleagues thought I must be some tribal (laughs). Soon the head of department called me to see who is this much talked about resident. After few minutes of conversation with me, he remarked "Arey ye to apna Punjabi mundahai." (Laughs)

Life wasn't easy after residency, I came back to Assam and was jobless for almost 1.5years. It was a very tough phase.I then joined Assam Medical College and Hospital, Dibrugarh and worked there for a long time before shifting to Guwahati in 1983. Finally, it did seem like life was going on the right track and that was the time when everyone said "hero ban gayatu to, achakiya Dermatology leke". These were the same people who were not too confident of my choices before. (Laughs)I struggled and worked very hard, till date every post that I have held (Associate professor, Assistant professor etc.) except the post of Principal, has been created by me. Even for the post of Principal I needed a High Court clearance and I made it possible.

I was the only fellow to have gottena WHO fellowship and to have worked in Oxford University and King's college. By God's grace I have been very lucky. I was happily surprised when I was selected for a WHO fellowship that too in U.S.A. I worked at the Washington DC,Albert Einstein Institute of Pathology and I had no idea that a WHO student gets such VIP treatment. In 2009, I was awarded the Guruvandana (Teacher par excellence) award by IADVL out of 600-700 nominees. It was a great pleasure to share the stage with my mentors.

Pearls for the young brigade : I was jobless for 1.5years after my residency and I have also faced tough times working in areas like Diphu which was

no less than a jungle but I never gave up. I have been felicitated worldwide which would not have been possible without God's blessings and the struggle I went through. Remember beta never give up because struggle karke hi zindarehnahai.And also, go out and explore because that is how you grow, you keep growing and changing when you work with world-class people.

Our future : While working in U.S.A. the doctors there always said, 'There is no sight like the sight of an Indian doctor'. They always said, Indian doctors don't need a biopsy to diagnose Hansen's, all they need is a look and few minutes with the patient. So remember, Clinical dermatology is like your eye and mind, trust that and nobody can cheat you. Clinical dermatology is like 'Jana Gana Mana', the whole population is your patient. So no matter what you do, where you go, never forget clinical dermatology.

Dr. Komal Agarwal, PG-1, Assam Medical College & Hospital, Dibrugarh, Assam.

DR. YOGESH MARFATIA

DR. YOGESH MARFATIA, is a leader, pioneer and a beloved teacher in the field of Dermatology. He currently holds office as the National president of the Indian Association of Dermatology, Venereology and Leprosy. Under his leadership the association is reaching new heights and benchmarks, we present a few pearls from the President himself.

Journey as a resident : My Journey as a resident was during such a time where there was only thermal cautery, hardly any instruments and procedures. It was totally clinical dermatology. There were lot of cases of leprosy and STD (2-3 cases/day), inpatient was full of cases having SJ/TEN, erythroderma, extensive pemphigus, TB cutis, lepra reactions and deep mycoses .HIV/AIDS was a newer entrant.

Drugs in our armamentarium were sulfa drugs, penicillin, doxycycline and steroids. Methotrexate and cyclophosphamide were not used freely. Oral retinoids were not available. First generation sedating antihistamines were the only option. Super potent steroids were not available. Treatment of Tinea was with griseofulvin and topical salicylic acid and later on, clotrimazole was added.

Psoriasis was treated with tar and salicylic acid. It was easy to enter Dermatology as Skin-V.D. tag during those years(1981-1984) was not lucrative and glamorous. The number of scientific events were very less. There was no internet or mobile. There was no opportunity to attend the national conference and hence the only option was the state conference.Thesis work was laborious.

Interesting experiences : Around the year 1981, HIV/AIDS started spreading and we were identified as key physicians in AIDS management. This gave us a lot of opportunities to learn, receive training and then train others. We served as AIDS care physician till ART centers were started. There was no taker for HIV/AIDS in pre-ART era and our community offered yeoman services. It was satisfying to see HIV become a chronic, manageable disease from a stigmatized fatal one.

It was interesting to see dermatosurgery, cosmetology & pediatric dermatology growing and it was a privilege to attend the initial events (first conference, founder membership).

Processing approximately hundred post-graduates was a unique experience throughout these years. Students were of different caliber, mindset, background and guiding and grooming them was a great learning experience. Newer drugs started making in-roads, pulse therapy was introduced, specialized dermatopathology services were available and that transformed patient management drastically and Dermatology became more of an outdoor specialty.

Procedures, surgery and LASERs upgraded the specialty and now it is chased by even top scorers. Of late, we have started prescribing biologics, cancer chemotherapeutic agents, immunomodulators and have started exploring the systemic counterpart of skin diseases. It is heartening to see many sub-specialties within the specialty of Dermatology.

Pearls for the young brigade : You are fortunate to have a wider choice in terms of clinical dermatology, dermatosurgery, procedural dermatology & LASER's but during residency, the focus must be on clinical dermatology, dermato-pharmacology and dermatopathology. Donot neglect diseases of public health importance like STD, HIV and Leprosy. Grooming yourself as a basic dermatologist is the first step. Later on, you can venture into an area of your interest. It is prudent to practice evidence based dermatology and rational therapy.Do restrict yourself while prescribing expensive therapy/cosmetic procedure with anecdotal evidences. While doing cosmetic procedures, proper selection of cases and counseling is a must to protect yourself from dispute and litigation. You have to fight against the nuisance created due to undue publicity given

to fairness products and abuse of topical steroids as self medication/OTC promotion.

Data keeping and research are the biggest lacunae in dermatology education. Every thesis provides a great research opportunity to be utilized fully.Do publish a paper based on your own data.

Our future : With fast growing diagnostics and availability of gene mapping, non-invasive imaging techniques, our diagnostic horizon will be wider. Treatment can be personalized on basis of pharmacogenomics. There will be target oriented treatment modalities, thereby, protecting patients from multi-system ADR. Many diseases hitherto considered incurable can be cured or controlled with a longer remission period.

Digitalization of clinics, E-recording of patient data, easy photo-documentation will facilitate presentation, research and publication. With paradigm shift in dermatology PG training, dermatologists will be able to offer comprehensive management including medical, surgical, LASER and aesthetics. People and other medical professionals have started looking at dermatologists with high esteem.

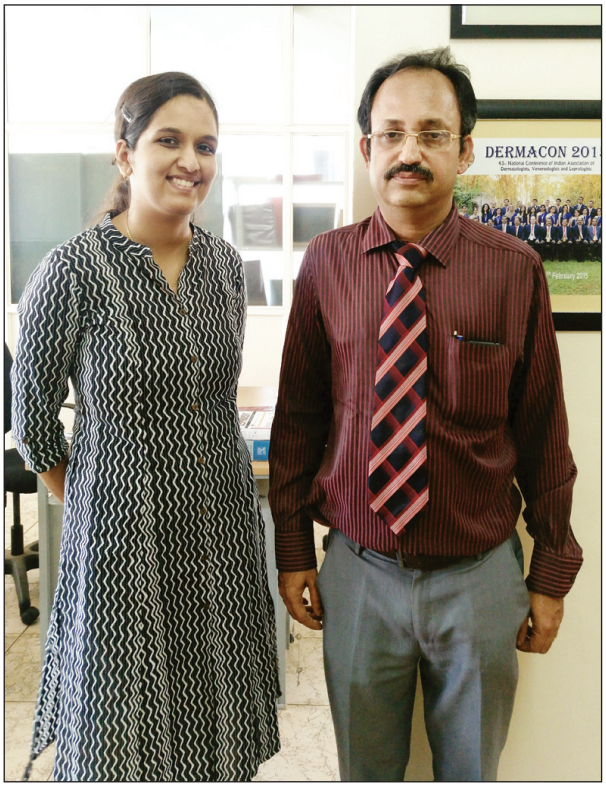
Dr. Ruchi Shah, PG-1,
Government Medical College,
Baroda, Gujarat.

DR. RAMESH BHAT

DR. RAMESH BHAT, former HOD of Dept. of Dermatology, Father Muller Medical college, Mangalore & the President elect of the IADVL is an eminent teacher, researcher & leader. His energetic & pragmatic self has always inspired students to achieve against all odds.

Journey as a resident : I did DVD from Kasturba Medical College, Mangalore and MD from Bangalore Medical College, Bangalore. It was a very nice journey, with lots of helpful colleagues both in Mangalore and in Bangalore.

Interesting experiences : It has to be managing difficult cases such as Toxic Epidermal Necrolysis, pemphigus etc. For an instance when I was a PG student, there was a patient who developed TEN, she was almost at her death bed; along with our fellow colleagues, we personally used to do the dressing because the nursing staff used to be quite scared to treat the patient.



The patient was a very young girl and later she improved. And even now for any minor skin ailments she comes here, all the way from Bangalore. This is one of the many interesting experiences I have had.

Pearls for the young brigade : Hard work and honesty! If these two things are there automatically success will follow.

Our future : Our future is bright! During our time, it was probably a transitional phase. Nobody wanted to take up dermatology. I was the first one to take dermatology through the All India entrance in Karnataka.

The two years prior to that the seat went vacant. All India entrance started during our batch. In the year 1988-89 nobody took a seat. I took the dermatology seat of the year 1990 in 1991 due to some delay.

During that phase, people started doing adventurous work in dermatology in Delhi, Mumbai etc. People like Dr. Behl & Dr. Sawant, are the ones who initiated dermatosurgery.

Dr. Preethi B Nayak, PG-3,
KS Hegde Medical Academy,
Mangalore, Karnataka.

DR. RASHMI SARKAR

DR. RASHMI SARKAR, With the heart of a tigress and stance of a visionary; With a helping hand and a mentor's wand, we present to you Dr. Rashmi Sarkar who is a teacher par excellence, former Secretary general of the IADVL and an International figure in the field of Dermatology. As the founding president of the Joint WDS-Indian WDS and Director of International society of Dermatology, she inspires the young dermatologists to follow in her footsteps.

Journey as a resident : I did my M.D. from PGI Chandigarh but it was actually not planned. I had done my MBBS from DMC Ludhiana where post graduation seats were allotted internally based on MBBS marks. So I could have gotten a PG seat internally. At that time the deciding factor for my career was the health of my father who was in terminal stage of cancer and so I had to come back home to chandigarh to take care of the family. I took up a house job in PGI Chandigarh where I met many academic people and realized that there was so much more to the branch of dermatology than I knew before and developed interest in it. So, I cleared the entrance exam.

The residency in PGI was very robust and academically fulfilling. We were put through a lot of challenging situations everyday along with a rigorous academic program. There were case conferences everyweek which were really a very tough test for all of us. We practically worked without lunch for many days. Besides the textbooks, we had to read up a lot of journals also. So I think overall it was very fulfilling, we had a lot of help from the seniors also.

I think after doing residency from PGI you would be able to standout anywhere as the curriculum is so grueling and you are put through the grind that you can shine anywhere.

Interesting experiences : Interesting experience was that at that time the dermatology ward was within the medicine ward, so I made a lot of friends in medicine. It was a lot of fun because of all the residents. Also, my mother used to cook meals at home and I would invite other residents to eat at my home from time to time. The other fun things were picnics that we used to have, one time we went to Shimla for a CME.

Moreover, we would hardly get time to have lunch on Thursdays because of the case conferences and we would get free around 5:30 or 6 pm so that is the time I used to look forward to because I used to visit the PGI cafeteria for bread-pakoda and the bread rolls tasted awesome or maybe we were just so hungry by that time. I remember prolific classes with the senior residents especially DrSandipan Dhar and Dr. Goutam Dawn.

Pearls for the young brigade

- For the first year residents, supposedly reading the aetiopathogenesis is very boring for you and puts you off, then at least read the clinical features of the disease as it is very important to have an overview of the clinical features in the first year.
- Another thing is that, straight away one should start reading from the main text books; you may find it's difficult initially but you will catch

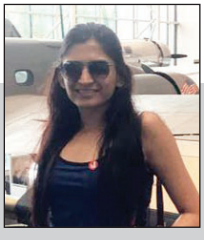
on. We spend a lot of time reading smaller books which is a futile effort in the long run.

- Pay more attention to leprosy and STD in the first year because those are the manageable ones and you have so much more to read in 2nd and 3rd years.
- Also read a little bit of journals, you might not be able to read all the journals but at least scan 4-5 main articles from the important journals every month. Screen the main articles, read the abstract and if you find it interesting then read the discussion.Even if you do not have the time to read the whole thing this keeps your abreast with the latest development because this is the only time you are going to read so much.
- One thing is group learning which is important, with your co residents. Have group sessions, ask each other questions and present cases in front of each other like rehearsals.
- The other thing is you have to develop and know your interest, you need to know if you are more into medical dermatology; if you are, then see more of clinical cases, see more pictures and do more histopathology. If you are more of a procedural person then you should know your indications well and learn as much as you can both in your department and attend as many hands-on workshop , also it's very important you be in touch with presentations at conferences and CME to hone your skills as a speaker . It is good to have a few publications as it catches somebody's eye.
- Another thing I feel is that one should be regular with studies and not let things pile on.

Our future : I think the future for residents in Dermatology is very bright. We wish to have more boys to opt for dermatology to have a good gender balance because without gender balance it will become a mundane.

I think today you have to integrate a lot more things in than in our times, you should know the right amount of theory, see as many clinical cases as possible because your clinical dermatology has to be very strong. In order to aid your knowledge you have to know the investigative procedures, dermato-surgical and cosmetological procedures and keep abreast with the latest technology; someone who keeps abreast with the latest technology and latest developments will shine. With the advent of new biologics, molecular advances we would be in a better position to treat the various diseases. So going forward, you have to take a pick if you are a technical person or a research oriented person or a procedural person. However, the main thing is none of these aspects can flourish without the other and you need to have to have a sound clinical base to pursue any of these things.

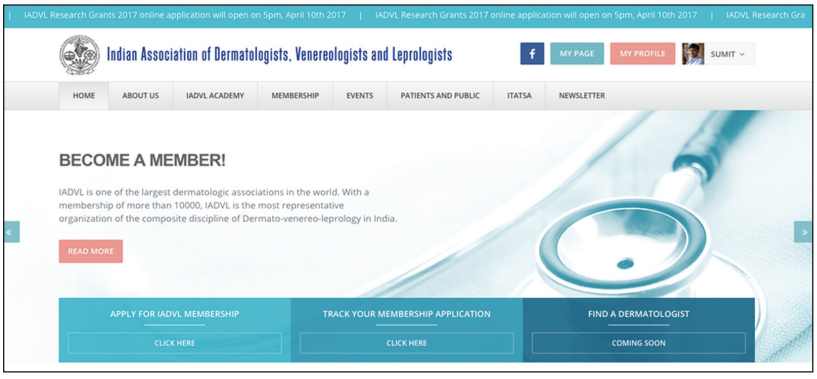
So, the future is very bright because as a specialty we're doing pretty well and there is a space for everyone but you need to know your interests and strengths.



Dr. Isha Narang, PG-3,
Maulana Azad
Medical College, Delhi.

THE ULTIMATE GUIDE TO THE IADVL WEBSITE

Utility and an Insight into IADVL Website for Residents



Over the past year, there have been significant changes in the IADVL national website which have simplified the membership application system, bolstered our reach to new & existing members and helped us update the membership database.

OMAS : IADVL is the largest representative society of the composite discipline of dermato-venereo-leprology in India. With a membership strength of more than 10,000, we are one of the largest dermatology associations in the world. All new Dermatology PG residents can now easily become members of this prestigious organization by a quick online process. Membership application is now completely and exclusively an online process. For application, you just need to log on to www.iadvl.org and click on the "Apply For IADVL Membership" button. It will open up a page with different categories of memberships and their definitions. One can click on the type of membership one needs to apply and follow the instructions. If the application and uploaded documents are in order, it is soon approved by the executive. Only after this approval, will the system ask for payment from the candidate which can then be made by an online gateway using either cards or net banking. The membership application can also be tracked until it's not complete.

The system is secure, accessible and has greatly increased the speed of new membership applications. The sagas of delayed couriers, misplaced cheques and missing documents are now old news.

DermaGyan Lectures : The IADVL website is a rich resource of academic content for benefit of all. The DermaGyan video lectures are from wide ranging topics such as Androgenetic Alopecia to STD's in Pregnancy by some of the most acclaimed national faculty. Apart from this there is a Dermatopathology Lecture Series and a Digital Lecture Series. More lectures are being planned and are being added to the website on a regular basis. All lectures are accessible to the IADVL members after signing up on the website. Also, there are plans

Application system for IADVL Scholarships and Observerships is also now exclusively online. Even the application assessment & scoring system is through an online process which ensures transparency and objectivity. One can look under the heading 'Academy Announcements' on homepage for updates.

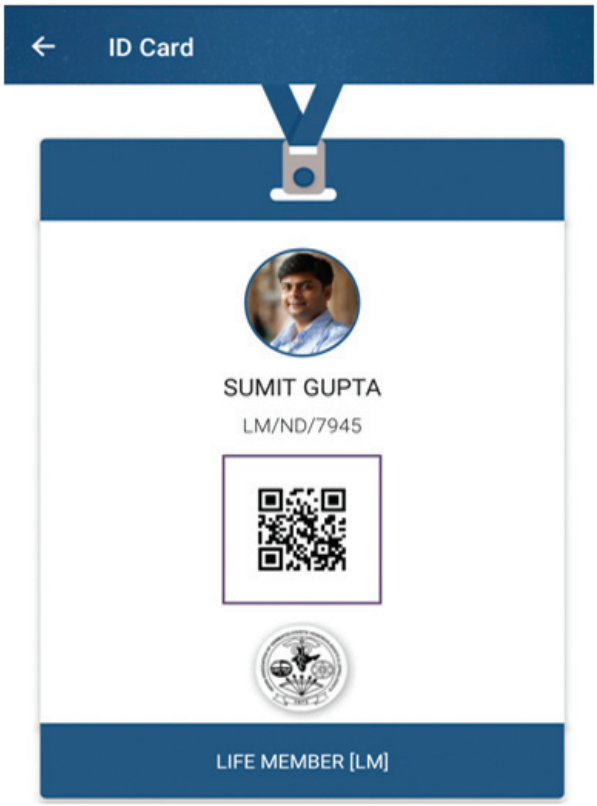
to add courses, conference coverages, e-posters, abstracts, webcasts, didactic slide decks on the IADVL e-learning portal.

E-Library Project : The IADVL-E library project was initiated in 2012 allowing IADVL members to access journal articles that are otherwise too expensive to download. Members can request articles from selectjournals and can obtain them within 24 hours. Log on to http://www.iadvl.org/e-library.php for more details.

Online Scholarship/Observership Application System : Application system for IADVL Scholarships and Observerships is also now exclusively online. Even the application assessment & scoring system is through an online process which ensures transparency and objectivity. One can look under the heading 'Academy Announcements' on homepage for updates.

Miscellaneous : As before, members can access the forthcoming events, conference details, important announcements and latest issues of our official journals right from the homepage itself. Members can also download the recommended procedure consent forms from here : http://www.iadvl.org/consent-forms.php. IADVL and SIG Newsletters are also easily accessible.

IADVL DermaApp : The official mobile app of IADVL has been developed to connect all IADVLites and foster a vibrant mobile community of the association. Members can access latest news, announcements from IADVL and get notifications for the same. They can access a number of features such as E-Learning portal including the DermaGyan lectures, the official journals, Members Directory etc. They can also register for E-Voting through the App. Members need to use the same credentials for signing in to the App that they use on the website. The app also has an ID card for each member which has a unique QR code. This ID card (as envisaged) will be used in the registration process



at all IADVLconferences in the future. The QR code will contain the information whether the delegate has registered for a particular conference.

The IADVL website and mobile app bring a plethora of opportunities to learn, connect and avail wide ranging benefits. To start availing them, all residents first must become members and all existing members must sign in to the website. It is a simple and quick process. After signing up, members can update their profiles and contact information. This will also help us to update our membership database. So, if any member has not been receiving copies of IJDVL or newsletters at their current address, he/she just needs to update that on the website and they will start receiving them soon.

Dr. Sumit Gupta,
LM/ND/7945,
Convener, IADVL
Website Committee 2016-17.

CANDID WITH DR. SEEMAL DESAI

Dr.Seemal R. Desai is a Dermatologist of international fame, based in Texas, USA. He takes keen interest in mentoring residents and serves as Clinical Assistant Professor of Dermatology at The University of Texas Southwestern Medical Center. He is also the Associate editor of the Journal of Clinical and Aesthetic Dermatology.

He takes special interest in vitiligo, melasma, pigmentary disorders, phototherapy, skin of color and is the National Secretary/Treasurer of the Skin of Color society. He is a member of the American Academy of Dermatology Congressional Policy Committee with a keen interest in advocacy and medical policy affecting dermatology.

I have actually seen chemical peels help hyperpigmentation. I use them as a mainstay of treatment. I have found them to be helpful in the right patient setting and when used serially every 2-3 weeks and safely following all standard chemical peel precautions. Yes, there can be adverse events so informed consent must be obtained but overall, I have found peels to be a helpful therapeutic option in my armamentarium against melasma, PIH etc.

Residream (RD) : Sir, what made you take up Dermatology?

Dr. Seemal Desai (Dr. SD) : The visual aspect of it. Combining medicine and art, and allowing visual senses to truly help a patient.

RD : What got you interested in working for the Skin of Color?

Dr. SD : I saw a need. My personal family experience with having a brother suffer from vitiligo got me interested in pigmentary disorders and skin of color from a very very early age, even though I was nowhere near medicine.

RD : What is the need for this separate focus? How is treating hyperpigmentation in skin of color different from that of in fair-skinned individuals?

Dr. SD : We have an increasing global population. People travel, they emigrate, people visit. We are really a world without boundaries and therefore it is important to be accustomed to all skin types. Also patients with darker skin types require education, guidance and also there is a need to dispel myths about skin disease.

RD : What are the cautions to be taken while performing cosmetic procedures in Skin of Color?

Dr. SD : Very important to have a patient stop using retinoids 5-7 days prior to any cosmetic treatment. Also, important to note that not all lasers are safe in skin of color. For example, laser hair removal should only be done via a Nd:Yag laser and not another modality.

RD : There's a general idea that hyperpigmentation occurs more often in colored skin with use of chemical peels. What are your views on it?

Dr. SD : I have actually seen chemical peels help hyperpigmentation.

I use them as a mainstay of treatment. I have found them to be helpful in the right patient setting and when used serially every 2-3 weeks and safely following all standard chemical peel precautions. Yes, there can be adverse events so informed consent must be obtained but overall, I have found peels to be a helpful therapeutic option in my armamentarium against melasma, PIH etc.

RD : In a country like India, where fairness of skin color defines beauty of a woman, where we have women frequenting Dermatology clinics asking for creams to enhance "glow", what role does a Dermatologist need to play?

Dr. SD : Education, education, education!!

Fairness does not equal beauty and it's our job to dispel those myths. We also need to educate about the dangers of lightening agents and that they too have adverse events.

RD : As a mentor, what would be your advise to Dermatology residents? How important are fellowships in our career?

Dr. SD : Fellowships are great. Networking and applying for scholarships to attend national and international meetings is very important. Make connections early on. Don't be afraid to send an email, reach to well known authors of publications, eminent speakers. There are lots of opportunities out there that don't cost money, but you have to look into all the different societies and meetings and take advantage of them

RD : Any memorable incidents during your residency? Please share.

Dr. SD : Just being humbled by my seniors and faculty when I thought I clinched a diagnosis but clearly did not!

RD : Are there any short-term programmes in US for overseas/Indian residents during residency?

Dr. SD : There are international observerships offered by the Women's Dermatologic Society and the International Society of Dermatology. Those are great options to look into. Also the Skin of Color Society has a nice mentorship program.

RD : Kindly shed some light on the prospect of Indian Dermatologists wanting to work in the US after residency.

Dr. SD : It's difficult but not impossible. The important thing is licensing and the need to take the USMLE exams. Also to obtain a dermatology residency it's very important to do clinical or basic research for a few years so that the right network is in place to help your residency application.

RD : How different do you find the work culture and Dermatology practice in India from that in the US?

Dr. SD : It's very different. I was born in the US and did all my training in the US so this is the only systemI know. However things in India seem challenging also.

RD : Finally, as a member of Women's Dermatology Society, do you think women can make any difference in changing the face of Dermatology?

Dr. SD : I am male member who is still active in the WDS.I think it's important for men and women to be members. The purpose of the WDS is networking and personal and professional growth. These missions apply to all dermatologists.

We are indeed honoured to have had an informative and educative conversation with Dr.Seemal Desai. Thank you sir for the guidance that you have provided to all the residents reading this newsletter.

Dr. Adrija Datta,
PG- 2, Medical College and Hospital, West Bengal.

THE TUSKEGEE SYPHILIS EXPERIMENTS

The infamous 'Tuskegee Study of Untreated Syphilis in the Negro Male' is a landmark in modern medical research.Having began in 1932 in Macon County, Alabama by the US Public Health Service, it finally came to an end in 1972.

A total of 399 African American males suffering from syphilis and 201 African American male controls were followed up till their deaths, with the objective of outlining the natural history of the disease. The participants were told that they were being treated for "bad blood", colloquial term for various illnesses ranging from syphilis, anaemia, fatigue to even leukemia. The treatment given were actually placebos, aspirin or mineral supplements. There was no informed consent taken, with the participants not having been informed of all the known dangers.The participants had to agree to an autopsy after their death. The misleading advertisement for the study had the slogan; "Last Chance for Special Free Treatment". In exchange for taking part in the study, the men received free medical exams, free meals, and burial insurance.

Penicillin became the treatment of choice for syphilis in 1945 and became widely accepted and available for the same. However, it was withheld from the subjects of the study, without their knowledge. They were never given the choice of quitting the study .The subjects were told they were receiving treatment when they actually weren't, even when penicillin, which was highly effective,came to be widely used.

In 1964 the World Health Organization's Declaration of Helsinki specified that experiments involving human beings needed the "informed consent" of participants. In spite of this, the Tuskegee study design was not modified.

In 1972, the study drew widespread media

attention and overwhelming criticism from the general public. The study was terminated in 1972, 25 years after the cure for syphilis was known and publicly available.By the end of the study, 28 persons had died from the disease, 100 persons had died from related complications, 40 had their wives infected and 19 children were born with congenital syphilis. In 1973, a lawsuit was filed by the study participants and their families. It ended with the U.S. government promising to give lifetime medical benefits and burial services to all living participants and forming the Tuskegee Health Benefit Program (THBP) for the same.

The Tuskegee syphilis study has often been regarded as the most controversial biomedical research study in US history; and also considered to be a prime example of racism in medicine and medical research.It forced the rethinking and redefining of practices involving human experimentation and continues to serve as a stern reminder of the indispensable need of bioethics in medical research.

Dr. Harshal Ranglani,
PG-2, Goa Medical College,
Goa.

THE ARENA

ARE FELLOWSHIPS THE NEED OF THE HOUR?

Fellowship is the period of medical training that acandidate may undertake after completing the residency, for sharpening one's skill and knowledge into aspecific area of interest in this vast ocean of medicine. Ofcourse, it solely depend son him / her to pursueit.

RUCHI : Sharpening thes word, with a tint of knowledge and experienceis what fellowship is all about. With a strong base of basic and clinical science, one canventure into a specific area, developing expertise in the field and excelin it in future. Dedicated work in that direction, underthe guidance of a renowned expertof the same, helps in fostering one's interest. The only source of knowledge is experience. Continuous exposure and acquaintance to a specific group of patients anda pattern of work, helps in developing one's skill, furnishing and polishing it.

KOMAL : 'Medicals' - one of the longest and most tedious journey in the world. By the time a doctor can call him/her self 'well settled' he is almost touching 40. Why add more years to this already exhaustive journey? More degrees does not necessarily make agood doctor but practice surely does. The peak and vigour of youth is spent confined to four walls of aclass room instead of treating patients and polishing one's skills. After spending 2/3rd of our lives studying, how much time are we left with to practice?

RUCHI : At the end of Residency, one stands ata wide horizon, with lots of opportunities awaiting his/her future. Looking at it as a fragmented puzzle or as added blocks to the picture is one's own point of view. Dermatopathology has trem endousscope with immunofluorescence and "marker" technology making in way. Fellowship in dermatopathology helps to combine and coordinate dermatology and pathology, implementing clinical knowledgein the labs, actually seeing and exploring what the mind already knows. From glancing overin the text books, to actually correlating the disease pathology over the slide, helps clearing the concepts and also helps the fellow cliniciansin reporting a perfect diagnosis. Surgery, as weknow, is all about the skill of your hands. Dermatosurgery, particularly, like Plastic surgery demands expertise becauseof the cosmetic concern. As we swear, Do No Harm. Faulty un-supervised techniques canlead to litigations. To protect one selves from it, learning the proper technique from aqualified and experienced dermatosurgeon is the basic requirement. In an institute providing such services, with more patient exposure and appropriate instruments, one cantry their hands on and master the skill subsequently during their fellowship period. Not only clinical, fellowships inthe field ofResearch is agrowing branch,broadening the scopefor future of medicine.

KOMAL : The question is why constraint your self to apond when there is a whole ocean to discover? Dermatology once upona time was ahorizonless work field. Most learned Dermatologists in the past had skills and confidence totreat everything related toskin, beit acne, eczema, moles, scars orthe more serious diseases like immunobullous disorders or beit psoriasis. But, in this newera of fellowships, Dermatology has been split and fragmented. With fellowships we have a separate specialist for everything, beit dermatopathology, dermatosurgery, aesthetics, lasers and so on. Asonedelves into these subspecialties one often loses touch with the wider subject as a whole. For eg: how many of us Dermatologists wouldbe comfortable and confident in treating acase of CHF, most of us would refer the patient to a cardiologist for better management, not because we do not have the basic knowledge but because we have been out of touch

with such cases for pretty long. Same thing applies here too. So, with this the number of referrals also increases, for the simple reason that in the by gone days a stable vitiligo/neonate presenting with askin condition was treated by a MD dermatologist and even the necessary surgery was performed but now one would rather refer them to a dermatosurgeon/ pediatric dermatologist respectively. Are we losing confidence in our own degree and skills?

RUCHI : In a country like ours, where most government set-ups, though with immense exposure to clinical dermatology duetohigh patient load, fail to provide sufficient training inthe upcoming fields of dermatopathology, dermatosurgery, LASER and aesthetics. Fellowships help to develop a nin-depth knowledge and experience in subspecialty under the field. With repeated exposure to similar yet, different cases during the period of fellowship, one can master the art and help others in future for the same. This, however, doesnot mean it erases the knowledge hard earned through the turmoil of 3years spent prior to fellowship (Read:Residency).

KOMAL : India is a developing country with majority comprising of rural/semi urban population. Being a tropical country there is high prevalence of skin diseases and the demand for a clinical dermatologist is ever increasing. The question is would any one with a fellowship in laser/ cosmetology/dermatopathology choose to settle in arural/semiurban area which lacks even the basic infrastructure, infact alot of our tertiary hospitals also lack the required machines and instruments.

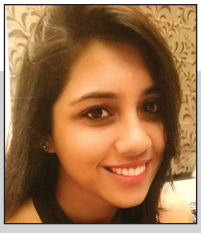
RUCHI : Agreed! Rural areas fail to provide the environment to practise once you are done with fellowships. Adding a feather to the cap does not mean the cap gets hidden. The basics and the concepts remain with us. In accordance with the work environment and facilities available, one can develop one's practice into the fieldof sub-specialty, be it dermatopathology, dermatosurgery, cosmetology and so on.

KOMAL : MD dermatology finishes like hot cakes during post graduate counselling, not because most people are interested in 'Clinical' dermatology but because the lucrative career of cosmetology lures them. Most such PGTs are disinterested in learning clinical dermatology during residency because for them thepost - MD fellowship acts as a safety net for the lack of knowledge in clinical dermatology. But how would one survive without the spinal cord. (read clinical dermatology)

RUCHI : No amount of glamour cantake away the satisfaction one gets by treating a needful patient. The newer additions to the family of dermatology only act as growing branches to the tree having strong roots of clinical knowledge and practice. It is just an added weapon in our armamentarium. One needs to change and evolve with the advancing times. India is acountry that needs more of whole some horizonless Dermatology than this wave of tunneling of vision that the era of fellowships is bringing along. It's important to keep the spirit of 'clinical' dermatology alive and makesure that the word 'Dermatologist' does not lose its value in this cacophony of much sought after fellowships.

We strongly believe in practicing clinical dermatology with a good grip on spot diagnos is and patient care. Fellow ships though not an absolute necessity, can be framed as an extra effort from our side to develop and streng then our strengths and provide satisfactory patient care, with clinical dermatology still taking the front seat.

Dr. Ruchi Shah, PG-1,
Government Medical College,
Baroda, Gujarat.



Dr. Komal Agarwal, PG-1,
Assam Medical College &
Hospital, Dibrugarh, Assam.

METAMORPHOSIS : FROM A RESIDENT TO A CONSULTANT

Among medical graduates, Dermatology is now no more a subject of 'no other choice' rather it has become the 'subject of choice'. With the growing awareness amongst the general population regarding the various skin diseases and its treatments, the demand for dermatologists has also drastically increased. People want to consult a skin specialist not only for skin diseases, but also for 'rejuvenation' and 'anti-aging'. Because of such changing trends amongst the patients' requirements, a few post graduate institutes have introduced the basic learning of Aesthetic dermatology as a part of their curriculum. However, without a thorough knowledge of basic and clinical dermatology, one should not incline himself purely towards dermatosurgery or cosmetology.

The journey of a resident, which might seem tough, is actually easier when compared to the journey after residency. Almost everyone finds themselves to be lost after clearing the post graduate exam. This becomes the most crucial time to channelize your energise and start planning. Talking to your seniors and discussing the various options definitely helps a lot. Few points should be made clear before one can decide what to do -

1. Whether you want to join a teaching institute or start private practice?
2. Which is your keen area of interest - clinical dermatology, paediatric dermatology, dermatopathology, trichology, dermatosurgery, aesthetic dermatology, leprology, dermato-oncology etc?
3. Where do you plan to settle down eventually?
4. Do you see yourself exclusively into a subspeciality like hair transplant/dermatopathology?
5. What are the skills you find lacking in yourself the most and whether you feel the need of dedicating some time acquiring them?

If you can find the answers to these questions, you might have a better understanding of what to do next. The various options that can be considered are :

1. Senior residency in a teaching institute.
2. **IADVL fellowships :** The list of the centres is released at the end of each year and candidates can apply by filling the forms through the IADVL website (http://www.iadvl.org/)

3. **RGUHS recognised fellowships (FRGUHS):** Only university recognized fellowship in India in Bangalore with options in aesthetic dermatology / dermatosurgery / paediatric dermatology, available in Bangalore Medical College, St. John's medical college, Venkat Charmalaya and CUTIS academy of cutaneous science.
4. **ACSI fellowships :** One month fellowship in different centres across India (Pune, Delhi, Chennai, Bangalore, Srinagar) in Dermatosurgery / Aesthetics/ Lasers. For details one can refer the website http://www.acsinet.net/

The end of college life might feel like the end of an era. This is the time to make the right choices. One should not get lured by high salaried jobs offered by commercial chains. Before joining any training course or fellowship, enquire about the place, the language spoken for interacting with patients (especially for international fellowships), the working hours, chances of getting hands-on for procedures, availability of accommodation & food. Weigh the value for money of the course (not all expensive ones are necessarily fruitful). Choose the course which suits your needs.

5. **International fellowships :** Post doctoral International Fellowships in Dermatopathology (http://www.ijdvl.com/article.asp?issn=0378-6323&year=2015&volume=81&issue=3&spage=334&epage=335&aulast). International fellowship options are also available in Thailand (Mahidol University), Singapore (National Skin Centre), USA (Miami, University of California San Francisco, Wake Forest University)
6. **Training in sub speciality of dermatology like Hair transplant or Dermatopathology :** Dedicated 1-2 years training should be obtained in these to acquire the fine skills and knowledge about the subject. Many renowned centres in India offer training cum jobs in hair transplant. However their might be fewer options for dermatopathology.
7. **Training courses offered by private institutes which are run by recognised dermatologists. Enlisting below are few centres which offer such courses :**

- Yuvacosmoderm (Indore and Pune)
- Rita skin foundation (Kolkata)
- Asia institute of hair transplant (Pune)
- SkinCity (Pune)
- S P Derma Centre (Madurai)
- Escallent Institute of Lasers and Aesthetic Medicine (Gurgaon)
- CUTIS academy of cutaneous science
- DermaClinix (Delhi) and many more.....

8. Working with a senior dermatologist and acquiring the practical skills of private practice.
9. Joining the chains of cosmetology clinics as a part time attachment along with a practice in clinical dermatology, making sure you are able to balance both.

The end of college life might feel like the end of an era. This is the time to make the right choices. One should not get lured by high salaried jobs offered by commercial chains. Before joining any training course or fellowship, enquire about the place, the language spoken for interacting with patients (especially for international fellowships), the working hours, chances of getting hands-on for procedures, availability of accommodation & food. Weigh the value for money of the course (not all expensive ones are necessarily fruitful). Choose the course which suits your needs.

In my experience taking the advice of your seniors always helps a lot. You can learn from their success as well as mistakes. Taking guidance under an established senior dermatologist teaches you the implications of what is written in books. You also learn to handle difficult situations in patient management and counselling. Losing touch with the subject can pull you back in practice. Keep reading and updating yourself. Attending relevant conferences and workshops can help you acquire newer skills. Contribute to the literature by publishing your experiences.

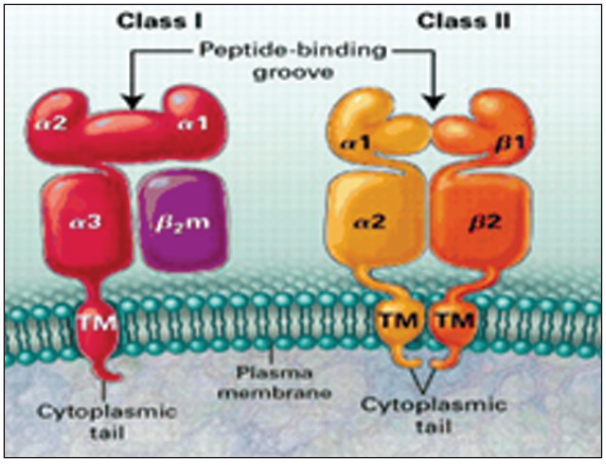
Dr. Priya Diwaker Shah,
Consultant Dermatologist,
Rita Skin Foundation, Kolkata.

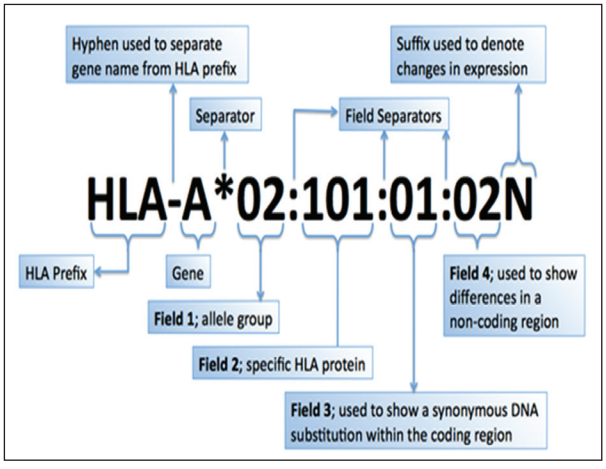
DERMATOLOGY NOTES

HLA IN DERMATOLOGY

- These are glycoprotiens that are expressed on almost all nucleated cells.
- Major histocompatibilty complex (MHC) genes : located on short arm of chromosome 6 (p21).
- Also known as human leukocyte antigen (HLA) complex : first detected on WBCs.
- Alloantigens are present on surface of leucocytes in man and are called humanleukocyte antigens (HLA) and the set of genes coding for them is named the HLA complex.

STRUCTURE :





'w' in front of a number indicates that its specificity was studied in an international workshop, and continues to undergo further definition.

Class 1	Class2
HLA-A,HLA-B,HLA-C(major);HLA-E,F,G(minor)	HLA-DR,HLA-DQ,HLA-DP(major);HLA-DM,DO(minor)
Binds with proteins synthesized within the body and it includes self antigen and viral proteins.	Binds to soluble proteins like bacterial or fungal products which are exogeneous
Present on all nucleated cells of the body and platelets.	Distributed sparingly on antigen presenting cells
Antigen recognition by CD8+ T cells.	Antigen recognition by CD4 +cells.
Cell surface molecules vary in their tissue specific expressions	Molecules corresponding to immune associated antigen. They are confined to Langerhans cells and some dendritic cells

ASSOCIATED DERMATOLOGICAL CONDITIONS		
DISEASE	**Positive Association**	**Negative Association**
DRUG REACTION		
1) Abacavir	HLA B5701	
2) Allopurinol	HLA Aw33/B17/B5801	HLA A2
3) SJS/TEN (Carbamazepine induced)	HLA B*1502	
Vitiligo (General association)	HLA DR4	HLA DR3
1) Early manifestation (<20 years)	HLA DR4	
2) Late development	HLA DRw6	
3) Positive family history	HLA DR4	HLA DRw6/A30
IMMUNOBULLOUS DISORDERS		
a) Pemphigus	HLA B15 (specifically-HLA B*1507 HLA Class II HLA DRB1*04/1*14 HLA DRw4/D/A10 HLA DQB1*0503/0302/B38	HLA-DQA1*0103 HLA DQB1*0601
b) Mucous membrane pemphigoid (general asso.)	HLA DQB1*03/01/DRB1*04 HLA DRB1*11/01	HLA DRB1*02
1) Ocular involvement	HLA DQB1*03/01/DRB1*04 HLA B12	
c) Linear IgA disease	HLA B8/Cw7/DR3/2/DQ2	
d) EBA	HLA DR2/DRB1*15/DRB1*15:03 HLA DRB1*13	
PAPULOSQUAMOUS DISORDERS a) Psoriasis(general assoc.)		
1) Type 1 psoriasis	HLA B37/Dw7/Aw30/C26/D	
2) Early onset (<40 years)	HLA DQB1*0201/0303/C:06:02	
3) Exacerbation following Streptococcal infection	HLA B13/Bw57/Cw6/DR7	
4) Guttate and erythrodermic	HLA Cw6	
5) Psoriasis with/without arthritis	HLA B13/17	
6) Psoriatic arthritis	HLA Cw6/B13/B16/B17	
7)Pustular psoriasis and acrodermatitis Of hallopeau with psoriatic arthritis and spinal involvement	HLA 27/B7/B38/B39/B57DRB1*04 HLA B27	
8) Peripheral polyarthritis		
9) Rheumatoid like psoriatic arthritis	HLA B38/39	

10) Pustulosis of palms and soles	HLA DR4	
11) Disease progression in early psoriatic arthritis	HLA Aw19/Bw35	
12) Disease progression in psoriatic arthritis	HLA B39/B27/DQw3	
13) Psoriatic arthropathy (central)		HLA B22
14) Guttate psoriasis		
15) Simultaneous skin and joint Involvement	HLA B27	
b) Lichen planus	HLA C:06:02 HLA B27/B39 HLA A3/HLA 5/B7/A28 HLA DR1/DR10/DRB1*0101	
INFLAMMATORY DERMATOSES		
a) LE (general asso.)	HLA B8/DR3/HLA*01/B*08	
1) SCLE	HLA DRB1*0301/DR3/DQ2DRw2	
2) SLE	HLA B13/B17/DR2/DR3	
3) Bullous SLE	HLA DRB1*1501	
4) DLE	HLA B7/B8/Cw7/DR2/DR3/DQw1 HLA A*03/B*07/DRB1*15	
b) Sjogren's syndrome	HLA B8/DR3/DRw52/ DR2	
c) Atopic dermatitis	HLA class I,II HLA Cw1/Bw6/DR4/DR53/ DQ1*0302 HLA A*32/B*18	
d) Seborrheic dermatitis		
e) Papular and nodular mucinosis In connective tissue diseases		
f) Systemic sclerosis	HLA DRB1*1104/DQA1*0501/DQB1 HLA DRB1*0804/DQA1*0501/ DQB1*0301	HLA DRB1*0701 DQA1*0201/DQB1*0202 DRB1*1501
Lichen sclerosis et atrophicus	**HLA Aw31/B40**	
INFECTIONS AND INFESTATIONS **a) Scabies**	HLA A11	
b) Leishmaniasis		
1) Cutaneous	HLA DQw3	HLA DR2
2) Localised cutaneous Leishmaniasis	HLA DQ3/DRB1*0407/DQA1*3011 /HLADPA1*0401/DPB1*0101	HLA DRB1*1500/1600/HLA DPB1*0401

3) Mucocutaneous	HLA DQw3	
c) Leprosy	HLA DR2/3 /B17	HLA DR2
1) Tuberculoid	HLA DQ1	
2) Lepromatous	HLA A1/A3/B8/Cw7/DQw2/DQw3/B40	
d) Paracoccidiodomycosis	HLA Cw1/A2/B7/B21 HLA B27	HLA Cw3/DR1/DQw1
e) Postgonococcal arthritis		
GRANULOMATOUS DISORDERS		
a) Granuloma annulare	HLA B31/35	
b) Sarcoidosis	HLA B8/DRB1*1101	
1) Acute disease and good prognosis	HLA DQB1*0201/DRB1*0301	
NEUTROPHILIC DERMATOSES		
a) Behcet disease	HLA B51/B5/B12	
b) Dermatitis herpetiformis	HLA B8/Dw3/DRw3/DQ2/DQ8	
METABOLIC DISORDERS		
a) Hemochromatosis/PCT	HLA A3	
GENODERMATOSIS	HLA A2/A28/Cw2	
INFLAMMATORY ARTHROPATHIES		
a) Reiter's disease	HLA B27/B35	
b) Ankylosing spondylitis	HLA B27	
Acute anterior uveitis	HLA B27	
Erythema multiforme	HLA DQB1*0301	
ASOCIATED WITH MALIGNANCIES		
a) Skin cancer: in renal transplant		
b) Multiple basal cell carcinoma	HLA A3 HLA DR1	
IMMUNE DISORDER OF HAIR **a) Alopecia areata**	HLA DQB1*0301/DRB1*1104	

Dr. Isha Narang, **Dr. Bhavya Swarnkar,**
Post Graduate Residents,
Maulana Azad Medical College, Delhi.

RITUXIMAB

"The only limit to our realization of tomorrow will be our doubts of today."
- Franklin D. Roosevelt

INTRODUCTION : Medical science has proven time and again that when the resources are provided, great progress in the treatment, cure, and prevention of disease can occur. This holds true in our field of dermatology as well. There is no denying the fact that most of the dermatological diseases are chronic and disabling at times. What we can do best is make most of the treatment options available in our armamentarium keeping in mind the overall well being of the patient. One modality that has come to our rescue in tackling chronic diseases in their severe form is biological therapy with its own pros and cons.

Biologicals or protein therapeutics have been around for quite some time now and are here to stay. Biologicals are basically a group of pharmacologically active protein-based molecules produced by living organisms that alleviate disease by inhibiting or imitating naturally occurring proteins in body. We are all quite aware of biologicals and hence I will be sharing my knowledge on the biological that I have had firsthand experience in i.e. Rituximab.

STRUCTURE : Rituximab is an IgG1, chimeric mouse/human anti-CD20 monoclonal antibody.

Mechanism of action :

1. Antibody-dependent cellular cytotoxicity.
2. Complement-mediated cytolysis.
3. Inhibition of signaling and apoptosis.

CD20 is a cell surface proteinexpressed by mature and pre-B cells. CD20expression is lost during the differentiation of B-cellsto plasma cells nor is it present in stem cells or pro B cells.

Since the CD20 antigen is not expressedby pro- or pre-B cells or by terminally differentiated plasma cells,rituximab does not prevent regeneration

of CD20-positive B cellsfrom precursor cells and does not directly interfere with the productionof immunoglobulins.Rituximab therapy generally leads to B-cell depletion within 2–3 weeks of initial treatment.Circulating B-cell populations recover to normal over the ensuing 6 months to 1 year.

Aside from playing a crucial role inantibody production, B-cells may also serve as antigenpresenting cells and have been shown to providecostimulatory signals, which promote CD4+ T-cellexpansion and effector cell function.

INDICATIONS :

FDA APPROVED :

a. Non-Hodgkin's B-cell lymphoma CD20+
b. Chronic lymphocytic leukemia CD20+
c. Rheumatoid arthritis
d. ANCA associated vasculitis : Granulomatosis with poyangitis (Wegener granulomatosis) and microscopic polyangiitis. (For induction of remission along with corticosteroids)

Off-label dermatological uses : Pemphigus group of diseases (pemphigus vulgaris, pemphigus foliaceous, cicatricial pemphigoid, bullous pemphigoid), systemic lupus erythematosus, dermatomyositis, vasculitis and primary Sjogren syndrome.

CONTRAINDICATIONS : Known hypersensitivity to murine proteins or rituximab.

Active severe infections

Severely immunocompromised patients, Uncontrolled heart disease or heart failure (New York Heart Association grade IV); and Live vaccination within 4 weeks of infusion.

Pregnancy prescribing status – category C

The patients should not ideally conceive till 12 months after infusion.

ADVERSE EFFECTS :

1. Infusion related reactions occur in upto 25% of patients receiving rituximab.The most frequent infusion related side effects include fever and rigor. Generally, these cases are mild and occur only with the first infusion. However, severe infusion reactions do occur, with a typical onset of 30–120 minutes. Patients with a history of cardiac or pulmonary conditions should be closely monitored.
2. Others being flu-like symptoms, nausea, vomiting, abdominal pain, and hypotension.
3. Cytopenias includingneutropenia may occur months after treatment.Late onset neutropenia is self-limiting and rarely has significant clinical sequelae.
4. Serious side effects like anaphylaxis and angioedema, requiring cessation of infusion can also occur.
5. The serious infectionsreported in pemphigus patients include bacterial sepsis, bacterial pneumonia,pyelonephritis,Pneumocystiscarinii pneumonia, bacterial arthritis, cytomegalovirus gastritis, Listeria monocytogenes sepsis, varicella zoster infection and cutaneous Mycobacterium chelonae infection.
6. Cutaneous adverse effectslike rash, exfoliation and vasculitis have also been reported. Toxic epidermal necrolysis and Stevens-Johnson syndrome have been reported with rituximab. Urticaria is a common side effect of rituximab.
7. Cardiovascular complications like sinus tachycardia, dysrhythmia and myocardial ischemia can occur and are more common in patients with pre existing conduction abnormality or heart failure. Such patients require careful monitoring during and after infusion. One of our patient developed brady-arhythmia at the end of infusion. It is very important to adhere to maximum approved speed of infusion to avoid infusion related cardiac complications.
8. Progressive multifocal leukoencephalopathy (PML) a JC virus infection of the brain has been reported in patients receiving rituximab. Such adverse effects are rare and were seen in less than 1:20 000 treated rheumatoid arthritis patients. PML has not been reported in rituximab treated pemphigus patients.
9. Risk of malignancy : There have been 3 cases of rapid-onset cutaneous squa¬mous cell carcinomaand 3 cases of rapid-onset Merkel cell carcinomafollowing treatment with rituximab.
10. Antibodies to the drug : Human antichimeric antibodies develop in about 25% of patients treated and can be associated with worsening of infusion or allergic reactions and failure todeplete B cells, although not predictably so.

Management of adverse reactions:

In immediate reactions, treatment should be discontinued. After waiting for about 30 minutes, rituximab infusion can be continued at a slow rate (half flow rate). Cortisone and antihistamines should be re- administered.

Rituximab therapy should be discontinued in the following situations: (a) severe infections (b) serious complications, e.g., anaphylactic reaction in patients who do not tolerate mouse proteins, and (c) pregnancy.

SCREENING

Pre-rituximab evaluation should include:

Complete haemogram

Liver function tests
Renal function tests
Chest X ray, Mantoux test, HRCT (when indicated)

Screening for viral infection including- HBsAg, anti-HBc, anti- HCV, HIV-1 and HIV-2

ECG and echocardiography

Few authors also recommend pre-treatment assessment of baseline immunoglobulin (Ig) levels as reduced baseline level of IgG is a risk factor for severe infections with rituximab.

TREATMENT PROTOCOLS : Rituximab is administered as an intra-venous infusion slowly over 5-6 hours in normal saline. The various treatment protocols followed include.

1. Lymphoma protocol- Most commonly followed protocol. Rituximab is administered at a dose of 375mg/m 2 body surface area weekly for four weeks. This protocol is also approved for Wegeners granulomatosis and microscopic polyangitis.
2. Rheumatoid arthritis protocol- Two doses of rituximab 1g is administered at an interval of 15 days. Increasingly used by dermatologists and is the protocol currently followed in our institute. Advantage over the lymphoma protocol include less cost and fewer infusions.
3. Combination therapy - Rituximab has been used in combination with IVIG, immunoadsorption and dexamethasone pulse therapy.
4. Long-term rituximab treatment with regular infusions every 4 or 12 weeks following an induction cycle of infusions every week.
5. Low dose protocol- 500mg infusion stat or administered as two doses a week apart.

AVAILABILITY IN INDIA : Rituximab is available by both its original manufacturer and as biosimilar offered by various pharmaceutical companies in India. It is available as 50 ml vial containing 10mg/ml of the drug maintained in cold storage at 2o – 8o C. As per DPCO (drugs price control order) the ceiling price exclusive of local taxes is Rs. 703.75/ml for marketing Rituximab in India.

The author has firsthand experience of using Rituximab in pemphigus (both vulgaris and foliaceous) and hence the protocol followed in pemphigus patients by the author along with the consent proforma will be discussed here.

Rituximab has given encouraging results in various studies although limited and non randomized, for the management of pemphigus especially pemphigus vulgaris. Rituximab is now being considered by some authors as first line agent in Pemphigus vulgaris. But, it is not yet officially approved as a first line agent by any regulatory agency and JEADV 2014 guidelines regard Rituximab as a second line agent in pemphigus vulgaris and suggests its use only when conventional modalities of treatment have failed or are not suitable for the patient.

It is prudent to start Rituximab under cover of corticosteroids and taper corticosteroids according to the response of the patient for maximal effect and to avoid initial flare seen in some patients treated with Rituximab as a sole therapy.

There are no set guidelines for the use or reintroduction of Rituximab in Pemphigus group of diseases.For most dermatologicalconditions, a single cycle of treatment is given (usually 375 mg/m 2or 1 g total dose, weekly for 2–4 weeks) in the context of concomitantimmunosuppressant agents such as corticosteroids.Subsequentcycles may be given on disease relapse if necessary, but notusually until 6 months have elapsed.

Dr. Akhilesh Thole,
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Hindu Rao Hospital,
New Delhi.

RITUXIMAB TREATMENT – CONSENT FORM

Name : _____

Hospital I.D. : _____

I understand that I have been diagnosed with pemphigus vulgaris, a condition that might possibly benefit from use of the drug Rituximab. I confirm that I have read and understood the information sheet provided on Rituximab. I have been informed about the side effects associated with Rituximab including but not limited to, Progressive multifocal lekoencephalopathy (PML) a fatal but rare viral infection, flulike symptoms, weakness, muscle aches, tiredness, dizziness, headaches, allergic reactions, breathlessness, painful mouth sores, ulcers, blisters on skin, abnormal blood counts causing anaemia, bleeding , risk of serious infections and death due to but not limited to infusion reactions, cardiac arrhythmias and serious infections. I will have regular blood counts done as advised by Doctors along with other investigations as necessary and should any of the above symptoms occur, I have to contact my doctor.

I understand that by signing this document I am consenting to receive Rituximab treatment.

Patient Signature : _____

Witness/Relative signature: _____

Date : _____

Consultant Signature : _____

Date : _____

RITUXIMAB DOSING SCHEDULE

(RHEUMATOID ARTHRITIS PROTOCOL)

1g IV infusion in 500ml of 0.9% N.S. to be administered stat followed by 1g after 15 days. Premedication: ½ hr before with 100 mg hydrocortisone IV, 45.5 mg Pheniramine maleate (2 c.c.) IV, Tab Paracetamol 500 mg; stat doses.

To begin with, dilute 1st vial of 500mg (50ml) of injection Rituximab in 250 ml N.S. This will make the final concentration of Rituximab to 1.66 mg/ml. (Using one vial of 500mg at a time will save another vial if any untoward infusion reaction occurs).

Start with 50 mg/hr and increase speed by 50 mg at every half hour. The speed at subsequent infusions can be doubled starting with 100mg/hr. It is very important to keep maximum speed at 400mg/hr (during all subsequent doses also)to avoid infusion related complications.

The number of drops in an ml delivered by the infusion set is mention on the package of the set and the drop rate can be calculated accordingly. Commonly available infusion sets deliver 16 drops/ml or 20 drops/ml.

RITUXIMAB INFUSION CHART

1gm of Rituximab (maintained in cold storage at 2o – 8o C) diluted in 500 ml of 0.9% Normal Saline and given as slow IV infusion after pre-medication with 100 mg hydrocortisone IV, 45.5 mg Pheniramine maleate IV, Tab Paracetamol 500 mg; stat doses ½ hr prior to therapy.

Patient Name : Age/Sex :

I.D :

Date: Dose number :

TIME	DROPS/ MIN	P.R/min	B.P	REMARKS

"The first step towards change is awareness. The second step is acceptance.Are we prepared to take our step?"

ROAD TO PUBLISHING ARTICLES

At the very outset, I would like to thank the Editor-in-chief of this newsletter, Dr. Saloni Katoch for asking me to pen down this article. To be very frank, it is much easier to draft a scientific paper, rather than writing an article on how to write scientific papers and make it worthy of publication in a "good" journal. It has been less than two years since I have completed my post graduation from Medical College and Hospital, Kolkata and I have come across many residents asking on tips to publish articles in good journals.

To be precise, publications are the need of the hour. If you are attached to a teaching institute, it is easier to publish articles (of course if you have the passion). If you are a hardcore practitioner, it is quite difficult to carry on with academics. But exception is the rule. Take the example of Dr. Koushik Lahiri who mentions "Publish or perish". I am fortunate to know him personally and work with him, as the editorial intern of Indian Journal of Dermatology for two consecutive years.

It all started in September 2012, when I was asked by my seniors to write down a small letter to editor for a journal. It was a case of eccrine spiradenoma on the chest and I was absolutely clueless as to how to proceed with the same. I approached my then HOD, Prof. Debabrata Bandyopadhyay, a doyen of clinical dermatology, from whom I have learned whatever I know as of now. The first thing which Sir asked me was "Why do you want to write this case?" I replied innocently, "Because my dadas (as we refer to our seniors in Kolkata) asked me to". Sir, as always replied in a very soft tone, "Before you start writing, go home and read this topic from wherever possible (books and journals). I went back to him a few days later, after getting a fair idea of the topic. Then he asked me "Why do you want to write this case? Think and tell me" I had to give the same reply. "My dadas and etc etc". Today I realize the inner meaning of his question and I can understand what he actually wanted me to convey.

The newsletter Residream, is read by dermatologists all across the country but to be very precise, I would like to mention that this write-up of mine, is specifically directed towards the young brains who have recently entered in this world of dermatology, who are yet to start writing or those who have recently started writing. I shall try to mention a few Do's and Dont's while quenching the thirst for publishing articles.

Recently, there has been a lot of hullabaloo regarding not to run after case reports and letters and quiz articles. But if you ask me, these are the stepping stones in publishing good quality original articles in future. It is only during these three years of your PGship when you will be literally "taught" clinical dermatology. Following your final exams, you are at sea. Trust me, nobody bothers to teach you the subject. That's why it is very important to learn the subject with utmost dedication and love. And while learning and seeing hundreds of variety of cases, you yourself will understand which case is not common or say, which case and its findings dont fit into the prototype description given in the textbook? Clinical dermatology is a dying branch,

as people say. But nothing is much more rewarding than clinical stuff, in my opinion. So, lesson No.1 is Do not neglect publishing case reports and letters. After all, Watson and Crick nailed it in a simple letter to editor only!! Besides, once you are getting used to writing and publishing articles, your focus should shift towards original articles.

Second thing which is very important to note is "Do not run after numbers" as mentioned by Dr. Shyam Verma, Ex Editor-in-Chief, Indian Dermatology Online Journal. I owe a lot to him, as he was highly instrumental in encouraging me to write more and more "good" cases. My first interaction with him, was over mails, regarding a case report on co-existence of pseudoxanthoma elasticum and nephrocalcinosis. The reviewers had asked me to "collage" the pictures so that the number of pics does not exceed the requirements of the journal and Bandyopadhyay sir (my HOD) was on leave. I was given a small deadline of 5 days. Dr Verma was kind enough to teach me the whereabouts of picture collages. Following this, I started interacting with him frequently and wrote a flurry of articles in a short span of time. But then, he told me "Do not run after numbers. It will reduce the quality of your articles". To be very frank, if you work in a Government Medical College and you have great mentors like Prof. Bandyopadhyay and Prof. Nilay Das (my friend and teacher), you will come across innumerable interesting cases daily and now, it depends on you, your thirst for publications and your zeal to write. Well, you should run after numbers I would say, but note it, run after publishing good quality articles in good journals, more the merrier!

Lesson No. 3 : Select an appropriate publication outlet. This is a crucial step in publishing articles because it avoids unnecessary harassment. You should read the requirements of the journal in "About the journal" section. Go through the past issues of the journal. You will get a fair idea of what they look for. In a quench of publishing more and more papers, many times, authors submit their articles simultaneously to more than one journal. Now, let me tell you, this is absolutely a BAD PRACTICE and this may blacklist you from submitting articles in a number of journals. Please, do NOT indulge in such nasty practices because you will end up gaining bad reputation for yourself and your institute.

Lesson No. 4 : Understand the meaning of "plagiarism", because if you don't know what it is, you may end up writing plagiarized articles and land up in serious trouble. To be short and simple, to plagiarize means to commit literary theft. Copying lines word by word from an article, not citing the article in the list of reference, copying lines from one's own article published in a different or same journal, using the same clinical and histopathological picture in two different articles, all of these are a few examples of plagiarism. There are various articles on plagiarism and how to avoid that, readers may ping me on my mail address, so that I can mail you the full text of these articles. Presently, I am working with my mentor Prof. Rashmi Sarkar for "Pigment International". She has been kind enough to explain the whereabouts of plagiarism and how to deal with such situations. I am working with her on a prestigious project (I am not supposed to declare this, as of now) and in due course of working on this mega project, I have been repeatedly asked to keep a strong check on "plagiarism". To summarize this point, "STRICTLY AVOID PLAGIARISM".

A very important tip which I would like to add here is that you need to find out a good mentor. Mentors shape you, guide you and bring out the best in you. When it comes to publications, I was fortunate enough to have someone like Prof. Bandyopadhyay sir, who unlike many other seniors would happily provide first and second authorships to post graduate residents. Again, quoting him,

"While you pass out from this Department, you should have at least 2-3 good articles in PubMed indexed journals". Of course, I must mention the name of Prof. Rashmi Sarkar, who stays in Delhi, but she is just a phone call away. She's been generous enough to introduce me to the Dream Team of Residream and has given lots of opportunities to numerous residents like me, in her books, newsletters and what not!

Fifth, you have written your article and it is ready for submission. Go back and read the abstract of the article (this holds valid for case reports, reviews and original articles). Remember, the title, introduction, keywords and conclusion should be crisp and it should narrate the entire story of what is written inside. It is like the trailer of a movie, more attractive the trailer is, chances of the movie being a HIT is higher. Try to make the abstract as best as possible. I would quote Prof. Bandyopadhyay here "Your abstract should be such that the reviewer or editor need not read the entire article, he or she should be impressed then and there!" In addition to this, try to include more and more figures, illustrations and tables in the article. Since data is the driving force of your article, depicting it in relevant illustrations would make your article more reader friendly. This is very crucial while writing any article and should be taken seriously.

Sixth, this is in reference to original articles. I must say I am extremely lucky to be able to work under Prof. Saumya Panda, Editor of IJDVL. He is the master of research methodology and basics of statistics. Whenever you are writing an original article, always remember that your article would be assessed thick and thin on the basis of the methodology which you have described. It is crucially vital to describe the study design, study area, sample size estimation, method of randomization in clinical trials, description of primary and secondary end-points etc. Describing this issue in detail, is beyond the scope of this article and I would strongly recommend the postgraduates to attend the research methodology workshops conducted by IADVL. If that is not possible, readers may also look up "Module on Biostatistics" published under Indian Journal of Dermatology, the section which is meticulously edited by Prof. Panda.

In addition to whatever I have discussed, it is important to acknowledge the relevant people who have contributed to the article but not to the extent which would justify authorship. Citation of references in strict accordance with the requirements of the journal is quintessential, because it is one of the most common reasons of outright rejection of articles.

After submission of the article, it is sent back to us (if not rejected outright). The reviewers and the editor put up certain queries regarding the article and these need to be addressed. While answering the reviewer's questions, always try to "be to the point" and do NOT beat around the bush. This should always be done after consultation with the senior most author of the article. Because, you have to be polite and at the same time, very straight forward.

To summarize the points, before you plan on writing an article, ask yourself a simple question. "Why would someone read your article?" If you get a clear and positive answer, go ahead. Publishing is always rewarding. Coming back to the question asked by Prof. Bandyopadhyay, "Why do you want to write this case?" Hope the readers got the answer!

Happy writing!!

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OF VAMPIRES AND WEREWOLVES!

We've all grown up with stories of vampires and werewolves. How these myths and legends came to be remains a mystery but here are some clues pointing to a likely disease - PORPHYRIA!

Porphyrias are a group of metabolic disorders caused by defects in heme biosynthesis leading to accumulation of various intermediates of the heme biosynthetic pathway called porphyrins, which cause the varied clinical manifestations of this disease.

Pallor is prominent in porphyria patient's due to defective heme synthesis. The classic picture of a vampire is that of a smooth, extremely pale skinned individual. Legend saysthat direct sunlight can kill a vampire. Porphyia sufferers are photosensitive due to accumulation of uroporphyrin in theirskin ,which, being a photosensitizing molecule leads to a painful blistering reaction on sun exposure. Hence, they avoid sunlight as do vampires.

Repeated sun exposure can lead to scarring, sclerodermoid changes and deformities in porphyria patients, often altering their facial features, leading to a thinned out nose, taut gums and everted lips, making the incisors appear more prominent, reminiscent of Dracula's 'fangs'!

A major treatment today for some porphyrias is heme injections. It was believed that the victims might have instinctively sought heme by biting human victims and drinking a large amount of their blood, as was supposedly the custom of vampires.

Porphyria also triggers hypertrichosis over the exposed parts of the skin, presumably as a protective mechanism. The forehead and cheeks become excessively hairy, quite like the appearance of a werewolf!

OUT OF THE BOX 2

The psychiatric symptoms of porphyria including strange behaviour and increased violence may possibly be linked to the characterization of werewolves and their aggressive, nocturnal behaviour.

The connection of porphyriasto vampiric myth is largely based on conjecture but it does make one think of the possibilities of its origin! It is likely that in the middle ages, the appearance of themost severely affected of the porphyria patients along with the complete lack of medical science lead to the emergence of these myths.

Dr. Harshal Ranglani,
PG-2, Goa Medical College,
Goa.

I. ECTO – MATCH (match the left column with one or more on the right column)

1. Goltz - Gorlin syndrome	A) Hidrotic ectodermal dysplasia
2. Brauer - Setleis syndrome	B) Hypohidrotic ectodermal dysplasia
3. Jessner - Cole syndrome	C) X-linked anhidrotic ectodermal dysplasia
4. Clouston disease	D) Ankyloblepharon - ectodermal defect - cleft lip/palate syndrome
5. Hay - Wells syndrome	E) Tricho-rhino-phalangeal syndrome
6. Christ - Siemens–Touraine syndrome	F) Focal dermal hypoplasia
7. Langer - Giedion syndrome (type II)	G) Focal facial dermal dysplasia
8. Ectodermal dysplasia 1	H) Ectodermal dysplasia

II. PANTHEON SPELL BEE

1. ..... (7) ..... (6) ..... (7) HANSEN
2. ..... (5) ..... (11) NIKOLSKY
3. ..... (8) KOEBNER
4. ..... (7) RAYNAUD
5. ..... (5) ..... (5) ROOK
6. ..... (3) ..... (8) HUTCHINSON
7. ..... (6) LESER & ..... (6) TRELAT
8. ..... (4) ..... (7) FORDYCE
9. ..... (6) ..... (4) ..... (3) WASSERMANN
10. ..... (8) FRACASTORO
11. ..... (7) ..... (8) FREI
12. ..... (5) ..... (4) ..... (4) BROCQ
13. ..... (9) ..... (4) DARIER

III. CRISS-CROSS

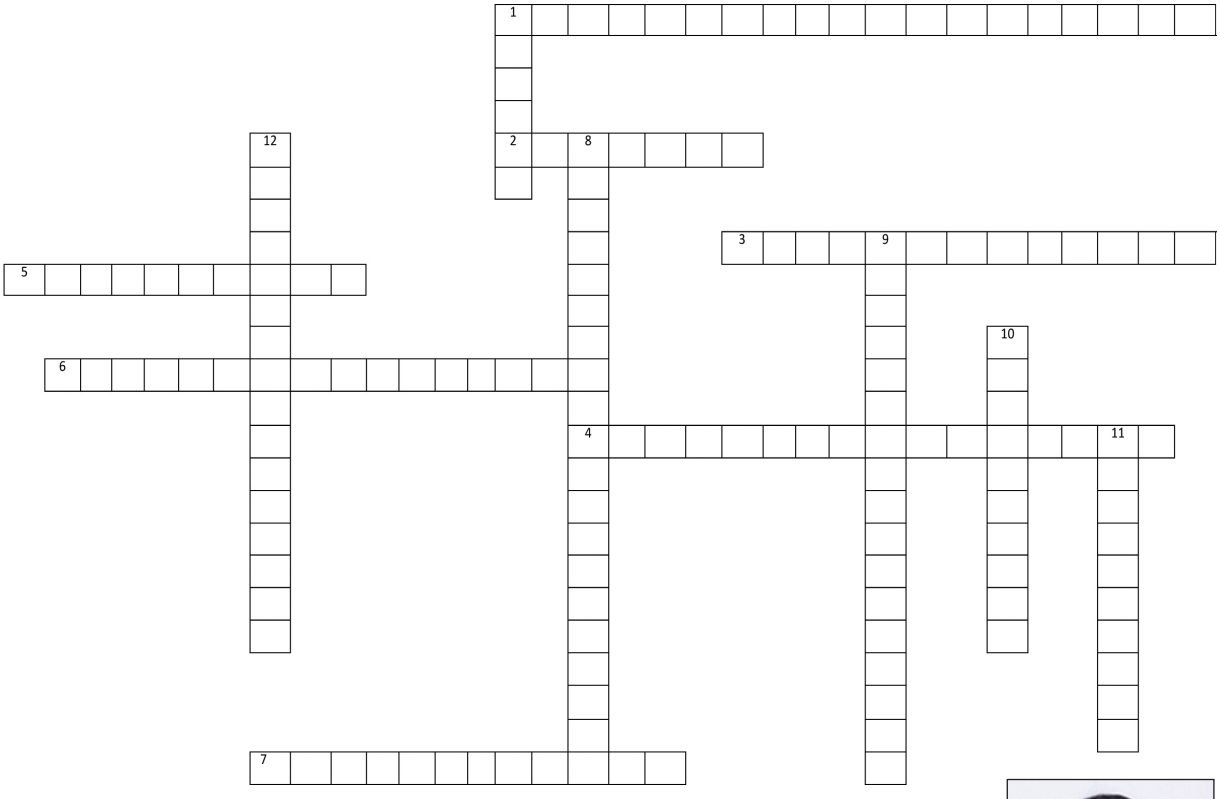
(Clue : The 1st word of all the conditions mentioned in this crossword is “ERYTHEMA”)

ACROSS

1. A) A perivascular 'sleeve-like' lymphohistiocytic infiltrate is seen (8+11)
2. It is a cutaneous reactive process and most common panniculitis (7)
3. It is associated with lung cancer (7+6)
4. It is seen in tick-borne zoonotic disease caused by the spirochaete, Borrelia burgdorferi (9+7)
5. It is a type of cytotoxic dermatitis resulting from cell-mediated hypersensitivity most commonly to drugs or infection (10)
6. It is a synonym of Bury disease (8+8)
7. It is caused by parvovirus B19 infection (11)

DOWN

1. B) It is mainly due to infrared radiation (2+4)
8. It is the development of persistent grey-blue hypermelanotic cutaneous macules with an inflammatory phase of erythema (12+8)
9. It is the appearance of red blotchy macules with histopathology showing eosinophils (7+10)
10. It is one of the duckett jones major criteria of rheumatic fever (10)
11. It is the occurrence of generalized hyperemia which fades by 24 to 48 hrs. (10)
12. It is a tuberculosis-associated panniculitis (9+2+5)



Dr. Preethi B Nayak,
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TO BE OR NOT TO BE... ... AN INDEPENDENT PRIVATE PRACITIONER?

The top-of-the-world feeling of becoming a dermatologist on successful completion of residency is so transient for most post-graduate students; it immediately unmasks the ever-perturbing and inherently discomforting question faced by each one: 'WHAT NEXT???'

First and foremost, take a few days off. Travel around, meet those far-off relatives of yours whom you could never visit during your studying years, read those novels covered with dust that you bought with great zeal, go on an adventure trip or simply laze at home, something you might not have done in years...then get ready for a 'Not-as-bad-as-you-had-expected' world out there. It needs many dermatologists, and has a lot of space left for many more.

The choices post-residency are innumerous: one can join a medical college and continue being academically inclined (teaching is highly satisfying for some), or join a government hospital (where clinical exposure is extremely good), work with established senior dermatologists (so many new things can be learnt from them, including the secrets of successful clinical practice), join a franchisee /established chain (most of these are cosmetically tilted or focus only on trichology/hair transplant- pay is decent-to-excellent but many have commitment bonds) or pursue that one-year fellowship you were so keen about (the shorter fellowships can be pursued at any time in your life, as and when you develop interest in a specific sub-speciality...Thank God dermatology is an end branch as of now!!!) or (here it comes finally)START OWN PRACTICE (a dream for most, where you can be your own boss). While each of these has its own pros and cons, let me dedicate this write-up on the intricacies of starting an own private practice.

Dermatology is a great branch for starting own practice as one can start with minimum capital (chairs, consulting table and patient bed might be just enough for a basic set-up) and then go on to expand gradually. Even for dermatosurgery& trichology practice, a dermascope, a radiofrequency unit, few chemical peels, dermaroller units and a centrifuge machine (preferably digital)would suffice. One can get lasers and operation theatres on rent during the initial phases (or even later on). Also, I have noticed people are more willing to give a chance to the less experienced dermatologists (as opposed to the surgical fields, or the emergency fields such as cardiology or ICU intensivists) at least for the consultancy part. If one is not comfortable in handling the responsibilities of clinic management (sometimes it can get on your nerves, but if I can manage, I'm sure anyone can!), one always has the option of joining a polyclinic/multi-specialty (Chamber) during the initial few years.

So if you ask me if one can start own private practice at an early stage, then my reply would be 'WHY NOT??' I always feel a person will give the best when he/she is on his/her own. There'll be many excuses for not taking the plunge (marriage, pregnancy, nuclear family with young children, long-distance relationships as well as the many uncertainties that life presents with), however, I seriously believe once the decision is finalized, solutions will always be reached upon, no matter what.

Let me make a confession here: I'm just about to complete a year of my practice. I'm sure you must be wondering 'Why the hell am I taking advice from this guy whom I've never heard about, and who might not be even having a successful

practice???' Thankfully, this write-up is not on how to be a successful dermatologist or how to market your practice. This is just me sharing my experience of starting an own private practice in this cut-throat competitive world, the hurdles I've faced, the mistakes I've made and the few successes (I guess very few)I've enjoyed.I wanted not to sound preachy, but that is exactly what I'm doing (I place the blame on the topic) by presenting my views in the form of DOs and DON'Ts (I'll like your clinic facebook page if you by chance manage to complete this article):

DOs:

1. **Generate GOODWILL :** The corner-stone of any doctor's success is a good word-of-mouth, which can happen only when he or she strives to generate goodwill. This might be in the form of lowering charges for poor patients, making the right referrals, giving the right prescription, arranging for costly medicines at discounted rates, giving time to each and every patient, or taking those extra efforts that willsooner or later find due appreciation. One may not be clinically brilliant, but can still go on to create a lot of goodwill by sincerity, dedication and hard-work.
2. **Be PUNCTUAL :** Gone are the days when patient felt that greatness of a doctor is directly proportional to the waiting period in his clinic lobby. A doctor who values not just his own time, but of his patients' too, is widely respected. Adherence to the appointment timings would help improve the patient-doctor relationship.
3. **Be HUMBLE :** Politeness always helps. Treat your patients, assistants, workers, colleagues and everyone else with humility and respect.
4. **Be AVAILABLE for your patients :** Long trips (be it personal or for conferences) might make your patient feel insecure, and should be kept to a bare minimum during the early stages of private practice. Though there are very few emergencies in our field, the patient must feel that he or she has someone when required. A couple of days here and there may not matter, but anything longer than that might affect the patient's trust.
5. **Be UPDATED :** Read journals, books, attend CMEs, participate in discussion, encourage debates (not fights), online forums will all serve as helpful tools to continue in the quest for more knowledge, which is essential for a sound clinical practice.
6. **Be a little CHARITABLE :** This can be in the form of weekly charitable attachments or periodic camps for the poor and needy, medicine donations, or even non-medical activities such as donating books, money for good causes. These will add-on to the goodwill generated through private, which might take some time initially.
7. **IMPROVISE on past mistakes :** Accept mistakes, even in front of the patients (let them see we are human too). More the mistakes, quicker the learning!
8. **Treat ALL PATIENTS EQUALLY :** Your clinic should be a great equalizer, try to mete out similar treatment to the VVIP celeb walking in and the vegetable vendor in torn clothes. Always remember 'What is today may not be tomorrow'
9. **Embrace DIGITALIZATION :** Any technology that improves the comfort of a patient, doctor or enriches the patient-doctor communication must be supported. Preference for e-cash, systematized appointment schedules, online

records for review will go a long way in enriching the patient experience. Social media such as facebook, websites, and blogs can become powerful marketing tools, if used rightly.

10. **Indulge in TEAM WORK :** It was a lot easier for me to join my brother (who's a dental surgeon) as there was no added pressure for rent payment, his established patients formed my initial walk-ins and both of us were there to cover for each other. In short, it is much better if there's a team at work, be it family, friends, colleagues, or anyone trustworthy from similar or different medical or paramedical fields that can be found. This is a true symbiotic relationship as optimum space utilization is possible (thereby bringing down the overall per consultant cost), propagation of goodwill and marketing are a lot easier and one can benefit from the cross-walk-ins.
11. **Learn TIME MANAGEMENT :** Taking lectures at college or giving a small talk at a CME, attending a wedding in family or an important conference, writing a manuscript for publication or reading the latest copy of a journal, time management is an art which few can master (I still haven't been able to). All these have to be accomplished without any of them impinging on the clinic schedule. It's a challenge that'll prevent life from becoming monotonous (I try to look at the brighter side).
12. **REFER when required :** No doctor should feel inferior if he or she must refer, always encourage a second opinion in difficult cases when one is not sure about the diagnosis or treatment. This will save a lot of your time and energy, as also that of the patient. One can always discuss difficult cases with their seniors or use online digital forums such as ACAD, where ever-helpful dermatologists show their generosity by giving free advice.
13. **Give CREDIT where due :** Be it the previous doctor whose effective treatment has made your job easier, or some colleague or friend who guided you towards the right diagnosis or some novel treatment which was mentioned by someone in a CME or journal, always be the first to give due credit to the rightful person. This will augment their helpfulness towards you and enhance your practice.
14. **Learn from JUNIORS :** The most I learn is from my juniors. They are full of enthusiasm, read a lot, think out of the box, are not afraid of making mistakes and adapt very easily. One must be always in touch with the juniors, as, in most cases, it is they who teach us about the recent advances and devise new procedural methods. (Not to discount the fact that the amount we learn from our seniors and mentors is immeasurable)
15. **Use HUMOUR wherever possible :** Most patients are already stressed when they go to a physician; using some light humour will make them more comfortable, strengthen the doctor-patient relationship and thus, improve the patient's compliance and outcome. Euphemisms can and should be used when the prognosis is guarded.
16. **Find time for HOBBIES :** Be it movies, writing blogs, travelling, meeting new people, playing music, learning new languages, attending concerts or adventure trips, it is utmost essential that you find time for those activities that refresh & rejuvenate you. Like the famous saying goes, 'All work and no play makes Doc a dull chap'.
17. **SOCIALIZE for fun with benefits :** It is quite helpful to mingle with other consultants as well as those from the other fields as sharing of ideas & knowledge is much easier when done informally. Socializing is a means of marketing too.

DON'Ts :

1. **Do not buckle under PRESSURE from Pharma companies :** they will offer gifts, free conferences, free lunches and much more. Well, nothing comes free in this world. Followed by all the above will be unwarranted pressure to prescribe suboptimal medicines. This might adversely affect the treatability quotient of the patients.
2. **Do not indulge in any UNETHICAL ACTIVITY / untoward activity :** Cut practice (giving away a chunk of hard-earned money in the hope of getting many more referrals may not be too fruitful in the long run. The more you feed greed, the more it'll bite you. There are a few good doctors out there who will refer without any expectations, try your best not to disappoint them)
3. **Do not participate in SHAMING COLLEAGUES publicly / on social media :** This is a very disturbing recent trend where doctors shame their competitors on social media in the hope of affecting the latter's practice. Remember, when two are fighting, the third wins.
4. **Do not SPEND UNNECESSARILY on advertising propaganda- gold memberships, paid articles:** people are a lot smarter these days, they know why a doctor's name features over the others on paid medical websites or why one receives such highly positive reviews in a short span of time. It might be more prudent to channelize one's time and efforts on honing the skills and knowledge. Golden rule: Only Word-of-mouth works in the longer run
5. **Do not CHIDE the patients for non-compliance:** You might care for the patient and may raise your voice at them for not following the proper instructions; however, at no point should the caring tone reek of high-handedness. Never belittle their sufferings, or make fun of their problems.
6. **Do not write a very LONG LIST of prescription medicines :** The prescription should be prioritized so that it is easier for the patient to adhere to the medicines. Patient may come to you with 10 different complaints, it is you who must make them understand the necessity of treating them sequentially lest the prescription might feel too long and practically implausible to follow
7. **Do not LOSE PATIENCE with patients :** Like all good teachers say, half the battle is always won by careful listening. Be attentive (even if the patient goes on blabbering), sympathetic (though the complaints may seem out of proportion to the symptoms) and never rush the patient.
8. **Do not let EGO surface :** Do not get OFFENDED if patients or juniors or colleagues point out mistakes
9. **Do not BUY EVERYTHING UNDER THE SUN at the start itself :** I know a lot of fancy stuff is available - so many things that we had never seen or heard about in residency!! Just try not to get too adventurous with the initial set-up and your clinic will stay away from losses.
10. **Do not get carried away by ONLINE CONSULTATIONS :** A proper history-taking and clinical examination (hand lens, torch, dermascope) is the only way to accurately arrive at a diagnosis, which is not the case with online consultations. So unless absolutely essential (emergencies routed via primary doctors or patients at far-flung places), avoid consultations on Whatsapp, facebook, skype or expert columns.
11. **Do not blindly IMITATE those more successful:** Every doctor has his/her own personality,

style, body language. Imitation of established doctors might rob one of his/her identity, which few patients will respect.

12. **Do not CRITICIZE colleagues, fellow doctors:** Always take a stand for your brothers (unless gross mistake which is extremely rare) as one day you might be in their boat. Give them the benefit of doubt (all doctors want their patients to be relieved of problems) as mistakes can happen by anyone. Over-zealous criticism usually has a ricochet effect.
13. **Do not disregard personal HEALTH:** Go for walks, exercise, follow regular diet, have frequent check-ups and avoid falling into the "bad-lifestyle cycle" (late dinner, lack of sleep and exercise, poor consulting or surgical posture, long term eye strain). Without good health, no ambition can be fulfilled.
14. **Do not try to SQUEEZE IN medical representatives in between patients:** neither the patients will like this nor will you be able to learn about the new products being developed or newly launched, due to the unnecessary rush. Always better to have separate timings for our pharmaceutical brothers.
15. **Do not ever JUDGE a patient:** The patient might be indulging in activities that might be disagreeable to you, but that should have no bearing on patient management. Our only job is to treat the patients, not judge them.
16. **Do not make UNNECESSARY PROMISES to the patient:** some conditions are difficult to treat, while some procedures may leave behind sequelae. Always good to be 100% honest (ok, 99%) and give realistic goals rather than making over-the-top promises and guaranteeing difficult-to-achieve results to avoid embarrassment later on.

That's it folks! (I never like the DON'Ts outrunning the DOs as it sends negative signals)

[Confession: over the past one year, I have tried to be more punctual, less critical of other consultants, made separate call timing provisions for pharma people, tried to make my prescription list shorter and priority-based, tried to be more polite, tried to be more patient, more attentive, pursued my hobbies (sports, movies). I have been partly successful, largely unsuccessful. Here's hoping things would change for the better]

Finally, to answer the title question of whether to be an independent practitioner or not, I'll quote these not yet famous words: ''BE what you want to be, and be a little more; because you have it in you – just BELIEVE!"

I wish you great luck and success for your new Endeavour (whenever you start). Welcome aboard!!!

Let me conclude with these famous words of 3 IDIOTS (pardon the MODIfication): 'If you run after success, patients will run away from you; but if you run after patients, success will surely follow you!'

P.S. If you are still reading this, then I salute your patience. Your practice will definitely thrive... And do invite me to like your clinic FB page when you make one!

Dr. Jimish Bagadia,
Consultant Dermatologist,
Bagadia's Clinic, Mumbai.

ANSWER KEY

I. ECTO – MATCH

1 – F	2 – G	3 – F
4 – A, H	5 – D	6 – B, C
7 – E	8 – B, C	

II. PANTHEON SPELL BEE

GERHARD HENRIK ARMAUER HANSEN

PYOTR VASILYEVICH NIKOLSKY

HEINRICH KOEBNER

MAURICE RAYNAUD

ARTHUR JAMES ROOK

SIR JONATHON HUTCHINSON

EDMUND LESER & ULYSSE TRELAT

JOHN ADDISON FORDYCE

AUGUST PAUL VON WASSERMANN

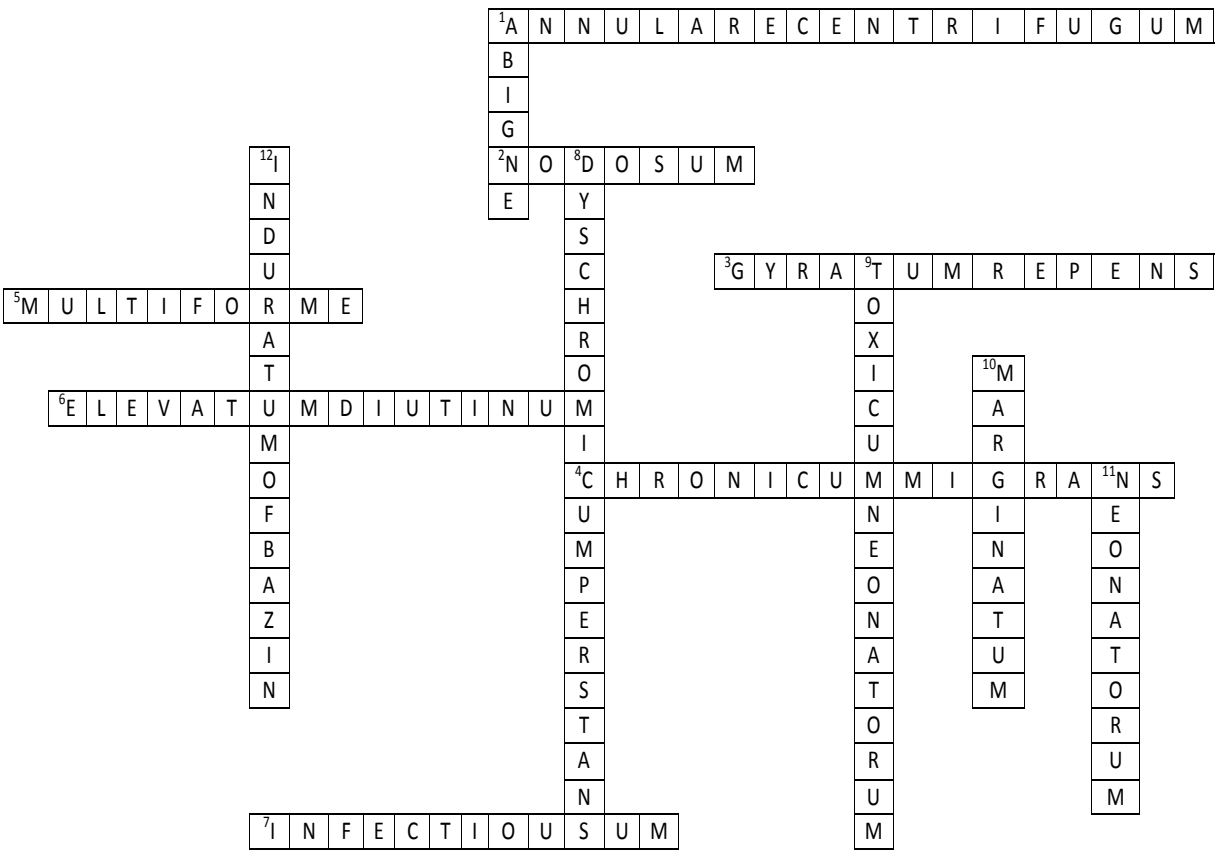
GIROLAMO FRACASTORO

WILHELM SIEGMUND FREI

LOUIS ANNE JEAN BROCQ

FERDINAND JEAN DARIER

III. CRISS-CROSS



IMPORTANT NOTICE

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NOTIFICATION FOR PLM TO LM CONVERSION

All Provisional Life Members (PLMs) of IADVL, who have **completed 5 years of provisional membership and/or obtained a postgraduate (PG) degree/diploma in Dermatology and registered their PG qualification with the MCI/State Medical Council**, are notified to become Life Members (LMs) latest by **31 August, 2017** to avoid lapse of their membership.

This is in consonance with the **IADVL Constitution** which grants Provisional Life Membership for a period of 5 years within which a PLM has to convert to LM, failing which he/she **ceases to be a member of the association**.

There are **many benefits and privileges of being an IADVL Life Member (LM)**. Only a LM can apply for orations, awards, grants, scholarships, observerships and also can become members of international societies. Moreover, life membership of the association will enable you to cast your vote in the IADVL Elections and participate actively in the functioning of the association at both State and National levels.

One can **apply for conversion from PLM to LM through the Online Membership Application System (OMAS)** on the IADVL website (www.iadvl.org). Those PLMs, who have migrated to another state branch after post-graduation, can write to the Secretary of the parent State Branch (where their PLM is registered) for a No Objection Certificate (NOC) and, thereafter, **apply for conversion from PLM to LM and State Branch transfer concurrently**.

Any PLM whose membership lapses by 31 August, 2017 on this count will have to apply afresh for membership of the Association.

Dr. Shyamanta Barua
Hon. Secretary General, IADVL

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Regards,

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