Resident-DREAM

January 2014, winter issue, Vol. 1, No. 1 (Inaugural Issue)

a newsletter for IADVL residents

There is something mysteriously powerful that can happen when young, inchoate minds come into contact with older and more worldly ones in a spirit of intellectual and creative endeavor - if I believed in progress, I suppose that's what I'd call it."

- Will Self

From the editor's pen

The beginning !!!!

I think the words of the novelist truly describe the spirit of our endeavor to bring out this first edition of our newsletter. Although there is immense pride in our hearts to see it finally come through and yes there is a lot of toil and sweat too, but central to the genesis of this remarkable feat lies a vision.

It started off when our beloved mentor and guide Dr. Rashmi Sarkar (mam), who in her never ending zeal to do something for the young generation had started off a small e-group and had asked residents to opine on what they think could be done to for them from IADVL.

For someone like me and many others, that was a beacon of hope, because I think for the first time there was someone who offered to listen to us. Residency like puberty is a period of immense transitions. It's that No-man's land between class room and the real world. There are too many pressures, looming doubts about future and confusions. Within no time mam was bombarded with ideas fresh out of untarnished minds of residents all across the country. That was the beginning of this journey and it was conceptualized that a newsletter would be an ideal start to help Residents all across the country. Dr. Rashmi Sarkar thought that this would work very well under the leadership of Dr. Deepak Parikh, the incoming President of IADVL 2014. I still remember , my first meeting with mam and members of our team at New Delhi and looking back now, it dawns upon me, that without her vision and inspiration, we would have been just a bunch of over-enthusiastic work junkies.

The prime focus of this newsletter will be to disseminate information to residents in every part of this country and bring about an awareness of opportunities that lie in front of them , to open the faculty of their minds to newer ideas and concepts and to make them think out of the box and not necessarily toe a hackneyed line .We deeply believe that although cosmetics is an integral part of Dermatologist's life now , but there are avenues far and beyond and we will try to bring views of National and International experts to help you out.

Our team comprises of residents from all four corners of the country. We have tried to bring a kaleidoscopic mix bag which consists of things like historical trivia , quiz , dermatopathology corner and to help the out going final years for their exams, we have included approach to common long cases and interviews with the university toppers.

It will be of importance here to mention, that this newsletter is by no means an attempt to replace a journal. Although our sincere endeavor would be to maintain highest scientific standards, but the feel of this newsletter would be less formal, more interactive and would echo with needs and aspirations of the today's generation. We have tried to incorporate a variety of segments that we sincerely hope would appeal to you , help you , inspire you.

Looking forward to more of your queries, more of your suggestions, more ideas, feedback and thoughts. Wake up from the slumber, churn up your minds, get the ball rolling and write to us, this is the newsletter for you, for us, THE RESIDENTS.

As Plato has said , "The beginning is the most important part of the work". …. So we have begun !!!

- Dr. Ishad Aggarwal

In this issue

Foreword
-By Dr. Deepak Parikh

Foreword
-By Dr. Rashmi Sarkar

From the Examiners
An approach to Immunobullous Disorders
- By Dr. Vijay Kumar Garg

Calendar of Events
Schedule of important meetings and conferences in 2014

Flashback from stalwarts
A message from the doyen to the budding dermatologists
- By Prof. Patrick Yesudian

Me and my meaningless musings
A journey in the world of dermatology from the eyes of a stalwart
- By Dr. Koushik Lahiri

Quiz

Derma Trivia

Research Methodology Workshops
An IADVL initiative to promote research in dermatology

The Southern Potpourri
An account of dermatoses in southern India
- By Dr. Saloni Katoch

Inspiration
People who inspire us
- Interview with Dr. Gobinda Chatterjee

Resident Voice
Debate on Advent of cosmetics in Dermatology : Boon or Bane
- By Dr. Ishad Aggarwal & Dr. Sumit Gupta

Toppers Speak
A guide to excel in the final exams
- By Dr. Niharika Ranjan Lal

Psoriasis
What's new in pathogenesis
- By Dr. Samujjala Deb & Dr. Anupam Das

Quiz Answers

Feedback

Foreword

President's Pen :

Dr. Deepak Parikh
President - IADVL
Hon. Prof. & HOD Pediatric Dermatology
Consultant Dermatologists Bombay Hospital
Chairman – Indian Society for Pediatric Dermatology

"I have always felt that today's residents are future IADVL leaders and they need their own space in our association. So I was pleasantly surprised when Dr Rashmi came to me with this brilliant idea of resident forum and newsletter. I saw a great endeavor in making and it was instant yes rom me. I was fortunate to meet her team of enthusiastic residents during ICD-DERMACON meet at Delhi. This brings unprecedented change in IADVL functioning. The newsletter is for the residents and will be edited by the residents

I sincerely hope this newsletter becomes voice of resident from all over India."

Foreword

Secretary's Desk :

Dr. Rashmi Sarkar
Honorary General Secretary IADVL (2014-15)
Professor,
Department of Dermatology
Maulana Azad Medical College

Perhaps it was waiting to happen all along. While coordinating the Scientific Program of First Pigmentarycon 2013, the first scientific conference of Pigmentary Disorders Society, I received a lot of correspondence, mainly inquiries from residents all over India. Interacting with them, addressing their concerns and anxieties and conducting a Special Session for The Residents with Senior Dermatologists answering their questions, made me start thinking. Are the postgraduates a lot that needs more face in IADVL ? After all they do need to be sensitized for the future-academics, teaching, research, administration. This opened a thread of emails for me-an open feedback thread between me and the residents, approximately 40 of them representative of different parts of India and I was amazed at their skills and frankness, their expression and eloquence. I already had Dr Sumit Gupta from my Department in MAMC, New Delhi who is multifaceted and Dr Anuj Tenani, a first year PG, a computer wizard. Dr Ishad Aggarwal, a final year PG from Kolkata had corresponded with me for ISD Mentorship Programs and PDS, and here was a person who seemed to know something about publishing, and I could see the enthusiasm and verve in him to be a leader and first Resident Newsletter Editor. Similarly, I was introduced to bright youngsters, Gillian Britto(Bengaluru), Saloni Katoch (Davangere), Anupam Das (Kolkata), Zubin Mandlewala (Mumbai), Jimish Bagadia (Mumbai) who volunteered to be on our editorial board of the First Resident Newsletter of IADVL. Not to forget, Samujjala Deb, a wonderful PG from Burdwan, an all rounder and a bundle of energy, who I discovered at one of the Women's Dermatologic Networking Receptions I had organized. All these residents were picked up on gut feeling and the infectious energy they exhibited and we had the first resident newsletter editorial board ready to take off! I needed Dr Deepak Parikh, the IADVL President, to support this idea and he was all for bringing youngsters to the fore!

All we needed was the name, for the Newsletter there were suggestions from Sumit, Ishad, Dr Koushik Lahiri (one of the youngest members), myself but we weren't quite getting it. I got help from my husband, Dr Srikanta Basu and finally the PGs and I got the name - The Resident-DREAM(Dermatology Residents'Education and Motivation bulletin!).

It is a new flight. We are just flapping our wings to test the air. Let us fly short distances right now……to embark on a long wonderful flight through the silvery clouds!

Flashback from the stalwarts

Authored By:

Prof. Patrick Yesudian FRCP. FAMS
Professor Emeritus, MGR Medical University
Chennai
Dr. K.C. Kandhari Awardee (2013)

ALL THAT I COULD SAY TO MY YOUNG FRIENDS

Why does one choose dermatology as a career?

Obviously the reason would vary from person to person. In my case, I would say that it was chance, serendipity, fate, god's will or whatever you wish to label it. During my internship in the late 50's, I was very keen to specialize in neurology. With this in view, I did an unprecedented stint of 2 months under the famous neurosurgeon, late Prof B Ramamurthy. Though it was fascinating to watch tumors and aneurysms in the brain, I slowly became disenchanted with neurology since very few of the central nervous system disorders could be cured at that point in time.

So during my housemen ship year, I was contemplating on changing my career option. Then quite by chance I overheard one of my roommates saying that there was a new professor of dermatology who regularly demonstrated skin cases on Tuesday afternoons. So during my community medicine postings one day, I quietly went in and sat in the last row since my knowledge of dermatology at that point was zilch.

The new professor was Dr A S Thambiah, the only qualified dermatologist in our state at that time having just returned from U.K with MRCP with dermatology as a special subject. There were less than 10 members of the Royal College of physicians in dermatology in the whole country in the 60's. On the day I attended the clinical meeting the professor was presenting cases of Porokeratosis, Kerion, Lipoid proteinosis etc… names I had not heard of during my UG days and so, for a moment I thought that I had entered a Latin class!

But then Prof Thambiah explained each case in turn the clinical features, histo-pathology and treatment that even I could comprehend the diagnosis. From then on, I never missed his clinical demonstrations. It was so fascinating to see and diagnose vide variety of skin disorders with distinct descriptive morphology. That is how I got hooked to dermatology.

He then encouraged me to go abroad and qualify since there were no post graduate courses in dermatology in most states of India at that time. After I passed my MRCP, I returned to India and joined the skin department, Madras medical college as assistant surgeon at a salary which was one tenth of what I was drawing as a house surgeon in UK and the rest is history.

I was lucky that I had a mentor like Prof Thambiah when I entered the specialty – a mentor who guided me, stimulated me, counseled me and encouraged me. In short he was my role model. I truly believe that such mentorship as it exists in many Universities in the West is essential in our country also, to turn out good and dedicated doctors.

Flashback from the stalwarts

When I entered the field of dermatology in the early 60's very few procedures were done by dermatologists like electro cautery, Cryo therapy using CO_2 sticks and skin biopsies. Dermatological career was the last choice for budding doctors. But over the next few decades more and more procedures were introduced like lasers, photo therapy etc… and the popularity of our specialty went sky high. Though in one way this has attracted brilliant young minds to dermatology the downside is that increasing time spent on procedures has put medical, academic dermatology in the back burner. This does not augur well for the future of dermatology since the foundation, the edifice on which our specialty has been built since the turn of the last century is medical dermatology.
Dermatology is a visual specialty. Many a time we make a diagnosis based mostly on morphology. We do resort to histopathology if there is doubt in clinical diagnosis. An accurate morphological description often leads to a correct diagnosis. This art is lost in recent times. Shelley's comment in this regard is worth recalling. "One swallow may not make the summer, but one classical papule – violaceous, flat topped, angulated with Wickham's striae will make the diagnosis of lichen planus"

Robert Willan, one of the founding fathers of British dermatology pioneered the description of the morphology of skin diseases. He had a very keen sense of observation. This has led modern day dermatologists like Parish and Happle to coin the term "Willan eye" for the special gift of observation in the field of dermatology. This may sound simple to the dermatology resident.

But Johan Wolfgang Goethe said,

> "What is hardest of all?
> That which seems most simple; to see
> With your eyes what lies in front of your eyes"

It is only the constant practice at the bedside that one can master the art of descriptive morphology. The sun should not be allowed to set on this golden era of descriptive dermatology which existed for nearly hundred years.

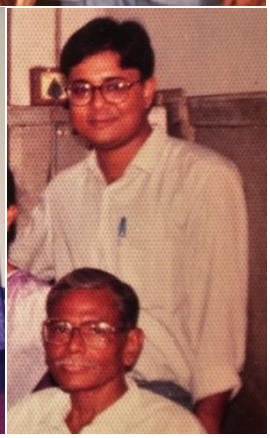
So summarizing, my advice to the new entrants to dermatology would be to have a mentor to guide you and secondly to have medical, academic dermatology as the nucleus around which to build your daily practice of procedures and thirdly to develop the art of descriptive dermatology.

Louis Duhring, the American dermatologist in his valedictory address to the medicos of the University of Pennsylvania said "The most important instrument in dermatology is, has always been and will forever be, the naked eye"

Me and my meaningless musings

Authored By :

Dr. Koushik Lahiri
MBBS, DVL(CAL), FIAD, FFAADV,
MRCPS (Glasgow), FAAD, Editor IJD,
Director ISD, President ACSI



Even before I was introduced to the English alphabet I became familiar with the decorative moss green famous mast head of a journal. Much later I was able to read the name, Indian Journal of Dermatology. The pungent smell of the letter press printing ink on the glossy art plates of that journal is still very fresh in my olfactory hard disk. My father **Dr. Bhabesh Chandra Lahiri (or Dr. B.C. Lahiri,** as he was popularly known as) was instrumental in starting the Department of Dermatology in Bankura Sammilani Medical College in 1969 and later in 1973 he became the first teacher in the Department of Dermatology at Burdwan Medical College and Hospital.In the years that followed his name became synonymous with dermatology all the adjoining districts of South Bengal. A founder member of IADVL, his devotion to the Association was evident but due to his shy and introvert nature he was always averse to pushing himself into the limelight.
Those days in the sleepy district towns like Bankura and Burdwan, life was uneventful and calm.

I was initiated to photography by my father at an age of six years, a hobby which became a passion in my later life and camera became an extension of my own body. Music was and still is my Achilles's heel. My love for music and literature came from my mother.

The gradual changes in the journal's get up were not missed by the schoolboy. I now realize with respectful reverence that even during trying times the journal kept ticking, without missing a single issue, and without compromising on the quality of the articles published in it. I pay my homage to the editors and guardians of the journal, whose untiring efforts during that difficult period made this possible during those difficult days.

My first teacher of Dermatology other than my father was Dr. Arijit Coondoo who is in real sense my friend, philosopher and guide My first PG teacher was an unassuming person **Prof P. K. Guha** who had astounding knowledge in both clinical Dermatology and dermatopathology.. After his retirement **Prof S. R. Sengupta** joined as my teacher and my perspective towards Dermatology changed forever. He was a great teacher, clinician, friend and an incorrigibly positive thinker. **Dr.Subrata Malakar** was the person who first introduced me to Dermatosurgery. He taught me punch grafting in vitiligo and many other procedures. **Dr.Sandipan Dhar** is my other guru. Without his affectionate and supportive presence in my life, I could never travel up to this point..

I still remember the winter afternoon, while working on my thesis on vitiligo surgery and could not find many of the articles needed considering the insurmountable difficulty we used to face in the pre-internet

era, when a big parcel reached my address with priceless articles with a hand written note from none other than the doyen of vitiligo surgery the legend, **Dr. Rafael Falabella.** from Columbia!. That packet was like a gold mine for me. Much later I could meet the master and got enriched with his unbridled love and affection towards me and towards all my humble and insignificant endeavours Tears of joy well up in my eyes when, with my humble efforts, a smile comes back on the lips of a young girl with vitiligo

I was introduced to **Dr. Ajit Kumar Dutta**, the renowned vitiligo worker, at a much later stage of his life.. He always inspired me to think beyond the obvious.

When I was inducted into the editorial board in 1997, my only job was to manually prepare the author index and subject index.. Those were the days of hard copy preparation and submission of manuscript in triplicate, distributing and sending the copy to the reviewers for manual proof correction, physically going to the printing press, and sundry other jobs. I consider myself extremely fortunate and privileged to have had the opportunity to be intimately associated, in various capacities, with the Indian Journal of Dermatology, for a decade and half that followed, and be a witness to the outstanding and mind-blowing metamorphosis of the journal.

There is a phrase 'publish or perish'.

I was fortunate that both my mentors and guides were extremely encouraging about documentation/publication.

They made me aware about the importance of publishing. Dr. B Haldar, the then editor of Indian Journal of Dermatology also used to encourage manuscripts submitted from new authors.

So, I started publishing during my residency with a case of multiple dermal cylindroma. I still remember the day when my first article was published in Indian Journal of Dermatology , while I was still a postgraduate student. I could not sleep that night.*The first time I presented in front of a National audience was in Ahmedabad in 1996 January on* ***the effect of topical tretinoin on acanthosis nigricans.*** *Other than reading text books it should be a habit to read high quality journals on a regular basis. We have astonishingly rich clinical materials at our disposal. It is sad we do not utilize it to the full. Publishing science is an art in itself. Different journals have different requirements/expectations/focus/priority and rate of acceptance. One needs to be aware/sensitized of these to exercise flexibility as and when required without compromising academic integrity. Even an iota of academic dishonesty(like any kind of plagiarism,data fabricating and falsification,duplicate submission/publication, stealing from others,deprivation/suppression and divergence about the right of authorship) should never cloud the mind of a worker.*

That is darkness.

That is death.

Let the flame burn within. And the passion to excel.

Always remember, civilization is progressing through you.

Other than Dermatology as many individual of my generation I was influenced by poet **Rabindranath Tagore,** director **Satyajit Ray** and author **Buddhadeb Guha**..

I have a couple of regrets to share:

- I have only 24 hours a day and do not have enough time to enjoy my kids growing up.
- I cannot devote much time for my instinctive attractions for writing, music, photography, nature.

To me God is not a distant alien entity. God is within us.

God is there in the writings of a Tagore or Tolstoy, in the voice of a Pandit Bhimsen Joshi or John Lenon.

God touches a poor patient through you, when you touch him/her with the intention to cure him/her.

You are God.

Calendar of Events - 2014

March

21st – 25th March

Annual meeting of the American Academy of Dermatology (AAD)
Denver, Colorado, USA. visit: www.aad.org

28th – 30th March

LEPCON 2014, 29th biennial conference of IAL
PGIMER, Chandigarh, India For more info, visit: www.pgimer.edu.in

April

9th – 12th April

21st Regional conference of dermatology (Asian-Australasian) incorporating the
6th Annual meeting of the Asian Academy of Dermatology and Venereology
Danang, Vietnam. For more Info, visit: www.asianderm.org

24th – 26th April

ACSICON 2014 – Annual Conference of Association of Cutaneous Surgeons Of India
Vythiri, Wayanad Hills, Kerala. For more info, visit: www.acsicon.com

May

7th – 10th May

73rd Annual meeting of Society for Investigative Dermatology (SID).
Albuquerque, Mexico. For more info, visit: www.sidnet.org

June

9th – 12th June

STD Prevention Conference
Atlanta, Georgia, USA. For more info: visit: www.cdc.gov/stdconference

25th – 26th June

2nd International Conference on HIV/AIDS, STDs & STIs
Valencia, Spain. For more info: visit: www.omicsgroup.com/hiv-aids-std-conference-2014

12th – 14th June

12th European Society for Paediatric Dermatology (ESPD) Congress
Kiel, Germany. For more info, visit: www.espd2014.com

July

10th – 13th July

COSDERMINDIA 2014
Mumbai, India
For more info, visit: www.cosdermindia2014.com

18th – 20th July

10th World Congress of the International Academy of Cosmetic Dermatology
Rio De Janeiro, Brazil. For more info, visit: www.iacdRio2014.com.br

August

15th – 17th August

IADVL MIDERMACON
Hotel Rama International, Aurangabad,
visit: www.iadvlmiddermacon2014.com

September

3th – 6th September

15th World Congress on Cancer of the Skin
Edinburgh, Scotland. For more info, visit: www.wccs2014.org

4th – 7th September

22nd International Pigment Cell Conference
Singapore. For more info, visit: http://www.ipcc2014.org

18th – 20th September

5th World Congress of TeleDermatology
Barcelona, Spain. For more info, visit: www.sbc-congresos.com

October

8th – 12th October

23rd European Academy Of Dermatology & Venereology (EADV) Congress
Amsterdam, Netherlands. For more info, visit: www.eadvamsterdam2014.org

22nd – 24th October

35th Annual meeting of International society for dermatologic surgery (ISDS)
Jerusalem, Israel. For more info, visit: www.isdsworld.com

November

4th – 7th November

4th Continental Congress of Dermatology and 37th Annual Convention of Philippine Dermatological Society. For more info, visit: www.pds.org.ph

Research Methodology Workshops

IADVL Academy with IADVL Executive Committee 2014 is organizing a series of research methodology workshops with the aim of developing dermatologists who will be conversant with the techniques of modern research methodology. It is meant to benefit postgraduate residents who are meant to undertake original research as a part of their theses and also beyond it.

VENUES & DATES

Mumbai

Date: Saturday, 15th February (12 noon-5.30 pm) & Sunday, 16th February (9 am-5 pm)
Venue: Auditorium, Ground Floor, College Building, BYL Nair Charitable Hospital and TN Medical College, AL Nair Road. Mumbai Central, Mumbai-400008

Kolkata

Date: Saturday, 22nd February (12.30-8 pm) and Sunday, 23rd February (8 am-5 pm)
Venue: Sushruta Auditorium, College of Nursing, 3rd Floor, Command Hospital (Eastern Command), Kolkata-700027

Bangalore

Date: Saturday, 8th March (9-5 pm) and Sunday, 9th March (9-5 pm)
Venue: Seminar Hall, Department of Skin, STDs & Leprosy, Room no. 52, Old OPD Building, Victoria Hospital. Fort, Bangalore-560076

Delhi

Date: Saturday, 3rd May and Sunday, 4th May
Venue: Maulana Azad Medical College, Delhi-110002

For more information on contact details, registration and programme highlights, please visit: www.iadvl.org

Inspiration – People who inspire us

Dr. Gobinda Chatterjee Prof. and Head , Dept. Of Dermatology, IPGMER , Kolkata gives us a candid interview

Dr. Gobinda Chatterjee has a vast experience of over 25 years in Dermatology. He has several publications in journals of national and international repute. He has immaculate clinical acumen and a very in-depth knowledge of the subject, with special interest in psoriasis , vitiligo and correlation of dermatology with internal medicine. Sir is a very affectionate mentor, an avid reader and traveler and always inspires us to be not just good doctors but better human beings too.

Dr. Ishad Aggarwal

Dr. Gobinda Chatterjee

Sir, please share with us , some experiences of your residency

While walking down the memory lane I still remember the day when I joined as a junior resident at PGIMER, Chandigarh on 1st January 1985. It was a chilly morning with a temperature of around 0° C, but the moment I entered the department, I was greeted with a warm welcome by my beloved teachers. The next three years were a great learning experience under the constant guidance of teachers and seniors. I was lucky to work and develop my skills under the affectionate guidance of teachers like Prof. Surinder Kaur , Prof. Bhushan Kumar, Prof. A.Kanwar and Prof. V.K Sharma

Sir, what would be your advice to residents for the three years of their residency?

The three years of residency are the building blocks for the residents to aspire to be not just good dermatologists but also good human beings. My advice to them would be to inculcate strong work ethics, diligent quest for knowledge , strive for academic excellence and develop empathy for patients. They must realise that India is in BHARAT.

Sir, what according to you is the current scenario of dermatology so that residents can prepare themselves for the future?

As Dermatology has become a subject of tremendous advancement in recent times, one may not be able to be inconsonant with all developments in all spheres of dermatology, it is advised that residents concentrate on sub-specialities like dermatosurgery, dermatopathology etc during residency, but one must not forget clinical dermatology while practicing such specialities like aesthetic dermatology.

Sir, how do you see the field of cosmetic dermatology?

Cosmetic dermatology has come up as a science which was being practiced by non-medical personnel and beauticians only. There has been a tremendous boost in this field with upcoming and knowledgeable dermatologists dedicating themselves to this specialty. With sound scientific knowledge in cosmetic dermatology, it will be one of the most exciting fields of medicine in the near future

From the examiners

Approach to Immunobullous Disorders

Authored By :

Dr. Vijay Kumar Garg
Director Professor and Head of Department
Department of Dermatology
Maulana Azad Medical College

Case Scenario:

A 45 year old male, tea vendor by profession, resident of Delhi, presented to the OPD with:

- Fluid filled lesions all over body for 1 month
- Raw areas in oral cavity for 10 days

Important questions to be asked:

What is the duration of disease?

Has this happened before?

What type of lesions appeared, over what type of skin, at what sites and how did they progress?

Presence/Absence of oral mucosal involvement?

Patient was apparently well about 1 month back, when he developed multiple fluid filled lesions at forehead and scalp associated with pain and burning sensation. The lesions were lentil sized to begin with and appeared on normal looking skin. Lesions were flaccid (with *thin and wrinkled roof),* and filled with clear fluid. Within 2-3 days, the fluid within lesions turned turbid and lesions ruptured on their own or on trivial trauma leaving behind raw areas which did not heal and extended beyond the margins of original lesions. In a span of 12 to 14 days, multiple similar lesions appeared on neck, chest, bilateral axillae, bilateral upper limbs and trunk.

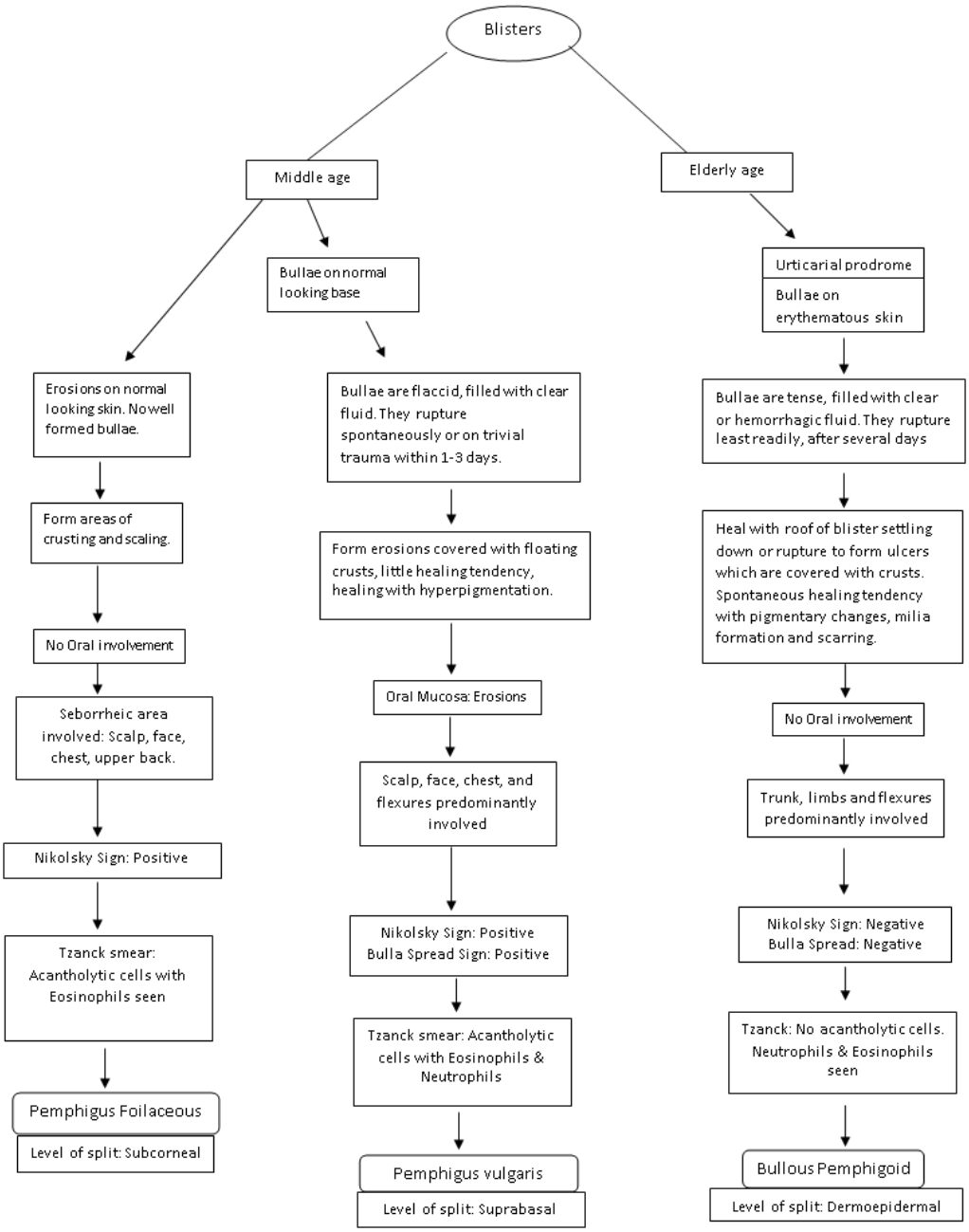
For past 10 days, patient has developed multiple raw areas in mouth associated with pain and difficulty in eating.

On examination:

Multiple vesicles and *flaccid bullae* of size 2 mm × 2 mm to 2 cm × 2 cm present on normal looking skin, filled with clear to turbid fluid over scalp, face, axillae and groins. Multiple erythematous erosions ranging from 1 cm × 1 cm to 10 cm × 8 cm large over scalp, face, chest and bilateral arms in different stages of healing, covered with 'floating crusts', having fishy odor, some of them healing with hyperpigmentation. Oral mucosa has erosions at palate and bilateral buccal mucosae. Proximal nail folds of right index and middle finger show erythema, swelling and tenderness (Paronychia).

From the examiners

A case of vesiculobullous disorder should be approached according to the following algorithm to arrive at correct clinical diagnosis. (Chart 1)



This is a *middle aged patient* with blisters which appear on *normal looking skin*. Blisters are *flaccid*, filled with clear fluid over *scalp, face, axillae* and bilateral arms. They *rupture within few days*, spontaneously or on trivial trauma leaving behind *erosions that extend* beyond original lesions. *Oral mucosae* have erosions.

According to the algorithm, the clinical description fits into Pemphigus vulgaris.

Nikolsky test and bullae spread sign were performed and were positive. Tzanck smear was made from base of bullae and showed multiple acantholytic cells alongwith eosinophils and neutrophils.

Further, the diagnosis of Pemphigus vulgaris can be confirmed by lesional biopsy for histopathology and direct immunofluorescence.

The Southern Potpourri

Authored by :

Dr. Saloni Katoch
PG-2 , JJM Medical College
Davangere, Karnataka

India is a versatile and diverse country. With its varied and multi-linguistic population, it is a blend of culture, customs and ancient rituals. The northern terrain being populated by the Aryan descendants, and the Deccan plateau by the Dravidian races, makes these regions socially and culturally different.

The southern part of the country apart from its red soil, tropical climate, lush green forests, spices and cuisine also has some unique social and religious practices like tonsuring (offering of scalp hair to gods and goddesses) to its credit. There are certain dermatoses that are more prevalent in this region and also some which are unique to it, a few of which have been enumerated in this article.

The equatorial climate of this region predisposes its population towards Dermatophytic infections. A study in rural south India found that the incidence of Tinea capitis was 28.5% and was mainly due to T .*violaceum.* Kamalam and Thambiah observed that Tinea capitis was endemic in school children in Madras. They postulated trauma during shaving of head for religious purposes as an important contributory factor. Tinea corporis has worldwide distribution, but a higher prevalence is reported from tropical or subtropical areas.

Pityriasis versicolor and Pityrosporum folliculitis are more common in tropical areas, the hot and humid climate being a major predisposing factor.

Mycetoma (Madura foot) is a chronic, suppurative, granulomatous disease of the subcutaneous tissue and bones, characterized by localized swellings with multiple sinuses discharging granules that are micro-colonies of the causative agents. It is more common in tropical and subtropical regions where most of the people walk bare feet. In the south, Actinomycotic mycetoma is commonly encountered, the dominant pathogen being S. somaliensis.

Rhinosporidiosis is a chronic granulomatous disease caused by a protistan parasite, Rhinosporidium seeberi .This disease is endemic in the states of Tamil Nadu & Kerala. The common denominator in these areas is probably the habit of taking bath in common ponds & stagnant water.

Dermatitis cruris pustulosa et atrophicans (DCPA) is a distinctive type of chronic superficial folliculitis, primarily affecting the lower limbs. It is characterized by symmetrical follicular pustules of both legs, with cutaneous edema, resulting in alopecia, atrophy and scarring. It was first described by Clarke, under the initial label of Nigerian shin disease. It was described in India predominantly as a disease of men and was reported to have high prevalence in some geographical regions; up to 3-4% in Madras, South India.

Tunga penetrans (Jigger, chigoe or burrowing flea) is one of the smallest fleas found in sandy coastal areas of Kerala and Maharashtra. Tungiasis initially presents with a black dot at the site of penetration which later undergoes necrosis to form an ulcer.

Bilharziasis (Schistosomiasis) is a chronic infection caused by Human blood flukes that parasitize the venous channels, cutaneous disease developing when the cercariae penetrate the human skin or because of an allergic reaction to their presence in the body. Endemic focal areas have been found in the state of Andhra Pradesh.

Moodi-chud is encountered in young women from Kerala. It is a lichenoid dermatitis characterized by mildly itchy, pigmented, follicular, flat-topped papules, 2-4 mm in diameter on the nape of the neck and exposed parts of upper back in girls who leave their hair loose after washing it. It is attributed to the frequent use of hair oils in this region along with friction and sweating.

In Southern India, kumkum is prepared at home by alkalizing pure turmeric powder. Brahmin males especially in South India apply sandalwood paste on their foreheads. Contact dermatitis has been ascribed to these agents. Kumkum dermatitis has the highest prevalence among dermatoses caused by cosmetics in South India. The state of Kerala accounts for more than 85% of area under natural rubber in the country and reports of contact dermatitis to rubber are prevalent from this state.

Frictional dermatitis presenting like Tinea corporis along the line of tying petticoat or sarees is common in the women of this region. Sweat retention, friction and tight tying of clothing are the major contributory factors.

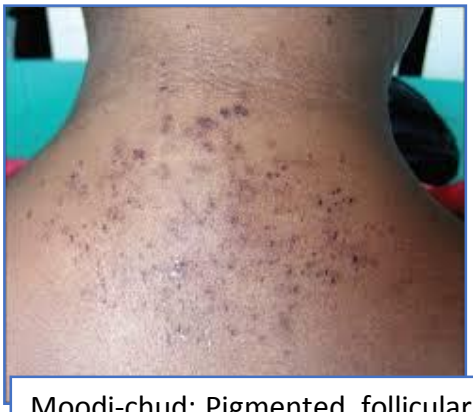
Pellagra is endemic in the Deccan plateau where Indian millet forms a major portion of the diet among the poor. Excessive intake of leucine as in a jowar-rich diet can induce pellagra by inhibiting conversion of tryptophan to niacin. The patients present with well-demarcated erythematous patches with pruritus, burning and pain on the sun-exposed sites.

Oro-dental hygiene seems to be an obsessive pre-occupation in Kerala. Each day starts with vigorous cleaning of the teeth and the ritual is never complete without cleaning the tongue. In the past split ribs of coconut leaves were used. With rapid urbanization, plastic and stainless steel strips became the preferred material. Traumatic baldness of tongue results due to these vigorous tongue cleaning practices. The location and shape of the bald patches depends upon the position of the tongue at the time of scraping and the style of stroking it. History itself is diagnostic, the lesions disappearing within a fortnight of stopping this practice.

In Karnataka, The Yellamma cult includes devotees who dedicate themselves to the service of Goddess Yellamma. These women or Jogathis have characteristic matted cobra like hair, referred to as Plica neuropathica (polonica) in our literature. It presents as a compact mass of scalp hair with irregular twists and irreversibly entangled plaits, with keratin cemented together with dirt and exudates. In the northern part of the country these dreadlocks are seen among religious men or sadhus. In contrast to this, women form the predominant population presenting with Plica neuropathica in the south, majority being involved in religious rituals.

Skin types IV, V and VI are predominant in south India. Acquired hyperpigmentary conditions like Melasma have higher incidence among darker individuals. Similarly, Dermatosis papulosa nigra is common among the dark skinned and is characterized by multiple, asymptomatic, small, smooth and dark papules on the face.

The southern lands of the country may be a hub for some dermatoses like the ones mentioned above, some like photodermatoses may be more prevalent but require further research, while some conditions like Kangri cancer may completely elude this region. The knowledge of an individual's environment and state of living can often help us in finding answers and drawing conclusions in our day to day clinical practice. Customs, traditions, and ritual practices often contribute to special characteristics of skin diseases. A careful review of the history of the way of life of a community is essential to understanding the ecology of such diseases, thereby aiding in their diagnosis & management.



Moodi-chud: Pigmented, follicular papules on the exposed upper back.
www.dermatlas.com

Moodi-chud: Lichenoid, hyperpigmented papules
on the nape of the neck. *(Kandhari S .Ecology of Skin Diseases in India. In: Valia RG, Valia AR, editors. IADVL Textbook of Dermatology. Mumbai: Bhalani, 2010; 1: 1-5.)

Chronic Pellagra: Rough, thickened and pigmented patches present
on the dorsum of hands and feet.
http://medicalpicturesinfo.com/pellagra/

Rhinosporidiosis: Sessile, fleshy polyp in the anterior nasal cavity.
www.internationalarchivesent.org

Plica Neuropathica: A jogathi with Cobra like matted hair.
www.dermatlas.com

References:

1. Kandhari S .Ecology of Skin Diseases in India. In: Valia RG, Valia AR, editors. IADVL Textbook of Dermatology. Mumbai: Bhalani, 2010; 1: 1-5.

2. Sugathan P, Najeeba R. Traumatic baldness of the tongue. Int J of Dermatol 1991; 30 : 68.

3. Nath AK, Thappa DM. Clinical spectrum of dermatoses caused by cosmetics in south India: High prevalence of Kumkum dermatitis. Indian J Dermatol Venereol Leprol 2007; 73(3): 195-6.

4. Patnaik R, Chowdary TN, Sesikeran B, Satyanath RV, Kumar PU. Nutrition and the skin. In: Valia RG, Valia AR, editors. IADVL Textbook of Dermatology. Mumbai: Bhalani, 2010; 2: 1267-93.

5. Ghodake NB, Singh N, Thappa DM. Plica neuropathica (polonica): Clinical and dermoscopic features. Indian J Dermatol Venereol Leprol 2013; 79(2): 269.

6. Kaimal S, D'souza M, Kumari R. Dermatitis cruris pustulosa et atrophicans. Indian J Dermatol Venereol Leprol 2009; 75(4): 348-55.

7. Venugopal PV, Venugopal TV, Abirami CP. Deep fungal infections. In: Valia RG, Valia AR, editors. IADVL Textbook of Dermatology. Mumbai: Bhalani, 2010; 1: 298-325.

8. Kanwar AJ, De D. Superficial fungal infections. In: Valia RG, Valia AR, editors. IADVL Textbook of Dermatology. Mumbai: Bhalani, 2010; 1: 252-93.

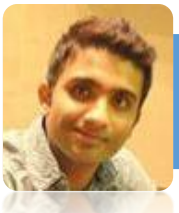
9. Nair TVG, Nair BKH, Jayapalan S. Diseases caused by Arthropods. In: Valia RG, Valia AR, editors. IADVL Textbook of Dermatology. Mumbai: Bhalani, 2010; 1: 397- 429.

10. Arora PN, Arora S. Diseases caused by Parasitic worms and protozoa. In: Valia RG, Valia AR, editors. IADVL Textbook of Dermatology. Mumbai: Bhalani, 2010; 1: 432- 80

11. Dhar S, Dutta P, Malakar R, Pigmentary disorders. In: Valia RG, Valia AR, editors. IADVL Textbook of Dermatology. Mumbai: Bhalani, 2010; 1: 736- 791.

Resident Voice

DEBATE on Advent of cosmetics in Dermatology : Boon or Bane



Dr. Ishad Aggarwal
PGY – 3, IPGMER
Kolkata

"The world as we have created it is a process of our thinking. It cannot be changed without changing our thinking." – Albert Einstein

The history of mankind , of medicine , if it could be measured , it would have to be in those few moments when change took place, it still continues, and it shall, because that's exactly what progress truly means.
As Cosmetic dermatology makes its foray into an ever increasing number of Dermatology clinics through out the country and world wide, for some it could be a matter of great concern, and yet for some it could be a new lease , a new beginning. It is just a matter of perspective. I for one consider it to be a great ally in a dermatologist's armamentarium .
There is a degree of skepticism in minds of a section of our community against cosmetic dermatology. With much respect to their opinion and upholding their experience with great high regard, I would like to say that the reasons behind such skepticism originate out of a few misunderstandings about this relatively newer 'science'. In it's very basics, cosmetic dermatology is a science, that relies upon interplay between knowledge of anatomy , the basics of skin , the diseases and biochemical molecules , much like any other medical stream. The scope of this 'youthful' branch , expands from precision of surgical techniques(dermatosurgery) to usage of ultra sophisticated machines (like lasers).
There is nothing more satisfying for a clinician , than to see relief on his patient's face. In this constantly changing world, which becomes appearance centric by the day , how many of us can argue that unsightly disease conditions like hemagiomas on face, unwanted hair, scars, pigmentation are any less traumatic to our patients than physical ailments? Isn't quality of life one of the prime factors that governs disease outcome? How many of us have seen poor young women suffer mental agony due to scars that not only affect their face, but also their lives, their psyche? How many of us have seen people suffer endlessly due to pigmentation? How many of us have

Dr. Sumit Gupta
PGY -2, MAMC
Delhi

The practice of medicine is an art, not a trade; a calling, not a business; a calling in which your heart will be exercised equally with your head... - Sir William Osler

The advent of cosmetic dermatology has had a huge impact on dermatology practice, training and discourse. It is a substantial phenomenon made evident by number of sessions devoted to it at conferences, types of products being launched and marketed by pharmaceutical and surgical companies, PG thesis topic preferences and changing public perception of our specialty.
In recent decades, we experience a culture of commoditization and commercialization of the body, with increasing emphasis on the external appearance. Dermatology comprises study of disorders of skin, hair, nail and mucous membranes. It is obvious that all these components constitute external appearance and concern with the public display of the self. Being trained in this discipline, we find ourselves in a unique position where we are likely to encounter people asking for aesthetic or cosmetic interventions. As medical professionals, our training and role in society have traditionally been to treat 'the disease' and not 'the desire to look good'. The question now is whether we should change/adapt our roles in response to the prevailing commercial forces.
Dermatology includes medical dermatology, surgical dermatology and dermatopathology. Venereology and Leprosy are also under the ambit of our discipline. These sciences are quite expansive in themselves. Cosmetic dermatology has further widened the compass. Three years of residency training is too short a time to learn and master all these disciplines. However, increasing prominence of cosmetic dermatology, its lucrative nature and society's expectations are putting undue pressure on the dermatology resident today to learn this skill, probably even at

DEBATE on Advent of cosmetics in Dermatology : Boon or Bane

However, with advent of cosmetics , we have answers to the questions on their silent faces and melancholic eyes posed to us over generations. The face of modern surgery wouldn't have changed , had surgeons shown reluctance to minimally invasive procedures and robotics. As dermatologists, are we going to shy away from accepting change, adapting newer scientific methods to treat these hitherto untreatable conditions?

According to the latest estimates, cosmetic dermatology has emerged as a multi-million dollar industry. It might sound offensive to a socialist's view point, and in it's face value, it could look like a money driven industry, however , greatest of the human reforms, greatest of services to mankind have been possible only with economic freedom. Cosmetic Dermatology not only provides better remuneration to dermatologists , but it also opens for them to invest into better technologies and offers a much more wider range of treatment and diagnostic options to the patients , not just for cosmetic problems, but also for other dermatological diseases. Since the results in cosmetic practice are faster, it offers a great deal of satisfaction , both to the patient as well as to the treating physician.

The fears , that the fast growing interest in cosmetic practice could be leading the fresh breed of dermatologists away from the old , text book principles of clinical dermatology, although seems apparent at the moment, but in reality are nothing more than just fears. As the spectrum of cosmetic Dermatology increases, it takes in it's expanse classical disease conditions. For a sustainable, successful cosmetic practice, a sound foundation of clinical Dermatology is vital.

In it's very outset , it is impossible to take the cosmesis out of dermatological practice. Significant morbidity of traditionally clinical conditions like psoriasis and vitiligo come from their unsightliness. Procedures like punch grafting, have been used since years to mitigate such problems. Cosmetic dermatology is an extension of what has always been a part and parcel of our of clinical dermatology. Cosmetic dermatology is no less intellectual than the real, ethical, and even moral practice of medical dermatology. It requires significant amount of expertise which is difficult to acquire during residency training. Most of the residency positions in dermatology are in government institutes. The socioeconomic stratum of the average patient coming to government hospitals is not consistent with the expensive nature of these treatments and it is unethical for the government to provide for these procedures as after all, we are a developing nation.

Despite being lucrative and glamorous, practicing cosmetic dermatology is not without its perils. Lot of patients or rather 'clients' who turn up at clinics for aesthetic procedures are young adults and adolescents suffering from 'body image' issues. It can often be a moral dilemma about what to offer them. Aesthetic procedures cannot replace proper counseling and healthy advice. The 'desire to look good' can often be so compelling that they are unlikely to be counseled by a dermatologist. They will surely present to another dermatologist who may offer the intervention. Moreover, this desire to attain the perfect face or body often makes it difficult for the patient to stop at one procedure. This makes them undergo repeated procedures exposing them to more complications rather than addressing the real problem. Options of aesthetic procedures have also put enormous social pressure on a lot of middle aged people. They undergo these procedures in a fervent attempt to delay ageing changes. Often, many of them tend to look unnaturally young rather than gracefully aged.

Setting up a cosmetic dermatology clinic also requires huge investments. On top of it, commercial nature of the treatments offered requires advertising and publicity. This is contrary to the code of medical ethics taught to us, but is actively done by corporate skin clinic

DEBATE on Advent of cosmetics in Dermatology : Boon or Bane

branch. Parameters are rapidly changing in today's world, and every field is ramifying into sub-specialities. Dermatology is no exception.
They say "old is gold" , it is indeed very true. Traditional teaching , sound principles of clinical dermatology have stood the test of time, however as prudence would dictate and history stands witness, it's important to adapt to change. Considering cosmetics an ally and building it over a strong foundation would be far more amenable given the vastness of opportunities it comes with. The more we see it as a boon, the more we can encourage our youngsters to pursue it with better freedom, in a more organized and guided way than the current scenario permits and we'd be able to put an end to how this science is being maligned by non-medical personnel , beauticians and quacks. All we need is to accept the change!!!

DERMATRIVIA

Source : http://www.bubblews.com/news/1781299-trivia-blue-man-paul-karason

BLUE MAN : PAUL KARSON whose skin turned blue after consumption of colloidal silver for his arthiritis, a condition known as ARGYRIA

across the country. Moreover, "clients" asking for aesthetic interventions are more likely to be dissatisfied with the results. In case of a complication, they are more likely to take a legal recourse. In this era, where courts of law incriminate medical professionals even when they act in good faith as per the best of their abilities, these patients can be potentially hazardous. Also, a lot of products or procedures used in cosmetic interventions are not FDA approved. Using off-label medications for diseases is one thing, but using off-label interventions in non-diseased, healthy individuals can be unnecessary perilous.
Our country is in dire need of a large number of dermatologists practicing clinical dermatology. Perhaps, dermatological diseases are the ones which are most often misdiagnosed and mistreated by general physicians. Skin diseases also have the dubious distinction of being attached with humongous social stigma. People usually do not seek any medical help for their skin ailments. A large number of patients also suffer at the hands of quacks and practitioners of alternative medicine. In such a scenario, we should focus our energies, skill and training towards practicing clinical dermatology and creating awareness about skin diseases in the society. Also, we are witnessing today an exciting era of research in dermatology with regard to new discoveries in disease etio-pathogenetic mechanisms, new molecules, therapeutic targets, drug delivery systems etc. Focusing on cosmetic dermatology will rob us the pleasure of being part of these developments.
Our field of endeavor already possesses so much amplitude that we need not look out for more. We are the specialists of the largest organ of the body with diseases which are ubiquitous. We need not change our roles.

Quiz

A 65 years old gentleman presented to the OPD with a pruritic plaque over the perianal region of 6 months duration. The surface showed erosions and crusts. The patient gave history of pain over the lesions. Hair, nail and other mucosa were normal. Patient had no systemic complaints. Systemic examination was non contributory. Routine investigations and lab parameters were within normal limits

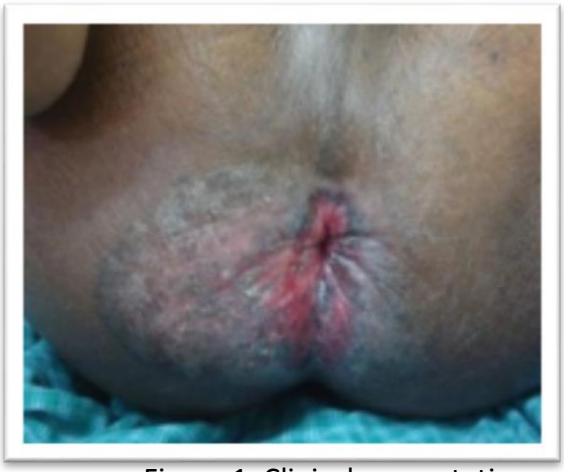


Figure 1. Clinical presentation

A punch biopsy was obtained from the lesion and sent for HPE using H&E stain. The images are shown in figure 2, 3, and 4.

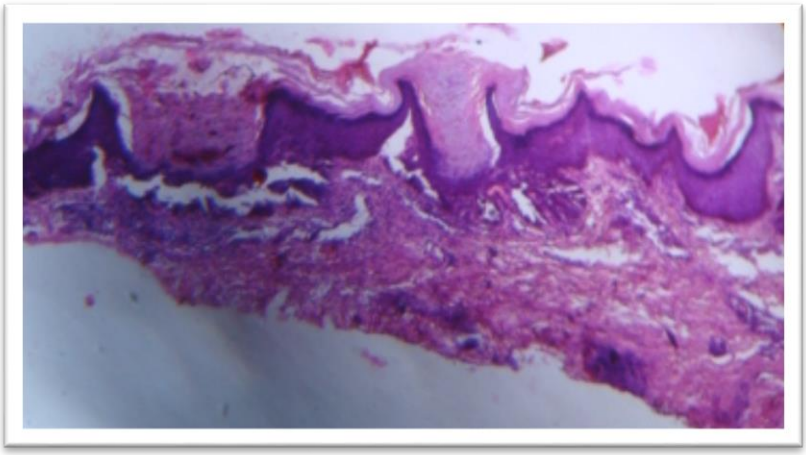


Figure 2. photomicrograph H&E x40

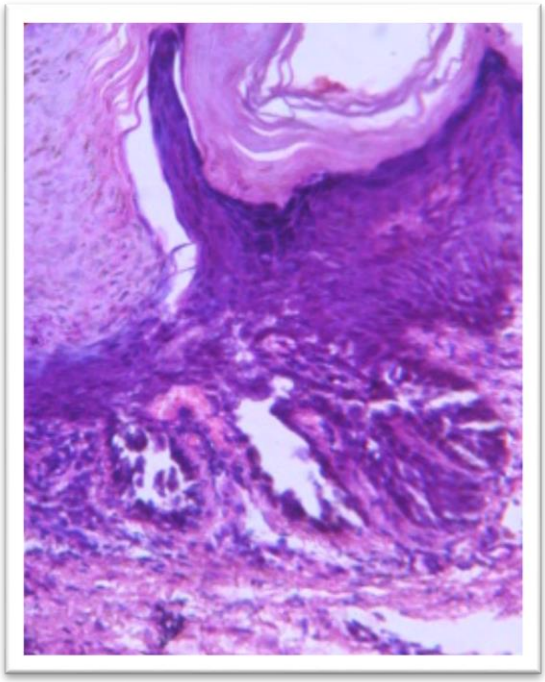


Figure 3. H&E x100

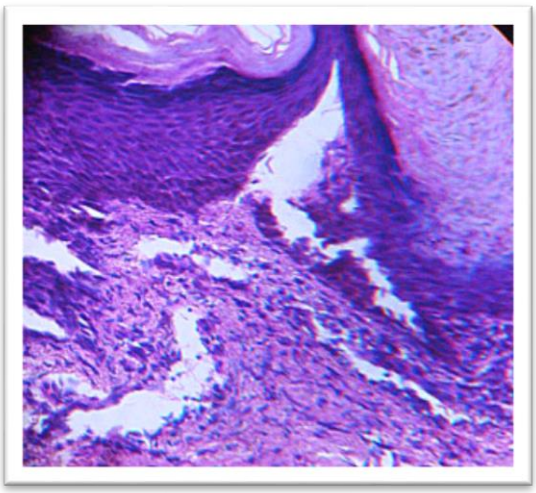


Figure 4. H&E x400

Questions:

1. What are your differential diagnoses
2. What are the major histopathological changes
3. What is your final diagnosis

Psoriasis – What's New

Authored by :

Samujjala Deb
PG – 2 , Burdwan Medical College, Burdwan

Anupam Das
PG-2 , Medical College and Hospital, Kolkata

- Complex pathogenesis with interplay of genetic, cutaneous, environmental and immunologic factors.
- Debate regarding role of Th1 vs. Th17 pathway & predominance of role of keratinocyte vs. immune dysregulation.
- Newer treatment modalities aimed against specific cytokines and genetically engineered targeted therapies.

Psoriasis is a chronic inflammatory skin disease with a strong genetic basis, characterized by alteration in epidermal growth and differentiation and multiple biochemical, immunologic, and vascular abnormalities.[1] There is complex interplay between genetics, environmental factors, immune dysregulation and defective skin barrier function leading to its pathogenesis.[2] Recent studies have provided deeper insight into the inter-connected pathways and everyday newer targeted therapies are being developed to intercept specific pathways or mediators. A brief discussion on the pathogenesis of psoriasis based on current available data is given below.

Genetic Factors: Presence of HLA-Cw6 haplotype is a major risk factor for developing psoriasis. Nine candidate loci have been identified from PSORS1-9 situated on different chromosomes.[3] Other non-MHC associations fall along four functional axes. They are IFN-γ/IL-23/IL-17 signaling pathway (involving IL12B, IL23A, IL23R), NF-κB signaling (TNFAIP3, TNIP1, NFKBIA, FBXLI9, TRAF3IP2 – these are stimulated by TNF-α), inflammatory Dendritic Cell function (PSMA6, ERAP1, NOS2) & genes responsible for keratinocyte differentiation (LCE3B, LCE3C, DEFB4).[4]Each of these have provided potential targets for development of newer drugs.

Skin Barrier Defect: Psoriasis is characterized by hyper proliferation and abnormal differentiation of keratinocytes along with endothelial changes and infiltration of lymphocytes. Increased Copy Number Variation (CNV) of defensin genes (DEFB) along with overexpression of cathelicidins, lead to increased levels of β-defensin and a potent pro-inflammatory state.[5, 6] Also there is decreased expression of aquaporins facilitating increased transepidermal water loss (TEWL).[7] Insertion/deletion of LCE3B & LCE3C (Late Cornified Envelope) genes also affects barrier function.[8]

Psoriasis – What's New

Immune System Dysregulation: Since long there has been a debate regarding role of Th1 or Th17 pathway in pathogenesis of psoriasis. Recently the Th17 pathway along with the Th22 pathway has been showed to have a significant role in the disease process. The Th17 pathway affects both the innate and adaptive immune system. TGF-β and IL-6 transform naïve T cells into Th17 CD4+ T Cells (Also Th22 subtype and Th1 cells in response to IL-12). IFN-γ released by activated Th1 cells, causes release of IL-23 from macrophages and dendritic cells (DC), which stimulates Th17 to produce IL-17 (especially IL-17A & IL-17F) and IL-22 which is critical to the pathogenesis of psoriasis. This leads to increased levels of IL-8, CCL-20, CCL-2, S-100, A7, β-defensin and lipocalin. The Th1 cells produce IFN-γ which amplifies this process by stimulating the DC's to produce more IL-23. All of these lead to a chronic pro-inflammatory state in genetically predisposed individual in response to environmental triggers. Overall a Th1/Th2/Th17 imbalance is a key functional and genetic determinant of psoriasis. [9, 10, 11, 12, 13]

IL-17 also plays an important role in innate immunity as it is released by dermal γδ T cells which express IL-23R, CCR6 and transcriptional factor RORγt. These act as first line of defense against foreign pathogens and promote and maintain chronic inflammation. [14] High levels of IL-6 in psoriatic plaques also suppress regulatory T cell function in psoriasis. NLR/CATERPILLAR family of genes also play a role in aberrations of innate immunity leading to dysregulated epidermal barrier function and pathogenic responses to environmental pathogens. [15]

Environmental Factors: Along with genetic susceptibility, defective skin barrier and immune dysfunction, environmental factors provide the stimulus for triggering or inducing psoriasis. Factors like drugs (β-blockers, lithium, anti-malarials, non-steroidal anti-inflammatory drugs and tetracycline etc.), trauma, stress, infections (β-hemolytic *streptococci*), smoking and alcoholism are involved. [16-20]

Psoriasis has a complex pathogenesis. No single factor can explain the process in isolation. Since time immemorial there has been a debate regarding keratinocyte dysfunction/immune dysregulation as the prime causative factor and predominance of Th1/Th17 pathway in the pathogenesis. The following diagram summarize the vicious cycle in a simplified manner.

References:

1. Gudjohnson JE, Elder JT. Psoriasis. In: Goldsmith LA, Katz SI, Gilchrest BA, Paller SA, Leffell DJ, Wolff K, editor. Fitzpatrick's Dermatology in General Medicine, 8th Edition. USA: The McGraw Hill Companies; 2012. p. 197-231.
2. Mahajan R, Handa S. Pathophysiology of psoriasis. Indian J Dermatol Venereol Leprol 2013;79:1-9
3. Trembath RC, Clough TL, Rosbotham JL. Identification of a major susceptibility gene locus on chromosome 6p and evidence for further disease loci revealed by a two stage genome-wide search in psoriasis. Human Mol Genet 1997; 6:813-20.
4. Nair RP et al: Genome-wide scan reveals association of psoriasis with IL-23 and NF-kappaB pathways. Nat Genet 41(2):199-204, 2009
5. Hollox EJ, Armour JA, Barber JC. Extensive normal copy number variation of a beta-defensin antimicrobial-gene cluster. Am J Hum Genet 2003; 73:591-600
6. Hollox EJ, Huffmeier U, Zeeuwen PL, Palla R, Lascorz J, Rodijk-Olthuis D, et al. Psoriasis is associated with increased beta-defensin genomic copy number. Nat Genet 2008; 40:23-5.
7. Lee Y, Je YJ, Lee SS, Li ZJ, Choi DK, Kwon YB, et al. Changes in transepidermal water loss and skin hydration according to expression of aquaporin-3 in psoriasis. Ann Dermatol 2012; 24:168-74.
8. Bergboer JG, Tjabringa GS, Kamsteeg M, van Vlijmen-Willems IM, Rodijk-Olthuis D, Jansen PA, et al. Psoriasis risk genes of the late cornified envelope-3 group are distinctly expressed compared with genes of other LCE groups. Am J Pathol 2011; 178:1470-7
9. Stockinger B, Veldhoen M. Differentiation and function of Th17 T cells. Curr Opin Immunol 2007;19:281-6.
10. Lee E, Trepicchio WL, Oestreicher JL, Pittman D, Wang F, Chamian F, et al. Increased expression of interleukin 23 p19 and p40 in lesional skin of patients with psoriasis vulgaris. J Exp Med 2004; 199:125-30.
11. Ouyang W, Kolls JK, Zheng Y. The biological functions of T helper 17 cell effector cytokines in inflammation. Immunity 2008; 28:454-67.
12. Nograles KE, Zaba LC, Guttman-Yassky E, Fuentes-Duculan J, Suárez-Fariñas M, Cardinale I, et al. Th17 cytokines interleukin (IL)-17 and IL-22 modulate distinct inflammatory and keratinocyte-response pathways. Br J Dermatol 2008; 159:1092-102
13. Nograles KE, Davidovici B, Krueger JG. New insights in the immunologic basis of psoriasis. Semin Cutan Med Surg 2010; 29:3-9.
14. Cai Y, Shen X, Ding C, Qi C, Li K, Li X, et al. Pivotal role of dermal IL-17-producing γδ T cells in skin inflammation. Immunity 2011; 35:596-610.
15. Mattozzi C, Richetta AG, Cantisani C, Macaluso L, Calvieri S. Psoriasis: New insight about pathogenesis, role of barrier organ integrity, NLR/CATERPILLER family genes and microbial flora. J Dermatol 2012; 39:752-60.
16. Wolters M. Diet and psoriasis: Experimental data and clinical evidence. Br J Dermatol 2005; 153:706-14.
17. Farkas A, Kemény L, Széll M, Dobozy A, Bata-Csörgo Z. Ethanol and acetone stimulate the proliferation of HaCaT keratinocytes: The possible role of alcohol in exacerbating psoriasis. Arch Dermatol Res 2003; 295:56-62.
18. Cheng SE, Luo SF, Jou MJ, Lin CC, Kou YR, Lee IT, et al. Cigarette smoke extract induces cytosolic phospholipase A2 expression via NADPH oxidase, MAPKs, AP-1, and NF-kappaB in human tracheal smooth muscle cells. Free Radic Biol Med 2009; 46:948-60.
19. Evers AW, Verhoeven EW, Kraaimaat FW, de Jong EM, de Brouwer SJ, Schalkwijk J, et al. How stress gets under the skin: Cortisol and stress reactivity in psoriasis. Br J Dermatol 2010; 163:986-91

Toppers Speak

West Bengal Health University Gold Medalist: Dr. Niharika Ranjan Lal gives us some tips!!

The mere thought of MD final exams sets students on a panic mode and I was no different! But with some planning and smart study, one will smoothly sail through the examination. Here are some study tips which not only the exam going batch but also 1st and 2nd year PGT's can make use of.

The theory part consists of 4 papers of which I feel and most students also agree is that preparing for paper 1 is the toughest. It deals with the basic anatomy and physiology of skin and its applied aspects. One has to secure atleast 50% marks to pass in this.

The best way to study for paper 1 is by making notes. Go through the last 10 years' question papers and study the question pattern, pool in relevant information from the common books that we study and prepare notes. Though the preference for books may vary from one student to another, make sure to go through Lever and Morschella as far as paper 1 is concerned. Do not forget to mention about the applied importance even if it has not been asked. It will fetch you extra marks.

I advise that all 1st and 2nd year PGT's start preparing paper 1 notes from now itself so that in final hours revision becomes easy.

Paper 2 deals with Clinical Dermatology. Prepare your answers under the following 6 headings: Definition, Etiopathogenesis, Clinical features, Investigation including histopathological findings, Differential diagnosis and Treatment. Study relevant points under the above mentioned headings and you will have a good answer which will fetch you good marks.

Paper 3 deals with STD and Leprosy. Again prepare answers as mentioned for paper 2 under the 6 headings. Paper 4 deals with Cosmetic Dermatology and 'whats new'. Apart from the usual questions go through new drugs or new treatment modalities that have come up.

- Write short sentences in point wise manner rather than in paragraphs
- Give diagrams (for paper 1) and flowcharts (mechanism of action for drugs, pathogenesis) as far as possible. A picture speaks for a thousand words
- Prepare your notes in such a way that you can finish writing them in stipulated time
- NEVER go unprepared for a question that has already been asked in the past.

Then comes what gives all of us cold feet...Viva voce!!

- Try to study in a group for viva
- Practice case presentation as much as possible
- During group study, make one student the examiner and yourself the examinee and then practice giving answers like you would on the day of the viva, then do vice versa
- NEVER try to know your case beforehand

Stay calm, composed and give 'to the point' answers. We all know the expected questions and also their answers, it is just how impressively you can present them.

Wishing you luck.

- Dr. Niharika Ranjan Lal

Quiz - Answers

1. Differential Diagnoses
   a) Intertrigo,
   b) Extramammary Pagets disease,
   c) Pemphigus Vegetans,
   d) Hailey-Hailey disease,
   e) Chronic Eczema,
2. Intraepidermal blister, showing acantholytic cells in a dilapilated brick wall appearance
3. Hailey-Hailey disease

Feedback

Hope you liked the inaugural issue of RESIDREAM newsletter. If you have any comments, queries, suggestions, contributions, please write to us at : *residreamiadvl@gmail.com*