Resident-DREAM

Dermatology Residents Education And Motivation Bulletin

June 2014, summer issue, Vol. 1, No. 2

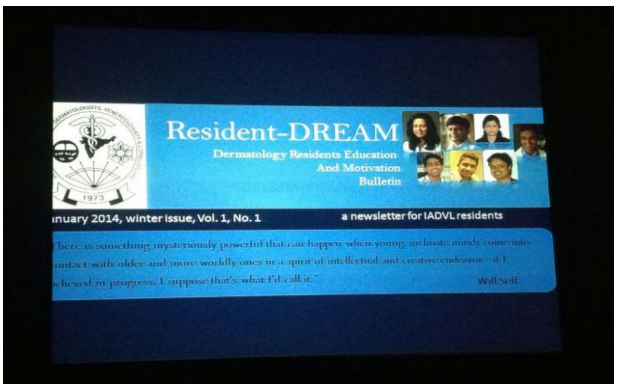
A newsletter for IADVL residents

The journey of a thousand miles begins with first step

-Lao Tzu

From the editor's pen :

The inaugural issue of Resi-DREAM was indeed the first step towards our goal to create a platform for dermatology residents where they could voice their opinions, share information, take guidance and disseminate knowledge and the response to it was heart-warming. The appreciation was widespread from length and breadth of our diverse country, not just from residents but also the faculty members. As Resi-Dream becomes the beacon of hope and aspirations of our peers and contemporaries, it did sensitize the Dermatology fraternity towards the need of making information accessible to everyone and in every part of the country.



An idea usually remains just a thought process until a visionary sees potential in it, and takes efforts to implement it. In today's world , when social networking sites have become integral to existence of our lives , it was our affectionate mentor, Dr. Rashmi Sarkar (ma'am), Hony. General Secretary IADVL, who saw the potential of creating an official resident's facebook page. And well the response to it has been tremendous. Over a span of few months of it's creation , it has become a hub of constant activity through out the day. With both faculties and residents joining it , from all over the country, teaching has shed it's conservative mould and has taken a step out of confines of clinics and institutions. Today a resident from extreme northern part of our country , can ask doubts to a faculty member sitting miles apart in south. How else can knowledge truly cross geographical boundaries. The page is teeming with rich discussions over clinical and histopathological images and for a lot of finals years who undertook their exams, it was an invaluable aid in prepration.

The response to first edition was humbling and we began working upon the new edition with a nervous excitement. With Dermatology ramifying into sub-

specialities, we bring you up close and personal with the stalwart of Dermatopathology in our country, Dr. Uday khopkar. We hope you will enjoy reading his interview, and also be inspired by the kaleidoscopic hues of this fascinating branch. Many a times , for a new resident , dermatology could be a perplexing subject. Therefore we bring you tips from esteemed and experienced faculty members like Dr. Anil Abraham , Dr. Rashmi Sarkar and Dr. Sandipan Dhar and other senior residents. As fellowships get competitive, we intend to make you aware of oppurtunities beyond residency , so Dr. Sidharth sonthalia writes his experience on a fellowship he attained through ISD. We have also included details of the AAD IADVL exchange program. In order to maintain our geographical diversity, we welcome an article from our resident in the North east. Along with that we continue our what's new section where our editor writes about newer updates of psoriasis. And since exams are part of a medical student's life , Respected Dr. Vishalakshi has written an approach to scleroderma for the benefit of all exam going PG's. We thank one and all for giving us such support and encouragement. We welcome all residents to share their opinions, to submit their articles or simply to state what's on their mind. It's important that we all come forward and together make ourselves more empowered, knowledgeable and aware. Remember , like was have said before , Resi-DREAM is by you and for you. Hope you enjoy reading this issue

Signing off

- *Dr. Ishad Aggarwal*
ishad1984@gmail.com

In this issue

Flashback from Stalwarts

Author :

Dr. Sandipan Dhar
Prof & Head, Dept Of Pediatric Dermatology
Institute of Child Health
Kolkata

In January 1989, I got in to my dream institute PGIMER, Chandigarh. I was doing my house job in Dermatology under Prof. S K Panja , my first teacher in Dermatology at my college, Calcutta National Medical College. We used to have just 2 rooms in the OPD and 4-5 beds under Medicine department. In PGI , when I saw 7 consultation rooms, one minor OT, one side lab in the OPD and 20 beds independently in the ward, I was fascinated . In the department the faculty were Late Dr.(Mrs) Surrinder Kaur (Prof. & Head), Dr. Bhushan Kumar(Additional Prof), Dr. S C Sharma (Associate Prof), Dr. A J Kanwar(Asso.Prof), Late(Dr). Inderjeet Kaur(Assistant Prof) and Dr. V K Sharma(Assistant Prof). The Senior Residents were Dr. Prasanta Basak, Dr.(Mrs) Arti Nanda and Dr. Rajiv Gupta. The first 6 months used to be spent in the ward. The days used to be extremely hectic. I used to feel home sick at times, fortunately I had couple of very good friends from Kolkata and we used to 'freak out' at the week ends as and when possible. In the department, we Bengalis and south Indians had problem in speaking Hindi and many such conversations with patients later became timeless jokes .The academic schedule used to be very meticulous. In our times when there was no internet facility, it used to be really tough to get a full article on a topic you wanted to search.

From Left to Right
Dr.BL Sahoo, Dr.Anshu, Dr.Rashmi Sarkar, Mrs.Mahajan (Dr.Vikram's wife), Dr.Iffat Hassan, Dr.Muralidhar, Dr.Nagarajan, Dr.Gautam Dawn, Dr.Sanjay Mandal, Dr.Vikram Mahajan, Dr.Manisha Watwe, Dr.Penchalaiah, Dr.Ravi Kumar

Flashback from Stalwarts

From Left to Right
Dr.V.K.Sharma,
Dr.Sandipan Dhar,
Dr.Nagarajan,
Dr.Ravi Kumar,
Dr.Rashmi Sarkar,
Technical Staff,
Dr.Sethuraman

Here are some tips for making the best use of one's residency/post-graduate period during first/second year of post graduate (DVD or MD) career:

1. Spend as much time as possible in the OPD and ward to learn all practical things about Dermatology, Venereology & Leprology. Whenever you see a new case , make it a point to read it up from books within next 2-3 days, if possible on the same day.

2. Sometimes reading alone can be boring. Hence, you can form a group amongst yourselves and do a 'group study' or case discussion.

3. Exhaustive theory should only be read for long case discussion, seminar or journal club etc. Other wise case-based study should mostly cover clinical features and treatment to start with.

4. Whenever you get a chance , sit with a colour atlas and just keep on flipping through the pages. Clinical Dermatology is all about 'Illustrative skin science'. You will learn a lot from the pictures and I have many times diagnosed a case for the first time in this way.

5. Finally you must enjoy your life also at the same time. Keep yourself happy and enjoy reading Dermatology ! It is the most challenging and fascinating super speciality of Medicine these days! Be proud of your speciality and try to contribute something to it which will help you in earning your bread, butter, name, fame & respect in future!

All the Best for your studies and career my dear STUDENTS !
May God Bless you all !

Golden Words Of Advice And Tips for First Year Dermatology Residents

Author :

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

- One should immediately start with one of the major textbooks (Fitzpatrick's, Rook's etc.) right from the beginning of the session as a number of readings are required to get a good grip on the subject.
- Initially the emphasis should be on reading and learning the clinical features, histopathology findings, treatment modalities etc. Once this portion is mastered, then one may go back and thoroughly read the etiopathogenesis and other sections that were previously skipped.
- Reading up different dermatologic diseases is often more interesting initially in comparison to basic clinical sciences which may seem a bit dry. This may be read up once the student has developed an interest and is dedicated to devoting a fixed duration for studying on a daily basis.
- Revision. Revision. Revision.
- Students should also read up Hasting and/or Jopling for leprosy in the first year itself.
- Another extremely important book is Lever's Histopathology of Skin. This book will help in many concepts of Dermatology as well and should be read thoroughly.

Exam Tips

Dr. Rimjhim Saha – Assam Medical College, Dibrugarh

Everybody has their own specific way of preparation but for dermatology few things are of utmost importance I feel –

1. Repeated and multiple revisions.
2. Regular review of photographs of the diseases.
3. Seeing photographs of uncommon ones will help to keep in mind at least a few of its important features.
4. During preparation it's better if one jots down the highlight points. Just going through them the day before exam helps in easy revision and one at least won't be totally blank regarding the subject. Besides basics, anatomy and of course immunity should be clear to understand the diseases.

Dr. Rahul Kumar Sharma – Christian Medical College, Vellore

Becoming a dermatologist requires a significant commitment of the student's physical, mental, emotional and financial resources. Thus significant and sustained self-study is absolutely essential in order to become a highly competent dermatologist. As you enter the field of dermatology :

1. Learn basic descriptive terminology of skin lesions.
2. Recognize important skin signs of systemic illnesses.
3. During the initial few months - concentrate on pathogenesis of various common diseases, reading cases seen during the day each evening, will facilitate increased uptake and retention of clinical knowledge.
4. Learn how to interview patients and obtain a thorough medical history.
5. Keep updating your knowledge with lectures, conferences, seminars, demonstrations, individual and group study of histologic slides, clinical rounds, instruction sessions in the patient care setting, chart and record reviews, local, regional and national meetings.
6. Try to participate in all regional and national dermatology quizzes.
7. Read all the resident articles, review articles and updates on various dermatological diseases including their new therapeutic options and diagnostic criteria.
8. For the preparation of university examination, read at least last five years question papers along with the meticulous revision of the subject.

Exam Tips

Dr. Sukesh M. S. – Mumbai Topper, LTM Medical College, Sion Mumbai

My views on how to read during residency -

1. Selecting a base textbook – Gather opinion, then read a chapter in all the standard textbooks and whichever you feel is comfortable, go ahead with it. But read that book thoroughly end to end and add on all the salient features from other text into it. This will save u lot of time during revision later. Have a structured approach.
2. Finish basic dermatology, leprosy and STI with a clinical dermatology book (Andrews) during your first year.
3. Second and third year should be meant for reading, adding salient features and revising your standard textbook.
4. All short, long and exam cases should be read n discussed as and when or on the same day of seeing the cases.
5. Form a core study group, reading a topic from all books together (by different people in the group) and discussing it together will save a lot of time and make it interesting. One day per week may be kept for reading journals especially the Resident pages.
6. And most importantly, finish off you thesis well before time!
7. During the pre-exam study break, revise previous year's questions as many times as possible.

Dermatrivia

Popularly known as the 'King of Pop', **Michael Jackson** suffered from Vitiligo. Jackson, an African-American started turning paler in the mid-1980's when he was thought to be taking skin bleaching treatments, applying whiteners and using light effects to appear whiter on stage and screen. He was widely criticized by psychologists & media as being a lousy role model for the African-American youth. Later, in 1993, he opened up about his skin disorder in an interview to Oprah Winfrey. He confessed about using depigmenting agents to even out his skin tone. Apparently, multiple tubes of Benoquin (monobenzyl ether of hydroquinone) was found in his home in June, 2009 after his death. World Vitiligo Day is celebrated on Jackson's death anniversary, 25th June, in memoriam of its most famous sufferer.

Northeastern potpourri

Author :

Dr. Kumud Agarwal
PG-3, Assam Medical College and Hospital
Dibrugarh, Assam

India is ethnically, religion-wise, linguistically, culturally, climatically, agriculturally diverse. Most importantly, the population can't be treated as one race & doesn't have the same anthropological feature throughout.

Northeast India has a predominantly humid sub-tropical climate with hot, humid summers, severe monsoons and mild winters. The economy is agrarian. Main industries in the region are tea-based, crude oil and natural gas, silk, bamboo and handicrafts. There are certain dermatological ailments more common in this region while certain are unique to it; few of them are enumerated in this article.

Relatively high humidity in this region predisposes to dermatophytic infections, the commonest organism being Trichophyton rubrum[1]. Sporotrichosis is endemic in Assam and other north eastern states[2]. Other deep mycoses like chromoblastomycosis and mycetoma are commonly seen in this region. Actinomycetoma is more common than eumycetoma due to moderate to heavy rainfall in this part[3].

Cutaneous tuberculosis is relatively common in this region, specially among the tea garden population. In a departmental study the incidence was found to be high (0.25%), commonest type of cutaneous tuberculosis seen was scrofuloderma (50%)[4].

Cutaneous Larva migrans also affects the tea garden workers who walk barefoot[5]. Simulium dermatitis caused by Simulium fly(blackfly), found in the hilly areas of northeastern region is characterized by chronic eruptions of pruritic papules, vesicles, and erythematous wheals resulting from a hypersensitivity reaction to biting of simulids or blackflies[6].

In India a pilot study found that people from Gujarat and Assam were more vulnerable to develop pemphigus[7]. In a study done in this region, the most common subtype seen was pemphigus vulgaris(84%) followed by pemphigus foliaceous(8%)[8].

Hand and foot eczema-the tea garden workers are particularly susceptible to develop contact dermatitis of hands or feet due to tea leaves plucking. Different pesticides are also used in tea plantation for prevention and protection of tea bushes contribute to it[9].

Northeastern potpourri

Penicilliosis is a AIDS defining illness caused by *Penicillium marneffei*. There has been an increase in incidence of this infection in North-eastern States of India where the disease was not known before. This is probably because of the abundance of the bamboo groves, the habitat of the putative carriers of *P. marneffei,* the bamboo rats[10].

AIDS related Kaposi sarcoma is very rare in India. Few cases have been reported from Manipur where there is an increasing prevalence of HIV infection and intravenous drug users[11]. Other dermatoses like pellagroid dermatitis, phytophotodermatitis and onchomycosis are also frequently encountered in this region.

Ecology and human health are directly connected, humans are a part of the ecosystem. Therefore, knowledge of the way of living of the community and the environment is essential to understand the ecology of disease.

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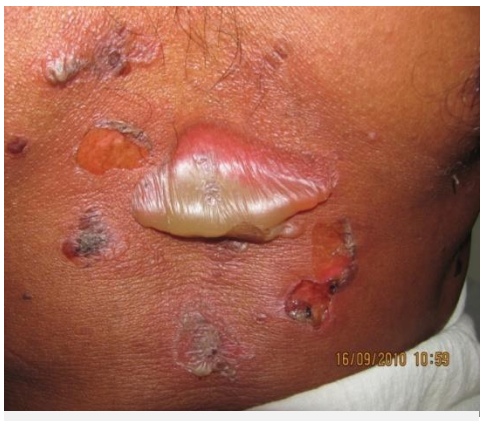
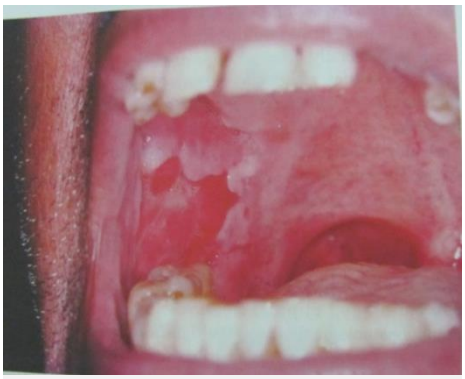
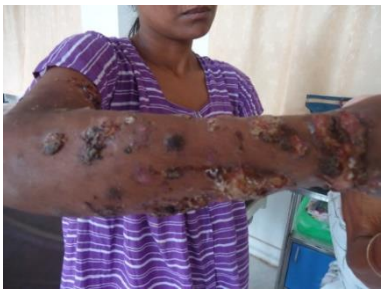
Northeastern potpourri



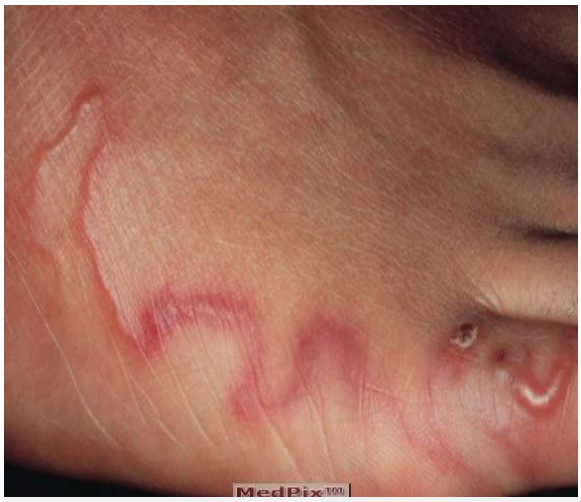
Pemphigus vulgaris: Flaccid bulla and erosions with crusting over the trunk



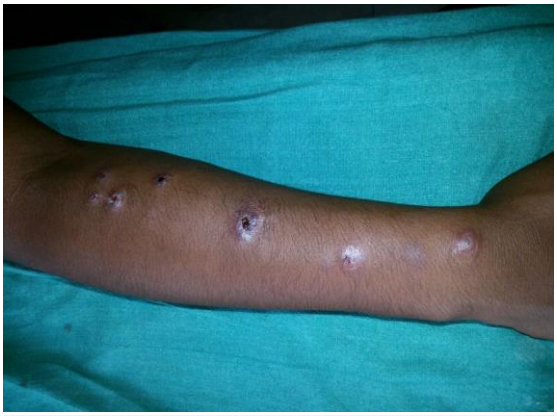
Pemphigus vulgaris: Oral erosions over the buccal mucosa.



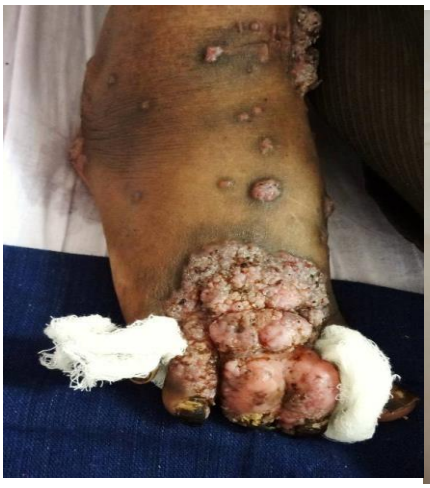
Sporotrichosis: multiple nodulo-ulcerative nodules over the upper limb.

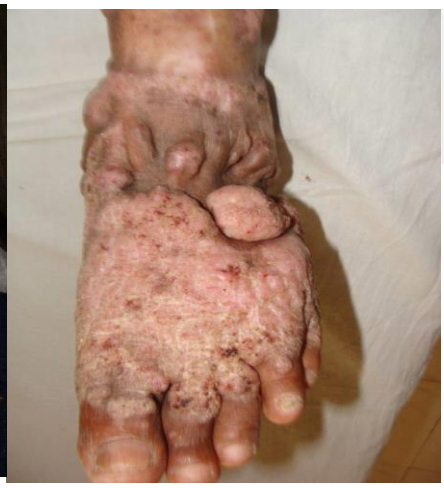


Cutaneous Larva Migrans: Serpiginous track of over lateral aspect of dorsum of foot.`



Sporotrichosis:Multiple erythematous nodules in a"sporotrichoid" pattern.





Chromoblastomycosis:Verrucous growth over dorsum of foot with similar satellite lesions.

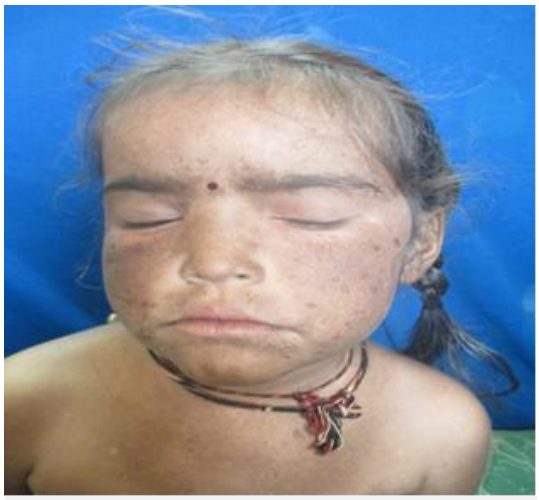
Syndrome of the Edition

Author :

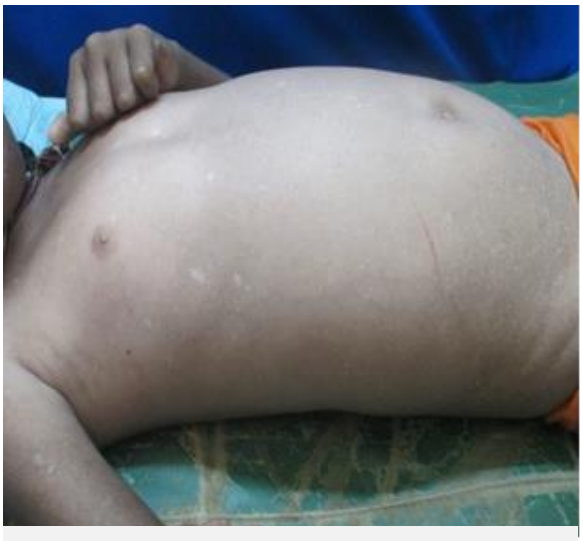
Dr. Saloni Katoch
PG-2 , JJM Medical College
Davangere, Karnataka

Chediak-Higashi syndrome

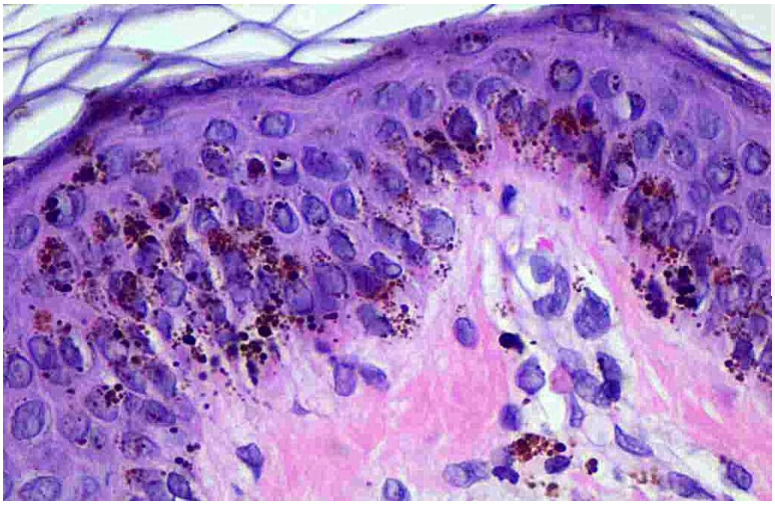
Chediak-Higashi syndrome, a rare autosomal recessive disorder and a part of the 'silvery hair syndrome', is characterized by partial ocular and cutaneous albinism, silvery blond hair, severe phagocytic immune deficiency, increased susceptibility to pyogenic infections and by the presence of large lysosome-like organelles readily seen in blood and marrow leukocytes, especially granulocytes; and in melanocytes. Other features include progressive sensory or motor neurological defects, photophobia, pancytopenia and hepatosplenomegaly.



Phototanning with freckles over the face with silvery to light blonde hair



Examination revealed abdominal distension with hepatosplenomegaly



Epidermis showing increased pigmentation of the basal layer with abnormally large melanin granules seen extending into the upper layers of epidermis and within melanophages in the papillary dermis

Beyond Residency

Author :

Dr. Sidharth Sonthalia
M.B.B.S. (Hons.), M.D., D.N.B., M.N.A.M.S., F.I.S.D.
Director, Consultant Dermatologist, Cosmolaser Surgeon & Venereologist at: SKINNOCENCE, Gurgaon & Visiting Consultant: Kalyani-Escorts Hospital, Mayom Hospital, Dr Kiran's Skin & Laser Centre, Gurgaon.
Email: sidharth.sonthalia@gmail.com

From left to right: **Dr. Alireza Firooz** (Co-mentor), **Dr. Sidharth Sonthalia** (Mentee), and Prof. **Yahya Dowlati** (Mentor)

It was indeed my good fortune that I undertook my advanced training in Dermatosurgery in **Tehran**, under the guidance of my mentor **Prof. Yahya Dowlati**, Head & Director; Center for Research and Training in Skin Diseases and Leprosy (CRTSDL), Tehran University of Medical Sciences, and Director, Dowlati Skin Clinic (DSC); and co-mentor **Dr Alireza Firooz**, Associate Professor in Dermatology, CRTSDL. I had an unprecedented exposure to a variety of dermatosurgical techniques and lasers, coupled with participation in the regular academic programs of the centre, which truly fostered my knowledge and skills as a dermatosurgeon. The CRTSDL and DSC are state-of-the-art centers for training in the subject. I learnt the gross as well as finer aspects of specialized techniques such as hair transplantation, liposuction, autologous fat transplantation, blepharoplasty, laser hair removal, fractional lasers, IPL and injectables. My mentors and other faculty members, especially **Dr. Pedran Mehryan** taught me the relevant theory as well as gave me hands-on experience enthusiastically, making sure I perform the procedures in a way that ensures utmost safety for the patients, yet giving them perfect results. I was also given access to one of the finest Dermatology libraries I have ever seen, with a collection of latest editions of possibly all dermatology & Dermatosurgery books and journals. Thus, theory and practical experience went hand-in-hand, making me a better Dermatologist & Dermatosurgeon.

Indians in general have a fixation for the western world being the dream destination for advanced studies. But thanks to my mentor, Dr. Rashmi Sarkar (the only Indian Member of the ISD Mentorship Committee and incoming General Secretary of National IADVL), who suggested to me to think out of the box and go to Tehran. She simply asked me – “Do you want to learn, or do you want a western country tag?” Thankfully, I chose the latter on her insistence and the rest is history……

Dr. Rashmi Sarkar, was also instrumental in guiding me through the entire process of application for ISD Mentorship Programme, and went out of her way by repeated communications with the ISD committee to get the approval, which for some reason was getting delayed. I came back to India, enriched in every way and am currently utilizing my learning in Tehran to optimize my patient outcomes.

Thus I encourage all young budding dermatologists, thirsty for true knowledge, to explore these horizons and apply for such coveted fellowships well in time. Please read the tips given in the box (BOX 1), which may help you to go ahead with it. Wishing all the very best to all my junior friends!

Beyond Residency

- ❖ Think what you want to excel at. Have a clear focus. e.g. if you like pediatric dermatology, just apply for it, instead of applying for different sub-specialties. FOCUS is the key.
- ❖ Chose the right mentor. You may have an informal communication with your mentors and also get a feeler from them about their level of interest in having you as a mentee.
- ❖ Become a member of ISD as soon as possible. It's a pre-requisite to apply for this program.
- ❖ Apply for ISD Mentorship, early in your career. First or second year of Senior Residency may be the best time.
- ❖ Do not have fixation for a 'foreign tag'. Prioritize – the program is for learning. So dare to be different, like I opted for Tehran as a place for my fellowship, instead of the USA.

BOX 1 :TIPS TO ISD MENTORSHIP PROGRAM ASPIRANTS

Focus Fundas for the First Years

Author :

Dr. Anil Abraham
Head of the Department of Dermatology
St Johns Medical College
Bangalore, Karnataka

1. There is no good 'muhurat' to start studying. Start from Day one.
2. Learn your basics – morphology, distribution, bed-side tests, side-lab investigations, basic histopathology. Foundation first. Then fancy frills. There is no substitute to basic dermatology. All other skills and knowledge are supplements to this ground reality. You cannot be an effective dermatosurgeon, trichologist, laser therapist, cosmetic dermatologist without being an excellent dermatologist.
3. Acquire accessory skills: statistics, photography, public speaking, quizzing, research, paper writing. This is the time to learn.
4. Do not exchange or sacrifice clinical learning for text – book or internet learning. See every case in the ward or OPD. Look, observe, absorb, touch, smell, listen and don't forget to develop your sixth sense.
5. The sixth sense is intuition. Clinical intuition. The sense that allows your experienced teacher to decide to do a VDRL as the patient enters the room. Or think about diabetes as the patient complains of seemingly unrelated pruritus. Or ask about stress to the young man who has come in for hair loss. Do not lose that sixth sense. Develop your intuition. It helps often in difficult clinical situations.
6. Organize your study. Organize your reading. Organize your references. Buy files and label them alphabetically. Create computer files for references and photographs. Buy an address book and enter good review articles references in alphabetical order. "I read this somewhere …. Can't remember" is tragic. Read, remember, record, retrieve – should be a continuous dynamic mantra of PG life.
7. Every day will be 'busy'. Cases, OPD, Wards, miscellaneous tasks, catching up with chores…… Identify your peak time and schedule <u>at least</u> an hour of dedicated study EVERY DAY.

Focus Fundas for First Years

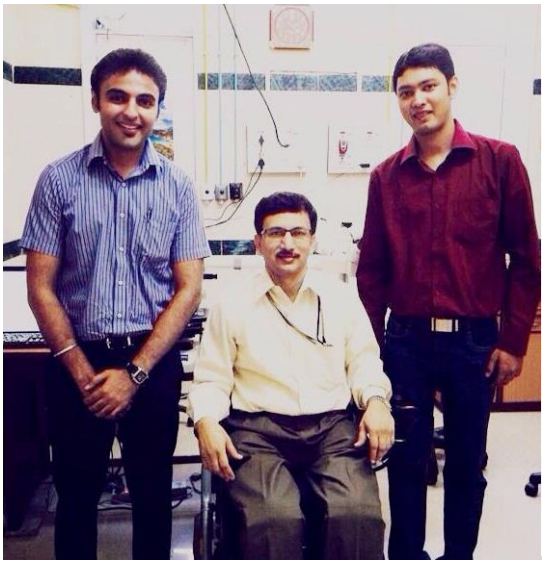
8. Do not miss any opportunity to learn a skill. It need not be rocket science. But add every day : How to given an injection to a child without causing pain. How to give a ring block. How to introduce medication to the drip during pulse therapy. How to minimize irritation during peel. How to explain effective sun protection. How to escalate NB-UVB in psoriasis.
9. Lose the attitude. You can learn even from the seemingly ineffective teacher. Learn to speak gently to the patient. Learn to examine thoroughly. Learn complete documentation. At least learn 'what not-to-do' in future. But learn from EVERYONE.
10. Communication is king. If you can learn people skills and effective communication, you can manage a practice effectively. Talk simply, completely, clearly. Avoid jargon. Do not over promise. Yet, do not remove all trace of hope with cold scientific facts. Practice empathy and kindness. It will make the difference between clinical success and failure.
11. Do not let the thesis be a burden at the end. Bite the bullet and choose a topic early. Work on your thesis regularly. Once a month, on a free day review your thesis. Where have I reached ? Where should I be ? Write out a time frame right in the beginning and check whether you are crossing your milestones at the right time. Introduction, Methodology and Review of Literature can be finished in the First year of Residency. Never leave things to the last minute.
12. Treat every presentation like an exam case. Treat every patient like a VIP patient. Treat every seminar like an award paper. Take things seriously – you never know the moment in life when something clicks based on your sincerity and excellence and doors open for better things. Take life seriously and like will take you seriously.
13. 'This too shall pass' – when things go very badly remember this advice. Remember all things pass and this moment too will be a memory. Teachers may be upset, seminars may flop, you may lose a quiz – move on. Feel bad for a moment; learn the lesson and MOVE ON.
14. If this list sounds too serious, here is the opposite view. Enjoy every moment. This is the last organized course of your life. Enjoy everything. The rivalry, the competition, the small arguments, the successes, the failures, the scoldings, the parties, the sleepless nights, the duties, the boring lectures, the endless OPD's. These will all be fond memories soon. Erase the negative; focus on the positive and enjoy your residency.
15. Keep the connect with GOD or GOODNESS. I know some of you will smile as I say this. I am not discussing religion. I am discussing basic GOODNESS. It is in all of us. Cultivate that. Retain that. Nurture that. It is easy to lose. We became doctors for a purpose. Enjoy everything that life offers including money. But while reaching for the skies, do not lose your roots. Stay grounded. Don't lose your innate sense of goodness and humanity.

WISHING YOU ALL SUCCESS IN LIFE.

A SCANNER VIEW INTO THE WORLD OF PINK & PURPLE

An interview is like a viva. The lesser the questions required to be asked, the better you feel it is going. Our editorial board members, Zubin Mandlewala and Jimish Bagadia, were privileged to have one such heartfelt conversation with one of the greatest stalwarts of dermatopathology, Dr. Uday Khopkar. Dr. Khopkar is Prof. & Head, Dept. of Dermatology, Seth G.S. Medical College & K.E.M. Hospital, Mumbai. We, hereby, take a sneak-peek into the exemplary life of a man who needs no introduction (for whom an introduction would span the entire newsletter nevertheless).

So here are a few excerpts from tete-a-tete with Dr. Uday Khopkar:



K Dr. Uday Khopkar
Prof. & Head, Dept. of Dermatology, Seth G.S. Medical College & K.E.M. Hospital Mumbai.

Z Dr. Zubin Mandlewala
Resident, Padmashree Dr. D.Y. Patil Medical College & Research Centre, Navi Mumbai

J Dr. Jimish Bagadia
Resident, K.J. Somaiya hospital, Mumbai

Z Sir, kindly take us through your wonderful journey into dermatology and thence to dermatopathology…

K Actually, I didn't have a particular interest in dermatology. I was interested in medicine or pediatrics. But it so happened that I had a spinal injury during my internship, and I thought of taking dermatology as it was one branch I felt I could manage sitting in my chair (*The accident paralyzed his lower half, but the great fighter refused to be bogged down*). Later on, my curious mind let me on to dermatopathology. When I started my residency, I always used to question. I probably asked too many questions that no one had asked before. My seniors called me "Mr. Why" (*chuckles*).

Of course, there were great teachers on the way. The late Dr. Leslie Marquis was a great personality who always insisted on biopsies. After he passed away, we were helped a lot by Dr. V.R. Mehta, who used to visit Nair Hospital every week just to teach us. He was a great stimulus to orient me to the field of dermatopathology.

The idea of undergoing training in dermatopathology came a little later after completion of residency. I had an opportunity to visit U.S.A. to attend World Congress. It was the first time they were giving scholarships to young dermatologists and I was fortunate enough to receive it. I was greatly influenced by Dr. Bernard Ackerman and so I thought, since I am going all the way, I might just as well learn from him. I wrote a letter to him. The great man welcomed students from all over the world. Later, I attended a month long course from him on dermatopathology in the summer 1992.

I want to emphasize that… (*Suddenly, his eyes become moist, voice reverberates with emotions and a long pause ensues. He apologizes, and thereby we are completely bowled over by sentimental human side of a man of such a magnanimous stature in the dermatology)*. I would like to emphasize that all this wouldn't have been possible without the invaluable help and unwavering support of Dr. S.L.Wadhwa who came with me personally to the States to ensure that I was comfortable.Travelling alone in a foreign country wasn't easy and it was of great help and encouragement for me.

It was because of all these people only that I could pursue my training.

A SCANNER VIEW INTO THE WORLD OF PINK & PURPLE

J How important is it to have a dedicated guide in this field?

K Extremely vital I feel, especially for a field like dermatopathology. Dr. Ackerman was dedicated to the field of dermatopathology and had a selfless attitude in teaching students. His sessions always began at 7 a.m. sharp and fellows would come at 5.30 a.m. to secure a spot at the microscope; else you didn't get a microscope. (*Laughs*) It's something for us to learn from. He received between 1200-1800 specimens per day, sent to him from all across the country; and he'd go through them himself. There used to be a pitcher and a catcher, that is, someone would insert slides and someone would remove them. He just looked at the slides like a machine.

Dr. Ackerman was a great influence because he did a lot of publications and also had served as the Editor of American Journal of Dermatopathology.

Z Which books did you refer during your residency?

K At that time, it was very difficult to find literature. Books weren't that freely available. We knew only one book – Lever's. We used to refer to Pinkus occasionally, but the correlation with dermatology was easier with Lever's. Even the books weren't colored, with a maximum of 3-4 colored plates in the entire book. No pink & purple you see, which is very difficult if you're trying to learn. Ready access at the fingertips couldn't have been dreamt of.

J Sir, how much time did you dedicate to pathology/slides during your residency?

K During my residency days, I didn't have a great liking for the microscope. Awareness about learning from slides came to me after my residency. When you see more cases, you realize that you really don't know. Then you take a biopsy, look at it and then try to correlate. It was only when I became more insistent about knowing the right diagnosis that I started spending more time on the slides.

Z Sir, what was your approach to slide viewing initially? Were there any glitches/problems you encountered ?

K My biggest mistake at the start was that I would see the patient and then the slide. When the mind is not free from the diagnostic prejudices, it prevents you from learning.
Also, in those days, we had a simple monocular outdated microscope. It was difficult to interpret slides and a lot had to be left to the imagination. We never understood words like "necrobiosis". It wasn't that the teachers weren't good; it was just lack of infrastructure. Learning dermatopathology by yourself is like re-inventing the wheel. It takes time to get a hang of it. When a teacher teaches you on a teaching microscope or a video screen, that timeline is drastically reduced. So, in that aspect, I believe you guys are really lucky.

J How essential is the knowledge of dermatopathology for a dermatologist?

K See, once you are out of the medical college, what happens is the cases that present to you are very different and very often have atypical presentations. You might consult your colleague and seniors, and still it doesn't fit in. In such a time, dermatopathology helps us in guiding towards the diagnosis. It keeps our mind open and gives us an insight.

A SCANNER VIEW INTO THE WORLD OF PINK & PURPLE

Learning dermatopathology is a humbling experience. The scope of doubt that lingers from the clinical conclusion propels one to gain further knowledge, which is essential to succeed in any field. It makes you a more complete doctor. K

Z How essential is Clinico-Pathological Correlation (CPC)?

CPC is the basis of dermatopathology. Don't try to diagnose the slide without the patient. Of course, first look at it without knowing what slide it is; but after that exercise is over and you've reached a differential diagnosis, you must have the patient by your side or remember the clinical findings. This to-and-fro interaction is the essence of understanding dermatopathology and thereby, dermatology. K

Z So a dermatopathologist must always see a patient if he wants to give a good diagnosis?

Not necessarily. Good diagnosis is possible in tumor pathology.
Many countries have pathologists reporting skin biopsies, and the reporting in most cases is very precise. However, it is different when an inflammatory pathology is present, where clinical correlation becomes essential. K

J So, a dermatologist is better suited at dermatopathology than a pathologist

Absolutely. A pathologist might get lost in the words. The terminologies in clinical dermatology are imposing and prohibitive. It's a little difficult for them as they cannot correlate clinically. However a lot of pathologists are taking a keen interest in dermatopathology. We shouldn't deny them. They are putting in a lot of hard work. Also, we as dermatologists might run the risk of over-interpretation and we might feel like a fool after knowing the clinical condition. But, we should not keep fear in our minds when we give a diagnosis, whether it is clinical or pathological. That is the biggest hurdle in learning. A child learns to walk only because he has no fear of falling. K

J So you did two fellowships with Dr. Ackermam ?

Yes, I was fortunate. First was a short training period in New York in 1992, while the second one was a full 1 year fellowship at Philadelphia in 1994-95. K

Z Sir, do you feel there is a dearth of dedicated dermatopathologists in India?

Definitely. I feel we do less biopsies here due to various considerations. Previously, diagnosis wasn't conclusive in many cases, hence people found no point in doing a biopsy many-a-time. Constraint of time in our busy private practice is another reason... Sometimes we ourselves may not be convinced and we would like to see respone to therapy before doing a biopsy.However, the scenario is gradually changing.. We have dedicated dermatopathologists now. So, today, biopsy has become more rewarding and easier. It is important as patients need answers. They are also happy. K

A SCANNER VIEW INTO THE WORLD OF PINK & PURPLE

Z We as residents have a habit of assigning terms to conditions like “swarm of bees” for alopecia areata, “claw-clutching a ball” for lichen nitidus, etc. Are we justified in doing so?

K Being with Dr. Ackerman made a lot of difference. He disliked this idea of labels because a particular finding characteristic of one condition might be present in various other conditions. For example, you might associate “flame figures” with Well’s syndrome, but they can be seen more commonly in insect bite reactions. So, while it suited residents for easy remembrance for the exam purpose, it does not suit someone actually practicing dermatopathology. It is a wrong approach to view a slide. Dr. Ackerman had a famous talk on it. He called it ‘*Clichés in dermatopathology*’. What I feel is that one should look at the crux of it. Many people who say Munro’s microabscess, they actually don’t know what it is. When you ask them to describe it, they are not actually able to. The components of Munro’s abscess are not just neutrophils, it is spongiform dermatosis within parakeratosis. We should look at dermatopathologic findings as a process. Move beyond the labels; try to understand the process, how the body is reacting, and that will help in managing the patients. To give an example, very frequently we come across psoriatic patients who have excessive itching. They don’t care as much about the skin lesions as the itching. They actually are atopic individuals who have a combination of eczema and psoriasis. In the biopsy, especially from the legs, we see spongiosis- not neutrophilic spongiosis, but proper spongiosis with exocytosis and lymphocytes. We don’t acknowledge that. As residents, when you write the findings of psoriasis, you don’t mention spongiosis. The reason is we are not thinking about the process, all we think about is labels. What is happening is that these atopics are responding to environmental antigens, which lead to inflammation of spongiotic type, and because they are prone to psoriasis, it is like a koebner’s occuring. So both the things occur together. Treating one will not help, as the other will perpetuate. So even if it is psoriasis, avoiding the allergen is more important in such cases.

Z Sir, is there any particular method of looking at a slide? Like start from the epidermis and move downwards or vice versa…

K Again I repeat myself – don’t reinvent the wheel. Pattern analysis is the correct approach. Whether it is inflammatory, neoplastic, granulomatous etiology, try proceeding systematically by analyzing the pattern. Whether you move from up to down, or bottom to top, it won’t matter as you will reach the same place.

J Sir, what do you think about dermatopathology as a full-fledged career for the young dermatologists? How feasible is it?

K Infrastructure can be an initial hurdle, but there are many easy ways if you want to start practicing it. Only a microscope is required, the processing can be outsourced. Even if you are not thinking of it as a separate career, the mere learning process is very satisfying.

J Do you feel India has ample opportunities to train young minds in this field?

K I can’t say that we have ample opportunities. I think there are hardly any courses available except at our institution where we have a full one year course. Quite a few people go abroad to do fellowships. 2-3 months I feel is less; you need at least a year to become an expert, which is what one would like to be. Otherwise, to just satisfy the curiosity, 1 month course may suffice, which is what the IADVL offers in the form of short-term fellowships.

A SCANNER VIEW INTO THE WORLD OF PINK & PURPLE

Z There are many notions regarding the skin biopsy procedure - adequate size, site, forceps, scissors, technique of moving in one direction etc.

K I don't think all that matters much. Most important thing is avoiding trauma, as skin biopsies are small and easily prone to compression artefacts. It's more important to have sharp punches. Regarding the size, we must understand that we live in a dynamic world. When I started, 5 mm punch biopsy was the standard. Today 3 mm is the standard and most of the times it suffices. The standard is again now changing from 3 to 2.5 mm. The important thing is that the purpose of biopsy should be justified. All other considerations are secondary. Sometimes, patient misleads you: 'Doctor, please don't take from there. Take from here.' Understand that you are responsible for the diagnosis, and not the patient. So you convince them politely. Not causing scars is an important consideration but not the primary one.

J Are we justified in avoiding biopsies from areas like palms and soles where painful scarring occurs?

K I mean it is generally better to avoid taking biopsies from such weight-bearing areas. The cause of painful scarring is the fibrosis that sets in, restricting the mobility. But don't be scared of taking biopsies if you have to. Like I said before, understanding the process is more important.

J Do you have a final word of advice or a take-home message for our residents interested in the field of dermatopathology?

K I don't have a message for those who are interested. I have a message for those who aren't (*chuckles*).

J Please tell me sir. I am one of them.

K No no, I don't blame you. Like I said, even I didn't have interest initially. I was interested only in clinical diagnosis. But then a time comes, when you move beyond the labels, you try to understand the process. There is no better person to be a dermatopathologist than yourself, even if you have not yet discovered an interest. To be a good clinical dermatologist, you must know dermatopathology well. Even cosmetic dermatology requires knowledge of skin pathology. Thus, an insight into dermatopathology is mandatory. Don't try to run away from it because that will suggest you are running away from dermatology itself.

(We leave him on his microscope with a stack of slides waiting to be reviewed, and with a quiet and gradual surge of interest in dermatopathology; hoping that the feeling would last)

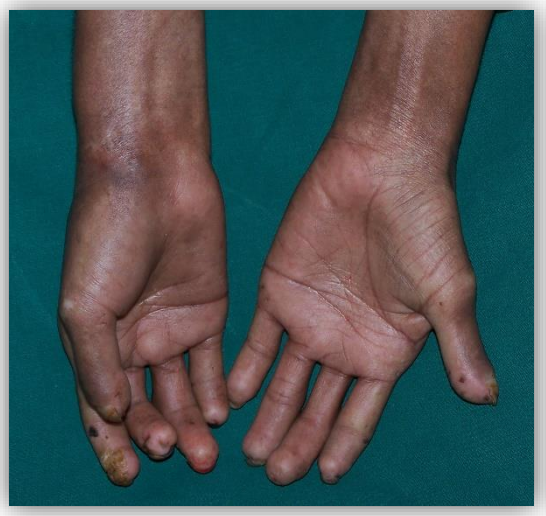
Systemic Sclerosis – Exam Case

Author :

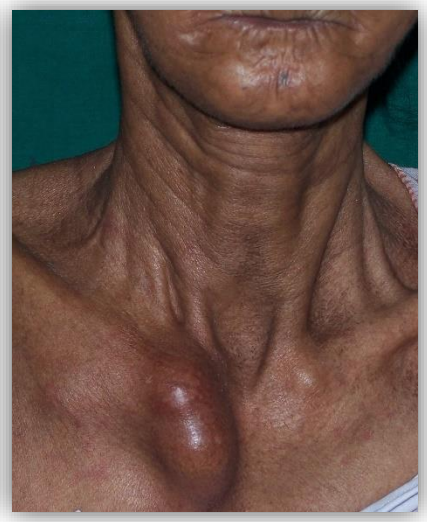
Dr. Vishalakshi Vishwanath
Head of Department, Dermatology, Rajiv Gandhi Medical College, Thane.

A 45 year old married woman presented with chief complaints of-

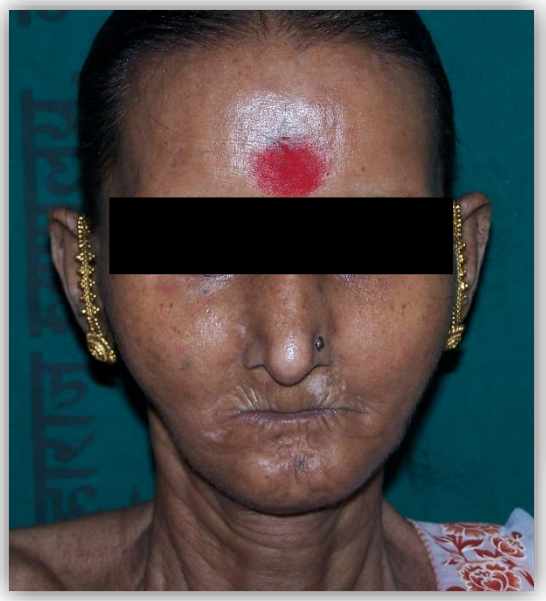
- Recurrent ulceration on the finger tips…. since two years
- Tightening of skin on the face and extremities…. since one year
- Swelling on the chest ….. since six months



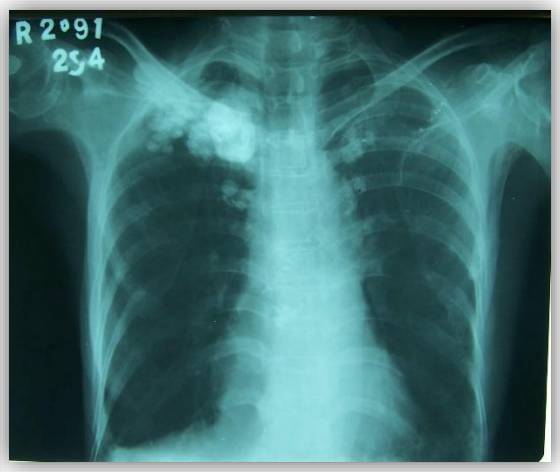
Digital Pitting and resorption



Calcinosis Cutis



Typical Facies



Calcific deposits on radiographic examination

Systemic Sclerosis – Exam Case

Relevant history elicited in this case-

Cutaneous-

- H/o painful bluish discoloration of fingers on exposure to cold followed by tapering of digits & ulceration on the finger tips
- H/o gradual alteration in facial appearance with pigmentation on face, trunk ,extremities
- H/o painless swelling on the chest with discharge of chalky material

Systemic -

- H/o dyspnoea & cough +, No H/o chest pain/ palpitation
- No H/o dysphagia/ abdominal pain/ altered bowel habits
- No H/o sudden onset headache/ swelling of feet

Associated connective tissue diseases-

- No H/o photosensitivity, oral lesion, joint pain &swelling
- No H/o difficulty in combing hair & standing from squatting position

Treatment history-

- Intermittent treatment received from general practitioners , no details available

CASE EXAMINATION-

General and systemic examination– (Details of Respiratory system to be included)

Cutaneous examination-

- Indurated appearance of skin with reduction in wrinkling
- Mask like facies, Inability to retract lower eyelid (**Ingram`s sign +ve**)
- Thin lips with purse-string appearance due to radial furrowing around lips
- Few areas of hypopigmentation and salt and pepper pigmentation on face, neck and back (**Barnets neck sign+**)
- Facial telangiectasia +,
- Firm-to-hard swelling on the sternal area
- Tautness of skin on UE extending till mid arm & on LE till thigh
- Sclerodactyly + / pitting & stellate scar on finger tips, resorption of distal phalanx +
- Nails- Pseudoclubbing+, No e/o periungual telangiectasia
- Scalp/ hair/ mucosae – NAD

DIAGNOSIS-

- Diffuse cutaneous systemic sclerosis (type) with dystrophic calcinosis with Pulmonary involvement (Organ involvement)
- Untreated (Rx/ UnRx)

RELEVANT QUESTIONS IN THIS CASE ON HISTORY AND EXAMINATION

Elicit-

Raynauds phenomenon	**Microstomia**	**Chest expansion**
Elicited by ice cube test wrapped in gauze and held for 20 mins Triphasic color change of : pallor, cyanosis and hyperemia	Limited mouth opening measured by patient`s own finger insertion- **Grade 1**- Three fingers **Grade 2**- Two fingers **Grade 3**- One finger	Reduced to below 3 cm at the end of maximum inspiration and expiration at T4 level

Systemic Sclerosis – Exam Case

Clinical signs-

Clinical signs	Types (SSc type Bold)	Common Sites in SSc
1. Calcinosis	Dystrophic, Metastatic,Idiopathic	Terminal phalanx, hands, feet, elbows, knees, hips, extensor forearms, along the spine
2. Telangiectasia	Mat like,Punctuate,Linear,Stellate	Face, lips, mouth, palms, periungual, upper trunk, thighs
3. Pigmentation	Hyper or hypo-pigmentation, Salt and pepper appearance Addisonian pigmentation	Face especially forehead, clavicles, post aspect neck, retroauricular, trunk, thighs

Nail examination in SSc-

- **Pseudoclubbing**- Result of soft tissue collapse due to severe bone erosion, distinguished from clubbing by preservation of nail fold angle and severe bone erosion
- **Pterygium unguium inversus**- fusion of hyponychia with proximal nail fold due to fibrosis
- **Nail capillaroscopic examination**- capillary loop dropouts, architectural disorganization, dilated tortuous capillary loops, angiogenesis &avascular areas.

Causes of Raynaud's phenomenon-

- Primary Raynaud`s phenomenon (Raynaud`s disease)
- Secondary Raynaud`s phenomenon
    a) Trauma or vibration
    b) Connective tissue diseases and vasculitis
    c) Obstructive arterial diseases
    d) Neurological diseases
    e) Haematological diseases
    f) Drugs and toxins

RELEVANT QUESTIONS ON DIAGNOSTIC ASPECTS

ARA criteria for SSc- 1 major or 2 or more minor criteria for diagnosis

Major criteria: Proximal scleroderma
Minor criterias:
1. Sclerodactyly
2. Digital pitting or scar; loss of fingertip pulp
3. Bi-basal pulmonary fibrosis

Minimal serological (auto-antibodies) investigation in SSc

1. ANA(speckled, homogenous, nucleolar patterns)
2. Anti Scl-70(DNA topoisomerase) antibodies (Dc SSc, ILD)
3. Anti centromere antibodies (CREST syndrome, LcSSc, pulmonary HT)

Systemic Sclerosis – Exam Case

When will you suspect or label a case as SSc- sine scleroderma ?
Presence of visceral organ involvement & serological abnormalities without skin manifestations

When will you suspect Scleroderma renal crisis ?

- Abrupt onset of moderate to severe hypertension
- Rapidly progressive renal failure
- Low platelet count

What are the poor prognostic factors in SSc ?

- Young patient, male gender
- Extensive involvement of truncal skin & visceral organ involvement
- Initial presentation with Scl 70 +ve,
- Anaemia, proteinuria, increased ESR, decreased DLCO

MANAGEMENT ASPECTS

Clinical Manifestations	Treatment modalities
Skin sclerosis	Immunosuppresives (methotrexate, mycophenolate mofetil, azathioprine, cyclophosphamide, cyclosporine) Biologicals, Tyrosine kinase inhibitors (imatinib) Other modalities (d- penicillamine, corticosteroids , UVA1/ narrow band UVB, rapamycin, topical halofuginone, haematopoetic stem cell transplantation, extracorporeal photopheresis, IVIg)
Raynaud`s phenomenon and digital vasculopathies	Use of gloves, oil massage, warm compresses Calcium channel blockers (nifedipine), Angiotensin receptor blockers (losartan), Eta receptor antagonist (bosentan), prostacyclin analogues(Iloprost), Statins (atorvastatin) Phosphodiesterase type 5 inhibitor (sildenafil, vardenafil, and tadalafil), pentoxyfylline, low dose aspirin, topical nitroglycerine
Pigmentation	Topical calcipotriol, tacrolimus, UVB therapy, Eta receptor antagonist
Calcinosis	Diltiazem, Minocycline, Biphosphonates, Probenecid, low dose warfarin, surgical excision, CO2 laser
Leg Ulcers	Bosentan, Erythropoeitin, Platelet gel, Becaplermin, G-CSF, Hydrocolloid dressings, Low molecular weight heparin, pentoxyfylline
Telangiectasia	Flash lamp pumped pulsed dye laser, Intense Pulse Light
Pulmonary	Cyclophosphamide, prostacyclin analogues, Bosentan
Gastro-intestinal	Frequent small meals, Proton pump inhibitors, H2 receptor blockers
Musculoskeletal	Glucocorticoids, IVIg
Renal	ACE inhibitors (enalapril), Dialysis, renal transplant

Residream Quiz

Authors :

Dr. Indrashish Poddar and Dr. Anupam Das
Residents
Medical College and Hospital
Kolkata

"Solitary painful nodule in a child"

A 6-year-old boy presented with complaints of gradually increasing, painful, swelling over the right forearm present since birth. On examination, a 3 cm × 3 cm, soft, tender, ill-defined, black to brown colored nodule, with smooth surface, better felt than seen was present over the flexor aspect of right forearm [Figure 1]. Hypertrichosis was present over the lesion. In addition, noticeable perspiration was evident following a gentle stroke over the lesion.

Skin biopsy revealed an acanthotic epidermis with dermal proliferation of eccrine glands, in close proximity to a few well-differentiated, thin-walled angiomatous channels, and adipose tissue. [Figure 2] No atypia or mitosis was found.

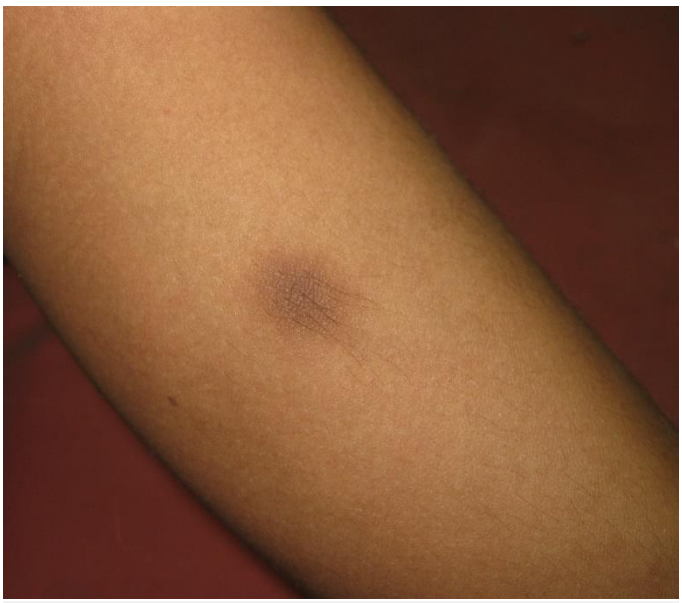


Figure 1 : Clinical photograph showing ill-defined brown-colored nodule over the forearm. Note the hypertrichosis

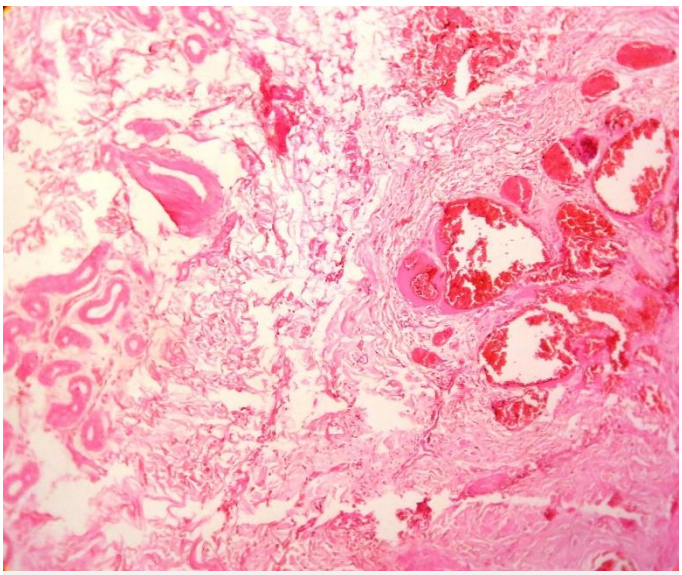


Figure 2 : Photomicrograph showing dermal proliferation of eccrine glands, along with thin-walled angiomatous channels, and adipose tissue. (H&E, 40X)

What is your diagnosis?

Drugs for Psoriasis – What's New

Authors :

Samujjala Deb
PG – 2 , Burdwan Medical College, Burdwan

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

Recently, many new drugs with novel mechanisms of action have been tried in the treatment of psoriasis. There has been an increasing trend for the use of biologics. Infliximab, etanercept, adalimumab and alefacept have been approved by the Food and Drug Administration (FDA) for use. Efalizumab was earlier included in the list of biologics for the treatment of psoriasis, but it has been withdrawn from the market due to its propensity for causing Progressive multifocal leukoencephalopathy (PML).

National Institute for Health and Clinical Excellence (NICE) recommendations on the use of biologics

1. Biological agents for psoriasis should be initiated and supervised only by specialist physicians experienced in the diagnosis and treatment of psoriasis.
2. If a person has both psoriasis and psoriatic arthritis, take into account both conditions before initiating or making changes to biological therapy and manage their treatment in consultation with a rheumatologist
3. When using the DLQI, healthcare professionals should take into account any physical, sensory or learning disabilities, or communication difficulties that could affect the responses to the DLQI and make any adjustments they consider appropriate.

Adalimumab and Etanercept

The recommendations for the treatment of adults with psoriasis .

1. Recommended as a treatment option for adults with plaque psoriasis for whom anti-tumour necrosis factor (TNF) treatment is being considered and when the following criteria are both met.
    - The disease is severe as defined by a total PASI of 10 or more and a DLQI of more than 10.
    - The psoriasis has not responded to standard systemic therapies including cyclosporine, methotrexate and PUVA; or the person is intolerant of, or has a contraindication to, these treatments.
2. Should be discontinued in people whose psoriasis has not responded adequately at 16 weeks. An adequate response is defined as either: a 75% reduction in the PASI score (PASI 75) from when treatment started or a 50% reduction in the PASI score (PASI 50) and a 5-point reduction in DLQI from start of treatment.

Infliximab

The recommendations for Infliximab for the treatment of adults with psoriasis

1. Infliximab, within its licensed indications, is recommended as a treatment option for adults with plaque psoriasis only when the following criteria are met :
    - The disease is very severe as defined by a total PASI of 20 or more and a DLQI of more than 18.
    - The psoriasis has failed to respond to standard systemic therapies such as ciclosporin, methotrexate or PUVA, or the person is intolerant to or has a contraindication to these treatments.
2. Infliximab treatment should be continued beyond 10 weeks only in people whose psoriasis has shown an adequate response to treatment within 10 weeks. An adequate response is defined as either:
    - a 75% reduction in the PASI score from when treatment started (PASI 75) or
    - a 50% reduction in the PASI score (PASI 50) and a 5-point reduction in the DLQI from when treatment started.

Drugs for Psoriasis – What's New

Ustekinumab

The recommendations for Ustekinumab for the treatment of adults with moderate to severe psoriasis.

1. Ustekinumab is recommended as a treatment option for adults with plaque psoriasis when the following criteria are met :
    - The disease is severe, as defined by a total PASI score of 10 or more and a DLQI score of > 10.
    - The psoriasis has not responded to standard systemic therapies, including cyclosporine, methotrexate and PUVA, or the person is intolerant of or has a contraindication to these treatments.
    - The manufacturer provides the 90 mg dose (two 45 mg vials) for people who weigh more than 100 kg at the same total cost as for a single 45 mg vial.
2. Ustekinumab treatment should be stopped in people whose psoriasis has not responded adequately by 16 weeks after starting treatment. An adequate response is defined as either:
    - a 75% reduction in the PASI score (PASI 75) from when treatment started or
    - a 50% reduction in the PASI score (PASI 50) and a 5-point reduction in the DLQI score from when treatment started.

NAME OF THE BIOLOGIC	COMMENTS
Agents targeting T-cells or antigen presenting cells (APCs)	
Alefacept	US-FDA approved bivalent recombinant fusion protein. LFA-3 portion of alefacept binds to CD2 receptors on T-cells, thereby blocking their natural interaction with LFA-3 on APCs. Dose : 10-15 mg im weekly or 7.5 mg iv weekly
OKTcdr4a, CTLA-4Ig, Denileukin diftitox; Basiliximab and daclizumab (anti CD25), Siplizumab (antiCD2)	In trial phase for psoriasis
Agents targeting cytokines	
Etanercept	Human dimeric fusion protein which functions as a TNF inhibitor by binding to and inactivating TNF-α. Approved for psoriasis and psoriatic arthritis. Dose : 50mg/week s/c
Infliximab	Human-mouse monoclonal antibody that binds to and inhibits the activity of TNF-α Dose : IV in doses of 5 or 10 mg/kg, over a period of 2 hours at weeks 0, 2, 6 and may be followed by repeat single infusions at 8-12 week intervals.
Adalimumab	Human IgG1 monoclonal antibody directed against TNF-α & blocks interaction with p55 & p75 cell surface receptors. Dose : 80 mg on day 1 and then 40 mg every other week beginning on day 8. The recommended dose for psoriatic arthritis is 40 mg every other week.
Onercept	Recombinant human soluble p55 tumor necrosis factor binding protein
Ustekinumab Briakinumab	Anti IL-12/23. In September 2013, the FDA approved the use of ustekinumab for the treatment of psoriatic arthritis.
Brodalumab Secukinumab	Anti IL-17. It is being tested for the treatment of moderate to severe psoriasis in Phase III clinical trials as of November 2013. Secukinumab is a human monoclonal antibody designed for the treatments of uveitis, rheumatoid arthritis, and psoriasis. It has completed Phase II clinical trials for plaque psoriasis in 2011 and now in Phase III.
Fezakinumab	Anti IL-22
Golimumab Certolizumab pegol	Anti TNF alpha. Golimumab is approved in Canada and the United States as a once monthly subcutaneous treatment for adults with moderately to severely active rheumatoid arthritis, psoriatic arthritis, and ankylosing spondylitis. On September 2013, the USFDA approved Certolizumab for use in the United States for the treatment of adult patients with active psoriatic arthritis.

Other newer drugs

1. **Protein kinase C inhibitors** : PKC family of serine/threonine kinases is pivotal in the immuno-pathogenesis of psoriasis. AEB071 is an oral PKC inhibitor, which inhibits T-cell proliferation. It blocks the production of inflammatory cytokines by activated T cells and keratinocytes.
2. **Janus kinase inhibitors** : Tofacitinib is a drug of the janus kinase (JAK) inhibitor class. It is currently approved for the treatment of rheumatoid arthritis (RA) in the United States and is being studied for treatment of psoriasis, inflammatory bowel disease, and other immunological diseases, as well as for the prevention of organ transplant rejection.
3. **Mitogen-activated protein kinase inhibitors** : Mitogen-activated protein kinases are important in various steps of pathogenesis of psoriasis including cell proliferation, inflammation, and apoptosis. A new p38 inhibitor, BMS-582949 (Bristol-Myers Squibb) has been studied in phase II trials for psoriasis.
4. **Phosphodiesterase 4 inhibitors** : Inhibition of phosphodiesterase type 4 (PDE4) leads to accumulation of cyclic adenosine monophosphate in leukocytes. This inhibits neutrophil degranulation, chemotaxis, and adhesion to endothelial cells. Apremilast is an oral PDE4 inhibitor. It is currently in phase III for ankylosing spondylitis, Behcet's disease and rheumatoid arthritis, psoriasis, and psoriatic arthritis. Apremilast was approved by the USFDA in March 2014 for treatment of adults with active psoriatic arthritis.
5. **Chemokine receptor blockers** : SCH527123 (Schering Plough) is an allosteric antagonist of CXCR1 and CXCR2 which inhibits neutrophil chemotaxis and release of myeloperoxidase in response to CXCL8 and CXCL1.

To conclude, these new drugs seem to offer promising therapeutic modalitiesr moderate to severe chronic stable plaque psoriasis and psoriatic arthritis, but long-term studies are warranted to assess the risk-benefit ratio of using these drugs over an extended period of time. Inspite of the economic restraints as a result of these, their actions have brought a new hope for psoriasis, both patients and doctors.

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Residream Quiz - Answer

Eccrine Angiomatous Hamartoma

INTRODUCTION:

Eccrine angiomatous hamartoma also known as Eccrine angiomatous nevus or Sudoriferous angioma, is a rare benign tumour like lesion, prevalent in childhood, which occurs as a result of increased proliferation of eccrine sweat glands and angiomatous capillary channels .

CLINICAL FEATURES:

- These lesions most commonly arise in childhood, affecting both sexes equally.
- They appear as nodules or plaques, flesh coloured or with a bluish colour, appearing as angiomatous masses.
- Most common site of predilection is the extremities particularly palms and soles, however other sites may be involved viz. other parts of feet, wrist [3], face, neck and trunk.
- Hyperhidrosis and/or pain may be apparent and sometimes, hair follicles are associated with this lesion and hypertrichosis may be present.
- Rarely they may be associated with knuckle pads.

VARIANTS: According to -

Number of lesions	Clinical features	Pathology/ Histology
Solitary (more common) Multiple	Painful (more common) Painless	Normal vascularization Increased vascularization/ predominantly angiomatous type

PATHOLOGY:

The exact pathogenesis is not known but various theories such as malformation of adnexal as well as mesenchymal elements have been proposed. There is proliferation of the eccrine sweat glands within a vascular stoma, situated in the middle and deep dermis.

HISTOLOGY:

Under the microscope, we would be able to find large, but otherwise normal eccrine sweat glands arranged in the form of nests; enmeshed in loose fibrous tissue, which contains numerous thin-walled, dilated blood vessels and lymphatics.

DIFFERENTIAL DIAGNOSES:

This tumour has to be differentiated from other painful skin tumours, which can be represented by a mnemonic: BLEND AN EGG; Blue rubber bleb nevus, Leiomyoma, Eccrine angiomatous hamartoma, Eccrine spiradenoma, Neurofibroma, Dermatofibroma, Angiolipoma, Neurilemmoma, Endometrioma, Glomus tumour and Granular cell tumour.

DIAGNOSIS:

The definitive diagnosis is essentially histological. However recently, Immunohistochemical staining for S-100 and carcinoembryonic antigen (CEA), for eccrine glands and the antifactor VIII-related antigens, for vascular channels have come as promising diagnostic tools.

TREATMENT:

Over aggressive treatment is not warranted. Deep excision with full-thickness grafting is the treatment of choice, especially for the painful lesions situated on the palms and soles. If surgery is not feasible, Botulinum toxin, intralesional sclerosants and Pulsed dye laser may be tried. In rare instances, even spontaneous regression has been noted.

IADVL-AAD ANNUAL MEETING SCHOLARSHIPS 2015

Dear IADVL Members,
IADVL EC is pleased to apply applications from IADVL PLMs or LMs for AAD Annual Meeting Scholarships for March 2015, San Francisco. There are 2 types of scholarships:

1. Scholarships for Registration
2. Poster Exhibit Scholarships

Applicants need to apply before 30th June to iadvlsecretary2014@gmail.com.

Please read criteria below and write this in your covering letter:
1. You HAVE to be an IADVL Member-PLM/LM and need to quote that
2. You should either be a PG or within 3 years of postgraduation
3. YOU NEED TO STATE CLEARLY whether you have received AAD or any other scholarship ENDORSED by IADVL before. If you have, IADVL would not endorse for a second time from now. Information should be clear
4. You should have a letter from Head of the Dept that you are doing PG in his/her dept.

Application should include:
1. Short CV of 1 page (Publication list can be attached).It should not be more.
2. Your abstract for poster or oral presentation(for registration).

PLEASE NOTE:
Results will be out by 15th July after decision by Jury and endorsement letters from IADVL will be given by IADVL to 2 best posters. The awardees have to upload the abstracts for Poster Exhibit themselves with Letter of Endorsement from IADVL

Feedback

Hope you liked the 2nd issue of RESIDREAM newsletter. If you have any comments, queries, suggestions, contributions, please write to us at : *residreamiadvl@gmail.com*