Resident-DREAM

Dermatology Residents Education And Motivation Bulletin

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a newsletter for IADVL residents

From the editor's pen :

It is indeed a privilege to be given the responsibility of editing the Resi-DREAM, a one of its kind resident mouthpiece by the IADVL. We have had the pleasure of association with this wonderful initiative since the inaugural issue. The feedback received from all over the country has been tremendous & encouraging. We further welcome all residents to share their opinions, to submit their articles or simply to state what's on their mind. We already have a thriving Facebook group where residents from all around the country share experiences, cases, opinions and advice. A Residents Forum will be held at the upcoming DERMACON, 2015 at Mangalore where distinguished faculty will guide us on areas of uncertainty. We hope to see you all at Mangalore.

This issue is an ode to 'Women and Dermatology'. We begin this issue by remembering the *Prima Donna* of dermatology in our country - Dr. Surrinder Kaur. Professor A.J. Kanwar provides us with a glimpse of life & times of Dr. Kaur. We also present few words of wisdom from a few 'superwomen of dermatology' in our country from the 4 corners – Dr S.Premlatha, Dr. Hemangi Jerajani, Dr. Jyoti Nath & Dr. Rashmi Sarkar. There are many more….Respected Dr. S. Premalatha narrates an interesting anecdote from her treasure trove of experience. We have also included a brief introduction on formation & objectives of Women's Dermatologic Society & its Indian chapter. Since we are talking about all things feminine, from the clinics, we have an approach to a case of vaginal discharge & a discussion on vulval dermatoses. Our team members, Dr. Gillian Britto & Dr. Saloni Katoch have written brilliant accounts on 'Acid Attacks' &'Fairness Creams' respectively. To set the mood, we commence this kaleidoscopic journey by a friendly debate on 'Do Women make better dermatologists?'

- Dr. Samujjala Deb, Dr. Sumit Gupta

THE GENDER WARS -
Who makes better dermatologists – Men / Women?

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If you want something said, ask a man, if you want something done, ask a woman.
– Margaret Thatcher

Since time immemorial, it has been believed that men are better than women in everything they do. Why not? Since till a few decades ago, women were mostly confined to taking care of their families and bringing up children. With

Do women make better dermatologists or are men better physicians of skin? Either of the sweeping statements are flawed, pretentious and borne out of either complexes reared in our psyche since eternity or due to

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passage of time women have come out and broken all stereotypes and worked shoulder to shoulder with men in all professions on this planet – be it doctors, lawyers, chefs, soldiers, business tycoons, models, athletes etc. etc. In spite of that, they have always been considered the 'weaker sex'. So does this extrapolate to physicians or more specifically to dermatologists as well? In recent years, a number of studies have been undertaken to study gender based differences in the skills of male and female physicians. And the results are truly trailblazing.

Yes, studies have proven that even though males have larger brains (10% larger) with more grey matter, females have more white matter and greater number of intracerebral hemispheric connections that enable them to correlate information more successfully. This is of quintessential importance to a physician and more so to a dermatologist because we work like detectives. And often being able to correlate the most subtle clues leads us to a clinical diagnosis that we would have otherwise missed. Females also have large fronto-temporal areas, which means they are endowed with better language skills. This in turn helps women communicate better, verbalize their thoughts and have a better impact on patients after consultation. Women are also better equipped at identifying emotions and subtle behaviours. Lastly the brain centers that control aggression and rage, are also more developed in them. All this leads to a significant difference in behaviors of male and female dermatologists. We all know that many dermatoses are chronic and less amenable to treatment. Many a times adequate and thorough counselling of patients is a must so as to ensure better compliance to treatment along with allaying of fears and misconceptions surrounding a chronic disease. In such a situation, women dermatologists score much higher on the doctor-patient relationship. Also some patients are quite difficult to handle, be it their internet acquired knowledge, self-medications, fear of systemic drugs, preference for alternative treatments etc. it often taking a toll on the doctors patience. Women who are better at controlling their aggression, are able to manage these patients better as well!

It has also been seen that women spend more time on an average with patients. This may seem less productive in terms of delivery of care but this extra time spent decreases the number of patients who come back because they either did not understand their condition or how to follow the treatment protocol. So a highly productive doctor is not necessarily a better one. It has also been seen that women physicians show greater compliance with established treatment guidelines and protocols and exhibit less risky behavior in terms of choice of medications. Females are more empathetic and approachable, and patients open up more to them and give better case histories, they also tend to ask more questions. This may seem counterproductive, but patients who get to ask questions and are satisfied by the explanation often respond better as well as show better adherence to the treatment prescribed to them.

disproportionate reaction to these age-old dogmas. Potential of human endeavour is essentially pluripotent. Ideas such as aptitude and 'gender specific ability' undermine this pluripotency. Gender is not a faculty that naturally enables oneself to be better at some field.

There are certain medical fields associated with unequivocal gender skewness. For instance, it is hard to find a female orthopaedic surgeon. Similarly, male gynaecologists are few and far between (especially in north India). These differences are more cultural than natural. Dermatology is being increasingly opted by females across our country. We see that in PG counsellings, dermatology departments, conferences etc. This is probably due to dermatology's perception as a 'light' field with plenty of academic as well as commercial avenues promising career success without compromising family welfare. Also, dermatology practice in our country is increasingly acquiring aesthetic & glamorous dimensions. Many female patients who wish to undergo aesthetic procedures might want to be treated by female dermatologists who they think might understand their 'need to look good' better than males.

There may be critical life events that may shape & influence one's ability to be good at something or the other. Traditionally, it is believed that the two genders are subjected to differential upbringing in our society. Females are taught to be more enduring and tolerant. Male upbringing generally, inculcates out-worldliness and confidence in one's strengths. All these qualities are important life skills that everyone acquires to some extent or other. It is difficult and maybe unwise to say if any quality gives an advantage to one gender over the other. Also, over the years, with modern thinking these differences in upbringing are being eliminated.

Most females undergo major upheavals at crucial junctures of their life. Change of residence after marriage, learning to stay away from parents, childbirth & childcare all happen at the time and age when most people are at a phase in their respective careers when they would like to devote maximum time & effort towards their fields. These hardships do take a toll on a large

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Dermatology is an amalgamation of art and science. When it comes to aesthetics, women have an eye for finer details, again due to great intercerebral-hemispheric connections, which often improves the final outcome of any aesthetic procedure.
Lastly a person is most vulnerable when he or she is unwell, and the strongest memory from childhood is that of one's mother caressing ones forehead with love and those are the same memories that come rushing back in when one is seen by a female dermatologists. Patients will often come back to the same doctor who made them feel at ease.
Dermatology is a visual science where adequate exposure is of vital importance. Many a times patients are shy in front of the piercing gaze of a male physician but the gentle soothing voice along with a soft touch can calm even the most distressed person and thus provide important clinical clues which leads to a better diagnosis.
It can thus be concluded that being a good dermatologist is not just gender based although women may have a slight upper hand when it comes to dealing with patients. A good doctor patient relationship is not just dependent on one's gender or clinical acumen alone, but also on how the patients feels after you finish interacting with them. Good interpersonal skills and behaviors can always be learnt and that is what we should aim for – both men and women!

number of women. Various studies done all over the world show that absenteeism is significantly higher in female employees compared to male counterparts. Recently, a major multinational company started offering incentives to its women employees who decide to freeze their eggs and delay childbirth to a later age. This evoked highly passionate reactions worldwide and a debate regarding sacrifices made by women during their lifetime started. Despite all these upheavals many women manage to shine in different departments be it career, family or homemaking. But, for achieving equivalent to their male counterparts, much more effort has to be made by women. We have so many examples of women in most fields including dermatology who have risen to the highest levels both in academics and practice. These women are a source of inspiration not only for other women but also for men.

The world is an eternal balance of Yin & Yang. World of dermatology is no different. We all represent this balance.

In this Issue

Flashback from Stalwarts

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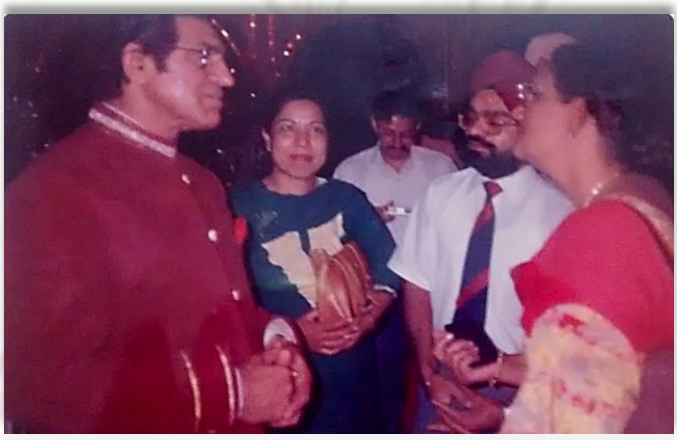
I had the first opportunity of meeting Prof. Surinder Kaur (she was then the Head of the Dept. of Dermatology, Venereology and Leprology, PGIMER, Chandigarh) when I was selected in an interview for the post of Associate Professor, held at the All India Institute of Medical Sciences, New Delhi on 26th March 1987, but unfortunately she could not come as she had missed her flight. I was thus very eager to meet her as I had heard a lot about her as a person. Finally when I travelled to PGIMER, Chandigarh, I was struck by her personality and charismatic persona. She was a very polite lady with an immaculate sense of dressing.

As I gradually got to know more about Prof. Kaur, I was really pleased to have had an opportunity of working with a remarkable lady like her.

Prof. Kaur grew up in an intellectual environment and her father, Dr. G. S. Talib was an eminent scholar who is credited with having translated the Guru Granth Sahib in English for the first time. Prof. Kaur had a MD in Internal Medicine and subsequently she did a refresher course in Dermatology. She was the founder of the Department of Dermatology, Venereology and Leprology at PGIMER, Chandigarh. She was an astute clinician and her main area of interest was leprosy in which she did a lot of work and also published many papers.

After I joined the department of Dermatology at PGI, within a span of 6 months, in 1988, the Silver Jubilee Celebrations of PGIMER were held along with a CME in our department, of which I was the Organizing Secretary, the event was a huge success and following that she entrusted me with lot more responsibilities and there was no looking back since then!



From Left to Right Amrish Puri, Dr. Inderjeet Kaur, Dr. Rajeev Sharma, Dr. A J Kanwar and Prof. Surinder Kaur.

Prof. Surinder Kaur
07. 03.1933-12.10.2004

Prof. Kaur was also the recipient of the prestigious Commonwealth fellowship for which she went to England in 1978. She was also the recipient of the Kanishka award and Hari Om Ashram Award of the Medical Council of India for her remarkable contribution to Dermatology. She was also instrumental in starting the Pediatric Dermatology clinic at PGIMER, and it went on to become one of the most well-known pediatric dermatology clinics in the entire North-India Regiion Within a span of 4-5 years the clinic reached Himalayan heights with over 60 publications, many of which were published by Dr. Sandipan Dhar, during his senior residency.

As an administrator she was a strict disciplinarian and was very punctual. In fact if anyone was late then they had to enter from the rear doors of the hall! But above all she was a wonderful lady with a magnanimous personality. She had remarkable oratory skills and had a powerful and orotund voice. She was always ready to help us out with formulating research protocols and writing papers. And even though she applied for and took voluntary retirement in 1993, I was lucky to have had a lifelong association with her till her demise in 2004 following a long battle with brain tumor.

One of my fondest memories of her is when she took us all on an impromptu trip to Filmcity in Bombay during one of the National Conferences in 1989. We were all pleasantly surprised and had a great time with stars like Amitabh Bachchan and Amrish Puri among others. She also took us for a trip to Elephanta caves during that trip.

Lastly I would like to emphasize that Prof. Kaur was one of the brightest stars in the constellation of Dermatology in India. She has her own place in history and no one can emulate her. She was an exemplary leader and a true visionary. In fact all lady dermatologists today should look up to her as a role model.

And if someone were to pick among all women dermatologists in India, then Prof. Kaur would be right there at the top!

Superwomen in Dermatology

Dermatologists as Detectives

A real incident

By Dr. S. Premalatha.,
MD., PhD., FAMS.,
Consultant Dermatologist, Chennai

Dr. S. Premlatha has won various international and national awards including the prestigious certificate of appreciation from ILDS.A storehouse of knowledge,and multitalented,she is affectionately called"dermamom" or "emom" on IADVL Yahoo groups by all.

More than three decades ago in 1982, a well-dressed adolescent girl with heavy makeup came to the female skin outpatient department at Government General Hospital (Madras Medical College, Chennai). I was then the Assistant Professor in charge of new cases for women and children

My first thought was that I must have seen her somewhere, but I was not able to recollect immediately. She had tinea corporis. She handed over her OP ticket to me. Her name was 'Angela' on the OP ticket.

I immediately asked her, "Are you 'Sara Bai' admitted to our female ward No. 45, Bed no. 8 about 10 years ago? Your mother used to pamper you and carry you on her waist in spite of your age because you were her only child. You used to pour water on your hands and feet to get relief from the pain!"

She said. "No. I am not Sara Bai. I am Angela. I was not admitted here. You are mistaking me for someone else". I asked her to return for review in one week and she departed.

I was confident of my memory. I often don't remember the name, unless I know the person well. However, if I see a characteristic photograph or talk to a person, I will invariably remember the face as a visual 'photographic' memory. I was sure that she was Sara Bai, even though the PG students sitting beside me thought I was wrong, when Angela was trying to convince me that she was not Sara Bai.
I was confident that she was one of the two cases of 'Erythromelalgia' that I had presented at the 1st Asian Congress of Dermatology in Chennai about a decade ago in 1970.

After the OP clinic, I went for ward rounds and opened the ward cupboard and took out the 'Interesting Case Register' that I used to maintain. This register had the name, address, short summary, and diagnosis of interesting cases that I used to enter on the day of discharge. I found her case in the book, with a date from 1970. Her mother was the informant, as Sara Bai was a 10 year old child. My PG students were wondering what I wanted to do with those details.

I wrote a postcard to the mother that she had to bring her daughter Sara Bai for review in one week (on the same day that I had asked Angela to return!...).

One week later….At the end of outpatient clinic, Sara Bai's mother came and asked me to forgive Sara Bai (Angela) who had lied to me the previous week. She had changed her name to Angela and was feeling guilty to see me for review.

Sara Bai, as a child in 1970, used to wet her palms and soles by urinating on them, if she did not have water to get relief from pain and burning sensation. She had developed extensive candidiasis of palms and soles due to the constant wetting. Sara Bai had metamorphosed into the modern Angela, with more makeup and better clothing. However, I was still able to make out her basic facial features even after a decade.

My PG students who thought that I was wrong were amazed at this incident in our Department, and were now convinced that Dermatologist's observation must be like that of Sherlock Holmes!

(Names have been changed to protect patient identity)

Superwomen in Dermatology

An Interview with Dr. Hemangi Jerajani. She has been the President of the Indian Association of Dermatologists, Venereologists and Leprologists (IADVL) 2009-2010. Currently she is Professor and Head of the Dept. of Dermatology, MGM Hospital, Kamothe, Navi Mumbai. She was also the Professor & Head, Dept. of Dermatology, L.T.M.M.College & L.T.M.G. Hospital, Mumbai.

What has been your experience and how has Dermatology in India changed over the years?

Dermatology in India has undergone a lot of positive change over the years. Back in the day it was quite amusing when people used to ask what's there in Dermatology? All you prescribe is calamine lotion, steroids and antihistamines! But what's fascinating is that, gradually this perception got completely changed and everyone has come to realize, that Dermatology just like any other specialty requires a certain level of expertise. In fact I can happily say that Dermatology is one specialty where there is a beautiful amalgamation of Art and Science!

You are on the Board of the International League of Dermatological Societies, in your opinion, where does Indian Dermatology stand in the world scene?

That's a very interesting question. It gives me great pleasure to share that in the last 10 years, Dermatology in India has grown by leaps and bounds. Previously our people were a bit subdued because we didn't know whether what we had learnt was accurate and at par with international standards. But over time as we attended international conferences and events, we realized that physicians abroad were quite open and receptive about our thoughts and ideas. Thus we need to realize that our focus should be on strengthening our knowledge and promoting treatment modalities emphasizing what India and Indian patients need. But at the same time highest levels of safety and ethical patient care must be adhered to stringently. Here I would like to mention the use of methotrexate. Internationally, dermatologists are wary of using this drug, but here in India we are managing patients successfully with this. So we need to promote and propagate treatment modalities which we are more confident in using and not just follow guidelines blindly.

Ma'am you were the first lady President of the Indian Association of Dermatologists, Venereologists and Leprologists, please share with us your experience as an administrator.

It was a wonderful experience and all my male colleagues and counterparts from all over the country were very gracious and supportive. In fact I was touched by the fact. that they many a times they went out of their way to help me! Regarding my role as an administrator, Since I had already been the Head of the Dept. of Dermatology, L.T.M.M.College & L.T.M.G. Hospital, Mumbai,I was able to implement my thoughts and ideas into action and fulfil my duties and responsibilities efficiently in IADVL as well.
Also I believe I need not be singled out as the lady President, since back in those days there were very few women in Dermatology. But nowadays the number of women in Dermatology has risen, so it is just a matter or of time when greater number of women will percolate into administrative posts as well!

Please share with us a message that you would like to get across to women dermatologists in India. And who has been a pillar of support in your life?

Well I feel all lady dermatologists need to believe deep down in their hearts that even though one's family is important, once her children are a bit grown up or the family has been taken care of, she needs to fulfil her dreams and aspirations too. She can surely start working in the lower ranks and gradually move up to higher posts. This is definitely the need of the hour.

And lastly my family especially my husband, my children, my parents and my mother-in-law have been my pillars of support. Surprisingly, although people may laugh, but our drivers and domestic helpers play a very important role in making our lives easier!
And last but not the least my students and friends have played a very important role as well. I believe the best way to progress in life is to move ahead taking everybody along and building up each other on the way!

Superwomen in Dermatology

Dr.Jyoti Nath, MBBS (Guwahati Medical College)
MD, AIIMS (New Delhi),
Professor of Dermatology, Venereology and Leprology,
Gauhati Medical College & Hospital.

What would be your advice to the upcoming dermatologists regarding profession and maintaining a healthy work-life balance?

After MBBS, one feels very excited and thinks he/she has the answer to everything but after MD it occurs that many things are still unanswered. Time and experience brings the realization that what we know is a drop in the ocean of ignorance. Thus we should be humble and remember that today's theory may be proved invalid in the near future.

Regarding work-life balance, one has to design his/her own game plan. A lot depends on the nature of profession and the stages of personal life. One with young children has to make an extra effort to take out time to balance both family and professional lives. Once the children grow up, they should devote equally to their profession as well as family life. This will also make the children independent, confident and they will learn the value of hard work and sincerity.

Any memorable incident that you would like to share with us?

There are many memorable incidents but to share a few. After MD Dr. L. K. Bhutani called us for dinner and before leaving he said, "where ever you are, keep the flag flying high". That very moment, I didn't realize the true meaning of his words but whenever I have done something fruitful or achieved something I always remember his words. I also remember another incident where a beautiful young girl and her mother came with a packet of sweets to share with me for passing H. S. exam. I didn't recognize them, looking at my expression they took out a five years old prescription of the daughter with a diagnosis of dermatitis artefacta. Then I remembered that she came with multiple scars on her extremities and face with extremely withdrawn state of mind. On enquiring the mother revealed that the family was going through extreme stress as the parents were at the verge of divorce. They were not willing to consult a psychologist. My deep feeling for the child made me go beyond my professional duty and I counseled the parents regularly to create an ambient atmosphere at home for the well being of the child. After five years I was overwhelmed with joy to see the transformation of the helpless child to a young confident lady.

How did you come to choose dermatology as your preferred specialization?

Actually I chose dermatology house job thinking that it would be a lighter subject and would give me enough time to study medicine and pediatrics which I had wanted to pursue for my post graduation. But I got so involved with the subject that I started to study dermatology and in the process, it became my passion.

Could you tell us about your role model and inspiration in your personal and professional life?

I was deeply influenced by Dr. Dharam Pal who was the HOD in the department of dermatology, Safdarjung Hospital, New Delhi. He was very affectionate and a fatherly figure for me. Dr. B. B. Ahuja, senior consultant, in the same hospital, was very encouraging and affectionate. The welcoming atmosphere in the department was one of the few reasons which made me to like dermatology. Later on I joined AIIMS, New Delhi and was deeply moved by late Prof. L. K. Bhutani, the HOD at that time. He was a great teacher, excellent orator and a stern disciplinarian. His presence could be felt in a crowd of thousands, but deep down his mask of discipline he was a very affectionate, sincere and kind hearted soul. I owe a lot to him for molding my life. I admire Prof. J. S. Pasricha for his inventive mind, patience and perseverance which I think has contributed greatly in developing my personality and career. I also respectfully remember Dr. Shanti Ghosh, HOD, Department of Pediatrics, Safdarjung Hospital, under whom I did house job in Pediatrics. She taught me spontaneity, sensitivity, compassion, hard work and a down to earth attitude by her relation with the patients and colleagues.

The models in my personal life were my parents. Though we were from a lower middle class family, our parents never let us realize the existence of the various classes of the society and we were blissfully happy. Durga Puja, Bihu, Eid and Christmas were equally celebrated in our family. My father used to stay awake the whole night to decorate the Puja Mandap as well as the Christmas tree and he never forced anything on us. My mother introduced us to mythology, literature and especially human relations which molded my personality. I am still being influenced by my patients, colleagues, students and even my grand children.

Superwomen in Dermatology

Interview with Dr. Rashmi Sarkar, Prof. Dept. Of Dermatology, MAMC and associated LNJP Hospital and Founding President of Joint WDS-Indian WDS

She is also the Honorary General Secretary of the IADVL. She is an alumnus of PGIMER, Chandigarh, and has had an illustrious career with numerous awards and accolades. She has been a teacher, role model and mentor to innumerable students across the country. She shares her experiences and vision on a number of topics with us in a candid and heartwarming interview.

Please share with us how the idea of forming the Joint WDS-Indian WDS was born?

Years back I had the opportunity to attend an AAD meeting as an invited speaker, and this was through the Women's Dermatologic Society, which awards Scholarships and Travel Grants. What evoked my thoughts was the reason as to why one of the most developed nations in the world needed its women dermatologists to form a separate association? That question was answered, as I became a member, then a committee member, chair and finally a Board member of the WDS. WDS stands for "**Physicians Leaders Mentors**". All over the world, as women get more involved in their family duties, they gradually begin to put their careers on the back burner. Being ambitious is often seen as a negative character trait among women. This is where the philosophy behind WDS comes in. The aim is not to discriminate on the basis of gender, but to foster friendships and promote better inter personal relationships between women physicians as well as men. To encourage women to believe in themselves and their abilities as physicians. And to nurture women to become leaders who are adept at handling their professional commitments as well as their families without having to sacrifice either!

It was my dream to bring this though to India as well, because I have personally seen women dermatologists who showed great promise early in their careers, were superbly talented and hardworking, but gradually resigned themselves to their families due to lack of support and encouragement. That is how the idea of Joint WDS-Indian WDS was born. To **empower, encourage and equip** women dermatologists in India with the knowledge and support to become better physicians, leaders and mentors themselves.

It's amazing that an organization can help bring people together in such an interesting fashion! Ma'am is there any special memory or compliment that you would like to share with our readers? And could you tell us about a lady who has been your role model?

I remember a compliment from Dr. Lenore S.Kakita, who is an eminent dermatologist from Japan. I was the International Representative on the Board of Directors of the Women's Dermatologic Society, and she said to me – "I like the fact that you are strong and that you can hold your own among the fierce women here in this meeting, you will be thus able to lead and give your thoughts to any Society that you form". The fact that a respected lady of her stature had faith in my capabilities, has thus helped me to overcome any obstacle or negativity that I came across during my entire journey so far!

My mother has been my rock. She has been a teacher and a housewife, bringing us up after my father's demise. And what's most endearing about her is her optimistic outlook towards life and this she has imbibed in me as well.

What will be your message to everyone reading this article?

I hope my initiative and words will help empower women dermatologists across the country, now and for generations that follow, to come up and realize their true potentials as physicians, leaders and mentors. And I also hope that the men in their lives will support and encourage them on this journey of self-realization! I want to get the message across that hard work, persistence, respect for others and humility along with a strong academic background is the key to being a successful dermatologist. One who has belief in her/his abilities and confidence to inspire others to bring out the best in them, work to their full potential.

Dermatology in our daily lives

A Tribute to the victims of acid attacks

Author :

Dr. Gillian Britto
PGY-3 St. John's Medical College Hospital, Bangalore

You hold the acid that charred my dreams.
Your heart bore no love. It had the venom stored.
There was never any love in your eyes. They burn me with caustic glance.
I am sad that your corrosive name will always be part of my identity that I carry with this face.
Time will not come to my rescue. Every surgery will remind me of you.
You will hear and you will be told that the face you burned is the face I love now.
You will hear about me in the darkness of confinement. The time will be burdened for you.
Then you will know that I am alive, free and thriving and living my dreams.

- By Laxmi

Laxmi was 15 when her friend's 32-year-old brother threw acid on her face at a bus stop in Delhi after she refused to respond to his romantic advances. She was left permanently disfigured after the attack.
After seven surgeries and eight years of hiding indoors, Laxmi decided to become an activist speaking out against acid attacks, which are very common in India, leaving many young women vulnerable and scarred for life.

Statistics

While globally there are 1500 cases of acid violence annually (according to ASTI), there are on an average between 500 and 1,000 cases yearly in South Asia, with Bangladeshi women experiencing a majority of these attacks.
There are no separate statistics for acid violence cases in India till early 2013 because the Indian criminal law did not recognize it as a separate offence. With the amendment in Indian Penal Code in February 2013, incidents of acid attacks are now being recorded as a separate offence under section 326A and 326B.
However, certain estimates have been made on the basis of past records & comparison with neighboring countries where similar socioeconomic conditions prevail. On that reckoning the number of acid violence cases could range anything from 100 to 500 per annum.

What is an acid attack?

Acid attack burns are a particularly vicious form of attack where the motive is not to kill but to cause permanent disfigurement.

What is the cause of such attacks?

Past cases reveal motives of revenge, sadism, and coercive action. The main causes are:

1. Family disputes; domestic violence; relationship conflicts
2. Refusal of indecent proposals or unacceptable propositions
3. Land or money disputes; business conflicts
4. Vengefulness and status jealousy
5. Suspicion of infidelity
6. Theft or robbery
7. Mistaken identity; accidental; collateral
8. Nemesis: perpetrator inflicts self-injury

Dermatology in our daily lives

A Tribute to the victims of acid attacks

Pathophysiology: The body has few specific protective and repair mechanisms for chemical, thermal, electrical etc. burns. Denaturation of proteins is a common effect of all type of burns.
However, chemical injuries have a few important differences, which are as follows:

Features	Chemical burns	Thermal burns
Duration of exposure	More likely produced by longer (minutes) exposure to chemicals, and this exposure may continue in an emergency room	Typically produced by short term exposures (seconds) to intense heat that relatively stops quickly
Biochemical	Protein destruction is brought about by other mechanisms, mainly hydrolysis which may continue in deeper layers	Rapid coagulation of protein due to irreversible cross linking reactions
Systemic toxicity	Present	Absent

The severity of a chemical burn injury is determined by:

- Concentration
- Quantity of burning agent
- Duration of skin contact
- Penetration
- Mechanism of action

Mechanism of action: There are six mechanisms of action for chemical agents in biological systems

Type	Mechanism of action	Examples
Oxidation	Protein denaturation caused by inserting an oxygen, sulphur, or halogen atom	Sodium hypochlorite, potassium permanganate and chromic acid.
Reduction	Binding of free electrons in tissue proteins	Hydrochloric acid (HCL), nitric acid
Corrosion	Protein denaturation on contact, soft eschar is produced, can progress to shallow ulceration	Phenol, white phosphorous
Protoplasmic poisons	Formation of esters with proteins or by binding / inhibiting calcium, other organic ions	formic and acetic acids
Vesicants	Ischaemia with anoxic necrosis at the site of contact, produces cutaneous blisters.	Mustard gas, dimethyl sulfoxide
Desiccants	Dehydration of tissues	Sulphuric acid, concentrated HCL

Dermatology in our daily lives

A Tribute to the victims of acid attacks

Types of chemicals

This classification is based on the chemical reactions that the chemical agent initiates. The ability to influence is one of the important characteristics of an injurious chemical agent. There are four classes:

a) Acids
b) Bases
c) Organic solutions
d) Inorganic solutions

Acids: They release hydrogen ions and reduce pH from 7 to values as low as 0. Acids with a pH <2 can produce coagulation necrosis on contact with the skin.

Bases: They remove hydrogen ions from protonated amine and carboxylic groups. Alkalis with pH>11.5 produce severe tissue injury through liquefaction necrosis, which loosens tissue planes and allows deeper penetration of the agent. Hence, alkali burns tend to be more severe than acid burns.

Organic solutions: Act by dissolving the lipid membrane and disrupting the cellular protein structure.

Inorganic solutions: Damage the skin by direct binding and salt formation.

General principles of management

The ABC of Trauma, primary and secondary assessment and all general principles of Trauma and Burn care apply to chemical burns. First aid measures involve several aspects, such as

a) Thorough history which is necessary to ascertain the responsible agent
b) Removal of chemical agent
c) Treatment of the systemic toxicity if any and side-effects of an agent
d) General support and local care
e) Special considerations for specific agents if appropriate

Removal of the chemical agent

Duration of the chemical's contact with the skin is the major determinant of injury severity. Therefore immediate removal of the agent is important. This requires thorough irrigation with water at the site of contact and when the patient arrives at the hospital. Irrigation should be copious and directed towards the floor. Lavage not only dilutes and removes the agent which is in contact with the skin but also helps to correct the hygroscopic effects that certain agents have on tissues.

Certain chemicals create significant exothermy when combined with water and others are insoluble in water. Phenol is insoluble in water and hence should be wiped off the skin using sponges soaked in solubilizing agents such as 50% polyethylene glycol. Sulphuric acid should be neutralized with soap or lime water before lavage.

Important exceptions in chemical burns treatment

No irrigation with water

Phenol: wipe off with 50% polyethylene glycol sponges before lavage; Sulphuric acid: soda lime or soapwash

Antidotes

Hydrofluoric acid: subeschar injection of 10% calcium gluconate until pain is relieved, up to 0.5 ml/cm2

General support and local care

General principles of trauma management are followed. Conventional thermal burn formulas for resuscitation are used when necessary.

Any patient having copious lavage to dilute chemical exposure is in potential risk for hypothermia. It is important to avoid this complication by maintaining the room temperature between 28 - 31ºC.

Following lavage and debridement of blisters, chemical burns can be treated with the same principles as for thermal burns. Chemo therapeutic agents, creams or dressings can be used. Early excision and grafting of nonviable tissues is advocated.

The eye is often involved in chemical burns and urgent ophthalmology consultation is required. Recent in vitro experiments on corneal cell cultures have shown that water decontamination could have a deleterious effect on cells, with hypo-osmolar effects increasing the cell volume with resultant lysis. A recent report suggested an ocular splash with delayed Diphoterine rinsing induces corneal healing.

Systemic toxicity and inhalation injury

Physicians must be aware of any possible toxicity from systemic absorption of the agent. Respiratory injuries may also occur in chemical burns when aerosolized chemical or smoke is inhaled.

Dermatology in our daily lives

A Tribute to the victims of acid attacks

Dealing with scars and contractures

Hypertrophic scars are the most common complication in such injuries and limits the survivor's ability to function as well as affects their body image. Various treatments have been used, such as custom pressure garments, silicone gel sheets, surgical reconstruction etc.

Contractures constitute a major impediment. Splints are used to help with movements and stretching exercises become a must.

Commonest acid used in acid attacks

Sulphuric acid is one of the most common agents used in acid attacks. Sulphuric acid and its precursor sulphur trioxide are strong acids that cause injury by dehydration damage and by creating excessive heat in the tissue. It produces coagulation necrotic eschars with thrombus formation in the lesions vasculature. Management includes immediate copious irrigation and early excision of deep burns.

Hydrochloric acid: this type of burn is less frequent than sulphuric acid burns. When in contact with skin, it denatures the protein into chloride salts. Management consists of quick and continuous water irrigation of the affected skin. It is important to remember that hydrochloric acid can produce pulmonary damage such as upper airway edema, pulmonary inflammation etc. when its fumes are inhaled.

Post Primary Care

Acid victims require ongoing care which is multipronged and holistic. Integrated efforts by several agencies such as psychotherapists, health care providers, doctors and counsellors is very essential to help them heal and re-assimilate into society to pick up the threads of a lost way of life. Women need to be made resilient enough to be able to gather will and courage to empower themselves and carry on with their lives. Psychologists are needed to work with women to remedy the feeling of hopelessness.

The 3-2-1-GO! Strategy developed by James Partridge would help greatly. This strategy includes a person (in this case women) to be ready in their (her) mind with:

- 3 things to do if someone stares at you (her)
- 2 things to say if someone asks what happened
- 1 thing to think if someone turns away

Tackling the problem

- The distribution and sale of acid should be banned except for commercial and scientific purposes.
- Acid should be made a scheduled banned chemical which should not be available over the counter.
- Compensate the victims and impose stiffer sentences.
- The landmark judgment of the Supreme Court has included acid attacks under a standalone provision in the Indian Penal Code. Section 326A (Hurt by acid attack) and 326B (Attempt to throw or administer acid) are non-bailable offences. The attacker could get a jail term of 10 years to life for causing hurt by acid and sent to jail for 7 years for attempting to do so.
- Formation of support groups and NGOs such as the Acid Survivors Foundation India (ASFI), Campaign and Struggle Against Acid Attacks on Women (CSAAAW) will not only provide legal support but will also ensure that the support provided by the State reaches the survivors. These support groups will help rehabilitate the victims and fight for justice.
- Educating and sensitizing people will go a long way in curbing this menace.
- Famous celebrities should be roped in to publicize and highlight this social issue.

Conclusion

Though acid attack injuries represent a small portion of burn injuries, victims undergo severe physical pain and mental trauma that changes the way they think. This has a rippling effect on their families too. They are unique injuries which need special attention and management because of their huge human and economic impact.

The gold standard for treatment is still copious irrigation with water, except in few chemical agents.

The perpetrators need to realize that it only takes a moment to scar someone's life; on the other hand victims should live with the attitude that though they are burnt, they are not destroyed. The public should empathize with the victims and be sensitive towards their needs

Acknowledgement

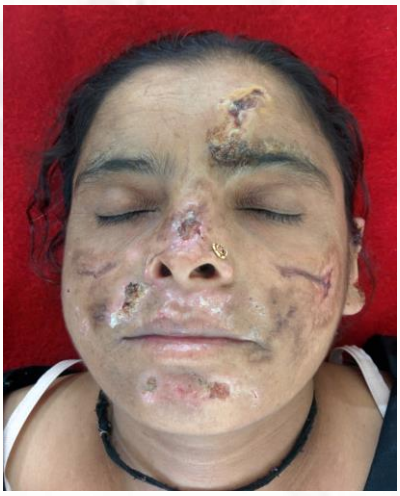
I would like to thank Dr. Madhukara J, Associate Professor, St. John's Medical College, Bangalore, for his guidance and help.

Quiz

- by Dr. Tanvi Gupta, PG-3, MAMC, New Delhi

A 30 year old female presented with multiple reddish raised lesions with ulceration over them healing with scarring and pigmentary changes over face, feet and hands associated with photosensitivity for 4 years and development of tense clear fluid and pus filled bullae on face and hands for 5 days.

On examination, well defined round to oval ulcers covered with yellow to hemorrhagic crusting were present on the nasal bridge, ears and B/L dorsa of hands. A solitary intact tense bulla 1x1 cm filled with turbid fluid was present on dorsum of left hand. 2 ill defined indurated subcutaneous plaques with overlying atrophy of the skin were present on both cheeks. She had diffuse hair loss and nails showed ragged cuticles and nail fold erythema.
Skin biopsy revealed epidermal thinning, keratotic plugging with cleavage at the dermo-epidermal junction with basal layer vacuolization and mononuclear infiltrate and prominent collagen degeneration and fibrosis in the dermis.



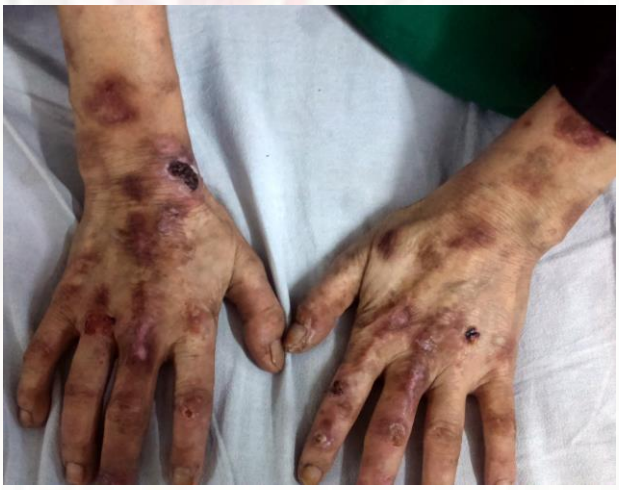
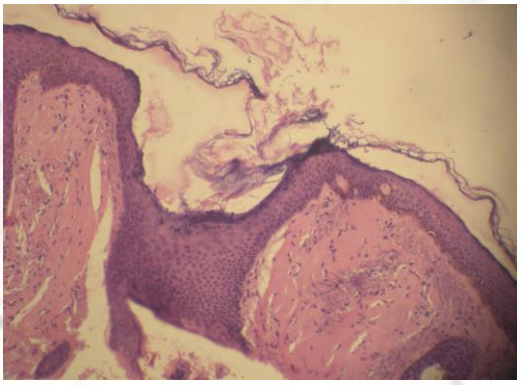
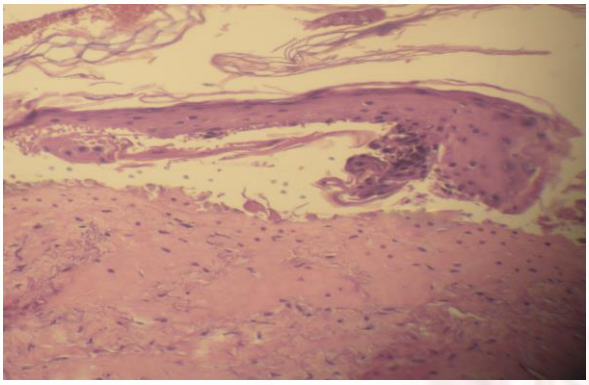


Figure 1 and 2: Clinical photographs showing the ulcers, bulla and atrophic plaques on the face and dorsa of hands





Figures 3 and 4: Photomicrographs showing keratotic plugging, epidermal thinning, dermo-epidermal cleavage and collagen degeneration (H&E Section, 40X)

?

1. What are the differential diagnoses?
2. What other investigations are required in this case?
3. What is your final diagnosis?

Approach to a case of Vaginal Discharge

Author :

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How will you take history of patient who complains of vaginal discharge?

Type of discharge-
Colour - yellowish/greenish yellow/greyish white/bloody
Odour /Consistency/Duration
Is it persistent? (malignancy)
Does it vary in relation to coitus/menstrual cycle (bacterial vaginosis)

Associated symptoms
Pruritus/Vulvar Pain/Dyspareunia
Lower Abdominal pain/Intermenstrual or postcoital bleed
Fluid filled lesions/Dysuria/Climacteric symptoms

Sexual history
History of similar complaints in sexual partner
New sexual partner/number of recent partners
Similar/any other abnormal discharge in the past and treatment taken

Drug history
Antibiotics/Oral contraceptives
OTC medication/prescribed medication

Other factors
Retained foreign body/douching
Contraceptive measures/Tight synthetic underwear
Any irritation with condoms/spermicides/vaginal creams/lubricants/antiseptics
Usage of common toilet seats or baths/poorly chlorinated water

Medical and Surgical history
Diabetes mellitus**/**HIV/Inflammatory bowel disease
Prolonged lactation/premature ovarian failure
Radiotherapy/Prolonged obstructive labour
History of pelvic /other gynaecologic surgeries

Family history
Similar complaints in family(genetic predisposition?)

Diet history
History of high dietary glucose intake

What are the points in history which support diagnosis?

No	Characteristics	Physiological	Bacterial Vaginosis	Trichomoniasis	Candidiasis
1.	Colour	Clear/white	Greyish/white	Green/yellow	Curdy white
2.	Odour	Odourless	Fishy	Foul smelling	Odourless/non-offensive
3.	Consistency	Thick	Thin	Homogenous,frothy	Thick
4.	Vulval itch	None	None	Present	Present
5.	Other symptoms	-	Irritation+/	Irritation+/ Dysuria/lower abdominal pain	Soreness Superficial dyspareunia Dysuria

How will you examine a case of vaginal discharge?

Per-speculum examination to be done to visualize posterior fornix, cervix to look for cervicitis, ulcerations, erythema and vesicles at vulva and vagina. The amount, consistency and location of discharge to be noted.

Per-vaginal examination to look for cervical motion tenderness and tenderness of the posterior fornix.

Approach to a case of Vaginal Discharge

What are the findings in examination which support the diagnosis?

No	Characteristics	Physiological	Bacterial vaginosis	Trichomoniasis	Candidiasis
1.	Vulva	Normal	Normal	Edema±	Erythema/fissures/pustules
2.	Viscosity	High	Low	Low	High
3.	Vaginal distribution	Dependent	Adherent	Adherent	Adherent
4.	Vaginal walls	Normal	-	Petechial hemorrhages/ Colpitis macularis	Whitish plaques/Moderate to severe erythema
5	Site	Posterior fornix	Introitus	Any site	Any site

How will you investigate a case of vaginal discharge?

Specimen	Procedure	Findings
High vaginal swab	Gram stain	Bacterial vaginosis(BV) Clue cells Reduced lactobacilli Candida (budding spores and pseudohyphae)
	Saline wet microscopy	Trichomonas vaginalis(TV) - flagellate organism
	Culture	Candida on Sabouraud agar
		Trichomonasvaginalis on Diamond's medium or Roiromn medium.(gold standard) HBt medium for Gardenella vaginalis (not diagnostic)
Endocervical swab	Nucleic Acid amplification test(NAAT)	Chlamydia and Gonorrhoea
	Culture	Gonorrhoea
Vulvovaginal swab(VVS)	NAAT	Chlamydia and Gonorrhoea
	Whiffs test	Exposure of vaginal secretions to 10%KOH detects fishy odour due to amines in bacterial vaginosis
	pH metry	>4.5- Bacterial vaginosis/Trichomoniasis <4.5- Candidiasis
Urine	NAAT	Chlamydia(less sensitive than VVS)
Blood	Fourth generation assays	HIV
	VDRL/TPHA/Treponema Pallidum enzyme immunoassay	Syphilis

Approach to a case of Vaginal Discharge

What is Whiff test or amine test?

Release of amines on mixing the discharge with 10%KOH(Whiff test)

What are Clue cells ?

Clue cells are vaginal epithelial cells with bacteria densely adhered to them and obscuring their borders.

What are AMSEL Criteria?

Criteria used to confirm the diagnosis of bacterial vaginosis.

Three of the following four criteria are necessary to confirm the diagnosis.

1. A raised vaginal pH>4.5
2. Presence of a homogenous thin grey or white discharge coating the vaginal walls
3. Release of amines on mixing the discharge with 10%KOH(Whiff test)
4. Presence of >20% clue cells on wet mount microscopy of the vaginal fluid

What are the causes of vaginal discharge

Physiological	Infective	Non-infective
Physiological discharge **Pregnancy** **Atrophic vaginitis**	Non Sexually Transmitted 1. Bacterial vaginosis 2. Candida 3. Desquamative inflammatory vaginitis 4. Toxic shock syndorme Sexually transmitted 1. Chlamydia Trachomatis 2. Neisseria gonorrhoeae 3. Trichomonas Vaginalis 4. Herpes simplex 5. Human Papilloma virus 6. HIV	Foreign bodies(retained tampons/condoms) Cervical polyps and ectopy Genital tract malignancy(vaginal tumors/cervical cancers and polyps/endometrial tumors) Fistulae Allergic reactions(Drug induced) Psychosomatic vaginitis Pyometra

What are the risk factors for pathological vaginal discharge?

Bacterial vaginosis

1. New sexual partner and frequent change of sexual partners.
2. Black African women, lesbians, and smokers.
3. Personal hygiene practices (vaginal douching)
4. STIs

Candidial vulvovaginitis-

1. Use of antibiotics, oral contraceptives, corticosteroids
2. Immunosuppressive drugs
3. Pregnancy
4. Diabetes ,high dietary glucose intake
5. Normal changes in the vaginal flora
6. Tight synthetic underwear
7. HIV
8. Genetic predisposition

Approach to a case of Vaginal Discharge

How will you treat candidial vulvovaginitis

Oral
Fluconazole 150mg stat dose
Itraconazole 200mgbd for 1 day

Vaginal
Clotrimazole pessary 100mg for 6 nights
Miconazole nitrate 2% once daily for 7 days
Econazole nitrate 150gm pessary for three nights
Nystatin 1lakh units vaginal tablet,1 tablet daily for 14 days

Pregnancy recommendation
Topical azoles are given for seven days

How will you treat trichomoniasis?

Metronidazole single 2gm oral dose
OR 400 mg twice daily for 5-7 days

Alternative regimens
Tinidazole 2g single dose

How will you treat bacterial vaginosis?

Three recommended regimens
Metronidazole 500 mg orally twice daily for 7 days
Metronidazole gel 0.75%, 1 full application (5 g) intravaginally, once daily for 5 days
Clindamycin cream 2%, 1 full application (5 g) intravaginally at bed time for 7 days

Three alternative regimens
Tinidazole 2 g orally once daily for 2 days
Tinidazole 1 g orally once daily for 5 days
Clindamycin 300 mg orally twice daily for 7 days

Three recommended regimens for pregnant women
Metronidazole 500 mg orally twice daily for 7 days
Metronidazole 250 mg orally 3 times daily for 7 days
Clindamycin 300 mg orally twice daily for 7 days

What are the criteria to diagnose recurrent infections?
Recurrent VVC is defined as four or more episodes in 12 months or atleast three episodes unrelated to antibiotic cover that occur within one year.

How will you treat recurrent infections?

Bacterial vaginosis

Oral
Metronidazole 400mg twice daily for 3 days at the beginning of menstruation

Intravaginal
Metronidazole (0.75%):5gm application twice weekly for 4-6 months after an initial 10 days course

Lactic acid gel(4.5%)5ml tube for 2-3 nights after menstruation or alternate evenings for one month.

VVC

Fluconazole 150mg every week for 3 doses.
Intravaginal
500mg clotrimazole suppositories once weekly for 6 months

Nystatin 100000units/5g vaginal cream daily for 14 days and weekly for 6 months.

Boric Acid 600 mg in a gelatine capsule used vaginally for 10 days

125gm of yoghurt containing lactobacillus

TV
Consider reinfection
Partner notification and compliance
Exclude vomiting with metronidazole and repeat standard regimen(check resistance)

Partner should be treated

Amoxicillin or erythromycin to reduce beta haemolytic streptococci which may decrease the efficacy of metronidazole

Paromomycin sulphate 250mg pessary once or twice daily for 2 weeks

Approach to a case of Vaginal Discharge

What are the complications of bacterial vaginosis ?

Gynaecologic

1. Pelvic inflammatory disease
2. Abnormal bleeding
3. Endometritis
4. Postoperative infections following pelvic surgery
5. Transmission of HIV
6. Acquisition of STIs

Obstetric

1. Mid trimester miscarriages/Preterm delivery
2. Intra and postpartum infections
3. Low birth weight

Describe the syndromic management of vaginal discharge?

Syndromic management of vaginal discharge includes-

Tab. Secnidazole 2 gm orally, single dose
Tab. Fluconazole 150 mg single dose
Tab. Azithromycin 1 gm single dose

Women's Dermatologic Society
- nurturing women dermatologists since 1973

Women's Dermatologic Society
Physicians Leaders Mentors

The Women's Dermatologic Society (WDS) was founded in 1973 in the United States of America with an aim to help female dermatologists fulfill their greatest potential as well as help them contribute to the specialty as well as society.

It all began in 1972, when Dr. Walter B. Shelley, President of the American Academy of Dermatology (AAD) asked Dr. Miriam Reed, to "Organize the Women!" Subsequently in 1973, Dr. Miriam Reed and Dr. Wilma Bergfeld (Founding President of WDS) organized a small gathering to bring together women dermatologists in the US and help them network. The Women's Dermatologic Society was thus born and there has been no looking back since then!

Today the Society has spread to more than 25 countries with 1600+ strong membership with 8% male members. The Society began with the vision committing itself to issue relevant to women and their families. The Women's Dermatologic Society aims to promote leadership among dermatologists, foster the development of interpersonal relationships through networking and mentoring, to provide service to the community, to provide a forum for communications pertaining to women and their families and to advocate excellence in patient care and education while adhering to the highest ethical standards.

The Women's Dermatologic Society/American Academy of Dermatology also provides for Travel Grants up to $2500 each year to Board certified female Dermatologists from outside the USA for attending the WDS Annual Meeting Luncheon, as well as the American Academy of Dermatology's Annual Meeting

The Women's Dermatologic Society has two sister societies currently – the Joint WDS – European WDS and the Joint WDS – Indian WDS.

Formation of Joint WDS-Indian WDS

Dr. Rashmi Sarkar organized the first WDS Networking reception in New Delhi, India in November 2009. Dr. Wendy Roberts (President WDS, 2009-2010) lent her support by launching the event and was also a guest speaker.

Over 70 dermatologists attended and the event was focused on 'Leadership and the Balancing Act'. The idea of having a Joint WDS-Indian WDS association was born here as well.

Subsequently receptions have been held at the National Conferences of the Indian Association of Dermatologists, Venereologists and Leprologists (IADVL) held at Lucknow (2010), Jaipur (2012) Ahmedabad (2013), CSI Conference in Mumbai (2010), WDS Retreat at New Delhi preceding the Annual Conference of IADVL Delhi (2011). Finally the Joint WDS – Indian WDS was founded in March 2012 with Dr. Rashmi Sarkar as the Founding President.

The first Joint WDS-IWDS Rose Parade of Cases in conjunction with the XIth International Congress of Dermatology and 42nd National Conference (DERMACON) of IADVL was successfully held at New Delhi in December 2013.

A number of national and international speakers graced the occasion including Dr. Wilma F. Bergfeld, (USA), Dr. Evangeline B. Handog (Philippines), Wendy E. Roberts (USA), Margot Whitfeld (Australia), Amanda Oakley (New Zealand), Dedee F. Murrell (Australia), Branka Marinovic (Croatia), Anisa Mosam (South Africa), Latika Arya (India), Rekha Sheth (India), Nina Madnani (India), K.N.Sarveshwari (India). A networking reception also followed the event and this too was a glorious opportunity for young dermatologists to interact with dermatologists of national and international repute.

The Joint WDS-Indian WDS is committed to contribution towards social welfare as well. And in this spirit a camp was organized by Dr. Rashmi Sarkar for orphan girls in New Delhi. Dr. Sarkar along with Dr. Kavita Mariwalla and Mona Gohara have also been working on tips for children and teenagers in India, where skin infections are more of a priority than sun protection.

Currently the Joint WDS-Indian WDS has more than 30 members.

Joint WDS – Indian WDS

Founding President – Dr. Rashmi Sarkar
Board Members – Dr. Hemangi Jerajani
Dr. Rekha Sheth
Dr. Jyoti Nath
Dr. Vibhu Mendiratta
Dr. Mukta Sachdev
Secretary – Dr. Latika Arya
Treasurer – Dr. Richa Sharma

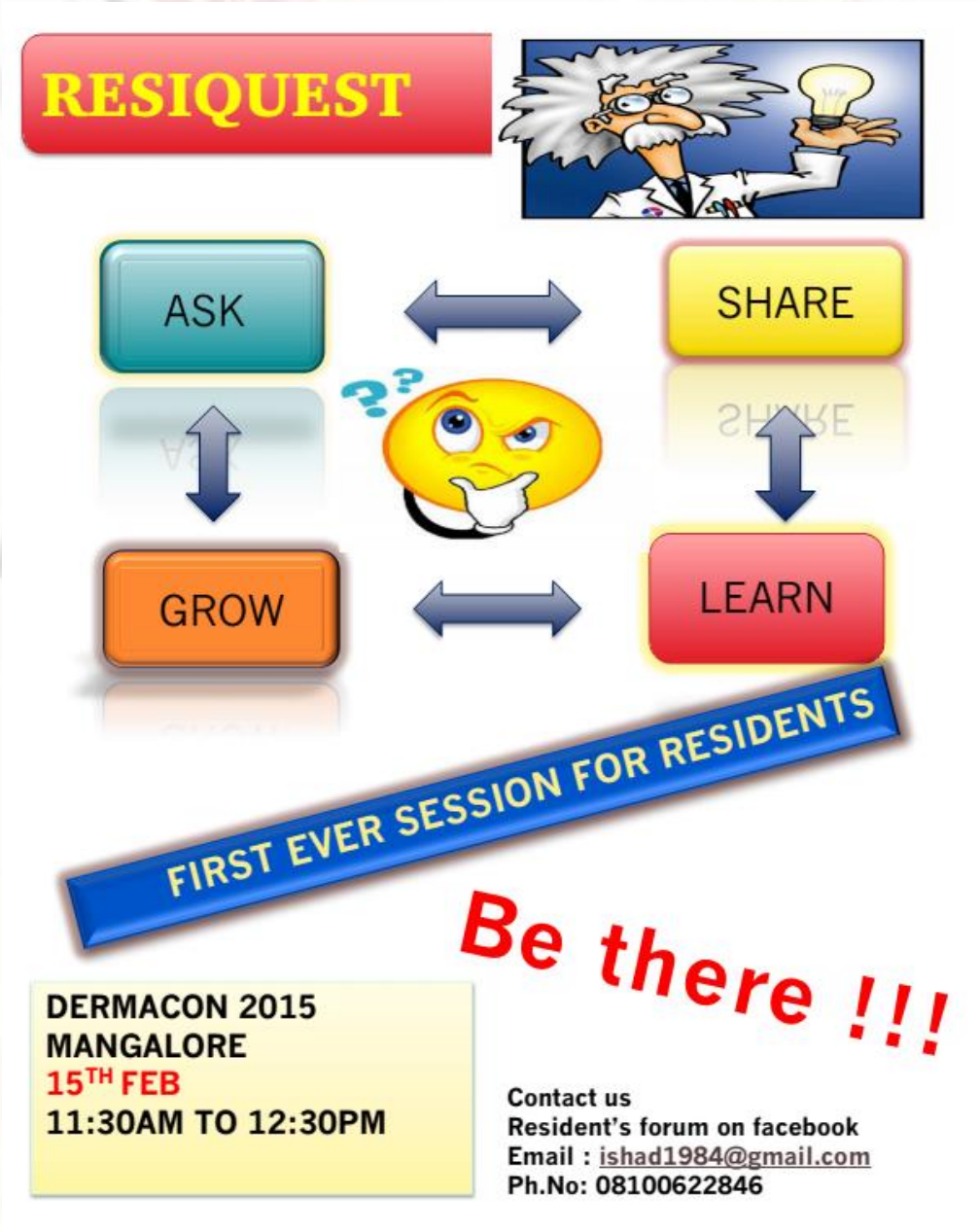
Women's Dermatologic Society
- nurturing women dermatologists since 1973

HOW TO BECOME A MEMBER

1. Log on to www.**womensderm.org**
2. Click on JOIN WDS
3. Scroll to the bottom of the page
4. Apply online as JOINT WDS/Indian WDS MEMBER

Residents Forum Session at DERMACON 2015

It gives us great pleasure to announce the first ever Residents Forum Session to be held at DERMACON 2015, Mangalore. It has always been a dream and finally came true because of the IADVL Residents Welfare Program. It will be an interactive session where Residents (both presently pursuing their course as well as recent pass-outs) will get to interact with teachers, consultants and seniors from all over the country and get all their queries answered!



Fair is Unfair

The fairness cream menace!

Author :

Dr. Saloni Katoch
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Davangere, Karnataka

"Suitable match for a FAIR, slim and beautiful girl pursuing M.A."

"FAIR, Handsome, well educated boy seeks proposals from FAIR, pretty, educated girl"

"I am a 28 year old man looking for an ideal, beautiful, FAIR and well mannered Indian wife"

The above matrimonial advertisements are just a few examples of the thousands appearing in India's leading daily newspapers, which indeed reflect our obsession with skin colour. With advertisements of girls turning from dusky to milky white in a few weeks, from being shy and helpless to being confident and courageous, fairness creams harp on this very deep rooted notion of our society that "Fair is beautiful".

The fairness cream market is flourishing in India and other parts of South Asia where light skin is associated with a sense of superiority, beauty and power. This colour based bias dates back to the indigenous defeat of the dark skinned Dravidians by the fair toned Aryans which sparked off the division of the Indian society into *varnas* (Sanskrit for colour). This widespread preference for fair skin is being exploited by the manufacturers of skin lightening products. These whitening cream advertisements propagate the myth that a woman or man has to be fair in order to be successful and charming. For most Indian women, these creams symbolize the dream of breaking free from social barriers, overpowering cultural norms and achieving goals which otherwise would have been impossible because of their skin colour.

So where did it all begin? The Mother of all fairness creams was launched in the year 1976 and the rest is history. Out of the current $180 million skin care market in India, which is growing by 10 to 15% annually, more than half the revenues are generated by fairness products alone. These over the counter products are easily available and are household names in a country like ours where celebrities take pride in endorsing them.
This menace has shadowed our society, where daily application of these products like bathing or brushing one's teeth is followed like a ritual for years together.

Most of these skin lightening creams are harmless, some hinder the production of melanin and few are mere sun blocks. The real problem arises when these creams contain a powerful steroid or chemicals like mercury that can be toxic and harmful to the skin. The alarming fact is that most of these products do not disclose their contents, many of which can cause potential damage to the skin in the long run.

Many fairness creams may contain skin bleaching agents like hydroquinone, steroids, mercury salts, lead, nickel, chromium, hydrogen peroxide and magnesium peroxide among others. Mercury derivatives may cause neurotoxicity, nephropathy and immunotoxicity. Hydroquinone preparations can cause ochronosis and neuropathy. Creams laced with topical steroids can cause a myriad of adverse effects from atrophy to excessive hair growth, from rosacea like dermatitis to flaring of acne, from extreme photosensitivity to addiction. Ayurvedic fairness preparations contain *Kumkumadi tailum*, studies on the efficacy and safety of which are lacking.

Whitening creams sell like hot cakes, although there is no documented benefit. Can we change what our genes determine? Constitutive skin colour is genetically determined and undergoes facultative colour changes on exposure to environmental factors. Can fairness creams with hoardings of a dark skinned unhappy woman morphing into a light skinned smiling one change our genetic skin tone?? The consumers should be aware that with skin lightening agents colour change may not happen beyond the constitutive level.
Fairness cream manufacturers promote a particular body image as the preferred one and then sell products to help people attain this particular ideal, this may be regarded as disease mongering. Advertisements stigmatizing dark complexion should be disapproved and banned. There are a few actors who have refused to be a part of this fairness bandwagon and have launched campaigns against these demeaning commercials. "Stay unfair, Stay beautiful" being headed by Nandita Das is one such step towards recognizing the beauty of all skin tones.

Fair is Unfair

The fairness cream menace!

With pigmentocracy and colorism deeply rooted in our culture, it is but natural for the generation next to turn to this fairness cream menace, to attain this ideal body image and flawless complexion being propagated by the media. Skin lightening creams that do claim to alter skin colour should be regarded as dangerous. Their safety and efficacy should be scientifically guaranteed before being marketed. Stringent regulations and laws should be imposed over skin lightening products and their advertisements especially the ones being circulated under the label of cosmeceuticals.
Dermatologists have a very important role to play in breaking this vicious cycle. Education and counseling of patients is very important. Dark is beautiful and true beauty indeed lies within are concepts that need to be drilled into our prejudiced society. Fetish for fairness can cause emotional and financial stress. Patients need to be brought face to face with the adverse effects of these skin whitening products. The youth need to know that the power of beauty comes from within and skin colour is in no way connected to strength of mind or intellectual powers. Awareness and education is the solution to this growing menace.

> I have a dream that my four little children will one day live in a nation where they will not be judged by the colour of their skin , but by the content of their character."

Martin Luther King, Jr.

Vulvar Dermatoses : An Insight

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Why should one know this?

Vulvar dermatoses are skin conditions affecting the vulva, and causing itching, burning and discomfort. The true prevalence of vulvar dermatoses is unknown, but it is well accepted that vulvar symptoms are a common problem. Unlike other areas of the skin, vulva is difficult for a patient to examine by herself. Moreover, compared to any other area, it is awkward to ask a family member or a friend to help. Besides, genital skin symptoms often trigger concerns of poor hygiene, sexually transmitted infections, or undiagnosed cancer, all of which can elicit embarrassment, fear, and anxiety. Most women with vulvar symptoms present initially to family physicians or gynecologists. However, the primary etiology may be a skin condition rather than a gynecologic disorder. Trained to identify cutaneous disease, optimize barrier function, treat inflammatory skin conditions, and biopsy all skin surfaces, a dermatologist can be integral to the evaluation and treatment of this special population of patients. The diagnosis of vulvar symptoms is also complicated by the fact that multiple inflammatory skin conditions tend to cause similar clinical findings and that the presentation of vulvar dermatoses differs from that of the same disease appearing on other skin surfaces. The majority of patients presenting with a vulvar skin condition will complain of either pruritus or some degree of pain or irritation.

What is vulvar pruritus?

An itch that produces a desire to scratch or rub and feels good when scratched.

What is vulvar pain ?

A sensation in the affected skin that may be described by patients as soreness, rawness, prickling, or burning and does not evoke a desire to scratch

What to ask your patient?

1. Discomfort : Itching/ soreness/ burning/ rawness
2. Urge to scratch your skin : Yes/No
3. Symptoms : Onset/ frequency/ aggravating factors/ relieving factors
4. Changes in vaginal discharge : Yes/No
5. Last menstrual period :
6. Last pregnancy:
7. Sanitary products used during menses :
8. Menopause achieved : Yes/No
9. Hormone replacement : Yes/No
10. What do you apply to your genital skin :
11. Sexually active : Yes/No
12. Sexual intercourse : Frequency/ Partners/ Pain/ Lubrication/ Contraception
13. Ever been told that you have
    - Abnormal pap smear : Yes/No
    - Genital warts : Yes/No
    - Genital herpes simplex : Yes/No
    - Herpes zoster Yes/No
14. History of
    - Eczema, asthma, rhinitis : Yes/No
    - Psoriasis/ any other skin disease : Yes/No
    - Diabetes mellitus : Yes/No
    - Irritable bowel syndrome
    - Cystitis : Yes/No
    - Easy fatiguability : Yes/No
15. Any other problem related to Gastrointestinal system, musculoskeletal system, cardiovascular system and respiratory system
16. What is the cause of your symptoms, as per your opinion?
17. Evaluation of Dermatology Life Quality Index (DLQI)

How to examine her?

Obtaining consent and examination in presence of a female attendant is crucial.
Position the patient to allow adequate exposure and lighting.
Consider taking clinical photos for the medical record.
Inspect all surfaces of the vulva for subtle erythema, swelling, lichenification, pigmentary changes, erosions, tumors, atrophy, fissures, excoriation, scarring etc
A skin potassium hydroxide (KOH) preparation or culture should be performed on any erythematous, scaling plaque or any intertriginous plaque to diagnose or exclude dermatophytosis

Vulvar Dermatoses : An Insight

Utilize a speculum to visualize the mucosa for erythema, erosions, and synechiae
A sample of the vaginal secretions should be studied microscopically via saline wet mount and with KOH to characterize the epithelial cells and to identify the presence of white blood cells, clue cells, lactobacilli, hyphae, or budding yeast.
A biopsy is warranted for any abnormal findings that cannot be defined clinically, do not respond to treatment as expected, or are suspicious for malignancy

Chalk out your clinical differentials

Cutaneous disease restricted to vulva	Lichen simplex chronicus, allergic contact dermatitis, irritant contact dermatitis, psoriasis, lichen planus, lichen sclerosus et atrophicus, plasma cell vulvitis, Hailey-Hailey disease, Darier's disease
Vaginitis/ vaginosis	Atrophic, candidial, bacterial
Infectious	Fungal : Candida, dermatophytes Bacterial : Trichomonas, Gonococcus, Chlamydia Viral : HSV, HPV, VZV, molluscum contagiosum Infestation : Scabies, lice, enterobiasis, threadworm
Neoplasms	Vulvar intraepithelial neoplasia, squamous cell carcinoma, verrucous carcinoma, basal cell carcinoma, syringoma, extramammary paget's disease, Langerhans cell histiocytosis
Generalised disease with cutaneous involvement	Atopic dermatitis Pemphigus vulgaris, Cicatricial pemphigoid, Linear IgA disease, Behcet's disease, Crohn's disease, Melkersson-Rosenthal syndrome, SLE, Acrodermatitis enteropathica
Drugs	Fixed drug rash
Psychogenic	Vulvodynia, Pruritus vulvae

What to look for, on histopathology?

Spongiotic	**Atopic dermatitis, allergic contact dermatitis, irritant contact dermatitis**
Acanthotic	**Psoriasis, Lichen simplex chronicus**
Lichenoid	**Lichen sclerosus et atrophicus, lichen planus**
Dermal homogenisation	**Lichen sclerosus et atrophicus**
Vesiculobullous	**Pemphigus vulgaris, Cicatricial pemphigoid, Linear IgA disease**
Acantholytic	**Hailey-Hailey disease, Darier's disease**
Vasculopathic	**Aphthous ulcer, Behcet's disease, plasma cell vulvitis**
Granulomatous	**Crohn's disease, Melkersson Rosenthal syndrome**

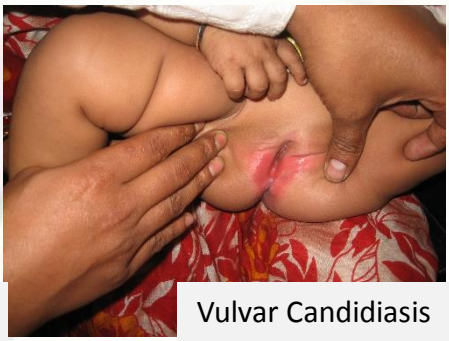
What and how to manage?

1. Restore skin barrier and prevent further irritation
2. Decrease skin inflammation
3. Treat symptoms of irritation and itching
4. Stop scratching
5. Treat and prevent infection
6. Schedule a follow-up appointment in 4 weeks

Vulvar Dermatoses : An Insight

Vulvar bowenoid papulosis with intertrigo

Vulvar SCC

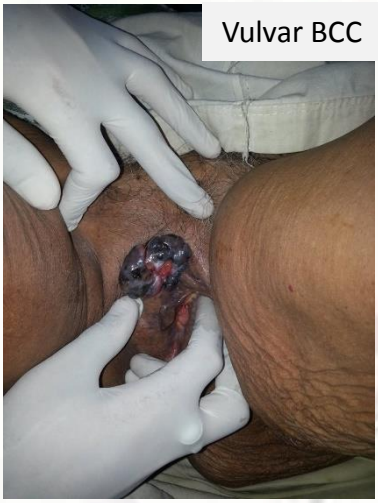


Vulvar Candidiasis

Vulvar lichen planus with VIN

Vulvar Verrucous ca

Vulvar BCC



Vulvar leiomyosarcoma

Vulvar warts

Vulvar lsa

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Quiz Answers

1. **Differential Diagnoses**:
    a. Chronic cutaneous lupus erythematosus
    b. Porphyria cutanea tarda (acquired)
2. **Additional tests**:
    a. Urine for uroporphyrins (negative in this case)
    b. PAS staining of the HPE slide (negative in this case)
    c. Direct immunofluorescence (band like IgG, IgA and IgM deposition seen at the basement membrane zone)
3. **Chronic Cutaneous Lupus Erythematosus**

Feedback

Hope you liked the 3rd issue of RESIDREAM newsletter. If you have any comments, queries, suggestions, contributions, please write to us at : *residreamiadvl@gmail.com*