RESIDENT dream

Vol : 3, Issue :3, September - December 2016

IADVL Newsletter For The Residents

RESIDENT DREAM

Dermatology Residents Education And Motivation Bulletin

September - December 2016, Vol.3, No.3. A newsletter for IADVL Residents

IADVL NATIONAL EXECUTIVE 2016

President
Dr. Devesh Mishra

President Elect
Dr. Yogesh Marfatia

Immediate Past President
Dr. Venkataram Mysore

Vice-Presidents
Dr. B. B. Mahajan
Dr. Anil Ganjoo

Hon. Secretary General
Dr. Shyamanta Barua

Hon. Treasurer
Dr. Rajib Gogoi

Hon. Joint General Secretaries
Dr. Prabhat Kumar
Dr. Biju Vasudevan

EDITORIAL BOARD

Chief Editor
Dr. Anupam Das

Advisors
Dr. Rashmi Sarkar
Dr. Ishad Aggarwal

Editorial Team
Dr. Akshi Bansal
Dr. Avtar Jaisinghani
Dr. Pankaj Das
Dr. Seujee Das
Dr. Somodyuti Chandra
Dr. Varun Khullar

Design Credits
Dr. Anupam Das
Dr. Somodyuti Chandra
Dr. Varun Khullar
Mrs. Jayati Chatterjee

From the Editor's desk :

It gives me immense pleasure to present to you the third anniversary edition of the newsletter, RESIDREAM. The journey started in 2014 under the secretaryship of Dr Rashmi Sarkar. From 2016 January, my team had the fortune of having Dr Shyamanta Barua as our guide. The newsletter received lots of accolades from residents as well as faculties, across the country. In each issue, we roped in some of the finest authors and seniors who shared with us, the tit-bits of everything related to academics, practice, fellowships, observerships and what not!

This being the anniversary issue, we have strived hard to bring out the best. We are highly thankful to Prof Devesh Mishra, National President, IADVL for being kind enough to send us a warm message for the issue. I have had the fortune of discussing the whereabouts of publishing and the basics of research and academics over a cup of tea with Prof. Saumya Panda, Editor Elect, IJDVL. Dr Sherina Laskar, one of the young and energetic brains who excels in dermatopathology, has guided Dr Isha Narang on how to approach a granuloma. Dr Pankaj Das and Dr Varun Khullar fight out a sweet battle on the pros and cons of attending conferences. Their conversation is worth reading and I am sure you will enjoy. Dr Biju Vasudevan, whom seniors refer to as the "congenital quizmaster" along with Dr Debdeep Mitra have given us some outstanding tips on how to do well in dermatology quiz. Who else than Dr Biju could have been a better choice to write this article! Dr Ishad Aggarwal who has a keen interest on facial aesthetics speaks on the scope of this speciality and how to go ahead with it. Dr Somodyuti Chandra and Dr Priyankar Misra will quiz you through an interesting crossword, hope you will enjoy solving the puzzle. Finally, my fantabulous teammates share with us, their experience with Residream, over the last 12 months. We thank the IADVL EC 2016 for being so supportive and encouraging throughout.

In this DERMACON KOLKATA, me and my team feel honored and privileged to release the third issue of our newsletter and I hope everyone enjoys reading this special issue.

"Life brings tears, smiles and memories. The tears dry, the smiles fade, but the memories last forever!"

Dr. Anupam Das
Chief Editor, Residream

HIGHLIGHT

IMPORTANT MESSAGE
Dr. Shyamanta Barua

IADVL PRESIDENT'S MESSAGE
Dr. Prof. Devesh Mishra

CHAI PE CHARCHA with Editor Elect IJDVL
Prof. Dr. Saumya Panda & Dr. Anupam Das

GRANULOMATOUS DISORDERS
Dr. Sherina Laskar & Dr. Isha Narang

CONFERENCES OF (OR FOR) RESIDENTS - BOON OR BANE?
Dr. Varun Khullar & Dr. Pankaj Das

DERMCROSS 2
Dr. Priyankar Misra & Dr. Somodyuti Chandra

HOW TO PREPARE FOR A DERMATOLOGY QUIZ
Dr. Biju Vasudevan & Dr. Debdeep Mitra

EXPERIENCE WITH FACIAL AESTHETICS
Dr. Ishad Aggarwal

IMPORTANT MESSAGE

Author
Dr. Shyamanta Barua
Hon. Secretary General
IADVL

Dear Provisional Life Members,

New Year greetings from the IADVL National Secretariat !

All of you, who are soon tocomplete 5 years of provisional membership and/or obtained a postgraduate (PG) degree/diploma in Dermatology and registered their PG qualification with the MCI/State Medical Council, are notified to become Life Members (LMs) at the earliest. It may be mentioned that Provisional Life Membership is granted for a period of 5 years only within which a PLM has to convert to LM, failing which he/she ceases to be a member of the association.

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

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

Objection Certificate (NOC) and, thereafter, apply for conversion from PLM to LM and State Branch transfer concurrently.

Best regards

Shyamanta Barua

Honorary Secretary General, IADVL

STEPS FOR PLM TO LM CONVERSION

1. Log onto www.iadvl.org
2. Go to 'Membership' tab on homepage and click on 'Apply for Membership'
3. On the new page, drag to the bottom and click on 'View Details & Apply' on the 'PLM to LM conversion' section.
4. You will open up a dialogue box stating the documents required. Make sure you have soft copies (in pdf or jpg format) of all the documents ready. Click Apply.
5. On the first page, enter your details - Name, Email, Mobile Number and existing PLM number. Click 'Save & Proceed'. You will receive an OTP on your phone - enter that.
6. On the second page, upload your recent photograph. Please choose the state branch you are presently residing / working / practicing in at the top of the page. If the state branch is different from the one your PLM is registered with, you will need a NOC from that branch. Enter your personal details and upload the documents in pdf or jpg format. Click 'Save & Proceed'.
7. On the third page, enter your details about education & practice and click 'Save & Proceed'.
8. On the fourth page, review your details and click 'Submit'/'Proceed' at bottom of the page.

IADVL President's Message

Author
Dr. Prof. Devesh Mishra
National President
IADVL

Greetings to RESIDREAM team for another successful year.

It gives me immense delight to know that young dermatologists and mainly PGs and residents who are members of our IADVL (Indian Association of Dermatologists, Venereologists and Leprologists) are compiling the latest work of academics, research and new developments in our subject and sharing it with our fraternity.

New RESIDREAM edition signifies emerging great expectations of our dermatologists from newer therapeutic advancements, understanding of disease processes and use of new technology and drugs for the betterment of the patients.

A new edition of RESIDREAM newsletter will be released and presented to members at 43rd annual Conference of IADVL – DERMACON at Kolkata, 2017. I am sure that dynamic members of RESIDREAM team led by Dr Anupam Das will make it a hugely cherished work.

My sincere best wishes.

Dr Prof Devesh Mishra

National President IADVL

Prof. Dr. Saumya Panda
&
Dr. Anupam Das

Department of Dermatology
KPC Medical College &
Hospital, Kolkata

CHAI PE CHARCHA with Editor Elect IJDVL

1. At the outset, heartiest congratulations to you, on being the Editor Elect of Indian Journal of Dermatology, Venereology and Leprology (IJDVL). What are your visions and goals with respect to the journal, in the years to come?

Thank you, Anupam.

The IJDVL at the current juncture is very much a journal on ascendancy. To the best of my knowledge, going by the Impact Factor, it is now the highest ranked biomedical journal in India, outranking not only other speciality journals but even the Indian Journal of Medical Research (IJMR) that is the journal of Indian Council of Medical Research (ICMR), and is a basic research journal to boot. Also, the IJDVL is now among just a handful of journals globally that is able to steadily increase its Impact Factor bucking the contemporary worldwide trend of dwindling IF with regard to dermatology journals, including biggies such as the Journal of Investigative Dermatology. All these facts should make us justifiably proud as a part of the Indian Dermatology fraternity, and is also a comment on the strong foundations of the reviewing and editorial processes of our journal. It is also a matter of great pleasure and pride that the IJDVL for quite some time now is able to attract articles on diverse subjects from a lot of contributors across the world.

You might think that to take over in such a scenario must be the dream of every incumbent. But, believe me, for me this is as tough as it could get. First, the expectations from the journal among our members are now sky high. This is the time for reality check. IJDVL got its first IF in 2009 (0.973). It has taken the journal 7 years to reach the threshold of 1.5, 1.488 to be exact. Only the editors know the tortuous uphill path towards an ever-rising IF. It is quite creditable for a clinical dermatology journal to approach an IF of 1.5. And it is quite another issue to continue steadily along a rising curve. Definitely, it will be my endeavour to do so, but for me the IF will not be the be-all and end-all. It will be just another milestone in our journey toward establishing IJDVL as a journal that will be globally respected by our peers, and will emerge as a voice that sets the research agenda of clinical dermatology in future.

But you don't build castles in the air. Any journal is only as good as its contributor base. Being an Indian journal, our base consists of our clinical dermatology research fraternity. It is a matter of considerable disquiet that still the basic concepts in research methods and biostatistics seem to be in the grasp of only a rare minority of our academic dermatology departments, going by the dispersion of quality of submitted original articles. Though there is no short cut to spreading these tenets over a large country of subcontinental dimensions having enormous diversity, I shall certainly strive to use the reach and resources of the journal to this end, if only for the sake of securing the future of the journal itself.

One last thing: The tenure of the Chief Editor being 3 years, it is not my job to think long-term and plan for the long run. My immediate aim will be to hold the course, knowing full well that the journal is off on a pretty good course. And, it is important not to be overambitious.

2. Indian Journal of Dermatology, Venereology and Leprology has always been a "tough" journal. What are the points you look for, in an article, when you find a new submission?

Well, I won't vouch for the 'always' part of your question, but certainly the going has been progressively tough for the authors during the tenure of the three previous editors, at least. And, I won't be mincing my word -- it's not going to be any easier during my time. I would definitely mention here, that as far as the editorial processes go, the IJDVL is certainly one of the fairest dermatology journals in the world. With around 40 members in the editorial team, it is a highly decentralized system of editorial decision making in place, making systematized bias almost an impossibility. As a result, if someone wants to publish in IJDVL successfully, (s)he needs only to assess her/his own work in light of the FINER criteria. Of course, novelty is at a premium. Not only case reports, for which uniqueness is an essentiality, 'me-too' original studies are also viewed with disfavor.

IJDVL is a journal that flaunts its character as a clinical dermatology journal unabashedly, almost as a badge of honour. And it takes its status of the national dermatology journal of India with some seriousness that gets reflected in its contents. So anything that is not primarily of interest to clinical dermatologists in this country is not likely to pass muster. We do not discourage basic research articles, but the translatability or relevance of the research as applied to clinical dermatology must be transparent.

A lot of original articles get rejected, as I have indicated, in the preliminary phase, or afterwards, if there are infirmities in design or statistical analysis. Sample size and its estimation, or the lack of it, is a common grouse. Inadequate follow-up, inappropriate statistical methods and poorly defined endpoints are other common causes of heartburn among editorial team members.

Then there are technical issues, like not registering a clinical trial prior to commencing a study, or failure to obtain consent for using facial photographs. As per prevailing global publishing standards, the journal is bound to take a hard line on these issues.

3. Selection of topic for dissertation has always been a difficult job. What is your message to the first year residents, regarding the matter?

First, the topic must be feasible. Minus the time taken for synopsis writing, getting ethical clearance, and writing the dissertation, the time for data collection is much less than a year. So the topic must be on any disease condition for which getting a sample of the estimated size in the available time frame is not an issue. Thus common sense should dictate that the topic should be something on, say, mild to moderate acne rather than on cutaneous lymphoma.

Second, the one reasonable goal of pursuing a dissertation that should be at the top of everyone's mind is to publish it. If that be the case it must not be a 'me-too' dissertation.

Third, the choice of subject must be close to one's heart. There is no scope of miscasting here. Someone having a penchant for procedural dermatology should not opt for a subject related to STIs or Hansen's.

The real problem is elsewhere: The large majority of Residents, rightly or wrongly, view the dissertation as a needless distraction that is to be finished somehow if one has to get the degree – the mindset's the same as that of a malarial patient having to take quinine for the sake of getting well. Plus, in the first year, one should not expect the Resident to have a deep insight in the subject, or even have a clear idea of his/her own academic predilections. So here comes the importance of mentoring. It is the job of the mentor to judge the potential and the academic proclivities of the Resident – that is why their designation is 'guide'. It is their job to guide the Residents.

4. A very common doubt is "how to convert a dissertation into an original article?" What is your take on the issue?

Scientific writing is as much about science as it is an art. In this context, it is important to stress that the same approach will not fit everyone. If someone has pursued a dissertation on, say, the effectiveness of dairy-free diet in inducing and maintaining remission in mild to moderate post adolescent acne (provided it is feasible!), a simple compression of the dissertation should suffice. More problematic are relatively bland observational studies, such as, say, one on epidemiology of melasma. Here one must try and find out a novel or hitherto unreported finding in the dissertation. Suppose if such a study documents that a significant proportion of pregnant patients with melasma has a significantly higher blood levels of TSH, it will certainly interest the editors and reviewers, because it may generate a new hypothesis on the disease pathogenesis. Every dissertation is not interesting, but many more dissertations can be made into interesting articles than is being currently done.

5. What is the concept of impact factor of a journal? Which is better? Publishing a letter to editor in a journal with higher impact factor? Or an original article in a journal with lower impact factor?

The impact factor is a measure of the frequency with which the average article in a journal has been cited in a given year. Generally speaking, a major concern about the validity of impact factor as a measure of journal importance is because of the effect of policies that editors may adopt to boost it, perhaps to the detriment of readers and writers. For example, basic science articles, per se, attract higher number of citations than clinical articles. Thus, as a matter of rule, the higher the impact factor of a dermatology journal, the lesser the number of clinical dermatology articles. Thus, these days journals that were hitherto known as clinical dermatology journals are catering progressively less space to clinical dermatology than to basic research, thus losing some of their appeal to their erstwhile readership. In IJDVL, we are trying to balance our concern about going on raising our impact factor at the same time remaining steadfast as a core clinical dermatology journal. That is why we give primary emphasis on the question of translatability of basic research that we are going to publish.

The question addressing the dichotomy of publishing an original article in a low-IF journal versus a letter to editor in a high-IF journal is an interesting one. The whole debate has suddenly become topical thanks to an ill-conceived circular by the Medical Council of India regarding promotion of the Faculty of Medical Colleges. So, Anupam, you should have asked the Chairperson of the MCI this particular question. Of course, we can guess what the response would be.

For the moment, let us forget about MCI. It would be easy for us to see that the IF does not really matter. What matters is the appropriateness of a journal for a particular article. Suppose you have written an article on Hansen's disease, and you have got it published in the British Journal of Dermatology. I daresay that if such an article is published in any Indian dermatology or leprosy journal, the probability of it being cited would be much greater. Same is the dichotomy between original articles and letters that is no dichotomy at all. All of us are perhaps aware that the DNA double helix structure was published by Watson and Crick as a letter. Would it have greater influence if it were published, perhaps a little later (original articles have longer gestation than letters), in another journal?

6. Case reports and case letters are dying out slowly. What should be the approach of residents towards this matter? Do you discourage publishing case reports?

The importance of case reports in dermatology could not be stressed more. I would not agree that case reports are 'dying'. I can definitely vouch for the fact based on the sheer number of case reports that are submitted to the journal every year. But, yes, may be the editors have become more discerning. In case of indexed journals, the pressure of publishing more citable articles sometimes gets to them. This has resulted in quite a few frontline clinical dermatology journals to discontinue with case reports altogether, and to come up with separate journals publishing only case reports and sharing the name of the parent journal as prefix. To me, it is a travesty of the journal's original mission as a medium to propagate clinical dermatology, as it irrevocably transforms the basic character of the journal. You simply cannot call yourself as a clinical dermatology journal without case reports. I cannot conceive of such a thing happening in IJDVL, not under my watch, at least.

But there are two other dimensions of this problem. How many of the Residents these days are interested in picking up the subtle nuances of clinical dermatology? Unless you develop a clinical eye – easier said than done – and toil hard for days peering down the microscope, how can you hope to even spot unique publishable cases in busy OPDs, let alone finally publish one?

We in IJDVL give a really high premium to novelty and real uniqueness in case of case reports. That is why, the number of case reports might have come down drastically. By real uniqueness, we mean some aspect of the case which must be hitherto unreported as also have some bearing on our understanding of the clinical condition. That is why the editors won't be terribly impressed by the first case of pseudoxanthoma elasticum reported from Sikkim. Not because of the lack of believability of such claim (though I would agree that these claims are hard to justify, and are thus discouraged), but because nothing that we know of the condition precludes its occurrence in these geographic locations. It would be a different issue altogether if we come across a case series of post-kala azar dermal leishmaniasis reported from the local inhabitants of Ladakh, say. So one need not be coming across a new entity in order to publish a case report in our journal, but the novelty quotient must be pretty high and the report must be able to evoke genuine interest in the form of new understanding of some critical aspect of the clinical condition.

7.What is your opinion on the increasing number of conferences these days? How should a resident choose as to which conference he or she should attend? Many a time, it becomes difficult to get permission from the department. Your views, Sir.

This is a crucial question. Though it is certainly an individual choice, I can only share with you what I have been doing since my student days, though those days and the present ones can never be compared because of the huge difference in the number and variety of conferencing opportunities. I think that right from my days as a junior resident, I have hardly attended any conference in which I haven't had any active role to play. I made this decision very consciously quite early in my career. Though I might have thus chosen to give misses to some exotic places – it was not easy given that I am a travel buff – I do not regret the decision. Unplanned attendance in conferences times without number really affects your productivity. So whatever you gain by networking, if anything, is neutralized by simultaneous loss of your focus, intensity and sense of purpose. However, this is an entirely personal view, and I do not recommend anyone to follow whatever I am doing or even my train of logic. I am sure those who are regular attendees in conferences have their own rationale, and I fully understand that. I have nothing against the conferences in general, or the individuals who participate in them.

8. Sir, I have been a regular follower of your talks and write-ups on evidence-based medicine (EBM). The topic is undoubtedly interesting but to be very honest, it is quite difficult to interpret as well. Kindly guide us on how to learn basics and the whereabouts of the same. Do you recommend any specific book? Or can we expect you to come up with a handbook for the residents?

First let me compliment you on the candour you display regarding this issue which is very rare to come across. All of us believe, once we have done a regulation dissertation for our MD and DNB, that we know everything about how to conduct research. That is such a misconception in a scenario where the large majority of dissertations are of a quality that leaves much to be desired, and a great deal of those is even now copy-paste job. This is a situation, let me tell you, that is not confined to our speciality but obtains across all disciplines. And, proficiency in EBM is a rare skill even on a global scale. EBM as a paradigm is very much the new kid on the block, with its origins in the 1990s. Also, the impetus to teach oneself the nuances of EBM is so purely an exercise in academics without any possibility of having any pecuniary benefits that it is very much a niche, almost an esoteric, activity. Finally, EBM is an episteme – a new system of understanding medicine – that is much at odds with the conventional view or knowledge system of medicine and its branches.

A necessary precondition of learning EBM is to unlearn much of what we learn about how to acquire knowledge of our clinical discipline. And, to complicate matters further, you need to have the instincts and the capability to be some kind of a polymath. In contradistinction to attaining skills in, say, dermatopathology or dermatosurgery, where you need be honing particular skill sets within the larger discipline of dermatology, in evidence-based dermatology you have to transcend the boundaries of dermatology, and, of necessity, delve into logic, statistics, philosophy even. At the end of the day, someone who can understand and talk in the language of evidence-based dermatology may certainly pose the question, a la CLR James: 'What do they know of dermatology who only dermatology know?' It certainly gives you a high, though totally on a cognitive plane. And it better be acknowledged that these days having the basic skills in EBD is as necessary for a practicing dermatologist as having those in basic dermpath or dermatosurgery.

Regarding the second part of your question, which I construe to be an implicit criticism of my verbal and written communications in EBD, I would be the first to accept my deficiencies in getting the messages across an uninitiated audience. Having said that, you cannot transmit the concepts of EBD very effectively within a short time span, and didactic lectures are not the best way to do that. So I would ask you and others with a genuine interest in EBD to attend workshops spread over a day or two, and most importantly, to put into practice whatever you learn immediately in whatever role you may, be it is a researcher, an author, a reviewer, or as an editor. The immediate application and continuous exercise is important, because EBD is much like vocal music. As long as you are singing with one Hemanta Mukherjee or a Lata Mangeshkar, you feel it is so easy. The moment the singer stops, the truth hits hard. The same with methodology and statistics. As long as you are in a workshop, chaperoned by a methodologist or statistician, designing or analyzing seems so easy as zip zap zoom. The moment you are doing it by yourself, the reality bites.

The best resource material, that I find the most lucid as well, is of course the textbook on 'Evidence-Based Dermatology', edited by Hywel Williams and others. Another very good introductory resource is 'How to Read a Paper: The Basics of Evidence Based Medicine' by Trisha Greenhalgh. On statistics, David Bowers' 'Medical Statistics from Scratch' is a good introductory text. Once you know the basics, you may try out some out-of-the-way books which are great resources. I recently came across an excellent, witty tome that is not a textbook, of course, but from which you learn a great deal on how to go about applying statistics: 'Statistics Done Wrong: The Woefully Complete Guide' by Alex Reinhart. Similarly, a great book that tells a good deal about misapplications in research methods and which I find a great learning tool is Ben Goldacre's 'Bad Pharma'. There are lots, really.

A very good template for a future handbook in the Indian scenario could emerge from the module on methodology and statistics that is being serialized currently in the Indian Journal of Dermatology.

9. A very pertinent question in today's era. What is your take on clinical dermatology versus aesthetic dermatology? A senior professor recently said in a clinical dermatology meeting "Now, everyone wants to open up a salon. Nobody is interested in learning clinics". Most of the rank holders call me up and ask whether the institute has laser equipments or not. What do you say? Is it a red flag sign that residents are joining dermatology to become beauticians and not clinicians?

My view is that it need not be either/or. One may be equally adept in aesthetic and clinical dermatology. Sometimes one may veer away from one to the other. It is very difficult to predict which way one's career would take. But I would also venture to opine that it takes a great deal more cognitive investment to excel in clinical dermatology than aesthetic dermatology. And the economic returns are negligible in the former compared to the latter.
I do not blame really the students these days who want to pursue aesthetic dermatology. Ultimately it all boils down to economics. Why are we – you and I – not practicing in some rural backyard? Would that not have been more in tune with the high-falutin ideals of our profession? Simply speaking, economics rules – in all aspects of our life choices. Whether we like it or not. That is why, I wouldn't be too judgmental, though it definitely bothers me a lot that many of our bright young colleagues, who could have been excellent clinical dermatologists otherwise, are getting wasted doing routine aesthetic procedures.

Finally, I am not very comfortable with designating whomsoever aspiring to become aesthetic dermatologists as beauticians. Let me tell you that my own dissertation was on a comparative study of TCA versus GA peel in cases of resistant melasma. It was twenty years back. I still do peels regularly in my clinical practice, though definitely a large volume of my practice is clinical rather than cosmetic dermatology. I know firsthand the kind of satisfaction you get seeing the radiant face of a woman in her sixties on whom you did aesthetic procedures, and the skills involved in knowing exactly which formulation of glycolic acid to choose, how much and for how long you peel, or which filler to use for augmenting just that much of her mid face volume which will make her look and feel just a few years younger. It is creative, it is a combination of art and science, and it does require skills. As you cannot compare apples with oranges, you cannot compare the skills of an aesthetic dermatologist with that of a first rate clinical dermatologist who can diagnose esoteric entities, or who can deal fairly successfully on a daily basis complicated clinical problems without much fanfare. Yes, the difference in social utility between these two tasks is pretty apparent. And, it is really sad to see clinical dermatology having to take a back seat on account of economic compulsions. Dermatology is, after all, the queen of clinical sciences.

10. One final question. After passing MD final exams, most of us get “busy” with private practice and gradually, priorities change. How to keep a balance between academics and practice?

This is a tough question. Again, this is a situation where there is no solution that can fit all sizes, so to say. You are so right to specifically pose this question with reference to the private practitioners. If you are in an academic institution, particularly one that caters to postgraduate teaching on the subject, remaining in touch with academics is, of course, part of your job profile. Of course, the unfortunate scene in our academia is such that barring a very few honorable exceptions among our institutions, exposure to an academic environment in this country leads to intellectual sclerosis rather than cognitive empowerment thanks to a stifling bureaucracy, mindless politicking, simply lack of any infrastructure and funds, and a general atmosphere of disincentive to pursuit of research, so that only the rarest and the brightest among the bright may beat this systemic inertia and continue to be creative and academically productive.

But the challenges of remaining aligned to academia are far greater among the large mass among our peers who, of necessity, are engaged in private practice. There is simply no other way but to remain focused in any way you find. One of the outlets that are readily available are the different academic chat groups, like the ACAD_IADVL Yahoo mail group that is open to all academically inclined members of the IADVL, or the various such groups in the social media. For those who wish to continue to excel, and have a long-term commitment to academic activities, getting associated with the journals – there are now 10-odd catering to our speciality in our country – could be really worth its while. In this regard, I am grateful to the Indian Journal of Dermatology for giving me, a private practitioner, the opportunity to pursue academics and hone my skills in writing, reviewing, and editing at a time when very few, if any, other avenues were open. So this is my message to the youngsters: if you get a call from an editor to associate with a journal, do not treat it lightly. It is an acknowledgment of your academic prowess, and it is a windfall in an intensely competitive academic market. Just grab it and make the most of it. May be you won't get a second chance.

Author
Dr. Sherina Laskar
Resident Physician,
Dermatology,
Gauhati Medical
College.

Author
Dr. Isha Narang
Junior Resident,
Dermatology,
Maulana Azad Medical
College, New Delhi.

Granulomatous Disorders

BASICS

GRANULOMA

- Focus of chronic inflammation consisting of relatively discrete collections of histiocytes or epithelioid histiocytes with variable numbers of admixed multinucleate giant cells of varying types and other inflammatory cells.
- It is formed in response to an antigen that is insoluble, non degradable and slowly released.

CHRONIC INFLAMMATION

Chronic inflammation is inflammation of prolonged duration (weeks to years) in which continuing inflammation, tissue injury and healing, often by fibrosis, proceed simultaneously.

GRANULOMATOUS REACTION PATTERN

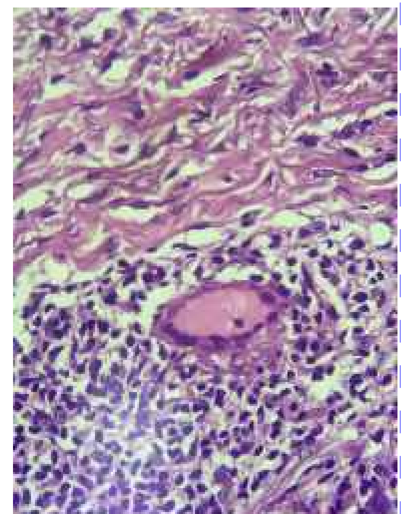
The granulomatous reaction pattern is defined as a distinctive inflammatory pattern characterized by the presence of granulomas.

FEW TERMS

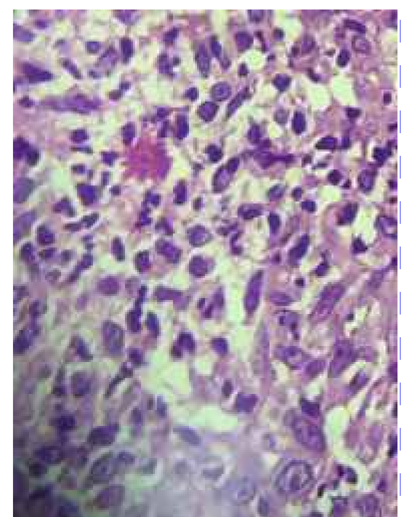
HISTIOCYTE: It is a tissue macrophage with large, ovoid, pale-staining, vesicular nucleus that can be eccentric or indented with a distinct nuclear membrane. Nucleolus is usually distinct, small, centrally located and can be single or multiple. Cytoplasm may be abundant but is indistinct.

EPITHELOID CELL: It is an activated histiocyte and is named so as it resembles epithelial cells. It has abundant eosinophilic granular cytoplasm and poorly defined cell borders.

MULTINUCLEATED GIANT CELL: It is formed by fusion of aging histiocytes and has a diameter of 40-50 microns. They may have more than 20 nuclei.



LANGHANS GIANT CELL



ASTEROID BODY

CLASSIFICATION OF GRANULOMAS

TYPE OF GRANULOMA	CHARACTERISTICS	EXAMPLES
1. Sarcoidal	Characterized by dense, discrete, non-caseating granulomas which are strikingly uniform in shape and size. The granulomatous infiltrate, which may extend into the subcutaneous fat, is composed of epithelioid histocytes and Langhans and multinucleate giant cells with a scanty rim of lymphocytes (hence known as "NAKED *GRANULOMA*"). Plasma cells are usually absent. Discrete, small, central foci of fibrinoid necrosis may be present, but caseation is absent.	Sarcoidosis, Blau's syndrome, Foreign body reactions, Crohn's disease, Secondary syphilis, Orofacial granulomatosis, Systemic lymphomas, Sezary syndrome, herpes zoster scars
2. Tuberculoid	Composed of epithelioid histiocytes, giant cells of Langhans & foreign body type with a sustained rim of lymphocytes & plasma cells, sometimes showing *caseous necrosis*. These granulomas are less circumscribed than sarcoidal granulomas and have a tendency to confluence.	Tuberculosis (TB), Tuberculids, Leprosy, Late syphilis, Leishmaniasis, Rosacea, Idiopathic facial aseptic granuloma, Perioral dermatitis, Crohn's disease
3. Necrobiotic	Poorly formed granulomas with central *necrobiosis (collagenolysis)*. Inflammatory component may be admixed with necrobiosis or form palisade around it.	Granuloma Annulare (GA), Necrobiosis lipoidica, Necrobiotic xanthogranulomas, Rheumatoid nodules, Rheumatic fever nodules, reactions to foreign materials and vaccines
4. Suppurative	Epithelioid histiocytes & multinucleated giant cells with *central collection of neutrophils*. Chronic inflammatory cells present at periphery.	Chromomycosis, Sporotrichosis, Non TB mycobacterial infection, Blastomycosis, Coccididomycosis, Mycetoma, Cat scratch disease, Lymphogranuloma Venereum, Pyoderma gangrenosum
5. Foreign body type	Composed of epitheloid histiocytes, multinucleate giant cells of *FB type* & variable number of inflammatory cells.	Exogenous: silk, nylon, sutures, wood or plant material. Endogenous:rupture of hair follicle or follicular cyst.
6. Xanthogranulomatous	Composed of *histiocytes with foamy/pale cytoplasm* with a variable admixture of other inflammatory cells and some *Touton giant cells*.	Juvenile Xanthogranuloma

PRESENCE OF SECONDARY CHANGES		
1. Caseation	Caseation is seen as a central homogeneous pink-staining zone containing cellular debris surrounded by lymphocytes and histiocytes.	TB, TT Hansen
2. Necrobiosis	"Necrobiosis' refers to areas of altered or degenerated dermal connective tissue, seen as areas of blurring and loss of definition of collagen bundles.	GA, Necrobiosis Lipoidica Actinic Granuloma, CSS, WG, Granuloma Multiforme
3. Suppuration	There is presence of central zone of suppuration characterized by a collection of neutrophils	Fungal, Atypical Mycobacterial infections
4. Fibrinoid	Fibrinoid necrosis is seen as bright, pinkish-red deposits in the center of the necrobiotic focus	Rheumatoid nodule, M. marinum, Nodule of RF
LOCATION		
1. Superficial / mid	Involving superficial or mid dermis	Lupus vulgaris ,TBVC, Lichen scrofulosorum , GA, Actinic Granuloma, TT, Erythrodermic sarcoid
2. Whole	Involving whole dermis	Sarcoidosis, Syphilis, Leishmaniasis, Papulonecrotic Tuberculid
3. Deep/ subcutaneous	Involving deep dermis or subcutaneous tissue	Scrofuloderma, Orificial TB, Vasculitis, Necrobiosis Lipoidica, Fungal, Rheumatoid Nodule, Subcutaneous sarcoid Subcutaneous GA
4. Special	Perifollicular	Rosacea, Lichen Scrofulosorum
	Perineural	Leprosy, Hypopigmented sarcoid
	Peri appendageal	Leprosy
CELL TYPES		
	Langhans type: The nuclei are arranged in a peripheral horseshoe pattern	
	Foreign body type: The nuclei are present in the centre or in haphazard pattern	
	Touton type: There is presence of circumferential wreath of nuclei around a central homogeneous pink cytoplasm and foamy cytoplasm peripheral to the nuclei.	

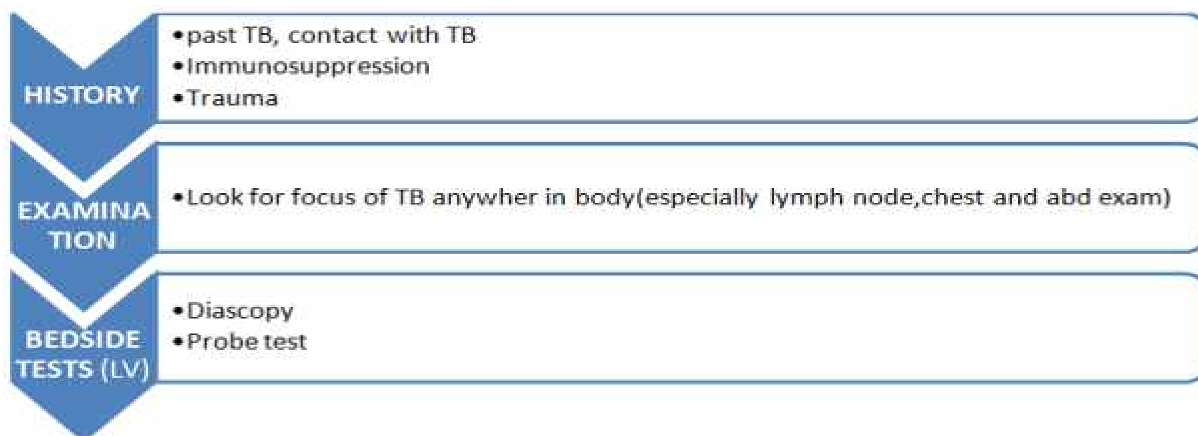
2. Predominant inflammatory cell	LYMPHOCYTE	TB, TT Hansen
	NEUTROPHILS	Fungal, Polyarteritis Nodosa, Wegener's Granulomatoes, Leshmaniasis, Neutrophilic palisading granulomatous dermatitis
	EOSINOPHILS	Chromoblastomycosis, Churg-Strauss
	PLASMA CELL	Syphilis, Leprosy
ETIOLOGY		
1. Infectious	BACTERIAL	Cutaneous T.B., Leprosy, Atypical mycobacteria Tertiary Syphilis, Lymphogranuloma venereum Cat scratch disease
	FUNGAL	Chromoblastomycosis, Blastomycosis, Cryptococosis Coccidioidomycosis, Paracoccidioidomycosis Sporotrichosis, Histoplasmosis, Phaeohyphomycosis, Majocchi's granuloma
	PARASITIC	Leishmaniasis
2. Non- Infectious		Sarcoidosis, Granuloma Annulare, Rheumatoid Nodules, Actinic Granuloma Erythema Nodosum, Necrobiosis Lipoidica Granulomatous Vasculitis, Lupus Miliaris Disseminatus Faciei, Granulomatous Foreign Body Reactions
CELL KINETICS	Granulomas can differ in terms of the relative number of new macrophages entering the granuloma, the rate of destruction of macrophages within the granuloma, and the extent of mitotic activity of the individual participating cells.	
1. LOW TURNOVER	When the insoluble irritant is nontoxic, the macrophage sequesters the ingested material for a long period of time. Macrophages live long, divide infrequently, and have a low rate of replenishment by mononuclear cells from the circulation.	
2. HIGH TURNOVER	Conversely, when the stimulus is toxic, the granulomas are characterized by high levels of cell death, increased recruitment of blood monocytes to replenish the infiltrate, and mitotic division of macrophages within the lesion. Extensive tissue damage with variable fibrosis ensues	

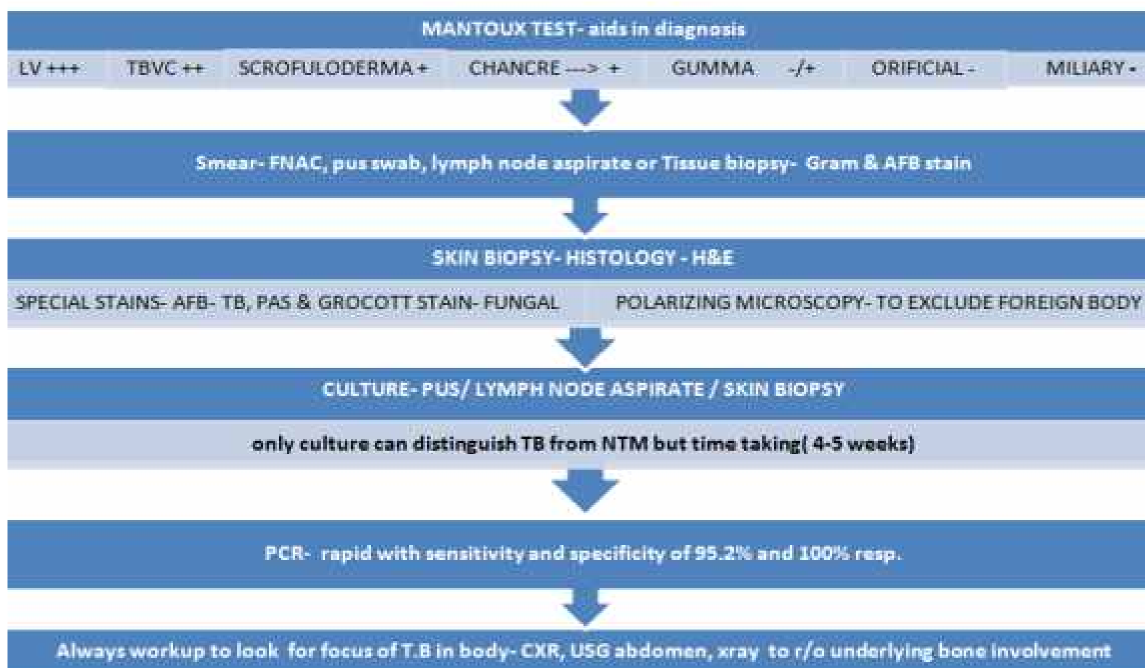
IMPORTANT GRANULOMATOUS CONDITIONS

TUBERCULOSIS

Typical tuberculoid granulomas can be seen in the dermal inflammatory reaction of late primary inoculation tuberculosis, late military tuberculosis, tuberculosis cutis orificialis, tuberculosis verrucosa cutis ('prosector's wart'), scrofuloderma, and lupus vulgaris.

The tuberculids like lichen scrofulosorum there is a superficial inflammatory reaction about hair follicles and sweat ducts which may include tuberculoid granulomas.

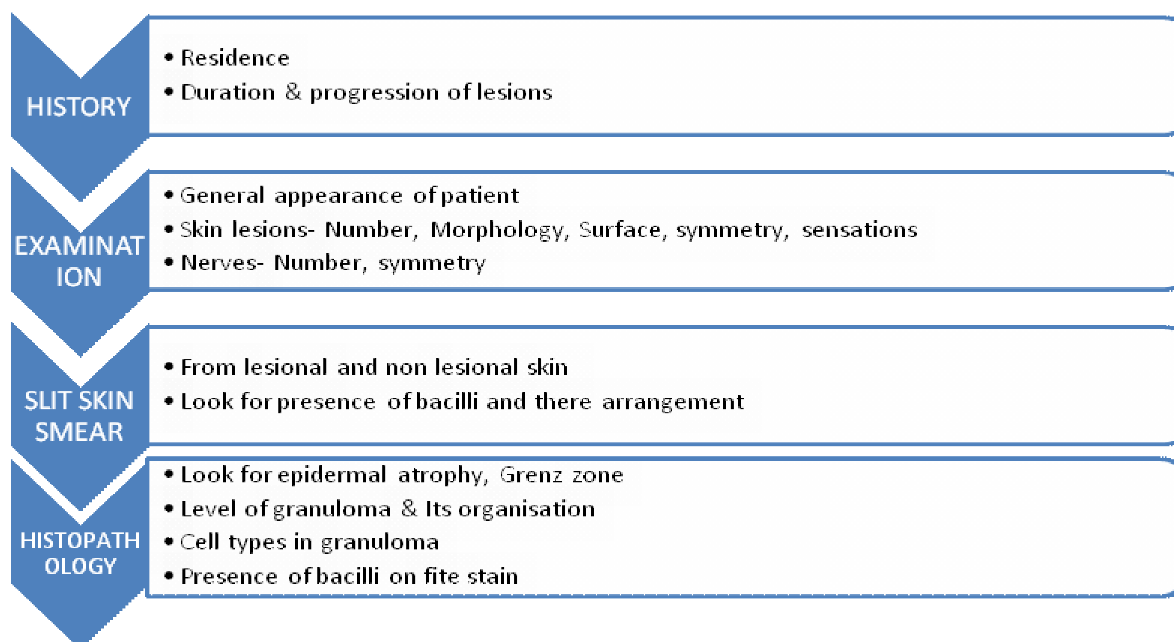




	LV	TBVC	SCROFULODERA	CHANCRE	GUMMA	ORIFICIAL	MILLIARY
MANTOUX	+++	++	+	- to +	-/+	-	-
HISTO-EPIDERMIS	Atrophy/ hyperkeratosis, pepillomatosis	Hyperkeratosis, acanthosis	Ulceration. Abscess formation in centre			ulceration	Centre of papule-microabscess
DERMIS							
GRANULOMA	upper dermis	mid dermis	deep dermis		-	deep dermis	-
CASEATION	Abs./min.	moderate	considerable	++	++		
AFB	-/RARELY	MAY BE + (> LV)	++	decrease with time	+	++	+(except milder cases)
SPECIAL FEATURE		Abscess formation in upper dermis or downward extension of epidermis		Infiltrate early phase- acute neutrophilic after 3-6 wks- EC and GC granuloma			

LEPROSY

Tuberculoid granulomas are seen in the tuberculoid (TT), borderline tuberculoid (BT), and borderline (BB) groups of the classification of leprosy introduced by Ridley and Jopling.



- Unlike LL, tuberculoid Hansen does not spare upper papillary dermis and may extend into and destroy basal layer and part of stratum malphigii
- Granulomas are characteristically arranged in and around neurovascular bundles and arrector pilorum muscles.
- They tend be oval and elongated (along course of nerves and vessels).
- Small cutaneous nerve bundles infiltrated and enlarged by inflammatory cells. There may be destruction of nerves sometimes with caseation necrosis.
- Well formed langhans type giant cells and less formed multinucleate foreign body giant cells.

	TT	BT	BB	BL	LL
Epidermal atrophy	Minimal atrophy	Mild	++	++	+++
Grenz zone	absent	Present			
granuloma	Well organised				Loosely organised
Epithelioid Cells	+++	++	+	few	Nil
Lymphocyte	+++	+	Scanty	++	Scanty
Giant cell	Langhans GC	Foreign body GC	_		
Macrophage	_	_	+	++	Foamy
Plasma cell	_	_	_	+	++
bacilli	Not seen	Usually absent in dermis but few maybe seen in dermal nerves	Present in dermis and dermal nerves	plentiful	Clumps

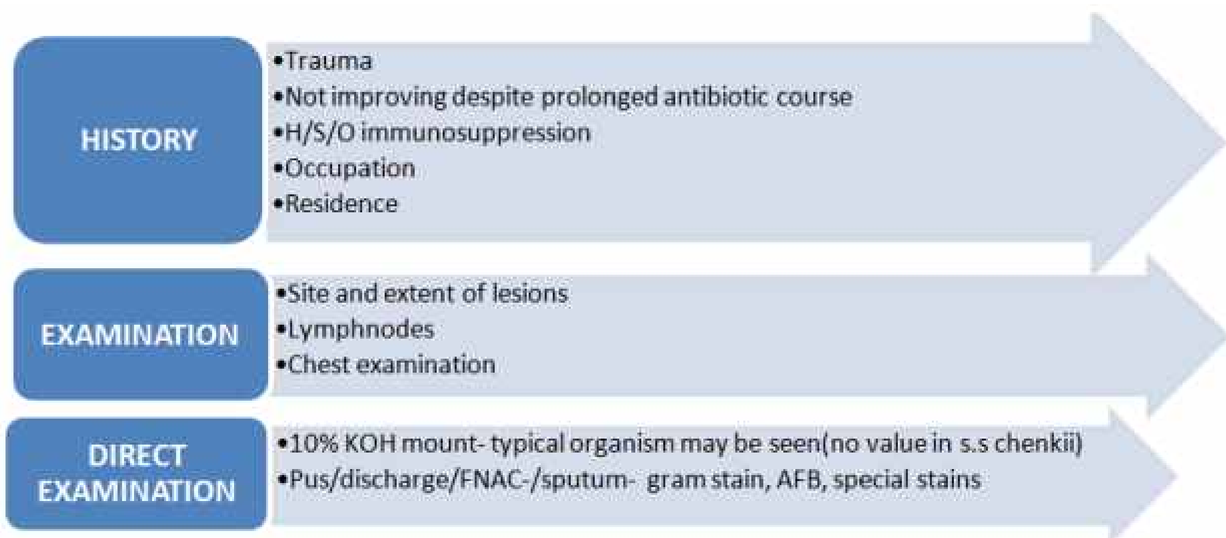
- ➔ Giant cell : TT/BT
- ➔ MACROPHAGE : BL <<< LL
- ➔ EPITHELOID CELLS : BT/TT
- Few: BL
- Absent:LL

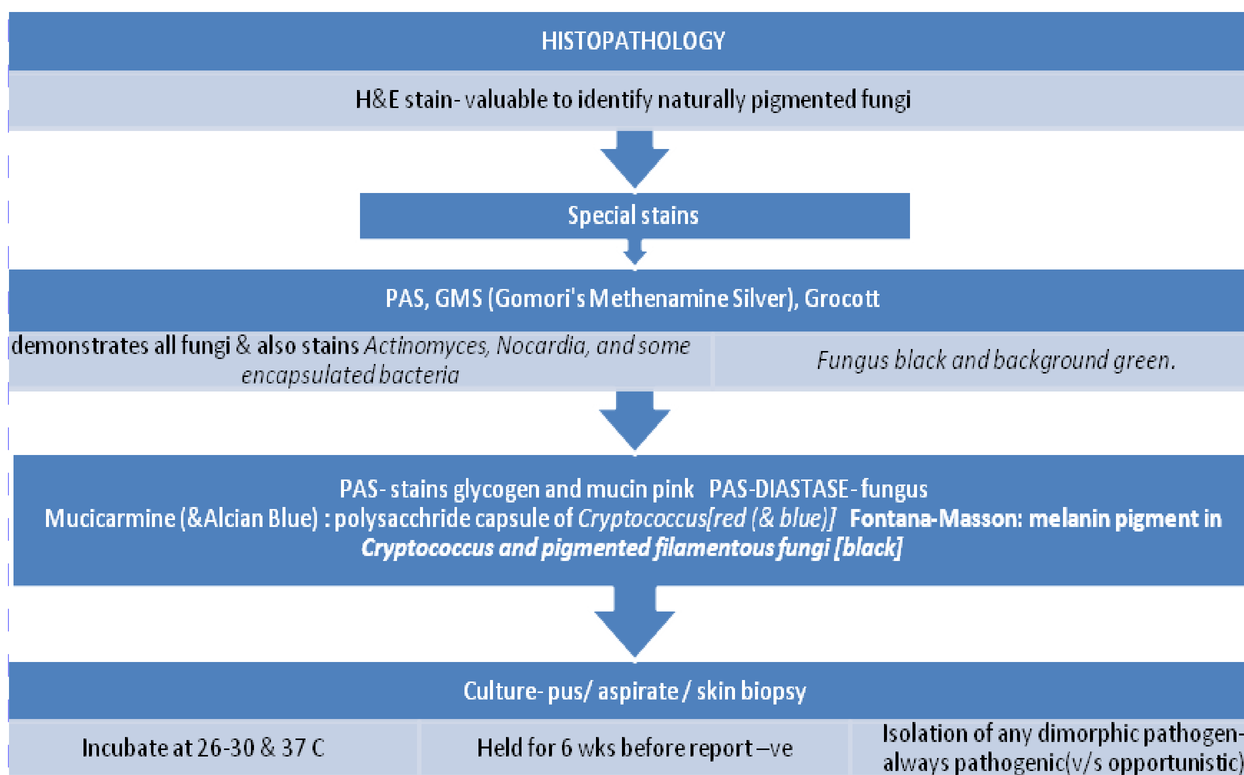
- ➔ PLASMA CELL : BL/LL
- ➔ LYMPHOCYTE : TT/BL
- Few : BT
- Scanty : BB/LL(BB histo cant diff. from sarcoidosis)
- Intraneural inflammation- upper pole
- Perineural inflammation (onion peel app.)- lower pole

SYSTEMIC MYCOSIS

Usually suppurative types of granulomas are found in subcutaneous and deep mycoses. Pseudoepitheliomatous hyperplasia with intraepidermal & dermal microabcess, suppurative granuloma and mixed inflammatory cell infiltrate.

Disease	*Appearance*	*Key Histological Features*
BUDDING YEAST IN TISSUE		
Histoplasmosis (*Histoplasma capsulatum)*	• 2–5 um • narrow-based "tear-drop" budding • surrounded by clear space/pseudocapsule (hence "*Capsulatum")* • predominantly intracellular but usually spill into surrounding tissue, where organisms tend to remain in clusters	
Blastomycosis (*Blastomyces dermatitidis)*	• 8–15 um • broad-based budding • thick double walls ("double contour") • multinucleation • cell walls can be weakly positive for mucin stains	
Cryptococcosis (Cryptococcus neoformans)	• 2–15 um • narrow-based budding • highly variable size &shape(Histo or Blasto- uniform) • Polysaccharide capsule (mucicarmine+, PAS+, AB+), India Ink + Fontana-Masson+; pigment not apparent in H&E).	
Paracoccidioidomycosis/ South American Blastomyces	• 5–30 um (wide size variation is characteristic) • large spherule with multiple peripheral narrow-based buds (although diagnostic, the multiple-budding cells are usually inconspicuous)	
Sporotrichosis (Sporothrix schenckii)	2–6 um • round or elongated "cigar-shaped" budding yeast, rare and difficult to find in tissue • "asteroid bodies" (Splendore-Hoeppli phenomenon) – crystalline structures found extracellularly and representing antigen-antibody complexes, classic for Sporo but not Specific	
NON-BUDDING SPHERICAL FUNGI IN TISSUE		
Coccidioidomycosis (*Coccidioides immitis)*	• thick-walled spherule (50–200 um) packed with endospores (2–5 um) • endospores frequently spill into the surrounding tissue and may resemble *Histoplasma (but these is no budding)*	
Chromoblastomycosis	• 6–12 um Pigmented fungi- stain on H & E • brown (melanin-containing) organisms- Fontana-Masson+ • thick-walled spheres with horizontal and vertical septae ("copper pennies", "medlar bodies", "sclerotic bodies") • overlying pseudoepitheliomatous hyperplasia is typical	
Hyphae in Tissue		
Zygomycosis	• eosinophils • wide (6–50um thick) hyphae with INFREQUENT septae • infrequent right-angle branching • undulating, twisting (ribbon-like), "empty-looking" hyphae • angioinvasive (like *Aspergillus)* • stain weakly with GMS and PAS; organisms best visualized by H&E • Definitive diagnosis requires culture because treated or degenerating *Aspergillus may look like Zygomycetes.*	





SYPHILIS

Some lesions of late secondary syphilis and nodular lesions of tertiary syphilis show a superficial and deep dermal inflammatory reaction in which there are tuberculoid granulomas. Plasma cells are generally but not always prominent in the inflammatory infiltrate and there may be swelling of endothelial cells.

NODULAR TERTIARY SYPHILIS	GUMMATOUS SYPHILIS
Confined to skin	Involves skin, bone & liver
Granulomas small & limited to dermis	Granulomas in dermis and subcutis
Necrosis not conspicuous	with central zone of acellular necrosis
Vessels may show endothelial swelling	Blood vessels throughout dermis and subcutis exhibit endarteritis obliterans with angiocentric plasma cell infiltration

LEISHMANIASIS

In chronic cutaneous leishmaniasis and leishmaniasis recidivans, tuberculoid granulomas are present in the upper and lower dermis. The overlying epidermal changes are variable. Occasionally the granulomas extend to the basal layer of the epidermis as in tuberculoid leprosy. Necrosis is not usually seen in the granulomas. Leishmaniae are usually scarce but may be found in histiocytes or, rarely, free in the dermis.

- Non healing chronic cutaneous leishmaniasis:Lesion of acute cut. Leishmaniasis persists as erythematous plaque of several years duration
- Leishmaniasis recidivans: Appearance of new lesions at centre or periphery of atrophic scar of previous cutaneous Leishmaniasis resembles lupus vulgaris
- Histopath- dense, diffuse or nodular infiltrate of epitheloid cell granulomas within superficial and deep dermis. Necrosis in centre- exceedingly rare. Leishman Donovan bodies absent/very small in no. Recidivans- scar tissue present

SARCOIDOSIS

- Multisystem disease may involve any organ of the body –MC seen in lungs, lymph nodes, skin, liver, spleen and eyes.
- 10%-35% of patients with systemic sarcoidosis have cutaneous lesions.
- Most commonly affects adults, rarely effects children.
- Epidermis – normal/ hyperkeratosis/ hyperplasic (ichthyosiform sarcoidosis)
- Epithelioid granulomas – Well demarcated collections of epitheloid cells, lower dermis, scattered throughout with occur extension to subcutis.
- Granulomas: with little or no necrosis.
- Few multi nucleate giant cells (langhans type)present more in older lesions.
- Small deposits of fibrin seen(ptd Tuberculoid leprosy)
- Inclusion bodies – Schaumann bodies, asteroid bodies, Residual bodies
- Asteroid bodies – star shaped eosinophilic structure, when stained with phospho tungistic acid – hematoxylin produce a center that is brown red radiating blue spikes.
- Schaumann bodies - are round or oval, laminated and calcified esp. at their periphery. Stain dark blue due to calcium.
- Sarcoidosis associated with sparse lymphocytic infiltrate part at margins of epithelioid granuloma.
- Scarcity of lymphocytes – naked granuloma.
- Occasional small foci of fibrin or necrosis showing eosinophilic staining are seen in center of granulomas.
- If granulomas involute – fibrosis extends from periphery towards center, with disappearance of epithelioid cells.
- Sarcoidosis is a diagnosis of exclusion and investigations for presence of foreign bodies and infection are necessary. Polarisation helps identify polarizable foreign bodies such as silicon, calcium, aluminium, potassium and sulphur and others such as tattoo pigment, talcum powder, beryllium, zirconium, acrylic and nylon fibers and cactus.
- Special stains for infective etiology must also be carried out in all cases with sarcoidal granulomas on histological examination and these include Gram, PAS, Grocott, GMS, Giemsa, Zeihl-Neelsen and Wade-Fite stains.

ACKNOWLEDGMENT

We would like to thank Prof. Rashmi Sarkar, Dermatology, Maulana Azad Medical College, New Delhi for thoroughly guiding us in writing the article.

Author
Dr. Varun Khullar
Junior Resident, Dermatology, Rohilkhand Medical College and Hospital

Author
Dr. Pankaj Das
Junior Resident, Dermatology, Armed Forces Medical College, Pune

CONFERENCES OF (OR FOR) RESIDENTS - BOON OR BANE?

Clinical Dermatology, Dematosurgery, Dermatopathology, Cosmetology, Paediatric Dermatology, Pigmentary Disorders, Lasers, Recent advances, Updates etc ...and at these levels - State, National, International; the conferences are too many and designed to suit tastes of different kinds of palate. The question is, how much or how many a resident can attend, for the quest of knowledge and at what cost?

So here we have two budding DERMATOLOGISTS debating on the same....

Physically Attending The Conferences:

Dr Pankaj says: The need of conferences? A platform to share cases and experiences. In the past we did not have effective means of communication apart from post and may be telephone. The IT revolution helped us in two ways. First- We have real time access of practically every query we seek on internet. Valuable database is at our fingertips- starting from basic review articles & case reports to Cochrane: Type it and Get it. The Second advantage: Distant Learning in form of webcasts. We haven't been able to embrace and harness technology in this context. Instead of changing posture from stoop to straight, we have started to walk on all four legs again. Over time, the frequent conglomeration of the 'us kind'; instead of reduction , have only increased in number, the theme ranging in all permutations and combinations creating confusion so as what to attend and what to skip. It is not National Security which cannot be discussed and streamed on media; I mean if the Prime Minister can do a "Chai Pe Charcha" with everyone tuning on to the television, why can't we do it.

Dr. Varun counters : I totally agree with the fact that everything is available on our hands these days..... Whatever we want to know...just type and enter in the search column and THERE IT IS...!!

But I just wish to ask, how many times is that is that the youth of today goes beyond Whatsapp and Facebook..??

How many times we open up a case to study or paper to read unless there is a seminar or paper presentation the next day..??? Whereas, getting to hear about the case or a disease from the

experiences of seniors or stalwarts as to how he/she dealt with it from the diagnosis to the management gives us a different insight altogether and this interaction with seniors is worth it...and this experience and interaction is something we cannot get on our palms.

Availability of the Residents & The Time-Money-Effort Paradigm:

Dr. Pankaj says : From a first year Resident's point of view- (read He/She for He from now on) "He is the workhorse of the Department. He will do Potassium Permanganate compresses, change dressings, take daily vitals of critical patients, monitor whether all drugs are being dispensed and topically applied correctly, fetch investigations and do OPD based procedures. He would not dare ask his seniors or faculty whether to attend a conference, because "He is too immature in the speciality." From the perspective of a third year resident- Time is the most valuable commodity, he is mourning on time- killed in the first two years, with the feeling of junior residents knowing better than him, with constant concerned voices from the faculty- "Don't tell me, you don't know this?" He is trying to meet deadlines of the dissertation, reading the books at least once before the exam, and staring into an uncertain future- the practice after PG. That leaves the most sought after guys for conferences- the Second year residents. Yeah they for sure can find time; the department won't mind their absence either. But there are other things. They have to register, book tickets, find a place to stay, all to attend the conference physically. Then what does he find? There are sessions to choose from, if there are four halls where sessions are going on simultaneously, even if he maintains his presence throughout the day, in effect only attends one-fourth of it. So he reaches out to the scientific session's leaflet given at the reception to let his wisdom decide- to drop three simultaneous sessions and choose one. That's not all. The conference provides enough distractions to choose from and indulge in it. The pharmaceutical companies, in order to lure the delegates, are generous to generate enough glitter, the rest is self-explanatory. So, all this money, time, effort and carbon foot print, to attend a conference physically but not able to make the best of it. My question is- Why not get the speakers onto the Interactive Webcast, and stream it Live? We can listen and learn from the comforts of our home, saving on the time, money and effort we invest to physically attend the conference. That's not all, in fact the greatest advantage is- with the concurrence of the speakers and organizers, if the contents of the scientific program can be archived on a website, looking at the sheer number of conferences- imagine the volume and diverse academic resource material we would generate, which can be readily accessible anytime, anywhere, which would be of immense value to not only residents, but also everyone. Sure it's a smart way of learning, than hurriedly taking notes or clicking pictures of the slides in the conference. Ever thought of, where do our registration fee, which we pay for the conference registration, end up? I have been a part of organizing teams for organizing conferences. The major chunk goes in for catering, hiring of venues, decoration, setting up stalls, organizing 'gala evenings' for the attendees and travel & stay of the speakers. The actual scientific session does not demand much in terms of capital, to be fair. So why pay for the pomp and show, when the primary aim of attending was to gain knowledge and skills? So, looking at the added amount of the money spent in travel, stay and the registration fees, I would rather spend the same money in subscribing few of the good journals for a year, which feeds me with the recent advances and updated guidelines.

Dr. Varun responds: A nice initiative which can be taken in times to come....in the form of live webcasts, but in order to carry out a webcast it too would involve time and money and it would be for a group of colleges and their residents in the vicinity. In a webcast there can be maximum of 2-3 more learned people and how many times in a year can someone afford this..??? Whereas in conferences you get to meet so many people of whom you have heard success stories

of, who are willing to share their experiences of difficult cases and their day to day practice. Meeting them in person, learning and seeking blessings from them is a different experience altogether. As far as the affordability of the conferences go - big PHARMA companies who lure us all provide options to make it really feasible to attend the conferences. And inside every resident there is a fun story to tell how he/she arranged everything through a big company.!!

Workshops in the conferences:

Dr. Pankaj says: The conferences have the advantage of holding workshops, as a 'hands on training experience' for the participants, to get an 'actual feel of the procedure'. Well, to that I would say- A good interactive webcast too, would do the trick. Dermatosurgery or Cosmetology is no rocket science, it can be learnt on the mass media too. Nevertheless, I agree to the fact that the learning curve would vary from procedure to procedure, but nothing can be just learnt, either in the workshops or in the mass media, until unless the stakeholder starts doing the procedure him/herself and learning the tricks of the trade while doing it.

Dr. Varun says: We all have books and that's something which hasn't left us since we took medicine 10 long years back and when we get a chance to go beyond books and learn something new.... Something which isn't taught in our daily routines in colleges... Something we aren't used to in our daily lives....

Every college has their own protocols and a student goes through a lot from making department registers as first years and studying like hell in final year as sir u already said earlier....does he/she not deserve an outing once in a while??

Let's just keep it as a knowledge filled vacation where we can also look it from a different prospective that rather than labeling as what all we are wasting why can't we see It as what we are gaining.

How to present a paper and learn the art....

How to make a poster and answer queries of the examiner on certain interesting cases...

How to develop the confidence of arranging a conference...

How to slowly from being a student to learn the traits from the mentor themselves to be like them one day....

To learn Epidemiological discrepancies in skin diseases due to different environmental factors.

To gather Medico-legal advices from seniors in private practice to handle things in future

Most importantly we all have to settle down and to learn how to initiate or establish your hospital/ clinic amongst well known dermatologists and to learn the Marketing policy is something not college will teach us...!!

Residents organizing conferences:

Dr. Pankaj says: I hope the Residents would strike a chord with me, who have been a part of organizing a conference, how difficult it is, considering the time and effort it takes to do so. The team consisting of Faculty and the Residents- no matter how early you begin to foresee, plan, prepare and enforce, hell eventually does break loose in the end. No matter how much do we deny, it takes a toll on the routine functioning of the Department and on the academics too. Yes, it

does bring us valuable experience in terms of gaining our organizing prowess, but at what cost? If it works out to be your Institution's turn to organize a conference when you are in the fag end of your residency, God be with you.

Dr. Varun says : Every good thing takes time and patience but rather than measuring what it brings to us and at what cost, we should cherish what we learnt and how much it taught us....and isn't it a matter of pride that you were in the organizing committee.?? That feeling is bliss I feel....people come to you for queries and you for a change answer them...you give a helping hand in the making of better Dermatologists in times to come.... Holding the position of quizmasters and being in the other side of the table is a different experience altogether....well only those who really have been a part of arranging or organizing the conference would be knowing the difference and will have many memories to cherish..!!!!

Points to ponder:

Dr. Pankaj : So, for us residents, there is a myriad of conferences to choose from, week after week, month after month, and theme after theme. How many conferences can we attend in our residency of three years and how much can we learn by and at what stake, when most of the resource is available in the print and internet, when the sought after person for a query or advice is a call or a mail away.

Dr. Varun: Where as I see what we all residents should focus on is the quality of conference rather than quantity...we shouldn't hurry and pack our bags for every conference. There are always pre schedules available so we can decide what's good for us and what will be a waste of time and energy. As far as the source of knowledge is to be considered- live experiences and new things in our field should always be preferred over textbook knowledge. At times when we are stuck in an examination on newer advancements...we just might thank our stars that it was available in one of the conferences! That actually happened with me!! And from a first year to a senior resident it's a long journey so we should never forget the reunions...we all like them after all..!!

Dr. Anupam

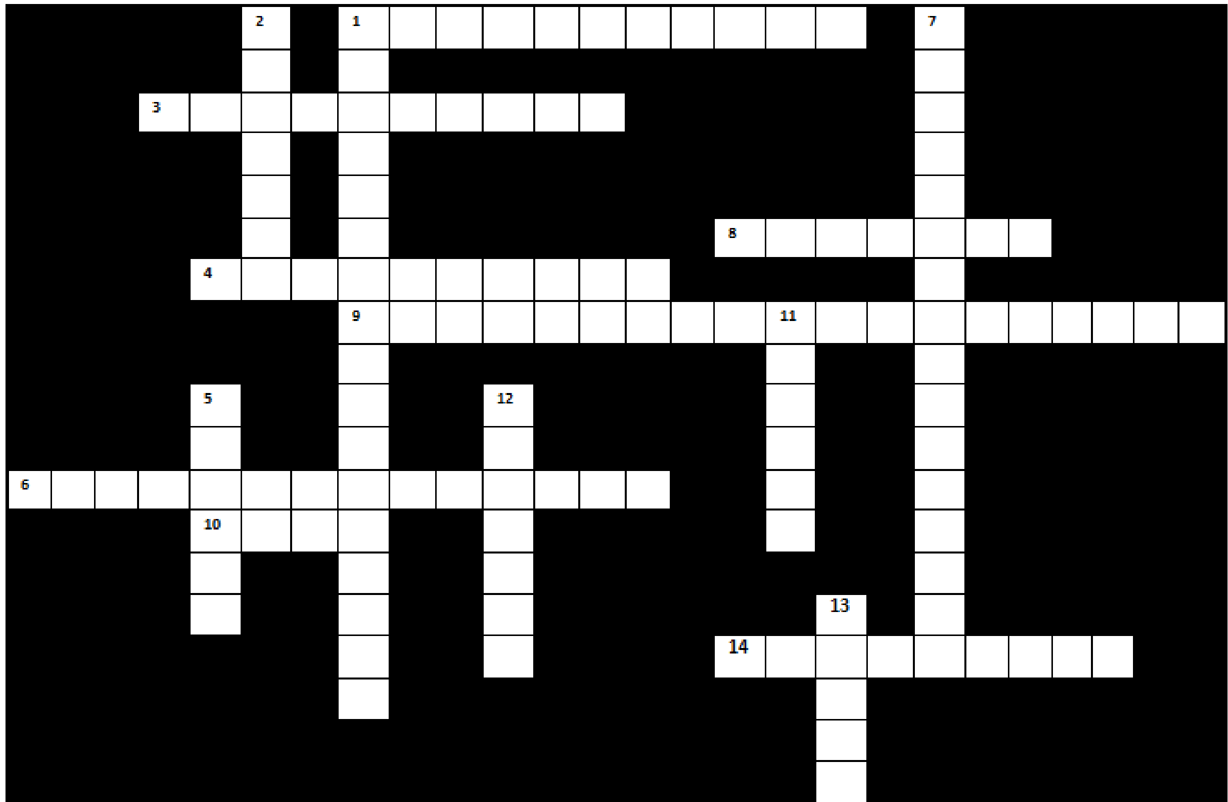
ORDER ORDER!! Get back to your books. Enough of hungama now. Be choosy and stay focused. Don't attend conferences just for the sake of attending and running away for sight-seeing, dancing at the gala night and doing what not!. If at all you get the chance, attend the sessions, try to learn, jot down the "take home messages" and share with your colleagues. Of course, there are a lot of "interesting" things to do in the conference as well..shall not discuss here!

Dermcross 2

Authors

Dr. Priyankar Misra
Junior Resident, Dermatology, Burdwan Medical College and Hospital

Dr. Somodyuti Chandra
Junior Resident, Dermatology, Medical College and Hospital, Kolkata



Down

1. A syndrome characterised by organomegaly, abdominal wall defects, neonatal onset hypoglycaemia, macroglossia and facial PWS.
2. The characteristic cell found in hereditary benign intraepithelial dyskeratosis on Tzanck smear characterised by rounded epithelial cells with yellow-orange-brown cytoplasm.
5. A rare X-linked lymphoproliferative disorder having haemophagocyticlymphohistiocytosis, fulminant infectious mononucleosis, lymphoma and hypogammaglobulinemia.
7. A 15-year-old girl presenting with poikilodermatous lesions over sun-exposed areas, sparse hair over scalp, eyebrow and eyelashes and osteosarcoma of tibia has which disorder?
11. An inherited disorder characterised by ichthyosis, retinitis pigmentosa, peripheral neuropathy, cerebellar ataxia and nerve deafness.
12. Mutilating PPK with peri-orificial keratotic plaques are distinctive features of this disorder.
13. Delusional parasitosis.

Across

1. FDA approved topical platelet-derived growth factor for the treatment of diabetic foot ulcer.
3. An anti-retroviral drug used in HAART that acts as a booster without itself having any anti-HIV activity.
5. A rare non-LCH histiocytosis characterised by progressive eruption of yellow-brown papules around eyes, axillae, antecubital and popliteal fossae with involvement of mucous membranes, CNS and bones.
6. Episodic painful bruising in middle aged women possibly due to auto-erythrocyte sensitisation.
8. Syphilitic chancre occurring in a cutaneous lesion of scabies is also known by this name.
9. A severe variant of dyskeratosiscongenita characterised by intrauterine growth retardation, microcephaly, cerebellar hypoplasia, progressive combined immunodeficiency and aplastic anaemia.
10. An autosomal dominant disorder with guttate hypopigmentation and punctate keratosis of palms and soles.
14. Large sized nail pits.

HOW TO PREPARE FOR A DERMATOLOGY QUIZ

Author
Dr. Biju Vasudevan,
Associate Professor,
Dermatology,
Base Hospital, Barrackpore.

Dr. Debdeep Mitra
Assistant Professor,
Dermatology,
Base Hospital, Delhi Cantt.

Quiz literally means a test of knowledge, especially as a competition between individuals or teams as a form of entertainment. However in this competitive world of Dermatology, Quiz is more than just entertainment and it is truly one of the most anticipated events in several national and state conferences. It attempts to test the intellectual abilities of the students in various fields of dermatology such as history of skin diseases, clinical dermatology, dermatopathology, venereology, leprosy, dermatosurgery and cosmetology to name a few.

Quiz has become an integral academic part in postgraduate training of Dermatology residents and an important benchmark in assessing the level of training imparted across several Dermatology post graduate centres in this country. Quizzes now-a-days are fiercely fought, as the winners bring not only good name to themselves but also laurels to the institution they belong to. Participating in quiz helps the postgraduate students in preparing for their exams, and also helps them to remember and recall interesting facts about various disorders and improve their clinical judgment.

The students that are equipped with enormous "stock knowledge," are tipped to pull through from a tough field composed of the brightest and smartest competitors. But in order to amass ample stock knowledge an aspirant must be able to come up with a comprehensive preparation and must be armed with techniques, strategies and right character. There is nothing to lose in preparing for any Dermatology quiz as the knowledge acquired during the preparation goes a long way in helping students prepare for their academic endeavors and also in their clinical practice in the years to come.

Dermatology is a visual specialty and many a times, diagnosis can be made by visual impression, remembering patterns, and recalling previous similar patients seen by self or even by others and discussed with the help of images. Quizzing helps in doing so by aiding memory recall of interesting facts about diseases in an interesting manner and utilizing the knowledge in clinical practice. The interest generated in a quiz environment ensures that students are more eager to learn the nuances of the specialty.

Quiz competitions are organized regularly in national and state Dermatology conferences. These days several Dermatology sub-specialties like Dermato-pathology, Dermato-surgery, Pigmentary, Skin and allied specialities, Hair and nail subspecialties also hold individual quizzes. Dermatology quiz gives an impetus to the postgraduate students to learn and understand this specialty in an interactive manner.

Few important aspects involved in preparation for a dermatology quiz are:

Knowledge of syllabus and resources- The syllabus and the resource material is the basic cornerstone in starting any preparation for a quiz. Standard text-books in dermatology need to be studied focusing on aspects which include salient features and trivia knowledge. In this age of technology, internet provides information not only about the latest and upcoming developments in the field of dermatology, but also highlights the long journey this subject has travelled across generations. The important resources available are Dermatology textbooks, Journal articles including the resident's page and review articles of important journals.

a) Few standard textbooks are:

- Rook's Textbook of Dermatology
- Fitzpatrick's Dermatology in General Medicine
- IAL Textbook of Leprosy
- Sexually Transmitted Diseases book by King & Holmes
- Lever's Histopathology of the Skin
- IADVL textbook of Dermatology

b) Internet resources

- Website of the group hosting the quiz : the website can at times give a clue about the past quizzes and the level of questions asked.
- Online discussion groups : There are many online discussion groups including acad_iadvl where one can be a member and learn about interesting as well as complicated cases with their clinicopathological correlations. Special interest groups of IADVL from time to time publish several important articles worth considering.
- Social media : Social media has opened new realms in learning where likeminded people can get together, discuss the subject of dermatology, and learn interesting aspects. Facebook pages are examples of such learning.
- Whataspp groups- These groups have opened up a plethora of opportunities by discussing various academic topics and the biggest advantage is the fast responses which one can get to queries.

c) Institute question bank- Every institute needs to formulate its own question bank and the faculty needs to encourage the students for active discussions and frequent presentations on Dermatology quizzes.

d) Dermatology conferences- These conferences are a treasure trove of learning where students not only can attend the quiz sessions but also learn about the latest trends in various fields of dermatology.

Knowledge of rounds which are are generally part of a standard Dermatology Quiz:

- History : Stalwarts in the field of Dermatology need to be studied. Important discoveries and milestones need to be covered in the preparation. It is important to address the history of the organization which is conducting the quiz.
- Clinical Dermatology: Dermatology is primarily a visual specialty and clinical correlation depends on the saying that 'The eyes see only what the mind knows'. Preparing for clinical Dermatology requires a thorough study of Dermatology text books and a regular clinical orientation of Dermatology cases.
- Leprosy: This round has questions ranging from history of Hansen's disease to recent advances.
- Sexually transmitted diseases : This round deals form age old diseases like syphilis to the modern enigma of HIV.
- Dermatopathology : This is the cornerstone of dermatological diagnosis and is one of the most important aspects of dermatology that every postgraduate should have a detailed knowledge about. Visual imagery is most important here along with detailed knowledge of various histopathological terminologies.
- Aesthetic Dermatology and LASER's: This is the new buzz word and the 'flavor of the season' as far as dermatology is concerned. This field is brimming with newer technology and is evolving at a very fast pace. Keeping abreast with the recent developments is a challenge in itself but is mandatory to successfully navigate this round.
- Rapid fire : In a standard quiz a quiz master always tries to balance the questions in this round, i.e. questions on a similar subject will be asked to all the teams. Teams need to aware of the questions expected in this round based on the pattern of the questions asked to the other teams. Team member coordination and time management is the key in this crucial scoring round.
- There may be specific rounds depending on the main topic around which the quiz revolves like: Pigmentary disorders, Connective tissue disorders, Genetic disorders, Hai & Nail disorders and so on.

Knowledge of format of rounds:

It is equally important to know the format of the quiz rounds. Following are the common formats:

a) 8 rounds with 4 teams in finals. First 4 rounds go clockwise with sequence being: Round 1 starts with Team A, Round 2 with Team B, Round 3 with Team C & Round 4 with Team D. The next 4 rounds are the reversed from Team D to Team A in an anti-clockwise manner.

b) Infinite rebound- Here the team next to the one which answers the correct answer is asked the next question. This reduces bias in case a strong team is stuck between 2 weak teams or vice versa and gives equal opportunity to score marks.

c) Buzzer rounds may be present and the team which presses the buzzer first gets to answer. Here hand eye co-ordination and quick mind and body reflexes are equally important as knowledge.

d) Various other formats like visual connect, verbal connect, audio clues can also be used.

Quiz is like an exam and requires strategy for preparation as it is difficult for anyone to read the entire depth and breadth of a subject. One should first know one's weaknesses and strengths and concentrate on improving them. Few important things to remember here are:

a) It is important to know the level and the past standard of questions asked in a particular quiz.

b) Quizzing is like a team sport where contribution from both partners is important for success. It is important to have good communication with your partner and one should decide beforehand as to who is going to answer as it can result in confusion and one can lose precious marks.

c) Quiz is generally multistep which includes a preliminary round and a final round. Different strategies are required for both the rounds. The preliminary round generally has multiple choice questions and favors those who are better at remembering difficult facts, while the mains is more likely to be helpful to those who have good visual recall and presence of mind. A successful team is prepared for both and the partners should complement each other in different rounds.

d) The main quiz is conducted on stage in the presence of a learned audience and it is very important to maintain composure and presence of mind. In contrast to the preliminary round, there are no negative marks for attempting wrongly and unanswered questions are passed to the next team. It is important to make intelligent guesses as one can get precious marks by doing so. However, there is a tendency of some students to attempt more questions in the preliminary round and end up accumulating negative marks, and not answering in the main quiz for fear of being ridiculed if a wrong answer is given. This tendency is to be curbed to enjoy success.

e) To qualify in the preliminary round is the first step and one should resist the temptation of attempting more questions by guessing, as most of the quiz formats have negative marking and one can lose a large number of marks because of wrongly attempted questions.

f) A successful quiz team highlights the efforts put across not only by the participants, but also by the college faculty and other students in the institute. Regular quiz discussions and forming an institute quiz bank is of prime importance in making a successful college team.

Quiz not only encourages academic discussion but also highlights the importance of team spirit, allegiance to one's own college and a sense of triumph over fellow colleagues. Quiz has the dual benefit of learning a subject while keeping the interest alive. It is not a difficult arena and with interest in the subject and guidance, one can achieve good results. Dermatology is a subject specially suited for quizzing as it is mainly dependent on visual pattern recognition, and quizzing provides a good platform for the postgraduate students to improve their knowledge in this wonderful and growing specialty.

EXPERIENCE WITH FACIAL AESTHETICS

Author
Dr. Ishad Aggarwal
Consultant Dermatologist
Kolkata

Almost three years post MD exams , while at times I still relive the cherished moments of my PG life in my thoughts , life does seem a little settled. If you are one of those sorted ones who are very sure about what they want to do and how they want to shape their careers by the time you finish your MD , well nothing can be better. But for the likes of me who once contemplated becoming a news reader at one point of time in life , the confusions hardly ever end. On the flip side we might take some time before we realise our true passion, but the silver lining is that once we are there , there is no turning back.

Life after MD exams is no bed of roses. It took me a while to figure it out , but my true calling came after having dabbled with the microscope (the mad scientist), the Laser beam (Veritable Laserman superhero fantasy), genetics, paediatric Dermatology, Dermatosurgery and even STD for that matter. But it was at a conference when I saw magic happening that I realised that this is what I want to do for the rest of my life. Facial aesthetics and contouring is one of the younger children of Dermatology and is my chosen field of interest.

Just like most subsets in Dermatology, this is a branch that's still evolving and on fringes overlaps with Dermatosurgery, Laser, Pigmentary medicine etc however botulinum toxin , hyaluronic acid fillers, threads and skin tightening devices remain at the very core of it.

There are however challenges as aspiring facial aesthetician faces. The biggest probably comes from a etched sense of resistance one faces from their teacher. Some old school teacher would go to an extreme comparing you to a beautician . Well with all due respect to everybody's view point all I have to say is that aesthetics is a science and needs through understanding of facial anatomy and it does involve a learning curve. Just remain committed to your craft , smile at the jeers and continue on your path because only you get to decide what you want to do in your life .

The second biggest challenge would be to start somewhere. Given that in most colleges, exposure to aesthetics is very limited , it is essential to start somewhere. There are many options. Fortunately IADVL is a supporting organisation and there are many courses one can avail benefit of through them. Working at a corporate skin clinic initially gives much needed financial respite and also helps to groom oneself and lay foundations for a successful career in cosmetic Dermatology. Attending various workshops in conferences helps and opens mind to possibilities. Whatever way one decides, it's important to realise that there are no short cuts. Even though Dermatology is an end branch, one has to be willing to devote considerable time in learning aesthetics post MD

What makes Facial aesthetics different

is the fact that it goes beyond just procedure performance. It inculcates highest standard of patient care, counselling, expectation alignment, personal grooming and presentation. Some of these aspects are new to most of us because they are not generally stressed upon during our medical journey. No where else is a good deal of interpersonal rapport building more important than it is in cosmetic Dermatology. One should be willing to shed that garb of a stern doctor and embrace a more pleasing demeanour and get attuned with latest trends outside the purview of medical science. Having said that, one has to be constantly aware that he or she is a doctor at end of the day. The balancing act is tedious but in time you get there.

Facial aesthetics is an art. If you have an appreciation of finer details , nuances and beauty , it may just be the thing for you. However as the adage goes , don't judge the book by its cover, don't be fooled by the glamour and money that's usually associated with it. Don't let that be the primary reason for choosing it. The glamour and money are by products , true reward is change that you can bring in someone's life. At heart of it lies knowledge of skin. It's easy to be a mechanical injector , but true craft lies in assessing each face and giving a treatment that enhances it. Give yourself time , take criticism positively , listen to your patients and their needs and expectations, stress on taking a medical history , be diligent about consent forms and photography and keep updating your skills.

Like any journey , there are failures. Like any procedure , there are complications. There are sleepless nights when idiosyncrasy wrecks havoc. There are days when one is over zealous. It's easy to give up when such a day arrives. But I certainly believe that every complication is a lesson learnt. It is prudent to go slow to limit these complications , yet when they occur and you manage them well, you do emerge a better care giver. Having a strong peer network really helps and one should never be shy of accepting failure and asking for help from seniors and friends.

Fillers and botulinum toxin sound very exotic. There is a tinge of sophisticated eliticism that they come with. And it's easier to get lost in the rat race for a numbers game. Grapevine is always replete with who is injecting how much and since finance gurus have infiltrated medical profession, data and numbers are always thrown at us. But prudence dictates that less is more in aesthetics and well rat race is for rats anyways!

A career in facial is fulfilling if you have an adaptability to a different working atmosphere than a freshly passed out medical post graduate is used to. As a facial sculptor and aesthetician, when you do bring about a positive change on someone's appearance , it does transform into a better quality of life for them and that's your signature and like every masterpiece , it's hidden beneath the layers.

As Rumi has said " Inside you there's an artist you don't know about... say yes quickly, if you know, if you've known it from before the beginning of the universe".

Trip Down The Memory Lane....

I am privileged to have been a part of team Residream. It was great to interact with the associated faculty and fellow residents, learning from each other and to contribute something. It's an opportunity and platform for the residents to share their thoughts and ideas. For the Residents, who take the baton from here on, I am sure the Residream would soar and touch new heights. I am honoured to have been part of the esteemed team. Thank you for providing me the opportunity.

Pankaj

"A learning extravaganza" is what I will describe in short my journey at Residerm as.

Being on the team was a dream come true and from designing the cover page to writing the final debate it was a journey well travelled. It gave me so much to cherish in a small span of time and today as I bid goodbye I want to just say a simple sentence to the upcoming team " JUST BE YOU"....and do your best to make ur teachers and team proud and they have bestowed their trust on u..!!

SPECIAL thanks to respected Shyamanta Baruah Sir, Rashmi Sarkar Mam and our dear Anupam Sir for giving me this opportunity to be a part of this amazing team. Good luck to all. Long live Residerm..!

Varun

Someone once said - “Take the journey even if it means alone”, but after being a part of this amazing team which launched 3 Residream issues over the past one year, I can confidently say that some journeys are only successful and fulfilling when taken collectively. Residream has been one such experience.

A bunch of residents from across the country coming together, bringing a plethora of ideas and abundance of energy, all channeled under the able guidance of Dr. Rashmi Sarkar who ensured that the dreams in the eyes got translated into meaningful, relevant and insightful words on an issue.

Personally this has been a very gratifying journey and I hope that we have been able to uphold the high standards set by our seniors and wish the coming batch the best of luck as we pass on the baton to the next bunch of Residream-ers.

Akshi

'Coming together was beginning, keeping together was progress and working together was success.'

Resident Dream provided me the platform to network, learn through each other's experience and build confidence by sharing thoughts and ideas. The journey has indeed been beautiful, memorable and enriching. I fall short of words to express my gratitude to Shyamanta sir, Rashmi ma'am and of course Anupam da who had given me this golden opportunity and without whose inspiration, guidance and encouragement this would not have been possible. I convey my best wishes to the new upcoming team.

Somodyuti

"Learning gives creativity, Creativity leads to thinking, Thinking provides knowledge, Knowledge makes you great." – Dr. A. P. J Abdul Kalam

It has been a great learning experience working for Resident DREAM. The journey of the past year has indeed been a fruitful one gathering knowledge, getting to know great people from different corners of the country, through this common platform. I am overwhelmingly grateful to the Honorary Secretary General IADVL, Dr. Shyamanta Barua Sir, for honouring me with this opportunity.

Finally, I would liketo offer my heartiest congratulations to the incoming team and look forward to their endeavours and wish them all the very best to take Resident DREAM to newer heights.

Seujee

At the outset, I would like to thank our respected Seniors Dr. Rashmi Sarkar and Dr. Shyamanta Barua for giving me the opportunity to be a part of team Residream. Residream is a amazing platform for learning and exchanging knowledge with our colleagues. It was an honour to be a member of editorial board of Residream and I had a great learning experience. Writing for residream makes us feel proud and boosts our confidence. I would suggest all the budding residents to contribute overwhelmingly and participate actively for the same. I would like to congratulate and thank the team Residream. All the best to upcoming Residream team. Let the legacy continue.

Avtar

Publishing House : **CHROMATICS**

6A, Hazra Road, Kolkata -700026, **Contact :** 9830215781 / 9830612478 **e-mail :** chromatic.js@gmail.com