VOLUME 7 ISSUE 2 FEBRUARY 2021

Residream

DERMATOLOGY RESIDENTS EDUCATION AND MOTIVATION BULLETIN

...of the residents, by the residents, for the residents

CONTENTS

Cover Page Insight

Inspire your Skin Confidence

Your appearance doesn't define you.

And they thought beauty was the outward show? But we always knew the truth- it's always about the inner fire. You're beautiful just the way you are. Shine on.
And dare anyone to turn off the lights. Let your confidence speak like an armour for yourself.
Stay beautiful inside-out.

Dr. Kinnor Das
Senior Resident
Silchar Medical College and Hospital, Silchar, Assam

EDITORIAL

Dr. Shanthy Devadasan
Editor-in-chief, Residream
Convenor, IADVL National Resident Connect Committee 2020

Dear residents,

I am extremely honoured to be releasing the Volume 7 Issue 2 of Residream. This will be my last issue as the Editor-in-chief and also as the convenor of the IADVL National Resident Connect Committee and I must express my sincere thanks to Dr. Kiran Godse, Dr. Feroz K and the rest of the IADVL EC for their constant guidance and support. Special thanks to our advisor, Dr. Preethi Nayak who was always available to help no matter how small or big the issue. The dedication and hard work of my editorial team of Dr. Dharini, Dr. Kinnor, Dr. Satarupa, Dr. Shreya and Dr. Soumya have to be acknowledged multifold as they are the reason why you have this issue on your screens right now.

The cover page “inspire your skin confidence” by our very talented editorial team member, Dr. Kinnor Das sets a positive tone for the issue which begins with the 2020 report of the myriad activities conducted by the IADVL National resident connect committee and the various state resident committees followed by an engrossing interview with a dermatology pioneer, Dr. D.G. Saple.

Congenital syphilis is quite well explained with ready reckoner tables in the Derma notes section and there is a new addition of ‘In a nutshell’ section providing a brief summary of long topics as well as interesting tidbits such as “corona” in dermatology and plants and microbes in dermatology. Dr. Shreya Poddar and Dr. Sinu Rose Mathachan inspire us by describing their experiences with winning scholarships during their residency.

Dr. Anupam Das gets into the nitty-gritty of poster presentation and gives us many valuable tips on the same. You can then work those grey cells with our brainteasers and revel in the talents of our residents in the 'talent hub' section.

This issue brings with it a very important topic which is also close to my heart – 'Resident burnout: a parallel pandemic' written excellently by Dr. Satarupa Kumar. Burnout is real and we need to openly talk about it and find solutions to the same. I hope all of you will read this piece and introspect about how to make your department a better workplace and extend support to juniors and colleagues. Remember, we can only provide the best care to our patients when we have done the same for ourselves.

Take care all!

Signing off with much love and gratitude,

- Dr. Shanthy Devadasan

Message from the IADVL National President 2021

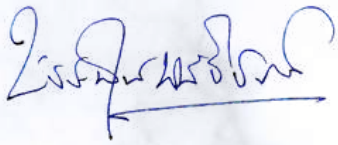
Dear Members of NRCC and Residents,

I am happy to note that your dreams are being given wings through RESIDREAM. The year annus horribilis is behind us. In face of adversity we have done very well to connect all residents and keep connected. The various activities speak for themselves about the dedication and enthusiasm of all of you.

I am sure the new year under the new team and a new president, that's me, will be more fruitful. I assure you my complete support and encouragement in all activities that you plan for future.

You all have done well, you will all do well and we will be there to help you do well.

Best wishes for a wonderful time ahead.



DR. JAYADEV BETKERUR
President, National IADVL 2021
Professor of Dermatology, JSS Medical College and Hospital, Mysuru

Parting Message from the IADVL National President 2020

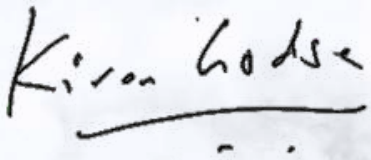
I am happy to note that the IADVL National Resident Connect Committee is coming out with another edition of RESIDREAM in my presidential year, which was indeed a very challenging year following the global pandemic.

I am indeed overwhelmed to see various activities being done under Resident Connect, the future potential leaders and academicians of IADVL , in spite many challenges like COVID 19 Pandemic , Lockdown etc. Congratulations to all the post graduates, on COVID duty since many months and for the dedication and service to humanity, in difficult times. I also congratulate all the winners of various competitions held as a part of observing Eczema day, Urticaria day and Psoriasis Day.

My sincere thanks and appreciations to the enthusiasm and hard work by the team Resident Connect under Dr. Shanthy Devadasan under the able guidance of our Secretary General, Dr. Feroz K. and Advisor, Dr. Preethi Nayak and the entire team of Resident Connect. On behalf of the IADVL National Executive 2020 and personally, I wish all the best to IADVL National Resident Connect Committee Team.

Stay safe and Take care

Long live IADVL
Regards,



DR. KIRAN GODSE MD, PhD, FRCP(Glasg.)
President, National IADVL 2020
Professor of Dermatology, D Y Patil University School of Medicine, Navi Mumbai

Message from the Honorary Secretary General

It is a matter of great pleasure that the Indian Association of Dermatologists Venereologists & Leprologists (IADVL) National Resident Connect Committee is coming out with the second edition of RESIDREAM this year. This was in fact a difficult year affecting all of us in one way or other in view of the pandemic, but we are successfully learning to create the situations into opportunities.

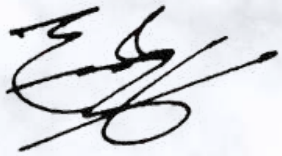
I appreciate the efforts taken by the office bearers and extend my congratulations to all members of the IADVL National Resident Connect Committee, especially the Convener, Dr. Shanthy Devadasan and the entire team of National Resident Connect Committee and the Advisor Dr. Preethi Nayak for their meticulous efforts . It was my privilege and honour to be part of this team as well.

Congratulations to all the winners of Poster, Slogan competitions held as a part of observing Eczema day and Psoriasis Day . Our residents and post graduates are working on COVID duty for the last few months. I must congratulate them for this sense of duty and service to humanity.

On behalf of the IADVL National Executive, I wish the very best to Team IADVL National Resident Connect Committee and hope that the efforts of the team are crowned with overwhelming success.

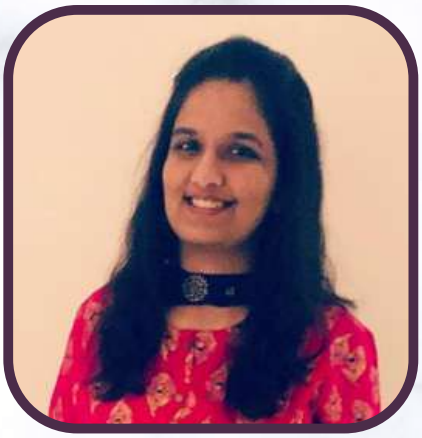
Long live IADVL

With warm regards,



DR. FEROZ. K
Hon. Secretary General , IADVL 2020-22
Dr. Feroz's SKIN CARE CLINIC, Fort Road, Kannur, Kerala . 670 001

Message from the Advisor



Dear Residents,

Warm greetings!

Dermatology being on top today, dermatology residents are among the brainy, skillful and competent minds. NRCC is for young budding dermatologists to showcase and nurture their talent. Given a right platform, at the beginning of their career, they can showcase and accomplish in plenty.
NRCC has been reaching greater heights due to collective efforts, hence I request all the residents to actively participate in various activities conducted by the IADVL National Resident Connect Committee.

We at the editorial board, are immensely grateful to Dr. Kiran Godse, Dr. Feroz K and all present and past, respected executive committee members for encouraging us in every path, in all possible ways. It is a matter of absolute glee to have got this opportunity to guide an enthusiastic, hardworking editorial team, led by zealous, and ever-smiling editor-in-chief, Dr. Shanthy Devadasan, along with residents from all over
India; Dr. Dharini, Dr. Kinnor, Dr. Satarupa, Dr. Shreya and Dr Soumya, blessed with extraordinary thoughts and immense creativity.

I am sure this issue of RESIDREAM will be a masterpiece and one of its kind.
Hope you have a good read!

Thanks & regards!

Dr. Preethi B Nayak
Advisor
National Resident Connect Committee, IADVL (2020-21)

IADVL NRCC 2020: A Report

IADVL NATIONAL RESIDENT CONNECT COMMITTEE

March: The IADVL National Resident Connect Committee was formed with previous year's convenor Dr. Preethi Nayak as advisor and Dr. Shanthy Devadasan as the new convenor.

Zonal Coordinators:
North east zone: Dr. Kinnor Das, resident of Silchar Medical College, Assam
North zone: Dr. Soumya Sachdeva, resident of ABVIMS and Dr RML Hospital, New Delhi
West Zone: Dr. Shreya Deoghare, resident of Dr D. Y. Patil Medical College, Pune
East zone: Dr. Satarupa Kumar, resident of Medical College, Kolkata, West Bengal
South zone: Dr. Dharini S., resident of Guntur Medical College, Andhra Pradesh

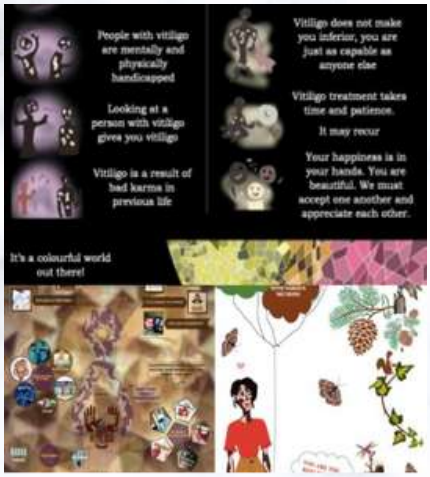
May: A Whatsapp group with one resident from each medical college across the country and a Facebook group with all the residents were created. This was to help disseminate information about IADVL activities for the benefit of all residents as well as to create an interface for all residents to communicate with one another.

June: On the occasion of World Vitiligo day, a trio of Poster, Poetry, Photography competitions on the theme "All colours are beautiful- eliminating the stigma of vitiligo" were held . Dr. Dharini S. and Dr. Satarupa Kumar were appointed as competition co-ordinators. Dr. Rakesh SV and Dr. Anuradha Kakkanatt Babu were assigned to judge the poster contest. Dr. Anil Abraham and Dr. Aseem Sharma were assigned to judge the poetry contest. Dr. Feroz Kaliyadan and Dr. Ashique KT were assigned to judge the photography contest. There was an overwhelming response from the residents and the winners were as follows:

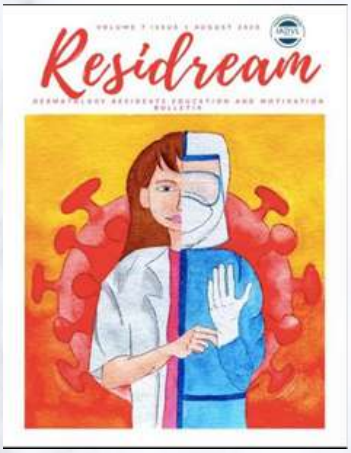
Poster Competition .
1. Dr. Vignesh Narayan R - PGIMER, Chandigarh
2. Dr. Ranjitha MS - Karnataka Institute of Medical Sciences, Hubballi
3. Dr. Febin Kallan - Azeezia Medical College, Kollam

Photography Competition
1. Dr. Soumya Alice Mathew - JSS Medical College, Mysore
2. Dr. Sai Pooja Anne - MNR medical college and hospital, Sangareddy, Hyderabad
3. Dr. Shruti Kharbanda - Subharti Medical College, Meerut

Poetry Competition
1. Dr. Moni Singh - Siddhartha Medical College, Vijayawada
2. Dr. Mihika Noronha - St. John's Medical College, Bangalore
3. Dr. Abirami C.- KIMS, Bhubaneshwar



July: "Residents of Dermatology" an initiative where the residents shared their own stories was started in our facebook group. Stories of inspiration, learning and patient interactions were shared by the residents.



August: Residream volume 7, issue 1 was released virtually on August 31st. The issue contained interviews from stalwarts and also articles from residents themselves. The issue also featured the winning entries of Vitiligo day competition.

September: On account of eczema awareness week from 13th to 19th September, slogan and poster competitions were held. Dr. Kinnor Das and Dr. Shreya Deoghare was appointed as competition co-ordinators. The poster competition was judged by Dr. Bhushan Madke and Dr. Anupam Das and the slogan competition was judged by Dr. Ishad Agarwal and Dr. Saloni Katoch. The winners were as follows:

POSTER COMPETITION

1st - Dr. Ranjitha MS, Karnataka Institute of Medical Sciences, Karnataka.

2nd – Dr. Thamizhinian K, Madras Medical College, Tamil Nadu

– Dr. Mitali Sethi, Jawahar Lal Nehru Medical College, Uttar Pradesh.

3rd – Dr. Pooja Kanumuru, Krishna Institute of Medical Sciences, Maharashtra

SLOGAN COMPETITION

1st – Dr. Sharang Gupta, GMC Patiala, Punjab

2nd – Dr.Anirudh P, Bangalore Medical College and Research Institute, Karnataka

3rd - Dr. Debashree Sahoo, Institute of Medical Sciences and SUM Hospital, Orissa.

- Dr. Preethi Ganesh Choudhari, Father Muller Medical College, Karnataka.

October:

Compilation of answers to past exam questions :The idea to prepare answers to past exam questions was put forth by residents in IADVL Resident Connect Whatsapp group. More than a 100 residents around the country volunteered to prepare the answers. IADVL NRCC provided a platform to coordinate this ambitious idea. The volunteers were divided into ten groups and each one was assigned a particular number of questions. The answers prepared were then compiled together by IADVL NRCC and the PDF was shared among residents.

Psoriasis day competition: On the occasion of world psoriasis day, a video making competition was conducted on the theme of "Psoriasis awareness". Dr. Kinnor Das and Dr. Soumya Sachdeva were appointed as competition co-ordinators. The competition was judged by Dr. Shyamanta Baruah and Dr.Dipali Rathod.

The winners were as follows
1 - Dr. Thamizhinian Kumaraswamy, Madras Medical College
2 - Dr. Chinmai C., Bangalore Medical College
3 - Dr. Mukesh Mithran J., Madras Medical College

YUVADERMA

DELHI:

The team is led by Dr. Gulhima Arora as the scientific advisor and Dr. Anuva Bansal as the editor-in-chief. The team has 5 associate editors - Dr. Soumya Sachdeva, Dr. Monalisa, Dr. Meghana Gupta and Dr. Ananya Sharma and 2 design and layout editors-Dr. Bhavishya Shetty and Dr. Anjali Bagrodia. A social awareness video about vitiligo was prepared by RCC Delhi and a poster making competition with the theme "Celebrate the beauty within" was also conducted on the occasion of World Vitiligo Day. The Yuvaderma – Delhi newsletter was released in July during the proceedings of the 1st E-clinical monthly meet. On the occasion of World Psoriasis day on 29th October 2020 patient awareness pamphlets and social awareness videos were prepared. The year was also marked by panel discussions on various topics. In December, the second issue of the newletter was released.

North-eastern states:

The second volume of the Yuvaderma newsletter was released during midcuticon 2020. The team is led by Dr. Indrani Dey as the chairperson and Dr. Dipak Kumar Agarwalla as the convenor. The team has 5 associate editors Dr Lily Singha, Dr Hitesh Khatri, Dr Ziaul Haque Ahmed,Dr Bhavna Lochav and Dr Linda Kongbam.

Karnataka:

Yuvaderma Karnataka was first started in 2016. The present team is led by Dr. Shilpitha Srinivas and Dr. Kirti P Katwe as the advisor. The team has one Associate editor Dr. Sanjay Thejaswi R and five Assistant Editors - Dr. Gagana B Gopal, Dr. Shibani Bhatia, Dr. Priyanka Karagaiah, Dr. Punya Suvarna and Dr. Chinmai C. A competition was hosted for the cover page of 10th edition of Yuvaderma Karnataka. The topic was 'Recent Changes in the field of

dermatology'. The painting sent by Dr. Rashmi Mallya was judged to be the most interesting and relevant one .

The concept behind her painting was that 'Change is constant'. This is definitely relevant in the face of the changing practices in Dermatology due to the ongoing Covid 19 Pandemic.

An essay writing competition was conducted on account of World Psoriasis day celebrated on 29th October every year. The topic was to write a letter to a patient with Psoriasis explaining their disease and how to treat, control and prevent it. The best essay was awarded to Dr. Madhurya Santhosh. A Slogan competition was conducted for Vitiligo day. The first prize was awarded to Dr. Kiran M S. The second prize was awarded to Dr. Madhu M. The winners had focused on educating the public about Vitiligo in order to end the stigma around it. A resident session was held during E-Cuticon held on 28th and 29th of November 2020. The session had presentations on the impact of COVID pandemic on the lives of the Residents. Dr. Chinmai C. had conducted a survey among 100 residents. The results of the survey was elaborated in the presentation. Importance of Social Media and how a social media presence is as important as clinical skills was the other presentation done by Dr. Priyanka Karagaiah. A Panel discussion was held on how a young dermatologist should start off in Covid times- do a fellowship or start their practice.

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Covid times- do a fellowship or start their practice.Himachal Pradesh, Chandigarh and Punjab:

Resident Connect Committee - Punjab, Chandigarh and Himachal Pradesh was formed with Dr. Mala Bhalla as chairperson and Dr. Priyanka Sharma as convenor. The team has 5 members Dr. Niharika Mittal, Dr. Shayna Aulakh, Dr .Neeta Negi, Dr. Surbhi Jain, Dr. Kanika Dogar. A Panel discussion on the management of chronic urticaria was conducted among the residents. A discussion session among residents on "Dermatology residency in COVID times: challenges and silver linings" was conducted on 10 January 2021.

COMPILED BY
Dr. Dharini S.
PG3
Guntur Medical College, Andhra Pradesh

IN CONVERSATION WITH

Dr. D. G. Saple

Dr. D. G. Saple, Former HOD, Dermato-Venereology & Leprology, Grant Medical College, Mumbai and Former President, IADVL (Maharashtra Branch) is a well-known teacher and researcher with 120+ papers in national and international conferences. He is a renowned academician and an Editorial Board Member of IADVL Textbook of Dermatology. He is currently a Medical Director & Senior Consultant at La'Mer Clinic, Mumbai.

What made you think that you should become a doctor ?

The fact that it was considered as a profession which offered noble services and was a respectable profession in the society inspired me to become a doctor.

What made you take up dermatology as your postgraduate branch?

I was in a dilemma whether to select general medicine or dermatology, but because of the expenses required for practicing as an MD medicine professional was more expensive than a dermatologist back in the days, for example as a physician I would be required to buy an X-ray screening machine and a side-lab set-up while in dermatology all that I required was a magnifying lens.

Any moments from your residency you would like to share with us?

Every day after finishing my OPD and daily ward work, I would go to the pathology lab and see and try to decipher all the dermatopathology slides. This really helped me hone my skills as a dermat as back then we did not have separate fellowships for learning dermatopathology, a luxury which today's young dermatologists have.

Do you think residency has changed with time? Would you like to elaborate?

There is a definite change in the nature of teaching. Back in the days , all the teachers were inclined purely for clinical dermatology. However with changing times, there is a shift in paradigm with the need to learn cosmetology, dermatosurgery and so on.

Any unforgettable patient-related experience which was a learning lesson for you?

There are numerous to enlist. But just to quote one, I remember in my first house post, there was a case of pemphigus vulgaris who was started on 60 mg of oral prednisolone. Although there was marked clinical improvement at the end of a week, the patient started talking gibberish with irrelevant talks. This soon came to our notice and on delving further we realized that it was in fact a case of steroid psychosis, an entity which I had always heard but never witnessed. It will always engraved in my mind.

Some say that the younger generation is taking up dermatology only to practice cosmetology. Your take on this?

I would say that this is quite true in a majority of cases. However we should see this in positive light, as only being a pure clinical dermatologist is not enough and we need to accept cosmetology with changing times. And while being adept at cosmetology, it is imperative that we maintain our clinical acumen.

Dentists and other non-professionals are practising various aspects of dermatology. What are your views about the same?

Most of the dentists are involved in botox, fillers and hair transplants. This trend is now being witnessed in most of the developed countries. What is important is that we maintain our ethical practice and outshine them with our skills.

Do you think there are any lacunae in dermatology teaching and if so, how can it be improved?

It is not just in dermatology but in most of the medical subjects. Lacunae are present because the interest in teaching has gradually decreased over time , and in these current money-driven times, a teaching post is treated more like a 9 to 5 job than a passion for teaching. Also I feel a post in general medicine & general surgery is important as an allied science.

How has COVID-19 pandemic affected you as a person and your dermatology practice?

COVID has taught all of us the value of our life, our health as well as the health of our near and dear ones. It has taught me to adapt in these tough circumstances and provide the best services taking utmost precautions for myself and my staff. It has also introduced me to the fantastic world of telemedicine.

Your advice to dermatology postgraduates in their 3 years of residency.

They should take the advantage of all possible teachers around them including the webinars which have turned to be a boon. A basic clinical and dermatopathology knowledge is a must. And to see as many patients as possible.

Any pearls of wisdom for fresh pass-outs wondering 'what-next?

When we start managing cases on our own, then we realize whatever we've learnt over the years is always incomplete. As we grow older and wiser, our knowledge of the subject seems lesser and lesser. So always keep learning !!!

Rapid fire

Your mentors : Dr. D .J. A. Rebello
Your go-to-book in dermatology : Lever's Textbook of Histopathology
Hobby : Tennis
Favorite quote : Knowledge is never ending.
Favorite movie : Five man army
Favourite song : Any folk song
One lesson the pandemic and lockdown taught you : Telemedicine is a boon!

Dr. Shreya Deoghare
PG2
Dr. D. Y. Patil Medical College and Hospital, Pune, Maharashtra

DERM | NOTES

CONGENITAL SYPHILIS

DEFINITION

Acquisition of syphilis to a newborn via transplacental route or during delivery from genital lesions.

MECHANISM OF TRANSMISSION

Treponema pallidum passes through the placenta into the fetal circulation

Risk of transmission to fetus in various stages of syphilis in mother-

- Primary syphilis-70-100%
- Early latent syphilis- 40%
- Late latent syphilis- 10%

In primary syphilis, 100% transmission risk and 50% develop congenital syphilis.

Outcomes of syphilis during pregnancy-

1. Preterm delivery
2. Still-birth (30-40%)
3. Congenital infection -2/3rd asymptomatic & 1/3rd symptomatic
4. Neonatal death

PATHOLOGY

T. palladium enters the fetal circulation and disseminates into tissue

Inflammatory response develops by infiltration of lymphocytes and plasma cells

Placenta - Fibrous, large, thick, pale

Umbilical cord- Necrotising funisitis - Barber`s pole appearance - due to alternate streaks of red blue and white colors

Histopathology – obliterating endarteritis with fibrosis

Gumma -Central gummatous necrosis surrounded by a peripheral rim of mononuclear infiltrate which is further surrounded by fibrosis

CLINICAL FEATURES

- Early congenital syphilis- Less than 2 years
- Late congenital syphilis – three years and above
- Stigmata – scars, and deformities

EARLY CONGENITAL SYPHILIS

Two-third newborn develop symptoms by 3rd -8th week. All newborns develop symptoms by 3 months.

ORGAN	CLINICAL FEATURES
Haematological	Non-immune hydrops fetalis (**Syphilis - most common cause**) Anemia Thrombocytopenia Lymphadenopathy- rubbery, non - tender Disseminated intravascular coagulation
GIT	Low birth weight Hepatosplenomegaly Pancreatitis Enteritis
Respiratory	**Syphilitic snuffles** (rhinitis)-most common and earliest feature; initially mucoid later purulent /bloody Hoarse cry Pneumonia

	osteochondritis **Wimberger /Cat`s bite sign**-bilateral metaphyseal destruction of the medial proximal tibia **Onion peel periosteum** **Wegner sign**- Serrated appearance at the epiphyseal margin **Celery stick appearance** -Long lines of rarefaction along metaphysis Syphilitic **dactylitis** in fingers Osteitis resolve by end of the first year
Mucocutaneous	**Cafe au lait tint** of skin-brown, wrinkled, dry skin **Copper red macules and papules**-palms & soles, diaper area Condylomata Lata & mucous patch Ulcers & fissures around the mouth **Syphilitic pemphigus** - Bullae less than 3 cm on extremities base have a papule with dull red eroded surface **Syphilitic alopecia**- patches of irregular hair; loss on sides and back with the center have abundant coarse hair **Syphilitic onychia** -syphilitic papules extend to nail bed leading to loosening and shedding of nails
Neurological	40-60% of patients - 10% symptomatic Aseptic meningitis Chronic meningovascular syphilis Cranial nerves palsies Hydrocephalus
Ocular	Uveitis, glaucoma, chorioretinitis

ORGAN	CLINICAL FEATURES
Ocular	**Bilateral Interstitial keratitis*** - commonest late feature (F>M) develop at 6-40 years; tearing pain, conjunctival congestion; brush like vessels , **salmon patch**- dull pink patch at periphery of cornea , later **ground glass appearance**
Auditory	**Bilateral 8th nerve deafness***- vertigo, tinnitus, deafness-; due to osteochondritis of otic capsule
Bones	Gummatous periostitis **Clutton's joints**- symmetric non-tender swelling of knees following trauma ; recovery is rule
Gumma	Perforation of nasal septum ,palate,
Neurosyphilis	Mental delay, Paresis> Tabes Dorsalis, convulsions, Cranial nerve palsy
Paroxysmal Nocturnal Hemoglobinuria	Dark red concentrated urine Fever, urticaria, Raynaud Phenomenon Hemolysin in serum react with Complement to sensitise RBC leading to hemolysis (**Donath Landsteiner reaction**)

*Hypersensitivity reaction l; No response to anti syphilitic treatment; Resolve by glucocorticoids

STIGMATA

HUTCHINSON TRIAD- Interstitial keratitis, Bilateral deafness and Hutchinson teeth

CLINICAL FEATURES	REMARKS
Hutchinson's teeth	Conical/ barrel-shaped incisors with notching at the free margin
Mulberry molars / Moon molars	Dome-shaped molars (1st molar)
High arched palate	
Saddle nose	Destruction of nasal cartilage due to gumma
Frontal bossing /Olympian brow	Osteoperiostitis
Craniotabes	Apparent softening of rest of skull; indents on pressure like stiff parchment
Hot cross bun skull	Gross frontal / parietal bossing with intervening and lateral depressions
Parrot nodes	Localised osteoperiostitis-rounded bony swelling on skull
Bulldog jaw	Due to maxillary hypoplasia and mandibular prominence
Stokes facies	When lack gross stigma, sleepy, tired clouded look, nasal bridge of Crayon portrait
Saber shins	Thickening of the middle portion of the tibia following periostitis
Scaphoid scapula	Concavity of vertebral border of the scapula due to periostitis
Higoumenakis sign	Ynilateral irregular enlargement of the sternoclavicular joint of the clavicle
Dubois sign	Very short little finger
Gummatous scars	Scar and deformity Perforation of nasal septum /palate
Increased carrying angle	
Ghost vessels	Secondary to interstitial keratitis empty blood vessels and corneal scarring on Slit lamp microscopy
Salt and pepper fundus	Pale atrophic areas bordered by areas of pigmentation
Rhagades	Linear scars radiate from angle of mouth, nares, anus

MANAGEMENT

	PROVEN/ HIGHLY PROBABLE	POSSIBLE	LESS LIKELY	UNLIKELY
When to suspect	**Physical examination consistent with CS** OR Serology - Non treponemal test **(NTT) positive or four fold higher** titre than mother OR **Dark field microscopy Or PCR for lesion or bodily fluids**	**Normal Physical examination** **Serology - NTT normal or less than fourfold** maternal titre Plus **Any one** of the following 1. Mother not treated, inadequately treated or no document of treatment OR 2.Non penicillin G treatment given OR 3.Treatment given 4 weeks before delivery	**Normal Physical examination Serology -NTT normal or less than fourfold** maternal titre Plus **Both of the following** are present 1**. Mother treated during pregnancy, appropriate for stage of infection,treatment given more than 4 weeks** before delivery 2.Mother has **no evidence of reinfection or relapse**	**Normal Physical examination** Serology -NTT normal or less than fourfold maternal titre Plus **Both of the following** 1.**Mother's treatment was adequate before pregnancy** 2.**Mother's NTT titre remained low and stable** before and during pregnancy and at delivery (VDRL < 1:2 , RPR < 1:4)
Investigations	CSF analysis- VDRL, Cell count (> 5 WBC/ mm^3) Protein (>40 mg/dl) CBC with DLC with platelet count X-ray long bones CXR, LFT , Ophthalmology and auditory brainstem response neuroimaging	CSF- VDRL, Cell count (> 5 WBC/ mm^3) Protein (>40 mg/dl) CBC with DLC with platelet count X-ray long bones	No investigations	No evaluation
Treatment	**Aqueous crystalline penicillin G I/V 1 lakh -1.5 lakh /U /Kg /day x10 days** (50,000 U /Kg / dose 12 hourly x 7 days followed by 8 hourly **OR** **Procaine penicillin G I /M** x 50,000 IU / Kg daily x10 days	Aqueous crystalline penicillin G I/V 1 lakh -1.5 lakh /U /Kg /day x10 days(50,000 U /Kg / dose 12 hourly x 7 days followed by 8 hourly **OR** Procaine penicillin G I /M x 50,000 IU / Kg daily x10 days - If any part of evaluation abnormal/ not performed, CSF analysis uninterpretable, F/U uncertain- 10 days treatment But benzathine penicillin 50,000 IU /kg /dose I/M single dose may be considered if- CSF , X ray long bones, CBC - WNL Follow up certain NTT - NR Mother' s risk of being untreated syphilis low	**Benzathine penicillin** 50,000 IU /kg /dose I/M single dose **OR** **serological follow up** every 2-3 months for 6 months If mother titre declined 4 fold after treatment Or remained stable for latent syphilis (VDRL < 1:2)	**No treatment if adequate follow up** Benzathine penicillin to be considered if NTT titre Positive and follow up uncertain

FOLLOW UP

All **neonates with reactive NTT** should receive careful follow up
Clinical examination
Serological testing (NTT) every 2-3 months till negative

Non Treated Infant

NTT **decline by 3 months**
NTT **non-reactive by 6 months**
If NTT **reactive-** considered infective and **treated**

Treated Infant

Persistent NTT titre by 6-12 months

CSF examination

Neonates with **initial abnormal CSF examination** would undergo repeat **lumbar puncture every 6 months** till tests are normal -If test persistently abnormal **re treatment for neurosyphilis**

Retreatment with 10 day course of Penicillin G may be considered

Neonates with negative NTT at birth, whose mothers were seroreactive at delivery **retested at 3 months**

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In a nutshell

APPROACH TO ECTODERMAL DYSPLASIA

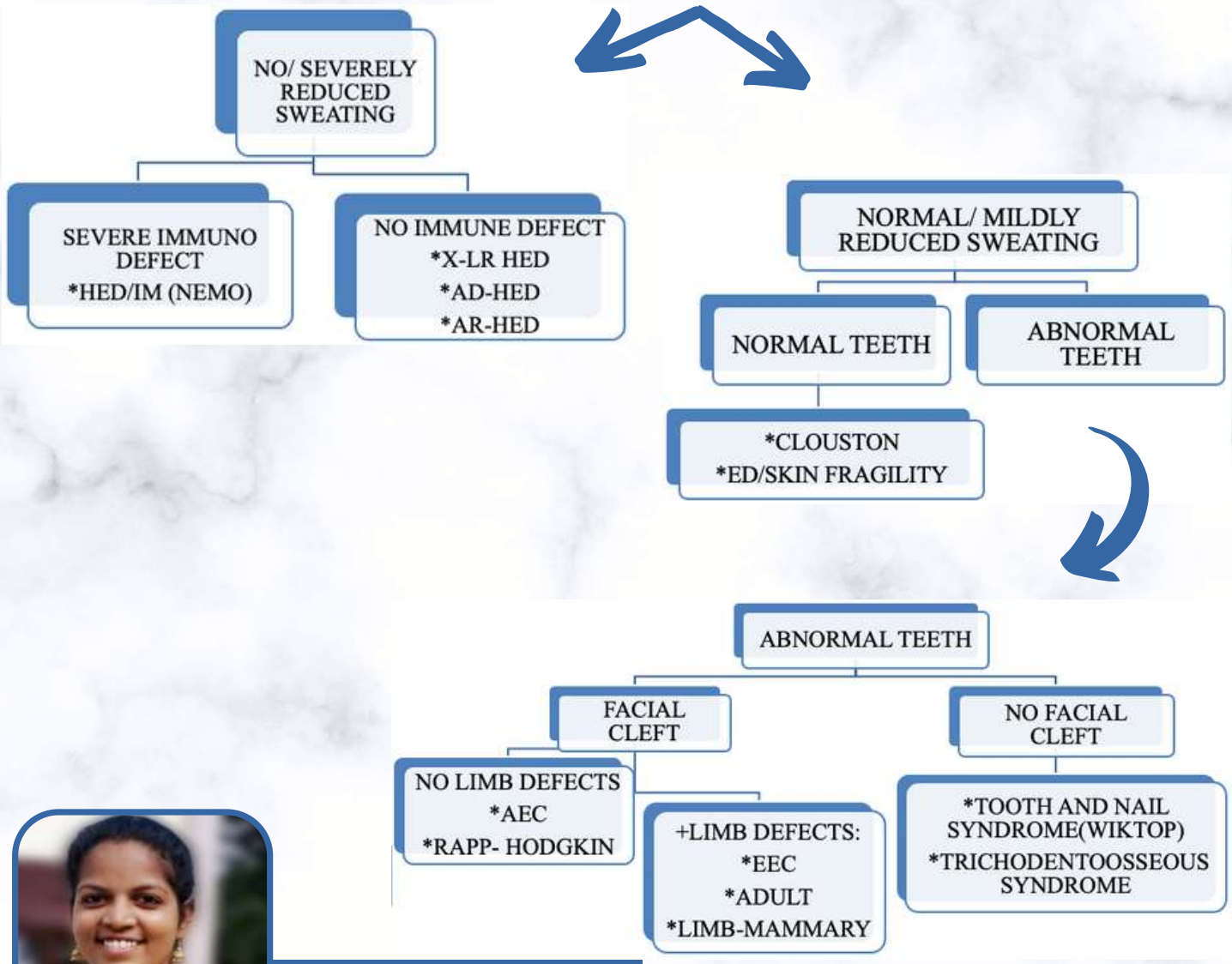
DEFINITION:

• Ectodermal dysplasia are a large group of heterogenous heritable disorders, characterized by developmental abnormalities of **two or more** of the following: hair, teeth, nails, sweat glands and other ectodermal structures (mammary gland, CNS, external ear, melanocytes, cornea, conjunctiva, lacrimal gland and lacrimal duct).

• More than 220 different conditions have been identified.

APPROACH TO ECTODERMAL DYSPLASIA:

When a patient comes to OPD with clinical features suggestive of ED, first we need to ask about history of sweat disturbances. The approach is as follows:



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TRICHOSCOPY: TYPES OF HAIR

1. **Yellow dots** - Alopecia Areata, Alopecia areata incognito, severe androgenetic alopecia ,DLE, Trichotillomania, chemotherapy induced alopecia.
2. **Black dots** - Nonscarring alopecias including alopecia areata, chemotherapy-induced alopecia, tinea capitis and trichotillomania.
3. **Pin point white dots** - Normal scalp.
4. **Red dots** - Discoid lupus erythematosus.
5. **Blue grey dots (Target appearance)** - Lichen planopilaris.
6. **Blue grey dots (Speckled pattern)** - Discoid lupus erythematosus.
7. **Keratotic plugs** - Discoid lupus erythematosus, Dissecting cellulitis.
8. **Grey white peripilar halos** - Central centrifugal cicatricial alopecia.
9. **Peripilar sign** - Normal scalp, Early androgenetic alopecia.
10. **Empty follicles** - Androgenetic alopecia,T elogen effluvium.
11. **Circle Hairs/Pigtail hairs** - Alopecia areata, Androgenetic alopecia.
12. **Exclamation Mark Hair** - Alopecia areata, chemotherapy-induced alopecia.
13. **Broken Hair** - Nonscarring alopecias, including alopecia areata, chemotherapy alopecia, tinea capitis and trichotillomania and after hair styling procedures.
14. **Monilethrix like Hairs/ Poh Pinkus constrictions** - Alopecia areata.
15. **Question mark hair** - Trichotillomania.
16. **Hook hair** - Trichotillomania.
17. **Flame hairs** - Trichotillomania, Traction alopecia, radiotherapy, chemotherapy, alopecia areata and central centrifugal cicatricial alopecia.
18. **Comma Hair** - Tinea capitis.
19. **Corkscrew Hair** - Tinea capitis.
20. **Morse- Code hair** - Tinea capitis (Ectothrix).
21. **Zig zag hair** - Tinea capitis, trichorrhexis nodosa, Alopecia Areata , monelithrix.
22. **Tulip hair** - Nonspecific feature seen in alopecia areata, trichotillomania.
23. **Trichoptilosis** - Not pathognomic for any alopecia type. May be observed in healthy individuals.
24. **Broom hair** - Maybe seen in all types of alopecia.
25. **i-hair/Block Hair** - Trichotillomania, Tinea capitis.
26. **Dark Lines** - Non-cicatricial alopecia, most commonly alopecia areata incognito.
27. **Trichoclasis** - Perming, traction combing.
28. **Coiled hair** - Trichotillomania.
29. **Hair tuft** - Tufted folliculitis, folliculitis decalvans, lichen planopilaris ,DLE, Centrifugal cicatricial alopecia , acne keloidalis nuchae.
30. **Rolled hair** - Trauma due to vigorous rubbing.
31. **Short regrowing hair** - Normal scalp, remitting phase of alopecia areata, telogen effluvium .
32. **Tadpole hair** - Alopecia areata incognito
33. **Trichonodosis** - Dry frizzy and curly hair.
34. **Trichorrhexis nodosa** - Ectodermal dysplasias, physical and chemical trauma, nutritional deficiencies .
35. **Vellus hair** - Male and female androgenetic alopecia
36. **Halo sign** (due to black dot) - Alopecia areata , trichotillomania.
37. **Wipe-out sign** (due to hair dust) - Alopecia areata ,trichotillomania.

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Incontinentia pigmenti with ambiguous genitalia : a rare case report from central India

INTRODUCTION

Incontinentia pigmenti is a rare multisystem ectodermal dysplasia, inherited in X-linked dominant pattern. Thus it presents classically in females and is usually lethal in males with a female to male ratio of 20:1.

The cutaneous features present in 4 stages(1):

- Bullous stage I- prenatal to few weeks after birth
- Verrucous stage II- start few month after birth disappear in late infancy
- Hyperpigmented stage III- begin in late infancy and fade in adolescence
- Hypopigmented , atrophic stage IV- from puberty onward then remains as stigmata in adulthood.

Skin lesions are linear and along the blaschko line which is explained by mosaicism secondary to lyonization.

Additional manifestations are

- Missing/conical teeth, linear absence of hair, dystrophic nails
- Cataract, microphthalmia, retinal abnormality
- Seizure , microcephaly, intellectual delay
- Scoliosis

We here present a unique case of a baby presenting to us with linear hyperpigmented lesions on the body with atypical genitals.

CASE REPORT

A 12 day baby was referred to the skin Outpatient department with complaint of dark linear lesions on the body with ambiguous genitalia since birth.

The baby was a product of non-consanguineous marriage with a history death of one older sibling with similar genitals at the 15th day of life. Parents gave history of tiny fluid filled lesions on the trunk, thigh, leg at birth which became dry and dark in the next few days.

On general examination the baby looked active, vitals stable and systemic examination was normal.

On cutaneous examination - multiple well defined hyperpigmented slightly raised lesions arranged in streaks and whorl pattern along Blaschko's line on B/L upper limb including axilla, trunk, B/L lower limb including soles along with few vesicular lesions on thighs (Figure 1) No abnormality was detected in hair, nail, teeth.

On examination of genitalia- hyperpigmented, gonad non palpable, single opening, complete labioscrotal fusion ,increase phallus length (Figure 2).

On examination of mother there were no cutaneous findings but dystrophic teeth were seen (Figure 3).

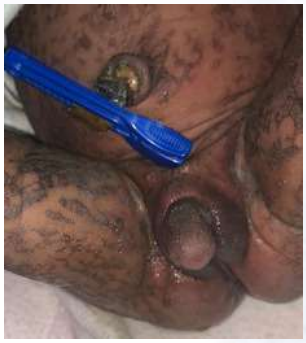


Figure 1

Figure 2

Figure 3

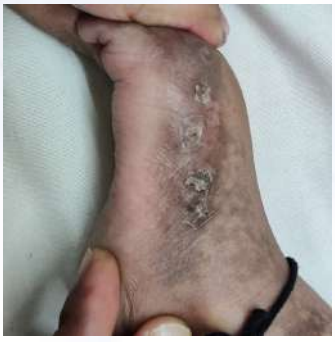


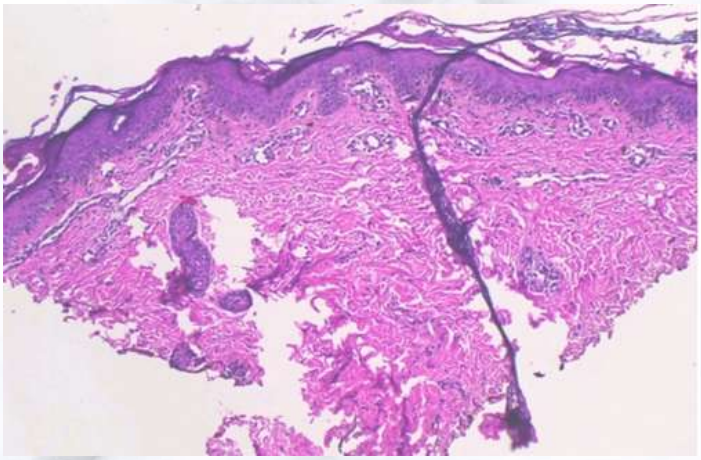
Figure 4

Based on history, morphology and examination of mother a clinical diagnosis of Incontinentia pigmenti with differential diagnosis of linear nevoid hyperpigmentation was made. A skin biopsy was taken from fluid filled lesion on the thigh.
Histopathology report was awaited and the baby was referred to the pediatric department for evaluation of ambiguous genitalia.

Test	Result	Interpretation	Normal value
Karyotype	46XX	Female	-
USG Pelvis	Uterus Present	Mullerian structures Present	-
17 OHP	400 ng/ml	High	< 2 ng/ml
Total Testosterone	863.44 ng/dl	High	< 12 ng/dl
Free testosterone	71.05 pg/ml	High	0.32-0.45 pg/ml
ACTH	257 pg/ml	High	10-60 pg/ml
Plasma Renin Activity	3435 ng/ml/hr	High	1.9-3.7 ng/ml/hr
Serum electrolytes (Na/K/Cl)	125/7.8/105	Hyponatremia Hyperkalemia	135-145/3.5-5/95-105
RBS	101 mg/dl	Normal	<50 mg/dl

Based on following :
Ambiguous genitalia
Non palpable gonads
Uterus present
Karyotype 46XX
Raised 17-OHP
Electrolyte abnormality

Diagnosis of - Congenital adrenal hyperplasia salt wasting type was made and the baby was managed with oral glucocorticoid , oral mineralocorticoid and salt supplementation.
Histopathology report was suggestive of inflammatory phase of incontinentia pigmenti.The epidermis showed several dyskeratotic cells and the dermis showed sparse perivascular lymphocytic and eosinophilic infiltrate.



Thus a *final diagnosis* of Incontinentia pigmenti with CAH-salt wasting type was made.

Treatment:
For skin lesions ,parents were reassured and conservative management with bland emollient all over body for twice daily application was advised.
For CAH - salt wasting type- oral glucocorticoid, oral mineralocorticoid and salt supplementation

On follow up:
9 month of age Baby presented with verrucous
lesions on dorsum of feet and hyperpigmented streaks along blaschko's line on trunk, thighs , legs.(Figure 4)

DISCUSSION
Incontinentia pigmenti is a rare XLD dominant disorder characterised by linear skin lesions along Blaschko's line. IP is a pro-apoptotic condition which is caused by mutation in the NEMO gene on chromosome Xq28. NEMO normally activates NF-κB pathway which protects against TNF-α induced apoptosis(2). Because it is an X-linked dominant proapoptotic disorder , it is lethal in males. Very rarely IP may be seen in males(3). We here describe a unique case of a 12 day old baby presenting with hyperpigmented and

few vesicular lesions along Blaschko's line with ambiguous genitalia.

Based on clinical examination, histopathologicalexamination and a wide range of biochemical investigations and radiological examination, a final diagnosis of Incontinentia pigmenti with congenital adrenal hyperplasia - salt wasting type was made.

Congenital adrenal hyperplasia has Autosomal recessive inheritance(5). Thus this case represents an unusual coexistence of an X-linked dominant disorder with Autosomal recessive disorder. Till date no similar case of association of Incontinentia pigmenti with congenital adrenal hyperplasia has been reported.

References

1. Minić S, Trpinac D, Obradović M. Incontinentia pigmenti diagnostic criteria update. Clin Genet. 2014 Jun;85(6):536–42.
2. Fusco F, Bardaro T, Fimiani G, Mercadante V, Miano MG, Falco G, et al. Molecular analysis of the genetic defect in a large cohort of IP patients and identification of novel NEMO mutations interfering with NF-kappaB activation. Hum Mol Genet. 2004 Aug 15;13(16):1763–73.
3. Pacheco R, Levy M, Collyer JC, de Parra NP, Parra CA, Garay M, et al. Incontinentia pigmenti in male patients. J Am Acad Dermatol. 2006 Aug;55(2):251–5.
5. El-Maouche D, Arlt W, Merke DP. Congenital adrenal hyperplasia. Lancet Lond Engl. 2017 Nov 11;390(10108):2194–210.

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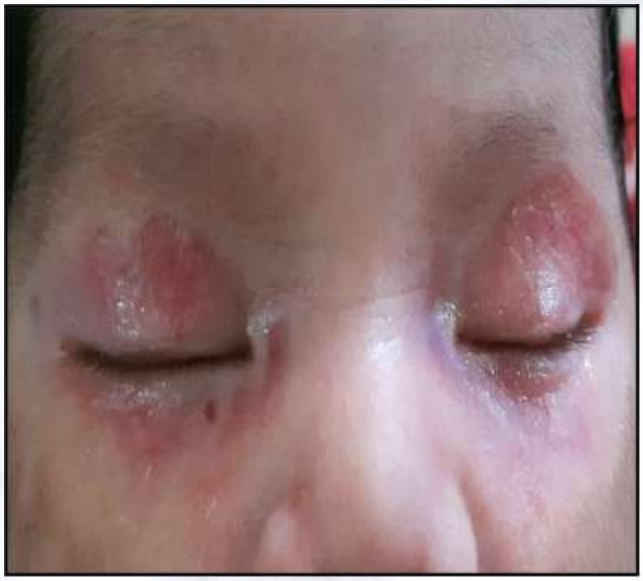
Neonatal Lupus Erythematosus - The mystery of "RACCOON EYES" unravelled

INTRODUCTION:

Neonatal lupus erythematosus (NLE) is caused by anti-SSA and anti-SSB antibodies, which are products of maternal autoimmune disorders (SLE, Sjogren, rheumatoid arthritis) and can be passively transported across the placenta. The prevalence of NLE is low. Symptoms usually resolve spontaneously at age of 6-9 months in association with disappearance of maternal antibodies from the infant's serum. Our case of NLE presented with raccoon eyes alone. The fact that the mother's illness was not known at the time of baby's birth made it difficult to establish the diagnosis.

CASE REPORT:

A female baby born at term gestation with birth weight of 3.6 kg was admitted in NICU immediately after delivery because of respiratory distress and meconium aspiration. The baby was delivered by cesarean section ,the indication being meconium stained liquor. Three days after birth baby presented with erythematous rash in periorbital region.On examination there was erythema,atrophy and telangiectasia in the periorbital region. The mother was completely asymptomatic. There was no history of photosensitive rash, or abortions in the past.



On the basis of clinical appearance of the lesions, neonatal lupus was suspected and therefore baby and mother were tested for antinuclear antibodies. Serology showed the presence, in both mother and baby, of anti-Ro/SSA, anti–la/SSB and ANA.Mother is also positive for anti ds DNA and anti Smith antibody. Blood counts were normal. The baby's ECG and 2D ECHO were normal .The abdominal ultrasonography is normal. Based on these findings, we made a diagnosis of NLE without visceral involvement.

TREATMENT AND FOLLOW UP:

The family was counseled and instructed to reduce sun exposure, use protective clothing and use sunscreen daily. Topical therapy with hydrocortisone was started and continued for 2 weeks. Instructions were given to take care that ointment does not come in contact with eyes. The rash resolved by more than 50% after 2 weeks of topical steroid and child was kept on monthly follow up.

DISCUSSION:

NLE is a rare neonatal immune mediated disease. The true incidence is not yet defined, because of under diagnosis and misdiagnosis; however, it is approximately 1:20000 live births. Females are affected twice as often as males. It is triggered by trans placental passage of maternal IgG against Ro/SSA, La/SSB and U1-RNP, after 16 weeks of gestational age. Anti-La/SSB Ab influence the development of cutaneous NLE; instead anti-Ro/SSA Ab is involved in the development of NLE with complete heart block. As the IgG are maternally derived, cutaneous forms of NLE are generally self-limiting in 6-8 months. In this case mother was completely asymptomatic at the time of diagnosis of neonatal LE in the baby. Although the prognosis of cutaneous NLE is usually excellent, proper measures should be taken to rule out conditions with similar cutaneous manifestations and the presence of any coexisting systemic disease.

REFERENCES:

1. Frey MN, Ioppi AEE, Garbin GC, Furian RD, Kiszewski AE. Congenital and neonatal lupus erythematosus: two case reports
2. Rooks text book of dermatology 9th edition
3. Savino et al. Italian Journal of Pediatrics (2016) 42:1 DOI10.1186/s13052-015-0208-5

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24th World Congress of Dermatology, Milan (2019)

Dermatology Scholarship: My Experience

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Throughout my post graduate journey, I have had short term goals to keep my pace steady and tried to focus on the course in its entirety. This included developing a clinical acumen as well as taking part in different meetings, workshops, quizzes, and paper presentations. It was met with encouragement at every step by my wonderful Faculty at IPGME&R, Kolkata where I was pursuing my MD course.

The opportunity to present at an international meeting back in 2019 was the highlight of my three-year long tenure. I am sincerely thankful to my Professor, Dr. Sumit Sen Sir who guided me through this. The procedure was as simple as submitting an abstract in the structured format on the website. I remember brimming with excitement and enthusiasm on finding out that my submission in the 'Late Breaking News' portal was received positively by the WCD committee and that I was invited to deliver an Oral Presentation at the 24th World Congress of Dermatology in Milan, the fashion capital of Italy. Further, my happiness knew no bounds when IADVL West Bengal accepted my Scholarship application and awarded me a travel grant.

The anticipation and wait was over when I boarded my flight for Milan with a hope to garner memories of a lifetime. Not only was I going to witness the World's biggest Academic gala and represent my Institute but also going to visit one of the most beautiful countries with a unique blend of art, culture, and history.

The 24th World Congress of Dermatology was a week-long event that took place the at Milan Convention Centre. Attending it so early on in my career was an eye-opener for me. The conference broadened my vision, opened the gates to new ideas as I got an insight into the diverse work being done by scholars all over the world. I tried to make the most of it by attending different sessions by esteemed faculties who had come from all over the world.

The conference ended on a very high note for me as I got the opportunity to present my work on the last day and get my work reviewed by veterans in the field of Dermatology. I was a bit nervous inside, but the presentation went well overall. I was encouraged and got honest feedbacks and suggestions from the respected Chairpersons. I also made sure to interact

with the other distinguished presenters and get their reviews.

This trip also hit the reset button for me as I did a bit of travelling with my colleague and friend, Shivangi. We had pre-planned our schedule and got our bookings done before hand for Rome, Vatican City, Venice, and Lake Como. The exploratory strolls along the cobblestone streets and ancient houses in the majestic city of Rome made us realise why they say it was not built in a day! The sunny view of the Vatican from the Dome of Saint Peter's Basilica was marvellous, and we were completely blown away by Michelangelo's artwork that adorned the ceilings of Sistine Chapel in Vatican City. Venice looked like a place straight out of a fairy tale as we enjoyed the Gondola Ride and Gelato on the Rialto Bridge. However, our most memorable moment was witnessing the serene, picturesque sunset at Lake Como while indulging in some food and wine on the rooftop of an Italian restaurant. It is said that every experience in your life is being orchestrated to teach you something that you need to move forward, and this conference certainly did that for me. Presenting a paper amongst academicians of the highest calibre on such a coveted platform really boosted my morale to continue doing some good work and undertake more such future endeavours. The travelling re-energised me, and I was reminded that there is so much out there in the world to see. I came back to work with a new vigour realising how important it is to hit pause and unwind.

I would like to extend my deepest gratitude to IADVL West Bengal for supporting my travel with this Scholarship. IADVL offers students a plethora of opportunities. We just need to have the confidence of presenting our work in the world arena with hopes of expecting a favourable response from the authorities. I hope to do this again in my academia journey when opportunities arrive so that I can look back and be proud of that I tried aiming for everything. However, my permanent abode will always be my country, India where my heart and soul belong. Until next time, Ciao!

IADVL SARCD SCHOLARSHIP 2019

Dermatology Scholarship: my Experience

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New Delhi

XIth SARCD Conference held in Nepal 2019 was an overwhelming experience packed with knowledge, interaction, fun, and adventure! The travel to Nepal became possible when I received the IADVL SARCD scholarship for the award paper presentation. Receiving a scholarship, presenting my work, and being one of the postgraduates who represented India boosted my confidence and encouraged me to devote more time for publications. This would not have been possible without the support from my friends, seniors, eminent faculty members in my department, and my family. The magnificence of snow-filled Himalayas, culture, food, view of a beautiful sunrise, and the adventure of traveling helped me to connect more with nature. I also enjoyed the sight-seeing and local tour with friends and other senior dermatologists from India.

I believe that publications and paper presentations will keep you updated, improve your profile, increase the odds of getting a scholarship, and above all the satisfaction of presenting/ publishing your scientific work. Each publication takes its own time, hard work, good literature review, patience and guidance. I was blessed to have a huge support and supervision from the faculty members. Always keep yourself motivated and devote additional time and try to be a part of the research activities in the department. All these gradually help in publishing articles during your postgraduate period. The outcome is fruitful with scholarships and the chance to present your work at national and international conferences. Also traveling, interacting with other experienced members, meeting your friends are blissful experiences that one can cherish.

IADVL provides different scholarships and travel grants to attend several national and international conferences. IADVL also offer scholarship to attend SARCD conference exclusively for postgraduates which is a great encouragement for residents. All you need to do is to keep a regular check on the IADVL and conference websites to look for any upcoming events and the scholarships that you can avail. And of course, a quality research work along with a good CV will be the pillar!

How to Present a Poster in a Conference

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My dear residents,
Residream holds a very special place in my heart, because I was one of the members of the maiden team of this newsletter, way back in 2014. The memories shall remain etched in my heart for years to come. The initiative of Rashmi mam was phenomenal to say the least, and it's an unmatched feeling to see the project grow by leaps and bounds. Now, if I start sharing my experiences of working for (in) Residream, the very purpose of this write-up will get diluted. So, I shall straight away come to the point.

Posters are an interesting format to share the findings of an interesting case, case series, results of a statistical analysis following a research work. During residency (and even beyond that), it is always prudent to attend scientific conferences to learn, to enjoy, to socialize and what not! Now, I have serious objections if you plan to attend a conference just for the sake of outing and socializing. It is advisable to submit abstracts for presentation (oral and/or poster), and wait for the decision of scientific committee. In most of the cases, the abstract gets selected for poster presentation; and in this write-up, I shall give you a few tips on how to present a poster.

I have presented posters in multiple national and international conferences, including Cuticon(s) and Dermacon(s), Pigmentarycon(s), World Congress of Dermatology 2015 and 2019; International Summer Academy of Practical Dermatology 2015; EADV symposium 2015 and 2017; and I was awarded scholarships by multiple societies and associations (Indian Association of Dermatologists, Venereologists and Leprologists, Pigmentary Disorders Society, Asian Society of Pigment Cell Research etc) to attend the conferences and present my work.

Please remember that preparing a poster involves not only creating pages or slides to be mounted in a hall, but you should ensure that the audience (including the judges) get attracted to the poster (content and visual appeal, both).

- **The story-telling should be crisp, precise, attractive and catchy.** Make sure that you provide them with a clear take-home message that they can grasp in the few minutes (maximum 2-3 minutes) they will spend at your poster.
- Write a **short, specific title that fits in large type size** on the title banner of your poster. The title will be potential readers' first glimpse of your poster, so make it inviting and easy to read from a distance—at least 40-point type (may be even larger)
- The content should not be "too long, dense, or detailed," or "too theoretical, technical, or jargony."

- **Do not clutter the poster with too much technical details.** Even though materials and methods form an indispensable part of any presentation, I personally feel you should not write too much relating to this section. [Keep in mind that the audience will spend hardly 2-3 minutes on your poster, and too much of methodological details may turn off their appetite]
- Use **at least 14-point type** for the body of the poster text. Please remember that, many in your audience have reached the bifocal age and all of them will read your poster while standing, hence long paragraphs in small type will not be appreciated!
- **Make judicious use of color**. Use a clear, white, or pastel for the background, with black or another dark color for most text, and a bright, contrasting shade to emphasize key points or to identify statistically significant results. I am personally not in favor of an exorbitantly colorful poster, after all, you are doing a scientific presentation, and it's not a festive occasion!
- **Let your figures do the talking** : Put more of pie charts, bar diagrams, plots and graphs. Trust me these are going to be your catch points, which will definitely attract the readers. A rhetorical question or summary of the main finding can give you some brownie points. Replace large detailed tables with charts or small, simplified tables.
- Whether you like it or not, statistical findings form the backbone of any research paper. But please remember, this is not an oral presentation, so please do not overdo. Use an approach to **present statistical significance that keeps the focus on your results.** A good idea is to replace the standard errors or test statistics with confidence intervals,

Dr. Anupam Das at the WCD 2015 (Vancouver) poster, which fetched him the IADVL Scholarship

p-values, or symbols, or use formatting such as boldface, italics, or a contrasting color to denote statistically significant findings.

- An easy and effective way of making your poster look good, is trying the **"W method" [who, what, when, where, why]**

---- Introduction : What you are studying, Why it is important, and What will your study add to the already existing literature.

----Methods : When, Where, Who collected, and how the data was collected. Make sure you mention about the calculation of sample size, inclusion and exclusion criteria, sources of bias (and how did you address them). If it's a clinical trial, there are many more things which should be discussed (beyond the scope of this write-up). I would strongly recommend all of you to go through this website https://www.equator-network.org/ and get back to me in case you have any difficulty in understanding the nitty gritties.

----Results : you need to present What you found.

----Conclusion : go back to What you found, and try to set the stage for future research

- **Prepare short answers to likely questions** about various aspects of your work. Most importantly, you need to anticipate the

questions beforehand, and be prepared!

- I consider this tip as the most important one ! **Practice your poster presentation in front of a test audience** acquainted with the interests and statistical proficiency of your expected viewers. What I feel is, your critic should not be too much familiar with your work. A fresh set of eyes and ears is more likely to identify potential points of confusion than someone who is jaded from working closely with the material while writing the paper or drafting the poster. Make sure you ask your reviewer to identify elements that are shady, flag jargon to be paraphrased or defined, and recommend changes to improve clarity!

How to gear up for THE DAY!!

- Dress well, look good, look confident and go for it
- Rehearse a two to three sentence overview of your research question, objectives and the positive findings
- Give short and concise descriptions of specific elements of the poster (background, introduction, findings and conclusion; followed by asking the viewers if they have any questions)
- Do not hesitate to solicit the inputs of the viewers, on the findings of your project

I have tried to summarise the most important points related to preparing and presenting a poster. In case you intend to discuss more, I am just a mail away (Shoot your queries to anupamdasdr@gmail.com) . Thanks to Residream team (specially Dr Kinnor Das) for giving me the opportunity to share my views.

Happy researching, reading and presenting!
Signing off !

Further reading :

- Beilenson J. Developing Effective Poster Presentations. Gerontology News. 2004;32(9):6–9.
- Briscoe MH. Preparing Scientific llustrations: A Guide to Better Posters, Presentations, and Publications. 2. New York: Springer-Verlag; 1996.
- Gundogan B, Koshy K, Kurar L, Whitehurst K. How to make an academic poster. Ann Med Surg (Lond). 2016;11:69-71.

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"CORONA" in Dermatology

World has been spinning around the term “Corona” virus since January 2020. The name "coronavirus" is derived from Latin corona, meaning "crown" or "wreath", itself a borrowing from Greek, which means "garland, wreath". In this article, it is interesting to read few dermatological conditions with the term Corona and crown like skin involvement in certain conditions.

Hirsuties Coronae glandis: (also known as hirsutoid papillomas and pearly penile papules; PPP) are small protuberances that may form on the ridge of the glans of the human penis. They are a form of acral angiofibromas. They are a normal anatomical variation in humans(1,2).

Corona phlebectatica is a cutaneous sign of chronic venous insufficiency, characterized by abnormally dilated veins around the ankle. Dilated venules behind and below the medial malleolus are termed ‘Corona phlebectatica paraplantaris’ and are invariably associated with venous hypertension (3,4).

Coronal alopecia: In early period, pattern alopecia involves frontal hairline ascorona alopecia. Ophiasis pattern of alopecia areata can involve frontal hairline which has been associated with worse prognosis to result in Coronal alopecia areata(5).

Corona seborrheica: Mild scaling on the scalp, popularly known as dandruff, may be an early sign of seborrheic dermatitis. It affects 5–10% of the population. There may be perifollicular, erythematous patches and scaling that are sharply marginated. Lesions may remain discrete or coalesce and extend over the whole scalp and beyond the frontal hairline and form the ‘Corona seborrheica’.

Corona psoriatica: The well-defined nature of the plaques of psoriasis is retained on the scalp in most cases. However, if there is associated seborrheic dermatitis, diffuse involvement may occur. Often, a band or corona of psoriasis, 2–5
cm wide which projects beyond the hairline on the forehead is known as ‘Corona psoriatica'.

Corona veneris: Dense papules on the forehead adjoining the papules in the hair margin produce a corona veneris in syphilis(6).

Cornoid lamella: A cornoid lamella is a thin column of closely stacked, parakeratotic cells extending through the stratum corneum with a thin or absent granular layer. It is seen in porokeratosis(7).

References:
1.Rapini Ronald P, Bolognia Jean L, Jorizzo Joseph L. Dermatology: 2-volume set. St Louis Mosby. 2007;247.
2. Gan SD, Graber EM. Treatment of pearly penile papules with fractionated CO2 laser. J Clin Aesthetic Dermatol. 2015;8(5):50.
3. Uhl J-F, Cornu-Thenard A, Satger B, Carpentier PH. Clinical analysis of the corona phlebectatica. J Vasc Surg. 2012;55(1):150–153.
4. Mortimer PS, Burnand KG. Diseases of the veins and arteries: leg ulcers. In: Champion RH, Burton JL, Burns DA, Breathnach SM, editors. Rooks Textbook of Dermatology. New York: Blackwell Publishing; 2004;2441–2494.
5. Gupta M, Mysore V. Classifications of patterned hair loss: a review. J Cutan Aesthetic Surg. 2016;9(1):3.
6. Zeeshan M, Jha AK, Kumar S, Chaudhary RKP. Condyloma lata in prepubertal male child: In the era of viral sexually transmitted infections (STIs). J Pak Assoc Dermatol. 2018;27(4):384–386.
7. Garg R, Singdia H, Rani N, Nijhawan S, Bhargava P. "Cornoid Lamellae Revisited." IOSR Journal of Dental and Medical Sciences, 19(2), 2020, pp. 43-45.

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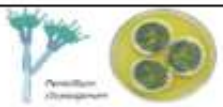
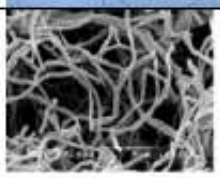
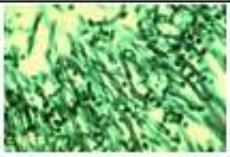
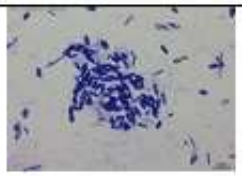
PLANTS AND MICROBES – SOURCE OF DERMATOLOGY DRUGS

NAME AND DERIVATIVE	IMAGE OF THE SOURCE
SYSTEMIC ANTIBIOTICS	
Pencillin G - *Pencillium chrysogenum* (Fungus)	
Cephalosporins - *Cephalosporium acremonium* (Mold)	
Vancomycin - *Streptomyces orientalis* (Actinomycetes)	
Rifamycin's - *Amycolaptus rifamycinia/Streptomyces mediterranei* (Soil mold)	
Clindamycin - *Streptomyces lincolnensis*	
Erythromicin - *Saccharopolyspora erythraea*	
SYSTEMIC ANTIFUNGALS	
Griseofulvin - *Pencillium griseofulvin* (Mold)	
Amphotericin B - *Streptomyces nodoses*	
SYSTEMIC ANTIPARASITIC	
Ivermectin - *Streptomyces overtitles*	

NAME AND DERIVATIVE	IMAGE OF THE SOURCE
TOPICALS	
Permethrin - *Chrysanthemum flower* (Pyrethroid)	
Bacitracin - *Tracey 1 strain of Bacillus subtilis*	
Polymyxin B - *Bacillus polymyxa*	
Neomycin - *Streptomyces fradiae*	
Mupirocin – *Pseudomonas fluorescens*	
Retapamulin - *Clitopilus scyphoides* (Fungus)	
Gentamicin - *Micromonospora purpurea*	
Nystatin - *Streptomyces noursei*	
Kojic acid – *Aspergillus oryzae* (Fungus)	

IMMUNOSUPPRESANTS	IMAGE OF THE SOURCE
Mycophenolic acid - *Pencillium stoloniferum*	
Cyclosporine - *Tolypocladium inflatum gams* (Soil fungus)	
Bleomycin - *Streptomyces verticillus*	
Tacrolimus - *Streptomyces tsukubaensis*	
Pimecrolimus - *Streptomyces hydroscopicus*	
Podophyllin - *Podophyllin peltateum*	
Sinecathechin - Green tea polyphenol extract from *Camellia sinensis*	
Colchicine - *Colchicum autumnale*	

CHEMICAL PEELS	IMAGE OF THE SOURCE
Glycolic acid - Sugarcane	
Lactic acid - Sour milk, bilberries, yogurt and tomato juice	
Malic acid - Apples	
Mandelic acid - Almonds, peaches, apricots	
Tartaric acid - Grape wine	
Ferulic acid - Tomato, rice bran sweet corn	
Phytic acid - Cereals	
Arginine - Brown sugar	
Jasmonic acid - Jasmine	

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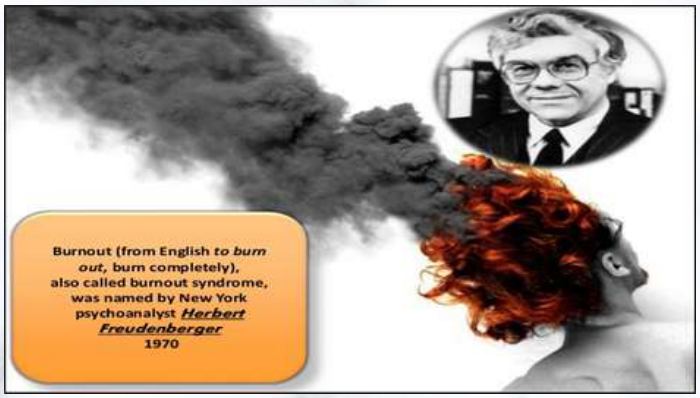
RESIDENT BURNOUT: A PARALLEL PANDEMIC

Burnout is a syndrome characterized by a triad of-

- **Emotional exhaustion** (loss of enthusiasm for work, lack of energy, feeling helpless/trapped/ defeated).
- **Depersonalization** (development of a negative, callous and cynical attitude towards patients and their concerns /colleagues/hospital; objectifying them).
- **Sense of decreased personal accomplishment** (tendency to see one's work negatively, without value /meaningless ('what's the use') and see oneself as incompetent).

Burnout is included in the 11th Revision of the WHO International Classification of Diseases (ICD-11) as an occupational phenomenon. Maslach Burnout Inventory, a 22-item questionnaire to measure all three burnout dimensions, is considered the gold standard for identifying burnout in medical research.

Dermatologists have the fastest growing rate of burnout.(1) According to the 2019 Medscape National Physician Burnout and Depression survey, 38% of dermatologists reported burnout.(2) Alarmingly, 19% of surveyed dermatologists also reported suicidal thoughts.(3) Medical residents, especially in their early years of training, are particularly vulnerable to burnout, with a prevalence rate ranging from 18-84% (4) across different specialties. Burnout during residency training has gained significant attention secondary to concerns regarding job performance and patient care. It leads to interference with the resident's ability to establish rapport, sort through diagnostic dilemmas, and work through complex treatment decision making.



Burnout is distinct from stress. The difference between Stress and burnout is the ability to recover in the time off. Burnout is more of a cumulative phenomenon and generally is associated with a convergence of stressors [Table 1].

TABLE 1. COMMON STRESSORS

Sleep deprivation
Lack of time for personal/family life
Dislocation from family and friends
Emotional drain of dealing with sickness and pain
Toxic work environment
Residency coinciding with major events of life
Financial strains

Some may associate burnout with being over-stressed to the point that the doctor cannot perform. In reality, doctors can apparently perform very well even though they're burned out. In fact, only extreme burnout is associated with decreased quality of care, suggesting that doctors tend to push through their symptoms of burnout. Importantly, burnout is not associated directly with an increase in tasks/duties and responsibilities. Rather, the degree of dissatisfaction and burnout appear to increase in inverse proportion to the resident's sense of control or perception of fairness of the responsibilities.

Residents are the "bottleneck" in the provision of services in the health-care team. They function as rate limiting step in the system. Pressure mounts to perform at full steam 24*7. In addition they have to balance between academics and the discharge of their duties. It has been found that residents with burnout had more than a threefold increase in odds of regretting their speciality choice.(5) Overall, burnout is associated with a variety of negative consequences including depression, risk of medical errors and negative effects on patient safety [Table 2].

TABLE 2. COMMON EFFECTS OF BURNOUT

Depression
Professional dissatisfaction
Professional impairment; increased medical errors/malpractice rates
Marital discord
Alcohol and drug abuse
Unhealthy attitude towards own needs
Suicide
Lower patient compliance and satisfaction

What can be done? Is resident burnout an inevitable consequence of the choice to become a doctor? Not by any means. The day-to-day nature of the battle between a fulfilling career and the 'hidden' forces of burnout mandates a role for active prevention, periodic monitoring and aggressive treatment. In 2019, over half of the dermatologists did not plan to seek help for burnout or depression.3 Dermatology training programs are academically rigorous; the recognition and prevention of burnout in dermatology residents should not be overlooked. Faculty play key roles in recognizing burnout, talking to residents and knowing resources for treatment. They need to address the modifiable determinants of burnout and develop targeted interventions to support residents throughout their training. Potential interventions include individual-driven measures viz. self awareness, healthy boundaries between work and non-work areas, creating focus where possible on work activities that provide the most meaning, promoting interpersonal professional relations, meditation and/or exercise and workplace-driven interventions viz. education about burnout/creating CME programs teaching the personal burnout measures as above, workload modifications, increasing the diversity of work duties, supporting flexibility in work hours, leadership skills and stress management training. Over 30% of dermatologists reported they were unlikely to participate in a workplace program to reduce stress or burnout, suggesting that dermatologists depend on individual coping mechanisms, if at all.(3) The top three ways dermatologists cope with burnout are exercise, sleep and isolation from others.(3)

Most of us as residents, are in a constant, invisible, soul eroding battle with burnout, inflamed further by COVID-19. Dermatology trainees have been called upon to join in the battle against this pandemic and are responding with an astounding display of selflessness, caring for patients despite the risk of profound personal harm. Admitting burnout challenges the inherent altruistic nature of our work and focusing on our own issues feels almost blasphemous. Our education and training still idolize workaholism and martyrdom and our promotion system rewards it. Practicing self care should not be equated with being selfish, reinforcing the concept of 'Medice, cura te ipsum' (Physician, heal thyself!). What can we as residents bring in to fight this evil?

We have invested over a decade of our lives in medical training and are intelligent, quick learning and hard working that has driven us to dermatology in the first place. Once we know the tactics to defeat burnout, no one will work harder at putting them into action. According to the Stanford Model, **promoting professional fulfillment requires three essential components; a culture of wellness, workplace efficiency and resilience**.(6) A congenial work environment that promotes motivation, support, teamwork, mentorship and allows flexibility to pursue academic interests may reduce burnout and increase practice efficiency. We have a life outside our hospitals where we can recharge and recuperate. Our families love and support us. We can also draw strength from them. In the interim, it is essential to identify and help struggling colleagues who may be inadequately coping with burnout.

References:
1. Shanafelt TD, Hasan O, Dyrbye LN, et al. Changes in burnout and satisfaction with work-life balance in physicians and the general US working population between 2011 and 2014. Mayo Clin Proc. 2015;90(12):1600-1613.
2. Martin KL. Medscape physician lifestyle & happiness report. 2019. Available at https://www.medscape.com/slideshow/2019 lifestylehappiness-6011057. Accessed December 14, 2020.
3. Kane L. Medscape dermatologist lifestyle, happiness & burnout report. 2019. Available at https://www.medscape.com/slideshow/2019-lifestyle-happiness-6011057 . Accessed December 14, 2020.
4. Shoimer I, Patten S, Mydlarski PR. Burnout in dermatology residents: a Candian perspective. Br. J. Dermatol 2018;178:270-271.
5. Dyrbye LN, Burke SE, Hardeman RR, Herrin J, Wittlin NM, Yeazel M, et al. Association of Clinical Specialty with Symptoms of burnout and career choice regret among US resident physicians. JAMA. 2018;320(11):1114–1130. doi: 10.1001/jama.2018.12615.
6. Colon A, Gillihan R, Motaparthi K. Factors contributing to burnout in dermatologists. Clinics in Dermatology 2020;38(3):321-327.

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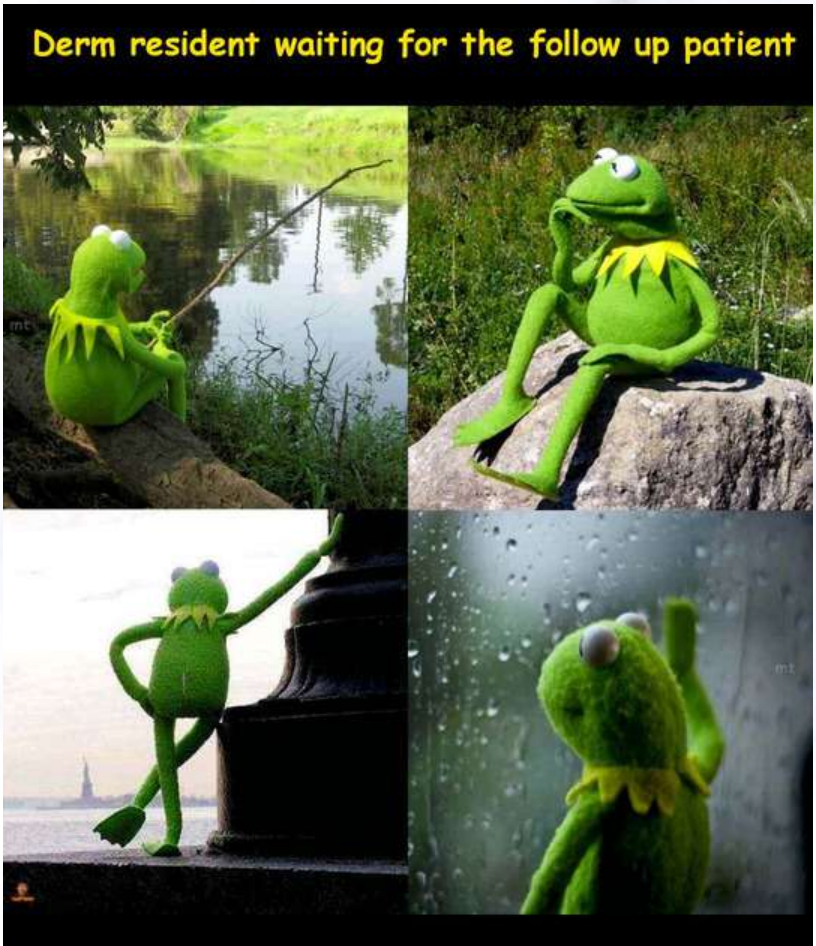


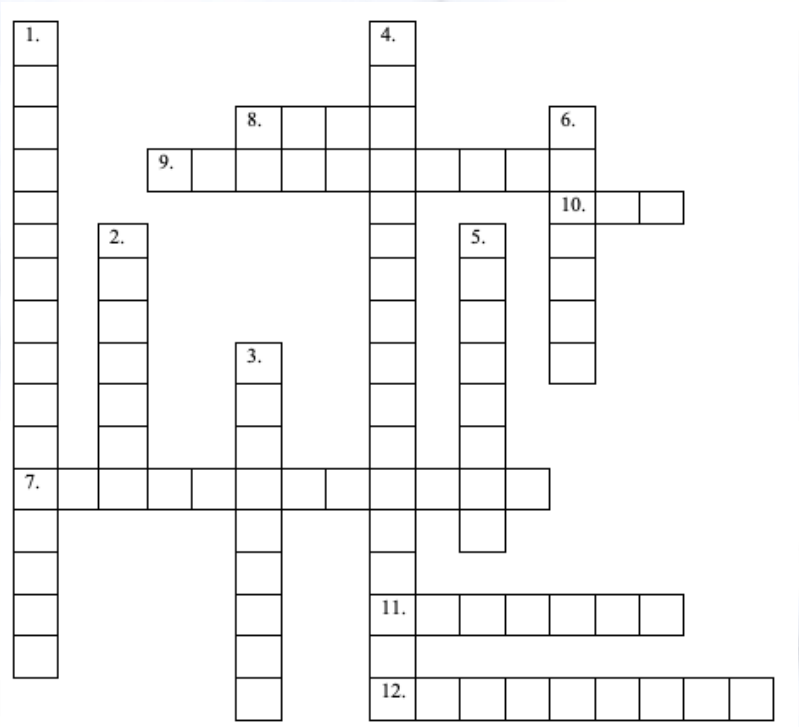
Crossword

DOWN:

1."Mace sign" in trichoscopy seen in___
2. Sign seen in dorsum of hands in bulimia nervosa.
3. ___ hand sign seen in arthritis mutilans
4. "coffee with milk" in coast of maine
5. Synonym of Neapolitan disease
6. Synonym of elephantiasis graecorum

ACROSS:

7. " Michaelis- gutmann bodies" seen in ___
8. Mutation in CARD15 gene
9. Plantar analogue of dupuytren's contracture
10. Caterpillar bodies seen in ___
11. Groove sign seen in ___ syndrome
12. Synonym of ' Eosinophilic pustular folliculitis'



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Match the Following

1. Apert syndrome	a) ABCA12
2. Nail–patella syndrome	b) Plectin (PLEC1)
3. Fabry disease	c) Plakoglobin
4. Tuberous sclerosis complex	d) PRKAR1A
5. Birt–Hogg–Dubé syndrome	e) α-Galactosidase A (GLA
6. Naxos disease	f) Hamartin (TSC1)
7. Harlequin ichthyosis	g) c-KIT
8. Epidermolysis Bullosa Simplex of Ogna	h) Folliculin (FLCN)
9. Carney complex (NAME/LAMB syndrome)	i) LMX1B
10. Piebaldism	j) Fibroblast growth factor receptor 2 (FGFR2)

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Answer key on page 49

'COLOUR' IN THE BLANKS – CHROMA IN DERMA!!

1. _____ ___ sign on dermoscopy differentiates scales from crusts (Figure 1)

2. Black-berry stomatitis is seen in _____mycosis, used to describe the granulomatous lesions over mucosa that bleeds easily.

3. The ___ ___ sign is a dermoscopic sign indicating malignant potential of a melanocytic lesion showing multiple 'shades of pink in the periphery'. (Figure 2)

4. White scale sign on dermoscopy is seen in _____ (Clue – disappears on application of emollients) (Figure 3)

5. _____ sign indicates color change in vitiligo lesions from white to red/pink during menstruation.

6. White _____ pattern is a characteristic dermoscopic sign seen in Prurigo nodularis and rarely in Cutaneous Leishmaniasis. (Clue – similar pattern in red is seen in Discoid Lupus Erythematosis) (Figure 4)

7. _____ sign is used to describe pigmentation of eyelids seen in Hyperthyroidism. (Clue – It's not Jellinek's but its synonym)

8. Most common dermoscopic feature of Unstable Vitiligo as shown in the figure is _____ pattern. (Figure 5)

9. Ink splash / Splash of paint appearance is used to describe lesion of ____ _____.

10. The sign describing the blue-black pigmentation of sclera seen in Endogenous Ochronosis is ____ sign.

11. Brown shadows on dermoscopy is a marker of _____ _____. (Figure 6)

12. The name of the pentachrome stain that stains elastic and collagen fibers simultaneously as black and yellow respectively is ____

13. ___ clods on dermoscopy are the hallmark of Hemangioma.

14. Absent pigmentary network on dermoscopy is described as '____ star'.

15. Onychoscopic pattern seen in Distal and lateral subungual type of Onychomycosis where the nail plate shows presence of multiple longitudinal lines of same or different colors (yellow, brown, white etc) is called the _____ _____ pattern. (Figure 7)

Answer key on page 49

Fig 1. Dermoscopy of nummular eczema showing crusts

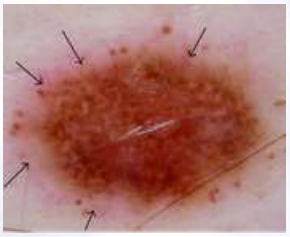

Fig 2. Dermoscopy of insitu melanoma

Fig. 3

Fig 4. Dermoscopy of Prurigo nodularis

Fig 5. Dermoscopy of Unstable vitiligo

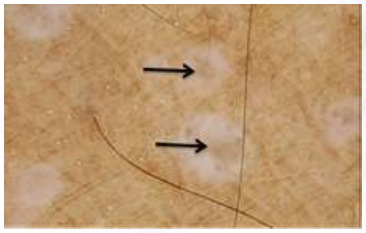

Fig 6. Dermoscopy showing Brown shadows

Fig 7. Dermoscopy of onychomycosis with the clue for the pattern being shown

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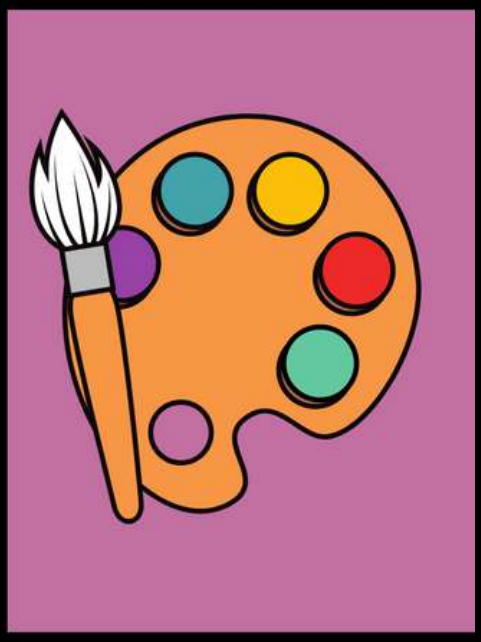
TALENT HUB



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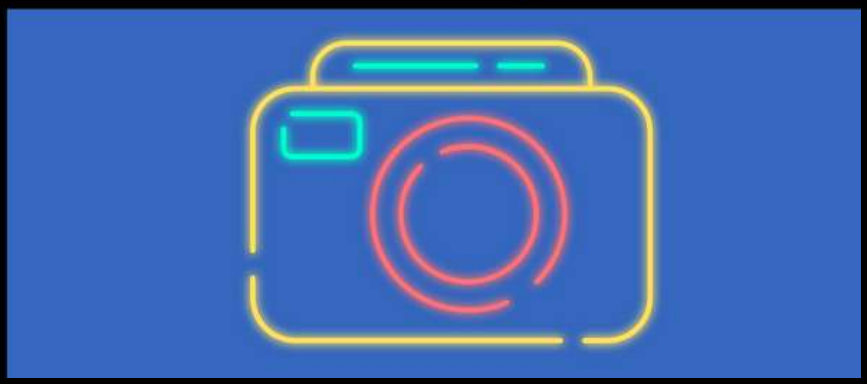

By the Hooghly

The breeze carries half broken words over the water,
A quiet cacophony of voices all looking out to the smooth undulations,
A meandering vein through the landscape,
Centuries and civilizations have risen and fallen around her,
She is lived through it all.

Through a hundred wars, famines and pandemics,
And uncountable lovers perched by her fringes,
Whispering sweet-nothings that nobody but the river hears,
She carries it all in her waters. .

Infinite men have stood by her banks, year after year of their tiny lives,
First running along her, rowdy boys in shorts, after school,
Lounging around her as young teenagers,
Young men seated by her whispering promises of love in a shy girl's ears.
Years later, quietly strolling along her, clasping their son's hands tightly,
Finally their ashes strewn into her, sinking into her, embraced by the river they grew beside. .

The river meanders on,
Untouched by the lives of fickle, fragile, transient humans,
Unaltered by life, death, disease.
Serving as the boatman's source of earning,
Only moved by the weather and the government's projects.

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Hand lens

I came to this girl of twenties
And my boredom empties.
She often wore a labcoat
Me in her pocket on that note.
She took me everywhere
Wherever she in this attire.
She fed me once
Was never hungry for months.
We met people together
Me with her in a tether.
She leaned on them saw their outerself
Me their innerself.
The trust in the eyes
The weep to help.
When I felt the warmth of their skin
Detangling of puzzles begin.
Days went by,months passed
Me miserably depressed.
Missed her rounds
Missed people.
No warmth
Stuck in a wrath.
Hunger creeped
Nobody cared.
Realised late
She got a new mate.
“Dermatoscope dermatoscope!” people shouted
“Is she the one?” I doubted
Had to travel with time
Now nothing else but whine.
Somebody else fed me
Only to desert me.
In this new life
Done with the strife.
Just started another one
Don’t leave me hon.

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And still, we rise

It has been more than a year since we have all been thrown into this whirlpool of new normal. The pandemic exposed yet another epidemic that had always been brewing just beneath the surface – grueling and real, but swept under the carpet and its existence denied, because, “what will people say”: the epidemic of sadness.

There is this very famous excerpt from the blockbuster Nanette (2018), concerning one of the most influential artists in the history of Western art - Vincent van Gogh, and his depression. The comedian narrates how an audience member once encouraged her to stop taking medicines for her mental health issues, saying that she is “an artist” who must “feel”. They mockingly say, “If Vincent van Gogh had taken medication, we wouldn’t have got the sunflowers”. Legend says his depression was so severe that he once ate yellow paint in a desperate attempt to keep his insides happy.
We have downplayed mental health issues for centuries, romanticizing and glorifying the “tortured genius” stereotype – isn’t the painting, “the vase with twelve sunflowers”, although breathtakingly glorious, a scant trade - off for a human being’s suffering?

As doctors, like great artists, we are held to high standards - we are “not allowed” to lose. The society doesn’t worship us anymore like they did, maybe decades ago. Yet we are still stuck on the high pedestal and stripped off of our right to make mistakes – and it’s incredibly tragic, this making of “Gods” out of humans - because even the best of us can lose our way.

With the pandemic piling onto the already existing work place stress, coupled with the pressure to perform, multiple quarantines and having being away from loved ones for perhaps more than a year, health care workers are facing mental break downs like never before. Our brittle psyches that had already been shredded little by little, each time we go beyond the confines of “humanely possible”, yet held together by numerous invisible bandages just beneath the surface, is finally shattering into a thousand tiny pieces.

On such days, let us cut ourselves a little slack. Maybe success is not always coming first in the rat race or saving every life, because it is impossible that way. Maybe success is as simple as a good night’s sleep. Maybe success is testing negative after a round of Covid duty. Maybe success is getting a laughing emoji for a risky text or finding two packets of taste maker in one packet of Maggi. Maybe in this confused world of messed up messiahs, even saving one life is enough and that life could very well be your own. Maybe success means embracing the beauty, even when a massacre lies ahead. Because, very often, living is easier than thinking about it.And then, when people ask you what you do, you can rightfully say, “Whatever it takes” – because that is what we do, every day, with every fiber of our beings and it’s time to celebrate that, no matter what the outcome. Because, not all battles can be fought for victory.ha Some are fought to tell the world that someone is still there on the battle field, even when everyone else has given up and moved on, like those people who flock into crowded areas with masks at their throats.

So, let’s go as far as we can see. Hopefully when we reach there, we will see further. Because, the beauty of being a human, is in our capacity to believe and hope, even when it’s exhausting. And perhaps, who knows, one day soon, all this will end and, in the aftermath, we can hang up our Covid duty scrubs and it won’t feel like a crime anymore to breathe without a mask and we will be finally able to show up at our homes. And yes, we are in an epidemic of sadness, but healing and happiness are pretty contagious too, because we will survive – we always do - just hang in there and keep showing up.

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TALENT

In this world, there are three types of people:
1. Who have talent
2. Who knows they have talent
3. Who actually use their talent

At the end of our educational life, we know what makes us feel alive. We believe in our dreams. We know our specialities. Often, we forget our talent when we choose our profession based on our educational qualifications. We neglect our interest and our talent starts vanishing.

Have you ever asked yourself, what is your talent? Do you doubt if you have any? Let us discover.

Everyone is born with potential to do extraordinary in life. Unfortunately, we settle for the ordinary. When someone asks what our talent is, we think for a while and say we don't have any.

In most cases, people have never tried to explore their talent. Everyone is unique in one way or other. Even a person with disabilities will have something special within him. Therefore, never ever doubt your existence in this world.

If you don't use things for a while, you certainly forget about them. The same happens with talent.

As Buddha said, "Everyone is gifted here, but some of us never opened their package". Have you opened your package yet?

Where can you find your talent? You can find it in your hobbies. You may be born with some natural gift. You can find your talent in your skills acquired during education. It may be in the form of writing, programming, designing, painting, singing, or cooking. It could be anything.

Sometimes we simply ignore our talent because it seems ordinary to us. For example, when you cook for your family, you know that you cook well and love doing it. But you might ask yourself, "How can this be a talent? This is my regular work and every homemaker does the same."

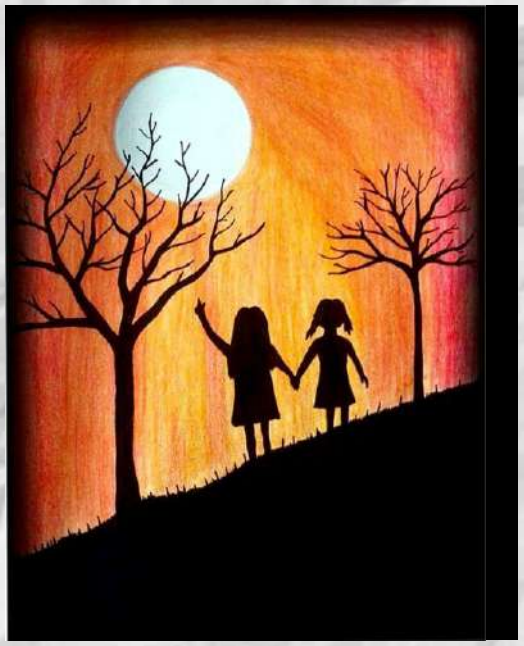
There is nothing like small, big or ordinary talent. Talent is a talent. If anyone asks you what your talent is, say it proudly that, "I can cook well". If you appreciate your talent, you give it a new direction to evolve. You never know where it might take you in your life.

It is Showtime now; use your talent. Once you identify your heart's call, don't sit idle. Don't wait for the perfect time, instead grab an opportunity and showcase your talent. As Ivan Panin said, "Not he deserves praise that has talents, but he that uses them."

The joy is not in dreaming about your talent, but in using that talent. Take the first step and explore the dimensions.

"Everyone has talent. Many know it but a few use it. That is where greatness lies."

Dr. Yashashree Dungarwal
PG1
Osmania Medical College, Hyderabad, Telangana



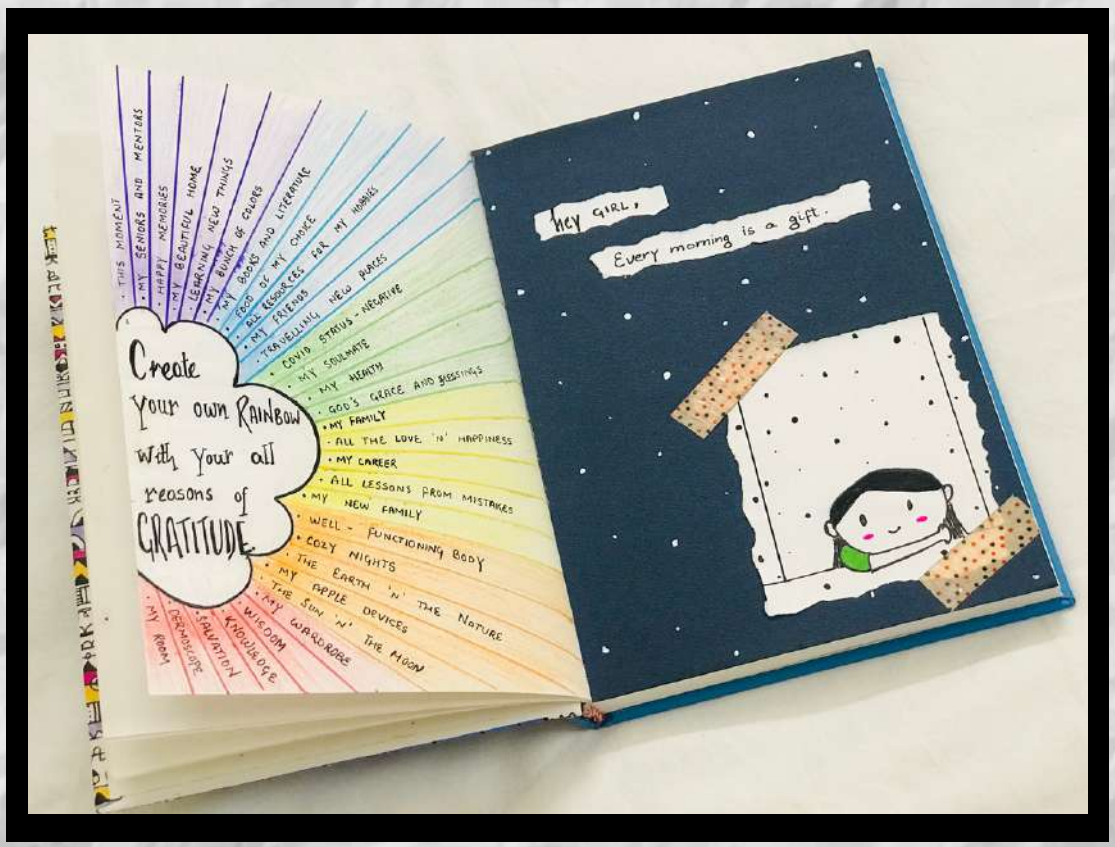
Dr.Gayathri Sundaram
PG 3
VMKV medical College
Salem, Tamil Nadu

SKETCH BOOK

Dr. Shreya Deoghare
PG3
Dr. D. Y. Patil Medical College and Hospital, Pune, Maharashtra

Dr. Bhagyashree B. A.
PG2
SVMC , Tirupati
Andhra Pradesh

SKETCH BOOK



Dr. Mitali Sethi
PG 2
Jawaharlal Nehru Medical College
Aligarh, Uttar Pradesh

LIFE, CAMERA, ACTION!

Mirror, mirror on the floor

Dr. Divya Manjegowda
PG3
Hindu Rao Hospital and NDMC Medical college, New Delhi

Stairway to heaven

Dr. Pooja Kanumuru
PG3
Krishna institute of medical science, Karad, Maharashtra

LIFE, CAMERA, ACTION!

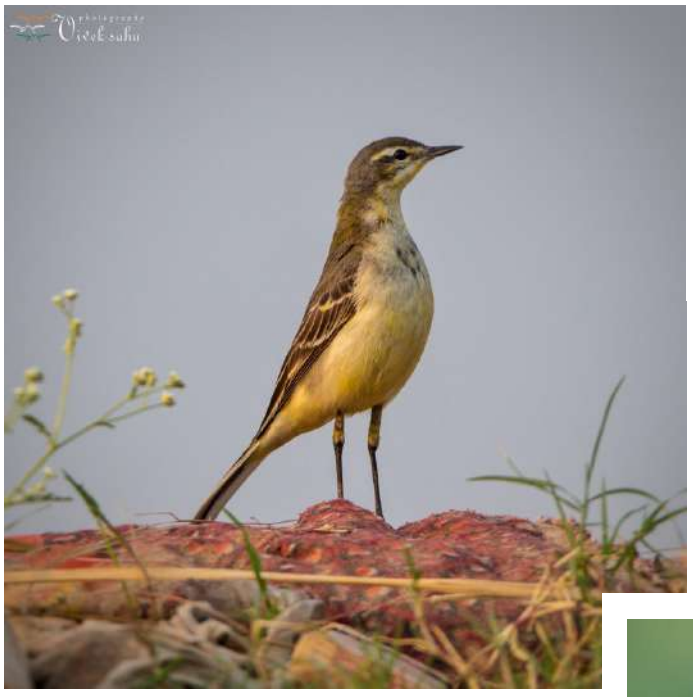
Carpe diem

Dr. Supriya Shakya
PG2
Index Medical College, Indore
Madhya Pradesh

Dare to stare

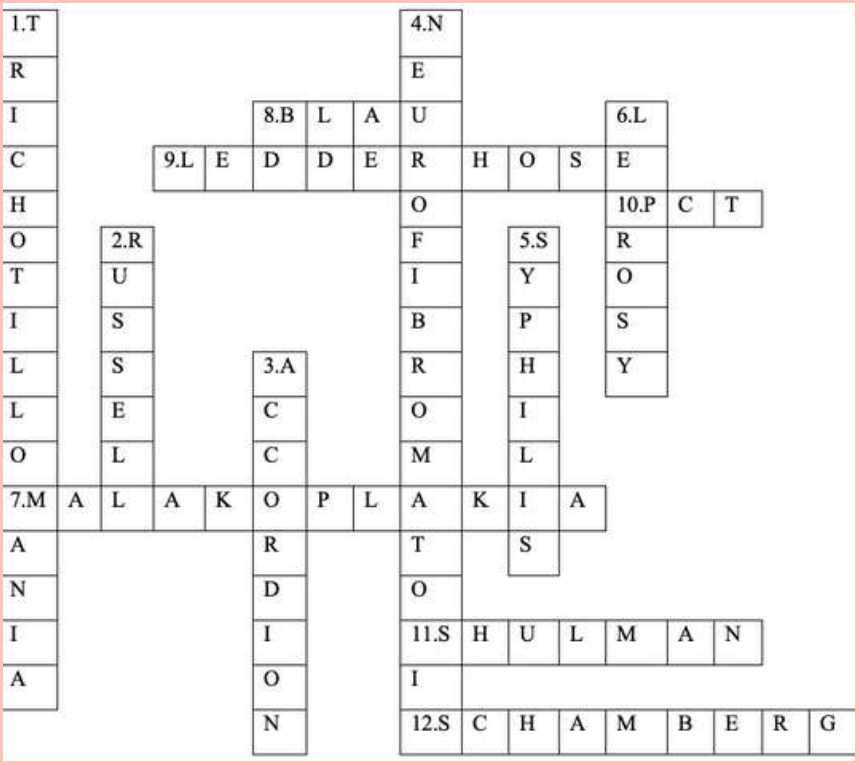
Dr. Dilip Kumar
PG1
Bangalore Medical College and Research Institute, Bengaluru
Karnataka

LIFE, CAMERA, ACTION!



Dr. Vivek Kumar Sahu
PG2
Silchar medical college and hospital, Assam

ANSWER KEY



'COLOUR' IN THE BLANKS:

1. Yellow Clod sign
2. Paracoccidioidomycosis
3. Pink rim sign
4. Xeroderma
5. Punshi's sign
6. White Starburst pattern
7. Rasin's sign / Jellinek's sign
8. Trichrome pattern
9. Nevus depigmentosus
10. Osler's sign
11. Lichen Nitidus
12. Movat's pentachrome stain
13. Red clods
14. Black star
15. Aurora Borealis pattern

MATCH THE FOLLOWING:

1. Apert syndrome --------Fibroblast growth factor receptor 2 (FGFR2)
2. Nail–patella syndrome---------LIM homeobox transcription factor 1β (LMX1B)
3. Fabry disease ---------- α-Galactosidase A (GLA)
4. Tuberous sclerosis complex------ Hamartin (TSC1)
5. Birt–Hogg–Dubé syndrome --------Folliculin (FLCN)
6. Naxos disease --------- Plakoglobin
7. Harlequin ichthyosis --------- ABCA12
8. Epidermolysis Bullosa Simplex of Ogna ------ Plectin (PLEC1)
9. Carney complex (NAME/LAMB syndrome) ------- PRKAR1A
10. Piebaldism-------c-KIT

1. ----- j)
2. ----- i)
3. ----- e)
4. ----- f)
5. ----- h)
6. ----- c)
7. ----- a)
8. ----- b)
9. ----- d)
10. --- g)

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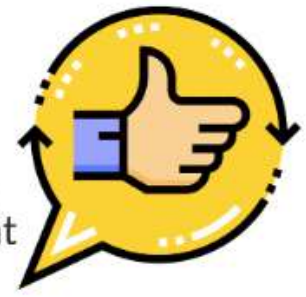

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