# RESIDREAM

Volume 9 . Issue 2 . February 2023

**With a focus on less-known subspecialities**

## The latest trends

# Editorial

*"It is the long history of humankind that those who learned to collaborate and improvise most effectively have prevailed."*

*– Charles Darwin*

Dear Residents,

Back in my post-graduation, I discovered about Resident Committee and their publication Residream, I was eager to be a part of the team. I always had a flare for creative writing and participating in extracurricular activities to my fullest capacity. As a resident, NRCC and Residream were a perfect opportunity for me to contribute and be connected with IADVL. I was fortunate to be associate editor and North Zone Coordinator in 2020, and it was one of my dreams, to serve as a convenor for NRCC and Editor in Chief for Residream one day. Today, a year has passed by, in my capacity as Convenor of NRCC, and it has been a beautiful year of connecting with residents throughout the country.

We expanded our social media outreach immensely this year and even participated in IADVL YUVA NRCC meet, held twice; where he conducted numerous sessions for dermatology residents, addressing every smallest query and concern that they have.

Residream Magazine is very close to my heart, as I have been associated with it for so many years, earlier as a contributor, then

associate editor and now as a chief editor. Today in my capacity as Editor in chief, I feel truly humbled and grateful to be releasing the Volume 9 Issue 2 of Residream. I express my sincere gratitude and appreciation to Dr. Rashmi Sarkar Ma'am, Dr. Dinesh K Devaraj Sir and the entire IADVL EC for their constant guidance and support and for placing their trust on me. Special thanks to our advisor, Dr. Kinnor Das who was always available to help no matter how small or big the issue.

I am extremely fortunate to be blessed with a wonderful team, with each member outwitting the other in terms of their commitment towards NRCC. Dr. Shreya Deoghare has beautifully designed the cover page. Dr. Drashti has eloquently penned the journey of NRCC in 2022.

The dedication and hard work of my editorial team of Dr. Vignesh Narayan R, Dr. Abirami, Dr. Shreya Deoghare, Dr. Priyanka Nawani, Dr. Anand Mannu, Dr. Prateek Nayak, Dr. Soumya Alice Mathew, Dr. Apoorva Maheshwari, Dr. Ankita Choudhary and Dr. Drashti Devani have to be acknowledged multifold as they are the reason why we have been able to put together a wonderful issue. The issue contains an amalgamation of academic articles, crossword puzzle, poems, memes, artwork and stories.

In the end I would like to conclude by saying ""If everyone is moving forward together, then success takes care of itself" – Henry Ford

Thanks to all the residents who contributed to the current issue. Hope you all have a great read!

With love and gratitude,

**Dr. Soumya Sachdeva**
MBBS, MD, DNB
Convener NRCC 2022
Editor in chief Residream 2022

# PRESIDENT'S PREAMBLE

Dear IADVL members,

Dear IADVL members,

It gives me great pleasure to be writing this message for Residream February 2023 issue, released and compiled during my tenure as IADVL President 2022.

The Residents' committee and Residream Bulletin have always been very dear to me and has been my pet project since 2014. From what began in 2014, the committee has grown beautifully with each passing year.

This committee led by Dr Dinesh Kumar Devaraj, Secretary General IADVL and the talented Convener, Dr Soumya Sachdeva has been very innovative and forthcoming the entire year. They have had a massive outreach both physically and on social media through a strong network of medical college representatives and social media posts, more than three times a week. The DermaPath quizzes by Dr. Drashti Devani, the Crazy Conundrum on Instagram by Dr. Vignesh Narayan R., the Lights Out Series by Dr. Shreya Deoghare; are few among the many initiatives taken by the team on Instagram.

All the members like Abirami, Apoorva Maheshwari, Prateek Nayak, Priyanka Nawani, Anand Mannu, Shreya Deoghare and Soumya Alice Mathew have worked very hard throughout the year. The current Residream magazine is a delight to read, with contributions from residents pan India.

More power to you Dr Soumya Sachdeva and team to keep the magic going with this and subsequent issues and making more PGs interested in working for IADVL.

Long live IADVL !

Rashmi Sarkar

**Dr. Rashmi Sarkar,** MD, FAMS
President IADVL 2022

# HONORARY SECRETARY GENERAL SPEAKS

*"Tell me and I forget, teach me and I may remember, involve me and I learn."*

**- Benjamin Franklin**

Dear Residents,

Dermatology Residents require ample support, care and guidance, so as to be able to achieve great heights. IADVL ensures that it can connect with the future of dermatology, by providing them with a platform to share their ideas and thoughts. The National Resident Connect Committee of IADVL ensures that they do this task to perfection, by being a connecting force between the residents and IADVL. They carry out numerous activities throughout the year with a very active social media, to make each and every resident feel one with IADVL. This ensures that our younger generation is moulded in the right way.

The Residream magazine, is one such initiative of the NRCC, where residents express themselves through poems, stories, memes, artwork and academic articles. All the contributors of Residream have done a fantastic job in maintaining the superlative quality of Residream and it is now a beautiful amalgamation of academic and practical tips for the budding dermatologist.

I congratulate NRCC Convener Dr Soumya Sachdeva; who is also donning the hat as the Editor in chief of Residream and associate editors Dr. Vignesh Narayan R, Dr. Abirami, Dr. Shreya Deoghare, Dr. Priyanka Nawani, Dr. Anand Mannu, Dr. Prateek Nayak, Dr. Soumya Alice Mathew, Dr. Apoorva Maheshwari,Dr.Ankita Choudhary and Dr. Drashti Devani for successfully bringing out this issue of Residream.

IADVL as an organization is aware about the needs of post graduate students, we have created several opportunities in the form of scholarships, quizzes, conferences tailor made for post graduates. I request all the residents to stay updated by visiting our website, social media pages frequently and to make the best use of these opportunities. We are open to your feedback and encourage your involvement and contribution towards a brighter IADVL.

**Dr. Dinesh Kumar Devaraj,** MD, FRCP
Honorary Secretary General, IADVL
Chairperson, NRCC

# MESSAGE FROM ADVISOR

Dear Residents

As we celebrate IADVL's golden jubilee year, it is a great honour for me to serve as an advisor to the IADVL National Resident Committe. This edition of IADVL Residream represents the finest efforts of our team. Dr. Rashmi Sarkar madam, President IADVL, and Dr. Dhinesh Kumar Devaraj Sir Secretary General IADVL and Chairperson IADVL NRCC, have enlighted and guided us every moment in this beautiful journey.

Dr. Soumya Sachdeva, chief editor and convenor of the IADVL NRCC, and her team of associate editors, Dr. Abirami, Dr. Drashti, Dr. Priyanka, Dr. Shreya, Dr. Vignesh, Dr. Prateek, Dr. Soumya AM, Dr. Anand, Dr. Apoorva and Dr. Ankita who have produced excellent work. A big shout out to them.

The IADVL resident connect committee is a first step in aiding the residents on the long road ahead. I urge all dermatology residents to join the IADVL NRCC and use the organization's resources.

A big cheers to all the IADVLites on this golden jubilee celebration.

With warm regards.

**Dr. Kinnor Das**
Advisor

# index


# CHARITY BEGINS AT HOME

Dr Dipti Desai, with 25 years of dermatology experience,is presently practising in Mumbai. She is the present president of the national community dermatology committee. She actively participates in information education and communication (IEC) activities in the schools, orphanages, for elderly people, for youngsters and the general population in the underprivileged areas through awareness camps, powerpoint presentation, speeches, and street play. Also she conducted more than 100 medical camps in the past, where free consultation and dermatological medicines were distributed free of cost where thousands of patients benefited till now. Few of these activities are conducted as a joint venture of NGOs. Her social service activities increased every year and last year she conducted 15 similar camps.

On asking Dr Dipti Desai, ' What made you start these activities?', " Though service mindset was from my college time, my charity work started from my home. My family background, their encouragement and support is the backbone of all the activities", she replied with a smile. She and her family conducted medical treatment camps in the Latur and Gujarat earthquake where hundreds of people benefited.

She focuses on awareness among the public about superficial fungal infection, their treatment, do's and dont's with free treatment for the needful. Also, she created awareness in the community about quackery

and "Dermatologists are the true skin, hair and nail expert" through IEC activities. She also conducted awareness and screening camp for leprosy.

She is presently working on IADVL vision - "Dermatology for all" to create awareness among health workers and patients. IEC activities include women empowerment and fairness mania among youngsters.

She is requesting youth participation in community services, whatever small they can to bridge the gap between haves and havenots, as a gratitude for seniors, teachers, family and community. We hope, her selfless activities in empowering patients may inspire young dermatologists to continue the same in future.

**Sqn Ldr (Dr) Anand Mannu**
**Final yr resident,**
**Dermatology, AFMC Pune**

# MASTERING CLINICAL PHOTOGRAPHY IN SKIN OF COLOUR

For clinical care and educational purposes, dermatology depends heavily on high-quality photographs.[1] It has long been a problem that photographic technology is biased against accurately capturing dark skin. Colour balance with film photography relied on reference cards showing white models, while digital photography still has difficulties taking in-depth pictures of people with darker complexion.[2]

In order to take images of patients with dark skin that are of the best quality, it is crucial to use the right photography techniques.

Appropriate photography begins with obtaining consent. Patient comfort in the clinical setting is very important. The doctor should be upfront about the photo's intended use, whether it be for study, publication, education, or social media, as well as how it will be used. When photographing delicate body parts, the clinician should always take suitable drapery into account, only exposing the portions required for an accurate clinical representation.

Following these guidelines can help clinicians get the best results while taking pictures of patients with skin of colour:[3]

1. **Natural Light -** The best option for bringing out the inherent features of dark skin is natural light [Fig 1(a), 2(a)]. In actuality, this can entail taking a picture outside or in front of a window. Due to flash artefact, flash and direct illumination should be avoided while treating patients with dark skin. [Fig 1(b), 2(b)]. A shine called a flash artefact can hide skin's finer details. The next best choice is room light, however this can result in colour distortions [Fig 1(c), 2(c)].[4]
2. **Indirect Light -** An ideal situation would involve indirect illumination that is reflected onto the subject. It ought to approach the subject from the rear, both sides, and the camera's side. To provide a reflected light source for the subject, one could hold a white sheet or muslin fabric on either side of the object.
3. **Avoid backgrounds with bright colours or patterns** since they may contaminate the subject's colour. The perfect background is one that contrasts the subject most sharply. Dark skin can be photographed well with white or light backgrounds because of the contrast and more light that they reflect onto the subject.
4. **For hair, a separate light,** such as an overhead exam light, might be useful when taking pictures of a patient with dark hair to highlight details that might otherwise be missed, such as at the hairline [Fig 1(d), 2(d)].
5. **Parallel light polarization -** The appearance of epidermal processes can be improved by parallel light polarisation, which may be especially helpful for a subset of photographs intended for publication or teaching. Cross-polarization can help in reducing light reflection and glare for lesions that primarily involve erythema or pigmentary changes, which can be especially helpful in darker skin types. A plastic linear polarizer sheet put over the camera lens and flash of a camera phone can be used to achieve this on a budget.[5]

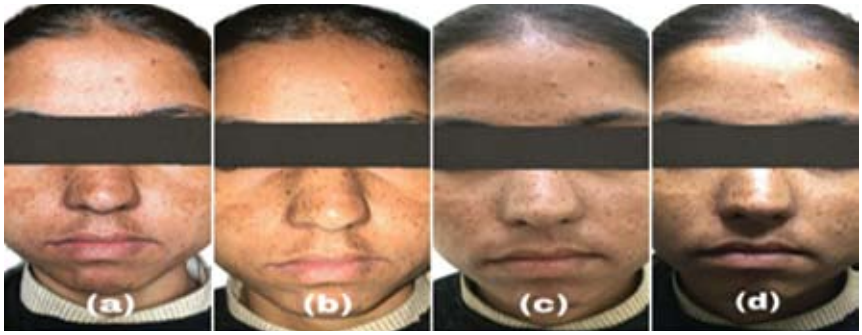
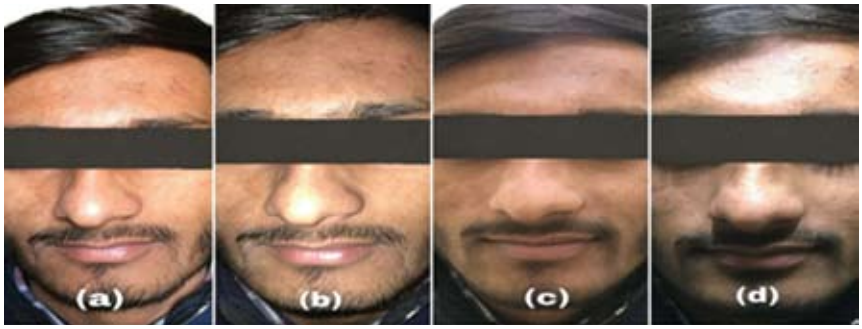



**Figure 1 : Photography in skin of colour with dermatoses**
**(a) Natural light,**
**(b) flash photography,**
**(c) room light,**
**(d) overhead light for photos focusing on hair.**

**Figure 2 : Photography in skin of colour.**
**(a) Natural light,**
**(b) flash photography,**
**(c) room light,**
**(d) overhead light for photos focusing on hair.**

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5. Bae JM, Ju HJ. Simple cross-polarized photography using a smartphone. J Am Acad Dermatol 2020; 82:e185–6.

**DR. SANJEEVAN KAUR**
**JR-2**
**Venkateshwara Institute of Medical Sciences, Amroha**

# VARIATIONS IN SKIN OF COLOUR

SKIN OF COLOUR (SOC) comprises of people of African, Asian,Hispanic and Caribbean origin.Africa is known as the cradle of civilisation,about 70,000 years ago humans migrated from Africa to Europe and Asia.As people moved away farther away from the equator ,a decrease in UVR resulted in decreased melanin level giving them a lighter tone.People living near the equator has more melanin and has a darker skin tone .Our genes have aided us by adapting to the environmental changes, but we have based the colour of skin as a reason to discriminate among each other. White is considered superior and powerful through out the globe,the colonial past of many countries can be one of the reason for this false perception.Most of the textbooks we follow are by western authors and there is lack of visual representation of brown or black skin colour ,this affects the way we diagnose our patients.

## VARIATIONS IN LAYERS OF SKIN

- Stratum corneum is thinner in individuals of Asian descent compared to individuals of African descent.
- People of African descent have a thick and more compact dermis as opposed to Whites who have a thinner and less compact dermis.
- The lipid content of the black skin is higher than the white skin.
- Fibroblasts are larger and greater in quantity in the black skin
- As the white skin absorbs more ultraviolet light, it has a greater capacity to form vitamin D than the black skin.

## VARIATIONS IN HAIR

- The spiral hair is characteristic of black skin.
- The cross section of the spiral hair has a flattened elliptical shape.
- Black hair is more pigmented.
- Elastic tissue anchorage to the hair follicle is reduced in the dark skin, resulting in more incidence of traction alopecia

## VARIATION IN PIGMENTATION

- According to Fitzpatrick skin type, SOC belong to type IV,V and VI.Regardless of the colour of skin, all humans have the same number of melanosomes but the size and dispersion varies.
- Melanosomes are larger and are dispersed throughout the epidermis in African people compared to the White skin, where melanosomes are mostly confined to the stratum basale.
- White epidermis contains more pheomelanin and eumelanin is present in darker skin tones.
- Oral macular physiological pigmentation is seen mostly on the gingiva ,hard palate, buccal mucosa, and tongue.
- Band of pigmentation on the nail plate is common in people of colour.

| Characteristic | Skin of Colour | Fair Skin |
|---|---|---|
| Stratum corneum | Asians have thinner epidermis compared to Africans | - |
| Cells of the stratum corneum | compact with greater intercellular cohesion | less compact |
| Melanocytes | Equal in number | Equal in number |
| Melanosomes | Large, dispersed | Smaller, absent in the upper layers of the epidermis |
| Melanin | Greater | Less |
| Hair | Spiral | wavy |
| Collagen fibers | Small | Larger |
| Fibroblast | Large, more in number | Smaller, less in number |

## COMMON SKIN CONDITIONS AMONG AFRICAN POPULATION

- Pseudofolliculitis barbae
- Acne keloidalis nuchae
- Central centrifugal cicatricial alopecia (CCCA)
- Traction Alopecia
- Keloids
- Pomade acne
- Keratosis palmaris et plantaris
- Dermatosis Papulosa Nigra:
- Sarcoidosis
- Facial Afro-Caribbean Childhood Eruption
- Melasma

## COMMON DERMATOLOGIC DIAGNOSES AMONG ASIAN POPULATION

- Xerosis
- Pruritis
- Nevus of Ota
- Nevus of Ito
- Lichen amyloidosis
- Photodermatoses
- Basal cell carcinoma

## DERMATOSES CAUSED BY CULTURAL PRACTICES IN ASIANS

- Allergic and irritant contact dermatitis to herbal medicines
- Kumkum, hennah, bindhi dermatitis
- Cupping
- Moxibustion
- Coining
- Mudichood

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1. Lester JC, Taylor SC, Chren MM. Under-representation of skin of colour in dermatology images: not just an educational issue. Br J Dermatol. 2019 Jun;180(6):1521-1522.
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**SHEBA JACOB**
**JR-3**
**Saveetha Medical College, Chennai**

# DERMATOGENESIS – A PATHOGENESIS EXPLANATION COMPETITION

The competition was conducted in October 2022 as part of celebrating World Psoriasis day 2022. The purpose of this competition was to allow residents to present their understanding of a disease pathogenesis in a creative, updated and simple manner.

The activity received tremendous response from Residents across India.

The competition was judged by :

**Dr. Soumya Jagadeesan**
Associate professor
Department of Dermatology
Amrita Institute of Medical Sciences, Kochi

**Dr Anupam Das**
Assistant Professor
Department of Dermatology
KPC Medical College and Hospital, Kolkata

The competition coordinators were:
**Dr Shreya Deoghare**
**Dr Soumya Alice Mathew**
**Dr Anand Mannu**

**And finally, the winners :**

**1st Place**

**Dr. Subhojit Ray**
2nd year PG resident
Department of Dermatology, University College of Medical Sciences & G.T.B Hospital, New Delhi

**2nd place**

**Sukhdeep Singh**
3rd year PG resident
PGIMER Chandigarh

**3rd place ( Tie)**

**Dr. Anjali Sahu**
2nd year PG resident
Lady Hardinge Medical College

**3rd place ( Tie)**

**Dr Neha Sharma**
3rd year PG resident
Government Medical College, Kota

**Dr. Soumya Alice Mathew**
**Consultant Dermatologist**
**DermaVue Skin Clinic,**
**Thiruvalla, Kerala**

# INNOVATIONS IN DERMATOLOGY

- Candidal intertrigo between the toes maybe due to fungus but treating for fungus alone will not cure the condition. Physical factors such as heat, moisture and lack of aeration are other factors which need to be addressed. An adhesive stretchable tape used as a toe separator, thus overcoming the disadvantages of metallic toe separator which is unlikely to be comfortable.

  **Srinivas, C.R. (2016). Innovations in dermatology. Indian Journal of Dermatology, Venereology and Leprology, 82, 641.**

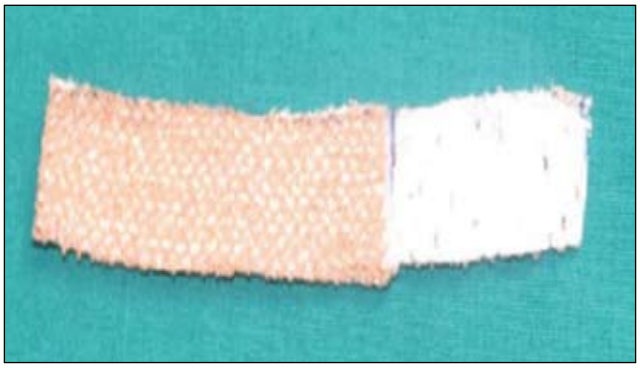


Fig 1. Adhesive stretchable tape folded upon itself

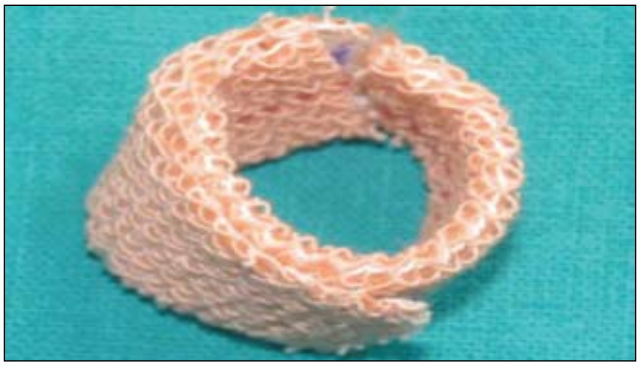


Fig 2. Toe separator

- Polyethylene tube as an attachment to universal serial bus (USB) dermatoscope for preventing cross-infection. Leucoplast adhesive tapes are commonly available in clinics and hospitals. The plastic tube which forms the core of these tapes [Figure.1a], was used as a front attachment for the USB dermatoscope [Figure.1b] It functions as a spacer between the skin and the device. Moreover, a single tube can be cut into 2–3 pieces. These tubes can be kept overnight in glutaraldehyde solution for sterility. The sterile tubes can be attached to the probe of the USB dermatoscope prior to performing dermatoscopy which ensures that the probe or the cover cap does not come in contact with the skin surface. Later, it can be discarded after use.

  **Jakhar, D., Grover, C., & Kaur, I. (2020). Polyethylene tube as an attachment to universal serial bus (USB) dermatoscope for preventing cross-infection. Indian journal of dermatology, venereology and leprology, 86(4), 459–460. https://doi.org/10.4103/ijdvl.IJDVL_376_19**

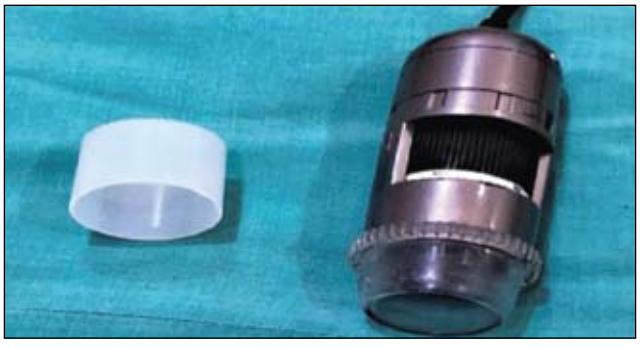


Fig.1a Polyethylene plastic tube

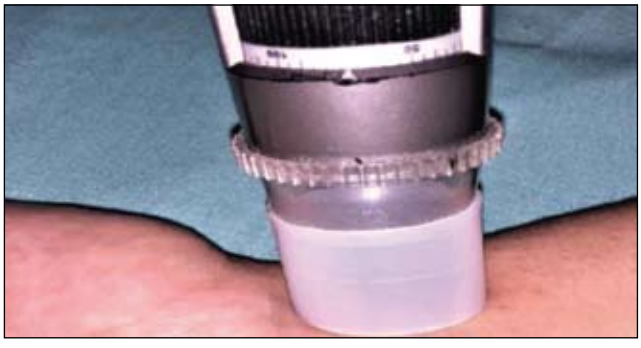


Fig. 1b The tube attached to the probe of dermatoscope

- Fractionated devolumizing keloid tissue: The 'pop' method: A novel technique to facilitate administration of intralesional corticosteroid in difficult keloid. A 4-mm biopsy punch is used to excise keloid tissue from multiple sites 1 cm apart after ensuring regional local anesthesia. A 4-mm punch is chosen for 2 purposes: to allow adequate debulking of keloid and to ensure adequate deposition of steroid in the adjacent keloidal tissue.

The tissue obtained via biopsy literally pops out of the keloidal mass as the tension within the keloid is relieved. Thereafter, injecting triamcinolone acetonide.

**Dhurat, R., Daruwalla, S. B., & Sharma, A. (2023). Fractionated devolumizing keloid tissue: The 'pop' method: A novel technique to facilitate administration of intralesional corticosteroid in difficult keloids. Journal of the American Academy of Dermatology, 88(2), e75–e77. https://doi.org/10.1016/j.jaad.2019.01.041**

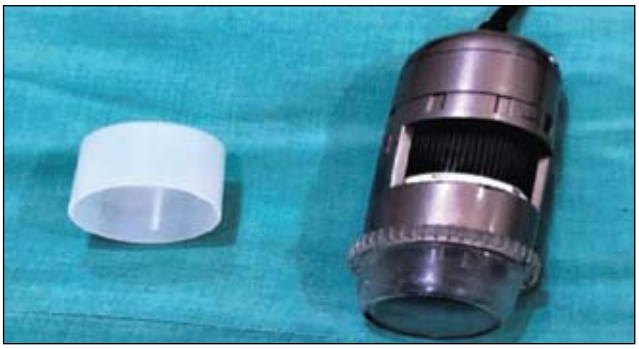


Fig.1a Polyethylene plastic tube

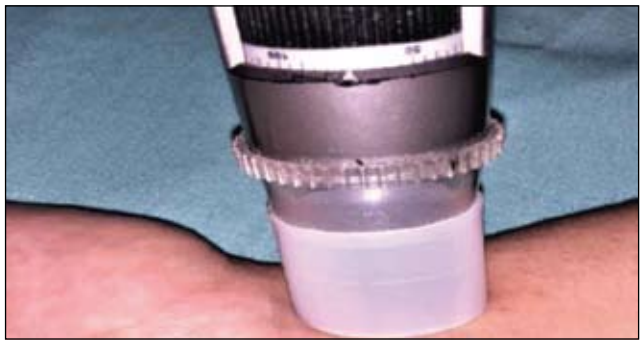
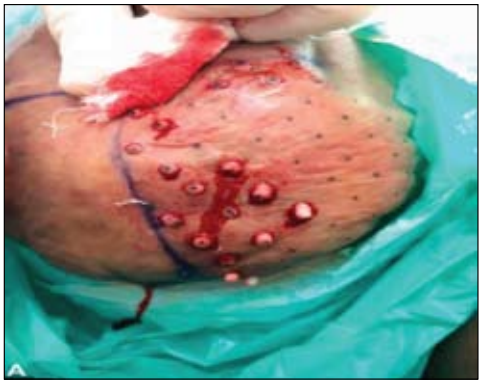


Fig. 1b The tube attached to the probe of dermatoscope



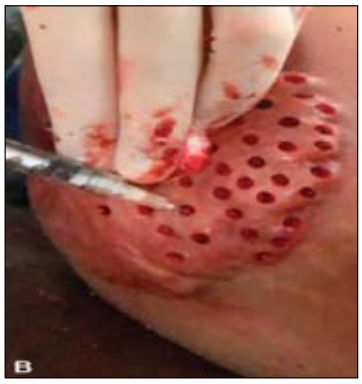


Fig 1.
A, Keloid tissue pop outs with use of a 4-mm biopsy punch.
B, Easy administration of intralesional triamcinolone acetonide within keloidal tissue through the created holes.

- Inamdar et al described a simple, cost effective method to combat heat tolerance in patients with anhidrosis using a thin cotton shirt, some waterproof material and gel icepacks. This simple innovation helped significantly improve the quality of life of patients without incurring a significant financial burden

  **Inamadar, A. C., Palit, A., & Khurana, N. (2017). An Innovative Cooling Jacket to Combat Heat Intolerance in Children with Anhidrosis. Pediatric dermatology, 34(4), 494–496. https://doi.org/10.1111/pde.13144**

- Reduction of Blister Formation Time in Suction Blister Epidermal Grafting in Vitiligo Patients Using a Household Hair Dryer. **Arora, S., & Kar, B. R. (2016). Reduction of Blister Formation Time in Suction Blister Epidermal Grafting in Vitiligo Patients Using a Household Hair Dryer. Journal of cutaneous and aesthetic surgery, 9(4), 232–235. https://doi.org/10.4103/0974-2077.197045**

- In patients of SJS-TEN, always there is an issue of skin fragility and sticking of the skin to the clothing and dressings. So to combat this problem we can use banana leaf as a non-adhesive dressing.

  **Srinivas, C. R., Sundaram, S. V., Raju, A. B., Prabhu, K. S., Thirumurthy, M., & Bhaskar, A. C. (2006). Achieving asepsis of banana leaves for the management of toxic epidermal necrolysis.**

**Dr. Ankita Choudhary,**
**Senior Resident,**
**Hindu Rao hospital Delhi**

# ....Genes are not destiny... Dr. Prateek Nayak in conversation with Dr. Manoj Srinivasa

Dr. Manoj Srinivasa is a consultant dermatologist at Dhanvanthri Health Care, the Centre for Human Genetics, Bangalore; consultant dermatologist at Amar Jyoti hospital; and former consultant at Oliva skin and hair clinic, Indiranagar, Bangalore.

He graduated from J.J.M Medical College Davangere and pursued MD Dermatology from K.V.G. Medical College & Hospital, Sullia. He started his career as a practitioner in Kerala and journeyed through various clinics and medical colleges to finally find his calling.

Apart from being extremely satisfied and happy with his 'career meal', he is an ardent table tennis player (former national player of Karnataka) who also derives therapeutic pleasure from cooking and is often found preparing sumptuous meals for his family, comprising of two young kids and his wife, an obstetrician and chief IVF expert at Motherhood, Bangalore.

Dr. Manoj Srinivasa was an invited faculty in Kerala Mid-Cuticon 2022 and spoke about genodermatoses and the role of practicing dermatologists. As part of the organizing team, I could hardly pay attention and was left curiously hinged on his talk. So, when the opportunity came knocking, I dragged my curious self all the way from Kochi to Bangalore to further understand the role of practicing dermatologists in genodermatoses.

In true Bangalorean spirit, Dr. Manoj invited me for breakfast at Third Wave Coffee café, and as we conversed over coffee and sandwiches, the glaring reality of genodermatoses in India became apparent but the new dawn with CHG and the team seemed like a hopeful beginning.

## Centre for Human Genetics & Epidermolysis Bullosa

### What is centre for human genetics?

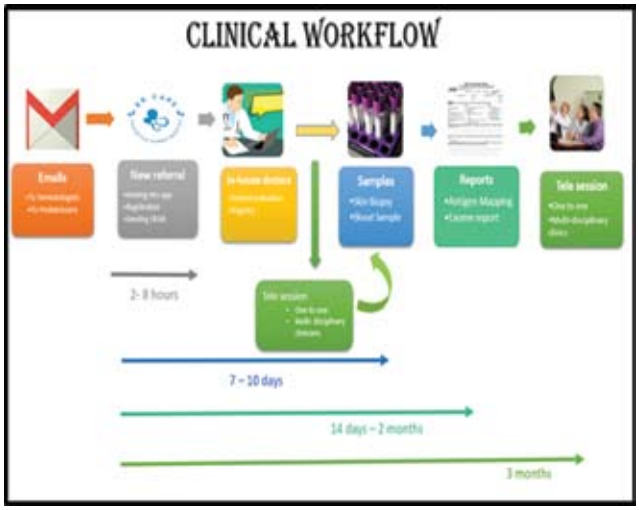
The Centre for Human Genetics (CHG) is a scientific organization that is involved in advanced research, education, and specialized training in human genetics, and also provides a platform that enables scientists and clinicians to provide diagnostic & counselling services for various genetic disorders. Epidermolysis Bullosa is just a small part of it and we as a team work from RH (Dr. Ravi Hiremagalore) lab providing end-to-end support for EB patients and clinicians involved in EB care.

### What is the workflow in CHG? How does a patient referral to CHG work? What is an EB-Kit?

Epidermolysis Bullosa Care and Registry Program primarily aims to establish a registry and estimate the disease burden. In addition, it is directed at characterizing the spectrum of mutations in the Indian patient cohort and providing wound care and further management of the diseases.

CHG sends information brochures through emails to dermatologists and pediatricians. Once a new referral is created, within 2-8 hours, the patient is contacted and

explained about the program. They are then invited to register on the Epidermolysis Bullosa Care and Registry Program (EB-CARP) application and an EB-Kit is sent. EB-CARP application has videos demonstrating wound care for both doctors and caretakers.




EB-kit contains a lancet to rupture the bullae and dressing material for a month's time. The cost of the kit is around 7-8 thousand rupees but we are able to provide it for free with help of the grants. Dr. Ravi Hiremagalore (Paediatric Dermatologist and Principal Investigator) and Dr. Gurudata (Faculty Scientist) have been largely successful in getting national and international grants being approved.

### How do you counsel the family?

Always remember, genes are not destiny. Do not put a white flag and devoid the family of hope. Explain the need for a biopsy and blood workup before giving a definitive diagnosis. Depending on antigen mapping, explain to parents the expected prognosis and role of multi-disciplinary teams in future complications. Teach them about wound care and dressing techniques. Educate them about possible crowdfunding options and other NGOs doing similar work. The most important aspect is genetic counselling and providing the family with one viable child – educate them about various ART techniques available and guide them to centers providing them the same.

Counselling session: Entire team with EB child

EB clinic in one of the medical colleges

### What has CHG run EB program achieved till date?

Over the last 7 years, we have successfully enrolled 220 patients into the study. Additionally, around 160 patients have registered in DocPluse and 55 patients are using the EB-CARP app. A total of 134 samples were sent for clinical exome sequencing and 105 were done free of cost. The wound care and dressing cost have drastically come down for those who have enrolled in the study. By means of the hub-and-spoke models across Karnataka, we have been able to reduce the financial burden on the patients Five families have been successfully directed for prenatal diagnosis.

## The challenges ahead

### What lies ahead?

Firstly, the greatest obstacle for any disease in India is lack of awareness, which in the case of EB can transcend to doctors as well. There is no Registry or

government-funded awareness program for EB. Isn't it our responsibility to reduce the burden of disease for future generations by actively educating the population about the ills of consanguinity and the advantages of genetic counselling?

Moreover, we still rely on western literature for most of our work and there is a definite paucity of data on disease burden and novel genetic mutations in Indian EB patients. A clear understanding of novel Indian mutation will further aid in developing therapeutic options.

Above all, you'll find it surprising to know that the Government of India doesn't recognize EB as a disability and all these lovely kids are deprived of financial aid and other government-sponsored opportunities. How difficult is it for a group of doctors to put in the work and fight to include EB in the disabilities act? The EB registry we are working on will help form a proposal for the inclusion of EB in the list.

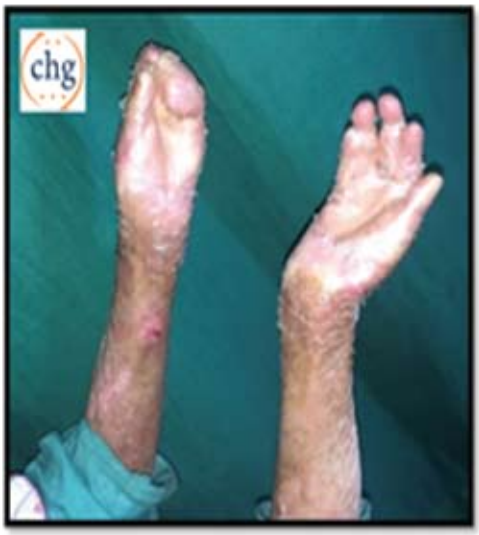
The goals are big. Dreams are even bigger and the work that needs to be done is insurmountable. How do you manage the funding?

Why should we always look for barriers, buddy? How many funding agencies are there? How do you think our EB program is running? Call it dignified begging but the more you ask and the more you work, the agencies are willing to help.

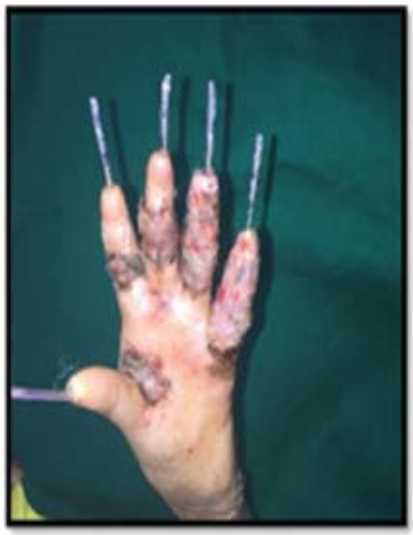
We all know that genetic tests are expensive. Our team approached Neuberg laboratories, showed them the work being done at CHG, and they were ready to help us by reducing the cost of testing. Just by talking and showing the efforts being put in, people are willing to help in some way or the other. Dr. Arun Imandar sir started a grant from BLDE for helping EB patients with dressing and materials, what a great initiative.

Engage your pharma representative to sponsor a session on EB or any other genodermatoses, and sensitize doctors around. You will be surprised to know how many people are just waiting for that opportunity to help. Many a specialist will be willing to do an intervention for free or minimal cost.

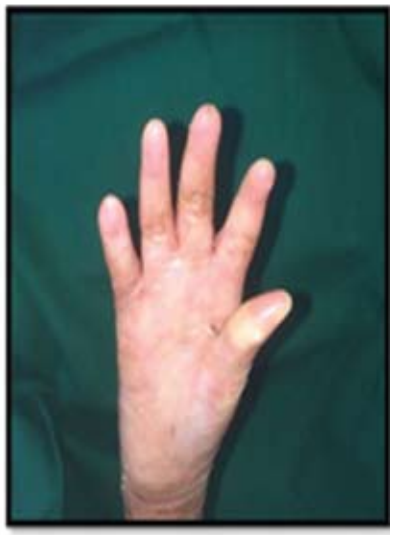
Crowdfunding is another successful tool to help these patients. With help of Ketto (fund raising website), we were able to mobilize funds for a 7-year-old DEB girl child. Reconstructive hand surgery followed by year-long physiotherapy has helped her regain her functions to a certain extent.




DEB child with finger contractures.



Post reconstructive hand surgery.



Crowdfunded through Ketto.

**In-Personal**

**How did you end up at the Centre for Human Genetics?**

Let's be honest here. As PGs, the majority of us would look after an EB child with curiosity and may present the case at the next conference. Apart from basic counseling and care, our hands were majorly tied and there was only so much we could offer. I was no different.

I was aware of the work being done by Dr. Ravi Hiremagalore and CHG through the email communications I used to receive and that was all about it. Call it fate if you may, late 2018 Dr. Ravi Sir called me one day and asked if I was interested in working at CHG. I wasn't sure for how long I could continue and conveyed the same to sir. I started working for two full days a week at CHG which involved both clinical and research related work. It has been 5 years at CHG and I guess I will only get more involved with this work.

**Despite having a flourishing practice and a young family, you have dedicated your time and constant effort to this cause. Do you believe this service-oriented attitude reflects your upbringing or is it a conscious effort towards a holistic living?**

…(chuckles)… I wouldn't call this service at all. As doctors, it is our responsibility to give back something to the fraternity or to society, especially through research. I had an amazing childhood and my parents did a great job with my education and everything, but we were not doing anything extra for the society. However, my schooling at the Sathya Sai Loke Seva alike-muddenahalli, where I had gurukul-like teaching at minimal fees did mould me to normalize this attitude. Though I don't believe in divinity, I acknowledge and appreciate the incredible educational and medical work done by their trust.

**It is easy to get caught up in the demands of life. 'Ye Dil Mange More' nonchalantly replaces 'the needs' versus 'the wants' battle. Where does your balance tilt or better say, what is your 'Ye Dil Mange More' dream?**

Apart from the obvious personal and professional goals, I feel 'EB house' is something really close to my heart. The constant efforts parents have to make for an EB child are insurmountable. In fact, most parents are hesitant to leave their child with a caretaker and are often left alone to manage the child's special needs. 'EB House' will be a well-equipped, fully funded, professionally run centre where parents can leave their child for a few days, under the dedicated care of trained nurses and doctors, and have some personal time to relax and unwind. Apart from managing the day-to-day needs of an EB child, the house will focus on the child's overall growth. Maybe something like a summer camp for EB children and a relaxation camp for parents.

…overtly ambitious and optimistic I believe (Chuckles)…

**You have dealt with many EB cases and constantly living through their journey. But one child or family which will always be close to your heart?**

Bharath (name changed) from Mysore was the first DEB case I saw. He presented with gross deformity and was already operated upon without splinting which led to recurrence. He had come with his parents and younger sibling Sanvitha, who also had DEB (lack of genetic counseling). I developed a personal bond with Bharath while Sanvita was very small and extremely scared of me as she remembered me as the person who did a biopsy on her.

We had to take multiple biopsies for both siblings, but somehow everything seemed to fail to expect the dressing. Bharath was adjusting well to his life, his wounds were healing well, and had recently started learning chess. However, he fell sick and passed away in months' time. It was a very emotional moment for me but we are glad that we were eventually able to provide the family with a viable child. I still believe Bharath returned in a repaired form as the third child.

My very first interaction with Bharath was good

enough to change my perspective. As a resident, I used to see EB cases out of curiosity but now I saw them to make a change in their life. Since then I began to complain a less lot about life in general.

**How do you measure your success when it comes to your work at CHG?**

As a team, we were able to scout for funds and support for a 3-year-old boy with DEB for All-In-One-time feeding gastronomy and circumcision. Following the operation, the child's wound healing time drastically reduced from 2 weeks to 1 week, he gained a healthy weight and is now able to stand and walk slowly. What more? He got adopted by a US-based couple and is growing well. If this isn't a stamp of success of our work, what else can be?

Providing these families with a viable child naturally or assisted reproductive way is another milestone that we really look forward to.

Moreover, a lot more dermatologists are getting sensitized and have shown interest in pursuing EB care locally after our EB conference sessions. I tell 10 people, and at least 2-3 will respond very enthusiastically. After Kerala Mid-Cuticon Dr. Devi ma'am, who was my moderator during the session, invited me to conduct a sensitizing program and multi-disciplinary clinic at Calicut Medical College. Now we are able to refer patients from Kerala to Calicut Medical college for dressing and wound care. Similar clinics have started in Hubli and KIMS, Bangalore. We have directly reduced the mental and financial burden of traveling for an EB child and their family which is again a big success for our program.

You mentioned about 'career meal' during your Mid-Cuticon talk. What is 'career meal' all about?

Initially, when I joined the medical college as an SR, I used to drive 20 km daily to work in Olivia. I did not want to dedicate my life to procedural dermatology but I would have never liked to send patients back because I did not know how to do fillers or Botox. Procedural dermatology or corporate setup work is important for your 'financial health', working in a medical college is important for your 'medical health', your personal self is equally important and what are you giving to the fraternity or what is your contribution to future dermatologists in terms of research is also important. Plan for a career meal, 60% clinical dermatology, 20% procedural dermatology, and 20% research. The percentage may change with age and your interest but keep that healthy scope to manoeuvre between everything.

**Take–away points**

**Where can I send samples for genetic mapping in India?**

Dr. Asha Kubba ma'am (Kubba Skin Clinic, Delhi) and Dr. Raghavendra Rao sir ( Department of Dermatology, Manipal) are doing the genetic mapping. Dr. Asha reports with great intent and you will be able to receive a working diagnosis within 7-10 days.

**What's our role as caregivers? How and where can I start contributing?**

"EB is our problem. We need to own it first and then designate it."

The smallest step you can take as residents or practitioners is to be able to provide wound healing and dressing care to EB children in and around your city. Get sensitized to adequate wound care, learn through online videos, enroll the child with the EB-CARP app, and educate the child's caretaker. Just by providing a local EB help centre you can bring a big change in their lives.

Once you grow over this role of providing clinical care, your next work begins as a co-founder. It is also our responsibility to try and build a team of paediatricians, plastic surgeons, gastroenterologists, dentists, physiotherapists, and nutritionists. You have to put extra effort to sensitize them about the problems faced by EB children, help them frame a plan, and let them attempt to do magic with their skills. And finally, once you have a definite diagnosis with help of a biopsy and blood workup, create a problem chart, discuss it with the multi-disciplinary team, and then work as a receptionist-counseling and guiding families to these specialists for selected

**The team at CHG, Bangalore :** • Dr. Divya Gupta and Dr. Manoj Srinivasa – Dermatologists, • Ms. Charitha and Mr. Raghavendra – Project Assistants, • Dr. Gurudutta – Faculty Scientist • Mrs. Silji- EB Nurse. • Dr. Ravi Hiremagalore– Pediatric Dermatologist and Principal Investigator.

interventions.

'Tell me buddy, is it so hard to do this for 1-2 EB children you may see in a year's time?' asks Dr. Manoj assertively.

**What would be your parting message to our readers?**

I would only like them to ponder over a couple of questions, especially since your readers will be practising dermatologist soon.

Do all of us need to practise procedural dermatology day in and day out?

How hard is to dedicate at least one day of the week to work on the concerns of a patient with EB or any other genodermatoses?

At the end of the day, as dermatologists it is our collective responsibility to address concerns of these patients and contribute towards reducing the genetic burden. There is no dearth of genodermatoses and every genodermatoses has its own problem chart. Start with the simplest thing and make a small change in their lives.

Dr. Manoj ends this interview by acknowledging the presence of mentors at various stages of his journey. He is extremely grateful to Dr. Manjunath P, Dr. Mallikarjuna his HOD at K.V.G. Medical College & Hospital, Sullia for giving him all kinds of exposure during residency; Dr. Rajetha Damisetty at Olivia clinic who taught him the crux of procedural dermatology; and Dr. Ravi Hiremagalore for providing him this wonderful opportunity to be part of clinical research and CHG team and handholding till now.

**Sources to access and read further :**

Refer patient to CHG registry: https://chgregistryapp.appspot.com/ng/mmd/pregister.html?ekey=ahBzfmNoZ3JlZ2lzdHJ5YXBwchMLEgZFbnRpdHkYgICAgPyEhgoM

**Link to EB-CARP application:**

https://play.google.com/store/apps/details?id=com.moxtra.chg&hl=en_IN&gl=US

**Epidermolysis Bullosa Wound Care :**

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3655403/

**Dr. Prateek Nayak**
**Final Year Resident**
**Amrita Institute of Medical Sciences, Kochi.**

# CHASE BANK LOANS – NEUROFIBROMATOSIS- MAJOR CRITERIA

C - Café-au-lait spots
B - Bony abnormalities (sphenoid wing dysplasia, pseudoarthrosis, sphenoid dysplasia, scoliosis)
L - Lisch nodules (iris hamartomas)
O - Optic glioma
A - Axillary/inguinal freckling (Crowe's sign)
N - >1 Neurofibroma or 1 plexiform neurofibroma
S - "Sister" aka 1st degree relative with NF1

**SPOROTRICHOID SPREAD**

**CAT N SPLAT**

C - cat scratch disease
A - atypical mycobacterium ( M. marinum)
T - tuberculosis (lupus vulgaris)
N - Nocardia
S - sporotrichosis
P - phaeohyphomycoses
L - Leishmaniasis
A - Anthrax
T - Tularemia

PCR - Drugs causing pemphigus

Drugs causing psoriasis – PLAB

P - NSAIDS
L - Lithium
A - ACE inhibitors and Antimalarials
B - B blocker

**Drugs causing SJS/TEN**

Natural & Clear SOAP
N - nevirapine, NSAIDS
C - Carbamazepine
S - Sulpha drugs
O - Oxicams
A - Allopurinol
P - phenytoin, penicillin

**BLEND AN EGG – PAINFUL TUMOURS**

Blue rubber bleb
Leiomyoma
Eccrine spiradenoma
Neuroma
Dermatofibroma
Angiolipoma
Neurilemmoma
Endometriosis
Granular cell tumor
Glomus tumor

PCR - Drugs causing pemphigus

P - Penicillamine, penicillin
C - Captopril
R - Rifampicin

**DRUG INDUCED ACNE – PIMPLE**

P - phenytoin
I - Isoniazid
M - Methylcobalamine
P - Progesterone
L - Lithium
E - EGFR inhibitors

**DR. PRIYANKA NAWANI**
**Senior Resident**
**GS Medical college, Hapur**

# NRCC 2022 FOR IADVL GOLDEN JUBILEE : A YEAR OF NEW BEGINNINGS

**As Plato has said, 'The Beginning is the Most Important Part of the Work.' Without the beginning there is nothing. Once a start is made (even not a great start) there is something to build on and improve… The beginnings !!!**

National resident connect committee(NRCC) is a platform involving all the dermatology residents pan India into Indian Association of Dermatologists, venereologists and Leprologists. The idea was rooted in 2014 by Dr Rashmi Sarkar ma'am with a vision to form a group in which dermatology residents from different parts of the country can interact, express, learn and share their knowledge without any limitations or boundaries. It initially started off as a small group called "National Residents' Committee" in which residents were asked to opine on what they think could be done for them from IADVL. The main motto was to make young residents a part of mainstream IADVL and support their young minds.

The initiation was done by releasing the first newsletter named The Resident DREAM(Dermatology Residents' Education and Motivation bulletin). The main goal of the newsletter was to enlighten residents across the nation about various opportunities that lie in front of them along with this it also sensitized the Dermatology fraternity towards the need of making information accessible to everyone and in every part of the country.

The first founding editors of the newsletter were from different parts of the country which included Dr Ishad Aggarwal (Kolkata), Dr Anupam Das (Kolkata), Dr Anuj Tenani (New delhi), Dr Gilian Britto (Bengaluru), Dr Jimish Bagadia (Mumbai), Dr Saloni katoch (Davangere), Dr Samujjala deb (Kolkata), Dr Sumit gupta(New delhi) and Dr Zubin mandlewala (Mumbai)

Now, NRCC has become a reality that is being appreciated by residents and faculty alike, across the length and breadth of this diverse country. Today this name has become familiar to various dermatologists across the country which was only possible because of the untiring efforts of all the residents along with the unconditional support of all the faculty members.

**Why NRCC ? :** Residency has always been a period of confusion with looming doubts about future and post residency practice. Be it the study material, research work, thesis submission, quizzes or various presentations, transition from UG-life to residency is always a bit overwhelming. Seeing all these challenges a national resident committee was formed where all the dermatology residents can interact with their fellows, seniors and various expert teachers in the field. The newsletter released yearly has a mixture of historical trivia, quiz, dermato-pathological corner, case report with approach to common cases, which are discussed by expert teachers with a significant focus on history and examination findings.

Various activities, competitions are organized yearly on occasion of world skin health day, vitiligo day, leprosy day, psoriasis day and so on. The categories included poster submission, article writing, photography and many more!

Every year new committee members are elected from different zones of the country thus giving equal chances to all.

**What all was done in 2022? Activities by NRCC in 2022-23**

The year started off in February 2022 when the new team was given the charge of the Residents' committee. Right after the handover of the committee to fresh convenor, the golden jubilee team was announced on all social media profiles of NRCC.

Introductory meeting of the committee with the president took place over zoom where Dr. Rashmi Sarkar ma'am, gave us a motto; "DO DIFFERENT" and each member of the committee made sure to to follow that, throughout the year.

First task of NRCC 2022 was taken up by all zonal coordinators, which was connecting with college representatives of various medical colleges of their respective zones and compiling a documentary of all of them. Dr Shreya Deoghare (west zone coordinator) then took an initiative and formed a telegram group for all the dermatology residents all over India, to increase the reach of NRCC, far and wide.

In view of further increasing the reach of NRCC and active participation of the residents, Dr Drashti Devani had several ideas of making NRCC's Instagram page richer. The First Instagram series "DermPath" was started in the beginning of March '22, a 12 posts series about histopathology of common disease.

Dr Shreya Deoghare then prepared conference updates for NRCC's page, for the months of march and April.

Next came the occasion of World Skin Health Day, on April 1st! NRCC organized "The Great Mnemonic Competition" to celebrate this International Day of Dermatology world, and the response was enormous with 63 entries. The competition coordinators, Dr Vignesh Narayan, Dr Abirami C., Dr Prateek Nayak and Dr Anand Mannu, worked well in coordination and the judges Dr AS Krishna Ram, from Velammal medical college Madurai and Dr Shekhar Neema, from AFMC Pune, decided top 3 winners.

April was full of milestones for us, NRCC reached 1000 followers on our Instagram page on April 13th!

Immediately after that, on April 18th, Dr Vignesh Narayan launched the next Instagram series of interesting

clinical cases, The Crazy Conundrums. In this a case scenario was presented with clinical, dermoscopic and histopathological images and 4-5 clues to crack the case. The first 5 correct answers, the first 2 who deduce all clues and 2 random winners were facilitated every week. This season had a total of 15 episodes with phenomenal responses.

June came bearing the first and most exciting event for NRCC, Yuva Utsav at Delhi, on 5th of June 2023, organized by IADVL EC and Yuva Cell, where we had a hour long session, with special focus on Residents. That hybrid session was attended by more than 800 dermatologists, both online and offline. There were multiple talks by Dr. Soumya Sachdeva, Dr Vignesh Narayan and Dr Abirami C. The Panel Discussion: Residency Blues, was moderated by Dr Drashti Devani. (You can find recordings of all the sessions on the Instagram page of NRCC! @iadvlnrcc)

June 21st is celebrated as World Vitiligo Day, and to promote the importance of counselling in a case of vitiligo among residents, NRCC came up with a Video making Competition - Counselling of a Vitiligo Patient: Your Way. Competition Coordinators Dr Drashti Devani, Dr Apoorva Maheshwari and Dr Ankita Chowdhry, under the guidance of convenor, received multiple entries which were evaluated by judges, Dr Dhanashree Bhide, HOD, KEM hospital Pune and Dr Pooja Agrawal, Asso. Professor at NHL medical college, Ahmedabad. The Top 3 videos were declared winners.

After the success of DermPath Instagram series, the next series on histopathology was started, on June 23rd '22, DermDetectives, by Dr Drashti Devani. It was a 12 post series about common findings seen in Histopathology slides, and how to find them.

ResiDREAM vol. 9 Issue 1 was being prepared with all hands-on deck throughout the month of august and September, to deliver a top-notch Newsletter to all the residents. Many residents got a chance to be featured, from all over India, in the first edition of this biannual publication.

On September 23rd, another brand-new Instagram series was launched by Dr Prateek Nayak, on Dermatology Drugs: "#UnravelDermatologyDrugs". It was a series with a quiz, similar to Crazy Conundrums, where the residents have to find out the name of a drug from the clues posted, some the usual drugs and some new gangsters (recently in market, or latest FDA approved) were highlighted.

Towards the end of September, on September 23rd, the 1st issue of 9th Volume ResiDREAM Newsletter was released at Mid-Dermacon, Lucknow. The Theme of this issue was "Renaissance in Dermatology." The cover page depicted Monalisa holding a Dermoscope was prepared by Dr Drashti Devani.

Another month, Another Initiative by NRCC! In October, The Instagram Live series: Residency Talks, was started with the first guest as IADVL President '22, Dr Rashmi Sarkar. Since then, every alternate Friday, a live session happens on the Instagram account of NRCC, at 9;30 PM with a new guest every time!

An innovative Instagram series called "Lights Out" was started on october 20th, by Dr Shreya Deoghare, which focused on the importance of morphology and site of dermatology lesions, asking residents to diagnose a disease with a black and white image!

On occasion of World Psoriasis Day, 29th November 2022, NRCC organized yet another educative competition; "Dermatogenesis" (A Pathogenesis explaining competition). The competition coordinated by Dr Shreya Deoghare, Dr Soumya Alice Mathew and Dr Anand Mannu received a great response with over 30 entries. It was judged by Dr Anupam Das, Assistant Professor, KPC Medical College, Kolkata & Dr Soumya

Jagadeesan, Associate professor, Amrita Institute of Medical Sciences, Kochi

In December, the team started preparing for the second volume of ResiDREAM, with many entries received from residents, which you're reading right now!

New Year, New Beginnings! In the month of January 2023, NRCC East zone coordinator Dr Abirami C and member Dr Soumya Alice Mathew began two brand new Instagram series on topics “what’s bugging you” about various micro-organisms of Dermatology and “Dermoscope Diaries” on Dermoscopy, respectively.

February 12th, YuvaUtsav 2023 By IADVL EC and YuvaCell, took place on physical platform, where NRCC had 2 hours-long session, double than last year! The committee members had spoken on multiple Resident-friendly topics, which was a huge hit. The recordings of the session were updated on Instagram account of NRCC.

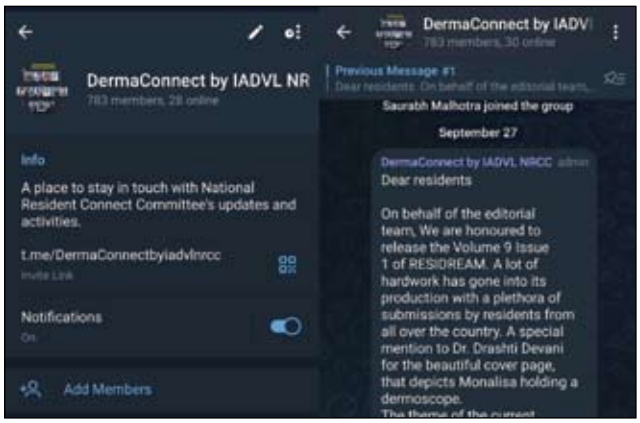
All that begins, comes to an end...

The year 2022 flew by, and NRCC had expanded its wings and broadened its horizons like never before, under the guidance of the president Dr Rashmi Sarkar and Hon. Secretary general and Chairperson Dr Dinesh K. Devaraj. From increasing the presence on social media to connecting with all Residents personally on Telegram Group, from various educational Instagram Series to having Resident centric sessions at YuvaUtsav, NRCC ‘22 had left no tables unturned for the betterment of the dermatology residents of India. We thank the President, hon. Secretary general and Executive Committee of IADVL 2022, for their continuous support and encouragement. As we are handing over the responsibility to the coming team, we wish all the residents and team members of NRCC, the Best!

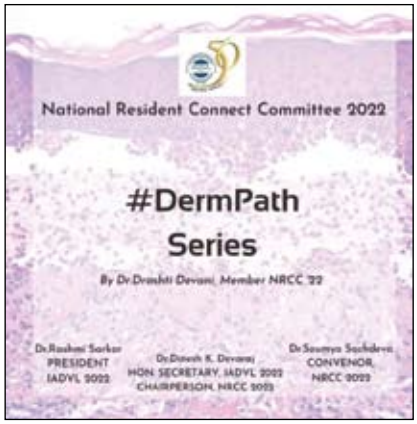
Adios Dear Residents! Long Live IADVL!


Announcement of Team NRCC 2022

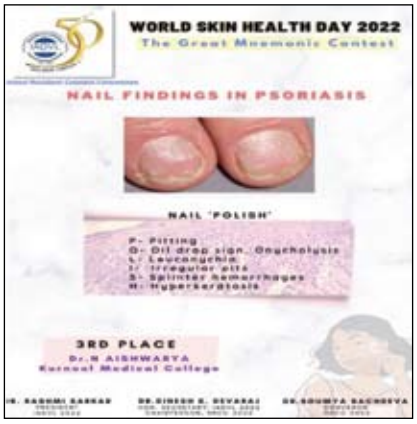
Introductory meet with the President




Telegram group

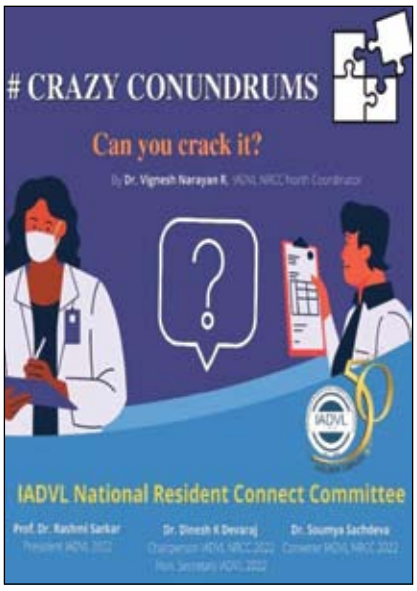







DermPath


Mnemonic competition winners

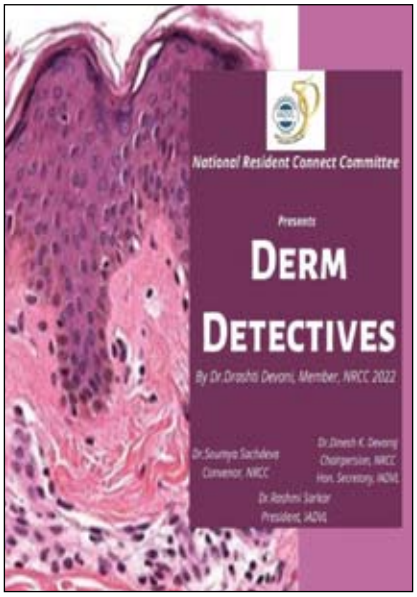



Crazy Conundrums


Conference update


NRCC session at Yuva Meet, Delhi


Vitiligo day competition winners

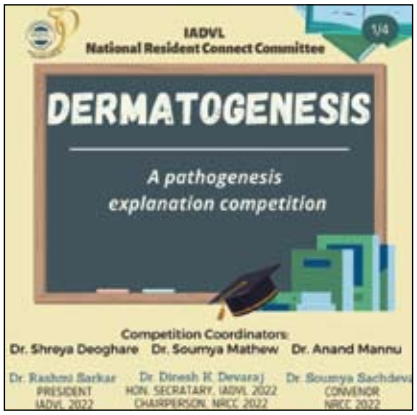



DermDetectives


Unravel Dermatology Drugs

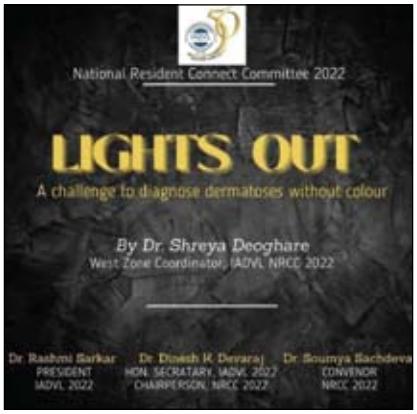

Residream vol 9 issue 1 announcement

Residream vol 9 issue 1 release

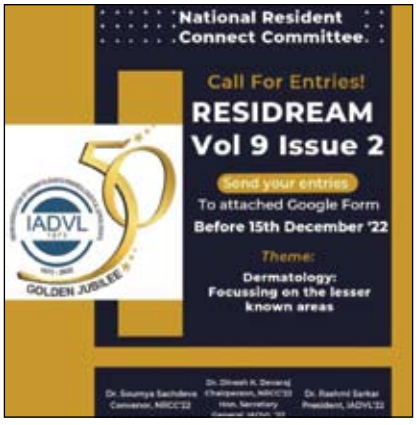



Dermatogenesis competition


Residency talks




Lights out by Dr Shreya Deoghare




call for entries of residream vol 9 issue 2


What's bugging you: Instagram series by Dr abirami C

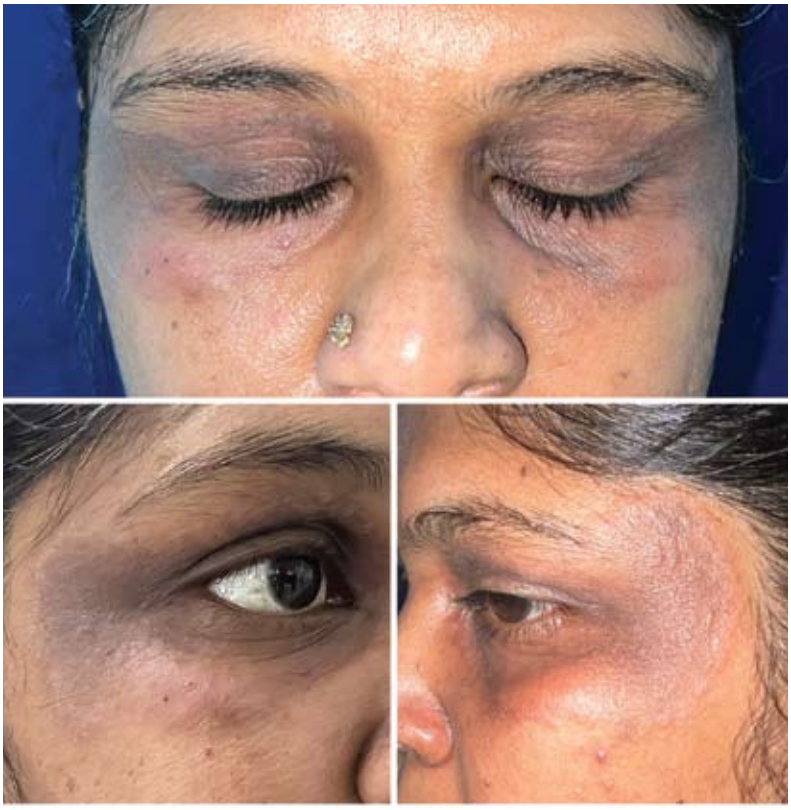

Dermoscope Diaries by Dr Soumya Alice Mathew on Dermoscopy

**Dr. Priyanka Nawani**
Senior Resident
GS Medical college, Hapur

**Dr. Drashti Devani**
Consultant Dermatologist
Clear Skin Hair MD Clinic, Pune

**DR. SUPRIYA SHAKYA**
**Senior Resident**
**NKSC, GMC,**
**KHANDWA, MP**

**DR. ABHAY SHAMSUNDER**
**JR-2**
**BANGALORE MEDICAL COLLEGE**





**Dr. Sadiya Ameen**
**JR-1**
**FIMS, KADAPA**

**Dr. Kolluru Raja Rajeswari**
**JR-3 Santhiram Medical College and General Hospital, Nandyal**


## AWAKENING THY SOUL

I've always been a fan of mind reading
But I realized that is misleading too
Volatile and fickle thoughts are what we read
While I hunt for the subliminal few
A dilemma it is
Similar to the two divergent roads
Similar to the right and left cerebral hemispheres
One goes to the conscious needs
Other to on what our conscience feeds
We're in dearth of people
The sapiens we were meant to be
All I see is machines with bone muscle and skin
With a tinge of materialistic fantasy thing

Emotions- they're intriguing
A story in themselves
We tend to look at the wrong place
And fill the void with doubts
Ifs and buts
Everything's just so superficial
Like we've forgotten to look in the eyes
Like we've forgotten to go any deeper than these faces let us to
Like we've forgotten to look beyond the selfish needs
And to look for these little things
The little hints people drop off
Like it's a part of their heart that they leave in them

It ain't a lecture about rights and wrongs
Or about disaster management
Ain't about human rights or taxations
Neither about heartbreak and love
It's just a rant from a being
A philosophical side of her
Too consumed with trying to search pure emotions
Finding inner peace with honest feelings
Contemplate
Empathize and deduce portions
During this timeless journey

**DR. TWINKLE RANGNANI**
**Narendra Modi Medical College,**
**LG Hospital, Ahmedabad**

## Happiness this way

Led a life of joy and comfort.
Thought it would always be the same throughout.
Is it destiny or something that I got upon myself ?
I'm standing at the end of this road screaming for help!

So many things coming my way into frame.
Doubting if things will ever be the same .
Don't know if this is how life is supposed to be,
Or did I make a wrong turn? Is it just me?

All the hopes on me are too high ,
But I sometimes think what if I said goodbye,
And lead a life in which my soul would soar,
But I don't know what my goal is anymore.

This was what I might have always dreamed of.
Now they have all become possible enough,
But it's turned out to be so hard to do,
That it would make me hope that dreams hadn't come true.

Do I have to leave the nest with bruises patched?
Can I not grow with the roots still attached?
Will I find a new me, a new way to which I belong ?
Or will I trip and fall just like I had thought all along?
The only thing I hear is "this is for the best",
Entering a battlefield to put my limits to a test.
Will all those hopes and promises come to defend?
Do all my feelings even matter in the end?

Feels like the wind is taking me places.
No clue where I would land what more phases.
Right now feel like hanging on to my base tight,
But born as a dandelion you are meant to leave the sight.

Hope all will be fine all will be great.
They say this road leads to a great fate.
If you don't hear from me well after I make this turn,
Please let the "Happiness this way" signpost burn.

**Dr. Ashwini D**
**3rd year Post Graduate**
**Department of Dermatology**
**Mysore Medical College and Research Institute, Mysore**

# Mold your own story

Another 365 days,
365 more days to look behind.
Another failed attempt,
another chance to retrospect and unwind.

Bygone is to be learned from,
yet to be forgotten for the good.
Beware of the time to come,
next calendar needs to be within your hood.

Let the tears you cried in 22
water the seeds you wish to plant in 23.
Let the lessons you learned,
guide you to go on a killing spree.

Life is strange, for all!
Sometimes, it gets deranged;
big time or small.

Many are there to mold our story,
we let them do; shame on our glory.
Better be detached; than to feel sorry,
keep your emotions aside, locked in inventory.

Never ever let them destroy it and devour;
show some strength, will and power.
They pretend to be sweet; then reality hits sour,
you better stand still and tall like a tower.

Life is strange, that's all!

Life is too short to regret;
so, just move on and forget.
Life is too busy to compare;
so, just deal with your own affairs.

Life is too hard to live;
so, just smile and forgive.
Life is too tricky to blame;
so, just sort the things in your brain.

**Dr. Hiteshwar Singh Kalsi**
**PG II, Department of Skin & V.D.**
**Saraswati institute of medical sciences, Hapur.**

# The world vs her

While the world always looked for her faults,
She found her own perfections,
While the world detested her pride,
She called it self respect,
While the world hated her arrogance,
She called it her laser focus,
While the world laughed at her failures, she built her own success,
While the world gossiped and bitched,
She created new paths and new friends,
While the world slept at 5 am,
She woke up or slept,
While everyone laughed at her choices,
She created a vision,
While the world thought she was lucky,
She set a higher goal,
While it was she who helped them,
It was they who walked away,
While the world rejected simple things,
She knew not to judge a book by its cover,
While the world watched her fail miserably,
She again stood up,
While the world thought she couldn't,
She moulded herself in burning coal,
The light over there:
That's the diamond like light
From her soul.

**DR. SOUMYA SACHDEVA**
**Assistant Professor, Saraswathi Institute of Medical Sciences & Visiting Consultant, Max Super Speciality Hospital, Vaishali**

# While walking the rugged path

While walking the rugged path,
I stumbled upon a rock and fell to my knee.
I got up, dusted myself, cleaned up my wounds
And I walked further as I felt, why me?

The next rock in my way
Was dealt with cautiously;
With the scars of my old wounds
I crossed them gracefully.

While walking the rugged path,
The weather wasn't so considerate.
The rain poured heavily on my path,
Leaving me to my unjust fate.

I walked days through such stormy weather.
Hoping someday I'll walk dry and clean:
Until the rain became my daily routine
And felt just like water trickling down my chin.

While walking the rugged path,
A gushing river trespassed my way.
Couldn't walk across it, the current so strong
Carried me along with it few miles away.

Just as I thought this was the end of it all,
The gushing river taught me to swim.
I could then skillfully ride the current
And I crossed a river with a grin.

While walking the rugged path,
The paths of many others crossed mine.
All their paths were cheerful and merry,
That filled me with sorrow but it's fine.

When the final test began,
We all walked the rugged path together.
Jumped the rocks and danced in the rain again
And crossed the river like a feather.

As I drifted through the rugged path,
I realised, it didn't feel so rugged anymore.
I stood at the peak of the mountain
While the others at the rock stumbled and could walk no more.

While walking the rugged path, I learnt something this day.
No matter how hard the situation might be, we'll get through it someday.
Walking through the rocks, rain and river today,
Will make us stronger, tougher and more skilled one day.

**Dr. Ashwini D**
**3rd year Post Graduate**
**Department of Dermatology**
**Mysore Medical College and Research Institute, Mysore**

# Who am I ?
# The Riddle Quiz


1) You last saw me in 1986, you will again see me only in 2061. Two brothers best know me. I am benign and love my family. I believe, you need to 'C' one to believe one. Who am I?
2) As I sift through gulleys, two brothers with scars along their mouth- cast a net and pull out my antlers -selling them for 5 carat gold. Who am I?
3) I am versicolor, or at times pale and blue. I am both bumpy and flat. Thus beta, I live for EVER and EVER after. Who am I?
4) With tooth and nail, I toil and cast my nets. Oh, woe to have a cancerous plaque in my mouth and fall in my blood.
5) For ten days, I have stayed under this Banyan tree, watching fat spotted mushrooms polyp up betwixt the cobble stone path yonder. Who am I?
6) I wear many scars dominantly, a patched eye, splayed ribs, spaces in my jaw and holes in my hand. Who am I?
7) I am dominant and wear 2 ties, yet I am blue because of the rubbery beans. You can treat me with an agent used to coat inserts in your heart. Who am I?
8) When I get pink, red and angry – I circumflex and bend a linear bamboo. Who am I?
9) I speak with an accent as I ride a camel, and in awe I spit my Buckleys into the wax below. Who am I?
10) It's a bright day, I am precocious and early to the CAMP. A camp situated on the coast of Maine, where I draw aromatic water from the ground with my glass. Who am I?
11) With mixed feeling I park my car at the carnival. Oh woe, I am blue at silence of the lambs. Who am I?
12) I love waxy donuts from Germany, but my pet dog is from China and my favourite letter is the 11th Greek alphabet. I am brave as a lion and have a heart of iron. Who am I?

**Dr. Vignesh Narayan R**
**Senior Resident,**
**MS Ramaiah Medical College, Bangalore**


# CROSSWORDS PUZZLE - FIND OUT THE BABIES IN DERMATOLOGY :

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| F | N | L | N | B | C | X | M | N | Y |
| A | I | Z | E | Z | N | O | R | B | V |
| H | F | A | B | L | N | C | Q | E | Q |
| D | F | S | D | F | G | D | H | E | J |
| L | U | Y | E | R | G | E | C | R | K |
| P | M | O | I | U | Y | R | O | Y | T |
| K | Y | L | Q | W | E | E | L | T | R |
| J | R | B | H | G | F | T | L | N | D |
| Q | R | R | L | Q | A | T | O | I | S |
| X | E | Q | J | U | T | A | D | L | I |
| L | B | E | K | D | E | B | I | E | L |
| I | E | R | E | L | Y | R | O | H | S |
| L | U | R | R | Y | W | O | N | C | V |
| O | L | G | T | Y | H | K | E | I | N |
| F | B | N | O | B | R | A | C | M | M |

**Dr. Kolluru Raja Rajeswari**
**JR-3 Santhiram Medical College and General Hospital, Nandyal**

## Clues

1. Complication of phototherapy
2. Parvovirus B19 infection
3. Cyanosis in an infant
4. Hamartomatous disorder involving adipose tissue or smooth muscle
5. Persistence of extramedullary hematopoiesis beyond fetal life
6. Chloramphenicol toxicity
7. Non-accidental trauma produced in a child by the parent or guardian or care-giver
8. A common phenotype to several forms of ichthyosis
9. Gradual and progressive hyperpigmentation involving the entire skin

Answer page no. 40

## Riddle Quiz (Answers)

1) Hailey Hailey disease – named after brothers Hugh Edward Hailey and William Howard Hailey. Hailey's comet was last seen in 1986 and is likely to be seen in 2061. It is also called as familial benign chronic pemphigus, and is caused by mutation in gene ATP2C1.

2) Galli Galli disease – named after two brothers in whom the disease was diagnosed. These patients have a mutation in keratin 5 and have a reticulate pigmentation and perioral scars.

3) Epidermodysplasia verruciformis- These patients may have a mutation in the EVER1 and EVER2 genes on chromosome 17q25. They have an increased risk of infection with beta HPV subtypes and may have plane wart like, pityriasis versicolor like and seborrheic keratosis like lesions. Histopathology typically shows cells in the spinous layer with a pale blue gray cytoplasm.

4) Dyskeratosis congentia- these patients have reticulate pigmentation and premalignant oral leucoplakia in addition to aplastic anaemia and increased dental caries, hypodontia, thin enamel structure. Its also called as Zinsser-Engman-Cole syndrome.

5) Bannayan-Riley-Ruvalcaba syndrome is caused by mutation in the PTEN gene. It manifests as penile lentiges, cobble stoning of the oral mucosa, lipomas and intestinal hamartomatous polyps.

6) Gorlin syndrome (nevoid basal cell carcinoma syndrome) is caused by mutation in the PTCH1 gene and presents with odontogenic keratocysts, bifid ribs absent, palmar pits and multiple basal cell carcinomas.

7) Blue rubber bleb nevus syndrome- also called as bean syndrome is caused by mutation in the TIE2gene and is inherited in an autosomal dominant fashion. One of the treatment options include sirolimus- an agent used to coat cardiac stents.

8) Netherton syndrome- caused by mutation in the SPINK5 gene. It is a cause of infantile erythroderma and these patients characteristically have trichorrhexis invaginate, or bamboo hair.

9) Psoariasis – the accented n sign refers to elongation of the rete ridges with a thin suprapapillary epidermis, hyperkeratosis with parakeratotic mounds. The regular elongation of the rete ridges gives a camel foot appearance. Scraping the plaques of psoriasis results in a moist surface called as Bulkleys membrane, followed by the appearance of pin point bleeding (Auspitz sign).

10) McCune Albright syndrome- characterised by precocious puberty, café au lait macules with coast of Maine border and ground glass appearance of bone on radiology. Urinary CAMP levels may aid in the diagnosis.

11) Carneys complex- caused by PRKAR1A gene mutation- it has blue nevi, ephelids, myxomas. It is also called as NAME/LAMB syndrome.

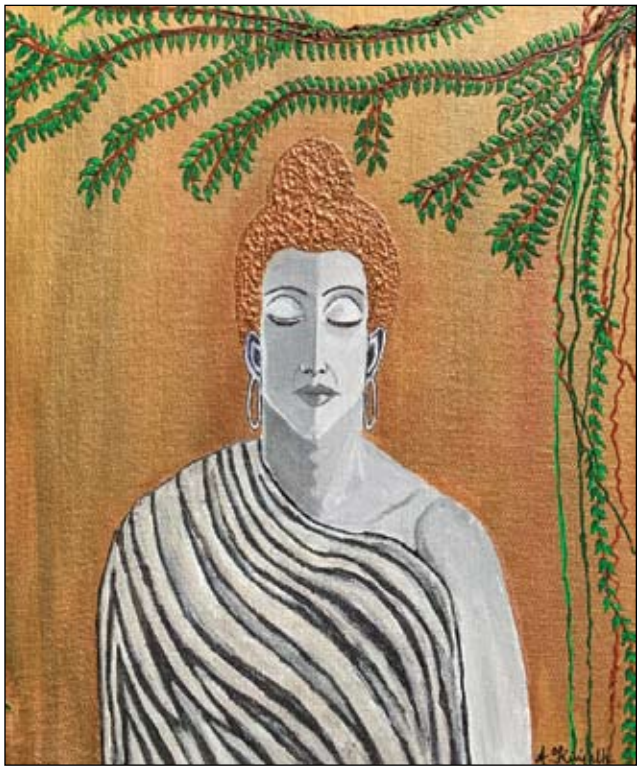
12) Scleromyxedema- presents with plaques on the proximal interphalangeal joints, as a central depression surrounded by an elevated rim (due to skin thickening) ("doughnut sign"). These patients can have a leonine facies and indurated, erythematous skin folds on the trunk "Shar Pei" sign. They typically have a linear arrangement of waxy papules. It is also called as Arndt Gottron disease, and the accumulated mucin stains with colloidal iron.

### CROSSWORDS PUZZLE - ANSWERS

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| F | N | L | N | B | C | X | M | N | Y |
| F | N | L | N | B | C | X | M | N | Y |
| A | I | Z | E | Z | N | O | R | B | V |
| H | F | A | B | L | N | C | Q | E | Q |
| D | F | S | D | F | G | D | H | E | J |
| L | U | Y | E | R | G | E | C | R | K |
| P | M | O | I | U | Y | R | O | Y | T |
| K | Y | L | Q | W | E | E | L | T | R |
| J | R | B | H | G | F | T | L | N | D |
| Q | R | R | L | Q | A | T | O | I | S |
| X | E | Q | J | U | T | A | D | L | I |
| L | B | E | K | D | E | B | I | E | L |
| I | E | R | E | L | Y | R | O | H | S |
| L | U | R | R | Y | W | O | N | C | V |
| O | L | G | T | Y | H | K | E | I | N |
| F | B | N | O | B | R | A | C | M | M |

# DERMA ART GALLERY

**Dr. Harsha Sarawgi**
**JR-2**
**Dept. of Dermatology**
**Medical College, Kolkatta**



**Aarushi Kinjalik**
**Senior Resident**
**Dept. of Dermatology**
**Apollo Hospital, Pune**

# EFFICACY AND SAFETY OF DEUCRAVACITINIB IN PLAQUE PSORIASIS (PHASE III STUDY)

**Deucravacitinib,a type 2 tyrosinase kinase inhibitor (TYK2), inhibits TYK2-mediated signaling of IL-23 and type I interferons and their downstream functional responses and has thus been investigated for its efficacy in management of psoriasis vulgaris. In a randomized, double-blinded, placebo- and active comparator controlled, phase 3 Program fOr Evaluation of TYK2 (POETYK) inhibitor in psoriasis, efficacy and safety of Deucravacitinib was compared with placebo and Apremilast.**

### Inclusion criteria:

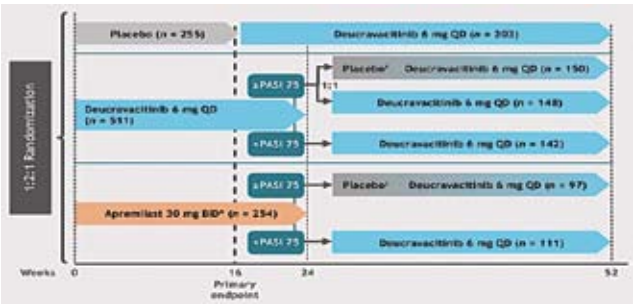
- Adults ≥18 years of age with moderate to severe plaque psoriasis (Psoriasis Area and Severity Index [PASI] ≥12, static Physician's Global Assessment [sPGA] ≥3, and body surface area involvement ≥10%) for ≥6 months before screening were enrolled.
- Patients with a history of prior therapy, including biologic therapy, were included after specified washout periods before randomization.

### Exclusion criteria:

- Patients were excluded if they had previously received Deucravacitinib or Apremilast.

### Study design:

In this 52-week long trial, 1020 patients were recruited and randomized in a 2:1:1 ratio to Deucravacitinib 6 mg every day (n = 511), placebo (n = 255), or Apremilast 30 mg twice a day (n = 254). The efficacy parameters included ≥75% reduction from baseline in PASI and a sPGA score of 0 (clear) or 1 (almost clear) with a ≥2-point improvement from baseline at week 16.




### Results:

In total, 885 (86.8%) patients completed 16 weeks of treatment, including 456(89.4%),212(83.5%),and217(85.4%)in the Deucravacitinib, placebo, and Apremilast groups, respectively, and 751 (73.6%) patients overall completed 52 weeks of treatment. Significantly more patients receiving Deucravacitinib versus placebo achieved the end points of PASI 75 (53.0% vs 9.4%; P<.0001) and sPGA 0/1 (49.5% vs 8.6%; P<.0001) at week16. Response rates for these outcomes continued to increase through week 24 and were higher with Deucravacitinib versus Apremilast at weeks 16 and 24. Superiority of Deucravacitinib versus Apremilast was also achieved for PASI 90 at week 24 (32.5% vs 19.7%).

Among Deucravacitinib-treated patients who achieved PASI 75 at week 24, responses were maintained through week 52 with continued treatment. Also, durability of effect was observed based on retention of PASI 75 response at week 52 in patients re-randomized to placebo at week 24.

As far as safety data was concerned, during weeks 0-16, nasopharyngitis and upper respiratory tract infection were the most common adverse events (AE) in Deucravacitinib-treated patients, whereas headache, diarrhea, and nausea were more common in Apremilast-treated patients. No new safety signals occurred during weeks 16-52 versus weeks 0-16. Rates of AE-related discontinuations were lower in the Deucravacitinib versus placebo or Apremilast groups.

### Conclusion

According to the above summarized findings, Deucravacitinib was superior to placebo and Apremilast and thus Deucravacitinib has the potential to be an efficacious and well-tolerated, once-daily, oral treatment option for plaque psoriasis.

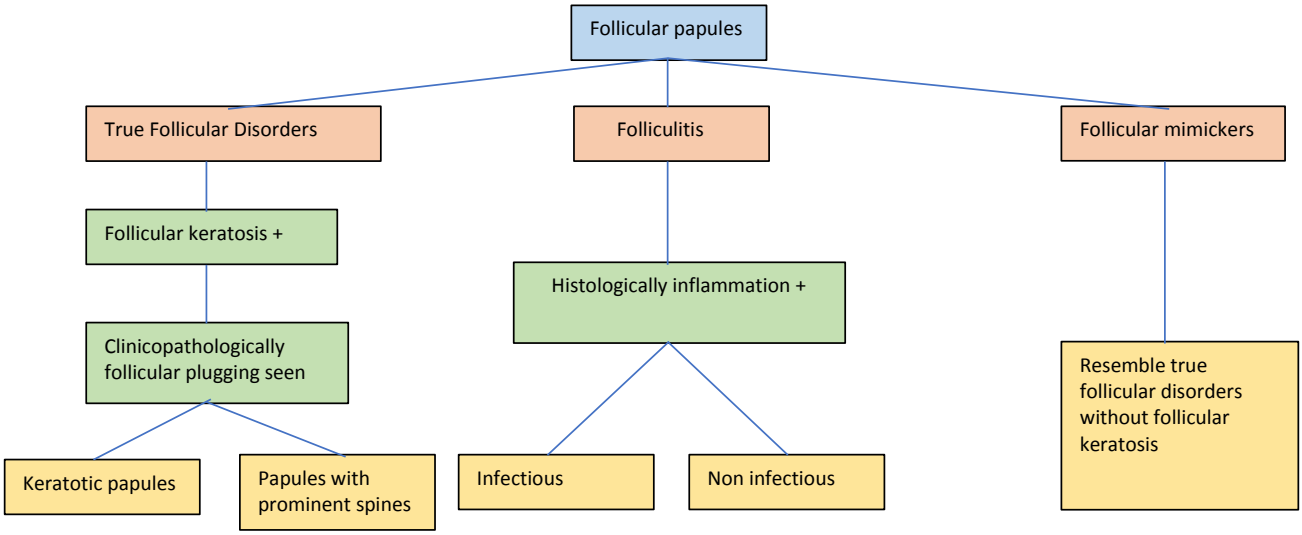
**DR. APOORVA MAHESHWARI**
**Fellow,**
**Medlinks Aesthetics**

# Follicular Disorders – A Review

**Definition:**

Follicular disorders refer to the dermatoses wherein papules are arranged around follicles and adnexae with a central keratotic plug or hair.

**They can be of 3 types:**



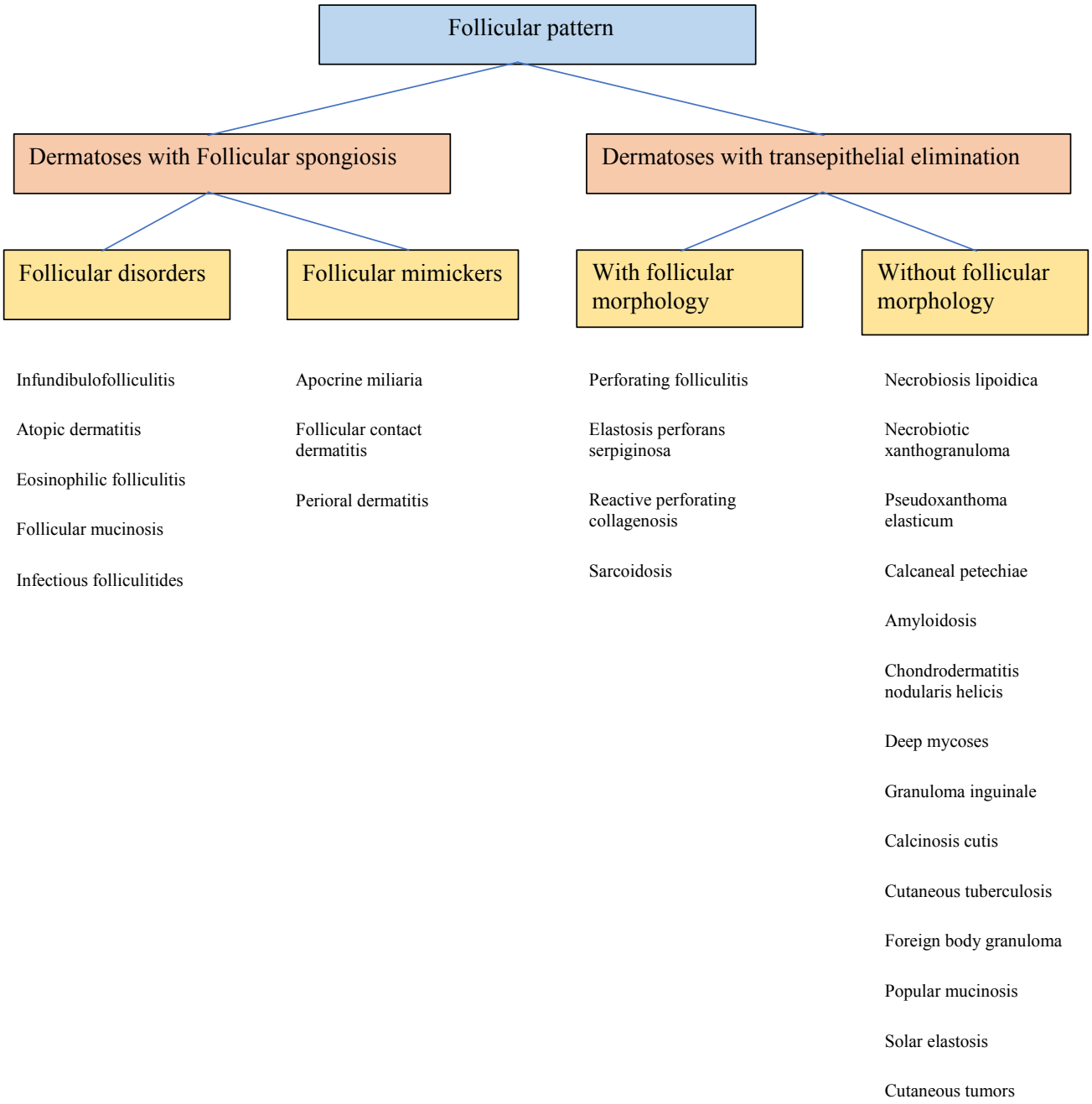

Eg:
- Keratosis pilaris
- Pityriasis rubra pilaris
- Keratosis follicularis
- Papular eczema

Eg:
- Bacterial folliculitis
- Dermatophyte folliculitis
- Herpetic folliculitis
- Molluscum folliculitis

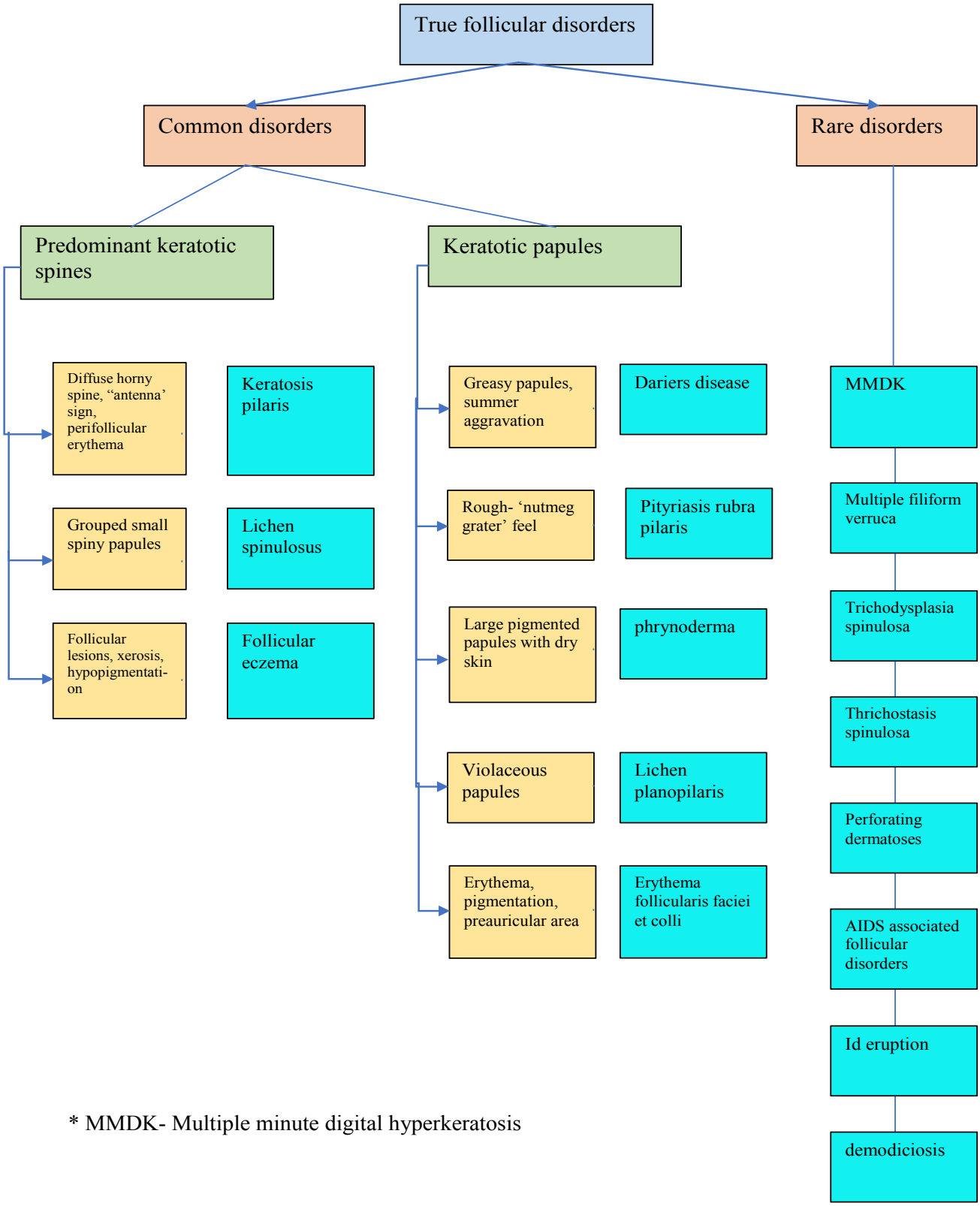
Eg:
- Miliaria
- Lichen nitidus
- Follicular contact dermatitis
- Appendageal tumors of face

**Most common site**: Trunk, extremities; face is relatively rare

**Follicular involvement seen histologically:**

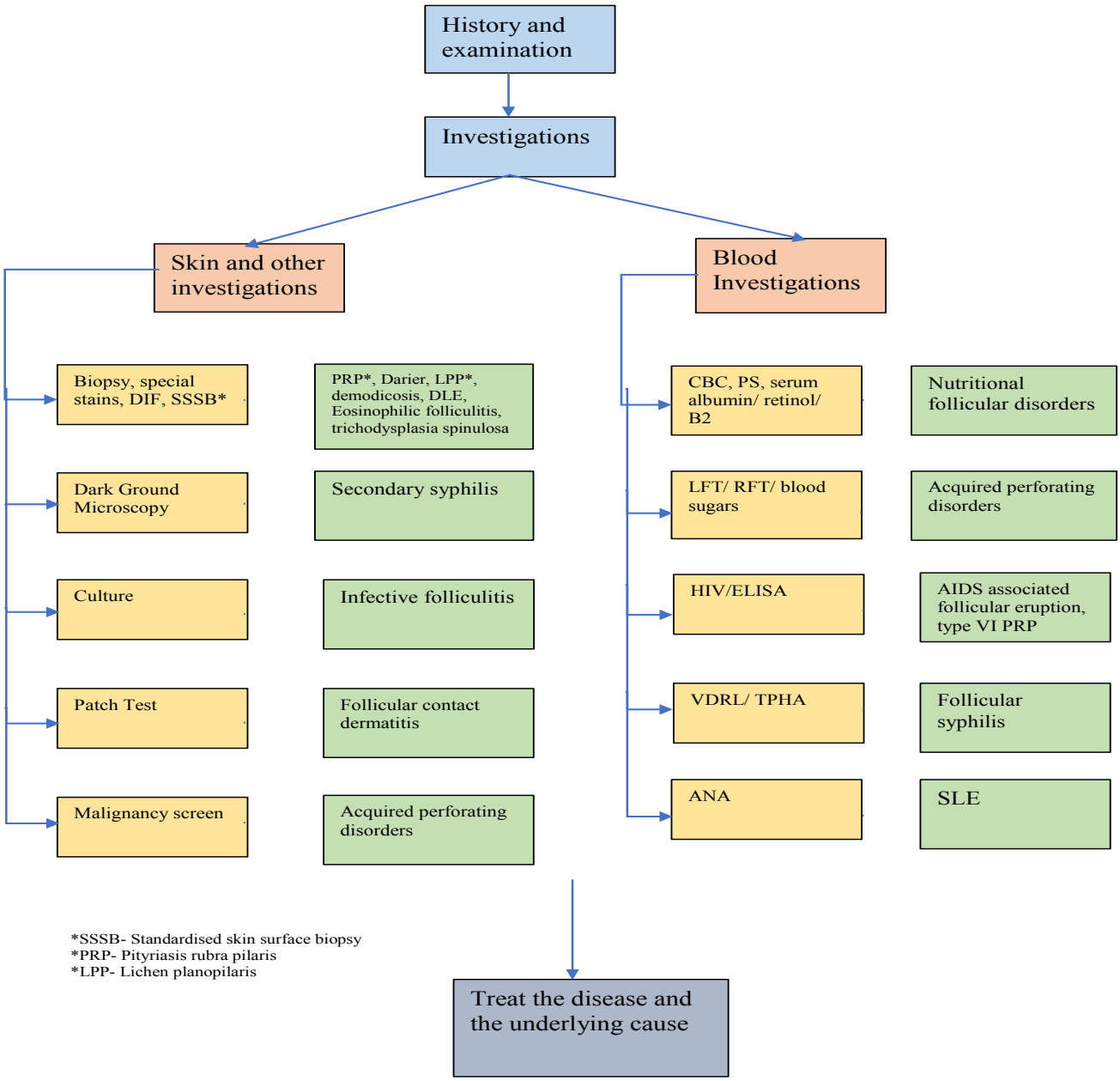


**Various Follicular Disorders:**[1]




* MMDK- Multiple minute digital hyperkeratosis

**Approach to a case of follicular disorder:**[1]




*SSSB- Standardised skin surface biopsy
*PRP- Pityriasis rubra pilaris
*LPP- Lichen planopilaris

**DR. ABHAY SHAMSUNDER**
**JR-2**
**BANGALORE MEDICAL COLLEGE**

# INTRODUCING THE DESMOGLIENS OF NRCC!

National Resident Connect Committee (NRCC) is the official connect group of Indian dermatology residents, under the umbrella of IADVL. The committee is chaired by The Honourable Secretary General of IADVL. Throughout the year, NRCC maps various events, contests and provides residents pan-India a platform to express themselves through the biannual magazine- Residream. Inception of this committee goes back to 2014 when Prof. Dr. Rashmi Sarkar ma'am wanted to unite the young minds of the organization, making them an integral part of the association. Since then, every year, applications are called for the posts of Convenor, Zonal representatives, and members to be a part of this prestigious and illustrious group. The Zonal heads then reach out to dermatology junior residents of various institutes. A volunteer is selected by the residents as the 'Institute Rep' who transmit all communication from the core NRCC group to all residents in their respective center. Thus, NRCC is Of, By and For the Residents!. The Desmogleins of NRCC, the institute reps of this term (2022-23) have enabled multifold growth by getting the word around and thereby ensuring active participation in various activities and media presence. The following is the Zone wise list of Institute reps.

| State | College | Representative |
|---|---|---|
| | **SOUTH ZONE** | |
| **Kerala** | Government Medical College, Kottayam | Dr. Neelima |
| | T D Medical College, Allepey | Dr. Anitha K |
| | Government Medical College, Calicut | Dr. Lenny |
| | Medical College, Thiruvanthapuram | Dr. Nikhila |
| | Malabar Medical College, Calicut | Dr. Neethu Jaleel |
| | Sree Gokulam Medical College, Trivandrum | Dr. Anantha Ghosh A N |
| | Travancore Medical College, Kollam | Dr. Akhil P.R |
| | MES Medical College, Malappuram | Dr. Sneha |
| | Azeezia Institute of Medical Science, Kollam | Dr. Sana Shams |
| | Pushpagiri Institute of Medical Sciences, Tiruvalla | Dr. Shabna |
| | Amrita School of Medicine, Kochi | Dr.Prateek Nayak |
| | Amala Institute of Medical Sciences, Thrissur | Dr.Meekha |
| | Government Medical College, Thrissur | Dr. Satchith |
| | Government Medical College, Pariyaram, Kannur | Dr. Aparna Praveen P |
| | Jubilee Mission Medical College and Research Institute | Dr. Karishma George |
| **Tamilnadu** | Sri Ramachandra Medical College, Chennai | Dr. Cassia Zuleira |
| | Christian Medical College, Vellore | Dr. Namrata |
| | Chengalpattu Medical College, Chengalpattu | Dr. Nivethitha |
| | Stanley Medical College, Chennai | Dr. Saranya |
| | Rajah Mutthiah Medical College, Annamalainagar | Dr. Durgadevi |
| | Madras Medical College, Chennai | Dr. Bagawath prasath |
| | Thanjavur Medical College, Thanjavur | Dr. Aishwarya M |
| | Madurai Medical College, Madurai | Dr. Srinivasan |
| | Kilpauk Medical College, Chennai | Dr. Hemapriya |
| | Velammal Medical College, Madurai | Dr. Shibani |
| | Saveetha Medical College, Kanchipuram | Dr. Neha Mariam Joseph |
| | Sree Mookambika Institute of Medical Sciences, Kanyakumari | Dr. Sushma |
| | SRM Medical College Hospital and Research Centre, Kancheepuram | Dr. Varri Divya Sree |
| | Tirunelveli Medical College | Dr. Aarti Bernett .A |

| | | |
|---|---|---|
| | Coimbatore Medical College, Coimbatore | Dr. Sarvajith S V |
| **Karnataka** | Bangalore Medical College, Bangalore | Dr. Dilip |
| | Mahadevappa Rampure Medical College, Gulbarga | Dr.Bindhu |
| | Father Mullers Medical College, Mangalore | Dr. P Anusha Dsouza |
| | Jawaharlal Nehru Medical College, Belgaum | Dr.Aparajita |
| | Kasturba Medical College, Manipal | Dr. Nivalika |
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# COMMUNICATION IS KEY

Over the past few months I have had to explain to a few female patients who have newly been diagnosed with psoriasis, about the perpetuity and chronicity of the condition. And quite often than not, the patient often broke out in tears. And why shouldn't they? Psoriasis can be quite disturbing physically, emotionally, as well as cosmetically. Getting to explain about the risks of arthritis and pustular lesions is the harder bit because they have already had to accept the existent disease but now they have got to be prepared for its potential complications.

A few days ago a woman walked in with a solitary psoriatic plaque over her knee. She had a history of recurrences and remissions over the past 2-3 years and her only treatment modality had been over-the-counter steroid creams and turmeric paste. She had presumed it was an allergy, all these days, that just wouldn't go, until we broke the news to her.

Another case we admitted last month was one of acute generalised pustular psoriasis. The woman, a known case of plaque psoriasis had stopped her ongoing Methotrexate therapy and moved on to traditional medicines which had led to this, with additional debilitating symptoms. The aggrieved mother however, chose to direct her distress at us until we counseled her along with the daughter.

Tuberculosis still remains widely prevalent and is regarded a taboo in the country. Harder to explain is cutaneous tuberculosis, as the common folk are only aware of the pulmonary kind and refuse to believe that the chronic non healing wound over their skin could be tuberculosis. We had a young girl walk into our OPD with a positive PPD. She was inconsolable and dejected and reluctant to start on ATT despite the diagnosis.

Dermatology on the outside might appear charming and uncomplicated until one is faced with a patient in deep anguish. No amount of medication would calm them down until and unless the doctor spends a good amount of time explaining to the patient in detail what they are going through and what they can expect, answering their questions and allaying their anxiety. Patience, gentleneess and kindness in my experience goes a long way. It could just be the early stages of acne or chronic plaque psoriasis with complications, communication is key!

**DR. EHRA KHAN**
**JR-2**
**Dr. B.R. Ambedkar Medical College & Hospital, Bangalore**

# Creative corner
# Residreary diaries,or was it?!!

The day I landed my post graduation seat, I remember feeling relieved, that life had finally come full circle, that I was done toiling. Getting a ' premium ' branch was supposed to be my solution to all of life's problems and now all the leisures awaited me.

Stupid! Stupid! Stupid!

Cut to a few months later into first year residency. Oh! How the mighty had fallen!

'Leisure' was the farthest thing from what my regular day working at a Municipal hospital Dermatology department looked like.

You walked into your OPD and all hell broke lose . The OPD queues snaking down two floors below, patients grappling you for attention, the bell ringing incessantly, the staff egging you on- ' Kya Madam, kitna time lagate ho,jaldi jaldi dekho na'. You were supposed to be a one stop gap for everything,know and remember everything - from the OPD and the instrument safekeeper, names ,diagnosis,to the patient's financial and sexual history, a bouncer to manage to crowds, a shoulder for your blubbering co PGs, a teacher to your wide eyed juniors, a computer wizard( Technologically challenged ol' me can now practically assemble a printer - trust me, a heft kick works best), Flash with superhuman speed to complete your procedures,biopsy and return to your assigned spot.

All I wanted to do was run away.

Coming from an internship in a Government institute which had next to no exposure in dermatology, I pictured Dermat to be all 'cream' cases , botox ,fillers with a smattering of tinea,scabies,eczema and acne. What more could it be ,anyways?!!

The opd was a great revelation. Every other case was a diagnostic dilemna. Everything looked the same,but apparently was not. Eliciting history was a skill we needed to master quickly. Getting patients to spill their guts about their most intimate habits, getting them to admit the myriad of topical preparatios they'd smeared on their face was not easy. We went by Dr House's adage- Everybody lies. Not to say there wasn't monotony. Hours of exposing patients and writing the same prescription for tinea ,scabies and eczema, we grew complacent. Imagine my crushing disappointment when I was summoned one afternoon and told I had gravely misdiagnosed a Hansen's patient as Tinea in my haste. That was such a lesson and till date , I never let a case go by without a thorough examination and history.

That was just the fun part of the day. Nothing could have prepared me for my first dressing of a Pemphigus case. Dear God! The first time I saw them, the sheer sensory overload and in my mind- 'She has no skin,no skin,no skin' They looked like burns patients but worse. How was I supposed to find a vein to cannulate with her so dehydrated. How was I supposed to coax her twice a day into letting me literally clean off the slough, rupture the large bullae and do dressing. Cajoling the patients to gather the strength for simple tasks like stand,bathe ,walk around. We learnt to counsel from our teachers, to make then believe they'd get better,into having faith. It was indeed gratifying. I will also never forget the day ,this 80year case of Pemphigus Vulgaris (80%BSA)walked out of my ward all better, save for some post inflammatory hyperpigmentation. Wards became our refuge, the nursing staff and even our patients became family. All of us co residents would spend hours writing notes and history,CT sheets, traffic patients to the right investigations, 3 hourly

monitoring, check medications and end up crashing in the doctor's room. The last minute dash to repeat and run abnormal electrolytes, the panic to manage a patient's fever that would not go down, the beautiful balancing act of figuring out just the right dose of Dexona and immunosuppresants , studying frantically so that you could answer in the rounds the next day and most times just racking our brains trying to diagnose a patient. There came a point that our patients began bringing us food . I kid you not, one of the best biryanis, idli sambhar and sweets on Diwali have been brought by adorable patients who took pity on us. The relatives would enquire about our day, scold us when we'd bicker ,comment on our choice of music (Old Bollywood classics for me) and even defend us to our teachers. Family indeed.

It was not all pretty. There were syndromic babies we could do actively do nothing for but monitor.The deaths were ghastly. One doesn't imagining losing patients in our branch. What we don't realise is the drastic morbidity from connective tissues disorders , Hansen's and the effervescent SJS,TEN. Nothing we did, could save patients with severe systemic involvements and some just arrived too late. 21 year old with sclerodactyly and recurrent Raynaud's, 25 year old pregnant female in SLE crisis, Neuropsychiatric LE, Young males with gross deformity due to Hansen's, housewives dealing with severe recalcitrant leprosy reactions, a 2 month old child with SJS and the list is never ending. Why do the worst conditions afflict those who can't afford the bare minimum. We felt so helpless. How do you counsel the forlorn relatives about the hopeless situation.

We didn't even realize when we transitioned from the overwhelmed, frightened kids to these self assured,albeit still confused Doctors at the end of three years. Third year brought with it the scary 'T' word. Hours of chewing data, writing ROLs, flowery language and generally regretting your non existent biostatistics skills. All of this while managing your daily schedule, personal life and study,study, study. We manifested and prayed and bargained to pass our M.D. exams. You live and your learn. Everyone teaches you. Right from the staff working with you, your juniors, your teachers, peers and most importantly, your patients. Every case is different and so is their response to therapy. Residency leaves you a lot more patient and humble than you started out. You realize there will always be a million things reeling out of your control at any point of time.All you can do is ,put in the work and let the rest slide.At the end of it ,I learnt simply, things turn around. We're so fortunate to be a part of this beautiful intricate branch.Nothing is worth your mental peace. Wait for the moment of utter peace you feel when a patient walks away from your care, all healed,or the joy of having your diagnosis come true in a histopath report, the relief when a patient finally starts responding to therapy. The litte things all add up and what is meant to be will find its way to you. Wait for it.

**DR. RUCHITA SARKAR**
**SR**
**GMERS Gandhinagar Civil Hospital**

# A patient who taught me Endurance and Faith: a case of extensive Pemphigus vulgaris

On one regular OPD day, a 40-year-old female patient of biopsy proven Pemphigus vulgaris was referred to us, for management of extensive disease. She was a working mother and only breadwinner of the family. On Dermatological examination, thick adherent crusts were covering full face, chest, axilla, inframammary area, whole back, and few lesions were present over the extremities. Few eroded areas were also present. Lips showed crusted and erosions were present on buccal mucosa. Eye lids were immobilized due to crusting and conjunctiva was congested. She was miserable. She told us "Madam bohot taklif ho rahi hai, bacha lo muje." Somehow from the very first-time I saw her, I felt that this lady needs to be saved and I will do everything in my capacity to try and get her back to her normal life.

Her treatment was started with methylprednisolone cyclophosphamide pulse therapy and IV antibiotics along with supportive treatment & nutrition. All routine investigations were done, with Procalcitonin levels, blood culture and skin swab for culture and gram staining. Sepsis is the most dangerous and common complication of pemphigus vulgaris, because of disrupted epidermal barrier and iatrogenic immunosuppression. Crusted lesions act as growth media for the infective agents to proliferate. As a resident, it was my duty & responsibility to ensure proper dressing, and asepsis. We aimed to eliminate all hotspots of bacterial growth. We advised the patient to cut her hair, and she understood. She was in excruciating pain, but she had faith in us, and followed every instruction given.

Daily Dressings, twice a day, were a part of my routine during the time she was admitted. Hyper-diluted condy's solution (in cooled down boiled water in a sterile container) to soak all her crusted lesions was used to facilitate removal of crusts. Her scalp was cleaned with the same solution. After soaking and removing of the crust, chloromycetin ointment was applied to thick crusts. Sterile paraffin gauze dressing was put on eroded areas. She was instructed to lie down on bed covered with Autoclaved Banana leaves in the first few days, later on sterile gauze pads soaked in liquid paraffin were used.

During our dressing sessions we use to talk, where I learnt that she used to work at a hospital and how she is the only one supporting her family. I used to tell her that "you are strong, you'll come out of this, and we are here to help you through it."

Just talking to your patients during dressing or daily rounds, in chronic cases like pemphigus vulgaris and toxic epidermal necrolysis, has a considerable impact on their mental health and gives them hope and strength to sustain the suffering. It increases the cooperation from the patient side as well. She took interest in learning how to dress such lesions at home and I happily taught her. During those conversations I also explained to her about her disease, and how she will need long term therapy, it's side-effects and how to manage them. These all ultimately lead to better adherence to the treatment regime and long-term suppression of the disease.

For first few days her lesions were progressive, new lesions appeared and large confluent area of denudation and crusting, covered entire back, buttocks, chest, neck, and major areas of abdomen. Face was completely covered with erosions and crusting including ears. Slowly and steadily, lesions begin to heal. New crush formation was reduced and re-epithelization started. Finally, after 14 days of

medicinal effects and local care, she was ready to go home. Figure 1 and 2 shows evolution of her lesions on back and face respectively.

I was delighted to send her back home, all better. She is in regular follow-up with us, and her disease is under control with low dose oral corticosteroid, oral methotrexate, and monthly Dexamethasone cyclophosphamide pulse therapy. During the whole process of managing her case, my professor Dr. Dhanashree Bhide provided guidance, support and motivation and I am extremely grateful for her to teach us every little aspect of patient care and its relevance. She taught us to have a patient-centric mindset. This was an extraordinary tale about a patient who would have landed up into serious life-threatening complications, if was not given importance to asepsis and local care, and how those few hours of a day spent in her care taught me some principal aspects of patient-care in dermatology diseases. Chronic Dermatological diseases take a toll on patients' mental health along with burdening their pockets, affecting all over quality of life, thus considering all these aspects of patient care, should be the end goal of a treating physician.

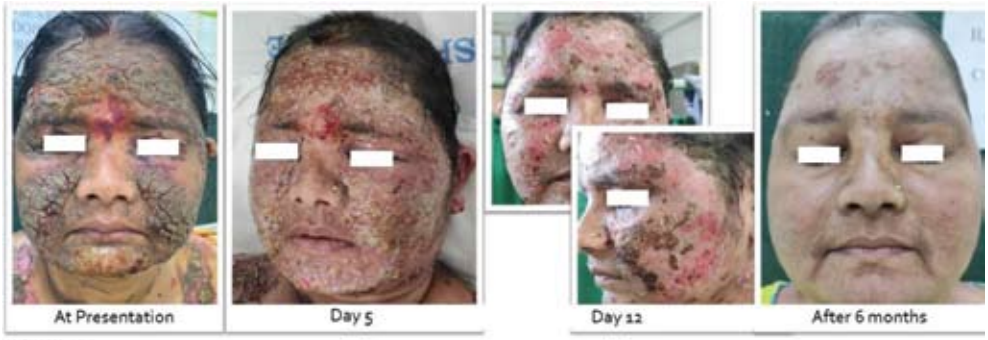
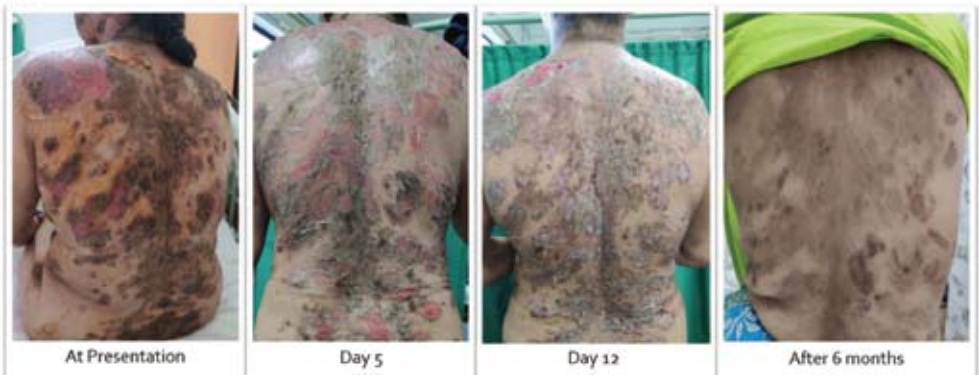



Figure 1

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